Stakeholder Health

Executive Summary

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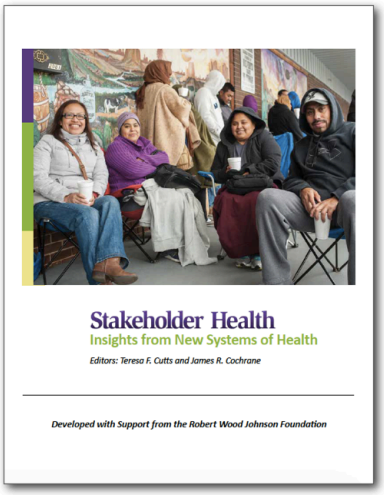

From

Stakeholder Health: Insights from New Systems of Health

Editors: Teresa F. Cutts and James R. Cochrane

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Order the book go to: http://stakeholderhealth.org/the-book/

www.stakeholderhealth.org

Stakeholder Health, a voluntary movement of health care leaders committed to addressing the underlying causes of poor health, presents the second generation of open source learning in a book titled *Stakeholder Health: Insights from New Systems of Health*. This book, written collaboratively by 44 authors, inspires new thinking about how health care can play a pivotal role in designing new models, not only for caring for individual health needs, but also for addressing complex social and structural determinants of health within communities.

Chapter 1 serves as an introduction to the book and sets the context for addressing the social or structural determinants that impact health. The authors embrace the moniker of mission-driven change agents who claim the moral ground of social justice and a desire to achieve equity in the health of the nation's diverse communities. The introduction suggests that the ensuing chapters seek to address these critical questions:

1. How should we think differently about and help improve social conditions in which our most vulnerable neighbors live?
2. How do we move toward establishing essential healthcare as a basic human right?
3. How do we help achieve health and other types of equity in our communities?
4. How do we use our positional authority and work in health systems to engage hearts and spirits of our local communities, as well as of our own employees?
5. How do we creatively and sustainably move health outcomes and the delivery of health care upstream in an environment with constrained resources?

Chapter 2 addresses the social determinants of health from a systems perspective. The World Health Organization states that the "social determinants of health" reflect the conditions in which people are born, grow, live, work and age. The authors remind readers that factors that have the greatest impact on health are not medical interventions or individual lifestyle choices, but instead arise from the environments in which we live, work, pray and play. The social determinants of health are best understood with a systems thinking paradigm of interrelationships rather than linear cause-effect chains, and longer-term processes of change rather than simply snapshots in time. Research conducted by the Population Health Institute at the University of Wisconsin demonstrates that clinical medical care accounts for just 20% of health outcomes while health behaviors, socioeconomic factors and the physical environment account for the remaining 80%. Addressing health at the population level will require a new level of thinking and strategic partnerships with entities not traditionally aligned with the health system. At its most progressive, this new thinking will push health care to partner with others to address food sufficiency, housing, education and workforce development as well as the built environment. Health system leaders can begin addressing social determinants of health through supporting public policies that enhance health, leveraging partnerships in the community, engaging local residents, playing a role in innovative payment system reform pilots and implementing best practices in community health prevention and interventions.

Chapter 3 urges health care leaders to make three significant shifts in management. First is the shift of power dynamics among and between stakeholders or a "right side up" maneuver which begins to pay attention to the wisdom at all levels of the organization. While technology, connectivity, science, transparency and logic all unleash potential gains for the whole community, they may also strengthen

roles of those formerly viewed as "lower" in the hierarchy. Teams of mutually empowered professionals are beginning to replace a single physician and the clinical space is growing to include retail clinics, homeless shelters, food pantries and places of worship. A second shift related to where leaders spend their time will call for movement from time at the desk with internal constituents to time in the community with a broader range of stakeholders. The leadership move is essentially "inside out" where the leader and organization is connectable with the agents of health that surround the system. The population in this view is not an entity to be managed, but the thing doing the managing. Those "outside" are not passive consumers, but, rather, agents of their own health in a complex ecology of roles. A third shift is a movement toward webs of trust. This moves leaders and organizations beyond high compliance to trusting that, within the future, are answers to today's best practices. High reliability will equal high adaptive capacity multiplied by the speed of trust divided by high compliance. Building trust within an organization must happen at a speed that exceeds decisions and behaviors that undermine trust. Trust becomes better or more efficient than mere control or managing by mandate. The authors posit that, as soon as we became liable for long term health dynamics of the large fraction of the humans living around us, we became subject to shared power with many others. We have significant influence on the many other systems in our communities, often as the largest component of most communities, as long as we don't try to control or "manage" them.

Chapter 4 advocates for relational technology within the information technologies employed by health care systems. According to the WHO, the US has the highest health care spending costs, but the poorest health outcomes when compared to other industrialized countries. Other industrialized countries spend much more on community based social services than on acute health care services. In our fragmented health care system, information technology has a strong role to play in bridging the gap in population health management. With 80% of poor health due to behavioral and social determinants, it becomes even more crucial that each patient encounter be optimized. The authors believe that asking patients about socioeconomic factors, recording them in the electronic health record and navigating patients to resources to address those needs will begin to align US practices with the practices in industrialized countries that have better health outcomes. There is a growing body of research calling for the integration of socioeconomic information and environmental risk factors into the Electronic Health Record as an important aspect of improving community and patient health, and achieving health equity. The authors also advocate for intentional inclusion of spiritual needs and resources into the patient information platform. While a standardized IT platform including socioeconomic information becomes a best practice, there is an emerging need for bi-directional communication between clinical providers, non-clinical caregivers and community based organizations that provide services to address socioeconomic needs. As systems are developed to better track patient needs and resources, the authors also advocate for the use of geo-coding/mapping of patients and community based resources to support population health management and development of critically placed community services.

Chapter 5 explores the importance of navigation in health care today. As people seek care and community based resources in our nation's fragmented health care system, even people with comprehensive insurance often struggle to navigate the systems. Health care systems are developing roles to assist individuals with access and to connect them with social services necessary to truly optimize their health. The authors describe an array of navigation roles that have been created and specifically focus on the community health worker (CHW) role. CHWs have made significant contributions to the Triple Aim and have also impacted what many consider a fourth aim of US health care reform—improved health

equity. In many ways CHWs go 'beyond the compass' in their relationships with patients because they are not simply directing people to resources, but are establishing caring connections with patients while assisting patients in addressing socioeconomic needs as well. CHWs have been documented to improve utilization of preventative services, reduce ED usage, improve birth outcomes, improve care transitions, provide culturally appropriate health education, reduce infant mortality, improve asthma self-management and increase knowledge and use of community services. In addition to improving utilization of health care resources and improving health of individuals, CHWs are becoming a new pipeline for health care careers and community economic development. Across the country, there are diverse models of training for CHWs. Some states are moving to a standardized training requirement with a certificate, while others are instituting a state licensure for CHWs. Currently, many CHW positions are funded by grants. Payment model reform, rewarding value and health equity, is helping CHW roles move from time-limited grants to stronger integration into care systems, workforce sustainability and increased opportunities to improve population health.

Chapter 6 discusses the important role of participatory community asset "mapping" methodologies in both building meaningful and useful partnerships between health systems and communities as well as augmenting data collected for hospital Community Health Needs assessments. This type of participatory mapping began in the 1970's and continues today. The history and specifications of select asset-based mapping methodologies are reviewed in the chapter with examples of processes, findings and outcomes. The reviewed methodologies include: Asset Based Community Development (ABCD); Mobilizing for Action Through Planning and Partnerships (MAPP); Participatory Inquiry into Religious Health Assets, Networks and Agency (PIRHANA); Community Health Assets Mapping Partnership (CHAMP); CHAMP Access to Care; Spiritual Capacities and Religious Assets for Transforming Community Health by Mobilization of Males for Peace and Safety (SCRATCHMAPS); Communities of Shalom and Participatory Hotspotting. Existing mapping tools (Community Health Improvement Navigator, Community Commons, County Health Ranking Roadmaps' What Works for Health [WWFH]) are also reviewed. While the above mentioned participatory community mapping methodologies can be viewed as specific forms of community engagement related to the federally mandated CHNAs, the authors caution that these mapping modalities should not be used as "an end unto itself," but rather as a springboard to developing partnerships with the community members to improve health. Additional considerations for mapping include addressing historical trauma to build trust, creating mutual accountability between health systems and community, as well as building a platform for Community-Based or Community-engaged Participatory Research and data gathering.

Chapter 7 delves further into the importance of understanding and treating the whole person, particularly related to the emerging field of trauma and resilience or the science around how social conditions impact our bodies even at the genetic and cellular levels. Health care systems are quickly realizing that engaging the patient in their whole life context is critical if they are to meet requirements of government and commercial payers regarding health outcomes and cost savings. Seminal studies related to Adverse Childhood Experiences (ACE) have identified correlated health outcomes for individuals who have experienced multiple traumatic experiences. Historical trauma describes the condition in which an entire population is subjugated over an extended period of time. Historical trauma studies that cross historical periods have found an increased disease burden in those with immediate experience, but, even more critically, the trans-generational transmission of poorer health outcomes. Perhaps the most hopeful thing about individual or community trauma is that resilience or the process of adapting well during times

of trauma or stress "trumps trauma." In other words, if trauma is fundamentally caused by dysfunctional or toxic relationships and systems, one of the most critical protective and healing factors for both individuals and communities is strong social relationships or social cohesion. The authors document the cost of ACEs in terms of correlated health outcomes and financial impact. They also describe the financial and personal cost of mental illness and substance abuse, particularly focusing on ED utilization costs. Evidence-based practices can be implemented at the community level and individual level to offset or prevent some types of mental illness and substance abuse. For instance, in preventing depression, such practices include strength-based and resiliency training, cognitive behavioral programs, web-based programs, the targeting of high risk populations (post-partum, elderly, college students, etc.) as well as addressing poverty and ACEs in children and youth. Finally, the authors advocate for increased integration of behavioral health and trauma screenings and services into care of the whole patient. Screening tools and evidence based practices which are emerging to address trauma, mental health, substance abuse and stigma are summarized for both individual and community interventions.

Chapter 8 discusses current dynamics and emerging financial trends in the context of health reform with a focus on implications related to the shift from fee-for-service to value-based reimbursement. While the United States (US) is the wealthiest nation on our planet, it ranks last among 11 peer countries related to health care access, efficiency and equity. The US spends only 60 cents on social services per $1 spent on health care compared to countries with better health outcomes that spend $2 for social services for every $1 for health care. The US approach to social service provision including childcare, housing, transportation and education seems to be a causal factor of our current state of health. Additionally, the authors posit that the history and legacy of discrimination has created pockets of extreme poverty, social dysfunction, and persistent health problems in communities across the country, highlighting the need for focused attention and investment, not just by health care organizations, but by a broad spectrum of stakeholders across sectors in order to produce meaningful and sustainable improvement. The following emerging models are highlighted as possible solutions to the issues that have created health inequity: federal support of state innovations, CMS programs supporting housing-related activities, federal waivers for housing, increased education funding, Pay for Success and local "collective impact" collaborations. Additional innovative possibilities for health care systems include leveraging funds with Community Development Funding Institutions (CDFIs) and partnering with employers to engage in health promotion.

Chapter 9 begins by acknowledging the reality, that, given the broad and complex range of factors that determine health, any single institution or sector, including health care, has a limited scope of influence. As noted in previous chapters, there is a need for shared partnerships to address the social structures and conditions that impact health, and the authors for this chapter suggest that foundations are a natural partner in the work of health improvement. While there are many types of foundations, two specific types are particularly relevant to health care: hospital or health system foundations and health conversion foundations (formed when a nonprofit hospital or system converts to, or is acquired by, a for profit entity). In addition to funding planning for programs (planning grant) and implementing programs (implementation grant), foundations also engage strategically in building the capacity of organizations, provide leadership development opportunities, introduce innovations, raise public awareness of key issues and advocate for policy change. Foundations also can fund individual hospital or health systems or community collaborative work. In fact, many foundations require partnerships as a component of a funding proposal. An additional role that foundations are well positioned to play is as a convener of cross-sectoral partners within a community.

Chapter 10 encourages people to open their experience and imagination to the increasingly rich, dynamic interactions that are occurring between local and global health systems. Health care applies international standards in diagnosing and treating certain diseases and epidemics. Professional exchanges with other countries and international health providers are occurring every day. While global health was equated in the past with international health and focused primarily on controlling the spread of epidemics, global health today is shifting from disease-control to a vision of health for all. This shift considers questions of human dignity and health equity, and views all human beings as agents able to jointly achieve better health outcomes. The redressing of systemic disadvantages and the promotion of inclusion and social justice become critical dimensions of any healthy community.

Global health perspectives across boundaries consider how to prioritize health care spending; how to engage market pressures for increasingly expensive drugs and treatments; how to address the social demand for access to health and well-being for all; and how to balance the tension between the historically powerful technical medical field and the complex, socially formed self-directed person that human beings are. While global health exhibits its own "pathologies"--including silo mentalities, over-reliance on technological solutions, unfulfilled promises, and over-confidence, many new shifts in policy and practice have opened up the possibility of major positive gains if the requisite intelligence and will are applied. This is a time where the promise of a better, more just future is within our grasp; where the possibility of reducing infections and maternal and child mortality to low rates universally, and of tackling chronic diseases and the impoverishing effects of health expenses, are realistic. The authors cite six strategies for addressing global health in the future including a systems approach that is people centric rather than market centric.

Chapter 11 calls faith based and mission driven organizations to reconnect and strengthen the heritage of whole person care that has deep roots in religious faith. The authors caution that faith based and charitable health care systems are facing challenges to their founding missions as the current national climate of mergers and acquisitions is often creating large bureaucratized and commoditized systems where identities of whole person care and care of the poor may be fading. In addition to reciting some of the history and theology of faith rooted health care, the authors speak about a change of language that arose in the second half of the 19th century where terms of war replaced terms of mission. In health care, we speak in language of fighting disease with batteries of tests, giving shots, utilizing arsenals of drugs, physician orders and discharging patients. The emerging language for health care in our current century is market focused and filled with references to customers, market share, productivity and product lines. The authors fully understand that finance and accountability and safety are important considerations, but raise the possibility that today's health care increasingly runs the danger of losing its charitable soul, devolving into yet another commoditized industry. It is incumbent on faith rooted and mission driven health care to move beyond the preservation of nostalgic language while still expressing commitment to charitable and meaningful service in a world with all of its rich cultural and religious diversity. In today's complex world, the moral vision of Stakeholder Health continues to call all toward creating a beloved community of life, health and hope in partnership with others, utilizing both the growing scientific knowledge of addressing disease, and the faith based knowledge of healing and whole person care. The vision of the beloved community of health is the yearning expression of faithful people to create better health for all people.