WePLAN 2020
Force of Change Assessment

Cook County Dept. of Public Health

Promoting health. Preventing disease. *Protecting you.*

October 23, 2015

Forces of Change Assessment Committee:

James E. Bloyd, MPH (Chair)
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Femi Jegede, MPH, CIC
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Background

The purpose of this assessment was to tackle health inequities and optimize health by completing one of four assessments required by the health planning process used by the Cook County Department of Public Health (CCDPH). The process is Mobilizing for Action through Planning and Partnerships (MAPP) (National Association of County and City Health Officials 2013). MAPP is widely used by US public health departments. Focus groups were conducted to assess the larger social forces that drive the conditions of daily living for residents of Cook County (National Association of County and City Health Officials 2014). Focus groups are carefully planned interviews in a group setting. Focus groups are not intended to solve problems, make decisions, or generate consensus, but "to get high quality data in a social context where people can consider their own views in the context of the views of others" (Patton 2002).

The Forces of Change Assessment (FOCA) Committee consists of seven experienced CCDPH staff members from multiple disciplines within public health. The Committee planned and carried out the assessment informed by the CCDPH Mission and Vision which reads in part that "health depends causally on its environmental, economic, technological, informational, cultural, and political contexts" (Cook County Department of Public Health 2011).

Forces of Change Assessment (FOCA) Committee members with their areas of expertise are:

- James E. Bloyd, MPH, Regional Health Officer (FOCA Committee Chair): social determinants of health inequity; school health; workforce development; health equity and policy.
- Kenneth Campbell, MPH, MBA, MA, Systems Operations Analyst: Public health administration.
- Claudius Isfan, MPH, Public Health Educator: Community Health; Tobacco Prevention; Policy, Systems, and Environmental Change.
- Femi Jegede, Communicable Disease: Communicable Disease Surveillance.
- LaTrice Porter-Thomas, MPH, LEHP, Sanitarian V: Environmental Health.
- Rachel Rubin, MD, MPH, F.A.C.P., Senior Public Health Medical Officer: Environmental Health, Communicable Disease Prevention, Public Health Administration, Occupational Safety & Health, Clinical health care, Quality Improvement.
- Keith Winn, MPH, Public Health Educator: Community Health; School Health; Violence Prevention.

The tasks of the FOCA Committee were to:

a. Interpret the MAPP guidelines for conducting the FOCA;
b. Elaborate a feasible process to implement the FOCA given the timeline, resources, and data needed;
c. Participate in a training on April 23rd to increase skills and capacity to conduct a focus group;
d. Study and apply the Healthy People 2020 social determinants of health conceptual framework;
e. Identify and recruit potential participants;
f. Identify and reserve suitable focus group sites;
g. Create, assemble and provide background materials to focus group participants;
h. Develop and practice using an interview guide;
i. Carry out focus groups;
j. Analyze data;
k. Report findings;
l. Disseminate findings;
m. Collaborate with three other MAPP assessment Committees.

The Committee's work is also informed by the values of public health. Health is a human right, and "humans have a right to the resources necessary for health," according to the Principles of the Ethical Practice of Public Health. Achieving health equity is also rooted in social justice. This assessment aligns with The Public Health Leadership Society's statement that addressing fundamental and systemic causes of health "is more truly preventive" (Public Health Leadership Society 2002). Public health has been influenced by the analysis and evidence of the 2008 Final Report of the Commission on the Social Determinants of Health of the World Health Organization. For example, Howard Koh, principle author of *Healthy People: A 2020 Vision for the Social Determinants of Health* and former Assistant Secretary for Health for the US Department of Health and Human Services, observes that "Using a social determinants approach can reframe the way the public, policy makers, and the private sector think about achieving and sustaining health (Figure 1) (Koh et.al. 2011). Applying a social determinants approach to planning is a public health leadership competency (Begun & Malcolm 2014).

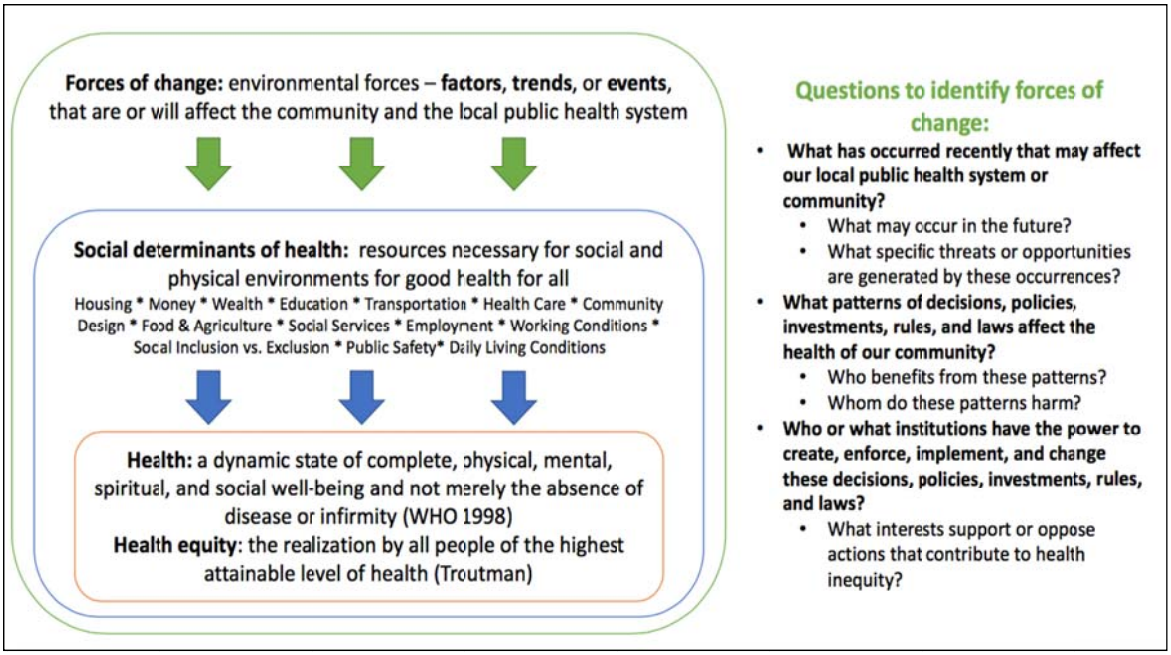

Figure 1. Forces of Change Assessment Health Equity Framework and Questions

Focus groups were used first in marketing in the 1950's, and later in the social sciences. This method of gathering data is different from conducting a survey from a statistically representative or 'random' sample. The goal of our sampling was to gain insight about Forces of Change from 'information rich' participants, not to make generalizable statements from the sample to a population (Patton 2002). Analysis of the data was carried out by the FOCA Committee. This summary attempts to make explicit the values, conceptual framework, and procedures employed in this assessment, in addition to reporting on its findings.

Identification of participants was based on several criteria. Purposeful sampling (Patton 2002) was used to invite participants, based on the potential of a focus group participant to provide useful information on resources necessary for health (Figures 2 and 3). Participants fit criteria for eligibility if they had significant knowledge based on their working experience in the areas of housing, income, education, transportation, health care, community design, food, social services, work and employment, social inclusion, public safety, and daily living conditions (Figure 1). These resources are the social determinants of health. Concepts and the underlying rationale are described in depth in two documents that provided the foundation for the assessment: Those documents are "Healthy People: A 2020 Vision For the Social Determinants Approach" (Koh, et al 2011) and the World Health Organization's social determinants of health conceptual framework (Solar & Irwin 2010).

Figure 2. Focus group participants represented leadership from a broad range of organizations and with several areas of expertise.

Participant Organization or Description	Participant Title
Advocate Health Care	Director Physician Network
Agency for Toxic Substances & Disease Registry USDHHS	Medical Officer
AIDS Foundation of Chicago; Black Youth Project 100	Community Organizer
Backbones	Executive Director
Chicago Southland Chamber of Commerce (2 Participants)	Physician Network Development (1) Board Member (2)
City of Harvey	Director, New Initiatives & Green Projects
Food Chain Workers Alliance	Co-Director
Grand Prairie Services	Chief Executive Officer
Greater Chicago Food Depository	Research & Evaluation Manager
Greater IL Chapter-National Multiple Sclerosis Society; DePaul University	Member; Student
Health & Medicine Policy Research Group	Policy Analyst
Illinois African-American Family Commission	Director of Operations
Illinois Caucus for Adolescent Health	Education Coordinator
Illinois Coalition for Immigrant & Refugee Rights	Health Policy Director
Illinois Self Advocacy Alliance	Community Organizer
Kenneth Young Center	Project Coordinator
Loyola Stritch School of Medicine	Director Community University Partnerships
Member of the Public	
Metropolitan Tenants Organization	Director
Northwest Compass	Program Director
Prevention Partnership	President/ CEO
Respond Now	Director
Restaurant Opportunities Center-United	Coordinator, Business Services & Training
Safer Foundation	Chief Operating Officer
SEIU Health Care Illinois	Health Systems Field Director
South Suburban College	Dean, Allied Health
US Environmental Protection Agency	Environmental Engineer

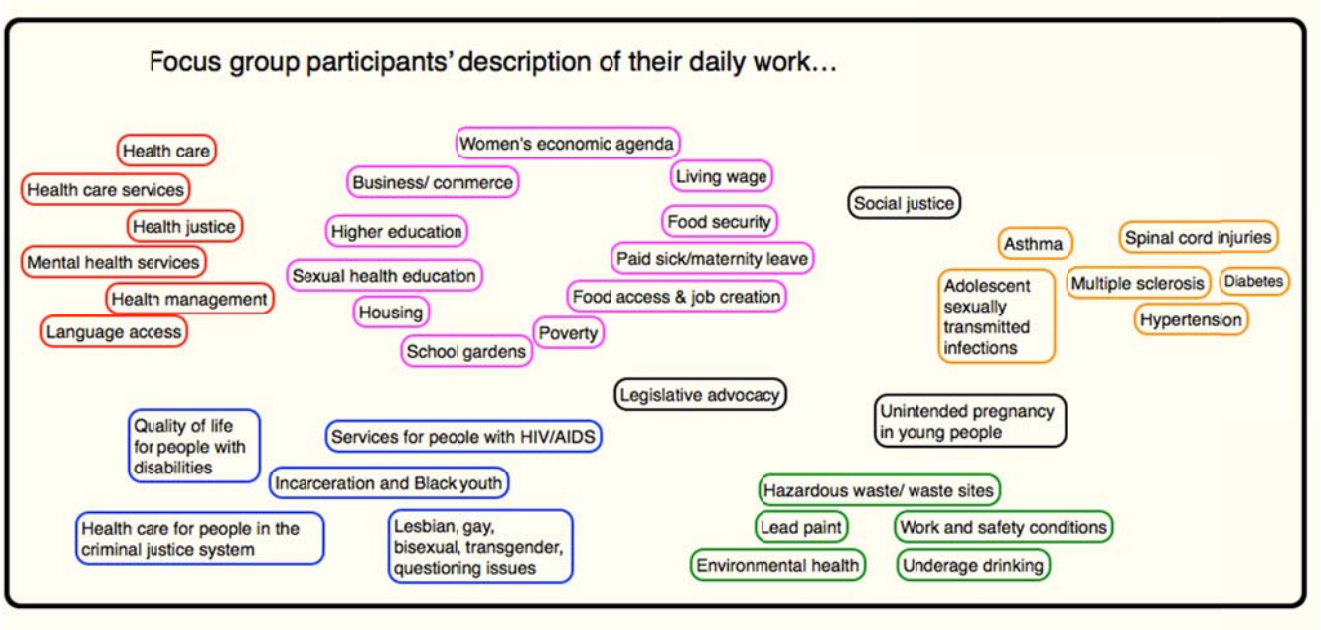

Figure 2. Focus group participants' work experience provided a rich source of information.

A partnership or collaboration with CCDPH was an additional criterion that guided inclusion in focus groups. Members of the CCDPH FOCA Committee developed a list of potential participants. Participation was limited by participants' availability for one of four scheduled dates and by the ability to travel to the focus group site.

Preparation

Focus groups were carefully planned. FOCA Committee members were guided by technical assistance from staff from the National Association of County and City Health Officials (NACCHO) and the University of Illinois, School of Public Health (UIC). Dr. Joseph Zanoni, PhD, a UIC professor provided training on focus group moderation skills, post-focus group reflection and debriefing, and suggestions on data organization and analysis. Tiffany Huang, MPH, MAPP Trainer, at NACCHO collaborated with the FOCA Coordinator in the development of the Equity Framework and focus group questions. Focus group participants were invited by email and telephone. They were emailed background materials explaining the purpose and background of the assessment. Sites were selected from across Cook County that were available free of charge, that we're accessible, and that could provide a comfortable and non-threatening environment (Figure 4). Participants were provided guidelines encouraging them to listen and interact with each other, and encouraged to express different opinions and points of view given that the purpose was not to develop a consensus, but to develop a range of opinions. Soft drinks and snacks were made available to participants. Key fobs were offered to some participants as a thank you. No incentives were provided.

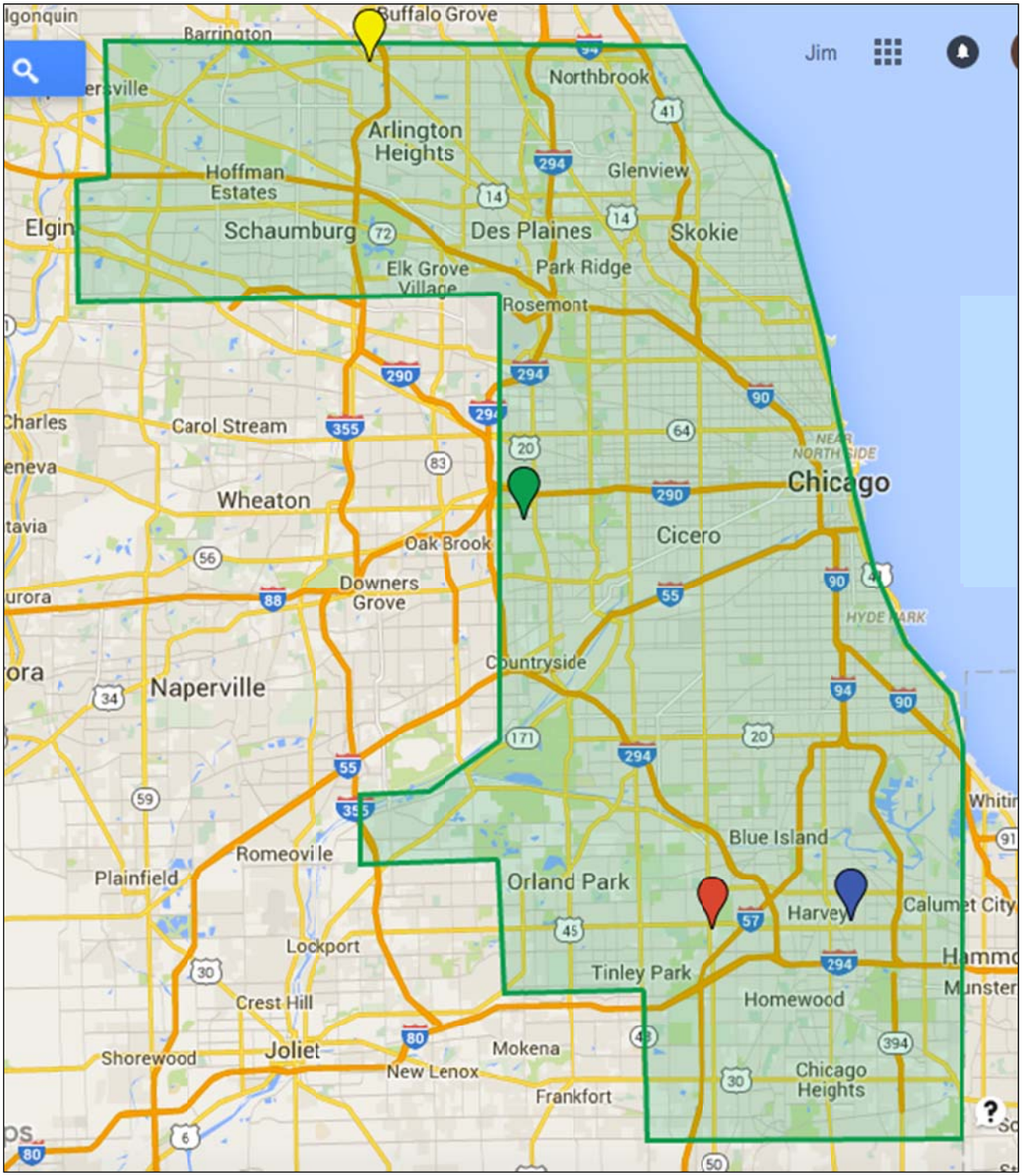

Figure 4. Focus groups were conducted in South Holland (South Suburban College, June 29th) , Westchester (Public Library, June 30th), Oak Forest (Cook County Department of Public Health, July 1st) , and Palatine (Vista Health Center, July 13).

Data Collection

Each focus group was staffed by a moderator and a note taker. These roles were rotated among the CCDPH FOCA Committee members. Focus groups were audio recorded. Recordings were transcribed to text by the assessment Coordinator, James E. Bloyd, using Siri voice recognition and Word software. A debriefing was conducted by the University of Illinois advisor after every focus group. Four focus groups were held on June 29, June 30, July 1 and July 13, 2015. Each session lasted about one hour. Twenty-six people participated in total. The number of people in each focus group ranged from 5 to 8. The total number of participants was 26. The group was diverse by race/ethnicity, gender, physical ability, and age.

Data Analysis

Four focus group transcripts were loaded to Atlas.ti Version 1.0.34; The FOCA Coordinator used the three overarching questions to develop preliminary codes. As recommended by the UIC assessment advisor, the transcripts and preliminary coded quotations were distributed to FOCA Committee members to review transcripts and coded sections, and to provide their opinion of the quotation and the preliminary codes. Committee members were encouraged to suggest new interpretations of quotations, and to identify any additional text they thought was significant. To help insure that Committee members were familiar with the meaning of the text, each transcript was assigned for review only to the group that contained a staff person who was a moderator or note taker for that particular focus group. This process enriched and strengthened the interpretation of the qualitative data produced by the focus groups. To further enhance the "trustworthiness" of the analysis, this draft report will be sent to all focus group participants for their reactions and insights (Marshall & Rossman 2011).

Findings

The organization of this summary of findings of the Forces of Change Assessment follows the sequence of the three over arching questions put to the focus group participants:

Question One: What has **occurred** recently that may affect our local public health system or community?

Question Two: What **patterns** of decisions, policies, investments, rules, and laws affect the health of our community?

Question Three: Who or what institutions have the **power** to create, enforce, implement, and change these decisions, policies, investments, ruled, and laws?

While the findings reported in this summary follow this three-question structure, much of the discussion from focus group participants is relevant to more than one. Some of the illustrative quotations in this summary report reflect that overlap.

Question 1: What has occurred recently that may affect our local community or public health system ?

This first overarching question was followed up with two sub questions. The first was about future occurrences. The second asked participants to provide their judgments about the occurrences in terms of "specific threats or opportunities."

Findings: Two significant occurrences that were described by the focus groups are

- The affordable care act
- The lack of a budget for the State of Illinois

Each of these major occurrences was described in terms of related threats and opportunities (Figure 5).

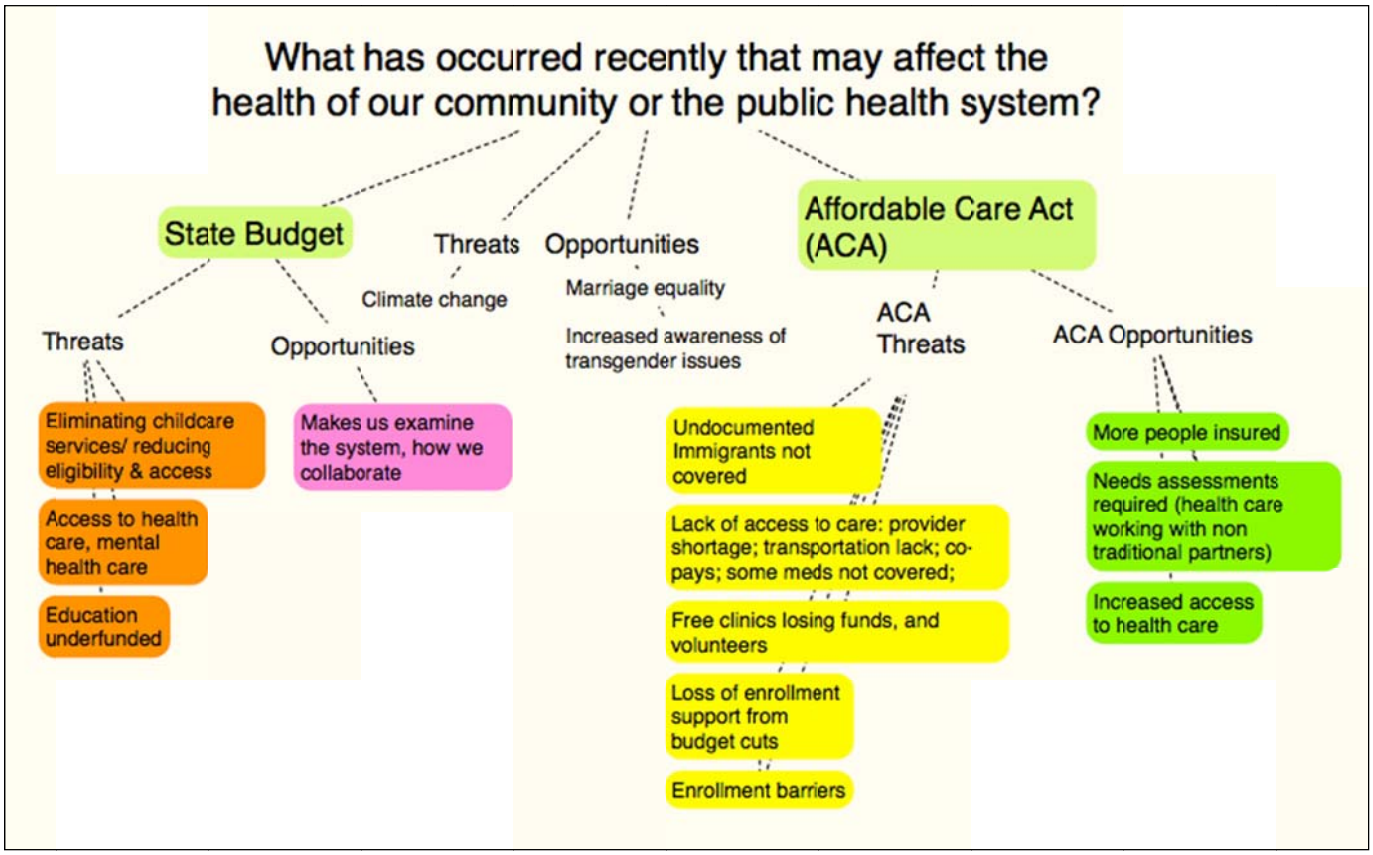

Figure 5. Question 1 Graphic summary of findings.

The Affordable Care Act-Threats:

- Undocumented immigrants not covered
- Shortage of providers
- Transportation barriers to access
- Costs: copayments and uncovered medications

The Affordable Care Act-Opportunities:

- More people have health insurance
- Needs assessment required of providers-expanded partnerships
- Increased access to health care.

Illinois State Budget Impasse-Threats

- Reduced access to child care
- Reduced access to health and mental health care
- Education underfunded

Illinois State Budget Impasse-Opportunity

- Requires us to examine the system and how we collaborate

Threat:

- Climate change

Opportunities:

- Marriage equality
- Increased awareness of issues of people who are trans-gender.

The Affordable Care Act (ACA) was seen as an *opportunity* by providing health insurance to more people, and thereby increasing access to health care. In addition, given the ACA's requirement for health care providers to conduct community health needs assessment, it promotes the new partnerships with hospitals and health care providers.

The ACA comes with a downside: Threats that were named by respondents include the exclusion of undocumented immigrants from benefits of ACA. The enrollment process was seen as too complex,

and is a barrier for people whose speak languages other than English. Families composed of documented and undocumented members—or "mixed-status"—face complexity in the enrollment process. Enrollment support programs are threatened by a lack of funding related to the Illinois budget impasse. Respondents observed that barriers to care exist beyond having health insurance: First, there continues to be a shortage of health care providers. Second, a lack of transportation to distant sources of care is a problem. Third, co-payments are high and some medications are not covered. Finally, some free clinics fear a loss of support due to a perception that ACA has met everyone's need for care.

The lack of a state budget in Illinois was noted principally as a threat. Respondents described funding cuts such that hospitals serving low-income communities might be forced to limit grant funded services and even face closing altogether. Access to mental health and behavioral health services are reduced due to the lack of a Budget. The Budget impasse is a threat to childcare services for working parents because of changed income eligibility guidelines. The budget situation was described as exacerbating, and related to a pattern of growing inequality.

The need by organizations to overcome divisions and collaborate more given the seriousness of the threat posed by the budget crisis was viewed as an opportunity. The budget threat has also forced people to examine the system.

Climate change was also named as a threat:

Quote: "...climate change impacts us. So what happens in the working class suburbs that has historically gotten flooded [...] you know every maybe three, four, five, years they get flooded, and they start getting a flood every year or couple of times a year"

Marriage equality and increased awareness of issues of people who are transgender is an opportunity:

Quote: "...there's marriage equality that will definitely impact our community of course, overall, and then the public health system, and it brings the conversation to the forefront as well as transgender people being in the spotlight through interviews and articles..."

But it was also noted that the benefits people with disabilities depend on are lost when people who are disabled marry. These rules are a threat to marriage equality for people with disabilities:

Quote: "...I think they left out something that not everyone is free to be married without penalties especially the disabled community because once you marry your income level changes, your access, the benefits change, and that screws up a lot of things for people with disabilities. Which is why they don't get married they just are stuck in domestic partnerships and they run into the same problem that the LGBTQ Community has for years, you know, their domestic partner won't have a say in their care or their decision-making."

Question 2: What patterns of decisions, policies, investments, rules, and laws affect the health of our community?

A follow up question asked was, Who benefits from and who is harmed by these patterns?

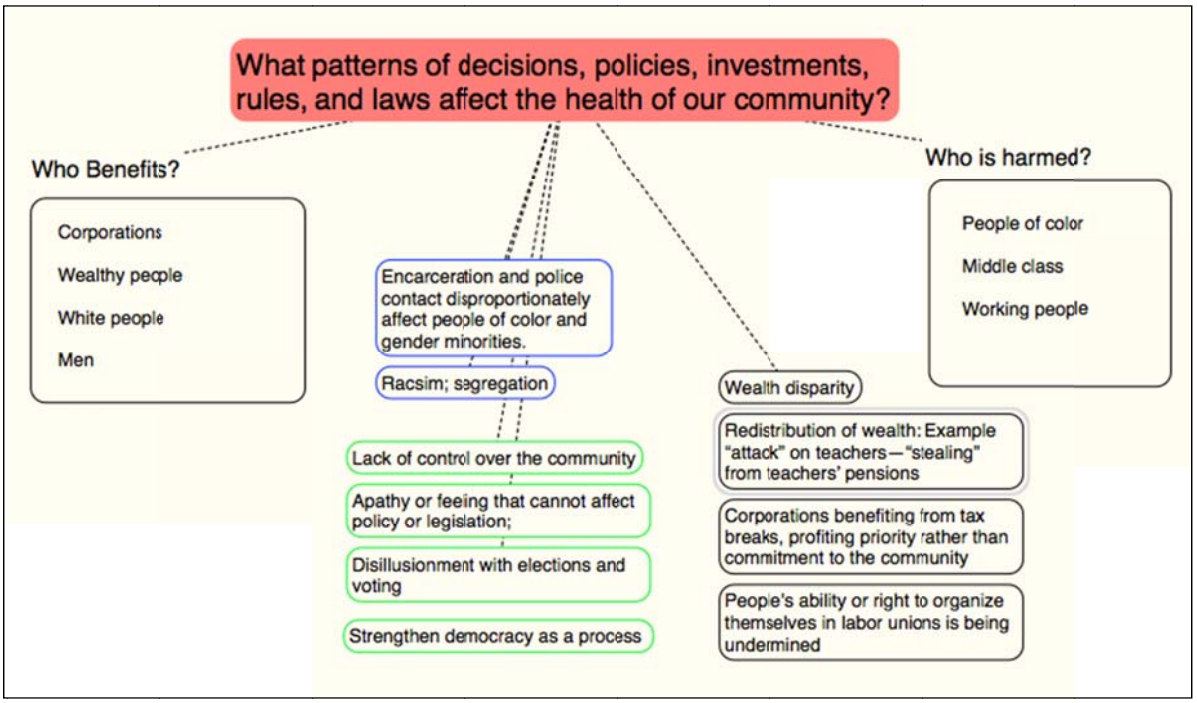

Figure 6. Question 2 Graphic summary of findings.

Several themes emerged from the focus groups' discussion to this second question (Figure 6).

- Disproportionate incarceration and police contact involving people of color
- Racism, residential segregation
- Lack of control over one's community
- Perception of inability to affect policy and legislation
- Disillusionment with elections and voting
- Need to strengthen democracy
- Wealth disparity
- Redistribution of wealth through weakening of pensions
- Lack of fairness in taxation of large corporations
- Undermining of right to organize in the workplace.

Patterns-Who is harmed:

- People of color
- Working and low-income people
- Middle class people

Patterns-Who benefits:

- Large corporations
- Very wealthy people
- Men
- White people

First, respondents expressed concern about increasing wealth and income disparity among the population. Participants discussed simultaneous factors contributing to this pattern. Some current policy proposals would result in reductions of worker's pensions benefits, and limits on or elimination of the right to collective bargaining. At the same time large corporations receive tax breaks:

Quote: "...the individuals just can't pay enough into the system in order to make sure that these services are provided for and so that from our perspective we're talking about the major corporations the one percent, the billionaire, millionaire class who are benefiting from these policies and it is working people who are suffering..."

These large businesses have a weak commitment to locating in low-income neighborhoods where people in need of economic opportunity reside:

Quote: "...this idea that CEOs get it like they understand what they're doing to her community when they leave, I guess my question is do they care? And I don't think that as individuals that they don't care but I think that as a corporation that they are ultimately responsible to shareholders and there responsibility is to make money and that there is no requirement for them to be good stewards to the communities."

Second: There is a lack of ability of people to control their living conditions and circumstances in their community through the political process. This inability is a combination of real and perceived lack of control [quote]. Included in this finding is a concern about disillusionment with elections and voting.

Third: Racism and sexism exists as a pattern at the systematic or structural level of society. Instances of this are seen in incarceration and disproportionate contact with police by people of color.

This pattern is also seen in residential racial segregation in housing, and employment in the restaurant industry.

Quote: "...from listening to everybody, I think that the other thing that's lacking in our policy is really to deal with the issue of race. I think that it's this core problem that nobody really, that we want to think that oh it's been solved but yet you know [...] segregation is still rampant, you know and in fact they have created all these kind of feedback loops that keep segregation in place and intact."

Focus group respondents indicated that large corporations, and wealthy, white males benefit from these patterns. Harmed by these patterns are people of color and low income and middle income people.

Quote: "...we have people that do have living wage positions but they're highly segregated often only occupied by white man and so it's this kind of issue like racial and gender dynamics and who gets the opportunities and who doesn't but even if we address it there's still not enough of those living wage positions to balance out to make it equitable..."

Regarding democracy, "...to me we should go back to basics. There are two areas I would be concerned about. One is sort of democracy, what kind of basic democracy do we have in our communities? Not just every four years, where if you're inspired you might vote, but all the decisions that get made in after that."

Focus group respondents indicated that large corporations benefit from these patterns. Harmed by these patterns are people of color and low income and middle-income people.

Question Three: Who or what institutions have the power to create, enforce, implement, and change these decisions, policies, investments, rules, and laws? The follow up question is what interests support or oppose actions that contribute to health inequity?

Discussion of this third question produced a complex and interrelated set of findings (Figure 7).

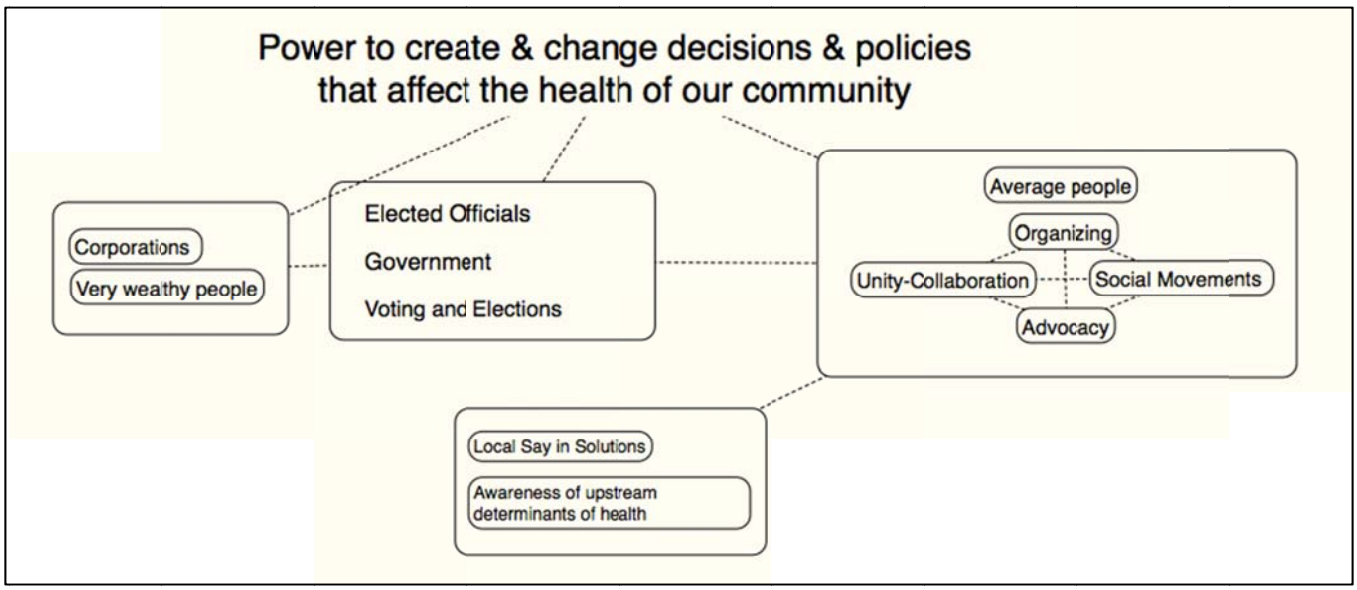

Figure 7. Question 2 Graphic summary of findings.

Individuals & institutions have the power to create, enforce, implement, and change decisions, policies, investments, rules, and laws that affect the health of our community:

- Corporations
- Very wealthy people
- Elected officials
- Government
- Average people

Related themes:

- Most people are not aware of the importance of upstream determinants, or 'non-health' factors
- Solutions should be proposed or rooted locally
- Elected officials and government more influenced by large corporations and very wealthy people
- Average people have less influence

- Voting and elections are important, but disillusionment exists
- Average people have power, but need support through
    - Organizing
    - Social Movements
    - Advocacy
    - Unity and collaboration

First, large corporations and the wealthy have disproportionate power to create, enforce, implement, and change decisions, policies, investments rules and laws, primarily through their influence over politicians.

Quote: "...people who have the money have the power at the moment but it has not always been that way."

Second, elected officials and government were named as have power in this area. Politicians were described as too often disconnected from the day-to-day lives of their constituents, and unaware of the scarcity of resources facing the people they represent.

"...social workers should be politicians and politicians should spend some time as social workers and then they'd understand."

Quote: "...they were just like 'Wow I've never met anybody on food stamps' and here they're debating, people are debating millions of lives. It's also a lack of knowledge. Yeah, and getting that data, the anecdotes in front of them in person."

Government was described as a tool to make changes in society to improve people's lives:

Quote: "...If we come together and get some power, and elect people that care about the things we care about, then we have the opportunity [...] to use our collective tool of government to change things."

Third, people without wealth have power if and when they unite to advocate for their interests. This can happen through social movements, effective advocacy of elected officials, and requires organizing.

"When I read the question and I was thinking about who or what institutions have the power to create, and we all clearly agreed on the systemic forces, the institutionalized racism, and the segregation, and the privilege that of the 1%, let's call it that...Right now the exploitation of communities and poor people makes them money and it's convenient for them and I don't know enough yet to change that but our communities are also an institution of power..."

Quote: "...it's the people that have the power, It's the voters that have the power, but they're not coming together like you mention. I mean it's people... I've done advocacy to the state capital and politicians don't know what the issues are until you make them aware of it. And it's the job of the people to do that but if the people can't come together and form a consensus of what they need, these things are not going to happen, they're not going to change, And I don't know how to do that I'm just seeing that people have the power."

Unity was not only important across population groups, but across social service agencies who are weakened by competition and strengthened by collaboration [quote]. Voting as a way to empower the majority of the population and offset the power of wealth in elections, but awareness and education is a prerequisite.

Quote: "...what your average person lacks in money they could potentially make up for in votes but I think a lot of us feel very disillusioned or have lost faith in the system that we feel like the odds are stacked against us that even if we do vote we are not heard or it's not going to make a difference we because there's some business out there that can contribute a lot more or its rich individuals mostly white men who are looking out for their wine club or golfing buddies..."

Most people are not aware of the effects on their health of 'non-health' aspects of life. A part of a successful effort to include residents in decision-making is to respect solutions and proposals that have local origins or support.

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