IOWA HEALTH CARE

Iowa's Center of Excellence for Behavioral Health

Webinar 5: Understanding and Identifying Your Population

FOUNDATIONS IN BEHAVIORAL HEALTH PREVENTION WEBINAR SERIES

August 8th, 2025

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CHANGING MEDICINE.
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Disclaimer

This training is hosted by Iowa's Center of Excellence (CEBH) for Behavioral Health. While Iowa CEBH is partly sponsored by the Iowa Department of Health and Human Services (Iowa HHS), please note that the views, opinions, and content shared in today's training are those of our trainers and do not necessarily reflect the views, opinions, or policies of Iowa HHS.

Learning Objectives

OBJECTIVES:

1. Understand the importance of data-driven identification of populations at greatest risk.
2. Analyze demographic, epidemiological, and community data to select an appropriate population of focus.
3. Apply principles of cultural humility and equity to engage the population effectively.
4. Integrate population of focus considerations into prevention planning, implementation, and evaluation.

Icebreaker Question

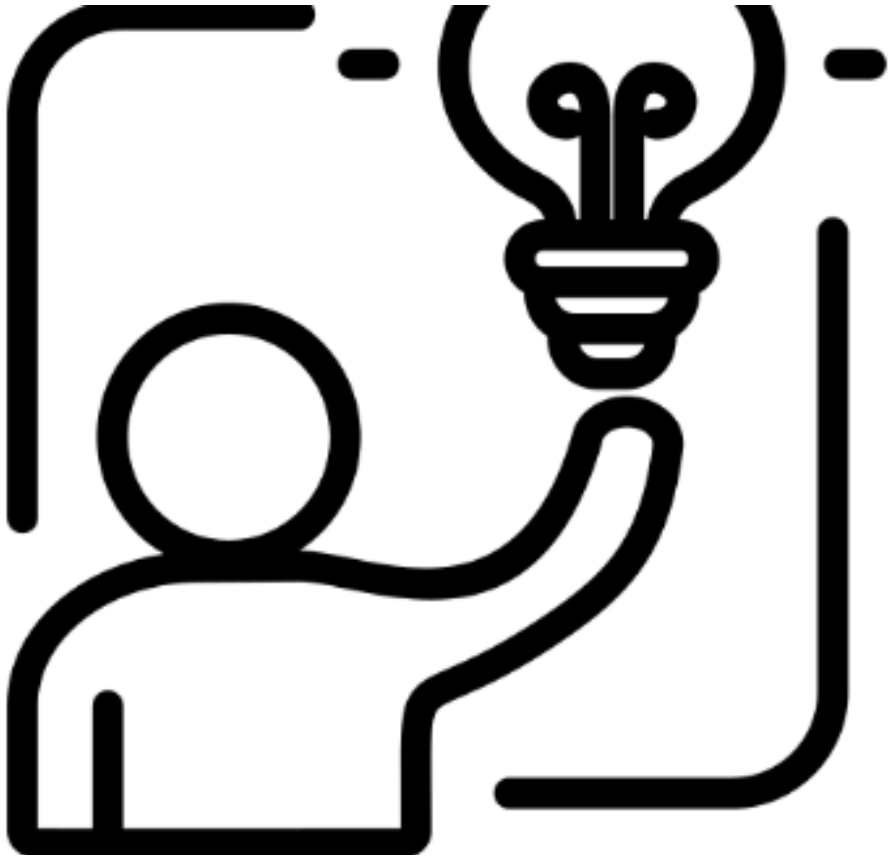
True or False:

Social Determinants of Health are the conditions which are in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Identifying Demographic and Social Factors

Identifying Demographic and Social Factors

- Historically, in the 19th century, pioneers in the field of public health and prevention started becoming aware of the factors that had an impact on the health and began to frame the role they played on the health of the population.



- (To meet certification requirements community prevention specialist are required to be able to identify community demographics and norms.)

Demographic Characteristics

- Demographics are the classifiable characteristics of a population

- Most commonly include:
  - Age
  - Gender
  - Race
  - Ethnicity
  - Geographic Area
  - Marital Status

- Additional characteristics:
  - Education
  - Occupation
  - Income

Disparities

- The differences in the quality of health and healthcare across racial, ethnic, and socio-economic groups can be understood as population-specific disparities which can be in the presence of disease, health outcomes, or access to healthcare.

Introduction of Social Determinants of Health (SDOH)

Key Categories of Social Determinants of Health

Neighborhood & Built Environment	Healthcare Access, Quality	Economic Stability	Education Access, Quality	Social & Community Context
				
Housing stability and quality	Health insurance coverage	Employment	Early childhood education	Support networks
Access to healthy food and water	Prevention services	Income level	High school graduation rates	Community engagement
Environmental safety	Health literacy	Financial resources	Higher education	Social inclusion
Access to green spaces	Culturally-informed care	Affordable food	Educational resources	Safe and supportive environments
Transportation	Specialized services	Affordable housing	Literacy rates	Criminal justice system
	Rurality vs Urban			Norms and attitudes

Neighborhood and Built Environment

- Includes one's community and surroundings that influence overall community health and individual behaviors that drive health.

Housing stability and quality
Access to healthy food and water
Environmental safety
Access to green spaces
Transportation

Health Access and Quality

- This includes how health care is both delivered and accessed by a population. Access to healthcare is defined by having “the timely use of personal health services to achieve the best health outcomes”.

- Health insurance coverage
- Prevention services
- Health literacy
- Culturally-informed care
- Specialized services
- Rurality vs Urban

Economic Stability

- Relates to how well one's income can meet their family's health and other needs. It is recognized that those with steady employment are more likely to be healthy without living in poverty.

Employment
Income level
Financial resources
Affordable food
Affordable housing

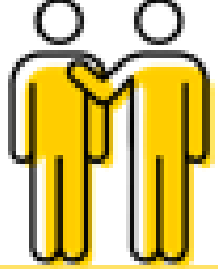
Education Access and Quality

- Education access and quality includes the quality of education received and the range of informal education obtained outside of the formal education system.

Early childhood education
High school graduation rates
Higher education
Educational resources
Literacy rates

Social and Community Context

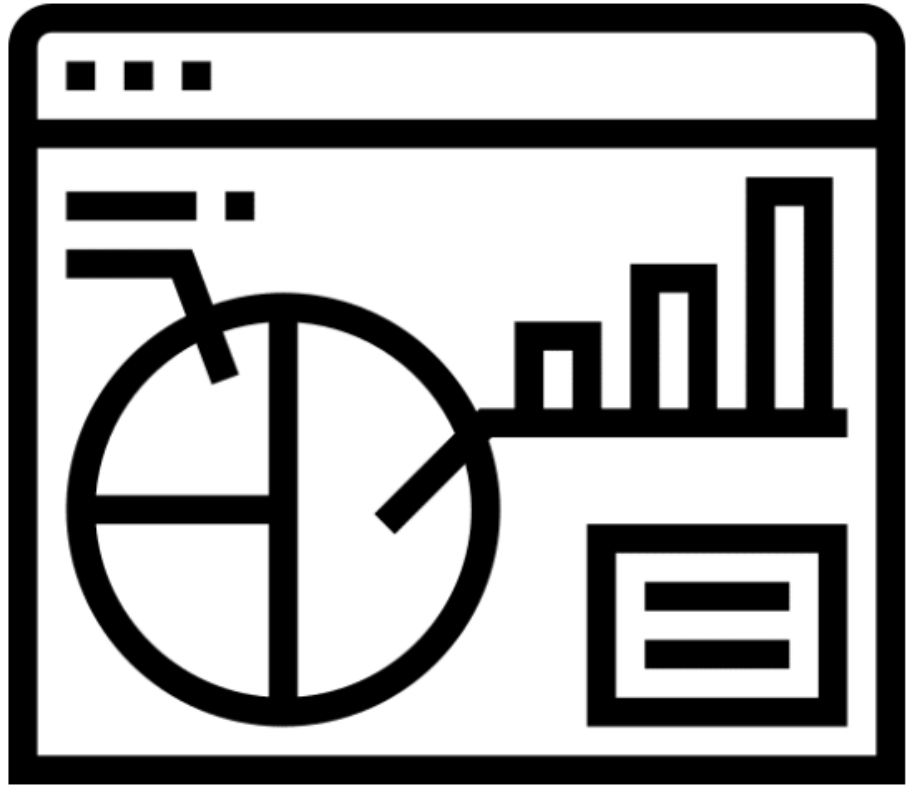
- A person's interaction with and connectedness to family, friends, neighbors, and co-workers and others in their network can affect their health and well-being.



Support networks
Community engagement
Social inclusion
Safe and supportive environments
Criminal justice system
Norms and attitudes

Social and Community Context

- Addressing both demographical characteristics and Social Determinants of Health (SDOH) can improve the health of populations and lead to better outcomes.



Data Driven Identification

Data Driven Identification

- These data tools are currently available for the state of Iowa and can be used to support prevention programs, monitor trends, estimate population needs, and inform public health policy. Some of these data sets include:
  - Behavioral Risk Factor Surveillance System
  - U.S. Census
  - County Health Rankings

Behavioral Risk Factor Surveillance System

- The Behavior Risk Factor Surveillance System (BRFSS) is a random-digit dial telephone survey that collects state-based data about adult residents regarding their health-related risk behaviors (including substance consumption), chronic health conditions, and use of preventative services.

U.S. Census Bureau

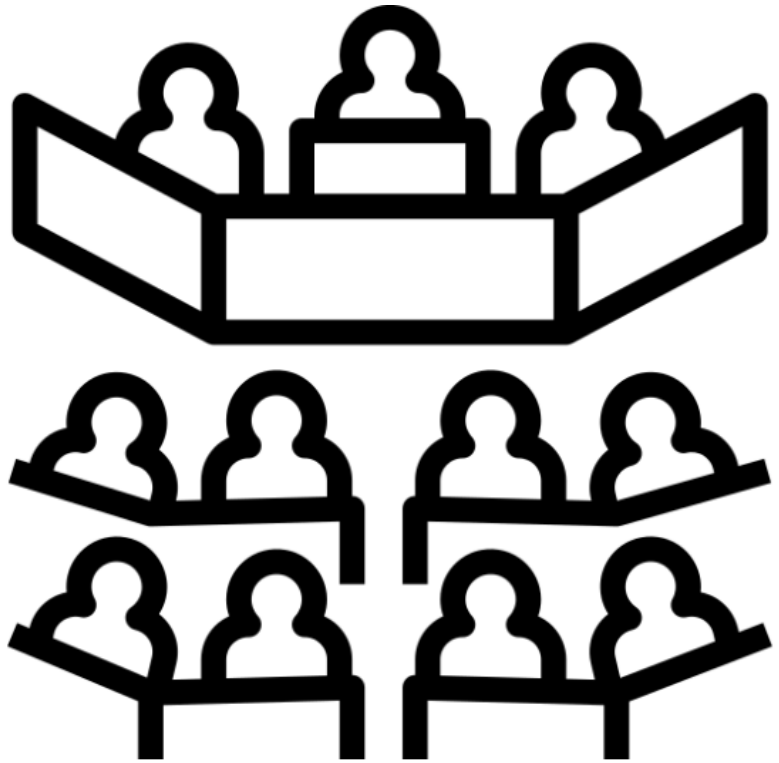
- The Census Bureau provides current facts and figures about America’s people and economy. One can access demographic, economic and population data from the U.S. Census Bureau, explore census data with visualizations and view tutorials.

County Health Rankings

- The County Health Rankings & Roadmaps website's annual data release provides a revealing snapshot of how health is influenced by where we live, learn, work, and play.

Previously Available Data Tool-Youth Risk Behavior Surveillance System

- The Youth Risk Behavior Surveillance System (YRBSS) measures health-related behaviors and experiences that can lead to death and disability among youth and adults. Data for 2021 and earlier are available but as of 2023 survey, Iowa is no longer participating.



Prevalence of Behavioral Health Conditions

- Prevalence is the proportion of a population who have a specific characteristic (typically in public health, a disease or a risk factor) in a given time period.

Prevalence of Mental Illness

2024

National Surveys on Drug Use and Health (NSDH)

61.5 million (23.4%) nearly 1 in 4 adults aged 18 or older had Any Mental Illness (AMI) in the past year.

14.6 million among adults aged 18 or older with AMI, 24% had Serious Mental Illness (SMI) in the past year.

2023

National Surveys on Drug Use and Health (NSDH)

58.7 million (22.8%), adults aged 18 or older had AMI in the past year.

14.6 million among adults aged 18 or older with AMI, 25% had SMI in the past year.

2022

National Surveys on Drug Use and Health (NSDH)

59.3 million (23.1%) adults aged 18 or older had AMI in the past year.

15.4 million among adults aged 18 or older with AMI, 26% had SMI in the past year.

Prevalence of Substance Use Disorder (SUD)

2024

National Surveys on Drug Use and Health (NSDH)

In 2024, 16.8% of people, aged 12 years or older (48.4 million) had a past year SUD.

2023

National Surveys on Drug Use and Health (NSDH)

In 2023, 17.1% of people, aged 12 years or older (48.5 million) had a past year SUD.

2022

National Surveys on Drug Use and Health (NSDH)

In 2022, 17.3% of people, aged 12 years or older (48.7 million) had a past year SUD.

Prevalence of Alcohol Use Disorder (AUD)

2024

National Surveys on Drug Use and Health (NSDH)

In 2024, 9.7% of people, aged 12 years or older (27.9 million) had a past year AUD.

2023

National Surveys on Drug Use and Health (NSDH)

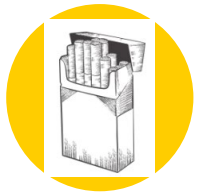
In 2023, 10.2% of people, aged 12 years or older (28.9 million) had a past year AUD.

2022

National Surveys on Drug Use and Health (NSDH)

In 2022, 10.5% of people, aged 12 years or older (29.5 million) had a past year AUD.

Prevalence of Cigarette & Nicotine Use

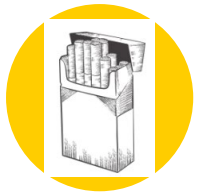


2024

National Surveys on Drug Use and Health (NSDH)

In 2024, 13.1% (37.8) of people age 12+ in the U.S. smoked cigarettes.

An estimated 1.2 million (3.0%) of people in the U.S. were underage (aged 12 to 20) who smoked.

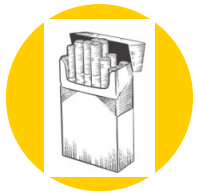


2023

National Surveys on Drug Use and Health (NSDH)

In 2023, 13.7% (38.7 M) of people (age 12+) in the U.S. smoked cigarettes.

An estimated 1.2 million (3.3%) of people in the U.S. were (aged 12 to 20) who smoked.



2022

National Surveys on Drug Use and Health (NSDH)

In 2022, 14.6% (44.1M) of people (age 12+) in the U.S. smoked cigarettes.

An estimated 1.2 million (3.1%) of people in the U.S. were (aged 12 to 20) who smoked.

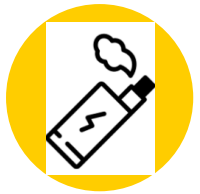
Prevalence of Vaping

2024

National Surveys on Drug Use and Health (NSDH)

In 2024, 9.6% (27.7M) of people, aged 12 years or older vaped nicotine.

An estimated 4.0 million (10.4%) of people were underage (aged 12 to 20).

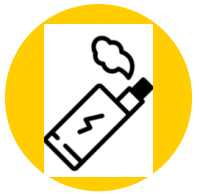


2023

National Surveys on Drug Use and Health (NSDH)

In 2023, 9.4%(26.6M) of people, aged 12 years or older vaped nicotine.

An estimated 4.5 million (11.7%) of people were underage (aged 12 to 20).



2022

National Surveys on Drug Use and Health (NSDH)

In 2022, 8.3%(23.5M) of people, aged 12 years or older vaped nicotine.

An estimated 4.7 million (12.2%) of people were underage (aged 12 to 20).

Prevalence of Suicide

2024

National Surveys on Drug Use and Health (NSDH)

An estimated 14.3 million adults had serious thoughts of suicide.

4.6 million made a suicide plan.

2.2 million attempted suicide.

2023

National Surveys on Drug Use and Health (NSDH)

An estimated 12.8 million adults had serious thoughts of suicide.

3.7 million made a suicide plan.

1.5 million attempted suicide.

2022

National Surveys on Drug Use and Health (NSDH)

An estimated 13.2 million adults had serious thoughts of suicide.

3.8 million made a suicide plan.

1.6 million attempted suicide.

Prevalence for Risk of Problem Gambling

2024

National Counsel on Problem Gambling (NCPG)

71% of American adults reported gambling on at least one activity in the past year.

8% of adults reported experiencing at least 1/9 problematic gambling behaviors “many times” in the past year.

2021

National Counsel on Problem Gambling (NCPG)

73% of American adults reported gambling on at least one activity in the past year.

11% of adults reported experiencing at least 1/9 problematic gambling behaviors “many times” in the past year.

2018

National Counsel on Problem Gambling (NCPG)

71% of American adults reported gambling on at least one activity in the past year.

7% of adults reported experiencing at least 1/9 problematic gambling behaviors “many times” in the past year.

BREAK

Identify Desperate Populations

- Having a focus in prevention work on “desperate populations” is asking “who should benefit from our efforts” and “who are those who are most impacted by a priority area?”

A Multidimensional Approach

- A proven multidimensional approach in public health includes 4 criteria based on which desperate populations can be identified to assist in guiding strategic choices within prevention planning. This framework includes:

    1. Biomedical
    2. Social
    3. Spatial
    4. Temporal

The Biomedical Approach

- The Biomedical approach is looking at vulnerable populations who are high risk and is characterized by concentrating specifically on a segment of the population through either risk behavior or biomarkers for example addressing smoking behaviors.

Whole Population Approach

- Having a focus on a “whole population” instead provides the given strategies to cover everyone, for example through laws or policies.

Biomedical or Whole Population Approach

Biomedical

Pros:
It addresses root causes of disease and may guide selection of desperate population segments.

Cons:
There is a danger of stigmatization.

Whole Population

Pros:
It focuses on everyone irrespectively of risk in what can be perceived more as primary prevention.

Cons:

The fundamental root causes (or underlying determinants) are not addressed.

The Social Approach

- It is recognized that health can be both unjustly and unevenly be distributed in various population segments according to a number of social determinants, such as socio-economic status, education level, ethnicity or gender depending on local contexts.

Benefits of the Social Approach

- Allows for selected social determinants to be used to identify a population segment for which tailored public health strategies can be directed.

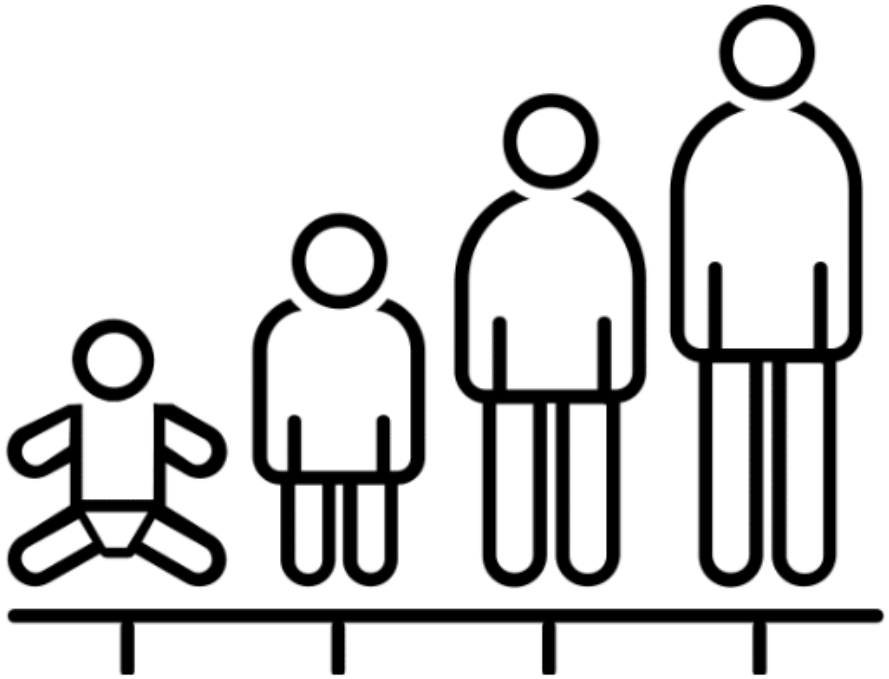
The Spatial Approach

- The spatial perspective holds that a desperate population is delineated by where they live. For example, in a neighborhood or municipality.

Benefits of the Spatial Approach

1. Neighborhoods are often characterized by particular risk profiles.
2. A given neighborhood is likely to fall within the mandate of a given local administration.
3. A group of people living in the same local community often have a sense of community and interact within social networks.
4. A given local community provides opportunities to engage in social interaction within the neighborhood.

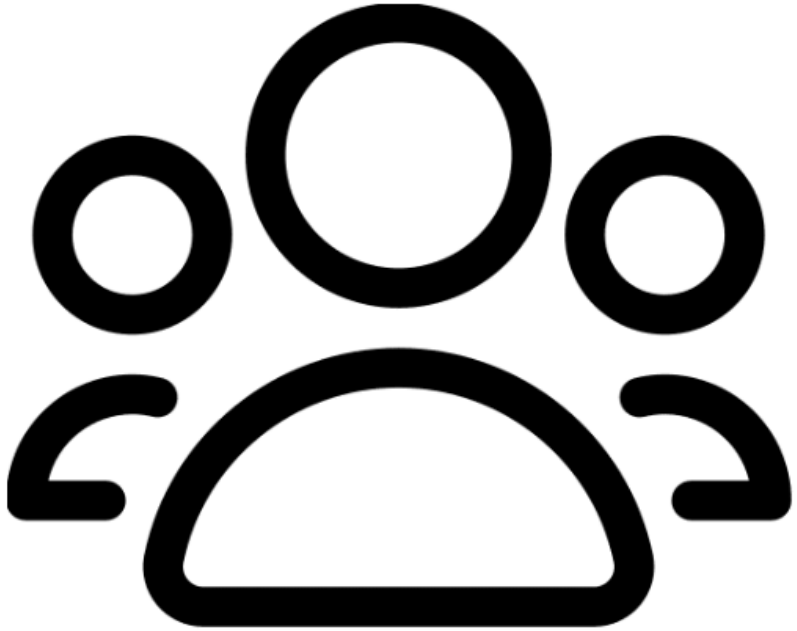
The Temporal Approach



- A focus on the various age phases ranging from fetal life and infancy to old age may guide selection of population segments for focused public health strategies.

Benefits of the Temporal Approach

- It addresses root causes of disease and may guide selection of specific population segments. Can provide a clear distinction for sub-populations who are also at high-risk.



Community Assessment

- A community assessment is a helpful way for organizations to obtain a comprehensive review of a community's current health status, needs, and issues.

Assessment Guiding Questions

What does health equity look like in our community? How equitable are the health outcomes in our community?

What are the sub-populations within our community that have higher health risks or poorer health outcomes?

What are the contributing factors that lead to higher health risks or poorer health outcomes of certain populations within our community?

What are the protective structural and social factors (including assets, strengths, and/or resources) in our community that support the health and wellness of community members and bring us closer to our vision of health?

How are the various types of community partners impacting health inequities in the community and/or contributing to the health and wellness of community members?

NACCHO’s MAPP Framework

- The National Association for County & City Health Officials (NACCHO) utilizes three assessments in their Mobilizing for Action Through Planning and Partnership (MAPP) Framework which is a community-driven strategic planning process to help achieve health equity.

Community Assessment Cont'd

- These three assessments provide a full picture of the community system that helps informs action. The three assessments include:
  - Community Status Assessment (CSA)
  - Community Context Assessment (CCA)
  - Community Partner Assessment (CPA)

Community Status Assessment

- The CSA collects quantitative data on the status of a community such as demographics, health status, and health inequities.

The CSA Seeks to Understand

Status of Community

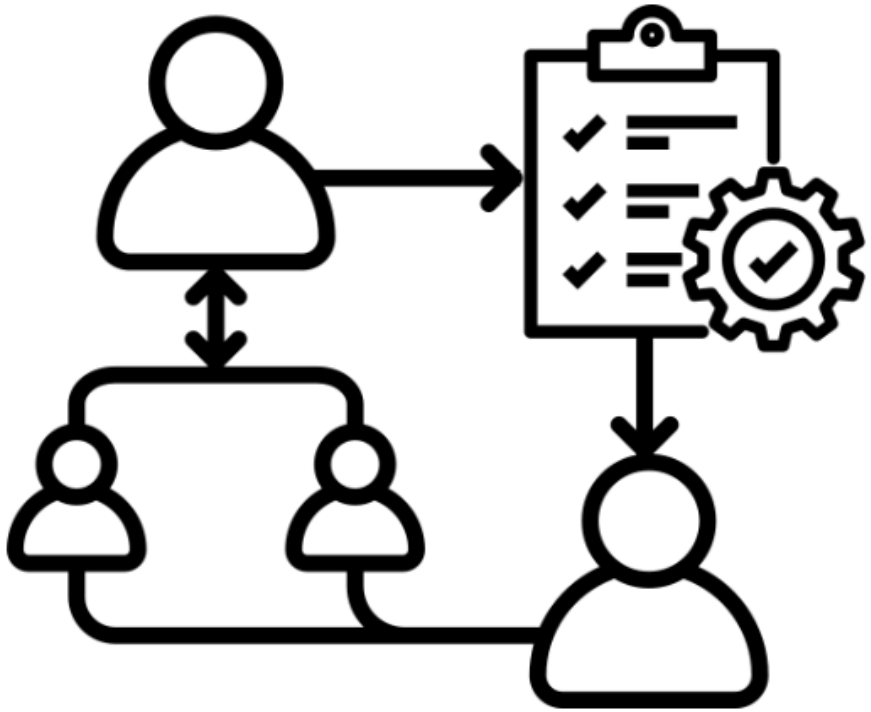
Inequities

Systems

What Questions Come to Mind for You In the Lense of Community Status?

Community Context Assessment

- The CCA is a qualitative tool to assess and collect data. It collects the insights, expertise, and views of people and communities affected by social systems to improve the functioning and impact of those systems.



The CCA Seeks to Understand

Strengths & Resources

Current & Historical Forces

Physical & Cultural Assets

Steps Which are being Taken

What Questions Come to Mind for You In the Lense of Community Context?

Community Partner Assessment (CPA)

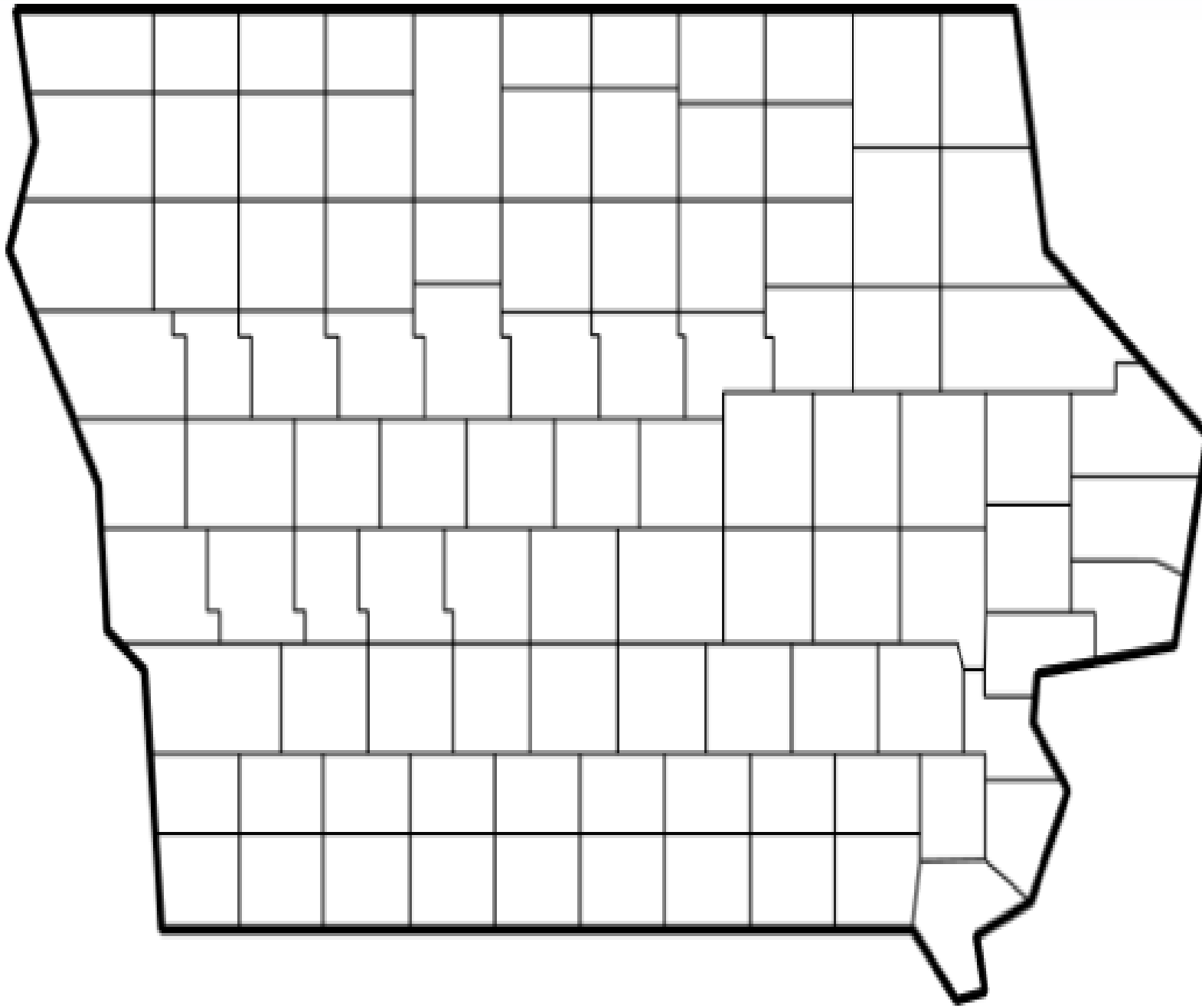
- The CPA allows community partners to look critically at their individual systems, processes, capacities and collective capacity as a network of community partners to address health inequities.

The CPA Seeks to:

- Describe Partnerships
- Name Roles
- Assess Capacity
- Document Landscape
- Identify Involvement

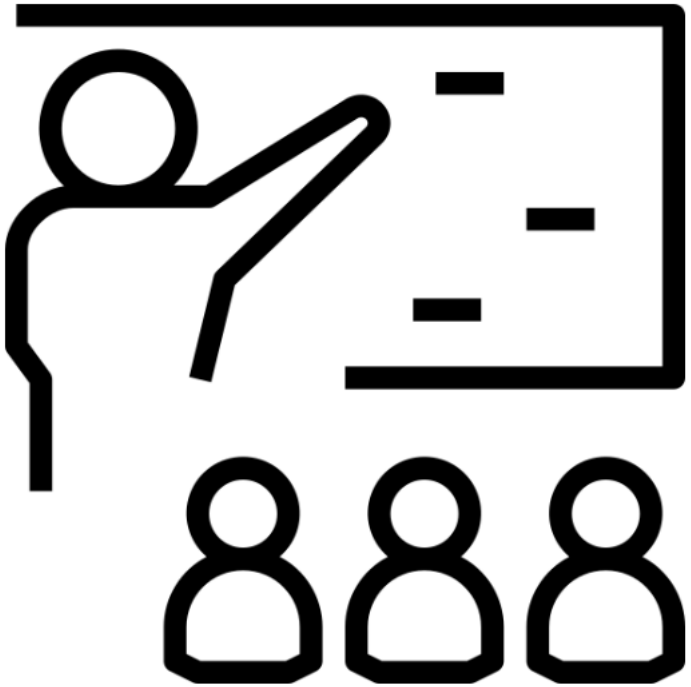
What Questions Come to Mind for You In the Lense of Community Partnerships?

Planning Prevention Interventions With Population Of Focus In Mind



Community Education & Outreach

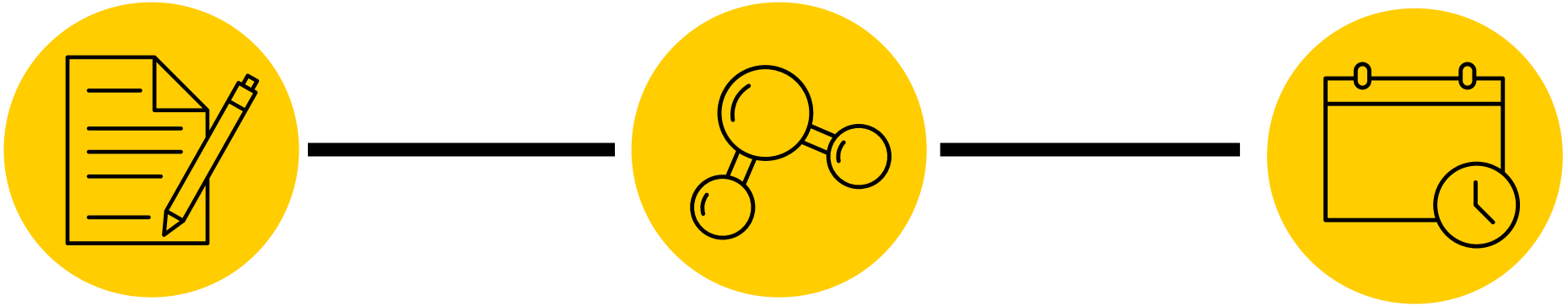
- Community education and outreach offers a variety of learning opportunities designed to help individuals and communities improve their health literacy.



Goals of Community Education & Outreach

- **The goals of community education and outreach are to increase awareness of:**
  - **Local health conditions.**
  - **The impacts of these conditions on individual and public health.**

Forms of Community Education



Small group conversations

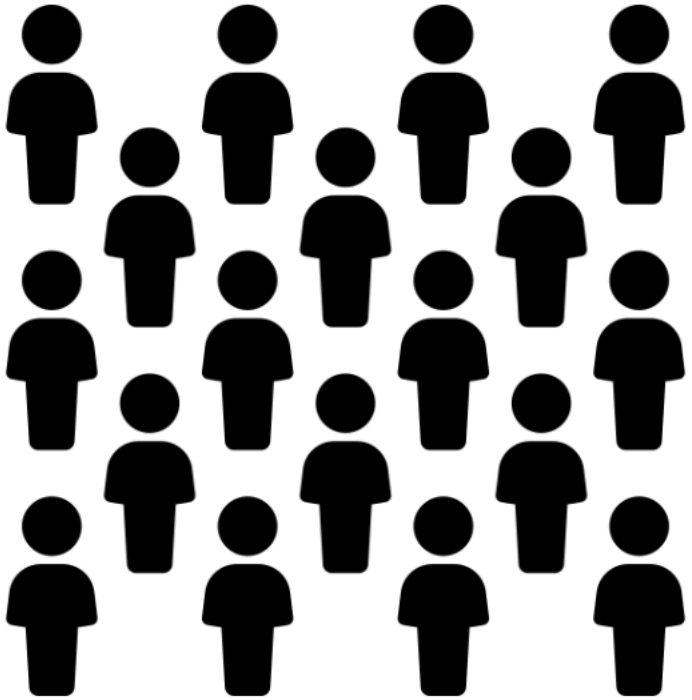
Community Workshops

Community Events

Cultural and Community Context

- The type and scope of the prevention work as well as the cultural and community context will help to determine which community engagement activities are most appropriate.

Aligning Intervention with Identified Need



- Implementing the most appropriate health strategies is a crucial step toward improving community health outcomes.

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Questions and Evaluation Link

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Thank you

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