Addressing Social Determinants of Health

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NC Division of Public Health

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Health is complicated…

ECOSOCIAL THEORY: LEVELS, PATHWAYS & POWER

Levels: societal & ecosystem
- global
- national
- regional
- area or group
- household
- individual

Processes: production, exchange, consumption, reproduction

Populations distribution of health
- racial/ethnic inequality
- gender inequality
- class inequality

Lifecourse:
- in utero
- infancy
- childhood
- adulthood

Embodiment
- Pathways of embodiment
- Cumulative interplay of exposure, susceptibility & resistance
- Accountability & agency

Political economy and ecology

Historical context + generation

Nancy Krieger
Societal Level

Community & Policy Level

Individual & Family Level

Pro-Equity Policies
Affordable Housing
Safe Neighborhoods
Good Paying Jobs
Quality Education
Access to Healthy Foods & Physical Activity
Incarceration Obesity

Address Structural Racism and Privilege
Healthy Environment
Access to Healthcare
Low Birth Weight
Homelessness
Untreated Mental Illness
Health Problems

Political structures & institutional practices that assure fairness & opportunity for all
Social, economic, & physical conditions that allow people to reach their full potential
Services for individuals and families to treat problems
Social Determinants of Health

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as “place.”

Reference: Healthy People 2020
Health equity is more than the absence of health disparities.

Health equity is every individual having access to the resources and opportunities that promote good health.
Health Equity

The opportunity for everyone to have good health.

Reference: NC Office of Minority Health and Health Disparities North Carolina Equity Report 2018
Life Course Approach

Life Trajectory Affected by Inequity

Optimal Life Trajectory

Health potential
Reproductive Potential

Risk Factors
Protective Factors

Early Programming
Cumulative Pathways
Socio-Ecological Model

- **Individual**: Knowledge, attitudes and skills
- **Interpersonal**: Families, friends and social networks
- **Organizational**: Organizations and social institutions
- **Community**: Relationships between organizations
- **Public Policy**
Health Care Spending

Other 10%

Plot Area

Direct Medical Care 90%
Drivers of Health

- Behavioral Patterns: 40%
- Genetic Predisposition: 30%
- Health Care: 10%
- Environmental Exposures: 5%
- Social Circumstance: 15%
Early Brain and Child Development
Human Brain Development

Neural Connections for Different Functions Develop Sequentially

Sensory Pathways (Vision, Hearing)

Language

Higher Cognitive Function

FIRST YEAR

Birth (Months) (Years)
Humans do not develop in isolation
Early Childhood is a Time of Rapid Brain Growth

MRI scans of human brain development
Levels of Stress

**POSITIVE**
Brief increases in heart rate, mild elevations in stress hormone levels.

**TOLERABLE**
Serious, temporary stress responses, buffered by supportive relationships.

**TOXIC**
Prolonged activation of stress response systems in the absence of protective relationships.

Center on the Developing Child, Harvard University
Lifespan Impacts of ACEs

- Critical & Sensitive Developmental Periods
- Adverse Childhood Experience
  - More Categories - Greater Impact
  - Physical Abuse, Sexual Abuse, Emotional Abuse, Neglect
  - Witnessing Domestic Violence
  - Depression/Mental Illness in Home
  - Incarcerated Family Member
  - Substance Abuse in Home
  - Loss of a Parent
- Genetics
  - Experience triggers gene expression (Epigenetics)

Brain Development
  - Electrical, Chemical, Cellular Mass

Adaptation
  - Hard-Wired Into Biology

- Chronic Disease
- Psychiatric Disorders
- Impaired Cognition
- Work/School
  - Attendance, Behavior, Performance
- Obesity
- Alcohol, Tobacco, Drugs
- Risky Sex
- Crime
- Poverty
- Intergenerational Transmission, Disparity

Source: Family Policy Council, 2012
Persistent Stress Changes Brain Architecture

Normal

Typical neuron—many connections

Toxic stress

Damaged neuron—fewer connections

Prefrontal Cortex and Hippocampus
Toxic Stress in Early Childhood

3 Year Old Children

Normal

Extreme Neglect

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Threats to Healthy Brain Development

- Lack of Stimulation/Neglect
- Poverty
- Poor nutrition (e.g. iron deficiency anemia)
- Unstable Housing
- Environmental Toxins (e.g. Lead)
- Adverse Childhood Experiences/Toxic Stress
Interpersonal Trauma/Adverse Childhood Events - ACEs

Research Article

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

The Adverse Childhood Experiences (ACE) Study

Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, PhD, Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH

© 1998 American Journal of Preventive Medicine

Collaborative effort between Kaiser Permanente and Centers for Disease Control and Prevention
Adverse Childhood Experiences (ACEs)
Traumatic or stressful live events experienced before age 18

Childhood abuse
- Physical abuse
- Sexual abuse
- Emotional abuse

Household dysfunction
- Household member who was depressed, mentally ill, or suicidal
- Alcohol or drug abuse in household
- Incarcerated household member
- Violence between adults in the household
- Parental divorce or separation
Trauma/ ACEs increase risk of behavioral, physical and mental health issues

<table>
<thead>
<tr>
<th>Behavior</th>
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<tbody>
<tr>
<td>Lack of physical activity</td>
<td>Smoking</td>
</tr>
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<td></td>
<td>Alcoholism</td>
</tr>
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<td></td>
<td>Drug use</td>
</tr>
<tr>
<td></td>
<td>Missed work</td>
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</table>

<table>
<thead>
<tr>
<th>Physical &amp; Mental Health</th>
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<tbody>
<tr>
<td>Severe obesity</td>
<td>Diabetes</td>
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<td></td>
<td>Depression</td>
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<td></td>
<td>Suicide attempts</td>
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<td>STDs</td>
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<tbody>
<tr>
<td>Heart disease</td>
<td>Cancer</td>
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<tr>
<td></td>
<td>Stroke</td>
</tr>
<tr>
<td></td>
<td>COPD</td>
</tr>
<tr>
<td></td>
<td>Broken bones</td>
</tr>
</tbody>
</table>
ACES can have lasting effects on:

- **Health** (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones)
- **Behaviors** (smoking, alcoholism, drug use)
- **Life Potential** (graduation rates, academic achievement, lost time from work)

ACEs have been found to have a graded dose-response relationship with 40+ outcomes to date.

*This pattern holds for the 40+ outcomes, but the exact risk values vary depending on the outcome.*
North Carolina’s Vision for Medicaid Managed Care

“To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health.”
Requirements

Address 4 Priority Domains:
- Housing
- Food
- Transportation
- Interpersonal Violence

Care Management

Integration with Department Partners

Value-Based Payment

Contributions to Health-Related Resources

In Lieu of Services

Healthy Opportunity Pilots

Quality Strategy
Screening Questions

- Developed by Technical Advisory Group
- Drew from validated and commonly used tools (e.g. PRAPARE, Accountable Health Community)
- Routine identification of unmet health-related resource needs
- Statewide collection of data
- Implementation
  - Public Review
  - Fall 2018 Pilot testing in 18 clinical sites and telephonically (n=804)
  - Ready Providers/Systems adopting
  - Encouraging everyone to use for all populations
  - Launch of Managed Care
    - PHPs Required to Include in initial Care Needs Screening

![Health Screening](image)

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

<table>
<thead>
<tr>
<th>Food</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Within the past 12 months, did the food you bought just not last and you didn’t have money to get more?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing/Utilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else’s home (i.e. couch-surfing)?</td>
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<tr>
<td>4. Are you worried about losing your housing?</td>
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<tr>
<td>5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?</td>
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<tr>
<td>Interpersonal Safety</td>
<td></td>
<td></td>
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<tr>
<td>7. Do you feel physically or emotionally unsafe where you currently live?</td>
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<tr>
<td>8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?</td>
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<td></td>
</tr>
<tr>
<td>Optional: Immediate Need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Are any of your needs urgent? For example, you don’t have food for tonight, you don’t have a place to sleep tonight, you are afraid you will get hurt if you go home today.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Would you like help with any of the needs that you have identified?</td>
<td></td>
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</tr>
</tbody>
</table>
What is NCCARE360?

NCCARE360 is the first statewide coordinated network that includes a robust repository of shared resources and a shared technology platform to connect healthcare and human services providers together to collectively provide the opportunity for health to North Carolinians.

NCCARE360 Partners:
## Infrastructure and Elements across all populations

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hot Spot Map</strong></td>
<td>• GIS map of social determinants of health indicators at census tract level</td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td>• Statewide Standardized Screening Questions</td>
</tr>
<tr>
<td><strong>NCCARE360</strong></td>
<td>• Statewide coordinated network with shared technology platform</td>
</tr>
<tr>
<td><strong>Workforce Development</strong></td>
<td>• Community Health Workers, Permanent Supportive Housing</td>
</tr>
<tr>
<td><strong>Aligning Enrollment</strong></td>
<td>• Coordinating enrollment across programs e.g., Medicaid, WIC, SNAP</td>
</tr>
</tbody>
</table>
Healthy Opportunities

• All North Carolinians should have the opportunity for health

• Access to high-quality medical care is critical to a person’s health, but up to 80% of a person’s health is determined through social and environmental factors and the behaviors that are influenced by them

• NC DHHS is focusing on improving the health and well-being for all North Carolinians by tackling the foundational drivers of health
Priority Domains

Food Security

Housing Stability

Transportation

Interpersonal Violence
Creating the Statewide Framework and Infrastructure for Healthy Opportunities

- Standardized screening for unmet resource needs
- “Hot Spot” map for Social Determinants
- Medicaid Managed Care – Core program elements Regional Pilots
- Multi-faceted Approach for Promoting the Opportunity for Health
- Aligning enrollment and connecting existing resources
- Work force e.g. Community Health Workers
- Statewide Resource Platform

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities
“Hot Spot” Map

- Statewide map now live: [http://www.schs.state.nc.us/data/hsa/](http://www.schs.state.nc.us/data/hsa/)
- GIS/ESRI Story mapping of 14 SDOH indicators with a summary statistic
- Displays geographical health & economic disparities

<table>
<thead>
<tr>
<th>Social and Neighborhood</th>
<th>Economic</th>
<th>Housing and Transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td>% &lt; HS Diploma</td>
<td>Household Income</td>
<td>% Living in Rental Housing</td>
</tr>
<tr>
<td>% Households with Limited English</td>
<td>% Poverty</td>
<td>% Paying &gt;30% of Income on Rent</td>
</tr>
<tr>
<td>% Single Parent Households</td>
<td>Concentrated Poverty</td>
<td>% Crowded Household</td>
</tr>
<tr>
<td>Low Access to Healthy Foods</td>
<td>% Unemployed</td>
<td>% Households without a Vehicle</td>
</tr>
<tr>
<td>Food Deserts</td>
<td>% Uninsured</td>
<td></td>
</tr>
</tbody>
</table>
Early Childhood Action Plan
GUIDING PRINCIPLES

• Brain and developmental science serve as the foundation for the Action Plan

• Children and families are at the center of our work

• Builds upon and expands existing strengths and partnerships

• Goals are ambitious and achievable

• Focus is on all of North Carolina’s children reaching their full potential, intentional about eliminating disparities

• Reflects the values of transparency, good stewardship, and accountability
North Carolina Early Childhood Action Plan - Vision

All North Carolina children get a healthy start and develop to their full potential in safe and nurturing families, schools and communities.

1) **Healthy and Safe:** Children are healthy at birth and thrive in safe environments that support their optimal health and well-being

2) **Nurtured:** Children grow confident, resilient and independent in stable and nurturing families, schools and communities

3) **Learning and Ready to Succeed:** Children experience the conditions they need to build strong brain architecture and school readiness skills that support their success in school and life
Early Childhood Action Plan
The Perinatal Health Strategic Plan

- Framework is based on the “12-Point Plan to Close the Black-White Gap in Birth Outcomes: A Life-Course Approach” developed by Lu, Kotelchuck, Hogan, Jones, Wright, and Haflon
- Broader focus encompassing infant mortality, maternal morbidity and mortality; and the health of women and men of childbearing age
- Data driven and focused on the best evidence available
- Infused throughout with issues of health equity and social determinants of health
North Carolina’s Perinatal Health Strategic Plan
2016–2020

The North Carolina Perinatal Health Strategic Plan (PHSP) addresses infant mortality, maternal health, maternal morbidity, and the health of men and women of childbearing age. The PHSP framework was adapted from the “Closing the Black-White Gap in Birth Outcomes: A Life-Course Approach” (2015) by Drs. Michael Lu, Milton Kotelchuck, Vijaya Hogan et al. to reduce Black-White disparities in birth outcomes using a life-course approach (Lu et al 2010) which “conceptualizes birth outcomes as the end product of not only the nine months of pregnancy but the entire life course of the mother before the pregnancy” (2010). The PHSP supports the Healthy People 2020 Approach to Social Determinants of Health (SDOH), reflecting five key areas of SDOH (Figure 1).

The 12-point plan is divided into three goals, comprised of four points each. In 2017, the PHSP Team voted on priority strategies noted by an asterisk (*).

**Goal I. Improving Health Care for Women and Men**
- Provide interconception care to women with prior adverse pregnancy outcomes*
- Increase access to preconception care*
- Increase the quality of preconception care*
- Expand healthcare access over the life course

**Goal II. Strengthening Families and Communities**
- Strengthen parent involvement in families*
- Enhance coordination and integration of family support services
- Support coordination and cooperation to promote reproductive health within communities*
- Invest in community building and urban renewal

**Goal III. Addressing Social and Economic Inequities**
- Close the education gap*
- Reduce poverty among families*
- Support working mothers and families*
- Underestimate

The PHSP team meets every two months. The four PHSP work groups (“Community and Consumer Engagement, Data and Evaluation, Communications, and Policy”) meet more often. The PHSP strives to find alignment and collaboration opportunities with other initiatives occurring in the state. This includes connecting with consumer, community, and organizational partners to share and evaluate the plan. By eliminating inequities, we will improve the overall well-being of our state’s individuals and communities.

For more information on the Perinatal Health Strategic Plan or to join the planning team, contact: Jasmine Dalmats-Wesson, MHA
Perinatal Health Strategic Plan Program Consultant + 919-507-5862 + PHSPquestion@dhhs.nc.gov

A Call to Action: Data Demonstrating Inequities in North Carolina

1 in 5 children live in households that lack consistent access to adequate food (2018)
45% of renters are cost burdened by spending more than 30% of their income on rent (2018)

4th grade Black and Hispanic public school students are less likely to score proficient in reading (2017)

NC Infant Mortality Rates per 1,000 live births

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>12.6</td>
</tr>
<tr>
<td>Black</td>
<td>12.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>5.7</td>
</tr>
<tr>
<td>American</td>
<td>5.0</td>
</tr>
<tr>
<td>Total</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Black infants are 2.5 times as likely to die than white infants (2017)

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2016-2020

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The 12-point plan is divided into three goals, comprised of four points per goal. In 2017, the PHSP Team voted on priority strategies noted by an asterisk (*).

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<th>Goal II. Strengthening Families and Communities</th>
<th>Goal III. Addressing Social and Economic Inequities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide interconception care to women with prior adverse pregnancy outcomes*</td>
<td>• Strengthen father involvement in families</td>
<td>• Close the education gap*</td>
</tr>
<tr>
<td>• Increase access to preconception care*</td>
<td>• Enhance coordination and integration of family support services</td>
<td>• Reduce poverty among families</td>
</tr>
<tr>
<td>• Improve the quality of prenatal care*</td>
<td>• Support coordination and cooperation to promote reproductive health within communities*</td>
<td>• Support working mothers and families</td>
</tr>
<tr>
<td>• Expand healthcare access over the life course</td>
<td>• Invest in community building and urban renewal</td>
<td>• Undo racism*</td>
</tr>
</tbody>
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Perinatal Health Strategic Plan Program Consultant • 919-707-5682 • PHSPquestions@dhhs.nc.gov
# Goal 1 – Improve Health Care for Women and Men

## Point 1. Provide interconception care to women with prior adverse pregnancy outcomes

<table>
<thead>
<tr>
<th>1A. Support healthy pregnancy intervals through access to <strong>effective methods of contraception</strong>, including increased access to <strong>Long-Acting Reversible Contraception (LARC)</strong>.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1B. Provide <strong>care coordination/case management/home visiting services</strong> that includes promotion of resiliency, mental health screening, substance use intervention, tobacco cessation and prevention, reproductive life planning, chronic disease management and access to health care.</td>
</tr>
<tr>
<td>1C. Assure women are <strong>transitioned from different points of care</strong> and have access to postpartum/primary/well woman care including access to ongoing health insurance coverage and a medical home.</td>
</tr>
<tr>
<td>1D. Provide <strong>outreach to all providers who care for children</strong> (pediatric and family practice clinics, community settings, etc.) to ensure women are receiving interconception care services.</td>
</tr>
<tr>
<td>1E. Increase <strong>quality and frequency of risk assessment</strong> at the postpartum clinic visit.</td>
</tr>
</tbody>
</table>
## Goal 1 – Improve Health Care for Women and Men

### Point 2. Increase access to preconception health and health care to women and men

<table>
<thead>
<tr>
<th>2A. Expand the college-based Preconception Peer Education (PPE) Program to reach additional women and men in colleges, universities, graduate schools, community colleges and adult learning programs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2B. Integrate preconception health care and messages into primary care for women of reproductive age.</td>
</tr>
<tr>
<td>2C. Integrate the use of evidence-based curriculum with adolescent and young adult population in educational and community settings.</td>
</tr>
<tr>
<td>2D. Implement the North Carolina Preconception Health Strategic Plan and Supplement.</td>
</tr>
</tbody>
</table>
Goal 1 – Improve Health Care for Women and Men

Point 3. Improve the quality of maternal care (includes prenatal, labor, delivery and postpartum care)

<table>
<thead>
<tr>
<th>3A. Expand the use of <strong>evidence-based models of prenatal care</strong>.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3B. Provide <strong>evidence-based clinical standards in prenatal care</strong> (e.g., early elective deliveries, cesarean rate, 17P, tobacco cessation, hypertensive disorders, gestational diabetes, mental health, substance abuse, intimate partner violence, perinatal mood disorders, etc.)</td>
</tr>
<tr>
<td>3C. Improve access to and utilization of <strong>first trimester prenatal care</strong>.</td>
</tr>
<tr>
<td>3D. Provide <strong>care coordination/case management/home visiting services</strong> that includes promotion of resiliency, mental health screening, substance use intervention, tobacco cessation and prevention, reproductive life planning, chronic disease management, perinatal mood disorders, and access to health care.</td>
</tr>
</tbody>
</table>
Goal 1 – Improve Health Care for Women and Men

**Point 3. continued - Improve the quality of maternal care (includes prenatal, labor, delivery and postpartum care)**

<p>| 3E. | Ensure that all pregnant women and high-risk infants have access to the appropriate level of care through a <strong>well-established regional perinatal system</strong>. |
| 3F. | Promote access to <strong>comprehensive breastfeeding support services</strong> including medical lactation services. |
| 3G. | Provide <strong>evidence-based culturally competent patient education</strong> and anticipatory guidance. |</p>
<table>
<thead>
<tr>
<th>Point 4. Expand healthcare access over the life course for all</th>
</tr>
</thead>
<tbody>
<tr>
<td>4A. Promote access to and utilization of the <strong>adolescent well visit</strong>.</td>
</tr>
<tr>
<td>4B. Promote access to and utilization of <strong>evidence-based preventive health services</strong>.</td>
</tr>
<tr>
<td>4C. Increase access to and utilization of <strong>medical homes</strong>.</td>
</tr>
<tr>
<td>4D. Provide <strong>affordable, comprehensive insurance coverage</strong>.</td>
</tr>
<tr>
<td>4E. Promote access to and utilization of <strong>immunizations</strong> according to the American Committee on Immunization Practice guidelines.</td>
</tr>
<tr>
<td>4F. Provide <strong>evidence-based culturally competent patient education</strong> and anticipatory guidance.</td>
</tr>
</tbody>
</table>
### Goal 2 – Strengthen Families and Communities

**Point 5. Strengthen father involvement in families**

| 5A. | Promote **parenting and co-parenting skills** and responsible strategies |
| 5B. | Improve/develop guidelines for the **inclusion of men in preconception, prenatal, and interconception health services** |
| 5C. | Use **evidence-based strategies to promote healthy family relationships**. |
| 5D. | Promote the **role of fathers to change the culture**. |
Goal 2 – Strengthen Families and Communities

Point 6. Enhance coordination and integration of family support services

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>6A. Promote <strong>agency and community coordination</strong> in providing services</td>
<td></td>
</tr>
<tr>
<td>6B. Decrease fragmentation in the service delivery system to <strong>reduce burden on families</strong>.</td>
<td></td>
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<tr>
<td>6C. Improve <strong>family and community driven service provision</strong>.</td>
<td></td>
</tr>
</tbody>
</table>
Goal 2 – Strengthen Families and Communities

**Point 7. Support coordination and cooperation to promote reproductive health within communities**

- 7A. Promote **reproductive life planning**.

- 7B. Expand **community stakeholder involvement and community engagement** in service design and implementation.

- 7C. Promote utilization of **breastfeeding friendly policies and services** in local communities.

- 7D. Promote utilization of **evidence-based strategies to prevent all forms of violence and promote coordinated community response**.
<table>
<thead>
<tr>
<th>Point 8. Invest in community building</th>
</tr>
</thead>
<tbody>
<tr>
<td>8A. Create and improve <strong>transportation systems</strong> and <strong>infrastructure</strong>.</td>
</tr>
<tr>
<td>8B. Support <strong>capacity building</strong> in areas of <strong>concentrated disadvantage</strong>.</td>
</tr>
<tr>
<td>8C. Improve environments to <strong>support healthy living</strong>.</td>
</tr>
<tr>
<td>8D. Create and promote local employment opportunities that provide at least a <strong>livable wage</strong>.</td>
</tr>
<tr>
<td>8E. Improve <strong>civic participation</strong> through building community networks</td>
</tr>
</tbody>
</table>
## Goal 3 - Address Social and Economic Inequities

### Point 9 – Close the education gap

<table>
<thead>
<tr>
<th>Point 9A</th>
<th>Promote and increase access to <strong>higher education</strong>.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point 9B</td>
<td>Increase high school and post high school <strong>graduation rates</strong>.</td>
</tr>
<tr>
<td>Point 9C</td>
<td>Expand <strong>race/ethnic/gender diversity representation</strong> in schools (administrators, faculty, and staff).</td>
</tr>
<tr>
<td>Point 9D</td>
<td>Promote and increase access to <strong>early childhood education</strong>.</td>
</tr>
<tr>
<td>Point 9E</td>
<td><strong>Disrupt the school to prison pipeline</strong>, beginning with pre-school.</td>
</tr>
</tbody>
</table>
# Goal 3 - Address Social and Economic Inequities

## Point 10 – Reduce poverty among families

10A. **Learn, collaborate, and partner** with organizations, agencies, and institutes that focus on poverty reduction.

10B. Formulate and/or enhance ways that data can be collected to comprehensively track on how living in poor or near poor homes and communities affects health outcomes over the life course.

10C. Recommend and support legislation of a **livable wage and equity in compensation**.

10D. Standardize **poverty reduction strategies** into systems, services, and programs.
## Goal 3 - Address Social and Economic Inequities

### Point 11 – Support working mothers and families

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>11A.</td>
<td>Create and expand <strong>paid parental and sick leave policies</strong>.</td>
</tr>
<tr>
<td>11B.</td>
<td>Increase affordable, available, and accessible <strong>high quality child care</strong>.</td>
</tr>
<tr>
<td>11C.</td>
<td>Increase <strong>support for breastfeeding</strong>.</td>
</tr>
<tr>
<td>11D.</td>
<td>Create <strong>safe work place and incarceration environments</strong> for women.</td>
</tr>
</tbody>
</table>
### Goal 3 - Address Social and Economic Inequities

#### Point 12 – Undo racism

12A. Infuse and incorporate **equity in the delivery of health services**.

12B. Promote **high quality training about institutional and structural racism** and its impact on poor communities and communities of color.

12C. Modify and **change policies and practices to address institutional and structural racism**.

12D. Promote community and systems **dialog and discussion on racism**.
Protective Interventions: Building Resilience

Significant Adversity

New Protective Interventions

Healthy Developmental Trajectory

Supportive Relationships, Stimulating Experiences, Health-Promoting Environments

Adapted from Center on the Developing Child, Harvard University