Synopsis and FAQ Resource

Social Determinants of Health (SDOH) Webinar Part 2: Incorporating SDOH into Overdose Prevention Activities

Project Introduction
Under the Overdose Data to Action Cooperative Agreement, CDC awarded funds to 47 states, Washington D.C., 16 localities, and two territories to increase the timeliness and comprehensiveness of data and inform public health response and prevention activities. In partnership with CDC, The Association of State and Territorial Health Officials (ASTHO) provides technical assistance and capacity building support to jurisdictions that have received the OD2A funding. As part of ASTHO’s support to OD2A recipients, ASTHO facilitates virtual learning communities to allow peer-to-peer sharing and content delivery from subject matter experts.

On Sept. 15, 2020, ASTHO and CDC partnered to hold an OD2A learning community session on the importance of health equity work and social determinants of health activities to address the overdose crisis. The session featured Rhode Island Department of Health Deputy Director Ana Novais who spoke about the work that Rhode Island does surrounding overdose prevention and health equity. This Synopsis and FAQ document serves as a complementary resource to this webinar. This session was a follow-up to the OD2A SDOH part 1 webinar, The Opioid Overdose Epidemic and Social Determinants of Health, which took place in February 2020.

Synopsis
During the discussion activity, participants were assigned a breakout room to explore the intersection of social determinants of health and aspects of overdose prevention. The 200+ participants discussed topics, including collaboration, data, evaluation, and implementation. This resource aims to provide a synopsis of the conversations that took place, identifying major themes, key takeaways, and emerging challenges that may help to inform priority areas for future technical assistance.

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<tr>
<th>Breakout Group Topic</th>
<th>Key Takeaways</th>
<th>Identified Challenges</th>
<th>Additional Resources</th>
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<tr>
<td>Collaboration - How to utilize local community groups and coalitions to further health equity.</td>
<td>• Some states have been successful collaborating with law enforcement to provide naloxone training, criminal justice and behavioral health departments, as well as faith-based organizations. Leveraging community groups fosters relationships with critical partners and allows greater access to advance health equity efforts in local communities. • Understanding how stakeholders’ priorities feed</td>
<td>• Harm reduction is not widely accepted among certain stakeholders, so communication is key to reframe messaging. • Challenges have arisen in fostering relations with local law enforcement. • Reinvigoring partnerships with private businesses for naloxone distribution is difficult. • Fatal overdose numbers are rising in Black and Latinx communities.</td>
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into the broader goal is crucial to developing and sustaining healthy collaboration.

- It is crucial that staff reflect the demographics and cultures in the city in which they work.

- The COVID-19 pandemic poses significant challenges to collaboration.

| Data - How to collect/measure SDOH data and identify target populations. | States would like to know more about what data sets are being used to determine how SDOH affect overdoses.  
- States have asked for and would like to know more about the kind of data collected (i.e., race, income, emergency department (ED) data) requested by local jurisdictions.  
- A prevention program that partners with and leverages the networks of street outreach workers has seen success collecting SDOH information.  
- In collaborating with a university, a homeless population was interviewed to surface overdose-related information on this vulnerable demographic. collaboration with a university.  
- Drug pattern surveys help determine who is using and what drugs they are using.  
- A statewide mandate for health systems reports REALD (race, ethnicity, language, and disability).  
- In one state, the HHC and CMS services have integrated with EHRs, asking patients about housing stability, food insecurity, transportation challenges, utility needs, etc. | Data collection has slowed significantly due to COVID-19.  
- Although one state collects data on race and ethnicity, the SDOH data is not complete.  
- Since COVID-19, there has been a decline in ED visits.  
- Stay-at-home orders may have led to an increase in OD deaths. | Health-Related Social Needs Screening Tool  
Race, Ethnicity, Language, and Disability Implementation |
| Implementation - How to begin addressing health equity. | • One state was able to leverage funding to address SDOH by including child and family services in their grants.  
• Training local staff on health equity and SDOH positively impacts their work in the community.  
• Contractors can help incorporate health equity in states’ work.  
• Using OD2A funding, a state is collaborating with a pediatric association to incorporate ACEs messaging into social media posts.  
• In some states, tribal communities and tribal health leaders serve as allies and champions outside of the organization.  
• A minority health taskforce ensures alignment across the agency and works to address both COVID-19 and substance use.  
• A health equity council supports building partnerships, improving practices, and driving initiatives.  
• Role models, especially in leadership roles, allow staff to feel comfortable voicing concerns and bringing ideas to the table. | • The COVID-19 response has delayed project work.  
• Beginning a meaningful dialogue around addressing systemic racism, policies, and practices is challenging.  
• Although there seems to be interest in health equity, many do not know how to translate interest into action.  
• One state noted that its stimulant crisis stems from a housing crisis, which is difficult to address as a public health organization.  
• Funding remains an issue as states have difficulty distinguishing efforts without overlapping OD2A and other sources of funding.  
• Implementation remains one of the most difficult factors in addressing systemic racism and health equity. |
| Evaluation - How to measure impact. | • A surveillance project where first responders collect zip codes and indicate race and ethnicity can provide insight into opioid overdose work.  
• There is room for improvement in states collecting SDOH data. | • Challenges to evaluation have arisen due to COVID-19.  
• COVID-19 has caused delays in local health departments starting activities. |
• Collecting SDOH data to create dashboards and heat maps can ensure that SDOH are incorporated into opioid overdose work.

FAQ on Rhode Island’s Health Equity Zones

This FAQ document serves to complement ASTHO and CDC’s OD2A learning community webinar, Social Determinants of Health (SDOH) Webinar Part 2: Incorporating SDOH into your Overdose Prevention Activities by providing additional information on the Rhode Island Health Equity Zone experience and considerations on how other OD2A-funded jurisdictions can implement a similar structure in their health equity work and infuse critical social determinants of health-related priorities in their overdose prevention and surveillance efforts.

What are some examples of health equity activities funded by OD2A?

Drawing from OD2A SDOH part 1 webinar, entitled The Opioid Overdose Epidemic and Social Determinants of Health, which took place in February 2020, the following serve as examples of allowable health equity activities under OD2A where jurisdictions have successfully integrated health equity and the social determinants of health in their work to address the overdose crisis.

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<tr>
<th>Jurisdiction</th>
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<th>Additional Resources</th>
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<tr>
<td>Harris County, TX</td>
<td>The aim of Harris Cares: A 2020 Vision of Health in Harris County is to assess the health status of the residents of Harris County, while examining the connection between public health and healthcare, and providing implementation-related recommendations to be considered by Harris County officials to enhance the general health and wellbeing of the community overall.</td>
<td><a href="https://publichealth.harriscountytx.gov/Resources/Harris-Cares">https://publichealth.harriscountytx.gov/Resources/Harris-Cares</a></td>
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<td>Colorado</td>
<td>Grounded in community and lived experience expertise, collaboration opportunities within CTC provide</td>
<td><a href="https://cdphe.colorado.gov/prevention-and-wellness/injury-prevention/communities-that-">https://cdphe.colorado.gov/prevention-and-wellness/injury-prevention/communities-that-</a></td>
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opportunities for collaboration in OD2A work, infusing a local collaboration effort with health equity and social determinants of health approaches to build upon local capacity to incorporate OD2A strategy interventions.

care/youth-substance-abuse-prevention
https://www.communitiesshatcicare.net/
https://www.chicolorado.org/prevention/ctc/

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<th>Kentucky Injury Prevention and Research Center (KIPRC)</th>
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<td>This initiative selected high burden counties for intervention in OD2A, analyzed a drug overdose fatality surveillance report, with particular focus on age and drugs in postmortem toxicology and race and drugs in postmortem toxicology.</td>
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<td><a href="https://kiprc.uky.edu/programs/overdose-data-action">https://kiprc.uky.edu/programs/overdose-data-action</a></td>
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<tr>
<td>FindHelpNowKY.org</td>
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<td><a href="https://kiprc.uky.edu/">https://kiprc.uky.edu/</a></td>
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What are the three leading priorities of the Rhode Island Department of Health (RIDOH) in demonstrating the purpose and importance of public health?

The three leading priorities that guide RIDOH’s work across all programs are addressing the social and environmental determinants of health, eliminating the disparities (gender, disability status, ethnicity, etc.) of health and promoting health equity, and ensuring access to quality health services, including those for vulnerable populations.

What are the five strategies that help RIDOH move these priorities?

The five strategies are: (1) promote healthy living throughout life’s stages; (2) guarantee access to safe and healthy food, water, and environments in all communities; (3) promote a comprehensive health system that is accessible and affordable; (4) prevent, examine, mitigate, and eliminate health risks and threats; and (5) analyze and convey information to improve the health of the public. Within these five strategies, there are 23 population health goals that RIDOH is working to advance. For each goal, there are specific metrics and activities being implemented. These are tracked monthly to ensure accountability.

What are Health Equity Zones?

Health Equity Zones (HEZ) are geographic regions that have discernible and documented health disparities, as well as poor health outcomes and socioeconomic and environmental conditions that bar people from enjoying health and wellbeing. Each project is implemented over a period of three or four years. Funding allows for the development of community-championed collaboratives and action plans that include a range of stakeholders, such as municipal leaders, residents, businesses, transportation and community planners, and law enforcement. There are nine local collaboratives across Rhode Island. Using RI’s HEZ as a model, other jurisdictions can explore how funding can be utilized to establish a
similar structure in their state. Moreover, state and local health departments can draw from the successes, challenges, and best practices outlined in the HEALTH EQUITY ZONES: A Toolkit for Building Healthy and Resilient Communities. Adapting the various steps – building a health department team, developing HEZ, financing HEZ, training to support HEZ, evaluating processes and outcomes, and ensuring HEZ sustainability – to meet particular needs, health departments can take elements from the RI model to create a community-specific initiative that can be effectively and sustainably implemented in the jurisdiction. For more information, please see the video: What are Rhode Island Health Equity Zones?

**What goals are the Health Equity Zones working to achieve?** HEZ objectives include (1) advancing the health of communities that experience high rates of illness, injury, chronic disease, or other negative health outcomes; (2) improving birth outcomes; (3) decreasing health disparities; (4) improving the social and environmental conditions of the geographical area; and (5) supporting the development and implementation of policy and environmental change interventions. HEALTH EQUITY ZONES: A Toolkit for Building Healthy and Resilient Communities provides helpful guidance on how local and state health departments can support vulnerable, underserved communities while working to close the gap in health equity that these communities and their residents often face.

**What type of data was used to carve out and identify the Health Equity Zones?**

Rhode Island allowed for the community to define the HEZ by drawing a line on the map to indicate how they were defining their specific zone. A minimum of 4,000 people stands as the criterion to effectively measure impact. Zones can range from those as small as neighborhoods to those at the city level. There were cases of some HEZ where two cities partnered together in their social exchanges, as well as instances of zones at the county level where between four and six cities come together to form a zone. As a requirement, the zones cannot overlap and there cannot be two zones in the same geographical area.

**Did the community health workers already exist, and how did you manage the existing workforce?**

The community health workers were already in place, and there were a variety of iterations of how best to train and certify community health workers. Moreover, part of the proposal for the HEZ was ensuring that certified community health workers were hired to maintain and sustain the workforce. The HEZ worked together in partnership with the association of community health workers to hold a series of job fairs, which connected employers with the workers.

**What kind of data is used to evaluate the impact of these interventions on drug overdose prevalence?**

Rhode Island behavioral health and mental health personnel work to ensure there is a menu of evidence-based interventions from which the community can choose. Evaluation exists at two levels – one at the local level, based on a workplan and the specific evidence-based interventions, and one established at the statewide level, called health equity indicators. These go beyond assessment at the program intervention level and evaluate impact on an overarching equity level.

**What are the statewide health equity indicators and how can they be leveraged to evaluate the impact of health equity interventions?**
The Rhode Island health equity measures include 15 determinants of health in five domains that impact health equity including, integrated healthcare, community resiliency, physical environment, socioeconomics, and community trauma. The Health Equity Indicator Fact Sheet provides additional information on how the health equity measures were developed and how to leverage the data to further advance health equity and help communities assess the effect of health equity interventions.

**To funnel in additional resources, are Health Equity Zones paired with more resourced areas?**

HEZ are not paired with other more resourced areas. However, resources are aligned to serve and respond to specific needs. For example, a lack of a bus line in a zone was identified as precluding access. Although a bus line could not be funded, resources and partners were leveraged to connect the HEZ with the department of transportation. So while the zones are not paired with more resourced areas, they can identify priority issue areas and leverage connections to address particular needs. Rhode Island’s HEZ initiative utilizes a singular, flexible approach to funding, braiding funds from a variety of sources, which allows for greater latitude in pursuing approaches that better align with community priorities. This funding strategy may serve as a model for other state and local jurisdictions that can be tailored and replicated on a national level.

**Additional Resources:**

Health Equity Zones (HEZ) Initiative

HEALTH EQUITY ZONES: Building healthy and resilient communities across Rhode Island

Rhode Island’s Health Equity Zones: A Model for Building Healthy, Resilient Communities

*For more information on the Health Equity Zones, please contact RIDOH Deputy Director Ana Novais ([Ana.Novais@health.ri.gov](mailto:Ana.Novais@health.ri.gov)). Please direct any questions concerning the OD2A project to your assigned project officer.*