health action PARTNERSHIP

JEFFERSON COUNTY, AL

Community Health Equity Report

2018

Acknowledgments

The Jefferson County Health Action Partnership (HAP) is supported by five backbone organizations and over 80 other organizations and agencies working together to make Jefferson County, Alabama a healthier place to live, learn, work and play.

United Way of Central Alabama, Inc.

COMMUNITY FOUNDATION OF GREATER BIRMINGHAM

Collaborative for Health Equity Jefferson County

COMMUNITY foodbank OF CENTRAL ALABAMA

Health Equity Report Contributors

Data Collection and Analysis

Dr. Monica Baskin	Jefferson County Collaborative for Health Equity/UAB School of Medicine
Bryn Manzella	Jefferson County Department of Health
Elisabeth Welty	Jefferson County Department of Health
Dr. Richard Sinsky	Jefferson County Department of Health
Thomas Veazey	Jefferson County Department of Health
Brett Isom	Regional Planning Commission of Greater Birmingham

Writing Group

Dr. Monica Baskin	Jefferson County Collaborative for Health Equity/UAB School of Medicine
Kadie Peters	United Way of Central Alabama
Bryn Manzella	Jefferson County Department of Health
Ryan Parker	United Way of Central Alabama
Chris Mackey	Lakeshore Foundation/National Center on Health, Physical Activity and Disability
Dee Caudel	Jefferson County Collaborative for Health Equity/AARP
Dr. Mark Wilson	Jefferson County Department of Health
Gus Heard-Hughes	Community Foundation of Greater Birmingham
Kathryn Strickland	Community Food Bank of Central Alabama
Rokeia Westbrook	Samford University School of Public Health

Table of Contents

I. Executive Summary 2

II. Introduction 6

III. Description of Census Tracts 10

IV. Community Characteristics and Social Determinants 12

V. Health Status 31

VI. Building a Healthier Jefferson County 42

VII. Conclusion and Recommendations 48

VIII. Appendices 50

A) More detailed census tract maps 50

B) Glossary of terms 58

C) References 61

I. Executive Summary

Preventable differences in the presence of disease, health outcomes, and/or access to health care between population groups are known as health disparities. Health disparities among racial and ethnic minority, socioeconomically disadvantaged, rural, and sexual and gender minority populations are well-documented. In addition, we know that where you live, learn, work and play can powerfully predict who is healthy, who is sick, and who lives longer. This report updates and expands the first-of-its kind community health equity report of Jefferson County, Alabama that was released in September 2013 by the Jefferson County Collaborative for Health Equity (formerly Jefferson County Place Matters). The current report is intended to inform the public, decision makers, and funders of the greatest health-related needs within our community and highlight ongoing collaborative efforts to improve health and well-being.

This map-based report provides a snapshot in time of the many factors that influence health and health disparities in our county. The report focuses on community characteristics such as education, poverty, neighborhood segregation, and healthy food access—that may impact health outcomes and life expectancy.

The report is guided by the primary research questions below:

1. What are the demographic characteristics of the population of Jefferson County?

2. What is the distribution of community characteristics and social determinants across Jefferson County?

3. What is the health status of Jefferson County?

4. Does health status vary by census tract?

The study found that:

- Jefferson County has greater racial diversity, but lower ethnic diversity than the state or the US. Five-year (2012-2016) population estimates describe the county as 52.4% White, 42.5% Black, 1.5% Asian, 1.5% Multiracial, and 2% Other. The county also includes 3.7% of the population who identify as Hispanic or Latino.

- The 5-year estimated percentage of Jefferson County residents living with a disability is 14.85% and is similar across males and females and among Whites, Blacks, and persons of two or more races. Asian and Hispanic or Latino residents have notably lower percentages of persons living with a disability (4.4% and 5.3%, respectively).

- Though Jefferson County has a higher level of educational attainment (only 11% of the population did not attain a high school diploma or equivalent), the poverty rate at each educational attainment level is higher than the state and the US. County poverty rates are notably higher among Hispanic or Latino, Black, and Multiracial populations and persons living with a disability.

- Life expectancy for Jefferson County in 2015 was 75.0 years compared to 75.5 years for Alabama and 78.8 years for the US. Life expectancy was 79.1 for White females, 76.9 for Black females, 73.8 for White males, and 68.5 for Black males. Life expectancy varied by as much as 28.9 years between census tracts with the highest versus lowest life expectancies.

- The infant mortality rate for Jefferson County in 2015 was 10.5 deaths per 1,000 live births, almost double the national rate of 5.9 deaths per 1,000 live births, and substantially higher than the Alabama rate of 8.3 deaths per 1,000 live births. The infant mortality rate for Black mothers was 2.3 times higher than White mothers. Census tracts with higher proportions of Black and Hispanic residents and persons living in poverty were generally associated with higher rates of infant mortality.

- Above all, this study found significant variation in racial residential concentration, disability status, poverty, life expectancy, infant mortality, and healthy food access between census tracks in the “Over the Mountain” and Trussville areas than census tracts near the Interstate 20/59 corridor. In general, “Over the Mountain” and Trussville census tracts were found to have a higher percentage of White residents, fewer persons living with disability, less poverty, longer life expectancy, lower infant mortality, and greater healthy food access. This finding is similar to the prior health equity report.

To be clear, these findings indicate only a correlation between neighborhood conditions and health; researchers cannot say with certainty that these neighborhood conditions caused poor health. With that said, data from this investigation point to an overall pattern of social and economic distress clustered in low-income and nonwhite neighborhoods that limit opportunities for people in these communities to live healthy lives.

While acknowledging the painful, deadly, and divisive history of racism and discrimination in this region, the Jefferson County Health Action Partnership (HAP) is part of a growing county-specific partnership network that is working to address health disparities by examining root causes, establishing common measurable goals and aligning efforts among over 80 organizations and agencies in direct response to community-identified needs and priorities.

Notable accomplishments by the HAP are briefly described in this report. However, based on this report, more work is needed. As such, we recommend the following to support efforts to advance health equity in Jefferson County and any other community in the US.

Understand the Community Context

A community-specific "place-based" approach is vital for diagnosing the problem(s) and identifying potential strategies for addressing them. Exploring how community conditions impact health is important for crafting holistic solutions with overall wellness as a central focus.

Create Strong Program Guidance

Be explicit in directing staff to ensure that all health improvement program activities intentionally include persons who are negatively impacted by health disparities (e.g., racial/ethnic minorities, older adults, lower socioeconomic status, physical or mental disability, geographic location).

Value Community Expertise

It is critical that the lived experience and perspective of community members—those ultimately impacted by any initiative—be respected and valued along with the technical expertise from those with education, training or work experience in the area.

Build and Sustain Community Capacity

"Community capacity" refers to the people, resources, infrastructures, relationships, and operations that enable a community to create change. Strengthening and sustaining this capacity is essential in improving the long-term health and well-being of a community and its members

Adopt a Collective Impact Model

Leveraging opportunities with diverse stakeholders is key to effective community efforts and ensures that all communities, especially those that are historically under-served and under-resourced, have the opportunity to be healthy, safe, and offer the resources and infrastructure needed for all to thrive. Given limited resources, including money, people and partnerships, there is very little room for duplication of effort.

Design Clear Messages

It is important that everyone (staff, community members, partners, and other stakeholders) has a shared understanding of the meaning of health equity and its related goals. This shared understanding needs to be developed with a proper understanding of the community context and culture. Without this, messages around health equity can go unnoticed or lead to unfavorable actions.

II.
Introduction

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JEFFERSON COUNTY, AL

County-Specific Approach for Regional Impact

With over 650,000 residents, Jefferson is the most populated county in Alabama. It is also home to the state's largest single employer, a world class research institution, and the nation's third largest pediatric medical facility in the United States. Despite these and other tremendous resources, our community continues to struggle to achieve optimal health, and, according to the 2018 Robert Wood Johnson Foundation (RWJF) County Health Rankings, Jefferson County is ranked 21 out of 67 counties in Alabama for overall health outcomes. The lowest rankings are in physical environment features (64), premature death (34), quality of life (25), and social and economic factors (20).[1]

To address the breadth of factors that influence community health, the **Jefferson County Health Action Partnership (HAP)** was formed in 2007, and currently includes over 80 organizational members working to improve the health of Jefferson County residents. The HAP is anchored by the Jefferson County Department of Health, United Way of Central Alabama, and the Community Foundation of Greater Birmingham, and these organizations have committed to the long-term sustainability of the partnership.

The HAP is part of a growing county-specific partnership network that is working to improve regional outcomes in alignment with the Bold Goals Coalition of Central Alabama (BGCCA). BGCCA is a community-based initiative to align efforts and address disparities in health, education, and financial stability in the Central Alabama region. Established in early 2014, the Bold Goals Coalition is committed to fostering change by examining root causes, establishing common, measurable goals and aligning current efforts. This collective impact process encourages collaboration and uses an "upstream" approach to make a greater impact, especially for populations in Central Alabama experiencing continued disparities in outcomes.

Responding to Community Needs

In 2014, the Jefferson County Department of Health (JCDH) completed a comprehensive, community-engaged assessment of the county's health and public health system[2] that identified five new priority focus areas:

- Reduce Health Disparities Associated with Race, Ethnicity, and Economic Status
- Optimize Healthcare Access, Availability, and Utilization
- Improve Mental Health
- Optimize the Built Environment, Transportation System, and Safety
- Promote Physical Well-Being Through Healthy Lifestyles.

In response, the HAP refocused its efforts to be responsive to community-identified needs. The current work of the partnership is centered around the above strategic priority areas with measurable goals in place. While the HAP has had multiple achievements in grant funding and population health improvement since its creation, an intentional and explicit priority to address health equity and the social determinants of health was not an established component until 2015.

Advancing Health and Health Equity

The HAP values include: promoting equity and justice, fostering greater collaboration, valuing diverse perspectives, a willingness to have candid dialogue, and learning from failures and successes. These values are reflected in the HAP mission and vision.

Mission: *The HAP works with diverse stakeholders to make Jefferson County a healthier place for all residents to live, learn, work, play and achieve their highest possible quality of life.*

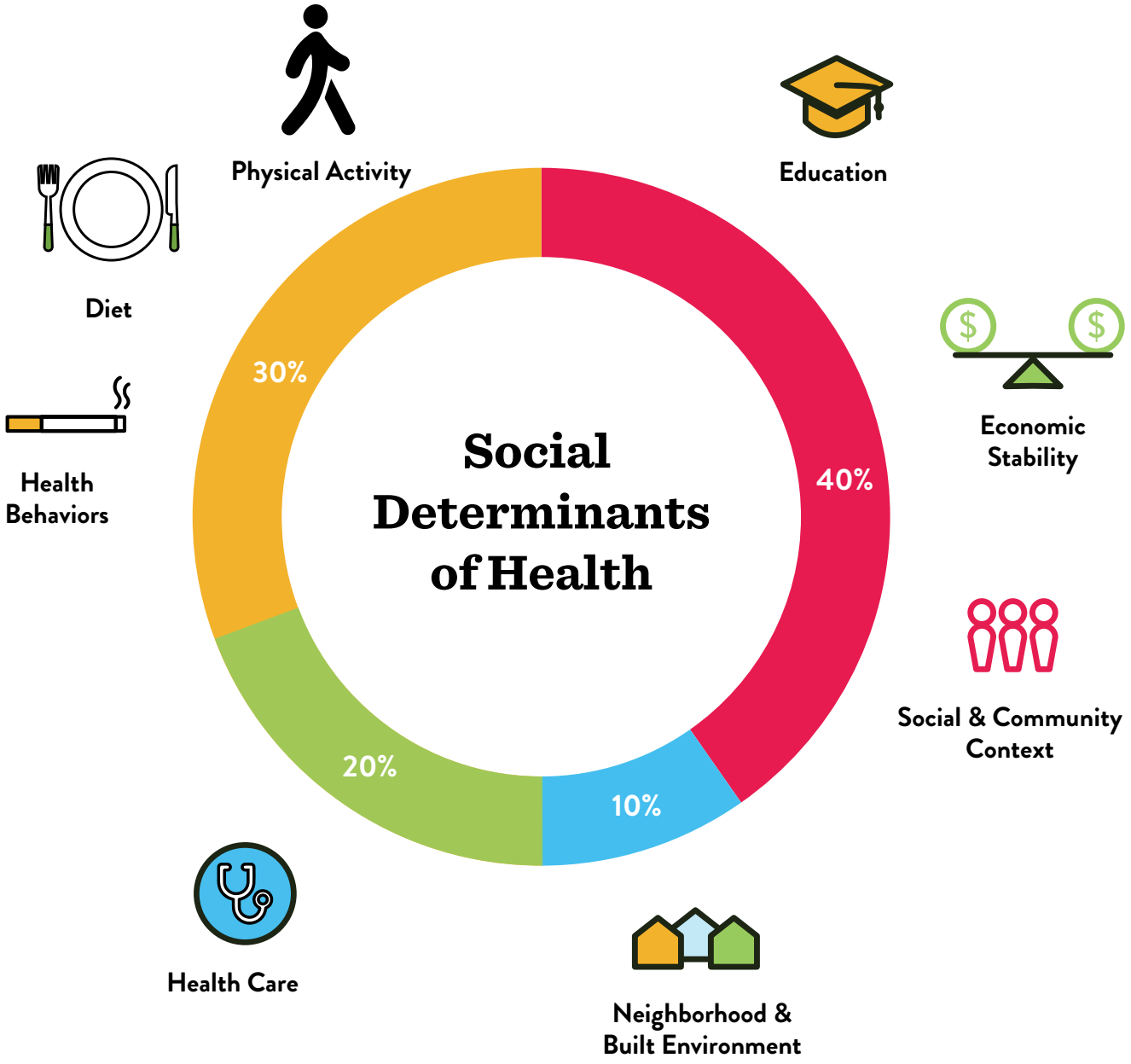
Vision: *Jefferson County is a healthy, thriving and connected community where all residents can achieve their highest possible quality of life, and is recognized as such statewide and nationally.*

Since a deliberate focus on health equity has been included in the HAP, the partnership has had a number of achievements:

First, the Advancing Health Equity (AHE) Priority Group informs and provides guidance on including health equity principles in all other priority groups and the HAP Leadership Team decision making process.

Second, media resources were created to motivate organizations, agencies and individuals to commit to advancing health equity. Resources include a brief video and a new website (www.healthequityal.org) that includes tools for organizations and agencies to act on advancing health equity.

Lastly, AHE now offers training resources to organizations hosting internal dialogues about health equity, privilege, structural racism, and social determinants of health.


Physical Activity
Education
Diet
Economic Stability
Health Behaviors
Social & Community Context
Health Care
Neighborhood & Built Environment
30%
40%
20%
10%
Social Determinants of Health

Multiple Influences of Health

National discussions of health often focus on health care access: (1) ability to gain entry into the healthcare system, typically via health insurance coverage, (2) availability of services in geographical areas of need, and (3) suitability of providers with whom the patient trusts and can form a relationship.[3] However, research shows that as little as 10%, but no more than 20% of health outcomes, are based on medical care.[4-6] The remaining 80-90% of our health relates to other factors such as health behaviors (e.g., diet, physical activity, tobacco use), social and economic circumstances (e.g., education, employment, income, social support) and the physical environment (e.g., housing, transit, parks and recreational facilities).[5] These other factors, also known as social determinants of health, are often powerful predictors of who gets sick, who lives longer, and who lives a higher quality of life.

> *Inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic factors.*
>
> —World Health Organization Commission on Social Determinants of Health (2008)

Purpose of this Report

This map-based Community Health Equity Report (CHER) is designed to provide a snapshot in time of the many factors that influence health and health disparities in Jefferson County. The report focuses on community characteristics such as education, poverty, neighborhood segregation, and healthy food access that may impact health outcomes and life expectancy. This report is meant to highlight the message that place matters and that the conditions in which people live, learn, work, and play have a profound impact on overall health.

This report updates and expands the first county-wide health equity report, *Place Matters for Health in Jefferson County, Alabama: The Status of Health Equity on the 50th Anniversary of the Civil Rights Movement in Birmingham, AL (A Special Report),* led by the Jefferson County Collaborative for Health Equity (formerly Jefferson County Place Matters) and released in September 2013 [available at www.healthequityAL.com]. While the previous report examined the history of racial oppression, the legacy of that oppression on residential patterns today, and the intersection of place and race in the persistence of health inequities, this report is intended to inform the public, decision makers, and funders of the greatest health-related needs within our community and highlight ongoing collaborative efforts to improve the health status of residents. While recommendations are made, it is not intended to function as a roadmap to achieving health equity, but instead serve as a community resource that illuminates the impact inequities have on overall community health.

III. Description of Census Tracts

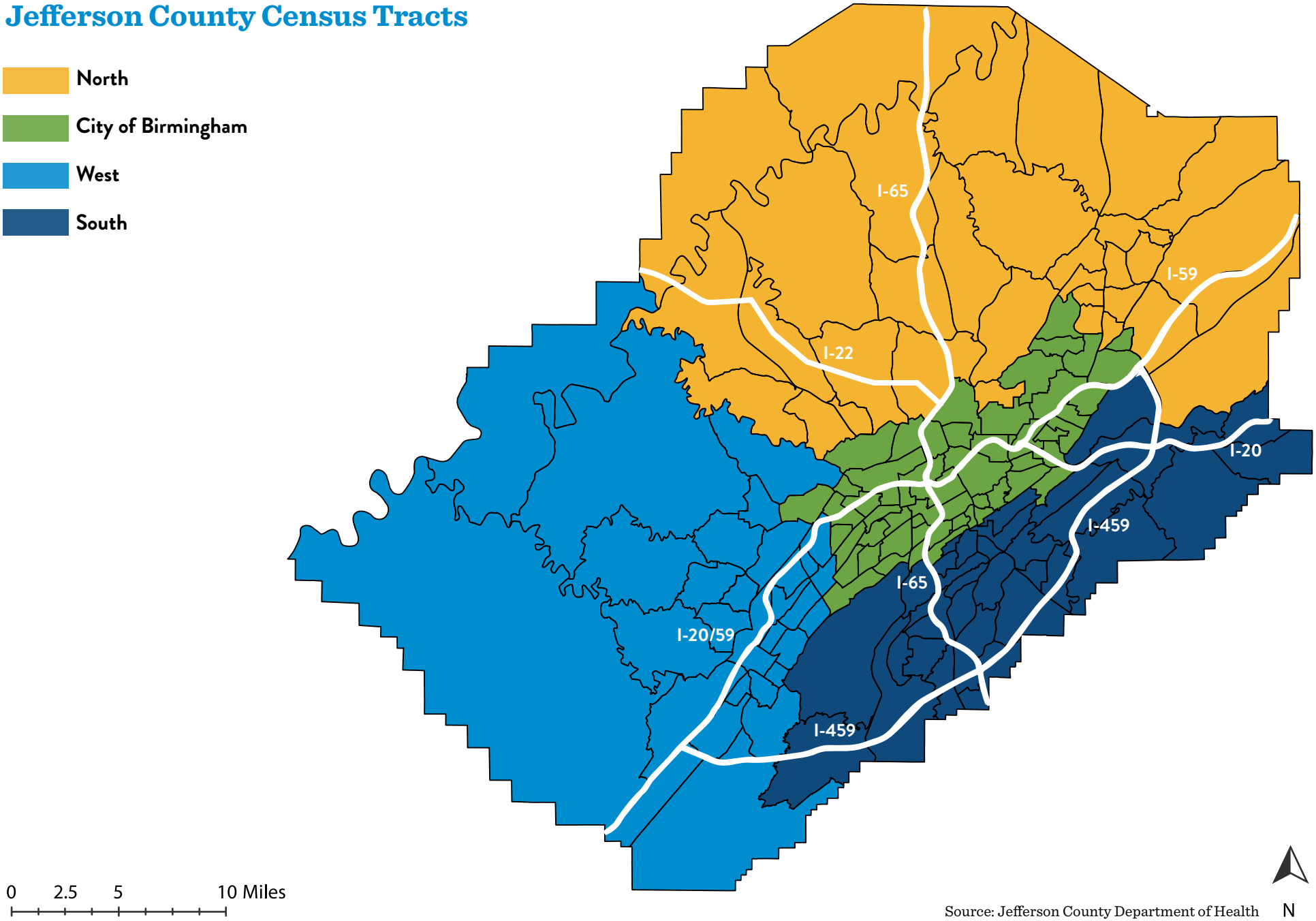
The majority of the data for this report comes from the U.S. Census Bureau's American Community Survey (ACS), which is an annual survey that provides vital information on the growth patterns across the nation. The ACS reports local data according to census tracts, which are small, relatively permanent areas within each county. The average census tract has a population of 4,000 people, and is restricted to a minimum area of 1,200 people and a maximum of 8,000 people. The geographic boundaries for each tract are determined based on population density, not on local municipal or neighborhood jurisdictions. Therefore, some cities contain many different census tracts, while other areas might have multiple cities within a single census tract.

In order to locate a census tract in this report, Jefferson County has been subdivided into four regions: City of Birmingham, South, West, and North. On pages 50-57, maps for each region, followed by a table showing the cities located within census tracts in that region. For larger cities, neighborhoods and communities are also listed.

Example:

Census Tract	City	Neighborhoods/Communities
100	Birmingham	North East Lake, Roebuck, Zion City
300	Birmingham	Woodlawn, South Woodlawn
400	Birmingham	Inglenook, Woodlawn

Jefferson County Census Tracts

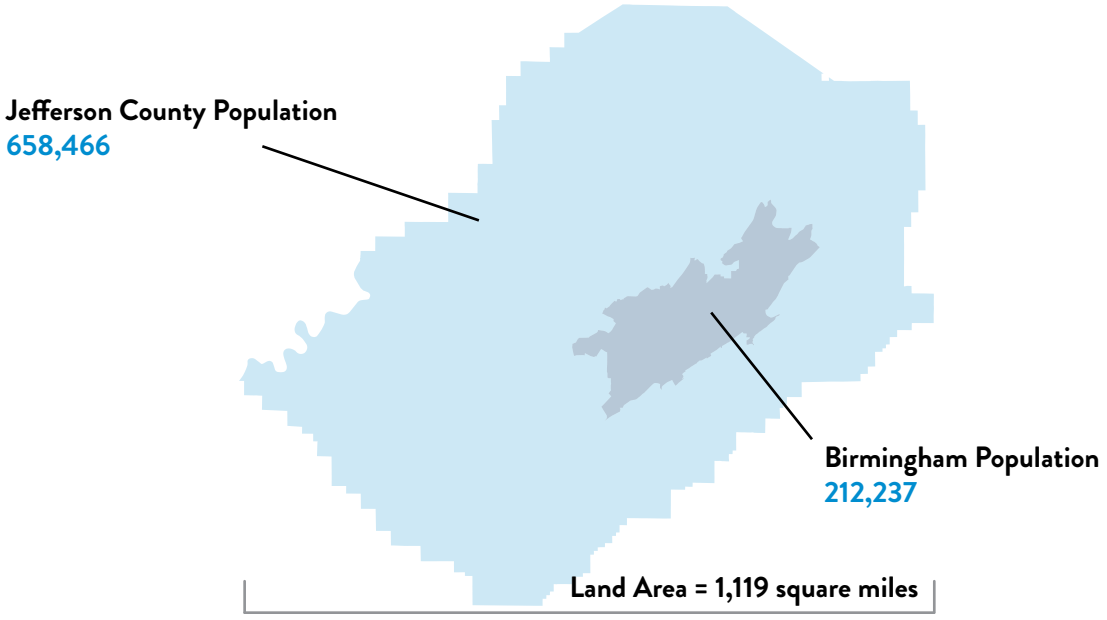


Source: Jefferson County Department of Health

IV. Community Characteristics and Social Determinants

Jefferson County is located in the north-central portion of Alabama, on the southernmost edge of the Appalachian Mountains. It is in the center of the former iron, coal, and limestone mining belt of the Southern United States. Jefferson County has a land area of about **1,119 square miles** and is the most populous county in the state. According to the 2010 Census, the county's population is **658,466** people, and Birmingham, the county seat, is the largest city in the state with a population of **212,237.**

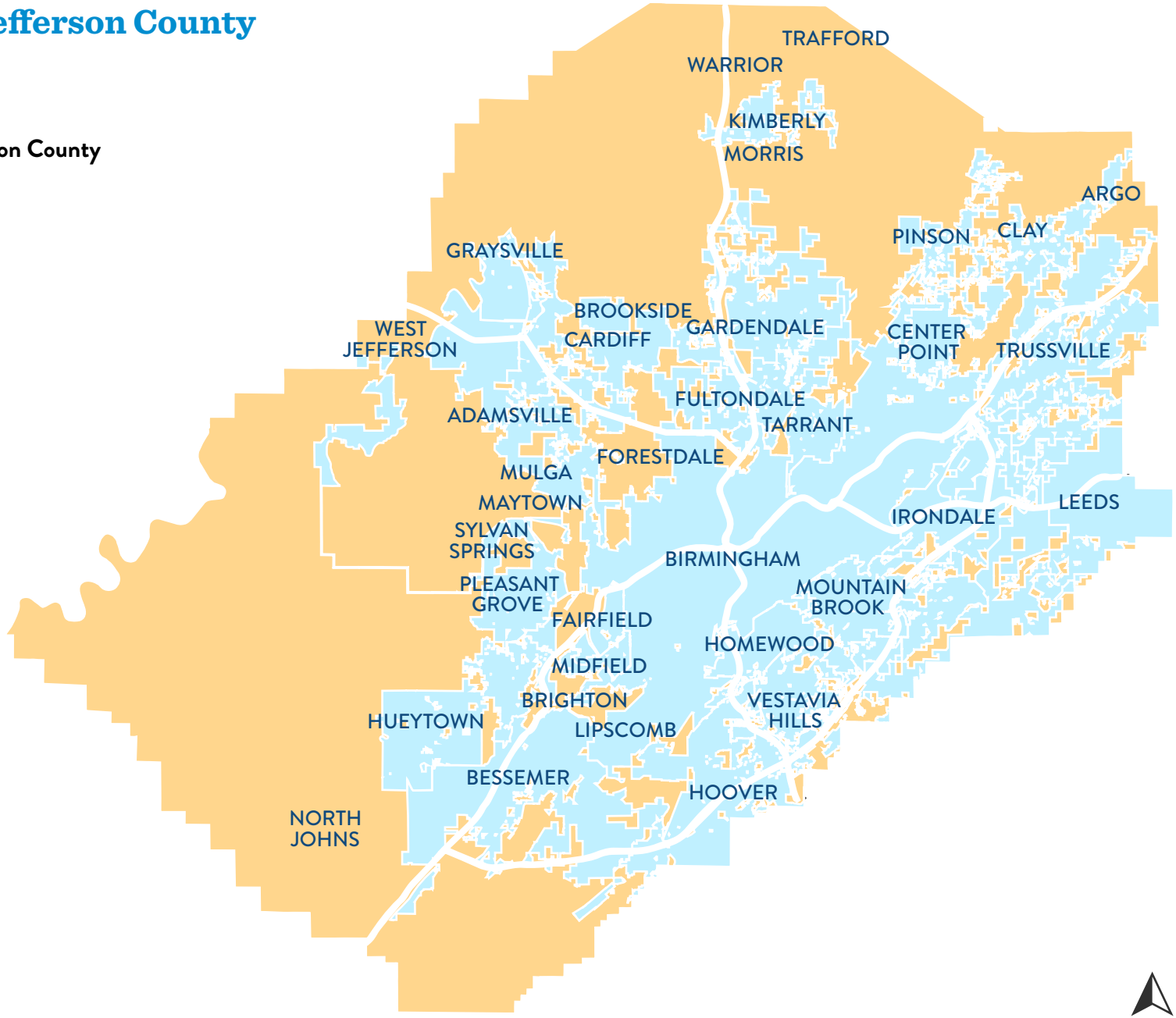
The Birmingham metropolitan area is a widespread urban center but the county also includes a substantial amount of rural area. Much of the urban areas are located along the major highways that bisect the state. The population distribution is further illustrated by the map of census tracts within the county. Much of this report is based on census tract data.



Municipalities of Jefferson County

Municipality

Unincorporated Jefferson County



0 2.5 5 10 Miles

N

Source: Jefferson County Department of Health

Demographic Characteristics

A community can be characterized by the diversity of its residents. There are several ways to analyze the composition of Jefferson County: race, ethnicity, sex, and age.

Demographic Characteristics
Race (2012–2016)

Race	Jefferson County	Alabama	United States
Total Population	659,096	4,841,164	318,558,162
White	52.4%	68.7%	73.3%
Black	42.5%	26.5%	12.6%
Asian	1.5%	1.3%	5.2%
Multiracial	1.5%	1.8%	3.1%
All Other	2.0%	1.8%	5.8%

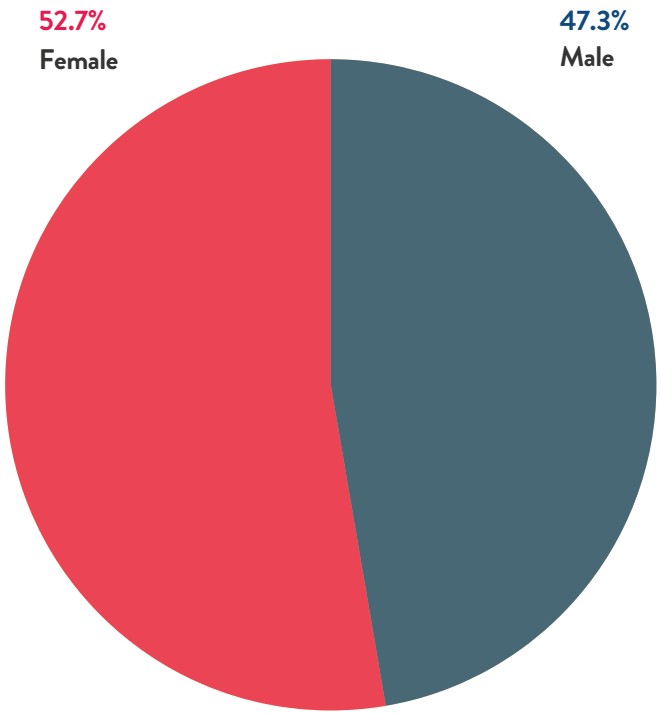
Source: U.S. Census Bureau, American Community Survey, Table DP05, 2012-2016 5 Year Survey

Demographic Characteristics
Ethnicity (2012–2016)

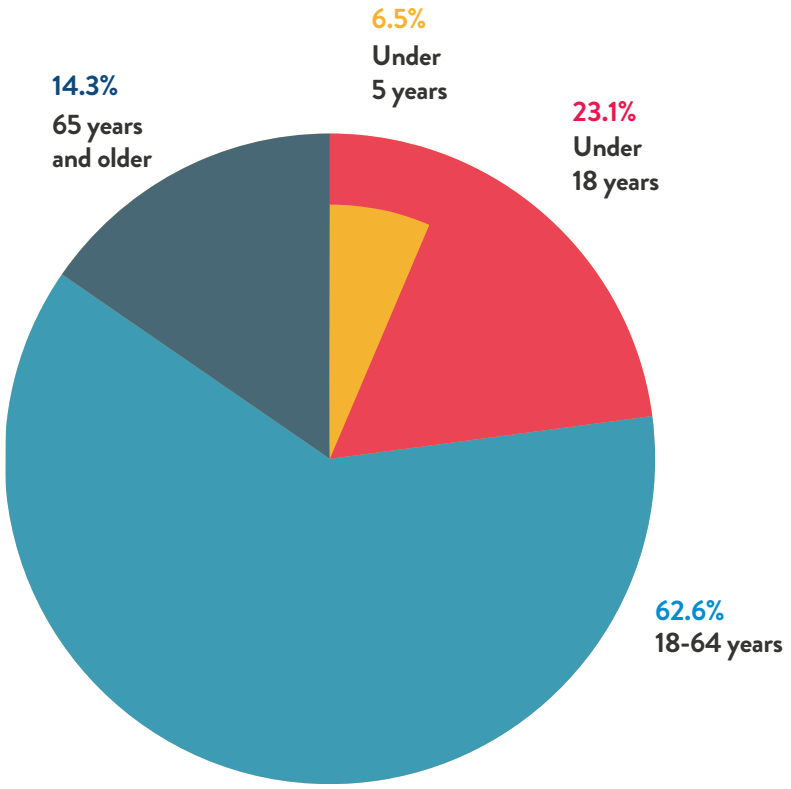
Ethnicity	Jefferson County	Alabama	United States
Total Population	659,096	4,841,164	318,558,162
Hispanic or Latino	3.7%	4.0%	17.3%
Not Hispanic or Latino	96.3%	96.0%	82.7%

Source: U.S. Census Bureau, American Community Survey, Table DP05, 2012-2016 5 Year Survey

Demographic Characteristics
Sex Composition (2012–2016)



Demographic Characteristics
Age Composition (2012–2016)



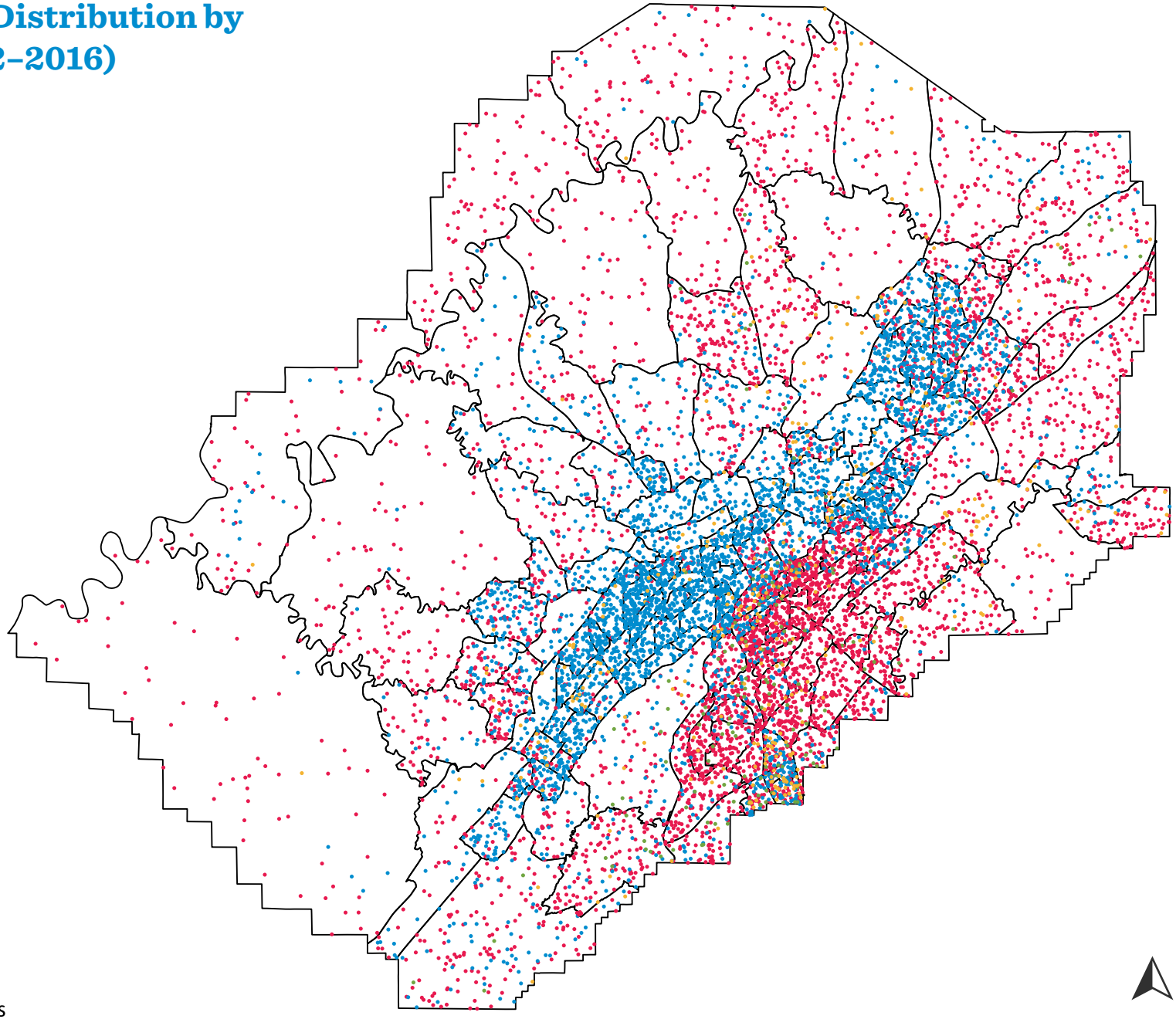
Source: U.S. Census Bureau, American Community Survey, Table DP05, 2012-2016 5 Year Survey

Racial and Ethnic Distribution by Census Tract (2012–2016)

Population Density

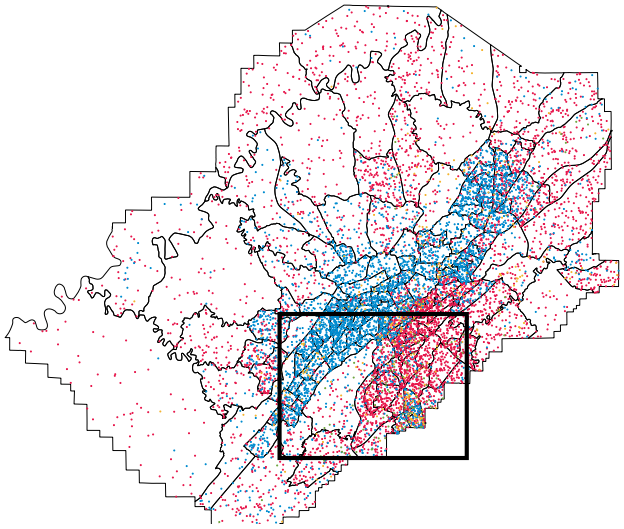
1 Dot = 65 People

- Hispanic or Latino
- Asian
- Black
- White



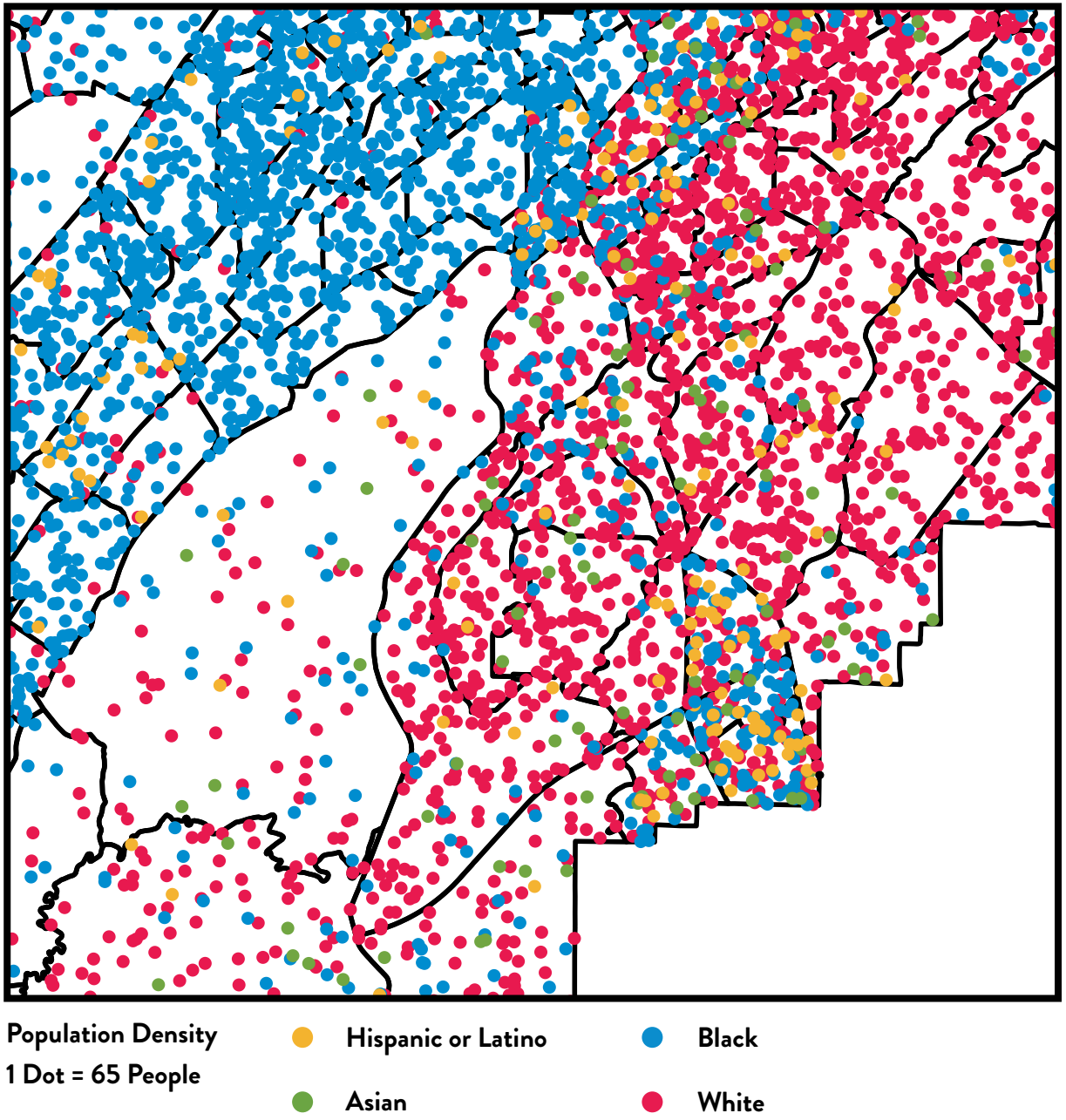
Source: Jefferson County Department of Health

Racial and Ethnic Distribution by Census Tract (2012–2016)



The distribution of Black and White populations in the county shows that in the less populated areas there is a dispersion of racial and ethnic groups, but in the Birmingham metropolitan area there are some clear groupings of Black and White populations.

The greatest concentrations of Hispanic and Asian populations in Jefferson County also live in the Birmingham metropolitan area.



Disability Characteristics

The estimated percentage of the Jefferson County population living with a disability is similar between males and females and among Whites, Blacks, and multi-racial populations. However, a higher percentage of the county's American Indian/Alaska Natives and Native Hawaiian/Other Pacific Islander populations are estimated to be living with a disability. Similarly, there is a notably higher percentage of persons age 75 and older who are living with a disability compared to younger age groups.

The distribution of persons living with disabilities across the county shows a higher concentration of persons living with disability within the Birmingham metropolitan area.

Disability Characteristics by Type of Disability (2012–2016)

	Population with Disability Estimate	Percent of Population with Disability Estimate
Hearing difficulty	22,818	3.5%
Vision difficulty	18,840	2.9%
Cognitive difficulty	36,351	6.0%
Ambulatory difficulty	57,452	9.4%
Self-care difficulty	21,416	3.5%
Independent living difficulty	35,716	7.1%

Source: U.S. Census Bureau, American Community Survey, Table S1810, 2012-2016 5 Year Survey

"We know that people living with disabilities and activity limitations experience some of the most significant health disparities. Therefore, community-wide health efforts must address people of all ability levels."

—Karin Korb
Policy and Public Affairs Coordinator
Lakeshore Foundation

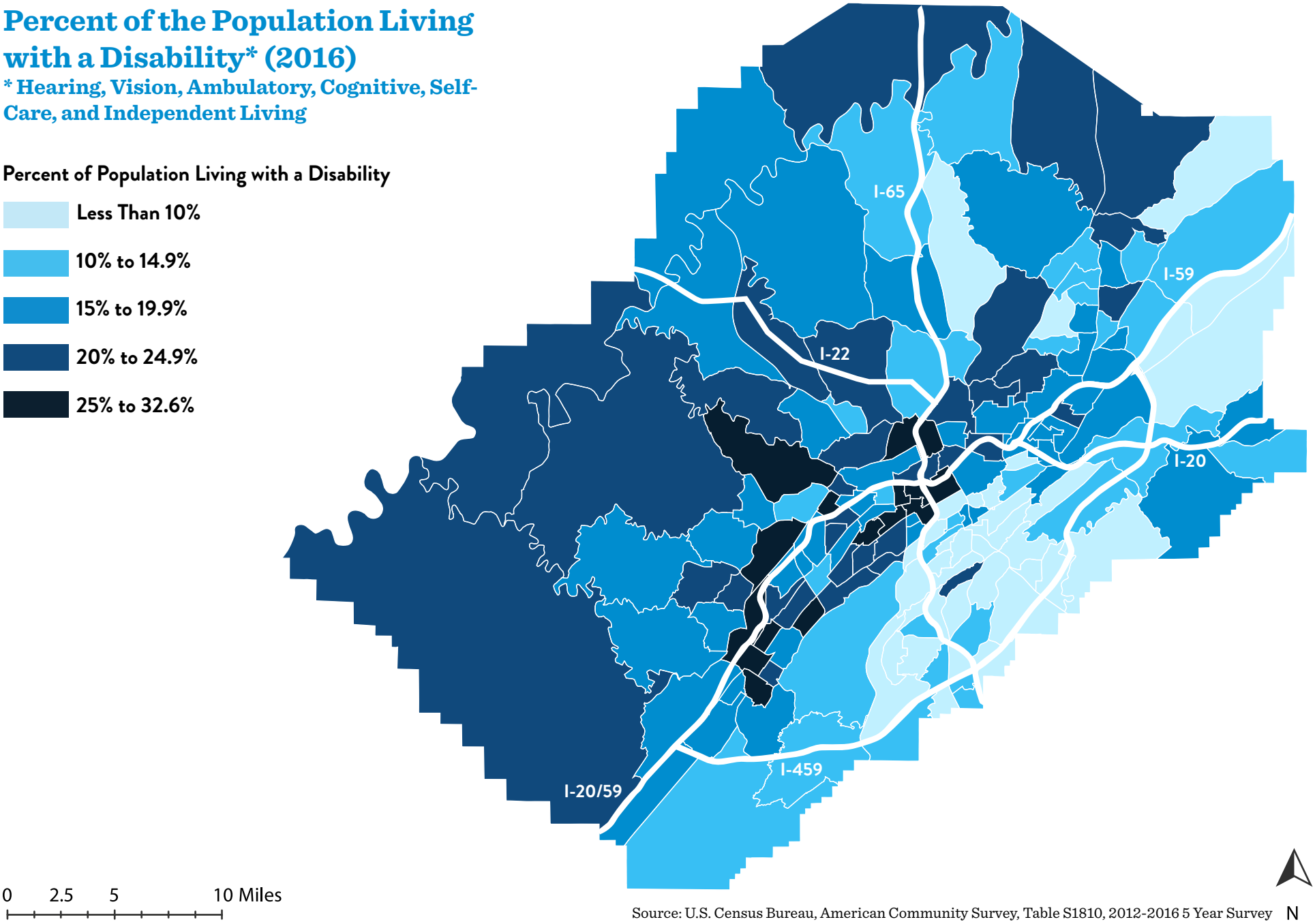
Disability Characteristics by Sex, Race/Ethnicity, and Age (2012–2016)

Demographic Characteristic	Total Population Estimate	Population with Disability Estimate	Percent of Population with Disability Estimate
SEX			
Male	307,582	44,041	14.3%
Female	344,264	53,829	15.6%
RACE & ETHNICITY			
White	342,132	49,896	14.6%
Black	276,587	45,186	16.3%
American Indian/Alaska Native	1,410	399	28.3%
Asian	9,899	433	4.4%
Native Hawaiian/Other Pacific Islander	198	39	19.7%
Some other race	12,107	503	4.2%
Two or more races	9,513	1,414	14.9%
Hispanic or Latino (of any race)	24,212	1,289	5.3%
AGE			
Under 5 years	43,079	300	0.7%
5 to 17 years	109,148	6,328	5.8%
18 to 34 years	153,799	10,655	6.9%
35 to 64 years	254,227	44,901	17.7%
65 to 74 years	51,943	14,550	28.0%
75 years and older	39,650	21,136	53.3%

Source: U.S. Census Bureau, American Community Survey, Table S1810, 2012-2016 5 Year Survey

Percent of the Population Living with a Disability* (2016)

*** Hearing, Vision, Ambulatory, Cognitive, Self-Care, and Independent Living**



Source: U.S. Census Bureau, American Community Survey, Table S1810, 2012-2016 5 Year Survey

Educational Attainment

The level of education attained is an important indicator of earning ability and is closely linked with poverty level. In general, people with less education are more likely to live in poverty. .

In Jefferson County, 11% of the total population did not graduate from high school. When educational attainment is compared across racial and ethnic groups, the Hispanic or Latino population has the largest percentage of the population (38%) having not attained a high school diploma or equivalency.

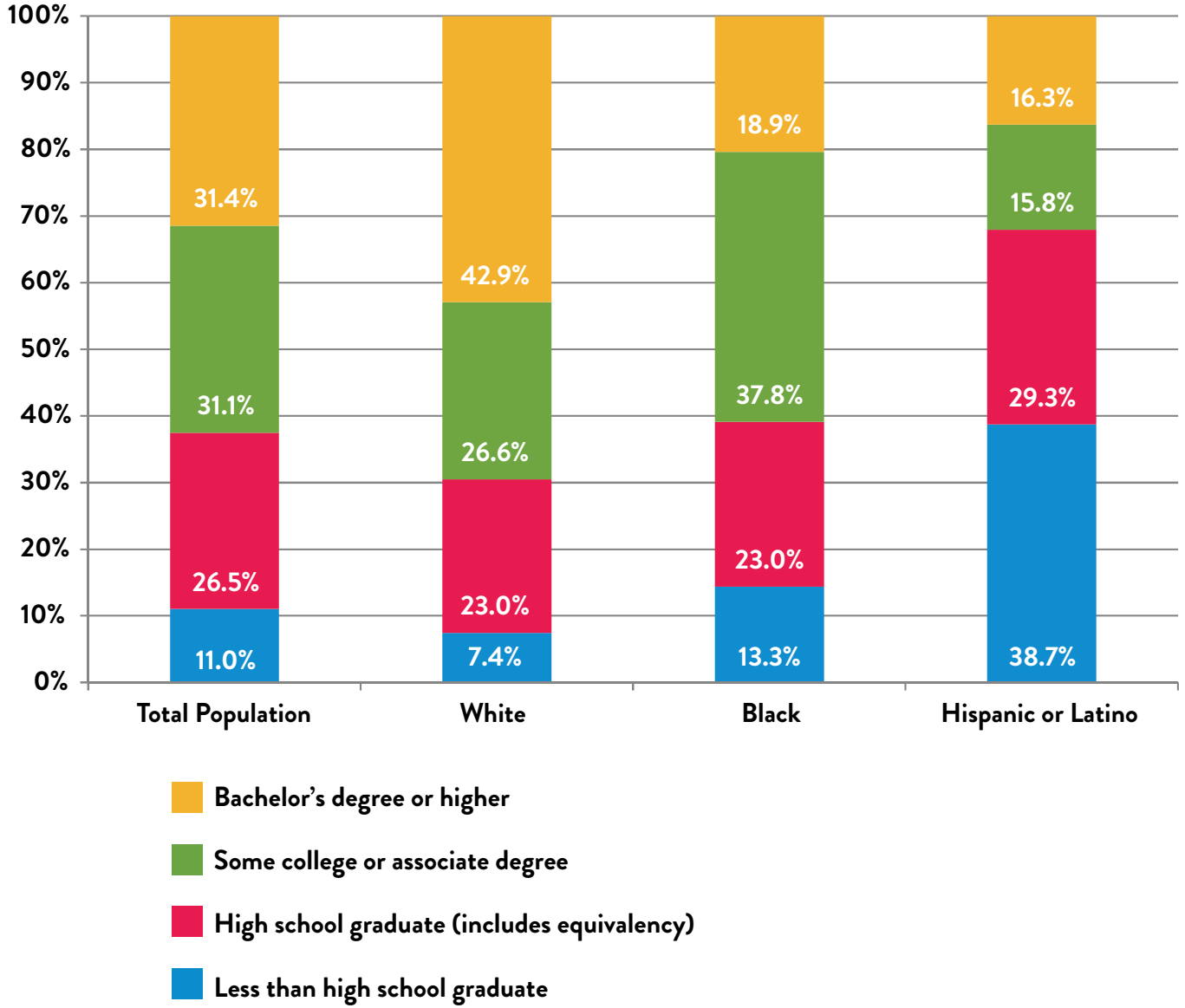
Higher educational attainment (some college or higher degree) in the county surpasses both the state and national percentages.

Educational Attainment Levels (2012–2016)

Educational Attainment Level	Jefferson County	Alabama	United States
Less than high school graduate	11.0%	15.2%	13.0%
High school graduate (includes equivalency)	26.5%	31.0%	27.5%
Some college or associate degree	31.1%	29.8%	29.1%
Bachelor's degree or higher	31.4%	24.0%	30.3%

Source: U.S. Census Bureau, American Community Survey, Table C15002, 2012-2016 5 Year Survey

Education Attainment by Race/Ethnicity (2012–2016)



Source: U.S. Census Bureau, American Community Survey, Table C15002, 2012-2016 5 Year Survey

Median Earnings by Educational Attainment (2012-2016)

Median Earnings by Educational Attainment	Jefferson County	Alabama	United States
Population 25 years and older with earnings	$35,814	$32,368	$36,231
Less than high school graduate	$18,438	$19,742	$20,361
High school graduate (includes equivalency)	$26,284	$26,442	$28,043
Some college or associate degree	$31,261	$31,208	$33,820
Bachelor's degree	$49,522	$47,022	$50,595
Graduate or professional degree	$60,195	$56,891	$66,857

Source: U.S. Census Bureau, American Community Survey, Table S1701, 2012-2016 5 Year Survey

Poverty Status in the Past 12 Months (2012-2016)

Poverty Levels	Jefferson County	Alabama	United States
<50% of poverty	8.1%	8.1%	6.7%
< 100% of poverty	18.1%	18.4%	15.1%
100-149% of poverty	9.8%	10.9%	9.4%
150-199% of poverty	8.8%	10.0%	9.1%

Source: U.S. Census Bureau, American Community Survey, Table S1701, 2012-2016 5 Year Survey

Economic Status

A greater proportion of Jefferson County residents have attained education beyond high school compared to Alabama and the US; however, the poverty rate at each level of educational attainment is higher in the county than the state or nation.

Poverty impacts all facets of the social determinants resulting in health disparities. The map of how poverty is distributed within the county shows that there are pockets of extreme poverty in the City of Birmingham, primarily within census tracts with predominantly Black residents.

Living in poverty often limits access to medical care, healthy foods, transportation, high-quality housing, and other resources that support good health outcomes. On average, people living in poverty live shorter lives and experience poorer health than more affluent people.

Poverty Rate for Population 25 Years and Older by Educational Attainment Level (2012–2016)

Educational Attainment Level	Jefferson County	Alabama	United States
Less than high school graduate	33.7%	30.9%	27.1%
High school graduate (includes equivalency)	17.7%	16.3%	14.3%
Some college or associate degree	14.2%	12.2%	10.4%
Bachelor's degree or higher	4.7%	4.4%	4.5%

Source: U.S. Census Bureau, American Community Survey, Table S1701, 2012-2016 5 Year Survey

If you live in Jefferson County, Alabama and have less than a high school diploma (or equivalency) you are 7.2 times as likely to live in poverty.

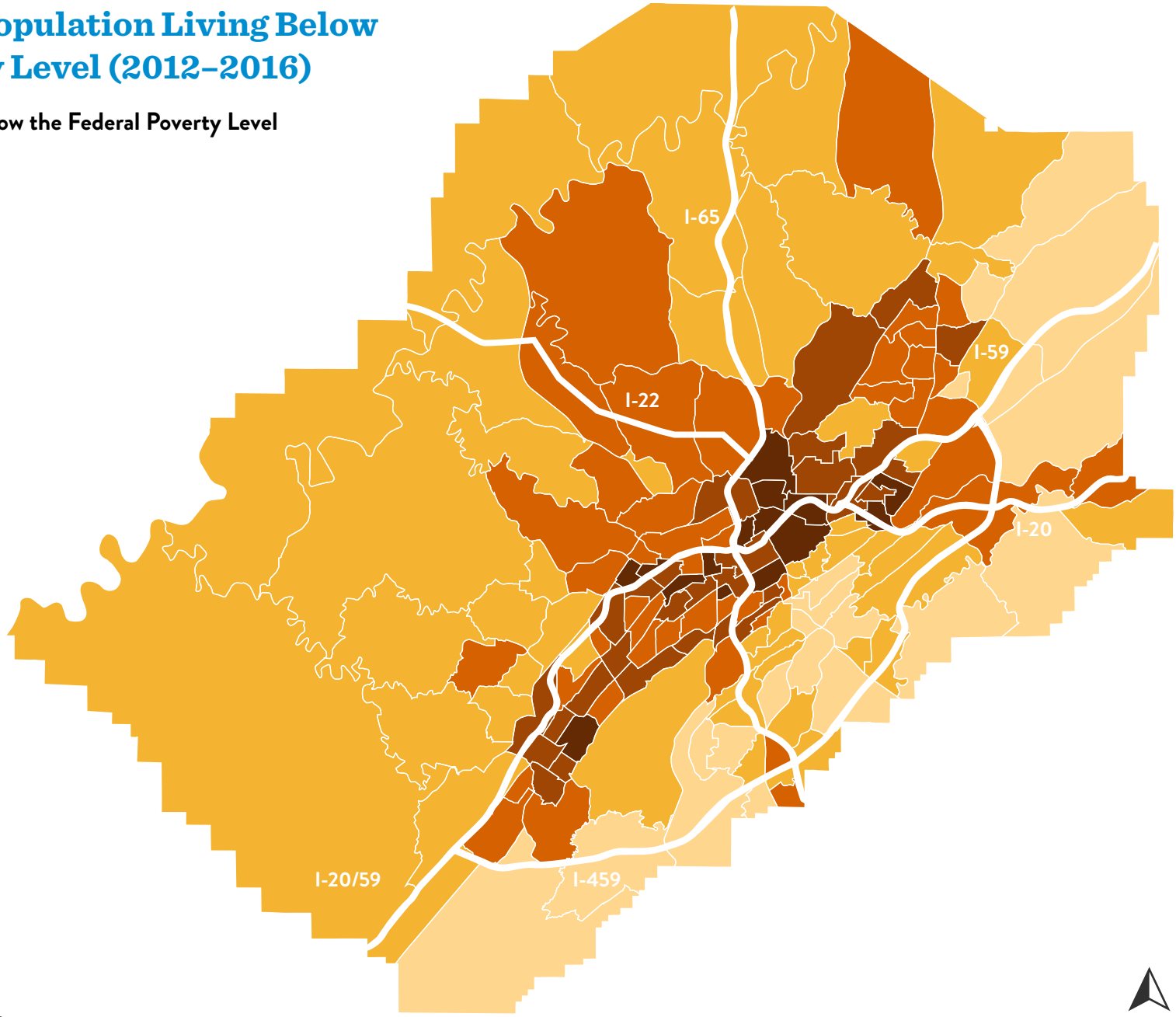
Jefferson County Population Living Below the Federal Poverty Level (2012–2016)

Percent of Population Living Below the Federal Poverty Level

- 0.6 to 5.9
- 6.0 to 16.0
- 16.1 to 28.3
- 28.4 to 42.3
- 42.4 to 64.5

Federal Poverty Level (FPL): A measure of income issued every year by the Department of Health and Human Services (HHS). The 2018 FPL is as follows for an individual to a family size of four.

- $12,140 for individuals
- $16,460 for a family of 2
- $20,780 for a family of 3
- $25,100 for a family of 4



Source: Jefferson County Department of Health, U.S. Census Bureau

Poverty Characteristics (2012–2016)
Ethnicity

Ethnicity	Percent of Population Living Below the Federal Poverty Level
Total Population	18.10%
Hispanic or Latino origin (of any race)	34.6%
White alone, not Hispanic or Latino	9.6%

Poverty Characteristics (2012–2016)
Race

Race	Percent of Population Living Below the Federal Poverty Level
Total Population	18.10%
White	10.2%
Black	27.0%
Asian	7.5%
Multiracial	25.5%
All Other	37.7%

Poverty Characteristics (2012–2016)
Age

Age	Percent of Population Living Below the Federal Poverty Level
Total Population	18.10%
Under 5 years	30.3%
5 to 17 years	25.2%
18 to 64 years	16.6%
18 to 34 years	21.1%
35 to 64 years	14.0%
65 years and older	10.4%

Poverty Characteristics (2012–2016)
Disability Status

Disability Status	Percent of Population Living Below the Federal Poverty Level
Total Population	18.10%
Population With Disability	25.4%
Population Without Disability	16.8%

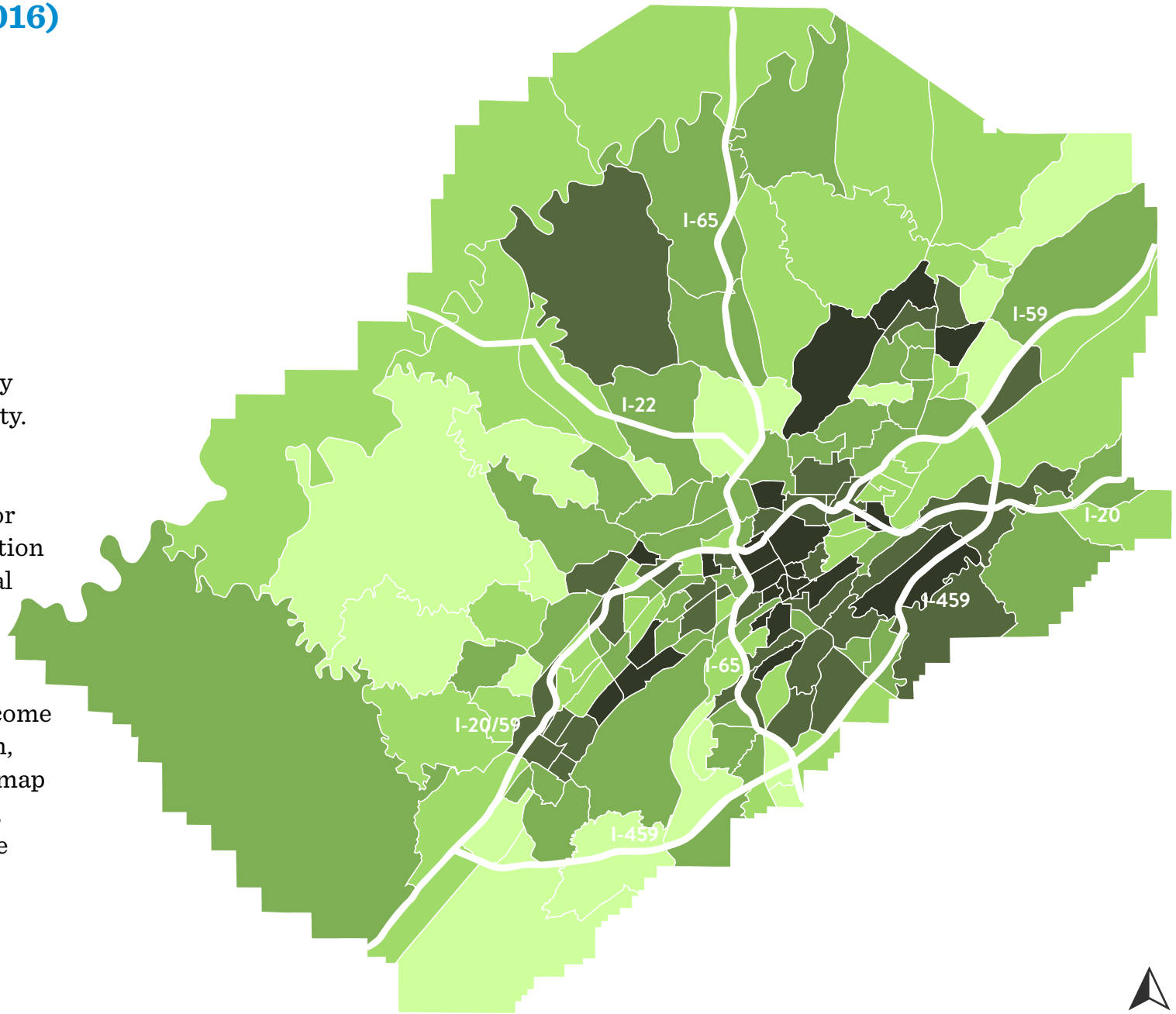
Source: U.S. Census Bureau, American Community Survey, Table S1701, 2012-2016 5 Year Survey

GINI Index of Income Inequality by Census Tract (2016)

GINI Index

- 0.3034–0.3715
- 0.3715–0.4129
- 0.4129–0.4563
- 0.4563–0.5127
- 0.5127–0.6426

The Gini Index is a summary measure of income inequality. It measures the extent to which the distribution of income among individuals or households within a population differs from a perfectly equal distribution. The index has a scale from zero to one, with rates closer to one indicating a high level of income inequality. This information, combined with the poverty map and poverty characteristics, can help inform how income is dispersed throughout the county.



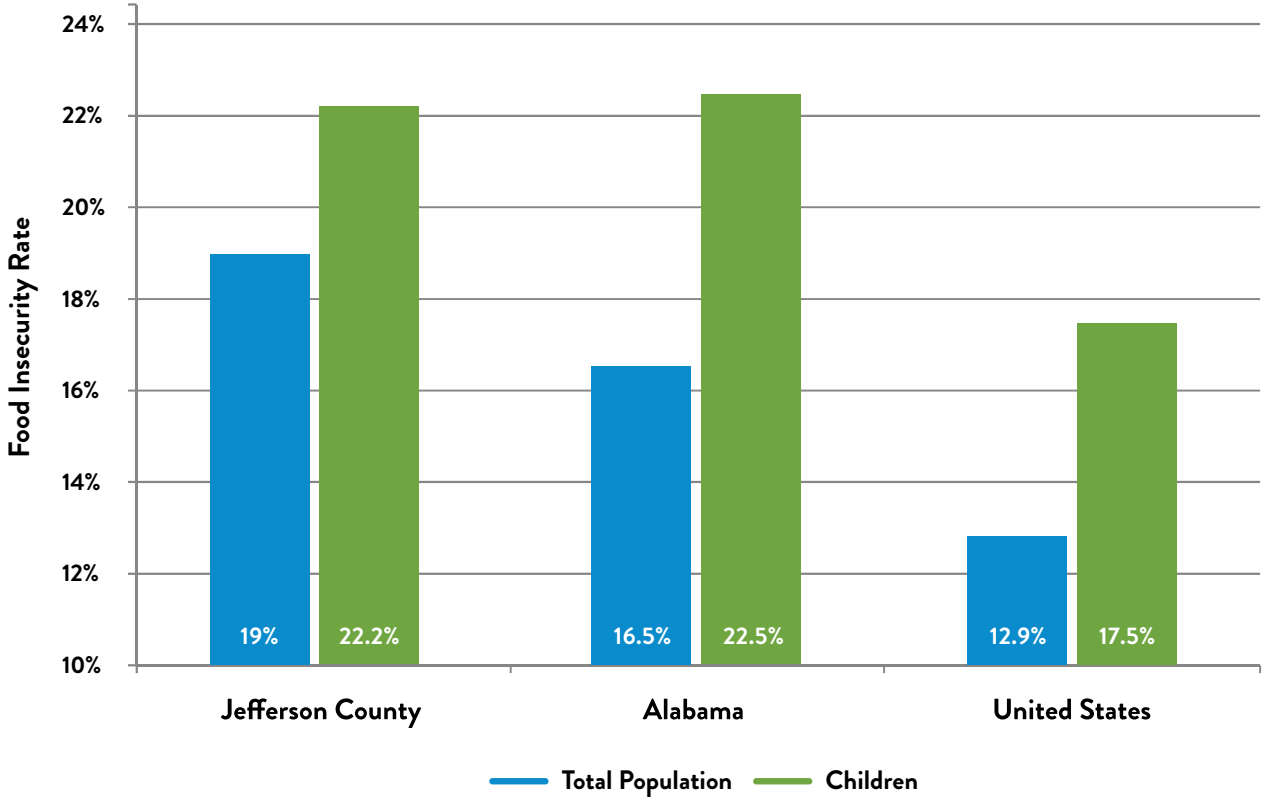
0 2.5 5 10 Miles

Source: U.S. Census Bureau, American Community Survey, Table B19083, 2012-2016 5 Year Survey

Neighborhood and Community Determinants of Health

Access to food retail locations with affordable, healthy food items and the availability of physical activity infrastructure are part of the community environment influencing health outcomes. Limited availability of healthy food access and opportunities to be physically active are barriers to individuals reaching their highest potential for a healthy life. Neighborhood and community environments may also influence the ability to improve individual health behaviors, one of the main drivers of overall health.

Food Insecurity (2016)

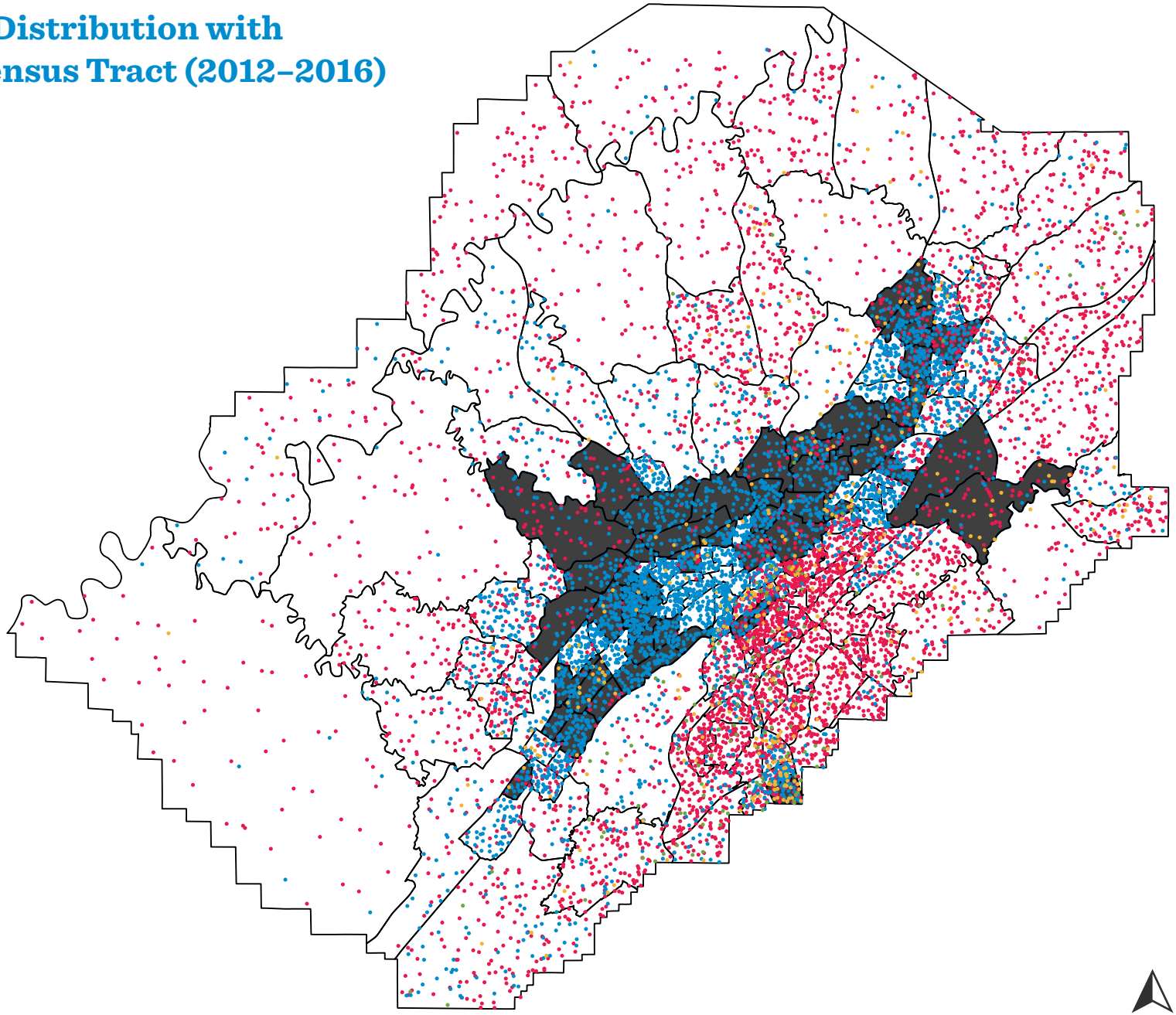


Source: Food Insecurity in the United States http://map.feedingamerica.org/

The US Department of Agriculture (USDA) defines food insecurity as a lack of consistent access to enough food for an active, healthy life.

In Jefferson County, 125,000 individuals of whom 33,870 are children lacked food security in 2016.

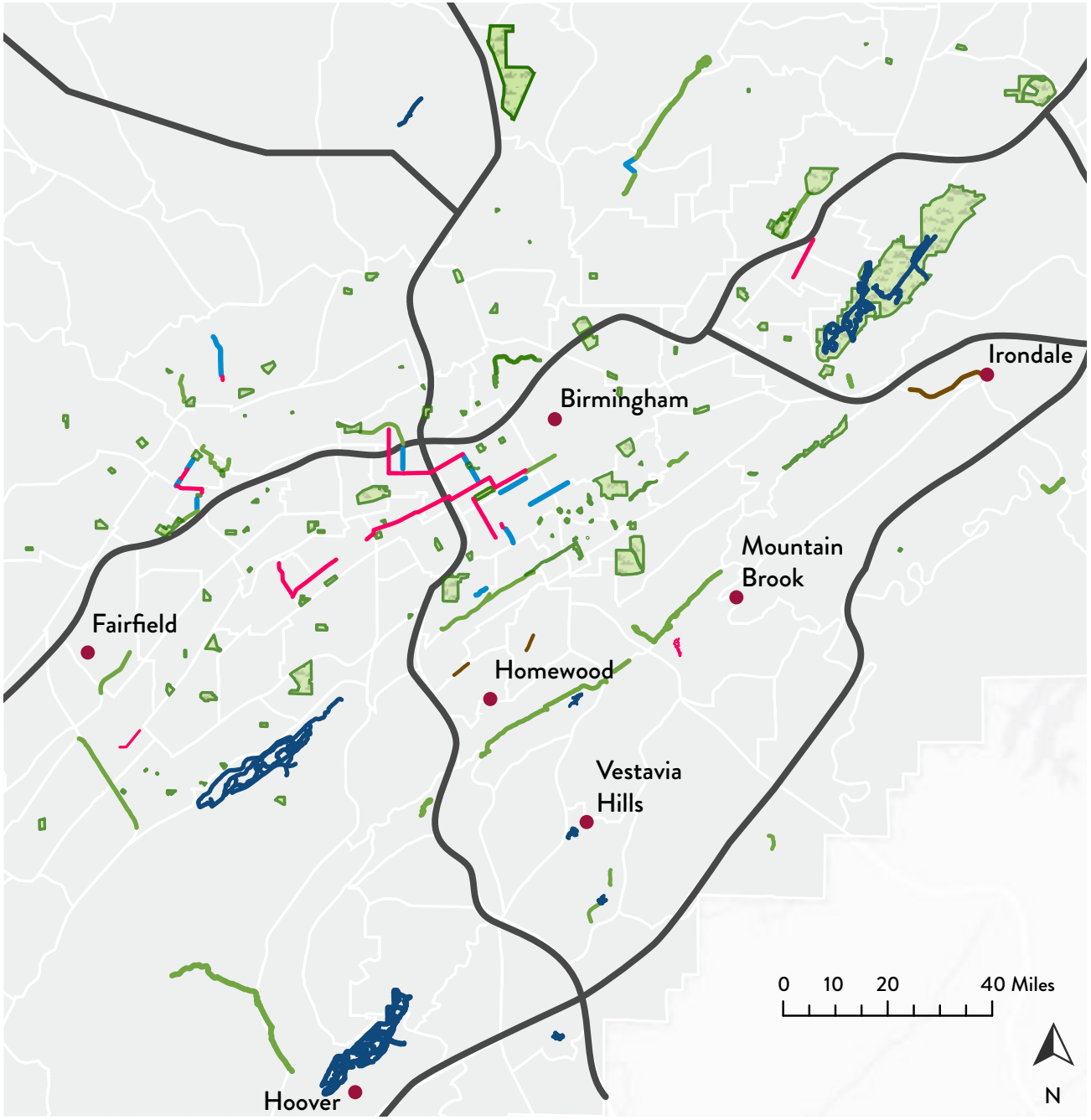
Racial and Ethnic Distribution with Food Deserts by Census Tract (2012–2016)

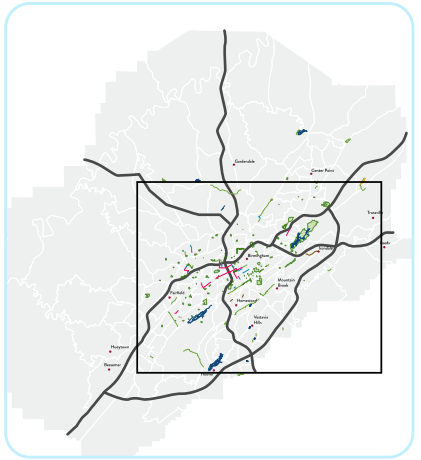


The USDA defines a food desert as a community with at least 500 people and/or 33% of the census tract's population residing more than one mile from a supermarket or large grocery store in urban areas. In rural areas, the distance is 10 miles.

Source: Jefferson County Department of Health; USDA Food Access Research Atlas

Parks and Trails of Jefferson County (2018)





Jefferson County Parks & Trails by Trail Type

- Bike Lane
- Bike Lanes with Sidewalk
- Greenway
- Natural Surface Path
- Shared Use Path
- Sharrows with Sidewalk
- Cities
- Birmingham Parks

Source: Jefferson County Department of Health; Regional Planning Commission of Greater Birmingham

V.
Health Status

Life Expectancy

Life expectancy at birth is the average number of years an individual is expected to live. Life expectancy at birth is calculated based on the age-specific death rate present in the year of birth for which the data are presented. In 2015, life expectancy in the United States was 78.8 years, 75.5 years for Alabama residents, while Jefferson County residents had a life expectancy of 75.0 years.

Life expectancy in Jefferson County for Blacks in 2015 was 3.5 years less than that of Whites. In addition, differences in life expectancy by race and sex have persisted for decades. In 2015, life expectancy was 79.1 for White females, 76.9 for Black females, 73.8 for White males, and 68.5 for Black males. There was also a difference in life expectancy by census tract. A 28.9 year difference in life expectancy exists between census tracts experiencing the lowest life expectancies and those with the highest life expectancies.

Multiple factors impact length of life. These include behaviors such as tobacco, alcohol and drug use, limited physical activity and poor diet. These behaviors are risk factors for several of the leading causes of early death: heart disease, cancer, stroke and diabetes. Life expectancy is also impacted by other conditions such as family income, level of education attained, access to healthy food, and quality health care, neighborhood safety and social support.

Health Outcomes (2015)

	Jefferson County	Alabama	United States
Life Expectancy at Birth	**75.0**	**75.5**	**78.8**
White	76.4	NA	78.7
Black	72.9	NA	75.1
All Cause Mortality *per 100,000 deaths*	**928.0**	**NC**	**733.1**
White	878.9	NC	753.2
Black	1,013.4	NC	876.1
Heart Disease Mortality *per 100,000 deaths*	**182.4**	**NC**	**168.5**
White	168.0	NC	171.9
Black	206.1	NC	210.1
Malignant Neoplasms Mortality *per 100,000 deaths*	**163.7**	**NC**	**158.5**
White	156.5	NC	163.7
Black	177.7	NC	185.1
Cerebrovascular (Stroke) Mortality *per 100,000 deaths*	**56.3**	**NC**	**37.6**
White	51.5	NC	36.4
Black	62.4	NC	52.2
Diabetes mellitus Mortality *per 100,000 deaths*	**19.9**	**NC**	**21.3**
White	16.4	NC	18.9
Black	33.1	NC	38.0
Infant Mortality *per 1,000 live births*	**10.5**	**8.3**	**5.9**
White	6.4	5.2	4.8
Black	14.7	15.2	11.7
Low Birth Weight* *percent of live births*	**11.2**	**10.4**	**8.1**
White	7.4	8.0	7.0
Black	15.1	15.3	13.0

Sources:

United States Life Expectancy, Mortality, and Infant Mortality:
Final Data for 2015; National Vital Statistics Reports; Volume 66, Number 6; November 27, 2017

Alabama Life Expectancy and Infant Mortality; Alabama and Jefferson County Low Birth Weights:
Alabama County Health Profiles (2015) Alabama Center for Health Statistics

Jefferson County Life Expectancy, Mortality, and Infant Mortality:
Jefferson County Department of Health; Alabama Vital Events Database

United States Low Birth Weight
Final Data for 2015; National Vital Statistics Reports; Volume 66, Number 1; January 5, 2017

Notes:

All Jefferson County and Alabama mortality rates are age adjusted to the year 2000 Standard Population to be comparable.

***NC:** Alabama mortality rates are not age-adjusted to the year 2000 Standard Population.*

***NA:** Race specific life expectancy is not reported for Alabama.*

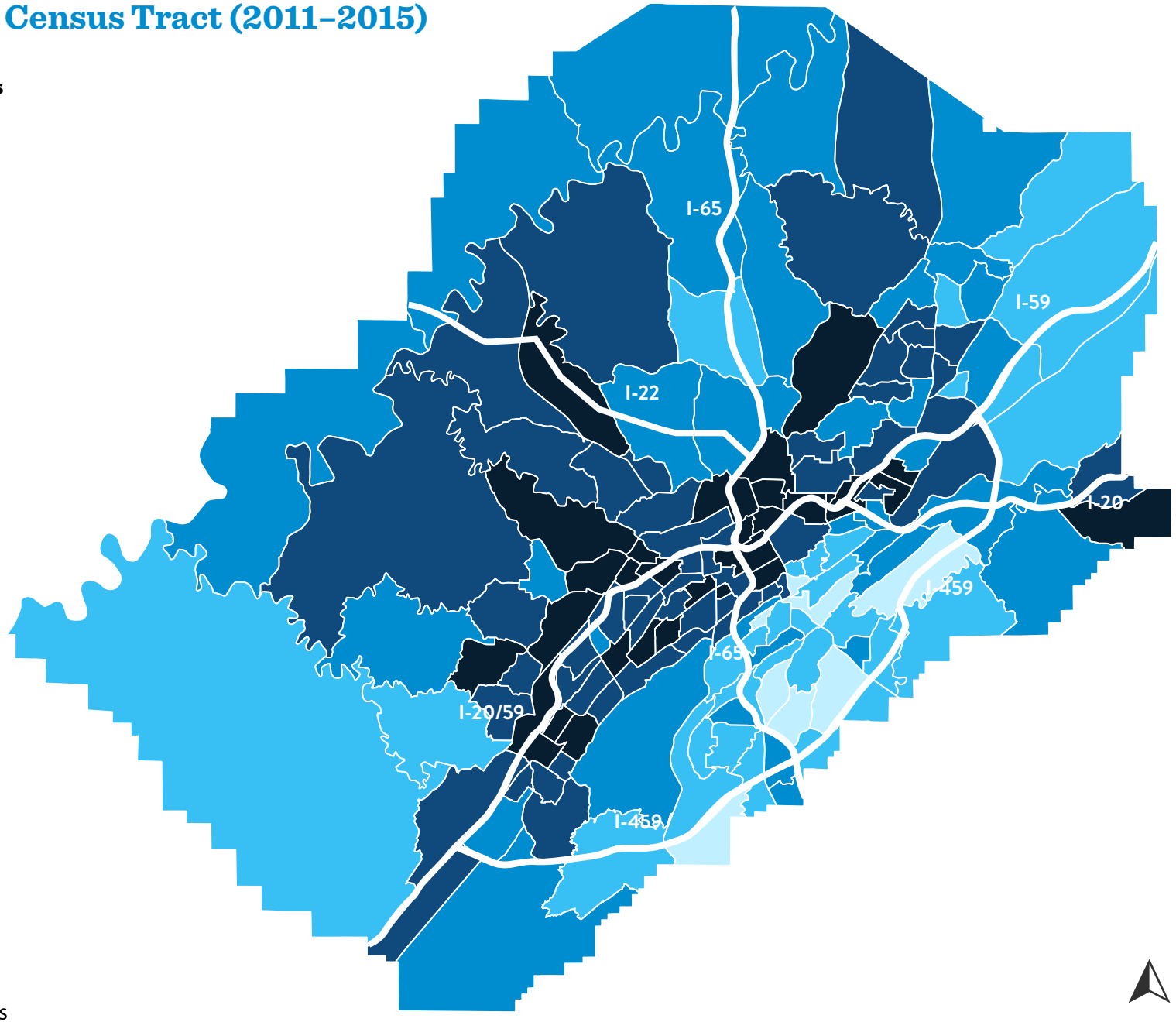
**Low birth weight refers to live births weighing less than 2,500 grams.*

Life Expectancy by Census Tract (2011–2015)

Life Expectancy at Birth in Years

- 61.8 to 70.1
- 70.2 to 73.7
- 73.8 to 77.7
- 77.8 to 82.5
- 82.6 to 90.7

Life expectancy at birth is the average number of years an individual is expected to live.

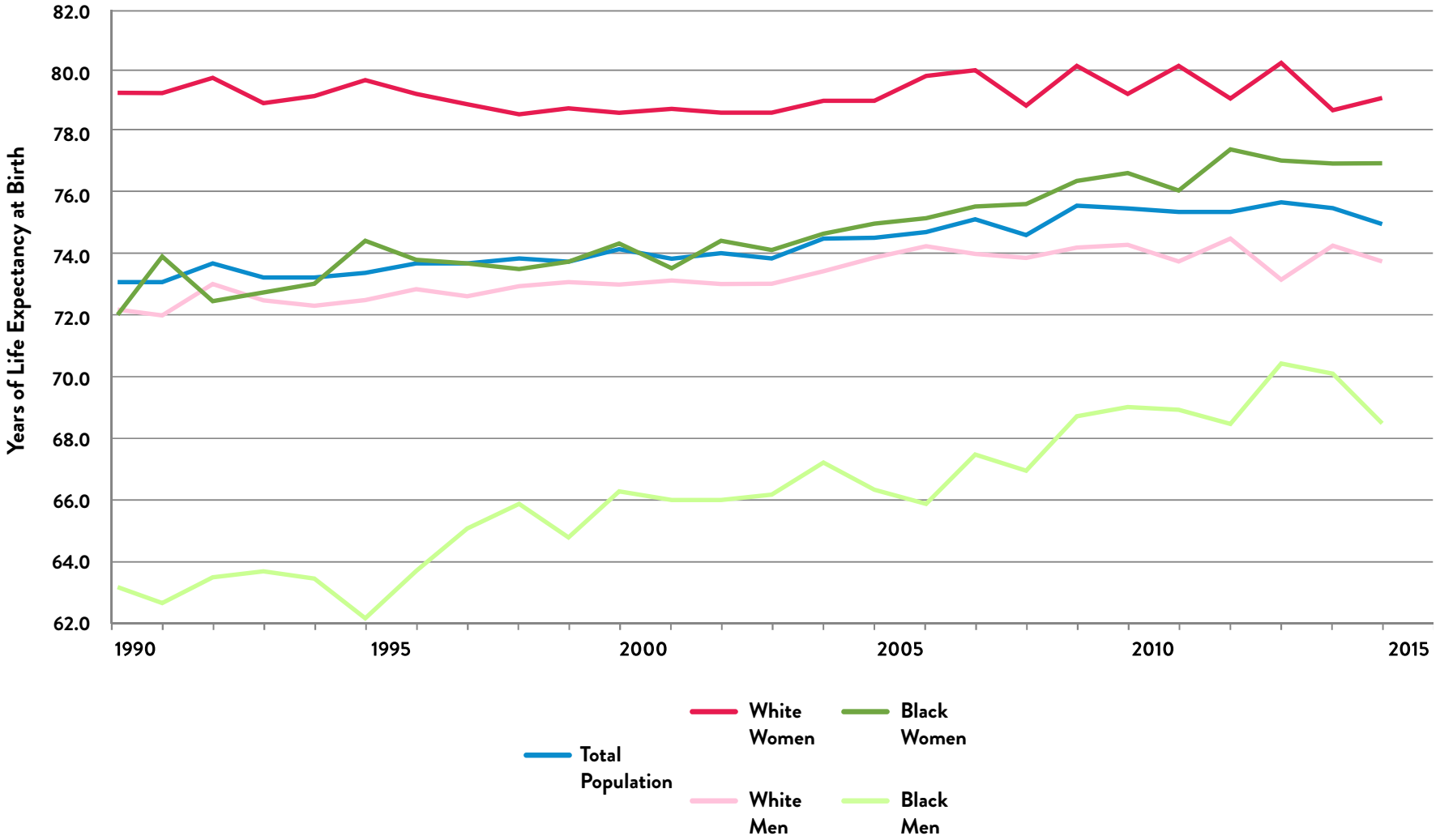


0 2.5 5 10 Miles

N

Source: Jefferson County Department of Health,; Alabama Vital Events Database

Life Expectancy by Race and Sex (1990–2015)



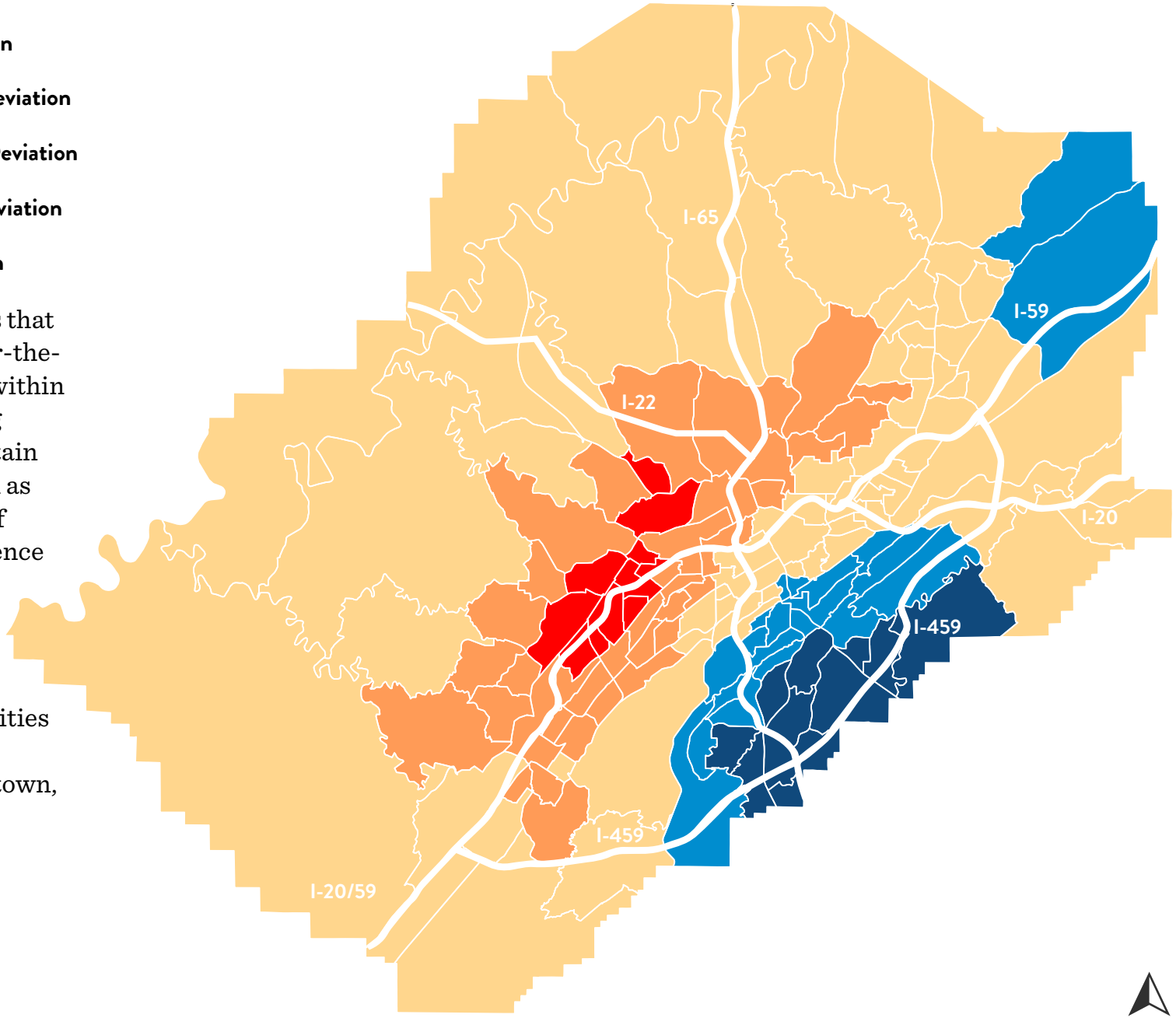
Source: Jefferson County Department of Health,; Alabama Vital Events Database

Hot Spot Analysis of Life Expectancy (2011–2015)

Hot Spot Life Expectancy
Gi* Z Score

- < -1.5 Standard Deviation
- -1.5 to -0.5 Standard Deviation
- -0.51 to 0.5 Standard Deviation
- 0.51 to 1.5 Standard Deviation
- > 1.5 Standard Deviation

A Hot Spot Analysis reveals that census tracts in some "Over-the-Mountain" municipalities within Jefferson County, including Homewood, Hoover, Mountain Brook, and Vestavia, as well as within the municipalities of Clay and Trussville, experience significantly higher life expectancy than the county as a whole. Conversely, some census tracts within the municipalities of Bessemer, Birmingham, Fairfield, Fultondale, Hueytown, Midfield, Pleasant Grove and Tarrant experienced significantly lower life expectancy than Jefferson County as a whole.



Source: Jefferson County Department of Health; Alabama Vital Events Database

Infant Mortality

Infant mortality is defined as a death of a live born infant prior to his or her first birthday. Despite the local availability of quality prenatal and pediatric care, Jefferson County's 2015 infant mortality rate was 10.5 deaths per 1,000 live births, almost double the national rate of 5.9 deaths per 1,000 live births, and substantially higher than the Alabama rate of 8.3 deaths per 1,000 live births.

Further, the infant mortality rate among Jefferson County's Black population was 2.3 times higher at 14.7 deaths per 1,000 live births than in the White population at 6.4 deaths per 1,000 live births. Comparatively, the national infant mortality rate for Black infants was 2.4 times higher than the national rate for White infants.

Low birth weight, defined as a weight at delivery of less than 2,500 grams, is a significant risk factor for infant mortality. In 2015, 11.2% of live born infants in Jefferson County were low birth weight, compared to 10.4% and 8.1% low birthweight in Alabama and nationally, respectively. In Jefferson County, the percentage low birthweight Black infants is approximately twice that of White infants.

Five Jefferson County census tracts had infant mortality rates between 34.2 and 53.5 deaths per 1,000 live births. Discretion should be used in analyzing these rates, however, due to the low number of births occurring in some census tracts. Multiple census tracts had either no infant deaths or rates of less than 3.3 deaths per 1,000 live births during the years of data analyzed for this report.

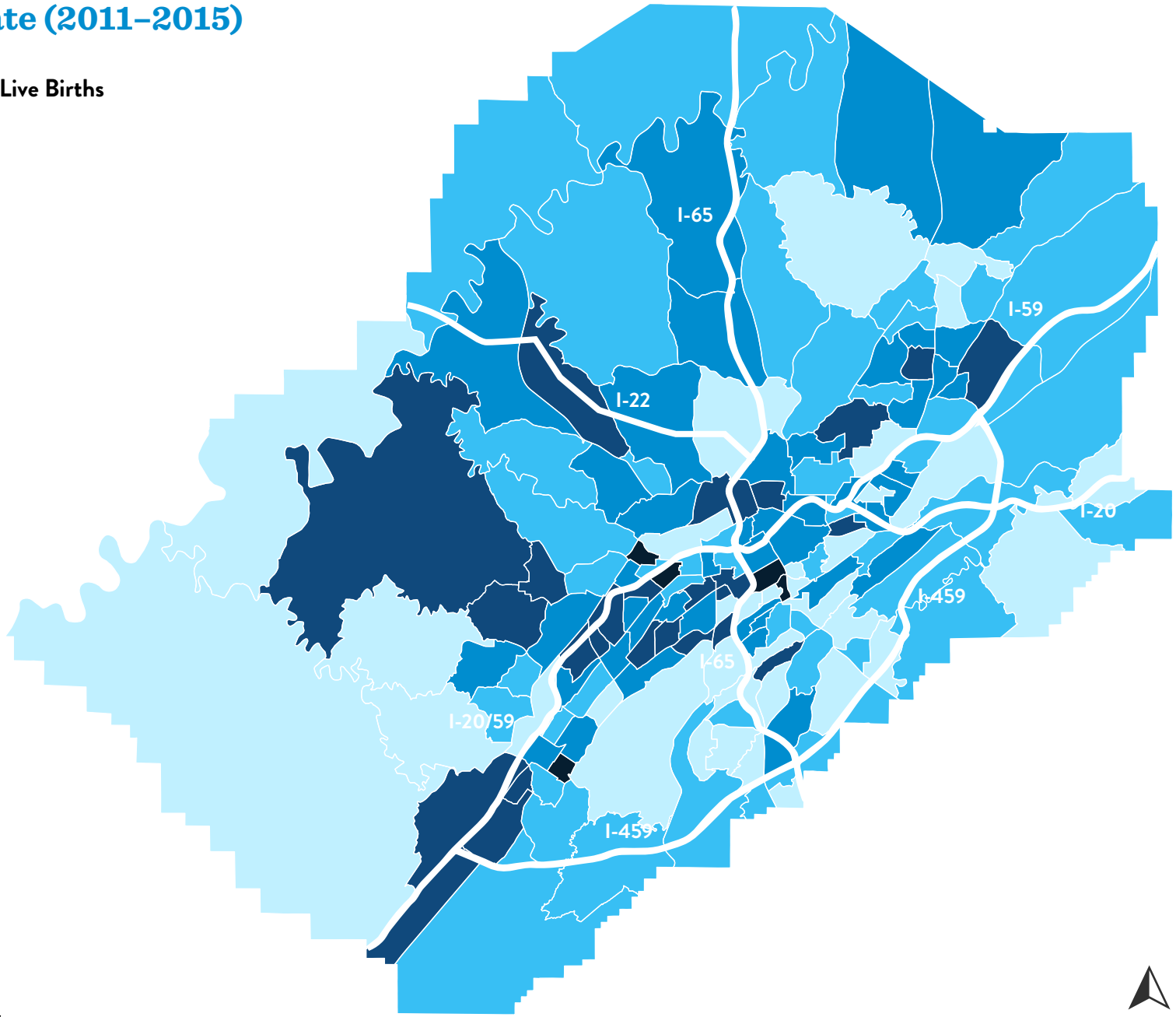
Jefferson County census tracts with higher rates of infant mortality are generally associated with having a higher percentage of the census tract's population living in poverty and higher proportions of racial and ethnic minorities.

Infant Mortality Rate (2011–2015)

Infant Mortality Rate per 1,000 Live Births

- 0 to 3.3
- 3.4 to 10.1
- 10.2 to 18.3
- 18.4 to 34.1
- 34.2 to 53.5

Infant mortality is defined as a death of a liveborn infant prior to his or her first birthday.



Source: Jefferson County Department of Health; Alabama Vital Events Database

Infant Mortality Rates in Jefferson County by Race (1990–2015)

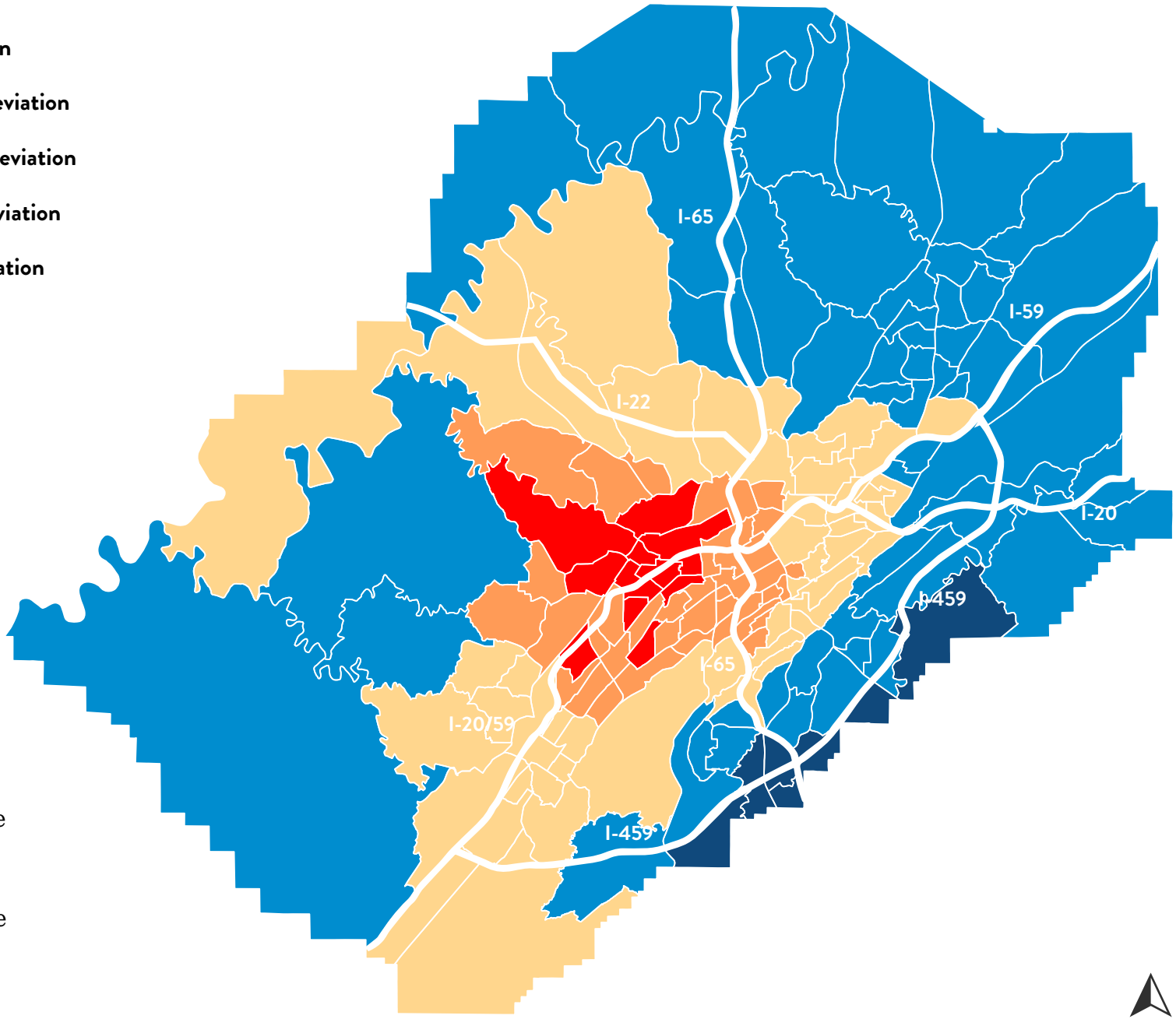
Source: Jefferson County Department of Health; Alabama Vital Events Database

Hot Spot Analysis of Infant Mortality (2011–2015)

Hot Spot Infant Mortality
Gi* Z Score

- < -1.5 Standard Deviation
- -1.5 to -0.5 Standard Deviation
- -0.51 to 0.5 Standard Deviation
- 0.51 to 1.5 Standard Deviation
- 1.5 to 2.1 Standard Deviation

A Hot Spot Analysis of the differences in infant mortality rates demonstrates that many of the census tracts in central Jefferson County, and especially those census tracts bounded within Interstate 22, Interstate 65, and Interstates 20/59, experience a higher infant mortality rate than the county as a whole. Interestingly, these areas of higher infant mortality rates correlate well with the presence of food deserts, but less well with census tracts experiencing extreme poverty levels.



0 2.5 5 10 Miles

Source: Jefferson County Department of Health; Alabama Vital Events Database

Deaths from Suicide and Drug Overdose

Of growing concern in Jefferson County are two preventable causes of death: suicide and death from drug overdose. In 2017, there were 67 deaths due to suicide. There were also 216 drug-related deaths, of which 173 were opioid-related.

Among zip codes with at least one suicide, the rate per 10,000 ranged from 0.2 to 10.4.

Among zip codes with drug-related deaths and opioid-related deaths, the death rate per 10,000 ranged from 0.4 to 14.5 per 10,000. Notably, among the 216 drug-related deaths during 2017, 173 (80%) were opioid-related.

In 2017, 80.8% of drug associated deaths in Jefferson County involved opioid use.

Characterization of 2017 Opioid Associated Deaths

	Number of Deaths	Percent of Deaths
Average number of drugs in system at time of death	2	
Maximum number of drugs in system at time of death	6	
Number with multiple drugs in system at time of death	120	69.4%
Overdosed	161	93.1%

Class of drugs present in decedents at time of death	Number of Deaths	Percent of Deaths
Fentanyl	83	48.0%
Heroin	83	48.0%
Other	71	41.0%
Cocaine	35	20.2%
Oxy/hydrocodone	27	15.6%
Ethanol	26	15.0%
Methamphetamine	21	12.1%
Methadone	8	4.6%
Unspecified Opioid	4	2.3%
Morphine	3	1.7%

Source: Jefferson County Coroner/Medical Examiner's Office

Selected Health Characteristics

Health status can also be considered based on perceptions of personal health and selected health behaviors. The table to the right compares selected health indicators for adult residents in Jefferson County, the state of Alabama and the United States as reported through the Behavioral Risk Factor Surveillance System (BRFSS) compiled by the Centers for Disease Control and Prevention (CDC). BRFSS data are generated through self-reporting of health-related data via telephone surveys.

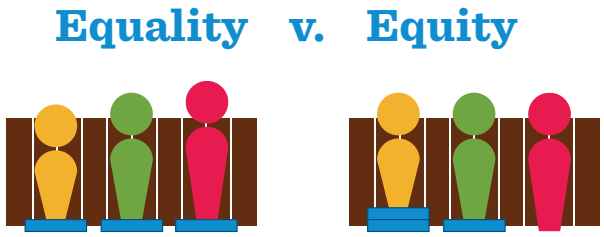
In the most recent BRFSS survey data at the time of production of this report, Jefferson County adults reported fewer days of poor mental and physical heath, diabetes diagnoses and current smoking than Alabama adults. However, the percentage of Jefferson County adults with obesity exceeds that of Alabama and the United States. Similarly, Jefferson County residents report lower rates of physical activity than do residents of Alabama and the United States overall.

Selected Health Characteristics (2016)

	Jefferson County	Alabama	United States
Average Poor Mental Health Days per Person per Month	4.28	4.6	NA
Average Poor Physical Health Days per Person per Month	3.86	4.4	NA
Percent of Adults who Smoke	19.6%	21.5%	17.1%
Percent Obese Adults	36.3%	35.7%	29.9%
Percent of Adults with Diabetes	13.2%	14.6%	10.5%
Percent of Adults Reporting Physical Activity	67.4%	70.6%	76.9%

Source: Behavioral Risk Factor Surveillance System; Centers for Disease Control and Prevention

VI. Building a Healthier Jefferson County



Advancing Health Equity Priority Group

In the strategic health planning process coordinated by the Jefferson County Department of Health in 2014,[2] community members and public health stakeholders identified the need to reduce health disparities associated with race, ethnicity and economic status as a top priority. The goal of this priority group is that everyone, regardless of race, age, disability status, sex, place of residence, socioeconomic status, etc., is given the opportunity to live a healthy life for as long as possible. The group, led by the **Jefferson County Collaborative for Health Equity:**

- Provides Education and Strengthens Capacity to Act by offering training and capacity building within the Health Action Partnership (HAP) and across the community. Priority group members facilitate a 1-hour Advancing Health Equity Orientation which defines health equity, highlights local health disparities, discusses the "head and heart" rationales and provides practical strategies to advance health equity.

- Leads Organizational Change by facilitating a two-day Equity, Diversity, and Inclusion (EDI) training to local and regional partners. The training prepares organizations to act more equitably through policies, programs and practices and explores common language, historical context, racism and implicit bias, privilege and oppression, equity lens, and policy.

- Offers Meaningful Communications by leading the development of this community health equity report, an update and expansion of the *Place Matters for Health in Jefferson County, Alabama* report that ignited the momentum for necessary discussion and action leading to the successes of the Jefferson County HAP over the past five years.

Improving the Built Environment, Transportation & Safety Priority Group

United Way of Central Alabama leads the Built Environment, Transportation and Safety Priority Group, which is focused on promoting physical environments that encourage healthy living. Providing safe, convenient access to recreational spaces such as connected trails, sidewalks and bike lanes allows people to incorporate exercise into their daily routine, a proven strategy for increasing physical activity. This Priority Group seeks to improve the rate of participation in physical activity across Jefferson County. This group intentionally engages persons living with a disability to inform strategies to increase physical activity, as this population has even lower rates of physical activity than populations living without a disability.

One way to promote healthier physical environments is to promote active forms of transportation, such as walking and biking. Complete Streets is a policy-based approach to re-prioritize how public space is used, ensuring that all road users have safe access, regardless of age, ability or mode of travel. In 2018, over 20 organizations partnered with the City of Birmingham to draft a Complete Streets policy to guide the city's infrastructure investments, host public engagement events to increase awareness of Complete Streets and provide training for city staff and community partners on effective tools for rapid implementation.

By changing the way we think about streets, the Complete Streets Birmingham Coalition is working to ensure that everyone, whether they walk, bike, roll, ride or drive, is provided a safe way to get to where they need to go.

The Birmingham City Council unanimously approved the Complete Streets policy in 2018, which included language committing investments in lower-income areas of the city and created an advisory committee to ensure public engagement in developing priority streets and evaluation metrics.

Promoting Healthy Lifestyles Priority Group

The Community Food Bank of Central Alabama leads the Promoting Healthy Lifestyles Priority Group. Along with partners across the county, this group has focused its efforts on pursuing smoke-free policies and increasing access to healthy food. One way this has been accomplished was by connecting residents to culturally-tailored, evidence-based tobacco cessation resources to help those who want to quit using tobacco achieve success.

Examples of work in healthy food access include:

- Establishing a free summer meal network for children
- Providing food resources in medical clinics
- Leading nutrition education, and
- Establishing an equipment library to foster access to fresh produce in food pantries, medical clinics, and more.

This Priority Group's work has been informed by the Advancing Health Equity Guiding Principles, specifically by valuing community and technical expertise and involving people negatively impacted by health disparities in the development, implementation, and evaluation of projects. For example, the summer meal site coordinators were convened to co-create the summer meal menu and make healthy adjustments to the menu based on feedback from children surveyed, focus groups, and observations. Staff from the Food Research & Action Council stated that the Community Food Bank of Central Alabama's Summer Meal Program was the only summer meal sponsor in the U.S. to convene its partners and build the menu by consensus.

Improving Mental Health Priority Group

The Community Foundation of Greater Birmingham leads the Improving Mental Health Priority Group. In 2018, through collaboration in the priority group, four local school districts and partners launched a coordinated plan to improve mental health training, assessment, and services in schools. The shared goal is to build more comprehensive school mental health systems to support student mental health and well-being, responding to a growing need for mental health support that school districts have heard from parents, teachers, administrators and students themselves.

The four partnering school districts represent a diverse range of communities and student populations. Homewood City Schools serves a more affluent area than the other partner districts, but is relatively economically and racially diverse for a suburban school district. Tarrant City Schools serves a predominantly Black and Latino student population in a city with a poverty rate of 32.6%. Blount County Schools, a rural district, is implementing this project in its two highest poverty feeder patterns. Pell City School System serves a mid-sized town in a rural county, and a majority of the school system's students participate in the free or reduced lunch program.

This project is an opportunity for these varied districts to share expertise and work together to improve mental health support for all their students. Homewood City Schools piloted the assessment component of the project, using a simple behavioral screening tool to help identify students in possible need of further support for two years before the other school districts implemented the assessment. Tarrant City School System worked with a provider partner for over 15 years to leverage Medicaid funding in support of student mental health services. This collaborative approach aims to improve health equity by sharing tested, cost-effective methods that can be applied in schools where both district and family resources are limited.

Optimizing Healthcare Access Priority Group

Led by **Jefferson County Department of Health,** the overall goal of this Priority Group is to improve primary health care access for Jefferson County residents to increase the utilization of preventative health screenings. Through impressive community partner engagement, the group focuses on numerous broad initiatives to improve the clinical care system in Central Alabama, support the retention of a skilled healthcare workforce, and address some of the most persistent poor health outcomes related to maternal and child health. Improving access to healthcare for people who have been most affected by health disparities, often related to income status, race, or ethnicity, is priority. A few achievements and current projects include:

- Implementation of a one-year post-graduate Family Nurse Practitioner Residency Program for Jefferson County designed to prepare nurse practitioners to provide primary health care to under-served populations and/or work in public health. This residency program is the only such program in Central Alabama.

  "Through mentorship and individual teaching in the residency program, I've gained an 'inside-out' understanding of public health in Jefferson County and in turn, have begun to grasp what it means to provide care for all residents of our community. The program cultivated a burgeoning interest in public health and nurtured a desire to care for the unserved."
  —Nurse Practitioner Residency Program graduate.

- Created a framework for implementing health interventions through the faith-based community and building capacity for broader community-level improvement.

- Launched the Maternal and Child Health Roundtable to engage organizations in activities supporting the reduction of infant mortality and identifying strategies for increasing communication and coordination among service and community providers.

  "The Maternal Child Health Roundtable has been a great place to become informed on what is available in the community and also to be able to voice the needs of Hispanic women and children in our community as we all are working toward better health equity for all those we serve."
  —Maternal Child Health Roundtable participant.

- Convened a Safety Net Leaders group, representing the main providers of primary health care services for low income, uninsured and under-insured residents of Jefferson County. Goals of this group include:
    - Improve health care access for low-income, under-insured, and uninsured residents
    - Gather information on the types of health care services available to low income and uninsured people from various health care providers in the county, and
    - Work together to develop a county-wide proposal for improving access to specialty and diagnostic health care services.

VII. Conclusions & Recommendations

Excerpted from "Advancing Health Equity Guiding Principles"

Understand the Community Context

Good individual and family health begins with good community health. Equitable access to health-promoting opportunities and a "place-based" approach in diagnosing problems and identifying strategies is vital. As such, we must look at each community separately to identify the factors that influence health outcomes in that place. The need to explore how community conditions impact health is important for several reasons. Chief among these is to ensure that meaningful solutions are not just focused on the individual or on simply increasing access to healthcare. A placed-based approach seeks holistic solutions with overall wellness at the center and takes into account all of the social determinants of health. Effective place-based solutions increase attention on prevention, identify multi-sector partnerships and community members, and change policies and systems. Ultimately, the goal is to explore ways the environment affects health and initiate strategies that positively impact choices, behaviors and outcomes.[7]

Create Strong Program Guidance

In order to establish strong program guidance to funders, grantees, staff, and the public, the overarching objectives of a program should clearly include a statement that the program's "target population includes people who are negatively impacted by health disparities (e.g., racial/ethnic minorities, older adults, lower socioeconomic status, physical or mental disability, geographic location)". This statement directs staff to develop the program's activities to include people experiencing health disparities. In addition, it sends a clear message that the organization has taken steps to be inclusive of all people.

Value Community Expertise

Many communities benefit from engaging individuals and organizations with technical expertise in certain health issues. Such expertise can provide lessons learned from initiatives in other settings, as well as guidance on how to avoid unnecessary barriers in implementation. However, it is critical that the expertise and perspective of community members—those ultimately impacted by any initiative—also be respected and valued along with the technical expertise.

Build and Sustain Community Capacity

"Community capacity" refers to the people, resources, infrastructures, relationships, and operations that enable a community to create change. Using and increasing community capacity, also often referred to as the "assets" of a community, is an essential step in improving the health of the community and its members. Community members are vital assets for broader community improvements and are most likely to have a long-term interest in the community's well-being.

Adopt a Collective Impact Model

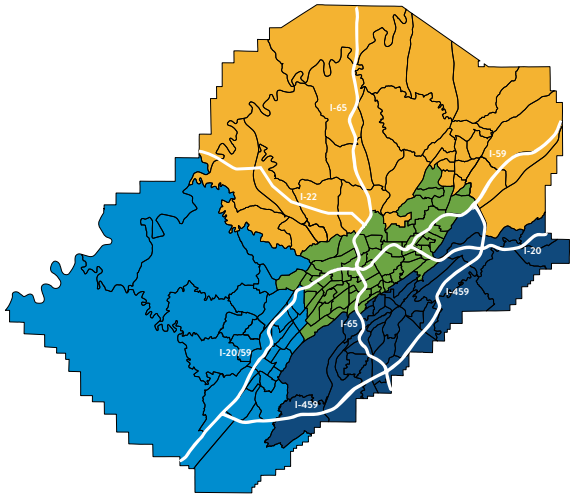
There is very little room for duplication of effort and it makes sense to capitalize on limited resources, including money, people and partnerships. Leveraging opportunities with diverse stakeholders is key to effective community efforts to improve health and quality of life and ensures that all communities, especially those that have been historically under-served and under-resourced, have the opportunity to be healthy, safe, and are offered the resources and infrastructure needed for all to thrive. By aligning efforts and working to change the environments, policies, and institutions that most touch our lives—from our neighborhoods and workplaces to our childcare centers and schools—community cooperation is a necessary component for the reduction and long-term elimination of inequities. (Adapted from Convergence Partnership http://www.convergencepartnership.org/cp-focus-areas/prevention-health-systems)

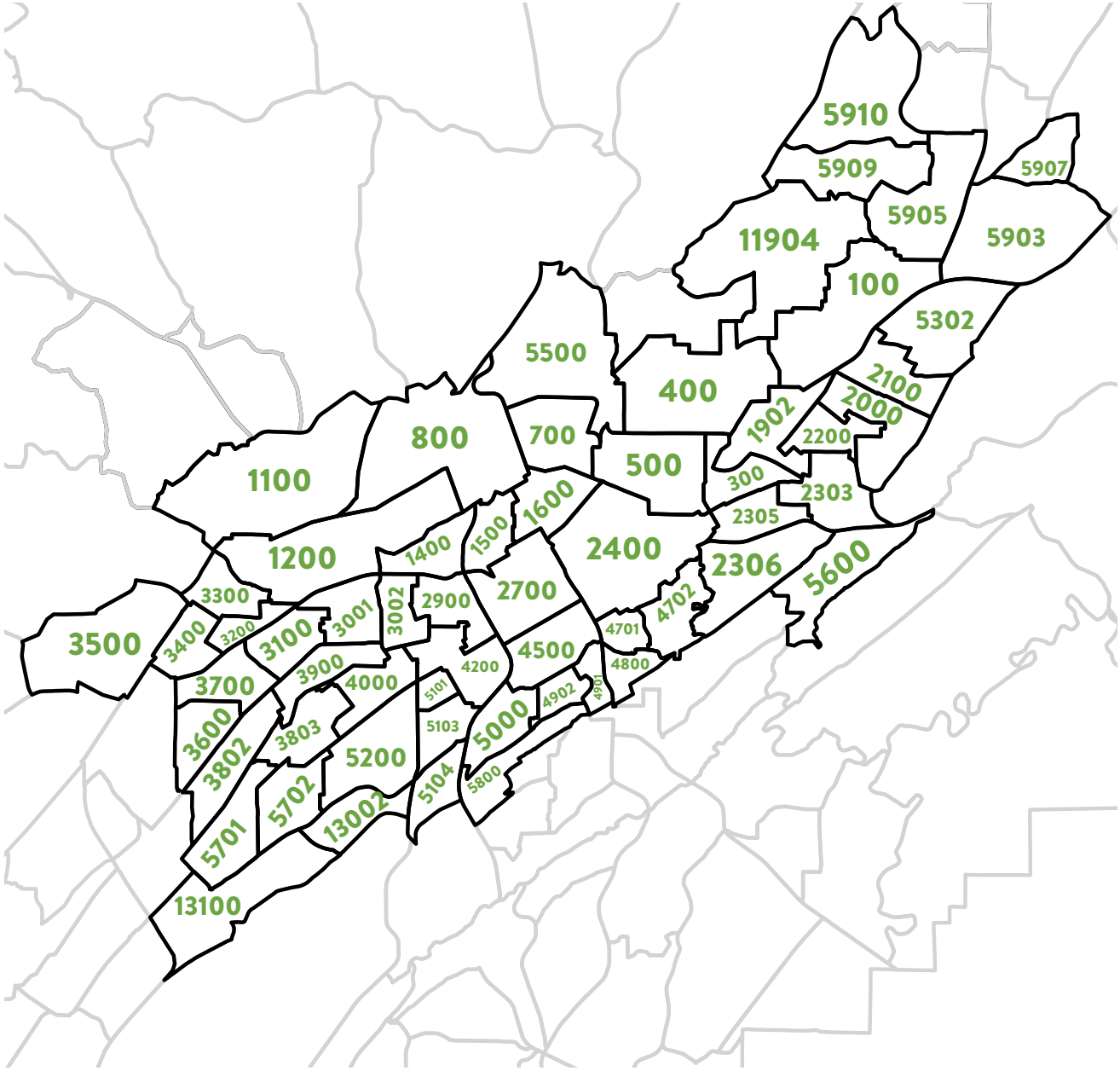
Design Clear Messages

It is important that everyone from staff and community members to partners and stakeholders have a shared understanding of the meaning of health equity and its related goals. A shared understanding needs to be developed with a proper understanding of the community context and culture. Without this, messages around health equity can go unnoticed or lead to unfavorable actions. It is important to consider the needs, assets, and priority issues of both community members and key stakeholders. Also, it is critical to think through the community's knowledge about and receptivity to the concept of health equity when developing messaging. Understanding these issues helps provide insight into common values, competing demands, fiscal priorities, and related efforts, all of which affect effective communications.

VIII. Appendices

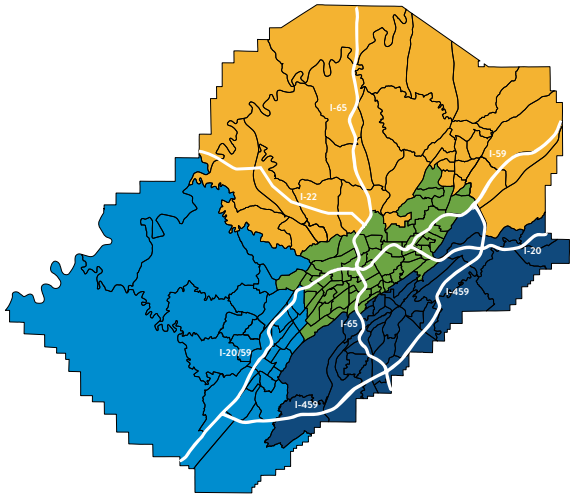
Birmingham City Census Tracts

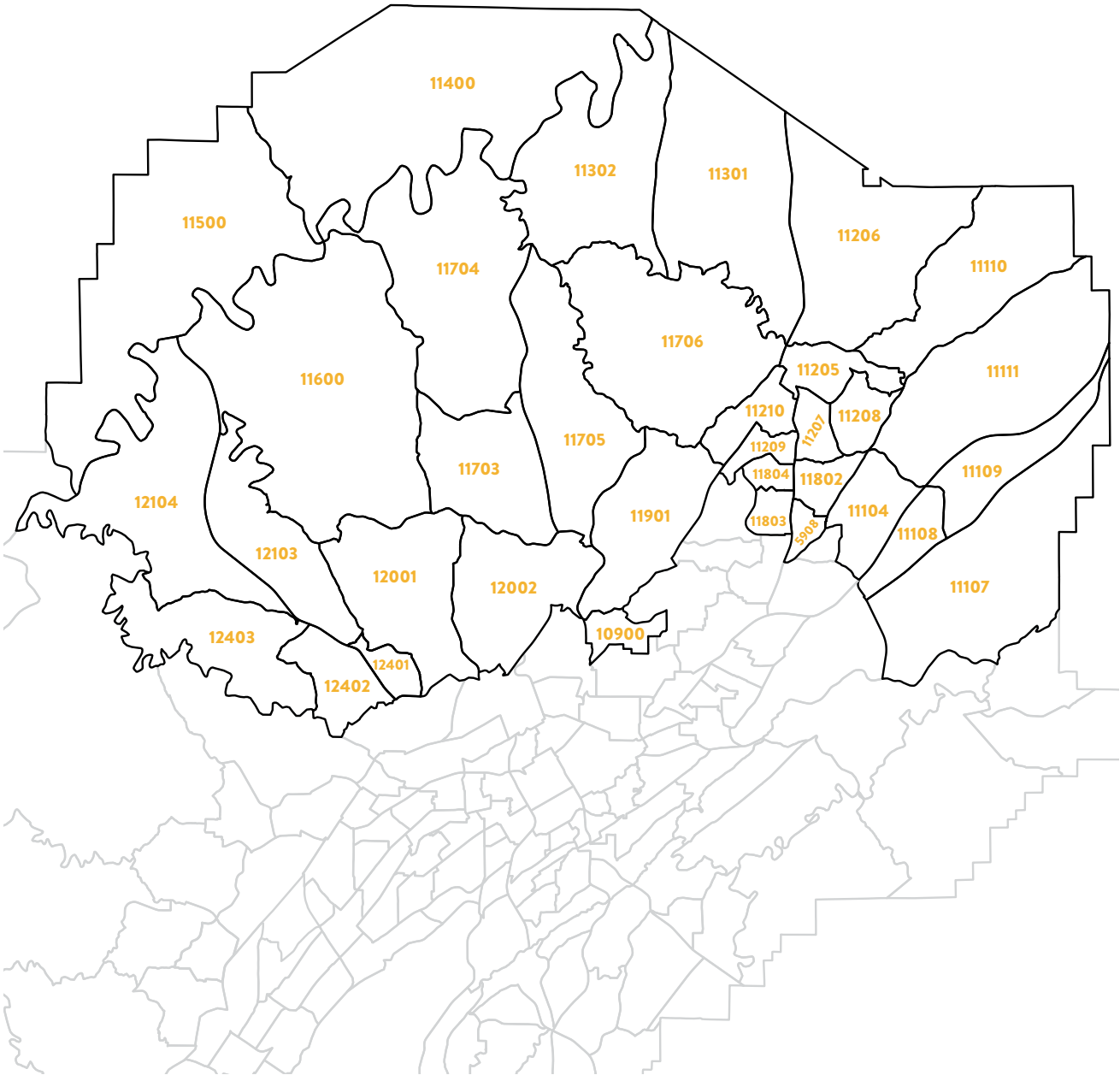




Census Tract	City	Neighborhoods/Communities
100	Birmingham	North East Lake, Roebuck, Zion City
300	Birmingham	Woodlawn, South Woodlawn
400	Birmingham	Inglenook, Woodlawn
500	Birmingham	Kingston, East Birmingham
700	Birmingham	Collegeville
800	Birmingham	North Birmingham, Hooper City, Acipco-Finley
1100	Birmingham	Smithfield Estates, North Pratt, Central Pratt, Sandusky
1200	Birmingham	Thomas, South Pratt
1400	Birmingham	East Thomas, Enon Ridge
1500	Birmingham	Druid Hills, Fountain Heights, Evergreen
1600	Birmingham	Norwood, Druid Hills
1902	Birmingham	Woodlawn, Wahouma
2000	Birmingham	South East Lake
2100	Birmingham	South East Lake
2200	Birmingham	East Lake, Brown Springs
2303	Birmingham	Eastwood, Gate City, Oak Ridge Park
2305	Birmingham	Crestwood North
2306	Birmingham	Crestwood South, Redmont Park
2400	Birmingham	North Avondale, Forest Park, Southside, Central City
2700	Birmingham	Central City, Fountain Heights
2900	Birmingham	Smithfield, College Hills
3001	Birmingham	Bush Hills
3002	Birmingham	College Hills, Graymont
3100	Birmingham	Fairview, Ensley Highlands
3200	Birmingham	Tuxedo, Ensley
3300	Birmingham	Ensley
3400	Birmingham	Ensley
3500	Birmingham	Wylam, Sherman Heights
3600	Birmingham	Belview Heights
3700	Birmingham	Ensley Highlands
3802	Birmingham	Green Acres, Central Park
3803	Birmingham	Germania Park, Oakwood Place
3900	Birmingham	Rising-West Princeton, Central Park
4000	Birmingham	Arlington-West End
4200	Birmingham	North Titusville, Smithfield
4500	Birmingham	Five Points South
4701	Birmingham	Highland Park
4702	Birmingham	Forest Park, Redmont Park
4800	Birmingham	Highland Park, Redmont Park
4901	Birmingham	Five Points South, Redmont Park
4902	Birmingham	Five Points South
5000	Birmingham	Glen Iris
5101	Birmingham	North Titusville
5103	Birmingham	South Titusville, Woodland Park
5104	Birmingham, Homewood	Glen Iris
5200	Birmingham	West End Manor, Arlington-West End, Woodland Park
5302	Birmingham	Roebuck Springs, South East Lake
5500	Birmingham, Fultondale	Harriman Park, Fairmont
5600	Birmingham	Crestline, Eastwood
5701	Birmingham	Riley, Jones Valley, Germania Park
5702	Birmingham	Germania Park, Jones Valley, West End Manor
5800	Birmingham	Glen Iris
5903	Birmingham	Huffman
5905	Birmingham	Roebuck, Killough Springs
5907	Birmingham	Spring Lake
5909	Birmingham	Echo Highlands, Killough Springs
5910	Birmingham, Center Point	Echo Highlands, Bridlewood
11904	Birmingham, Tarrant	Brummitt Heights, Pine Knoll Vista, Penfield Park, Maple Grove, Airport Highlands
13002	Birmingham	Powderly, Mason City
13100	Birmingham	West Goldwire, Garden Highlands, Industrial Center, Grasselli Heights, East Brownville

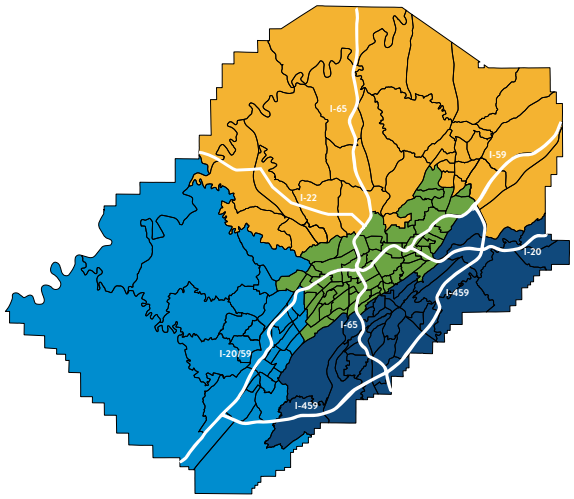
North Jefferson County Census Tracts

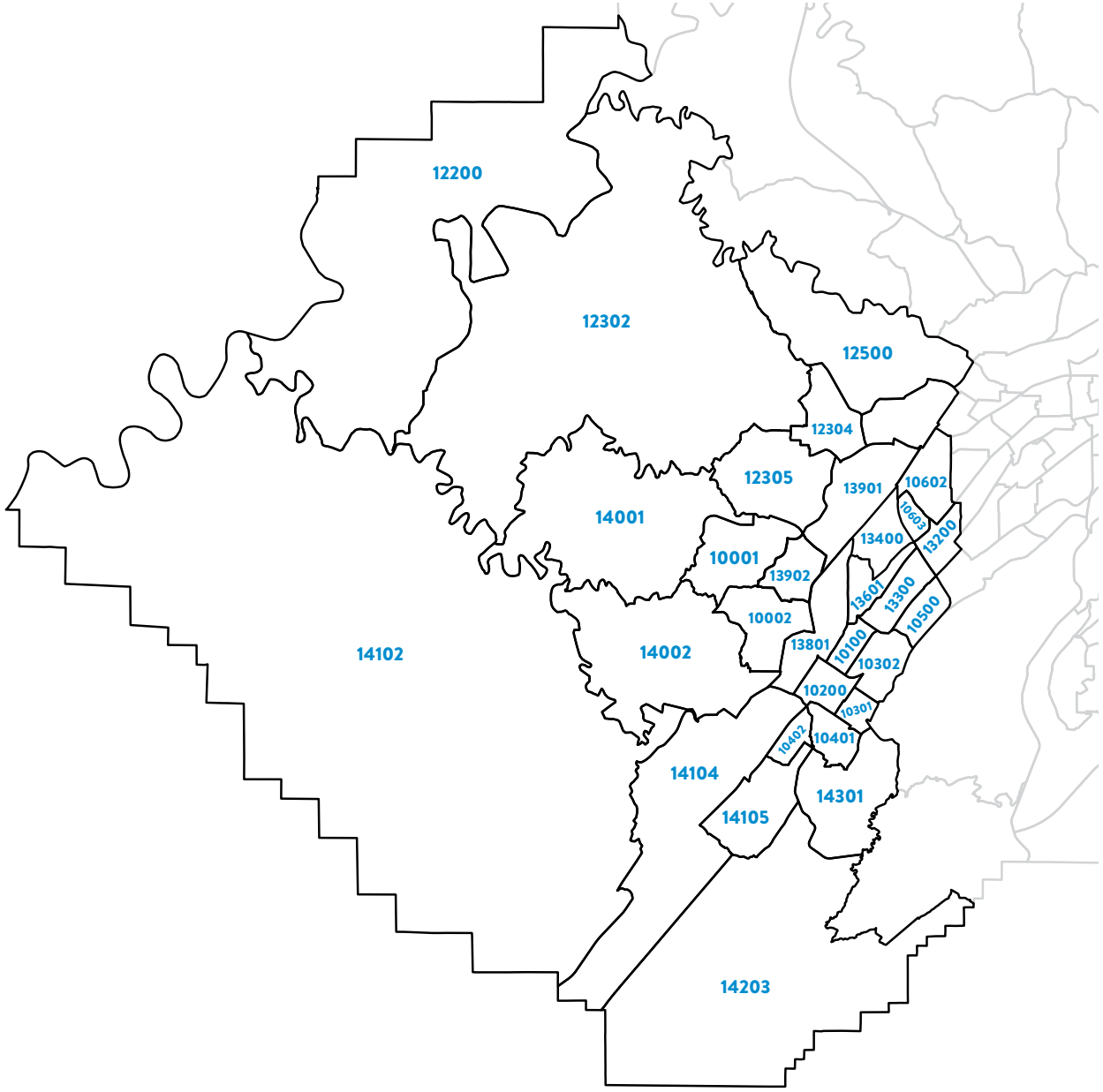




Census Tract	City	Neighborhoods/Communities
5908	Birmingham, Center Point	Spring Lake
10900	Tarrant	Oak Park
11104	Birmingham, Trussville	Spring Lake, Grayson Valley
11107	Birmingham, Trussville	Liberty Highlands, Roper
11108	Trussville	Jefferson Memorial Gardens
11109	Trussville, Argo	Trussville Springs
11110	Clay	Ayres
11111	Clay, Trussville	Chalkville
11205	Pinson, Clay	Silver Lake
11206	Pinson	Palmerdale
11207	Birmingham, Center Point	Apple Valley, Holiday Park Estates
11208	Clay, Pinson	Chalkville
11209	Birmingham, Center Point	Apple Valley
11210	Birmingham, Center Point	Sun Valley
11301	Trafford, Jefferson County	Bradford
11302	Kimberly, Morris, Trafford	
11400	Warrior, Jefferson County	Corner
11500	Jefferson County, West Jefferson	Bagley
11600	Brookside	
11703	Gardendale	Fieldstown
11704	Gardendale	Mt. Olive
11705	Gardendale	Castle Pines
11706	Gardendale, Jefferson County	Crosston
11802	Center Point	Centerwood Estates
11803	Birmingham, Center Point	Bridlewood
11804	Birmingham, Center Point	Sun Valley
11901	Fultondale, Birmingham, Tarrant	Ketona, Robinwood
12001	Birmingham, Brookside	Smithfield Estates
12002	Birmingham, Fultondale	Fairmont
12103	Graysville, Adamsville	
12104	Graysville, Adamsville	
12401	Birmingham, Jefferson County	McDonald Chapel, Mulga
12402	Adamsville, Jefferson County	Crumley Chapel
12403	Adamsville, Jefferson County	Docena

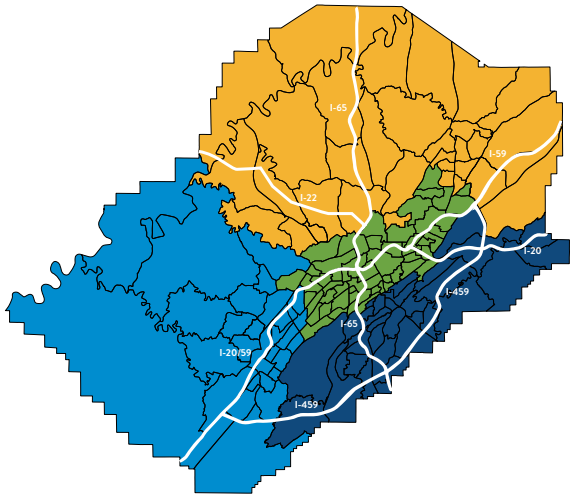
West Jefferson County Census Tracts

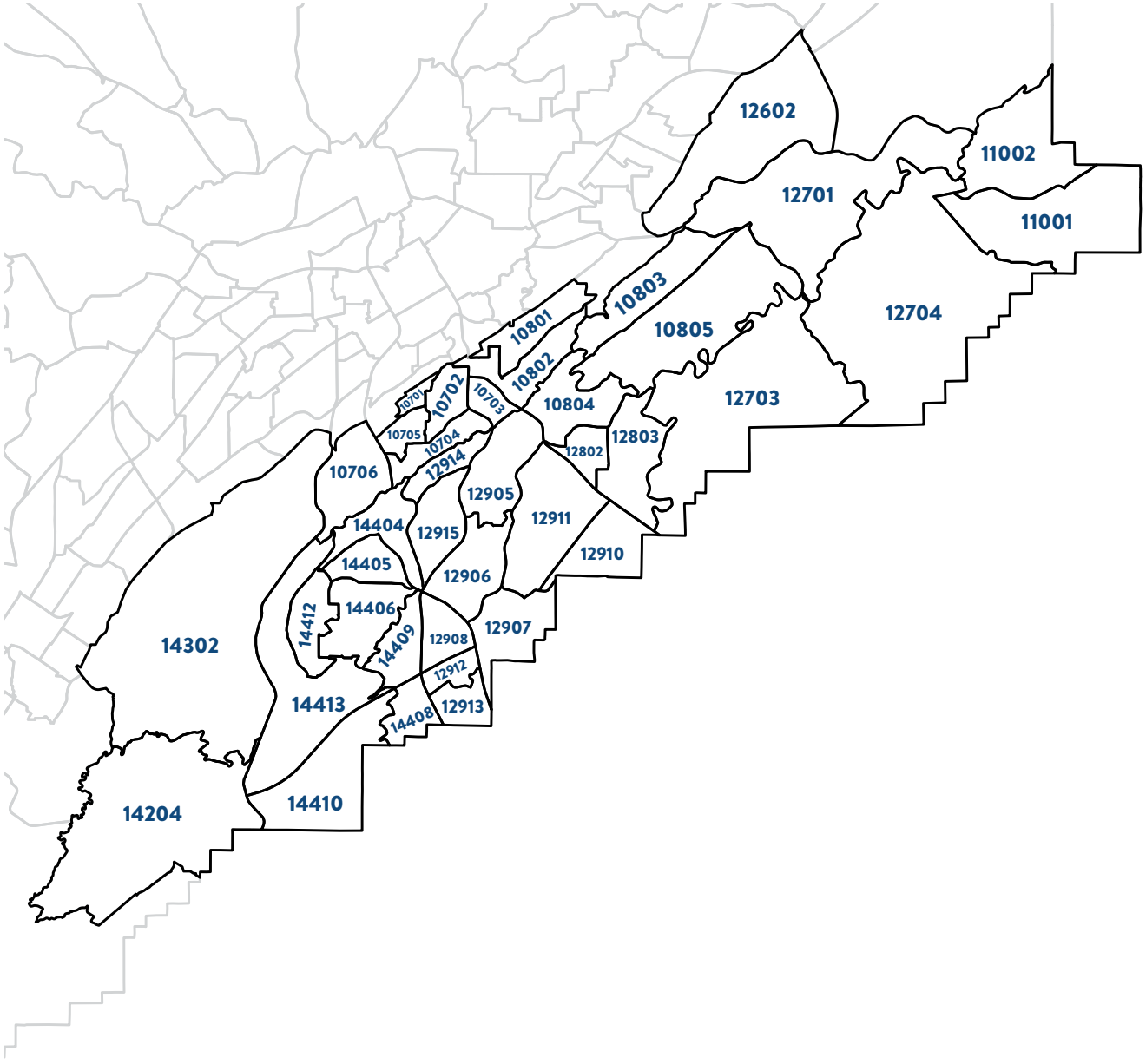




Census Tract	City	Neighborhoods/Communities
10001	Hueytown	Hueytown Crest, Harlem Heights
10002	Hueytown	Avalon Park, North Highlands
10100	Bessemer	Downtown
10200	Bessemer	Downtown, West Lake Highlands
10301	Bessemer	Legacy Park
10302	Bessemer	Brickyard Junction, Bessemer Homestead
10401	Bessemer	Jonesboro
10402	Bessemer	Lakewood Estate
10500	Lipscomb, Birmingham	West Brownfield
10602	Fairfield	Fairfield Village, Belwood
10603	Fairfield	Forest Hills
12200	West Jefferson, Jefferson County	Bankhead Lake
12302	Sylvan Springs, Jefferson County	Maytown
12304	Pleasant Grove	Pleasant Grove Estates
12305	Pleasant Grove	Cottage Hill
12500	Jefferson County	McDonald Chapel, Mulga
13200	Midfield	Walnut Grove
13300	Lipscomb, Birmingham	Roosevelt
13400	Fairfield, Midfield	West Fairfield, Glen Oaks, Fairfield Highlands
13601	Brighton, Midfield	East Brighton, Bon-Air
13801	Bessemer, Brighton, Midfield	Woodward
13901	Birmingham, Fairfield	Dolomite
13902	Hueytown	Industrial City, Bush
14001	Jefferson County	Concord, Rock Creek
14002	Hueytown	
14102	Jefferson County	North Johns, Adger
14104	Bessemer, Jefferson County	McCalla, Old Jonesboro, McAdory
14105	Bessemer	Flint Hill, Hickory Grove
14203	Bessemer, Helena, Jefferson County	McCalla, Rockdale
14301	Bessemer	Shady Brook

South Jefferson County Census Tracts





Census Tract	City	Neighborhoods/Communities
10701	Homewood	Grove Park
10702	Homewood	Rosedale
10703	Homewood	Hollywood
10704	Homewood	Southwood, Lake Shore Estates
10705	Homewood	Edgewood
10706	Homewood	West Homewood
10801	Mountain Brook	Crestline Village, English Village
10802	Mountain Brook	Mountain Brook Village
10803	Mountain Brook, Irondale	East Irondale
10804	Mountain Brook	Overton
10805	Mountain Brook, Irondale	Brentwood Hills
11001	Leeds	Leeds Memorial Park, Cahaba Hills
11002	Leeds	Russell Heights
12602	Irondale, Birmingham	Liberty Highlands
12701	Irondale	Pineview
12703	Vestavia Hills	Liberty Park
12704	Leeds, Birmingham	Overton
12802	Vestavia Hills	Cahaba Heights
12803	Vestavia Hills	Cahaba Heights
12905	Vestavia Hills, Homewood	Brookwood Village, Cherokee Forest
12906	Vestavia Hills	Tanglewood
12907	Hoover	Loch Ridge
12908	Hoover	Patton Chapel
12910	Vestavia Hills	Acton
12911	Vestavia Hills	Dolly Ridge
12912	Hoover	Woodmeadow
12913	Hoover	Riverchase
12914	Homewood, Vestavia Hills	Lakeview Estates
12915	Vestavia Hills	Mountain Woods Park
14204	Hoover, Bessemer	Russett Woods, Morgan
14302	Hoover, Birmingham	Oxmoor, Ross Bridge
14404	Homewood, Vestavia Hills	Gentilly Forest
14405	Hoover, Vestavia Hills	Shades Cliff
14406	Hoover	Country Club Highlands
14408	Hoover	Chace Lake
14409	Hoover	Star Lake
14410	Hoover	Stadium Trace
14412	Hoover	Bluff Park
14413	Hoover	Moss Rock

Glossary

Excerpted from "Advancing Health Equity Guiding Principles"

Health Disparities

Preventable differences in the presence of disease, health outcomes, and/or access to health care between population groups.

Disparities adversely affect groups of people who have systematically experienced greater obstacles to optimal health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or sex; geographic location; or other characteristics historically linked to discrimination and/or exclusion.

Health Equity

Everyone has a fair opportunity to live a long and healthy life.

Health Equity requires creating fair opportunities for health and eliminating gaps in health outcomes and access to health care between different population groups.

Health Inequities

Differences in health that are unnecessary and avoidable, and could be considered unfair and unjust.

Health inequities are rooted in social injustices that make some population groups more vulnerable to poor health than other groups.

Social Determinants of Health

Conditions in which people are born, live, learn, work, play, worship, and age that affect health and quality of life.

These conditions are shaped by the amount of money, power, and resources that people have, all of which are influenced by policy choices. The most commonly referred to social determinants of health include: education, employment, access to healthcare services, environmental quality, and transportation.

Disparity

The condition of being unequal; a noticeable difference.

The term disparities is often interpreted to mean racial or ethnic disparities, however, many dimensions of disparity exist in the United States, including sex, sexual identity, sexual orientation, age, disability, socioeconomic status, and geographic location.

Health Outcome

A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.

Such a definition emphasizes the outcome of planned interventions (as opposed, for example, to incidental exposure to risk), and that outcomes may be for individuals, groups or whole populations. Interventions may include government policies and consequent programs, laws and regulations, or health services and programs, including health promotion programs. It may also include the intended or unintended health outcomes of government policies in sectors other than health.

Social Injustice

The unfair denial or violation of economic, sociocultural, political, civil, or human rights of specific populations or groups in the society based on the perception of their inferiority by those with more power or influence.

Populations or groups that suffer injustice may be defined by racial or ethnic status, socioeconomic position, age, sex, sexual identity, sexual orientation, or other perceived population or group characteristics. Social injustice may include policies or actions that adversely affect the societal conditions in which people can be healthy.

Power

The ability to control others, events, or resources; to make happen what one wants to happen in spite of obstacles, resistance, or opposition.

Power can be held, coveted, seized, taken away, lost, or stolen, and used in what are essentially adversarial relationships involving conflict between those with power and those without.

Food Insecurity

Food insecurity is a state in which consistent access to enough food for an active, healthy life is limited by a lack of money and other resources. It can be temporary or long-term.

Hot Spot Analysis

Spatial analysis and mapping technique used to identify the clustering of spatial phenomena by using statistical analysis in order to define areas of high occurrence vs areas of low occurrence.

A Hot Spot Analysis calculates the z-score and related p-value for each census tract and defines hot spots as census tracts bordering other census tracts with an equal or higher value. The areas with the highest and lowest raw values are therefore not necessarily hot spots or cold spots. A census tract with a low negative z-score and small p-value indicates a spacial clustering of low values. The higher (or lower) the z-score, the more intense the clustering. A z-score near zero indicates no apparent spatial clustering.

Advancing Health Equity Guiding Principles

1. Involve people negatively impacted by health disparities in development, implementation, and evaluation

Program development, implementation, and evaluation should include input from people who have a greater presence of disease, poorer health outcomes, and/or less access to health care (e.g., racial/ethnic minorities, older adults, lower socioeconomic status, physical or mental disability, geographic location).

2. Ensure objectives target people and communities negatively impacted by health disparities

Program objectives should explicitly and unambiguously state that the target population includes people who are negatively impacted by health disparities (e.g., racial/ethnic minorities, older adults, lower socioeconomic status, physical or mental disability, geographic location).

3. Ensure health equity messages are appropriate and widely disseminated

Consider the needs, assets, and priority issues of community members and stakeholders prior to developing messaging and promote shared understanding of health equity goals.

4. Value both community and technical expertise

Respect and incorporate expertise and perspective of community members with technical expertise provided by health experts.

5. Support and build community capacity to act

Build on the capacity of community members by increasing their awareness of health inequities and providing skills on how to intervene.

6. Leverage opportunities to advance health equity

Connect with efforts led by organizations, groups, and/or individuals with complementary goals to heighten visibility of health equity work to reinforce messaging.

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