Transcript:

Assessing Local Impact of COVID-19 & Planning an EBP Response

Presenter: Aliana Havrilla & Chuck Klevgaard
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ANN SCHENSKY: Hello everyone, and welcome to our webinar today Assessing the Local Impact of COVID-19-- Planning for an Evidence-Based Prevention Response. Our presenters today are Chuck Klevgaard, Prevention Manager for Great Lakes PTTC, and Aliana Havrilla from-- she is an Action Learning Coach at the County Health Rankings and Roadmaps.

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We have a couple of housekeeping details for you today. Today's webinar will be recorded. And the recording and the slides and all other relevant materials will be available on our Great Lakes YouTube channel and the Great Lakes PTTC products page.

Certificates of attendance will be sent to all attendees. Bear in mind it might take up to two weeks. At the end of today's webinar, you will be directed to a very short survey. And we would really appreciate it if you could take just a few minutes and complete it.

If you are having technical issues during the webinar, please individually message either Kristina Spannbauer or Stephanie Behlman in the chat. And they will be happy to assist you. If you have questions for the speakers, please put them in the Q&A section rather than the chat section. And we'll be sure to answer them at the end of the presentation. If you want to know what we're doing with the Great Lakes PTTC in addition to the Great Lakes MHTTC and the Great Lakes ATTC, please follow us on social media.

Our speakers today are Ali Havrilla-- Ali Havrilla, sorry, and Chuck Klevgaard. Chuck delivers training and technical assistance to support substance misuse prevention throughout the Midwest. Klevgaard has supported communities and health agencies as they adapt evidence-based alcohol, opioid, and other substance misuse programs and policies. Chuck has also served as the

prevention manager to the Great Lakes Prevention Technology Transfer Center.

Ali is an Action Learning Coach at the County Health Rankings and Roadmaps, a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. She is part of a team that develops online tools to connect communities to evidence-informed strategies and community change resources, fosters peer learning and connections, and delivers knowledge and skill-building sessions, and recognizes and celebrates health improvements. And I would like to welcome you both. And I am going to turn this over to Chuck.

CHUCK KLEVGAARD: Thanks, Ann, and good morning, everyone. I'm happy to be back with you all. My focus today will be a couple of roles in terms of grounding us in prevention, sort of being an anchor to some of what we think of as prevention in the slightly different ways that we'll talk about this kind of planning. There's certainly a lot of parallels, but I'll help you to make those as we move along.

I'm also going to take a moment as we get started to bring us back to where this conversation started. So many of you have joined us for earlier webinars where we've talked a lot about social economic determinants of health. We've talked a lot about issues around what's happening with increases in alcohol misuse. We've talked a lot about issues with regard to what the impact of support systems being impaired has been like. So we'll review some of that real quickly.

So I want to begin with just a quick way of getting you engaged with the webinar. So Ali's going to bring us to a poll slide. And you can type in the chat as practice here and tell us what your state bird is.

So again, this is just a quick way to get you comfortable with the technology we're going to use today. Here's a fast poll. Tell us whether your state bird is a cardinal, a robin, or a loon, or something else. And that other, if you want to hit other, you can also type the bird in there. Or you could say I don't know in that case. Again, just getting you comfortable with the technology, practicing using polling and getting you engaged as we get started. Awesome.

Well, big mystery solved. Lots of folks are cardinal. And I should make sure and mention that the cardinal is the state bird for Indiana, Illinois, and Ohio, which is why so many folks. Similarly, the robin is the state bird for Michigan. And depending on which website you look at, Wikipedia says that Wisconsin has the dove, but most other sites say Wisconsin is also a robin.

Minnesota is, of course, our loon, and then lots of other folks. So it's great to see lots of folks from around the country joining us today. If you're outside of one of those three birds, it means you're not in this region. So thank you for practicing with us.

I also want to go to the next slide and tell you a little bit about-- this is us. And we'll move into some objectives and talk a little bit about that review real quickly. So we're going to spend some time as I mentioned identifying ways that the pandemic has impacted your community.

We're going to look at some methods and tools for assessing community conditions, and then we'll talk in much of the webinar this morning about evidence-based strategies for strengthening your community.

So these are, again, positive action kind of objectives, rather than the earlier webinars where we've talked a lot about erosion of social and economic determinants. And we've talked about them in a number of ways.

I think one of the most important distinctions we've made is that I think when we work with prevention folks outside of this conversation who may be less familiar with determinants, it's important to talk about the fact that health is largely determined by these kinds of conditions and that health doesn't happen only in the doctor's office. And getting people comfortable and familiar with this kind of thinking is a real helpful way of grounding folks in this.

So in these earlier webinars and listening sessions on determinants, we talked about what's happened with some of those leading drivers of health outcomes, talked about jobs data and losses of income and livelihood for so many people. We talked about safety issues with regard to the increases in domestic violence and all kinds of sort of situations around violence.

We've talked a lot about the alcohol and other drugs kinds of issues with regard to the increase in availability, and again, large concerns around issues with regard to how people are using alcohol, buying cheaper alcohol and using it to deal with stresses being a huge driver of some potential alcohol misuse that might lead to alcohol use disorders for folks.

So those are some of the bad news that we talked about in these earlier calls was really looking at how concerning it is that these kind of drivers are being eroded as we move through this pandemic.

So with that in mind, I think this is the point where we're going to say now we're going to talk about so what? What do we do about this? And so we've painted this very grim picture through multiple webinars. And we want to move now into a place of thinking about how do I can get a handle on what has happened where I live? And what can I do about it? So I'm going to turn this over to my colleague Ali who's going to begin to kind of lead those conversations with you.

One more piece. Sorry, forgot about this. So we've spent some time talking about roadmaps. And we're using that term today as well. And we've talked about roadmaps on the County Health Rankings site. There is a different framework in mind.

And I think that this is a framework that we're familiar with as prevention. We think about starting with an assessment of problem and related behavior. And we also do that primarily through the lens of consequences and consumption around substance misuse.

And so you're going to see some of the early distinctions as Ali talks about assessment is looking a little different than that. So it's that, but it's also more than that. We're also interested in thinking about using risk and protective factors, intervening variables or causal factors.

Here, you're going to once again see some, I think, really familiar parallels in the way that we think about causal factors in the way that conditions at the community level contribute to health outcomes, including alcohol use disorders or behavioral health problems. So that's going to start to feel familiar.

So now that we're not going to present it exactly in this format, but we also then are going to talk about interventions in some similar ways, interventions that, again, directly address conditions or determinants that are drivers of health outcomes. As you work it that way, it's going to begin to feel more and more familiar in the way that you'll hear Ali talk about this. OK.

ALIANA HAVRILLA: Great. Thanks, Chuck.

CHUCK KLEVGAARD: Thank you, Ali.

ALIANA HAVRILLA: Oh. Yeah, thanks. And thanks to the whole team and Kristina, everybody for getting us set up for today. I so appreciate the time and the opportunity to share and learn together as we explore how to move into action and select strategies. As Chuck and others have mentioned, I'm with the County Health Rankings and Roadmaps program, which is housed at the University of Wisconsin Population Health Institute.

And we're a collaboration with the Robert Wood Johnson Foundation. All of that to say, I actually reside in Maryland. So I'm joining you from Maryland where our state bird is the oriole. So I would be in the other category today.

Want to start us off just with a little bit of grounding. So County Health Rankings and Roadmaps, starting with the ranking side, the data side of our work, and really thinking about the importance of data. And we lift up that it's a useful tool to help us across and throughout the community improvement process. It can be, as Chuck's already lifted up, a starting place to assess the health and well-being of a community.

Data is a tool for engagement as this image represents. You can put even just a simple piece of data up on a board. And it might start spurring conversations. It's also a great opportunity to look at and identify the root causes of health in your communities so you can start digging deeper. And

along the way, I'd invite you to pop in any questions that you have in the Q&A box. And we'll definitely have some time at the end to respond to those.

So hopefully, this model looks familiar to some. This is the County Health Rankings model. And it's the model that then leads in to your county snapshot if you've had a chance to take a look at that at County Health Rankings and Roadmaps. We rank the health of nearly every county in every state. And we've done that for the past decade.

So I'll just real quick orient to this model. If you look at the green boxes at the top, we look at health outcomes, which is length of life and quality of life, or phrased a little differently, how long and how well we live in community. And then if I draw your eyes to the blue boxes, those are health factors. And those are the areas that we can explore and hopefully improve to then improve our length and quality of life.

And when we look at the health factors, we at County Health Rankings and Roadmaps look at these in four buckets-- health behaviors, clinical care, social and economic factors, and the physical environment. And so working together across community within community, we can seek to think about what are the policies, programs, strategies that we can implement to make a difference and make change.

And so we've got a second poll today. And so I'd ask, either if the poll gets lifted up or to chat, just we wanted to hear from you. What are you most interested in as we look across those health factors-- health behavior, clinical care, social and economic factors, physical environment?

Do we have the poll results? Great. So it looks like most interested in health behaviors, some interest in the social and economic factors, and what really excites me is at the end of the day, there's interest in areas across the model. And I think that speaks to how we work together. It's working together across the model and taking action in many spaces. So great. Thank you for sharing.

So one of the things that we always lift up is that it's important to think about how do we contextualize all these different data points as a single data point alone might not have much meaning. But how do we contextualize it with other data, with community story, with lived experience? And so I wanted to lift up one way that we at County Health Rankings and Roadmaps in this time of pandemic are working to help continue to contextualize the data that we make available.

And so this is the US COVID Atlas from the University of Chicago and partners, including County Health Rankings. And the map, I know it's a little small, but just wanted to-- so that's looking at the prevalence of cases across the country, as of yesterday.

And then on the right, where it has Dane County, Wisconsin, what I wanted to highlight was you can see at the top that's COVID data from the Atlas, and then the socioeconomic indicators are from the County Health Rankings county snapshots.

And so here, what they're looking at across the country is pairing social and economic indicators with prevalence of COVID data. And they're using it to look at what's emerging and how communities are being impacted in relation to their social and economic factors.

And I'd invite you, if you want to learn more about this initiative and how we're continuing to learn about contextualizing the data, County Health Rankings and Roadmaps is hosting a webinar with the University of Chicago on July 21. And I'll make sure as follow-up that we get that link out to everybody joining us here today.

So pivoting from this idea of data to action and, again, especially right now as there are multiple pandemics-- epidemics facing the country, how do we think about-- what is the opportunity in this moment to move from data to action in a nimble, efficient way that meets the needs of our communities?

And so what we just offer up here is this opportunity to think about how do you conduct a rapid assessment that is a blend of qualitative and quantitative data that then helps you refine and define your focus? And as you're doing that, you're understanding assets, needs, and especially the strengths and the opportunities in your community.

And then along the way, you're thinking about, OK, what are those feedback loops that can help us track progress, implement some continuous quality improvement opportunities? Perhaps if you're piloting, how do you then think about scaling up, scaling back, and then provide ongoing support? So if a strategy is implemented, and you're feeling that it's gaining traction, what does the long-term sustainable support look like for that initiative?

And so thinking about that, this is one image that we lift up at County Health Rankings and Roadmaps. And this is taking us to the roadmap side of our work, which is the take action cycle. And it at least feels to me similar to the steps that Chuck introduced just a few minutes ago. This has a couple of more steps in it.

But I think at the end of the day, what we're lifting up is the opportunity to think strategically about how we can work together to create change. And while this image, it's circular, what I would offer is that sometimes you might be in one step like focus on what's important. And you might need to take a step back to assess needs and resources.

So I guess what I'm lifting up, while it's circular, it might be sort of more of a spiral where you might go forward and then back and then forward. And I

would just highlight that in the middle, what we lift up is this idea of collective action. It's working together holding community members at the heart of the work and thinking about how they are also a part of the work.

So wanted to take a minute and dig in and just lift up that notion of working together and what that means as we think about it. It's important to understand the cultural considerations. What are the norms and the ways of work in the community that you're working with? The importance of providing access to resources and information-- do you need to provide materials in many languages? What might that look like?

How do you work with community ambassadors and leaders? How do you create power within the community, which speaks to the increase in civic capacity? It's always important. We always like to name consider who else should be included. Ask who's missing. And lead with trust. You want to establish trust as you begin to work together and have that strong foundation.

And so as we're thinking about this idea of where are we in the process of implementing and thinking about evidence implementing strategies and taking action, are you at the data assessment phase over here on the left?

Are you more in the middle, so really thinking about your process and what that process might look like to take action? Or are you at that place of selecting strategies and really thinking about, OK, what evidence do I need? What's the context in community?

So maybe just share in the chat. Are you getting started using data doing some light assessment? Are you outlining your process for change? Or are you at the point of selecting and implementing? See some chats coming in. That's great.

So the meat of what I'm excited to share about today is to introduce one of our tools What Works for Health. And when we look at What Works for Health, it looks at across the health factors so these blue boxes that are circled on your screen. And it looks at effective policies and programs that can improve a variety of factors that in turn shape the health of communities.

It's a living resource. And we're going to go live to it on our website here in a little bit. And it's continually updated. And to date, it includes more than 400 strategies across these health factors.

So before we go live, I just wanted to take a minute to lift up and highlight what you will find within each of those 400 strategies. So it has an evidence rating, which conveys the likelihood strategies will work based on the best evidence. We include a short summary of the literature that highlights who the strategy can benefit and what it can do. And if we have it, we also include cost to implement.

We assign a disparity rating to help communities use an equity lens as they explore strategies, and then we have, again, as available implementation resources including toolkits, examples of communities in action, and things like that.

And so before we go into What Works for Health, I also want to lift up the idea of it's what we call sometimes evidence plus. So it's what is the context of community? And is this a good fit? Does it align with the needs, the strengths, and the opportunities?

And so as we think about that, I want to introduce this idea of-- so it's strategies but also thinking about perhaps principles. And these principles were shared yesterday by Dr. Camara Jones. And I thought they were really powerful.

So as we're selecting strategies and thinking about strategies to implement in community, consider thinking about these three principles from Dr. Jones. Does it value all individuals and populations equally? This includes where and whom to invest, how those investments are made, who and how we engage in planning and decision making and problem solving.

The second principle is to recognize and rectify historical injustices. So as we're thinking about strategies, is it something that recognizes and rectifies historical injustices? Part of this principle is taking the time to learn the history, and then rectify the injustices. And so it's important to learn.

And then the third principle is provide resources according to need. And so thinking about what is not only metrics around data, but what's metrics around need? And what might that look like in your community? So like I said, just thinking about this idea of as we select strategies using data evidence and then perhaps these three principles to help us continue to take an equitable approach to change.

And so I'm going to take a second and switch over to the County Health Rankings and Roadmaps website. And so I'm actually going to go. So again, hoping that some of you are familiar with the County Health Rankings and Roadmaps website. This is our main landing page, countyhealthrankings.org. And to find What Works for Health, it's under take action to improve health, and then from here, you can see it's right in the middle, What Works for Health.

And so want to just pause. This is brand new as of this week. Chuck, I don't even think you and I talked about it. We have worked with our team. And we've lifted up strategies for COVID-19 response and recovery.

It links to an article based on pandemic health equity criteria. I won't go into that deeply here. But know that these are both-- so this first link will take you to the strategies that they've pulled. And it's just over 100. And then this will

take you to how they're assessing evidence around pandemic health equity criteria.

And so like I said, if you think back to when I was introducing What Works for Health, we look across those health factors. And that's what you see lifted up in-- excuse me-- in these boxes. We see health behaviors, clinical care, social and economic factors, and the physical environment.

Wanted to start with a place where hopefully you all can see yourselves and your work and wanted to talk about I think one of the things that has been unfortunate in this time of pandemic, which is if we were to look at alcohol access restrictions in public places, at least I know in my community, much of this has been loosened in an effort to create more outdoor spaces for our restaurants and dining.

And it's had some unintentional consequences in an effort to do good. And so I know that perhaps this is a place that you all have worked before in trying to create policy advocacy and change.

So we're just going to walk through-- so again, this is bringing the strategy to life. We can see there is an evidence rating for this. This strategy is rated expert opinion. Then as you scroll down, you see the short description at the top.

The expected beneficial outcome-- so when it says rated next to it, that's what's driving this expert opinion. So we believe that this strategy would reduce excessive drinking and reduce underage drinking. And again, that's based on the literature and is tied to the rating.

Other potential outcomes-- reduced alcohol related harms. And this is perhaps mentioned in the literature, but it's not rated. So we include it because it was mentioned enough, but it was not strong enough to be included as expected beneficial outcomes.

So you can see that evidence of effectiveness. And I've heard from folks that I've worked with this is really helpful. If you're securing funding and working to write grants, you can come. And you can check out the citations in the literature.

I mentioned the impact on disparities. The implementation examples-- so here, we link to an example in Santa Fe, as well as Gulf Shores, and then there's some resources. So it looks like Helping Services for Northeast Iowa, which has an alcohol management-- that looks like an alcohol management plan.

And then as available, you can see the citations and implementation examples. And then just for reference, because as I said, this is a living

resource, we do include when the strategy was last updated. And so you could see this was last updated in 2017.

So from here, I'm going to go back. Got to go back one more time. We're going to go in to family and social support and take a peek at one other example that we wanted to lift up. And I believe Kristina might have sent right before this a resource guide that lifted up many resources. And in them, What Works for Health is included, as well as many other links. I'm not seeing the-- I'm going to go back. Apologies, folks.

So there's many ways to search, you can see. So I was going in through the health factors. You can also do a keyword search. And what we wanted to lift up today was the trauma-informed approaches to community building. As Chuck and I were talking, this is one that I think, again, in this moment in this time both provide some really useful resources and can be a really powerful tool.

I've worked with several communities addressing ACEs that once they understood the root causes and some of the risks in their community, they then began a trauma-informed approach to community building. And so again, just familiarizing yourself. We can see which health factor this is linked to, family and social support, and, again, the evidence.

And then within this one, we were excited for the implementation resources, as well as the implementation examples. You can see that SAMHSA offers guidance on this, as well as the trauma-informed community building model developed by the BRIDGE Housing Corporation. In addition to that, there's some great resources in these guides listed down here. So I think with that, I'm going to put us back to the slides.

And I think I'm close to wrapping up. Just wanted to highlight that across our community, these are the ways that County Health Rankings and Roadmaps, we support communities. So we talked about the data through the County Health Rankings model and the county snapshot evidence, which you can find out What Works for Health guidance.

So I sit on the Community Transformation team with a team of action learning coaches. And if you use the Contact Us button, we're happy to chat with you, coalitions, community leaders, about any of our resources and tools and how to put them into action.

And along the way, we learn with others to hear stories and harvest what we're learning about the efforts that it takes to create community change and how, again, how we build on those assets, opportunities, and strengths to transform communities. And so I think-- let me check in with Chuck. Are we at a place where we can take some questions?

CHUCK KLEVGAARD: Yeah, let's definitely do that. If folks have been typing questions all along, you can use-- remember, don't use the chat. Type it into the question and answer section of that. As folks are doing that, go ahead and type your questions in now, I'll again say thank you, Ali. That is so incredible, the resource. And you're right. It's updated since we last spoke, which was just days ago. [LAUGHTER] So it's nice to see that it's that fresh.

I want to let folks know that as you were looking and saw her scanning through evidence-based practices, you're going to see crosswalks with language on the side. For example, you'll see that there are references to the approach looking at community capital or family capital.

So using the broadest sort of strokes we can, I think if you're looking at bringing a community together, you might find folks in the recovery community that are much more familiar with talking about recovery capital.

So know that using lots of language in this way will help people feel more anchored and grounded in this conversation because we're really talking about very much the same thing. So when we think about building resilience in a community or trauma-informed care, that language transfers very directly into some of the approach sections of that website. So I think you'll find that helpful.

And again, I think that's always a reminder for me to think about who's in the room when I start to use language. I want to make sure people feel included and comfortable in what we're talking about. So I appreciate that tour, Ali. Let's see if there are questions.

ANN SCHENSKY: Hi, this is Ann. We currently do not have any questions, but I encourage anyone to please put them into the Q&A section. Also, just a quick reminder that the recording of this webinar along with the slides and the handout will all be included on the Great Lakes PTTC products page for you. Sometimes, that will take us a week or so to get all of those up there.

And also, just another quick reminder that everyone will be emailed a certificate of attendance. So if you have any questions also that you would like to send to us if you think of them after the webinar, or if you've had time to go through the website and have a question, you can feel free to send that to us as well. And we'll get you the answers.

So we do have a question from Dennis that we are seeking current student data. Short of school restarting, that seems to be the only option now.

ALIANA HAVRILLA: So is that question asking about student enrollment data? Or maybe tell me a little bit more about what type of student data if that's possible, Dennis.

ANN SCHENSKY: For student drug use.

ALIANA HAVRILLA: Student drug use. I don't have a specific resource in mind. But I'm happy to reach out to our data and science team and see what they might be able to offer and follow up. I can send to Ann or Kristina. They can perhaps send it to you.

ANN SCHENSKY: Also, the 30-day alcohol use. Sounds like Dennis is kind of just looking at some trends and--

ALIANA HAVRILLA: 30-day alcohol use--

ANN SCHENSKY: --have been out of school for so long.

ALIANA HAVRILLA: Student data. OK. Yeah, I'll certainly-- that's sort of the beauty of having a whole data and science team. They will have the best resources available. And I will certainly follow up.

ANN SCHENSKY: Excellent.

CHUCK KLEVGAARD: A couple of thoughts I would add to that, Ali, too, as you check with your folks, I hear folks trying to use social media hits with key word information to look at what young people are talking about.

So I think that there are a number of ways that there still is communication happening and that there's ways to at least look at the conversations that are occurring around that. And that's one piece of the story. It won't be the same comprehensive like a YRBS survey for you. But it will be some indication about what's happening.

I also hear folks already engaging in at least some focus groups with young people to get a better sense about how this pandemic has impacted them. Obviously, they've been isolated from friends in the same way that the rest of us have been.

So in terms of how they're coping and what it is that's going on in their lives, this is a really critical piece of information for that assessment that Ali talked about. How did young people fare? I think there's a lot of early indicators that they are going to be-- and particularly, the age of the child matters here a lot.

But I think that they may be far more traumatized by that social isolation than some of us that are adults. Some of us prefer social isolation as adults whereas young people are really dependent on that for a whole host of reasons that make a ton of sense developmentally. So finding ways to get a handle on how young people have been impacted using qualitative measures is probably your best avenue because that can still be done remotely.

ALIANA HAVRILLA: Yeah, Chuck, can't underscore the importance of belonging and connectedness as it relates to our well-being. I totally agree.

ANN SCHENSKY: Thank you both. Those are excellent points. We do have a quick question. Someone asked if they could get the same information for Dane County. And I think, Ali, if you have a resource where people could get the most current, that would be awesome.

We would be more than happy to put that up there. Because as we all know, data like this changes quickly. And by the time we assemble it and mail it out to people, it could be-- the numbers could have changed.

So the next question is our county has quite diverse population sectors, one large urban community, and many very, very rural communities. Does the county data account for those differences in any way?

ALIANA HAVRILLA: Yeah, that's a great question. And so I think a couple-- I would look up a couple of things in response. So we always encourage-- the county health rankings are certainly a starting point but not an ending point. So important to think about where else data might exist in your community. Community health needs assessments are a great starting point. So look across your community and think about where else might data exist.

The second way that I might respond to that is that within the county health rankings-- and I don't have the list in front of me-- but that we have 11 measures that do provide disaggregated data by race and ethnicity. And there are measures that you can find subcounty data.

So again, it's that idea of digging deeper into the data, so starting with the county health rankings. And if somebody is-- if this individual's unfamiliar with the county health rankings, they can contact us. And a member of our team would be happy to walk through that with them.

ANN SCHENSKY: Excellent. Thank you. Are there psychosocial assessment templates that question specific that COVID-19-specific impacts on socioeconomic status, physical location, health behaviors, et cetera?

ALIANA HAVRILLA: Can you repeat that question one more time?

ANN SCHENSKY: Yeah, are there psychosocial assessment templates that have questions specific to COVID-19 impacts on socioeconomic status, physical location, health, and behavior?

ALIANA HAVRILLA: I think that's a great question because I can think of individual ones, but not one that has it all together. [LAUGHTER] Chuck, yeah, I was going to see if anything was coming to mind for you.

CHUCK KLEVGAARD: Yeah, I would say in the same way that your site was just updated, Ali, already within days, we put together a collection of some of the most common assessment tools for looking at these issues with regard to socioeconomic determinants. And a number of those have places within their

site where they list other resources. And they've added a whole bunch of stuff specific to COVID on each of those sites.

So it reminds me as well that if you all work in a state health department, you know this that your individual state has probably also been identifying how they're going to get a handle on all of this issue. And some of that may be also something you could get in a disaggregated form from your state health department.

So know when you get that handout, the first section of the handout just deals with assessment. And I think we list four or five. Many of these come from very rural settings with regard to being able to get that data for rural folks as being more challenging.

I think the other thing that, again, even since we've done that, which I can pull together and send out to folks afterwards, is looking at the issue of equity. I think schools have done a lot more assessment around the issues of looking at access to Wi-Fi and devices as being a major issue to understand equity.

As we move into certainly the next phase of this pandemic and whether schools start again or not, having access to education is something that, again, is now a significant equity issue for folks as well.

So know that we'll look at stuff like that as that quick assessment. We talk about a lot of areas to look at. The word quick probably isn't completely fair but the rapid assessment so that you don't spend too much time gathering data. You want to move to action as quick as you can.

I really appreciate Ali's example of thinking about resiliency after trauma as being a place that all of us can agree is a really important place to start. So as you think about how folks have been impacted, and creating that connectedness and belonging and opportunities for people to reconnect in safe ways is going to be something every community will have to consider.

So I think that there are some real concrete ways to think about getting started that Ali provided for us that, again, we think it can be completely overwhelming to think about all of the different data points you'd like to have. But it can also then be for putting us in a place of not doing anything. And I think that there are lots of basic places to start with regard to thinking about reconnecting in your community and building resilience.

ANN SCHENSKY: Thank you. We have another question that says in the County Health Rankings model, family and social support is in social and economic factors. How is social support quantified? Number of close friends, for example.

ALIANA HAVRILLA: Yeah, that's a great question. So within the measures that are part of that, it's community organizations, so the capacity within

community to have a Lions Club. I don't know if rotary, for example. I was trying to remember if youth organizations were included in that or not, and I'm not remembering within the measure, but so the capacity to engage with community.

And then social connection. That was the one that was jumping out. We can go look. That might be the easiest so that I'm not making it up.

So I am in Washington County. That's where I sit. And so if we go down to social economic factors, so it's social associations-- that's the one that I was just referencing-- which is membership associations per 100,000 people in a population. And that would be the ranked measures. I don't know.

So we look at disconnected youth, or the opportunity youth is another measure of social connectedness or social disconnectedness. We look at residential segregation. Those are the ones that would I would say make up the social conditions and community that are ranked-- or that are measures, some ranked, some not ranked.

ANN SCHENSKY: Thank you. We do have one more question related to children. And Dennis says that he noticed the county-level data does not include info about children. Is there something he's missing?

ALIANA HAVRILLA: So I would want to hear more about what aspects of children? So we do include children in poverty, children experiencing poverty.

ANN SCHENSKY: Health behaviors related to children.

ALIANA HAVRILLA: Apologies for the scroll. So we include teen births. We do not include child obesity. We have actually talked about that as a team. So he's correct in that sense. And I'm not sure without going into the measure detail around physical activity or physical inactivity if that includes youth or not. I'd be happy to circle back and to understand why we are not including youth data.

Most likely, is it either we don't have access to the data set at a national level. Yeah, I'd have to find out. That's usually why data is excluded. So in order to include measures in the rankings model, the data set has to be available at a national level and then at the county level. And that sometimes can be a stumbling block.

ANN SCHENSKY: OK, and also, I noticed in your slides like you have said several times, feel free to contact you and the team if you have any questions. And you can help people walk through the data if they're not familiar with how to look for things.

ALIANA HAVRILLA: Absolutely. Yeah.

ANN SCHENSKY: So definitely, if you have questions about where that data may be, feel free to contact the County Health Rankings team. It looks like we have answered all of the questions. So unless anyone else has questions, and again, if you think of questions, feel free to send them to us. And we will make sure that they are addressed.

But I want to thank Chuck and Ali-- oh, one more question. Is the graphic you used in the beginning of the presentation available on the website? It is a truly great way to explain where missions align.

ALIANA HAVRILLA: Yeah, it's a downloadable graphic on the website. So you can go to the main page, and then click to the County Health Rankings. And you'll be able to download that image.

ANN SCHENSKY: Fabulous.

ALIANA HAVRILLA: Yeah, and I appreciate the interest in it. And we encourage people to share it.

ANN SCHENSKY: Great. So I would like to thank everyone for their time, Ali, Chuck, the production team, and all of you who listened. Again, if you have questions, you can contact us or a reminder that this recording and all of the materials we discussed will be available on our PTTC products page. So with that, I thank you all. And have a fabulous afternoon and weekend.