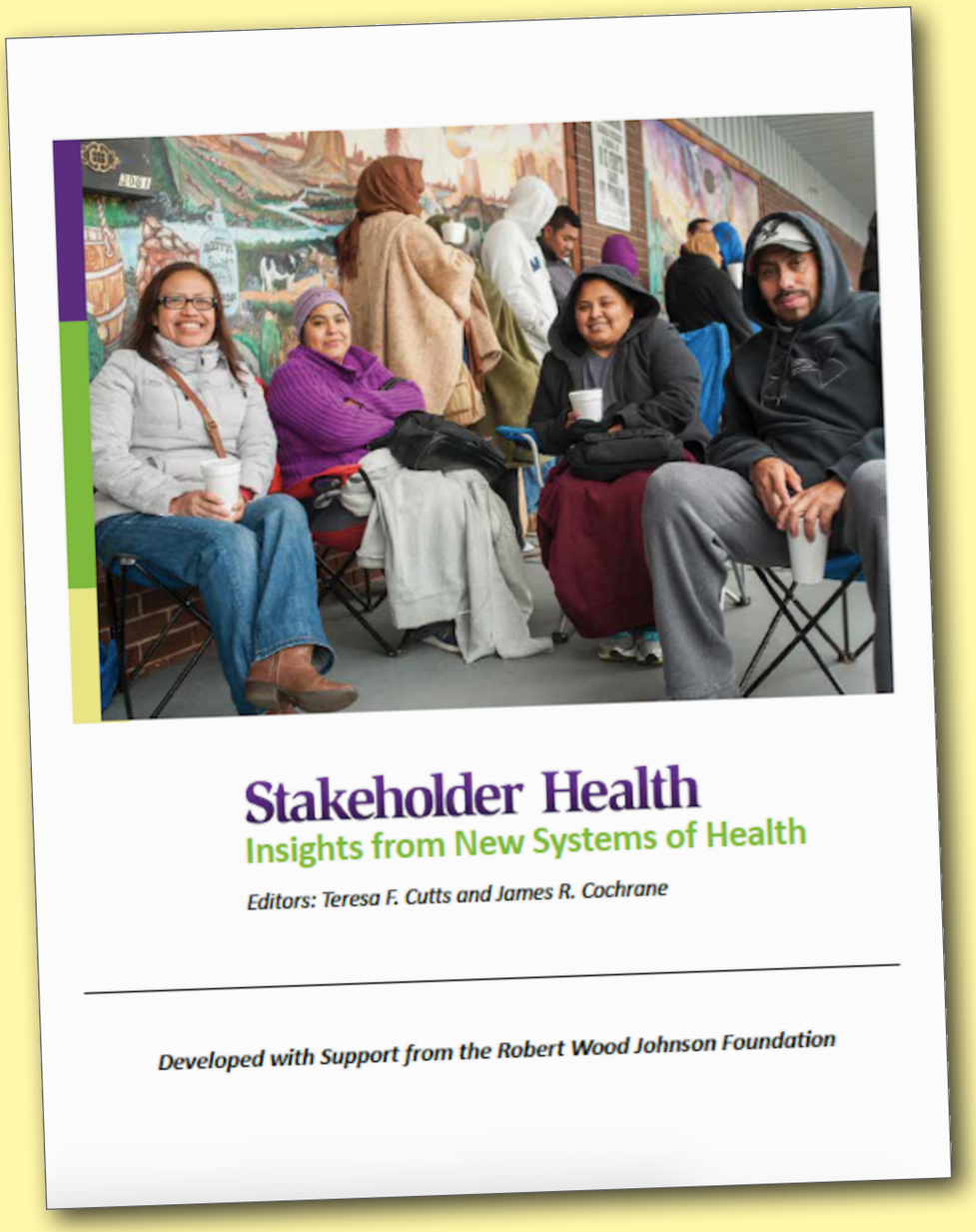
Hospitals & Social Drivers of Health

Hospitals & Social Drivers of Health

"The social drivers engage the role of a hospital not just as a provider of therapies but as a social presence—usually the largest social/political/economic structure in a community and region. This requires us to see ourselves from a community perspective."

Book Announcement!

Stakeholder Health: Insights from New Systems of Health



Stakeholder Health: Insights from New Systems of Health
Editors: Teresa F. Cutts and James R. Cochrane

$19.95

Stakeholder Health: Insights from New Systems of Health, developed with support from the Robert Wood Johnson Foundation, is a rich and detailed review of some of the best practices in the areas of community health improvement, as well as clinical and community partnerships, spanning 11 chapters.

The chapters range from a crisp review of the social determinants or drivers of health to leadership for new partnerships between health systems and communities, relational information technology, community health navigation, financial aspects of partnering with community in a new “social return on investment” model, leadership, implementing resiliency models integrated across hospitals and the broader community.

To Order Click HERE!

Hospitals & Social Drivers of Health

Table of Contents

www.stakeholderhealth.org

Mainsails & Social Drivers of Health

By Gary Gunderson

Perhaps you've met a human. You have probably noticed that we can be hard to help. Perhaps you've been to a planet like Earth and noticed the same thing, except in 7 billion different ways. How do you help something with 7 billion moving parts be healthier?

Advancing population health depends on understanding not just the medical problems, but the drivers of health… at community scale… over time. Those drivers are largely social and they are not determinants because none of the 7 billion of us

humans are determined. Words guide our imagination, shape our ability to talk about what to fear and what to hope for. So it is a big deal to see the 100 Million Lives Campaign leave "determinants" for "drivers."

It's important for anyone in any position to influence a single life to talk about life as changeable and choosable—but shaped by power drivers that have to be confronted. This is especially true for those in positions to influence the big social structures like hospitals or faith networks. Recently in Washington, DC, the Association of Academic Health Centers met to explore how their huge organizations can align themselves with the leading edge understanding of the social drivers of health. This is a huge shift for them— or us, as I am a VP of one. They brought in the big voices including none other than Dr. Michael Marmot the author of the stunningly powerful studies of social position over time, The Health Gap. And our friend Dr. Denise Koo, one of the principle forces behind the new array of useful tools emerging from the CDC such as the Community Health Improvement Navigator.

The closing panel of the whole conference was our "ground game" in Winston-Salem. This was explained and embodied by Jeremy Moseley, Wake Forest Baptist Health's Director of Community Engagement; and Annika Archie, the lead Supporter of Health. Dr. Teresa Cutts laid down the data beat like a bass player in a jazz ensemble. I had two minutes at the end to set a metaphor like a sail to catch the wind of the spirit moving where you wouldn't expect it.

Heading toward life

The social drivers engage the role of a hospital not just as a provider of therapies but as a social presence—usually the very largest social/political/economic structure in a community and region. This requires us to see ourselves from a community perspective: inside out and upside down. At Methodist Healthcare in Memphis we found ourselves in a covenant relationship with more than 600 congregations that pulled us inside out. In Winston-Salem we have followed the deeply grounded intelligence found in some of our lowest wage workers into relationships that are not just inside-out, but upside down or, better, right side up. We were steering toward life, not just away from death.

Proactive mercy is way cheaper than reactive charity. That's the whole and complete logic of "population health management." But if you don't understand the humans, you can't expect to be proactive. Being proactive depends on the intelligence about– and trust with– the neighborhoods where the costs of reactivity are concentrated. This requires not just the

preeminent brilliance of our surgeons, but of all 14,000 humans on the team. Wake Forest Baptist Health President and CEO Dr. John McConnell and Annika Archie embodied this new deep discovery in a recent video interview.

That's what works.

Mainsails, not anchors!

It is new for big organizations to hold ourselves accountable for social factors. That has always been on the side, a by-product, an unintended consequence. Now it's central. Some say we should think of ourselves as "anchor institutions," but that image reinforces our worst habits of domination. What could be worse than focusing on anchors of determinants? I'm depressed just typing it!

We should be mainsail organizations.

The mainsail is the large sail on a clipper ship low and strong that you leave up even amid the heaviest weather and hardest storm. This includes the storm-tattered neighborhoods you can see outside the windows of the urban medical center. You leave the mainsail up because in deep and heavy water you have to keep going or the waves will overwhelm you. The last thing you need is to drop an anchor. That's what you see in Annika, Jeremy, TC and their hundreds of colleagues setting themselves to catch the same wind of Spirit—surgeons, nurses, social workers and revenue cycle VP's– that share a hope and mission.

You can even hear it now from some our community partners, glad that we have finally joined them in their journey toward health. They don't want an anchor; they want to go somewhere new.

Last Saturday Wake Forest's Rev. Dr. Francis Rivers received the major award from the Hispanic League of Winston-Salem honoring him (and the FaithHealth team) for leaning way into the heavy seas of anti-immigrant venom surging currently in North Carolina in creating the ID Drive. Francis' award honored him, but also his mainsail organization—and not just the tiny part of it called FaithHealth. The medical center put up a big sail amid very heavy seas that helped other key institutions do their critical work. The Sheriff, the police, the DA, a network of churches called Love Out Loud, many Hispanic organizations and Que Pasa media). And don't forget the most important FaithAction—the small faith-based organization that does the actual work of validating identity so that an ID card can be issued and trusted.

Catch the wind

A fully rigged sailing ship is a complicated thing with many sails and miles of rigging. So, too, is any network of partners committed to helping their community move away from the rocks and into a safe harbor. But none of the partners could have stepped into the heavy wind themselves, much less alone. That role was for the mainsail and a ship built for deep water.

You might be so embarrassed by all the mean hateful things religious people are doing these days that you want to stop the metaphor right there. But you'd be leaving out the most interesting part of sailing—the wind. The sail doesn't have any power; it only catches the wind. Greek traces the same word for wind to breath and… Spirit.

We know in North Carolina that the Spirit can blow toward or away from the rocks; it depends on the skill of the sailors and the courage of those who climb up the rigging and set the sails. These are days filled with stupid religious venom, so I don't blame anyone who wants to move culture and institutions and society without faith. But nothing at cultural scale ever happens without Spirit blowing really hard. You can stay below decks and hope for the best. Or you can find someone who knows how to set a mainsail and head to deep water. Francis, Annika and the others on the edge, live way up in the rigging where the wind blows with raw power. They teach us to its respect power but not to fear.

Dr. King spoke realistically when he said "the arc of history bends toward justice." It is a slow bending curve, more tectonic than sharp. We don't choose this way or that but lend our days to the slow bend, helping each other keep courage for the long turning. We set our sails for heavy seas and a long arc toward a horizon worth the journey.

Images from Creative Commons. From top: Bonhams London, Krusenstern horrid (pink mainsails), Bonhams.

How Can Hospitals Impact Social Drivers of Health?

By Marice Ashe, Dora Barilla, Eileen Barsi and Stephanie Cihon

Achieving the Triple Aim of improved experience of care, reducing per capita cost of care, and improving the health of populations, not to mention paying attention to SH's "quadruple aim" that includes equity, requires engaging in the hard work of changing the systems driving preventable diseases and avoidable costs.

The good news: You are not alone when you seek to find ways to go beyond the limits of traditional institutional boundaries and responsibilities. Many resources are available to help get the job done and innovations are underway that help. The most effective interventions to drive population health improvement—those at the bottom of the Health Impact Pyramid—cannot be achieved by the health sector alone. They require new kinds of partnership with people and organizations in communities in collaboration with multiple government agencies and non-governmental sectors outside of the health sectors' immediate areas of influence or expertise. Evidence for this integration of issues across traditional silos is found throughout academic literature and increasingly through successes in the field.

Hospitals Can Support Public Policies that Enhance Community Health

Public policy is your best friend. Think about it. Public policy largely determines what happens base level of the Health Impact Pyramid: housing affordability; the quality of local school systems; whether there is access to healthy foods, safe places to walk and play, or smoke-free environments. Every state in the nation can develop public policies based on a Health in All Policies model that ensure the default conditions in which people live are healthy. Most local governments can augment the baseline state rules to tailor public policies so they are even more reflective of local health needs and priorities, too. Hospitals are in a key position to ensure that the public policies in the communities they serve work for rather than against popu-

lation health. While this is not necessarily an easy task, it remains a crucial role that is within leaders' competency, running a key social institution.

The good news is that the ChangeLab Solutions website offers a large library of free resources designed exactly to support the policy changes needed to address the social determinants of health. The model policy solutions are a great starting place to find what is needed to create a just, vital and thriving community. Likewise, the "What Works for Health" section of the County Health Rankings website also highlights explicit multi-sector policy, programs and systems changes, all reviewed and curated for level of evidence supporting the recommendations.

Hospitals can Creatively Leverage Partnerships

Partnerships are everywhere and leadership opportunities abound. As anchor institutions driving large portions of local economic activity, hospitals enjoy significant economic and political clout, and have a diverse array of strong allies that can be mobilized to ensure that healthy public policies are the norm. Non-traditional and innovative partnerships across government agencies and multiple sectors of civic life are the new norm to achieve population health. Hospitals are able to exert wonderfully creative leadership in the multiple sectors of civic life—business, economic development, education, faith and more—that can ensure the health message is heard and acted upon by decision-makers.

Hospitals Can Engage Local Residents

One of the most potent partner groups that hospitals can engage are local residents, who are deeply invested in the health and well-being of their neighborhoods, agencies and citizens. Hospital leadership who take the time to truly know and understand the local residents served by a hospital and respond to what information or needs are shared, can enrich community health needs assessment, provide useful data for strategic planning, as well as help health systems do a better job serving patients and families. Such partnerships can yield both improved community health outcomes in the long-run and improved margins in caring for vulnerable populations in the short-term.

Hospitals Can Implement Best Practice Models

Scientific research is rich and best practices are abundant. An enormous array of readily available resources are at your fingertips—especially related to the 4th tier of the pyramid

in changing the context so that default conditions lead to health rather than disease:

- National Prevention Strategy: This guides our nation to the most effective and achievable means for improving health and well-being. The Strategy prioritizes prevention by integrating recommendations and actions across multiple settings to improve health and save lives. It provides a strong foundation for all prevention efforts and provides evidenced-based recommendations that are most likely to reduce the burden of the leading causes of preventable death and major illness.

- CDC Community Guide to Preventive Services **and** Community Health Improvement Navigator: The Guide to Community Preventive Services is a free resource to help you choose programs and policies to improve health and prevent disease in your community. Systematic reviews are used to answer these questions:

- Which program and policy interventions have been proven effective?

- Are there effective interventions that are right for my community?

- What might effective interventions cost; what is the likely return on investment?The CDC Community Health Improvement Navigator is a website for people who lead or participate in CHI work within hospitals and health systems, public health agencies, and other community organizations. It is a one-stop-shop that offers community stakeholders expert-vetted tools and resources for:• Depicting visually the who, what, where, and how of improving community health

- Making the case for collaborative approaches to community health improvement

- Establishing and maintaining effective collaborations

- Finding interventions that have the greatest impact on health and well-being for all.

Adapted from Stakeholder Health: Insights From New Systems of Health, edited by Teresa Cutts and James Cochrane.

Artwork: "What?", Véronique Debord-Lazaro, Creative Commons

Q & A: Soma Stout of 100 Million Healthier Lives

Soma Stout, MD, MS is the Executive External Lead for Health Improvement for the Institute for Healthcare Improvement and serves as Executive Lead of 100 Million Healthier Lives, which brings together hundreds of partners across communities to support 100 million people globally to live healthier lives by 2020. She also directs the Innovation Fellows Program at the Harvard Medical School Center for Primary Care and is Lead Transformation Adviser at the Cambridge Health Alliance (CHA).

Dr. Stout is deeply committed to improving the health and wellbeing of underserved people and communities and has worked as a primary care doctor in the safety net for over 15 years. Previously, she served as Vice President for Patient Centered Medical Home Development at CHA, where she led a whole system transformation that garnered numerous national awards for achieving breakthrough results in the Triple Aim. In 2012, she was awarded the Robert Wood Johnson Foundation Young Leader Award for her contributions to improving the health of the nation.

Interview by Gary Gunderson.

Stakeholder: Let's start with a little bit about your background.

Stout: I began on this journey to figure out what it takes to support well-being and people in less fortunate communities when I was a kid growing up in India in a family that made about ten dollars a month. My mom had an amazing ability to see the gifts that people have and to build on strengths and to develop a sense of service. In India every night I would see from the veranda people on the streets or living in shanty-towns with no electricity. I didn't see them when I first came

to the U.S., but when I got to Harvard for my undergrad, I suddenly saw them again and I didn't understand. I understood why they were there in India. Poor people had moved from the villages often together as families and you put people in relationship with one another. You didn't think there was something wrong with them because they were poor.

Whereas in the U.S. when I began talking with the homeless men and women of Harvard Square and hearing their stories it became clear that poverty in the U.S. is very different. It was a poverty of social isolation, stigma, and mental health issues. Also, it seemed like something was fundamentally missing in a system in the wealthiest country, outside the wealthiest university in the world. A simple technology like housing hadn't been equitably distributed. I loved molecular biology and could imagine making wonderful contributions developing new therapies but I couldn't be confident that those technologies would be equitably distributed either. So I became interested in understanding what decisions lead to communities that are thriving, especially in places that have historically not had a great deal.

I ended up getting my public health background in the UC-Berkeley/UCSF joint medical program. Along with my medical degree, I was in Guyana learning from the second poorest country in the Western Hemisphere with a non-governmental organization that had only a little health background and an enormous amount of knowledge gained from the community's approaches to social and economic development. They saw that the purpose of development was to unlock the capacity within those communities to create health and well-being for themselves. These communities didn't have a lot materially but they had a deep and coherent sense of what it meant to be a community. They understood that health wasn't something that somebody else delivered to them but rather something that they needed to create for one another.

All the rest of my career has been applying those core principles that understood people and communities as noble, as having enormous gifts and trapped and untapped potential that could be released through effective processes. And that you didn't have to know the answers at the beginning, you just have to have a humble spirit of learning and improvement and a willingness to change to do what was needed.

I came back to the Boston area for my residency. In my first job out of residency, I was asked to start a new community health center in one of the Harvard Health System's Cambridge Health Alliances and within six months was asked to also take over the hospital of service. I didn't know that you were not supposed to do that in partnership with communities, so from the very beginning we worked with our local health departments and community-based organizations to address things in the community. Within a couple of years applying the methods that I had learned in Guyana we created what became a national model.

I was elected the president of the medical staff when Massachusetts' healthcare reform financing shifts happened, and our system had to figure out how to survive them. In that moment of survival, instead of focusing only on what was going wrong, we decided to create a vision of what we wanted to be in 2015. We applied those skills from Guyana and it took us on a journey to think about — as a public health system, working with two hospitals and twelve community health departments — what it meant to improve the well-being of a population that had historically had poor health outcomes because of the social drivers of health.

I quickly realized that it was the social and behavioral drivers of health that were creating the poor health outcomes. What was crazy was how easy it was to get to outcomes, both within the community of Revere and Everett and across the entire 130,000 people we served. We were able to take 10 percent of costs out and improve health and well-being outcomes substantially. You know, mostly because we created changes from the population up rather than from our own theory about what it took to create change and again applying those principles that I had learned in Guyana.

It was really that same journey — once I realized that it was those determinants — it became clear that that's not how most people were thinking about health care reform. So I began to wonder what it would be like as we saw people having that same "ah-ha" moment across places. What would it be like to be a community of people working together to learn what it looks like to improve health and well-being in our country and scale? That was what brought me to 100 Million Healthier Lives, which I now serve as executive over at IHI.

Stakeholder: One of the hallmarks of the 100 Million Healthier Lives effort has been an explicit respect for the potential of the younger leaders, the ones who still think of themselves as students. Would you share what you learned about transformation from the 3,000 students who were part of your experience in Guyana?

Stout: I was a student when I got to Guyana, and they used me as a person coming in from the outside who could give a different point of view. I was convinced that I would have no value to them and that it would just be me learning — and I still maintain that it was 90 percent me gaining value and 10 percent them gaining value. What was remarkable was seeing that my insights could be useful. I could notice that if the program depended on people coming in from the outside, and if the capacity of people to take over the program wasn't developed, that it wouldn't be sustainable. I could notice that they had only up to a fifth-grade education and that meant teachers went up only to the fifth grade and then went back to teach the kids. This system of trickle-down education over the generations didn't necessarily lead to great health outcomes. So there were contributions that I could make as a student.

Similarly, there were community health workers, villagers, and teachers with no more than a fifth-grade education who had brilliant ideas about how to improve health. When those

community members took over the development process that you began to see things like malaria rates decrease by 90 percent while eliminating malnutrition among widows. They figured out how to remove — absolutely eliminate — acquired developmental delay. I realized that it wasn't the experts who figured out how to do that, it was the people who came to it with a different perspective, who actually weren't burdened by too much of an idea of what the solutions were. They actually looked at what was going on and created the local solutions. I came to value those fresh perspectives of people who didn't have the traditional view because, frankly, if the traditional view could have solved it, it probably would already be solved.

So at the Cambridge Health Alliance, we had students — from engineering students to art students to college students to high school students — from all over the greater Boston area who came in and shadowed patients and worked with them to create plans. This was a phenomenal way to showcase a rich resource in the greater Boston area, that actually that all communities have. And those students made dramatic improvements. So when we got into 100 Million Healthier Lives it was important to have students play that role of being curious and being young enough to not be afraid to ask the hard questions or just a different question and wonder what a different answer might be.

Stakeholder: 100 Million has been careful with vocabulary and language. What's striking is the increased sharpness, which is aspirational. And the shift from determinants of health to drivers of health is indicative of that. Can you unpack what that means?

Stout: We shifted from determinants to drivers because we place a high value on bringing in people with lived experience. Say you're working on homelessness. A person who has been homeless has a much better understanding of the systems that support homelessness than any professional in any one of the agencies. When you value the expertise that people with lived experience have, you suddenly see language differently. So if you're saying something is a determinant that means there's no choice, that something has been determined for people. I know that we use the word determinant as a way of saying "let's not blame the individual," and we have tried to shift to language that is generative and that creates space and potential for people to grow. The shift to driver is very much about that. It communicates that this is driving an outcome — it's sort of like trying to go up on a down escalator — it's driving but people still have a way of addressing it. And maybe if we're able to change the system we can get it to go up instead of down.

Stakeholder: Can you tell us about the goal of 100 million people living healthier lives by 2020?

Stout: For us it was a way of creating a goal that was so large that we couldn't continue business as usual. No one organization could achieve it alone, which meant that we had to learn how to work together, because that was one of the gaps that we saw. Everyone was trying to create health but in their own silo, and lots of people were falling through the cracks of our various silos. The real goal with 100 Million was to change our mindset, to change the way we think and act to improve health, wellness, and equity. Most people don't think their way to a new way of thinking; they actually act their way to a new way of thinking.

So, the other piece was to create a goal that would inspire and incite a critical mass of people in our country to think differently and acting differently. So while there's action — what could you do that would help 100 million people live healthier lives by 2020 — but in doing that action, there are a whole set of new behaviors and ways of thinking, whether it's about social drivers or about how you partner with people with lived experience or co-designing and valuing what people, like community health workers or school kids might have to contribute to creating solutions.

Stakeholder: You use the metaphor of "escape velocity." Can you tell us what that means in this context?

Stout: We spent a year talking with people about what it would mean for us to have a shift in the country. We looked at where have people done this before and found a helpful example in the space program where John F. Kennedy set a goal of

landing a man on the moon and bringing him back home safely within a decade. We spoke with Jim Hester, who had been an early sort of intern in the space program, an actual rocket scientist. He told us when they set that goal, they set it as an audacious goal. They didn't have the technology worked out. They didn't even have NASA, but by setting that goal, it inspired them to create NASA. It brought together scientists and people who were working in a huge number of fields to put their pieces together, to try things, see what happened, and then try again. So it helped them break out of gravity. And the first stage of that was to achieve escape velocity, to escape the forces of gravity that would move you from the earth at least into orbit around the earth.

That felt important, because people have been thinking about how to improve health for decades. Hundreds of groups working in the U.S. alone are thinking about that. But we weren't working together effectively, nor did we have that kind of goal. So that idea of working together to break free of gravity was the idea behind escape velocity.

Stakeholder: 100 Million Lives meetings are full of extraordinary, aspirational thinking. It's catching and you see people behaving differently towards each other. But it's striking that this is happening during the most polarized, mean-spirited public discourse in history.

Stout: Every action creates an equal and opposite reaction. That's a law of physics, right? We need a different narrative. We are at a place where extreme wealth and poverty, where changes in social class and their implications in social class on health and well-being have reached a critical point. Discourses of anger and loss and zero-sum game begin with some people winning and some people losing.

You counteract that discourse not by arguing against it but by creating a different model, to see ourselves as abundant. We recently spent four days in Oklahoma City with 100 people from all walks of life — from librarians and teachers and health system innovators to businesses — thinking together about equity. We grounded ourselves in what we know about the discourse and equity but then created a vision that equity isn't the goal, the goal is the interconnectedness of the human consciousness.

What does it look like to move from a discourse about pathology to a vision of interconnectedness, of the possibility that can be released? The bright spot stories created hope and belief in something. It was amazing. And by the end of the session we watched person after person reframe their thinking to be about human interconnectedness. What we're building the foundation for is that interconnected human consciousness and it was amazing to watch how it created a much more whole discourse on equity that wasn't about anger about a black and white conversation nor was it about a historic anger and injustice, though those were acknowledged up-front, nor was it about white privilege only and leading to white guilt and shame, but rather a call for all of us to become conscious together and create a solution that didn't require us to keep thinking in black and white as we move toward that solution.

Stakeholder: What I experienced at 100 Million Healthier Lives was the embrace of the possibility of being a sharply defined alternative view of what's possible without bringing with it, sort of a conflict or even some of the pride of difference that you commonly see in other groups. So there's the non-conflicting but very clear alternative voice that's actually very compelling and very invitational.

Stout: We celebrate diversity as we would celebrate flowers in a garden that have many different colors — it makes the garden more beautiful. It's not that we want everything to be one color. We invite the diversity of thought, the approaches of people and their cultures — we had an impromptu Native American ceremony on the last day — people brought their whole selves and felt welcome to do that, but it was founded in this understanding of our common humanity. Our job is to create the narrative of what it means to be united in our diversity, what it means to recognize interconnectedness and create a whole different way of thinking.

Stakeholder: 100 Million talks about co-design. Where do the fields of co-design and improving the

health of the public intersect? And why is it important?

Stout: Plenty of efforts by people to improve health for those who don't have it have failed globally. We have tons of evidence that that doesn't work. There's no reason to replicate that experiment and think we will get to a different outcome — that's the definition of insanity. So we begin with the understanding that if we're going to have any hope of getting a different outcome, it has to be informed by people who are living in that. That's one of the five core principles of 100 Million, partnering with people with lived experience.

An example of how we do that is leading from within, which is our inner work of leadership leading together, which is really what it means to see and understand where each other is and to collaborate toward common, shared goals together, leveraging each other's assets, leading for outcomes and equity. In leading for outcomes we say the three buckets of skills are the skills of design and co-design, the skills of improvement science, and the skills of implementation or knowing how to make the path easier.

For design and co-design, we teach skills and practices where people begin by grounding themselves in what's actually happening. This is something we did, for instance, in Oklahoma City. Instead of sitting in a boardroom and thinking about a how to solve a problem, you actually look at the data to understand who is thriving and who isn't within the same population. And you actually go out, walking people's footsteps and understanding what's happening.

You hear stories. We listened to the story of someone who had been in and out of prison for 20 years as part of a school-to-prison pipeline in Chicago and used that story to understand the system that was producing that result. We just listened deeply to the story and then broke it down to understand people from across perspectives. There were people who had lived that experience alongside people who might be a mayor or a health system leader or a community leader sitting at the

table together. They were using things like silent idea generation so that one voice doesn't dominate.

And within an hour they created one of the most coherent maps you could imagine of what the system looked like, what the different interacting systems were, where the barriers were, where the opportunities for interruption might be, where there were assets that might be leveraged, what critical strategic partnerships might help to interrupt the system, and where there were bright spots and evidence of where people might have figured out how to interrupt part of the cycle.

Start first with what's happening with real people in real neighborhoods. Actually look at seven example lives, people who have agreed to share. Ninety percent of the data and the insight probably lies right there. Generate solutions from a wide range of voices and through methods that allow people to come up with unlikely solutions. Where we are stuck and not moving further, we usually need the unlikely things. And you just can't get unlikely thinking with the usual people with the usual powers.

Stakeholder: When you are talking about 100 million people, with so many bright spots, how do give them all a sense of cohesion?

Stout: First, we're inviting people to put that in a Bright Spot Library using iMap. Everyone has bright spots, they're just all scattered in different publications and what we would love is to have those put in one place.

Second, bright spots don't usually spread in the absence of relationships, so we're also helping people find generative centers for learning as they need them. Our idea of Hubs is to help people find an area where they want to learn, they can connect with others who may have developed bright spots in that area.

The third thing, as people have said what they're doing — for instance, around addressing opioid overdose or incarceration — we're creating maps of the system we're tying in what bright spots exist to interrupt a particular part of the system alongside it with links to those particular programs.

Link to 100 Million Healthier Lives.

Art: Creative Commons, Farbfeld-Marerei. Gmhofmann

Dignity Health: Reaching the underserved through innovation

By Les Gura

Like providers nationally, California-based Dignity Health has adapted its care delivery system to adjust to the requirements of the Affordable Care Act.

But Dignity Health has done so with an innovative and diverse array of programs spread across its 40 hospitals in California, Arizona and Nevada. The non-profit, with 60,000 caregivers and staff members, is the fifth-largest health care system in the nation.

Addressing the social drivers of health

Pablo Bravo (pictured at right), Dignity's vice president of community affairs, says the expansion of outreach programs was important to reach underserved populations.

"With the passage of the Affordable Care Act, the whole industry is really looking at population health management," Bravo says. "That being the goal, what we want to do outside in the community is really create the support of structures—or support other structures already in place—to be able to address these issues in the community before individuals land in the hospital or go to a doctor and get bad news.

"And we want to be able to address these issues with our partners in the community."

Dignity Health's multifaceted approach to improving population health includes:

- Loans made at below-market interest rates to non-profits working to improve health and quality of life in the community.
- Grant programs addressing community health needs collaboratively with non-profits.
- Programs that promote sustainability and a healthy environment.
- Co-sponsoring a Learning and Outreach Center in Bakersfield, California, that touches the needs of hundreds of families with programs for children, families in need and the elderly.

"The ultimate goal is really to address health issues identified in communities through Community Health Needs Assessments," Bravo says. "Issues such as asthma and chronic disease, homelessness. We try to target resources to those popula-

tions, and use 'hotspotting,' which can track people in certain ZIP codes."

Investing in social innovation

One example of Dignity Health's work to reach underserved populations is a new social innovations grant program. Dignity Health offered a total of $700,000 in grants to organizations that proposed innovative ways to address health.

Meredith Barrett is vice president of science and research for Propeller Health, a company that has developed a device to improve management of respiratory disease.

The company puts a sensor on asthma inhalers that can track adherence to use of inhalers by individuals. The goal is to give care providers information about when people are struggling with asthma so they can be assisted before a crisis lands them in an emergency department.

"It's a small little cap that fits on top of a dose inhaler," she says. "We're able to passively and objectively track where and when people are using their medications."

Propeller Health already has completed a randomized study with Dignity Health's support in Sacramento and Woodland, California, two areas where a large number of people suffer from asthma. Now, a social innovation grant from Dignity Health is helping pay for a new study in Bakersfield that is targeted toward tracking inhaler use among children and adolescents.

"Dignity has been a leader in the field of how to incorporate technology," Barrett says. "They're interested in addressing environmental exposures and serving underserved populations, so they've been a really great partner."

Looking upstream

Bravo says Dignity will continue to seek out projects that can address big-picture health concerns, especially among the underserved.

"We funded a project in the Central Valley (of California) to address water purification; the drought has caused a lot of issues with access to clean water. We funded a project that addresses the high use of the emergency department by the homeless.

"We're identifying populations and trying to steer our programs to them," Bravo says. "The idea is we're looking upstream and seeing what's triggering health issues so we can possibly make a change."

Video: A Healthy Tomorrow

Dr. Sanne Magnan uses a video to help start community conversations. “With partners Twin Cities Public Television, Citizens League and the Bush Foundation, we facilitated conversations between health care providers, citizens and community stakeholders on the Triple Aim.”

“Included was a conversation starter video, ‘A Healthy Tomorrow,’” said Magnan, former president and CEO of the Institute for Clinical Systems Improvement. “In a somewhat humorous way, it illustrates the social determinants of health and shows how rising health care costs are taking money away from education, housing, walkable communities, and so on—and why we should care.”

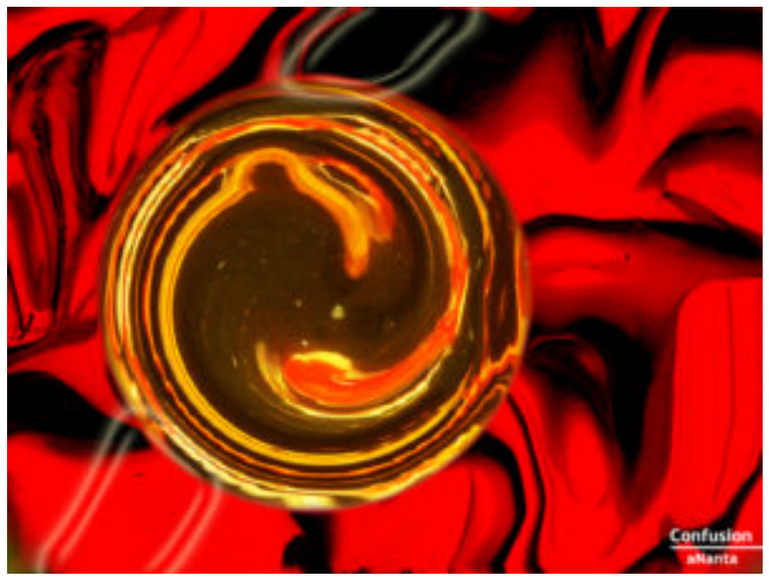
“If you talk with people about their preferences, you get insight, support and commitment for better outcomes,” says Magnan. “A conversation with the community is going to be messy, but it will tap into everyday people’s perspectives on physical, mental, spiritual and social well being.”

“We in health care are so entrenched in our systems that we often don’t know how to solve some of our most perplexing challenges, but community groups have the wisdom and resources to help,” she says. “Some clinicians are finding new ways to engage with their patients that reach beyond the snapshot they get in the exam room and the prescription pad. They’re realizing they can be more effective and have greater impact if they collaborate with others in the community.”

Links: Social Determinants of Health

Compiled by Molly Miller

The concept of social drivers of health can be difficult to wrap one's head around, especially if you are just starting to research or work in the field of population health. After all, social determinants of health include an overwhelming number of variables, ranging from place to race and from income-level to educational attainment. Below, we have included some of the best resources for developing a strong understanding of social drivers of health and how they can be incorporated into your work.



Videos

Armando Hasudungan, "Global Hands – Social Determinants of Health" – This short video provides an overview of exactly what social determinants/social drivers of health are and how they can be improved through engaging drawings and clear narration.

TEDx Talks, "Social Determinants of Health: Claire Pomeroy at TEDxUCDavis" – This video features a TEDx talk from Claire Pomeroy, who describes her personal experience of dealing with the social determinants of health while living on the streets and bouncing through the foster care system as a child as well as the reasons why individuals should focus on lifting up those who have the least among us.

Articles & Reports

ChangeLab Solutions, "Partners for Public Health: Working with Local, State, and Federal Agencies to Create Healthier Communities," 2010 – This report, published by ChangeLab Solutions, provides information about ways in which community advocates who are interested in working to improve the social drivers of health can form partnerships with different levels of government.

Ted Howard and Tyler Norris, "Can Hospitals Heal America's Communities?," 2015 – This report, published by **The Democracy Collaborative**, examines the role of hospitals in creating healthy communities and argues for an "anchor mission" for hospital s that focuses on addressing social determinants of health in their business and non-clinical practices as well as in their clinical practices.

Other Resources

Centers for Disease Control and Prevention, "CDC Community Health Improvement Navigator," 2015 – The Community Improvement Navigator website provides a variety of resources for how community health advocates can work to make changes in their community's social determinants of health.

Robert Wood Johnson Foundation, "County Health Rankings & Roadmaps: Building a Culture of Health, County by County – RWJF's County Health Rankings are updated annually with up-to-date statistics on important social drivers of health. Their interactive website allows users to drill-down to the county level *and* provides roadmaps for how those who are interested in improving the health of their counties can do so successfully.

www.stakeholderhealth.org