



Move Utah

ACTIVE, HEALTHY, CONNECTED COMMUNITIES

Transportation and Land Use: Social
Determinants of Health



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A young boy with Down syndrome is focused on painting a wooden railing with a brush. He is wearing a red and white striped t-shirt. Behind him, a man with a beard and long hair, wearing a blue t-shirt, is smiling warmly. To the left, a woman with blonde hair is also smiling. The background shows a red building and green foliage. A dark blue banner with white text is overlaid at the bottom of the image.

The Alliance for the Determinants of Health



West Town – 84000

High school/college 71%

Below poverty 24%

Household income \$40,000

Life expectancy 75.8

Zip Code Determines Health
More than Genetic Code

East Town Heights – 84100

High school/college 97%

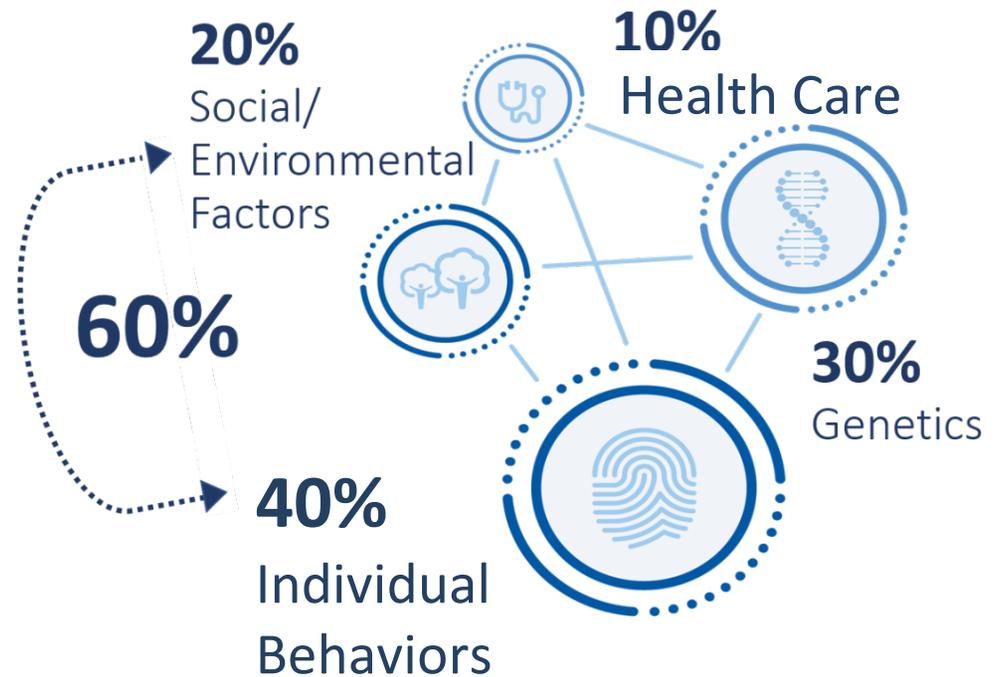
Below poverty

5%

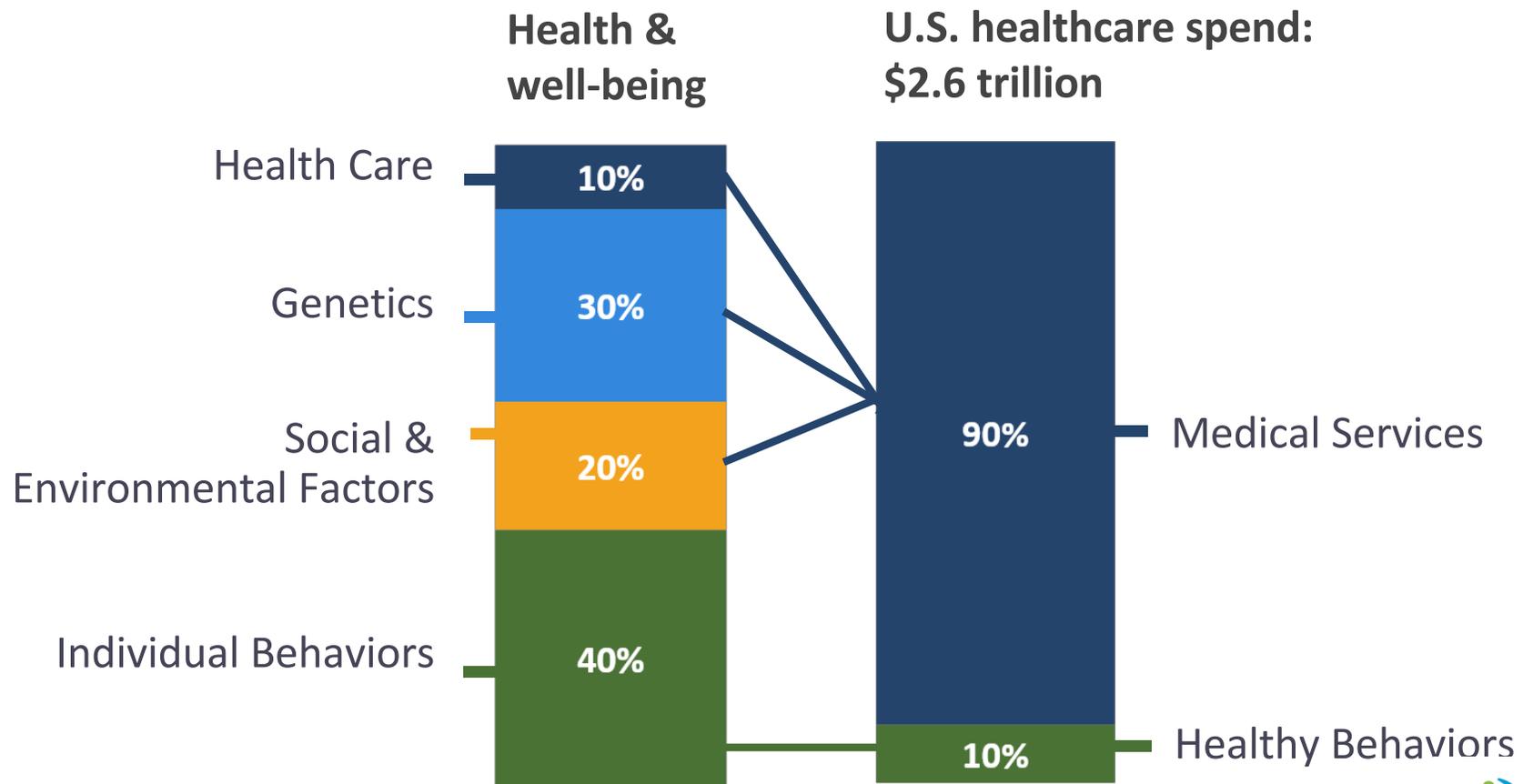
Household income \$77,000

Life expectancy 85

**Helping people
live the
healthiest lives
possible**

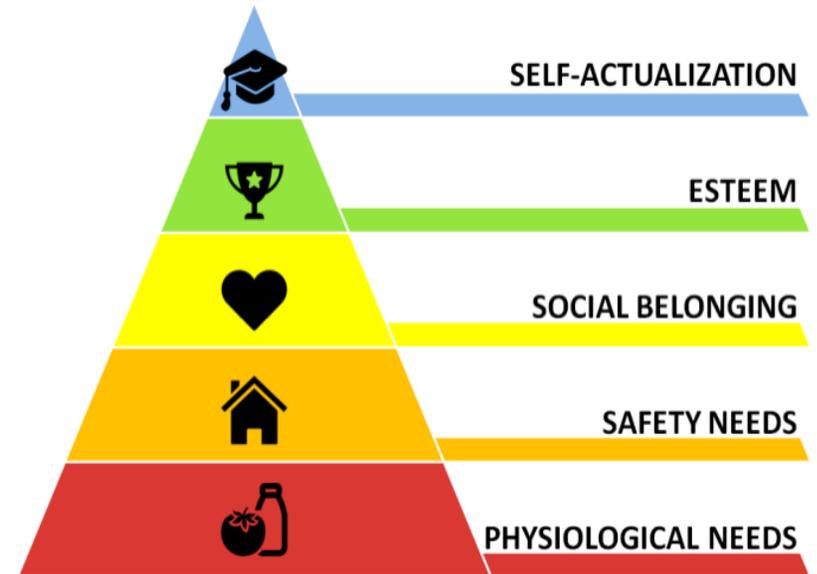
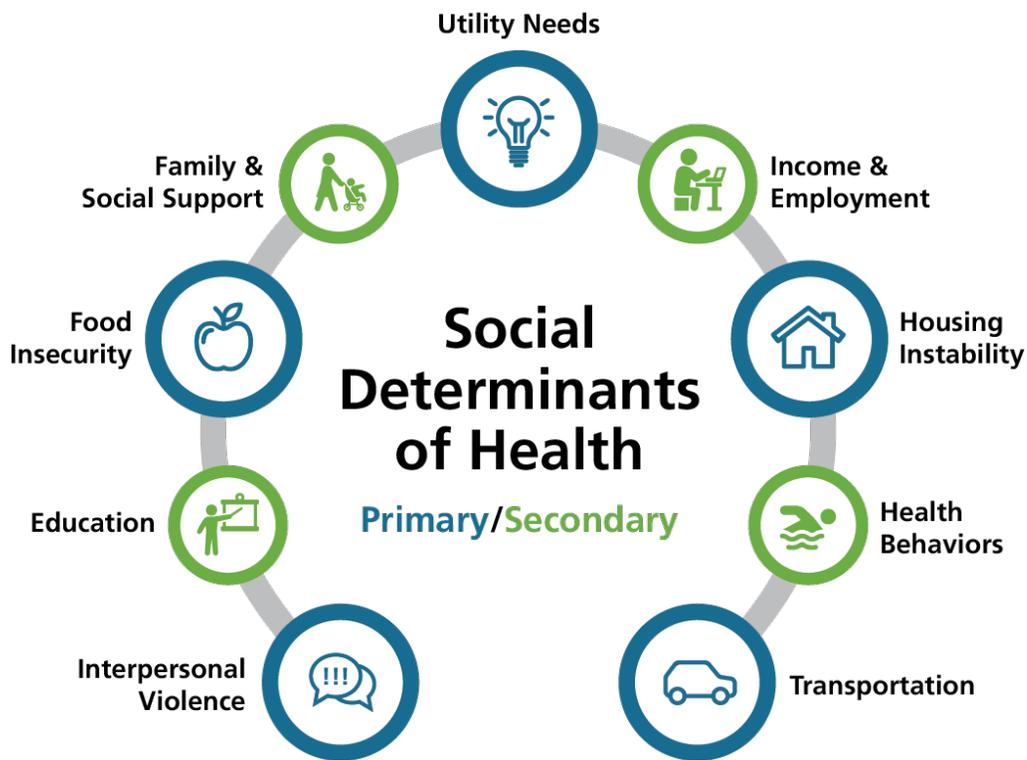


Mismatch Between Drivers of Health and Spending

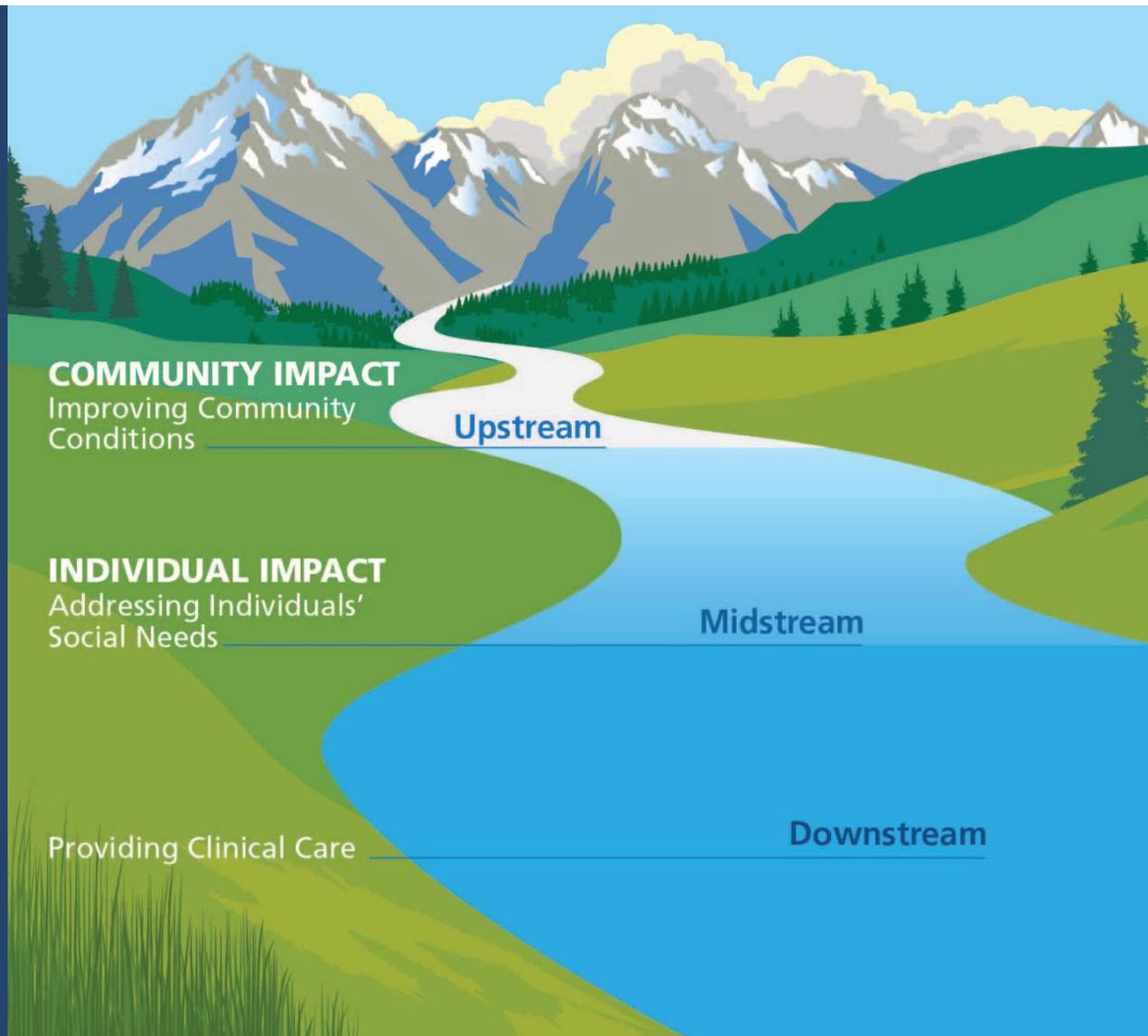


Source: *Institute for the Future*, University of California-San Francisco, CDC, 2007

Influencing The Social Determinants

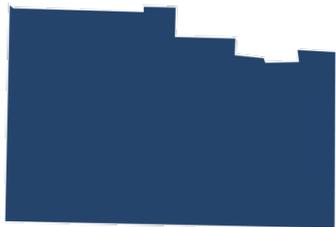


Meeting Social Needs and Addressing the Social Determinants of Health



The Alliance for the Determinants of Health

\$2 million annually per community for 3 years



WASHINGTON COUNTY



WEBER COUNTY

- Lower than average life expectancy
- High behavioral health needs
- High emergency room use for non-emergency needs

Alliance Objective:

Improve health outcomes, reduce healthcare costs, and be a model for change by addressing social determinants of health



- Align social services and care delivery



- Remove silos among delivery systems, public health and community partners through innovative partnerships



- Use technology and data sharing to find solutions

AWARENESS

ASSISTANCE

ALIGNMENT



Local Mental Health Authorities and Federally Qualified Health Centers



Community Based Organizations



Intermountain Emergency Departments and Clinics



selecthealth.



Screening for Social Determinants Of Health



Community Health Worker



Digital Platform



Navigation Services



Individualized Social Care and Treatment Plan



Community Resources

Connect Us Coordinated Network

Community Based Organizations in Weber County

Association for Community Health
Catholic Community Services
Habitat for Humanity
Housing Authority of Ogden City
Lantern House
Midtown Community Health Center
Ogden City Fire Department
Ogden Weber Community Action Partnership
Parents as Teachers – Prevent Child Abuse Utah
United Way of Northern Utah – Welcome Baby
Weber County – ICAN Project
Weber Housing Authority
Weber Human Services
Weber Morgan Health Department
Youth Futures
YMCA of Northern Utah

Impact of Alliance Collaboration



Alliance Communities

- Referral infrastructure
- Collaborative relationships
- Improved integration of medical and Behavioral health



Alliance Community Organizations

- Data sharing
- Digital platform



SelectHealth Medicaid Members & Households

- Connect to services addressing social determinants of health



SelectHealth Medicaid Members

- Improve coordination of medical and behavioral health
- Connect to services addressing social determinants of health

Community Health Workers

Alliance for the Determinants of Health in partnership with AUCH

What is a Community Health Worker?

“A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.”

— Cited from The American Public Health Association (<https://www.apha.org/>)

2 Teams of 6 AUCH CHWs serving

Weber and Washington County

Criteria for Referral to CHW:

Patient has 2 or more chronic conditions PLUS:

- One uncontrolled condition;
- No insurance;
- No PCP
- Recent ED visits; and/or
- Recent SDOH crisis
- Must be a Select Health Community Care Member

CHWs work with patients for up to six months and help by:

- Addressing social needs (SDOH) through referrals to community resources
- Supporting patients to become engaged in their health through goal setting, health coaching, and resource navigation



A selfie of Sarai (left) and Jasmine (right) from the Washington County team.



A photo of Ashlyne, Shardae, Jackson, and Alycia from the Weber County team in front of Midtown Community Health Center.

Who We Are and What We Do *for You*

Resource Navigators - We help guide you to nutrition, legal, medical, utility, transportation and clothing resources

Connectors - We connect you to affordable and accessible healthcare

Listeners - We live in your community and understand your concerns

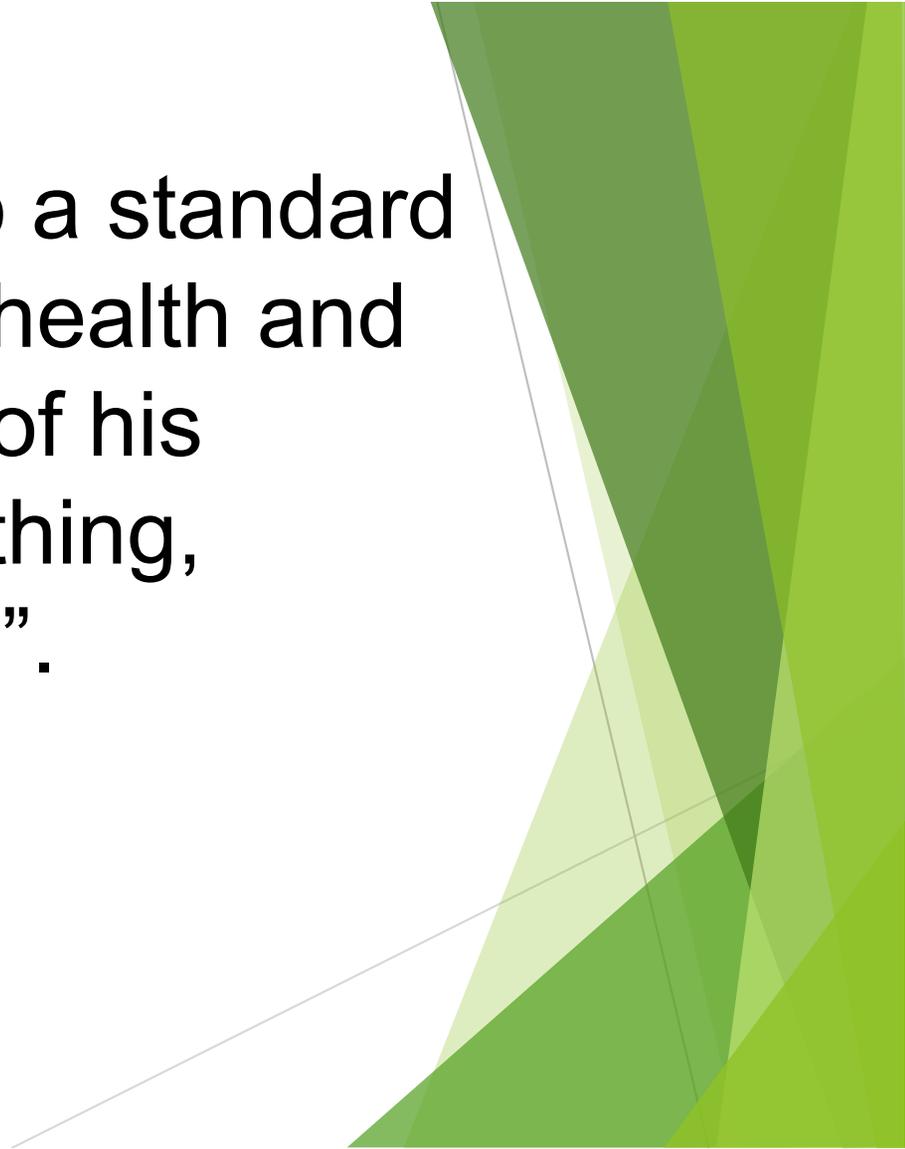
Problem Solvers - We listen to your needs and work with you to find solutions

Wellness Advocates - We help you make and keep health-related goals and provide support to help you manage your ongoing conditions



Socially Equitable Affordable Housing and Health

“Everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing and medical care”.



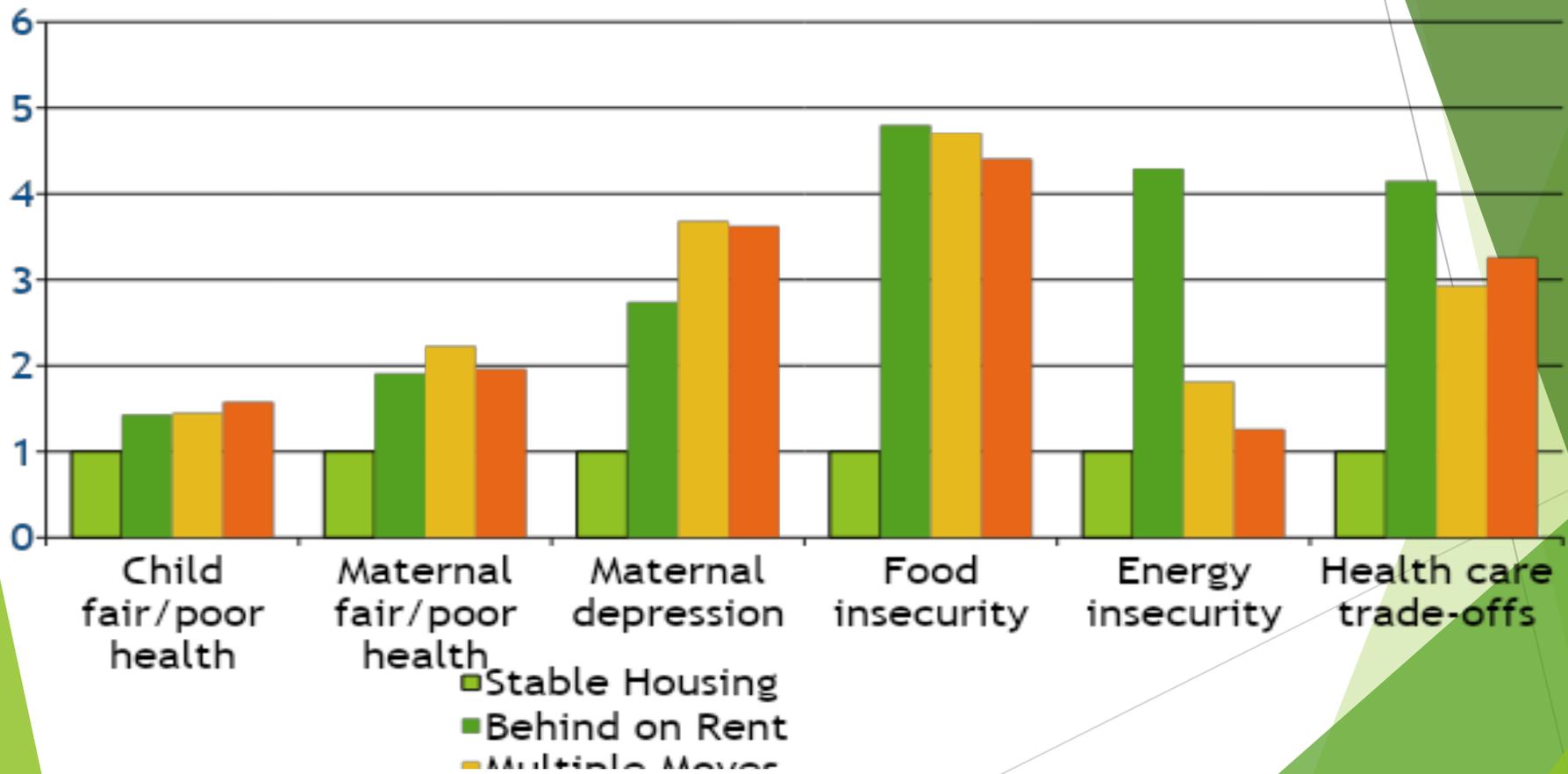
Evidence on Home Quality

- Accidents/Injuries - exposed wiring, needed repairs
- Development and worsening asthma, allergies tied to home
 - Pests (cockroaches and mice)
 - Molds/Chronic Dampness
 - Tobacco smoke
- Lead exposure tied to long term effects
 - Developmental delay, Attention deficit

Poor Indoor Air Quality

- People spend 80% of time indoors
- Damp housing :
 - due to poor construction and materials, inadequate heat, lack of ventilation
 - Ideal conditions for mold
 - Evidence of link is strongest in children
- House dust mites, cockroaches
- Pets
- Tobacco smoke
- VOCs (volatile organic compounds)- in cleaning products, paints- ex- formaldehyde
- Radon
- Cooking and heating equipment

Outcomes of unstable housing with hardship outcomes; (BMC Pediatrics 2018)



Socially Equitable Affordable Housing

- ▶ Frees up resources for food and health care
- ▶ Reduce stress and related adverse health outcomes
- ▶ Home ownership can increase self- esteem
- ▶ Well constructed and managed housing can reduce poor health as related to poor indoor air quality
- ▶ Stable housing can improve health for seniors and those with disabilities
- ▶ Access to neighborhoods for purposes of income mobility
- ▶ Alleviating crowding
- ▶ Alleviating stress

The Positive Impact of Affordable Housing on Health: A Research Summary
Center for Housing Policy

THE WELLNESS BUS

A Chronic Disease Prevention and Education Program
Addressing Social Determinants of Health



September 26, 2019

Nancy Ortiz, Operations Manager Mobile Health Program

THE WELLNESS BUS

What is The Wellness Bus?

The Wellness Bus is a 39 foot mobile health clinic that brings preventive and education services to people in places they live, work, and play.

It is a part of the Driving Out Diabetes Initiative- a partnership between the Larry H. & Gail Miller Family Foundation and the University of Utah.



DRIVING OUT
DIABETES

A LARRY H. MILLER FAMILY
WELLNESS INITIATIVE

LARRY H. & GAIL
MILLER
FAMILY FOUNDATION



THE WELLNESS BUS

Vision:

To create healthier communities by offering chronic disease screening, nutrition education, health and wellness counseling, and referrals to social services, particularly in medically underserved areas.



THE WELLNESS BUS

Who's on The Wellness Bus?

- Community Health Workers
- Registered Dietitians
- Connect2Health Volunteers
- Health Coaches
- Dental Students



Screenings & Services offered:

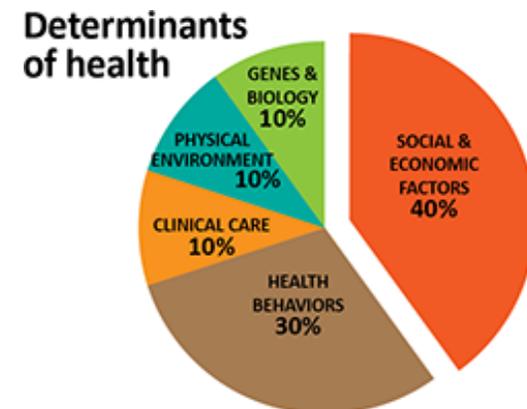
- Blood Glucose
- A1c
- Blood Pressure
- Cholesterol
- Body Mass Index
- Dental /Oral Health
- Nutrition Counseling
- Health Coaching
- Social needs referrals



THE WELLNESS BUS

Connect2Health

Connect2Health is a University of Utah program staffed by student volunteers that offers *referrals to free or low-cost local community resources* which include medical and social needs support such as food, housing, clothing and **transportation**.



THE WELLNESS BUS

Connect2Health Transportation Referrals:

- **The HIVE Bus Pass** – Reduced price bus pass through UTA for SLC residents
- **Crossroads Urban Center** – Gives out day-use bus passes/tokens and also gift cards to Sinclair to help pay for gas
- **Priority 1 Transportation** – Provides non-emergency transportation at a fee
- **LDS Church Welfare Square** – Hands out bus tokens
- **Non Emergent Rides for Medicaid** – Free transportation options for Medicaid members
- **New- United Way Ride United Program** – patients can get free rides through Lyft for medical/health services, food assistance, or public benefits.



THE WELLNESS BUS

Where does The Wellness Bus go?

Mon 9-1PM **Midvale**- Cornerstone Church

Tues 3-7PM **Glendale**- Sorenson Unity Center

Wed 3-7PM **Kearns** High School

Thur 3-7PM **South Salt Lake**- Central Park Community Center

Fri /Sat **Local Community Events**



THE WELLNESS BUS

Thank you!

- Phone: 801-587-5257
- Email: nancy.ortiz@hsc.utah.edu
- Website: WellnessBus.org
- @utahwellnessbus



DRIVING OUT
DIABETES

LARRY H. & GAIL
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