THE WEBINAR WILL BEGIN SHORTLY

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Working upstream in rural communities: Addressing social determinants of health through the CHA/CHIP

Friday, March 23, 2018

Learning objectives

- Understand Healthy People 2020 social determinants of health framework
- Assess social determinants of health rather than health outcomes
- Hear practical examples from rural communities of selecting social determinants of health priorities
- List tools and resources available on NACCHO's website to facilitate SDOH work

Speakers

Barbara Laymon
NACCHO

Astrid Newell
Whatcom County Health Department

Eric Faisst
Madison County Health Department

Overview of SDOH

Assessing for context or the conditions in which people can be healthy.

AKA: the Social Determinants of Health

Healthy People 2020 Framework

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

- World Health Organization

Improving Community Health in Whatcom County:

A Focus on Social Determinants of Health

Astrid Newell, MD

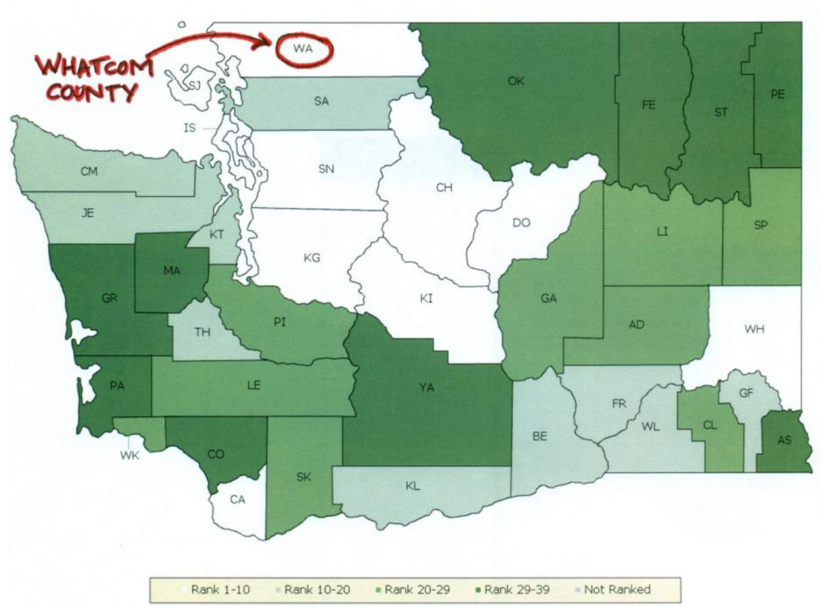
March 23, 2018

Overview

1) Provide snapshot of Whatcom County
2) Review CHA and CHIP processes
3) Discuss tools and resources for focusing on SDOH
4) Highlight two SDOH opportunities from our CHIP

Photo Sources: Wikimedia Commons, The Northern Light, Whatcom Land Trust

Whatcom County Snapshot



- **Population**
  - Size: 210,000 (half urban/half rural)
  - Demographics: Mostly white (80%), growing Hispanic & Asian populations, 2 tribes
- **Community Assets**
  - Higher education, hospital, schools, outdoor recreation
- **Jobs/Economics**
  - Education, healthcare, oil refineries, agriculture, seafood
- **Politics**
  - Divergent (Progressive and Conservative)
- **Health Status**
  - Ranked **5th** healthiest county in the state by County Health Rankings, but...

Whatcom County Health Department

- **Organizational Structure**
  - County government
  - Five divisions (Admin, Community Health, Human Services, Environmental Health, Communicable Disease)
  - Two separate locations
- **Personnel**
  - 82 FTE (99 staff)
- **Governing/Advising Structure**
  - Board of Health = County Council
  - Public Health Advisory Board

Mobilizing for Action through Partnerships and Planning ~ (MAPP) Process

Organize for Success	Community Assessments	Community Health Improvement Plan

Leadership Formation & Partnership Development → Visioning → Community Health Assessment → Strategic Issues → Goals & Strategies → Action ⇄ Evaluation

Sponsors

- Whatcom County Public Health Department
- PeaceHealth St. Joseph Medical Center

Technical Assistance

- Critical Junctures Institute (WWU)

Leadership

- Community Leadership Group

Primary Partnership Groups

- **Public Health Advisory Board**
- **PeaceHealth Community Health Committee**
- **Funders Alliance***
  - City of Bellingham
  - Whatcom Community Foundation
  - St Luke's Foundation (Chuckanut Health Foundation)
  - United Way

* Partial Listing of Funders Alliance participants

Community Health Status
(Quantitative Indicators)

Community Themes
(Qualitative Data)

Forces of Change
(Environmental Scan)

Systems Review
(Public Health, Medical, Dental &Behavioral Health)

Community Assessment Report

Community Health Improvement Plan

Evidence-based community-wide strategic planning process for improving community health. *National Association of County and City Health Officials*

Shared Vision

We are Whatcom County, a people and a place, culturally and geographically diverse, united in our vision for a healthy and vibrant future where:

- **Every child** grows in a safe and nurturing environment;
- **Every person** has access to comprehensive and integrated health services and social supports across the lifespan and spectrum of needs;
- **Every population** shares in the abundance of opportunities for healthy active living, outstanding education, satisfying employment, and meaningful community participation;
- **We all flourish** through our connections and commitments to each other and to the air, land and waters that surround and sustain us.

Created through group process, Dec 2010

Key Assessment Findings

- Disparities hidden among the averages
- Communities experiencing disparities have limited voice, but critical insights and solutions
- Widespread interest and concern about impacts of childhood adversity (“Adverse Childhood Experiences”) on lifelong health and well-being
- Recognition of role of “place” and built-environment in health
- Opioid crisis and housing/homelessness seen as cross-cutting issues

CHIP 1.0 Priorities

Overarching Goals: ***Improve health, reduce disparities, advance equity***

Strategic Priority	***Focus Area***
Community Connectedness and Resilience	*Responding to Opiate Crisis*
Child and Family Well-being	***Supporting Young Children and Families***
Healthy Active Living	***Integrating Health into Community Planning***
Health Care Access and Service Delivery	*Addressing Complex Health Needs*

Community Health Improvement (CHI 1.0)

2011

Whatcom County Community Health Assessment

PeaceHealth St. Joseph Medical Center

Whatcom County Health Department

October 2011 - Revised April 2013

2012–2016

Community Health Improvement Plan

WHATCOM COUNTY

Update September 2013

our community our health

CHI 2.0 in progress…

Going “Upstream”

The “Stream”

Societal Level

Community & Policy Level

Individual & Family Level

Pro-Equity Policies

Affordable Housing

Good Paying Jobs

Access to Healthy Foods & Physical Activity

Incarceration

Obesity

Safe Neighborhoods

Quality Education

Address Structural Racism and Privilege

Healthy Environment

Access to Healthcare

Access to Transportation

Low Birth Weight

Homelessness

Untreated Mental Illness

Health Problems

Political structures & institutional practices that assure fairness & opportunity for all

Social, economic, & physical conditions that allow people to reach their full potential

Services for individuals and families to treat problems

King County, WA, 2011

Going "Upstream"

Early Death

Disease, Disability, and Social Problems

Adoption of Health-risk Behaviors

Social, Emotional, and Cognitive Impairment

Disrupted Neurodevelopment

Adverse Childhood Experiences

Death

Conception

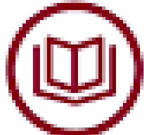
Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

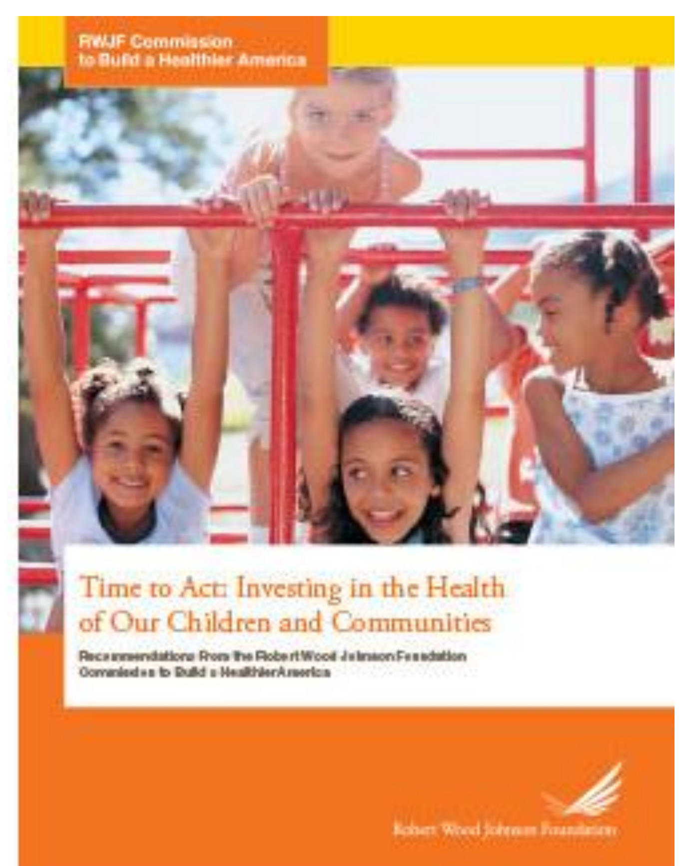
Source: Centers for Disease Control and Prevention
https://www.cdc.gov/violenceprevention/acestudy/about.html

Framing Social Determinants

Whatcom County
HEALTH
Department

A New Way
to Talk About
THE SOCIAL
DETERMINANTS
OF HEALTH




RWJF Commission
to Build a Healthier America
Time to Act: Investing in the Health
of Our Children and Communities

CHIP 1.0 Priorities & Social Determinants of Health

Neighborhood and Built Environment

Health and Health Care

Social and Community Context

Education

Economic Stability

SDOH

Integrating Health Into Community Planning

Supporting Young Children and Families

Source: Healthy People 2020, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

CHIP 1.0 Priorities & Social Determinants of Health

Integrating Health Into Community Planning

Supporting Young Children and Families

Supporting Young Children and Families

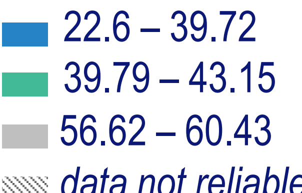
- Children and families consistently identified as priority in CHA/CHIP
- Growing science of early child development and awareness of impacts of childhood adversity compel us to act
- Effective strategies are available

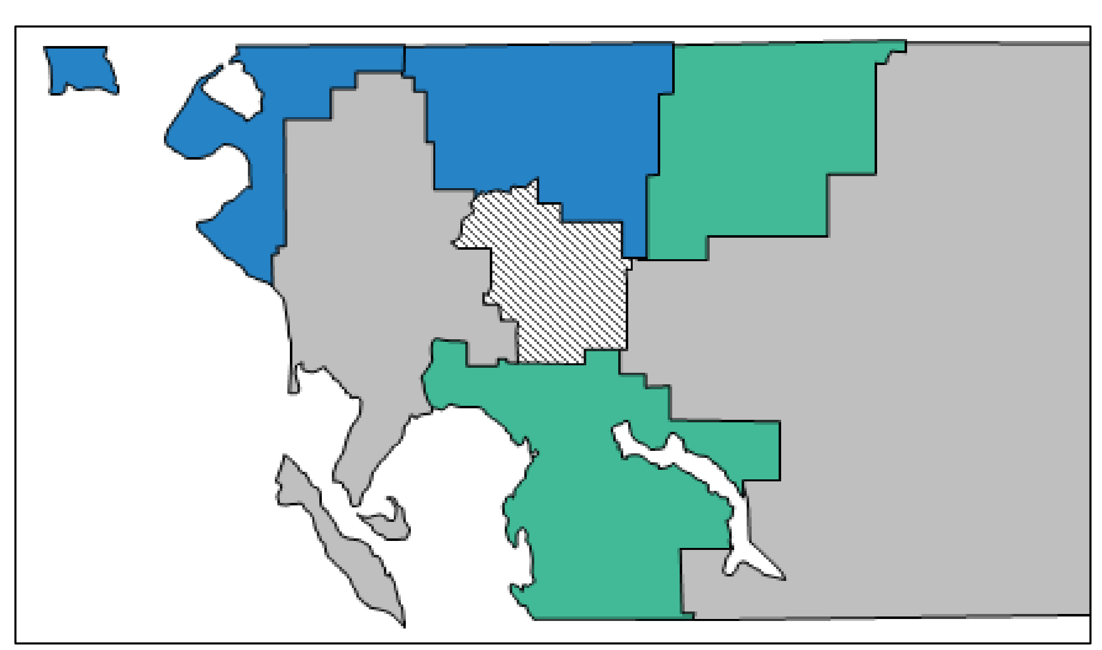
Supporting Young Children and Families: *Key Indicators*

Victims of child abuse and neglect in accepted referrals,
rate per 1,000 children, Whatcom County (DSHS)

Supporting Young Children and Families: *Key Indicators*

Whatcom County HEALTH Department





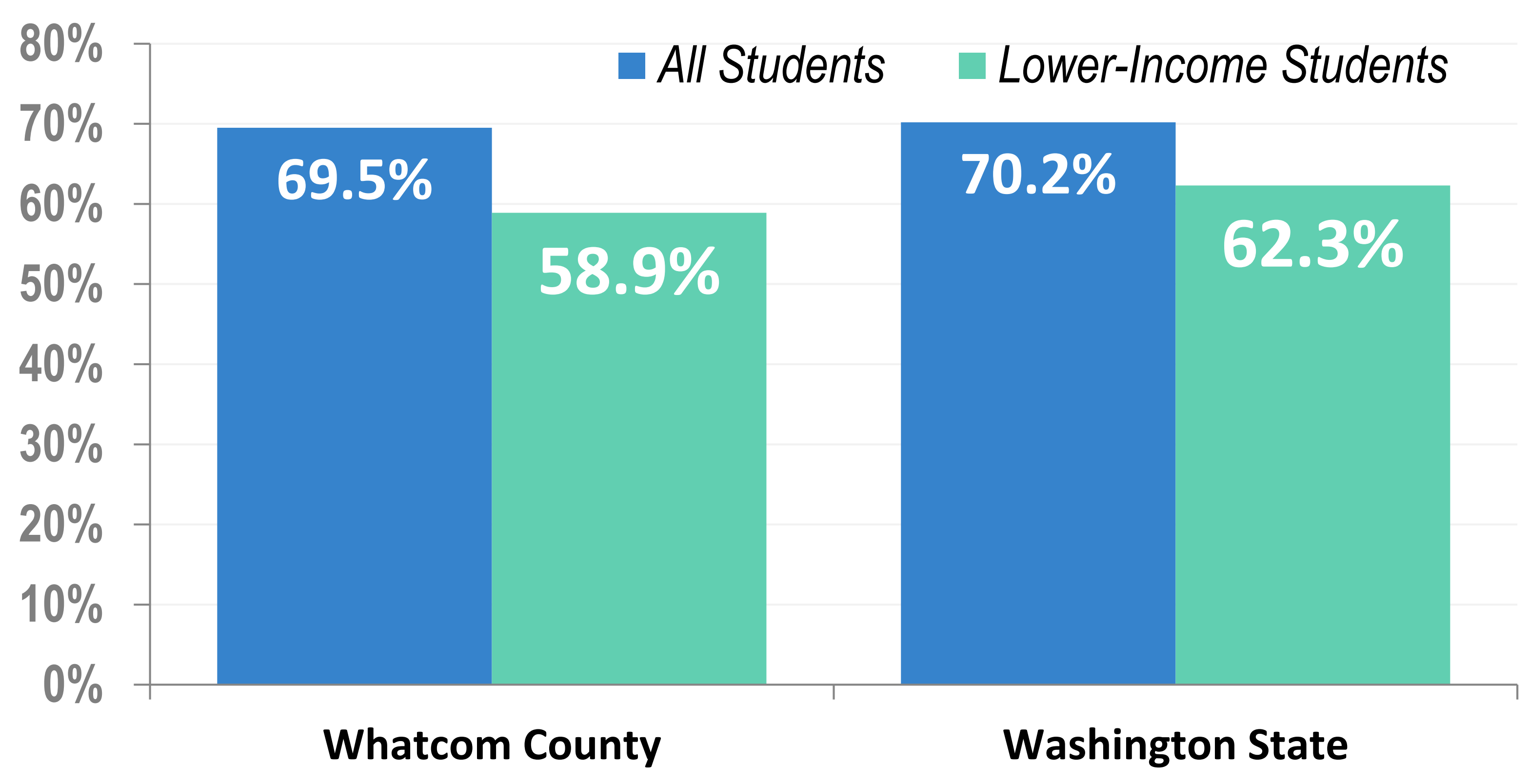
Rate of child abuse and neglect by school district,

Whatcom County, 2005-2016

10 year average rate of child abuse and neglect per 1,000 children (DSHS)

Supporting Young Children and Families: *Key Indicators*

Whatcom County HEALTH Department



Percent of students who demonstrate social-emotional readiness characteristics of entering kindergarteners, 2016 (OSPI)

Supporting Young Children and Families: *From Talk to Action*

Generations Forward Initiative:

Envisioning a Future Where All Whatcom County Children Thrive

A collaborative community initiative focused on enhancing the well-being of young children and their families in Whatcom County

Generations Forward
Future Search Conference
Oct 10-12, 2017

- Co-sponsored by the Opportunity Council and Whatcom County Health Department
- Multi-sector Planning Committee
- Local Funding Support
- 8 Stakeholder Groups
- 74 participants (20+ parents), diverse representation

Generations Forward Initiative

Commitments	What We Want (Results)
• **Overarching Commitment:** All Whatcom County children and families thrive • **Family Economic Stability** • **Child Care & Early Learning** • **Affordable Housing** • **Parent/Family Support and Education** • **Coordinated Services** • **Integrated Health Care** • **Community Building** • **Equity, Culture and Diversity** • **Reliable Financing**	**Children are safe, healthy and ready to learn** **Families are strong, stable and supported from the start** **Communities are welcoming and supportive places for children and families to live, learn, work and play**

Supporting Young Children and Families

Areas of Concern

Strategies & Actions

- **Family Economics**
  - More than one third of families with income less than household survival budget
- **Family Dynamics**
  - Parental mental health and substance use
  - Child maltreatment
- **Child Development**:
  - Social-emotional and behavioral challenges
  - School readiness

- Build **community commitment** and **investment** in:
  - Parenting and family education and support
  - Affordable family housing
  - Affordable quality child care and early learning
  - Health care access (particularly behavioral health supports)

Integrating Health into Community Planning

- Built-environment recognized as important to health
- Groundwork in place (*ACHIEVE and Community Transformation Grants*)
- Technical resources (*ALTA Planning, National Parks Service*)
- Many activated community members

Image: Walking along highway in Kendall area

Integrating Health into Community Planning

Areas of Concern Strategies & Actions

Areas of Concern

- **Healthy Food Access**
  - Food desert in rural East Whatcom County, and some areas within Bellingham
- **Pedestrian and Bicycle Safety**
  - Lack of accessible walk/bike facilities in rural/urban growth areas
- **Safe Affordable Housing**
  - Limited supply of affordable housing options
  - Many housing cost-burdened households/people with housing problems

Strategies & Actions

- Review comprehensive land use plans (City and County) and incorporate evidence-based recommendations
- Support targeted **food access** and traffic safety projects in rural East Whatcom County

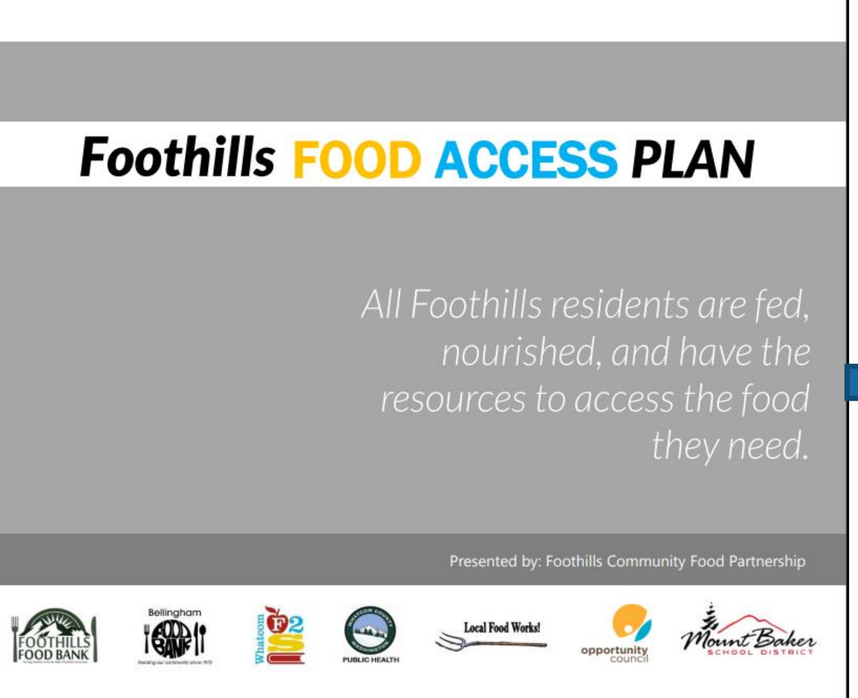
Integrating Health Into Community Planning: *Key Indicators*

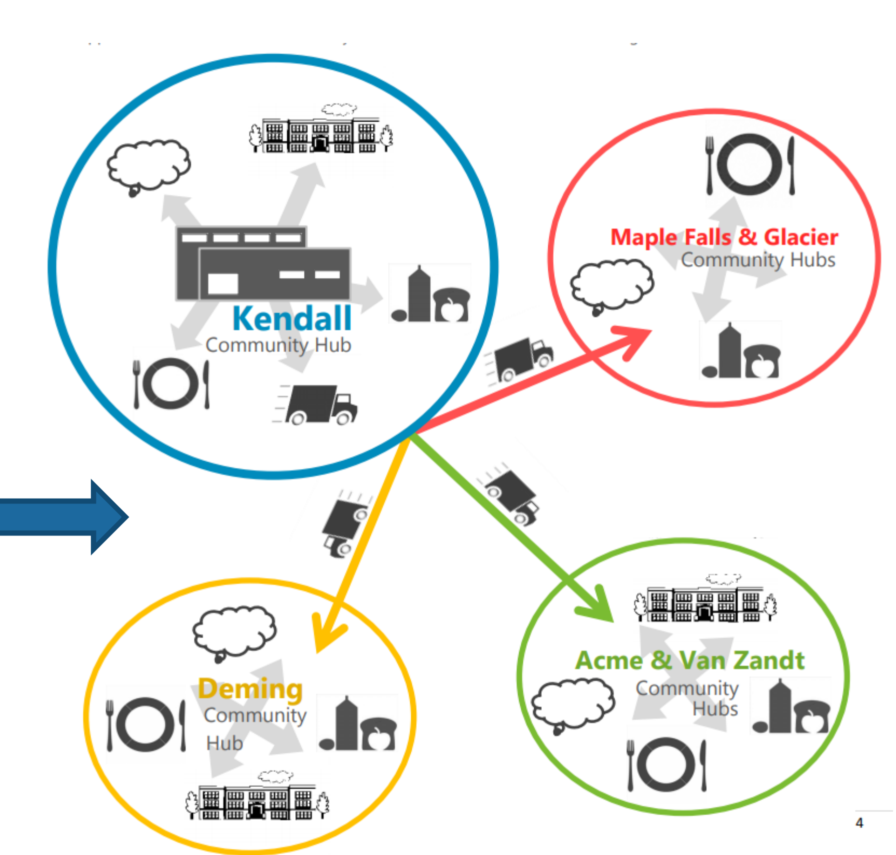
East Whatcom County

Source: USDA Economic Research Service, ESRI. For more information: https://www.ers.usda.gov/data-products/food-access-research-atlas/documentation

Census tracts with low income and low access to grocery stores within 1 mile (urban), 10 miles (rural), USDA Food Access Research Atlas, 2015

Integrating Health Into Community Planning: *Food Access*





Integrating Health Into Community Planning: *Food Access*

Foothills Community Food Partnership, 2018

Resources

- **Time to Act: Investing in the Health of Our Children and Communities (Robert Wood Johnson Foundation)** **https://www.rwjf.org/en/library/research/2014/01/recommendations-from-the-rwjf-commission-to-build-a-healthier-am.html**

- **New Ways to Talk about the Social Determinants of Health (RWJF)** **https://www.rwjf.org/en/library/research/2010/01/a-new-way-to-talk-about-the-social-determinants-of-health.html**

- ***Results-Based Accountability*** **https://clearimpact.com/results-based-accountability/**

Contact information

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A Healthy Madison County
by Design
Eric Faisst
Director of Public Health
Madison County, NY
Photos by John Hubbard

Rural, but not Remote
Madison County, NY

Demographics

- Pop: 73,442
  - White: 95%
  - Black/AA: 1.8%
  - Asian: 0.8%
  - AI/AN: 0.7%
  - Hispanic/Lat. : 1.8%
- Median age: 40.3
- Median Inc.: $55,858

- Individuals below poverty level: 11.9%
- Percent High-school grad or higher: 90.4%
- Unemployment rate: 4.9%

CHIP – Guiding Principle

Refocusing Upstream on Systemic Issues

Setting the "upstream" discussion

- **Keynote** : Dr. Cathleen M. Walsh, Goals Team Leader for the Office of Strategy and Innovation, CDC, presented on the Health Protection Goals to a forum of local community leaders and agencies

- **Panel discussion:**
  - How healthy activities are currently incorporated in community sectors like businesses, agriculture, faith-based, and community-based organizations, and
  - How independent health activities may be integrated using local partnerships, expertise and networks to engage communities and map out what society can do to ensure the conditions for a healthy Madison County.

Strategic Health Issues

How do we advance health and healthy conditions in community development?

Access to Health Care

Community Economic Develop.

Built Environ.

Social Capital

Thriving Individuals & Families

Health Literacy

Public Well Being

Health Marketing

Natural Environ.

Public Policy

Vision for a Healthy Madison County

- Welcoming neighborhoods and a sense of individual belonging
- Values that protect its agricultural traditions, rich history and natural scenic beauty
- Maintenance of its clean environment through planning and preservation
- Safe, affordable housing for all ages
- Access to affordable health care, education and recreation, promoting health and wellness for all
- Opportunities for ample employment and business prospects for all
- Dynamic partnership of citizens, government agencies, employers, faith based, educational, community and service organizations

Smart Growth Principles

- Foster distinctive, attractive communities with a strong sense of place
- Preserve open space, farmland, natural beauty, and critical environmental areas
- Mix land uses
- Take advantage of compact building design
- Create a range of housing opportunities and choices
- Provide a variety of transportation choices
- Create walk-able neighborhoods
- Strengthen and direct development towards existing communities
- Make development decisions predictable, fair, and cost effective
- Encourage community stakeholder collaboration in development decisions

Community Development Affects our Health

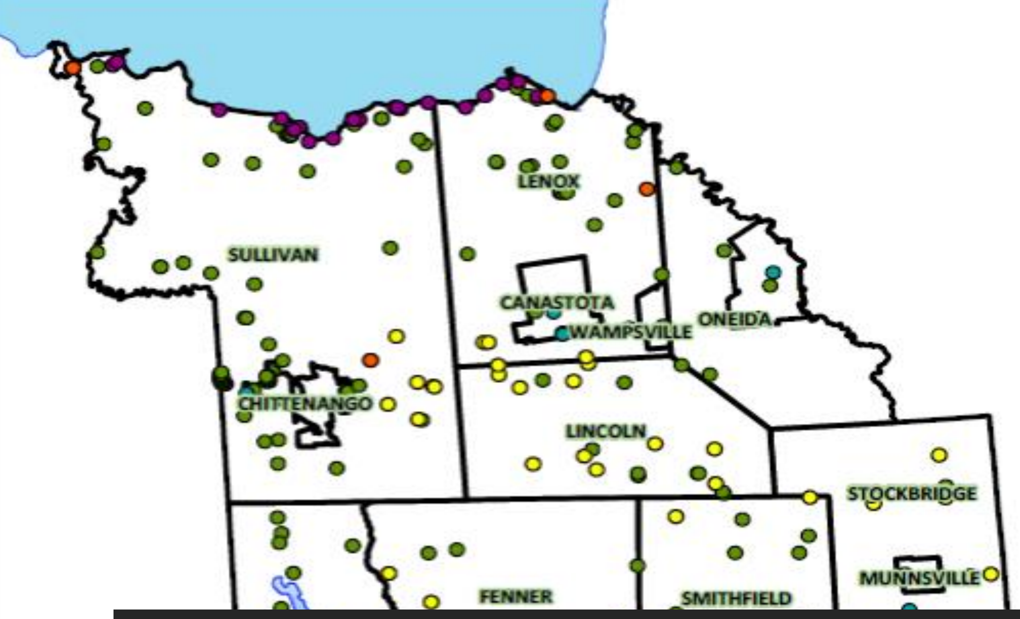
Smart Growth & Development can:

- Decreases depression and sense of isolation and increases the perception of safety.
- Increases recreational activity and decreases ailments associated with inactivity.
- Keep communities compact and less auto-dependent
- Concentrations of plant life improve air quality and helps decrease respiratory problems.
- Parks provide more opportunity for formal and informal social interaction.
- Develops social and cultural capital
- Provides more opportunity for walking to destinations such as community gardens and parks for more vigorous exercise.

Land Use Planning for Public Health: The Role of Local Boards of Health in Community Design and Development. NALBOH. 2006

NYS Smart Growth Act & NYS Prevention Agenda

- The NYS SG Act (2010)
  - minimize sprawl development
  - Requires state departments to align with Smart Growth
- 2008 NYS Prevention Agenda (State "CHIP")
  - **Built environment**: *How the built environment is designed and maintained* can affect human health through the products and materials used and *through land use, zoning, economic development and infrastructure decisions* that affect access to nutritious food and opportunities for physical activity



Rural “Sprawl”

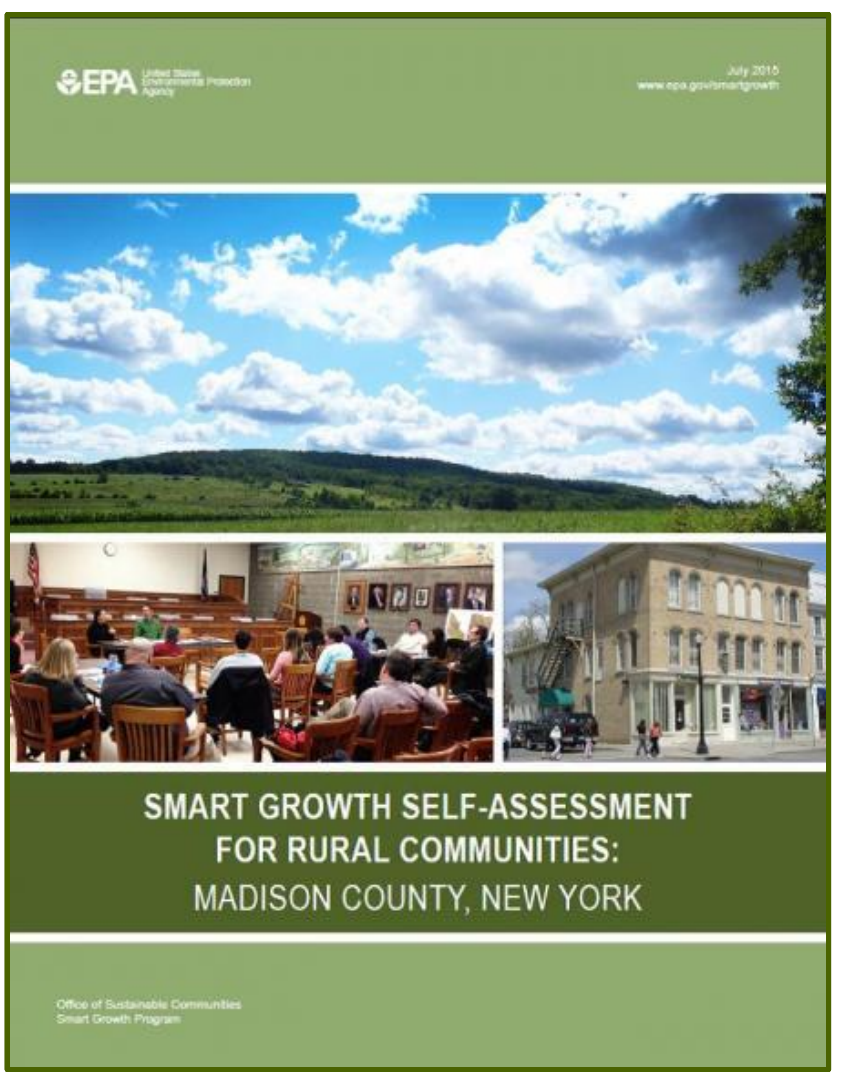
About half of Madison County’s municipalities have no comprehensive plans, and many have no zoning ordinance or planning board.

Tool Kit & Accessories

- Community Workshops
  - Smart Growth & Livable Communities
  - Shades of Green in Madison County
- **Smart Growth Audit Tool**
- Walk-ability Survey
- Elderly Survey
- Health Impact Assessments
- Healthy Design – Marketing
  - Vision for a Healthy Madison County – Video
  - Press releases & Presentations
  - Reports
  - Trails of Madison County
  - Art Contest
- Healthy Community Design Primer
- Healthy Community Design Newsletter

Smart Growth Audit Tool

- EPA Smart Growth Technical Assistance Grant
- Pilot test:
  - City of Oneida
  - Town of Brookfield
  - Village of Chittenango
- Distribute to municipalities
- MC Planning Department
  - Technical Support



Plan(health)ning

- **Understanding our role**
  - Social Determinants of Health
- **Identifying new partners**
  - CEDC
  - Transportation Steering Com.
  - Partnership for Community Development
  - Planning Departments
- **Adding value**
  - Health Improvement Plans
  - Health Assessments
  - Data and expertise
  - Resources
  - Networks

Strategic Health Issues

Health Literacy

- Definition: Health Literacy is the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.
  - (36%) of individuals (age 16+) has difficulty understanding and acting upon health information
  - In Madison County this equates to **26,440** individuals

Health implications of low literacy

- Higher rates of hospitalization and use of emergency services.
- Less frequent use of preventive services.
- Enter the healthcare system when they are sicker.
- More likely to report their health as poor.
- Associated with higher health care cost.
- Negative psychological effects (e.g., sense of shame).
- Lack knowledge or have misinformation about the body as well as the nature and causes of disease, and therefore do not understand the relationship between lifestyle factors (e.g. diet) and various health outcomes.
- More likely to have chronic conditions and less able to manage them effectively.
- More likely to be uninsured
- Less ability to negotiate the health care system

Barriers and Challenges

- Use of specialized medical language ("medicalese") or technical jargon by health care providers
- Increased complexity of health care and health care system
- Increasing prevalence of chronic conditions (e.g., diabetes, congestive heart failure) require patients to know how to manage their own health care outside the clinic and hospital
- Lack of training of health care providers in dealing with low literacy patients
- Lack of time spent with patients during a visit.

Activities

- Improved health information and health services
  - Made written materials easier to read
    - Materials to the general public
    - Facebook posts
    - Website navigation
- Provider "Tool Kits"
- Maternal & Child Health Visiting Nurses Program – revised practices, forms, info.
- Literacy Coalition of Madison County
  - Kindergarten "readiness"
  - Project Grants – e.g., Health Literacy

Resources for SDOH Assessment

A snowy morning scene in March 2018 at the Ocean Grove pier in New Jersey. Posted to EarthSky Facebook by John Entwistle.

Healthy People 2020 and Social Determinants of Health

NACCHO's partnership with Healthy People 2020 (HP 2020) is designed to support and increase the use of HP 2020 among local health departments (LHDs), non-profit hospitals, and other organizations related to community health assessment and improvement planning. All programmatic activities will be designed to support the HP 2020 ten-year agenda for improving the Nation's health.

With fewer resources and staff, many LHDs face significant challenges in providing essential services that ensure the health and safety of their communities. The HP 2020 approach offers an evidence-based, easy-to-use tool designed to aid LHDs and other organizations in community health assessment work.

The HP 2020-NACCHO Partnership is sponsored by the U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion.

Below you will find resources to help your department apply HP2020 concepts and address the social determinants of health (SDOH).

Funding for rural LHDs focused on SDOH

Community Health Improvement Matrix: A SDOH Perspective

Healthy People 2020 Stories from the Field

HP2020 and the CHA/CHIP

Healthy People 2020 and Community Benefit

https://www.naccho.org/hp2020

Community Health Improvement Matrix

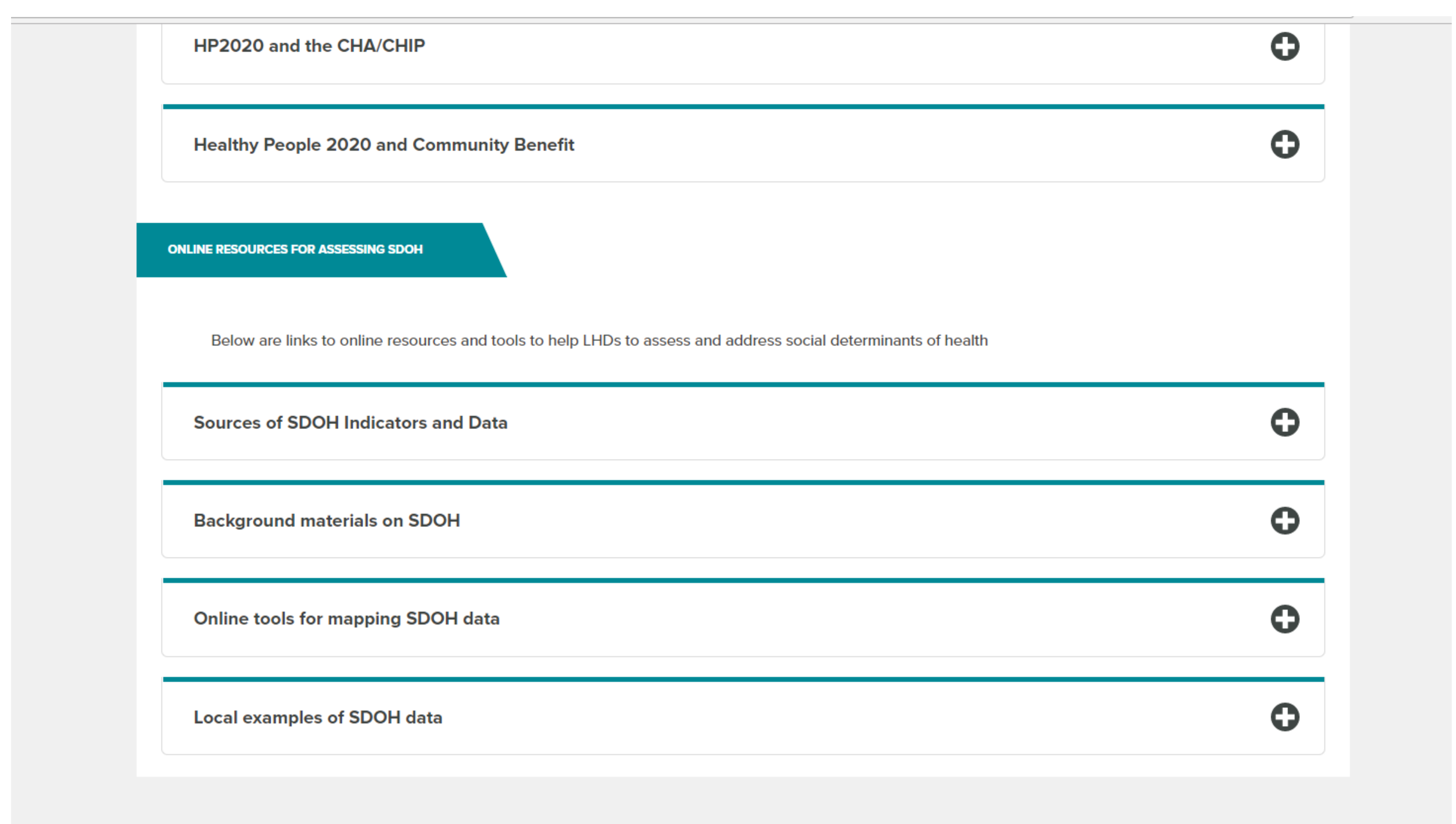
NACCHO
National Association of County & City Health Officials

Community Health Improvement Model

Objective:

PREVENTION LEVEL	Individual	Interpersonal	Organizational	Community	Public Policy
Contextual/ Primary					
Secondary					
Tertiary					

INTERVENTION LEVEL



https://www.naccho.org/hp2020

Sources of SDOH Indicators and Data

General sources of SDOH Indicators and data

1. AARP livability index The AARP Public Policy Institute promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life. Their Livability Index measures community livability. Users can search the Index by address, ZIP Code, city, or county for livability scores in seven categories for every neighborhood in the US. The Index takes a holistic approach to understanding livability, including the health of residents and the quality of the built environment, but also considers engagement, opportunity, and the natural environment.

2. Brookings Institution Metro Monitor The Brooking Institution Metro Monitor measures the performance of the nation's major metropolitan economies in three critical areas for economic development: growth, prosperity, and inclusion. In response to increasing income inequality in U.S. cities, inclusive economies are those that offer opportunities for prosperity across the population. According to the Brookings model, inclusive economies are more equitable, participatory, growing, sustainable, and stable.

4. CDC data set directory of social determinants of health at the local level The directory contains an extensive list of existing data sets that can be used to understand social determinants of health. The data sets are organized in 12 categories of the social environment.

5. The Community Indicators Consortium The Community Indicators Consortium advances and supports the development, availability and effective use of community indicators for making measurable and sustainable improvements in quality of community life. The CIC has an online database of tools for community indicators as well as communities of practice.

6. County Health Rankings and Roadmaps The County Health Rankings & Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The annual County Health Rankings measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income, and teen births in nearly every county in America.

7. US Census Bureau Under the U.S. Census Bureau are a range of surveys, data, and visualization tools for learning about the U.S. population. Within the Census, the American Community Survey (ACS) is an ongoing national survey of U.S. households that provides data to guide the distribution of federal funds. You can access data from the American Community Survey estimates, released every year in a variety of tables, tools, and analytical reports.

8. NACCHO guide to Resources for Social Determinants of Health Indicators

When thinking about the social determinants of health, there are several perspectives you may take as you pursue data collection for the assessment

Panel Discussion

Q&A

Thanks for joining!