SOCIAL DETERMINANTS OF HEALTH CARE

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Minneapolis/St Paul: 3 miles could add up to 1.3 year life span difference

New Orleans: Life span varies by 25 years across neighborhoods, just a few miles apart

Chicago: 16 year difference in life expectancy between Washington Park and the loop

MAKING THE CONNECTIONS: OUR CITY, OUR SOCIETY, OUR HEALTH

https://www.youtube.com/watch?v=q-3mUiGi6bA&feature=youtu.be
10.2% of Wisconsin population


FOOD DESERTS IN WISCONSIN


HUD's Annual Homeless Assessment Report

https://www.wpr.org/hud-nearly-5k-wisconsin-individuals-homeless-2018

2017 WISCONSIN POVERTY MEASURE

https://www.irp.wisc.edu/resources/who-is-poor-in-wisconsin/
Food insecurity in Wisconsin by race and education, 2005-2014

Milwaukee Journal Sentinel 5/21/2017
https://www.jsonline.com/story/news/health/2017/05/20/milwaukee/323003001/

How can healthcare address these issues?
HEALTHCARE ANCHOR NETWORK

The long-term goal is to reach a critical mass of health systems adopting as an institutional priority to improve community health and well-being by leveraging all their assets, including hiring, purchasing, and investment for equitable, local economic impact. By doing so, we can powerfully impact the upstream determinants of health and help build inclusive and sustainable local economies.

Community Partnerships

45 Health Systems nationwide

HOUSING EXAMPLES

Bon Secours Baltimore – helped build more than 800 units of affordable housing with Low Income Housing Tax Credits.

Geisinger Health System – acquired 110–115 million+ in five years to support affordable housing initiatives.

Dignity Health – operates a $140 million loan fund which supports economic development in low-income communities.

Kaiser Permanente – impact investing commitment of up to $200 million through its Thriving Communities Fund to address housing stability and homelessness.

Providence St. Joseph Health – low-interest loans to community development financial intermediaries.

GUNDERSEN HEALTH SYSTEM HOUSING PROJECTS

Gundersen Brewery Lofts – 85 unit housing (68 affordable) - Gundersen provided the land and building to a private developer who used Low-Income Housing Tax Credits and Historic Tax Credits.

Resident housing in Neighborhood

La Crosse Promise

Tax Incentives for Employees who live in the neighborhood

Habitat homes in the Neighborhood

Project RE-NEW

La Crosse Collaborative to End Homelessness
DETROIT – ASTHMA AND LEAD POISONING PROJECT

The Healthy Homes and Asthma Program addresses lead hazards, asthma and allergy triggers, and home safety for Detroit families who have children five years old or younger with diagnosed asthma.

The asthma prevalence rate for children in Detroit is approximately 30%, three times the national average, and asthma is the leading chronic condition causing school absenteeism and preventable hospitalization for children under 18.

1. Case manager identifies hazards and provides education
2. Family Action Plan is customized, listing products to reduce triggers, etc
3. Referral to partner agencies

Work with Community Based Development Corporation (CBDC) for help with funding programs.

https://clearcorpsdetroit.org/programs/healthy-homes-detroit/

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March of Dimes 2018 Preterm Birth Report Card

Cleveland

- Black women are 40% more likely to have a PTB vs. white women

Cuyahoga County

- Black women were 20 out of 100 times more likely to have PTB

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The UH Rainbow Center for Women & Children opened July 9th, 2018

- Project
  - Health of Primary Care
  - Women’s Health Care
  - Family Health Care
  - Infant and Child Health Care
  - Women’s Center
  - Pediatric Center

Extended Hours

Maternity Unit: Women’s Health Center
Pediatrics: Pediatric Center

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Transportation

- No-show rate 5-30% or more
- 3.6 million Americans miss appointments due to a lack of reliable transportation

- Lyft and Hitch Health (tech company) conducted a pilot study at Hennepin Healthcare in Minneapolis and were able to reduce no-shows by 27% in previous patients with no-shows (2018)
- Used texting technology to offer Lyft rides to patients in need.
- Increased revenue by $270,000 (297% ROI)

- Uber Health – allows healthcare providers, clinics, and hospitals assign rides for their patients with a centralized dashboard – without requiring the patient have the Uber app or smartphone
- Boston Medical Center reported $500,000 in transportation savings by using Uber Health
SCREENING FOR SDOH

One person’s data is another person’s difficult life experience.

SCREENING FOR SDOH

1. Screening for SDOH
   Practices should consider the social determinants prevalent in the population they serve and whether
   those SDOH needs are issues that the practice can assess and refer for within their workflow constraints.

2. Referral to Community-Based Organizations
   What organizations can handle referrals? Know where your patients live to make referrals convenient
   for them.

3. Get Patients the Needed Services
   Making sure the patient follows through on referrals.

4. Closing the Communication Loop
WHAT CAN YOU DO?

1. Pick a topic
2. Don’t wait for perfection or system solutions.
   Refer your patients.
   Empower your staff to refer.
   Use your local community resource listings – 211
3. Get involved in systemic issues in your community
   Habitat, food pantries, Boys & Girls, Salvation Army, United Way
   Your presence provides credibility & power

QUESTIONS?