

County Health
Rankings & Roadmaps
Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

THE POWER OF STORYTELLING: GIVING LIFE TO VOICES & DATA



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February 7, 2017

www.countyhealthrankings.org



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

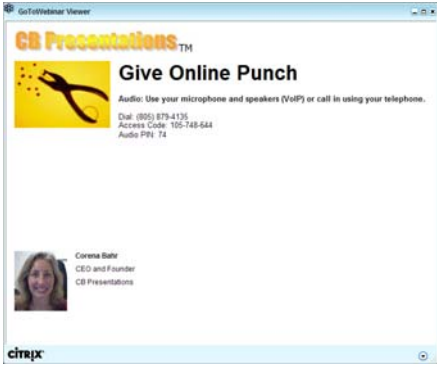
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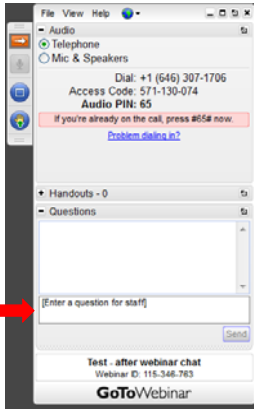
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GO TO WEBINAR ATTENDEE INTERFACE

1. Viewer Window



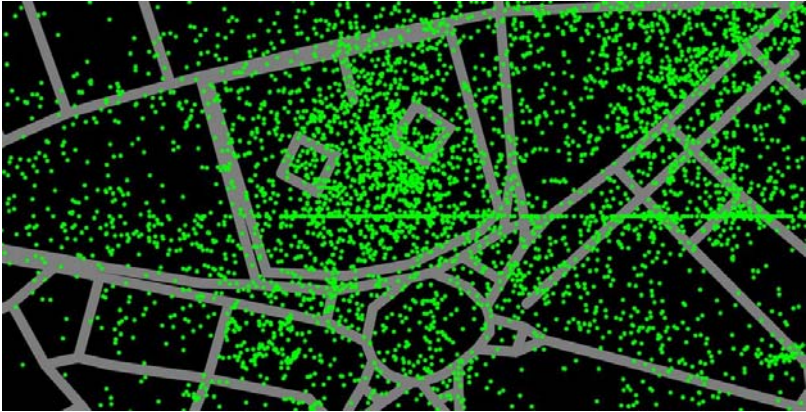
2. Control Panel



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GUIDING QUESTION

How can we use the combination of story and data as a tool for powerful change in our communities?

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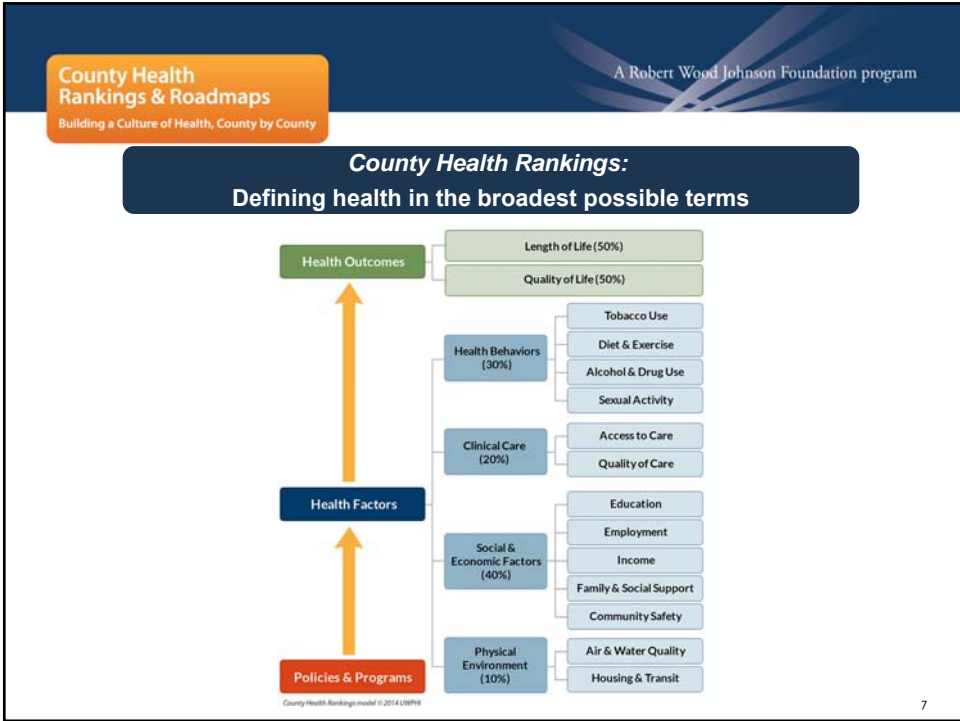
ROADMAP FOR TODAY'S WEBINAR

- *County Health Rankings & Roadmaps* overview
- Tools & Resources for Powerful Storytelling
- Interview with Heidi Gill & Delia Mannen, New Haven, CT
- Q & A
- Wrap Up and Invitation to Post-Webinar Conversation
- *Q & A Continued*



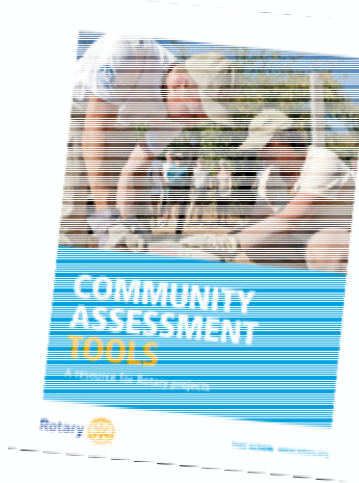
County Health Rankings Logic Model





COMMUNITY ASSESSMENT TOOLS

- ▶ Community meetings
- ▶ Surveys
- ▶ Interviews
- ▶ Focus groups
- ▶ Asset inventory
- ▶ Community mapping



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This is a picture of some housing units in the city. These buildings are not good for people to live in. They have no air conditioning and heat is only on the ground floor. The guy who owns the Florida Dolphins football team owns them and refuses to make them better. This could relate to building a culture of good health by reminding people that hospitable shelter is a human right. This could educate people by showing them an example of bad living units.

Photo Credit: Tangela Morris, UWW Photovoice project

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FINDING MORE DATA

Wisconsin

Data Sources

These data sources provide information for communities looking for more local data. These sources provide either unique, local data; more information on demographic breakdowns (e.g., age, sex, race/ethnicity); or data for sub-county geographic units (e.g., cities, zipcodes or school districts).

Wisconsin Data Sources

Name	Description	Breakdown
Healthiest Wisconsin 2020 Baseline and Health Disparities Report	This report provides baseline data for the health focus areas in <i>Healthiest Wisconsin 2020</i> . It also provides information to document a range of health disparities found for some of the populations and communities in Wisconsin.	Demographic
Wisconsin Bureau of Communicable Diseases and Emergency Response	The Wisconsin Bureau of Communicable Diseases and Emergency Response provides data on HIV/AIDS and other sexually transmitted diseases.	Demographic
Wisconsin Crash Outcome Data Evaluation System	This site provides various data on motor and other vehicle crashes at the city, county, and state level.	Sub-County

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HEIDI GIL & DELIA MANNEN

New Haven, CT

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WHY?...COMPELLING REASONS

Connecticut Department of Social Services
Making a Difference



Project is funded by the Nursing Home Diversification Program

5 Department of Social Services Priorities:

1. Transition 8000 people from SNF to Community through Money Follows the Person by 2020 (originally 700)
2. Increase \$\$ to Home and Community-Based Services (vs. institutions)
3. Increase hospital discharges to the community vs. institutions
4. Increase probability of returning to community within 1st 6 months of institutionalization
5. Increase % of Long Term Services and Support users served in the community vs. institutions

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WHY?...COMPELLING REASONS

Leeway - Hope Happens at Home in the Community

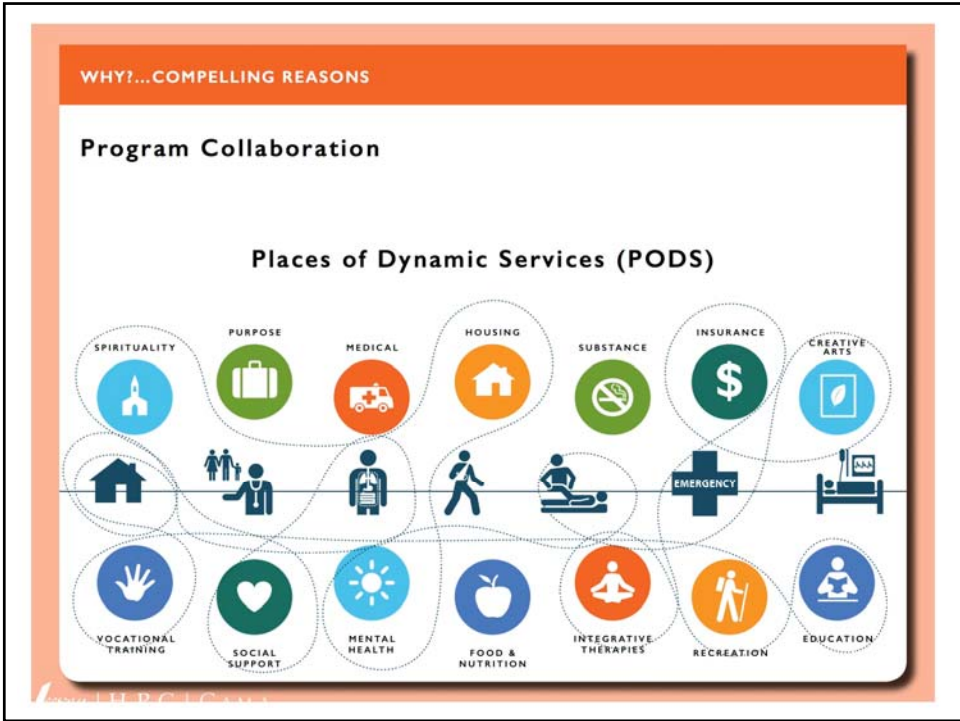
Catherine Kennedy

Leeway's founder and supporting pioneers were committed to solving for a significant gap and to filling the need for specialized care and services.

With that same spirit in mind, this project will expand Leeway's mission and position as an innovator dedicated to those individuals most in need.



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WHAT?...TARGET POPULATION AND EXPECTED RESULTS

The target population being considered is individuals with:

- Multiple chronic conditions/illness (including behavioral health and substance abuse) with functional limitations who are medically and socially compromised
- High risk for readmissions and/or have history of multiple readmissions
- High risk multiple Emergency Department visits
- Individuals who are recommended home care services and or meet SNF level of care and decline (complex cases)
- Individuals referred to SNF/home whose placement is delayed due to lack of payment source
- Individuals with high cost and high need

WHAT?...TARGET POPULATION AND EXPECTED RESULTS

Desired Outcomes

- Integration of medical care and social determinants for change
- A well coordinated grass roots system of community based services and supports
- Decreased utilization of nursing homes and hospitals
- Lower costs and improved health/social outcomes
- Increased choice and quality of life in the New Haven Community

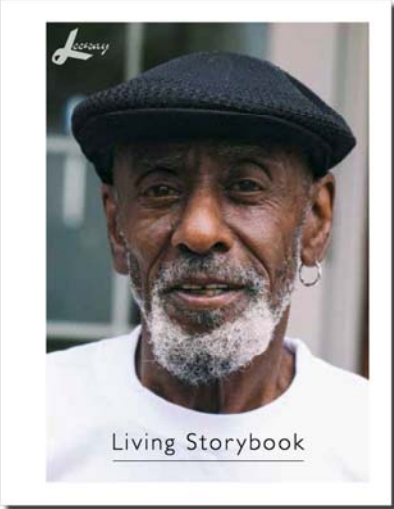
HOW?...PROCESS FOR CO-CREATION AND IMPLEMENTATION

Living Storybook

The story of co-creating a Community Living Model through collaborative, grass-roots, and data-driven change.

Chapter 1

- Introduction to Project



Living Storybook

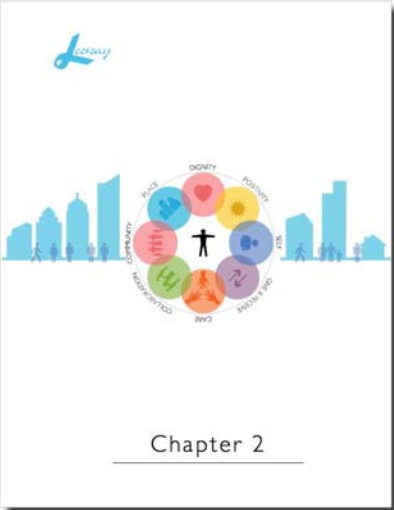
HOW?...PROCESS FOR CO-CREATION AND IMPLEMENTATION

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Chapter 2





- Philosophy towards Change
- Guiding Principles
- Data and Alignment with City Initiatives
- Movement towards Action



Chapter 2

HOW?...PROCESS FOR CO-CREATION AND IMPLEMENTATION

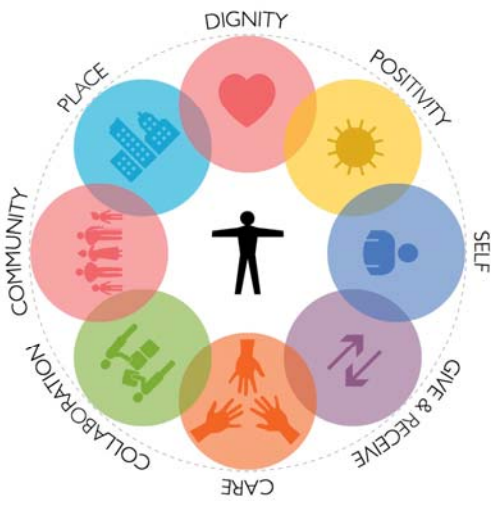
Philosophy towards Change

 <p>286 Individual Voices (from interviews, focus groups & meetings)</p>	 <p>69 Organizations</p>
 <p>Ap-pre'ci-ate, v.,</p> <p>1. Valuing ...</p> <ul style="list-style-type: none">The act of recognizing the best in people and the world around us;Affirming past and present strengths, successes, and potentials;To perceive those things that give life (health, vitality, and excellence) to living systems. <p>2. To increase in value, e.g. the economy has appreciated in value.</p> <ul style="list-style-type: none">Synonyms: valuing, prizing, esteeming, and honoring.	 <p>In-quire' (kwir), v.,</p> <p>1. The act of exploration and discovery.</p> <p>2. To ask questions; to be open to seeing new potentials and possibilities.</p> <ul style="list-style-type: none">Synonyms: discovery, search, study and systematic exploration.

www.H.P.C.I.C.org

HOW?...PROCESS FOR CO-CREATION AND IMPLEMENTATION

Guiding Principles The 8 Powers



The diagram consists of a central black silhouette of a person. Surrounding this central figure are eight overlapping circles, each containing a different icon and a label. Starting from the top and moving clockwise, the circles are: a pink circle with a heart icon labeled 'DIGNITY'; a yellow circle with a sun icon labeled 'POSITIVITY'; a blue circle with a person icon labeled 'SELF'; a purple circle with two arrows pointing in opposite directions labeled 'GIVE & RECEIVE'; an orange circle with two hands reaching towards each other labeled 'CARE'; a green circle with two hands reaching towards each other labeled 'COLLABORATION'; a red circle with a group of people icon labeled 'COMMUNITY'; and a blue circle with a city skyline icon labeled 'PLACE'.

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HOW?...PROCESS FOR CO-CREATION AND IMPLEMENTATION

Data and Alignment with City Initiatives

SOLVING FOR DOWNSTREAM OUTCOMES

How do we keep people out of the hospital and skilled nursing facilities?

How do we support an individual to thrive and flourish within the City of New Haven?

IMPLEMENTING UPSTREAM GOALS AND TARGETS

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HOW?...PROCESS FOR CO-CREATION AND IMPLEMENTATION

Data and Alignment with City Initiatives

Aligning with City Wide Upstream Goals to Affect Downstream Outcomes

We reviewed reports and data supplied by Danatstev, City Transformation Plan, Yale New Haven Hospital, and the Healthier Greater New Haven Partnership. From these resources, the following downstream outcomes and upstream goals and targets revealed areas of needed focus.

KEY:

- ① DANATSTEV
Report 1: Greater New Haven Community Health 2016
Report 2: Greater New Haven Community Health 2017
Healthier Greater New Haven Partnership
- ② YALE NEW HAVEN HOSPITAL
Report 1: Greater New Haven Community Health 2016
Report 2: Greater New Haven Community Health 2017
Healthier Greater New Haven Partnership
- ③ HEALTHIER GREATER NEW HAVEN PARTNERSHIP
Report 1: Greater New Haven Community Health 2016
Report 2: Greater New Haven Community Health 2017
Healthier Greater New Haven Partnership
- ④ CITY OF NEW HAVEN
Report 1: City Transformation Plan
Report 2: City Transformation Plan
Healthier Greater New Haven Partnership

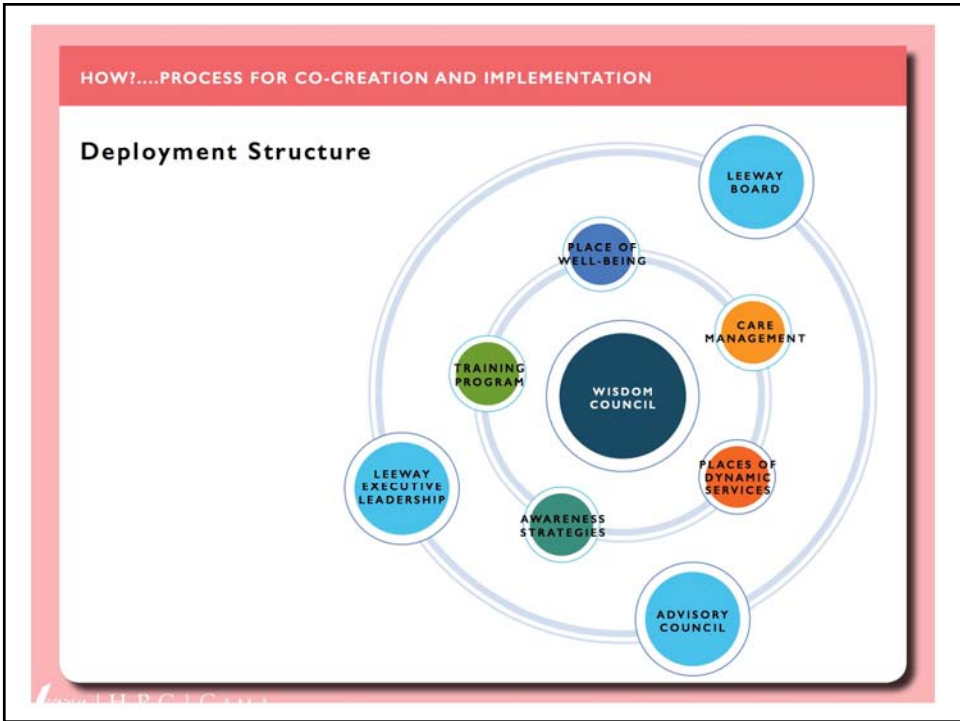
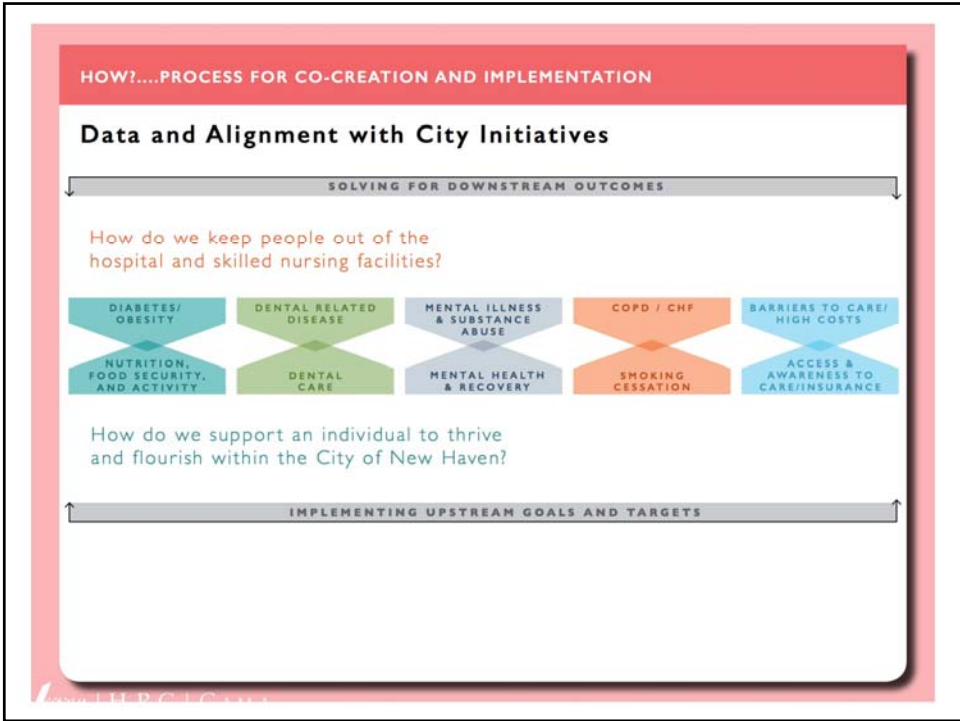
DOWNSTREAM OUTCOMES

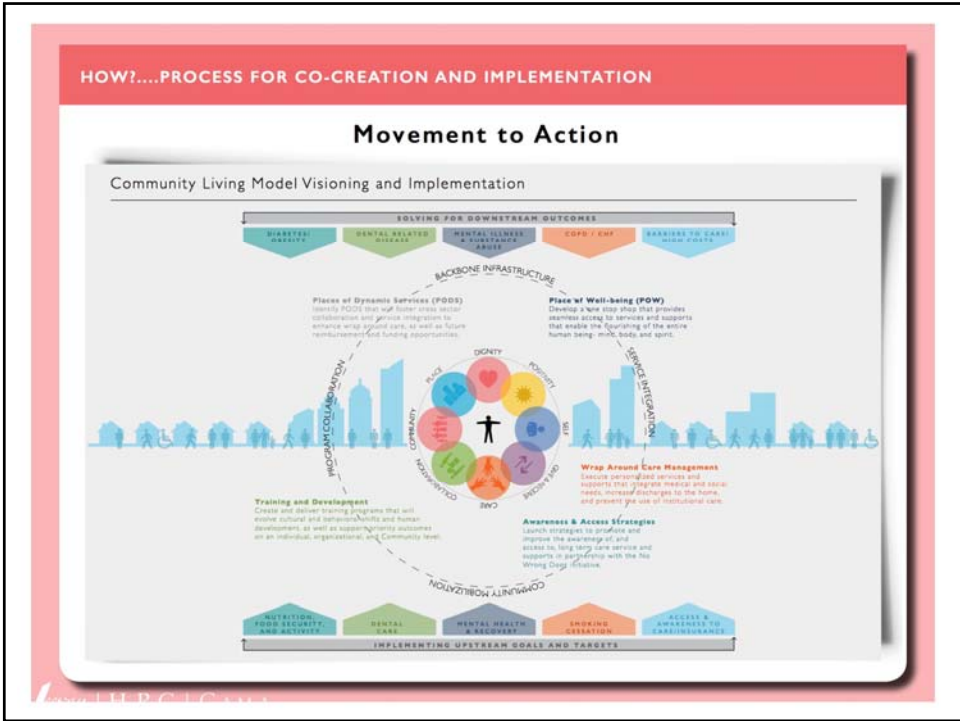
How do we keep people out of the hospital and skilled nursing facilities?

<p>DIABETES / OBESITY</p> <p>Obesity, insulin or glucose meter users have increased 15% in the past 5 years. About 12% in 2016.</p> <p>25% of patients in the City of New Haven self-report being obese. This number increased by 10% in the last five years. 17% self-report being diabetic.</p> <p>The City of New Haven has 17% from hospital admissions from diabetes per 10,000 residents 78% that the average of greater New Haven (9%). The lower than 19% and the lower than 19%.</p>	<p>DENTAL RELATED DISEASE & ABUSE</p> <p>1 in 100 of the population requires hospital care being over a dental in the past year and 4.4% the highest of all years in greater New Haven and 1% higher than self-reports of oral infections.</p> <p>The City of New Haven has 80% more hospital admissions from periodontal dental conditions per 10,000 residents (200) than the average of greater New Haven (16). The lower than 19% and the lower than 19%.</p>	<p>MENTAL ILLNESS & SUBSTANCE ABUSE</p> <p>15% of adults in the City of New Haven self-report being anyone who has 12% self-report depression. These are the highest self-reporting percentages of any year in Greater New Haven.</p> <p>Alcohol dependence with withdrawal is one of the top 10 primary diagnoses for 10% of the population.</p> <p>Smoking cessation and alcohol related issues are 2 of the top 10 primary diagnoses for 10% of the population.</p> <p>Substance abuse related issues were the 8th highest reason for ER admission.</p> <p>Substance withdrawal is the 8th highest reason for admission within 30 days of discharge.</p>	<p>CHRONIC DESTRUCTIVE PULMONARY DISEASE (COPD) / CONGESTIVE HEART FAILURE (CHF)</p> <p>The City of New Haven has a disproportionately higher % of current admissions for Chronic Obstructive Pulmonary Disease and CHF than the average of Greater New Haven.</p> <p>COPD is the 3rd leading cause of 30 day readmissions and 11 of admitted patients.</p> <p>CHF is the 3rd leading cause of 30 day readmissions.</p>
<p>PREVENTION AND ACHIEVEMENT</p> <p>Preventive health screening and physical activity.</p> <p>84% of 18-24 year olds report good overall health. 22% in 2016.</p>	<p>MENTAL CARE</p> <p>Patients who receive inpatient services.</p>	<p>MENTAL HEALTH & RECOVERY</p> <p>Balance training for providers in mental health practices.</p> <p>Expand provider coordination among local mental and health resources for patients with complex medical and/or behavioral health disease.</p> <p>Increase awareness of current substance abuse and mental health issues to local providers.</p> <p>Reduce the number of 911 and hospitalizations for mental health-related concerns by 25%.</p>	<p>ACCESS TO CARE / INSURANCE</p> <p>Expand the number of people who are regularly insured by insurance intermediaries.</p> <p>Expand the number of people experiencing difficulty in accessing health care services due to lack of transportation.</p>

How do we support an individual to thrive and flourish within the City of New Haven?

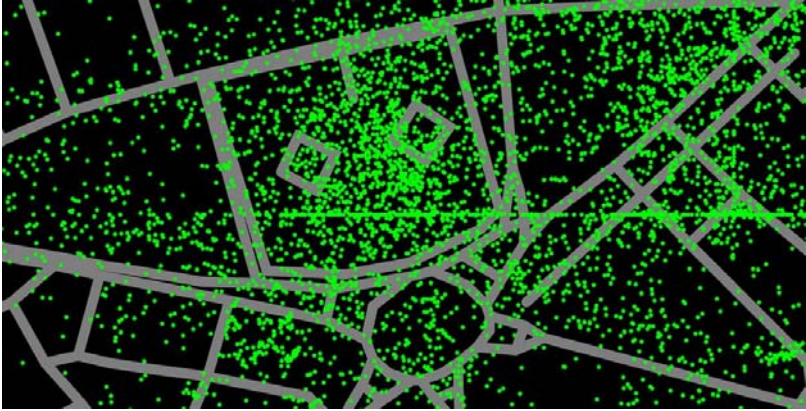
UPSTREAM GOALS AND TARGETS





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REFLECTION QUESTIONS

- Who else do you need to share this information with?
- What is one idea for action that you're taking from this webinar?
- What else do you need to know to take action/use this information?



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COMMUNITY COACHES



Ready to take action, but not sure what to do next?

GET HELP



SUPPORTING YOUR COMMUNITY'S JOURNEY TOWARD HEALTH

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STAYING CONNECTED

- ▶ Follow @CHRankings
- ▶ Like Facebook.com/CountyHealthRankings
- ▶ e-Newsletter, email chr@match.wisc.edu to subscribe



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POST-WEBINAR CONVERSATION: THE POWER OF STORYTELLING

- ▶ **When:** February 14, 2:00 CT/3:00 ET
- ▶ **Why:** deepen the webinar learning AND strengthen networks around using data & storytelling
- ▶ **What:** interactive learning experience, opportunity to share ideas and ask questions about using data & stories to build community & advocate for change
- ▶ **How:** video conference and/or phone
- ▶ **Who:** YOU! (Space is limited)


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POST-WEBINAR CONVERSATION NEXT STEPS

- ▶ Register
- ▶ Check technology
- ▶ Be prepared to discuss
 - What about the webinar stood out for you? (1-2 words)
 - What parts remind you of your own work/your community?
 - Where is more work needed in your community?



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THANK YOU!

www.countyhealthrankings.org

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(608) 265-8240


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Q & A CONTINUED

- ▶ Continue with us for an additional 15 minutes
- ▶ Submit your questions via question box



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