

# Fallbrook Regional Health District Health and Wellness Center

**Board Committee Meeting**

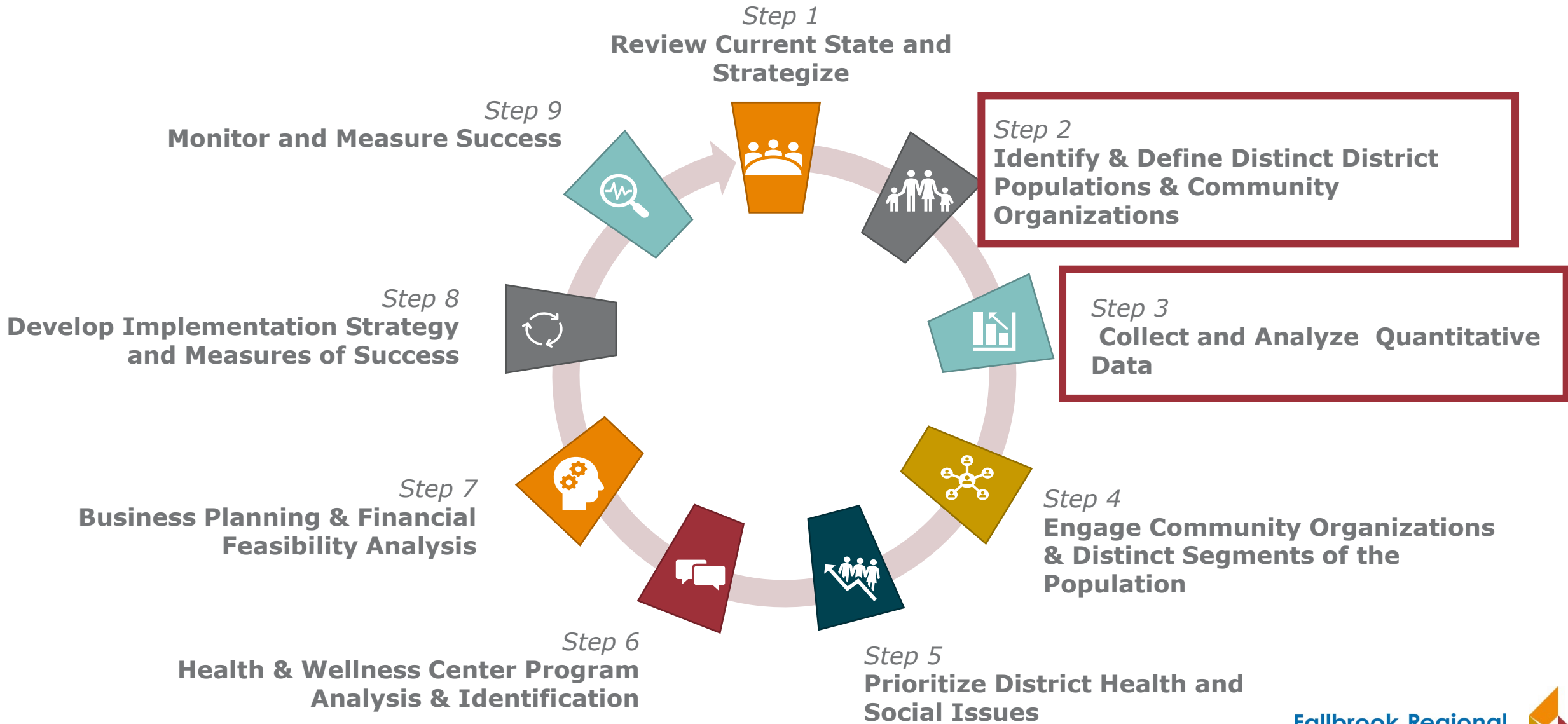
**October 14, 2020**



# Board Meeting Agenda

- Review Project Status
- Community-Based Organizations Collaboration
- Preliminary Review of Data
- Community Engagement Strategy Criteria
- Discussion

# FRHD Health and Wellness Center: Phase 2



# FRHD Health and Wellness Center: Phase 2

	Project Month	August					September				October				November				December				January				February				
	Project Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	Week of	3-Aug	10-Aug	17-Aug	24-Aug	31-Aug	7-Sep	14-Sep	21-Sep	28-Sep	5-Oct	12-Oct	19-Oct	26-Oct	2-Nov	9-Nov	16-Nov	23-Nov	30-Nov	7-Dec	14-Dec	21-Dec	28-Dec	4-Jan	11-Jan	18-Jan	25-Jan	1-Feb	8-Feb	15-Feb	22-Feb
Review Current State & Strategy		[Grey Bar]																													
Identify/Define Distinct Pop & CBO		[Grey Bar]																													
<b>Steering Committee Meeting 1</b>					SC1																										
Collect and Analyze Data		[Grey Bar]																													
<b>Board Kick-off Meeting</b>							9-Sep																								
<b>Steering Committee Meeting 2</b>										SC2																					
<b>Board Meeting 1</b>											14-Oct																				
Engage CBO and Distinct Pop Groups																															
<b>Virtual Feedback Sessions</b>																															
<b>In Person Feedback Sessions</b>																															
<b>Steering Committee Meeting 3</b>												SC3																			
<b>Board Meeting 2</b>																	12-Nov														
Prioritize District Health & Social Needs																															
<b>Board Facilitation 1</b>																															
Health & Wellness Center Program Analysis & ID																															
<b>Steering Committee 4</b>																															
<b>Board Facilitation 2</b>																															
Business Planning/Fin Feasibility																															
<b>Steering Committee 5</b>																															
<b>Board Meeting 3</b>																															
Implementation & Measures of Success																															
<b>Board Meeting 3</b>																															
Monitor and Measure																															



Fallbrook Union High School District



Camarillo Health Care District



# 18

Community Organizations Identified

# 50+

Service Offerings Identified

# 60+

Main Data Indicators

# Using Data to Determine Priority Health and Social Issues

Combining all data sources to develop one cohesive viewpoint

## Population Data

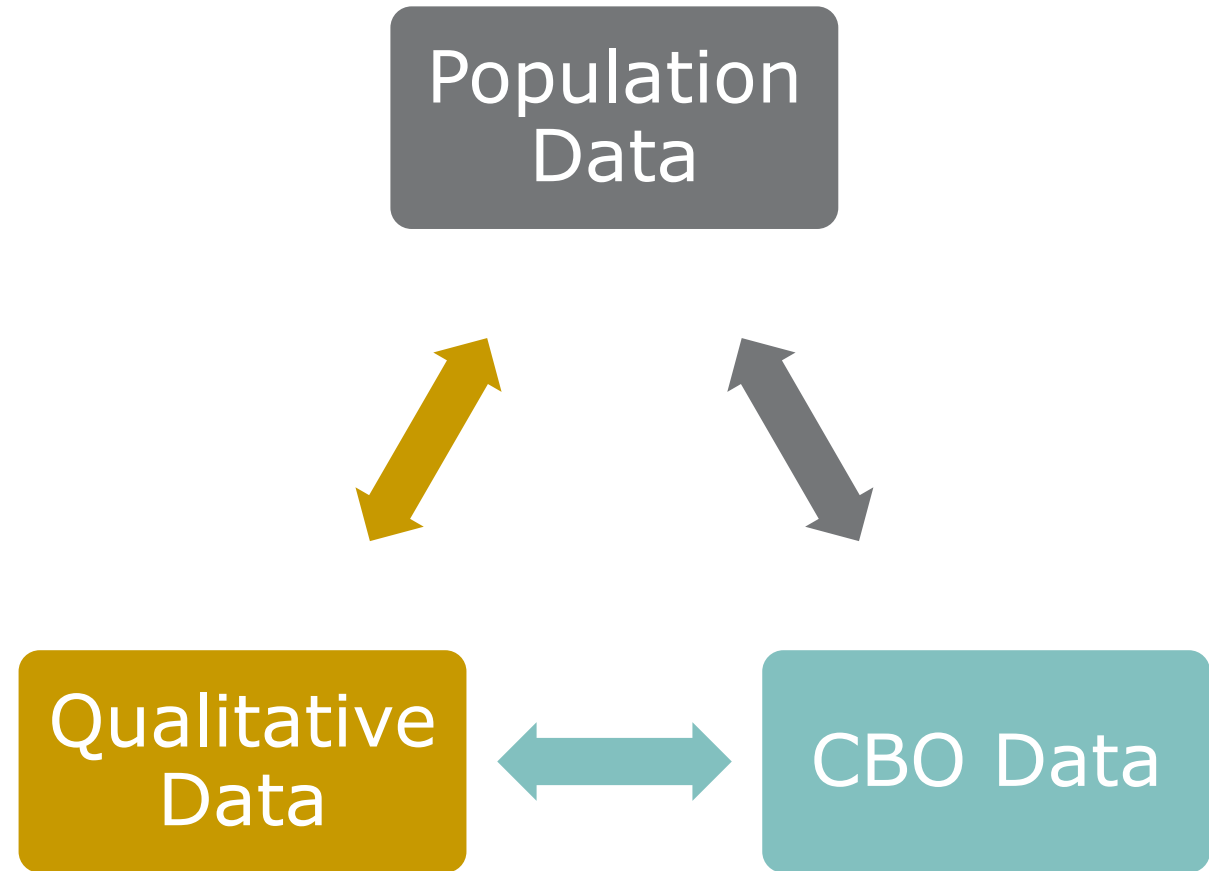
- Social determinants of health benchmarks
- Zip code/census Tract level data
- Comparison populations

## CBO Data

- Population/customer data provided by community-based organizations

## Qualitative Data

- One to one interviews with CBOs focusing on current service offerings



# Population Data

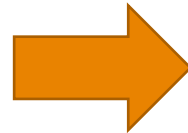
## Sources, Methodology and Compare Groups

### Social Determinants of Health

Drill down by FRHD zip codes and census Tracts to analyze the communities' Social Determinants of Health (SHOH) categories and the indicators within each category.

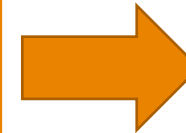
#### Data Sources

- Catalyst
- Data Contours
- Truven Analytics
- California Healthy Index
- Various Community Data Sources



#### Comparative Populations

- National
- Southern California
- Camarillo Health District
- San Mateo County Health District



#### Social Determinants of Health Categories

1. Economic
2. Education
3. Transportation
4. Social
5. Neighborhood
6. Clean Environment
7. Housing
8. Healthcare Access



# Data Driven Program Planning Approach

## Overall ranking

Overall census tract rank

Census tract rank within SDOH category

## SDOH analysis

Analyze census tract SDOH

Prioritize census tract SDOH issues

## Social and health needs analysis

Analyze SDOH across census tracts

Determine priority SDOH

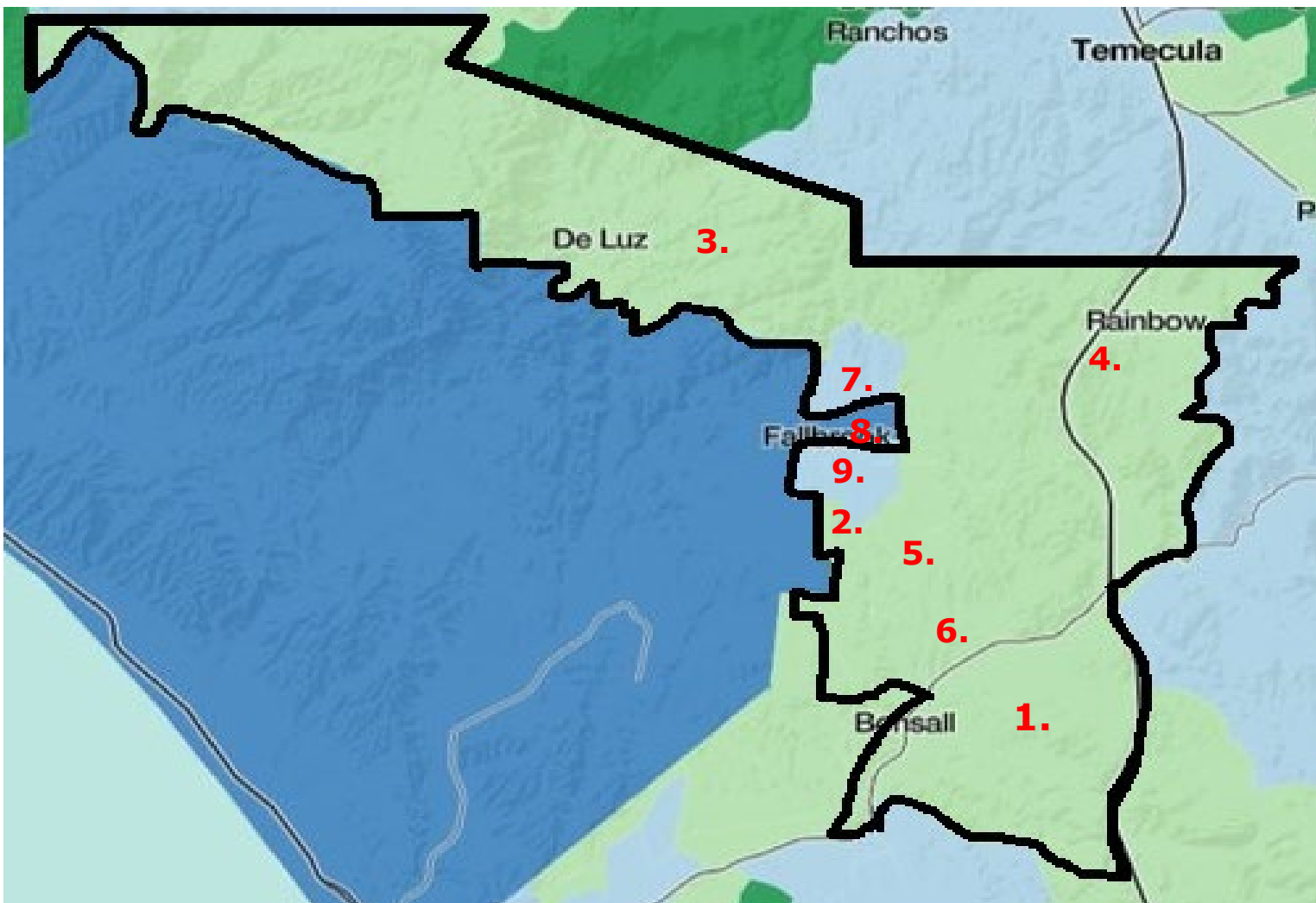
- Findings from the analysis will inform the conversations with the communities and CBOs
- Focus of programming is the intersection between geographic needs and social and health priorities identified through data analytics AND existing community services





# FRHD Geographic Area

## Zip Codes, Boundaries, Census Tracts, and Key Landmarks

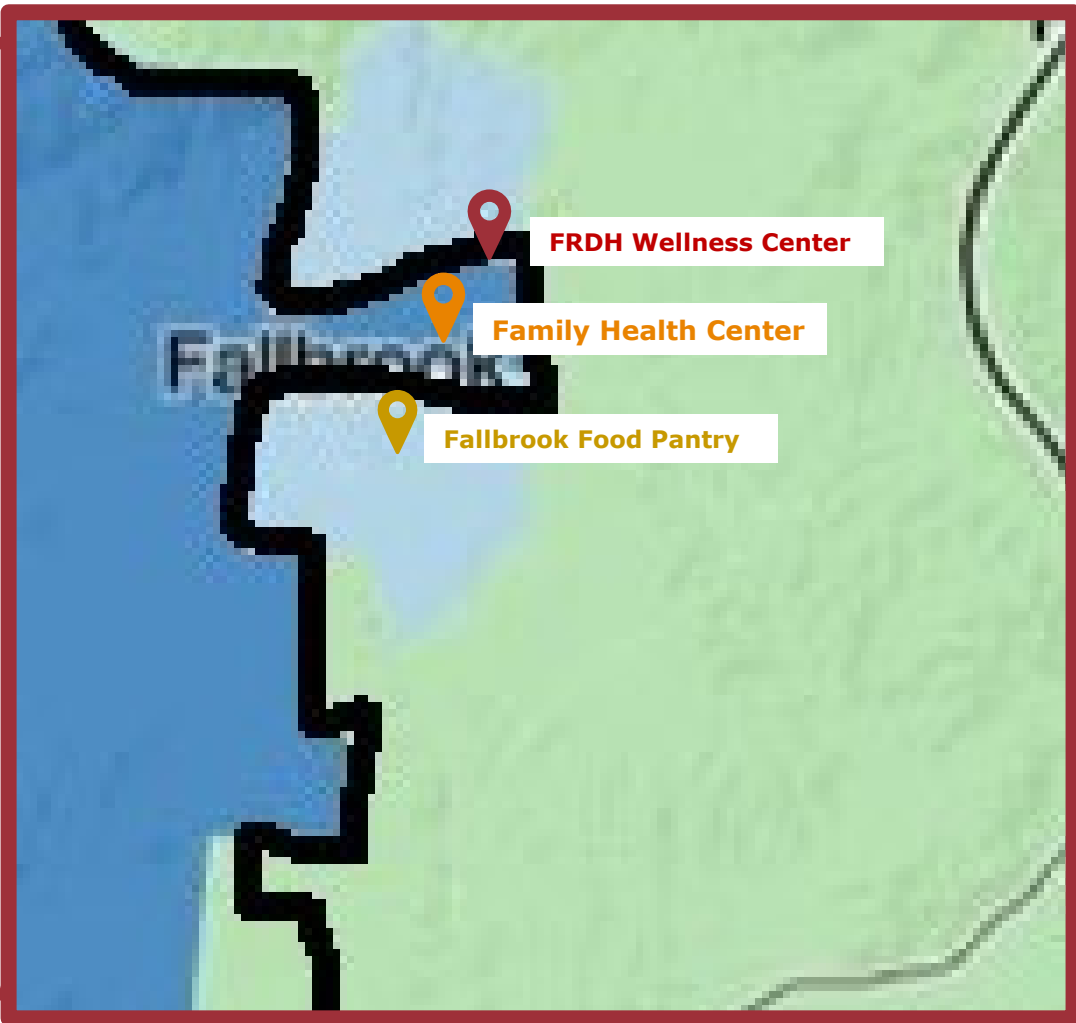
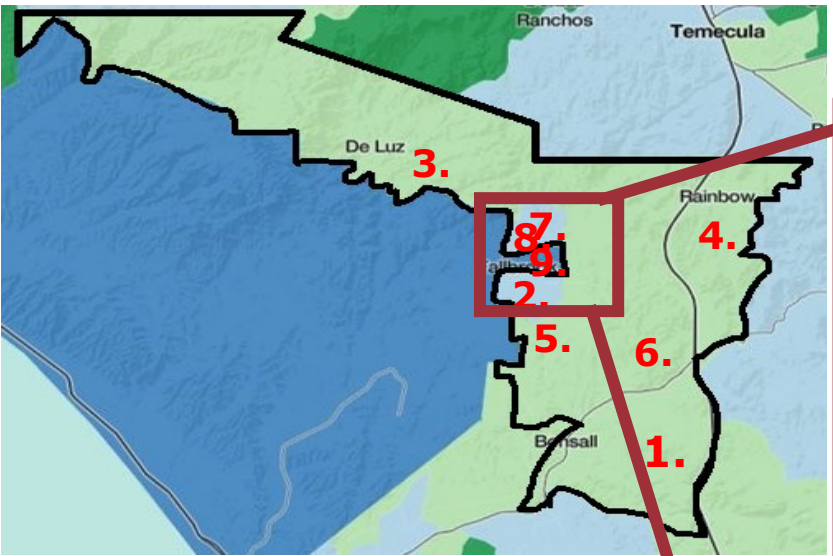


- FRHD Zip Codes**
- 92003
  - 92028
- FRHD Census Tracts**
- 1. 6073018803
  - 2. 6073018906
  - 3. 6073019001
  - 4. 6073019002
  - 5. 6073018801
  - 6. 6073018802
  - 7. 6073018903
  - 8. 6073018904
  - 9. 6073018905



# FRHD Geographic Area

Zip Codes, Boundaries, Census Tracts, and Key Landmarks



FRHD Zip Codes	
92003	
92028	
FRHD Census Tracts	
1.	6073018803
2.	6073018906 ●
3.	6073019001
4.	6073019002
5.	6073018801
6.	6073018802
7.	6073018903 ●
8.	6073018904 ● ●
9.	6073018905 ●

# Healthy Places Index (HPI) Measure

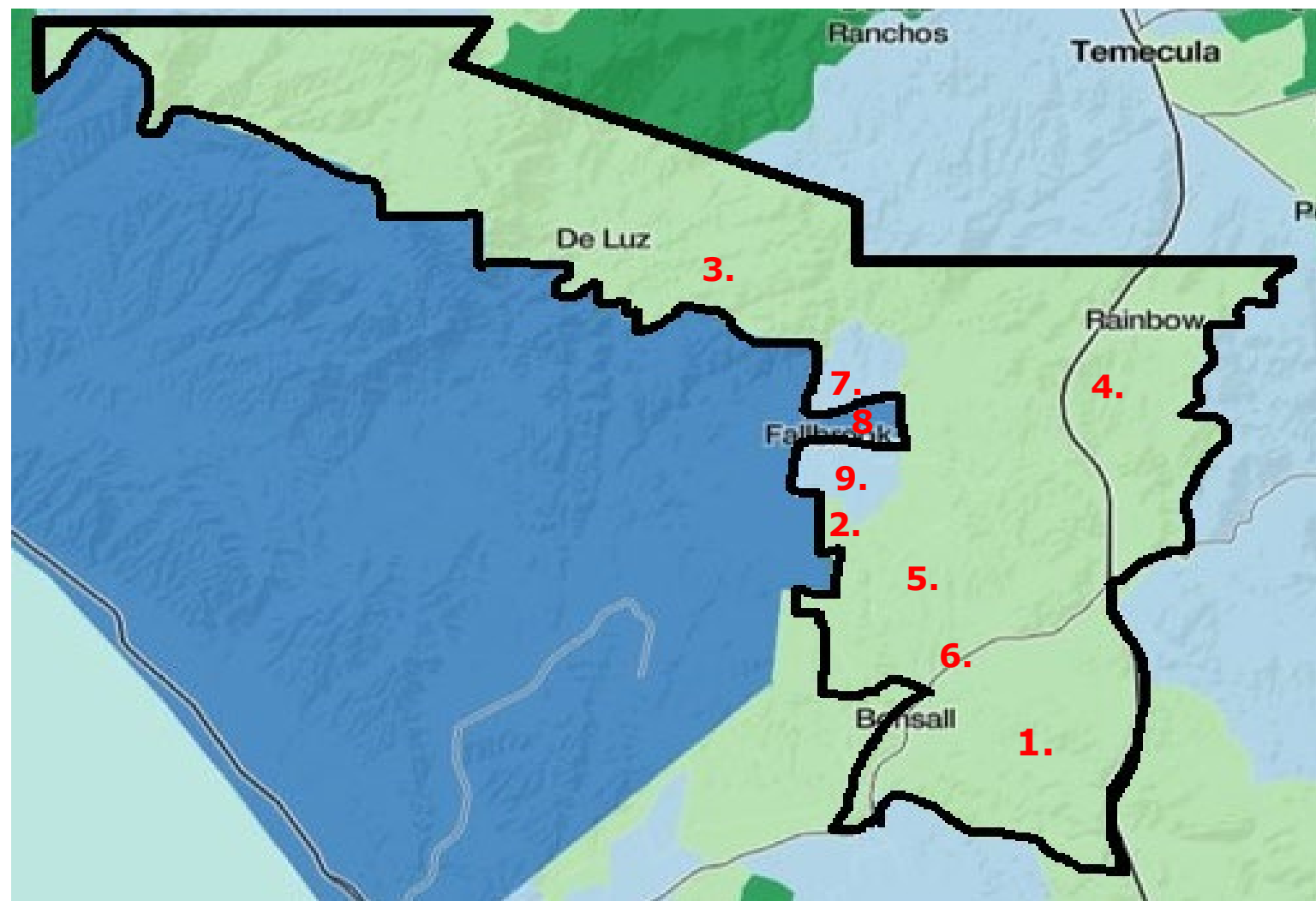


- Database and comparative tool developed by the Public Health Institute's Public Health Alliance of Southern California
- HPI is used to identify the cumulative impact of community conditions at the census tract level as well as other pre-determined boundaries
- Provides both actual and percentile ranking for each of the 8 social determinants of health (SDOH) for the geography selected
- Each SDOH category percentile ranking is based on 2-3 drivers



# FRHD Community

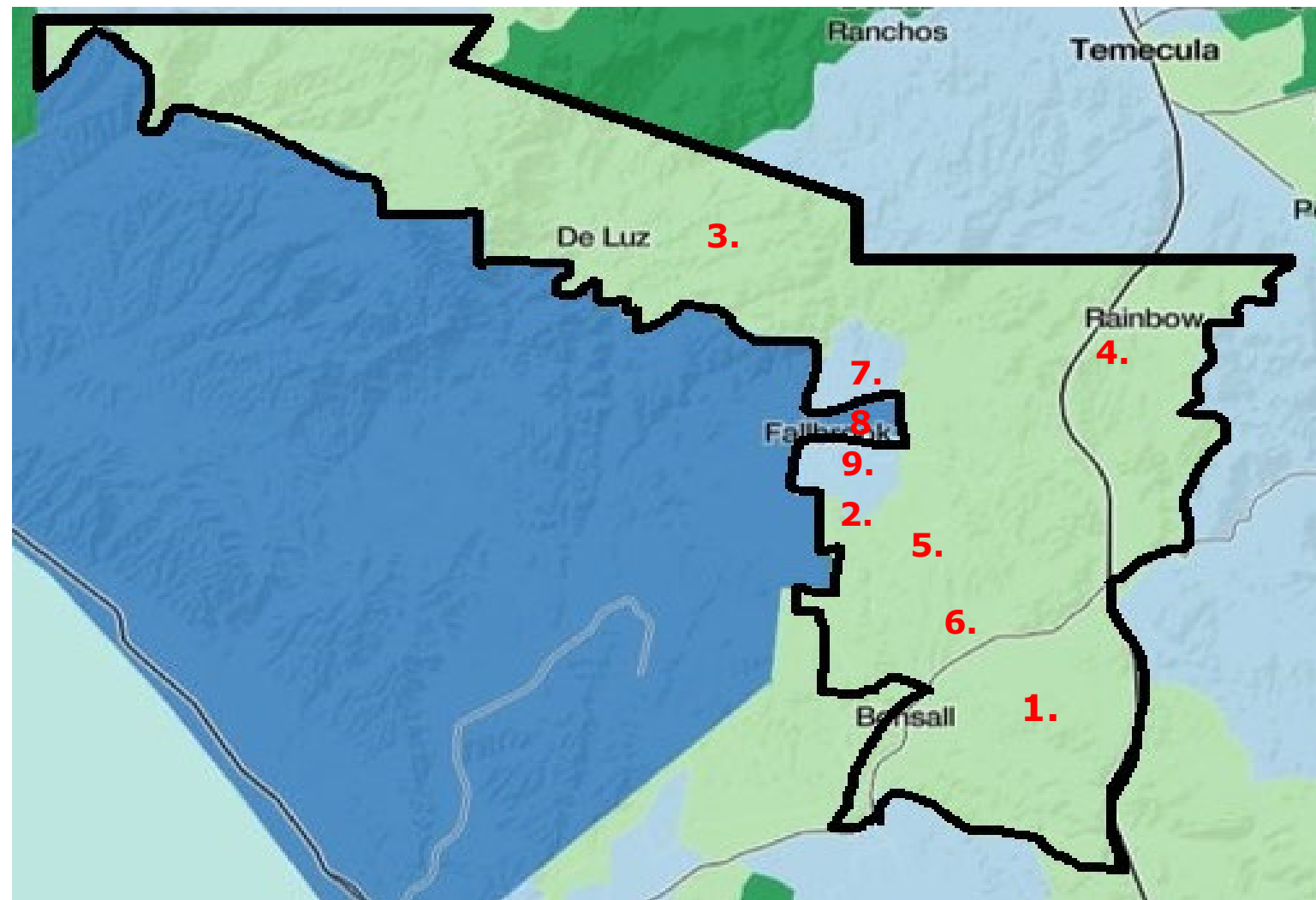
## Overall California Healthy Places Index Percentiles



FRHD Census Tracts Percentiles	
1.	6073018803 - 71.3
2.	6073018906 - 37.7
3.	6073019001 - 52.3
4.	6073019002 - 52.0
5.	6073018801 - 70.4
6.	6073018802 - 52.3
7.	6073018903 - 26.0
8.	6073018904 - 18.2
9.	6073018905 - 29.8

# FHRD Community

## Social Determinant of Health – Economic Position\*

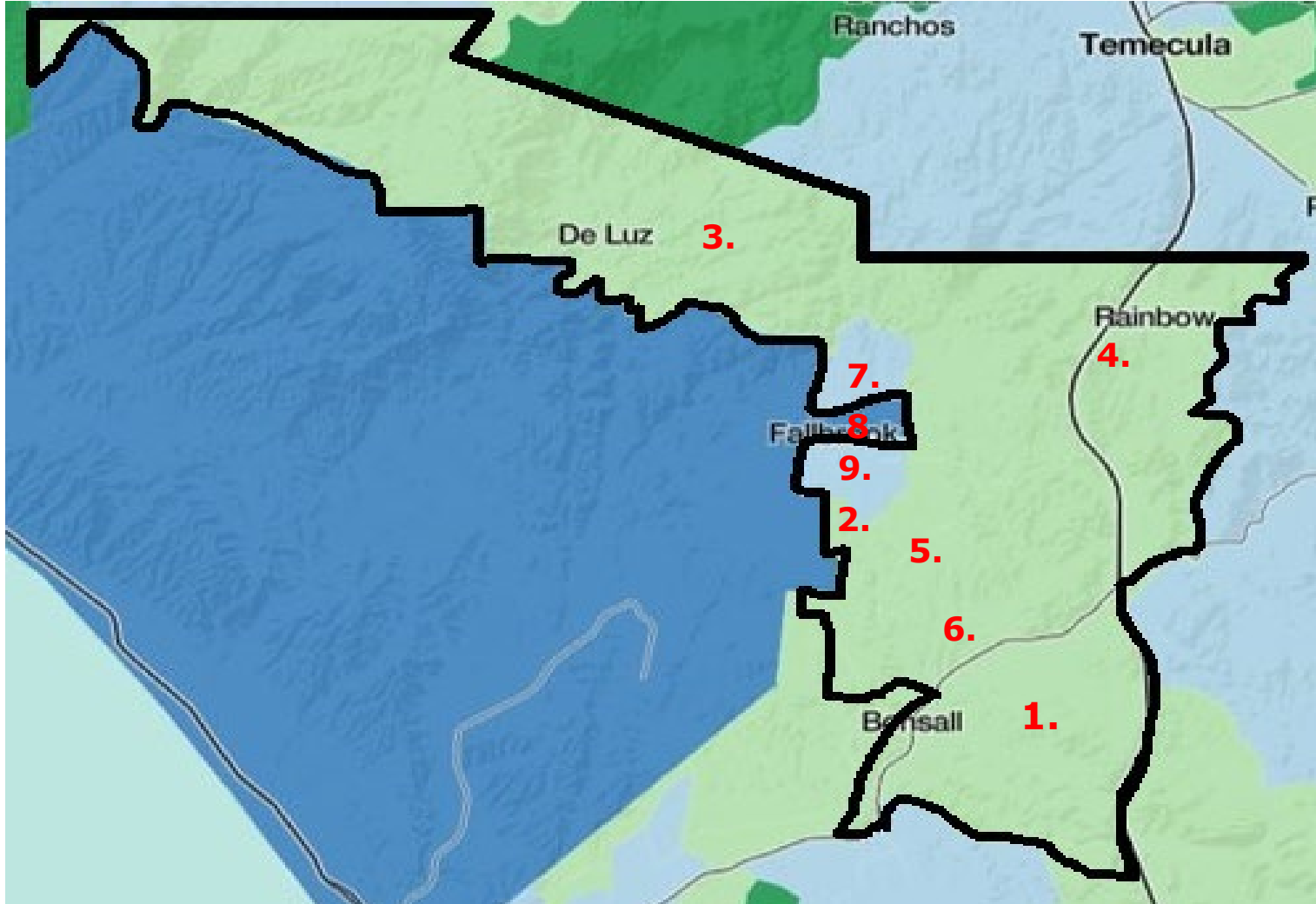


1.	6073018803	–	64.0
2.	6073018906	–	24.0
3.	6073019001	–	56.5
4.	6073019002	–	46.7
5.	6073018801	–	53.1
6.	6073018802	–	47.7
7.	6073018903	–	22.8
8.	6073018904	–	22.6
9.	6073018905	–	20.8

\*This tract is compared to other California census tracts using 3 Social Determinants of Health Indicators: Poverty, Employment, and Median Household Income.

# FHRD Community

## Social Determinant of Health – Percentile Above Poverty\*



### FHRD Poverty Percentile Indicator by Census Tract

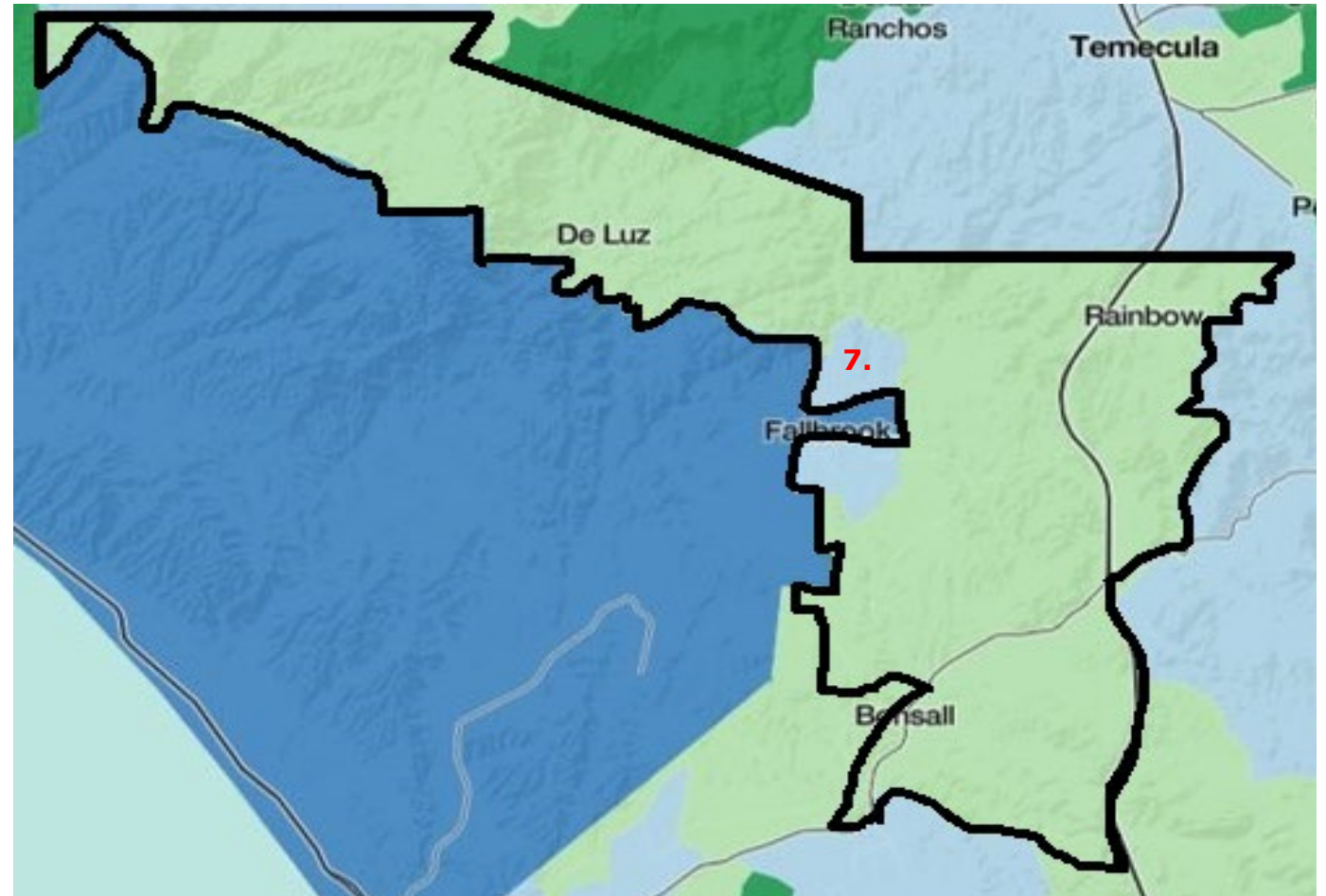
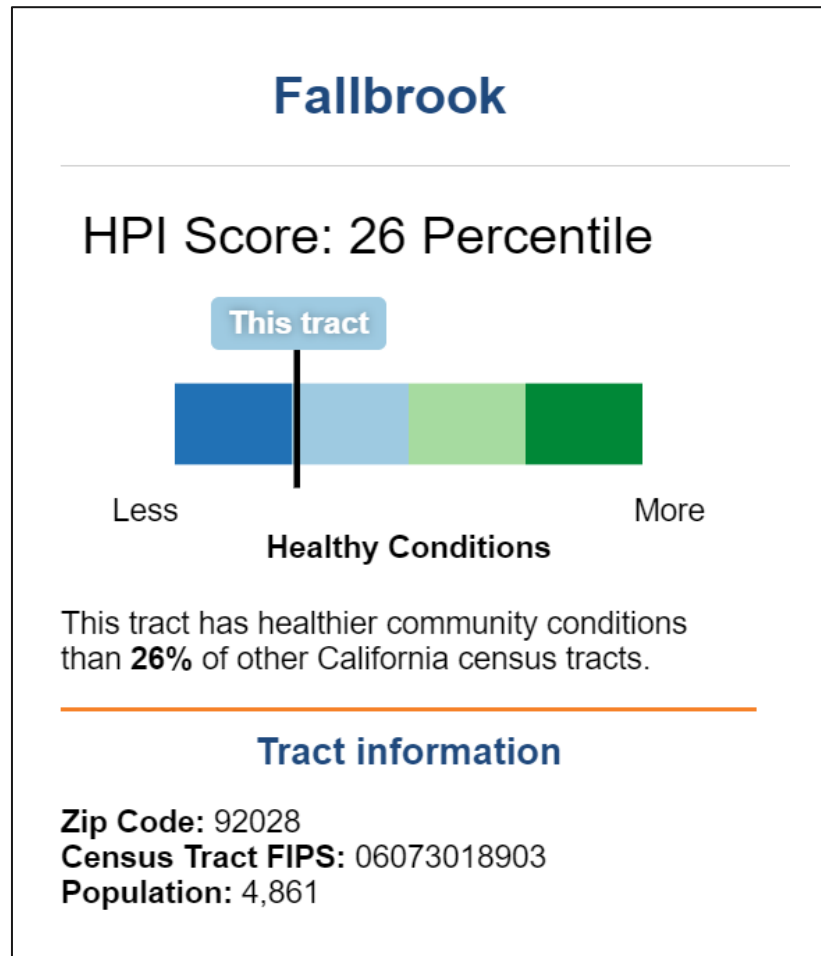
1. 6073018803 – 80.7
2. 6073018906 – 31.9
3. 6073019001 – 53.0
4. 6073019002 – 70.1
5. 6073018801 – 67.3
6. 6073018802 – 72.7
7. 6073018903 – 30.0
8. 6073018904 – 23.9
9. 6073018905 – 25.0

\*Percent of people earning more than 200% of federal poverty level (200% is often used to measure poverty in California due to high costs of living)



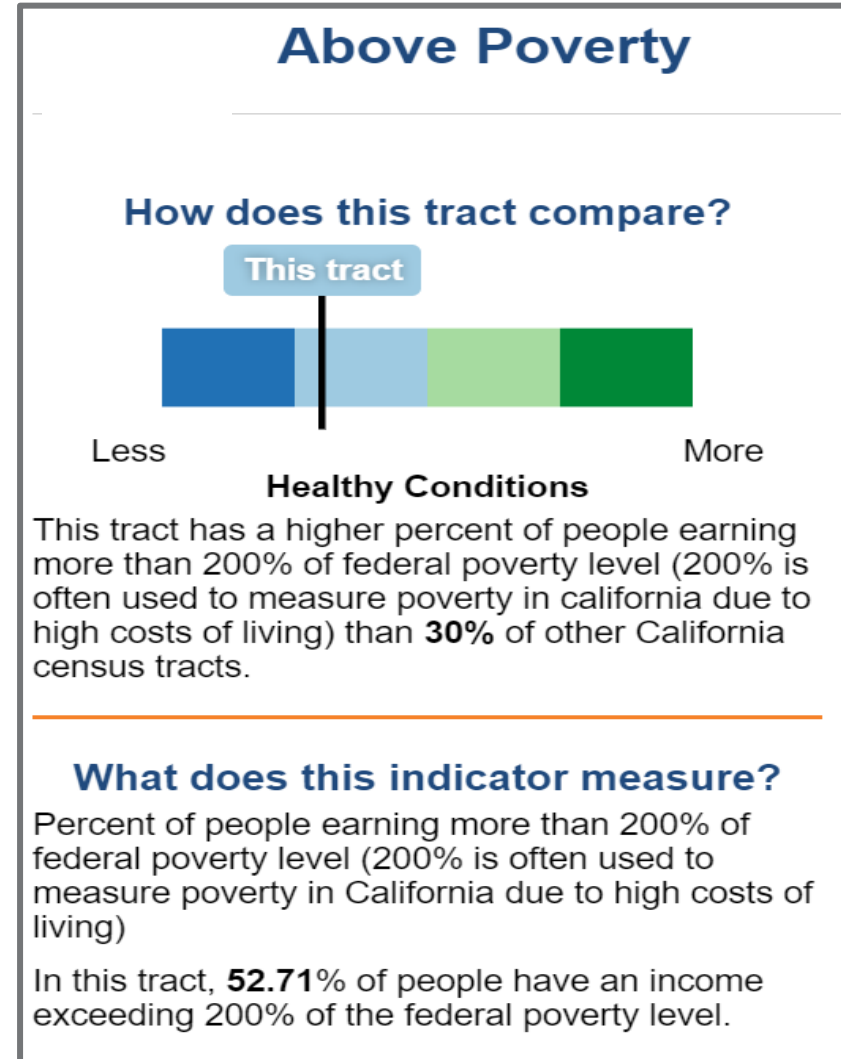
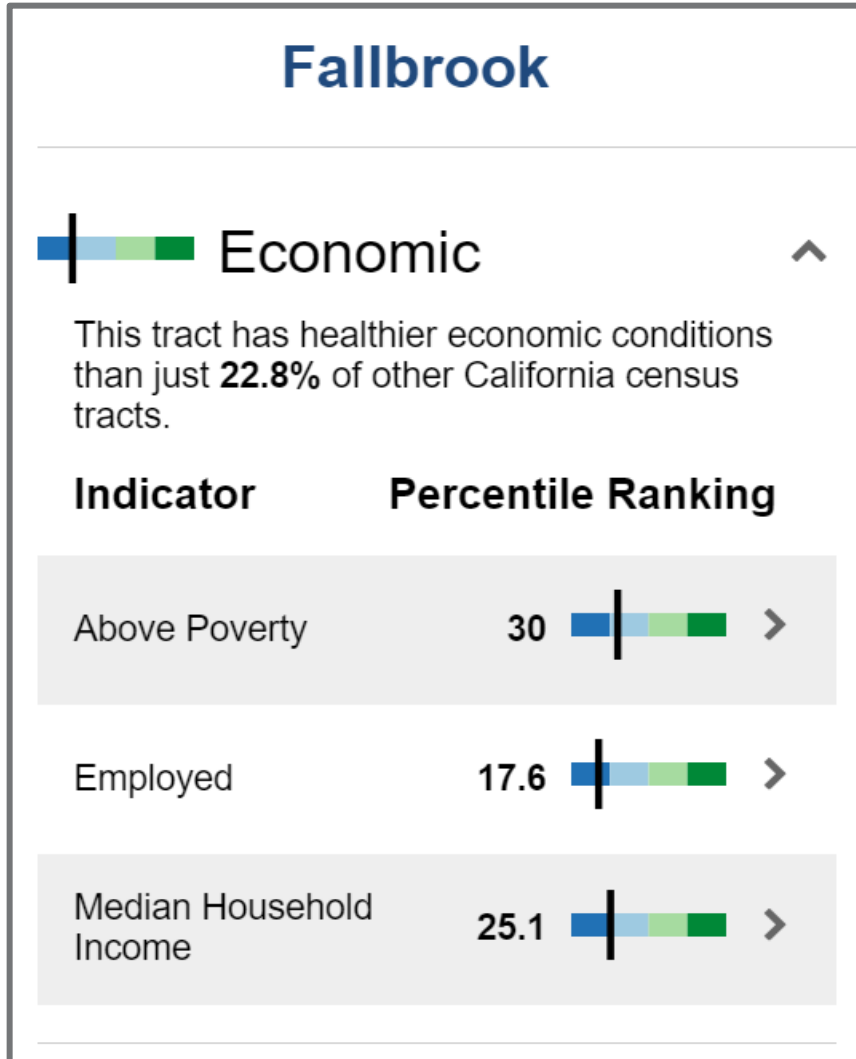
# Fallbrook Census Tract – 6073018903

## Overall Social Determinants Of Health Score



# FRHD Census Tract – 6073018903

## Economic Indicator





# Poverty – Health Connection

## What is the impact and connection of Poverty to health?

Every household should be able to afford the necessities of a healthy life—medical care, healthy food, quality housing, education, and other basics.

Research indicates that economic opportunity is one the most powerful predictors of good health, and that impacts on health are especially pronounced for people in or near poverty.

## Poverty Contributes to Level of Health and Health Screening

Category	Indicator	189.03	Fallbrook	Southern California	Camarillo	National
Medical Care	Cervical Cancer Screening	85.3%	85.3%	84.0%	85.1%	83.2%
	Chronic Obstructive Pulmonary Disease	4.7%	4.7%	5.0%	4.9%	6.4%
	Colon Screening	67.4%	67.5%	62.6%	68.8%	63.7%
	Coronary Heart Disease	4.4%	4.4%	4.7%	4.9%	5.5%
	High Blood Pressure	26.7%	26.5%	26.2%	27.6%	30.8%
	No Health Insurance	13.0%	12.8%	15.8%	13.7%	15.6%
	Obesity	23.0%	23.1%	25.2%	23.1%	31.6%
	Routine Doctors Visits	66.6%	66.6%	65.9%	65.1%	69.0%

# Poverty - Housing and Food Insecurity Connection



High housing costs and housing instability are associated with increased stress and depression, communicable diseases like tuberculosis, and decreased children’s wellbeing and educational outcomes.

Category	Indicator	189.03	Fallbrook	Southern California	Camarillo	National
Housing	Average Rent	\$ 2,604	\$ 1,990		\$ 2,275	\$ 678
	Homeowners	46.8%	65.4%	55.4%	70.5%	70.8%
	Renters	53.2%	34.2%	44.6%	29.5%	26.7%
	Housing Cost Burden	20.5%	20.5%	21.6%	18.5%	11.3%

Everyone should have access to healthy food options in their community. Having access to a nearby supermarket can encourage a better diet and eating behaviors, lower the costs of obtaining food, reduce chronic diseases, and lower the risk of food insecurity.



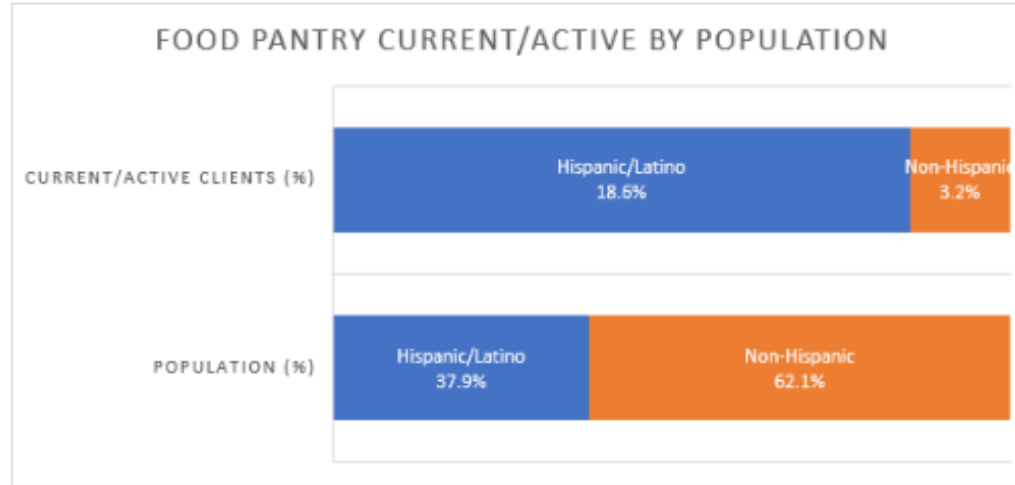
Category	Indicator	189.03	Fallbrook	Southern California	Camarillo	National
Healthy Food	Food Insecurity	11.0%	10.9%	11.1%	7.6%	13.2%
	Limited Access to Healthy Foods	3.1%	3.2%	3.5%	3.3%	7.1%



# CBO Data Snapshot

## Food Pantry

2019 Total Population (Zip Code: 92003, 92028)	55,299	Current/Active Monthly Food Pantry Clients	5,017	Population Served by Food Pantry	9.1%	Average Household Served By Food Pantry	3.3
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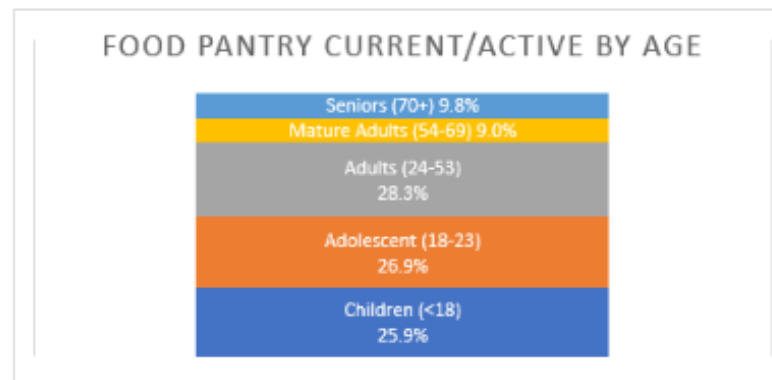
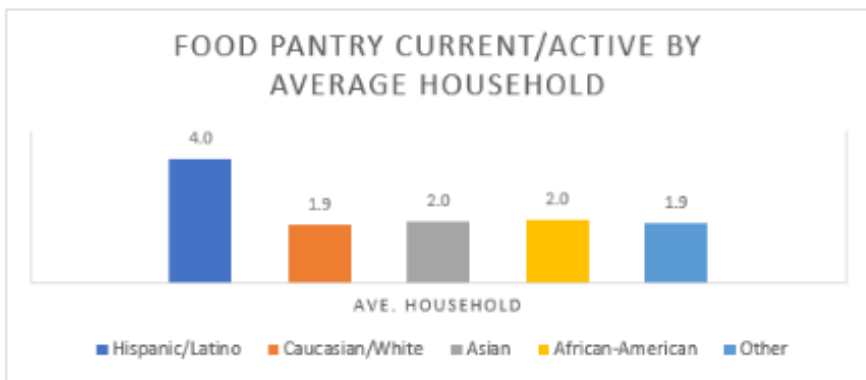


Homeless Served by Food Pantry	104
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Veterans Served by Food Pantry	106
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Disabled Served by Food Pantry	234
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Seniors Served by Food Pantry	498
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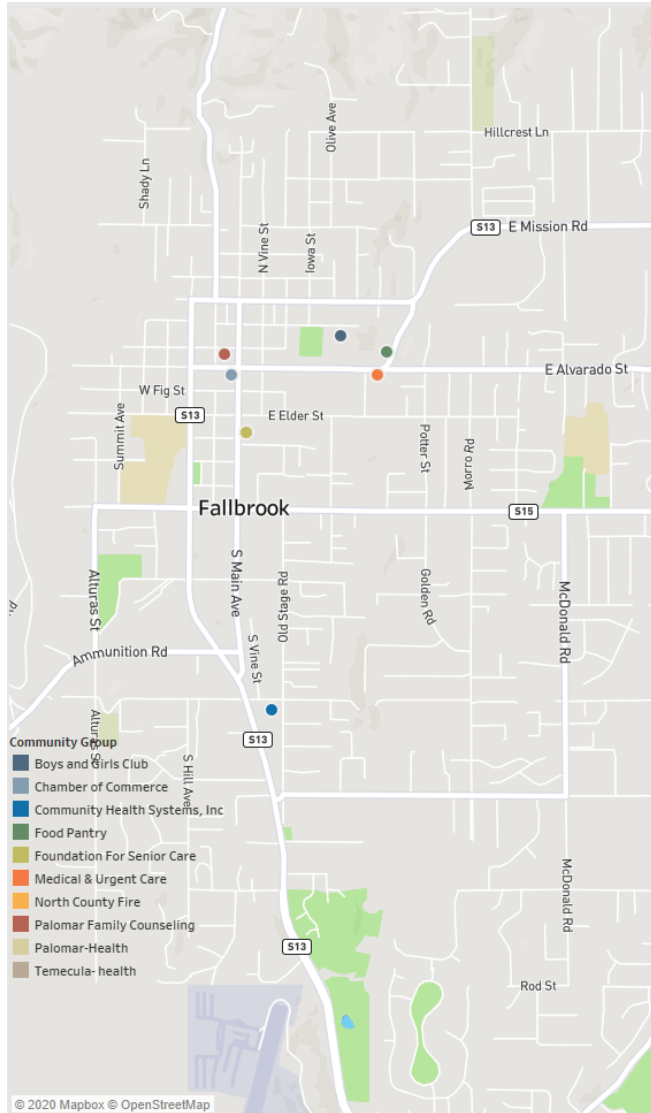


100% of Seniors Served by the Food Pantry are on fixed income (Social Security Insurance)

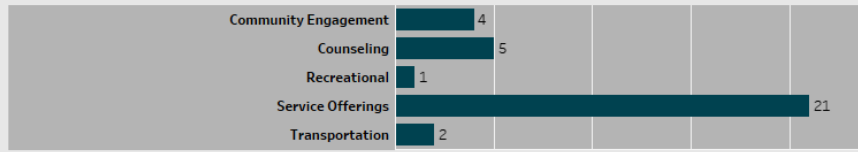


# Current Services in Fallbrook

Qualitative Data 20



- (All)
- Boys and Girls Club
- Chamber of Commerce
- Community Health Systems, Inc
- Food Pantry
- Foundation For Senior Care
- Medical & Urgent Care
- North County Fire
- Palomar Family Counseling
- Palomar-Health
- Temecula-health



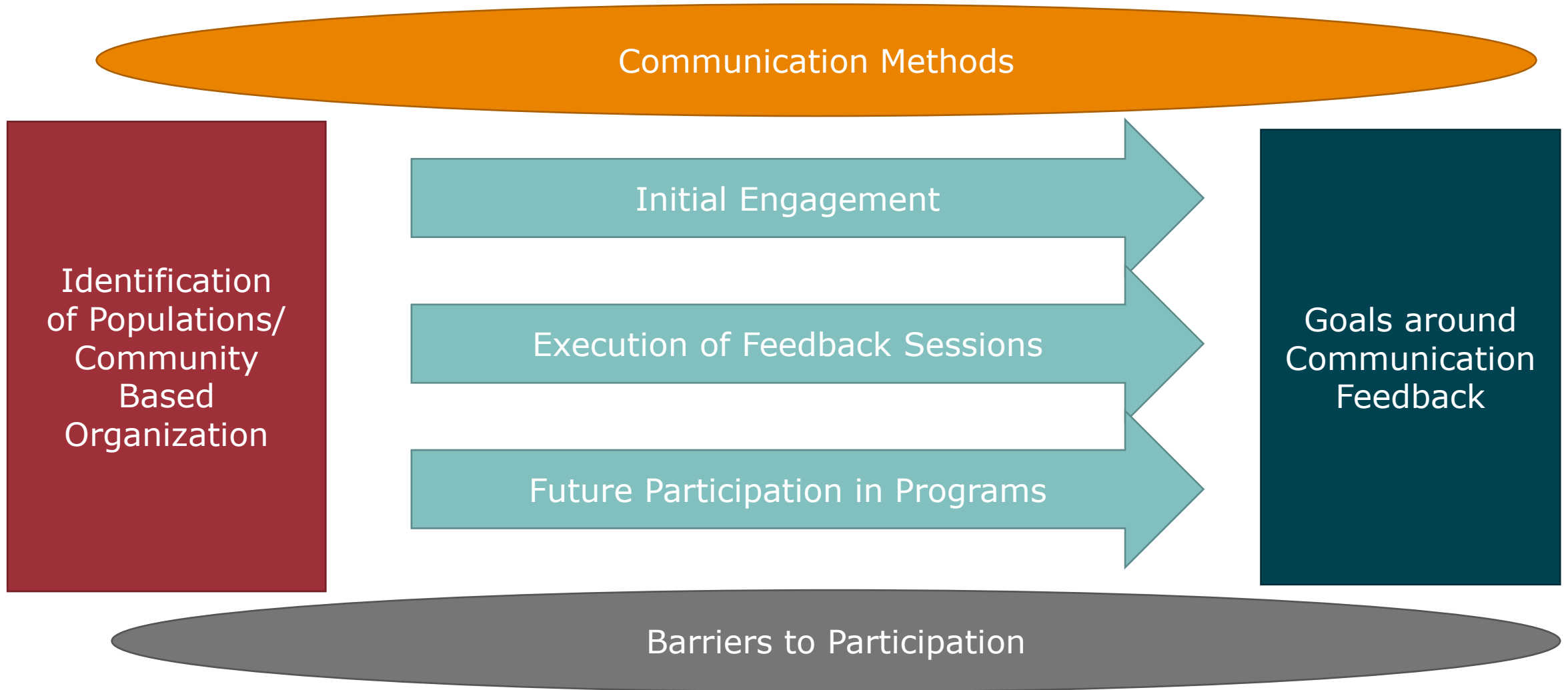
Service Description	Cost	Language
Senior Care Advocacy	Free	Not Mentioned
Adopt-A-Family	Null	Not Mentioned
Backpack Program	Null	Not Mentioned
Behavioral Health-Psychiatric Services and Counseling	Null	Not Mentioned
Car Van Transportation	Null	Not Mentioned
Character and Leadership Development- Public Speaking, spiritual values, academic performance	30 Monthly	En
Community events	100-285 annually	Not Mentioned
Community food Drives	Null	Not Mentioned
Comprehensive Perinatal Services Program	Null	Not Mentioned
Computer Learning Center	Free	Not Mentioned
Cooking Matters	Null	Not Mentioned
Counseling for Children, Youth, Adults and Families - Clinical therapy and family, couple support	Null	En and Sp
Dental, Vision and Chiropractic Care	Null	Not Mentioned
Education and Career Development-Computer Lab	30	En
Emergency Food Assistance Program	Null	Not Mentioned
EMT and Paramedic	Null	Not Mentioned

## Gap Analysis\*

- No special program for veterans
- Need more recreation and educational programs for families/youth
- More robust transportation system

\*Not Comprehensive

# Communication Plan = Community Engagement Strategy



# Community Engagement Strategy Criteria

Combined data sources will inform the community engagement strategy.

Identification  
of Populations/  
Community  
Based  
Organization

1. Data Sources:
  1. Population Data
  2. CBO Data
  3. Interview/Qualitative Data
2. Consider the short and long-term community impact on the Social Determinants of Health.
3. Projected growth in population and Social Determinants of Health on the District.
4. Consider how the indicators relate to the goals and strategy of Fallbrook District.
5. Consider depth and breadth of current community to determine if Fallbrook would benefit from enhancing or aligning.
6. Extent to which populations have already been engaged.



# Next Steps

- Complete intra- and inter-census tract analysis of the social determinants of health data to inform conversations with the communities
- Develop and execute the community engagement strategy for the feedback sessions
  - Use data analytics to validate communities/populations to meet with
  - Identify the best way to reach out to the specific groups and how we will incentivize their participation
  - Develop and implement the community feedback tool or process



Questions?





# Federal Poverty Income Rate

Federal Poverty Income Rate		
Number in Household	100%	200%
1	\$12,760.00	\$25,520.00
2	\$17,240.00	\$34,480.00
3	\$21,720.00	\$43,440.00
4	\$26,200.00	\$52,400.00
5	\$30,680.00	\$61,360.00
6	\$35,160.00	\$70,320.00
7	\$39,640.00	\$79,280.00
8	\$44,120.00	\$88,240.00

- Based on 2020 rates
- Contiguous 48 States
- Over 8 in a household add \$4,480 for each additional person.

