



CAPITAL REGION PUBLIC HEALTH NEWSLETTER

Issue #16 • November 2019

Happy Holiday season!

In this issue we continue our focus on Social Determinants of Health (SDH). Our [quarterly topic](#), written by our very own SDH expert Shelby Leonard shows how SDH influence people at every income level. In this [infographic](#) we can see that as income increases health improves.

We combine findings from our most recent [disparity report](#) and [a study conducted with Siena](#) to show how a concentration of both socioeconomic and health needs in small geographical locations impact health. By looking at indicators like Years of Potential Life Lost (YPLL) and the Area Deprivation Index (ADI) we can see that disparities exist across the socioeconomic spectrum and are more prevalent in underserved areas. See our latest [disparity report](#) for regional comparisons of six communities and check our [quarterly topic](#) to learn more about how social determinants of health impact everyone.

Want to learn about social determinants from leading experts? Join us on December 12th from 9 AM-11 AM to learn from 3 speakers from our Capital

Region community who are actively working to address Social Determinant of Health needs. You can register for the Healthy Way Symposium [HERE](#).

Don't forget to check our list of [professional development opportunities](#) and [upcoming events](#).

SAVE THE DATE CAPITAL REGION
Healthy Way SYMPOSIUM*
Thursday, December 12, 2019, 9-11 a.m.
at **IGNITE U**
333 Broadway, Suite 350, Troy, NY

Social Determinants of Health
Data, Theory & Practice



THE LATEST IN NEW YORK STATE HEALTH INITIATIVES

Population Health Improvement Program

Under the [NYS Prevention Agenda](#), local health departments and hospitals in the Capital District have been working together along with other community partners to identify and address health priority issues. Each county is in the final stages of completing their community health improvement plan for 2019-2021. Five of the six plans include addressing obesity. We are also seeing a focus on interventions to address tobacco use and substance use disorders. You can expect to see the updated plans early next year on our website with points of contact if you want to be part of the solution!

New Product Guide

We put together a quick reference guide highlighting all of our public health data resources in one succinct source. This product guide covers the most relevant and up-to-date public health data in the Capital Region. Check it out [HERE](#).

Here at HCDI we are proud to support our partners in their efforts to improve population health throughout the Capital Region. This summer we asked our partners to help us look back and understand how we have added value. We surveyed our partners and found that the total amount of grant money raised with PHIP support or collaboration totaled over **\$7 Million dollars**.

We are proud to share that to date we have created and distributed over **380 public health materials and resources** to help promote best practices and strategies to improve population health and reduce health care disparities in the region.

DSRIP/PPS/VBP

VBP Updates

The New York State Department of Health (NYSDOH) is seeking a four-year amendment to further support and expand DSRIP efforts. As of September 2019, NYSDOH updated the 5th edition of [Redline Version Submitted to CMS](#) which outlines the State's VBP plans going forward. The VBP Bootcamp regional learning series has concluded, but you can still access these session presentations and full session recordings! Click [HERE](#) for VBP Bootcamps, information and materials for VBP University, the VBP Roadmap, the VBP Portal for Providers, and more!

Local PPS updates

Focused on social determinants of health, Alliance's new Independent Practice Association (IPA) – Healthy Alliance, IPA – links social care organizations, behavioral health providers, medical providers and managed care organizations in a technology-enabled referral platform that supports value-based care. Our goal remains the same: improve the health of the communities we serve. They now have 40 organizations participating in the IPA. You can learn more at on their updated website [HERE](#).

SHIP UPDATES

As the need for Community Health Workers continues to grow, training the workforce becomes ever more important. To continue our initiative to promote workforce development in the field of Care Coordination, we hosted our bi-monthly Munch & Mingle for Community Health Workers and related professions on October 16. At this event, which took place at the Mount Pleasant Library in Schenectady, we focused on Domestic and Intimate Partner Violence which included an interactive training from Kathy Grant at In Our Own Voices.

Our next Community Health Liaison Task Force meeting will be held on *November 26th @ 8:30a.m.* The next Munch and Mingle will take place on *December 18th*, where we will be focusing on *de-escalation and conflict resolution*.

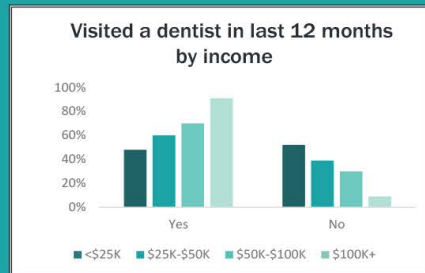
In addition, HCDI had created a LinkedIn group for Care Coordinators called Care Coordination in the Greater Capital Region. This group is designed to serve as a space for Community Health Workers to e-network, share resources, and learn from others successes & challenges on their own time. The group can be found [HERE](#) and is open to all CHW in the region. Feel free to share and repost the group!

QUARTERLY TOPIC: UNDERSTANDING HEALTH EQUITY AND PLACE

As the healthcare system works toward partnerships to improve care and individual health-related social needs we should continue to acknowledge and find ways to address the complexity of the challenges to health and well-being at the community level. A recent post from [HealthBegins](#) notes that “Even the most effective relationships between healthcare and social services still take place in unequal systems, where the communities in which patients live and work are shaped by unjust structures and unhealthy policies.” Meeting an individual’s social needs such as food or housing is important but incomplete. We know that a person’s environment is linked to their health. As the greatest impact on their health, we should grapple with the implications of a broader complex system. Most would agree that we cannot end with medical-only interventions, but few are finding ways to prioritize social needs, develop important relationships with community development or economic development initiatives, or [develop a pathway for transforming health on a regional level](#). “While targeted, small-scale social interventions provide invaluable assistance for individual patients, we must also remain focused on the social determinants that perpetuate poor health at the community level.” [Health Affairs](#)

Impacts of Social Determinants of Health in the Capital Region

Health outcomes and health behavior differences at 4 different income levels demonstrates a social gradient indicating that SDOH influence people of all income levels.



See more 2019 Capital Region Community Health Survey results

As income increases...

HEALTH OUTCOMES



Self-rated health, days with good physical health, days with good mental health

HEALTH BEHAVIORS



Engaging in healthy behaviors (healthy diet, regular exercise, refraining from alcohol and tobacco use)

COMMUNITY FACTORS



Safety in home/neighborhood, air/water quality, education availability for young people and adults, affordable recreational facilities, social participation

ACCESS TO CARE



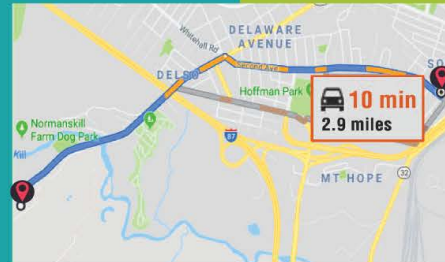
Dentist, Primary Care visits

...health improves.

A TALE OF TWO NEIGHBORHOODS

Bethlehem and South End (Albany County)

SDOH accumulate over the lifecourse, compounding on certain individuals leading to community-level inequities. These two neighborhoods are less than five miles away from each other, yet the sociodemographic and health indicator data demonstrate the connection between socioeconomic conditions and poor health.



INDICATOR	Bethlehem	South End
Household Income ¹⁰	\$47k	\$22k
Incarceration Rate ¹⁰	<1%	4.50%
Median Rent ¹⁰	\$1,300	\$674
Poverty Rate ¹⁰	2%	46%
Diabetes ED Rate	89.8*	810.5*
Assault Hx. Rate	0.6*	18.1*
Asthma ED Rate	18.2*	251.1*
Teen Pregnancy Rate	5.1*	82.9**
% Premature Deaths (<65 yrs) ⁸	13.70%	50.40%

See our neighborhood equity report for more information.

Our biology is not separate from our environment. The conditions in which we are born, grow, live, work, and age, affect our health at each stage of development and accumulate over the lifetime. They do not affect us equally and often compound on certain individuals. The Social Determinants of Health (SDH) movement calls for public health, healthcare, and health policy to recognize that not addressing these data-based determinants, leads to health inequality. At birth, predictions can be made with scary accuracy on life expectancy. This is because the community in which a baby is born has the potential to either support or impede good health.

SDH Affect Everyone – Social Gradient

Much of the conversation surrounding SDH interventions centers around addressing individuals' social needs, which are generally focused on the most vulnerable members of the population. This leads many to think that this is an issue, which only affects individuals in poverty, but this is far from the truth.

As income, educational attainment, and work position improve, health outcomes and health behaviors incrementally improve forming a social gradient. This gradient shows there are environmental and social differences happening at each income level, employment grade, and class that are fundamentally changing our biology causing chronic disease prevalence increases at each level. If this were simply a lack of resources issue, we wouldn't see that. We wouldn't expect for example, that someone who is a senior executive officer would have a lower life expectancy than a senior administrator. Even when the richest and poorest people in society are removed, a clear gradient between middle classes exists.

The health and well-being of the entire community are pulled down when health inequalities are present. In fact, in countries where more inequalities are present, even the group with the best outcomes are still worse than comparable countries with fewer inequalities.

But how?... It all comes back to the community

4 Mechanisms through which SDOH cause poor health

1. Lack of resources—deprivation

Not having access to healthy food and safe housing can directly cause illnesses through inadequate nutrition and toxin exposures. Lack of access to medical care or transportation can prevent the treatment of arising illnesses before they develop into chronic conditions.

Although undoubtedly beneficial, resource referral interventions are creating individual solutions to a community problem. For example, if a family is food insecure and is referred to a food pantry but the root cause is there is no grocery store in a reasonable distance to the family, the problem isn't really solved. Rather than addressing the outcome (food insecurity), we need to address the cause (no grocery stores).

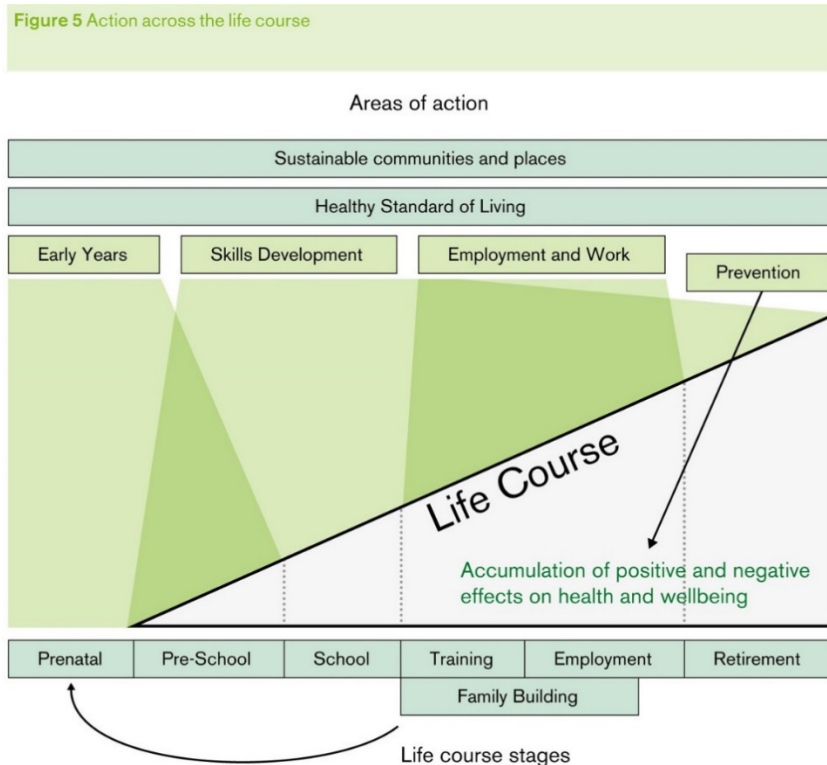
2. Health Behaviors

Health behaviors such as diet, physical activity, and substance use explain around 40% of outcome differences suggesting they do account for some of the differences between health outcomes, but they do not explain everything.

The essence of SDH is always searching for the causes of the causes. Even if it is found that poorer people, for example, make unhealthier decisions, why does that happen? Much of that comes back to the community. For example, school performance is associated with community structure, targeted advertisements overwhelm certain communities, resource placement and availability frames choices, and access to green spaces and safe recreational areas are not available in every community.

3. Lifecourse accumulation

Actions across the lifecourse accumulates positive and negative effects on health and wellbeing. Lifecourse accumulation combines SDH over an individual's lifespan and has a compounding effect resulting in diminished health. It also notes critical transition stages where people are particularly vulnerable and resilient stages, indicating key intervention opportunities such as adolescence.



Source: [Fair Society Healthy Lives \(2010\)](#)

4. Biological Changes

Two different biological mechanisms through which SDH, directly and indirectly, cause disease are stress and epigenetic changes. When stressed, the body activates its "fight or flight" system. This is necessary for immediate survival providing extra resources to the

respiratory and circulatory systems but in order to do that, the body must take away energy from parts not as integral for immediate survival (e.g. reproduction, immune, and digestive systems). Consistent activation of these responses through daily stressors can lead to immune deficiencies reducing the body's ability to fight disease and infection. Development of chronic conditions such as obesity and cardiovascular disease result from the inability to maintain homeostasis due to chronic stress.

There's a growing body of research indicating genetic changes due to SDH that can lead to disease and even affect future generations. These changes interfere with the expression of certain genes without altering the DNA sequence. Evidence of these epigenetic changes demonstrates the urgent need for communities to address SDH.

Although SDOH affect certain individuals more than others, every individual is impacted and we must work together to achieve health equity. Cross-collaborative commitment has dramatically reduced some of the negative outcomes due to SDH in multiple case studies. Policies and interventions should be designed with health equity in mind and should reduce, and most certainly not enhance SDH associated with unequal, negative health outcomes.

UPCOMING EVENTS AND RESOURCES

FEATURED EVENT

Our Quarter 4 event will close out the year with a discussion of Social Determinants of Health. As Public Health and Healthcare professionals, we all care about improving health

outcomes for the individuals and populations we serve. Much of our work is directed towards this goal, but how much of our efforts focus on the root cause of these health issues? Social Determinants of Health, is a fairly new and hot topic. Many of our partners have a familiarity with SDOH's, however, the programs and work being done to address these issues are still not widely known. At this next event, we will have three speakers from varying backgrounds set the foundation for what we mean by SDOH and provide an overview of the work being done to address them in the Capital Region.

Join us December 12th from 9AM-11AM to learn from 3 speakers from our Capital Region community who are actively working to address Social Determinant of Health needs! Reserve your spot here: <https://www.eventbrite.com/e/81761>

SAVE THE DATE CAPITAL REGION **Healthy Way SYMPOSIUM***

Thursday, December 12, 2019, 9-11 a.m.
at **IGNITE U**
333 Broadway, Suite 350, Troy, NY

Social Determinants of Health
Data, Theory & Practice

* Healthy Way Symposium, formerly known as PHIPAC, provides an opportunity for community partners to learn about current public health topics.

Community

December

Monday, December 2, 2019

Huddle for IHANY/Fidelis contract
10:00 a.m. – 11:00 a.m.
The Collaboratory, Trinity Alliance
3 Lincoln Square, Albany, NY 12202

Tuesday, December 3, 2019

Obesity/Diabetes Task Force
8:15 a.m. – 9:30 a.m.
Healthy Capital District Initiative
175 Central Avenue, Albany, NY 12206

Wednesday, December 4, 2019

Prevention Subcommittee Meeting
9:00 a.m. – 10:00 a.m.
The Collaboratory, Trinity Alliance
3 Lincoln Square, Albany, NY 12202

Thursday, December 5, 2019

Albany County Asthma/Tobacco Coalition Meeting
1:00 p.m. – 2:30 p.m.
Healthy Capital District Initiative
175 Central Avenue, Albany, NY 12206

Wednesday, December 11, 2019

Rensselaer County Heroin Coalition Meeting
10:00 a.m. – 12:00 p.m.
Rensselaer County DSS Administration Building
127 Bloomingrove Drive, Troy, NY 12180

Thursday, December 12, 2019

Healthy Way Symposium (Formerly PHIPAC)
9:00 a.m. - 11:00 a.m.
IGNITE U
333 Broadway, Troy, NY 12180

Wednesday, December 18, 2019

PHIP Steering Committee Meeting
Healthy Capital District Initiative
175 Central Avenue, Albany, NY 12206

Thursday, December 19, 2019

Albany County Strategic Alliance Meeting
9:00 a.m. – 10:30 a.m.
Albany County Department of Health
175 Green St, Albany, NY 12202

Wednesday, December 18, 2019

Munch & Mingle

2:00 p.m. – 4:00 p.m.

Location TBD

January

Monday, January 6, 2020

Huddle for IHANY/Fidelis contract

10:00 a.m. – 11:00 a.m.

The Collaboratory, Trinity Alliance

3 Lincoln Square, Albany, NY 12202

Wednesday, January 8, 2019

Prevention Agenda Work Group

8:30 a.m. – 10:00 a.m.

Healthy Capital District Initiative

175 Central Avenue, Albany, NY 12206

Tuesday, January 28, 2019

Community Health Liaison Task Force

8:30 a.m. – 10:00 a.m.

Healthy Capital District Initiative

175 Central Avenue, Albany, NY 12206

Thursday, January 23, 2020

BHNNY Care Coordination Care Management Meeting

9:30 a.m. – 11:30 a.m.

Albany Medical Center

1275 Broadway, Albany, NY 12204

Friday, January 31, 2019

PHAB Accreditation Meeting

11:00 a.m. – 12:00 p.m.

Healthy Capital District Initiative

175 Central Avenue, Albany, NY 12206

Professional Development Opportunities

Community Technical Assistance Center of New York (CTAC)- Medicaid Managed Care Crisis Intervention Benefit: Mobile Crisis Component Webinar

This webinar is for children and adult mobile crisis providers designated by NYS. It will address processes for NYS approved mobile crisis providers related to billing and collecting insurance information. Compliance with requirements related to the delivery of the services reimbursed by this benefit and clinical considerations will also be discussed.

Tuesday, November 26, 2019

10:30 a.m. - 11:30 a.m.

Location: WebEx

FREE Opioid Overdose Prevention Training

Training is open to anyone and does not require RSVP. Learn the signs and symptoms of Opioid Overdose and how to use Naloxone (Narcan) to respond to an overdose. Each individual will receive an Intranasal Naloxone kit as part of the training.

Tuesday, December 3, 2019

11:00 a.m. – 12:00 p.m.

Albany County Department of Health, 175 Green St, Albany, NY 12202, USA ([map](#))

For More Information Contact Joseph Filippone at 518-449-3581 Ext 130 or

josephf@cocalbany.org

Free Overdose Prevention & Narcan Training 2019

Schenectady County Public Health Services (SCPHS) was granted a Certificate of Approval to operate an Opioid Overdose Prevention Program. The purpose of this program is to educate individuals on opioid overdose prevention by teaching attendees how to recognize an overdose, how to respond to a suspected overdose, how to administer Narcan, to provide a Narcan kit and/or N-CAP information, and related resources. This program is not medical education for providers. We are offering this **free** program to all Schenectady County employees, Ellis Hospital employees, and Schenectady County CBO employees.

Please RSVP to Lauren Stairs, either by phone (518) 386-2824 ext. 256 or email lauren.stairs@schenectadycounty.com by the 5th of the month in which you plan to attend, space is limited.

Wednesday, December 11, 2019

9:00 a.m. – 10 a.m.

Ellis McClellan Conference Center, 600 McClellan St, Schenectady NY 12304

Mental Health First Aid- Veterans- MHANYS Capital Region Project AWARE

Free Webinar Series: Health Disparities— Community Health Workers' Resources
Community Health Workers (CHWs) are trusted, knowledgeable frontline public health workers who typically come from the communities they serve. The Standards of Medical Care in Diabetes of the American Diabetes Association® highlights the importance of CHWs in diabetes prevention and management, especially among underserved communities. This webinar will focus on integrating CHWs into the public health care workforce as a strategy for increasing health equity and access and improving population health, while decreasing costs. Learn more and register at professional.diabetes.org/CHWWebinars.

Wednesday, January 8, 2019

8:00 a.m. – 5:00 p.m.

Location: Zaloga American Legion Post, Albany, NY

Cost: Free (training sponsored by SAMHSA); Register at www.mhanys.com

Free Webinar Series: Health Disparities—Community Health Workers' Resources

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for increasing health equity and access and improving population health, while decreasing costs. Learn more and register at professional.diabetes.org/CHWWebinars.

Wednesday, December 11, 2019 1:00 p.m.

Continuing Education: 1.0 CME/CE

Alliance for Better Health (Alliance) MCOL webinar on social determinants of health, entitled "SDoH Change Moves at the Speed of Trust."

Together with our partners, The Food Pantries for the Capital District and MVP Health Care, Alliance will discuss: 1) Social Determinants of Health (SDoH) Initiatives, 2) Technology and the importance of a curated network and closed-loop referral platform, 3) How Alliance is working to improve and promote person-centered health between social care providers and health plans, 4) How Alliance furnishes providers with SDoH data, allowing them to connect patients with community-based organizations to improve health and reduce costs

Thursday, December 5th at 1 pm EST

Purchase Tickets: <https://healthexecstore.com/products/webinar-sdoh-change-speed?fbclid=IwAR1UIZfDFw6KQEJFxFVDDKgpweQrtZHHa7jGJpmWICOg-LduqoDXrwG-hDzQ>

Webinar- Writing for the Public : The Building BRIDGES Approach

Learning Objectives: 1) Describe the rhetorical triangle and its components, and how it can be used to analyze communication, 2) Identify assumptions you have about your audience and how these influence your writing, and 3) Construct an empathy map to help focus your writing.

Speaker: Anne Marie Liebel, EdD, President Health Communication Partners LLC

Tuesday December 3rd, 2019

12:00 p.m. - 1:00 p.m. ET

Required 2 step registration:

1. Registration: <https://www.surveymogizmo.com/s3/5321460/2019-12-03-Registration>
2. Join Livestream with your email address at [livestream.com](https://www.livestream.com)

Columbia and Greene ACE's Training

This workshop will focus on gaining the knowledge and skill needed in the area of trauma-informed care (including ACES - Adverse Childhood Experiences), and practical models for discussing trauma and resilience with individuals and communities who may have experienced adversity.

Monday, January 6, 2020

8:30 a.m. – 4:30 p.m.

Please register at: www.eventbrite.com/e/aces-call-to-connection-tickets-83057450069

Grants

1. **Dementia Care: Home- and Community-Based Services (R21 and R01 Clinical Trial Not Allowed)**

Grants for research on the outcomes of care for persons with Alzheimer's disease and related dementia by identifying home- and community-based services used, as well as barriers to accessing care and unmet needs. Explaining geographic disparities, such as urban versus rural, in access to and quality of care is a suggested research topic.

Geographic coverage: Nationwide and U.S. territories

Letter of Intent (Optional): Jan 3, 2020

Application Deadline: Feb 3, 2020

Sponsors: National Institute on Aging, National Institutes of Health, U.S. Department of Health and Human Services

Visit: <https://grants.nih.gov/grants/guide/rfa-files/rfa-ag-20-037.html>

2. **Community Food Projects Technical Assistance**

One-on-one technical assistance, educational resources, and professional development opportunities for current grantees and potential applicants of the USDA Community Food Projects grant program.

Geographic coverage: Nationwide and U.S. territories

Date: Applications accepted on an ongoing basis

Sponsors: New Entry Sustainable Farming Project, Tufts University Friedman School of Nutrition

Visit: <http://www.ruralhealthinfo.org/funding/3722...091819>

3. **Mobility for All Pilot Program Grants FY2020 Notice of Funding**

FTA makes available \$3,500,000 in funding for the Mobility for All pilot program; Catalog of Federal Domestic Assistance (CFDA) number: 20.513). As required by federal transit law, funds will be awarded competitively to finance innovative capital projects that will improve the coordination of transportation services and non-emergency medical transportation services.

This funding opportunity seeks to improve mobility options through employing innovative coordination of transportation strategies and building partnerships to enhance mobility and access to vital community services for older adults, individuals with disabilities, and people of low income.

Dates: An applicant must submit a proposal electronically by 11:59 p.m. EDT January 6, 2020. Any agency intending to apply should initiate the process of registering on the Grants.gov site immediately to ensure completion of registration before the submission deadline.

Visit: <https://www.transit.dot.gov/funding/applying/notices-funding/mobility-all-pilot-program-grants-fy2020-notice-funding>

4. **Make the Road New York (MRNY)**

MRNY's CVI Project goals are to: (1) Enhance community member engagement to better understand the delivery system changes happening to Health + Hospitals (New York City's public hospital system) and to the One City Health (OCH) PPS (Performing Provider System) (2) Improve OCH PPS's infrastructure and funding to allow for community member engagement and Community Based Organization (CBO) involvement in the PPS, as well as increase programmatic funding for CBOs (3) Increase involvement of Community Health Workers in the OCH PPS (4) Advocate for the importance of the Affordable Care Act (ACA) and a robust Medicaid program.

MRNY is working to achieve these goals by educating community members, organizing Community Health Workers, obtaining earned media, enhancing their relationship with the OCH PPS and collaborating with coalition partners and ally organizations. MRNY will also partner with key elected officials to protect the ACA and maintain a robust Medicaid program.

Contact Person: Rebecca Telzak, Health Programs Director

Visit: www.healthinnovation.org/work/body/CVI-Program-Description-2.pdf

5. **Assessing the Burden of Diabetes by Type in Children, Adolescents and Young Adults (DiCAYA)**

The purpose of this Notice of Funding Opportunity Announcement (NOFO) is to conduct surveillance to assess the incidence and prevalence of diabetes among children, adolescents and young adults in the United States and provide estimates by diabetes type, age, sex, race/ethnicity and geographic area. This NOFO has three (3) components to achieve the purpose of the program • Component A focuses on surveillance of incidence and prevalence of diabetes among children and adolescents (<18 years). • Component B focuses on surveillance of incidence and prevalence of diabetes among young adults (18 to <45 years). • Component C serves as a Coordinating Center to provide an infrastructure for standardized approaches, analytical methods, and surveillance measures. It also serves as a repository for the Component A and B data and provides consolidated estimates by diabetes type, age, race/ethnicity and geographic area.

Letter of Intent Due Date: Dec. 9, 2019

Current Closing Date: Jan. 14, 2020

Expected Number of Awards: 11

Estimated Total Program Funding: \$15,000,000

9:30 am - 3:00 pm

The Queensbury Hotel in Glens Falls

<https://ahihealth.org/event/volume-to-value-a-path-towards-data-driven-health-outcomes/>

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Bartley M. *Health Inequality: an Introduction to Concepts, Theories and Methods*. Cambridge, UK: Polity Press; 2017.

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