



What do we mean by the
“Social Determinants of
Health?”



Social Determinants of Health

From the CDC (2018):

Conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.

<https://www.cdc.gov/socialdeterminants/index.htm>

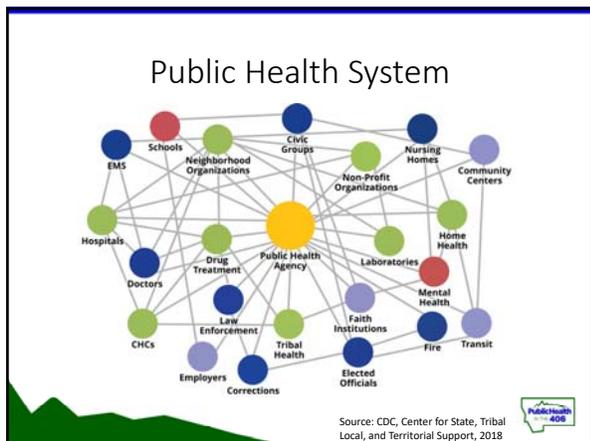


What is Public Health?

“The activities that ensure conditions in which people can be healthy. These activities include community wide efforts to identify, prevent, and combat threats to the health of the public.”

-- Institute of Medicine





Estimated Deaths Attributable to Social Factors in the US (2011)

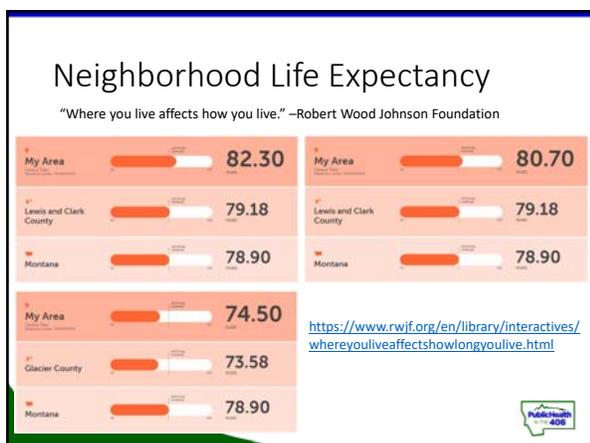
Estimated Deaths Attributable to Social Factors in the United States
12/16/2011, 10:00 AM, Revised from: BMC Medicine 9:142 (2011) doi:10.1186/1745-2875-9-142

Authors suggest that approximately 245,000 deaths in the US in 2000 were attributable to low education.

- 176,000 to racial segregation
- 162,000 to low social support
- 133,000 to individual level poverty
- 119,000 to income inequality,
- 39,000 to area-level poverty.

Compared with 192,898 deaths caused by acute myocardial infarction, which was the leading cause of death in the US in 2000.

- Cerebrovascular disease: 167,661
- Lung cancer: 155,521



From the State Health Assessment:

<https://dohhs.mt.gov/Portals/85/ahealthiermontana/2017SHAFinal.pdf>

- 86% of Montana high school students overall completed high school within four years, compared to 66% of American Indian students (2015-2016).
- The median household income in Montana was lower than the US from 2012 to 2016, and the median household income was lower among Montana American Indians (\$29, 837) than Montanans overall (\$49,939) (2012-2016).
- In 2018, of the 56 Montana counties:
 - 54 are designated as Primary Care Health Professional Shortage Areas (HPSA),
 - 55 as Mental Health HPSA, and
 - 41 as Dental HPSA.
- In 2011, 60% of Montana adults reported at least one ACE and 39% reported two or more ACEs. A higher percent of American Indian than white adults reported experiencing four or more ACEs, as did:
 - Adults who had not completed high school compared to those who had more education,
 - Adults with lower annual incomes compared to those with higher incomes, and
 - Adults with disabilities compared to those without disabilities.
- Adults with ACE scores of four or more reported poor physical or mental health more often than those with no ACEs, and reported smoking, drinking, or misuse of prescription drugs and being obese more often (2011).



From the Robert Wood Johnson Foundation resource:

“What is health equity, and what difference does a definition make?”

Defining Health Equity for Different Audiences

A 30-second definition for general audiences:

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

A 15-second definition for technical audiences: For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.

A 20-second definition for audiences who ask about the difference between equity and disparities:

Health equity is the ethical and human rights principle that motivates us to eliminate health disparities; health disparities—worse health in excluded or marginalized groups—are how we measure progress toward health equity.

An 8-second version for general audiences (health equity as a goal or outcome): Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

Another 8-second version for general audiences (health equity as a process): Health equity means removing economic and social obstacles to health such as poverty and discrimination.



What do we do? First, talk about it.

- The concept resonates, but the wording doesn't
- Help people make the connections that they already know to be true—for example, availability of quality health care
- SDoH affect all Americans, not just one specific subpopulation of people
- Personal responsibility shared with social responsibility



Then, make sure it gets considered.

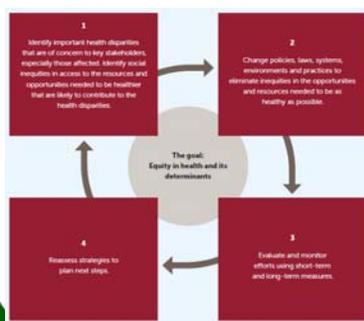
From the National Association of City and County Health Officials (NACCHO):

- 1: How is our organization contributing to or exacerbating health inequities?
- 2: How can our organization play a greater role in addressing the various factors that are contributing to poor health outcomes such as housing, transportation, or education?

Are you reviewing an internal policy or procedure any time soon? Consider taking a look with a health equity lens.



Key steps to advancing health equity



Source: Robert Wood Johnson Foundation, "What is Health Equity? And what difference does a definition make?"



Additional SDoH resources

The Public Health Foundation

https://www.train.org/main/training_plan/3840

Healthy People 2020

<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

HealthEquityGuide.org

<https://thehealthequityguide.org/>

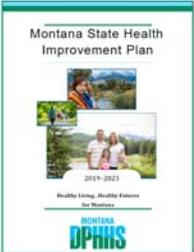
The Community Tool Box

<https://ctb.ku.edu/en/table-of-contents/analyze/analyze-community-problems-and-solutions/social-determinants-of-health/main>



State Health Improvement Planning





Find them online at dphhs.mt.gov/healthiermontana

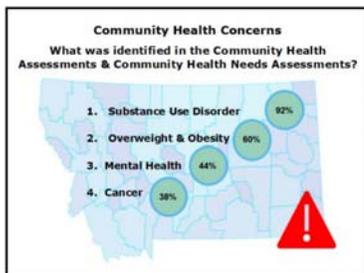


State Health Assessment (SHA)

- First SHA completed in 2012
- SHA repeated in 2017
- Detailed information on access to health care, causes of death, chronic diseases, communicable diseases, maternal and child health, unintentional injury, mental health substance abuse, environmental health, and social determinants of health



What do Montana Communities care about?



State Health Improvement Plan (SHIP)

- Developed by the State Health Improvement Coalition
- **Mission:** *to protect and improve the health of every Montanan through evidence-based action and community engagement*
- Used the information available in the SHA to identify five health priorities to focus on as a state over the next five years
- Designed to be a collectively owned and living document to improve collaboration amongst statewide partners



Using the SHIP

- Review the contents. Ask yourself, is your community or organization addressing any of these issues? How can work in your community be coordinated around these health issues?
- Work with local or tribal health departments to participate in the planning process at the community level.
- Encourage your organization and other groups in your community to align their plans and policies with the strategies in the SHIP.



Why does the state health department care about local community health planning?

- Used as a secondary data source for state-level planning
- Align and improve collaboration on key health issues
- Increase capacity of local and tribal public health departments to provide essential services
- Strengthen the public health system as a whole



Terminology

Step 1:
Do an assessment

Step 2:
Make a plan

CHA

CHNA

CHIP

IP



What is the value of partnering?

- Share costs and resources
- Maximize resources
- Brings more credibility in the community
- Brings more stakeholders to the table and more buy-in
- Able to extend population/demographic reach
- Results inform state-level planning activities



Examples of Successful Collaborations

- Daniels County
 - Collaboration led to MHCF grant to help implement the CHIP
- Valley County
 - Collaboration led to successful PHSD grant to implement the CHIP
- Richland County
 - Collaboration led to yearly county conference
- Yellowstone County
 - Successful collaborations between public health and two major health care organizations



Thank you!

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