



Common Ground

December
2008

*Creating Equity through Public Policy
and Community Engagement*



Table of Contents

I.	Executive Summary.....	3
II.	Introduction	7
	a. Purpose of Report	7
	b. Focus: Who Is Affected.....	8
III.	Correcting the Inequity	19
IV.	Overview of Health and Socio-economic Factors	21
V.	Public Policy that Impacts Health Disparities.....	29
VI.	An Approach for Fulton County	34
VII.	Common Ground Targeted Opportunities.....	39
	a. Serving At-Risk Teens (START) System of Care.....	41
	b. Oak Hill System of Care for Youth and Families	47
	c. North and South Fulton Community Centers	53
	d. Neighborhood Union Primary Care Partnership	57
	e. Intergenerational Communities	61
	f. Approaches and Timelines	66
VIII.	Conclusion	67
IX.	Appendices.....	68
	a. County Service Maps	70
	b. References	76
	c. Definitions.....	79

Executive Summary

This document seeks to introduce the concept of social determinants of health, to explain their multiple impacts on the socio-economic and health status of Fulton County residents, and to describe six projects that target social determinants of health in our communities. Called *Common Ground: Creating Equity through Public Policy and Community Engagement*, this report is a compilation of efforts to date, as well as a set of proposals for future efforts to bring about system-wide change.

Social Determinants of Health

Scientists, practitioners and policy makers have long recognized that there is a distinct relationship between an individual's health status and the social and environmental conditions in which he or she lives. A solid body of research confirms these observations: Certain essential factors and resources – often described as “social determinants of health” – are known to contribute to or detract from the health of individuals and communities. Among the key social determinants of health are education levels, income levels, access to essential services, and the physical conditions of the built environment (such as the proportion of abandoned homes or the level of neighborhood crime). Furthermore, inequitable distribution of the social determinants of health has a significant influence on persistent health disparities in our most underserved communities.

Policy Change

The intent of public policy is to improve the quality of life for all residents. Public policy can influence social determinants of health and, therefore, can lead to negative or positive health outcomes. It is also important for stakeholders and policy makers to understand that public policies that do not focus *directly* on health can still have health implications.

A social determinants of health perspective recognizes that the economic viability and health status of a community are intertwined. Community and neighborhood survival depends on a strong local economy that can employ residents; communities that lack jobs typically have decaying infrastructure and transient residents. Concurrent with the need for job creation is the need for quality, affordable housing with accessible financing programs. Research indicates that communities with a low threshold of home ownership also have a low health status.

However, a number of studies show that improving the quality of public services, the community infrastructure, and the socio-economic conditions in which people live can also improve their health. In other words, neighborhoods with an array of socio-economic opportunities – such as strong business and industry, affordable housing, shopping centers with restaurants, cultural activities, theatres, playgrounds, good transportation, parks, walking trails, enhanced street lighting, and public safety – will also have a better health status. Environmental attributes such as walking trails, parks and recreation can have a major positive and preventive impact on residents' health problems such as obesity, hypertension, diabetes, and cardio-vascular disease.

Modifying service delivery through the lens of social determinants of health is a new perspective for conducting government. Using this approach, Fulton County government should seek to enhance those policies that have a positive impact on the social determinants of health. For example, in south central Los Angeles the city government is considering a ban on new fast food restaurants. Such an approach will be a major policy statement made by government to address the health outcomes of its citizens. Similarly, specific policies to be reviewed in Fulton County relate directly to the physical and social environment and infrastructure. Among these are policies dealing with public safety; zoning for such businesses as fast food stores, liquor stores, and fast cash and loan establishments; parks and recreation; grocery stores; use of vacant land; and economic development.

Public policy must also address what is termed “social exclusion.” Policy research literature defines social exclusion as “the economic hardship of relative economic poverty” that leads to “the process of marginalization – how groups come to be excluded and marginalized from various aspects of social and community life.” (Alameda County Health Disparities Report, 2002). Public policy must support the inclusion of all residents and their communities; empowered communities and community leaders should help drive the process. These public policy efforts should be all-inclusive and provide for wrap-around services including both traditional socio-economic approaches and new approaches that address the physical environment.

Community Engagement

In all community-oriented initiatives, the preferred strategy is to work with residents and community organizations. Due to the inextricable link between social policies and health status, system-level policy changes must be proposed and implemented in concert with community input and engagement. Future conversations involving social determinants and health equity in Fulton County must engage a wide array of organizations. To address these issues in a substantive way, all sectors of county government and as well as other stakeholders must be involved. This approach will require Fulton County departments and divisions that have not historically worked together to begin to do so. It will also enjoin multiple segments of the community in order to sustain the process successfully.

Governmental Agencies	Community Agencies and Stakeholders
Elected Officials/ Policy Makers Department of Economic and Community Development Department of Family and Children Services Fulton County Department of General Services Department of Public Works	The Atlanta Regional Commission United Way MARTA Community-based Organizations Faith-based Organizations

Fulton County Arts Council
Fulton County Library
Fulton County Police Department
Department of Housing and Community
Development
Code Enforcement
Fulton County Parks and Recreation
Cooperative Extension

Neighborhood Planning Units
Local Businesses
Institutions of Higher Education
School Boards
Grady Hospital
Federally Qualified Health Centers

The movement toward addressing the social determinants of health in Fulton County was founded upon an interdepartmental collaboration with current and future community partnerships. By forging solid relationships with other Fulton County agencies, businesses and community representatives, Fulton County will be able to utilize its assets more effectively to combat poverty, housing inadequacies, environmental stressors and other social determinants of health that affect our communities.

The “Common Ground” Initiative

At the direction of the County Manager, the Health and Human Services cluster began to investigate actions that could be taken to optimize service delivery among cluster departments within the Fulton County Government. This task evolved into a much larger strategic initiative that is investigating a system-wide approach to addressing the social determinants of health in Fulton County. In August 2008, the Health and Human Services cluster (the Department of Health and Wellness; the Department of Mental Health, Developmental Disabilities and Addictive Diseases; and the Department of Human Services) was charged with developing a proposal that would address inequities with regard to racial, ethnic and other socio-economic disparities in relation to their impact on health status.

Initially, the Health and Human Services cluster met to identify agency programs that are currently addressing the issues of health disparities. Secondly, the cluster identified opportunities for further partnerships; thirdly, the cluster collaborated on opportunities to create new programs and policies that would address local inequities. The effort has evolved into the current initiative, titled *Common Ground: Creating Equity through Public Policy and Community Engagement*.

“Common Ground” Targeted Opportunities

Six options, or targeted opportunities, in Fulton County have been identified and are discussed in this document. These targeted opportunities are anticipated to lead to intended outcomes of positive behavioral change and healthier living in revitalized communities – in sum, improved health outcomes. Each targeted opportunity is described in detail later in this document:

1. Serving At-Risk Teens (START)
2. Oak Hill System of Care for Youth and Families
3. North Fulton Community Center

4. South Fulton Community Center
5. Neighborhood Union Primary Care Partnership
6. Intergenerational Communities

Each of these targeted opportunities, in the short, middle and long term, seeks to

- Influence public policy change
- Leverage resources
- Increase systems of collaborations
- Improve communities
- Enhance quality of life
- Change the infrastructure of a community
- Provide for a new way of conducting government
- Increase community capacity building
- Empower neighborhoods
- Increase awareness of public policies
- Increase fresh markets or community gardens
- Increase health care access
- Provide for safer communities

These actions target the following outcomes:

- Improved health outcomes
- Increased high school graduation rates
- Increased employment levels
- Increased walking and biking in communities
- Increased access to health care
- Improved infrastructure to promote healthy, sustainable, livable communities

In summary, the conditions in which people live have an impact on individual and community health status. Policy drives the conditions in which people live and work. In order to affect the health status of the residents of Fulton County on a large scale and over the long term, government must shift the way it conducts business and provides services by creating and implementing policies that address the social determinants of health.

I. Introduction to *Common Ground*

Purpose

Strong families and neighborhoods have always been the staple of cities, towns, and counties. As times change and the economy moves in a downward spiral, more and more families are suffering. Economic and housing development is diminishing. Communities and neighborhoods have an increasing number of vacant houses and they begin to look barren. It is becoming increasingly difficult for families to survive.

For many Americans, the American dream must be reinvigorated. Our nation was built on the concept that all people shall have “the inalienable rights of life, liberty and the pursuit of happiness” – and shall be treated equally, regardless of the color of their skin. But as we look around at our communities and our people, we still cannot say that all of us are equal. The inequity of resource distribution has kept the poor “poor” and the rich “rich.” The pursuit of happiness is merely a dream for many of poor Americans. They oftentimes cannot meet their basic needs. Research has shown that the lack of basic necessities such as food, shelter/housing, education, health care, and employment have a devastating impact on people’s physical, emotional, and mental health. This is especially true for minority groups. For instance, when reviewing the following indicators -- unemployment, mortality rates, low-weight babies, infant mortality, HIV, foster care, crime statistics, and various health and chronic diseases -- the percentage of minorities in these categories is unacceptably high when compared to their percentage of the total U.S. population.

In early 2008, the Georgia Department of Community Health released a publication titled *Health Disparities Report 2008: A County-Level Look at Health Outcomes for Minorities in Georgia*. In the report, Fulton County received an overall failing grade for health outcomes and health inequity. This grade indicated “extremely poor outcomes and/or extremely severe racial inequality” in Fulton County. The report encapsulated the results of a long history of adverse environmental and social conditions that have affected the health status of Fulton County. Some of the factors the authors graded include:

Social and Economic Indicators	Primary Care Access
Mortality	Physician Racial-Ethnic Diversity
Hospital Admissions	Mental Health Care Access
Emergency Visits	Oral Health Care Access
Prenatal Care & Birth Outcomes	% Speaking Non-English Language at Home

A great many of the problems cited in the report are the result of inequities and disparities in our society. Mental health, physical health, and human service programs were established to ensure that services are in place to help people sustain themselves and to offer a safety net when times are difficult. While great strides have been taken over the years to support people through social and health programs, the negative economic condition of the country is overtaking the impact of traditional social services support systems. People are suffering from poor health conditions and preventable diseases because of these great inequities in our support systems. It is apparent that the Fulton

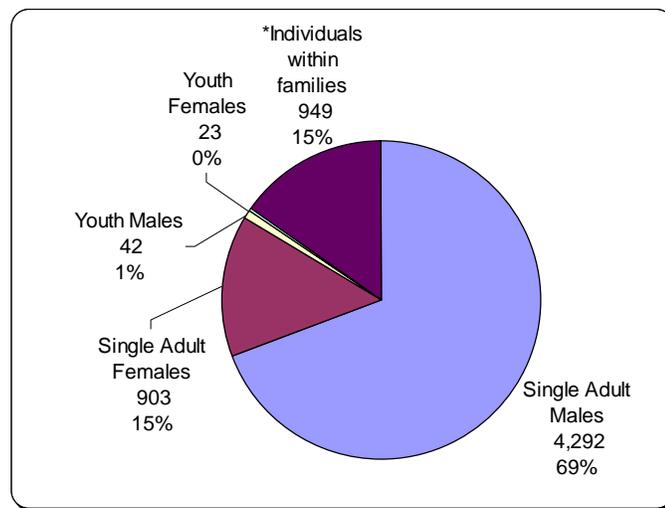
County government needs to do something different to address health disparities among its residents.

Focus: Who Is Affected by Health Disparities?

The Homeless

Data indicate that homeless people are one of the fastest growing segments of the population in the United States.

- According to the 2007 (most current point-in-time count) Homeless Census, there was a total of 6,209 homeless individuals in Fulton County, which is inclusive of parts of the City of Atlanta. The following chart shows the number of homeless individuals by group. Of these groups, 9% are Caucasian and 91% are African American.



There are multiple reasons why the homeless are in this situation. The data from Fulton County's homeless program show the following reasons for homelessness:

- 26% had job loss
- 22% relocated
- 15% had family breakup/violence
- 10% were released from jail
- 10% have alcohol/drugs problems/in detox
- 9% were evicted
- 5% have health problems or disabilities
- 3% other reasons

Most homeless people are isolated from their families because of one or more of the above conditions. Yet these conditions are all related to inequity in the social

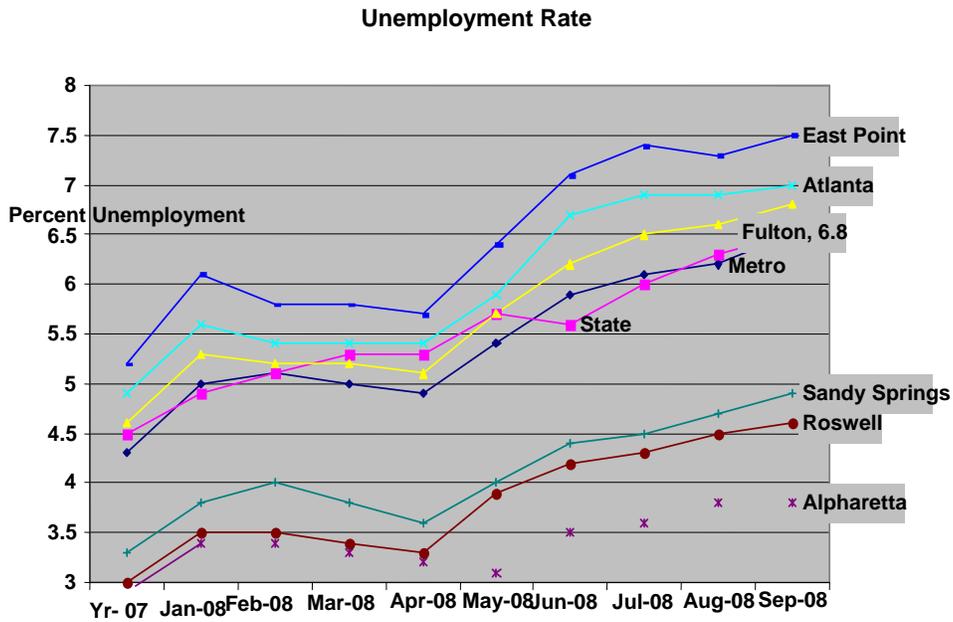
*Individuals within families include the men, women, and children of the family unit. Ages 31-54 represent the largest group of homeless individuals.

determinants of health. The single largest reason for homelessness is job loss. With workforces downsizing, when people lose their jobs, they invariably lose their health insurance. This puts them in the “disenfranchised population,” those who will most likely suffer from preventable illness because of lack of health care.

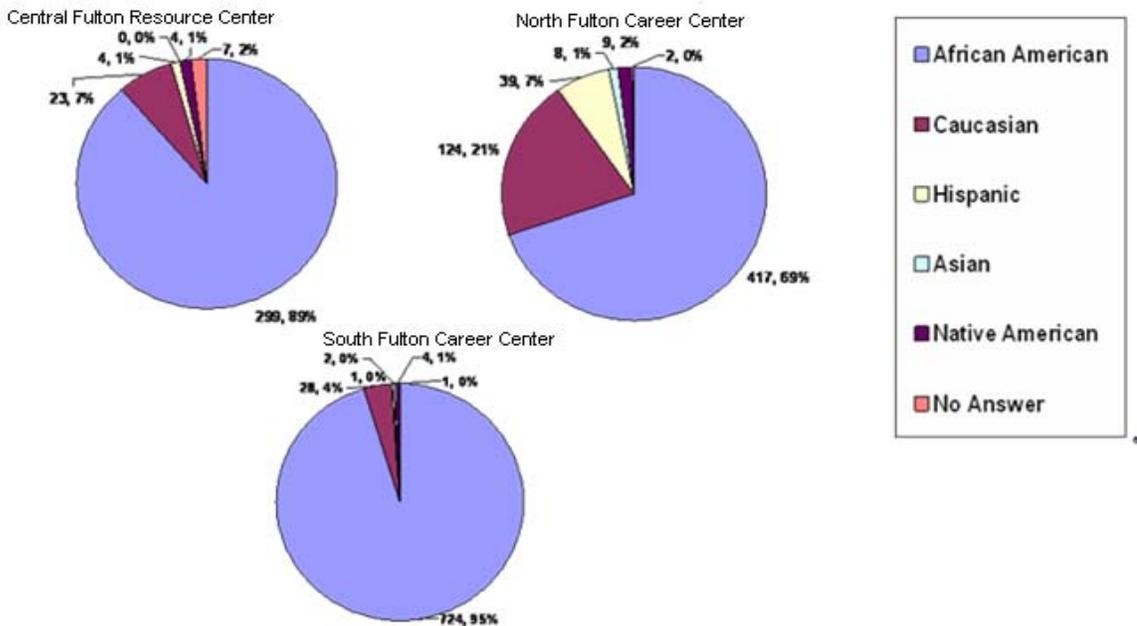
Unemployed

Another disenfranchised group is the unemployed or underemployed. Often, these persons have limited education or job skills. They have dropped out of school and are “job churners,” those who move in and out of jobs many times during a year. These individuals may have low educational achievement because of the socio-economic condition of the family, because of a sub-par education system, or because the community does not have the social or physical infrastructure to support families well. A majority of these individuals are African American and are likely to be part of a single-parent family living at or below the poverty level. These individuals are living in an environment that contributes to health disparity.

The following charts show the rate of unemployment in Fulton County by three geographical areas, a racial breakdown of the consumers seeking services from career centers, and race and career center intake by district. This information highlights the impact of the economy and lack of needed resources on individuals.



Workforce Intake Data October Thru December 2007 Racial Data By Centers



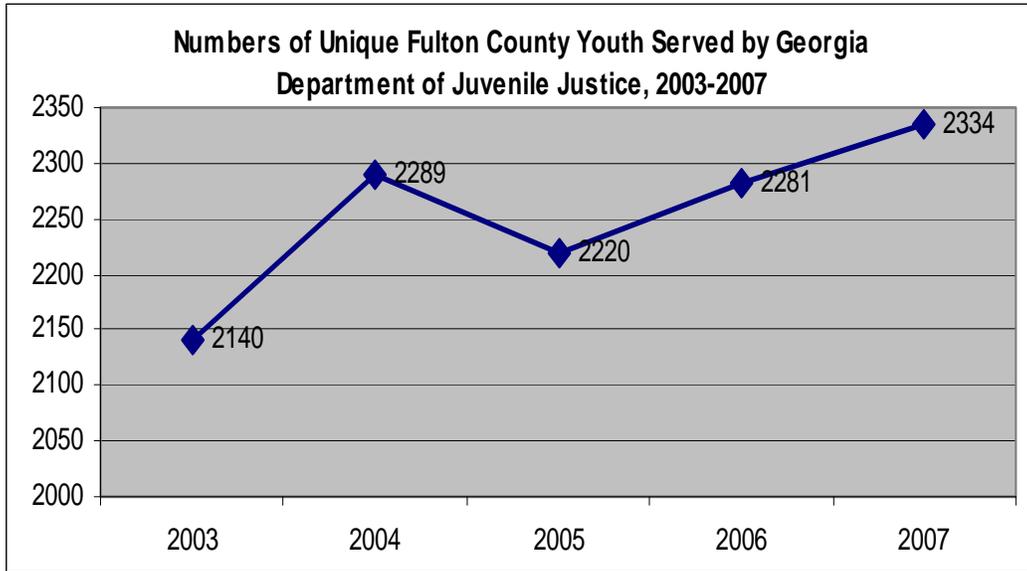
The Office of Workforce Development (OWD) data above show that the majority of consumers seeking employment assistance across all three service centers in Fulton County are African American.

The Juvenile Justice System

Data for Fulton County juvenile courts show an over-representation of African American males compared to their percentage of the total population. In general, these youth are representative of the “Have Nots.” They and their families have seldom had access to the services or opportunities that might have kept them out of the juvenile justice system. A viable strategy to improve outcomes for these youth is to address the social determinants or causes of juvenile crime. These youth are more likely to have been raised in poverty, to suffer from mental illness, to engage in substance abuse, or to be in the foster care system. Typically, they lack an adequate education, and they have probably never had adequate health care. They represent another example of the inequitable distribution of resources – and the negative outcomes of the lack of these resources, i.e., spending much of their youth in the juvenile justice system.

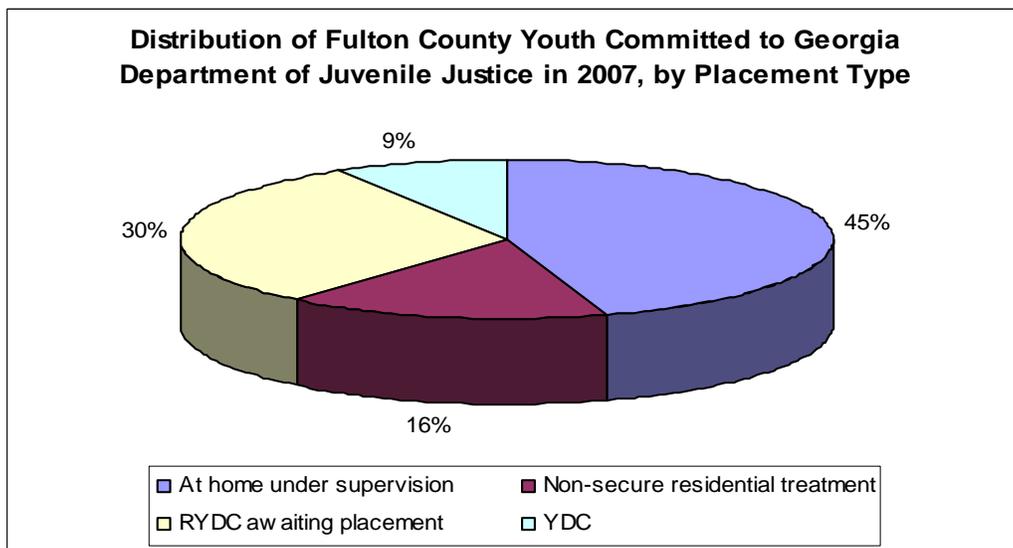
Georgia Department of Juvenile Justice

The Georgia Department of Juvenile Justice (GDJJ) administers 30 state-run juvenile detention centers in Georgia: 22 Regional Youth Detention Centers and 8 Youth

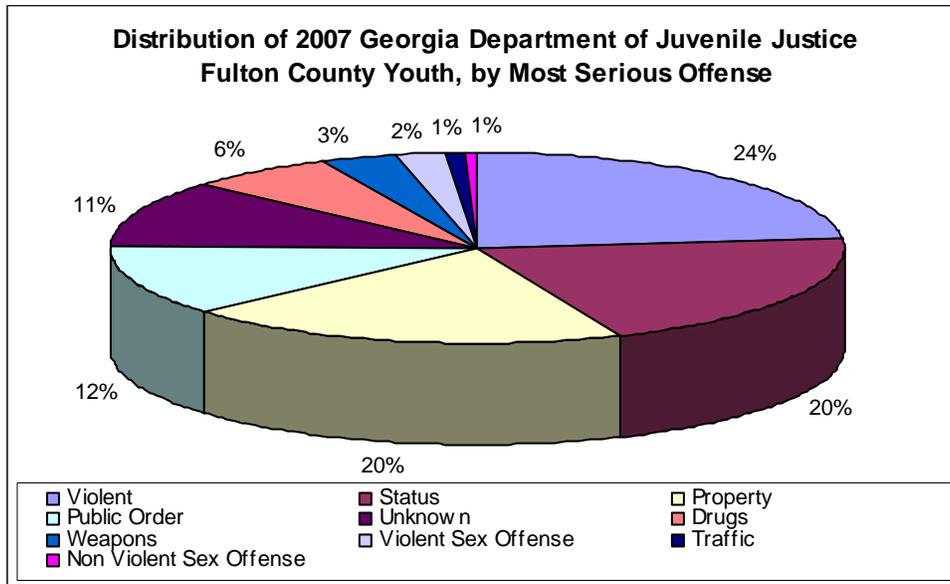


Development Campuses. In 2007, there were 2,334 Fulton County youth involved with the Department of Juvenile Justice (GDJJ, Statewide Statistics).

Of the total number of 2,334 Fulton County youth currently served by GDJJ, 22% (n=520) were committed to GDJJ in 2007. According to GDJJ statistics, court-ordered placements of these 520 Fulton County youth included 411 at-home supervision placements, 148 non-secure residential treatment placements, 276 Regional Youth Detention Center placements (youth awaiting placement), and 80 Youth Development Campus placements. (Because the 520 youths committed to GDJJ in FY 2007 may have experienced more than one type of placement during a period of one year, the total number of placements exceeds the total number of youth who were committed to GDJJ in 2007.)

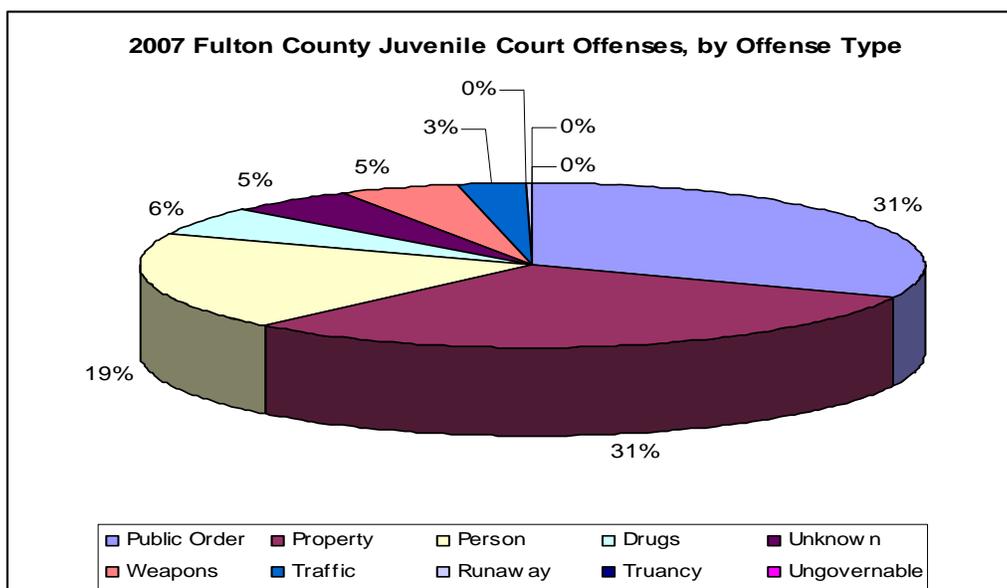


One fourth (n=599) of all Fulton County youth involved with GDJJ in 2007 had committed at least one violent offense (including violent sex offenses). Property crimes were reported as the most serious offense committed by 20% (n=463) of the GDJJ-involved youth. Another 20% (n=472) of youth involved with GDJJ in Fulton County had a “juvenile status” offense (i.e., an offense related to one’s status as a juvenile, such as under-age drinking) reported as their most serious offense, and 12% (n=277) had a public order offense reported as their most serious offense in 2007 (GDJJ, Fulton County Descriptive Statistics FY 2007).



Fulton County Juvenile Court

Fulton County Juvenile Court reported a total number of 9,239 offenses for calendar year 2007. Offenses classified as *Public Order*, *Property*, and *Person* were the most frequently committed and detected offenses, comprising 81% of all offenses committed by juveniles and detected by law enforcement throughout Fulton County in 2007.



Public Order (n=2,890) and Property (n=2,828) offenses comprised the top two largest numbers of juvenile offenses reported in Fulton County Juvenile Court in 2007. Offenses against Persons comprised the third largest number (n=1,773). Drug (n=517) and Weapon (n=459) offenses comprised 6% and 5%, respectively, of all juvenile offenses. In 5% (n=486) of offenses, the offense class was reported as “unknown.”

Senior Population

While youth data show disturbing numbers of young people (especially African Americans and other minorities) dying from homicide or preventable illnesses, data on the opposite end of the spectrum show that the senior population is living longer. The “Aging of America” is occurring, and by year 2030, the population in Georgia over the age of sixty-five (65) will double.

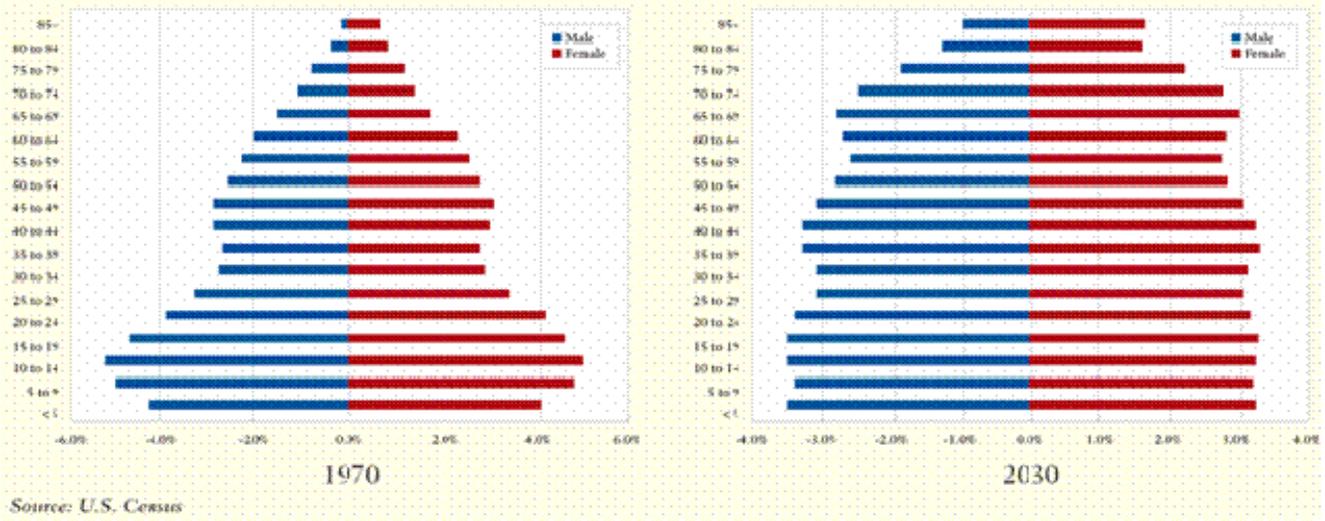
U.S. Census 2000 estimates indicate a Fulton County senior population aged 55 and older of 128,603. The Fulton County Department of Environment and Community Development calculated Fulton County population estimates by Fulton County Commission District using 2000 Census data. The following chart and graph present these estimates for the Fulton County senior population aged 55 and older.

Number of Fulton County Seniors per Fulton County Commission District				
Fulton County Commission Districts				
3	4	5	6	7
6,876	8,387	6,567	5,848	7,355
4,101	5,159	5,815	4,291	5,217
2,838	3,951	4,835	3,468	4,032
2,366	3,910	4,129	3,049	3,185
1,732	3,759	3,257	2,350	2,800
1,105	2,759	2,264	1,741	1,880
879	3,268	2,101	1,620	1,712
TOTALS				
19,897	31,193	28,968	22,367	26,181

Aging Population Projections

Fulton County, along with the rest of the nation, will witness a dramatic increase in the number of senior citizens over the course of the next three decades. The following graph illustrates the anticipated growth of the U.S. aging population.

Figure 1. Projected Growth in Elderly Population



Graph adapted from the Atlanta Regional Commission

Fulton County Aging Population Demographics

Senior Population Age Groups by Sex

	Population age 55 to 59 years	Population age 60 to 61 years	Population age 62 to 64 years	Population age 65 to 66 years	Population age 67 to 69 years	Population age 70 to 74 years	Population age 75 to 79 years	Population age 80 to 84 years	Population age 85 years and older
Male	17,066	5,166	6,304	3,698	4,814	6,708	5,071	3,158	2,382
Female	17,965	5,726	7,381	4,517	6,096	9,926	8,825	6,595	7,200
Total	35,031	10,892	13,685	8,215	10,910	16,634	13,896	9,753	9,582

Senior Age Group by Race

	Population age 55-64			Population age 65-74			Population age 75-84			Population age 85 and older		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
All races	28536	31072	59608	15220	20539	35759	8229	15420	23649	2382	7200	9582
White alone	16211	15701	31912	8414	10471	18885	5331	9408	14739	1564	4611	6175
African American alone	11210	14369	25579	6331	9509	15840	2726	5757	8483	774	2528	3302
Asian alone	628	558	1186	267	264	531	90	123	213	22	19	41
Pacific Islander or Native Hawaiian alone	11	8	19	3	4	7	1	1	2	0	2	2
Native American	49	43	92	13	36	49	7	13	20	5	2	7
Other	199	138	337	62	58	120	22	22	44	4	7	11

Source: US Census 2000

The aging of our population can be attributed to several factors. Increased life expectancy and declining fertility rates are two trends underlying an aging population (Population Reference Bureau, 2002). Over the past century, the average life expectancy has nearly doubled (Population Reference Bureau, 2006). Average life expectancy at birth in the U.S. increased nearly 63%, from 47.3 years in 1900 to 76.9 years in 2000 (U.S. Census).

According to the Georgia Department of Human Resources, Georgia ranks tenth among states with the fastest-growing age 60 and older population (GDHR, 2005). Georgia's 893,049 residents who are over age 60 comprised 13% of the state's total population in 2000 (U.S. Census, 2000). By 2010, the state's age 60 and older population is expected to increase by 76.3%, from 893,049 to 1,574,346 persons (GDHR, 2005).

The Atlanta region's age 65 and older population increased by 30% between 1990 and 2000 (ARC). Projections indicate that by 2030, the number of people age 60 and over in the Atlanta region will triple, from 400,000 to more than 1.2 million (ARC). Fulton County residents age 65 and over comprised 8.5% (n=68,990) of the county's total population in 2000 (U.S. Census). There were 93,567 Fulton County residents age 60 and older during that time (U.S. Census, 2000). If this number triples over the next 22 years, Fulton County will have 280,701 residents age 60 and over in 2030.

One may also note from the above chart that the oldest segment of the senior citizen population, defined as those seniors age 85 and over, is growing as well. U.S. Census figures indicate that between 1990 and 2000, the highest percentage increase among the U.S. elderly population occurred in the 85 and over age segment (U.S. Census, 2001). Georgia experienced a 53% increase in the number of residents age 85 and older between 1990 and 2000 (U.S. Census 1990, 2000), and is ranked tenth among states demonstrating the fastest-growing 85 and older populations in the nation (GDHR, 2005). While Fulton County residents age 85 and older comprised only 1.2% of the total county population in 2000 (U.S. Census), we can expect this number – and subsequent levels of aging-related needs – to rise dramatically in coming decades.

Health of Fulton County Seniors

Mortality: In 2006, there were 5,721 deaths in Fulton County. Deaths among seniors age 60-74 comprised nearly a quarter (n=1,265) of all Fulton County deaths, and deaths among seniors age 75 and older comprised another 47% (n=2,693) of all Fulton County deaths in 2006. Cardiovascular disease was the number one cause of deaths among seniors age 60 and over. In 2006, there were 421 deaths resulting from major cardiovascular disease among seniors age 60-74, and 956 among seniors age 75 and older.

Morbidity: Major cardiovascular disease was the number one sickness among seniors age 60 and older at the time of hospital discharge.

The aging population needs to be able to access the same, or perhaps even more, services as they age as they accessed before becoming seniors. However, most Fulton County seniors live on fixed incomes, and the majority live at or below the poverty level. They have chronic illnesses such as hypertension, diabetes, and cardio-vascular disease, and many show signs of Alzheimer's or dementia. Communities must be transformed to become livable communities so that seniors can age in place, have access to quality health care, and enjoy a physical environment that supports healthy living.

Substance Abuse

Excessive alcohol consumption in the United States is responsible for approximately 75,000 deaths per year, making it the third leading cause of preventable death.

- Nearly 47% of homicides, 23% of suicides, and 40% of fatal motor vehicle crashes are directly attributable to excessive drinking.
- More than 600,000 retail alcohol outlets are licensed in the United States. In 2005, this meant 2.7 outlets per 1,000 people aged ≥ 18 years.

One of the widely recognized approaches to reducing the harms associated with excessive alcohol consumption is local regulation for density and location of retail establishments that sell alcoholic beverages. As a group, African Americans consume less alcohol per capita than Caucasian Americans. However, alcohol abuse in the African American community results in disproportionately higher rates of certain alcohol-related problems, such as cirrhosis of the liver, esophageal cancer, violent crime, and accidents. In spite of this fact, marketers continue to target poor and disadvantaged areas for the sale and distribution of certain alcohol products. Neighborhoods with high concentrations of alcohol establishments have a higher incidence of drinking, assaults, accidents and associated violence. Minority neighborhoods across Fulton County have more alcohol outlets, more outdoor alcohol advertising, and greater availability of beverages with higher alcohol content than do non-minority neighborhoods.

Addiction to alcohol and other drugs is an insidious process. The environment in which people live is a contributing factor in this process. Often, people turn to alcohol and drugs as a way to cope with the challenges presented in their everyday reality. They self-medicate in an effort to lessen the pain associated with poverty and other harsh realities they face from day to day. Often, individuals began a cycle of drug use to mediate the symptoms of depression or other behavior health disorders. Research suggests that approximately 60% to 70% of individuals who have substance abuse disorders also have a co-occurring behavior or mental health disorder. Unfortunately, the jails and criminal justice system have become the “de facto” treatment centers for these individuals.

However, if appropriate resources such as housing, case management, linkages to community social service agencies, and outpatient behavioral health and health services, to name a few, were available within the community, inpatient institutions such as the local jails, Grady Memorial Hospital and hospital emergency rooms would not be inappropriately utilized or over-utilized.

For example, some individuals enrolled in the Mental Health Treatment Diversion Program are known to have cycled through the Fulton County Criminal Justice System more than five times. They may have diagnoses of schizophrenia and alcohol dependence, as well as a long history of not taking medication, combined with unstable housing and other community issues. As is often the case with individuals with behavior, health, and substance use disorders, once released into the community, they may not have the necessary resources such as housing, job assistance, appropriate health treatment, financial assistance and other resources to live independently within that community.

Needless to say, they will probably commit another misdemeanor and will subsequently be re-incarcerated.

If individuals are provided with the right resources (mental health, housing, aftercare, employment services, physical health care) and can become stabilized, their success rate will be improved and their recidivism reduced. This kind of support can help reduce health disparities in Fulton County.

Success for these individuals can be a remarkable example of the positive outcomes our society can achieve when communities direct their resources into safe, affordable housing and other supportive social services resources within communities. Individuals receive the assistance they need, and the total resource allocation represents a much lower burden to society and taxpayers, while simultaneously reducing the burden on the criminal justice and health systems.

One approach for addressing these kinds of issues from a Social Determinants of Health angle, for example, is the use of regulatory authority (through licensing, zoning, and other means) to limit the density of alcohol outlets in a given community. Such an approach will help prevent excessive alcohol consumption and related harms, based on significant research evidence of a positive association between alcohol outlet density and specific social and physical disparities among the resident population.

Simply put, we must abandon our “silo” approach to providing services to our citizens. We are all inextricably tied together and have a duty to work collaboratively to raise the overall health status of our community. We cannot continue to simply “blame the victim.” for his or her problems. Rather, the overarching social conditions that allow these problems to breed and flourish have to be addressed through a continuity of service delivery.

Mental Health

Mental illness results from various complex psychological, social, and biological interactions. Additionally, it is influenced by a number of risk and protective factors. Low self esteem, lack of control over work and home life, insecurity, and continuing uncertainty all contribute to long-term stress and may result in mental health problems. The unemployed and socially isolated people have higher prevalence of mental health disorders than people who are employed and socially connected. Many of these contributing elements can be minimized within a strong and supportive community environment.

People’s social and economic circumstances are directly related to their overall health. Good mental health results from the combination of social, emotional and spiritual well being. The stress of living in an impoverished environment can certainly contribute negatively to one’s mental health.

When individuals are continually exposed to stressors that evoke the “fight or flight” response, there may be serious physical and mental health ramifications – because our

bodies instinctively respond to threats to our well being. Our bodies cue us to stay and face the threat (fight), or to turn and run (flight) in an effort at self preservation. When this innate mechanism is triggered, our blood pressure, heart rate, anxiety level, and alertness are all increased. Continual triggering of this response, as is often the case in poverty stricken environments, can lead to multiple physical and mental problems including depression, hypertension, stroke, or heart attack. The “fight or flight” stress many people routinely experience in impoverished communities is only one example of how unequal distribution of power, resources, goods and services can contribute to health disparities across our nation.

In Fulton County, many disadvantaged communities exist in the shadow of many well-to-do communities. While the physical health of persons residing in these communities is the more obvious issue, mental health (or the lack thereof) is of equal importance. Living from day to day in an environment with high levels of violence, drug activity, hopelessness, and poverty is stressful. All of these factors have powerful effects on both physical and mental health.

A typical mental health services consumer in Fulton County may present with a generational history of problems associated with poor mental health, cycles of abuse, or systemic “missed opportunities” for proper intervention and community support. Their environmental conditions often include a gang-infested neighborhood that is over-run with drugs, weekly shootings, and rat infestations. Schools are poor, and there is little or no social support from neighbors or relatives. It is not surprising that individuals in these circumstances may seek help sporadically for depression, feelings of suicide, or loss of control. Inevitably, if there are children in the home, the adults’ mental health problems are manifested in their children through behavior disorders. In some cases, the children may be removed and placed in foster care.

The rhetorical question in this scenario is “Who is to blame?” Should we blame “the system” or the individual? Most people looking at such a situation are acutely aware that social factors are at the root of this person’s problems. Oftentimes, it is only when the criminal justice system intervenes – through a jail sentence – that the individual will receive the help that he or she desperately needs.

While we work to help adults facing mental health issues, we must not forget the children. They are the silent voices that beg for someone to step in and break the generational cycles of abuse, poverty, poor living conditions, inadequate schools and health systems, gang-infested neighborhoods and other societal woes that victimize the youngest citizens. We must recognize and address this simple truth: If so many of our people continue to live in less than optimal living conditions, we will continue to breed generations of dysfunctional children, families, and adults.

Finally, we must initiate public and private campaigns aimed at reducing the stigma, particularly in the African American community, that many still associate with seeking help for mental or behavioral problems.

III. Correcting the Inequity

SOLUTION: SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDH) are the essential factors and resources that contribute to or detract from the health of individuals and communities. The relationship between social and environmental factors that an individual lives with as essential determinants of health status has been accepted by scientists, practitioners and policy makers for quite some time. The relationships between the social determinants and subsequent health outcomes are complex and inextricable, a reality that often hinders progress towards addressing health status from a social determinants perspective. Furthermore, inequitable distribution of the determinants in question has significant influence on persistent health disparities in our most underserved communities.

Early efforts to describe the relationship between these conditions and health or health outcomes focused on factors such as food safety or water and air quality. Efforts over the last ten years have delineated a broader spectrum of factors that affect health, including such indirect aspects as housing and community design, employment status, health care access, availability of healthy foods choices, and pollution.

These factors include, but are not limited to, the following:

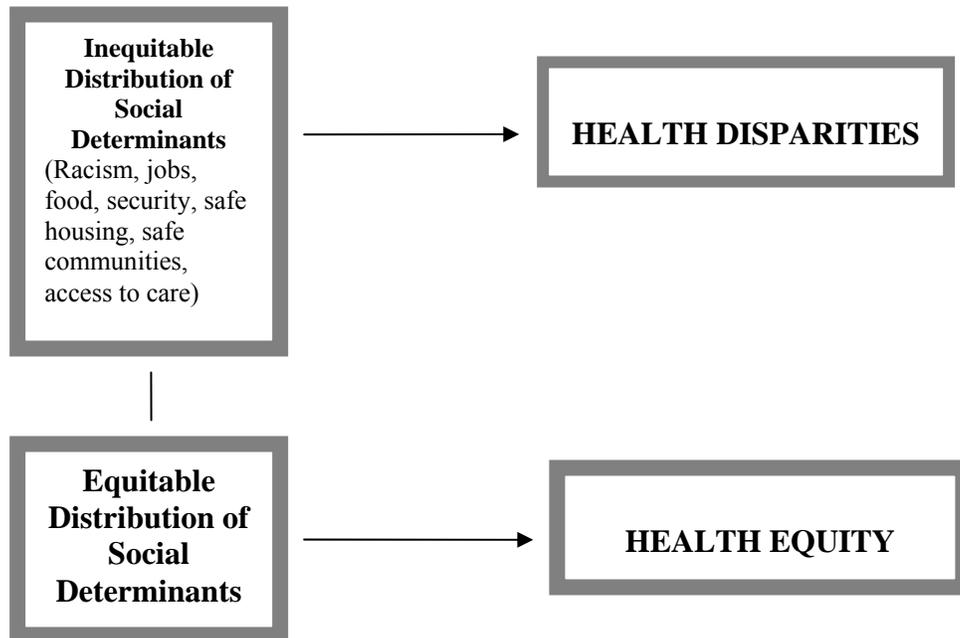
Social Determinants of Health

Socio-economic status	Education
Transportation	Violence
Housing	Income
Access to services	Social gradient
Social or environmental stressors	Norms
Policies and laws	Social networks
Social support	Culture
Social capital	Racism / discrimination
Transportation	Neighborhood characteristics
Physical living conditions	

According to the CDC Division of Prevention Research and Analytic Methods, there has not been enough research conducted to describe the relationship between social determinants and health outcomes or to develop and test interventions to change them. There are few disease-specific prevention programs or research projects currently examining these factors in an in-depth manner.

National guidelines are being developed by the CDC's Healthy People 2010 (HP 2010) initiative to address the relationship between these conditions and subsequent negative health impacts. The stated vision of the HP 2010 project is "healthy people living in healthy communities." HP 2010 recognizes that to be successful, "communities, states, and national organizations will need to take a multidisciplinary approach to achieving

health equity – an approach that involves improving health, education, housing, labor, justice, transportation, agriculture, and the environment, as well as data collection itself.”



To develop initiatives that increase health equity in our communities, it is critical to gain the engagement of non-traditional partners that customarily may not have been part of public health initiatives, such as community organizations and representatives from government, academia, business, and civil society. To be successful, and because social policies have long-term impacts on health, we must implement system-level changes, in concert with community input/engagement and policy changes. Changes should include policies that affect socio-economic factors and environmental factors. Policy strategies coupled with individual behavioral change and clinical services will improve the likelihood of individuals’ and communities’ success.

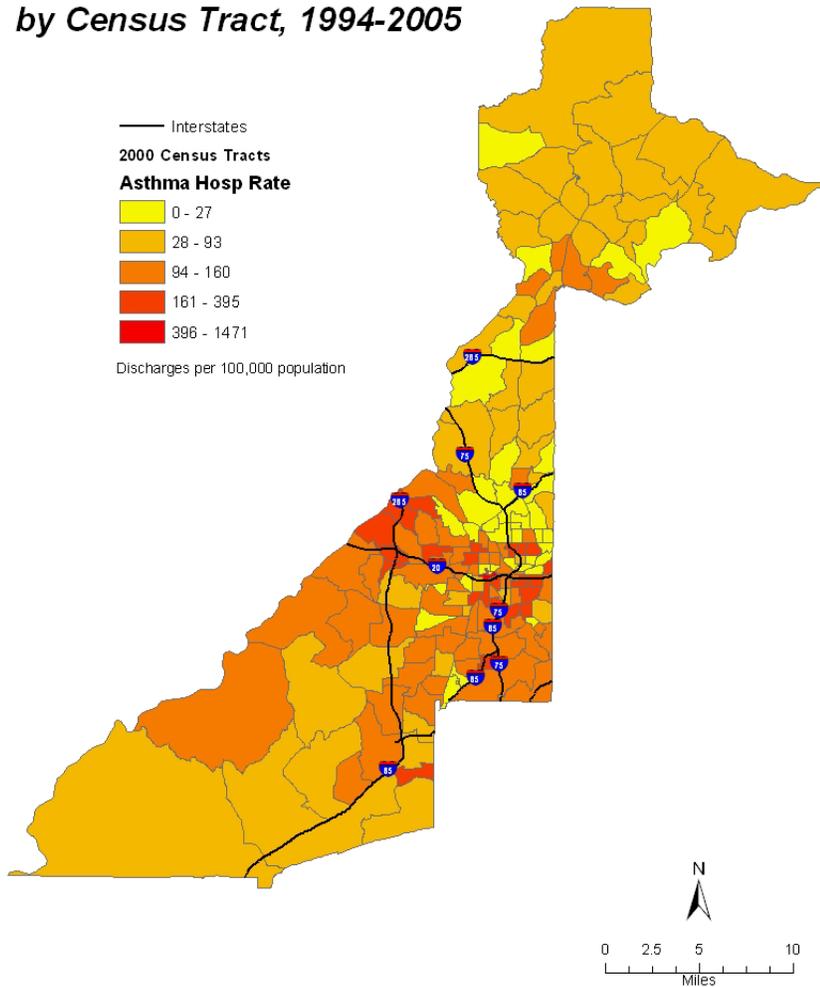
IV. Overview of Health Disparities and Socio-economic Status (SES) in Fulton

Asthma

Asthma is a useful measure from a social determinant perspective due to the many factors that influence the rate and severity of attacks, particularly in children. These include, environmental triggers, the health literacy of caretakers, having a primary care medical home and management plan, access to treatment, and asthma's effects, including the child's loss of time in school and caretakers' loss of income as they stay home to care for the child.

In March 2007, Atlanta was ranked #1 among the 10 worst cities for asthma by the Asthma and Allergy Foundation of America. The greatest burdens of this disease can be found in urban settings where certain conditions tend to increase the incidence and severity of asthma.

**Asthma Discharge Rates
under 17 years age
by Census Tract, 1994-2005**



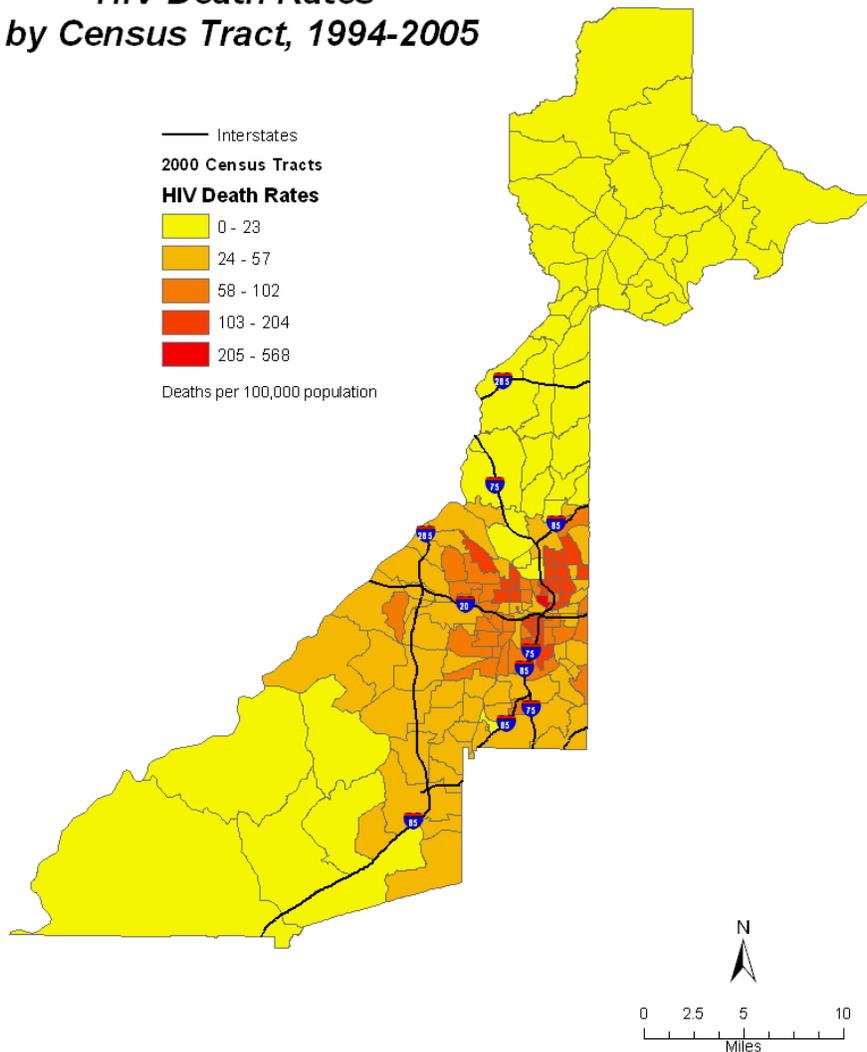
- 1 in 6 households (210,000) are affected by asthma
- 54% of asthmatic children in Georgia miss 540,000 days of school annually
- 30% of parents with asthmatic children miss 390,000 days of school or work
- 25% of these children live in homes where one or more of the adults smoke
- Asthma costs Georgia \$296 million annually in direct health care expenses
- There were more than 47,000 emergency room visits in 2003 with asthma as the primary diagnosis

*SOURCE: The American Lung Association of Georgia
and The Asthma and Allergy Foundation of America*

Human Immunodeficiency Virus (HIV)

Deaths due to HIV infection have fallen markedly over the past decade, particularly among African American males who live in Fulton County. Significant improvements in treatments have allowed patients to live longer with the infection, and increased outreach case-finding efforts, and increased knowledge about the disease and its risk factors have made a difference. Despite this positive trend, the burden of this disease continues to be high among African American males in Fulton County, particularly when compared to the state of Georgia as a whole.

HIV Death Rates by Census Tract, 1994-2005



Infant Mortality Rate

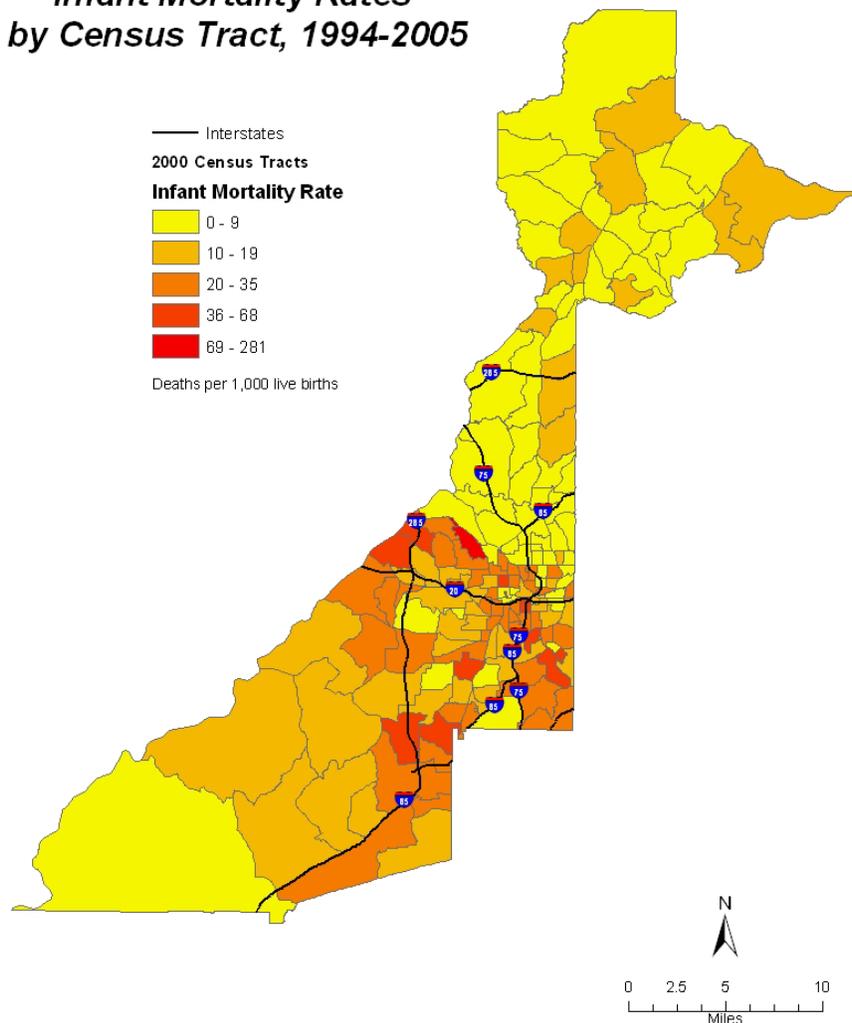
Infant mortality is one of the most important indicators of the health of a nation, as it is associated with a variety of factors such as maternal health, quality and access to medical care, socio-economic conditions, and public health practices. The U.S. infant mortality rate has declined overall throughout the 20th century. In 1900, the U.S. infant mortality rate was approximately 100 infant deaths per 1,000 live births, compared to 6.89 infant deaths per 1,000 live births in 2000. However, the infant mortality rate in the U.S. did not decline significantly from 2000 to 2005, which has generated concern among researchers and policy makers.

Recent data show that the U.S. infant mortality rate for non-Hispanic African American women was 2.4 times the rate for non-Hispanic Caucasian women. Rates were also elevated for Puerto Rican and American Indian or Alaska Native women. Increases in preterm birth and preterm-related infant mortality account for much of the lack of decline in the United States' infant mortality rate from 2000 to 2005.

The Healthy People 2010 target goal for the U.S. infant mortality rate is 4.5 infant deaths per 1,000 live births. The current U.S. rate is about 50% higher than the goal. United States Infant Mortality Rates for 2004 through 2006, were 6.78, 6.86 and 6.71 per 1,000 live births.

The burden of infant mortality falls more heavily among the African American population in Georgia and in Fulton County. African American infant mortality rates run significantly higher than among other races, and the highest rates of infant mortality are found in urban settings, driven largely by a higher proportion of African American residents within the City of Atlanta.

**Infant Mortality Rates
by Census Tract, 1994-2005**

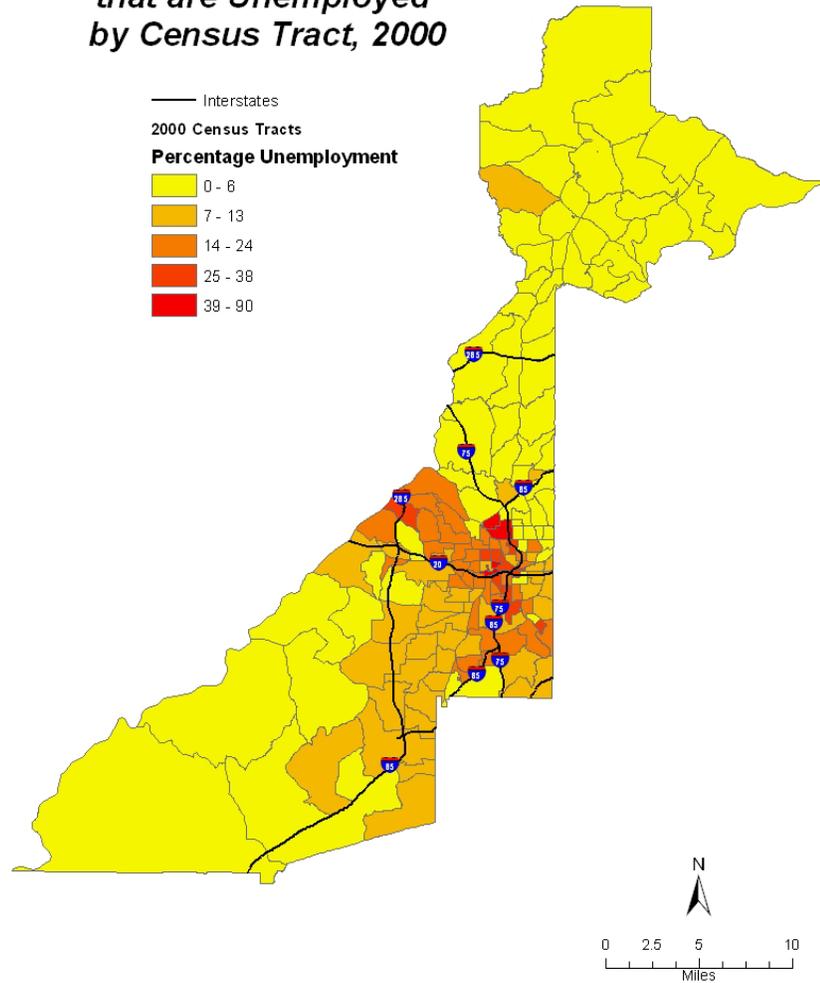


The following graphs depict the data from the Geographic/Geospatial Information System (GIS) mapping, which is used to identify concentrated areas of Fulton County that appear to indicate problematic circumstances around the following social determinant factors:

Unemployment

As one might expect, areas of Fulton County with the highest percentage of unemployed eligible workers correspond with high-poverty areas. Patterns of unemployment among eligible workers also appear to be consistent with patterns of no high school diploma and homicide rates.

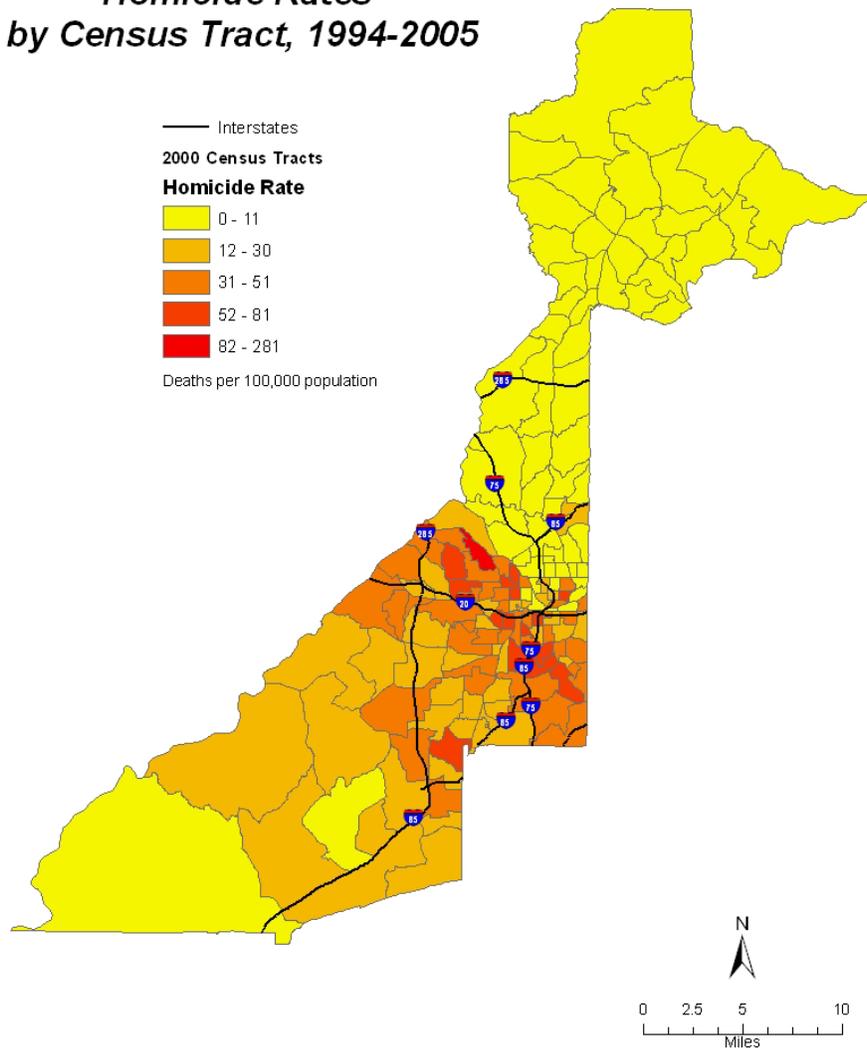
**Percentage of Eligible Workers
that are Unemployed
by Census Tract, 2000**



Homicide Rate

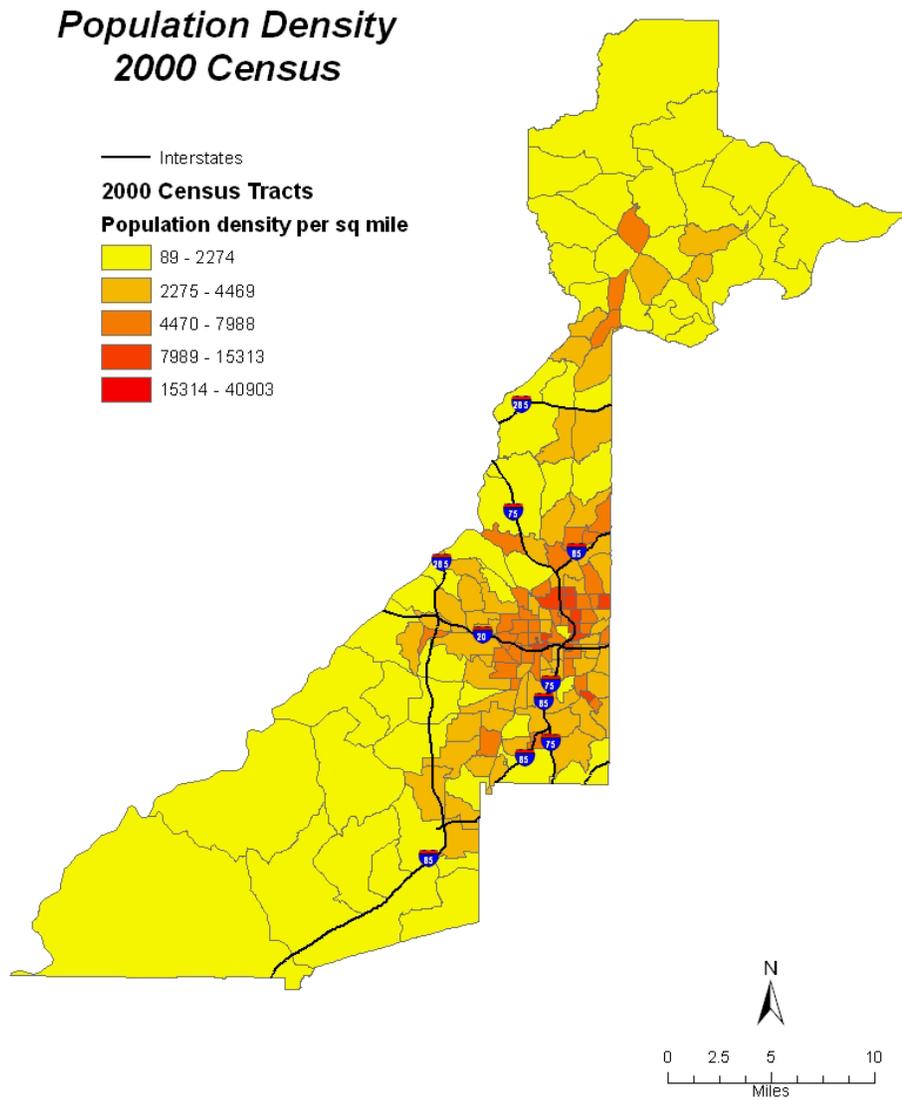
Homicide rates from 1994 to 2005 correspond with eligible unemployed workers and high poverty. The geographical pattern of high homicide rates is strikingly similar to those patterns of unemployed eligible workers and no high school diploma. Homicide rate patterns also appear to correlate with more densely populated areas and highly concentrated poverty areas.

Homicide Rates by Census Tract, 1994-2005



Population Density

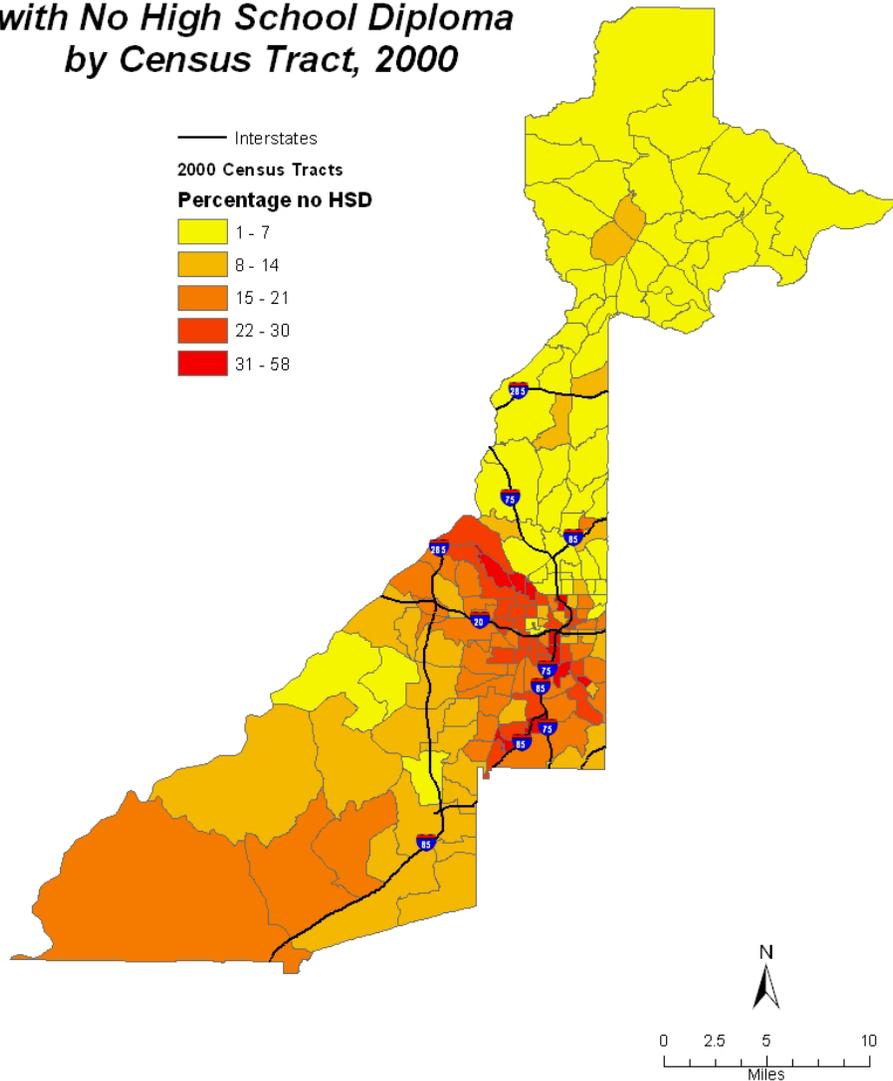
The highest population density areas of Fulton County are evident around the Atlanta urban city center, with a few other densely populated areas located in north Fulton.



Education

Areas of Fulton County with the highest percentage of residents with no high school diploma are most evident in the south-central and southern regions of the county. Areas containing high percentages of the population with no high school diploma appear to be consistent not only with areas of high unemployment, but also with areas having higher homicide rates.

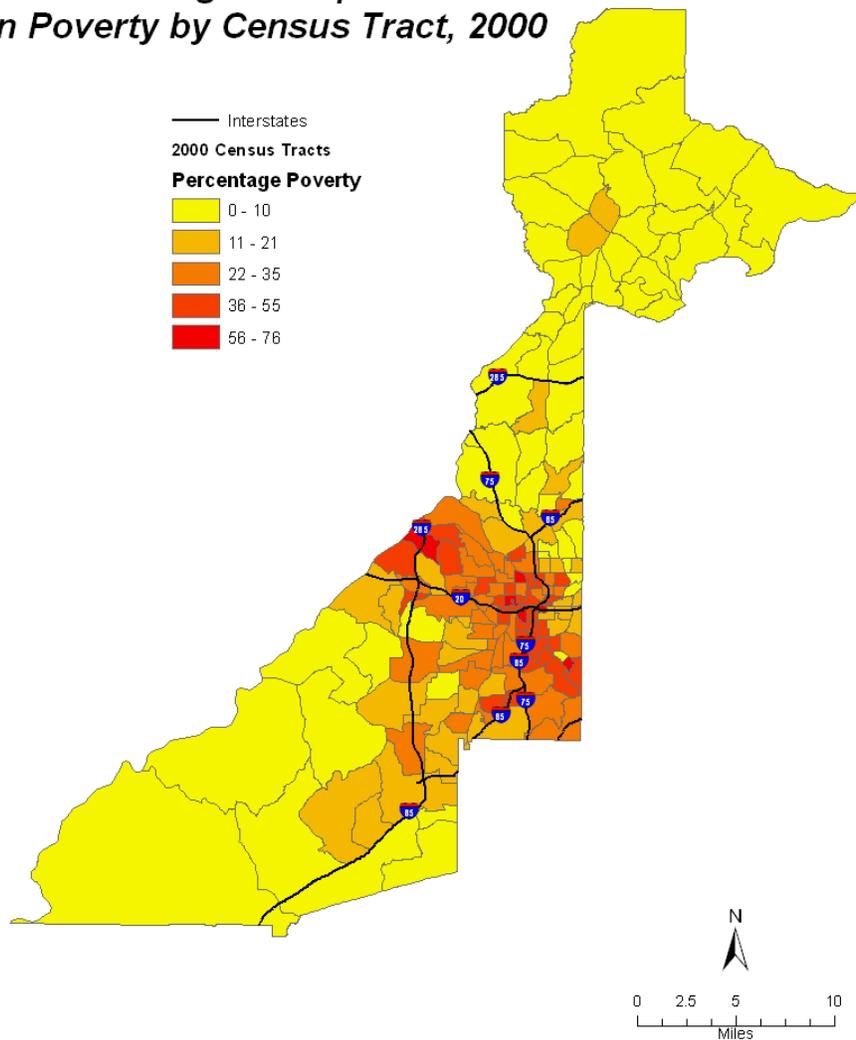
Percentage of Population with No High School Diploma by Census Tract, 2000



Poverty

Fulton County exhibits concentrated poverty. The highest poverty areas appear to be concentrated together, located in the central urban region of the county. This high-poverty concentration forms an area that stretches from one end of the county to the other, east to west, and contains mostly moderate to high population density areas. A Brookings Institution study found that Atlanta is among the worst in the country in terms of concentrated poverty, with Atlanta ranking 5th among U.S. cities (Berube and Katz, 2005).

**Percentage of Population
in Poverty by Census Tract, 2000**



V. Public Policy that Impacts Health Disparities

Public policy impacts the services in a community. Furthermore, a distinct relationship exists between the health outcomes for people and the community environments in which they live. Taking these two factors into consideration, then, public policy can drive the social determinants of health. Public policy must not contribute to health disparities and inequities; rather, public policy should promote health behavior by placing accessible, convenient resources in the community that enhance the socio-economic conditions of residents. Good public policy should alleviate deficiencies that lead to negative health outcomes.

In order to create sustainable and livable communities throughout Fulton County, a thorough analysis of current public policies affecting residents must take place. Public policy change is imperative if the inequities and disparities within given communities and among populations is to be addressed effectively and eventually eradicated. Effective public policy can improve the quality of life for all residents by promoting and encouraging healthy communities, and by placing emphasis on community infrastructure as well as intervening support services.

In this regard, it is important to understand that policies that do not focus directly on health can still have health implications. A substantial body of research and literature indicates that improving public services, community infrastructure, and the socio-economic condition of people can also improve their health. For instance, an optimal neighborhood has an array of socio-economic opportunities, strong businesses and industry, affordable housing, shopping centers with restaurants, cultural activities, theatres, playgrounds, good transportation, parks, walking trails, enhanced street lighting, and adequate public safety. Unfortunately, few urban neighborhoods have all these elements, which all work together to contribute to good health outcomes for residents. Many of these elements are especially lacking in impoverished neighborhoods and communities that are not connected to mainstream resources.

Yet people have basic needs that must be met if they are to survive and thrive. Community development should deliver an environmental infrastructure that can support the residents and their basic needs. For instance, in order to improve the health outcomes of residents, a community must have the right resources. Research shows that if a community has good schools and housing, then the odds of that community and its residents staying healthy are much higher than for communities without those resources. Many communities already have health and human service programs (local health clinics, social service centers, libraries, recreation centers, schools, etc.) or agencies that residents can access. But these services are only the beginning of what is needed to make a community livable. Communities must continue to be empowered to identify their needs. Communities that are failing should be helped to make changes through public policy that adds essential services and infrastructure to make them successful.

Among the specific policies that need to be reviewed – policies that are directly related to communities' physical and social environment and infrastructure – are public safety;

zoning for fast food stores, liquor stores, fast cash and loan establishments; parks and recreation; grocery stores; use of vacant land; and economic development. Some of these categories are directly related to the negative influences in a given community and the need to reduce these influences. Others highlight strengths that exist in healthy communities. In this regard, public policy should enhance communities' positive, strong attributes, and policy makers should perform a careful review those policies that contribute to negative environmental indicators. For example, in the south section of Los Angeles, the government is considering a ban on new fast food restaurants. This is a major policy initiative by government to address the health outcome of its citizens.

In fact, many major health issues are directly tied to the environment and the community in which one lives. For instance, childhood obesity has directly been linked to lack of exercise, fast food consumption, low nutritional meals, and in some cases, heredity. To have an impact on this health issue, policies that directly link to licensing and zoning of fast food establishments should be reviewed. In some instances, if policies do not exist, then government and the community should consider drafting policies that determine how many fast food restaurants or liquor stores will be permitted in a given community. Such measures are not uncommon: for example, saturation or critical mass policies are in place in many jurisdictions regarding such establishments as group homes, regardless of the clientele to be served. It is time to apply "critical mass" analysis to establishments that impact negatively on the health of people and the survival of neighborhoods.

Economic well-being is another major measure of the health of a community. Economic well-being typically reflects the growth or decline of industries that provide job opportunities for residents. Communities with a strong base of business or industry yield vibrant and self-sustaining neighborhoods. Communities that lack this economic support typically have decaying infrastructure and transient residents who do not offer stability for a community. Obviously, the economic health and viability of a community are intertwined; community and neighborhood survival relies on a strong economic base with ample employment opportunities for residents.

Therefore, policies relevant to economic development should address partnerships with municipalities to employ residents. A major factor in corporation relocation is the availability of a skilled workforce. A strong partnership between local planners, economic developers, and workforce development specialists must exist to ensure that a trained labor force is ready for the new industry. Research confirms that when people have well-paying jobs and health insurance and own their homes, they have a better chance of not developing major health problems. Living within a stable financial situation helps a family to purchase the essentials needed for improved health outcomes. Financial stability also decreases stress levels and subsequent health issues.

Concurrent with new industry is the need for housing. In general, communities with a low threshold of home ownership also have more negative health impacts. In the private sector, new housing developments are now adding many desirable environmental attributes such as walking trails, parks and recreation to their plans. These elements can have a major impact on residents' health problems such as obesity, hypertension, diabetes, and cardio-vascular disease. In the public sector, public housing policy should

always address financing programs that support affordable housing and home ownership. As affordable housing is created, plans must include building communities with infrastructure, services and resources that improve the social determinants of health. To achieve these goals, policy makers and planners are advised to use an all-inclusive approach to housing development projects. Not only should community stakeholders be at the table, but also, the planning team should include representatives from agencies and organizations that help keep residents healthy and strong. These are the agencies that invest in the “human capital” of a community – the traditional human and social service agencies.

In summary, public policy has to be designed to eliminate “social exclusion.” Literature describes social exclusion as “the economic hardship of relative economic poverty and includes the process of marginalization – how groups come to be excluded and marginalized from various aspects of social and community life” (Alameda County Health Disparities Report 2002). Public policy must support the survival of residents and their communities and should be created through empowering communities to drive the process. It should be all-inclusive and provide for wrap-around services that are traditionally socio-economic, as well as innovative new approaches that are connected to the physical environment.

Common Ground: Creating Equity through Public Policy and Community Engagement – A Model for Fulton County

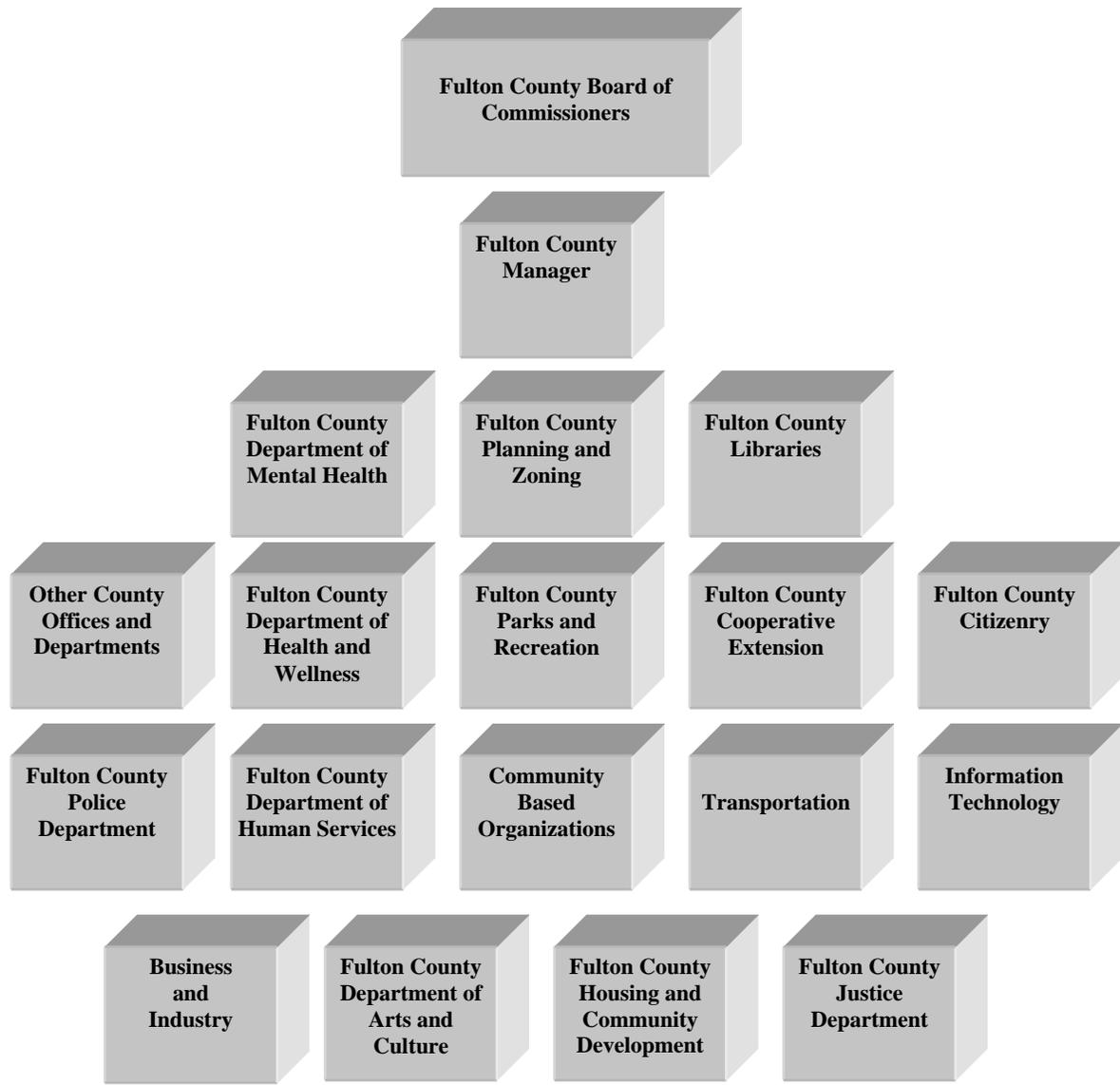
In August 2008, the Fulton County Health and Human Services Cluster, which consists of the Department of Health and Wellness, the Department of Human Services, and the Department of Mental Health, Developmental Disabilities and Addictive Diseases, was charged with developing a proposal that would address Fulton County population inequities with regard to racial, ethnic and other socio-economic disparities. Recognizing the complexity and magnitude of an initiative that would require a major paradigm shift from the usual business of county government, the Human Services cluster garnered the support of the entire local government and many other community agencies. Governmental entities that are involved include:

- Elected officials/ policy makers
- Department of Economic and Community Development
- Department of Family and Children Services
- Fulton County Department of General Services
- Department of Public Works
- Fulton County Arts Council
- Fulton County Library
- Fulton County Police Department
- Department of Housing and Community Development
- Code enforcement
- Fulton County Parks and Recreation
- Cooperative Extension Service

Other community agencies/ stakeholders that will be invited to become a part of this initiative include:

- The Atlanta Regional Commission
- United Way
- MARTA
- Community-based Organizations (CBOs)
- Faith-based Organizations (FBOs)
- Neighborhood Planning Units (NPU)
- Local Businesses
- Institutions of higher education
- School boards

As stated earlier, in order to address these issues in a substantive way, all sectors of the County must be involved. This will require Fulton County departments and divisions that have not historically worked collaboratively to begin to do so. The approach will also enjoin multiple sectors from the community, with the understanding that in conversations involving social determinants and health equity in Fulton County, everyone has to be active in the process. The multiple stakeholders in this process include many of our county departments but also include community sectors as well.



Initially, the Health and Human Services cluster met to identify all agency programs that are currently addressing the issues of health disparities. Secondly, the cluster identified opportunities for further partnerships in these areas; thirdly, the cluster collaborated on opportunities to create new programs and policies that would address local inequities.

VI. An Approach for Fulton County in Addressing Social Determinants of Health

In order for Fulton County to address the social determinants that contribute to existing health disparities for Fulton residents, all participants must recognize that this approach is not an overnight process. It goes directly to societal conditions, economic conditions and political structures, including a variety of resources. The interrelatedness of these constructs is undeniable, yet great disparities continue to exist. When we begin to understand how health outcomes are affected by societal conditions, individual health behaviors, and access to health care, then we can begin to move toward health equity in Fulton County.

CDC Adaptation

The Centers for Disease Control and Prevention (CDC) published a resource guide to help communities address social determinants of health. This national model offers a comprehensive template for local communities to replicate. Key steps of the model include:

- Creating community partnerships
- Assessing social determinants of health to create a shared vision for community change
- Building community capacity
- Developing and implementing an action plan
- Assessing progress
- Maintaining momentum over time

The Fulton County model thus far describes the process of beginning a Social Determinants of Health Initiative from the perspective of policy makers and internal county departments. What follows is the Fulton County *Common Ground* presentation of “targeted opportunities” using the approaches recommended by the CDC methodology for implementing a Social Determinants of Health project.

The Fulton County Approach

Fulton County government is uniquely positioned to make desirable social determinants of health balanced and equitably distributed among all residents. County departments, the traditional health, social and human service agencies, and the physical environment and infrastructure agencies are all focused on the vision of creating communities that are livable, safe, and promote healthy lifestyles.

The movement toward addressing the social determinants of health disparity in Fulton County was founded upon interdepartmental collaborations with current and future community partnerships. By forging solid relationships with other Fulton County agencies, businesses and community representatives, Fulton County will be better able to effectively utilize its assets to combat poverty, affordable housing inadequacies,

environmental stressors and other social determinants of health that affect our communities. The following is a brief listing of initial goals for this effort.

- Initiate an interdepartmental collaborative approach
- Influence change – public policy
- Improve health outcomes
- Increase external systems of collaborations
- Improve/enhance communities
- Leverage resources for maximum benefit to communities
- Change the infrastructure of troubled communities
- Establish a new way of governing that supports social determinants of health

At the direction of the county manager, the Health and Human Services (HHS) Cluster began to investigate actions that could be taken to optimize service delivery among HHS Cluster Departments within the Fulton County government. This task evolved into a much larger strategic initiative that is investigating a system-wide approach to address the social determinants of health.

A “systems” approach that combines policy makers, elected officials, advocates, and family members as well as public and private partnerships is drastically needed in order to address and remediate the problems of social, economic and health disparities with regard to social services, health, housing, education, mental health and substance abuse treatment. Continuous interventions that address both short- and long-term goals must be defined and implemented vertically, horizontally, and across all spectrums. Community engagement and involvement is one of the most critical factors that must be invoked.

Using an interdepartmental collaborative approach, the Human Services Cluster has formed a Social Determinants of Health (SDH) Task Force and has been developing a service delivery improvement plan. The intention is to optimize service delivery in general among Human Services Cluster Departments and begin to engage other appropriate agencies (public works, zoning, planning, housing, parks and recreation, public safety) within the Fulton County government.

The first milestone for the task force was completion of a comprehensive inventory of all programs within the Human Services Cluster and an evaluation of the program’s position in the sequence of events that influence the social determinants of health. Follow-up work has included evaluating information technology solutions to reduce redundancy and increase efficiency, as well as consultation with authorities in the field of SDH for direction and guidance. According to Dr. Camara Jones, Research Director on Social Determinants of Health, this local, interdepartmental collaboration to create a coordinated prevention initiative to reduce disparities and improve health outcomes is one of the first such efforts in the nation.

In creating this document, a vast amount of information was located and reviewed. This review process found that two of the nation’s most progressive municipalities have addressed this issue from a holistic, system-wide perspective: King County, Washington,

through its *Equity & Social Justice Initiative*; and Alameda County, California, with its *Place Matters* initiative. Each of these programs provided invaluable insight into beginning a similar process for Fulton County, despite the obvious differences among these three communities.

This document, titled *Common Ground: Creating Equity through Public Policy and Community Engagement*, is a compilation of efforts to date and future efforts to address system-wide changes. These changes fall within three broad categories: (1) policy change, (2) culture change, and (3) community change. It is essential that policy makers are informed on the long-term effects of their decisions on the most disadvantaged levels of the community. Conversely, it is crucial that these communities be engaged in a constructive, positive manner in order for effective changes to take place.

Targeted opportunities exist within the county to pilot this initiative. The future opening of the newly renovated Neighborhood Union Health and Community Center provides a targeted opportunity to implement programs in a needy community that shift the approach from traditional interventions to a perspective that considers the social determinants affecting health outcomes. With the expansion and renovation of the Historic Neighborhood Union Health Center, an additional 14,000 sq. ft., of new building will offer enhanced services to the residents of Vine City. In addition, pre-literacy outreach training and involvement with local daycare and schools will focus efforts to prevent dropouts and improve overall graduation rates. This building will serve as the nexus for many critical services for the residents of the Vine City community.

The other targeted opportunities are the Serving At-Risk Teens (START) System of Care for Children and Youth, the North and South Fulton Community Center Intergenerational Community Program, and the Oak Hill Mental Health System of Care for Children and Youth. Each of these opportunities will be discussed further in this document.

Using the social determinants of health approach, all associated groups must come together to plan and implement practices that will improve health outcomes for all people. The social and physical environment in unincorporated South Fulton is managed by Fulton County. Because this area is under one government authority, its policy development or changes, budgeting, and planning for services are all controlled by one entity. In other targeted opportunity locations, the Fulton County Health and Human Services cluster will work collaboratively with local governments (incorporated cities) to build partnerships that will help to negotiate the political boundaries that control or influence policies and community development.

In all communities, the preferred strategy is to work with the residents and community organizations. The action agenda will be driven by community needs and build on existing resources to provide a full array of service supports. Enhancing the SDH support systems will be the focal point for providing wrap-around services that will yield equitable resource distribution, livable communities, and positive health outcomes for residents.

As this document was being drafted, the Centers for Disease Control and Prevention issued a valuable workbook, *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health*. This national model offers a comprehensive template for local communities to replicate. The Fulton County model intends to follow the CDC recommended methodology. Key results of the model include:

Expected Results

The Fulton County *Common Ground Initiative* seeks to:

- Influence change of public policies
- Leverage resources
- Increase systems of collaborations
- Improve/ enhance communities
- Enhance quality of life
- Change the infrastructure of a community
- Provide for a new way of conducting government
- Increase community capacity building
- Empower neighborhoods
- Increase awareness of public policies
- Increase fresh markets or community gardens
- Increase health care access
- Provide for safer communities

The initiative hopes to realize the following outcomes:

- Improve health outcomes
- Decrease chronic diseases
- Increase high school graduation rates
- Increase adult employment
- Increase walking and biking communities
- Empower neighborhood residents
- Increase access to health care
- Improve infrastructure of communities to support healthy living

Preventing disease and reducing health disparities are among the many future aims of this pioneering effort in Fulton County. As a strategy, prevention is distinguishable from traditional health promotion methods in specific ways. Fundamentally, prevention strategies require coordination and collaboration by multiple stakeholders involved in large-scale efforts to modify policies that affect the target environment.

These stakeholders, including the county's human service cluster agencies, environmental agencies, political leaders, and the community, will drive the SDH agenda. The expanded task force will oversee community assessments using a strengths-based model. The task force will also monitor the activities of each department as the target community projects are implemented.

Successful programs and policies will bring about the intended outcomes of positive behavioral change and healthy living in revitalized communities and in turn, improved health outcomes. The major underpinning for the SDH approach across all county departments and in programs or policy change will be *prevention*. Policies across all departments will be reviewed to determine if they include prevention strategies that directly or indirectly impact improved health outcomes for citizens. Some of these strategies may include improved street lighting so that people can walk in a safe environment, more zoning for grocery stores and less for liquor stores, creation of open urban gardens, community resource centers, health coverage and accessible health care, great schools, industry and business development that will provide livable-wage jobs, and a reliable safety-net support system for all people.

Principles

Equality in service delivery and opportunities is paramount to ensuring that all Fulton County residents can improve their socio-economic status and ultimately reduce the county's health disparities. An equitable distribution of resources and wealth is critical to helping an at-risk family stay in its home, to making sure that educational systems prepare young people for job opportunities, and to supporting healthy community living so seniors can age in place. Support programs must uplift people to a higher level of functioning so that they can avoid entering the criminal justice, substance abuse, and mental health systems, which almost always lead to poor health outcomes. Prevention services will intervene prior to the development or onset of disease or negative behavior. From a cost basis, prevention has a much greater return on investment than dollars spent on treatment.

If we can help people find and maintain well-paying jobs with at least a livable wage, health insurance, adequate education, affordable housing, and a stable community with an infrastructure that will support the needs of the people, then we will be on our way to improving health disparities. These ideal communities must be available to everyone, and not limited to only the fortunate few who have in the past benefited positively from their status. We can no longer afford to provide social support systems and policies that only nurture human needs; instead, we must look more broadly at the physical environment and build infrastructures that support social determinants of health.

The full engagement of all SDH factors will combat the health disparities among our people and eventually result in more positive health outcomes for everyone, not merely the select few who are in the higher social gradient. This approach will help to answer what Dr. Martin Luther King, Jr., called "Life's Most Urgent Question": "What are you doing for others?"

VII. *Common Ground* Targeted Opportunities to Implement Social Determinants of Health Strategies in Fulton County

Fulton County is a culturally diverse population. Research has shown that this is an asset to any community. However, the data discussed in this report also indicate that there are inequities in the distribution of resources to help families and communities. A review of various neighborhoods and communities in Fulton County indicates that some communities need only the basic support systems to keep them thriving, while other communities need a total renovation.

The communities and projects discussed in this section are examples of inequality in wealth and social determinants distribution. The projects will focus on building and re-building communities and enhancing the potential of the residents to become economically stable. Specifically, many social determinant services will be provided to residents to help them move into a higher socio-economic gradient and eventually improve the health disparities of the population.

START (Services to At-Risk Youth) – Through the establishment of an Advisory Council on Children, Youth, and Families, Fulton County will create a system of care continuum for youth. This collaborative model for planning and service delivery to youth is designed to coordinate and target funds and programs for at-risk youth and their families. At the core of START is the Advisory Council, which provides the planning structure, system-wide oversight, and coordination of funding.

Oak Hill System of Care for Youth and Families – The Fulton County Oak Hill Child, Adolescent, and Family Center serves as a “one-stop shop” resource to enhance access and coordination of treatment services. This center presents an ideal opportunity to serve as the foundation for a county-wide system of care to coordinate comprehensive services to include support and prevention, early intervention, focused intervention, and crisis intervention.

North and South Fulton Community Centers – To coordinate essential government services with nontraditional services that target the needs of individuals and families, new state-of-the-art community centers will anchor services in both North and South Fulton County. Through redesigned County Service Centers and engagement of nontraditional partners, residents will benefit from full-service centers that not only meet their county service needs, but also provide support services that promote a healthy community. Services will include daycare, adult and youth education classes, a farmers market, a fitness center, and a healthy foods market.

Neighborhood Union Primary Care Partnership – The newly renovated Neighborhood Union Health Center serves as a springboard to couple traditional public health, mental health, and human services with primary care services. This holistic approach to health service delivery allows patients to access a menu of programs and supportive services that promote wellness and more. This model is designed to encourage healthy behaviors and healthy lifestyles.

Intergenerational Communities – Among the resources that are essential to any livable community are resources necessary to promote successful and healthy aging. From access to quality childcare to support services for older adults, intergenerational communities promote family stability. A key focal point is an intergenerational center that offers families – including grandparents raising grandchildren – an array of resources ranging from legal and financial assistance to counseling services, educational opportunities, TANF assistance, Medicaid services, and access to the WIC program.

Opportunity:

SERVICES TO AT-RISK TEENS (START) SYSTEM OF CARE

Program Description:

In response to the seriousness of the problems of youth, a coordinated approach to service delivery must be in place through a system-of-care model that focuses on children and their families. In order to accomplish this goal, a youth system of care must be family-oriented, must focus to a greater extent on prevention services, and must be able to support different service delivery models (such as the mental health best practice model). These concepts are directly related to the social determinants of health. If the social supports that individuals need to help them to become healthy are available, then they will be less likely suffer from health problems and their position on the socio-economic gradient will be more likely to be improved; positive behavior is the outcome.

The rationale for a coordinated management approach is predicated on the fact that there are many agencies in Fulton County providing services to youth. Millions of dollars are being spent across the departments and community-based agencies. However, no single entity oversees these services. How do we measure the effectiveness of our multiple investments of resources to address the problems of youth?

The establishment of an Advisory Council on Children, Youth, and Families (ACCYF) is needed to oversee planning, budgeting and needs assessment for youth in Fulton County. The Council will also manage a collaborative system of care for youth known as START, or Services to At-Risk Teens.

The START system of care will ensure that an array of services is available for youth that help to lead them toward healthy development. This youth system of care will be focused on providing services at four junctures: prevention, intervention, assessment and treatment, and aftercare. All of these interventions should be constant with a strong focus on family involvement at all times.

START System of Care Continuum:

- Assessment – Assessment should be conducted by each agency using a common assessment tool developed by the ACCYF. The purpose of a standard assessment tool is to increase the standardization of common assessment criteria to be used by all child-serving agencies. Such standardization will not impact the unique assessment tools that are needed by each agency. All the tools will be culturally sensitive and use the strength-based model, which analyzes the strengths of the youth and his/her support system.
- Prevention – These services are for at-risk youth or those youth who have not dropped out of school or entered into one of the deep-end programs such as foster care and juvenile justice. These programs and services are community-based and consist of referrals to the following:

- Mentoring services link a youth with an adult who serves as an advisor, advocate and role model.
- Prevention programs educate youth who are at risk and/or those who are not making positive choices; provide youth with alternative life choices; and build youth's internal capacity to survive in a community with negative factors. Prevention programs include front-door diversion programs such as :
 - After-school enrichment programs to provide tutoring, homework assistance, cultural enrichment, or mentoring;
 - Workforce development training to assist the idle or disconnected youth to prepare to get a job, enter college and/or enhance existing skills;
 - Counseling to provide specialized individual sessions for youth to assist them with coping skills;
 - Specialized recreation programs; and
 - Workforce preparation programs that help prepare idle or disconnected youth for targeted industry jobs.
- Treatment and Intervention– The specific treatment of youth will be determined by the presenting problem. Many of the youth who are at-risk present with multiple issues such as developmental disorders, mental health problems, and substance abuse. These types of disorders require more than short-term interventions. The program strategies must be multi-faceted and able to address the needs of at-risk youth, including those who may have committed their first offense as well as youth who have multiple entries into the juvenile justice system. Therefore, the strategy must be inclusive of a wide of array of programs to meet the unique needs of the different youth to be served. The services must be community-based, culturally competent, child- and family-focused, comprehensive, integrated and coordinated.
 - Treatment services consist of the following:
 - Substance abuse
 - Mental health
 - HIV
 - Chronic medical illness
 - Individual and group counseling for the youth and family.
 - Family intervention/therapy
- Aftercare - Aftercare encompasses the range of programs, services, and strategies intended to assure a juvenile's successful transition from residential placement to life in the community (National Center for Juvenile Justice). These programs and resources need to be enhanced to prevent recidivism among juveniles. The continuum must also support aftercare programs for

youth leaving treatment programs such as mental health and substance abuse, and children exiting foster care.

Who Will Be Served?

The numbers of Fulton County's at-risk, disadvantaged youth are increasing. Youth are transitioning in and out of the juvenile justice system and foster care system. Families are failing and the traditional extended family support is fading. As youth move toward adulthood, most are either in school, in the workforce, or in the military. These young people's lives are shaped by the challenges and routines of an important societal institution, and by the social networks they encounter. However, a persistent minority -- nearly one in ten youths between the ages of 16 and 19 -- are neither studying nor working. These young people are sometimes referred to as "idle youth."

The target population for the START program is youth ages 8 to 18 who present with the following issues:

- Known to the juvenile justice system (juvenile court and juvenile detention)
- Foster care youth
- Youth raised by grandparents
- School drop-outs
- Low academic performing students
- Youth with emotional dysfunction and mental health problems
- Youth who have a history of substance abuse
- Idle or disconnected youth (unemployed, not in school)

Why Is START a *Common Ground* Project?

The Common Ground is a Social Determinants of Health initiative that identifies and provides all the social and economic opportunities that help families and children survive and prevent major health problems. These are service supports that can move families and children out of poverty and into a higher socio-economic gradient.

The START system of care is a Common Ground project that will allow for resources to be identified and provided to at-risk youth through prevention programs and supportive services to the family. Programs and systems will address serious problems and deficits in the social support system. These services will help youth stay in school and graduate, make the right choices, and obtain employment, training, and treatment services. Youth who have an adequate social and economic support system will have better health outcomes than youth who do not have these resources. Therefore, it is essential that wrap-around services are provided to youth and their families. The equitable distribution of these services will impact the health disparities that affect so many poor and minority persons.

Coordination and Partners

The Advisory Council on Children, Youth, and Families (ACCYF) consists of representatives from the following county entities: mental health, health, human services, the school system, the juvenile court and justice system, recreation and parks, cooperative extension, libraries, arts and culture, police, and support agencies such as the Housing Authority. The Council should also include non-government partners such as community-based organizations, citizens and the faith community. The chair of the Council will be appointed by the County Manager.

The ACCYF will have responsibility for assuring coordination among county departments and programs. Each department will develop an annual plan that addresses the Board of Commissioners' priority areas, children and juvenile justice services. The plan will include goals and agency priorities along with a commitment of resources to meet the objectives. The agency plans should be developed in conjunction with the ACCYF, which will have overall responsibility for a master plan for children and youth services. The master plan will encapsulate broad goals for youth and their families. This will be the basic foundation for agency programming and reprogramming.

Services to youth will be monitored and evaluated through the ACCYF. The Council will be the clearinghouse for support services and will broker services for youth. The ACCYF will also be used as a single point of entry for persons seeking resources for children and youth.

The START system of care services to at-risk youth will use a systemic approach through ACCYF, with a departmental point of entry to identify youth and begin services. START will address the immediate needs of youth using long- and short-term strategies. All youth will be seen and referred for services either through the service delivery system for that department or through another child-serving agency.

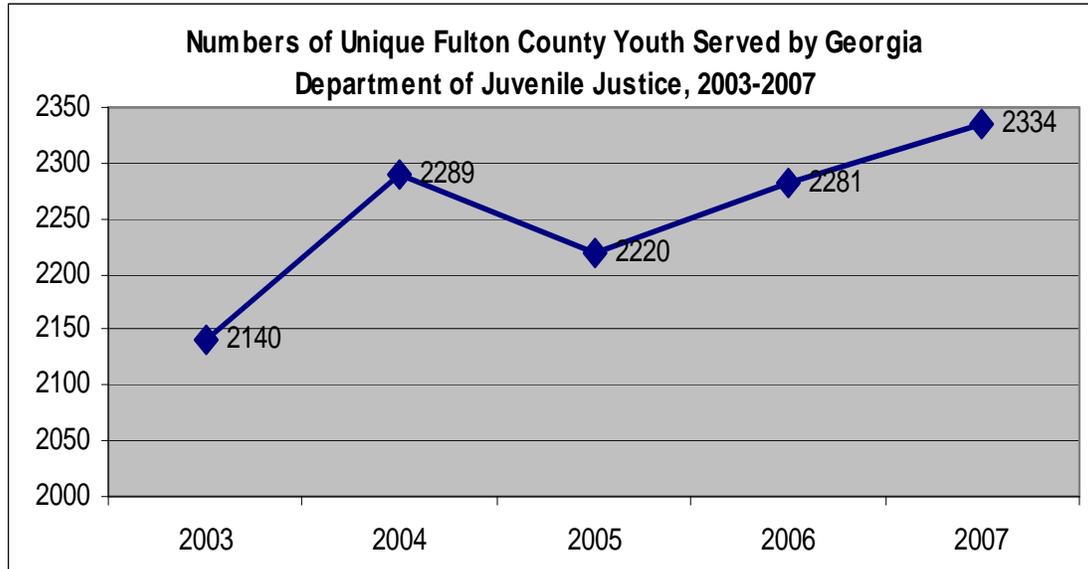
START will use all the resources and programs listed above and in the continuum to help prevent juvenile delinquency, increase youth graduation rates, provide appropriate treatment, and help younger youth make positive choices. Existing resources in Fulton County government will be coordinated to provide supportive services to youth and their families to prevent youth from falling into dysfunctional behavior patterns. The START system of care will identify youth in the school system, juvenile court, mental health and addiction programs who are at-risk and in need of comprehensive support services.

In the START system of care, services to youth will be coordinated by the ACCYF, which will establish entry points into the system of care appropriate to the problems presented by each individual youth. Referrals for youth resources will be sent to several treatment agencies, with one agency serving as lead agency for case management.

Each youth will have an individual service plan that will include follow-up support, family intervention, and referral. Programs provided directly by Fulton County departments as well as those that are community-based and funded by the departments will be listed as part of the youth services continuum inventory of support services.

Data to Support Project

In 2007, there were 2,334 Fulton County youth involved with the Department of Juvenile Justice (GDJJ Statewide Statistics).



Of the 2,334 Fulton County youth served by GDJJ in 2007, 22% (n=520) were committed to GDJJ in 2007. Court-ordered placements of these 520 Fulton County youth included 411 at-home supervision placements, 148 non-secure residential treatment placements, 276 Regional Youth Detention Center placements (youth awaiting placement), and 80 Youth Development Campus placements (GDJJ, Fulton County Statistics). (Placement totals reflect multiple placements for some youth throughout the year.)

Fulton County Juvenile Court

Fulton County Juvenile Court reported a total number of 9,239 offenses for calendar year 2007. Offenses classified as *Public Order*, *Property*, and *Person* were the most frequently committed and detected offenses, comprising 81% of all offenses committed by juveniles and detected by law enforcement throughout Fulton County in 2007.

The data above indicate what often happens to youth who are at risk. When teens are neither in school nor employed, they are disconnected from the roles and relationships that set most young people on pathways toward productive adult lives. This detachment, especially if it lasts for several years, increases the risk that a young person will enter into juvenile delinquency, leave school, or will have lower earnings and a less stable employment history than peers who stayed in school or found a job.

Budget

It is anticipated that the budget to support this program will consist of current funds in each department dedicated to children, youth and family services. New funding for 2009 will include staff costs to support the Advisory Council for Children, Youth, and Families, as well as new funding to support critical underserved populations and new best practice programs.

Outcomes:

The following are the desired outcomes for START:

- Reduction in juvenile crime
- Reduction in children entering the deep-end treatment systems, juvenile justice and foster care
- Increase in youth staying in school and graduating
- Reduction in youth who are substance abusers
- Increase in youth employment

Opportunity:

OAK HILL SYSTEM OF CARE FOR YOUTH AND THEIR FAMILIES

Description of Project

Problems facing today's children, youth, and their families are more complex, numerous and interrelated than ever before. Such problems include poverty, unemployment, poor health, low school performance, child abuse, delinquency, mental health, substance abuse, housing and many more societal ills. In providing services to families and their children to ameliorate problems, agencies have generally focused their services on distinct populations such as delinquent youth, abused and neglected children, or persons needing mental health services. However, as problems of children and families have become more complex, services are often needed from more than one agency. The existing system fosters duplication and a lack of coordination and cross-agency planning that often results in gaps in services. In addition, the existing system encourages a focus on a particular problem, rather than a family-focused approach to service delivery. In response to the seriousness of these problems, a coordinated approach to service planning and service delivery must be in place, utilizing a system-of-care model that focuses on children and their families.

The Oak Hill project is a system-of-care initiative. The partner agencies listed below will engage in strategic planning in the first phase of development of the Oak Hill System of Care for Youth and Families in Fulton County. Based on the outcomes and recommendations from the planning phase, the partner agencies will then engage in the implementation of care management and delivery of services. Finally, the partner agencies will engage in continuous monitoring of outcomes and quality improvement.

Fulton County has many service providers and many services offered by both county and community agencies. As the system is currently configured, services are provided programmatically in a "silo" structure – that is, as stand-alone services. Services are sometimes fragmented and duplicative. For families who need services, this approach often results in multiple hand-offs and multiple agencies. The screening process is variable and inconsistent at intake. Each child and family is assumed to be in need of the same set of services, which may often not be the case, and the family is not always actively involved in the case planning process. Often, the same agencies and community partners are involved in multiple "collaboratives" with overlapping responsibilities. The need for one over arching system of care is evident.

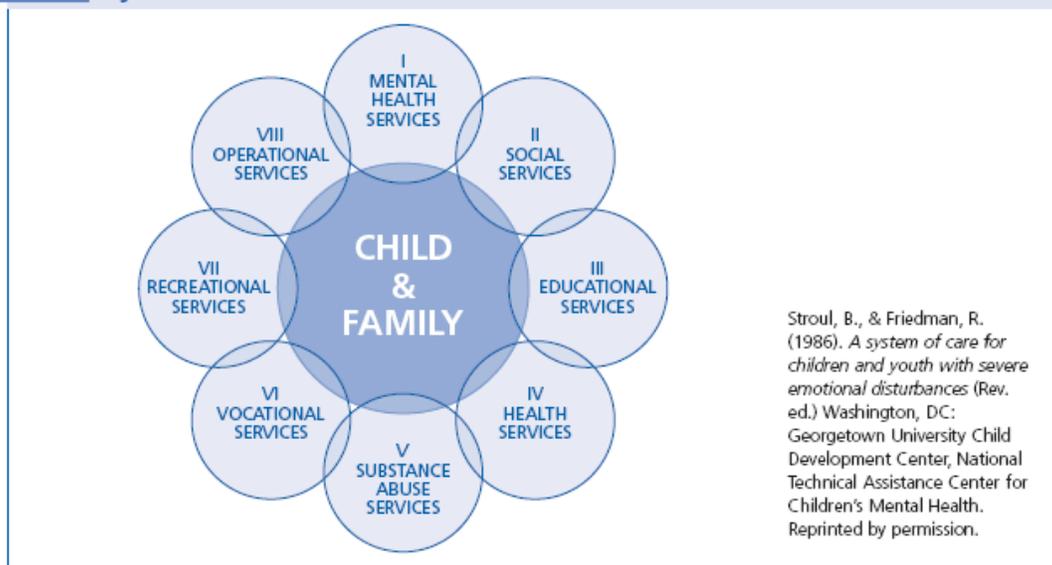
Fulton County government is well-positioned, well-qualified, and has the capacity to build the foundation for a county-wide, culturally competent system of care for children and families. The Fulton County Department of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD) has designed and will be implementing a treatment system that will have responsibility for the coordination of a comprehensive, efficient and fiscally sound system of care for children and their families in Fulton County. It will focus on service delivery. The Departments of Mental Health,

Developmental Disabilities and Addictive Diseases; Health and Wellness; Juvenile Justice; Human Services; and Family and Children's Services will be the lead partners in the service collaborative, with MHDDAD serving as the fiscal agent. Other key stakeholders in this process will include Fulton County Libraries, the Department of Parks and Recreation, Housing and Community Development, the Office of the District Attorney, and Fulton County and City of Atlanta public schools.

Finally, while Fulton County believes that the system-of-care concept is a framework and a guide, we also believe that an identified location for collaboration, planning and service delivery is a value-added enhancement to any system of care – a “one-stop shop” resource center to enhance access and coordination of services. The Fulton County MHDDAD Oak Hill Child, Adolescent and Family Center is an ideal location for these processes. Located at 2799 Metropolitan Parkway, this 22-acre campus has the ideal physical plant for the service collaborative. Currently, this facility has an unoccupied building with ample space for all of the members of the collaborative, the collaborative coordinator, and an administrative assistant, as well as space for interagency and collaborative meetings. There is ample parking and the site is easily accessible by private and public transportation. Furthermore, the Center is located in Zip Code 30315, which, according to our needs assessment review, has the highest level of substantiated child maltreatment. The center is also located near the intersection of Districts 5, 6 and 7, which are the districts with higher levels of youth living below the federal poverty guidelines and presenting the most juvenile court offenses in Fulton County.

Our target community is Fulton County and our target population will be children and families who present for services at the lead agencies. The Interagency Council will further develop specific criteria for matching the level of services to the needs of the youth and families in the target population. The general framework for the levels of services will be Support and Prevention, Early Intervention, Focused Intervention and Crisis Intervention. The current vision is that there will be “no wrong doors” for referral into the system, but there will be an identified “one-stop shop” to ensure that services are coordinated and delivered.

FIGURE A System of Care Framework



PROGRAM OBJECTIVES

The general objectives of the system-of-care model for providing services to the youth and families of Fulton County are to:

- Improve access to a comprehensive array of services
- Provide individualized services, needs and strengths
- Provide services in the least restrictive environment
- Include families as full participants
- Integrate services and agency linkages
- Ensure effective case management and coordination
- Encourage early identification and prevention
- Enhance transitions to adult services
- Provide services that are sensitive to cultural differences and special needs

Who Will Be Served?

The intent is to serve a minimum of at least 500 Fulton County youth and their families through this coordinated system of care in FY 2009.

Why Is This a *Common Ground* Project?

According to *Building Systems of Care: A Primer* (Georgetown University, 2002), systems of care recognize that “quality of life issues such as safety and opportunities for recreation in neighborhoods and communities affect the emotional well being of children and their families.” Effective systems of care further recognize that systems of care, front-line practice and community development are all necessary to “improve emotional

outcomes for children and families, in addition to strengthening the capacity of families themselves to guard and enhance their own and their children’s emotional well being.”

Coordination and Partners

The first phase of this initiative will focus on building on the foundation and goals of the Fulton County System of Care for children, youth and their families managed through the County’s Advisory Council for Children, Youth, and Families (ACCYF). The Oak Hill project will be a mental health service system of care using a collaborative approach to provide services to children. The partners in this collaborative are listed below:

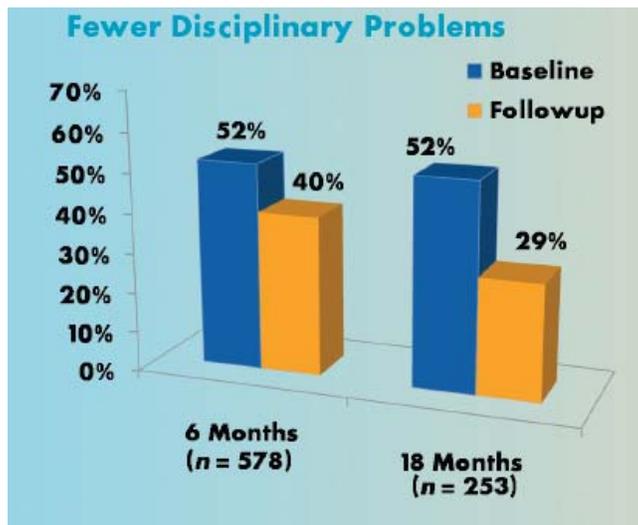
- Fulton County Department of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD)
- Fulton County Juvenile Court
- Fulton County Department of Health and Wellnes
- Fulton County Department of Family and Children’s Services
- Fulton County Department of Human Services
- Fulton County and City of Atlanta Schools

The MHDDAD will be the fiscal agent for the collaborative and will chair the mental health interagency council. The “one-stop shop” will be located at the Oak Hill Child and Adolescent and Family Center.

Data to Support Project

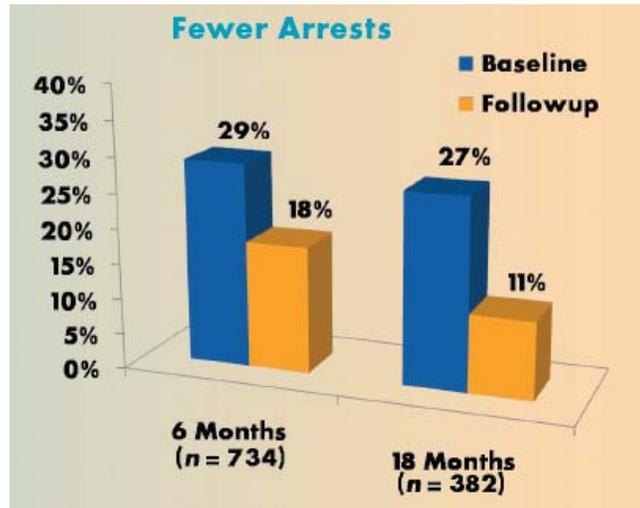
The charts below illustrate results from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) data regarding youth who participated in systems of care:

YOUTH ARE SPENDING MORE TIME IN SCHOOL



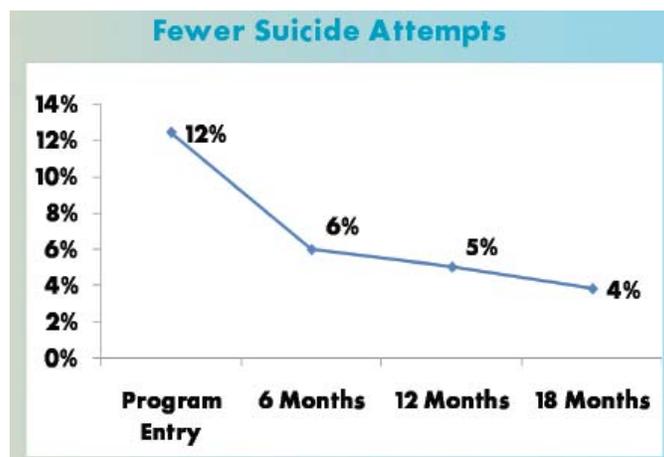
The data in this chart show that youth ages 14 to 18 who received services in systems of care had “significantly fewer disciplinary problems after entering services. At 18 months after entering services, the percentage of youth suspended or expelled from school was reduced by 44% (from about 52% to 29%).” (SAMHSA System of Care Short Report, 2008)

YOUTH BEHAVIORS ARE IMPROVING



Self reports of youth who participated in systems of care demonstrate that “arrests fell by more than half, dropping from 27% upon entering systems of care to 11% at 18 months. The drop in the number of arrests resulted in substantial cost savings. After 6 months of services, the average cost savings per youth was \$808.32. After 18 months, the cost savings was \$1,259.91 per youth.” (SAMHSA, 2008)

YOUTH ARE DEMONSTRATING IMPROVED EMOTIONAL HEALTH



According to the SAMSHA study, “Youth suicide attempts were reduced by more than half within 6 months after entering systems of care (from 12% to 6%), and were further

reduced by more than two thirds after 18 months (to approximately 4%).”

Outcomes

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), research demonstrates that expected outcomes of a System of Care include:

- Improved level of youth functioning
- Improved youth and family strengths
- Improved family functioning and lessened caregiver burden/ strain
- Reduced out-of-home placement
- Reduced juvenile justice involvement
- Improved school attendance and functioning

Another potential benefit to the County is cost savings. A review of SAMHSA data that looked at declines in juvenile arrests demonstrated a cost savings of up to \$1,259.91 per youth.

The 500 youth and families served in this coordinated system will report at least one of the expected outcomes listed above as a result of their involvement with the Fulton County System of Care for youth and their families.

Opportunity:

NORTH and SOUTH FULTON COMMUNITY CENTERS

Description

Accepting that the government and its policies have an impact on health, this proposal seeks to create healthier communities and improve health outcomes for Fulton County residents by creating two full-service community service centers (one at each end of the county) to provide a spectrum of services that residents can access in one location. By engaging other nontraditional partners through a state-of-the-art, full-service location, Fulton County can more effectively direct service delivery to address the needs of residents and their families, long before the issues that influence their daily lives begin to have a negative impact on their health.

In addition to a full spectrum of available services, clients will be greeted at a concierge station, possibly staffed by a cadre of volunteers, who will greet each client, process them, conduct an initial assessment, make suggestions and appointments, and direct them to the service providers they need to visit.

Fulton County currently owns an array of buildings that house a disparate selection of programs in different agencies. By consolidating into one centralized facility in North Fulton and one centralized facility in South Fulton, the county will benefit from economies of scale in maintenance and administrative staff at both locations. Each state-of-the-art, modern building will project an image of excellence in service to the community and impart a clear message to residents that their government cares about their concerns. Each location will become a destination that is responsive to citizens' needs, rather than a location that patrons are obliged to attend. These sites could even become safe havens for teens, as well as functional gathering places for community groups.

Fulton County government would relocate services from multiple locations across each end of the county. For example, in north Fulton, the Health and Wellness unit would propose closing its Sandy Springs Health Center and relocating its services into the new location. Human Services would move Office of Workforce Development staff from the Roswell Road location. The Mental Health unit could terminate its sub-contract to provide mental health services at Northside Hospital and direct these funds (\$365,000) to the provision of mental health services in the newly remodeled North Annex. When the transition is complete, the North Annex building would be renamed the North Fulton Community Services Center.

Who Will Be Served?

The desire is to place services at the location that will draw county residents from either end of Fulton County. The services to be installed will intentionally attract a wide variety of clients, each of whom will be seeking distinct services. Regardless of the services sought, individual programs in separate departments or partner organizations will have

multiple opportunities to evaluate clients and comprehensively assess in real-time other services from which they may potentially benefit, and then direct clients to the service at that location.

In 2007 Mental Health provided services to more than 3,000 clients at the Northside Mental Health Center. Health and Wellness serves nearly 3,500 clients annually in one of the smallest and busiest centers in the system. The Office of Workforce Development services approximately 4,000 clients per year at the Roswell Road location.

Why Are the North and South Fulton Community Services Centers a *Common Ground* project?

The social determinants that influence a family’s health status must be addressed in order to bring about a positive influence on their health and the health of the community. The social determinants that affect health are by and large dependent on a range of governmental policies. Furthermore, the government is responsible to its citizens for the provision of equitable and quality services. Consolidating governmental and community-based organizations in one comprehensive, functional and welcoming location, Fulton County will elevate its efficiency, credibility and influence in the community. As a result, Fulton’s agencies will more effectively deliver services that will positively affect the social determinants of health.

Coordination and Partners

The North and South Fulton Community Services Centers proposal enjoins the collective capacities of the Department of Health and Wellness, Department of Mental Health, Developmental Disabilities and Addictive Diseases, Department of Family and Children’s Services, Department of Human Services, and other Fulton County government agencies as well as a potential myriad of other community-based organizations. This coordinated “one-stop shop” for services will greatly increase efficiency and eliminate duplication of services in both North and South Fulton. Additionally, services such as a daycare center with a training program could be established to alleviate concerns for staff while at work and for center patrons seeking services. A program such as this would not only create jobs and contribute to workforce development; it would also contribute to improving the lives of citizens in need of assistance. It is our intent to work in a coordinated effort with our internal departmental stakeholders and with potential external stakeholders to provide access to the diverse array of services in the North Annex.

Proposed Services in the North and South Community Services Centers	
Government Services	
Health and Wellness	
	Immunization – child, adult, travel
	Tuberculosis screening and treatment
	HIV testing
	Family planning

Proposed Services in the North and South Community Services Centers

Government Services

Lead screening
Eye, ear, and dental screening
Health Check exam
WIC nutritional services
Oral health

Mental Health

Psychiatric assessments
Nursing assessments
Medication management
Treatment planning
Group therapy
Individual therapy
Family therapy
Case management services
Alcohol and drug treatment services

Department of Children's and Family Services

Temporary Assistance to Needy Families (TANF)
Food stamps

Human Services

Workforce development

Library

Literacy services
Mini-branch

Tax Office

Homestead exemption

Housing and Urban Development

First-time Home Ownership program

Arts Council

Teen Artists program
Thematic exhibits
Community arts classes

Other Potential Services

Concierge – volunteer services
North Fulton Community Charities
Fitness center
Food pantry
Clothes closet
Daycare center
Adult education
Farmers market
ESL classes
Community meeting space
Recycling area
Food market (healthy choices)
Outside courtyard and garden area with wireless internet service

Data to Support Project

County service delivery is currently offered from multiple locations throughout each end of the county. Some spaces are rented, some are provided through contracts with other agencies, and some are county buildings. Many of the buildings are in need of expensive refurbishment and renovation due to deferred maintenance and inadequate size. Through the creation of a Community Service Center in each end of the county, agencies will reduce the costs of building maintenance and maximize the benefit to clients.

Outcomes

- Fulton County residents have access to services affecting social determinants of health in a convenient, effective one-stop community center.
- Fulton County government services are decentralized to meet the needs of residents in their communities.
- Residents experience increased services.
- Coordination of services to residents is improved.
- Residents have access to affordable health care.
- Residents have improved health outcomes.

Opportunity:

NEIGHBORHOOD UNION PRIMARY CARE PARTNERSHIP

Description

In 2009, Fulton County faces an unprecedented health crisis, brought about by the current instability of the health care system, a high proportion of uninsured residents, and high levels of disease burdening our communities. More than half the visits to Grady's emergency department are for non-emergencies, or for urgent but primary-care treatable or preventable conditions such as asthma, high blood pressure, diabetes, or even depression. This proposal provides a partnership plan for public health and primary care to better serve the community's health needs and to mitigate the number of emergency room visits at Grady Hospital by establishing a primary-care medical home for many Fulton residents.

The location of the newly renovated, historic Neighborhood Union Health Center (NUHC) makes it uniquely situated to serve as the site for this proposed partnership and to function as a springboard for current and future county initiatives that address the social determinants of health. The building was recently renovated to house community partners and also includes a large meeting room for community use. Programming and build-out included the provision of mental health and human services. This decision was based on a survey of the community conducted by neighborhood residents.

The Vine City area surrounding the Neighborhood Union is known to be a high-crime and high-risk drug area. The area has an extensive homeless population with a higher percentage of the chronically mentally ill than is typically found in the general population. Mental health services at the Neighborhood Union Center will serve to decrease the risk of incarceration and the risk of homelessness within the community. Offering substance abuse services within the community, to include community outreach, should be substantially more successful than having substance-abusing clients venture out of the community for treatment. The medical literature on this issue describes the effectiveness of treatment in an individual's natural environment.

A successful partnership will be seamless for clients and will provide a complete and efficient array of services to residents in the community at one location at the time of their visit. A partnership with a clinical academic institution such as the nearby Morehouse School of Medicine will have benefits beyond the addition of clinical primary care. The Neighborhood Union will have access to university-based resources such as research and analytical skills to assist with addressing community issues, enhanced monitoring and tracking of health outcomes, and assistance with acquisition of future grant funding. Furthermore, Fulton County Health and Human Services would have a strong partner in future initiatives that address the social determinants of health.

This model is designed to reach out into the community to form partnerships in an effort to improve healthy behaviors and healthy outcomes. It requires a bridge built on teamwork among community health workers, public health nurses, and the clinical staff

working inside the clinic for primary care. This model creates an ideal setting for future county efforts utilizing a social determinant perspective to address health outcomes.

The partnership will also engage other safety-net providers, including the West End Medical Center and Southside Medical Center, and will promote an open referral process for other services for clients. The partnership will work towards achieving reciprocity with Grady for services such as pharmacy for prescriptions that are not included in the clinic's formulary and for Medicaid eligibility screening, which can be a time-consuming process. The partnership anticipates an increase in Medicaid revenue over time as clients change their primary care providers to those based at Neighborhood Union.

A major strength this particular location is the center's ability to serve as a springboard for future county initiatives that address the social determinants of health that contribute to health issues being treated at the clinic. Services at NUHC have already been slated to include addiction treatment, mental health counseling, workforce development, and job training. The design also included modest office space to be shared by community-based organizations that are current Health and Wellness partners, as well as a large meeting room intended primarily for use by the community.

Who Will Be Served?

All Fulton County residents will be eligible to receive services at the NUHC. In particular, market outreach will target children, adults and families living in the Vine City and English Avenue areas.

Why Is the Neighborhood Union a *Common Ground* project?

The project seeks to couple traditional public health, mental health and human services with primary care services, in addition to other county services that are scheduled to be integrated at the NUHC. This plan responds directly to the mounting need for adequate, accessible health care for the underserved living in the surrounding community. Other Fulton County agencies have been provided space in the NUHC to conduct services not traditionally found in one location, such as drug abuse counseling by Mental Health professionals and workforce training by Human Services. The desire is to see a patient/client, provide all services available to that individual, and coordinate those services to ensure maximum benefit.

Coordination and Partners

Current partners include Fulton County government agencies (Department of Human Services, Mental Health, Developmental Disabilities and Addictive Diseases and Health and Wellness), community-based organizations, and potentially, the Morehouse School of Medicine to provide primary care services. The Department of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD) will provide staffing to include licensed clinicians, a psychiatrist, nursing support, and a case manager. Should a contract be approved, Health and Wellness will serve as the contract manager.

The NUHC is nearing completion of the renovation. All county departments that have been involved in the project from the beginning are prepared to move in and begin providing services. Negotiations are underway with the Morehouse School of Medicine to provide primary care. Once the contract is drafted by staff and approved by the Board of Commissioners, a task force will convene to implement the plan for operations.

The approach to merge staff from Health and Wellness and from Morehouse provides an economy of scale which will result in fewer staff, greater efficiency, and increased ability to see more patients. Other models that merely share space have considerably higher costs, particularly related to staff, and much lower efficiencies in services to the client. This service delivery option is the most effective model for improving health outcomes, because this model increases the proportion of care provided in an appropriate and cost-effective primary care setting.

Data to Support the Project

The established catchment area for the Neighborhood Union Health Center is predominantly African American (98%) with a median household income of \$20,000 per year. The area has a disproportionately high number of female-headed households with no husband present and a high proportion of residents who live below the poverty level.

The infant mortality rate is roughly twice as high as the rest of Fulton County; the HIV mortality rate is 2.5 times higher; and the number of hospital discharges due to asthma in children is 1.3 times higher than the rest of Fulton County (Table 1). The percentage of the population living in poverty and the percentage unemployed are 2.6 and 2.0 times higher than in Fulton County as a whole.

Outcomes/Risk Factors	Georgia	Fulton	NUHC Area	
Infant mortality	7.0	6.3	13.4	<i>Per 1,000 live births</i>
HIV deaths	8.1	24.7	61.0	<i>Per 100,000 deaths</i>
Asthma discharge rate (≤ 17)	174.0	165.2	219.0	<i>Per 100,000 discharges</i>
Percent living in poverty	13.0	15.0	39.2	<i>Percent</i>
Percent unemployed	6.0	6.0	12.0	<i>Percent</i>

Outcomes

In addition to clinical primary care and community-based health promotion activities, a third essential element of this model is a data feedback loop that allows continuous measurement of health outcomes in the community and informs discussion on the appropriateness of care being provided. For example, emergency department visits can be monitored for a variety of outcomes such as uncontrolled asthma, diabetes, or hypertension, to measure our efforts to move this care back into more cost-effective community settings. By working in concert with the Grady emergency department to refer such patients back to their primary-care medical home, costs at the ER will be reduced and care to the client will improve.

Utilizing the above-mentioned staff, it is expected that service can be provided to approximately 350 clients annually at this location. Mental health and/or substance abuse screenings will be conducted on all referred individuals. Based on the assessment and individual needs, referrals will be made as appropriate to other agencies, other departments (public health, human services), and different levels of care within the departments of MHDDAD.

It is challenging to calculate the exact number of hospitalizations or visits to Grady's psychiatric emergency room. Fulton County Health and Human Services seeks to form a collaborative partnership with Grady hospital personnel to begin collecting this necessary data. Given the high rate of homelessness for the mentally ill population, case managers will emphasize housing and employment, thereby increasing the ability of the chronically mentally ill to live productively in their chosen community or neighborhood; these steps will ultimately contribute to community improvements.

Opportunity:

INTERGENERATIONAL COMMUNITIES

Description of the Project:

Intergenerational communities provide opportunities for families to live in neighborhoods that provide affordable housing and the social determinant services that can support them. The Fulton County Housing and Community Department, in collaboration with human services, mental health, health and wellness, arts and culture, parks and recreation and cooperative extension, will provide funding to renovate and sell affordable housing to families. This partnership will result in the establishment of an intergenerational community in South Fulton. The project will be funded with monies provided by the federal government to provide assistance in communities with high foreclosure rates. These funds are from the Federal Neighborhood Stabilization Program (NSP). The Housing Department will identify the neighborhoods with the greatest need for assistance. These will be areas with the greatest percentage of foreclosures, areas with the highest percentage of homes financed with subprime loans, and those believed to be most likely to face a significant rise in the rate of home foreclosures in the future.

Housing opportunities are essential for low-income families, especially grandparents raising grandchildren. Many grandparents or other relatives raising children have either downsized their living or are living on fixed incomes and are now faced with the additional, unanticipated expenses of raising children. They usually cannot afford the cost of housing in the current market. The NSP is a great opportunity to develop an intergenerational community that provides all of the social determinant supports within the community. The intergenerational community can become a livable community with all the resources available to families in the neighborhoods.

It is essential for a livable community to have the resources necessary to support families and other extended-family residents such as grandparents raising grandchildren (GRG) and other “kinship care” arrangements. (According to the Child Welfare League of America, “kinship care” can be defined as the full-time nurturing and protection of children by adults who are not the children’s parents but who have a family relationship bond.) Best-practice programs and services have been developed across the nation aimed at supporting GRPs and other kinship-care families in one-stop community center environments. These community resources are described as intergenerational resource centers. Such centers enhance neighborhoods and create livable communities for grandparents and other residents. The centers typically include all the social determinants services that help families to achieve a better socio-economic status and improve health outcomes.

The Fulton County Intergenerational Resource Center (IRC) is intended to provide education, social and mental health services, and respite to adults caring for grandchildren or, as well as providing social, educational, and skill-building activities for the children residing with adult relatives. The IRC would not only offer services to adults and children but, equally important, it would make available the necessary resources to

support those individuals through such services as advocacy, case management, tutoring, financial and education workshops, transportation, legal and financial assistance, health and mental health counseling services, TANF, Medicaid, the WIC program, and recreational activities for both caregivers and children.

Over the past decade there has been a rise in young parents having substance abuse issues, undiagnosed and untreated mental illnesses, and high incarceration rates. This trend has resulted in an increase in grandparents raising their grandchildren. Estimates indicate that one in ten grandparents will take on the role of primary caretaker to a grandchild for at least six months before the child is age 18. The U.S. currently has 5 to 6 million children living in grandparent-headed households. In the state of Georgia, current figures show more than 160,000 children living in households headed by grandparents (7.6% of all children in the state).

Some of these grandparents, as well as some children, may develop or have pre-existing mental health issues that need to be addressed. To address mental health care, the Fulton County Intergenerational Resource Center will assist grandparents who are experiencing challenging situations (i.e., stress, anger, anxiety or depression over present circumstances). Grandparents will receive assistance with coping strategies for the new and daily responsibilities of raising grandchildren. The grandparents and grandchildren will also have access to individual and group counseling services, case management services and family therapy services. As persons are identified with needs not provided on-site, the IRC staff will make referrals to other providers within our extensive network. The MHDDAD will also provide the services of a licensed clinician and a case manager to support the activities of the center.

The Intergenerational Resource Center will be located in an area of Fulton County that is accessible to the targeted population. The building space should be at least 10,000 to 15,000 square feet and should include the following: reception/waiting area; administrative office space; exercise room; a youth activity room used for childcare; an arts/crafts room; a game room; a computer lab; indoor/outdoor basket ball court; tennis court; a conference room and a multipurpose dining room; a food pantry; an industrial kitchen; restrooms; bathrooms; and adequate parking. (These recommendations are based on information from the Clayton County Kinship Care Program, which serves approximately 100 families).

Who Will Be Served?

The IRC will provide services to grandparents raising grandchildren and other kinship caregivers throughout Fulton County. In the Fulton County area it is estimated that over 8,000 seniors are raising their grandchildren. More than 50% of these grandparents are African American, more than 75% are over 60 years old, and approximately 21% live below the poverty level. These families are often plagued with financial issues and are in need of respite and counseling services. Many may have significant physical and mental health issues, and many face housing challenges.

Why Is the Intergenerational Resource Center a *Common Ground* Project?

Due to the rise in young parents having substance abuse issues, undiagnosed mental illnesses, and high incarceration levels, the number of grandparents raising their grandchildren has increased. The proposed IRC is a *Common Ground* project because it helps meet our mission to provide citizens resources and high-quality services that promote greater self-sufficiency, a better quality of life, and more resilient communities. In addition, the services needed to serve this unique population require the collaborative resources of agencies serving seniors (grandparents) and children.

Coordination and Partners

Fulton County Intergenerational Resource Center collaboration with partners is designed to build a new approach as a “one-stop shop” for delivery of services. The collaboration needs to include the following services: advocacy, case management, tutoring, financial and education workshops, transportation, legal and financial assistance, health and mental health counseling services, TANF, Medicaid, the WIC program, and recreational activities for both caregivers and children. Anticipated partners are as follows: Fulton County Department of Mental Health, Atlanta Legal Aid Society, Anchor Center Inc., Atlanta Regional Commission, Families United, Fulton County Juvenile Court, Grandparents on the Move, Housemate Match, and Project Grandad.

Data to Support Project:

According to the 2000 U.S. Census, the total number of grandparents co-residing with their grandchildren in Fulton County is 17,828; 47% (8,384) of these grandparents have primary responsibility for their grandchildren. The percentage of grandparents raising their grandchildren in Fulton County is roughly comparable to state and national data.

Table I: Distribution of Co-Resident Grandparents and Grandchildren: 2000

Location	Number of grandparents living with grandchildren	Number of grandparents responsible for co-resident grandchildren	Percent of co-resident grandparents responsible for grandchildren	Number of grandchildren living in grandparent-headed households	Number of grandchildren in grandparent households, no parents present	Percent of grandchildren in grandparent households, no parent present
Fulton County	17,828	8,384	47.0	16,890	9,627 (est)*	57.0 (est)*
Georgia	193,825	92,261	47.6	164,423	98,773	60.1
United States	5.8 million	2.4 million	41.4	4.5 million	2.5 million	55.5

Sources: U.S. Census Bureau, Census 2000 Summary File 3(SF-3) – Sample Data; Census 2000 Summary file 1 (SF1): P28 100-Percent Data; Children’s Living Arrangements and Characteristics: March 2002; AARP: Georgia: State Fact Sheet on Grandparents and Other Relatives Raising Grandchildren.

Table II: Distribution of Grandparent Families in Municipalities in Fulton County: 2000

Municipality	Co-resident Grandparents	Grandparents Responsible for Grandchildren	Percent Responsible for Grandchildren
Alpharetta	321	110	34.0%
City of Atlanta	11,563	5,947	51.0%
College Park	683	349	51.0%
East Point	1,208	648	54.0%
Fairburn	193	132	68.4%
Hapeville	222	111	50.0%
Mountain Park	220	79	35.0%
Palmetto	100	72	72.0%
Roswell	844	200	24.0%
Sandy Springs	736	320	43.0%
Union City	264	150	57.0%

Source: U.S. Census Bureau, Census 2000 Summary File 3.

Note: 2005 population estimates of grandparent caregivers for these municipalities are currently unavailable.

According to the U.S. Census 2000, Fulton County has 8,384 grandparents who are responsible for their grandchildren; these caregivers are not eligible to receive assistance through the foster care system or other programs that would lend assistance if the children were not living with a family member. In many situations, assuming responsibility for grandchildren creates mental, physical, and/or financial hardships for the grandparent, which also negatively impacts the children. As outlined above, the Intergenerational Resource Center will enable seniors who have the responsibility of raising their grandchildren to access needed resources, attain support from other grandparents, obtain mental health services for themselves as well as their grandchildren, and provide care and services to the children simultaneously.

Outcomes

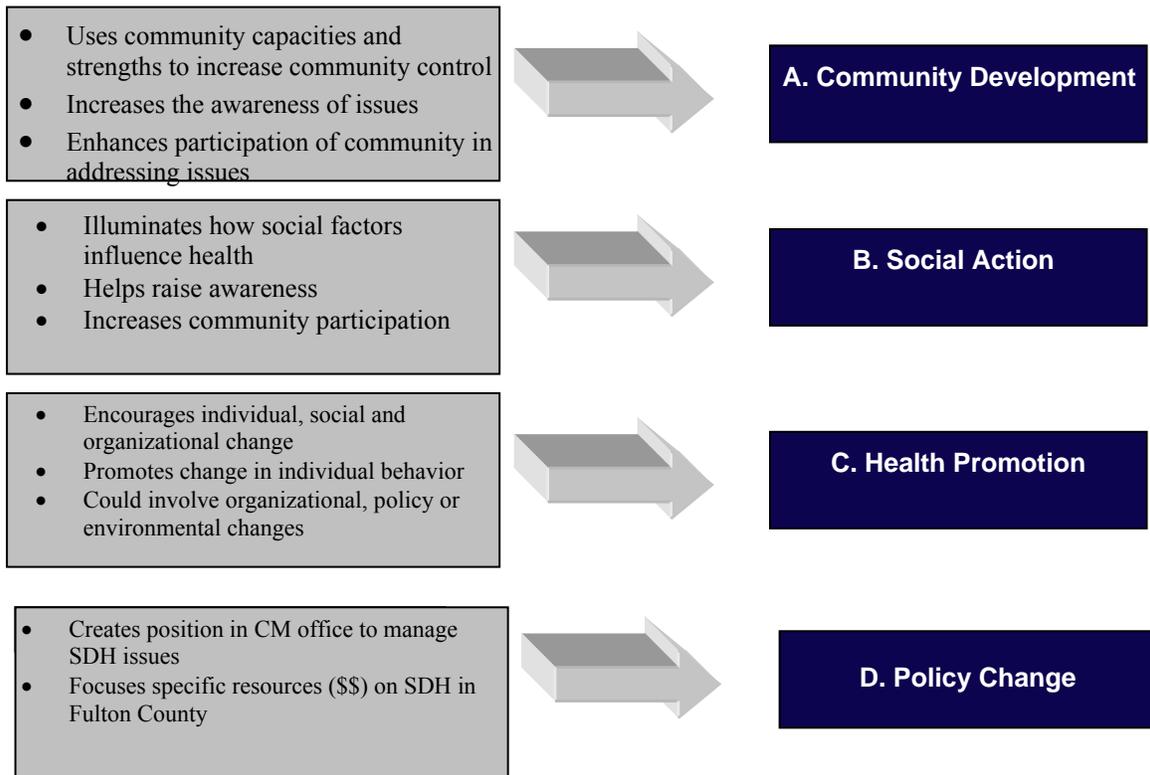
Fifty or more families in which grandparents are responsible for raising their grandchildren will be receiving services and resources they otherwise would not be able to access. The expected outcomes for grandparents raising grandchildren include:

- Improved family functioning and lessening of grandparents' burdens/strain
- Improved youth and family strengths
- Reduced out-of-home placements (through foster care or juvenile justice involvement)
- Improved mental health and emotional state of grandparents and grandchildren

Another potential benefit to the county is cost savings. By assisting grandparents with the issues of raising their grandchildren, the cost savings to the state in keeping these children out of foster care would be \$5,840.00 per child, based on an average rate of \$16.00 per day for foster care in Georgia. Supporting grandparents or other extended-family caregivers in caring for these children costs only one-third as much money as to support the children in foster care. (*Source: Georgia Department of Human Resources, September 2008. Rates effective as of October 1, 2008: children ages 0 to 5, \$14.60 per day; ages 6 to 12, \$16.50 per day; ages 13 and older, \$18.80 per day.*)

Approaches and Timelines

A variety of approaches may be used to address the social determinants of health in Fulton County. Ultimately, a combination of approaches that complement each other will be the most effective. Whether we choose to raise the awareness of a particular sector of the community or to implement policy changes, thus limiting the number and type of business being approved, it is likely that multiple approaches applied in concert will increase our chances of changing the health status of our citizens. Some of these approaches are clearly led by government and policy makers while others are strictly community-based and led by grassroots efforts.



VIII. Conclusion

This report brings to the forefront the absolute need for continued and increased collaborative efforts to address health concerns within our community. The concept that health disparities are a public health responsibility is a flawed notion that is destined to contribute only to the status quo. There are many factors that influence health status, all of which are interrelated. These factors include employment, education levels, income, housing, environmental conditions, crime, mental health, diet, physical activity, drug and alcohol use, and access to preventive health care. Succinctly put, an individual's and a community's health status transcends public health.

Fulton County is committed to providing the highest quality services for its clients. The county has been actively and consistently engaged in communities to provide comprehensive, population-based services to the underserved. Departments strive to devise and implement strategies aimed at eliminating health disparities and promoting healthy lifestyles and behaviors, with the purposeful intention of improving health outcomes for underserved populations within Fulton County. A considerable amount of work remains to be done in examining and implementing at effective ways to address the social determinants of health.

This collaboration and the creation of the *Common Ground Initiative* is both timely and urgently needed to help the county understand how best to provide the highest quality care to residents, and to shift our ways of looking at the processes we employ to address health disparities.

The task force will continue the larger conversation with the participating departments. Furthermore, the task force will be aware of opportunities that present themselves as a result of the greater conversation instigated by this publication. The task force members will avail themselves of the funding opportunities to assist with facilitating the larger conversation around health disparities and the causative social determinants and will serve as a resource to whomever, whenever requested and whenever possible.

IX. APPENDICES

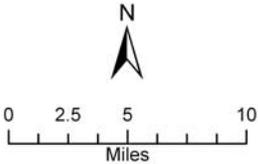
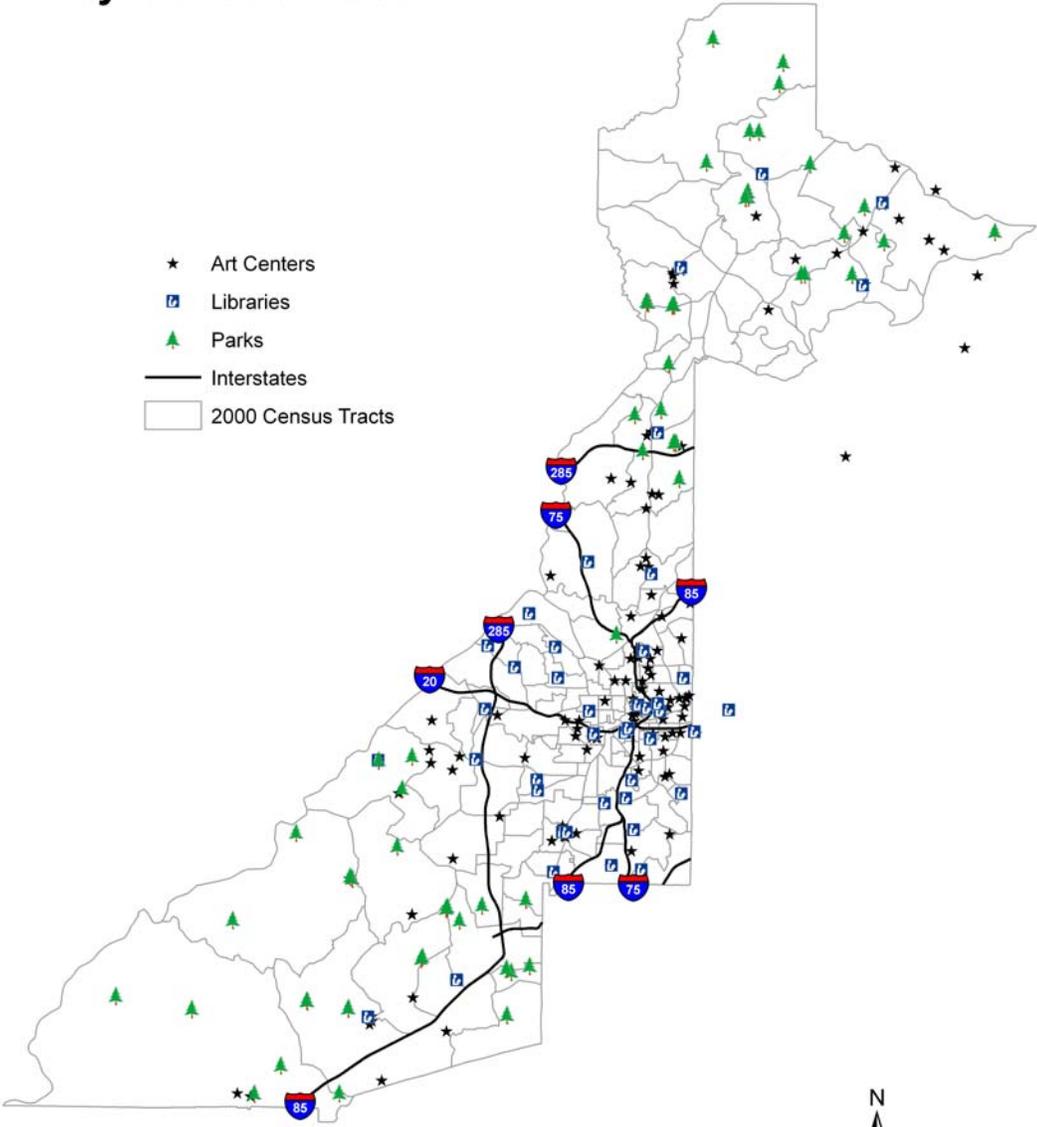
SERVICE MAPS

The following are maps indicating where Fulton County services are located:

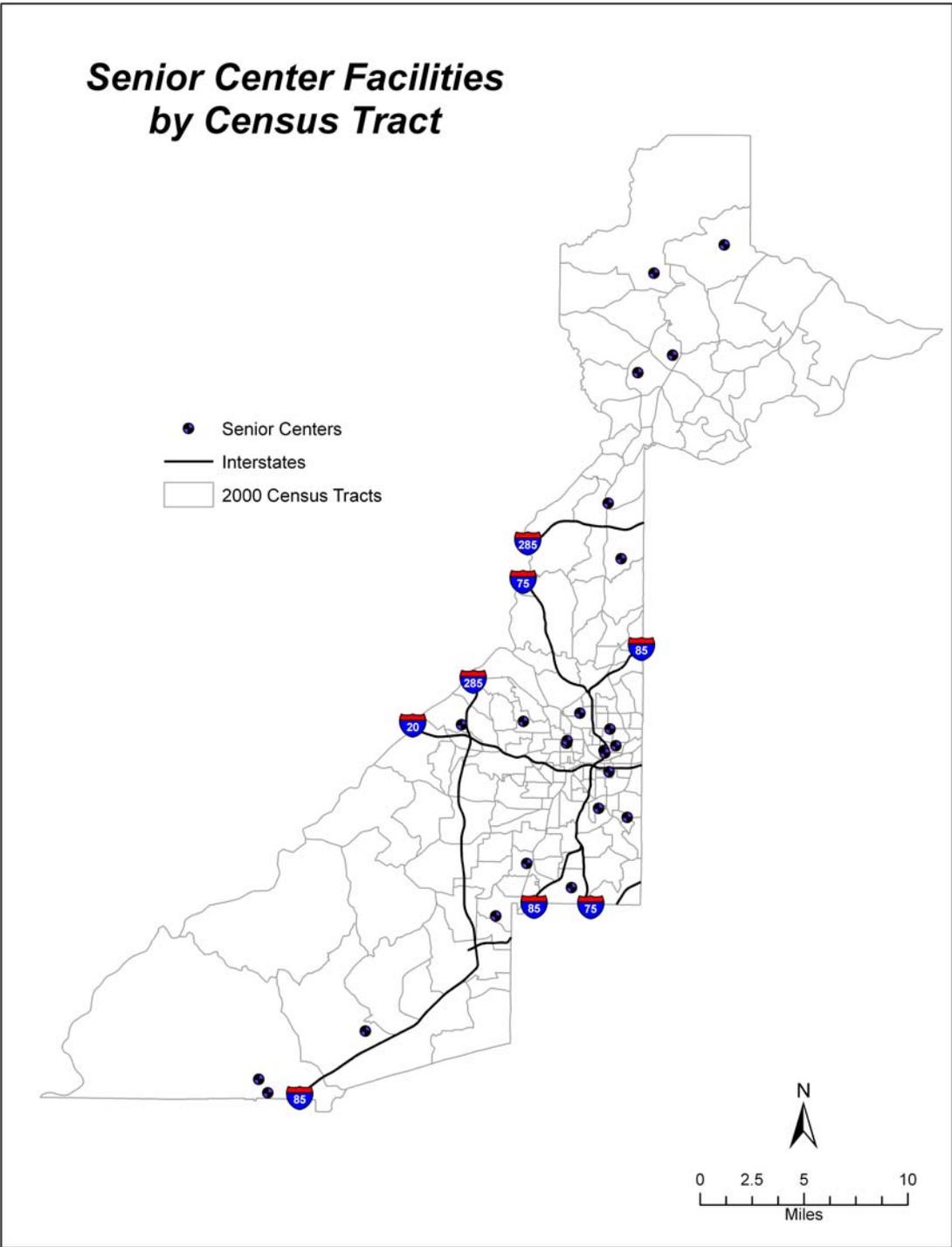
1. Public Facilities by Census Tract
2. Senior Facilities by Census Tract
3. Ryan White Partner Agencies by Census Tract
4. Poverty Outreach Facilities by Census Tract
5. Health and Medical Facilities by Census Tract
6. Human Services Grant Recipients by Census Tract
7. Cooperative Extension Facilities by Census Tract

Public Facilities by Census Tract

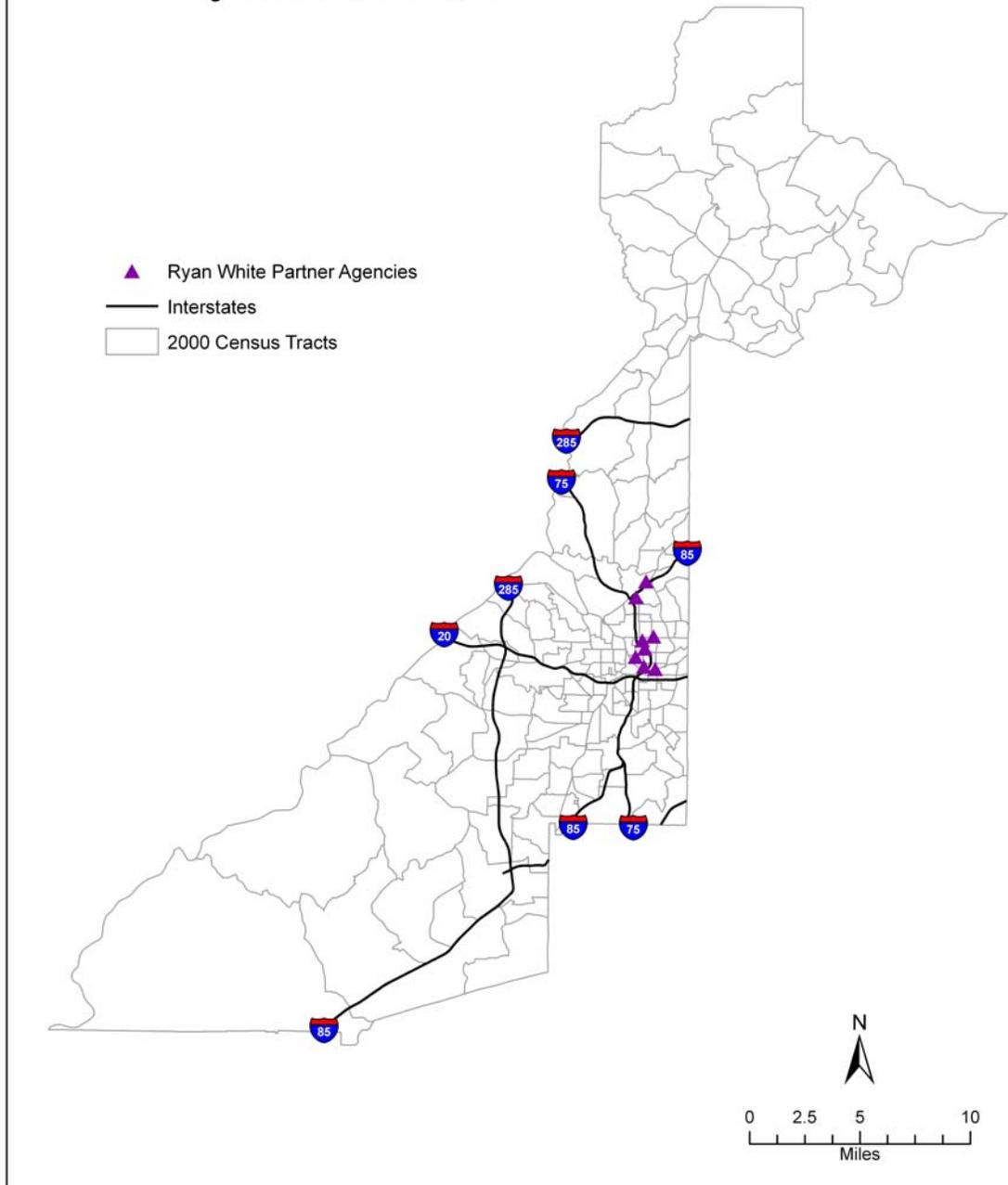
- ★ Art Centers
- 📖 Libraries
- 🌲 Parks
- Interstates
- 2000 Census Tracts



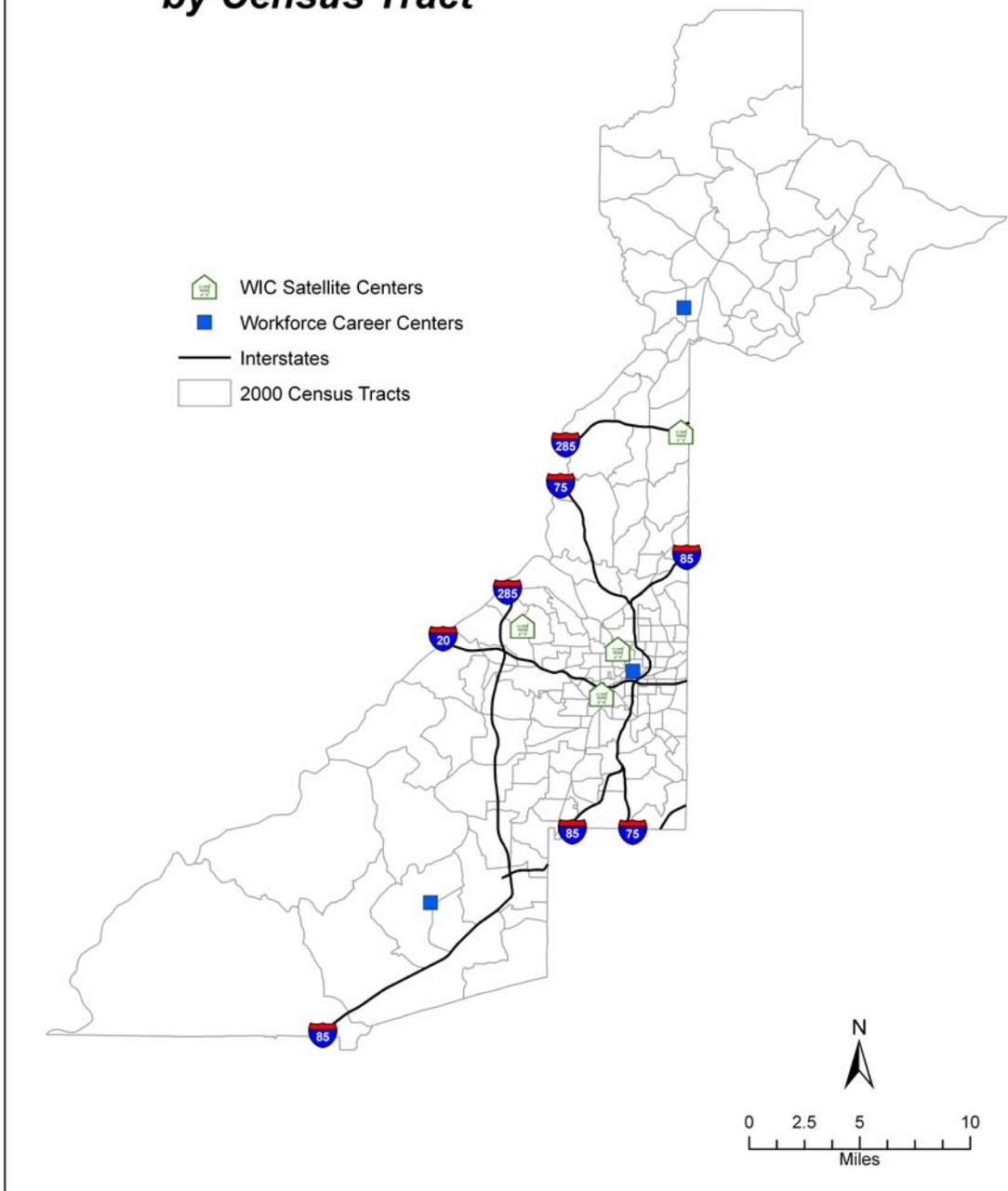
Senior Center Facilities by Census Tract



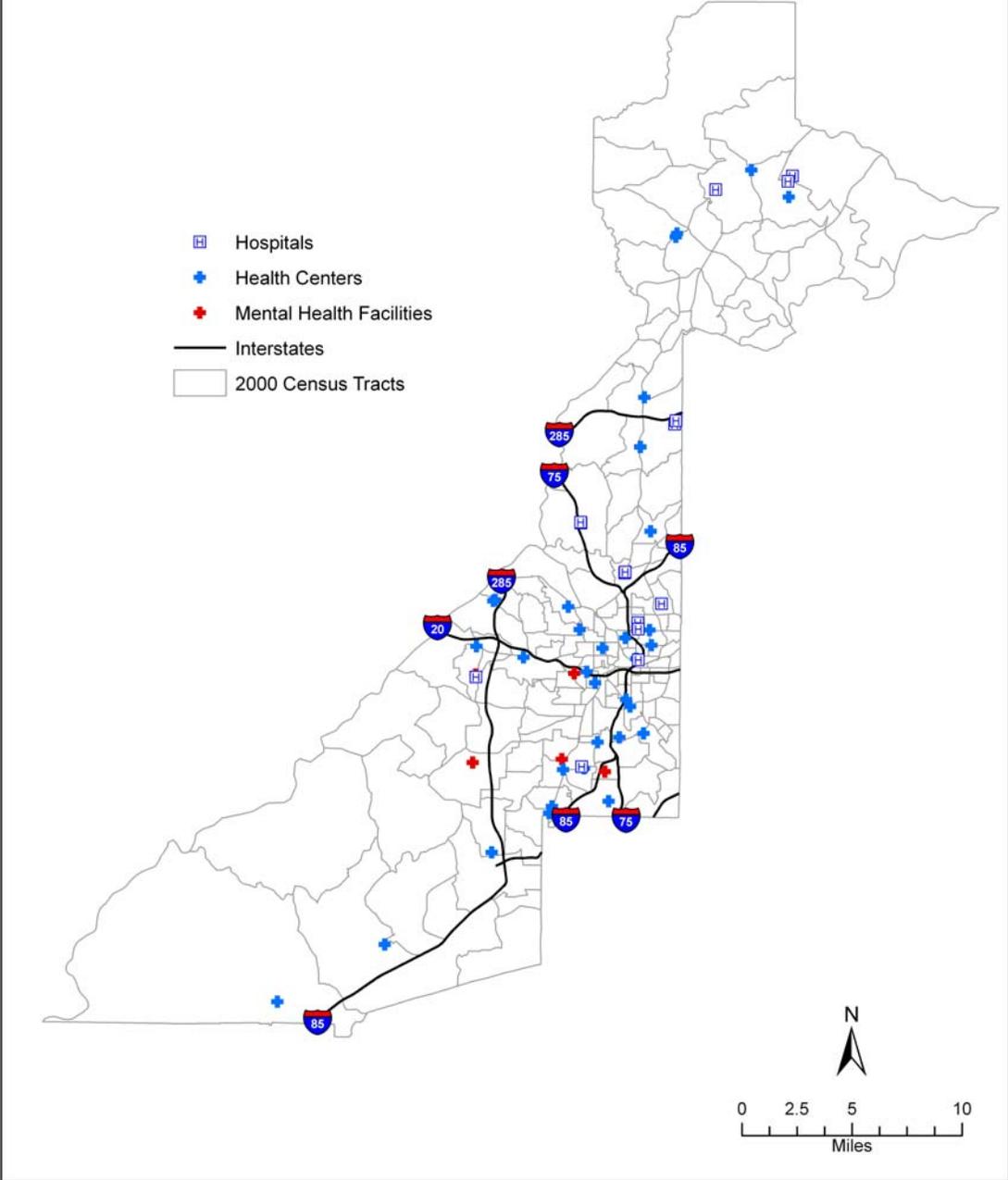
Ryan White Partner Agencies by Census Tract



Poverty Outreach Facilities by Census Tract

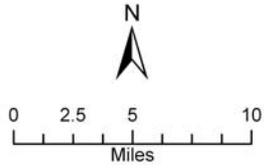
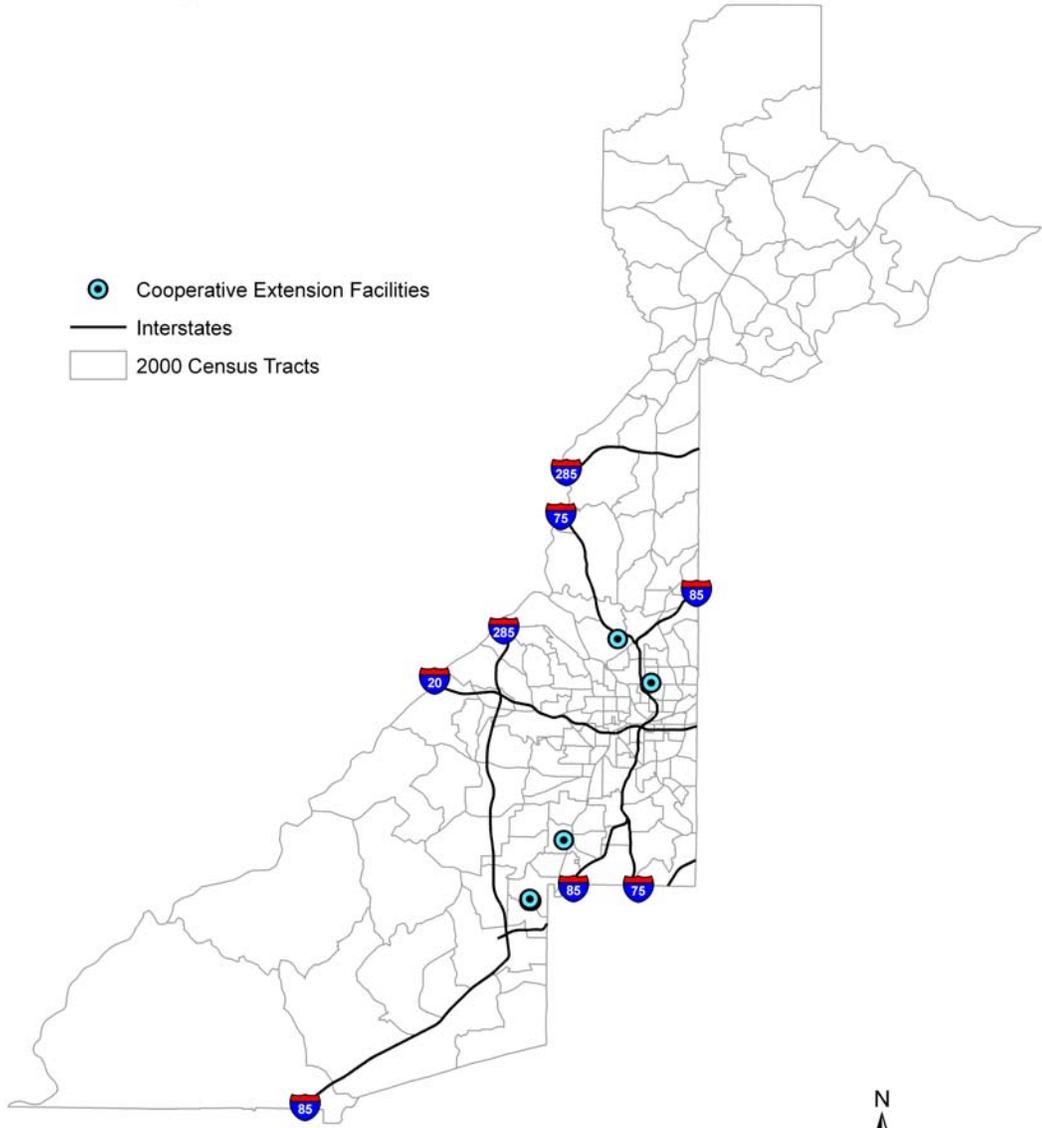


Health & Medical Facilities by Census Tract



Cooperative Extension Facilities by Census Tract

- Cooperative Extension Facilities
- Interstates
- 2000 Census Tracts



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Definitions

Geographic Equity. The concept of geography equity calls for providing equal and impartial services to all areas of a district, regardless of the demographic and socio-economic status of its residents. Decision-making on the provision of services is fair and impartial and demonstrates equality.

Alcohol Outlet Density. An *alcohol outlet* is a place where alcohol may be legally sold for the buyer to drink either there or elsewhere. *Density* refers to the number of outlets in a given area.

Social Determinants of Health. Social determinants of health are the essential factors and resources in the social environment that contribute to or detract from the health of its individuals and communities.

Social Exclusion. Social exclusion refers to the economic hardships of relative economic poverty and the resulting process of marginalization – how individuals or groups come to be excluded and marginalized from various aspects of social and community life.

Social Gradients. Social gradients refer to the stratifications (levels) of status in a society, specifically as these status levels relate to the burden of specific diseases among the population.

Socio-economic Status. Socio-economic status describes an individual's or group's position within a hierarchical social structure. Typically, socio-economic status depends on a combination of variables, including not only income and wealth, but also occupation, education, and place of residence.

Stakeholders. Stakeholders are organizations and people that will ultimately be affected by the efforts of a given project or undertaking.

Sustainable Communities. Communities planned, built, or modified to promote “sustainable” living are able to be maintained relatively easily over a very long period of time. Sustainable communities tend to focus on environmental sustainability (including development and agriculture) and economic sustainability, but can also focus on sustainable urban infrastructure and/or sustainable municipal infrastructure.