INVEST HEALTH
Strategies for Healthier Cities

A Project of the ***Robert Wood Johnson Foundation*** and ***Reinvestment Fund***

Missoula Public Health
City-County Health Department

Missoula Invest Health Neighborhood Report

December 1, 2020

Introduction

This report explores three Missoula neighborhoods facing the biggest barriers to better health:

Franklin to the Fort, Northside-Westside, and River Road

The Missoula Invest Health initiative aspires to produce resident-driven transformative resolutions to improve health outcomes for all Missoulians by addressing the social determinants of health: housing, the build environment, transportation, jobs, education, & community safety.

Missoula Invest Health Team Members:

Hallie Cardé - Missoula City-County Health Department

Kaia Peterson – NeighborWorks Montana

Karen Myers – Providence St. Patrick Hospital

Laval Means – City of Missoula

Lisa Beczkiewicz - Missoula City-County Health Department

Susan Hay Patrick – United Way of Missoula County

Please contact Lisa Beczkiewicz at lbeczkiewicz@missoulacounty.us with questions.

A special thank you to Hailey Vensel, Invest Health intern who helped create the report.

Using Local Data to Make Changes

To create awareness and foster good health for all, we need to provide and share accurate, local data regarding the social determinants of health at the population level. This data helps to identify which members of our community experience limited resources and poorer health outcomes. We can and should use this information to fully address the factors that most significantly impact every Missoulian's quality of life**.**

Investing in Health - Together

People who live in neighborhoods with persistent generational poverty (20% or more of individuals in poverty for the past 30 years) experience limited access to resources and thus disparate poor health outcomes.

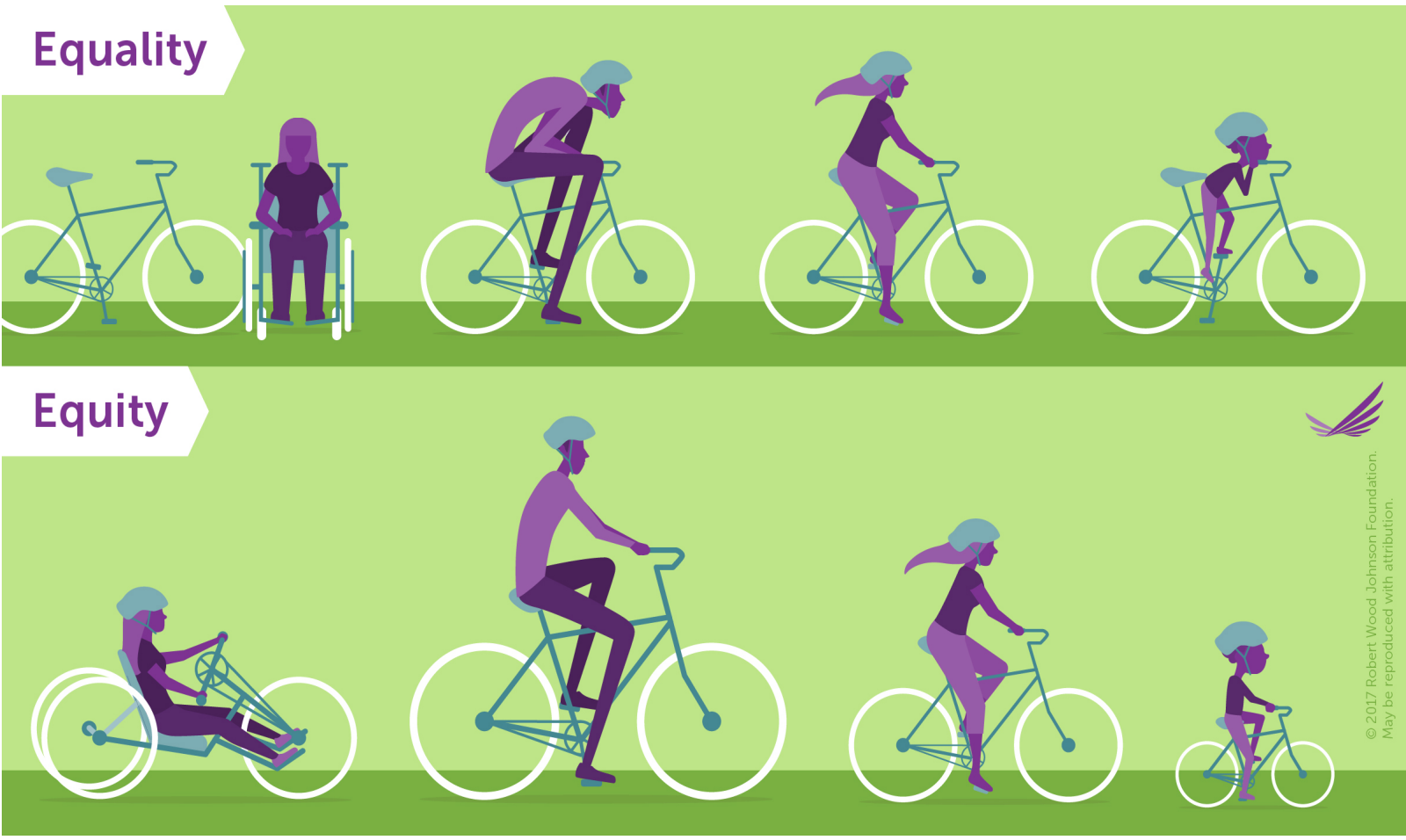
This is an unfortunate reality for many members of our community today.

The Missoula City-County Health Department's mission is to build conditions that support the health of all people, environments, and communities. It will take the effort and commitment of the larger community, however, to invest time, energy, and funding into the resources drive health. Health equity calls us to ensure that all Missoulians have equitable access to safe and affordable housing, opportunities for employment, a living wage, safe spaces to play and exercise, and quality education.

Explore the Missoula Community Health Map!
https:/gis.missoulacounty.us/mcchd/healthmap

Data Note:
This report used PolicyMap to provide much of the data for our community. PolicyMap offers a wealth of data pertaining to the health and well-being of communities at a variety of population levels.
www.policymap.com

Equity vs. Equality



Equity

Accounts for the systemic inequities created by laws and policies by customizing the level and types of resources needed to eliminate disparities and ensure sufficiently similar outcomes.

Equality

The same level and types of resources are provided across population groups.

What is Health Equity?

"Health equity means that everyone has a fair & just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, & their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education, housing, safe environment, and health care."
-Robert Wood Johnson Foundation

"Everyone having the opportunity to attain their highest level of health."

-American Public Health Association

"Health equity means ensuring fair opportunities for everyone to lead healthy and long lives by eliminating the barriers to, or addressing the fundamental conditions necessary for achieving good health, especially among populations that have experienced cumulative disadvantages or stigma."
-Allies for Reaching Community Health Equity

Sources: PolicyMap
Robert Wood Johnson Foundation
Allies for Research and Health

Health Equity

An Explanatory Model for Conceptualizing the Social Determinants of Health

NATIONAL INFLUENCES
GOVERNMENT POLICIES
U.S. CULTURE & CULTURAL NORMS

LIFE COURSE	SOCIAL DETERMINANTS OF HEALTH			+	HEALTH FACTORS			=	POPULATION OUTCOMES
	ECONOMIC OPPORTUNITY	PHYSICAL ENVIRONMENT	SOCIAL FACTORS		HEALTH BEHAVIORS & CONDITIONS	MENTAL HEALTH	ACCESS, UTILIZATION & QUALITY CARE		
PREGNANCY	• Income • Employment • Education • Housing	Built Environment •Recreation •Food •Transportation Environmental quality •Housing •Water •Air Safety	• Participation • Social support • Leadership • Political influence • Organizational networks • Violence • Racism		• Nutrition • Physical activity • Tobacco use • Skin Cancer • Injury • Oral health • Sexual health • Obesity • Cholesterol • High Blood Pressure	• Mental health status • Stress • Substance abuse • Functional status	• Health insurance coverage • Received needed care • Provider availability • Preventive care		QUALITY OF LIFE MORBIDITY MORTALITY LIFE EXPECTANCY
EARLY CHILDHOOD									
CHILDHOOD									
ADOLESCENCE									
ADULTHOOD									
OLDER ADULTS									

Public Health's Role in Addressing the Social Determinants of Health

- Advocating for and defining public policy to achieve health equity
- Coordinated interagency efforts
- Creating organizational environments that enable change
- Data collection, monitoring and surveillance
- Population based interventions to address health factors
- Community engagement and capacity building

Colorado Department of Public Health – Social Determinants of Health Workgroup

Health Equity Resources

Health Equity: Moving Beyond Health Disparities
PolicyLink

A Tale of Two Zip Codes
The California Endowment (YouTube)

National Equity Atlas

Regional Planning for Health Equity
PolicyLink

Local Government Budgeting and Racial Equity
National Collaborative for Health Equity

A Practitioner's Guide for Advancing Health Equity
Centers for Disease Control

Advancing Health Equity: Key Questions for Addressing Policies, Processes, and Assumptions
Minnesota Department of Health

Health in All Policies: A Guide for State and Local Governments
Public Health Institute

Equity Impact Review Tool
King County Office of Equity and Social Justice

Confronting Power Dynamics and Engaging the Community's Voice in Collective Impact (video)
The Collective Impact Forum

THRIVE: Tool for Health and Resilience in Vulnerable Environments
The Prevention Institute

Roots of Health Inequity Training
National Association of County and City Health Officials

To discuss these resources or local health equity training opportunities, please contact Hallie Cardé, MCCHD Coordinator for Health Equity at hcarde@missoulacounty.us

Source: Colorado Department of Public Health

Principles of Health Equity

Community Voice

Focus on needs of marginalized community members who face persistent barriers to health.
Keep them at center of solutions.

Policy Systems & Practice Change

Create a fair social environment that allows all people from all backgrounds and resources to thrive and achieve a good quality of life.

Social Determinants of Health

Prioritize factors that impact health: economic security, education, housing, transportation, built environment, social connections, & healthcare access/quality.

Diversity & Inclusion

Prioritize diversity & inclusion.
Invest time & resources in supporting people who have frequently been overlooked.

Acknowledge, discuss, & address racism, sexism, classism, & other dehumanizing forms of systemic oppression.

Authentic Relationships

Establish & maintain authentic relations with community members who face persistent barriers to health.

Work collaboratively with them to solve challenges related to inequalities.

Community Power

Recognize & leverage community power to advocate for policy, systems, practice, & environmental changes that improve living conditions & expand access to health - promoting opportunities.

Working With All People

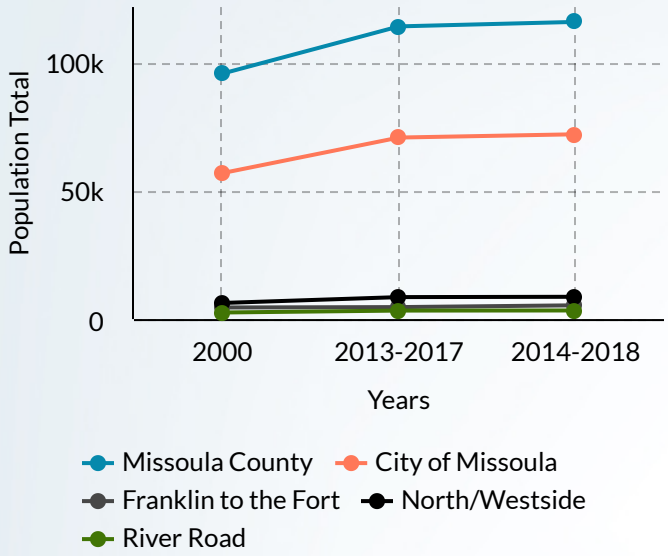
Working with community members across sectors, issues, and social groups.

Engage in mutually reinforcing activities that support the common goal of creating culture of health.

These Principles of Health Equity were created by and sourced from *Allies for Researching Community Health Equity*: https://healthequity.globalpolicysolutions.org/

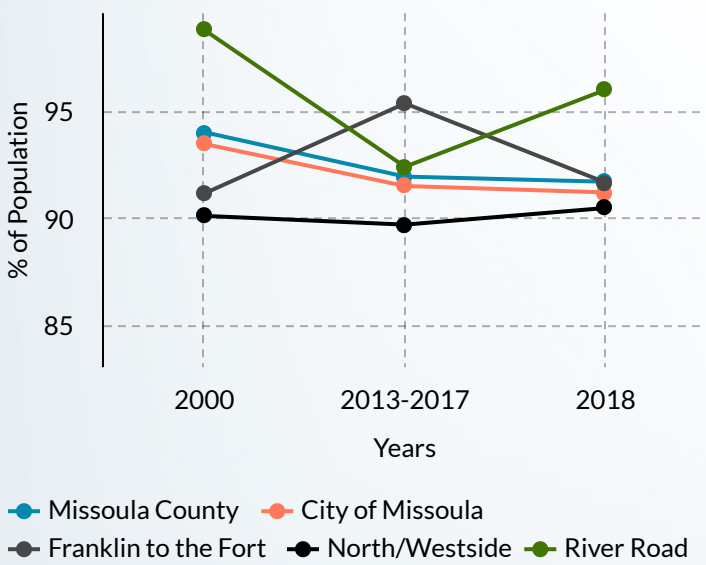
Population & Race

2000-2018 Population

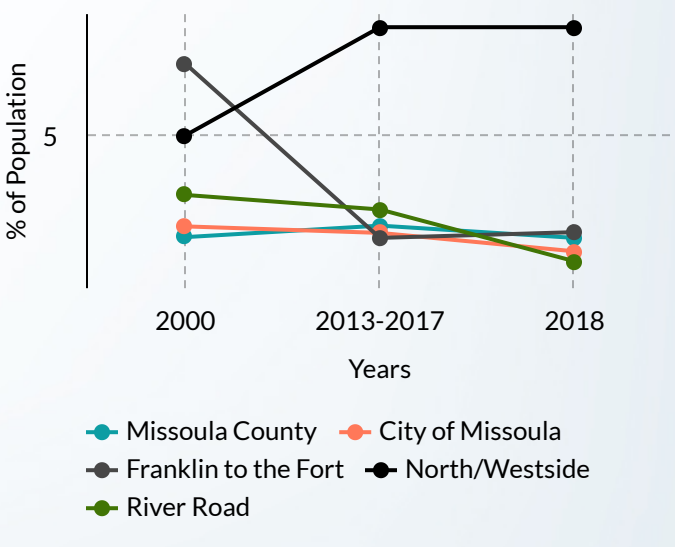


Population & Race
Having baseline information regarding population, age, and race helps to create a complete picture of our community.
We can use information to adapt systems for the benefit of all community groups.

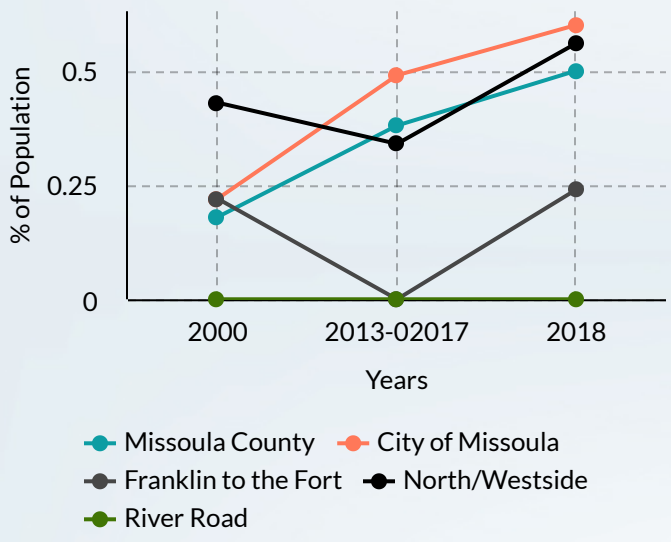
2000-2018 White



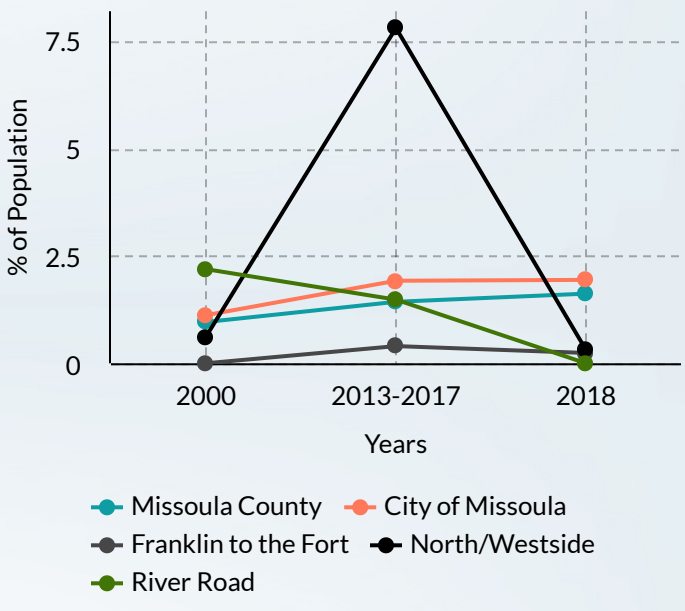
2000-2018 American Indian/Alaskan Native



2000-2018 Black or African American

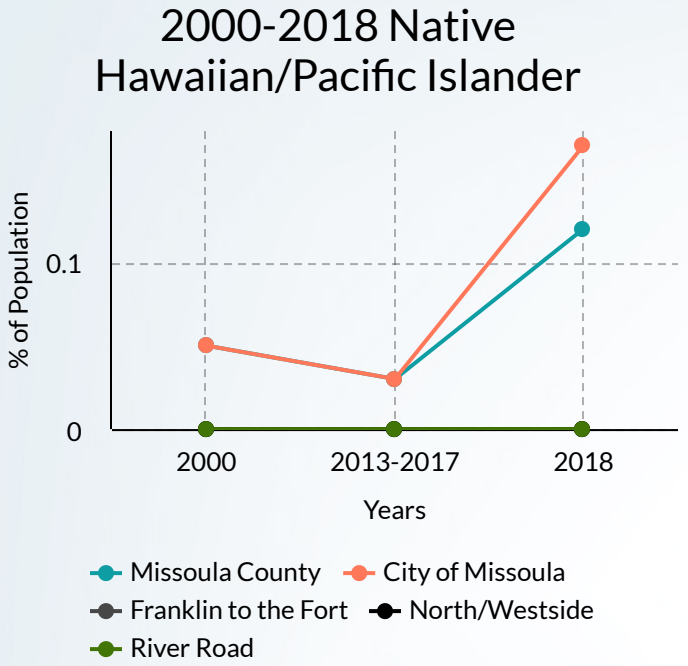


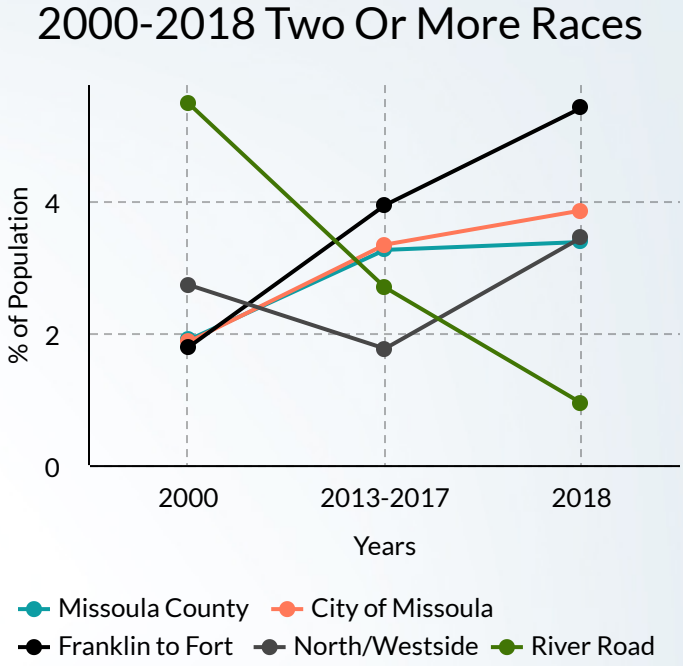
2000-2018 Asian



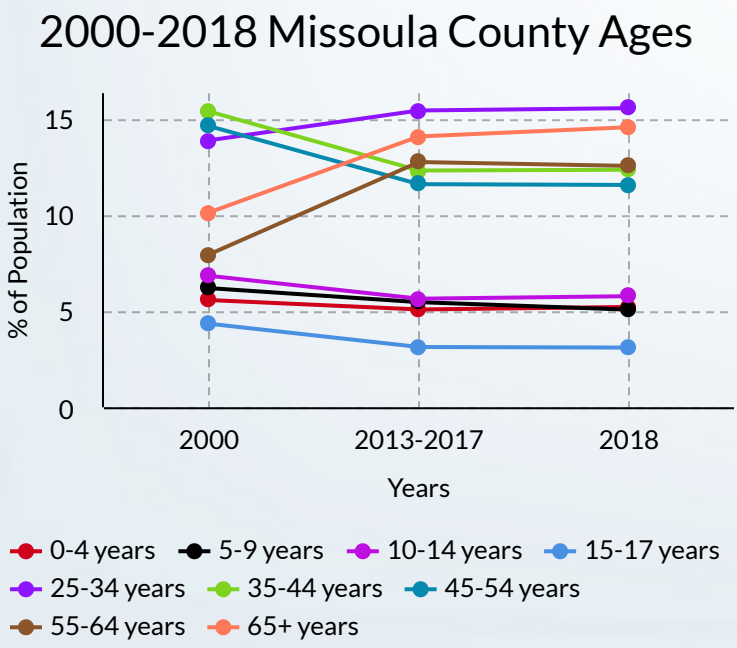
Source:PolicyMap

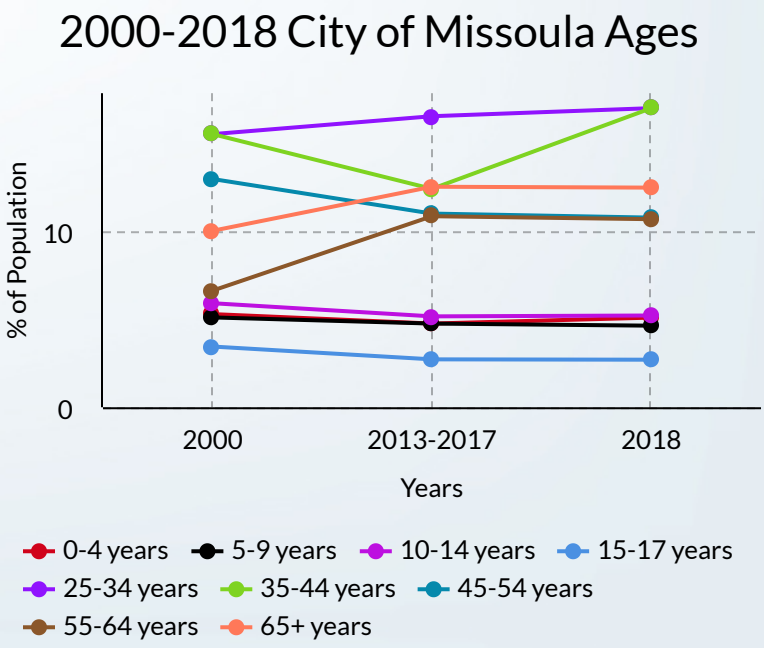
Population & Race Continued





Population & Ages

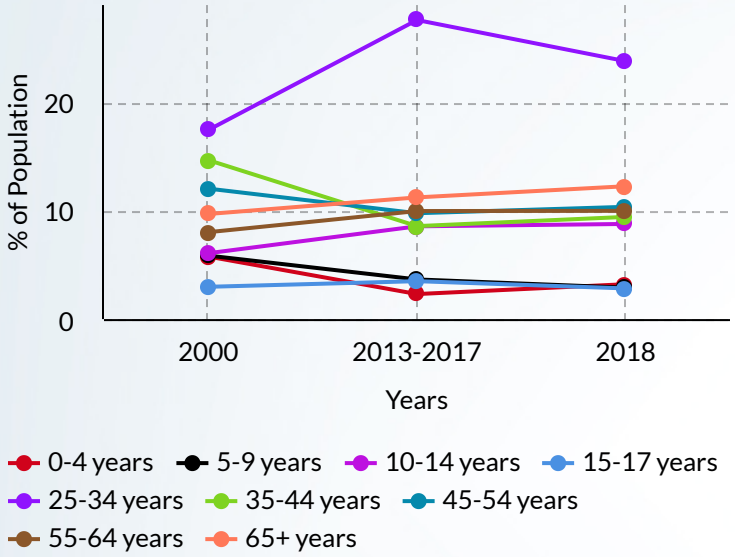




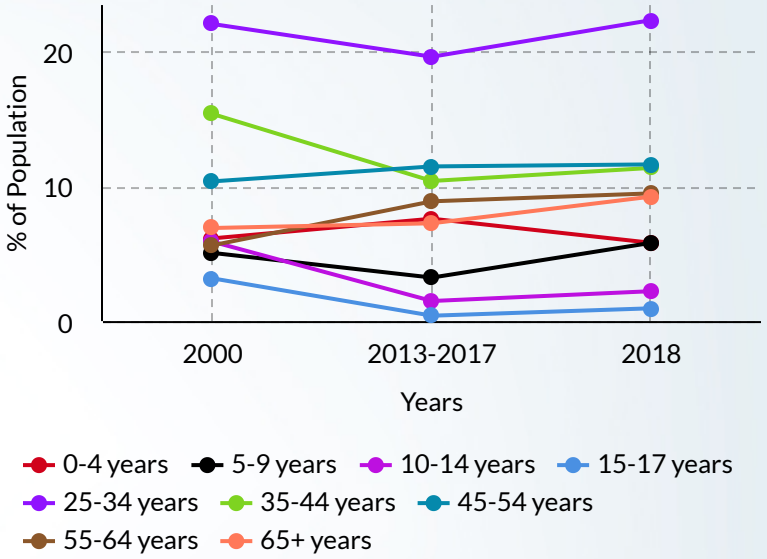
Source:PolicyMap
American Census Bureau

Population & Ages Continued

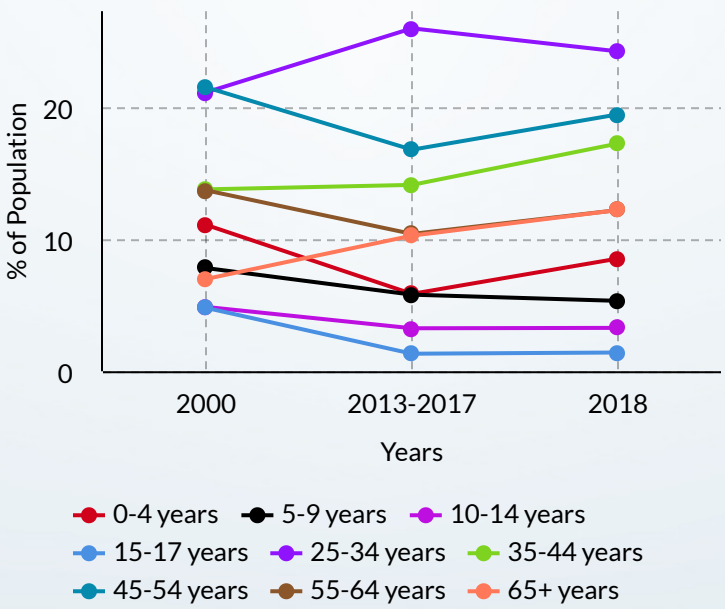
2000-2018 Franklin to the Fort Ages



2000-2018 North/Westside Ages

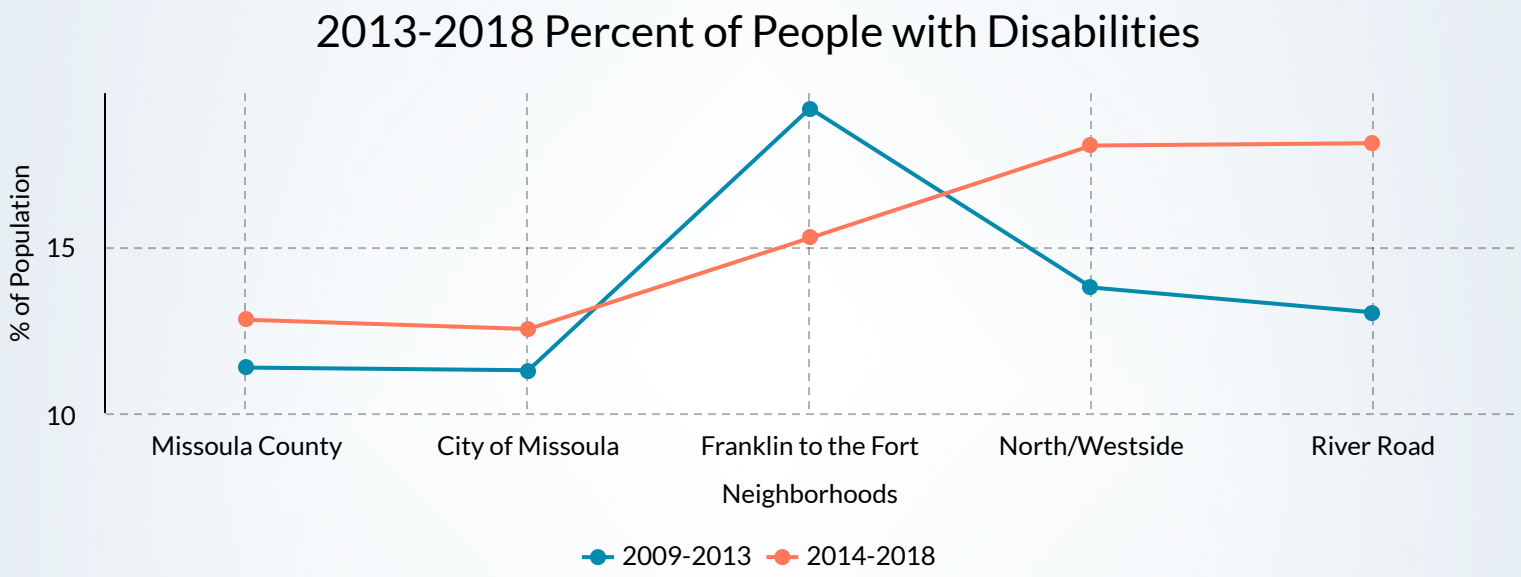


2000-2018 River Road Ages

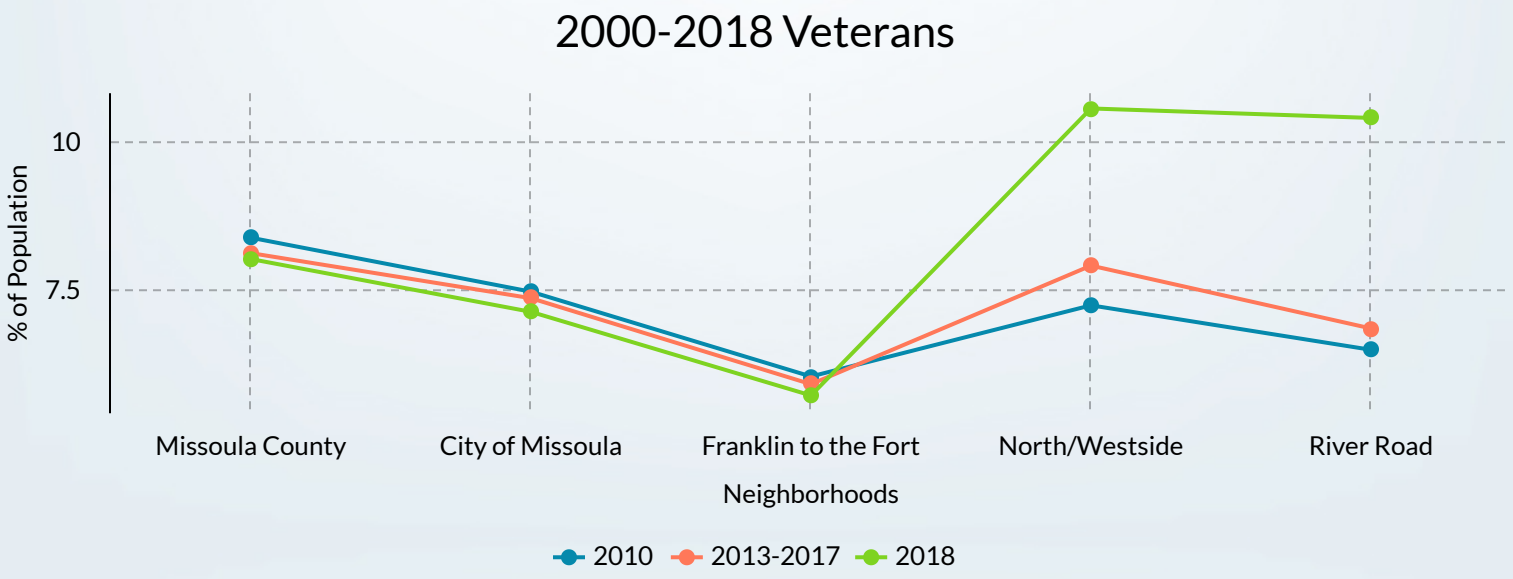


Population & Disability

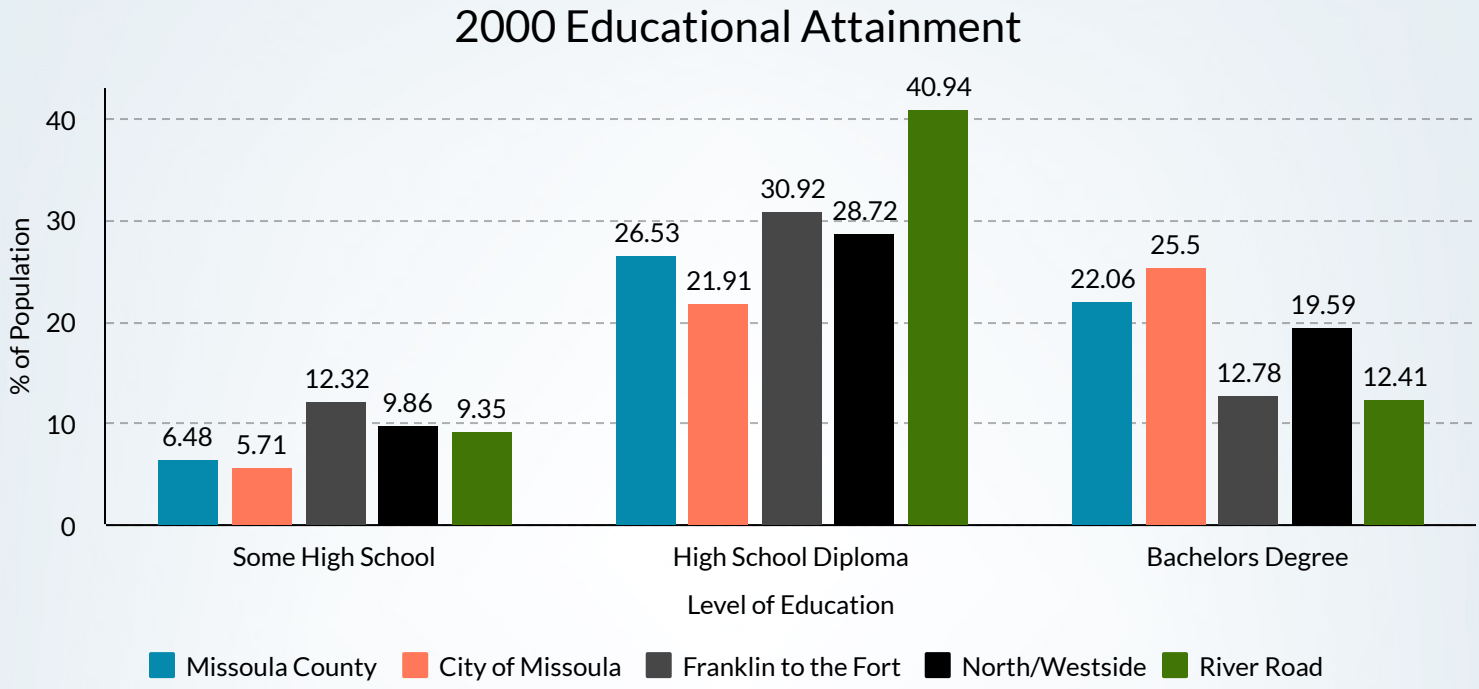
Population with disabilities: Estimated percent of the civilian non institutionalized population with one or more types of disabilities, between 2014-2018.

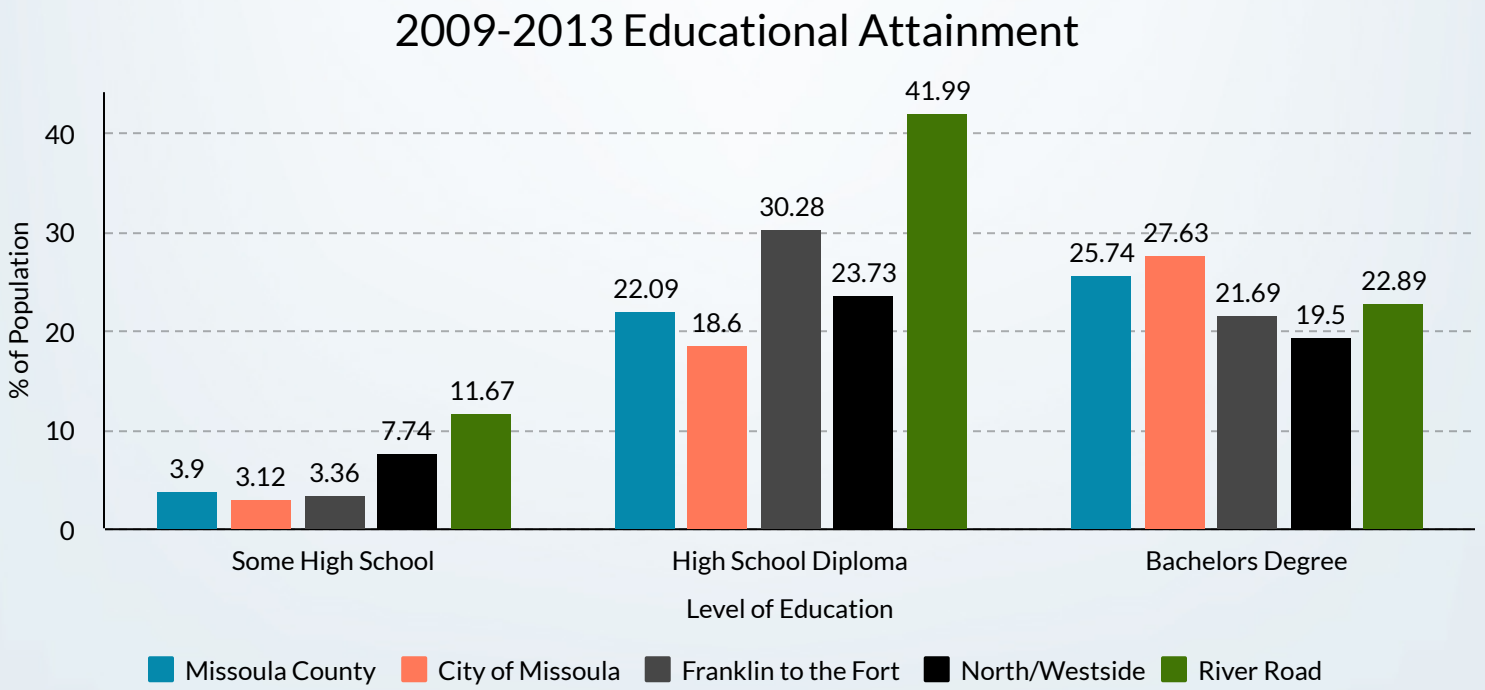


Population & Veterans

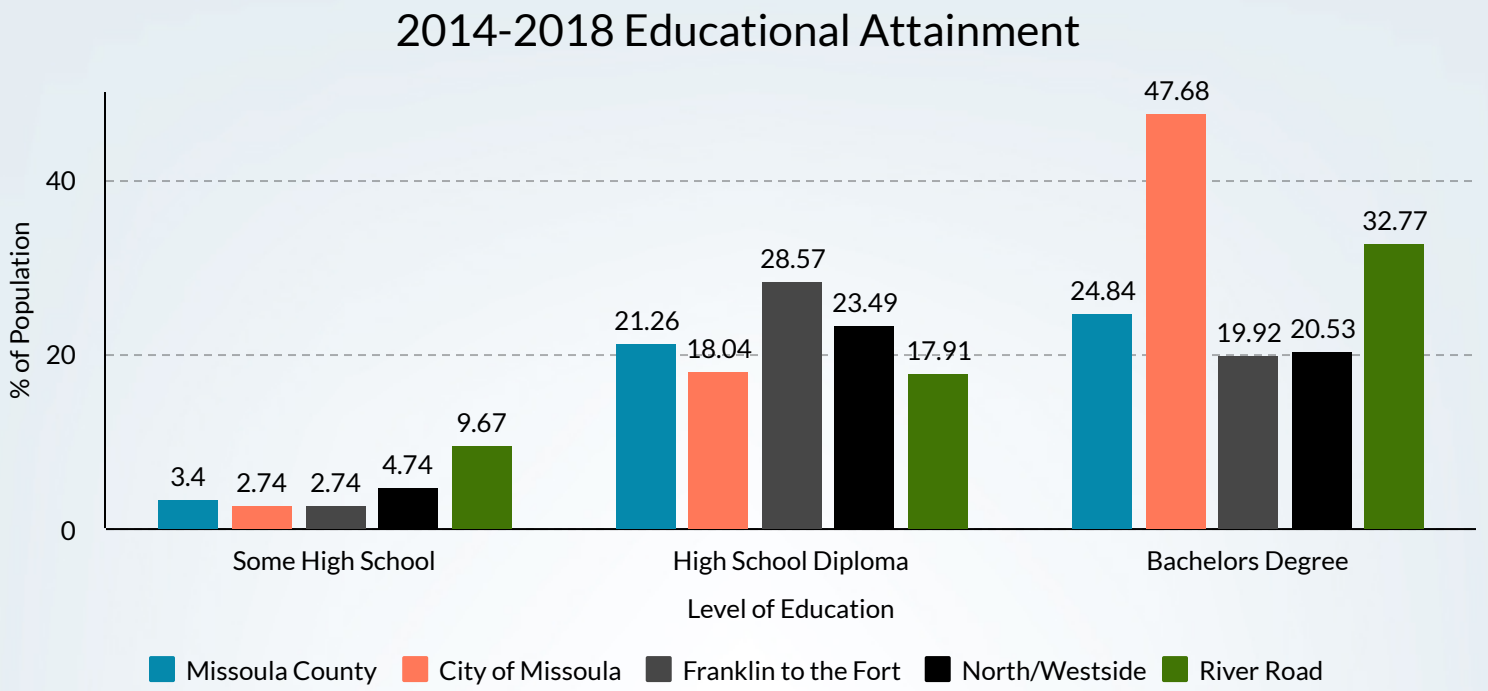


Education

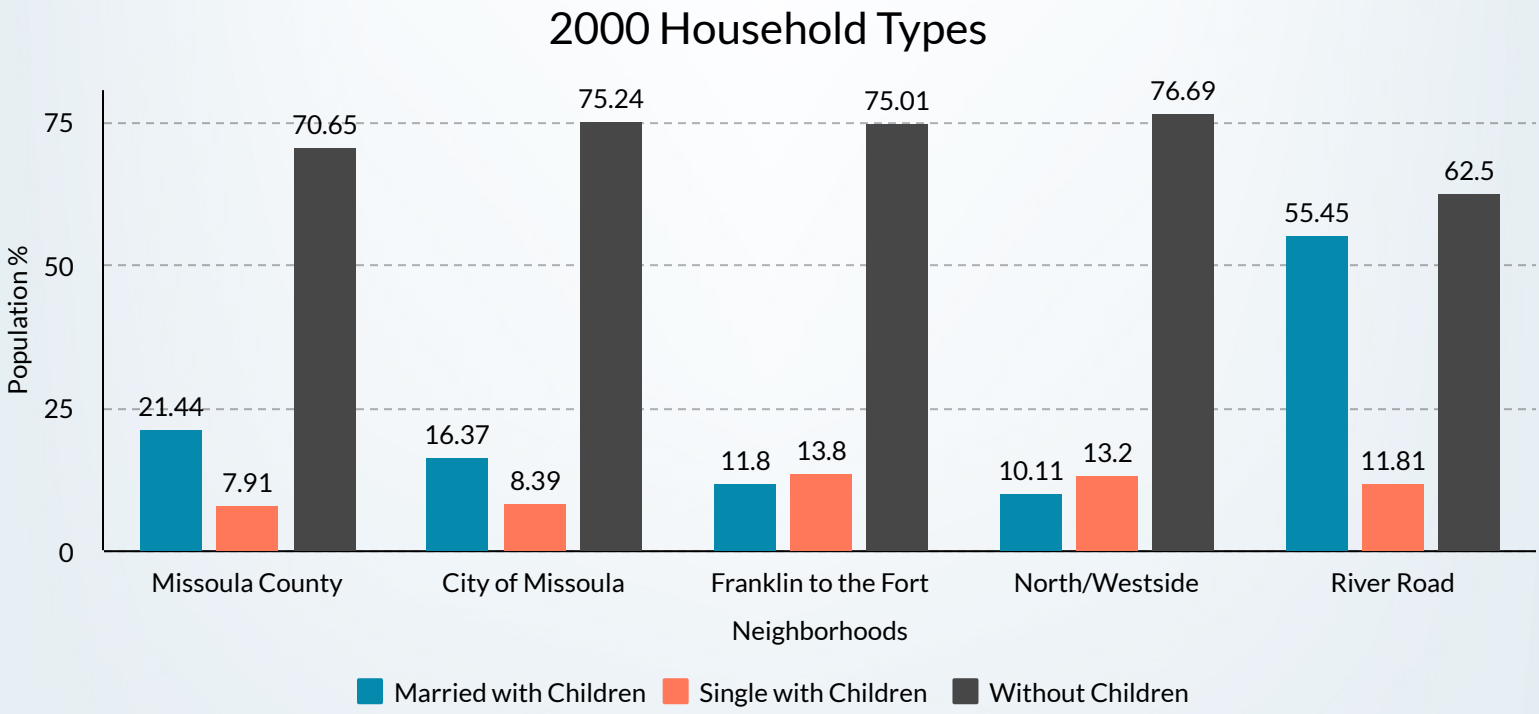




Source:PolicyMap
American Census Bureau



Housing & Population



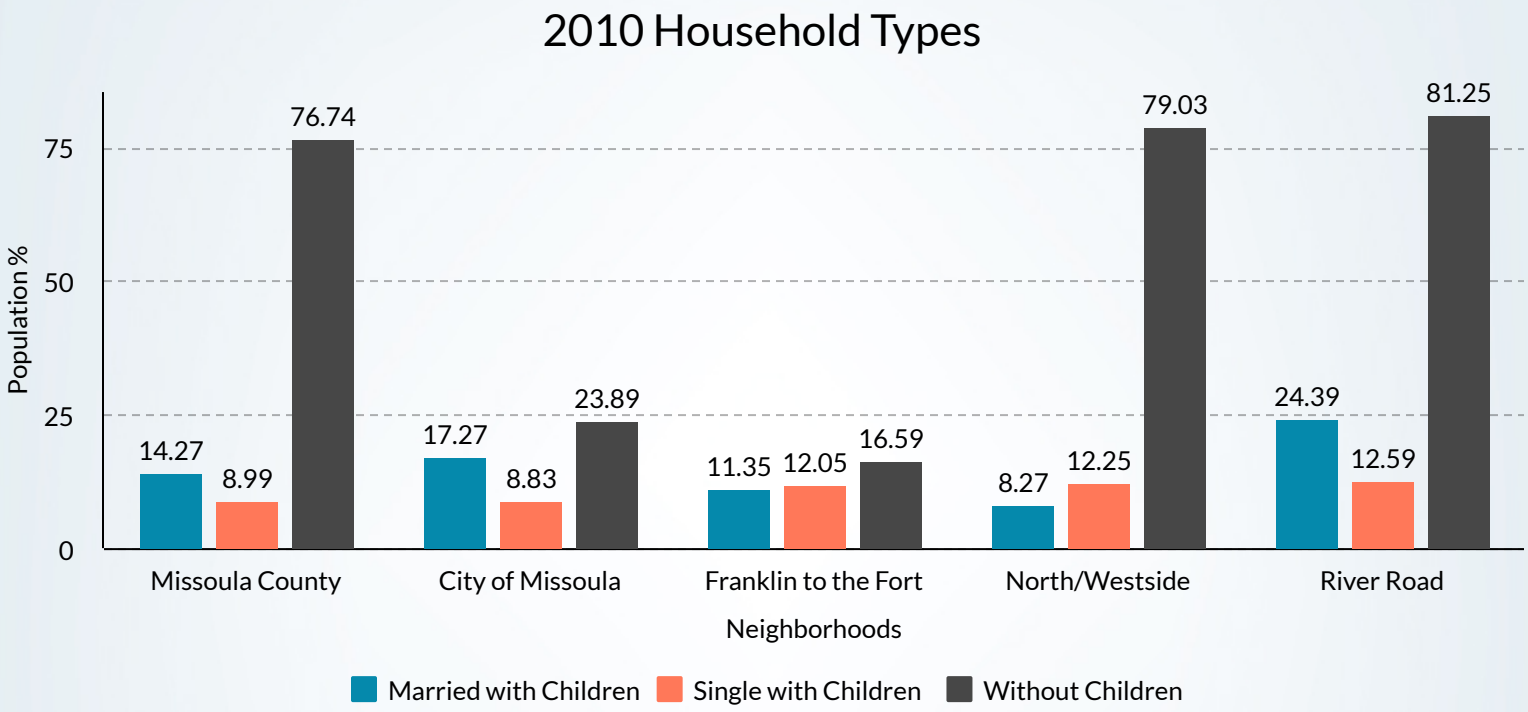
Household types: Married with children, single headed with children, and without children.

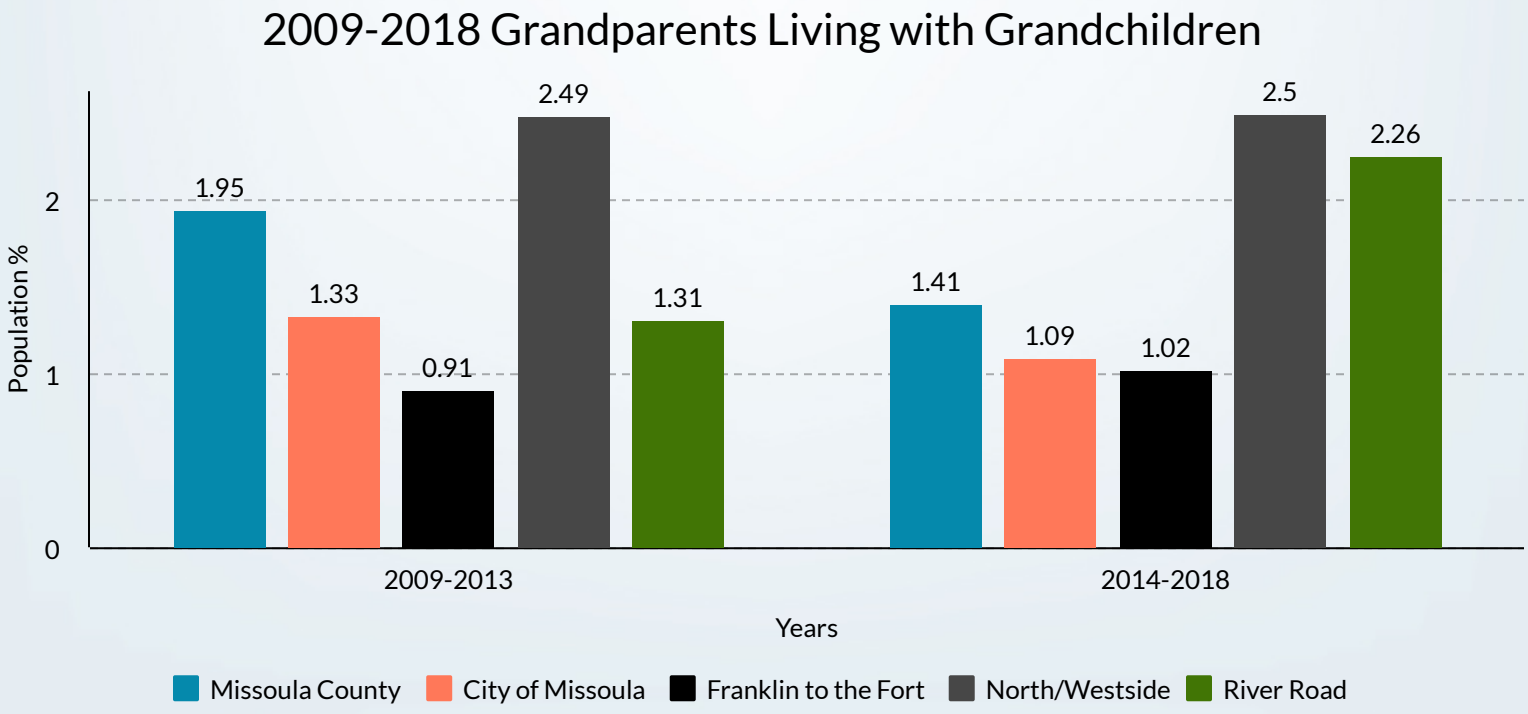
Married with children: Percent of households that are married couple families with own children in 2010. A household includes all the people who occupy a housing unit as their usual place of residence.

Single with children: Percent of households that are single-headed families (male householder with no wife present, or female householder with no husband present) with own children from 2000 to 2010. The US Census Bureau identifies the householder as the person in whose name the home is owned, being bought, or rented. If there is no such person present, any household member 15 years and older can serve as the householder.

Without Children: Percent of households without children from 2000 to 2010. A household includes all the people who occupy a housing unit as their usual place of residence. Percentage calculations were suppressed in cases where the denominator of the calculation was less than 10 of the unit that is being described.

Housing & Population





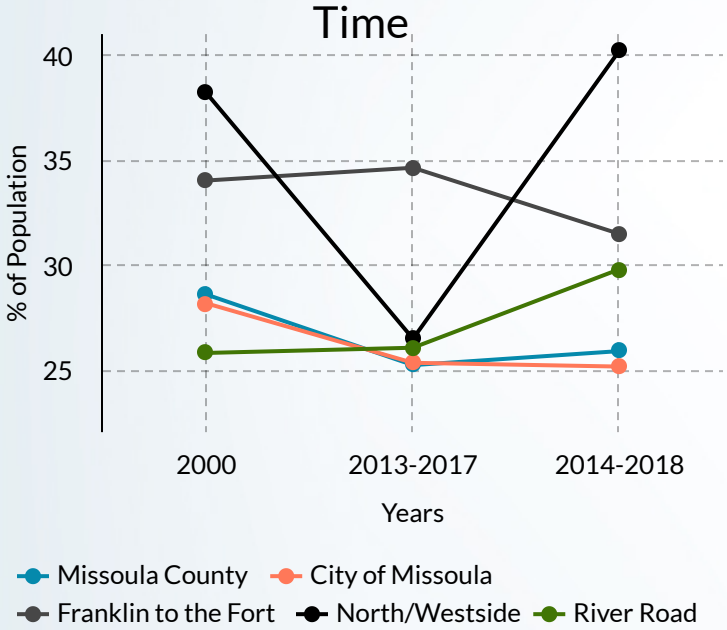
Grandparents living with Grandchildren: Estimated percent of households that have grandparents living with their own grandchildren under age 18, between 2014-2018. Includes households where the grandparents either are or are not responsible for their grandchildren.

Housing & Cost Burden

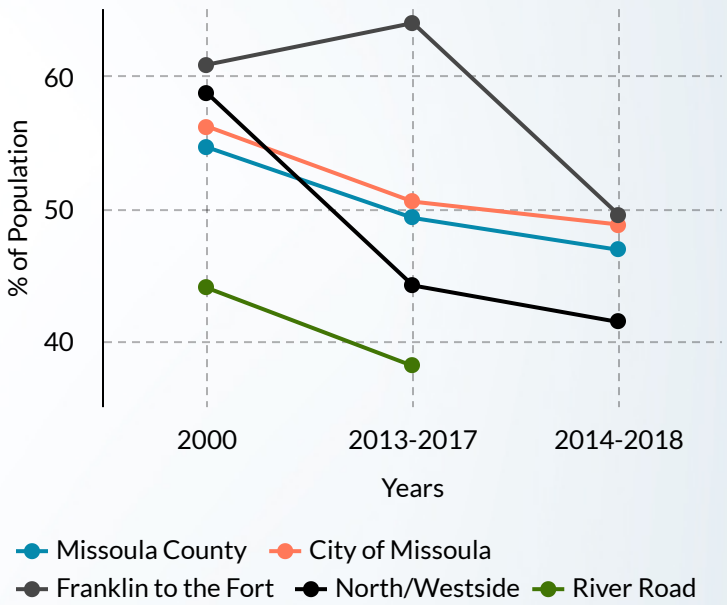
Cost burdened households: Estimated percent of owner households for whom selected monthly owner costs are 30% or more of household income between 2014-2018.

Cost burdened renters: Percent of renter households for whom gross rent is 30% or more of a given households income, between 2014-2018. Gross rent is the contract rent plus the estimated average monthly cost of utilities and fuels.

Cost Burdened Homeowners Over Time



Cost Burdened Renters Over Time



Poverty & Health Equity

Health outcomes associated with low-income populations:

Lower life expectancy	Obesity
Smoking	Lower rates of exercise

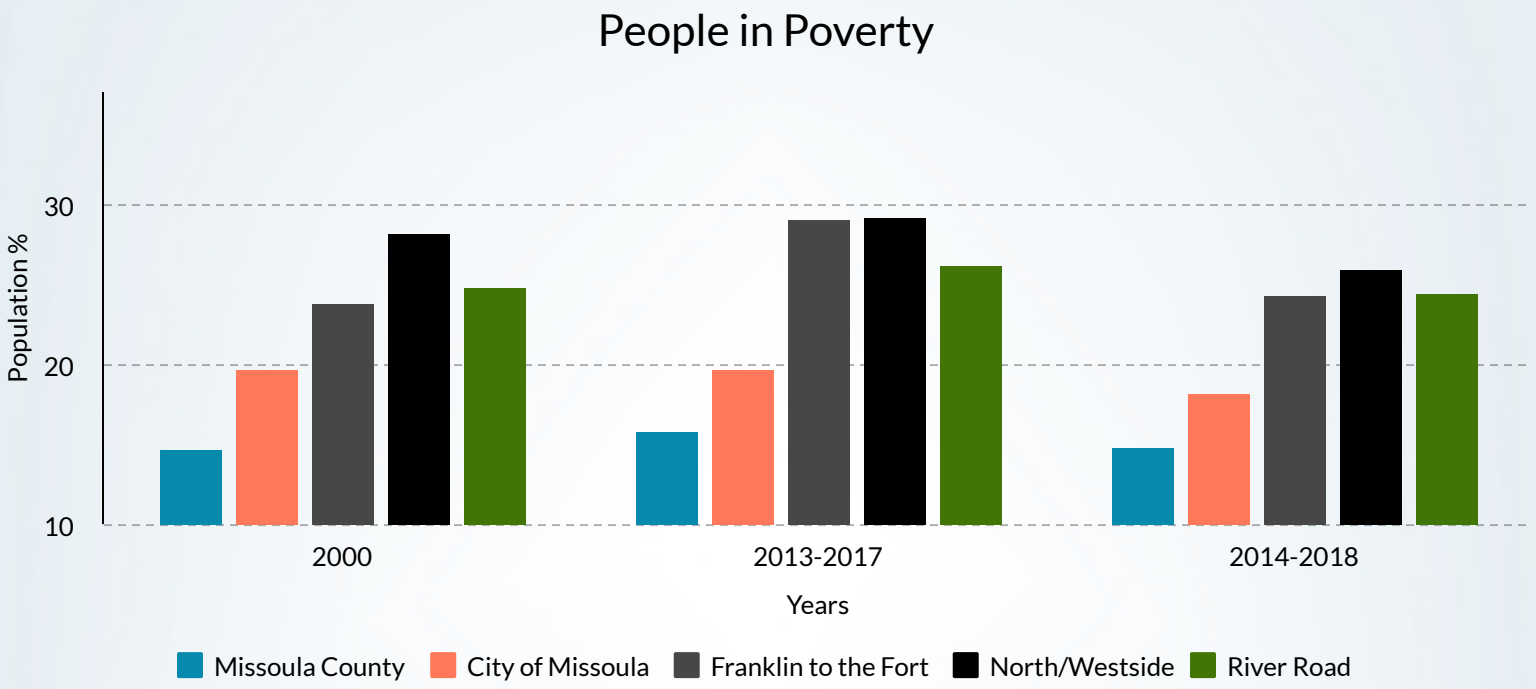
You can find more information about poverty and health equity here:

The Robert Wood Johnson Foundation: https://www.rwjf.org

Allies for Research and Health Equity: https://healthequity.globalpolicysolutions.org/

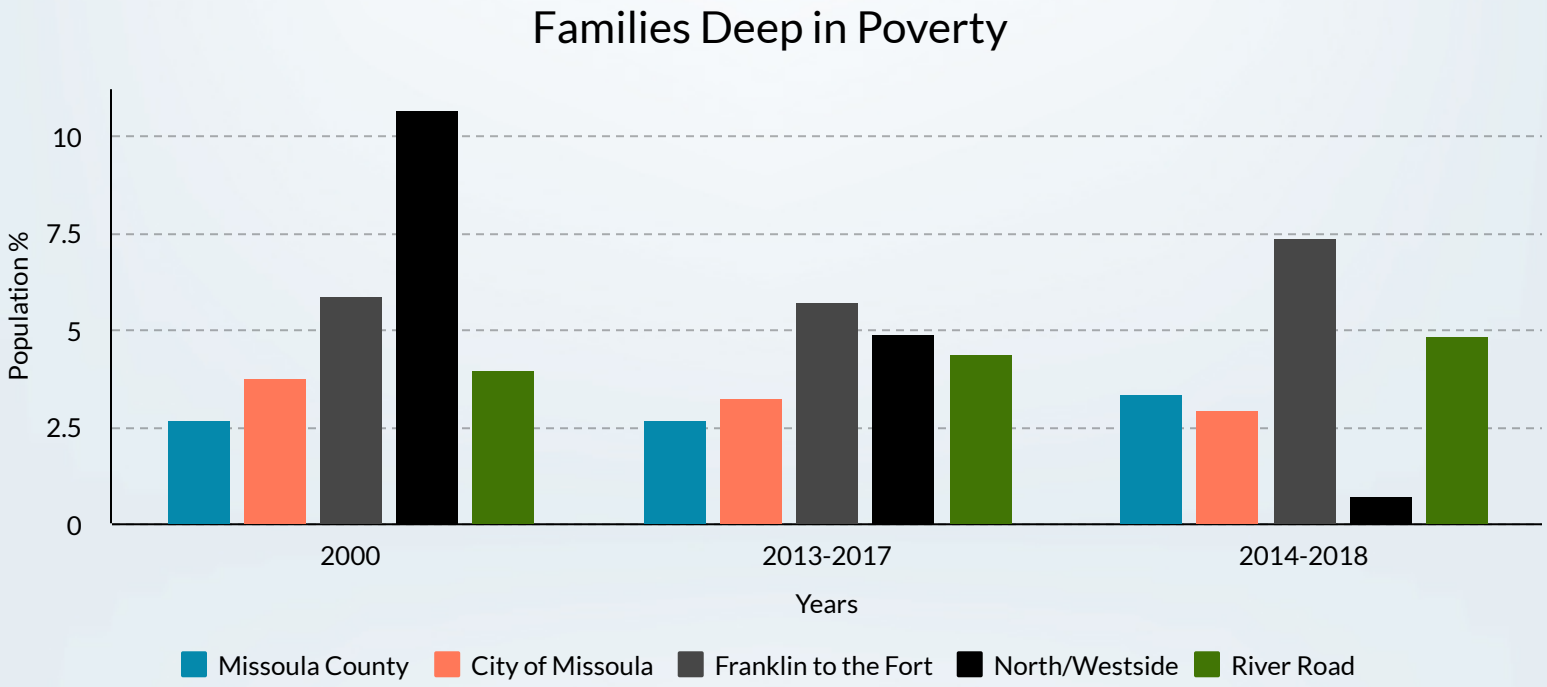
Sources: PolicyMap
Robert Wood Johnson Foundation
Allies for Research and Health

People in poverty: estimated percent of all people that are living in poverty as of 2014-2018



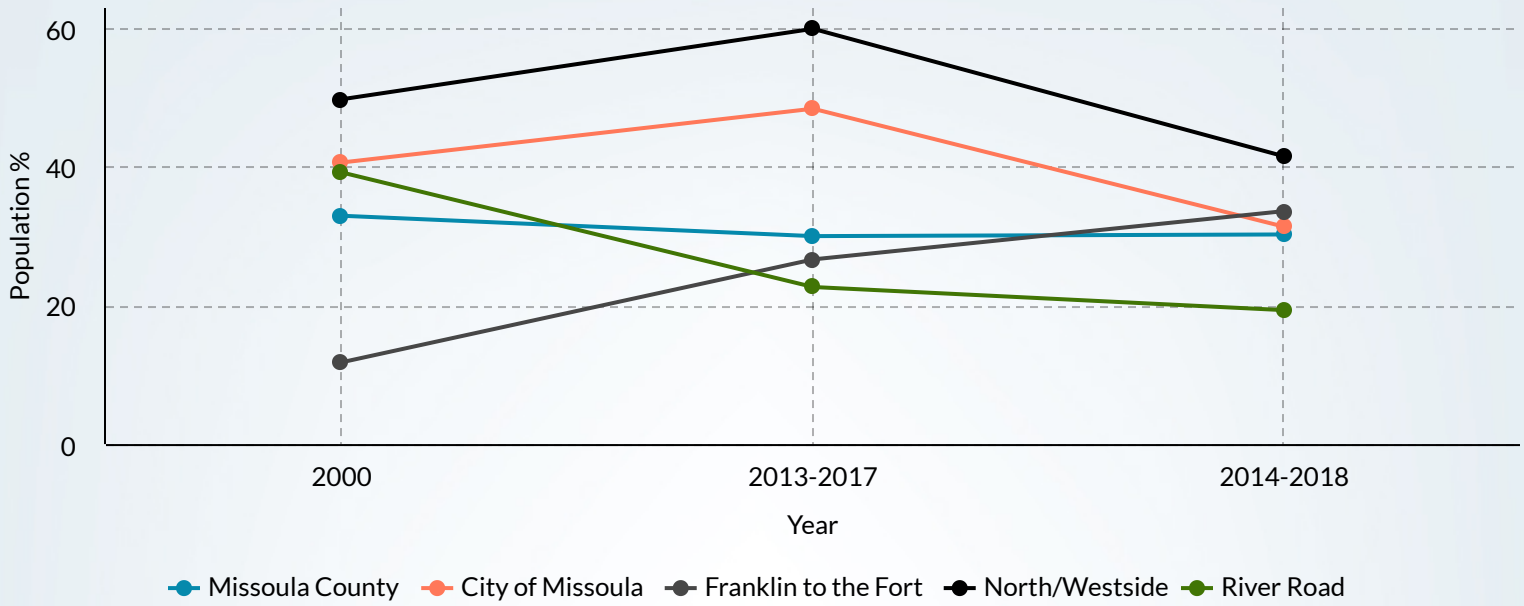
Family: A group of two or more people that reside together and are related by birth, marriage, or adoption (PolicyMap)

Deep poverty: Estimated percent of families living in deep poverty (at least 50% of the poverty level between 2013-2017 (PolicyMap))

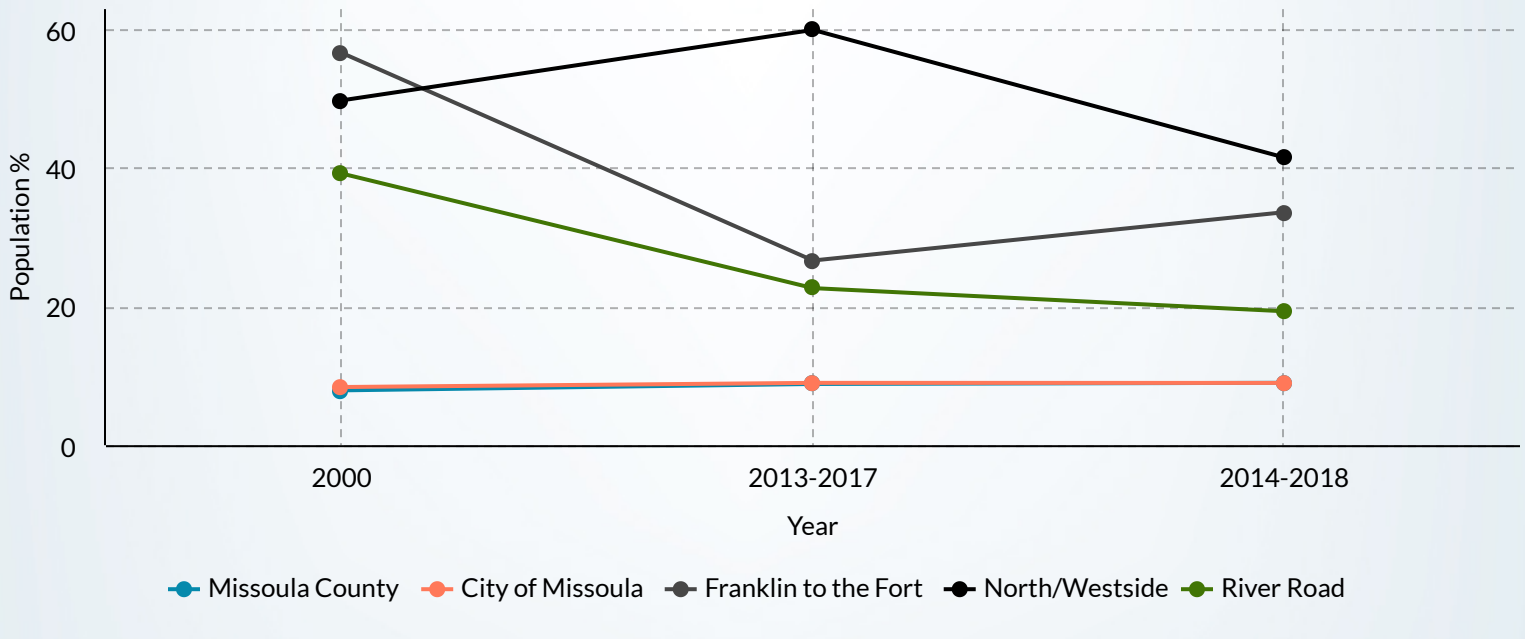


Sources: Census Data
USDA: Geogrpahy of Poverty

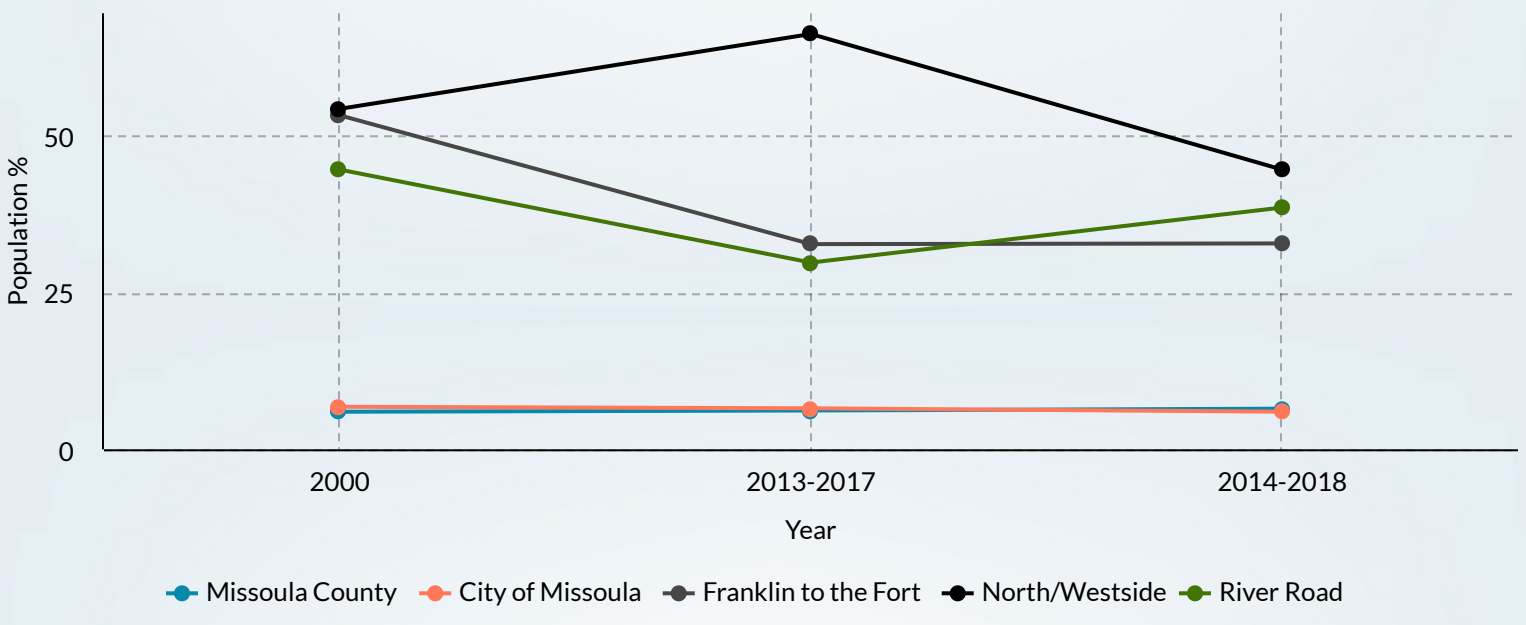
Families with One Adult & Child in Poverty



Single Headed Families with Children in Poverty

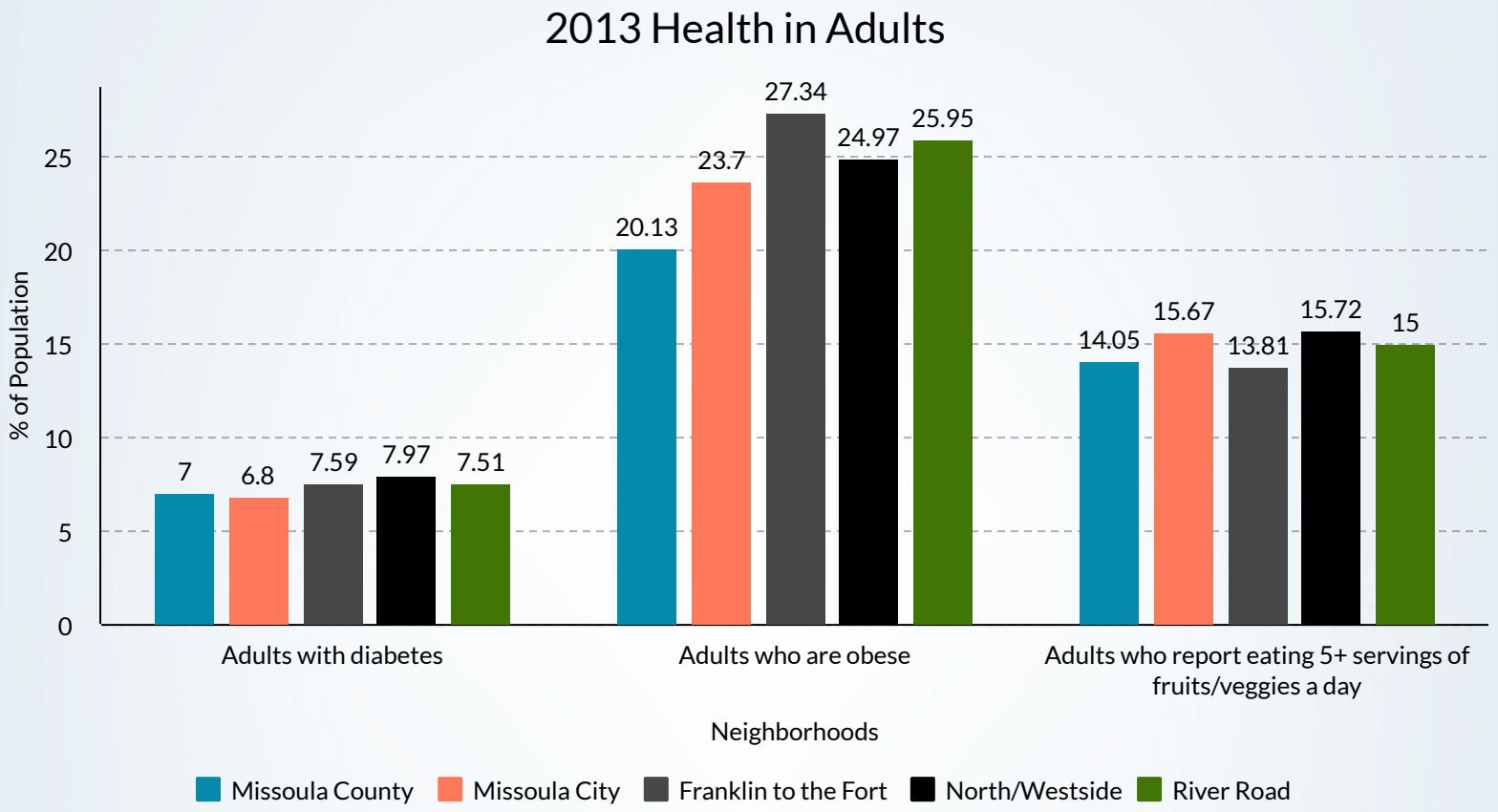


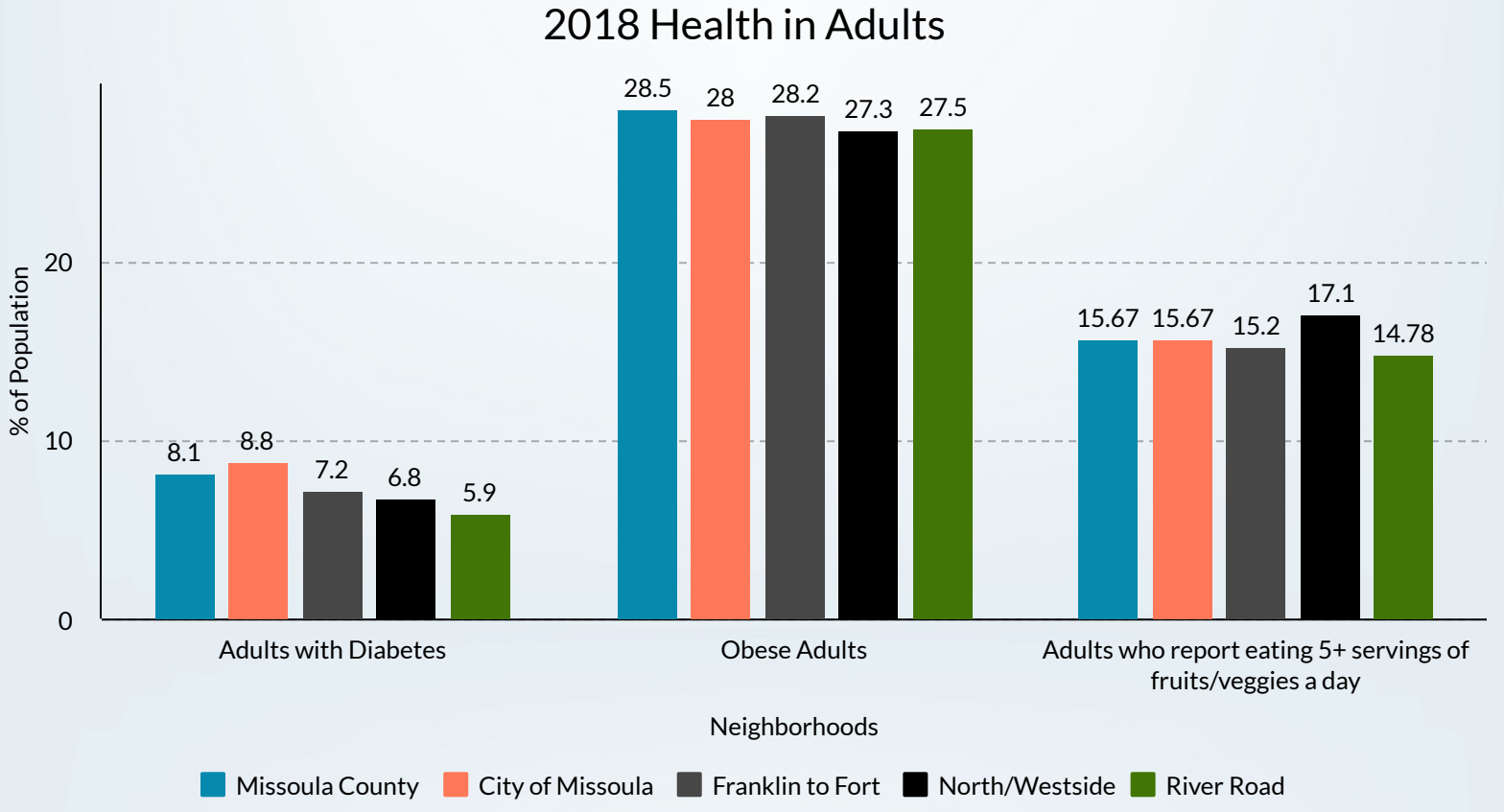
Single Female Headed Families with Children in Poverty



Adult Health

Obesity: A BMI (body mass index) greater than 30

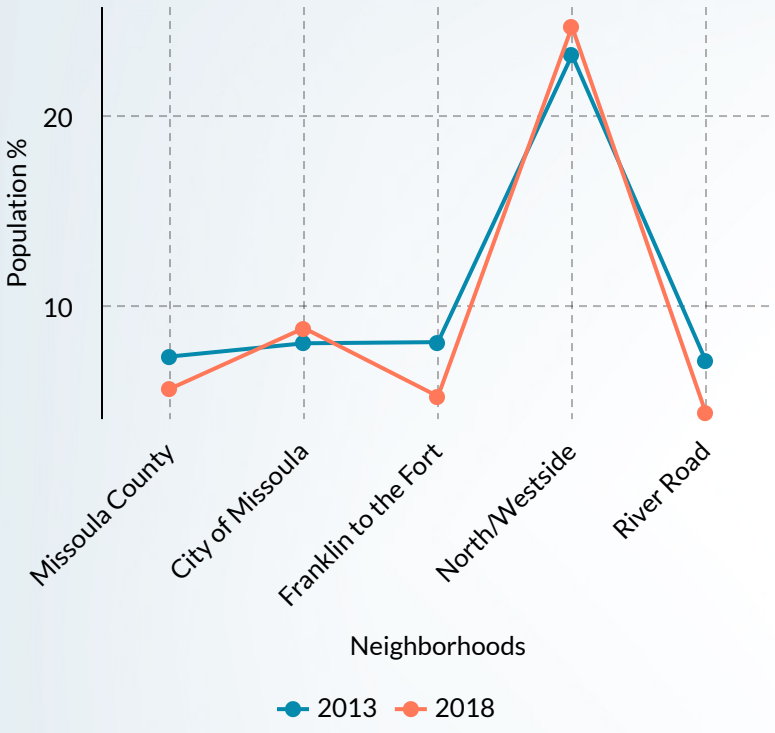




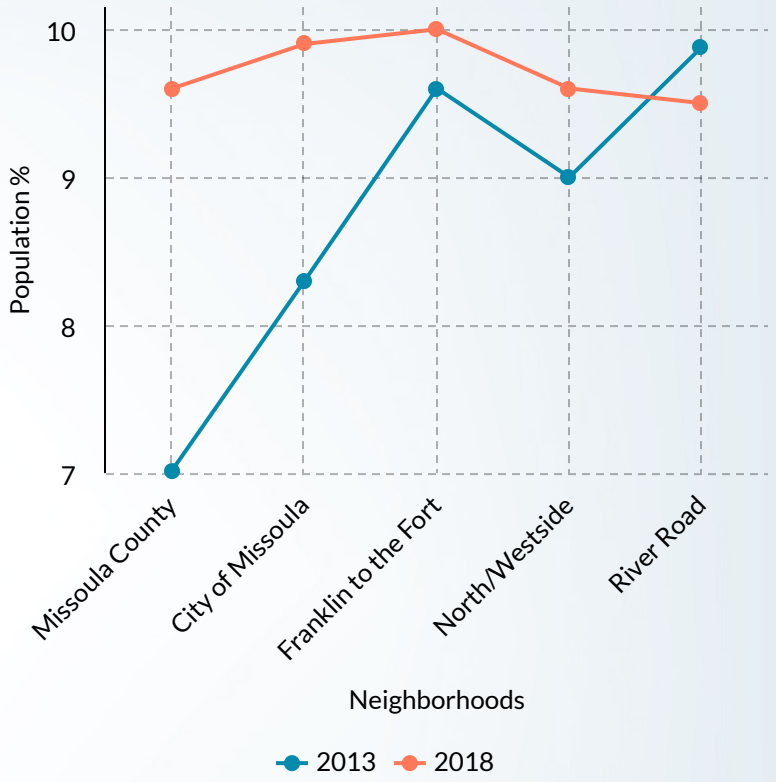
Source: PolicyMap

Adult Health

Adults with Chronic Obstructive Pulmonary Disease (COPD)

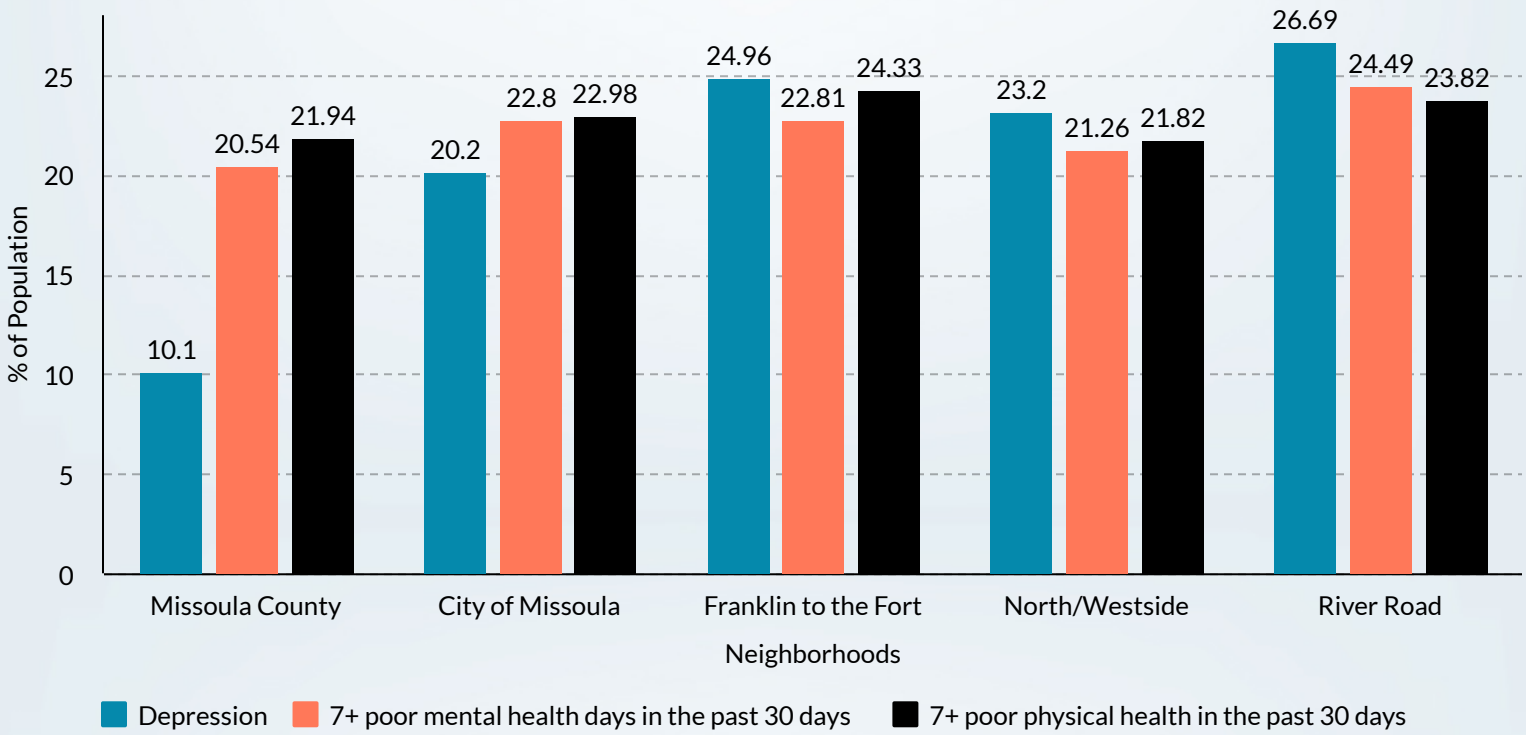


Asthma in Adults



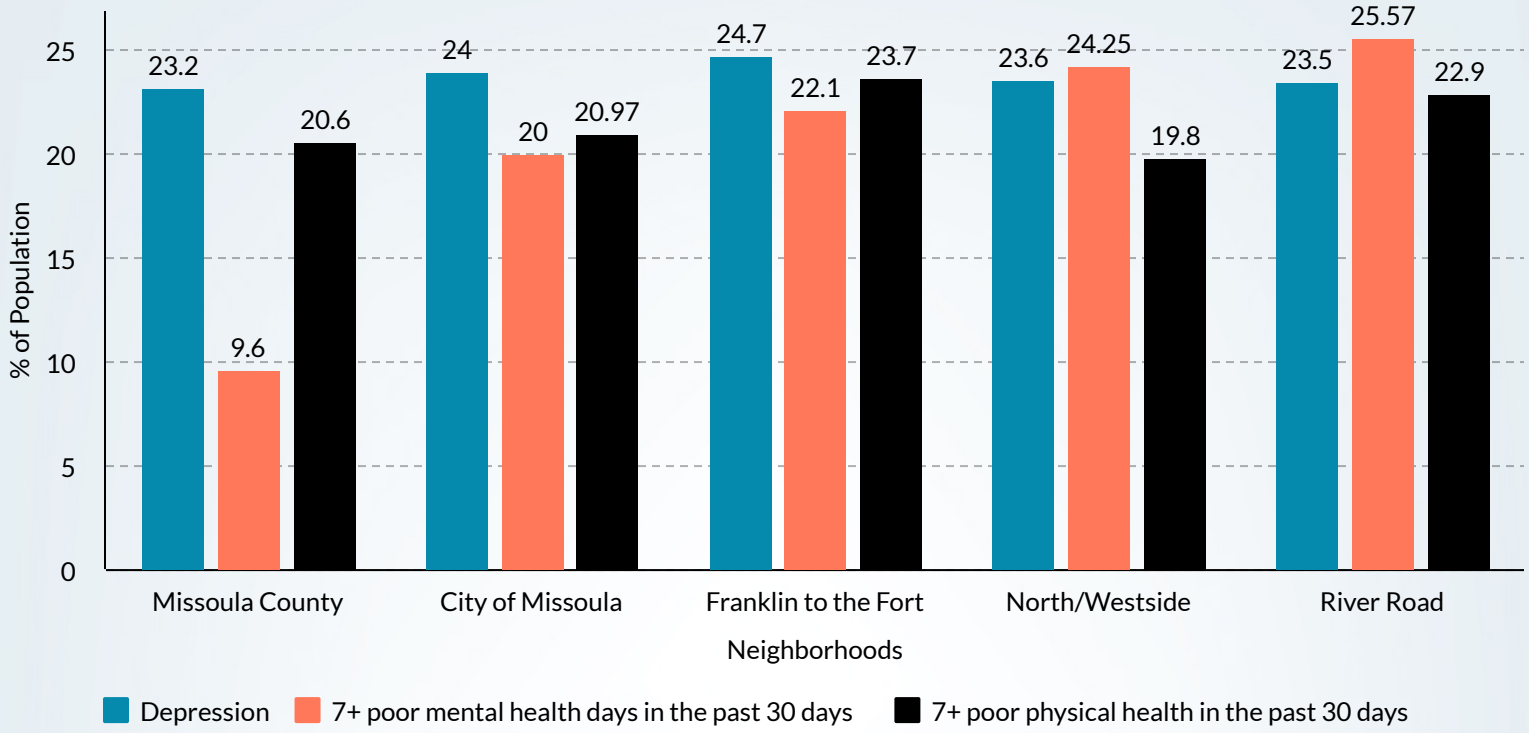
Mental Health, Physical Health, and Depression

2013 Mental/Physical Health & Depression in Adults



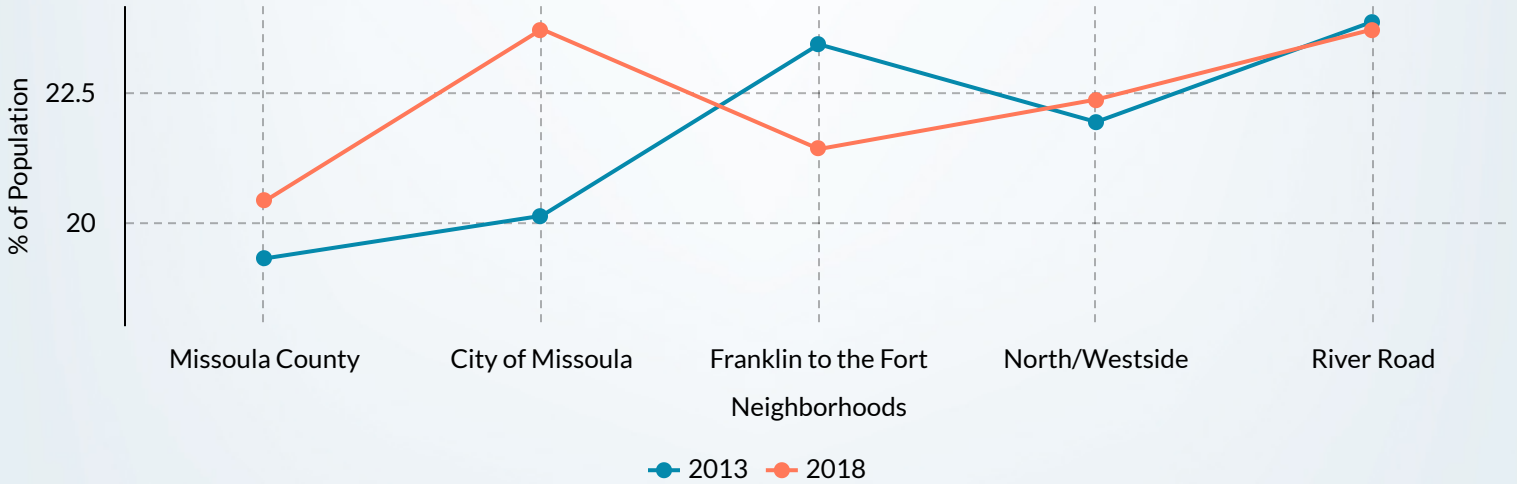
Source: PolicyMap

2018 Mental Health, Physical Health, and Depression in Adults

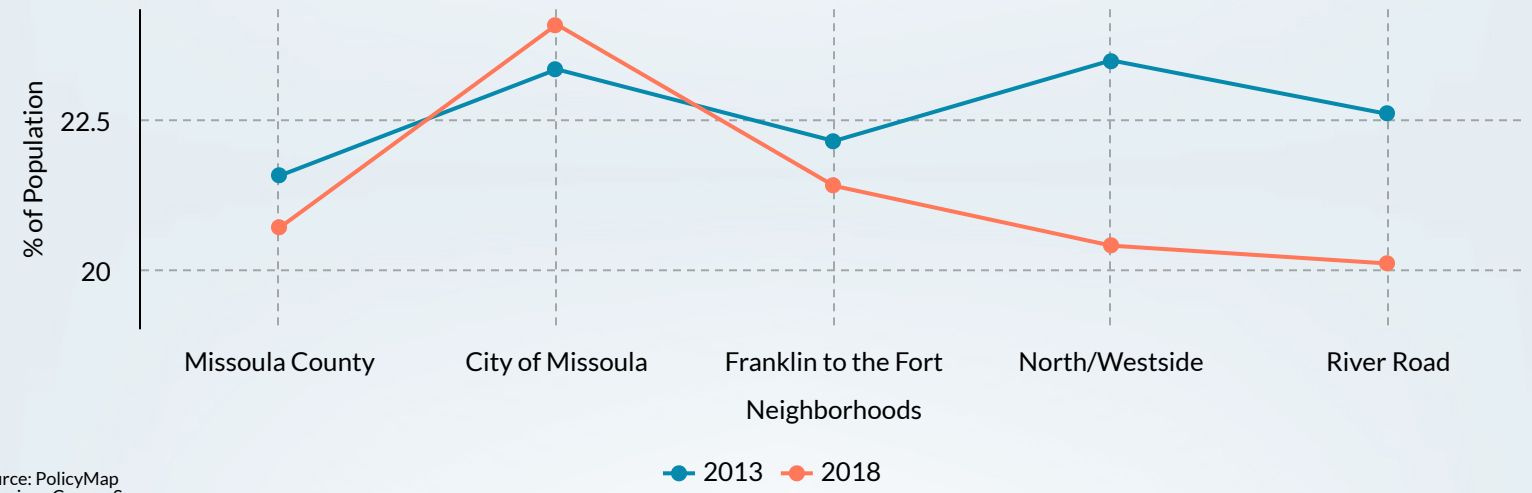


Health Risk Factors

Adults Reporting to Engage in Binge Drinking



Adults Reporting to Engaging in Smoking



Source: PolicyMap
American Census Survey

Resources

The sources used in this report were as listed:

Allies for Researching Community Health Equity

https://healthequity.globalpolicysolutions.org/resources/organizations/active-living-research/

American Census Survey

https://www.googleadservices.com/pagead/aclk?sa=L&ai=DChcSEwix-uXxttHsAhX3IK0GHR-rAyQYABAAGgJwdg&ohost=www.google.com&cid=CAASE-Rokpvt9oZG5UqaXQBbzPCdzp4&sig=AOD64_1WzxwxM35hE1EkEEIj6oPY5_pDag&q&adurl&ved=2ahUKEwiC_N7xttHsAhXO3J4KHbtZBPwQ0Qx6BAgWEAE

Census Data

https://www.census.gov/

Colorado Department of Public Health

https://www.colorado.gov/cdphe

Pennsylvania Department of Health

https://www.health.pa.gov/Pages/default.aspx

PolicyMap

www.policymap.com

Robert Wood Johnson Foundation

https://www.rwjf.org/

USDA: Geography of Poverty

https://www.ers.usda.gov/amber-waves/2015/july/understanding-the-geography-of-growth-in-rural-child-poverty/

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