





# DATA EQUITY WEBINAR SERIES

OVERCOMING BARRIERS TO
ADDRESSING HEALTH INEQUITIES IN
RURAL POPULATIONS

**DECEMBER 12, 2022** 

### English

If you are a monolingual English speaker, please select the world-like interpretation icon at the bottom of the screen, then select English. If you are using zoom via a telephone/tablet, you will select the three dots to see more options, followed by interpretation and then English.

#### Español

Si solo habla/o prefiere escuchar en español, seleccione el icono de interpretación que parece a un mundo en la parte inferior de la pantalla, luego seleccione español y no olvide silenciar el audio original. Si está usando Zoom en un teléfono o tableta, seleccionará los tres puntos para ver más opciones, seguido por interpretación y después español.





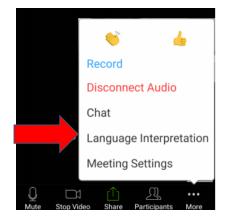
Raise Hand, & Reactions Levantar Mano y Reacciones

#### **ZOOM APP ON PHONE OR TABLET**

APLICACIÓN DE ZOOM POR TELÉFONO O TABLETA



SELECT THE THREE DOTS
SELECCIONE LOS TRES PUNTITOS





SELECT YOUR LANGUAGE
SELECCIONE SU LENGUAJE

## This presentation is being recorded



## Tools located on the bar at the bottom of your screen



Access resources and send messages within the meeting



Read live transcriptions/ closed captions



Enter questions for the presenters, and read their responses.









# **About Us**

The **Center for Wellness and Nutrition** (CWN), a program of the *Public Health Institute*, is a national leader in developing campaigns, programs, and partnerships to promote wellness and equitable practices in the most vulnerable communities in California and across the country.





# **CONTEXT AND FOCUS FOR TODAY**

Historically, policies and systems in this country have been deeply rooted in racism resulting in the stark inequities we see today.

Achieving health equity and racial justice with the communities we serve requires that we are intentional about data practices and strategies, especially those that transform data into action.

# Todays Webinar will:

- Describe the barriers and proposed solutions for using data in addressing health inequities in rural populations.
- Share best practices for using data to identify connections between social factors and varying health outcomes.
- Highlight the training modules developed by Solutions in Health Analytics for Rural Equity (SHARE) on data visualization and communicating effectively about health equity.







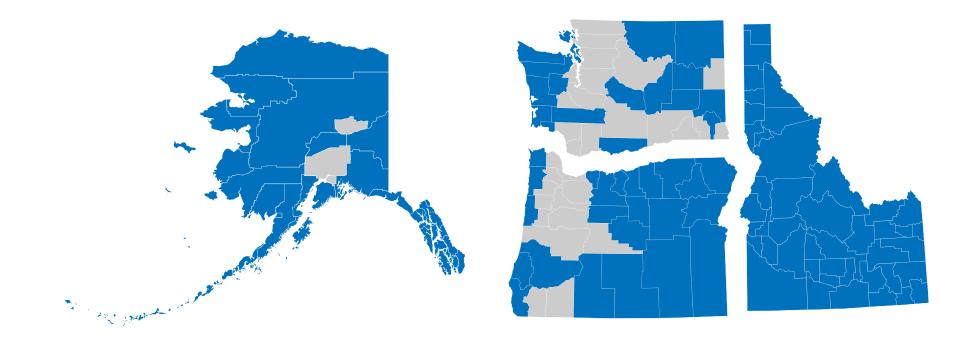
# **BACKGROUND AND RATIONALE**

SOLUTIONS TO OVERCOME CHALLENGES AND BARRIERS









# **SHARE-NW**

Solutions in Health Analytics for Rural Health Equity across the Northwest (SHARE-NW) is responding to a need for greater capacity in state and local governmental public health agencies to use data to achieve health equity.







# PRACTICE-CENTERED GOALS

- Providing data for decision-making, identify LHD priorities and existing gaps
- 2. Improving access to data
- 3. Increasing capacity for data use and data-driven decision-making











# POLL







# PRIORITY: LIMITED CAPACITY FOR DATA USE

## Challenges/Barriers

- Staff and funding are more limited in rural areas compared to urban areas
- Limited knowledge, skills, and understanding of data applicability
- Limited understanding of health disparities
- Lack of data use to address health disparities

### **Possible Solutions**

- Training on how to lead community conversation about data
- Training on how to navigate and use a data dashboard
- Training to include equity lens in their decision-making







# PRIORITY: LIMITED ACCESS TO DATA

# Challenges/Barriers

- Difficult to know where data are because they are scattered in different places
- Data are not in easily usable formats

## **Possible Solutions**

 Create dashboard that incorporates multiple data sources







# **USING DATA TO IDENTIFY HEALTH INEQUITIES**

NAVIGATING THE SHARE-NW DASHBOARDS







# **IDENTIFYING HEALTH INEQUITIES: PROCESS**

- Select a health priority area: Diabetes
- Look at related data: Utilization of Care
- What could explain any relationship you find?
  - Think about social determinants of health you know that tend to affect diabetes rates





# SHARE-NW DASHBOARDS

- Dashboards display data for health priority areas
- SDOH data is in Demographics dashboard
- Data available for Alaska, Idaho, Oregon, and Washington



## Solutions in Health Analytics for Rural Equity across the Northwest

See where rural health disparities exist in your community by exploring the data dashboards, and better understand how you can make data-driven decisions to reduce those disparities with training support.

#### **Data Dashboards**

Access data by the topics listed below. Within each dashboard you can select a subtopic and filter by state and/or local jurisdiction.



#### Demographics

Subtopics: Personal Characteristics, Education, Work and Income, Housing, Renting and Evictions, Homelessness. Health Insurance



#### **Obesity and Physical Activity**

Subtopics: Obesity, Physical Activity, Food Access, Food Insecurity, Food Assistance



#### Injury and Violence Prevention

Subtopics: Unintentional Injury, Firearms, Adverse Childhood Experiences, Crime, Domestic Violence



#### Oral Health

Subtopics: Prevention, Access to Care, Health Outcomes



#### Mental and Behavioral Health

**Subtopics:** Mental Health, Drug Use, Alcohol Use, Suicides, Programs and Services



#### Diabetes

Subtopics: Diabetes, Primary Care Utilization



#### Tobacco

Subtopics: Tobacco Use, Health Effects, Cessation,





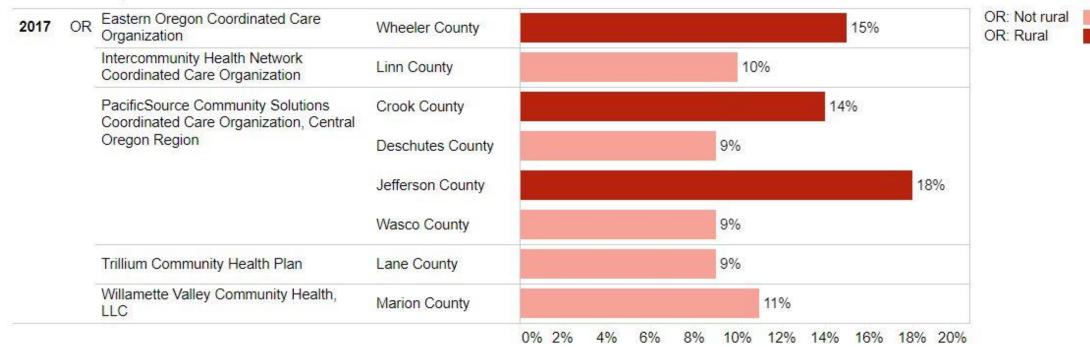


# **SELECT A HEALTH PRIORITY AREA: DIABETES**

Which county has the highest rate in this region?

#### Adults aged 20+ with diagnosed diabetes: Percent(%)

Hover over data point for more information





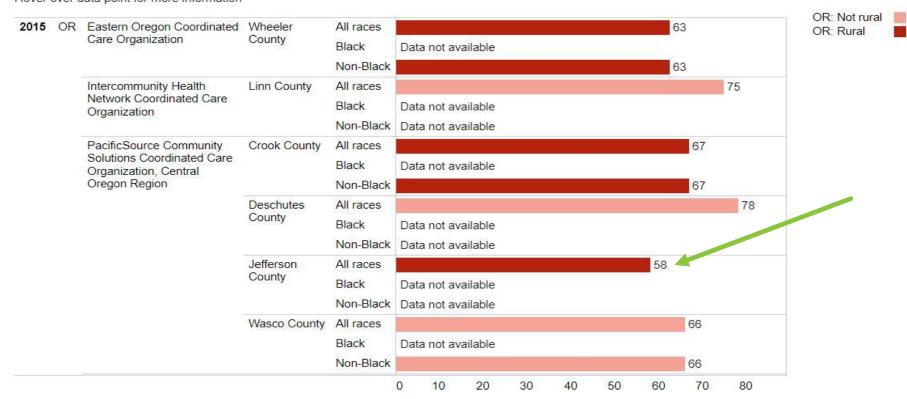




# **LOOK AT RELATED DATA: UTILIZATION OF DIABETES CARE**

Does that county have higher, lower, or average utilization of care?

# Medicare enrollees with diabetes who received blood lipids testing: Rate per 1,000 Hover over data point for more information







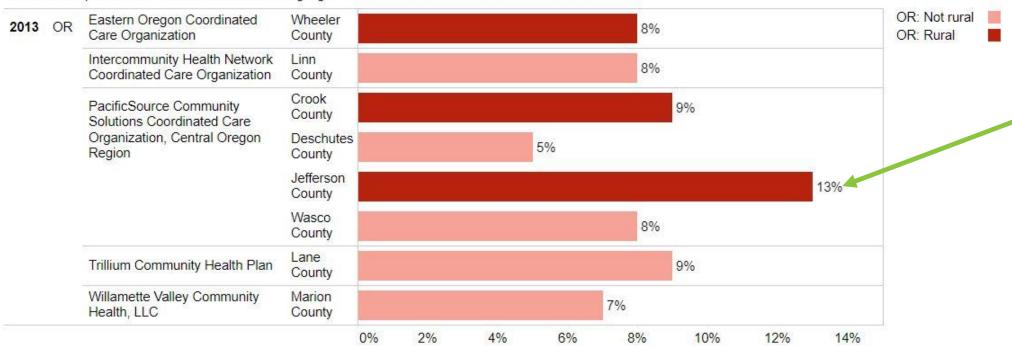


# WHAT COULD EXPLAIN THE RELATIONSHIP YOU FIND?

 Think about social determinants of health you know that tend to affect diabetes rates for a county

#### Civilian population aged 16+ who are unemployed: Percent(%)

Hover over a point for more details and click to highlight









# **TRAINING RESOURCES**

DATA FOR RURAL HEALTH EQUITY







# **CURATED TRAININGS**

## **Specific training focal areas include:**

- Data and health equity
- Mental and behavioral health
- Obesity and physical activity
- Diabetes
- Injury and violence prevention
- Tobacco
- Oral health









me Data Dashboards 🕶

Trainings and Webinars \*

Resources

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#### Trainings and Webinars: Obesity and Physical Activity

This training topic corresponds to data on this website. Trainings listed here are publicly available and evaluated for quality by the SHARE-NW team. Using the data and these trainings and webinars, you can make data-driven decisions to improve the health and well-being of the communities you serve.

All trainings and webinars featured on the SHARE-NW website are free.



#### **Selected Trainings and Webinars**

#### A Systems Approach to Understanding Childhood Obesity

#### Learning objectives:

- Describe public health as part of a larger inter-related system of organizations that influence the health of populations at local, national, and global levels.
- Describe different stakeholders with the power to address childhood obesity.
- Explain how local health departments (LHDs) can use systems thinking approaches while planning intersectoral initiatives to reduce inequities in childhood obesity.

Format: Online module

**Source:** Region 2 Public Health Training Center

Go to training >

### Best Practices in Program Planning for Local Obesity Prevention

Learning objectives:

Format: Online module

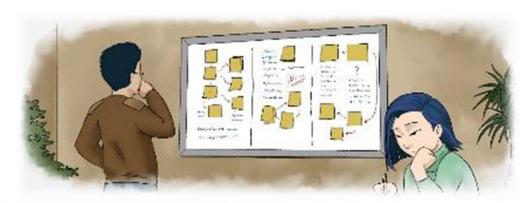
Source: Region 9 Public Health

Training Center

# **FEATURED TRAININGS**

# Data for rural health equity trainings cover the following topic areas:

- Understanding Population Health Concepts
- Communicating Effectively
- Visualizing Data Stories







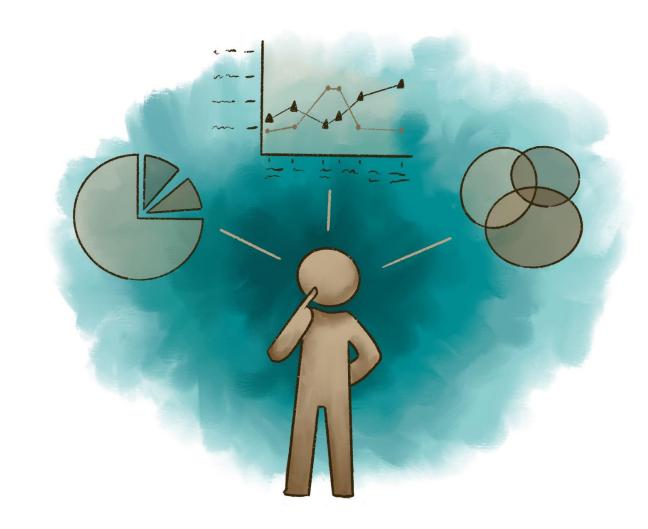






# UNDERSTANDING POPULATION HEALTH CONCEPTS

- Define health equity, health disparities, and health inequities
- Explain how social factors influence health
- Use data to identify connections between social factors and varying health outcomes in a community









# **COMMUNICATING EFFECTIVELY**

- Explain the difference between persuasive and informative communication and why both are needed
- Describe your audience and what motivates them
- Identify the most important content/data to share with a specific audience



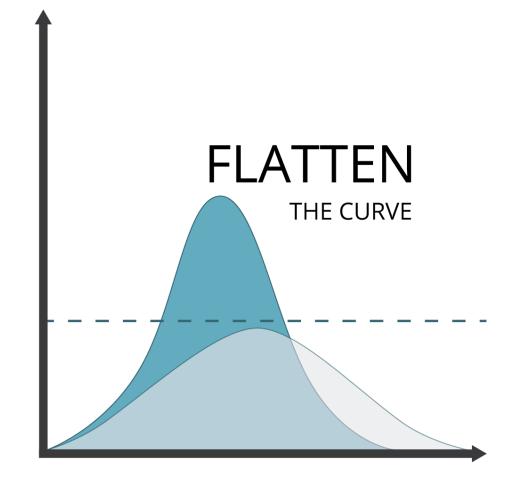






# VISUALIZING DATA STORIES

- Use appropriate graphic and other visualization techniques for communicating data about health disparities and inequities
- Tailor data messaging and visualizations to a specific audience
- Use design principles to create presentations and data visualizations that tell a "data story"





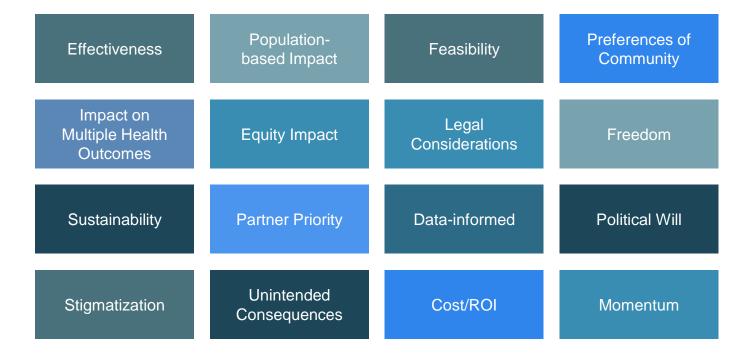




# VIRTUAL INTERACTIVE LIVE TRAINING

- Two live, interactive workshops
- Based on real public health experiences and situations
- Apply tools and methods to prioritize public health program and policy options for addressing health inequities
- Develop skills and confidence in effectively communicating with data, including sharing data visually in charts and graphs

#### SAMPLE DECISION CRITERIA









# CONTACT

## **Greg Whitman**

PROJECT MANAGER
Northwest Center for Public Health Practice

**Contact Information** 

Email: gwhitman@uw.edu

Website: <a href="https://sharenw.nwcphp.org/">https://sharenw.nwcphp.org/</a>







# **Thank You**



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Have a question? Write to us at info@wellness.phi.org

