Constructing a Community Profile for Public Health Preparedness: OHIZ and SDOH Dashboards

Association for Health Commissioners Conference – Fall 2024

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Office of Health Opportunity

Center of Public Health Excellence

Ohio Department of Health

Objectives

- Utilize the OHIZ and SDOH dashboards effectively to construct a community profile geared toward public health preparedness.

- Identifying opportunities to address community response inequities and inaccessibility.

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Ohio Department of Health Mission:

Advancing the health and well-being of all Ohioans.

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Office of Health Opportunity - Key Objectives

Establish	• Establish equity as a pillar of public health.
Improve	• Improve clinical care and experiences for the most vulnerable.
Elevate and Address	• Elevate and address the social determinants of health, by impacting upstream social and community conditions of health.
Ensure	• Ensure an equitable response to COVID-19 and other communicable diseases.

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Whole Community

- Involving people in the development of national preparedness documents.
- Ensuring their roles and responsibilities are reflected in the content of materials.

E.g.: Individuals and families, including those with access and functional needs, business, faith-based and community organizations, non-profit groups, schools and academia, media outlets, and all levels of government

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Preparedness and Community Resiliency Considerations

- Preparing the masses and the inclusion of Access and Functional Needs.
- What about other communities that don’t fit in those categories?
  - People experiencing homelessness.
  - People with chronic diseases.
  - People without broadband or computing devices .
  - People who do not own a car.
  - People who live below the Federal Poverty Line.
  - Limited English speakers, etc.
- Engage your community in conversation/planning.

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Social Determinants of Health

- The World Health Organization defines social determinants as "**conditions in which people are born, grow, live, work and age**."

- These factors influence the health of the economy, allocation of resources, and distribution of power.

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Intersection of SDOH and Preparedness

- Resource availability and employment security.
- Chronic health conditions and emergency medical services.
- Infrastructure quality and environmental hazards.
- Social cohesion and trust in authorities.
- Emergency knowledge literacy and communication.
- Evacuation and mobility.
- Nutritional needs.

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Intersection of SDOH and Preparedness

- Equitable Response.
- Targeted Interventions.
- Resource Allocation.
- Mitigation of Disparities.
- Enhanced Community Resilience.

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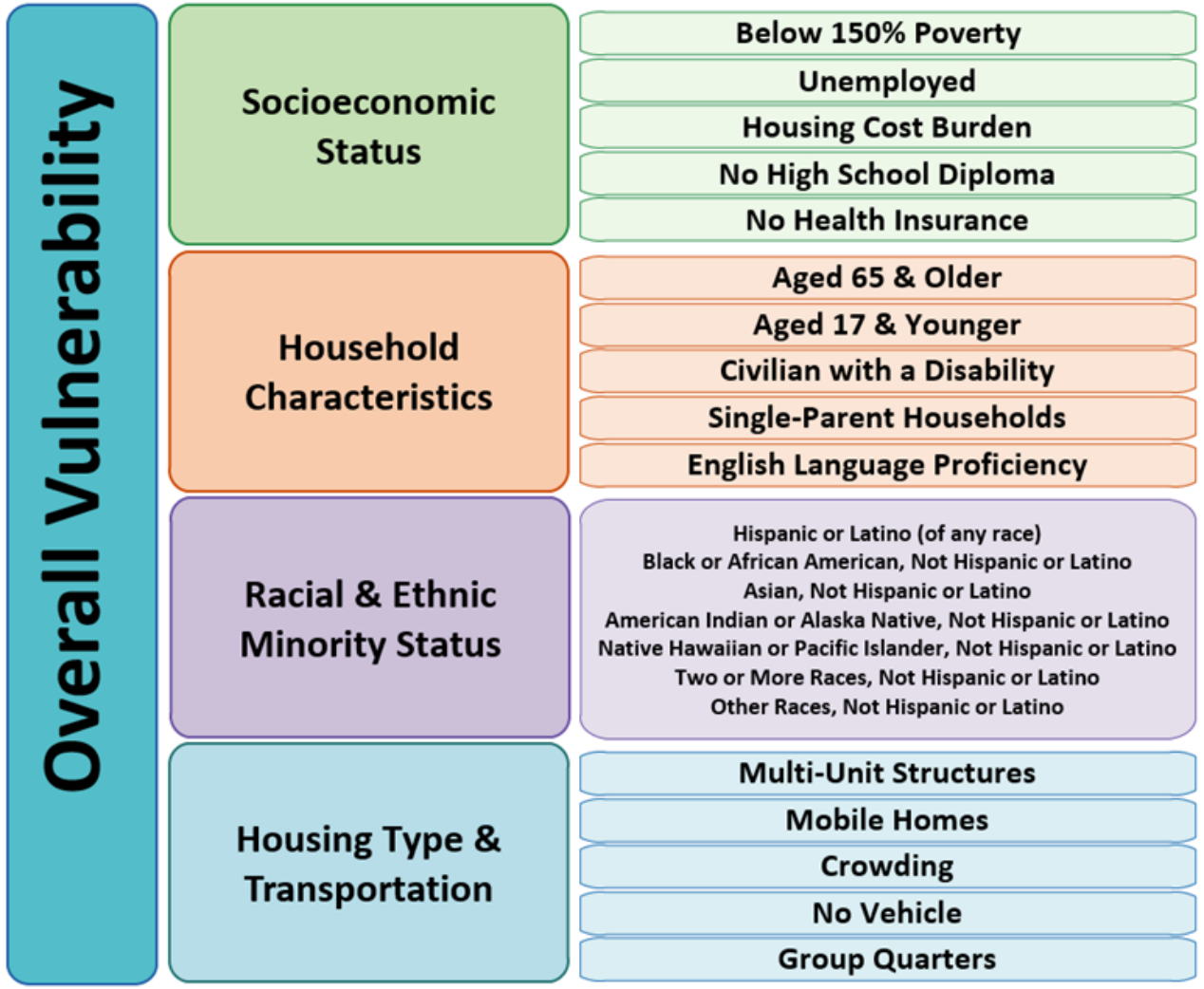
Ohio Health Improvement Zones

- Identify communities with specific risk factors.
- Better understand community risks and strengths.
- CDC SVI score of ≥ 0.75.
- Ohio Health Improvement Zones.



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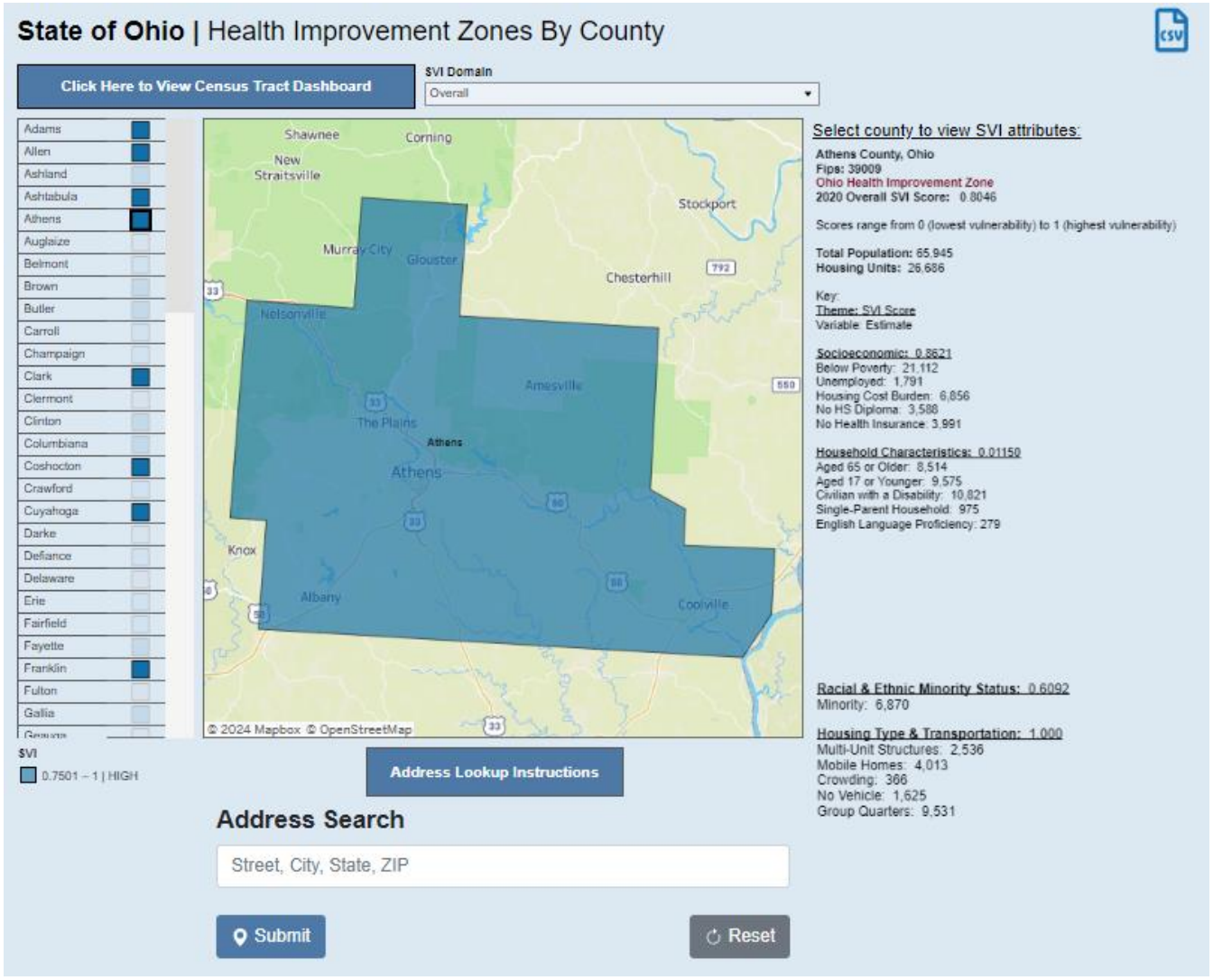
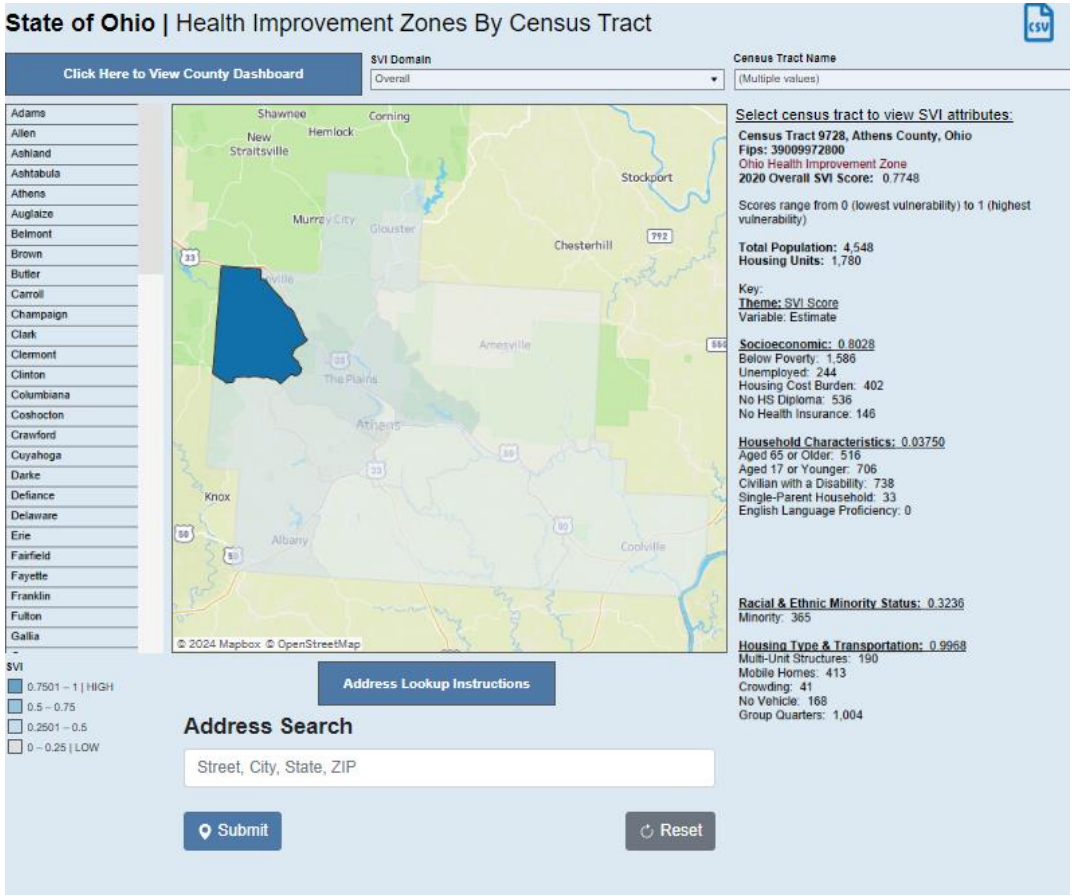
Ohio Health Improvement Zones Dashboard





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Community Well-being: Social Determinants of Health Dashboard

- Utilizes data from Census Bureau, CDC, and ACS data at the census tract and county levels.
- Six domains and over 155 metrics.
- Organizes publicly available data for easy visualization.
- Helps to target the right resources in the right communities.
- Helps set up-stream targets for positive impacts to health.

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East Palestine Example

What is the Dashboard and what data is Included in Dashboard?

The Community Wellbeing: Social Determinants of Health dashboard is relevant to anyone serving Ohioans that would benefit from greater insight into community conditions for funding, program, and policy considerations - to make the greatest impact. Users who benefit include (but certainly are not limited to) state and local governments, health and educational organizations, and non-profit organizations.

There are five (5) domains including economic vitality, neighborhood and physical environment, healthcare access and quality, education access and quality, and social and community environment and 131 key community attributes, including single parents, chronic diseases and, children living in poverty. Data is utilized from the Census Bureau, CDC and American Community Survey at the census tract level and is displayed in easily consumable formats including maps, bar charts and CSV download.

Applying the Dashboard to Maximize Impact

This dashboard can proactively identify where funding, programs, and policies can make the greatest impact and begin to narrow health, educational, economical, and community disparity outcomes for Ohioans. View the Community Wellbeing: Social Determinants of Health dashboard on the DataOhio Portal (data.ohio.gov) or visit the Ohio Department of Health, Health Opportunity webpage for more details.

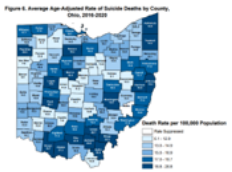
Demographics of Columbiana County

Columbiana County, Ohio is located in northeastern Ohio and borders Pennsylvania. The county has a population just under 100,000 people. Nearly half of the population is age 19 and young or over the age of 64. Fifteen percent of the population report a disability.

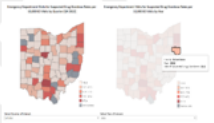
- 14.31% of the population live in poverty
- 24% children under 5 live in poverty
- 22% of children 18 and under live in poverty
- 14% of households in Columbiana Co receive SNAP benefits
- Community has a 6.56% unemployment rate
- Nearly 12% of the county does not have a high school diploma
- 6.4% of the population is uninsured while 27% of the population has veterans, Medicare or Medicaid insurance.
- While the vast majority of the population has insurance there is still about 15% of the population that does not utilize preventative screenings and that number is higher for women seeking mammography and cervical screenings.
- Prevalent chronic diseases in the county: Arthritis, binge drinking, heart disease, high blood pressure cancer (excluding skin), smoking, depression,
- Less than 1% of the population reports speaking limited English

- Nearly 6% report being single parent households
- Nearly 14% of household report no computing devises, broadband access varies across the county
- Nearly 45% of households are spending more than 30% of their income on housing
- The vast majority of housing available in the county was built before 1979

Suicide rates in Columbiana County:



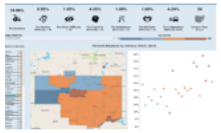
Accidental Overdose rates in Columbiana County:



Demographics of East Palestine

Utilizing the lasso feature in the Community Well-being Dashboard we can garner publicly available data for East Palestine. While a few community conditions in East Palestine align with the county profile demographics many are less prevalent while others are more prevalent. ODH does not look at accidental death/ overdose or suicide data by census tract. The other chronic disease data is available at that level. The overall Social Vulnerability Index(SVI) for both Columbiana County and East Palestine indicate that they do not meet the criteria for an Ohio Health Improvement Zone(OHIZ) designation.

The population of East Palestine is approximately 4,700 people.



In looking at the County demographics, less than 2% of the population identifies as Hispanic. There are a handful of census tracts in Columbiana Co that have a higher percentage of the community's Hispanic population and EP is one of those tracts but is still under 3%. ODH might consider translating materials. East Liverpool has the County's largest percentage of the Hispanic population- this is located directly south of EP.

- The two census tracts that are closest to EP have about 5% of their population as children with disabilities.
- The same two census tracts have less than 3% of the minor children living in poverty:
- The same two census tracts, according to the ACS data, suggests that there are higher rates of asthma, COPD, Cancer, Smoking, Coronary heart disease, and poor health:
- The census tract that EP is in has a higher rate of self-reported mental health concerns, per the ACS:
- The census tract immediately to the north of EP has an aging population:
- The tract to the north of EP is less likely to have health insurance:
- The average income across all educational attainment is $32,178
- The unemployment rate is 8%
- 8.4% of households report being single head of household
- More than 80% of households report subscriptions to broadband services
- 24% of those living in EP report having low income and low access (distance) to food
- 13% of households in P report receiving SNAP benefits
- 45% of housing in EP was built prior to 1939

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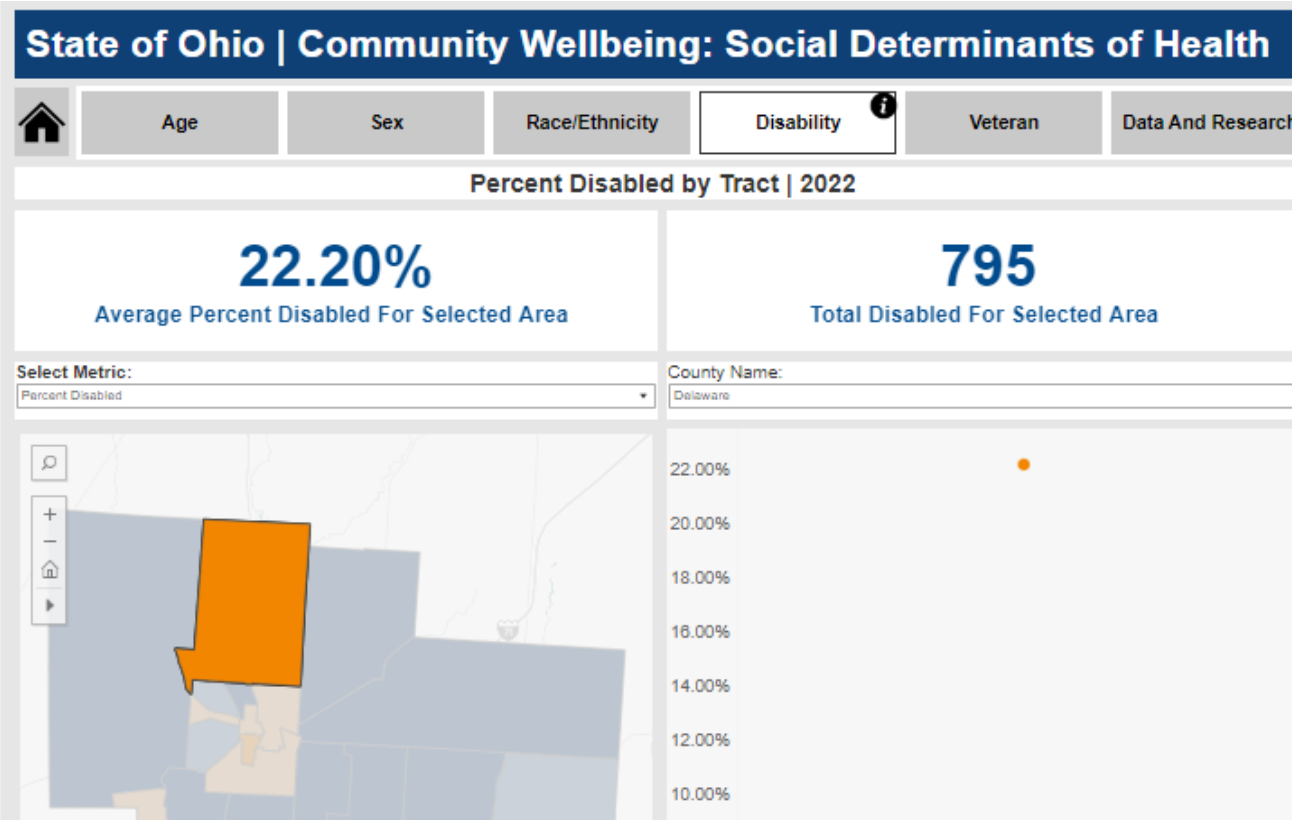
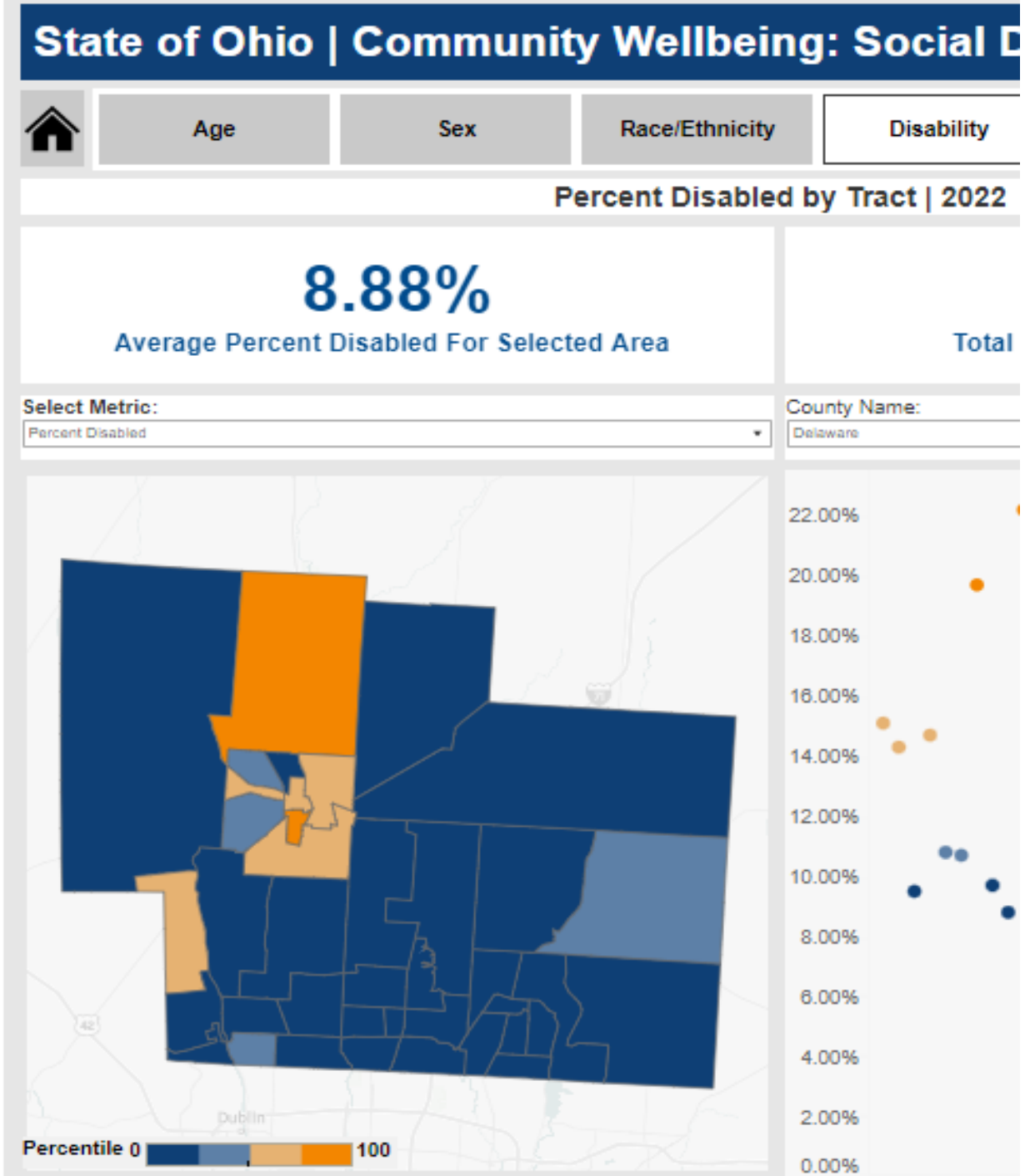
Building a Community Profile

- Purpose.
- County Profile vs. Census Tract Profile.





Building a Community Profile

- **Eight Sections:**
  - Social Vulnerability Index Score (OHIZ Dashboard).
  - Demographic Profiles (SDoH Dashboard).
  - Education Quality and Access (SDoH Dashboard).
  - Health Access and Access (SDoH Dashboard).
  - Neighborhood and Built Environment (SDoH Dashboard).
  - Economic Stability (SDoH Dashboard).
  - Social and Community Context (SDoH Dashboard).
  - Community Partners.

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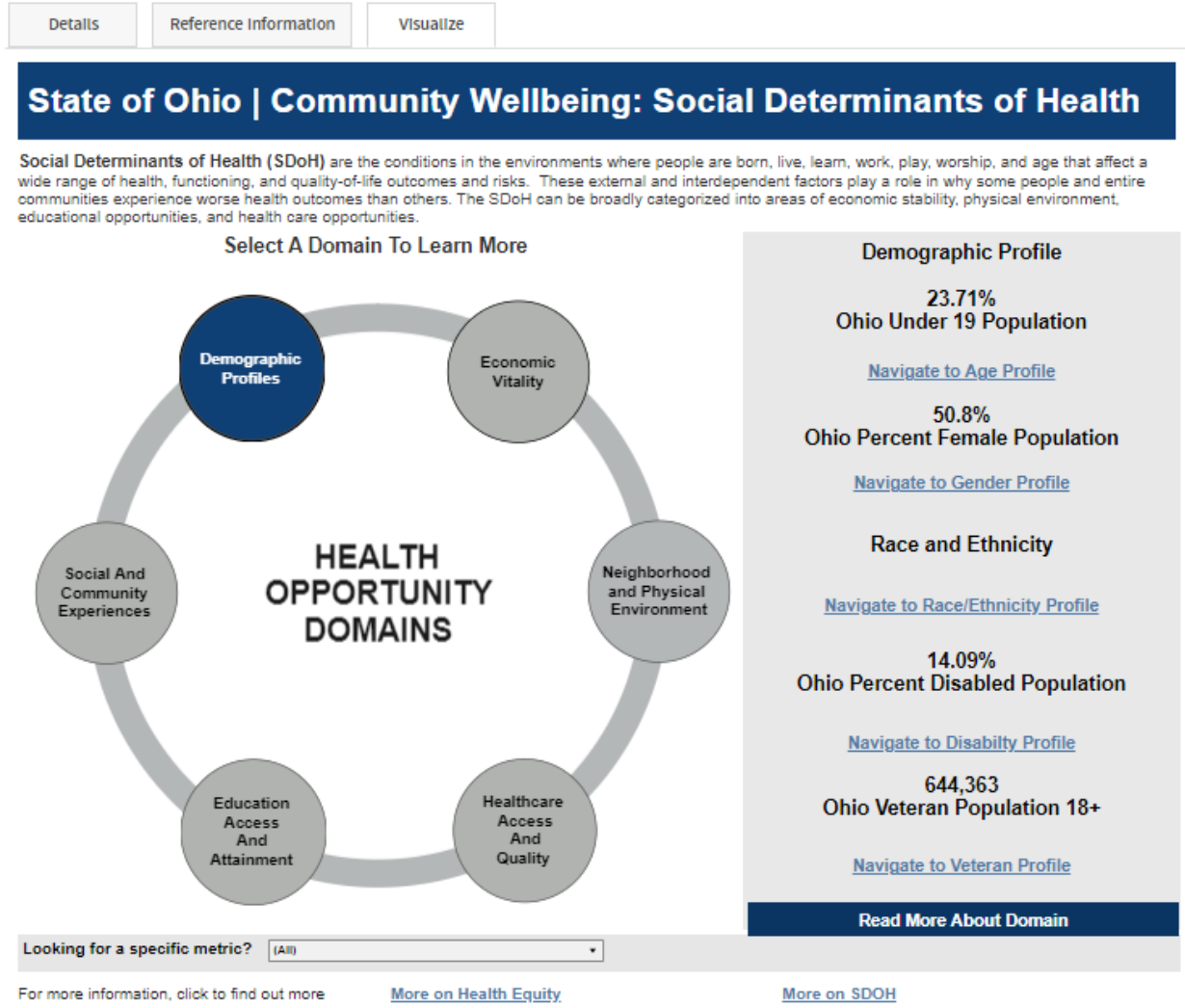
Community Well-being: Social Determinants of Health Dashboard

[Community Wellbeing: Social Determinants of Health | DataOhio]



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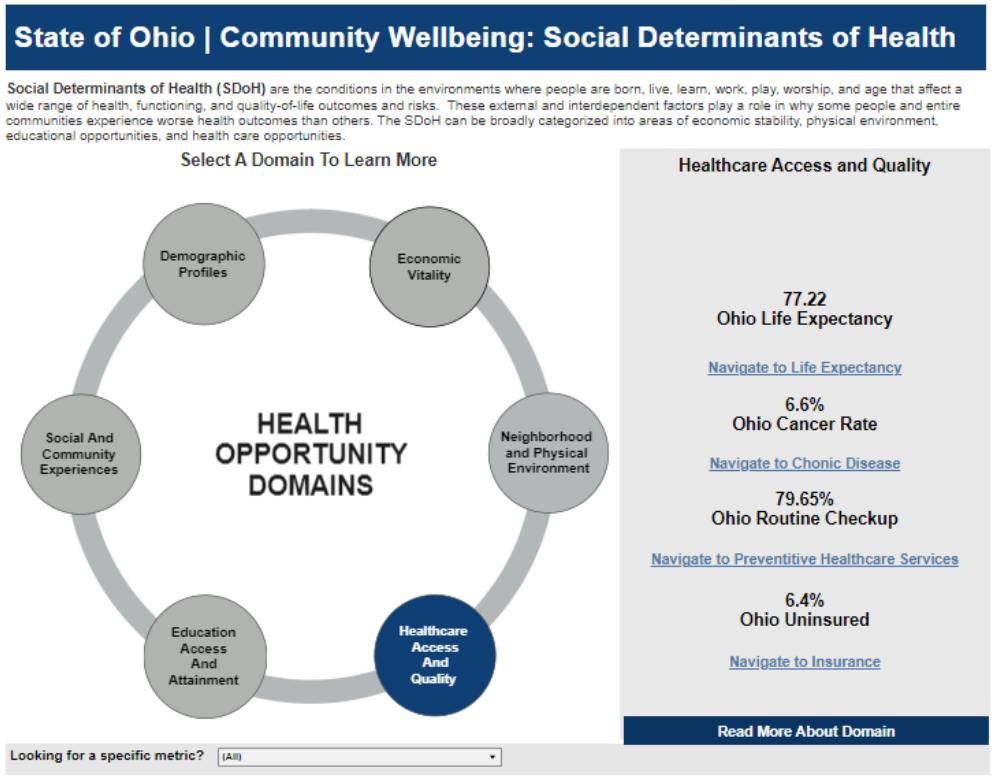
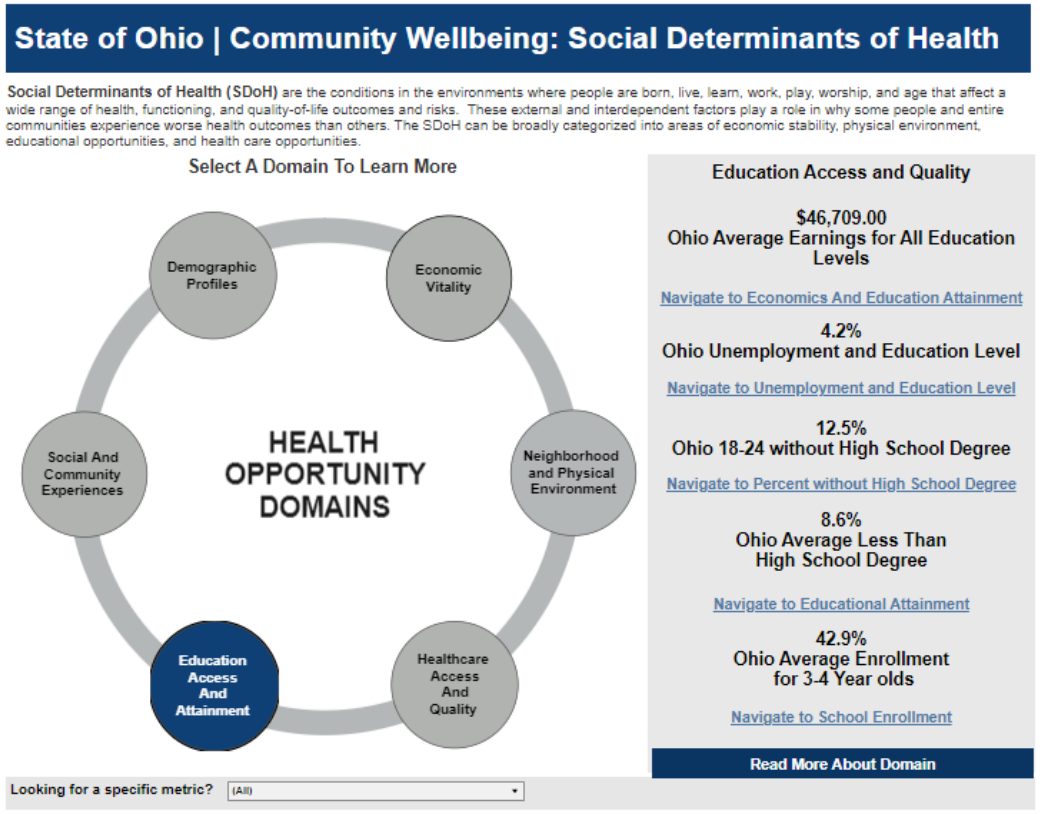
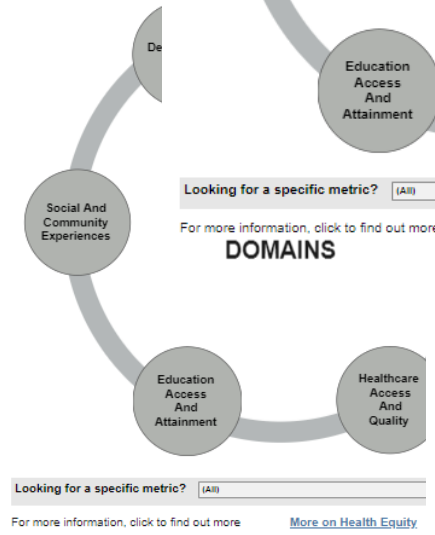
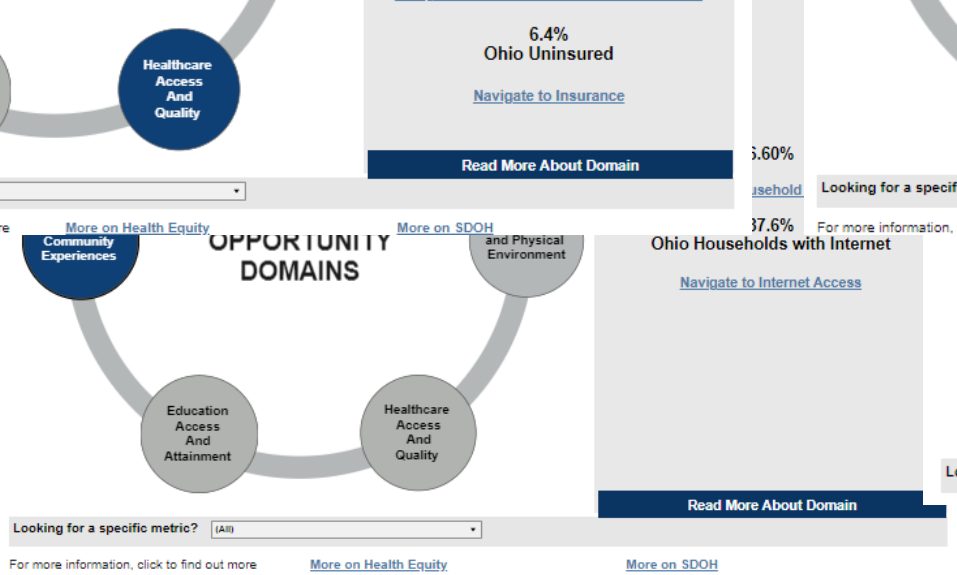
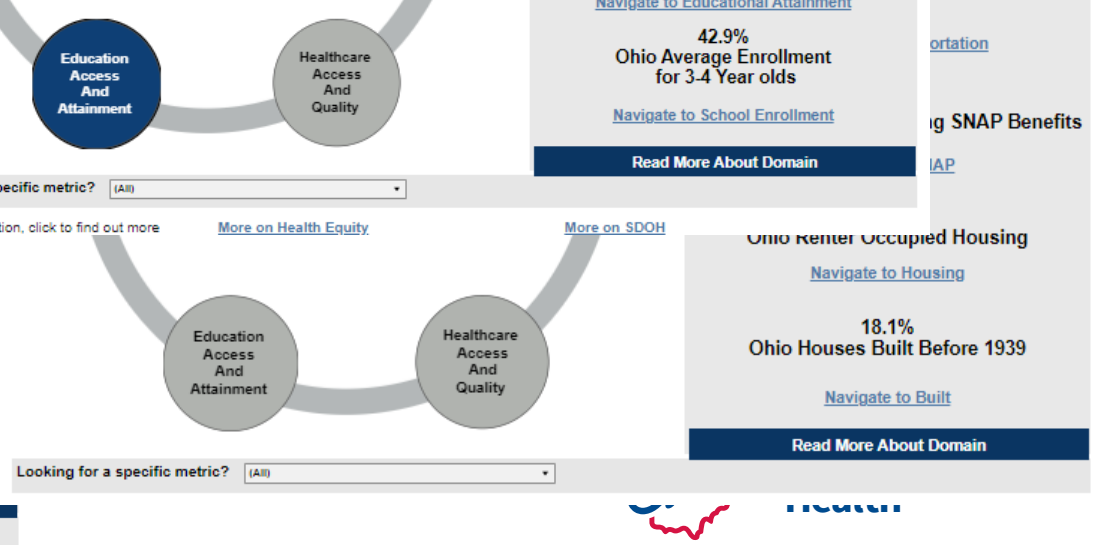
Community Well-being: Social Determinants of Health Dashboard (cont.)











Build Your Community Profile

Build Your Community Profile

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Use the Ohio Health Improvement Zones (OHIZ) dashboard and the Community Wellbeing: Social Determinants of Health dashboard (SDoH) to fill in the blanks below.

County or Census Tract(s): _____

Please use the **Ohio Improvement Zones Dashboard** to find the data for the sections below.

County or Census Tract Overall SVI Score (OHIZ)

Socioeconomic Status SVI: _____ *(For example, 0.75)*

Household Composition SVI: _____ *(For example, 0.75)*

Race/Ethnicity/Language Status SVI: _____ *(For example, 0.75)*

Housing/Transportation SVI: _____ *(For example, 0.75)*

Please use the **Community Well-being: Social Determinants of Health Dashboard** to find the data for the sections below.

County or Census Tract Demographic Profile (SDoH)

Data for this section can be found under the "Demographic Profile" domain on the SDoH dashboard.

Insert percentage or population # for each line. (For example, 15%)

Age Demographics	
Population Under 19	
Population 19-64	
Population 64 and Up	

Racial/Ethnic Demographics	
Percent While Population	
Percent Black Population	
Percent American Indian and Alaskan Native Population	
Percent Asian Population	
Percent Native Hawaiian and Other Pacific Islander	
Percent Some Other Race Population	
Percent Two or More Races Population	
Hispanic or Latino Origin Population	

Gender Demographics	
Percent Female Poplulation	
Percent Male Population	

Veteran Demographics	
Percent Veteran Population 18+	

Disability Demographics	
Percent Disabled	
Percent with Hearing Difficulty Under 18	
Percent with Vision Difficulty Under 18	
Percent with Cognitive Disabiltiy Under 18	
Percent with Ambulatory Difficulty Under 18	
Percent Self-Care Difficulty Under 18	
Percent with Independent Difficulty Between 18-64	

Special Populations *(ex. Migrant seasonal farm workers, Haitian-Creole population, Mauritanian population, etc.)*

Does your county offer Translation Services?

☐ If so, list languages below:

Build Your Community Profile

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Economic Vitality (SDoH)

Data for this section can be found under the "Economic Vitality" domain on the SDoH Dashboard.

Insert percentage or population # for each line. (For example, 15%)

Percent population in poverty.		Percent unemployment.	
Percent of children under 5 live in poverty.		Labor Force Participation (20-64 years old).	
Percent of children 18 and under live in poverty.		Labor Force Participation (20-64 years old) (Any Disability).	
Percent living in poverty with a disability.		Labor Force Participation (20-64 years old) below poverty in the last 12 months.	
Median household income.			

Neighborhood and Physical Environment (SDoH)

Data for this section can be found under the "Neighborhood and Physical Environment" domain on the SDoH dashboard.

Insert percentage for each line. (For example, 15%)

Households without a vehicle.		Spending 40% or more of income on rent.	
Housing units built 1939 or earlier.		Spending 50% or more of income on rent.	
Housing units built 1940-1960.		Households in county receive SNAP benefits.	
Housing units built before 1979.		Walkability.	
Spending 30% or more of income on rent.			

Healthcare Access and Quality

Instructions: Data for this section can be found under the "Health Access and Quality" domain on the SDoH dashboard.

Insert percentage for each line. (For example, 15%)

Percent of the population is uninsured.		Seeking Preventative Services.	
Percent uninsured with a disability.		Top 5 prevalent chronic diseases in the county:	
Percent uninsured under 19.			
VA Health Coverage.			
Medicare Coverage.			
Medicaid Coverage.			

Education Access and Attainment (SDoH)

Instructions: Data for this section can be found under the "Education Access and Attainment" domain on the SDoH dashboard.

Insert percentage for each line. (For example, 15%)

Percent of the population does not have a high school diploma.		Average earning for all education levels. *Insert dollar amount here (For example, $32,000)*	
25 years or older with less than a 9th-grade education.		Percent of students economically disadvantaged.	

Build Your Community Profile

Department of Health

Social and Community Experiences (SDoH)

Data for this section can be found under the "Social and Community Experiences" domain on the SDoH Dashboard.

Insert percentage for each line. (For example, 15%)

Percent of the population reports speaking limited English.		Percent of households have broadband access.	
Percent households report no computing devices.		Percent report being single-parent households.	

Community Partners to Consider

For this section, consider your organization's current and potential partners.

Faith-Based and Community Organizations:

Businesses:

Nonprofits:

Government:

Schools and Academia:

Hospitals and Health Centers:

Media Outlets:

Other Non-Traditional Partners:

Additional Resources:

Accidental Overdoses: The State of Ohio Integrated Behavioral Health Dashboard provides a county and state-level picture of long-term trends in opioid use disorder, overdoses, and treatment, critical information in helping public health and others understand service needs, outcomes, and opportunities to reduce substance misuse.

Resiliency Analysis and Planning Tool: The FEMA Resiliency Analysis and Planning Tool (RAPT) is a GIS planning tool that informs emergency preparedness, response, and recovery strategies. RAPT has more than 100 preloaded layers that include community resilience indicators, current census data, infrastructure, and hazards. Some helpful metrics in this tool include specific language demographics and the number of hospitals, nursing homes, and long-term care facilities located within a particular area.

Benefits to Building a Community Profile

- Improved planning and response.
- Risk Identification and Assessment.
- Enhanced Communication and Outreach.
- Strengthened Community Engagement.

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Ohio Health Improvement Zones Dashboard

Community Wellbeing:
Social Determinants of Health Dashboard

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ODH Community Profiles - AOHC Fall Conference

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QUESTIONS?

CONTACT THE OFFICE OF HEALTH OPPORTUNITY

HEALTHOPPORTUNITY@ ODH.OHIO.GOV

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