

Socially Determined: Moving Chronic Disease Programs to Public Health 3.0

From What and Why to How

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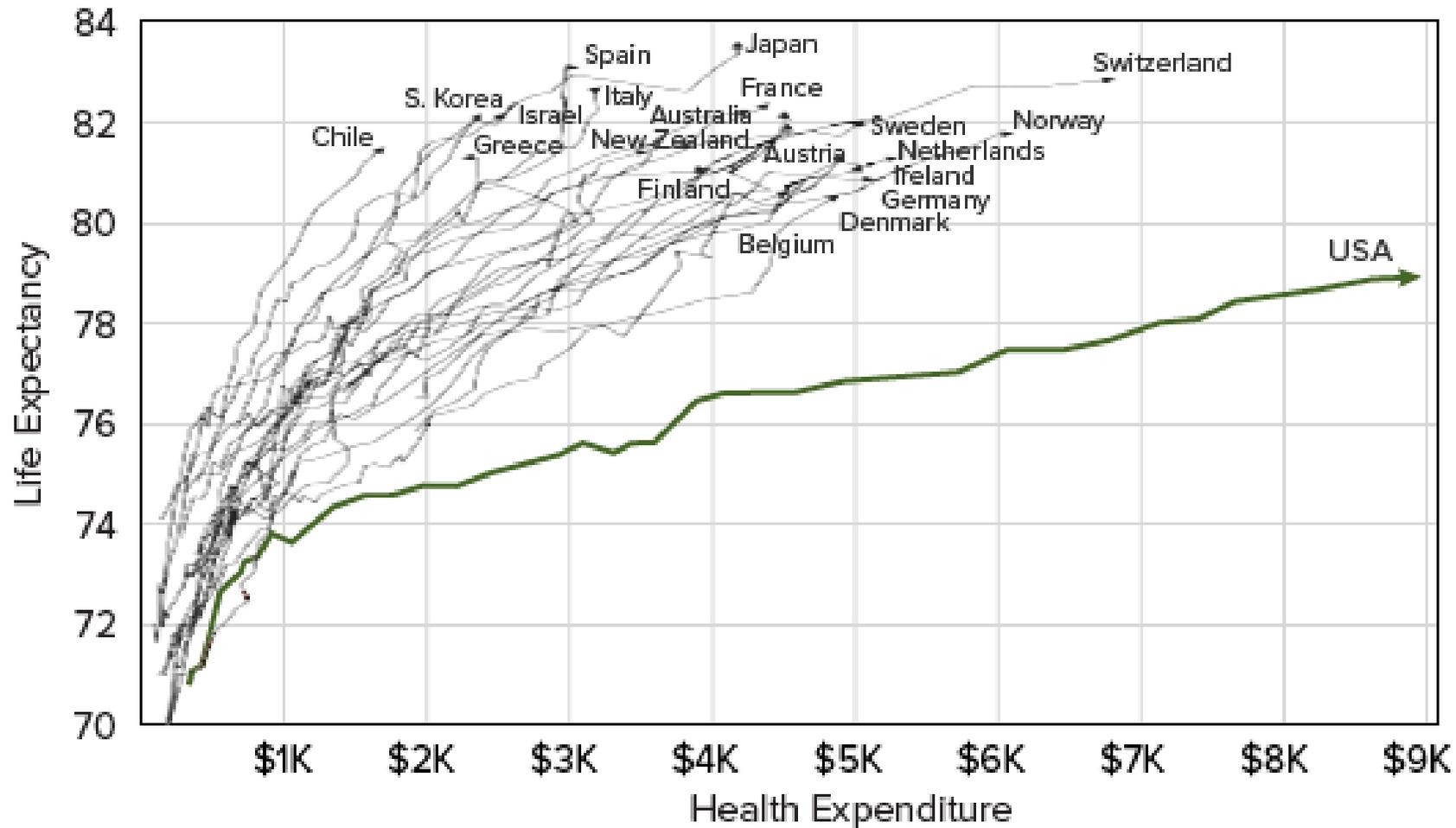


NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS

Chronic Disease Academy

U.S. Life Expectancy vs. Health Expenditure

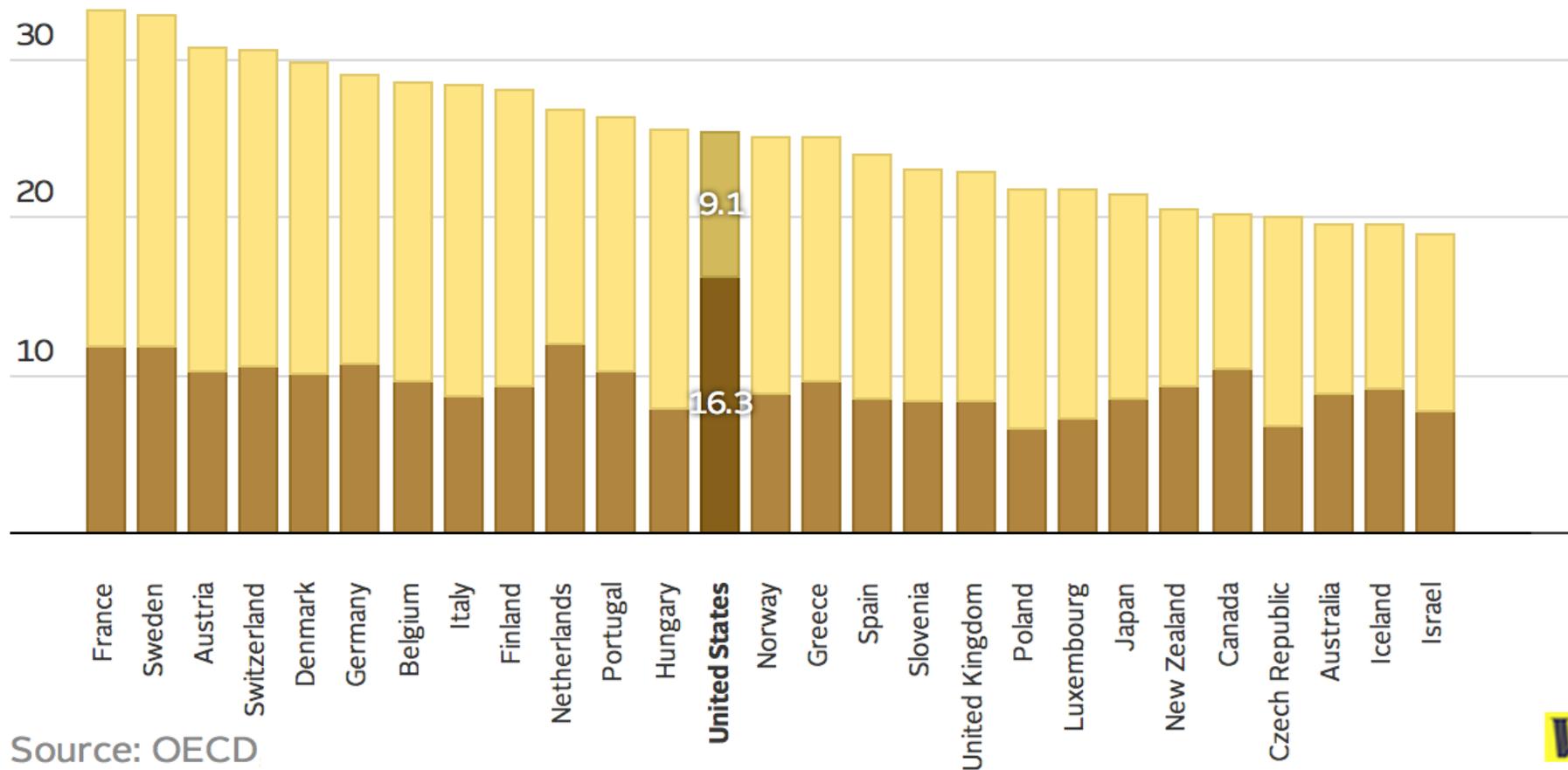
From 1970 to 2014, citizens of OECD countries have outlived their American counterparts – for a fraction of the associated costs.



Source: Visual Capitalist

The U.S. is an anomaly in health and social spending patterns

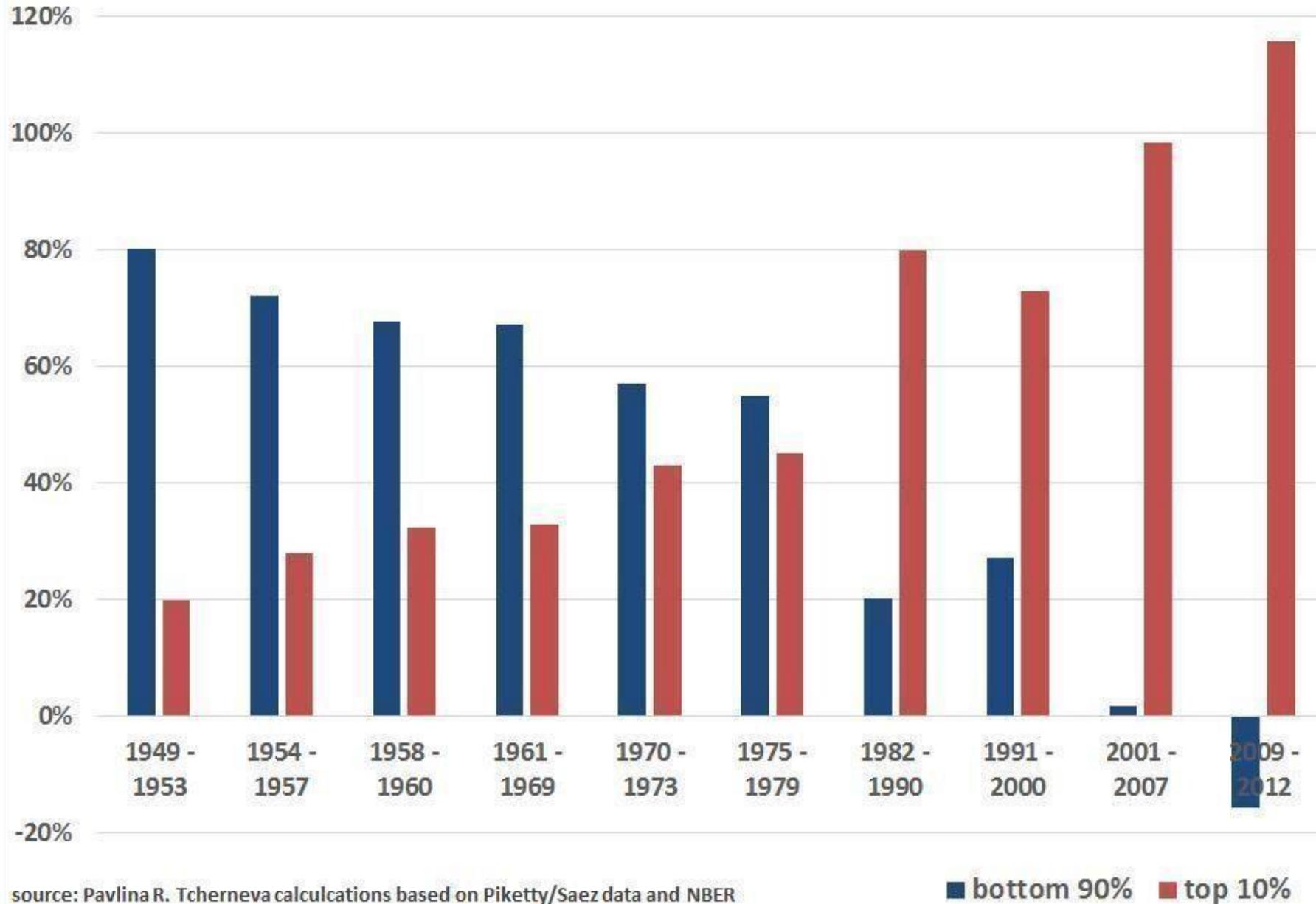
■ Health expenditures as % of GDP ■ Social service expenditures as % of GDP



Source: OECD



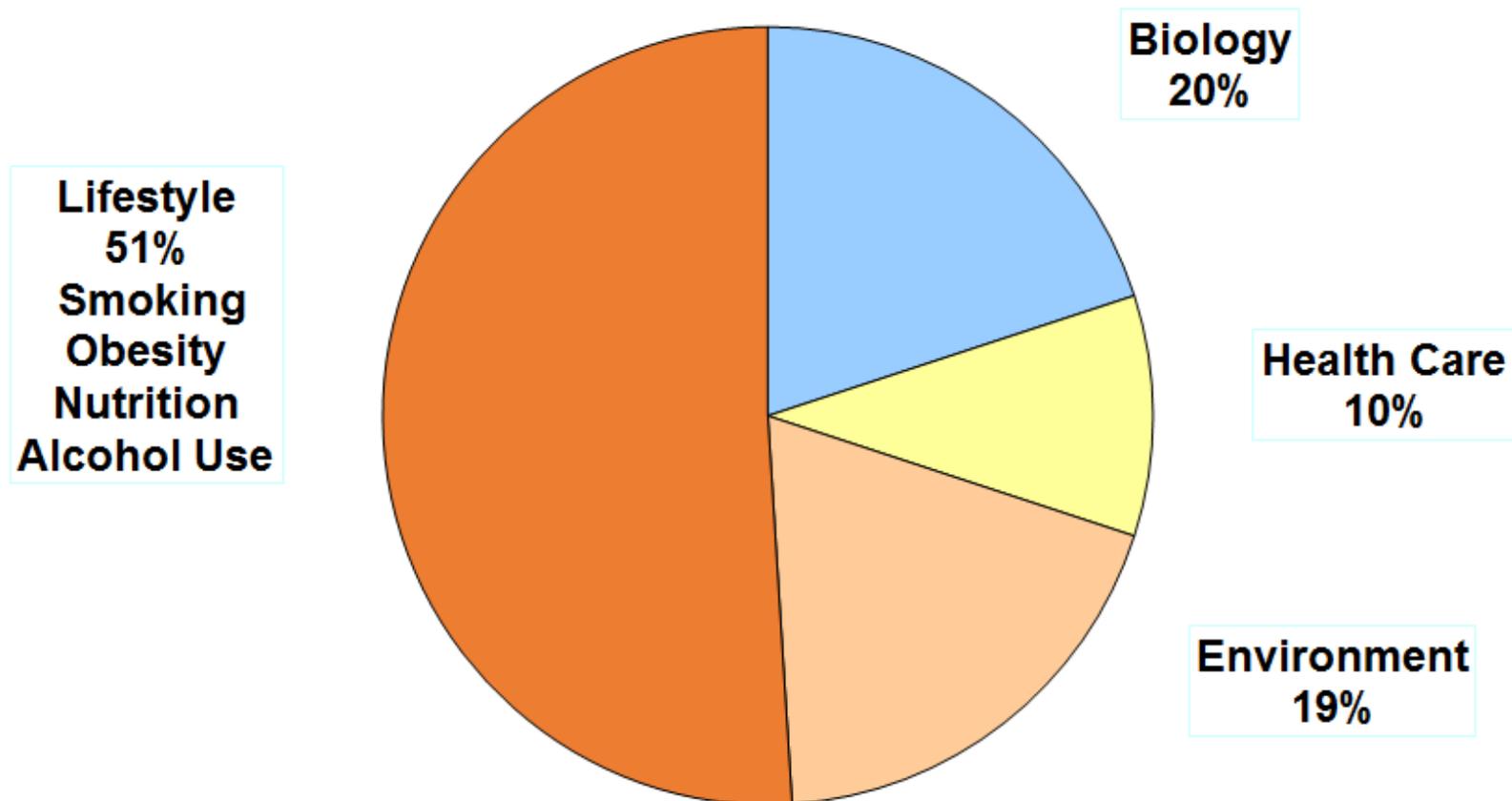
Distribution of Average Income Growth During Expansions



source: Pavlina R. Tcherneva calculations based on Piketty/Saez data and NBER

■ bottom 90% ■ top 10%

Factors Influencing Health Status



Source: McGinnis, J.M and Foege, W.H. (1993). "Actual Causes of Death in the United States," Journal of the American Medical Association.

Future Directions for Public Health

Public Health 1.0

- Infection control through treatment - TB
- Clinical preventive measures – immunizations

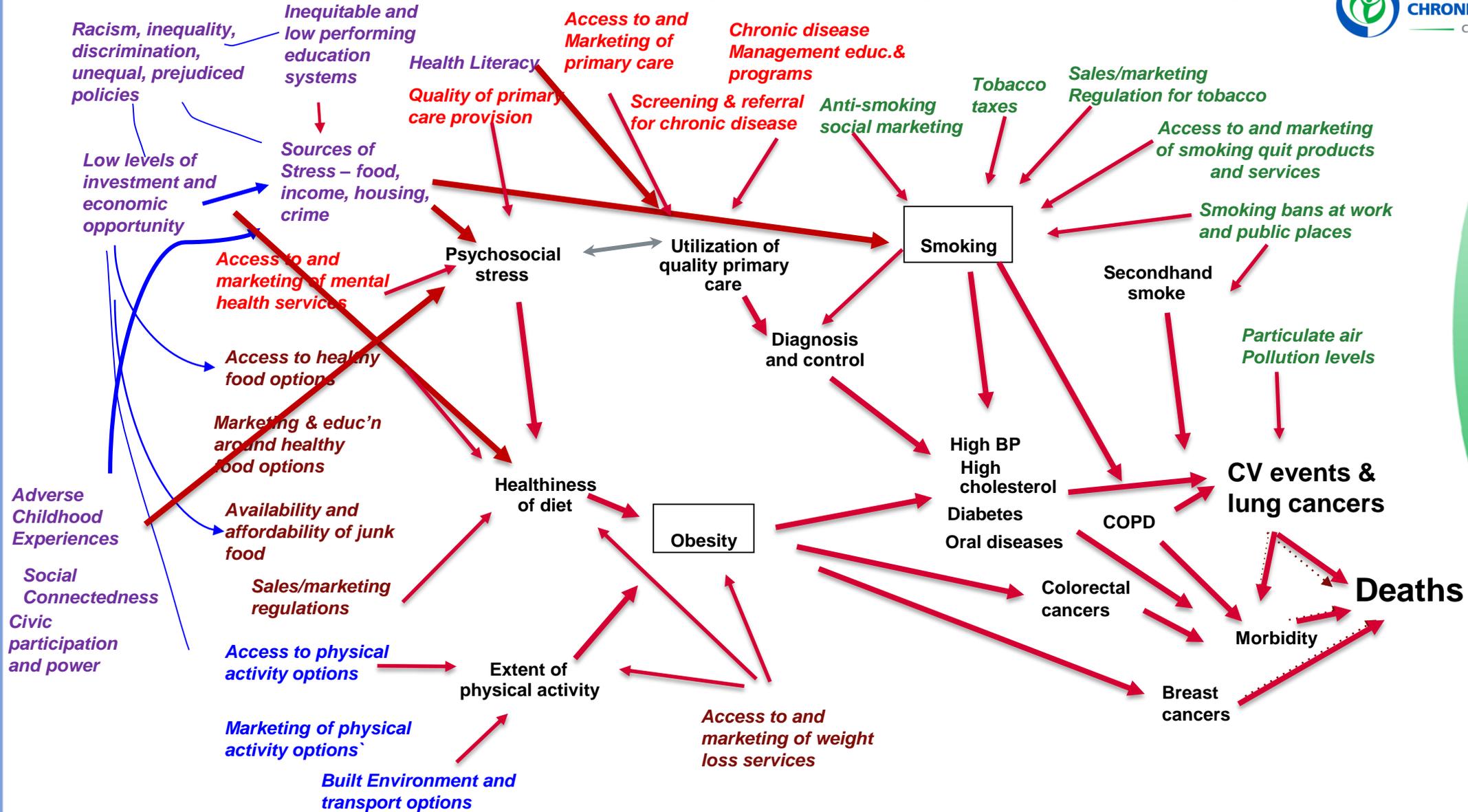
Public Health 2.0

- Policy and environmental change – seatbelts, tobacco tax
- Systems building – Diabetes Prevention Program

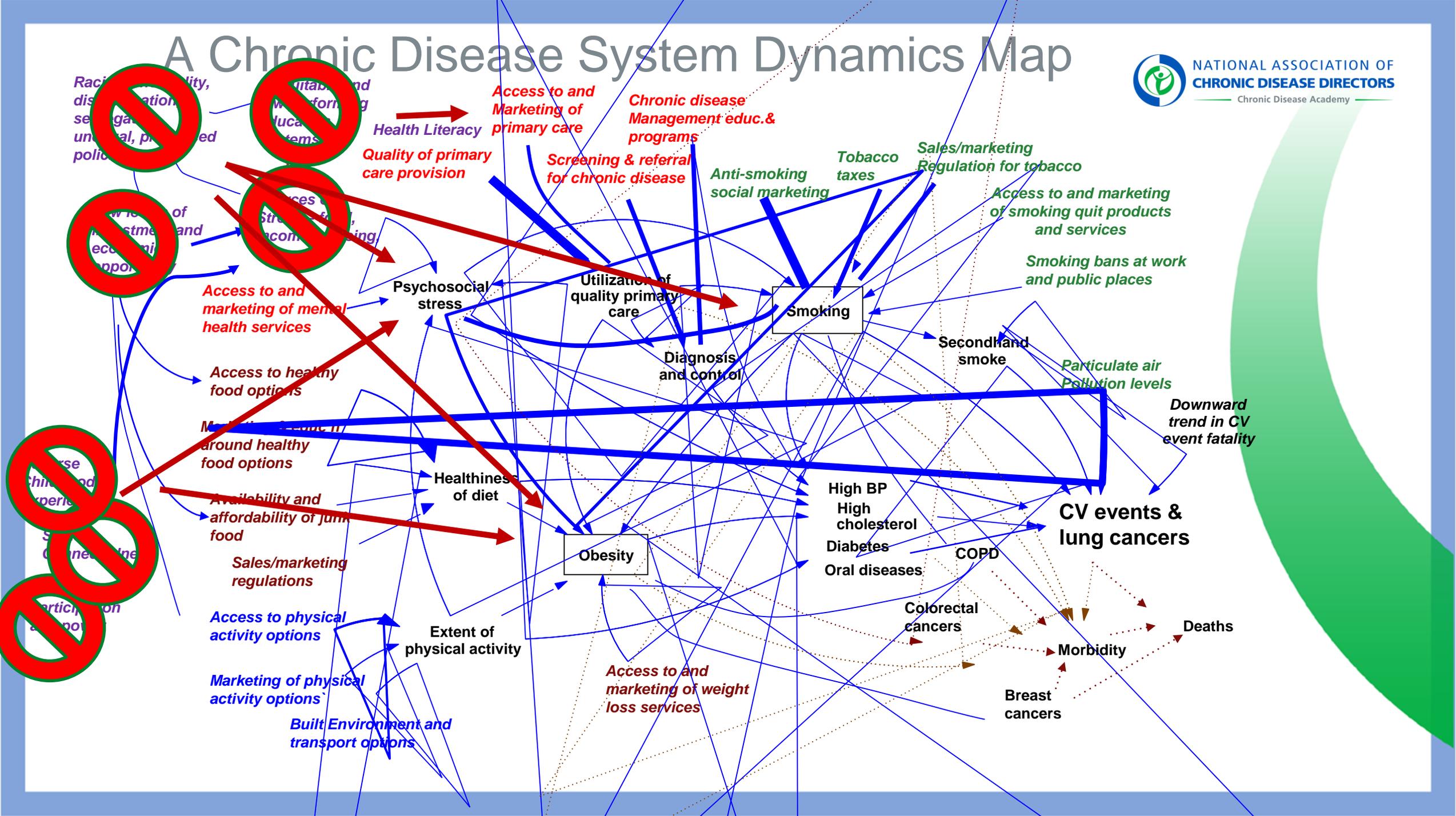
Public Health 3.0

- Social determinants of health – food, housing, transport
- Partnerships – Education, Human Services, Transportation, Housing, Revenue....

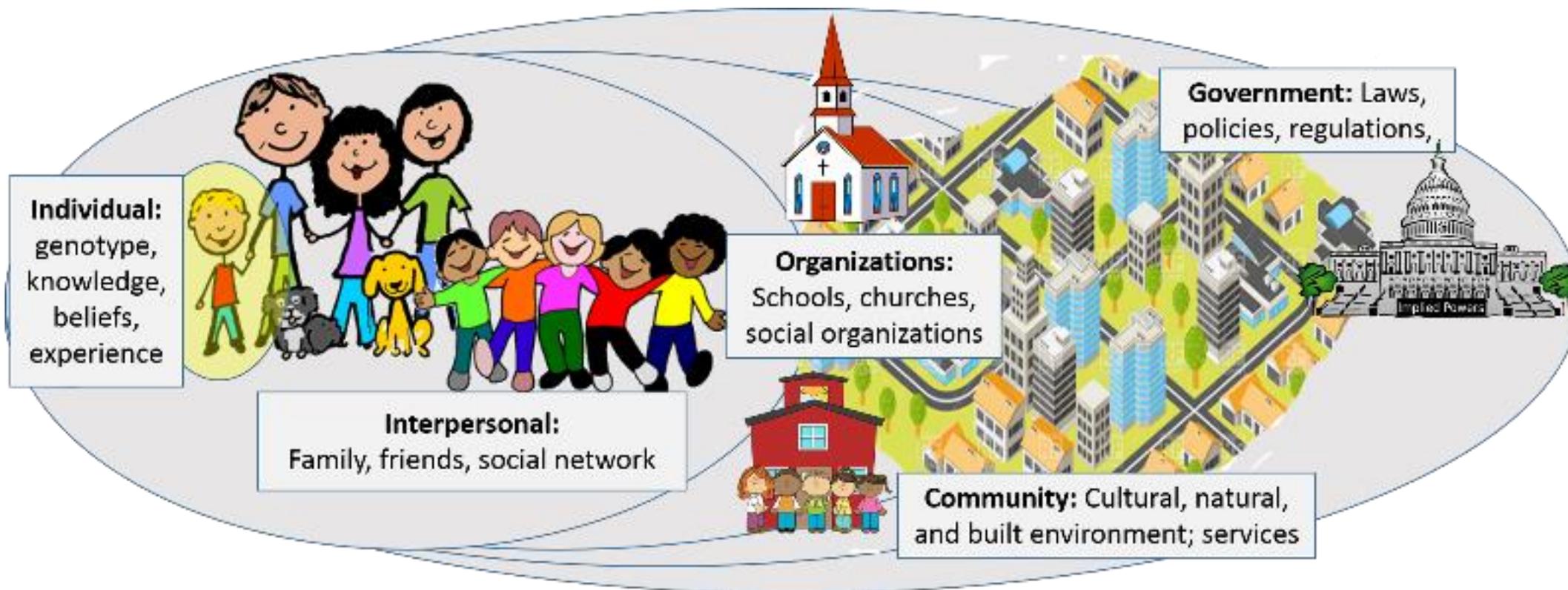
A Chronic Disease System Dynamics Map



A Chronic Disease System Dynamics Map



Socio-ecological model - how public health thinks



Source: Wayne W. LaMorte, MD, PhD, MPH, Boston University School of Public Health http://sphweb.bumc.bu.edu/otlt/MPH-Modules/QuantCore/PH717_ExposureAssessment/PH717_ExposureAssessment2.html Date accessed: 7/25/2018. Date last modified: January 30, 2018.

Five Domains of the Social Determinants of Health

Healthy People 2020

View content related to:

All Domains



Economic Stability

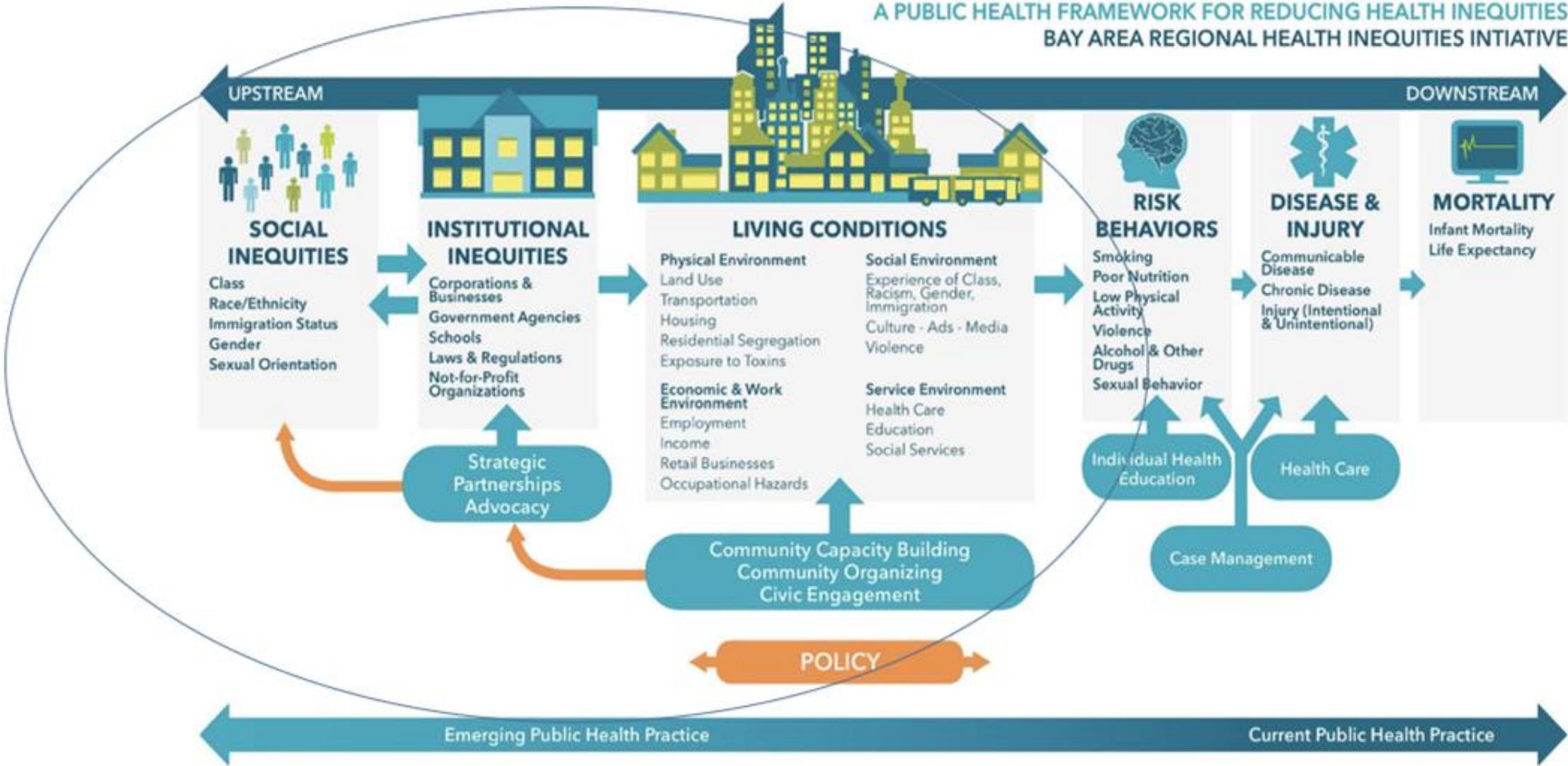
Education

**Health and Health
Care**

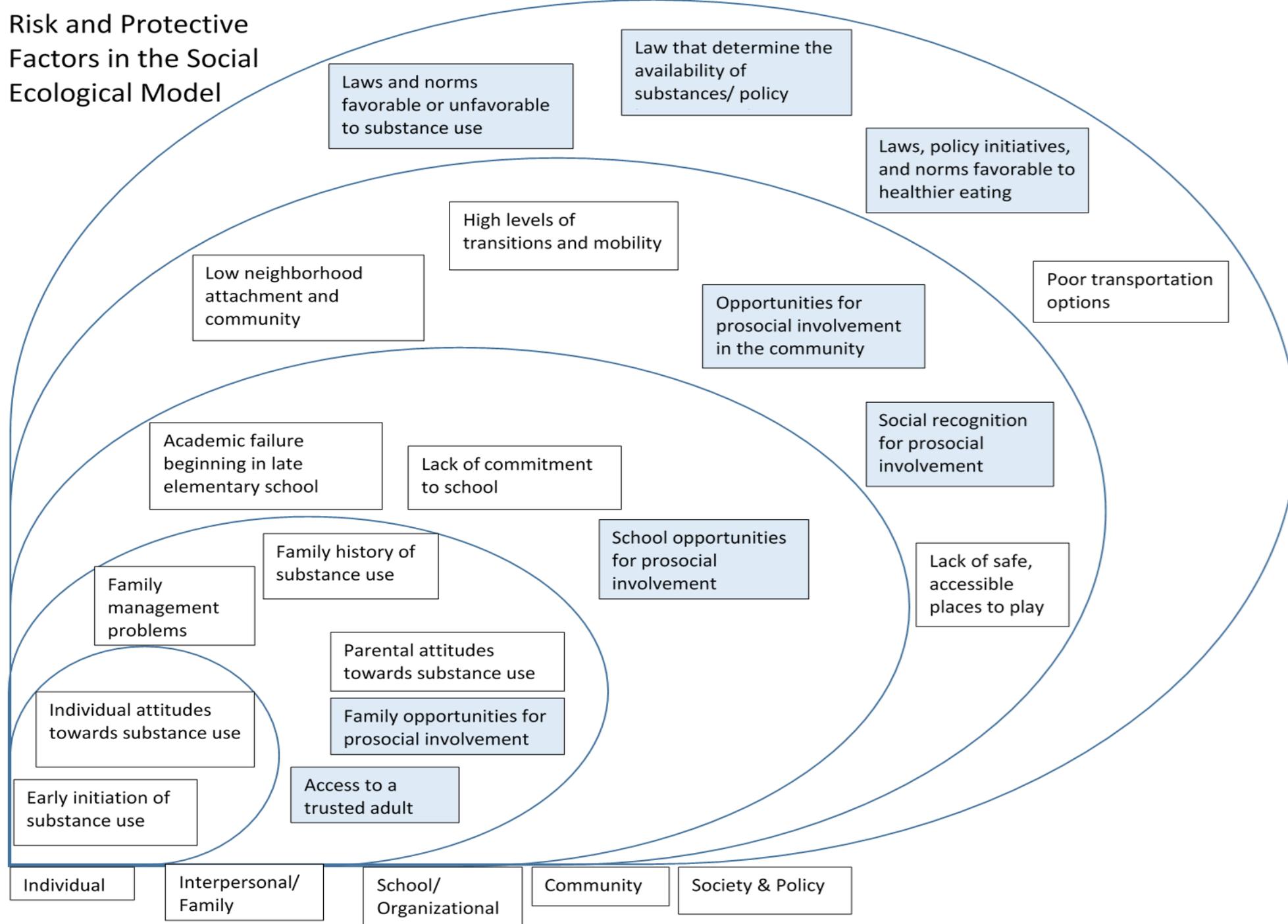
**Neighborhood and
Built Environment**

**Social and
Community Context**

A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES
 BAY AREA REGIONAL HEALTH INEQUITIES INITIATIVE



Risk and Protective Factors in the Social Ecological Model

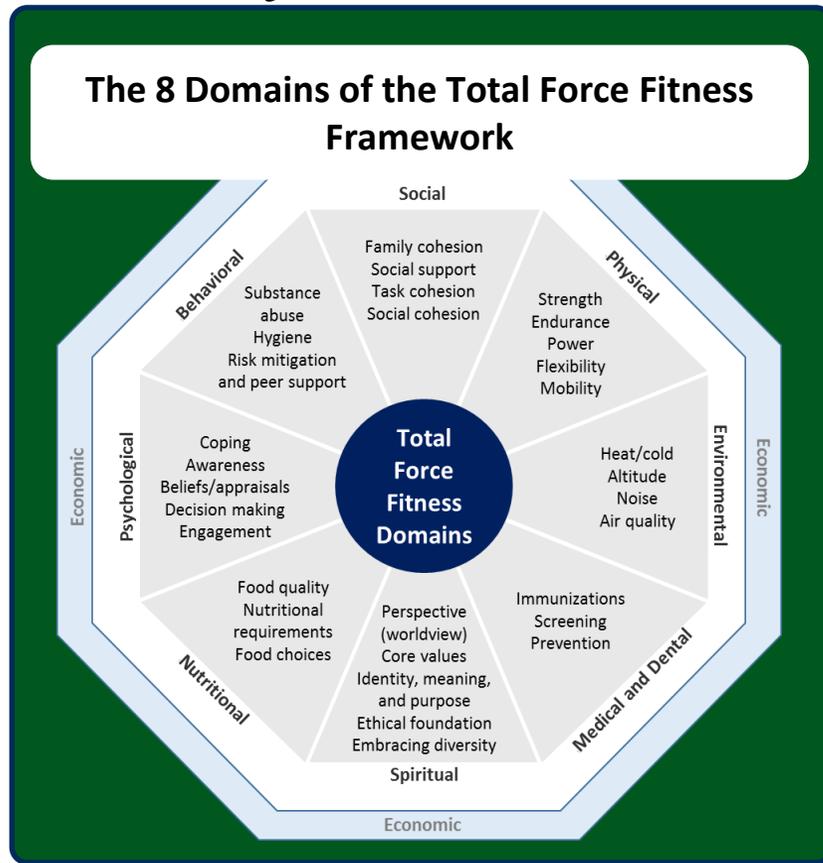


Case 1: Health Military Communities, U.S. Department of Defense

Public Health Need: Military Readiness

Proposed Solution:

Building Healthy Military Communities



- Focus on Reserve and National Guards
- Optimizing readiness, resiliency, and well-being
- 6 themes:
 - Transportation and geographic dispersion
 - Community resources coordination
 - Mental healthcare and substance abuse
 - Jobs and employment
 - Family support
 - Adverse health behaviors

BHMC Pilot: Qualitative Data Analysis

After the initial quantitative data analyses, the BHMC Pilot team conducted a baseline **Rapid Needs Assessment (RNA) via scripted semi-structured interviews** of DoD (unit leaders, retention non-commissioned officers, and recruiters) and non-DoD stakeholders (community health organizations, state and local health departments, employment assistance programs, and local healthcare providers). **The RNA examined available resources and existing needs** and used these qualitative data to identify six themes of the current gaps in optimizing readiness, resiliency, and well-being.

The 6 Themes

**Transportation and
Geographic Dispersion**

**Mental Healthcare and
Substance Abuse: Access
and Stigma**

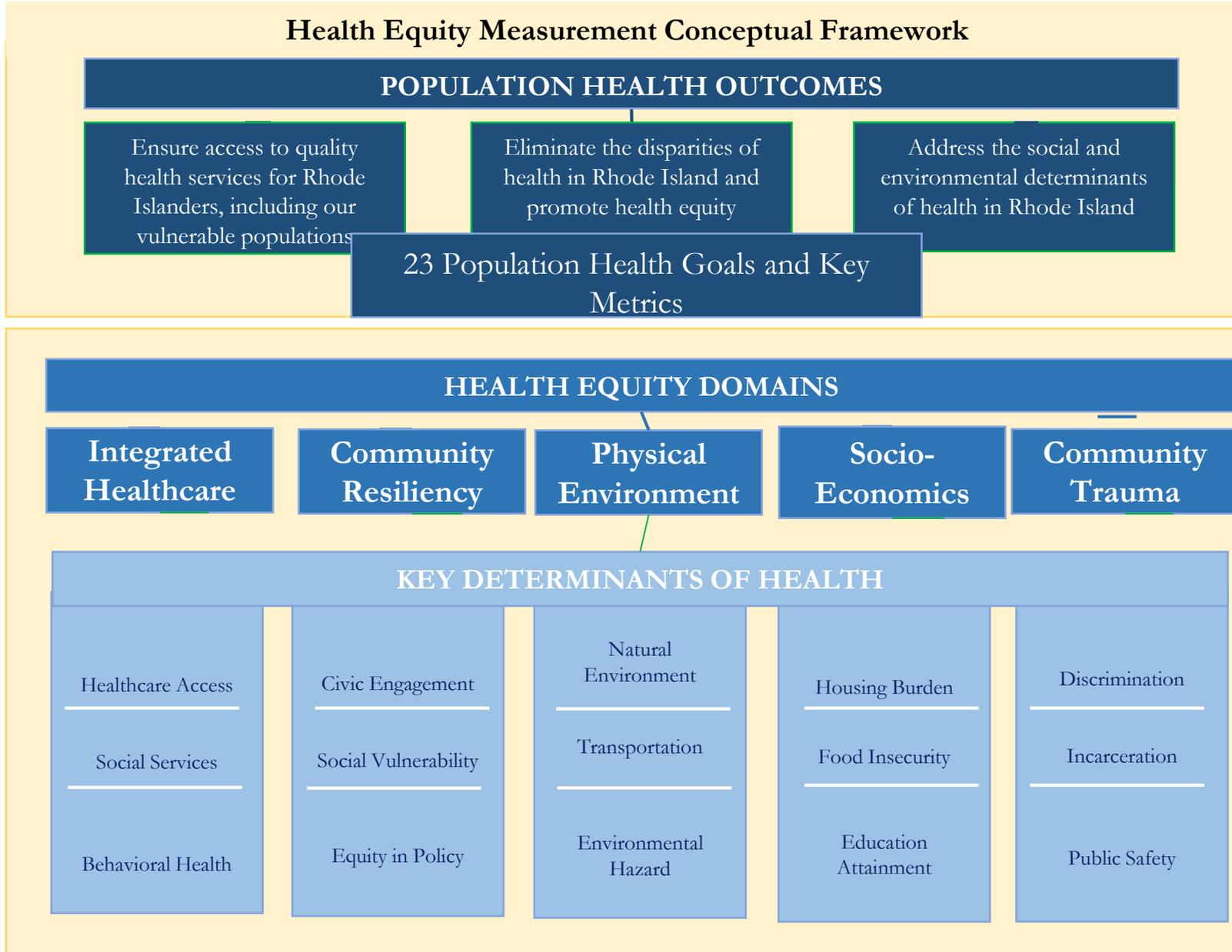
**Family Supports:
Childcare, Spousal
Employment, Higher
Education Opportunities,
and Housing**

**Communication and
Coordination Between
DoD and Community
Resources**

**Jobs and Employment:
Shifting Location,
Employer Expectations,
Financial Literacy**

**Adverse Health
Behaviors: Nutrition,
Obesity, Chronic
Conditions, and Tobacco
Use**

Case 2: Health Equity Zones, Rhode Island



Measuring Determinants of Health

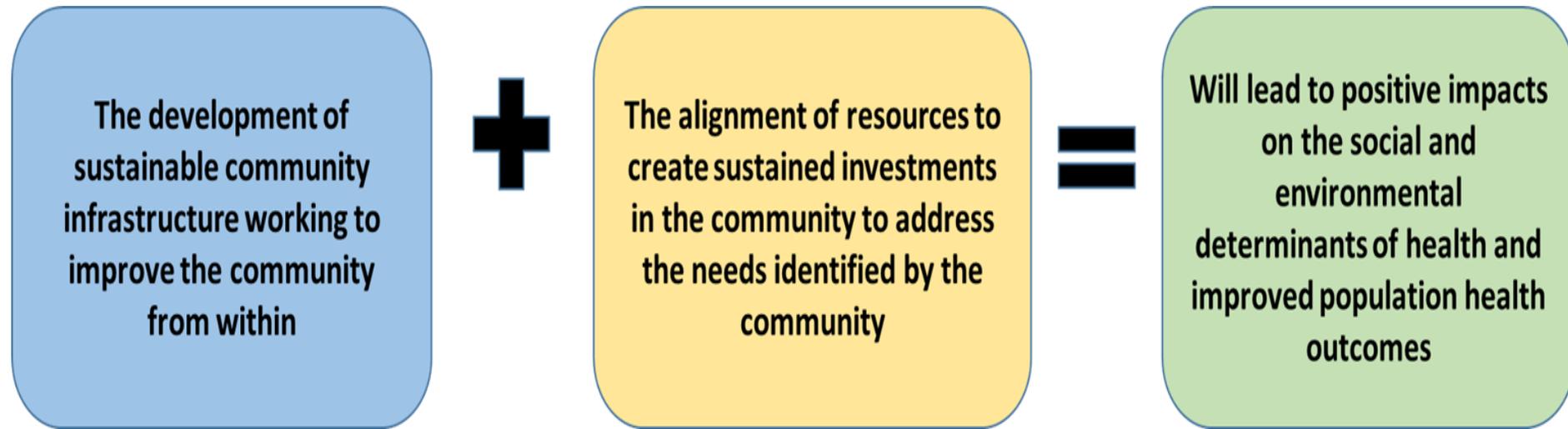


Domain	Determinant	Indicator
Integrated Healthcare	Healthcare Access	% adults in 2016 reported not seeking medical care due to cost by race/ethnicity
	Social Services	Ratio of # HH receiving to # HH eligible for SNAP (aka % of eligible HH receiving SNAP/benefits) (by city/town)
	Behavioral Health	RATIO: # of naloxone kits to # of overdose deaths (by city/town) (PORI)
Community Resiliency	Civic Engagement	% reg. voters participating in 2016 election (by city/town?)
	Social Vulnerability	CDC Social Vulnerability Index
	Equity in Policy	Ratio of # low-moderate income housing units to # low income families (by city/town)
Physical Environment	Natural Environment	Percentage of overall landmass with tree canopy cover (by city/town)
	Transportation	% of households reporting unsatisfactory or no public transportation in their neighborhood
	Environmental Hazards	# and % of children with lead blood levels >5mg/dL
Socioeconomics	Housing Burden	COMPOSITE: % Cost burdened renters AND owners by City/Town
	Food Insecurity	% of pop. 18+ reporting how often in past 12 months worried or stressed about having enough money to buy nutritious meals
	Education	% of students graduating with a regular diploma within four years (by city/town)
Community Trauma	Discrimination	% of women who experience discrimination right before or after a pregnancy by race/ethnicity AND % of adults reporting racial discrimination in HC settings in the part 12 mo. by race/ethnicity
	Incarceration	COMPOSITE: # of non-violent offenders under RI probation and parole PER 1,000 residents age 18
	Public Safety	Violent crime rate and non-violent crime rate (per 100,000 people) (by city/town)

The Theory of Change for Addressing Determinants of Health



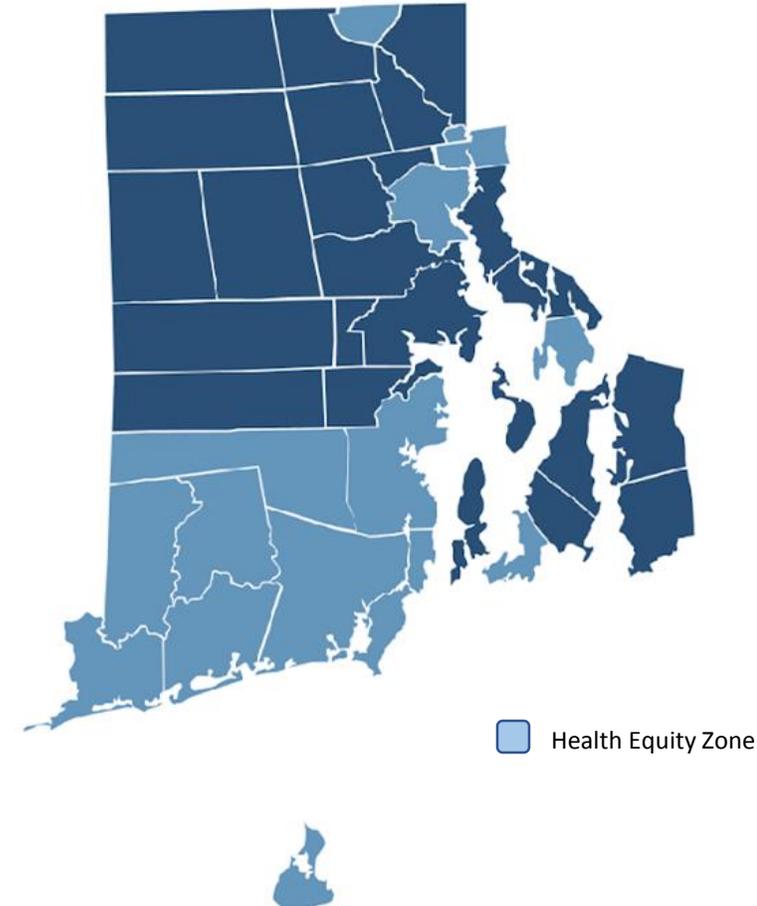
- **IF** Rhode Island collaboratively invests in defined geographic areas to develop sustainable infrastructure, and aligns a diverse set of resources to support community-identified needs...
- **THEN** we will positively impact the socioeconomic and environmental conditions driving disparities and improve health outcomes.



RIDOH Health Equity Zones



- Launched in 2015
- Nine local collaboratives throughout Rhode Island.
- Geographic areas with measurable health disparities, and socioeconomic and environmental conditions that keep people from being as healthy as possible.



Case 3: Racial Equity Initiative & Community Health Initiatives

BCHAP Racial Equity Initiative

Vision

A workplace that is inclusive, stimulating, safe



Staff that are active, engaged, aware, respectful, open-minded, healthy



Programs that are community-centered, disparities-focused, equity-informed



Policies that are actionable, practice-driven, systems-focused, responsible



Communities that are inclusive, engaged, partners in change



Charge

Develop and implement strategies to address the impact of racism and other systems of oppression on BCHAP staff, programs, policies and clients.



Equip staff to understand racial and health inequities and to develop strategies to address them in our work.

Purpose

Work

Training / Orientation



Practice



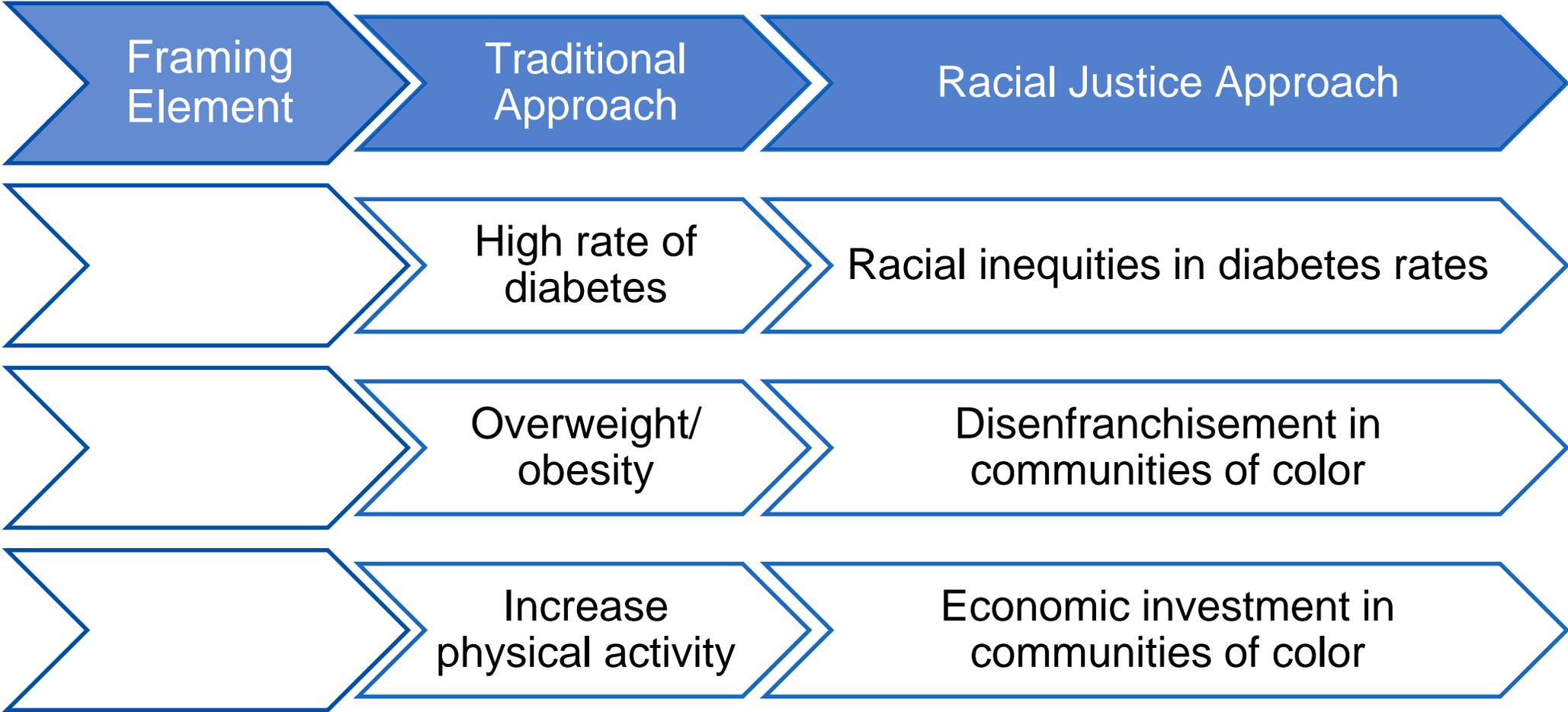
Implementation



Infrastructure & Sustainability



Example: Racial Justice Reframing



Community Health Initiative in Massachusetts

- Part of the Determination of Need
- 5% investment in a community need is required for all capital projects.
- Community must be engaged in the planning

DoN Health Priorities

The DoN Health Priorities are six (6) common social determinants of health:

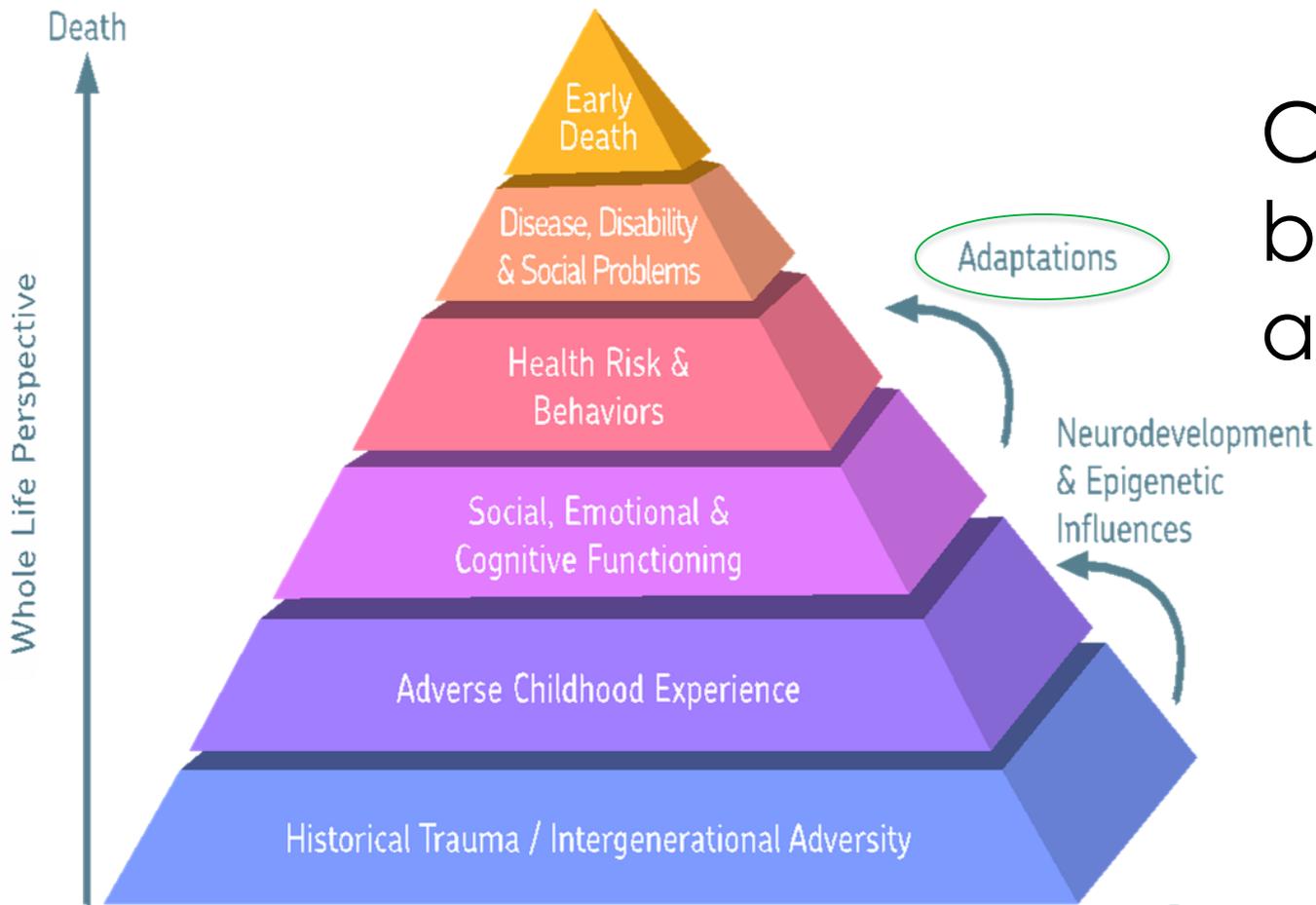
- 1) Social Environment
- 2) Built Environment
- 3) Housing
- 4) Violence and Trauma
- 5) Employment
- 6) Education

Current EOHHS/ DPH Focus Issues

Statewide trends and overall burden of morbidity and mortality point to:

- 1) Substance use disorders (SUDs)
- 2) Housing Stability/Homelessness
- 3) Mental illness and mental health
- 4) Chronic disease with a focus on Cancer, Heart Disease and Diabetes

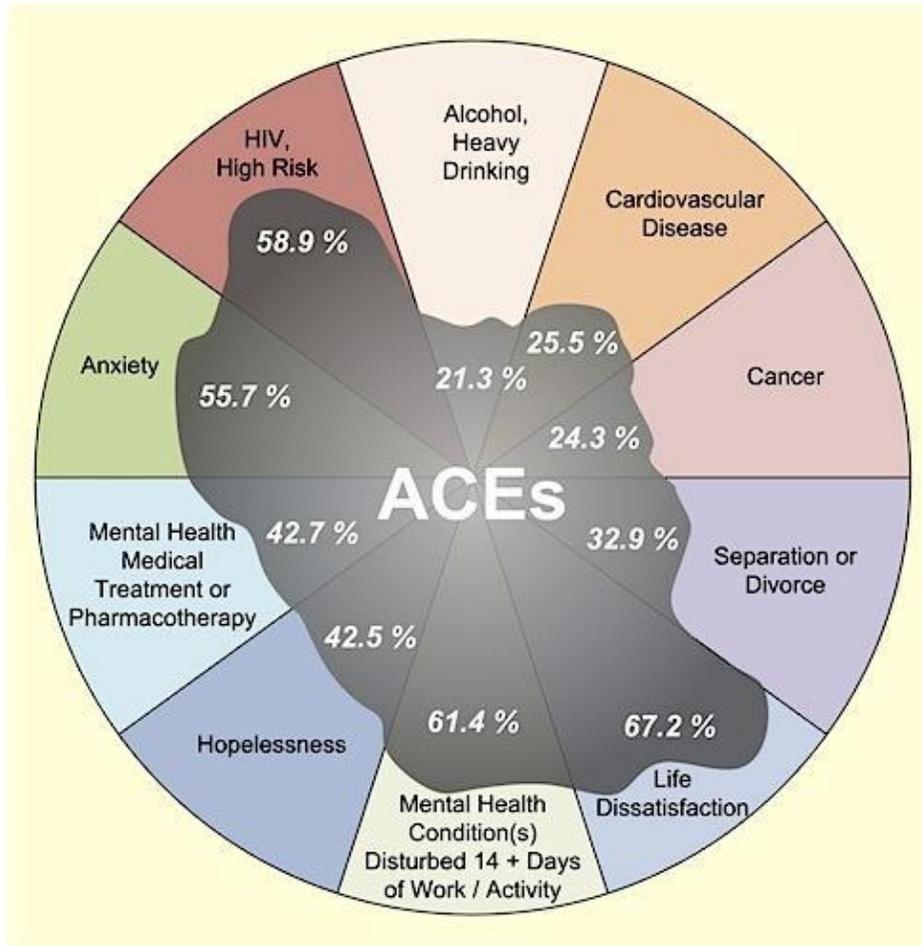
Case 4: Michigan - Changing Our Thinking



Consider health risk behaviors as adaptations

Shift from “what’s wrong with you” to “what’s happened to you”

The Magnitude of the Solution



A focus on **ACEs** and **building resilience**

- Feeling social/emotional **support** and **hope**.
- Having **2 or more people** who help (giving **concrete help** when needed).
- Community reciprocity: watching out for children, intervening when they are in trouble, doing favors for others (**social connectedness**).
- **Social Bridging**: reaching outside your social circle to get help for family and friends.

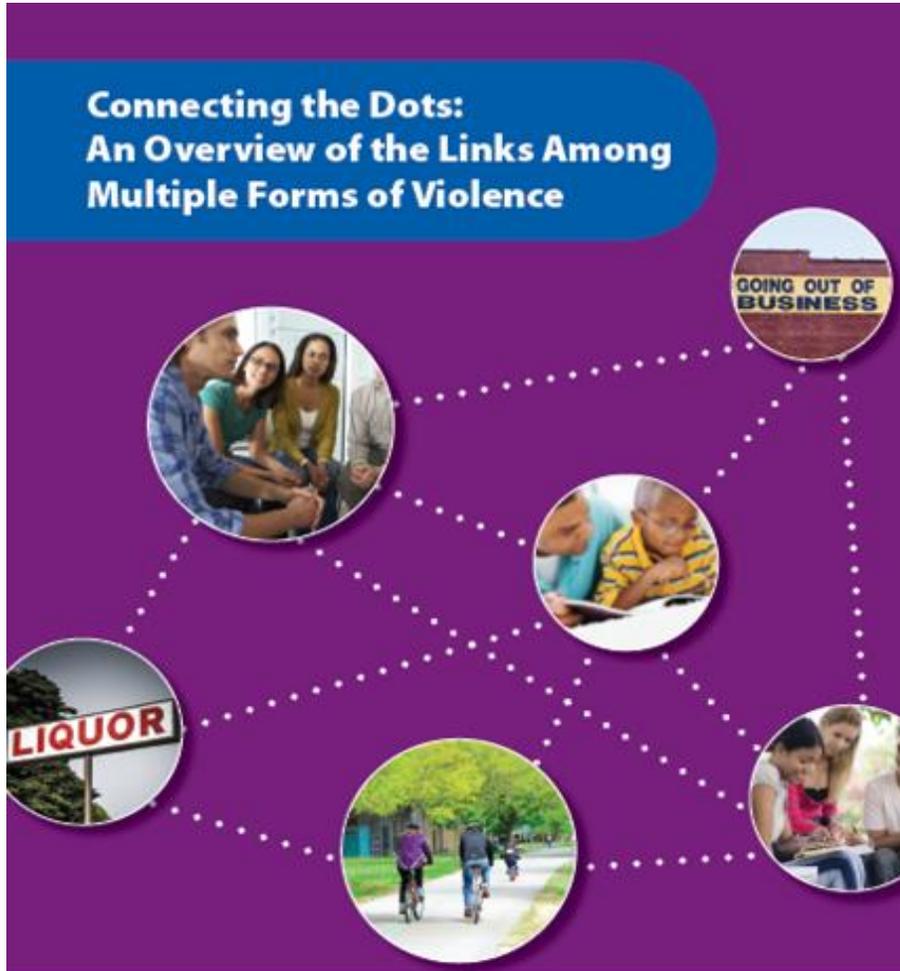
can address the many chronic diseases that we are working to improve, and ultimately lead to better health outcomes.

Case 5: Shared Risk and Protective Factors, Violence & Injury Prevention and Behavioral Health Promotion, Colorado

CONNECTING THE DOTS

Many forms of violence and injury are connected and share same risk and protective factors.

Focus efforts upstream on common factors.



Creating connected, thriving & resilient communities free from violence and injury

In order to improve the environments where we live, work, learn and play, we are using these resources

- Research on issues and effective strategies
- State & federal funding
- Existing program resources
- Experienced staff
- State and local partnerships
- Violence and Injury Prevention Network

to implement these strategies

- Apply a Health Equity Lens to All Work, Materials and Outreach
- Strengthen Policies, Systems, Environments
- Influence Health Care Systems
- Engage Communities
- Enhance Surveillance and Evaluation Systems
- Communicate Positive Norms
- Build Capacity for Injury and Violence Prevention at the Local Level

and ensure all Coloradans experience



Connectedness: the degree to which people are socially close, interrelated, or share resources with others.



Social Norms: refers to the rules of behavior and informal understandings considered acceptable in a group.



Behavioral Health: refers to the promotion of wellbeing in both mental health and substance use.



Economic Stability and Supports: refers to the level of economic resources and equality of distribution of resources among individuals and communities.

and ultimately reduce

- Suicide
- Older Adult Falls
- Prescription Drug Overdose
- Motor Vehicle Injuries and Fatalities
- Bullying
- Sexual Violence
- Teen Dating Violence
- Intimate Partner Violence
- Child Maltreatment
- Traumatic Brain Injury



across the lifespan of all Coloradans.

Focus on What Public Health Does Well

- Scientific rigor
- Modeling disease processes
- Collect and analyze data
- Acting as a trusted partner
- Leveraging resources
- Distribute resources
- Educate about policy and environmental changes

Use these strengths to find a way forward...

Public Health 3.0

- Leverage public health expertise
 - Community policing/safety
 - Nurse/family partnership
 - Streetscape designs for active transportation
 - Communities that Care

Public Health 3.0

- Leverage public health expertise
- Resources to grease the skids
 - School grants for healthier vending
 - Funding for community coalitions
 - Referral inventories
 - Streamlining social services application

Public Health 3.0

- Leverage public health expertise
- Resources to grease the skids
- More muscular advocacy
 - Raising tobacco taxes
 - Investments in pre-distribution
 - Studies on guns and health

Public Health 3.0

- Leverage public health expertise
- Resources to grease the skids
- More muscular advocacy
- Potential projects
 - Re-entry for incarcerated individuals
 - Social services prescription systems
 - Health impact assessment policies
 - Community banking and investment

Principles for the Development of **Public Health 3.0**

- Don't reinvent the wheel, learn from others
- Don't stop doing what you're doing
- Use your training

Thank you

- For more information, go to:
 - <https://www.chronicdisease.org/page/PresChallenge>
 - Podcasts of interviews with
 - **Karen DeSalvo**, former Acting Assistant Secretary for Health
 - **Anthony Iton**, Senior Vice President for Healthy Communities, California Endowment
 - **Len Nichols**, Professor of Economics, George Mason University
 - **Monica Bharel**, Commissioner, Massachusetts Department of Health & **Ben Wood**, Healthy Community Design Coordinator
 - **Douglas Jutte**, Executive Director, Build Healthy Places
 - **Isabel Sawhill**, Senior Fellow, Economic Studies, Brookings Institution
 - **Ana Novais**, Deputy Director, Rhode Island Department of Health
 - **Jodi Spicer**, Adverse Childhood Experiences (ACEs) Consultant, Michigan Department of Health and Human Services