

County Health
Rankings & Roadmaps
Building a Culture of Health, County by County
A Robert Wood Johnson Foundation program



GOING ALL IN TO IMPROVE HEALTH THROUGH MULTI-SECTOR COLLABORATION AND SYSTEMATIC DATA SHARING

A County Health Rankings & Roadmaps and Data Across Sectors for Health Co-Webinar

May 15, 2018

countyhealthrankings.org

allindata.org

dashconnect.org

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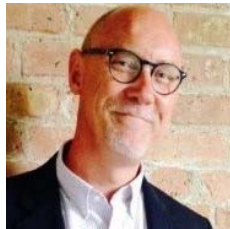
County Health Rankings & Roadmaps is a collaboration between
the Robert Wood Johnson Foundation and the University of
Wisconsin Population Health Institute.

countyhealthrankings.org

YOUR FACILITATORS AND PRESENTERS



Justin Rivas
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CHR&R



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Project Supervisory Attorney
Medical Legal Partnership
Legal Aid Foundation of Chicago



Martha Davidson
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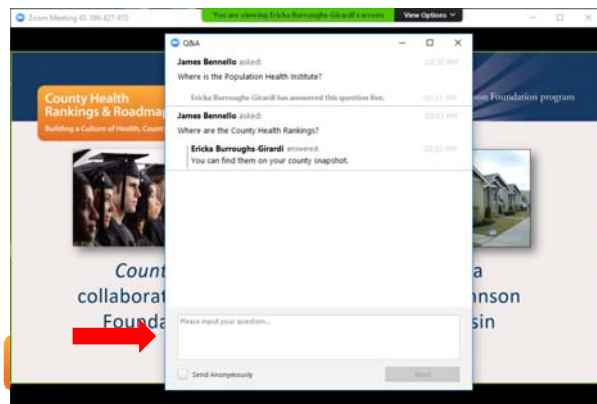


ASKING A QUESTION IN ZOOM WEBINAR

Viewer Window



Question Box



CHATTING IN ZOOM WEBINAR

Viewer Window



Chat Box



LEARNING OUTCOMES FOR TODAY

- ▶ Understand CHR&R approach, data, tools and resources
- ▶ Understand All In/DASH approach, tools and resources
- ▶ Overview of value in multi-sector data sharing - gain insight on how to start and how to deepen work
- ▶ Learn from Trenton, NJ and Chicago, IL examples on best practices for data sharing across sectors



GUIDING QUESTIONS



How can your community pursue and/or build upon your data sharing work?

How can you benefit (and also provide benefit to others) by being part of a nationwide learning collaborative?



WHY WE DO WHAT WE DO

Improve Health Outcomes





WHY WE DO WHAT WE DO

Increase Health Equity

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HOW WE SUPPORT COMMUNITIES



DATA



EVIDENCE

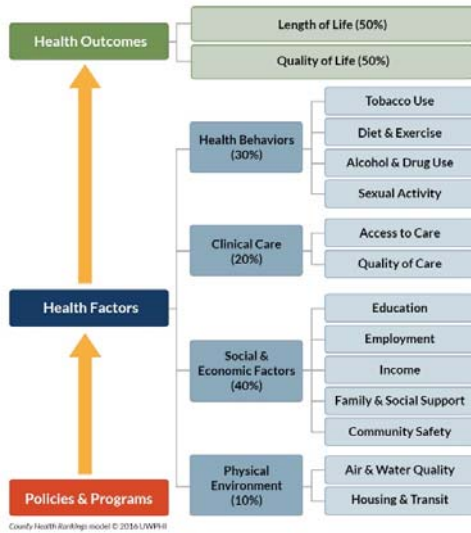


GUIDANCE



STORIES

OUR MODEL



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DATA

Using data to reveal the factors that influence health



About Us | News & Events

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Explore Health Rankings Take Action to Improve Health Learn From Others What Is Health? 🔍

Take Action To Improve Health

We're here to help. Below you'll find strategies that we know work, guidance for setting a plan in motion, and resources to help you partner with others.

What Works

Explore a menu of evidence-informed policies and programs that can make a difference locally.

What Works for Health

How to Take Action

Find step-by-step guidance and tools to help you move with data to action.

Action Center

Who to Work With

Identify the right partners and explore tips to engage them.

Partner Center



HOW TO TAKE ACTION: ACTION CENTER

Steps to Move Your Community Forward

The steps below provide a path to help your community move with data to action. In each you will find key activities and suggested tools to guide your progress. Keep in mind: action isn't always linear. Revisit these steps to find the right resources when you need them.



- ▶ Step-by-step guidance and tools
- ▶ Seven Action Steps
- ▶ Key Activities and suggested tools to guide your progress

★ **TIP:** Set the Action Center as a favorite in your browser. Come back often to find the right resources when you need them.

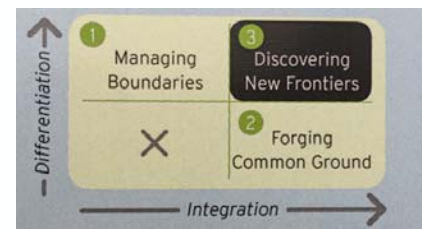
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Data Across Sectors for Health

SPANNING BOUNDARIES TO PARTNER ACROSS SECTORS

Action Center > Work Together > Key Activity #3: Manage Boundaries



Source: *Boundary Spanning Leadership*, Center for Creative Leadership (2018).

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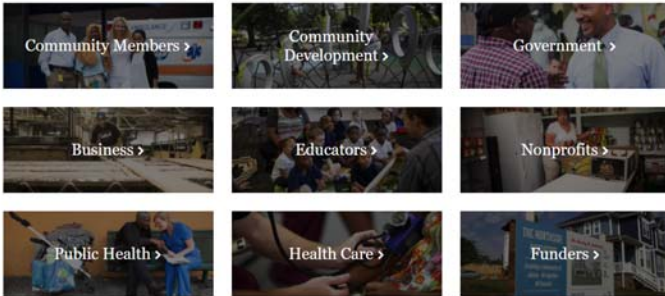
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WHO TO WORK WITH: PARTNER CENTER

What roles do you play in your community?
Who do you want to partner with?

Think about the people in your community who make positive changes happen. Call them leaders, changemakers, or stakeholders - these are the people with whom you want to partner. This section is all about joining with others to make lasting change in your community.



- ▶ Provides guidance around:
 - Why different sectors might care about creating healthy communities
 - What they can do
 - How to engage them

★ **TIP:** If you don't see yourself in any of the sectors listed in the Partner Center, start with Community Members.



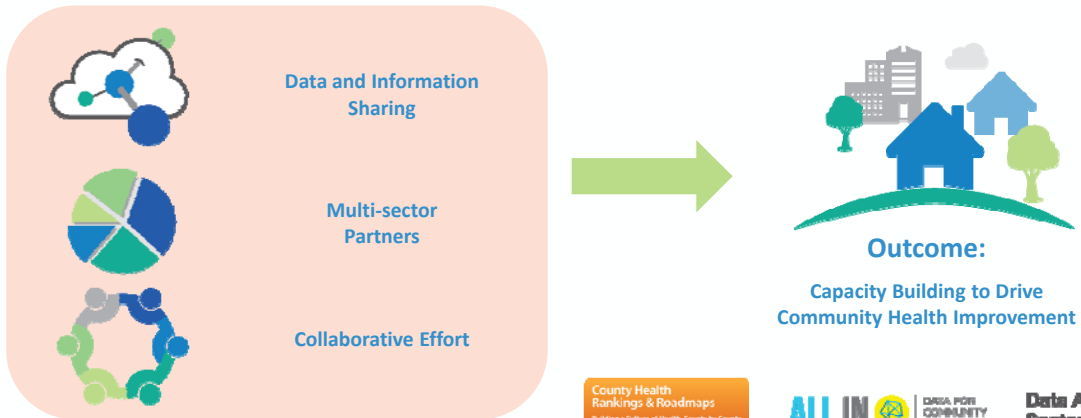
SHARING DATA IS HARD, SO WHY DO IT?

- ▶ And slower and expensive and complicated politically and technically...
- ▶ There are things we want to do in our communities that we cannot do alone.
- ▶ Accelerating interest in health equity drives interest in multi-sector collaboration and data-sharing.
- ▶ Multi-sector approaches tell us more about our communities and are more responsive to complex social conditions.
- ▶ Shared community data documents the problems that we suspect, points us to new opportunities, and supports new kinds of interventions.



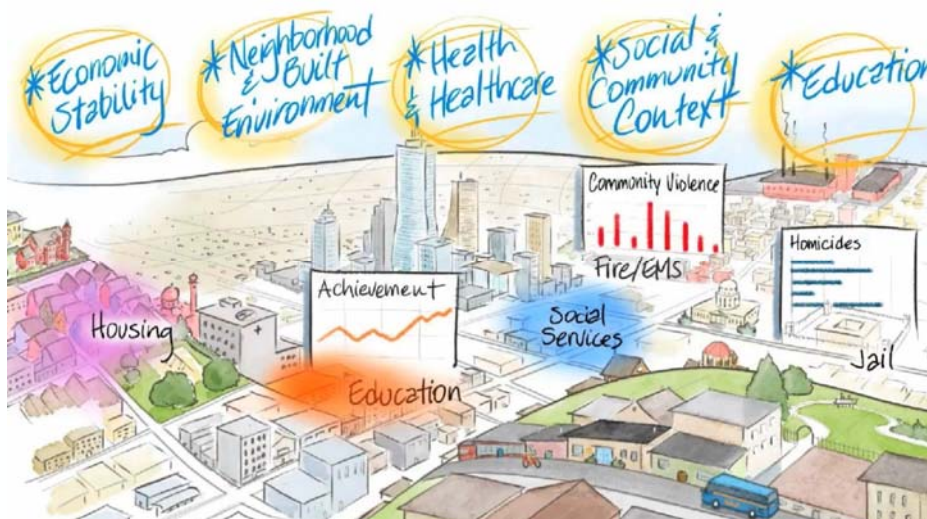
CORE COMPONENTS OF ALL IN

Support local initiatives that focus on:



ALL IN VIDEO

<https://vimeo.com/220337044>



SPOTLIGHT: PREVENTING FALLS, BALTIMORE, MD

- ▶ Led by: Baltimore City Health Department with BFRIEND stakeholder advisory group
- ▶ Goal: Decrease the rate of falls leading to ED visit or hospitalization among older adults by 1/3 in 3 years
- ▶ Leverage discharge data from health information exchange (HIE), CRISP, for public health surveillance



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SPOTLIGHT: ADDRESSING FOOD INSECURITY, DALLAS, TX

- ▶ Led by: Parkland Center for Clinical Innovation, the Parkland Health and Hospital System and North Texas Food Bank
- ▶ Goal: Use the Dallas Information Exchange Portal to improve the dietary intake of patients experiencing food insecurity who have been diagnosed with a chronic disease



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SECTOR REPRESENTATION

Common sectors involved in *All In* projects










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COMMON DATA TYPES

-  Service (EHRs, case management) data
-  Surveillance data
-  Administrative data
-  Outcomes data
-  Geographic data
-  Community-generated data
-  Personal demographic data

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ALL IN: MISSION AND GOALS



1. Co-create and support a movement acknowledging the social determinants of health as we address health equity



2. Build an evidence base for the field of multi-sector data integration to improve health



3. Utilize the power of peer learning, collaboration and consultation



ALL IN PARTNERS



Community Health Peer Learning Program



Data Across Sectors for Health (DASH)



The BUILD Health Challenge



Connecting Communities and Care



The Public Health National Center for Innovations



New Jersey Health Initiatives



Population Health Innovation Lab



ALL IN COMMUNITIES



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HEALTH FORWARD/SALUD ADELANTE

The BUILD HEALTH Challenge

Partners

- LAF (formerly the Legal Assistance Foundation)
- Cook County Health and Hospitals System (CCHHS)
- Chicago Department of Public Health (CDPH)

LAF Equal justice starts here.

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

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HEALTH FORWARD/SALUD ADELANTE AIMS

- ▶ Reduce negative effects of social determinants of health by sharing data
- ▶ Document health benefits due to legal interventions.
- ▶ Build a community-directed program to address systemic barriers.
- ▶ Provide “upstream” response to legal issues that affect health.



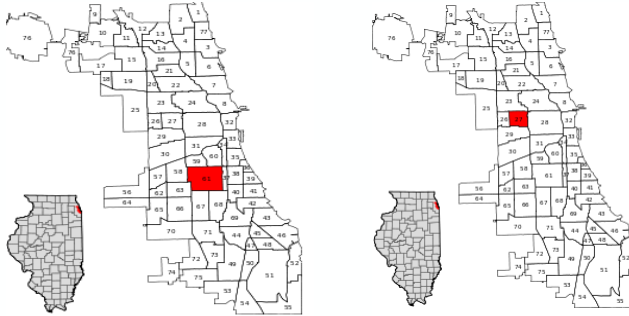
USING HEALTH SYSTEM AND PUBLIC HEALTH DATA TO DESIGN THE MLP

MLP partners used data to:

- Select priority neighborhoods for the MLP focus
- Select medical/legal issues of focus



PRIORITY NEIGHBORHOODS

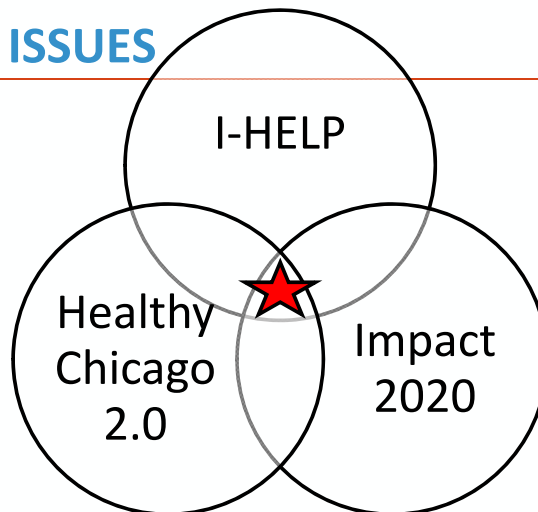


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TARGETING LEGAL ISSUES

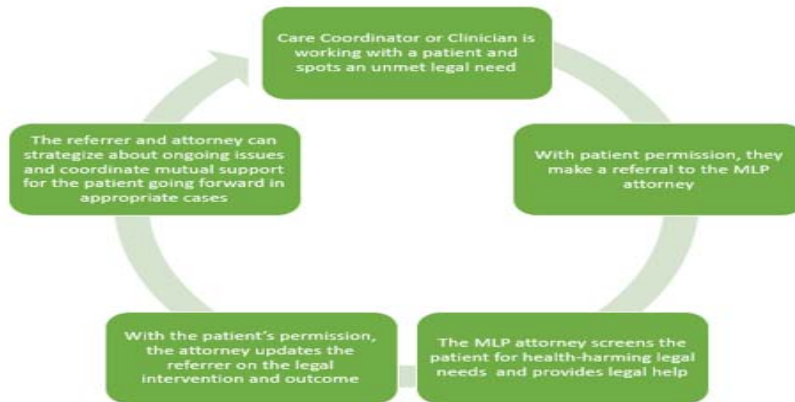


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HEALTH FORWARD/SALUD ADELANTE SERVICE MODEL



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Referring Patients for Legal Assistance: A Desk Reference Health Forward/Salud Adelante Medical-Legal Partnership (MLP)

For each of the I-HELP issue areas, we have listed common Health Harming Legal Needs.
▶ Refer to the LAF attorney for advice or representation
▶ Refer to the LAF attorney for warm handoff/referral to appropriate program/agency
▶ Please do not refer for this issue; ask LAF attorney for info/referrals to share with patient

<ul style="list-style-type: none"> Denial or termination of Medicaid, SNAP, or cash assistance Overpayment of SNAP or cash assistance Reduction, termination, or overpayment of SSI or SSDI benefits Denial of veteran's benefits 	<ul style="list-style-type: none"> Applying for SSI or SSDI only if: <ul style="list-style-type: none"> HIV positive Homeless Severe mental illness Extended hospitalization Denied twice and now at ALJ hearing level 	<ul style="list-style-type: none"> Applying for SSI or SSDI in other situations (use handout) Applying for Medicaid, SNAP, or cash assistance
Housing and Utilities Public, Section 8, or other subsidized housing: <ul style="list-style-type: none"> Eviction or termination of program Conditions problems (mold, lead/peeling paint, pests) Utilities shut off/notice of disconnection Disability housing accommodations 	<ul style="list-style-type: none"> Issues with private housing Homelessness (without additional legal issue) 	
Employment and Education <ul style="list-style-type: none"> Lost job because patient was on medical leave or caring for sick family member Expungement of juvenile criminal record Denied unemployment benefits 	<ul style="list-style-type: none"> Injury at work Expungement of adult criminal record 	
Legal Status <ul style="list-style-type: none"> Undocumented patient is victim of a crime Undocumented patient is victim of domestic violence Human trafficking (warning signs: patient brought to US against her will, employer controls identification documents) 	<ul style="list-style-type: none"> Needs other immigration advice 	
Personal & Family Stability <ul style="list-style-type: none"> Domestic violence or other abuse A family member needs to create Power of Attorney docs for healthcare or property Victim of a crime 	<ul style="list-style-type: none"> Needs guardianship of child or adult Divorce, custody, child support (if there is no domestic violence involved) 	



Screening form used for referring patients for legal assistance

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Trenton Health Team History

Background

- Declining public health indicators in Trenton
- Lack of primary care access & lack of collaboration between providers
- Closure of an Acute-care Hospital (Capital Health – Mercer Campus)

Katz Report 2006:

- Create an integrated health care structure
- Provide specialty care through improved funding and access
- Develop consumer engagement strategies and plan
- Establish a health database and information system linking Trenton providers
- Expand primary care access
- Improve public health indicators

Four Founding Partners:



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Our Community

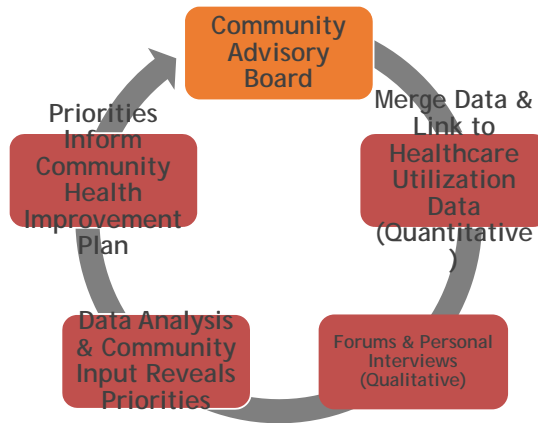
- Demographics:
 - 84,034 population
 - 52% African-American
 - 34% Hispanic (underrepresented, from Census data)
 - 26% living in poverty (200% FPL) with average household income of \$36,662 (contrasted with NJ poverty rate of 11% and average income of \$71,629)
 - Violence rates 4-5 times NJ average
- Disease prevalence:
 - Hypertension 31%
 - Diabetes 16%
 - Clinically Obese 39%



2013 Community Health Needs Assessment
 (<http://www.trentonhealthteam.org/wp-content/uploads/THT-CHNA-2013-July.pdf>)



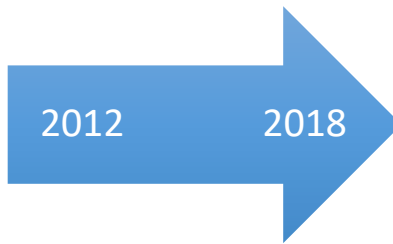
Unified Community Health Needs Assessment (CHNA)



Community Advisory Board



29 agencies started CHNA process



60+ agencies, 150 representatives: CHNA/CHIP, Trinity Health, Plan4Health, BUILD Health Challenge



Multi-Sector Stakeholders



BUILD Health Challenge

- Bold, Upstream, Integrated, Local, Data-driven

Goal: Improve community environments to lead to positive health outcomes by encouraging healthy lifestyle choices that reduce obesity and the burden of chronic disease

- Our plan: transform Brunswick Avenue into the “Safe & Healthy Corridor”
- Engage organizations, businesses, faith communities and residents along corridor to set priorities
- Work alongside community-based organizations and hospital & health systems
- Sustainable infrastructure improvements (lighting, Complete Streets, pop-up markets, etc.)
- Matching funds from Capital Health and Trinity Health



BUILD Health Corridor - Vacant Buildings

Vacant Buildings	2014	2018	Change
	308 (18.5% of total buildings)	267 (16% of total buildings)	-39



2011: 101-103 New York Ave



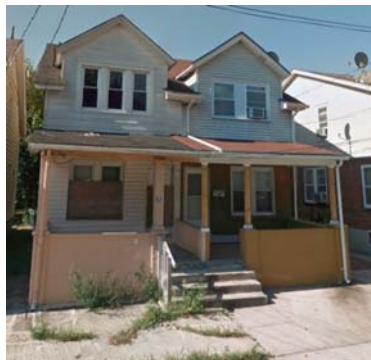
2018: 101-103 New York Ave

Current conditions/vacant buildings slides courtesy of Isles, Inc. (www.isles.org)

Vacant Buildings

Between 2014 and 2018,
81 Buildings changed from **Occupied** to **Vacant**
118 Buildings changed from **Vacant** to **Occupied**

57 Heil Ave

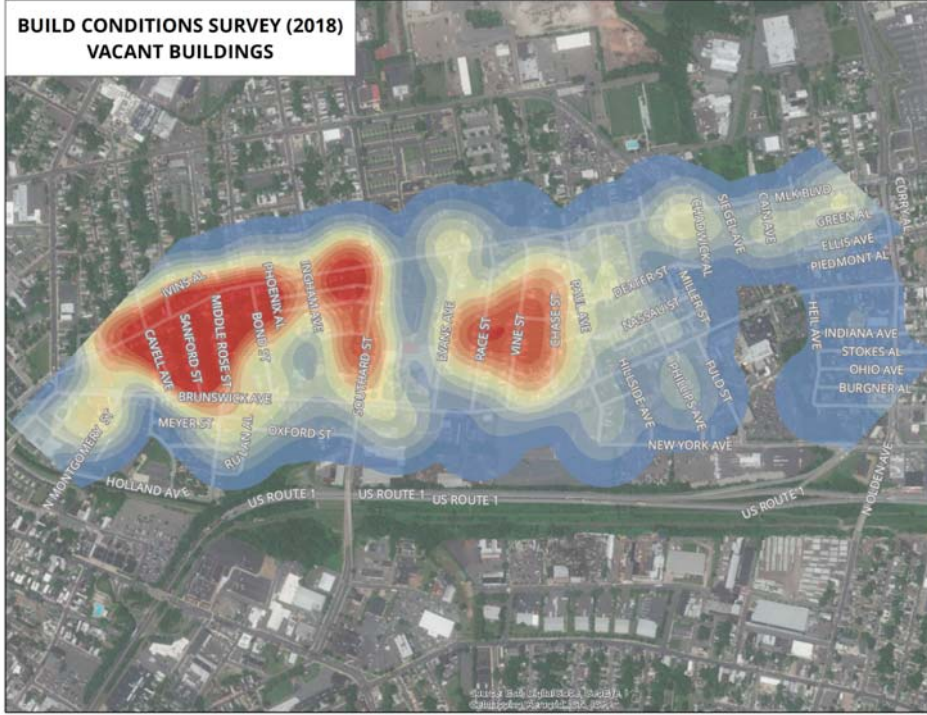


2013

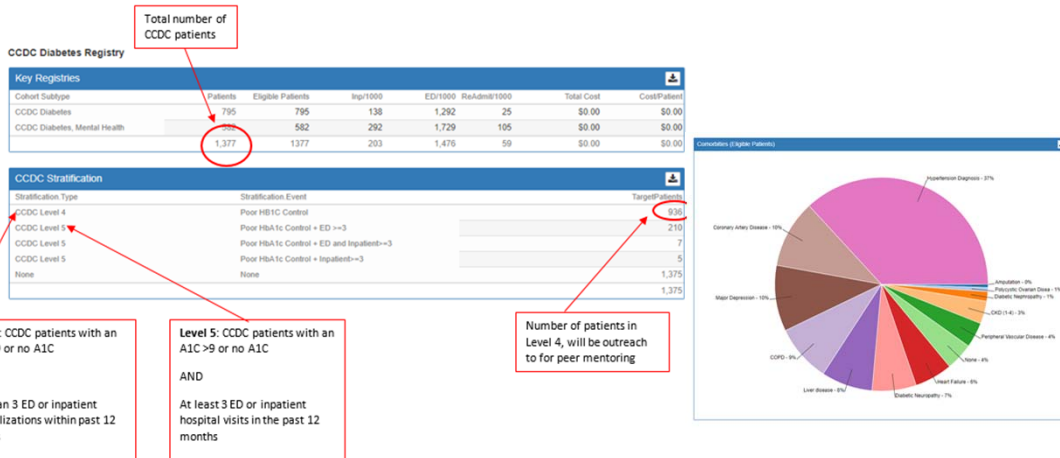


2017

**BUILD CONDITIONS SURVEY (2018)
VACANT BUILDINGS**



Population Identification and Stratification



Next Steps

- Use Trenton Health Information Exchange to extract health data for the BUILD Health geography
- Overlay health data with geo-mapped housing information ✓
- Identify and implement targeted interventions based on data-driven findings



ALL IN ACTIVITIES

Webinars



Publications



Podcast



Blogs / Spotlights



Presentations



Newsletters



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Continue the conversation



Access resources



View upcoming events



Connect with peers

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TIPS TO MAXIMIZE THE PLATFORM

- ▶ Complete all fields for your individual profile
- ▶ Contact info@allindata.org to add a project profile
- ▶ Attend an office hour session for an in-depth tour of the site features

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Questions?

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LET'S CONTINUE THE DISCUSSION!

- ▶ **When:** Monday, May 21, 2018 3:00 EST
- ▶ **How:** videoconference and/or phone
- ▶ **Why:** deepen the webinar learning, allow further exploration
- ▶ **Who:** YOU! (Space is limited)
- ▶ **What:** interactive learning experience, opportunity to share ideas and ask questions



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- ▶ Join the online community: allin.healthdoers.org
 - Access webinar materials (after event): <https://allin.healthdoers.org/webinars/>
- ▶ Review the monthly [All In newsletter](#) for activities and opportunities
- ▶ Follow [#AllInData4Health](#) on Twitter
- ▶ Attend an upcoming webinar: *Employing Health Information Exchanges (HIEs) to Address the Social Determinants of Health, June 14 @ 3:30 – 4:30 pm ET*



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