NNIP PARTNERS' ROLE IN THE SOCIAL DETERMINANTS OF HEALTH

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The social determinants of health, and the structural inequities that influence them, create a disproportional effect on the health and well-being of people with low-incomes and communities of color. However, the health care system alone is not positioned to act on the deep-rooted causes of differential health experiences. Instead, to address the social determinants of health, stakeholders in health care would benefit from collaboration with locally embedded, data-driven organizations with community connections, an understanding of neighborhood-level context on a range of topics, and a strong grasp of community context. The organizations in the National Neighborhood Indicators Partnership (NNIP)—a national network of organizations that ensure communities have access to data and the skills to use information to advance equity and well-being across neighborhoods—are prime examples of such organizations.

During our country's experience with the COVID-19 pandemic, communities of color and low-income communities have suffered higher rates of infection and death (Koma et al. 2020).[1] The major drivers of these differences are based in the social determinants of health; that is, the environments where people live, work, and play and the resources they have access to, which are shaped by deep-rooted inequities. Black Americans have been segregated and redlined into neighborhoods where fewer resources are invested.[2] During the pandemic, fewer testing resources have been allocated to Black and Hispanic neighborhoods,[3] despite more Black and Hispanic residents working in higher-risk, frontline occupations.[4] And, over time, wealthier communities with larger white populations received more public and private investments in community amenities, such as green space and parks, resources that have become even more important for people to stay mentally and physically healthy during the pandemic.[5] These are only a few examples of how social determinants of health have driven negative health outcomes for communities of color during the COVID-19 pandemic.

THE DRIVERS OF HEALTH AND WELL-BEING

Well beyond the pandemic's outcomes, the structural and social determinants of health drive differences in the everyday health and well-being of people based on the context and environments in which they live. Economic, political, and social structural mechanisms—which have been led and perpetuated by privileged groups that continue to hold power—unequally distribute access to opportunity and resources. The Urban Institute's Drivers of Health and Well-Being model (figure 1) breaks these opportunities and resources into eight categories—employment and working

conditions, social care and supports, education and training, safety and justice, health care systems and services, food and nutrition, income and wealth, and housing and neighborhoods. As the model shows, the distribution of these eight drivers is influenced by larger structural factors, such as the distribution of power, equity, dignity, and fairness in society. The distribution of the drivers of health and well-being then shape "intermediary determinants" of health, such as assets, behaviors, mental and social factors, and access to the health system (Solar and Irwin 2010).

The County Health Rankings and Roadmaps shows how these drivers of health and well-being play out. The healthiest counties had higher high school graduation rates, lower unemployment, fewer children experiencing poverty, more adequate and affordable housing, and better access to healthy foods, parks, gyms, and other exercise facilities (Catlin et al. 2014). With adequate access to resources and healthy environments, people can more easily make healthy choices and get access to the health care they need.

In recent years, the health care community has begun to take a deeper look at the social and environmental drivers of inequitable burden of disease. Some positive efforts have focused on health-related social needs—addressing patients' social needs to reduce future health care use. Health systems and health care providers have begun to screen for the underlying social and environmental factors that

might contribute to or exacerbate patients' health conditions. For example, they may inquire into the housing status of people who show up in the emergency room and try to connect patients who are experiencing homelessness to housing resources, which can reduce their health care use (Chhabra et al. 2019).

However, by targeting the social and structural determinants of health with community-level interventions, we can take interventions upstream. This could mean pursuing increases in funding for more affordable and supportive housing in our communities to stem the flow of patients experiencing homelessness who require emergency room services. Shifting to upstream interventions promotes addressing the social determinants of health—preventing health issues—instead of intervening after someone is already sick.

COMMUNITY COLLABORATIONS AND DATA ARE NEEDED TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

Collaborations and partnerships are needed to offer new insights and tools to accomplish the daunting goal of reducing the negative effects of the structural and social determinants of health. Shifting how communities allocate resources, where quality education and affordable housing exist, how neighborhoods are policed, and how wealth is distributed are each major undertakings and are beyond the reach of any one organization. Instead, through

building partnerships across organizations and in our communities, we can coordinate across fields, analyze data to understand connections, and ensure various stakeholders participate in decisionmaking, including community members and grassroots leaders.

Outside health care, organizations are targeting the different aspects of the social determinants of health. Nonprofits, governments, and even some for-profit entities aim to improve economic outcomes, housing stock, and access to green, recreational spaces. For example, government policies and services influence how schools are run, how physical resources are distributed, and how social support services are delivered in communities. Nonprofits provide various services in communities and strive to address social issues, like overpolicing of Black communities. Private industry affects the availability of healthy foods through the placement of restaurants and grocery stores and the development of high-quality, affordable housing. Often, these sectors are working in parallel and may not be focused on how their work intersects to affect health outcomes.

With data, communities can fully understand how the outcomes and interventions across different issue areas interact. The various drivers of health and well-being play out differently in each place—across neighborhoods and racial and ethnic groups. Nuanced neighborhood-level data analysis gives a clearer picture of the different drivers and gives communities the information to understand where supports and

interventions are most needed. A few innovative communities and partnerships have coordinated to bridge data silos and conduct analysis across organizations and fields to better understand the relationship between the social determinants and health outcomes in their communities.

Beyond quantitative data, organizations can more effectively identify a community's unique context and needs if they incorporate community members' perspectives. People who live in a place have the most at stake and the best understanding of how factors in their communities and environments affect them, and they should be active participants in efforts to improve the social determinants of health around them.

Community data organizations like NNIP Partners have experience working across sectors and already explore how factors interact in the community. They combine and analyze data across topics and neighborhoods and have local knowledge and connections with communities. Many Partners engage residents to ensure they are included in interpreting data and making decisions on how to respond. They are experienced in providing the big picture of complex community factors and have a role in helping stakeholders craft solutions.

HOW NNIP PARTNERS ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

NNIP Partners are already bridging fields and sectors to show how community and social

factors affect health outcomes. They have collaborated with organizations in their communities on numerous projects that have shaped social supports, community resources, government policies, and health outcomes for residents.

In Cleveland, the NNIP Partner joined a collaboration to share data and analysis with other local organizations to distribute previously siloed information across sectors and create a big picture of the factors at play in the community. The Center on Urban Poverty and Community Development (the Poverty Center) at Case Western Reserve University joined forces with other local organizations to create the Cleveland Healthy Home Data Collaborative through the BUILD Health Challenge.[6] This data collaborative strives to provide the public, physicians, and public health officials with access to useful information around health inequities, particularly on asthma and lead poisoning. For example, they will make lead inspection data available to the public through their housing and health platform. Using the Poverty Center's powerful integrated housing data system, they also plan to merge their housing and neighborhood data with health outcome data provided by two local health systems.

Many NNIP Partners also create community status reports or profiles that give a comprehensive view of community health, resources, and social determinants of health. As one example, DataHaven in New Haven,

Connecticut, develops its Community Wellbeing Index reports every three years using its unique statewide survey, in-depth interviews, and administrative data from local, state, and federal government agencies. The reports combine social, economic, and health information to document the opportunities and challenges that affect community residents where they live, work, and play. For example, the Greater New Haven Community Index report shows there is a 15-year life expectancy difference between neighborhoods in the region, and only 42 percent of adults who earn less than $30,000 a year report they are in good health, compared with 73 percent of adults who earn $100,000 or more.

Figure 1 shows how Partners are working to address the eight areas that drive the social determinants of health.

"The data in the Fairfield County Community Wellbeing Index has helped to identify and develop priorities for collective action to build a stronger, healthier, and more equitable Fairfield County and to measure the progress we are making against these priorities through ongoing surveying and data collection."

—Juanita James
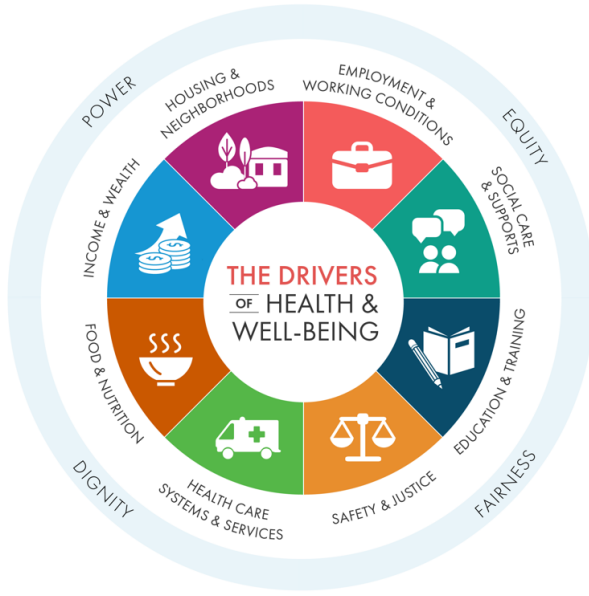*Fairfield County's Community Foundation*

Figure 1

NNIP Partners have already made great strides in the social determinants of health. This graphic shows how NNIP Partners have played key roles in addressing the eight areas that drive the social determinants of health.

Employment & Working Conditions

At the start of the COVID-19 pandemic, Boston Indicators analyzed Boston's workforce to determine who were most likely to still be working as "essential" workers and therefore at risk of infection. Learn more here.

Social Care & Supports

The Polis Center, with the Domestic Violence Center, combined multiple datasets to identify the number of unique reported domestic violence survivors each year in Indianapolis and what services and supports they need. The organizations used these data to develop a local intervention that reduced repeated acts of domestic violence. Learn more here.

Education & Training

The Center on Urban Poverty and Community Development is committed to addressing the negative effects of childhood poverty in Cleveland, including the lifetime health impacts. They partnered with the Cuyahoga County's Universal Pre-Kindergarten Pilot to evaluate if pre-K education can set young students on a path to success. Learn more here.

Safety & Justice

The Urban Strategies Council guided the City of Oakland's Department of Violence Prevention in their plans to reduce gun violence, domestic violence, and commercial sexual exploitation by engaging community members who were most affected. Learn more here.

Health Care Systems & Services

Communities Count contributed to the 2018–19 Community Health Needs Assessment for the Seattle and King County area to identify the population's current health status and the community's access to health care services and supports, by race, area of the county, and income level. Learn more here.

Food & Nutrition

Based on their analysis of Houston's food insecurity and food deserts, the Kinder Institute for Urban Research proposed ways Houston's nonprofits, government programs, and businesses could collaborate more effectively to address the region's inequitable food systems. Learn more here.

Income & Wealth

The University of North Carolina at Charlotte's Urban Institute compiled national data and, where possible, analyzed disparities in the racial wealth gap in the Charlotte and Mecklenburg County area. They identified historical trends and wealth-building mechanisms that contributed to the inequitable distribution of wealth and resources and proposed strategies to close the gap. Learn more here.

Housing & Neighborhoods

The Baltimore Neighborhood Indicators Alliance created an equity analysis for Baltimore's Department of Planning to better direct their Capital Improvement Program investments. They analyzed the characteristics of communities that did and did not receive funding, including racial makeup, income, and life expectancy in those communities. Learn more here.

CONCLUSION

The social determinants of health are deeply rooted in the environments where people live, work, and play, and many communities' environments are vastly different, shaped by discriminatory policies and inequitable distributions of resources. But through collaborations, local actors can better understand how these factors play out in their communities and build solutions with those community members most affected.

NOTES

[1] "Health Equity Considerations and Racial & Ethnic Minority Groups," Centers for Disease Control and Prevention, updated July 24, 2020, https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html.

[2] "Equity Toolkit," Baltimore Equity Toolkit and Power Mapping, accessed August 27, 2020, http://www.equitybaltimore.org/.

[3] Stephen F. Gray, "COVID-19 Puts Structural Racism on Full Display—Will We Finally Do Something to Correct It?" Next City, May 11, 2020, https://nextcity.org/daily/entry/covid-19-puts-structural-racism-on-full-display.

[4] Soo Rin Kim, Matthew Vann, Laura Bronner, and Grace Manthey, "Which Cities Have the Biggest Racial Gaps in COVID-19 Testing Access?" FiveThirtyEight, July 22, 2020, https://fivethirtyeight.com/features/white-neighborhoods-have-more-access-to-covid-19-testing-sites/.

[5] Kimberly Burrowes, "Is COVID-19 Uncovering Park Inequities?," *Parks & Recreation*, April 23, 2020, https://www.nrpa.org/parks-recreation-magazine/2020/may/is-covid-19-uncovering-park-inequities/.

[6] "Cleveland Health Home Data Collaborative," BUILD Health Challenge, accessed August 27, 2020, https://buildhealthchallenge.org/communities/2-cleveland-healthy-home-data-collaborative-2/.

REFERENCES

Catlin, Bridget, Amanda Jovaag, Patrick Remington, and Julie Willems Van Dijk. 2014. *County Health Rankings and Roadmaps: Key Findings Report*. Madison: University of Wisconsin Population Health Institute; Princeton, NJ: Robert Wood Johnson Foundation.

Chhabra, Manik, Anneliese E. Sorrentino, Meagan Cusack, Melissa E. Dichter, Ann Elizabeth Montgomery, and Gala True. 2019. "Screening for Housing Instability: Providers' Reflections on Addressing a Social Determinant of Health." *Journal of General Internal Medicine* 34 (7): 1,213–19.

Koma, Wyatt, Samantha Artiga, Tricia Neuman, Gary Claxton, Matthew Rae, Jennifer Kates, and Josh Michaud. 2020. "Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus." San Francisco: Kaiser Family Foundation.

Solar, Orielle, and Alec Irwin. 2010. *A Conceptual Framework for Action on the Social Determinants of Health: Social Determinants of Health Discussion Paper 2*. Geneva: World Health Organization.

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NNIP is a learning network, coordinated by the Urban Institute, that connects independent partner organizations in more than 30 cities that share a mission to ensure all communities have access to data and the skills to use information to advance equity and well-being across neighborhoods. The Urban Institute is a nonprofit policy research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities.