Identifying Effective Strategies to Address the Social Determinants of Health

August 1, 2012

Presented by:
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University of Wisconsin Population Health Institute
Webinar Logistics

- The lines are muted. If you wish to mute/unmute your line to ask/answer a question, please do the following:
  - To unmut e 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.
Webinar Learning Objectives

At the completion of the session participants will be able to do the following:

• Describe the project and PHAB documentation requirements for strategy selection and implementation.
• Discuss what types of actions will best address the root causes of health inequities or social determinants of health.
• Discuss the role of policy change in addressing the social determinants of health.
• Plan strategies and tactics for addressing the social determinants of health along with community members and LPHS partners.
• Name a resource for evidence-based or “model” or promising strategies that address the social determinants of health.
• Describe methods to overcome challenges in addressing the social determinants of health.
• Identify additional partners or stakeholders to involve in addressing the social determinants of health.
• Describe how strategies aimed at improving the social determinants of health can be part of a multi-level intervention approach or strategy “bundling” to maximize effectiveness.
PROJECT REQUIREMENTS & PHAB STANDARDS AND MEASURES: SOCIAL DETERMINANTS OF HEALTH
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.
Project Requirements: Addressing the Social Determinants of Health

Required Characteristics of Processes to Conduct the Community Health Improvement Process:

• 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.

• Include relevant data and other resources from the County Health Rankings project to help understand these (social determinants of health) conditions.

• 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.
Project Requirements: Addressing the Social Determinants of Health

Required Characteristics of Processes to Conduct the Community Health Improvement Process:

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;

- Including at least one of these issues as a priority for community health improvement efforts in addition to other health priorities in the CHIP; and
Project Requirements: Addressing the Social Determinants of Health

Required Characteristics of the Community Health Profile:
Data and analyses that do the following:

• Demonstrate the use of indicators, data collection methods, and data analysis techniques that allow for the identification and examination of health inequities.

• Choose indicators that represent a broad range of items that community members have indicated, or literature shows, may be inequitable.

• Use data and data collection methods that can be analyzed and reviewed for health inequities (i.e., if a data source already exists for an indicator but the data cannot be analyzed for health inequities, consider using another data source or collecting new data on this indicator to fulfill this need).

• Ensure that sample sizes are large enough, when appropriate, to allow for data analysis to examine health inequities between and among sub-populations.
Required Characteristics of the CHIP:
Priority issues section that does the following:

• Describes the process by which the priorities were identified.

• Outlines the top priorities for action. The priorities need to include at least one priority aimed at addressing a social determinant of health that arose as a key determinant of a health inequity in the jurisdiction. *(See slide #11 for more information)*

• Includes a brief justification for why each issue is a priority.
Project Requirements: Addressing the Social Determinants of Health

Requirements of the Community Health Improvement Process Report:

*CHA and Community Health Profile overview:*

- Describe how the site addressed the social and economic determinants of health in conducting the CHA.
- Discuss what type of data analyses were conducted to do the following:
  - Ensure that analyses were meaningful and appropriate for jurisdiction/community size and characteristics. When possible and appropriate, data analysis should allow for review of trends and sub-population-specific data and these data should be presented in the CHA report; and
  - Ensure that health inequities in sub-populations were identified to the maximal degree allowed by the data.

*CHIP overview:*

- Specify how your strategy aimed at addressing a social or economic determinant of health/health inequity was identified.
Project Requirements: Addressing the Social Determinants of Health

Project Requirements Highlight:

‘Priority issues section that includes at least one priority aimed at addressing a social determinant of health that arose as a key determinant of health inequity in the jurisdiction’.

This does not have one specific priority aimed at addressing a social determinant of health. It could be that social determinants of health are considered as underlying or cross-cutting themes among all priority areas chosen. If you choose to approach these issues in this manner, please be prepared to simply describe this in your final Community Health Improvement Process report.
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)
QUICK REVIEW OF THE MULTIPLE DETERMINANTS OF HEALTH
Evans & Stoddart Multiple Determinants of Health, 1994
RWJF Commission to Build a Healthier America. *Overcoming Obstacles to Health, 2008*
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.
DISCUSSION QUESTIONS

As you move into implementation planning, what are some of the challenges you are facing when you ask your community to consider the multiple determinants of health?

How do people perceive the “social” determinants of health?”
THE CONTINUUM OF INTERVENTION STRATEGIES
Spectrum of Prevention (Prevention Institute)
www.preventioninstitute.org

THE SPECTRUM OF PREVENTION

Influencing Policy and Legislation
Changing Organizational Practices
Fostering Coalitions and Networks
Educating Providers
Promoting Community Education
Strengthening Individual Knowledge and Skills
National Prevention Strategy
Smoking Rates are Associated with Education

- Less than a high school diploma: 30%
- High school diploma or GED: 30%
- Some college: 22%
- College graduate: 9%

Source: National Health Interview Survey, CDC, 2009
Social Ecological Model (McElroy, Bibeau, Steckler, & Glanz, 1988)
## Social Ecological Model In Practice

<table>
<thead>
<tr>
<th></th>
<th>Obesity</th>
<th>Education</th>
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</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>Weight Reduction Exercise Programs</td>
<td>Attend class</td>
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<tr>
<td></td>
<td></td>
<td>Do homework</td>
</tr>
<tr>
<td><strong>Family/Interpersonal</strong></td>
<td>Family Nutrition Classes Active Family Challenge</td>
<td>Attend parent teacher conferences</td>
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<td>Turn off the TV</td>
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<tr>
<td><strong>Institutional</strong></td>
<td>Healthy Nutritional Choices Competitive Pricing Activity Challenges Point of Decision Prompts</td>
<td>Service learning Early intervention for truancy</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>Bike and Walking Trails Safe Routes to School</td>
<td>Families and Schools Together (FAST)</td>
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<td>Mentoring Programs</td>
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<td><strong>Policy</strong></td>
<td>Junk Food Tax Transfat Bans</td>
<td>Reduce class size</td>
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<td>School reform</td>
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Social Ecological Model(s) Left Version: McElroy et al, 1988; Right Version: Linda Rae Murray, 2010
DISCUSSION QUESTION

As you think about the continuum of interventions, what are your challenges to moving people towards policy & systems change?

What examples of policy & systems change have you implemented, observed, or considered in the area of social and economic factors that determine health?
FINDING THE EVIDENCE
WHAT WORKS FOR HEALTH

What Works for Health provides communities with information to help select and implement evidence-informed policies, programs, and system changes that will improve the variety of factors we know affect health.

To learn more about potential strategies, select a factor such as tobacco use or education in the model below.
Systematic Review Resources

Systematic reviews are considered the gold standard of evidence. These web sites include systematic reviews for various content areas:

- The Campbell Collaboration Library of Systematic Reviews
- The Cochrane Library
- The Guide to Community Preventive Services (The Community Guide)
- health-evidence.ca

Rating Organizations

Many government and private organizations assess the effectiveness of policies and programs. Organizations focus on a variety of topics; each has its own criteria to assess and rate evidence of effectiveness. Examples include:

- AHRQ Evidence-based Practice Centers
- AHRQ Health Care Innovations Exchange
- Best Evidence Encyclopedia
- Blueprints for Violence Prevention
- The California Evidence-Based Clearinghouse for Child Welfare (CEBC)
- FindYouthInfo.gov
- Promising Practices Network
- Public Health Law Research (PHLR)
- SAMHSA National Registry of Evidence-based Programs and Practices (NREPP)
- Social Programs that Work (SPTW)
- Violence Prevention Evidence Base and Resources
- What Works Clearinghouse
<table>
<thead>
<tr>
<th>Rating</th>
<th>Evidence Criteria: Amount &amp; Type</th>
<th>Evidence Criteria: Quality of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scientifically supported</strong></td>
<td>1 or more systematic review(s), or 3 experimental or quasi-experimental studies, or 6 descriptive studies</td>
<td>Studies have:</td>
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<td></td>
<td>• Strong design</td>
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<td></td>
<td></td>
<td>• Statistically significant finding(s)</td>
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<td></td>
<td></td>
<td>• Large magnitude of effect(s)</td>
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<tr>
<td><strong>Some evidence</strong></td>
<td>1 or more review(s), or 2 experimental or quasi-experimental studies, or 3-5 descriptive studies</td>
<td>Compared to 'scientifically supported', studies have:</td>
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<tr>
<td></td>
<td></td>
<td>• Less rigorous design</td>
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<td>• Smaller magnitude of effect(s)</td>
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<td></td>
<td></td>
<td>• Effects may fade over time</td>
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<tr>
<td></td>
<td></td>
<td>• Statistically significant finding(s)</td>
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<td></td>
<td></td>
<td>• Overall, evidence trends positive</td>
</tr>
<tr>
<td><strong>Expert opinion</strong></td>
<td>Varies, generally less than 3 studies of any type</td>
<td>Body of evidence less than 'some evidence'</td>
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<td></td>
<td></td>
<td>• Recommendation supported by logic, limited study</td>
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<tr>
<td></td>
<td></td>
<td>• Methods supporting recommendation unclear</td>
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<tr>
<td><strong>Insufficient evidence</strong></td>
<td>1 experimental or quasi-experimental study, or 2 or fewer descriptive studies</td>
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<td></td>
<td></td>
<td>• Varies, generally low quality studies</td>
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<tr>
<td><strong>Mixed evidence</strong></td>
<td>Two or more studies of any type</td>
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<tr>
<td></td>
<td></td>
<td>• Body of evidence inconclusive</td>
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<td></td>
<td></td>
<td>• Body of evidence mixed leaning negative</td>
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<tr>
<td><strong>Evidence of Ineffectiveness</strong></td>
<td>1 or more systematic review(s), or 3 experimental or quasi-experimental studies, or 6 descriptive studies</td>
<td>Studies have:</td>
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<td>• Strong design</td>
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<td>• Statistically significant finding(s)</td>
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<td></td>
<td></td>
<td>• Large magnitude of effect(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Evidence of harm</td>
</tr>
</tbody>
</table>
WHAT WORKS FOR HEALTH

*What Works for Health* provides communities with information to help select and implement evidence-informed policies, programs, and system changes that will improve the variety of factors we know affect health.

To learn more about potential strategies, select a factor such as tobacco use or education in the model below.

Health Outcomes

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

Health Factors

- Health behaviors (30%)
- Clinical care (20%)
- Social and economic factors (40%)
- Physical environment

Tobacco use
- Diet & exercise
- Alcohol use
- Sexual activity

Access to care
- Quality of care

Education
- Employment
- Income

Family & social support
- Community safety
- Environmental quality
WHAT WORKS FOR HEALTH
Policies and Programs that can improve health

Early childhood home visitation programs
Community Safety
Family and Social Support
Early childhood home visitation programs are those in which parents and children are visited in their home prenatally and/or during the child’s...

Housing First program
Family and Social Support
Housing First addresses chronic homelessness by providing rapid re-housing as well as support services like crisis intervention, needs assessment,...

Moving to Opportunity
Family and Social Support
Moving to Opportunity (MTO) was a program sponsored by the United States Department of Housing and Urban Development (HUD) from 1994 to 1998. The...

Nurse-Family Partnership
Family and Social Support
EARLY CHILDHOOD HOME VISITATION PROGRAMS

Evidence Rating

Scientifically Supported

Health Factors
Community Safety
Family and Social Support

Decision Makers
Healthcare Professionals and Advocates
Government Officials
Community Leaders

Early childhood home visitation programs are those in which parents and children are visited in their home prenatally and/or during the child’s first two years of life by trained personnel who provide some combination of the following: information, support, and training regarding child health, development, and care.

Expected Beneficial Outcomes:
- Decreased child injury and maltreatment
- Improved cognitive and socio-emotional development
- Improved parental attitudes and behaviors
- Increased birth weight and gestational age

Evidence of Effectiveness:
There is strong evidence that early childhood home visitation programs prevent child injury and maltreatment (CG-Home Visiting, Sweet 2004, CDC-MMWR Hahn 2003, Roberts 1996, Bilukha 2005, MacLeod 2000) and improve cognitive and socio-emotional development outcomes (Sweet 2004). There is less evidence that such programs affect other parental behaviors and parental attitudes (Kendrick 2000, Sweet 2004) as well as birth outcomes (Issel 2011). Home visitation programs may not be successful and may even be harmful when implemented in populations of drug and alcohol abusers (Cochrane-Turnbull 2012, Cochrane-Doggett 2005).

Home visiting programs vary substantially in implementation and target a variety of outcomes. For example, such programs can be delivered by professionals (e.g., nurses), paraprofessionals, and non-professionals, and can start both before and after a child is born. Visits by paraprofessionals appear to have stronger effects on maltreatment outcomes and visits by professionals appear to have stronger effects on cognitive outcomes in.
**Impact on Disparities:**
Likely to decrease disparities

**Implementation Examples:**
Home visiting programs have been around since the late 1970s and are implemented in at least 40 states. Widely recognized models include: Healthy Families America (HFA), Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse-Family Partnership (NFP), and Parents as Teachers (Parents as Teachers). These programs are implemented in many states (Johnson 2009, Guttmacher-Boonstra 2009).

**Implementation Resources:**

**Citations - Evidence:**

Citations - Implementation Examples:
NFP - Nurse-Family Partnership. Making new beginnings possible.
Parents as Teachers - Parents as Teachers. Federal Home Visiting Program.
HIPPY - Home Instruction for Parents of Preschool Youngsters (HIPPY).
HFA - Healthy Families America (HFA).

Last Verified:
2012-06-05

* Journal subscription may be required for access.

More Policies & Programs

Comprehensive early childhood development programs  |  Kinship care for children removed from home due to  |  Neighborhood watch

BROWSE ALL POLICIES & PROGRAMS
Acting on evidence

Finding relevant evidence is not the end

Consider:

• How well the strategy addresses your priorities
• Community fit
• Feasibility to implement (time & resources)
• Political will
• Need to adapt? Can you assess effects?
DISCUSSION QUESTION

What are the challenges you face as you consider evidence in selecting interventions to address the multiple determinants of health?
Marathon County Example

Costs of Out of Home Placements are Too High (Particularly Juvenile Justice)

Change Criminal Justice System
  - Change judges’ attitudes
  - Change laws

Strengthen Parenting
  - Parenting Classes
  - FAST
  - Universal Screening
  - Ongoing home visitation
  - Access to contraception
  - Education
  - Decrease unintended pregnancies

Change judges’ attitudes

FAST

Universal Screening

Ongoing home visitation

Access to contraception

Education

Decrease unintended pregnancies

Improve juvenile behavior

Improve school attendance

Intervene earlier

Decrease AOD use

Decrease unintended pregnancies
Questions and Discussion
Additional Resources

- **Tackling Health Inequities through Public Health Practice: Theory to Action**
  
  *Richard Hofrichter and Rajiv Bhatia*

- [http://policylink.com/](http://policylink.com/)
The next CHA/CHIP training webinar will be on:

‘Topic TBD’

*Presenter and Date:* TBD

Please complete the evaluation before logging off the webinar.