Finding Data to Maximize the Health Co-Benefits of Built Environment Plans and Projects

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9 Local Health Departments:
- Orange
- Long Beach (City)
- Los Angeles
- Pasadena (City)
- Riverside
- Santa Barbara
- San Bernardino
- San Diego
- Ventura

Nearly 60% of CA Population
Public Health Alliance Vision

All Southern California communities are healthy, vibrant and sustainable places to live, work and play.

Priority Initiatives

- Healthy Transportation
- Healthy Food Systems
- Data Committee
How do we maximize the health benefits of our built environment plans and projects?

- Use health status data to identify health disparities
- Use social determinants data to understand drivers of health inequities
- Plan with the social determinants in mind
Social Determinants of Health Status

A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES
BAY AREA REGIONAL HEALTH INEQUITIES INITIATIVE

UPSTREAM

SOCIAL INEQUALITIES
• Class
• Race/Ethnicity
• Immigration Status
• Gender
• Sexual Orientation

INSTITUTIONAL INEQUALITIES
• Structural & Systemic Barriers
• Government Agencies
• Schools
• Law & Regulations
• Non-Profit Organizations

STRAIGHT PARTNERSHIP ALLIANCE

LIVING CONDITIONS
• Physical Environment
• Social Environment
• Economic & Work Environment
• Living Conditions

DOWNTOWN

RISK BEHAVIORS
• Smoking
• Substance Use
• Nutritional & Physical Activity

DISEASE & INJURY
• Infectious Disease
• Maternal & Child Health
• Mental Health

MORTALITY
• Infant Mortality
• Life Expectancy

COMMUNITY CAPACITY BUILDING
• Community Organizing
• Civic Engagement

POLICY

Emerging Public Health Practice

Current Public Health Practice
### Social Determinants

- **Built environment, socioeconomic status**

**Pros:**
- Often more actionable by local agencies
- Data accessible

**Cons:**
- Connection between the social determinants and health is not always publicly understood

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### Health Status

- **Disease rates, obesity, behavior**

**Pros:**
- Helps screen areas that need assistance.
- Resonates with decision-makers

**Cons:**
- Difficult to access some data, not always directly actionable

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### Health STATUS Data

<table>
<thead>
<tr>
<th>Dataset</th>
<th>Geography</th>
<th>Data origin</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>500 Cities Data Project</td>
<td>Census tract for 500 largest US Cities—covers 59.1% of CA population</td>
<td>Uses demographic and socioeconomic characteristics at CT level to model health behaviors/outcomes based on Behavioral Risk Factor Surveillance System (BRFSS) and the National Survey of Children's Health.</td>
<td>- Includes useful measures, such as physical activity. - Measures likely to be updated over time.</td>
<td>- Doesn't cover all SCAG region. - Doesn't cover rural/low-population areas</td>
</tr>
<tr>
<td>Ask CHIS Neighborhood Edition</td>
<td>Zip code level statewide</td>
<td>California Health Interview Survey (CHIS) responses modeled at zip-code level.</td>
<td>- Wide ranging questions related to behavior and health status</td>
<td>- Questions on the survey are not consistent over time - No updated data on time spent walking</td>
</tr>
</tbody>
</table>
Health STATUS Data: 500 Cities

~60% of CA population falls within dataset

Behaviors
Binge Drinking
Current Smoking
Obesity*
Physical Activity

Health Outcomes
Arthritis
Cancer (except skin)
Chronic Kidney Disease
Chronic Obstructive Pulmonary Disease
Coronary Heart Disease
Current Asthma
Diabetes
High Blood Pressure
Pap Smear Test
Physical Health
Sleep
Stroke
Teeth Loss

Preventive Health Services
Annual Checkup
Cholesterol Screening
Colorectal Cancer Screening
Core preventive services for older men
Core preventive services for older women
Dental Visit
Health Insurance
High Cholesterol
Mammography
Mental Health
Taking Blood Pressure Medication
Health STATUS Data: 500 Cities

Useful because:
- Each indicator can be compared census tract to census tract, and city to city
- Useful in making the case to public, electeds for health interventions

- What factors are driving these health outcomes?
- What can local government do about it?

Social Determinants

Health Status
### Social Determinants of Health Data

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</thead>
<tbody>
<tr>
<td>Public Health Alliance of Southern California Health Disadvantage Index “CA HDI”</td>
<td>Census tract</td>
<td>Publicly available data from ACS, State, Satellite and other sources weighted in an index.</td>
<td>-shows percentile ranking for component indicators -points toward actionable policy at local level to ‘move dial’ on health</td>
<td>-under revision -does not currently include race -some important social determinants left out</td>
</tr>
<tr>
<td>PolicyLink/ USC PERE National Equity Atlas</td>
<td>City, State-level data</td>
<td>Publically available data</td>
<td>-provides clear messaging on socioeconomic drivers of equity -visualizes data in charts (but not maps)</td>
<td>-doesn’t articulate links to health at this time -doesn’t get down to project level</td>
</tr>
</tbody>
</table>

### Social Determinants: CA HDI

- **SDOH**: Social Determinants of Health
- **Neighborhood and Built Environment**
- **Economic Stability**
- **Health and Health Care**
- **Education**
- **Social and Community Context**
Social Determinants: CA HDI

Useful because:

- Each component can be compared, but index allows an overall assessment of cumulative health disadvantage
- Provides actionable areas for local jurisdictions to address health

- New version 2.0 will include ‘decision support’ tools
- A policy guide is being built around the tool, with actionable, local-level tools to ‘move the dial.’
Plan with the Social Determinants in Mind

High Housing Cost

What Does This Indicator Measure?

The Connection to Health

Policy Opportunities to Address the Health Impacts of This Indicator

Getting the most “health bang” for your ATP dollar:

• Link here
• Addressing SDOH to maximize investment benefits
**Data Resources For Health (Part 1)**

Clearly articulating how a policy/program/project can improve public health can be helpful in building support and ensuring positive outcomes. Because population health is often determined by the health status of the most vulnerable persons in the community, the following table suggests data sources for describing health vulnerability at different geographies that may be relevant to your work.

<table>
<thead>
<tr>
<th>Target Geography</th>
<th>Recommended Tool</th>
<th>Recommended Health Indicators</th>
<th>Example statement related to health vulnerability and Proposal Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>School-based project (Safe Routes)</td>
<td>California Department of Education Physical-Fitness Report &quot;Fitnessgram&quot;&lt;br&gt;<a href="http://www.cde.ca.gov/sd/ls/rt/fitgmn.asp">http://www.cde.ca.gov/sd/ls/rt/fitgmn.asp</a> (Click on &quot;Physical Fitness Test&quot; in the question 2 dropdown menu)</td>
<td>• Aerobic Capacity (% in Healthy Fitness Zone, % Needing Improvement, % Needing Improvement – Health Risk)&lt;br&gt;• Body Composition (% in Healthy Fitness Zone (Healthy Weight), % Needing Improvement (Overweight), % Needing Improvement - Health Risk [Obese])</td>
<td>This project will specifically work to improve the health of the % of students whose health &quot;needs improvement&quot; based on the CA DOE fitness testing by addressing the following improvements/cultural challenges in the school boundary...</td>
</tr>
<tr>
<td>School-based project (Safe Routes)</td>
<td>School-based survey</td>
<td>• Time walking/biking&lt;br&gt;• Time playing outside&lt;br&gt;• Barriers to outside play&lt;br&gt;• Parent identified health concerns</td>
<td>This project will work to address the following parent-identified health concerns by...</td>
</tr>
<tr>
<td>Neighborhood level (Area level)</td>
<td>California Health Disadvantage Index&lt;br&gt;<a href="http://health.data.gov/hvi">http://health.data.gov/hvi</a></td>
<td>• Overall HDS Score&lt;br&gt;• Years of life lost&lt;br&gt;• Population with a disability&lt;br&gt;• Asthma hospitalizations</td>
<td>Based on the California Health Disadvantage Index score of XX, the target neighborhood is facing the following health vulnerabilities:...</td>
</tr>
<tr>
<td>Neighborhood level (Area level)</td>
<td>500 Cities Project&lt;br&gt;<a href="http://www.500cities.org/">http://www.500cities.org/</a></td>
<td>• Obesity Rate&lt;br&gt;• Leisure time Physical Activity&lt;br&gt;• Asthma, cardiovascular disease,</td>
<td>The obesity rate in the community to be served is XXX, as compared to a statewide average of XXX. Though obesity has a range of causes, increasing physical activity in the obese population can improve health. This plan will specifically address physical inactivity in the obese population by...</td>
</tr>
</tbody>
</table>

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**Data Resources For Health (Part 2)**

<table>
<thead>
<tr>
<th>Target Geography</th>
<th>Recommended Tool</th>
<th>Recommended Health Indicators</th>
<th>Example statement related to health vulnerability and Proposal Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community level (Zip code)</td>
<td>Health Department Dashboards&lt;br&gt;<a href="http://health.aliceal.gov">http://health.aliceal.gov</a></td>
<td>• Obesity Rate&lt;br&gt;• Adults with diabetes&lt;br&gt;• Adults with likely psychological distress&lt;br&gt;• Self-reported health, good to fair</td>
<td>The obesity rate in the community to be served is XXX, as compared to a statewide average of XXX. Though obesity has a range of causes, increasing physical activity in the obese population can improve health. This plan will specifically address physical inactivity in the obese population by...</td>
</tr>
<tr>
<td>Corridor/Program/Plan encompassing multiple communities</td>
<td>In the case of a large-scale corridor project, program or plan, we recommend narrowing the scope of your question 5 response to focus either on a limited geographic area with poor health outcomes (see above) or to a distinct target population (e.g. the elderly, students, or others) whose health outcomes you wish to improve.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighborhood or other sub-population</td>
<td><a href="http://health.aliceal.gov/health_atlas">http://health.aliceal.gov/health_atlas</a></td>
<td>Identify vulnerable neighborhoods or populations based on:</td>
<td>Though this proposal crosses multiple communities, we have specifically considered how we might improve health outcomes within (a geography, a demographic category)</td>
</tr>
<tr>
<td>The County’s Community Health Assessment</td>
<td><a href="http://health.aliceal.gov/health_atlas">http://health.aliceal.gov/health_atlas</a></td>
<td>• Age&lt;br&gt;• Socioeconomic status&lt;br&gt;• Disability, need for special accommodation&lt;br&gt;• Health vulnerability</td>
<td>The County’s Community Health Assessment establishes priorities for improving health for specific demographics groups, and sometimes within distinct geographic communities. This can be a helpful guide for prioritizing projects.</td>
</tr>
<tr>
<td>County-wide Community Health Assessment/Community Health Improvement Plan</td>
<td>The County Community Health Improvement Plan identified goals (goal here) a priority for health improvement. Our plan/project targets will help move the needle in this area through the following strategies:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>