



Healthy Sacramento Coalition Meeting October 24, 2012 Meeting Summary

Meeting Outcomes:

- Share progress updates and development of Coalition's infrastructure
- Update of community health assessment, policy scan and communications strategies
- Continue building effective working relationships in service of the Coalition's efforts

Welcome, Introductions and Agenda Review

Gregory Hodge, Meeting Facilitator, began the meeting by having everyone introduce themselves and participate in a brief get-to-know-you activity. Gregory provided an overview of the agenda for the day and the meeting outcomes. Gregory invited Diane Littlefield, Sierra Health Foundation Vice President of Programs and Partnerships, to provide a summary of our progress to date.

Summary of Our Progress and Where We Go From Here

Diane Littlefield announced the one-year anniversary of the Healthy Sacramento Coalition (HSC). She set the framework for the work to be completed by the coalition in the following year by recognizing the beneficial process of the collective efforts of each member of the coalition. She presented a history of where the coalition has been since November 2011. The greatest task of the HSC is to develop an implementation plan by early 2013 and set up systems and policies to support families. The potential impact is huge – on families, neighborhoods, communities, or even the whole county. It is exciting to challenge ourselves on understanding what this means and how to utilize all the knowledge and resources in the coalition to make this happen. **The next big project for the community to organize around is the development of the implementation plan, which is due April 2013.** The turnaround time is short between now and March 25. Diane encouraged everyone to continue to move forward to reach the next phase in October 2013, which will be the beginning of implementation.

Diane Littlefield highlighted the five CDC focus areas:

These three focus areas are mandatory:

- I. Tobacco-Free Living
- II. Active Living and Healthy Eating
- III. High Impact Quality Clinical and Preventive Services

These two are optional:

- IV. Social and Emotional Wellness
- V. Healthy and Safe Environments

In Sacramento, we struggle with the desire to want to do everything and not let go of anything. According to the CDC, we have been advised not to dilute our efforts. CDC said: focus, focus, focus. We have to agree on how we are going to move forward together by the end of the day today, Greg will lead this discussion later today. One thought is to do all three that are required and make sure to include areas four and five as part of areas one, two and three from the list above. This is an idea for everyone to consider because we will have to find closure through this process.

Diane Littlefield explained that we will use the month of November to focus on area one: Tobacco. We will tackle one focus area at a time and come up with policy recommendations for each one. We will have the data (community health assessment report) and policy scan to help us understand the issues and problems. We will develop policy recommendations around tobacco followed by communications and training strategies to implement those policies. We will learn from this and move on to the other focus areas: active living and healthy eating, and high impact quality clinical and preventive services, and integrate the last two areas: social and emotional wellness, and healthy and safe environments. To really do the top three effectively we have to think about focus area four and five.

Diane clarified the particular interest of Sierra Health and of many organizations in the coalition, which is to close the gap around health disparities with a focus on advancing health equity. In terms of the community health assessment report, we will have to be deliberate and tap into the expertise in the community to do this very well. The community partners were brought on to help us do this work because we cannot do this alone. Many applied and joined the coalition. Where there were some gaps, organizations were invited to participate. Diane introduced Heather Diaz, Valley Vision and CSUS, and asked everyone to think about two or three facts that each person can take away and share as data points.

Community Health Assessment Presentation

Heather Diaz presented the final results of the Community Health Assessment report. This presentation will be available on the Sierra Health web site. Heather started with the end in mind: The intention and reason for doing this work is to demonstrate changes in certain health indicators as listed in the CDC guidelines. We are done with one year and have four years to go. There is a focus on structural, systems changes to cause real, lasting change.

With a focus on primary prevention as the approach, at the conclusion of a five-year plan, applicants should define and justify concrete, achievable targets for these objectives in their area, demonstrating, as required by law:

- a) Changes in weight
- b) Changes in proper nutrition
- c) Changes in physical activity
- d) Changes in tobacco use prevalence
- e) Changes in emotional well-being and overall mental health

Q: *Are those the only five things or is it also measurable reduction in heart attack and stroke?*

A: **These are the specifics; I would assume that those are embedded in these five outcomes. We can talk about that in a little bit.**

Heather revisited the HSC guiding principles and reviewed the assessment goals in relation to communities (15 zip codes) experiencing the greatest health disparities, especially related to chronic diseases. She described the design of the assessment, including the primary and secondary data (means someone else collected this data originally) organized into different buckets: variables. Health Outcome Indicators were described and highlighted patterns by race and ethnicity and cross checking to see if similar data was valid. Other factors included in the assessment were socio-demographic data. Whether you own a home or are renting – we see that renting in the public health field seems to be a variable that carries weight in terms of the fluidity and stability of a community. Behavioral Health and environmental indicators were two buckets; the most challenging thing was to acquire zip code-level behavioral data. Environment was defined loosely – both physical environment and anything that would be related to a person’s interactions and the way they navigate their life.

California Health Interview Survey (CHIS) was contracted to gather select behavioral data at the zip code level. It was challenging because of the limited sample size in our county. To ensure we had some local data captured, some came from Kaiser Permanente's Community Benefits infrastructure data to help fill in some of the gaps for indicators such as fruit and vegetable consumption. She walked everyone through various data sets and maps of varying data to examine the overall impression of the county.

The focus of the research team was on the geographic areas in the county, specifically zip codes that showed patterns of emergency room visits per 10,000 population, for diabetes and other health conditions. The pattern indicates that the rates for hypertension and diabetes are very similar in certain zip codes. Another interesting pattern for emergency room visits related to mental health causes being very similar in terms of chronic disease causes. We saw some communities with high rates of both. The data was analyzed to identify 15 zip codes/communities that showed up for chronic diseases and mental health indicators and were consistently in the top 20% (highest rates) and drastically above county and state rates and comparing that to the mortality data (age adjusted?). The 15 areas called communities of concern are in three categories: North, Downtown and South area with corresponding zip codes and community names and neighborhoods.

One data table displayed the disparity levels and revealed patterns by comparing three zip codes from the communities of concern with an affluent zip code (Folsom area) to understand the level of disparity when comparing different determinants of health (variables) and health outcome indicators.

Overall findings of the report include:

- Access to Care
 - Primary, medical home - roadblocks
 - Lack of coordination of care between providers
 - Chronic diseases - care lacking; prevention focus absent
 - Dental - absent
- Mental Health
 - Coping with life stressors - money, family stress, immigrant stress, community safety, stress of disease
 - Lack of treatment in the area - physical; insurance coverage
- Healthy Environment
 - Cued for disease and illness
 - Access to healthy foods limited
 - "Safe" recreational areas to play
- Community full of assets
 - Systems approach at managing/preventing chronic diseases
 - Improving (streamlining) the coordination of services and care for all areas of the person

Questions:

Q=Questions, C=Comment, S=Suggestion

Q: *Going back to the original maps with the areas of concern, were the population denominators of those rates the population of those areas or of the county?*

A: **It was of the population of the zip codes.**

Q: *The maps had an area that lit up every time, which was not in the 15 zip codes – can you tell us what area that is? Is that Rancho Cordova?*

A: **It is Rancho Cordova/Rosemont area; it was actually our 16th zip code. What ended up happening is that in general it was high in the outcome data, however it was not consistently high in the mental health bucket. So we really are providing our recommendation to you all. Is 15 the magic number? No, it is not. This data will be available for you to look at that community (zip code) further.**

Q: *Is the full report available on the Sierra Health web site and also the PowerPoint?*

A: **Valley Vision has given Sierra Health the report. It is under review by three members of the leadership team, and our goal is to make it available on our web site by mid-November. It is not just the report, but our goal is to make the data user-friendly and accessible on our web site. All of the report is public information; we want to make it accessible so that you can manipulate the data. Yes, all the presentations will be on the web site.**

Q: *Could you define shortage of physician or medical personnel? Does that mean in existing care facilities that there isn't enough staff or does that mean there is not access to medical personnel if you are a medical consumer?*

A: **It's actually health professional shortage area – comes out of the Bureau of Health Professions and is defined specifically as areas that have a critical shortage of primary care health professionals and is designated as per 500 individuals. Health professional is loosely defined as primary medical care.**

Q: *So if you live close to UCD Med Center, does that change the data versus if you happen to live further from a hospital?*

A: **I don't know the exact answer to that question, but we can find out how it's defined. My assumption is yes, it would.**

C: **It seems counterintuitive, with the map that all the hospitals are grouped in a central area of the city, yet this area has been identified as a health professional shortage area, even though I know it's primary care.**

A: **It's also based on population density.**

Q: *Will there be detailed data as far as rates of smoking or obesity by zip codes, and also did you look at retail environments and things like that?*

A: **In answer to your second question, we looked at retail environments for alcohol, but not for tobacco.**

Q: *I'm wondering if we mapped liquor stores and convenient stores because they will be indicators for tobacco.*

A: **Yes, we do have a map. It's not tobacco. It is active off-sale retail licenses per 10,000 (alcohol, not including tobacco). To answer the first question, the way the report is organized is by area: North, Downtown and South. Then we looked at those zip codes/communities in these areas that consistently were jumping off the map and then we further detailed that by the five focus areas.**

Q: *You were able to get CHIS data for those 15 zip codes?*

A: **We were. It was regionally oriented and it required combining zip codes to get up to certain population levels. We got a little more data beyond Sacramento County.**

Q: Do we have data on what type or kind of renting, multi-family housing renting?

A: **No we do not have specific data, just total percent of individuals in a given area that are renting, and that data came from Dignity Health. That is a variable they collect in their assessments.**

Q: *As a first time attendee, I have a general question. I want to go back to the focus areas, and I thought it was interesting that the focus is on the top 3 as opposed to all 5. It seems like it should be reversed; Social and Emotional Wellness, Healthy and Safe Environment (should come first) and then the other areas?*

A: **That is actually a conversation we are going to have today to decide. It was a proposal around taking the top 3 and integrating 4 and 5 into it. However, the report addressed all five areas.**

Q: *Regarding tobacco-free, what about the use of medical marijuana since that is legal in California?*

A: **We did not include that. It would have been interesting data, though.**

Q: *Did you look at the CHKS (CA Healthy Kids Survey) data for student tobacco, alcohol and drug use for some of these other indicators?*

A: **We didn't for a number of reasons. One was that this data was unavailable at the sub-county level and if it was, it was not available based on demographics, so we were very cautious. We made a decision as a (research) team to not go down the road of "kid data" – instead we focused on the (chronic outcome) later stage, chronic disease and disparity focus.**

Q: *About the age groups; what age group did you start and end at, if you were not focused on children?*

A: **All of the data except for the fruit and vegetable and obesity data went down to 12 years of age and everything else is adult data. Qualitatively we only spoke to adults. We didn't look at age of each data set, but it is probably 18 and up. We do not have an age breakdown. We could find out each variable and get back to the group. OSHPD data is emergency room visits and hospitalizations. We don't have the age breakdown of every participant.**

Q: *I'm thinking about if it includes seniors? Is that a demographic we should be targeting or is that included in adult?*

A: **That data has been provided to Sierra Health as electronic files with all spreadsheets – one file has data by age, race/ethnicity and gender and is available and a way to examine this information. I didn't talk at all today about what we were seeing racially and ethnically, because that would have taken longer.**

Primary Prevention and Policy Scan Presentation

Juliet Sims, Prevention Institute, greeted everyone. The presentation by Prevention Institute will be available on the Sierra Health web site. Juliet shared data from Alameda County showing the life expectancy in Oakland based on where people live (flat lands versus the hills). The difference in the two areas include demographics, home ownership, green space and community design elements. Alameda County assessed life expectancy to be significantly less (by 15 years) for a child in the flat lands as opposed to living in the hills. Community factors of health are rooted in place. Environments that people live in determine the kinds of foods that are available, community design, exposures (air quality), and what is sold and how it's promoted. These factors are important to think about when talking about place-based change. The focus of today will be on **primary prevention**, which lends itself to environmental and place-based change.

The **definition of primary prevention**: promoting healthy environments and behaviors to prevent problems from occurring before the onset of symptoms; it's preventing illness and injury in the first place.

With the Prevention Continuum framework, it's helpful to consider the different strategies that fall into varying levels of prevention:

- **Primary**: approaches that take place *before* illness or injury
- **Secondary**: responses *after symptoms or risk* of illness or injury
- **Tertiary**: responses *after onset* of illness or injury

The reason why Primary prevention weighs heavier than the other two is because it focuses on population-based approaches and has the capacity to affect the largest group of people. Currently only 5% of public health dollars go to primary prevention. The majority of dollars go to tertiary. While 70% of health outcomes are linked to environment and behavior and only 5% are allocated to primary prevention, there is a mismatch in resource allocation.

Prevention Institute has a nationwide network called UNITY: Urban Networks to Increase Thriving Youth. This is a violence prevention initiative that takes a public health approach to preventing violence in the first place.

A group of youth (UNITY) came up with a framework with youth-friendly language:

- **Up front**: approaches taken before violence has occurred to prevent initial victimization
- **In the thick**: Immediate responses after violence has occurred
- **Aftermath**: Long-term responses after violence to deal with the lasting consequences

Juliet reviewed the spectrum of prevention framework, which has six levels. It is a planning tool to think about change; all levels are critical for comprehensive change. Prevention Institute's focus is on the top three levels: influencing policy and legislation, changing organizational practices, and fostering coalitions and networks. When thinking about policy change, the aim is primary prevention (quality). Aimed at community environments, it is comprehensive and focused on changing norms about making the easy choice the default choice.

The Policy Scan is focused on Sacramento County practices and policies. An update on the initial findings: There is significant history of tobacco policies, with a shift in multi-unit housing to create smoke-free zones, as well as looking at community strategies to create smoke-free corridors near businesses and institutions. There is significant work currently underway around active transportation and built environment; in many of the general plans there is language including walk-ability and bike-ability. There seems to be some challenges with implementation of this language, and perhaps one of the directions this coalition moves toward is thinking about how to bring these issues to legislators and decision makers in the region. There are strong examples of organizational practices that institutions are adopting.

This coalition is thinking about equitable health outcomes. There is valuable work happening in the county, and by looking at the existing policy work we can think about models in better-served communities and translate it into underserved communities. The policy scan should be finalized within the next few weeks.

Q: *UNITY – can you provide the acronym again?*

A: **Urban Networks to Increase Thriving Youth. If you are interested, I can connect you with the program manager.**

C: Thank you very much for the presentation, especially on primary prevention. It's hard work, it moves very slowly and sometimes you don't see results for years and years. Thank you. I appreciate you providing this.

In honor of the recent loss of two members of the United Lu-Mien community, the coalition acknowledged Brian and Raphael Saechao, who died last week in a tragic accident.

Update on CTG Infrastructure

Debra Oto-Kent, Health Education Council, provided an overview of the coalition infrastructure. To date, we have met two outcome deliverables: community health assessment and policy scan. Another one was the community engagement and coalition building aspect. The primary focus is the CDC goal areas and being a population-based initiative. Diane mentioned the word grassroots a lot, and many of us work at this level. Many of us have experienced a feeling of wanting to do something. The other approach is that if we work with communities experiencing health disparities, we can better know what needs to change. Within the framework how do we translate what is going on at the grassroots level to the grass tops.

There has been a lot of process, at least six coalition meetings, and no less than six workgroup meetings. Many have volunteered to sit on workgroups. Every meeting has struggled with what is our role. Two steering committee meetings and one leadership team meeting have also taken place. How this coalition operates as a group is recognizing assets and the great deal of good work going on in the county. There is lots of robust work taking place right now in Sacramento related to many issues, including obesity and violence prevention. There is a parallel Health Care Partnership that is convened by Sierra Health, which is looking at similar and complimentary issues. The approach has been not to duplicate existing work, but to cast a wide net to connect the dots.

Debra mentioned that there were a couple of questions that emerged from the community health assessment, like how do we create working operating guidelines to better work together, and how to create a systems approach to coalesce all the assets. This has been the biggest question the coalition has – how do we think through structuring the coalition. Another question is how can the Healthy Sacramento Coalition be a vehicle for Sacramento County to collectively promote and advocate for health? Not just CTG issues, but on a variety of health issues. There is a great deal of collective power in this room and how can we use this collective voice to advocate for changes that we need to move the dial and change health disparities in the county. Many have asked multiple questions around individual roles, how organizations fit into the coalition, how will agency work be integrated into the implementation planning process, what do we bring, and what do we want to get out of our involvement. Questions at the workgroup level include what are we suppose to be doing?, where do we start?, what do we mean by policy?, how do we get on the same page?, who are we supposed to be communicating with?, and who are we supposed to be training and whose capacity are we building?

Debra provided an update from the Steering Committee on the development of the coalition operating guidelines. The goal is to provide a draft to the coalition by the end of November and to answer such questions as how does one formally become a member? There are three workgroups: Policy, Communications, and Capacity Building and Training. In order to bring more clarity and definition, we need to design a formal process to register and be a member in progress. See the Steering Committee and Leadership Team lists for more details. Efforts are being made to ensure communication across workgroups and the coalition at large.

The Steering Committee will be discussing the flow of work, how to set priorities and make decisions. The coalition meeting in November will focus on the first priority area of tobacco-free living. The workgroups are where we sink into the health assessment data to move forward. We hope to answer the questions that have been raised.

Finalizing Decision on How to Prioritize CTG Topic Areas

Gregory Hodge provided the coalition with two options to decide on how to move forward with the five focus areas. Start with proposal A: Take topics 1, 2, 3 and integrate 4 and 5. Proposal B: Only focus on 1, 2 and 3 at this time and leave out 4 and 5. Using the gradients of agreement 1-5, the coalition voted on this item.

Q: *Could you clarify what is included under High-Impact Quality Clinical and Preventive Services? I'm not sure what's in that bucket.*

A: **One group has been gathering information on high-impact clinical interventions that can prevent heart attacks and strokes. An example of this is to make sure that every patient who has been diagnosed with hypertension or heart disease gets a simple low-cost generic bundle of medication and get them using it (and make sure it's subsidized). If you do this, you can prevent 60-80% of heart attacks in Sacramento. In addition to that, when someone goes to a clinic, they receive education and information on comprehensive care on what they can do. One environmental thing we could do is get people taking their blood pressure and know their numbers at work, or at the grocery store (on billboards). This is an environmental piece.**

C: I think it's a no brainer that we should do all five; we cannot divorce the other two. The only reason is because the big funder wants us to focus on the top three. We still need to include them. It may take more work, but we can't do a good plan for Sacramento if we don't include them. Satisfy the funder and satisfy us.

The group voted and the final decision is Proposal A: Take topics 1, 2, 3 and integrate 4 and 5 into the top three. The implementation plan will focus on the top 3 and weave in 4 and 5.

Member reservations:

C: I agree trying to address all 5. I'm having a difficult time, knowing what the CDC wants us to go narrow and deep and how are we going to do that with integrating it. I may not know how this will work.

C: Ideal to do all 5; it takes a lot of resources or it may take resources from other programs. It's better to do a few items and do them well. It may be ideal to do all five. I would prefer to do a couple and do those very well.

C: I'm a one. The details, let's be sure how we are incorporating 4 and 5, need to be clear how to do this. This may take place during workgroups.

- C: People approach, one is the emotional response. But we also have to add some logic to see how it breaks down. There are valid points that we need to take into account. Not just our emotional desire to do all five.
- C: I think you have to implement all of them to get to our goals.
- C: How do we make sure and get there, be very direct in our indicators to measure impact and evaluation. Ask questions around these 4 and 5 areas. What does that look like.
- C: Just to clarify, we're just adding those as part of the lens for 3. It's not the entire lens. It's just saying let's keep these in mind as move forward.
- Q: *Are we measuring 4 and 5?*
- A: **Yes, articulate there will be some form of measuring in context of the top 3 for the 4 and 5.**
- Q: *Are there other groups who have done this in the past? What are they doing?*
- A: **We don't know. On the CTG web site you can look up all the other web sites.**
- C: Propose an amendment, in 6 months we take a second vote to see if this plan is working or not. Maybe we need to modify this. The agenda for 6 months from now, let's take a second look. We should just take a second look at some point later in time. Maybe the decision could be adjusted as we move forward.
- C: Ask the policy workgroup to write an amendment to make sure this is done in a way to achieve those top goals.

Next meeting

Scheduled for Wednesday, November 28, 2012, from 9 a.m. to 12 p.m. Registration is required. Visit the Healthy Sacramento Coalition web page at www.sierrahealth.org/healthysacramento today.