

Office of Disease Prevention and Health Promotion
Healthy People 2020 Spotlight on Health Webinar:
Social Determinants of Health
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CARTER BLAKEY: Welcome, everyone, to the Healthy People 2020 Spotlight on Health Webinar series. The theme of today's Webinar is Social Determinants of Health. During the Webinar you will hear from several distinguished speakers. We have with us Dr. Aaron Wernham, Director of the Health Impact Project, a collaboration of the Robert Wood Johnson Foundation and the Pew Charitable Trusts, will provide an overview of the social determinants of health, and highlight how SDOH is being applied to the field. Rear Admiral Sarah Linde, who's a Medical Officer in the Commissioned Corps of the U.S. Public Health Service and Chief Health Officer for the Health Resources and Services Administration, will articulate why the social determinants of health are a Healthy People 2020 topic area, and how the social determinants of health are addressed at HRSA. Dr. Patty Tucker, Acting Associate Director for Health Equity within CDC's Division of Community Health, will highlight specific examples of SDOH in action.

So to set the stage for today's presenters, I'd like to give you a quick overview of Healthy People and the new Topic Area on Social Determinants of Health. Next slide, please.

So, what is Healthy People? Healthy People is often called a roadmap for nationwide health promotion and disease prevention efforts. Healthy People is about understanding where we are now and taking informed action to get to where we want to be over a ten-year period. It provides science-based objectives for improving the health of the Nation, engages a network of multidisciplinary, multi-sectoral stakeholders at all levels, creates a comprehensive strategic framework for health promotion and disease prevention issues, and includes specific measurable objectives with target to be achieved by the year 2020. Perhaps most importantly, Healthy People calls for the tracking of data-driven measures and outcomes that monitor our progress over time, allowing us to see trends and to motivate, inform, and focus action. Next slide, please.

Healthy People is used in many ways by health officials at the national, state, or local level, national membership organizations, businesses, health professionals, and researchers. You can actually consider Healthy People and its comprehensive set of objectives as sort of a menu from which you can choose a la carte the items that you think meet your needs. It's used as a data tool for measuring program performance, a framework for a program planning and development, a goal setting and agenda building platform, a foundation for teaching public health courses, a benchmark for comparing state and local data, a national agenda for forging partnerships, and it has even been used by other countries to model their own disease prevention and health promotion programs. Next slide, please.

Healthy People is the longest-running disease prevention and health promotion plan in the Nation. Since its inception in 1979, the number of science-based objectives has increased with each decade, a reflection of an increasing knowledge base and stakeholder support. Healthy People 2020 has grown from the 200 objectives in the first iteration to about 1,200 in this current decade. Each of these objectives is housed within one of 42 Topic Areas and this number of Topic Areas has also grown over the last few decades from, I think, a beginning number of about 15 up to the grand total of 42 now.

You can see from this slide that Healthy People has evolved over time to incorporate some of the really important and pivotal public health issues that have occurred over the decades, such as issues dealing with immunization, HIV, tobacco use, overweight and obesity, and a host of other issues. Next slide, please.

Healthy People is guided by a vision, mission, and overarching goals. For Healthy People 2020, we have four overarching goals and they are: to attain high quality longer lives free of preventable disease disability, injury, and premature death; to achieve health equity, eliminate health disparities, and improve the health of all groups; create social and physical environments that promote good health for all; and, finally, promote quality of life, healthy development and healthy behaviors across all life stages. The Healthy People 2020 objectives and Topic Areas were each developed with these overarching goals in mind. The Healthy people graphic that you see on the slide depicts visually the ecological and determinants approach that Healthy People 2020 takes in framing the national health objectives. The concept of determinants describes how the conditions in which we live, work, and grow, such as our physical and social environments and access to health services, as well as our individual behavior and biology, can have an enormous impact on health. The graphic framework also attempts to illustrate the fundamental degree of overlap among the determinants of health, as well as emphasize the collective impact and influence on health outcomes and conditions. Next slide, please.

Healthy People 2020 includes what we call a set of Leading Health Indicators or LHIs. The LHIs represent critical health issues that, if addressed appropriately, will dramatically reduce the leading causes of preventable deaths and illnesses. These indicators or critical health issues are linked to specific Healthy People objectives and Social Determinants of Health is one of those indicators. Healthy People 2020 is available online to stakeholders across the country and around the world. The healthypeople.gov website offers an array of user-centered interactive tools that allow you to conduct custom searches based on your own interests, whether you're looking for specific objectives data, evidence-based interventions and resources, eLearning opportunities, and much more. Next slide, please.

This slide gives you a screen shot of one of the pages of healthypeople.gov. From the healthypeople.gov website, you can access the Social Determinants of Health Topic Area. Rear Admiral Linde will address this specifically in her remarks little bit later.

AARON WERNHAM: Thank you to the Healthy People 2020 team, who organized this webinar and invited me to talk with all of you. This slide highlights a problem that's probably familiar to most of the people on the call today. Although the United States spends more per capita on health care, our life expectancy and many other health indicators lag behind those of other developed nations that are spending considerably less. Over the last decade this has prompted a re-examination of not only our medical care system, but also the range of social, economic, and environmental factors that influence the health of Americans. These are what we're talking about today, the social determinants of health. Next slide.

The term social determinants of health really encompasses a wide range of upstream factors that can influence health, factors such as employment, housing, income, access to healthy foods and safe places to exercise, environmental pollution, and education. To be sure, this is not a new idea. Even in the 1800's, for example, Rudolf Virchow, often called the father of modern pathology, said that physicians are the natural attorneys for the poor and social problems fall largely within their jurisdiction. So the recognition that

poverty, unsafe working conditions, and poor housing can contribute to ill health has been central in some way to prevention and disease control efforts from the very beginning. Yet today, health care expenditures constitute nearly 20 percent of all the goods and services in the U.S. and illnesses such as type 2 diabetes, asthma, and obesity are still on the rise.

My own perspective and experience in the social determinants of health was formed as much by years of clinical practice in primary care as by my public health training. I spent years in practice working with low-income urban communities, as well as with Alaska native villages up to four hundred miles from the nearest road. In both settings, I often found that my patients ran up against the social determinants personally and daily. When I tell somebody to get more exercise, if she lived in a neighborhood like the one on this slide, where you can see a yellow circle around someone trying to make their way across this very busy street, it's potentially difficult or even dangerous to follow my advice. When I was in my medical residency, I once admitted a six year-old boy to the hospital with his third serious exacerbation of asthma in less than two months. Each time that he was admitted and each time he went home on higher doses of medication. The medical team scratched their heads about what else could we be doing for this boy. His mom mentioned to me that they lived in a rundown apartment with lots of mold and I remember asking the senior attending physician whether there was any way to actually prescribe a new apartment. Unfortunately, the prescription pad really didn't work that way. This story really does highlight the critical importance of beginning to engage other sectors involved in the policies that shape the social, economic, and environmental conditions in American communities, if we hope to effectively improve Americans' health. Next slide.

This has become an increasingly common call in the field of public health. This is a quote from the Institute of Medicine looking at the future of public health in 2002. This realization has really led to increasingly urgent and frequent calls from within the field of public health and a new interest in the role that other sectors such as transportation, housing, education, and land use planning play in determining the conditions that drive Americans' health. Next slide.

The World Health Organization had a very prominent commission on the social determinants of health and this has become a leading priority for global public health and prevention efforts. This report was issued in 2008 and is available at the website shown on this slide. The commission focused on important influences on health that come from the early childhood environment and education, the importance of healthy physical environments, healthy places, fair and decent employment, social protection, and also equity and political empowerment and social inclusion—all being very important fundamental factors that shape health and illness around the globe. Next slide.

Several years later, WHO sponsored a world conference, which led to a political declaration on the social determinants of health. This declaration called for the participating nations to pledge to promote improved health and health equity by working across different sectors, by implementing recommendations of the commission, by strengthening international collaboration, and empowering the role of communities. Next slide, please.

I think this puts a nice context around the phenomenal work that's now a part of Healthy People 2020 on the social determinants of health. This is just a brief slide highlighting some of the important Healthy People 2020 indicators on the social determinants. By adopting a new set of indicators, the program has put social,

economic, and environmental conditions and the policies made by sectors outside our standard sphere of influence squarely on the map as an important part of national, state, and local efforts to improve Americans' health. This looks at issues such as economic stability, education, social and community context, certainly access to health care, and also things like neighborhood and the built environment as being central to efforts to prevent illness. Next slide.

I do want to acknowledge that this breadth creates very real challenges for anyone in the field of public health or anyone else seeking to improve health in the U.S. It's one thing to acknowledge—just picking one example—that transportation policies are important to health, but it's entirely different to take that knowledge and figure out how to translate it into real, concrete policy changes on the ground. Doing this takes a practical understanding of the regulatory, political, technical, and budgetary constraints within which policy-makers in other sectors have to practice. And we may need to recognize that public health considerations are only one of many that have to be factored into a new policy or project. In short, beginning to work with other sectors on the social determinants of health really presents a cross-cultural communication challenge and a need for us to learn an awful lot about the way that policy-makers in other fields do their work.

On the next slide, I will introduce one tool that we're beginning to see used around the U.S. as a way to accomplish these goals and surmount these challenges. I'll spend the rest of the time talking about health impact assessment, or HIA, a field which has proven to be effective and, I think, an exciting way to begin to move to action on the social determinants of health. This is a National Research Council report and guidance on conducting health impact assessments and it can be downloaded free at the National Academy's website. I'll just emphasize a few things from this definition of HIA that the National Academy has presented. A health impact assessment includes a defined process, but it's not one single analytic method. The assessment of impacts takes quantitative data, gray literature, stakeholder input, and even expert judgment into consideration. Stakeholders are engaged at every step of the process and this includes those in the community that will be affected by a decision, policy-makers, and others with an interest in the outcome. And, importantly, despite the fact that the name emphasizes "assessment," the main point of an HIA is actually to get practical, actionable recommendations, things that a decision maker could do in the process of crafting a new policy or permitting a new project that would minimize harms and maximize benefits.

I'll give you an example. This is one I often like to use to introduce health impact assessments, partly because it was fairly simple. It was conducted in a matter of less than two months, requiring fairly minimal investment of staff time and, I think, led to some really pretty concrete tangible benefits. This health impact assessment was done to inform the design of a proposed low-income senior housing building near a major freeway and a large port. It was done as a rapid HIA, which means that it took less than two months. The Health Impact Assessment identified several health issues about the way the building had been proposed. First of all, the risk of poor indoor air quality because the building was right near two major outdoor sources of air pollution. Secondly, the risk of sleep disturbance and other health concerns associated with noise. And finally, given that the residents in this building were elderly, how easily and safely they would be able to walk to local shops and services in the neighborhood. It was pointed out that some of the intersections they would have to cross were actually quite dangerous. Next slide.

So, the outcomes of doing this work were that the health impact assessment presented several practical recommendations, essentially all of which have, I think, at this time been implemented. The building is built. It includes some alterations in the window designs from what had been planned as opening balcony windows facing the freeway exits to, now, sealed bay windows facing the freeway. They installed a particulate filtration system in the building to keep the freeway pollution out of the apartments and they moved the entryway and installed a noise-buffered courtyard to reduce noise in the building. They also have been working with the city on implementing what are called traffic-calming measures, measures that would help slow the speed of traffic in the neighborhood, so that people could cross a little bit more safely. A resident of this building summed up their experience of moving here this way: "The way that they designed this building, it's for your health. We can open up the air purifiers to get fresh air and even on the side facing the freeway, but the building is soundproof, so you barely hear the traffic. It's so peaceful. Before I lived here, I had to have shots for asthma and go to the hospital for oxygen to get my breathing down to the right level. Since I've lived here, I haven't had to do that once. I love it." So, this was a relatively small investment of time and appears to have led to a real opportunity for people living there to be healthier than they might have without that involvement. It involved collaboration between city planners, public health people, and architects and builders.

If you go to the next slide... this just summarizes a few key things about health impact assessments, some of which I may have already covered. So briefly, it informs an active decision-making process on a proposed action, such as new legislation and new regulation, a permit, a building plan, and what have you. It identifies potential risks and benefits of the proposed action. It takes a broad perspective, looking at social, economic, and environmental factors that might influence health, has a real strong emphasis on interagency collaboration, so if there's a planner making a decision, you need to not do a report and then mail it into them; you need to work with them through the whole course of doing the work. Go to the next slide.

I will very briefly talk about the health impact assessment process. I don't want to get too deep into the technical details and I'd encourage you to look at the website on this slide if you'd like more information. Briefly, the steps of a health impact assessment typically include: screening, in which we decide whether a health impact assessment would add any valuable new information and whether it can be done with the time and resources available, scoping, which determines the scope of the health effects that would be focused on in the health impact assessment; the assessment phase, in which potential impacts are analyzed in greater depth; recommendations, in which the findings of the assessment guide development of feasible, practicable, actionable recommendations to minimize any harms and maximize benefits; reporting, in which the results are disseminated to the public, policymakers, and decision-makers; and finally, evaluating the work. Next slide.

Health impact assessment has its origins in a couple of settings. First, in European nations and the European Union, as well as in Australia, they've been using it for at least twenty years as a way to factor health into social policies and also to look at healthy environments, healthy communities, and how land use planning and health interact.

Second, it has also been used in the context of environmental impact assessment for large projects, such as oil and gas and large mining projects. This started in Canada in the 1990's. It is actually now becoming more and more common over the last few years to talk about ESHIAs, environmental social and health impact

assessments, rather than just environmental impact assessments, recognizing that it's important to achieve a balance between the environmental and social and health concerns that often accompany a large project. Corporations are actually beginning to use HIAs increasingly, recognizing that proactively addressing public concerns early and well can ultimately lower business costs and create a stronger project and better relationships with the community. Go to the next slide.

The map of HIAs and the US as we think it existed in 2007. This is a study that was led by CDC and some other researchers. We were aware at that time of only 27 HIAs that had been completed in the US. Today the field is growing fast...if you go to the next slide... and we're aware of well over 200 that are completed or in progress and we hear about more every day, so this slide is continually out-of-date. The healthimpactproject.org has a navigable map where you can look at where they're being done. It's updated as often as possible. Next slide.

Health impact assessments have addressed a wide range of topics relevant to the social determinants - social policies in education, economy, and employment. For example, there have been recent health impact assessments looking at proposed legislation on alternatives to incarceration in Wisconsin; state policies on school integration--there was an HIA released just a couple of weeks ago in Minnesota; paid sick days legislation—several states have adapted one HIA that was done for a federal law and have had success in informing decisions on both bills around the country. Transportation and housing have been a very common area for Health Impact Assessments. This includes comprehensive plans, zoning, transit corridors, and transit-oriented development, highway upgrades, as well as proposals for increasing green space for bike routes. Also, energy and natural resource development, hard-rock mining, oil and gas development, and power plant development have been common topics for health impact assessments.

I'll finish just by giving you a couple more examples, starting on the next slide, of health impact assessment that have been completed and then what happened as a result of that work. In Massachusetts, the energy crisis has spiked after hurricane Katrina really increased the financial burden for families trying to heat their homes over the very severe winter of 2005-2006. The question at hand was: Should the state increase low-income housing funds? The health impact assessment recognized that under-heating really put families at risk for problems such as pneumonia, as well as burns and carbon monoxide poisoning from using unsafe space heaters, as well as having to make tough choices between heating, buying enough food, and buying medications. This has all had implications for Medicaid expenditures, as well. As a result of the health impact assessment, the state comptroller recognized there were both health and fiscal impacts for failing to fully fund this program and elected to increase funding for the low-income housing energy assistance program there.

The last example I'll give, on the next slide, is a proposed bill to fund what was called the Farm to School Program, a program that would involve procurement by schools of foods grown in Oregon, fresh fruits and vegetables, for use to feed students in school lunches. The health impact assessment looked at both the potential for improved nutrition in school and improving nutritional habits life-long, but also looked at the other economic issues involved in this field. This was a time when Oregon didn't have a lot of extra money to spend on legislation, so they looked also at the economic impacts and found that bill would also create 260 jobs, mainly in rural communities that had been hard hit by the recession. The health impact

assessment contributed to an amended bill that strengthened the requirement for procuring food within the state of Oregon. Also, the legislature finally funded a pilot Farm to School Program. Next slide.

I'll just conclude by saying that, if you're interested in using health impact assessments in your work or just learning more about it, there are a number of great resources: first of all, with the Centers for Disease Control and Prevention and the National Network of Public Health Institutes. The Health Impact Project is sponsoring the second National Health Impact Assessment Meeting in September. Registration is open but capped at somewhere under 500 and, I think, going fairly fast. The Health Impact Project has lots of great resources to help you learn about the field, as well as connect people who are practicing it in an area you're interested in. And, finally, the Centers for Disease Control and Prevention's Healthy Community Design Initiative has been a long-time leader in the field of health impact assessment and has a wonderful website with great resources. Last slide. Thank you all very much.

SARAH LINDE: It is a pleasure to be here. Next slide, please. Overall, I know the webinar is addressing the relationship between social determinants of health and health outcomes, addressing social determinants of health to reduce health disparities. The speaker subsequent to me will be talking a little bit about the use of social determinants of health in the local community, as Dr. Wernham provided examples of, as well. My talk specifically is going to address Social Determinants of Health as a Topic Area in Healthy People 2020 and then give you some examples of how we use social determinants of health in the work that we do at HRSA. Next slide, please.

Social determinants of health, as we all know, are not a new concept, but as Dr. Wernham mentioned, are increasingly recognized as essential elements that have to be addressed if individual, public, and population health are to improve. In addition to examples that Dr. Wernham provided, the importance of SDOH is highlighted by an Institute of Medicine report that was released in January of this year entitled US Health: An International Perspective- Shorter Lives, Poorer Health. In that report, the US was noted to be among the wealthiest, but not the healthiest of nations, and our health disadvantage was attributed to health systems, including large numbers of uninsured patients and more limited access to primary care, health behaviors, such as our generous calorie consumption, drug abuse alcohol-related motor vehicle crashes, firearms, and social and economic conditions, as well as physical environment. So, explicitly stating that creating social and physical environments that promote good health for all as an overall Healthy People objective and including it as one of the ten Leading Health Indicators, as Carter mentioned, really puts SDOH in center stage. And then, establishing Social Determinants of Health as a new Healthy People Topic Area is designed to shine the spotlight even brighter and effect real change.

So, we know Social Determinants of Health is an important topic area, but in order for it to be a Healthy People Topic Area, it has to meet certain requirements. It must have objectives within it and the objectives must be measurable and actionable. With regard to data, even though the work related to addressing social determinants of health is largely done at the local level, each measure must have a reliable national data source. So, the Healthy People SDOH workgroup has therefore been looking at measures that can be available at multiple levels, such as the U.S. census data. With regard to targeted improvement, to date, no 2020 targets have been set, but they could be set at any point in the decade.

Unique to the SDOH Topic Area... this Topic Area uses a place-based approach to address SDOH and concentrates attention to take action where people live, learn, work, and play. And finally, the life course approach emphasizes the relevance of these issues from birth to death. Next slide, please.

The SDOH organizing framework included five key determinants shown here and these may look familiar, as Dr. Wernham highlighted them earlier. They are neighborhood and built environment, education, economic stability, health and health care, and social and community context. Next slide, please.

These determinants were developed into this graphic, which shows the determinants as interconnected or as a continuum, in that each influences and impacts the others. Now this model is not the only way to view SDOH. Rather, it provides a framework for developing and tracking specific SDOH objectives or connecting complementary objectives that is, those in other Healthy People Topic Areas and related to SDOH. Furthermore, this framework identifies relevant and related interventions and resources to support SDOH implementation activities. Next slide, please.

Each of the five determinants reflects or includes several key issues and the next several slides include examples of these key issues for each of the five determinants. Again, this should look familiar, but Dr. Wernham and I thought these were so important that we would both include them in our presentations. So, the first are the issues related to neighborhood and built environment. Next slide, please.

This slide shows the key issues related to education. Next slide, please. Economic stability. Next slide, please. Health and health care. Next slide, please. And finally, social and community context. Next slide, please. So, now that you understand why and how SDOH has become a Healthy People Topic Area, as well as the thinking and the factors that have shaped it as a Topic Area.

HRSA's mission is to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. We achieve our mission by implementing our strategic plan, which has four broad goals: improving access to quality health care and services, strengthening the healthcare workforce, build healthy communities, and improve health equity. Under each goal are sub-goals. Examples of those sub-goals, especially those that focus on public health, are listed here. As you can see, social determinants of health are weaved throughout the essence of the work we do and are explicitly addressed under goal four.

So how does HRSA achieve its mission? With a budget of more than nine billion dollars and eighty different grant programs, we support the Health Center program, which includes community health, migrant health, homeless health, and public housing centers. Combined, there are nearly 9,000 sites, which serve 21 million patients. Our Maternal and Child Health program forms partnerships with states and local governments. The largest of these programs, the Maternal and Child Health Services Block Grant to States, supports local efforts to reduce infant mortality and childhood illness.

The Ryan White HIV/AIDS Program provides care and services for half a million people living with HIV and AIDS. And there's our National Health Service Corps, with its over 9,000 healthcare professionals, who are stationed in medically underserved communities in exchange for loan repayment or scholarship. HRSA gives

financial support to colleges and universities and, through that, we develop a diverse and culturally competent health workforce in the areas of medicine, dentistry, nursing, and public health.

Through the Department's Office of Rural Health Policy, we are the lead federal agency that bolsters rural hospitals and coordinates coalitions of rural health providers, to make health care more accessible for more than 60 million residents of rural America. We oversee organ, tissue, and blood cell donation. We are the federal agency primarily responsible for poison control and we administer a drug discount program, known as the 340B program that allows the neediest patients to receive discounted drugs through eligible providers participating in the program. In all of what we do, we are mindful that, in order to achieve our mission, in addition to the health and health care aspect of what we do, we pay attention to the neighborhoods, the environment, the economic and that social and community context in which the vulnerable populations we serve live, learn, work, and play. While the primary determinant where HRSA addresses SDOH is health and health care, we have long incorporated other determinants of health principles into what are commonly known as enabling or supportive services. Our Health Center program is a well-known example of this.

This slide is a quick review of the Health Center model. Key components of the model include that the Health Center be located in or serve a high need community, be governed by a community board, composed of a majority, 51 percent or more, of Health Center patients, who represent the population served. The Health Center must provide comprehensive primary healthcare services, as well as supportive services – education, translation, transportation, outreach, care coordination – all of these that promote access to health care. In addition, Health Centers provide services on a sliding fee scale and there are other performance and accountability requirements they must meet. HRSA tracks the use of enabling services in its uniform data system.

This information is used to inform program and policy development, not only at the individual Health Center level, but within HRSA and among our partners. For example, one of HRSA's grantees, the Association of Asian Pacific Community Health Organizations, undertook the Enabling Service Accountability Project. AAPCHO used electronic health record data to evaluate the impact of enabling services, which are demonstrated here as the various codes on the x-axis. They used this evaluation to evaluate healthcare access and outcomes. This information is used by Health Centers to demonstrate to payers and to policy-makers the value that enabling services bring to address health disparities within the Asian-American, Native Hawaiian, and other Pacific Islander communities.

Many of HRSA's other programs also provide enabling services and address social determinants of health. Shown here it is the Maternal and Child

Health pyramid of health services. The Title V Maternal and Child Health block grant is envisioned as a pyramid with four tiers of services and levels of funding that provide comprehensive services for mothers and children. The pyramid also displays the uniqueness of the MCH block grant, which is the only federal program that consistently provides services at all levels of the pyramid.

You will see the enabling services are a critical component of that pyramid. This slide shows the different enabling services for the Healthy Start program in fiscal year 2010. Examples include case management, outreach, home visiting, parenting skill building, transportation, translation, child care housing assistance, and jobs training. Today, through a lifespan approach, Healthy Start aims to reduce disparities in access and

utilization of health services, improve the quality of local healthcare systems, and empower women and their families, as well as increase consumer and community voices and participation in healthcare decisions. The Maternal, Infant and Early Childhood Home Visiting program facilitates collaboration and partnership at the federal, state, and community level to improve health and development outcomes for at-risk children through evidence-based home visiting programs. The statutory purposes of the program are to strengthen and improve programs and activities carried out under Title V of the Social Security Act. In addition, the purpose is to improve coordination of services for at-risk communities and identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

The MIECHV includes grants to states and six jurisdictions, as well as grants to Indian tribes, tribal organizations, and urban Indian organizations. The legislation requires that grantees demonstrate improvement among eligible families participating in the program in the benchmarked areas as shown on the slide. As you can see, several of the benchmarks reflect a strong emphasis on the social determinants of health. The Ryan White program works with cities, states, and local community-based organizations to provide HIV-related services to more than half a million people each year. The program is for those who do not have sufficient healthcare coverage or financial resources for coping with HIV. Ryan White fills gaps in care not covered by these other sources. The majority of Ryan White funds support primary medical care and essential support services. A smaller, but equally critical portion, funds technical assistance, clinical training, and research on innovative models of care.

This slide shows the numerous support services funded in 2010, to include case management, child care, housing, linguistics, and legal services, just to name a few. If you think back to the neighborhood and education determinants that shape the Social Determinants of Health Topic Area, crime and violence and school environment are two of the issues to be addressed. Since bullying can impact children's educational success and can have lasting social and emotional consequences, HRSA invested in the issue through the Stop Bullying Now campaign. Since 2002 HRSA has

Collaborated with health and safety, mental health, law enforcement, and educational professionals on bullying. Today, the SBN campaign has over 80 active partners and six federal Departments, to include Health and Human Services, Education, and the Departments of Interior, Justice, Defense, and Agriculture.

Another example of HRSA's work to address SDOH is the Comprehensive Approach for Community-based Programs to Address Intimate Partner Violence and Perinatal Depression. A life free of violence, including intimate partner violence, is directly related to the mental health of each mother and child. Public awareness regarding the adverse maternal and child health outcomes associated with the intersection of maternal depression and intimate partner violence has increased. Still, many pregnant and postpartum women experiencing both intimate partner violence and perinatal depression remain unidentified by healthcare providers and others within the health and social support system. Consequently, they fail to receive timely and necessary intervention. This guide shown on the slide highlights innovative state and community-based strategies and provides a resource that assists community-based organizations with addressing the intersection of intimate partner violence and perinatal depression.

PATTIE TUCKER: I'm also excited to be a part of today's webinar and equally excited about sharing some of the CDC Division of Community Health Initiatives that have resulted in policy, systems, and environmental improvement which have affected the health of individuals, families, and communities. Next slide.

Through the work of local communities, we can now see that momentum is building for healthy behaviors where people across the U.S. live, learn, work, and play. Our goal at the CDC Division of Community Health, or DCH, is to create sustainable improvements that address the major risk factors for chronic disease, such as tobacco use, physical inactivity, and unhealthy food and beverages. Next slide.

The Division of Community Health has supported hundreds of community-based initiatives since 1999. These initiatives include the Racial and

Ethnic Approaches to Community Health; Steps to a Healthier U.S.; Action Communities for Health, Innovation, and Environmental Change; Racial and Ethnic Health Disparities Action Institute; the Pioneering Healthier Communities; Strategic Alliance for Health; Communities Putting Prevention to Work; and most recently, the Community Transformation Grants. Next slide, please.

In order to promote good health for all, it is important to take an approach which includes creating new and maintaining existing traditional and nontraditional partnerships across multiple sectors. Bringing everyone to the table adds value when others bring their unique skills and expertise and points of view to the mix. It also makes for a win-win scenario and creates opportunities to leverage resources. In addition, it generates the type of buy-in and support needed for critical sustainable change. Next slide.

Oftentimes, in public health, we choose to either focus on reducing health disparities or to implement interventions that are designed to achieve population-wide health impact. By taking one or the other of these approaches, we're aiming for two separate goals. An alternative approach is to combine population-wide interventions that have a health equity lens with interventions focused on the populations experiencing the greatest disease burden. While we acknowledge that there are many examples of great work that is occurring in the communities across this country to improve access to safe and affordable housing, healthy food, safe places and spaces for physical activity, and environments that are free from life-threatening toxins, I would like to share a few examples of CDC-funded communities, as well as communities that are not funded by CDC that are also taking action to address the determinants of health. Next slide.

Our first example is from the Division of Community Health Initiatives' REACH awardee, or Racial and Ethnic Approaches to Community Health awardee, the Medical University of South Carolina. MUSC is addressing the lack of access to quality health care and treatment of type 2 diabetes among African Americans in Charleston and Georgetown County, South Carolina. In 1999, the lower limb amputation rate for African Americans with diabetes in Charleston and Georgetown County was 38.7 per 1,000, compared to the national baseline of 4.8 per 1,000 African Americans with diabetes. Actions taken by the REACH Charleston-Georgetown Diabetes Coalition included developing partnerships with federally qualified health centers, a university health center, and other government health systems, as well as other organizations and agencies. This multi-sector partnership was established to bring about policy improvement and changes to the healthcare delivery and community support systems for people with diabetes. The Charleston-Georgetown Diabetes Coalition's approach to diabetes-related amputations in South Carolina has resulted in a 44 percent reduction for African Americans and an over 50 percent reduction for African American men with

diabetes. These dramatic reductions are in part due to the increased access to medications and supplies, especially for those who are uninsured and underinsured and due to the increased access to timely and appropriate foot care and to amputation prevention education. Next slide.

Another example is the Communities Putting Prevention to Work awardee, the Philadelphia Department of Public Health. Philadelphia, Pennsylvania is home to more than 1.5 million residents and it is where an estimated 68 percent of adults and 41 percent of youth are overweight or obese. In north Philadelphia, almost 70 percent of youth, the majority of whom are Black or Hispanic, are overweight or obese. This nearly doubles the obesity and overweight rate for youth in the United States. And in the Philadelphia community, fruit and vegetable consumption is a challenge for residents, with 30 percent of adults and nearly 25 percent of youth getting only one serving or less per day. Furthermore, approximately 25 percent of youth do not get sustained physical activity even once a week.

To tackle obesity throughout the community, a cross-sector comprehensive approach was implemented. In taking a twin approach, Philadelphia has implemented obesity prevention efforts throughout the community to benefit the entire population. Plus, they have initiated the Farmers Market and Philly Food Trucks for vulnerable population groups. As a part of this initiative, 160 schools have developed health improvement plans to expand the food and physical activity environments in their schools. Approximately 80,000 students will be impacted by this initiative. These changes are making healthy living easier for members of the Philadelphia community. Next slide.

Another REACH awardee, Community Health Councils in south Los Angeles, identified several critical gaps in comparison to the west Los Angeles area. In south Los Angeles, the number of people per grocery store was significantly higher than that of west Los Angeles. The few food markets existing in south Los Angeles were less likely to carry needed items for a healthy diet, such as fruits and vegetables... fresh fruits and vegetables, and the plethora of restaurants in south Los Angeles were less likely to prepare healthy foods and to allow food substitution, such as brown rice for French fries. The Community Health Councils and the African Americans Building a Legacy of Health actions included addressing the lack of access to healthy food options, including the limited local food retailers in south Los Angeles. The coalition and its partners leveraged funding to develop and implement an initiative that provided information and education to south Los Angeles residents and decision-makers. This community-based participatory approach resulted in an increase in the number of supermarkets and sit-down restaurants and 750,000 residents of south Los Angeles have access to fresh fruit, vegetables, and low-fat foods. Next slide.

Another community taking the twin approach to addressing environmental determinants is the Communities Putting Prevention to Work awardee, the Boston Public Health Commission. With an understanding that secondhand smoke contains more than a thousand chemicals and hundreds of toxins and with the motivation to make smoke-free multi-unit housing the norm, the Boston Public Health Commission partnered with the Boston Housing Authority, local agencies, community-based organizations housing providers, housing agencies, and landlords. In addition, the Commission leveraged support from residents in public housing, affordable housing, as well as market-rate housing, to ensure that those residents most vulnerable to secondhand smoke had clean air to breathe in their homes. Through a series of steps, smoke-free multi-unit housing policies were established to limit smoking in and around multi-unit housing complexes. Those Massachusetts residents needing assistance with smoking cessation treatment are now able to also access free cessation services. Addressing second-hand smoke in Boston has had a

great impact on residents in multi-unit housing. Twenty-three thousand residents now live in twelve thousand smoke-free units. That means that 100 percent of Boston Housing Authority units are smoke-free and community development corporations have begun to transition units into smoke-free units, as well. Although it's only the beginning, there are well over six thousand non-public smoke-free units in the Boston area.

While CDC is supporting a number of communities to address the determinants of health, there are also communities that are successful in addressing the determinants of health without the support of a federal funding. The Winter Park Health Foundation, a private, not-for-profit organization located in Orange County, Florida and the Florida Hospital recognize the alarming high rates of obesity, inactivity, smoking, and mental health challenges facing residents in Winter Park, Maitland, and Eatonville, Florida. To address these issues, the Healthy Central Florida Initiative was founded to create large and small scale changes and a culture of well-being. Respected leaders in health and wellness work closely with the mayors and key leaders in government from these three central Florida communities.

After reading the Prescription for a Healthy Nation, the Foundation chose the CDC Action Communities for Health, Innovation and Environmental Change model because of its credibility, the tools, the training and the technical assistance opportunity, and its national network for learning and sharing. Listed on the slide are just a few of the Healthy Central Florida successes. The initiative was launched in 2012 and Dr. Oz, host of the Dr. Oz Show, was on hand to offer encouragement and praise to the more than five hundred participants. The Healthy Central Florida, or HCF, is also using a behavioral change strategy of asking individuals to take a 333 pledge. It's a commitment to be active three days a week for thirty minutes for three months. In addition, HCF has an interactive web-based tool to help residents discover community resources, fitness classes, parks, trails, and events at no or low cost for individuals and families in three communities. They have passed the Complete Streets Resolution and added miles of sidewalks. And the Healthy Central Florida is assisting employers with establishing employee health and wellness policy programs. To date, they have at least 50 worksites that are adopting policies that promote health. Next slide.

CDC has also supported the Healthy Community awardees in the Midwest, who have also increased access to healthy foods and safe places for community members to participate in physical activity. For example, visitors to any of the 556 parks located in Chicago, Illinois have access to vending machines that contain 100 percent healthy food items. The Lockland school district and Princeton City schools located in Hamilton County, Ohio implemented competitive food guidelines which provide healthier foods in the a la carte line and vending machines to more than 6,000 students. And approximately 99,685 community members in Davenport, Iowa have increased access to physical activity due to the repaving and widening of a nine mile bike trail and the addition of mileage signs. Next slide.

Hernando, Mississippi is another community that has successfully addressed social and environmental determinants without CDC funding. In 2010, Hernando was selected as the healthiest hometown in the state by the Blue Cross/Blue Shield of Mississippi Foundation. Robert Wood Johnson Foundation ranked Desoto County as the healthiest of Mississippi's 82 counties. Although Hernando has not received federal funds, the city has implemented public smoking bans to create smoke-free environments for its community members. Hernando has improved access to healthy foods with the establishment of a farmers market and

the making of a community garden. The city continues to expand its parks and recreation opportunities and has instituted the Complete Streets policy that promotes bicycle and pedestrian-friendly routes. Next slide.

Within the Division of Community Health, the Community Transformation Grants awardees, like the Sault Ste. Marie Tribe of Chippewa Indians in Michigan, are also addressing social and environmental determinants. Sault Ste. Marie Tribe of Chippewas is working to increase the percent of smoke-free Tribal-owned worksites and government buildings. This effort will reach 442 employees at Tribal restaurants and hotels, as well as the over 280,000 patrons that visit these facilities annually. The Tribe is also working to increase the number of food policies voluntarily adopted by public service venues to improve access to affordable healthy food. And they are working to increase the number of schools in the nine school districts that voluntarily implement school-based physical activity policies. Sault Ste. Marie Tribe of Chippewas expects to achieve these and other improved health outcomes by the year 2016. Next slide.

Community engagement is critical to successfully plan, implement, evaluate, and sustain community-based strategies and policy systems and environmental improvements. To accomplish these improvements requires recognizing elements that are responsive to the unique needs of each community and its members. Trusted organizations should include as partners various sectors and consider those organizations that are trusted and valued by members of the community. Recognize and engage community leaders and key organizations. They are often the best facilitators and stimuli for the community's improvement. Ownership...there is no one person or organization or agency that can improve the community alone. It takes a shared interest and a collective outlook for making healthy community improvements. Community-based participatory approaches involve all partners in decision-making processes and recognize each partner's unique assets. And sustainability speaks to the whole policy system and environmental community improvements that are self-sustaining and will benefit the community's healthy future for years to come. Next slide.

By the end of the year, this year 2013, the Division of Community Health anticipates the release of a new tool designed to assist those working to advance health equity. The name of the tool is A Practitioner's

Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Diseases. This Practitioner's Guide for Advancing Health Equity is a major CDC resource that adds to the practice and evidence base on advancing health equity and chronic disease prevention. The Division of Community Health has engaged a number of stakeholders, including our awardees, national partners, as well as subject matter experts, in the development of this resource. The Guide provides take-away points and questions for reflection as the user plans, develops, and implements with the health equity lens. The Practitioner's Guide also includes equity-oriented strategies focused on tobacco-free living, healthy food and beverages, as well as active living.

To receive information on this and other resources, I encourage you to subscribe to the CDC Division of Community Health Weekly Newsletter at dchnews@cdc.gov. Next slide.

Accessing healthcare services, being physically active in safe environments, engaging in local neighborhood activities, as well as accessing appealing fresh fruits and vegetables, are just a few of the quality of life and influence health outcomes for everyone. In public health, it's all about preventing disease and promoting good health within groups of people in all the places where they live, learn, work, and play. Health equity is

achieved when every person in those places has the same opportunity to attain their full health potential. Health equity is just good public health.

CARTER BLAKEY: One of our listeners has asked, "What is a simple and clear way to distinguish between health impact assessment and Health in All Policies?"

AARON WERNHAM: Thank you for the question. I think it's a good one and it's one that that I think people working in both arenas struggle with a little bit, so I'll try to give you the best answer and I hope it's simple and clear enough. Health impact assessment is a tool for Health in All Policies. Health in All Policies, I think, refers to a broad conceptual approach, that being incorporating public health or using a health lens to inform decisions made outside the health sector in housing, education, transportation, social policy... what have you. Health impact assessment is one way to accomplish that. I think the last presentation highlighted a lot of other ways, not all of which, in fact, many of which did not include health impact assessment.

CARTER BLAKEY: Aaron, here's another one for you. Can you share any examples of health impact assessments that specifically look at poverty reduction efforts?

AARON WERNHAM: Absolutely. I think that one way to answer that question is just to note that many health impact assessments, because they're engaging in the social determinants of health...the determinants of health are often felt most strongly by people in low-income neighborhoods and environments... many HIAs address some aspect of poverty. There have been, for example, health impact assessments that looked at proposed living wage ordinances, paid sick days legislation for low-income workers. The low income housing energy assistance HIA was an example, looking at one specific poverty reduction program. Actually, a companion health impact assessment looked at the Massachusetts voucher program for low-income families. Many HIAs have also addressed issues of housing affordability, for example, around a new transit project. Public health has widely recognized public transit as being a good way to increase physical activity. There are also, though, gentrification and displacement concerns. So we've seen health impact assessments very intentionally engage in ensuring that affordability of housing is improved. So, I think we interact with poverty in a number of ways; the website I showed, healthimpactproject.org has a navigable map, which you can also search by search terms. So, you might try looking at that map and even putting poverty in as a key word and seeing what you come up with.

CARTER BLAKEY: Great. So, anyone else want to add to that before I move on? Here's one. I'll throw this over to HRSA to begin with and the rest of you, I'm sure, could probably add on. Dr. Linde, can you speak to your experience establishing the necessary partnerships between policymakers, companies, organizations and public health professionals, for example, that are implementing health impact assessments or implementing a social determinants of health approach and reaching across different sectors to make a difference?

SARAH LINDE: Absolutely. There are two examples that immediately come to mind. One is something that we have worked on at HRSA, the Healthy Weight Collaborative. This is a joint effort between HRSA, as a funding agency, the National Institutes for Children's Health Care Quality, and a number of other partners both within the health field and outside of the health field, to look at ways to test and disseminate evidence-based and promising practices to prevent and treat obesity in children and families across the country. There were several strategies used in this learning collaborative effort. One of them had to do with consistent messaging among primary care providers, public health in the community, and community-based

organizations. Teams in the learning collaborative were formed between primary care, public health, and community. One of the issues that they addressed was consistent messaging within the community related to nutrition and that was something that went into the schools. In some areas, it was in the grocery establishments and in other places beyond the healthcare setting. So, that is one example. Another example is a partnership that HRSA is forming with the United States Department of Agriculture and specifically their Food and Nutrition Service area, which runs the summer...excuse me, the School Feeding Program. This is the program that provides either reduced or no cost breakfast and lunch to low-income children. We know that this USDA program is serving the same sort of vulnerable populations that HRSA serves through the Health Center Program, for example, or by our National Health Service Corps providers. So, we are connecting those components of our agency within

HRSA and this program at USDA to make sure... or to explore areas for collaboration and making sure maximum services are provided to these vulnerable populations, both from the health aspect, but also access to healthy food aspect.

CARTER BLAKEY: Great. Thank you. Dr. Tucker, would you like to add something to that?

PATTY TUCKER: We in the Division of Community Health are beginning to have some early conversations with some of the some of the other federal agencies and looking at how we might partner. That includes HUD, the Housing and Urban Development agency, as well as the Food and Drug Administration, with their tobacco initiative. So we're looking at how our communities might work along with theirs.

CARTER BLAKEY: So we'll move on to another question. Dr. Wernham, how are health impact assessments validated and what is needed to adapt them to other countries?

AARON WERNHAM: Well, I think that when you talk about validating health impact assessments the real proof, I think, is in whether successful relationships are built between public health people, the community, and decision makers and what the ultimate outcomes are. When we look at the assessment, we draw on multiple, different streams of evidence. There's peer-reviewed literature to analyze a complex pathway involving social determinants, and we draw on that, certainly. We also draw 'though on input from the community, input from other stakeholders, and on (gray?) literature, sometimes doing new analysis, as well, and combine that all into a judgment of what the potential impacts are and what could be done about them.

There is often considerable uncertainty in that. We're dealing with pathways that are multifactorial and have long causal chains, with some missing links sometimes. So we have to be careful not to overstep our bounds, not to predict things as certainties that are very uncertain. We have to state our limitations clearly. We do try to rely on peer review, at least through stakeholder advisory bodies, who work with us along the way to keep us honest and make sure that we're not over-reaching what the data say. Often, we also rely on the concept of adaptive management. That really just expresses that, if you make a prediction and base some management decision on that, then you can make sure you're also monitoring the outcomes and that they're, in fact, the right results. If they're not. You go back to the drawing board and reassess and maybe change your management. So, that adaptive management concept is very important and one way to handle the uncertainty of initial prediction.

CARTER BLAKEY: Okay. Thank you. Dr. Tucker... or, I suppose, any of you, but I will start with Dr. Tucker. One of our listeners has asked, "How can I learn more about or get more involved with social determinants of health in my state or local community?"

PATTY TUCKER: A lot of the work that's being done out of the Division of Community Health is posted on the website... Let me get the website. I'm sorry. I have to pull it up and announce what it is, but all of the community initiatives and where they are located are posted on the CDC website.

AARON WERNHAM: Similarly, at healthimpactproject.org/hia/us, you'll find that map, which shows you where health impact assessments are being done. Often, that involves some of the real leaders, both community-based organizations and nonprofits, local health departments, planning departments, and others that are doing this work. They could be a good place to start, as well

CARTER BLAKEY: Great. There are a few questions about technology and social determinants of health and all this information floating around. Can any of you predict how advances in health information technology will affect this work on either SDOH or health impact assessment? It could be ranging from electronic health records... That gives us a lot to think about.

SARAH LINDE: This is Dr. Linde. In the federal government, we're not really in the business of prediction, but what I can say is that, as technologies advance, absolutely, they can be leveraged to address social determinants of health. The example that I gave in my presentation, where a particular group represents a particular population; you can gather data from electronic health records, separated from the individual patient information to understand use of these services. It absolutely helps in the planning of policy and program development. If you're assessing the use of transportation... it is particularly high in community...transportation services... then action can be taken to coordinate and collaborate more closely with our transportation colleagues, for example. So, use of electronic health records is just one example of that.

AARON WERNHAM: I can add just briefly...I also probably can't make a prediction. But at least add a hope. This is one of the things you could hope to see out of having electronic health records, but really only if there is good interoperability and data sharing, such that public health efforts can begin to compile statistics from individual health records, There's a great example from... I think it was Boston Children's that was in the news within the last month or two, where the hospital actually analyzed ER visits for asthma and determined that that a lot of people were coming out of the neighborhoods with typically very low housing quality, dilapidated older housing, and began to actually implement community-based interventions to improve the housing on the spot. So, they would do a site visit, go out and identify mold, old carpeting and actually do remediation. I think they've had a great deal of success both in reducing visits for asthma and potentially reducing costs, as well. I can't remember if they addressed that.

SARAH LINDE: This is Dr. Linde again. One more thing I'll add. There's a great effort within HRSA, between HRSA and the Centers for Disease Control, and then with many outside organizations working to integrate primary care and public health. The example of asthma is a good one. HRSA and CDC co-funded an Institute of Medicine study on this topic. It's not the first study that's been done, but this report that was released earlier this year really provides some specific areas of focus and recommendations where, if primary care

and public health are integrated or better integrated, we can really see improvements in population health and data sharing is absolutely one of the focus areas. So, if folks are interested in learning more about that, there's a wonderful video on the Institute of Medicine website. So, if you go to the IOM website and click on their area of primary care and public health integration, you can read more about the ongoing work.

CARTER BLAKEY: Thank you. We have more requests for clarification of some of our terminology here. What is the difference or distinction between social determinants of health, health disparities, and health equity?

AARON WERNHAM: I can certainly start. I think social determinants of health we think of as the upstream conditions in the places where we live, learn, work, and play, that is, the social conditions, environmental conditions, such as air quality and housing quality and access to healthy foods and safe places to exercise. Economic, poverty, a family with resources to pay for things that are essential to health. All of those we think of as the social determinants of health. Health equity, I think, was defined very well in one of the talks, I think by Dr. Tucker, as being the results of everyone having the conditions that would support their ability to reach their optimal health. Health disparities refer to the different rates of diseases that are seen between different populations, whether you're dividing people according to income groups, racial and ethnic groups, urban versus rural, et cetera.

CARTER BLAKEY: Here's the second part of that question. Can you talk about a way to measure and evaluate the achievement of health equity? Dr. Tucker, would you like to tackle that one?

PATTY TUCKER: Hello, okay, So, one of the things that we are beginning to look at in the Division of Community Health within our various initiatives is, how to evaluate that differentiation? So, while we recognize that...oftentimes when I've mentioned about the twin approaches, we talk about having the impact on the larger population. There are instances where that impact actually has an adverse effect on the population with the greatest burdens. So, we are in fact beginning to look at how to examine and evaluate the differential impact between what's implemented in the population and how interventions are implemented for this population with the greatest disease burden.

CARTER BLAKEY: Great. Thank you. I will just add on behalf of Healthy People 2020 that... you'll remember that one of our overarching goals is to achieve health equity and eliminate health disparities for all Americans. Each of our population-based objectives does measure health status of different demographic groups, different population groups, whether it's race/ethnicity, by sex, geographic location, and so our goal is that all of those populations will achieve the same health status and improve. So that's an underlying theme across Healthy People in all of our objectives, so we would view having achieved the elimination of disparities and, hopefully by then, achieving health equity, if we could achieve all of our objectives for all population groups. Another question that we have had has to do with the federally qualified Health Centers. It's another prediction, so I don't know if you'll be able to look into your crystal ball to answer that question, but how do you think funding for the federally qualified health centers will be impacted by a focus on social determinants of health?

SARAH LINDE: Well, what I can say is the Affordable Care Act greatly increased the funding for the federally qualified health centers, in part obviously to address the lack of access to health care by a great portion of

the population. Really, as I pointed out in the Health Center model slide, one of the unique features of the Health Center program is the concentration on the support services, which is not seen necessarily in the private healthcare delivery system. So, as funding for the Health Centers increased through the Affordable Care Act, we were able to provide more care to patients. We are also providing more of these enabling services that address social determinants of health.

CARTER BLAKEY: Great. Thank you. Another question and whoever is able to answer it, please speak up. Many of the examples mentioned today address an urban setting as examples of implementing social determinants of health. Are there any examples of programs and actions occurring in rural areas?

AARON WERNHAM: There are. Actually, as I say, I began my own work in health impact assessment working with Alaska native communities in rural Alaska. Oil and gas and mining projects often occur in rural areas and have been a fairly common topic of health impact assessment. Beyond that, certainly the Oregon Farm to School HIA was one that dealt with farming communities. I think it is less common in health impact assessment practice than urban land use planning, but we've seen a number of health impact assessments that have gotten into comprehensive planning, redevelopment efforts, and also food supply in rural America.

CARTER BLAKEY: Great. Thank you. We have another question about... more or less partnering or working with our stakeholders out in the field. Can you give us examples of your partners influencing policy, whether at the federal level or the community level? So Dr. Tucker. Would you like to answer that one?

PATTY TUCKER: I'm sorry. Could you repeat the question?

CARTER BLAKEY: Can you give us examples of your partners or advocates acting in a way that has influenced policy at either the federal or the local level in terms of social determinants of health?

PATTY TUCKER: One example that comes to mind is in the New York area, in the Bronx area, where they've partnered with the hospitals and healthcare delivery systems, as well as members of the communities, as well as the faith-based community, as well as schools. They were looking at increasing access to low-fat milk in the public school systems. So that district or the area...school area for the Bronx became a partner and they worked with the Bronx Health REACH program to institute a policy to allow low fat milk in the public schools. From that local area policy, it became a district-wide policy and now is moving to a statewide policy for children to have low fat milk in the public schools.

AARON WERNHAM: I'll just add generally that many of the health impact assessments we have on our website and certainly the examples I gave you today, each of those resulted from the work of a community coalition, typically involving smaller community-based nonprofit organizations, sometimes public health departments or health experts as consultants. But health impact assessments are very commonly being done through multi stakeholder partnerships and having a lot of success in influencing policies. So, I think it's a nice tool. It's not overly technical and can certainly be done by a community organization, community partners as an effective way to influence policy.

CARTER BLAKEY: I think we've just about come to our time to wrap up. So before I close out the Webinar, I'd like to ask our speakers if any of you has anything else you'd like to say before we close out the Webinar.

Ok, well I'd like to thank everyone for joining the Webinar. And if you haven't already done so, I'd like to invite you to participate in our closing evaluation poll on your experience with today's Webinar. We do encourage you to complete the survey because it helps us produce a better product the next time we undertake a Webinar. So on behalf of the US Department of Health and Human Services and the Office of Disease Prevention and Health Promotion, I'd like to express our sincere gratitude for today's - to today's presenters for sharing their expertise and insights; I know you all put a lot of work in to this afternoon's Webinar. And I'd like to remind our participants that some of you had asked for bios and contact information for our presenters – and that information is available in the PDF that was downloadable in the Webinar.

So again, many thanks to everyone, and until next time.