**Social Determinants:
Going Beyond Acute Needs**

Paul Kuehnert, DNP, RN, FAAN
Associate Vice President--Program
Robert Wood Johnson Foundation
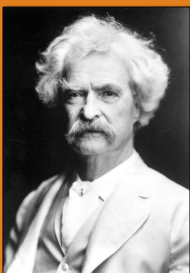
2018 Association of Public Health
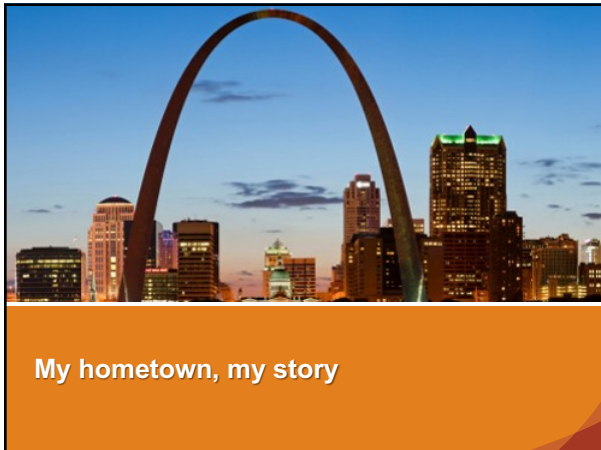Nurses Annual Conference
May 1, 2018

Robert Wood Johnson Foundation

Presentation Overview

- My story, my inspiration
- Setting the context
- Key challenges …. and opportunities
- Call to action

"The two most
important days
in your life are the day
you were
born and the day you
find out why."
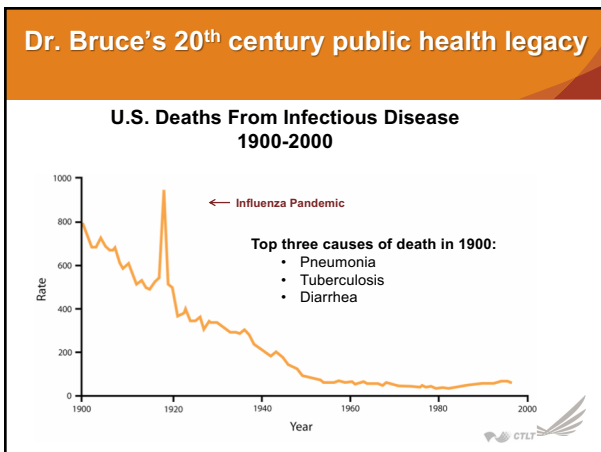			-Mark Twain

My hometown, my story

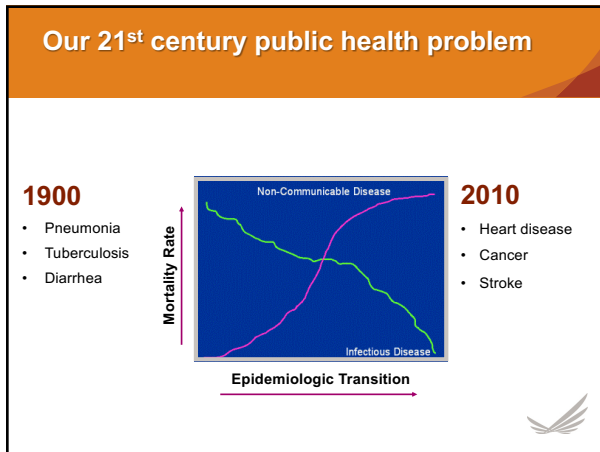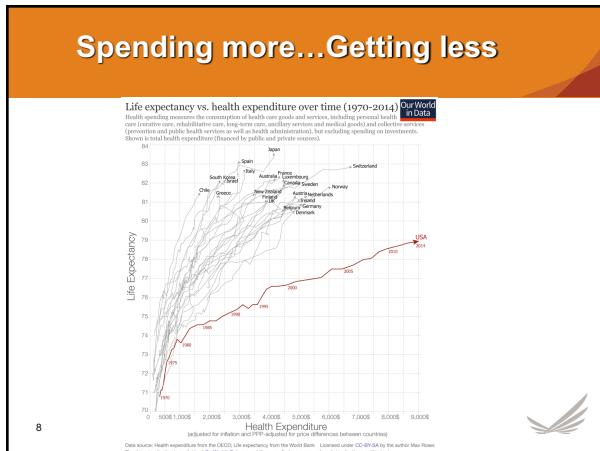**My inspiration**

- City of St. Louis Health Department (1947 – 1981)
- Health Commissioner (1972 – 1981)

Helen Bruce, MD
1907-1994

Dr. Bruce's 20th century public health legacy

U.S. Deaths From Infectious Disease
1900-2000

← **Influenza Pandemic**

Top three causes of death in 1900:
- Pneumonia
- Tuberculosis
- Diarrhea

Rate

Year

Our 21st century public health problem

1900
- Pneumonia
- Tuberculosis
- Diarrhea

2010
- Heart disease
- Cancer
- Stroke

Non-Communicable Disease

Mortality Rate

Infectious Disease

Epidemiologic Transition

Spending more…Getting less

Life expectancy vs. health expenditure over time (1970-2014)

Low life expectancy at every age

Ranking of US Mortality Rates by Age Group vs. Peer Countries, 2006-2008

•**For both sexes, the US never ranks higher than 15 out of 17 countries before age 75.**

Source: IOM Report, Shorter Lives, Poorer Health, 2013

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We can't solve problems by using the same kind of thinking we used when we created them.
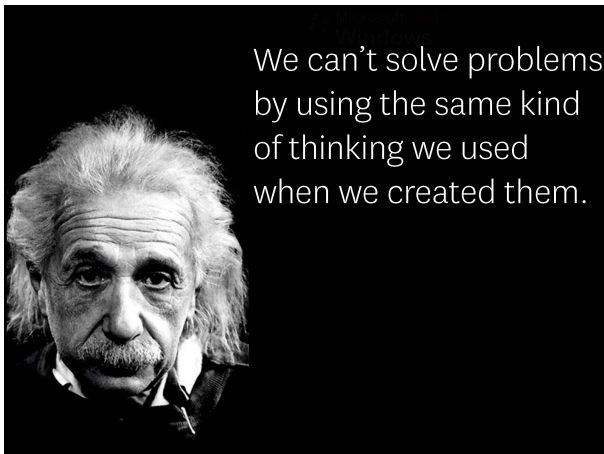

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions in which we are born, we grow and age, and in which we live and work. The factors below impact on our health and wellbeing.

Childhood experiences

Housing

Education

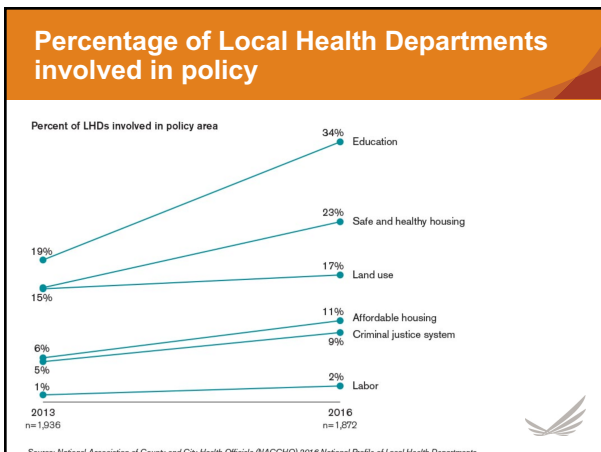Social support

Family income

Employment
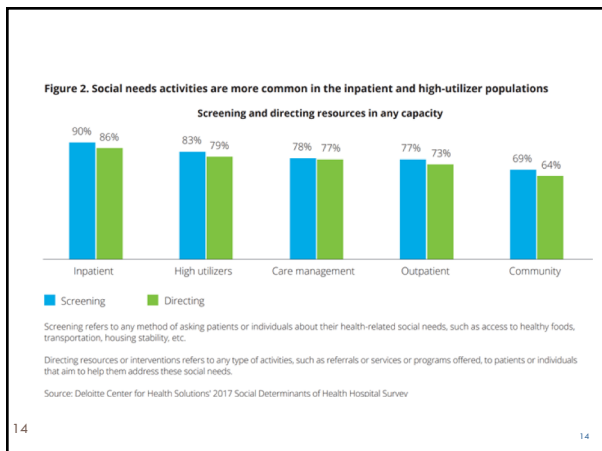
Our communities

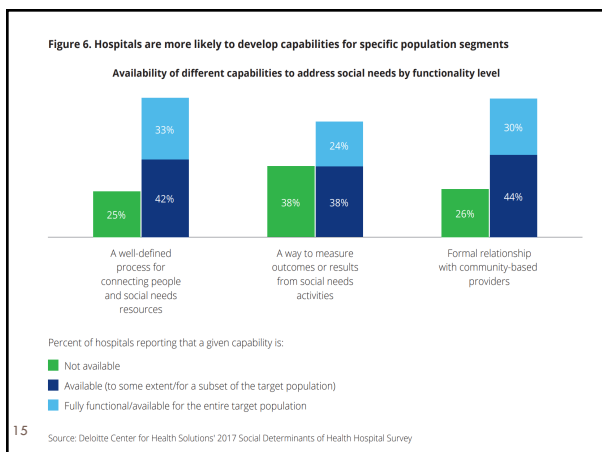Access to health services

Source: NHS Health Scotland

Percentage of Local Health Departments involved in policy

Percent of LHDs involved in policy area

34% Education
23% Safe and healthy housing
19%
17% Land use
15%
11% Affordable housing
9% Criminal justice system
6%
5%
2% Labor
1%

2013
n=1,936

2016
n=1,872

Source: National Association of County and City Health Officials (NACCHO) 2016 National Profile of Local Health Departments

Health care and the
Social Determinants of Health

80% report leadership commitment to systematically address social needs

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Figure 2. Social needs activities are more common in the inpatient and high-utilizer populations

Screening and directing resources in any capacity

	Screening	Directing
Inpatient	90%	86%
High utilizers	83%	79%
Care management	78%	77%
Outpatient	77%	73%
Community	69%	64%

■ Screening   ■ Directing

Screening refers to any method of asking patients or individuals about their health-related social needs, such as access to healthy foods, transportation, housing stability, etc.

Directing resources or interventions refers to any type of activities, such as referrals or services or programs offered, to patients or individuals that aim to help them address these social needs.

Source: Deloitte Center for Health Solutions' 2017 Social Determinants of Health Hospital Survey

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Figure 6. Hospitals are more likely to develop capabilities for specific population segments

Availability of different capabilities to address social needs by functionality level

	A well-defined process for connecting people and social needs resources	A way to measure outcomes or results from social needs activities	Formal relationship with community-based providers
Fully functional	33%	24%	30%
Available	42%	38%	44%
Not available	25%	38%	26%

Percent of hospitals reporting that a given capability is:

■ Not available
■ Available (to some extent/for a subset of the target population)
■ Fully functional/available for the entire target population

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Source: Deloitte Center for Health Solutions' 2017 Social Determinants of Health Hospital Survey

Our opportunity….and our challenge

"I'm on the bus for population health; in fact, I'm driving the bus. But I need help shifting my core business—all of which focuses on sick care—to focus on creating health and well-being. I need a roadmap to help me know how to do that."

Healthcare CEO, quoted in
"Pathways to Population Health
www.pathways2pophealth.org

Challenge today:
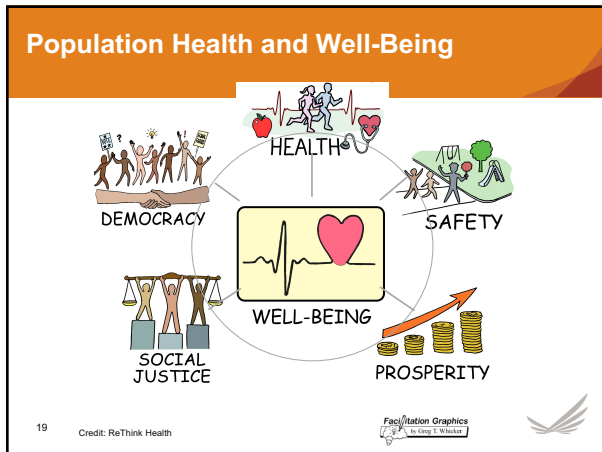**Going Beyond Acute Needs by**
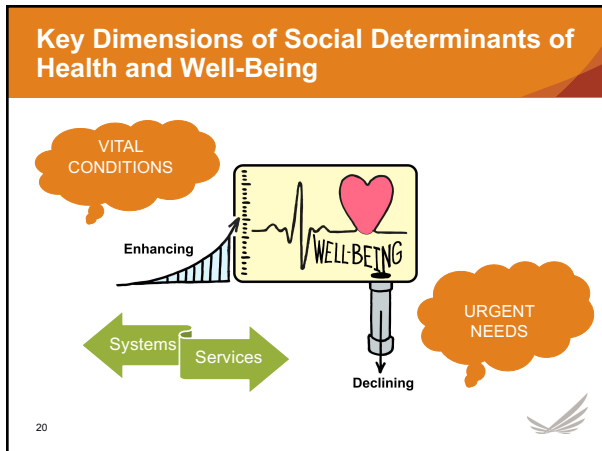*GOING DEEPER*

Understanding of ---- and actions on :

1. Social Determinants of Health
2. Community engagement
3. Multi-sector relationships and organizations

Going Beyond Acute Needs by
GOING DEEPER

Understanding of ---- and actions on :

1. Social Determinants of Health

Population Health and Well-Being

19   Credit: ReThink Health

Key Dimensions of Social Determinants of Health and Well-Being

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Creating Opportunities for Population Health and Well-Being

VITAL CONDITIONS

WELL-BEING

URGENT NEEDS

1. Education
2. Jobs, wages, wealth
3. Stable housing
4. Safety
5. Healthy food
6. Physical activity
7. Healthy environment
8. Public transportation
9. Tobacco, alcohol, drug prevention
10. Preventive health care

1. Acute care for illness or injury
2. Addiction treatment and recovery
3. Criminal justice, emergency response
4. Environmental cleanup
5. Unemployment, income assistance
6. Homeless services

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Using Food as a Tool to Build Health, Wealth and Social Change

Guiding Principles

- **Grassroots**
- **Collaboration**
- **Community Organizing**
- **Youth Leadership**

Community Cooks

Urban Agriculture

Breaking Bread Café & Catering

Business Incubation

Good Food Movement

Employment & Training

Going Beyond Acute Needs by *GOING DEEPER*

Understanding of ---- and actions on :

2. Community engagement

Nothing about me…
…without me!

Effective Community Engagement

Transforming a region's system for health requires the balance between practices across all three outcomes.

Resident Awareness and Participation

Feedback and Input from Residents

Active Resident Leadership

Credit: ReThink Health

Effective Community Engagement

Belonging

Power Trust

Credit: ReThink Health

http://www.neighborhoodgrants.org/contact-us/

People Matter
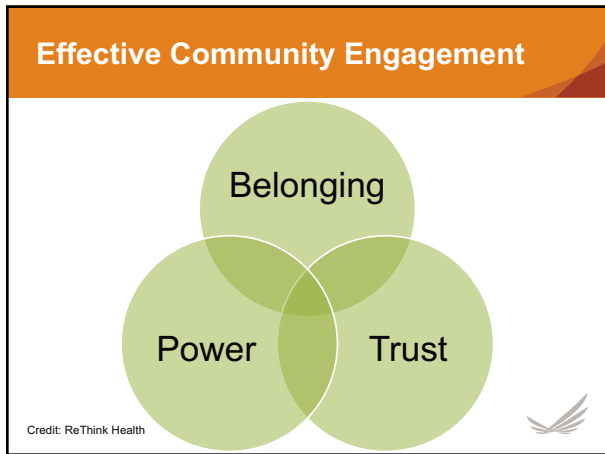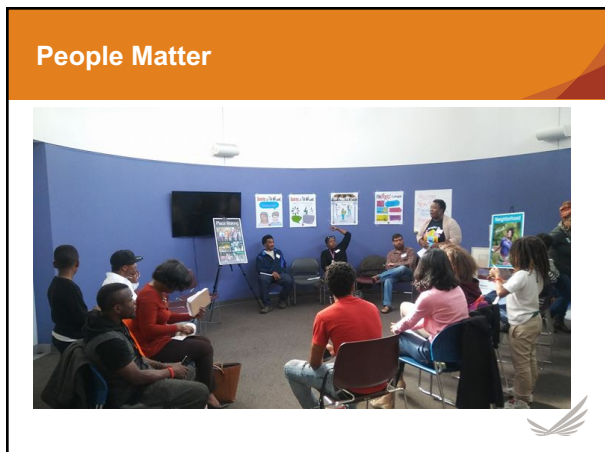
Systems Matter

Place Matters

Effective Community Engagement

Transforming a region's system for health requires the balance between practices across all three outcomes.

Resident Awareness and Participation

Feedback and Input from Residents

Active Resident Leadership

Credit: ReThink Health

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Going Beyond Acute Needs by
GOING DEEPER

Understanding of ---- and actions on :

3. Multi-sector relationships and organizations

Percentage of Local Health Departments with formal partnerships/collaborations

Health care partners

Emergency responders 81%
Hospitals 57%

Community health centers 38% → 39%
35%
Physician practices/ medical groups
26%
Health insurers 24% → 23%
21%

Community-based partners

K-12 schools 59%

Colleges or universities 45%

Community-based non-profits 34% → 38%
30%
Cooperative extensions 28%

Faith communities 19%
18% → 18%
Media 13%
Libraries 11% → 10%
8% Businesses
7%
5%

2008 (n=414-447)   2016 (n=218-483)   2008   2016

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NACCHO National Profile of Local Health Departments, 2016

Percentage of Local Health Departments with formal government partnerships

Local planning 26%

Criminal justice system 19%
Parks and recreation 17%

14%

Economic and community development 11% → 10%
9%
Transportation

7%

2008   2016
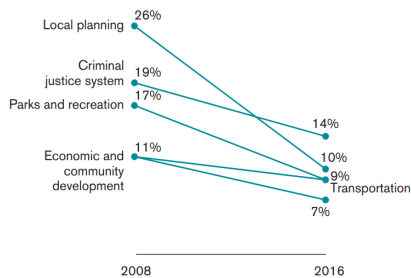
NACCHO National Profile of Local Health Departments, 2016

Problem: We don't *walk* the *talk!*

Most multi-sector community partnerships are:

- **Young and fragile**
- **Highly influenced by market & policy environment**
- **Struggle with financial sustainability**
- **Lack formal governance structures**
- **Lacking senior leadership involvement**
- **Focused on projects rather than systems & policy change**
- **Are not connected to other community & economic development partnerships**

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Partnership Organizational Continuum

- **Networking:** exchanging information for mutual benefit

- **Coordinating:** exchanging information and altering activities for mutual benefit and a common purpose

- **Cooperating:** exchanging information, altering activities and sharing resources for mutual benefit and a common purpose

- **Collaborating:** exchanging information, altering activities, sharing resources and enhancing the capacity of another for mutual benefit and a common purpose

From: Arthur T. Himmelman , COLLABORATION FOR A CHANGE (revised January 2002). Definitions, Decision-making models, Roles, and Collaboration Process Guide. Himmelman Consulting, Minneapolis, MN

Partnership Organizational Continuum

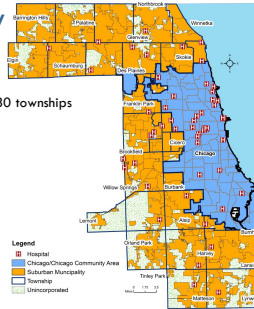|	Networking	Coordinating	Cooperating	Collaborating
Organizational Relationships	Informal	Formal	Formal	Formal
Characteristics	Minimal time commitments, limited levels of trust, and no necessity to share turf; information exchange is the primary focus	Moderate time commitments, moderate levels of trust, and no necessity to share turf; making access to services or resources more user-friendly is the primary focus	Substantial time commitments, high levels of trust, and significant access to each other's turf; sharing of resources to achieve a common purpose is the primary focus	Extensive time commitments, very high levels of trust and extensive areas of common turf; enhancing each other's capacity to achieve a common purpose is the primary focus
Resources	No mutual sharing of resources necessary	No or minimal mutual sharing of resources necessary	Moderate to extensive mutual sharing of resources and some sharing of risks, responsibilities, and rewards	Full sharing of resources, and full sharing of risks, responsibilities, and rewards

Partnership Development Pathway
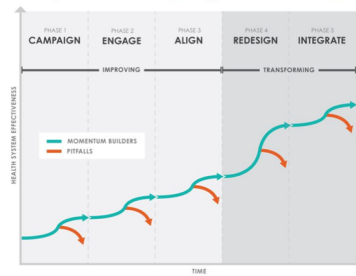
Credit: ReThink Health, Pathway for Transforming Regional Health
https://www.rethinkhealth.org/resources-list/pathway/

Health Impact Collaborative *of* **Cook County**

Working together for healthy communities.

Setting: Chicago & Cook County

- Population: 5.24 million residents

- City of Chicago: 77 community areas
- Cook County Suburbs: 130 municipalities/30 townships

- 6 certified local health departments, each completing individual CHA/CHIP

- ~50 non-profit hospitals

Legend
- Hospital
- Chicago/Chicago Community Area
- Suburban Municipality
- Township
- Unincorporated

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

Cook County Public Health
Promoting health. Preventing disease. Protecting you.

Source: Cook County Department of Public Health

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Vision and Values

Health Impact Collaborative *of* **Cook County**
Working together for healthy communities

Vision: Improved health equity, wellness, and quality of life across Cook County

Values:

1. We believe the highest level of health for all people can only be achieved through the pursuit of **social justice and elimination of health disparities and inequities**.

2. We value having a shared vision and goals with alignment of strategies to achieve **greater collective impact while addressing the unique needs of our individual communities**.

3. Honoring the diversity of our communities, we value and will strive to include all voices through **meaningful community engagement and participatory action**.

4. We are committed to emphasizing assets and strengths and ensuring a process that identifies and **builds on existing community capacity and resources**.

5. We are committed to **data-driven decision making** through implementation of evidence-based practices, measurement and evaluation, and using findings to inform resource allocation and quality improvement.

6. We are committed to building **trust and transparency** through fostering an atmosphere of open dialogue, compromise, and decision making.

7. We are committed to **high quality work to achieve the greatest impact possible**.

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5/24/18
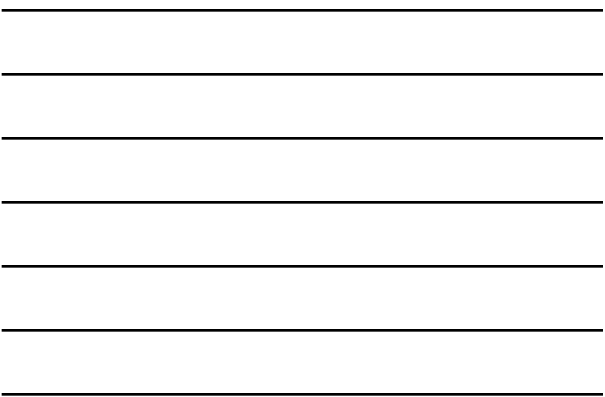
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Collective Purpose, *as of July 2017*

Improve population and community health by:

- Advancing **health equity**
- **Capacity building, shared learning, and connecting** local initiatives
- Addressing **social and structural determinants of health**
- Developing broad city/county wide initiatives and **creating systems**
- Engaging **community partners** and working collaboratively with community leaders
- Developing **data** systems for population health to support shared impact measurement and community assessment
- Collaborating on **population health policy and advocacy**

25-35 hospitals
6 local health departments
100+ community & regional stakeholders
IPHI as backbone organization

Collaborative Action

| Local and Regional Initiatives | Collaborative-Wide Initiatives |

IMPACT

PHN leaders are *going deeper*:

**1)SDOH
2)Community engagement
3)Collaborative organizations**

- Define health in the broadest possible terms.
- Address both urgent needs and vital conditions
- Build *strategic* systems changes and policy-oriented long-term solutions.
- Put fair and just opportunity for health for all at the center of your work.
- Harness the collective power of community members, leaders at all levels, and partner organizations.
- Secure and make the most of available resources.
- Measure and share progress and results.

"The best way to predict the future is to create it." -Peter Drucker

Contact Info:

**Paul Kuehnert
Associate Vice President - Program
(609)-627-6319
pkuehnert@rwjf.org
*Twitter: @PaulKuehnert***

References and contacts

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CATALYSTS
FOR CHANGE
Harnessing the Power of Nurses to
Build Population Health in the 21st Century

Executive Summary
September 2017

https://rwjf.ws/2prjD6X
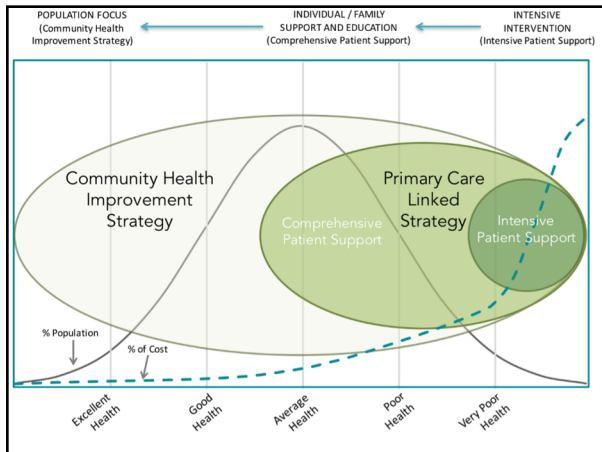
Working Definitions

Investments to Assure Vital Conditions — Properties of places and institutions that all people need regularly to be healthy and prevent threats to well-being.		Services to Address Urgent Needs — Services that anyone under adversity may need temporarily to regain or restore well-being.	
Education	Lifelong learning and literacy from early childhood through high school graduation and career (e.g., Head Start, Pre-K, K-12, job training, student loans)	Acute Care for Illness or Injury	Efforts to deliver acute and post-acute care for physical and mental illness (e.g. EMS, ER, acute hospitalization, trauma-informed care)
Jobs, Wages, Wealth	Efforts to foster economic development, access to well-paying jobs, and community wealth (e.g. living wage policies, employment programs, worker cooperatives, public transit)	Addiction & Recovery Services	Behavioral health care, substance abuse treatment, recovery from chemical dependency or addiction (e.g., AA, NA, Narcan, SBIRT, Recovery Homes)
Stable Housing	Efforts to assure permanent housing that is adequate, safe, and affordable (e.g., subsidies to construct/renovate affordable housing; mixed income design to avoid gentrification)	Criminal Justice, Violence, Emergencies	Efforts to identify, adjudicate, and enforce violations of the law (e.g., courts, jails, prison, parole); first responders in a crisis (e.g. fire, ambulance, 911, suicide hotline, poison control, emergency operations)
Safe Neighborhoods & Homes	Efforts to design and keep neighborhoods and homes safe from crime, injury, and violence (i.e. community-police partnerships, youth development, fire safety, lighting, greenspace, zoning)	Environmental Cleanup	Efforts to clean up hazards in air, water, soil, homes, workplaces, and communities (e.g., lead abatement)
Healthy Food	Efforts to assure easy access to affordable, nutritious food (e.g. school lunch, food labeling, transfat bans, fruit/veg discounts, farm-to-work programs)	Unemployment and Income Assistance	Assistance for those unemployed or disabled; supports for disadvantaged (e.g. TANF, energy assistance, childcare assistance); efforts to reduce hunger, food insecurity, and malnutrition (e.g., SNAP, WIC, food banks)

ReThink Health

PATHWAYS TO POPULATION HEALTH

Learn | Act | Improve | Join | About Us

An Invitation
to Health Care Change Agents

Join The Movement

https://www.pathways2pophealth.org/index.html

Slide 1

Working Definitions

Investments to Assure Vital Conditions		Services to Address Urgent Needs	
Properties of places and institutions that all people need regularly to be healthy and prevent threats to well-being		*Services that anyone under adversity may need temporarily to regain or restore well-being*	
Physical Activity	Efforts to enable routine physical activity (e.g. after school programs, physical education in school, land use planning, active transport, bike share programs)	**Homeless Services**	Short-term housing for the homeless (e.g. emergency shelters)
Healthy Environment	Efforts to protect clean air, water, soil; and to avoid extreme heat, flooding, wind, radiation (e.g., emission limits, carbon tax, toxic use bans, building codes)		
Public Transportation	Efforts to establish public transportation that assures access to jobs, active transport, and avoids environmental hazards (e.g., complete streets, light rail, reduce air pollution)		
Tobacco, Alcohol, Drug Prevention	Efforts to prevent substance abuse, either by preventing initiation or enhancing cessation of tobacco, alcohol, and other drugs		
Routine Care for Physical and Mental Health	Efforts to deliver routine preventive services and chronic disease management (e.g. preventive health care)		

Note: There may be complicated cascades where certain vital conditions prevent needs, and those needs are themselves conditions that prevent other needs.

ReThink Health

Slide 2

Working Definitions

Strategies to Build Civic Muscle
Strength to overcome inertia or resistance, alter the status quo, and generate more inclusive value for all.
Strategies to assure equity and social justice; democratic power to shape programs, policies, and common culture; eliminate stigma, discrimination, and oppression; counter ISMs; foster social connection; and develop inclusive leadership (e.g., human rights, civil rights, civic organizing, mutual accountability, leadership, transparency, governance, communications, measurement)

Laura Landy, President & CEO
Fannie E. Rippel Foundation
14 Maple Avenue, Suite 200
Morristown, NJ 07960

973 540 0101 ext. 301
973 540 0404 (fax)
www.rippelfoundation.org
llandy@rippelfoundation.org

ReThink Health

Slide 3

Michelle Horovitz
Executive Director
Appetite For Change
1200 West Broadway Ave #180
Minneapolis, MN 55411
michelle@afcmn.org
612-588-7611(w)
612-655-6791(c)

Tom O'Brien
Program Director
Neighborhood Connections
216.361.9269
tobrien@neighborhoodgrants.org

www.neighborhoodgrants.org
www.neighborhood-voice.com

Slide 1
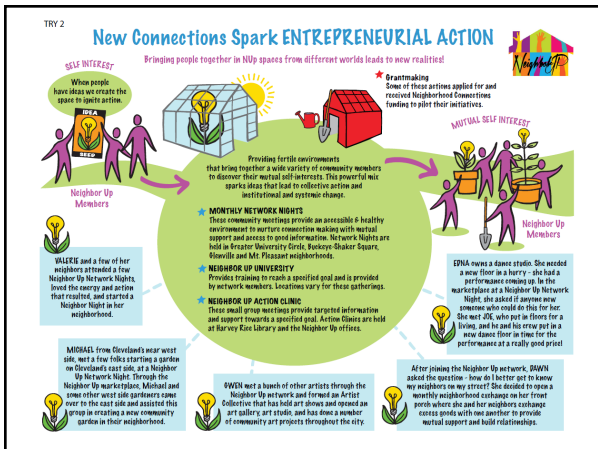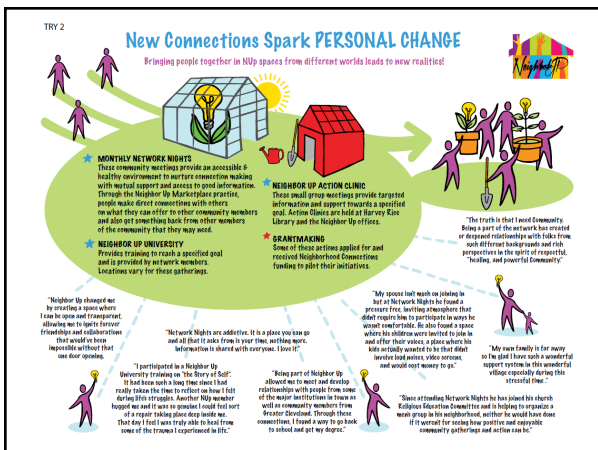
Capacity Building for Social Determinants of Health (SDOH)

Asset-Based Approaches

Leadership Development

Partnership and Inclusive Decision-Making

Measuring What Works

Capacity Building for SDOH and Health Equity

Culture and Attitudes

Organizational/ Institutional Capacity

Knowledge and Skill-Building

Health Impact Collaborative of Cook County
Working together for healthy communities.

HEALTHY CHICAGO HOSPITAL COLLABORATIVE

"**Capacity Building** generally refers to a process to increase the skills, infrastructure, and resources of individuals, organizations and communities."
CDC https://www.cdc.gov/hiv/programresources/capacitybuilding/

Aspen Institute, Measuring Community Capacity Building
http://www.iaced.org/wp-content/uploads/2016/05/Measuring_Community_Capacity_Building.pdf

California Endowment "Drivers of Change"
http://www.calendow.org/building-healthy-communities/

Communities in Action: Pathways to Health Equity
http://nationalacademies.org/hmd/reports/2017/communities-in-action-pathways-to-health-equity.aspx

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European Union, Building Capacity for Health Equity
http://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/Working-Document-5-Capacity-Building.pdf

Stakeholder Health "Transformative Partnership"
https://stakeholderhealth.org/the-movement/transformative-partnership/

Triple Aim for Health Equity http://www.astho.org/Health-Equity/2016-Challenge/Ehlinger-Commentary-Article/

100 Million Healthier Lives "Equity, the price of admission"
http://www.100mlives.org/approach-priorties/#healthequityandprosperity

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Slide 2

Jessica.Lynch@iphionline.org

ILLINOIS PUBLIC HEALTH INSTITUTE

ALLIANCE for HEALTH EQUITY | Hospitals and Communities Improving Health Across Chicago and Cook County