Webinar Logistics

• The lines are muted. If you wish to mute/unmute your line to ask/answer a question, please do the following:
  • To **unmute** your own line, **press** *7
  • To **mute** your own line, **press** *6.

• Throughout the presentation and during the Q&A session, if you have a question, please use ReadyTalk’s ‘raise your hand’ feature or use the chat box to indicate you have a question. The facilitator will call your name and ask for your question.
PROJECT REQUIREMENTS:
ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

Reena Chudgar, NACCHO
Setting the Gold Standard for CHAs and CHIPs

• Your work will set the standard for others!

• Demonstration Project Key Features:
  • Engaging community members and LPHS partners in a meaningful way.
  • Addressing the social determinants of health.
  • Using QI and quality planning techniques.
The CHAs conducted should consider multiple determinants of health, especially social determinants like social and economic conditions that are often the root causes of poor health and health inequities among sub-populations in their jurisdictions.

Sites must engage non-traditional partners (i.e., those not historically involved in community health improvement processes) to address the root causes of health inequities in their communities. (CHIP)
The project seeks to ensure that the CHAs conducted have a particular focus on the following:

- **Identifying populations** within their jurisdictions with an inequitable share of poor health outcomes;

- **Assessing the social determinants of health** in their jurisdiction and ensuring that they are considered in indicator and data source selection, data collection, and data analysis; and

- **Include relevant data and other resources from the County Health Rankings project** will be used to help understand these (social determinants of health) conditions.
Webinar Learning Objectives

1. Present to their partners and to community members the variety of elements that relate to or impact social health and health inequities.

2. Discuss why examining and addressing the root causes of health and health inequities is important in health improvement efforts.

3. Identify which additional partners, particularly non-traditional partners, need to be invited to participate in their community health improvement process to ensure a focus on the social determinants of health and health inequities in the site’s CHA and CHIP.

4. Discuss the Barry-Eaton District Health Department’s and its partners’ efforts to focus on discussing the social determinants of health or health inequities with community members, local public health system partners and elected officials in preparation for focusing on these issues in the CHA and applying a social determinants of health model to CHA conduct and CHIP development.
5. Identify the types of indicators that may need to be considered in a CHA to gather information on the social determinants of health and health inequities among sub-populations.

6. Describe how the social determinants of health are relevant within the context of PHAB accreditation, including in the PHAB CHA and CHIP-related Standards and Measures Version 1.0.

7. Re-state the CHA/CHIP demonstration site project requirements for addressing the social determinants of health.

8. Identify what their site needs to do in the next three months to position itself to meet the CHA/CHIP demonstration site project requirements for addressing the social determinants of health in the CHA and CHIP.
Addressing the Social Determinants of Health in Community Health Assessment

Julie Willems Van Dijk, RN PhD
University of Wisconsin Population Health Institute

Anne Klein Barna, MA
Barry-Eaton District Health Department

January 11, 2012
PHAB Standards & Specific Mention of Social Determinants of Health, Disparities, or Equity

- Community Assessment—Health status disparities, health equity, and high health risk populations must be addressed (Standard 1.1.2L)

- Data Collection—May collect data on social conditions (such as unemployment, poverty, or lack of accessible facilities for physical activity) (Standard 1.2.4L)

- Data Analysis—May consider social conditions that affect health and may consider reports of health disparities (Standard 1.3.1A)
Evans & Stoddart Multiple Determinants of Health, 1994
RWJF Commission to Build a Healthier America. Overcoming Obstacles to Health, 2008
Health Outcomes

Mortality (length of life): 50%
Morbidity (quality of life): 50%

Health Factors

Health behaviors (30%)
- Tobacco use
- Diet & exercise
- Alcohol use
- Unsafe sex

Clinical care (20%)
- Access to care
- Quality of care

Social & economic factors (40%)
- Education
- Employment
- Income
- Family & social support
- Community safety

Physical environment (10%)
- Environmental quality
- Built environment

Programs and Policies

County Health Rankings model © 2010 UWPHI

NACCHO
National Association of County & City Health Officials
Healthy People 2020

A society in which all people live long, healthy lives

Overarching Goals:

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.
Do we know how much each of the major determinants contributes to health?

a. Historical perspective
b. Literature review
c. Analysis of ability to predict health outcomes
Historical Perspective

1930-1950: Sanitary revolution and improvements in environmental health
1950-1970: Increasing role of health care
1970-1990: Contribution of health behaviors (smoking/diet/exercise) increases
1990-present: Social and economic determinants
The Case For More Active Policy Attention To Health Promotion

To succeed, we need leadership that informs and motivates, economic incentives that encourage change, and science that moves the frontiers.

by J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman
Review of the Literature

The oft cited McGinnis et al (2002) paper states: "...using the best available estimates, the impacts of various domains on early deaths in the US distribute roughly as follows: genetic predispositions, about 30%; social circumstances, 15%; environmental exposures, 5%; behavioral patterns, 40%; and shortfalls in medical care, 10%."
## Analytic Approach

<table>
<thead>
<tr>
<th>Determinant Category</th>
<th>Empirically Derived Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care</td>
<td>21%</td>
</tr>
<tr>
<td>Health behaviors</td>
<td>27%</td>
</tr>
<tr>
<td>Social and economic factors</td>
<td>55%</td>
</tr>
<tr>
<td>Physical environment</td>
<td>-3%</td>
</tr>
</tbody>
</table>
Speaking to Our Partners
(From A New Way to Talk About the Social Determinants of Health, Robert Wood Johnson Foundation, 2010; http://www.rwjf.org/vulnerablepopulations/product.jsp?id=66428)

- Avoid jargon—such as social determinants
- Connect with messages they believe in
- One fact—not dozens
- Offer solutions
- Incorporate the role of personal responsibility
- Mix conservative & progressive values
- Focus on improving health for all
Factors that Affect Health

Smallest Impact

Socioeconomic Factors

Largest Impact

Changing the Context to make individuals’ default decisions healthy

Long-lasting Protective Interventions

Clinical Interventions

Counseling & Education

Examples

- Eat healthy, be physically active
- Rx for high blood pressure, high cholesterol, diabetes
- Immunizations, brief intervention, cessation treatment, colonoscopy
- Fluoridation, 0g trans fat, folic acid fortification, iodization, smoke-free laws, tobacco tax
- Poverty, education, housing, inequality

### Health Factors

- **Health behaviors (30%)**
  - Tobacco use
  - Diet & exercise
  - Alcohol use
  - Unsafe sex

- **Clinical care (20%)**
  - Access to care
  - Quality of care

- **Social & economic factors (40%)**
  - Education
  - Employment
  - Income
  - Family & social support
  - Community safety

- **Physical environment (10%)**
  - Environmental quality
  - Built environment

### Possible Partners

- Addiction specialists, Educators, Advocacy groups, Policy makers, Faith leaders, Wellness coordinators, Bar owners/tenders, Health care providers, Community members

- Health care providers (all types), Ombudsmen, Advocacy groups, Community members

- Educators, Business owners, Policy makers, Advocacy groups, Labor Unions, Neighborhood organizations, United Way, Economic development, Law enforcement, Community members

- Planning/Zoning, Transportation, Foresters, Community members
Social Determinants of Health Indicators

- Use your model to guide your indicator selection
- Treat all determinant areas as actionable
- Disaggregate as many indicators as possible
- Consider multiple ways to disaggregate data:
  - Race/ethnicity
  - Income
  - Education
  - Geography
  - Gender
Data Set Directory of Social Determinants of Health at the Local Level


Introduction

There is widespread interest in the role of social health determinants at the local level. Federal, state, and local government agencies, academic institutions, and community organizations are increasingly recognizing the need to understand and address the socioeconomic contexts; such as, where people work and play to improve their health and welfare. There is renewed emphasis on implementing interventions to improve socioenvironmental conditions. Such interventions have the
Possible Data Categories

- Economic security and financial resources
- Livelihood security and employment opportunity
- School readiness and educational attainment
- Environmental quality
- Availability and utilization of quality medical care
- Adequate, affordable, and safe housing
- Community safety and security
- Civic involvement
- Transportation
Engaging the Community on the Social Determinants of Health in the Capital Counties, Michigan (Clinton, Eaton, Ingham)

January 11, 2012
Our efforts to focus on discussing the social determinants of health or health inequities with community members, local public health system partners, health department staff, and elected officials.
Barry-Eaton District Health Department and Mid-Michigan District Health Department

• Serve Eaton and Clinton Counties, respectively
• Serve primarily “rural/suburban/non-minority” communities with medium to high median incomes
• Relatively conservative values and view of limited role of government entities – however there are a sizable number of moderate independents

• Traditionally have focused on service provision, such as narrowly defined categorical clinical services (WIC, Immunizations, Family Planning) and Environmental Health (assurance of Public Health Code, etc.)
Ingham County Health Department

- Serves the City of Lansing (the capital city of Michigan), a Midwest post-industrial community with sizable populations of color and persons living in poverty.
- the rest of the county (“out-county”), is similar to Eaton and Clinton counties in income, land use, mindset.
- Serves East Lansing, home to Michigan State University (40,000 students) with a large community of students and faculty.
- Historically a more progressive health department.
1998-2008 Ingham Community Voices / Capital Area Community Voices
See chapter 3 in Community Voices: Health Matters by Treadwell, Po, and Perez (2011)
Notion: working ‘with’ rather than ‘for’ the community and leading from behind

“It represents a movement to create change from the bottom up. It is the antithesis of ‘officials’ telling the man on the street what’s best for him.”

Five community practices for accelerating community improvement:
• Engaging and mobilizing community members
• Facilitating dialogue and creating connections
• Identifying and supporting civic leadership
• Using all the assets of the community for change
• Sharing and using data and information to support and monitor progress
Dialogue methodology has become ‘the way we do things here’
Dialogue is different than **DEBATE**.

<table>
<thead>
<tr>
<th>Debate</th>
<th>Dialogue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highlights competing factions</td>
<td>Highlights commonality of purpose</td>
</tr>
<tr>
<td>“Best” solution</td>
<td>Multiple, complementary solutions</td>
</tr>
<tr>
<td>Emphasis on persuading</td>
<td>Emphasis on listening</td>
</tr>
</tbody>
</table>

‘Facilitated Dialogue’ is adapted from the Technology of Participation methods developed by the Institute of Cultural Affairs. [http://www.ica-usa.org/](http://www.ica-usa.org/)
2005  Ingham County Social Justice Project Began

2008  Social Justice Facilitator Cohort 1 Trained

2008  Social Justice Workshops Began

Hundreds of health department staff (primarily ICHD) and community members have completed a four-day workshop on social justice and health equity concepts, resulting in an increase in recognition of the importance of social determinants of health, a decline in the perceived importance of behavior on health outcomes, and nearly 8 in 10 recognized opportunity and power as social determinants.
Distinguishing Disparity from Inequity

**Health Disparity**

A disproportionate difference in health between groups of people.

*(By itself, disparity does not address the chain of events that produces it.)*

**Health Inequity**

Differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.*

*Margaret Whitehead*
DISCUSSION:

What do you notice about this picture?

How might it depict the difference between “disparity” and “inequity”?
Where does Prevention Begin? Where do we Focus?

Social Determinants of Health

The economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole.

They include, but are not limited to:

- Safe Affordable Housing
- Quality Education
- Job Security
- Social Connection & Safety
- Living Wage
- Access to Transportation
- Availability of Food

Dennis Raphael, *Social Determinants of Health*; Toronto: Scholars Press, 2004
Root Causes

- Institutional Racism
- Class Oppression
- Gender Discrimination and Exploitation

Power and Wealth Imbalance

- Labor Markets
- Education Systems
- Globalization & Deregulation
- Housing Policy
- Social Safety Net
- Social Networks
- Tax Policy

Social Determinants of Health

- Safe Affordable Housing
- Living Wage
- Quality Education
- Transportation
- Availability of Food
- Social Connection & Safety
- Job Security

Psychosocial Stress / Unhealthy Behaviors

Disparity in the Distribution of Disease, Illness, and Wellbeing

Adapted from R. Hofrichter, *Tackling Health Inequities Through Public Health Practice*.
In Eaton County...

Telling the story of public health to our board of health: www.healthiestnation.org

Board Orientation and Ongoing Education: Allowed us to introduce the notions of
- the difference between ‘healthcare’ and ‘public health’
- 10 essential services
- disparities
- policy change
What makes someone healthy...or not? How can we prevent you from being unhealthy?
Prevention: Behaviors and Conditions affect health

**Behaviors**
- Tobacco Use
- Substance Misuse
- Poor Nutrition
- Lack of Exercise

**Conditions**
- Targeted sales
- Marketing/No taxation
- Food Deserts
- Poor infrastructure
Hold a film-viewing and dialogue session using an episode from the film as the ‘trigger’ information – you might also include local data relating to the topic of the episode.
Many of the concepts discussed in the social justice workshops are addressed in this course.

Need to get yourself or your team up to speed quickly? Take the Roots of Health Inequity Web Course!
### Changing the Questions

<table>
<thead>
<tr>
<th>Instead of only asking:</th>
<th>Perhaps we should also ask:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Why do people smoke?</strong></td>
<td><strong>What social conditions and economic policies predispose people to the stress that encourages smoking?</strong></td>
</tr>
<tr>
<td><strong>Who lacks health care coverage and why?</strong></td>
<td><strong>What policy changes would redistribute health care resources more equitably in our community?</strong></td>
</tr>
<tr>
<td><strong>How do we connect isolated individuals to social supports?</strong></td>
<td><strong>What institutional policies and practices maintain rather than counteract people’s isolation from social supports?</strong></td>
</tr>
<tr>
<td><strong>How can we create more green space, bike paths, and farmer’s markets in vulnerable neighborhoods?</strong></td>
<td><strong>What policies and practices by government and commerce discourage access to transportation, recreational resources, and nutritious food in neighborhoods where health is poorest?</strong></td>
</tr>
</tbody>
</table>
Your QUESTION is so important!

Healthy! Capital Counties visioning question.

What would our community be like if everyone had an equal chance of living a healthy life?

versus just…

What are the community’s health needs?
or How can we be healthy?
How have **Social Justice** and **Social Determinants of Health** have been woven into our work so far?

“Some people have fewer opportunities than others to live in good health.”

**WATCH:** Why is Jason in the Hospital?

What indicators would you use to measure whether the community was getting healthier or not? Be creative!

List, then sort
List color-coded:

HEALTH INEQUITY
- Measuring the gap and disparity among the entire populations overall well-being
- Income gap
- Existence and extent of social connection/social capital
- Unemployment
- Affordable and safe housing
- Cultural competencies related to veterans

COMMUNITY CONDITIONS
- Barriers to access
- Community resources
- Parks
- Smoke-free environments
- Resiliency of youth (protective factors of youth in schools, middle and high school age)

FOOD
- Access to healthy foods
- Neighborhood access to affordable fresh produce
- Consumption of healthy food
- Fruit and vegetable consumption
- Nutrition
- Neighborhood food security

HEALTHCARE
- Access to healthcare (3)
- To afford health insurance coverage (2)
- Health coverage and medical home
- Decrease in emergency room use
- Inappropriate use of inpatient care

BEHAVIORS and ADDICTIONS
- Increased physical activity
- Tobacco use
- Tobacco-related death
- Prescription and Over-the-Counter-related Poisoning and Deaths
- Alcohol-related fatalities and injuries

HEALTH OUTCOMES
- Lower rates of diabetes and hypertension
- Improved oral health
- Years of premature mortality
- Longevity (years of life lost)
- Health outcomes

INFANTS and CHILDREN
- Low birth weight
- Infant mortality
- Child abuse
- Sudden Infant Deaths
- Stillborns (drugs, diet, prenatal care)

OBESITY and WEIGHT STATUS
- Healthy weight in all age groups
- Obesity (4)
- Body Mass Index (BMI) (2)
- Children with appropriate BMI
Our Model for How Health Happens:

**Opportunity Measures**
Evidence of power and wealth inequity resulting from *historical legacy, laws & policies, and social programs.*

**Social, Economic, and Environmental Factors** *(Social Determinants of Health)*
Factors that can constrain or support healthy living

**Behaviors, Stress, and Physical Condition**
Ways of living which protect from or contribute to health outcomes

**Health Outcomes**
Can be measured in terms of quality of life (illness/morbidity), or quantity of life (deaths/mortality)
Indicator sources we used:

- LOCAL Advisory Committee list
- County Health Rankings
- Health Indicator Warehouse section on social determinants
- Healthy People 2020 Critical Health Indicators
- LOCAL conversations with knowledgeable local people on specialized topics, such as the built environment or water quality
<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>INDICATOR GROUP</th>
<th>INDICATOR</th>
<th>MEASURES</th>
<th>SOURCE</th>
<th>Geographic Level *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity Measures</td>
<td>Income</td>
<td>Income Distribution</td>
<td>Gini coefficient of income inequality</td>
<td>ACS</td>
<td>HCC geo groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Housing Segregation</td>
<td>Gini coefficient of minority-headed households</td>
<td>ACS</td>
<td>HCC geo groups</td>
</tr>
<tr>
<td>Social, Economic, and Environmental Factors</td>
<td>Social and Economic Factors</td>
<td>Income</td>
<td>% children in poverty</td>
<td>ACS</td>
<td>HCC geo groups</td>
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<tr>
<td></td>
<td></td>
<td>Education</td>
<td>Education distribution in &gt;25 adults</td>
<td>ACS</td>
<td>HCC geo groups</td>
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<tr>
<td></td>
<td></td>
<td>Social Connection &amp; Support</td>
<td>Social Capital</td>
<td>BRFS</td>
<td>HCC geo groups</td>
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<tr>
<td></td>
<td></td>
<td>Community Safety</td>
<td>Rate of violent crimes per person</td>
<td>Possibly uniform crime report/MSP</td>
<td>HCC geo groups</td>
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<tr>
<td></td>
<td></td>
<td>Affordable Housing</td>
<td>Households who spend more than 30% of income on housing</td>
<td>ACS</td>
<td>HCC geo groups</td>
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<tr>
<td></td>
<td></td>
<td>Quality of Care</td>
<td>Rate of Ambulatory-Care Sensitive Hospitalizations (Preventable)</td>
<td>MDCH Vital Statistics</td>
<td>HCC geo groups</td>
</tr>
<tr>
<td></td>
<td>Environmental Factors</td>
<td>Environmental Quality</td>
<td>% water wells showing evidence of significant nitrate contamination</td>
<td>Local Health Departments</td>
<td>HCC geo groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Built Environment</td>
<td>Food desert status</td>
<td>USDA</td>
<td>Census tract</td>
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<tr>
<td>Behaviors and Physical and Mental</td>
<td>Diet and Exercise Obesity</td>
<td>Weight Distribution (BMI Categorical)</td>
<td>Weight Distribution (BMI Categorical)</td>
<td>MIPHY</td>
<td>County</td>
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<tr>
<td>Condition</td>
<td>Tobacco</td>
<td>Current Smoking in adolescents</td>
<td>Current Smoking in adolescents</td>
<td>MIPHY</td>
<td>County</td>
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<tr>
<td></td>
<td>Alcohol Use</td>
<td>Binge Drinking in adolescents</td>
<td>Binge Drinking in adolescents</td>
<td>MIPHY</td>
<td>County</td>
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<tr>
<td></td>
<td>Access to Care</td>
<td>Persons with a primary medical provider</td>
<td>Persons with a primary medical provider</td>
<td>BRFS</td>
<td>HCC geo groups</td>
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<tr>
<td></td>
<td>Communicable Disease Prevention</td>
<td>% children 19-35 months who receive recommended immunizations</td>
<td>% children 19-35 months who receive recommended immunizations</td>
<td>MCIR</td>
<td>HCC geo groups</td>
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<tr>
<td></td>
<td>Mental Condition</td>
<td>Mental Health</td>
<td>Adolescents with major depressive episodes</td>
<td>MIPHY</td>
<td>County</td>
</tr>
<tr>
<td></td>
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<td>Poor mental health days in adults</td>
<td>Poor mental health days in adults</td>
<td>MIPHY</td>
<td>County</td>
</tr>
<tr>
<td>Health Outcomes</td>
<td>Maternal &amp; Child</td>
<td>Maternal &amp; Child</td>
<td>Low birthweight births</td>
<td>MDCH Vital Records</td>
<td>HCC geo groups</td>
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<td></td>
<td>Quality of Life</td>
<td>Quality of Life</td>
<td>Perceived health status (good vs. poor)</td>
<td>BRFS</td>
<td>HCC geo groups</td>
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<td>Consequences of Social Norms</td>
<td>Consequences of Social Norms</td>
<td>Alcohol-related motor vehicle injuries</td>
<td>MSP: OHSP</td>
<td>HCC geo groups</td>
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<td>MSP: OHSP</td>
<td>HCC geo groups</td>
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<tr>
<td></td>
<td>Premature Death</td>
<td>Premature Death</td>
<td>% deaths before age 75</td>
<td>MDCH Vital Records</td>
<td>HCC geo groups</td>
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<tr>
<td></td>
<td>Maternal &amp; Child Health</td>
<td>Infant Mortality Rate</td>
<td>Infant Mortality Rate</td>
<td>MDCH Vital Records</td>
<td>HCC geo groups</td>
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<td></td>
<td>Chronic Disease</td>
<td>Chronic Disease</td>
<td>Deaths due to cardiovascular disease</td>
<td>MDCH Vital Records</td>
<td>HCC geo groups</td>
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<tr>
<td></td>
<td>Safety Policies and Practices</td>
<td>Deaths due to accidental Injury</td>
<td>Deaths due to accidental Injury</td>
<td>MDCH Vital Records</td>
<td>HCC geo groups</td>
</tr>
</tbody>
</table>

*HCC Geo Groups = for the Cities of Lansing, East Lansing, and Lansing Township, the geo groups are four groups of census tracts by median home value. For the rest of Clinton, Eaton, and Ingham counties, the geo groups are four groups of townships and cities divided by population density and median home value.
Ideas for Social Determinant Indicators to Include (besides those previously mentioned)

- NACCHO’s list of social determinant domains and examples of possible indicators and sources (e-mailed with the November CHA/CHIP Update)
- CDC’s Data Set Directory of Social Determinants of Health at the Local Level
- Connecticut Health Equity Index Project
<table>
<thead>
<tr>
<th>Social determinant questions…purple alludes to inequity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do people have money to meet basic needs? What about enough to live a life of quality?</td>
</tr>
<tr>
<td>Are kids in our community ready for school? Will every child go to a safe, well-resourced, high-performing school?</td>
</tr>
<tr>
<td>Are people secure in their employment?</td>
</tr>
<tr>
<td>Can all people get health care? Of high quality?</td>
</tr>
<tr>
<td>Does everyone have a safe home at a reasonable price?</td>
</tr>
<tr>
<td>Is the community empowered to improvement through civic action or grassroots action?</td>
</tr>
<tr>
<td>Can people get where they need to go?</td>
</tr>
</tbody>
</table>
Questions and Discussion
Project Reminders

• Community Health Improvement Process Cost-Tracking Report Due by 8 p.m. ET, Tuesday, 1/17/12 to CHACHIP@naccho.org
The next CHA/CHIP training webinar will be on:

‘Collecting Quantitative Data in Your CHA’

Presenters: Julie Willems Van Dijk

Monday, 1/23/12 at 2:30 PM ET

Please complete the evaluation before logging off the webinar.