Expanding the Role of Family Medicine Practices in Achieving Health Equity: Learning from the Community

Family Medicine for America’s Health-Health Equity Team
Presented by

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Conference on Practice Improvement

Family Medicine for America’s Health, Health Equity Team 2017-2018

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Lloyd Michener, MD

Join the conversation on Twitter: #CPI17
Disclosures

• No conflict of interest to disclose
Goals for today

- Information- Health Equity Team
- Interactive workshop- how do we link our teaching practices to the community to achieve health equity
The FMAHealth Health Equity Team Is Focusing on a Few Strategic Objectives

• Hosted a Health Equity Summit April 2017
• Build on the success of the Summit by coordinating efforts with existing networks and coalitions.
  – Make the business case for health equity
  – Address rural health disparities
  – Work on social accountability metrics
  – Social media strategy
• Work with all our family medicine organizations to expand efforts to achieve health equity in ways that align with their missions.
• Work with the AAFP’s Center for Diversity and Health Equity to expand efforts to achieve health equity
Family Medicine for America’s Health, Health Equity Team for Starfield Summit II:

Viviana Martinez-Bianchi, MD; Team Leader.
Jennifer Edgoose, MD, MPH
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Member of Summit Advisory Panel: Kim Yu, MD, Lloyd Michener, MD
Summit lead note taker: Brian Park, MD MPH, PGY-3

Portland, Oregon — April 22-25, 2017
STARFIELD II: HEALTH EQUITY SUMMIT

Primary Care's Role in Achieving Health Equity

PORTLAND, OREGON — APRIL 22-25, 2017

“In its most highly developed form, primary care is the point of entry into the health services system and the locus of responsibility for organizing care for patients and populations over time. There is a universally held belief that the substance of primary care is essentially simple. Nothing could be further from the truth.”

—Barbara Starfield, MD, MPH
The Devine Solution

- Non-black adults can be motivated to increase their awareness of bias against blacks, but their concerns about the effects of bias and to implement strategies were effective in producing substantial bias that remained evident three months later.
- Implicit biases viewed as deeply embedded habits that can be replaced by prejudice-reducing strategies such as stereotype replacement, countering implicit biases, and increasing opportunities for cross-race contact.


- Stressors addressed: housing, immigration, income, support, food, education access, disability, family law
- A child with asthma in a moldy apartment will not breathe symptom free, regardless of meds, without improved living conditions

Zuckerman et al. Pediatrics, 2004

Keynote Address
David Williams, PhD, MPH

A Call to Action

"Each time a man stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope, and those ripples build a current which can sweep down the mightiest walls of oppression and resistance."

- Robert F. Kennedy
IGNITE Theme 1: Social Determinants of Health in Primary Care

- Understanding Health Experiences and Values in Order to Address Social Determinants of Health
  - Nancy Pandhi, MD, MPH, PhD & Sarah Davis, JD, MPA
- Identifying and Addressing Patients' Social and Economic Needs in the Context of Clinical Care
  - Laura Gottlieb, MD, MPH
- Communities Working Together to Improve Health and Reduce Disparities
  - J. Lloyd Michener, MD
- Using Community-Level Social, Economic, and Environmental Data to Monitor Health Disparities and Guide Interventions
  - Elizabeth Steiner Hayward, MD
- An Action Learning Approach to Teaching the Social Determinants of Health
  - Viviana Martinez-Bianchi, MD, FAAFP
- Improving patient outcomes by enhancing student understanding of social determinants of health
  - Brigit Carter, PhD, RN, CCRN

https://fmahealth.org/resources/starfield-summit-i-speaker-presentations/
IGNITE Theme 2: Vulnerable Populations

- Why Rural Matters
  - Frederick Chen, MD, MPH
- People with Disabilities (Developmental and Intellectual Disabilities)
  - William Schwab, MD
- Racism, Sexism and Unconscious Bias
  - Denise Rodgers, MD, FAAFP
- Immigrant Populations
  - Michael Rodriguez, MD, MPH
- Intersectionality – The Interconnectedness of Class, Gender, Race and Other Types of Vulnerability
  - Somnath Saha, MD, MPH

https://fmahealth.org/resources/starfield-summit-ii-speaker-presentations/
IGNITE Theme 3: Economics & Policy

https://fmahealth.org/resources/starfield-summit-ii-speaker-presentations/

- International Efforts to Reduce Health Disparities
  - Michael Kidd, MD, MBBS
- ACA Opened the Door for Payment Reform and Practice Transformation to Address SDoH, Now What?
  - Craig Hostetler, MHA
- Community Vital Signs: Achieving Equity through Primary Care Means Checking More than Blood Pressure
  - Andrew Bazemore, MD, MPH
- How Social and Environmental Determinants of Health Can Be Used to Pay Differently for Health Care
  - Robert Phillips, MD, MSPH
- Access to Primary Care is not Enough: A Health Equity Road Map
  - Arlene Bierman, MD, MS
SHIFTING THE PARADIGM TOWARD SOCIAL ACCOUNTABILITY

Sonali Sangeeta Balajee, MS
Jennifer Edgoose, MD, MPH
Joedrecka Brown Speights, MD
Bonzo Reddick, MD, MPH

https://www.youtube.com/watch?v=wxboH4rZNmc
TOWARD SOCIAL ACCOUNTABILITY
SOCIAL ACCOUNTABILITY

The World Health Organization (WHO) describes social accountability as, ‘the obligation [of physicians and medical institutions] to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve’ (Boelen & Heck 1995).

For care to be socially accountable, it must be equitably accessible to everyone and responsive to patient, community, and population health needs (Buchman et al 2016).
Social Accountability

Social accountability in health care intentionally targets health care education, research, and services and addresses social determinants of health towards the priority health concerns of the people and communities served, with the goal of health equity.
ARE WE SOCIALLY ACCOUNTABLE?

Are we aiming the work of our practices to achieve health equity?

Healthcare institutions are generally **socially responsible** (being aware of their duty to respond to society’s needs) and some can be seen being **socially responsive** (implementing interventions to address these needs). But few are wholly **SOCIALLY ACCOUNTABLE**.


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**Table 1** The social obligation scale.

<table>
<thead>
<tr>
<th>Social needs identified</th>
<th>Responsibility</th>
<th>Responsiveness</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional objectives</td>
<td>Implicitly Defined by faculty</td>
<td>Explicitly Inspired from data</td>
<td>Anticipatively Defined with society</td>
</tr>
<tr>
<td>Educational programs</td>
<td>Community-oriented</td>
<td>Community-based</td>
<td>Contextualized</td>
</tr>
<tr>
<td>Quality of graduates</td>
<td>«Good» practitioners</td>
<td>Meeting criteria of professionalism</td>
<td>Health system change agents</td>
</tr>
<tr>
<td>Focus of evaluation</td>
<td>Process</td>
<td>Outcome</td>
<td>Impact</td>
</tr>
<tr>
<td>Assessors</td>
<td>Internal</td>
<td>External</td>
<td>Health partners</td>
</tr>
</tbody>
</table>
City of Medicine Academy Program

The Duke AHEC Program partners with the City of Medicine Academy (CMA) each year to offer specially designed programs and experiences for enrolled students. The CMA is an academically rigorous high school designed to prepare high school students for post-secondary health care education or to enter into the health care workforce. The Duke AHEC Program has partnered with Durham Public Schools health career focused academy (school) since the mid-1990s to provide...
“Learning how to educate and learning how to listen are equally important for health professionals, students, and trainees if they are to work effectively in and with communities.”

A Framework for Educating Health Professionals to Address the Social Determinants of Health. NAP 2016
DEVELOP A PLAN TOWARDS EQUITY IN HEALTH
Health disparities preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.
Disparities in Life Expectancy in Raleigh-Durham, North Carolina:

- Shorter: 77 years (ZIP 27703)
- Longer: 82 years (ZIP 27715), 88 years (ZIP 27637), 81 years (ZIP 27646), 76 years (ZIP 27610)

Life expectancy at birth (years):

- Shorter
- Longer

2 miles

Follow the discussion #CloseHealthGaps

© 2015 Robert Wood Johnson Foundation
Where people live matters more than the healthcare they receive.

Your zip code can be more important than your genetic code.

A Short Distance to Large Disparities in Health

Life span disparities reflect differences in wealth, education and environment across all community residents. The differences are even more dramatic—sometimes double—if you compare black and white residents.
Let’s go to your city!  
https://www.cdc.gov/500cities/
Health equity means that everyone has a fair and just opportunity to be as healthy as possible.
Health equity is the absence of unfair and avoidable or remediable differences in health among social groups.
“The principle of health equity attracted many of us to medicine, and in particular to family medicine. In our DNA runs the desire to be person-centered, to take care of people of all ages and all life circumstances, to be accountable to our communities, to improve community and population health, to be engaged leaders, to provide continuous, integrated and whole person oriented care. For many of us Family Medicine became our vehicle for social justice”. Viviana Martinez-Bianchi
Health equity is realized when each individual has a fair opportunity to achieve their full health potential. What can we do from our role in our health system?

Allan Weill in a recent editorial in Health Affairs asks: If equity is one dimension of what the Institute of Medicine (IOM) defined as health care quality, what are the obligations of the health care sector to achieve health equity?

Drawing “Equidad”, by Fernando Miguez, Argentina
Population Health

Requires a collaborative strategy between leaders in healthcare, politics, charity, education, and business

Robert Wood Johnson Foundation, 2014
Pursuing health equity requires

• Addressing inequities:
  – Understanding the roles of bias and discrimination in health care systems
  – Looking at gaps in access or inadequate care for disadvantaged groups

• Addressing health determinants (negative and positive ones)
  – Attention to root causes of disease and wellness
Pursuing health equity requires

• Adopting patient-centered medical home models, and community centered models
• Partnering with community organizations
• Engaging in cross sector dialogue
STOP tolerating inequity
How do we get started?
Multiple frameworks and requirements for addressing the social determinants of health
IHI
“Health care professionals should play a major role in improving health outcomes for disadvantaged populations.

Go beyond access to care, improving cancer screening for URM, and decreasing disparities in care provided,

Leverage the economic, social, and political power of the health care industry and of each organization within it.”
There are five key components of the framework:

• Make health equity a strategic priority;

• Develop structure and processes to support health equity work;

• Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact, such as health care services, socioeconomic status, physical environment, and healthy behaviors;

• Decrease institutional racism within the organization; and

• Develop partnerships with community organizations to improve health and equity.
HQ Pathway 5: Resident/fellow and faculty member education on reducing health care disparities

Formal educational activities that create a shared mental model with regard to health care quality-related goals, tools, and techniques are necessary for health care professionals to consistently work in a well-coordinated manner to achieve a true patient-centered approach that considers the variety of circumstances and needs of individual patients.

**Properties include:**

- Residents/fellows and faculty members receive education on identifying and reducing health care disparities relevant to the patient population served by the clinical site. *The focus will be on the extent to which individuals receive education on the clinical site’s priorities and goals for addressing health care disparities in its patient population.*

Source ACGME CLER brochure accessed 4.10.17

[https://www.acgme.org/Portals/0/PDFs/CLER/CLER_Brochure.pdf](https://www.acgme.org/Portals/0/PDFs/CLER/CLER_Brochure.pdf)

ACGME CLER visits
# The Family Medicine Milestone Project

A Joint Initiative of
The Accreditation Council for Graduate Medical Education
and
The American Board of Family Medicine

## PROF-3: Demonstrates humanism and cultural proficiency

<table>
<thead>
<tr>
<th>Has not achieved Level 1</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistently demonstrates compassion, respect, and empathy</td>
<td>Displays a consistent attitude and behavior that conveys acceptance of diverse individuals and groups, including diversity in gender, age, culture, race, religion, disabilities, sexual orientation, and gender identity</td>
<td>Incorporates patients' beliefs, values, and cultural practices in patient care plans</td>
<td>Identifies health inequities and social determinants of health and their impact on individual and family health</td>
<td>Anticipates and develops a shared understanding of needs and desires with patients and families; works in partnership to meet these needs</td>
<td>Demonstrates leadership in cultural proficiency, understanding of health disparities, and social determinants of health</td>
</tr>
<tr>
<td>Recognizes impact of culture on health and health behaviors</td>
<td>Elicits cultural factors from patients and families that impact health and health behaviors in the context of the biopsychosocial model</td>
<td>Identifies own cultural framework that may impact patient interactions and decision-making</td>
<td></td>
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</tbody>
</table>

**Comments:**
Health Equity Research and Policy

Toolkit: Communities, Social Justice and Academic Medical Centers

Recent events in Baltimore and elsewhere have rekindled the ongoing national dialogue about social injustice. Let’s continue the conversation we started at Learn Serve Lead 2015: The AAMC Annual Meeting and develop concrete actions that an individual, an institution, or the AAMC can take to address social determinants and health inequities. We encourage you to use this toolkit to engage your institution and the communities it serves to explore how your clinical, research and education missions can improve community health and close health and health care gaps.

- Facilitator Guide PDF
- Slides PPT
- Reflection Sheet PDF
- Table Discussion Sheet PDF

If you have any questions or want to share details about your institution’s experience with the
2016 Institute of Medicine: Framework for lifelong learning for health professionals in understanding and addressing the social determinants of health.
1. Linking Quality and Equity
2. Creating a Culture of Equity
3. Diagnosing the Disparity
4. Designing the Activity
5. Securing Buy-in
6. Implementing Change
## Appendix: Best Practices to Reduce Disparities

### Finding Answers: Disparities Research for Change

<table>
<thead>
<tr>
<th>Practice</th>
<th>Rationale</th>
<th>Possible Strategies</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect and stratify race, ethnicity, and language (REL) data in tandem with other equity efforts</td>
<td>REL data is an important part of reducing disparities, but it is not necessary to put all equity efforts on hold until REL data is available.</td>
<td>Use qualitative methods (e.g., surveys, interviews) to identify disparities if quantitative data isn’t available. Continue to foster a culture of equity across the organization while REL data collection is in progress.</td>
<td>Disparities efforts are not stalled. The organization is primed to address disparities once REL-stratified data is available.</td>
</tr>
<tr>
<td>Foster a culture of equity</td>
<td>Success is more likely if staff recognize that disparities exist within the organization and view inequality as an injustice that must be redressed.</td>
<td>Share feedback with providers and incentivize disparities reduction. Include equitable health care as a goal in mission statements. Build a workforce that reflects the diversity of the patient population. Institute a Community Advisory Board and develop ties with community-based organizations.</td>
<td>Staff, patients, and community members share a definition of equitable care and value equity in health care delivery.</td>
</tr>
<tr>
<td>Appoint staff and protect their time for equity programs and hold them accountable for results</td>
<td>Without staff time and effort, equity programs are unlikely to reach their full potential.</td>
<td>Include equity goals in job descriptions and performance reviews. Prepare for leadership and staff turn over by cross-training staff and documenting institutional knowledge. Identify equity champions to lead the effort.</td>
<td>Staff is not overtaxed and remains committed to the program over time.</td>
</tr>
<tr>
<td>Target multiple levels and players across the care delivery system</td>
<td>The causes of disparities are complex; solutions need to address multiple factors.</td>
<td>Avoid focusing exclusively on patients - design programs that intervene with providers, organizations, community groups, and policies, as well as patients.</td>
<td>Programs effectively address the multiple causes of disparities. Improvements are systematic and comprehensive.</td>
</tr>
</tbody>
</table>
Population
Health
Milestones
address
health equity, social
determinants of health
Accountability requires a social determinants framework.
## Equity and Empowerment Lens

<table>
<thead>
<tr>
<th>PEOPLE</th>
<th>PLACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is positively and negatively affected (by this issue) and how?</td>
<td>What kind of positive “place” are we creating?</td>
</tr>
<tr>
<td>How are people differently situated in terms of the barriers they experience?</td>
<td>What kind of negative “place” are we creating?</td>
</tr>
<tr>
<td>Consider physical, spiritual, emotional and contextual affects.</td>
<td>How are public resources and investments distributed geographically?</td>
</tr>
<tr>
<td></td>
<td>How are you considering environmental impacts as well as environmental justice?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROCESS</th>
<th>POWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>How are we meaningfully including or excluding people (communities of color) who are affected?</td>
<td>What are the barriers to doing equity and racial justice work?</td>
</tr>
<tr>
<td>What policies, processes and social relationships contribute to the exclusion of communities most affected by inequities?</td>
<td>What are the benefits and burdens that communities experience with this (issue)?</td>
</tr>
<tr>
<td>Are there empowering processes at every human touchpoint?</td>
<td>Who is accountable?</td>
</tr>
</tbody>
</table>

Source:
SAMPLE METRICS WE USE TODAY IN PRIMARY CARE
Asthma specific disease management measures include:

- Appropriate medication use
- Influenza vaccination
- Pneumococcal vaccination
- Assessment of tobacco use
- Assistance with tobacco cessation

Additionally, HEDIS 2015 includes 4 asthma specific measures falling under 2 domains of care (Effectiveness of Care and Utilization and Relative Resource Use):

- Use of Appropriate Medications for People With Asthma
- Medication Management for People With Asthma
- Asthma Medication Ratio
- Relative Resource Use for People

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service.
IOM recommended Social and Behavioral Domains for inclusion in EHRs


<table>
<thead>
<tr>
<th>Domains</th>
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<tbody>
<tr>
<td>Individual-level (patient-reported)</td>
<td></td>
</tr>
<tr>
<td>Race/ethnicity&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
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<tr>
<td>Education</td>
<td></td>
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<tr>
<td>Financial resource strain</td>
<td></td>
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<tr>
<td>Stress</td>
<td></td>
</tr>
<tr>
<td>Depression&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Physical activity</td>
<td></td>
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<tr>
<td>Tobacco use and exposure&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Alcohol use&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>Social connections and social isolation</td>
<td></td>
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<tr>
<td>Exposure to violence: intimate partner violence</td>
<td></td>
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<tr>
<td>Community-level (geocodable)</td>
<td></td>
</tr>
<tr>
<td>Neighborhood and community compositional characteristics (residential address&lt;sup&gt;a&lt;/sup&gt;; census tract-median income)</td>
<td></td>
</tr>
</tbody>
</table>
BUT WE KNOW THIS WON’T GET US TO HEALTH EQUITY GIVEN...
WHAT WE DON’T TRACK

Beck AF, Huang B, Chundur R, Kahn RS.

<table>
<thead>
<tr>
<th>Community VS</th>
<th>Indicators</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Built environment</td>
<td>Fast food restaurants per 100,000 population; liquor stores per 100,000 population; population density</td>
<td>American Community Survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>US Census Bureau, county business patterns</td>
</tr>
<tr>
<td></td>
<td></td>
<td>US Census Bureau, ZIP code business patterns</td>
</tr>
<tr>
<td>Environmental exposures</td>
<td>Median housing structure age; number of person-days with maximum 8-hour average ozone concentration over the National Ambient Air Quality Standard (monitored and modeled data); number of person-days with PM2.5 over the National Ambient Air Quality Standard (monitored and modeled data); percent of occupied housing units without complete plumbing facilities; percent of population potentially exposed to water exceeding a violation limit during the past year</td>
<td>American Community Survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Center for Disease Control and Prevention (CDC), Environmental Public Health Tracking Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Environmental Protection Agency, Safe Drinking Water Information System</td>
</tr>
<tr>
<td>Neighborhood economic</td>
<td>Dependency ratio (old-age); estimated percent of foreclosure starts over the past 18 months through June 2008; estimated percent of vacant addresses in June 2008 (90-day vacancy rate); Gini coefficient—inequality; overall percentile ranking for the CDC Social Vulnerability Index</td>
<td>Agency for Toxic Substances and Disease Registry</td>
</tr>
<tr>
<td>conditions</td>
<td></td>
<td>American Community Survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Department of Housing and Urban Development, Neighborhood Stabilization Program</td>
</tr>
<tr>
<td>Neighborhood race/ethnic</td>
<td>Count and percent by race; residential segregation (dissimilarity and exposure)</td>
<td>American Community Survey</td>
</tr>
<tr>
<td>composition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighborhood resources</td>
<td>Low access tract at 1 mile and at 1/2 mile for urban areas or 10 miles for rural areas; metro/non-metro classification codes; Modified Retail Food Environment Index (no. of healthy food stores divided by all food stores); percent of people in a county living more than 1 mile from a supermarket or large grocery store if in an urban area, or more than 10 miles if in a rural area; percentage of population living within 1/2 mile of a park; recreation facilities per 100,000 population; Urban Classification Code—rural, urban cluster (&gt;10,000 population, &lt;50,000 population), urban area (&gt;50,000 population)</td>
<td>Center for Disease Control and Prevention, Environmental Public Health Tracking Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>US Census Bureau, county business patterns</td>
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<td></td>
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<td>US Census Bureau, ZIP code business patterns</td>
</tr>
<tr>
<td></td>
<td></td>
<td>USDA Food Access Research Atlas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>USDA, Economic Research Service</td>
</tr>
<tr>
<td>Neighborhood socioeconomic</td>
<td>Number with Bachelor's Degree or higher; median household income; number and percent of persons in managerial, professional, or executive occupations; percent below 100% of Federal Poverty Level (FPL); percent below 200% of FPL; unemployment rate</td>
<td>American Community Survey</td>
</tr>
<tr>
<td>composition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Deprivation Index</td>
<td>A composite measure of social deprivation validated to be more strongly associated with poor access to healthcare and poor health outcomes than a measure of poverty alone.</td>
<td>Robert Graham Center</td>
</tr>
</tbody>
</table>

It is time for our exercise!

Let’s share your thoughts and ideas
Small Group Question

You have noticed that your group is seeing an increasing number of kids with asthma and adults with COPD and asthma exacerbation. Others in clinic have noted this as well. After discussing this in a team meeting you realize the need to address this issue, and teach how to address it.

What do you do?
Population Health

Two questions:

What is it?

Why is it important?
Population Health is…

... the study of health in a meaningful group.

This includes:

- Health outcomes and their distribution within the group
- Patterns of health determinants
- Policies, interventions and other socioecological factors linking determinants and outcome distribution

Another way to view Population Health

Health is determined by the interaction between:

- Individual
- Political Environment
- Social Environment
- Physical Environment
- Community or Group
- Health System

In population health we study these interactions

Most of what affects patients’ health happens outside of the clinical setting. Solving problems requires involving the stakeholders who:

Understand the issues and can provide patients with:

- Necessary resources and supports
- Help making the needed changes to our health care system, and our social, material, and political environments.
Practice of Clinical Medicine

Family doctor – patient dyad
Family doctor- Family relationship
• Important
• Relevant

Can miss the bigger picture if it doesn’t also pay attention to the community and population outcomes.

Need to redefine who the patient is – not just the patient panel
2012 Institute of Medicine Report *Primary Care and Public Health: Exploring Integration to Improve Population Health* Calls for increased linkages between primary care and public health

Why?

- Avoid duplication of efforts
- Create systems that connect diverse individuals and populations to the care and services they need
- Strategically allocate our limited resources to produce improved health of the population.
What we need to do at the practice level

• Redefine population based on the public health definition as geographic as opposed to a practice patient panel

• Recognize and integrate the public health infrastructure with the medical neighborhood

• Continuous collaboration and communication with the public health infrastructure to operate as a continuous unit with a common goal
Population Health
A Competency Map Approach

- Set of competencies that form an organizational framework for curricular planning and training.
- Article published last year in *Academic Medicine*
- 4 Domains of Competency for Teaching Population Health
  - Public Health (PH)
  - Community engagement (CE)
  - Critical thinking (CT)
  - Team skills (TS)

*Academic Medicine, Vol. 88, No. 5 / May 2013*
Teaching Population Health: A Competency Map Approach to Education

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Abstract

A 2012 Institute of Medicine report is the latest in the growing number of calls to incorporate a population health approach in health professionals’ training. Over the last decade, Duke University, particularly its Department of Community and Family Medicine, has been heavily involved with community partners in Durham, North Carolina, to improve the local community’s health. On the basis of these initiatives, a group of interprofessional faculty began tackling critical thinking, and team skills to improve population health effectively in Durham and elsewhere.

The Department of Community and Family Medicine has spent years in care delivery redesign and curriculum experimentation, design, and evaluation to distinguish the skills trainees and faculty need for population health improvement and to integrate them into educational programs. These clinical planning and training. This framework delineates which learning objectives are appropriate and necessary for each learning level, from novice through expert, across multiple disciplines and domains. The resulting competency map has guided Duke's efforts to develop, implement, and assess training in population health for learners and faculty. In this article, the authors describe the competency map development process as well as examples of its application and implementation.
Population Health Competencies

- Public Health
- Community Engagement
- Critical Thinking
- Team Leadership
- Advocacy
Public Health
Public Health

10 Essential Services

- Monitor Health
- Diagnose & Investigate
- Inform, Educate, Empower
- Mobilize Community Partnerships
- Develop Policies
- Enforce Laws
- Link to / Provide Care
- Assure Competent Workforce
- Evaluate
- System Management

Understanding public health as not something in “that other silo”

Public Health Functions Project, U.S. Dept. of Health and Human Services.
Slide adapted from Mellanye Lackey presentation Public Health 2.0 in Slideshare.org
**Medicine**

- Focus on individuals
- Diagnosis & treatment
- Clinical interventions
- Well-established profession, standardized education & certification
- Clinical sciences integral; social sciences less emphasized
- Experimental studies with control groups: RCTs.

**Public Health**

- Focus on populations
- Prevention & health promotion
- Environment & human behavior interventions
- Diverse workforce, variable education & certifications
- Social sciences integral; clinical sciences peripheral to education
- Observational studies: case control & cohort studies

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Slide from Mellanye Lackey. UNC. Presentation Public Health 2.0 in Slideshare.org
Durham's vitality is built upon the health of our residents and the capacity of our community to foster and enhance the wellbeing of every citizen.
Community Engagement
Why emphasis on community?
Think of the community, not just the patients that show up to our offices

Most illness and care occur in the community

- 1000 persons
- 800 report symptoms
- 327 consider seeking medical care
- 217 visit a physician’s office
  - (113 visit a primary care physician’s office)
- 65 visit a complementary or alternative medical care provider
- 21 visit a hospital outpatient clinic
- 14 receive home health care
- 13 visit an emergency department
- 8 are hospitalized
- <1 is hospitalized in an academic medical center

Community Engagement

- In order to successfully improve the health of a community, the community must be involved.
- The process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people.
- Builds trust and forms partnerships to facilitate change.
Seeing the patient in the context of community Hypertension in Durham

Note: density plots depict ACTUAL patients and respective blood pressures in Durham County

Source: DSR data from 1/1/06-5/1/09; patients seen at DUHS
Conference on Practice Improvement

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Quality and Equity Improvement

• Quality improvement (QI) consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

• Quality and Equity Improvement (QEI) related specifically to health equity includes knowledge and skills to improve care for underserved populations.
HIV

North Carolina Adult/Adolescent HIV Rates per 100,000

5-year trends

Blacks 9X higher

Hispanics 3.7X higher

Quality and Equity Improvement

• Uses data to discover and prioritize disparities in health care across patient groups.
• Uses data to improve care for vulnerable populations
• Uses health care data to address scientific, political, ethical or social health issues
Community-engaged research is…

…Research conducted “collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being.”

Patient-Centered, Team-Based Care

NP/PA
Social Worker
MD/DO
Pharma D
Physical Therapist
Patient
Nursing
Staff
Residents
Community Health Workers and Educators

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Leadership Level

• Facilitate collaboration and communication amongst health systems and public health organizations

• Drive change within hospitals or health systems to partner with public health organization
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Advocacy

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Advocacy

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Population Health
A Competency Map Approach

• Set of competencies that form an organizational framework for curricular planning and training.

• 4 Domains of Competency for Teaching Population Health
  – Public Health (PH)
  – Community engagement (CE)
  – Critical thinking (CT)
  – Team skills (TS)
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Please break into small groups

It is time for a small group exercise!

You’ll need the article, a pen, paper, and a person to record your groups thoughts and ideas
Small Group Question

You have noticed that your group is seeing an increasing number of kids with asthma and adults with COPD and asthma exacerbation.

Others in clinic have noted this as well.

After discussing this in a team meeting you realize the need to address this issue, and teach how to address it.

What do you do?
Teaching Population Health
A Competency Map

Public Health
Community Engagement
Critical thinking
Team Skills
Conference on
Practice Improvement

Join the conversation on Twitter: #CPI17
## Appendix 1

**A Competency Map for Integrating Population Health Into Clinician Education, Duke University School of Medicine, 2011**

<table>
<thead>
<tr>
<th>Competency and training level</th>
<th>Foundational (basic): awareness*</th>
<th>Applied (intermediate): skilled participation†</th>
<th>Proficient (advanced): independent practice‡</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public health (PH)</strong></td>
<td>Learners will be able to …</td>
<td>Learners will be able to meet all basic objectives, plus …</td>
<td>Learners will be able to meet all basic and intermediate objectives, plus …</td>
</tr>
<tr>
<td>PH-1: Examine the characteristics that bind people together as a community—including social ties, common perspectives and interests, and geography—and how these relate to health</td>
<td>• Define community</td>
<td>• Assess unifying characteristics of a population</td>
<td>• Assess the characteristics of communities and groups that are associated with disproportionate burden of disease</td>
</tr>
<tr>
<td></td>
<td>• Discuss the role of community in health</td>
<td>• Consider how these characteristics can help or hinder a proposed intervention</td>
<td>• Describe key disease states that demonstrate disproportionate burden of disease within specific populations</td>
</tr>
<tr>
<td></td>
<td>• Define a meaningful population for health improvement purposes</td>
<td>• Identify the characteristics of communities and groups that are associated with disproportionate burden of disease</td>
<td></td>
</tr>
<tr>
<td>PH-2: Address the role of socioeconomic, environmental, cultural, and other population-level determinants of health on the health status and health care of individuals and populations</td>
<td>• Describe population-level determinants of health</td>
<td>• Explain population-level determinants affecting the health of a population</td>
<td>• Collaborate with stakeholders to design and implement strategies to address population-level determinants of health</td>
</tr>
<tr>
<td></td>
<td>• Discuss how these factors influence health status and health care delivery</td>
<td>• Discuss potential strategies for addressing population-level determinants of health</td>
<td>• Report on the social and economic determinants of the burden of disease in specific populations</td>
</tr>
<tr>
<td>PH-3: Use community assets and resources to improve health at the individual and population levels</td>
<td>• List potentially helpful community assets and resources</td>
<td>• Describe relevant assets and resources for population health improvement within a specific community</td>
<td>• Analyze gaps in community resources</td>
</tr>
<tr>
<td></td>
<td>• Refer individual patients to resources that can assist in meeting their health needs</td>
<td>• Discuss potential collaborations with community resources to improve</td>
<td>• Develop partnerships and programs to fill these gaps</td>
</tr>
<tr>
<td></td>
<td>• Assess these assets for their potential to provide better access to health care</td>
<td></td>
<td>• Demonstrate leadership skills</td>
</tr>
</tbody>
</table>

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Where to go for examples and help

http://www.practicalplaybook.org

LEARN
Explore what integration is, what it is not, and the value of working together.
- The Principles of Integration
- The Value of Working Together

DO
Start an integrative project or move your project forward with guidance and tools.
- The Stages of Integration
- Topics for Your Project

SHARE
See how communities across the country are working together to improve population health.
- Success Stories
- Connect with Others

Join the conversation on Twitter: #CPI17
INVEST IN YOUR COMMUNITY

WHAT
Know What Affects Health
- 40% Socioeconomic Factors
- 20% Clinical Care
- 30% Health Behaviors
- 10% Physical Environment

WHERE
Focus on Areas of Greatest Need
Your zip code can be more important than your genetic code. Profound health disparities exist depending on where you live.

WHO
Collaborate with Others to Maximize Efforts
- Nonprofits
- People
- Community Developers
- Government

HOW
Use a Balanced Portfolio of Interventions for Greatest Impact
- Action in one area may produce positive outcomes in another.
- Start by using interventions that work across all four action areas.
- Over time, increase investment in socioeconomic factors for the greatest impact on health and well-being for all.

Visit www.cdc.gov/CHInav for tools and resources to improve your community’s health and well-being.

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Now more than 500 known partnerships across the US

Find a Partner: Multi-Sector Partnerships in the US from 2012-Present

543 Entries
From 49 States
And Growing…

CRITERIA:
- Must include partners from the following sectors:
  - public health
  - healthcare
- Project focus addresses an issue of health
- Project has occurred no earlier than 2012, though it does not have to be happening currently

www.practicalplaybook.org/page/find-partner
As health care changes to emphasize outcomes of entire populations, we are uniquely situated to serve as leaders in improving the health of diverse communities.

Get involved in community engagement, public health, and working with interdisciplinary teams and analyze the community’s data to improve health through meaningful programs and solutions.
Ultimate goal
Family doctors who are excellent clinicians, and agents of social transformation, who detect real problems, and find original and creative solutions to improve health.
Health professionals who can see the river of disease that flows into our clinics and hospitals and will go to identify what happens upstream
Payment models

• Can we think of payment models that can support the work of clinicians in the community?
  – Connecting with local agencies
  – Getting outside of the practice into the neighborhood
Questions?

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Resources and References


- Health Affairs. June 2017; Volume 36, Issue 6 Pursuing Health Equity. All articles in this edition of health Affairs: [http://content.healthaffairs.org/content/36/6.toc](http://content.healthaffairs.org/content/36/6.toc)


More Resources and References


- ZSFG Certificate Health Equity [http://stepup.ucsf.edu/](http://stepup.ucsf.edu/)


More Resources andReferences

• A Framework for Educating Health Professionals to Address the Social Determinants of Health authored by the Committee on Educating Health Professionals to Address the Social Determinants of Health; Board on Global Health; Institute of Medicine; National Academies of Sciences, Engineering, and Medicine. The PDF is available from The National Academy Press at [http://www.nap.edu/21923](http://www.nap.edu/21923)

• NCHHSTP Social Determinants of Health [https://www.cdc.gov/nchhstp/socialdeterminants/resources.html](https://www.cdc.gov/nchhstp/socialdeterminants/resources.html)

• The Population Health Milestone-Based Curriculum.

• A New Way to Talk about the Social Determinants of Health. Vulnerable Populations Portfolio, RWJF [http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023](http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023)

• Integration of Primary Care and Public Health. [https://www.practicalplaybook.org/](https://www.practicalplaybook.org/)

More Resources and References


• Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century
  http://www.nap.edu/catalog.php?record_id=10542#toc

  Academy Press; 2007

• Council on Graduate Medical Education Twentieth Report, Advancing Primary Care, 2010

  Medical School Objectives Project, June 1998

• Summary of the Meeting: Developing a Strong Primary Care Workforce. Macy Foundation Report
  http://www.macyfoundation.org/docs/macy_pubs/jmf_primarycare_summary.pdf

• Educating Nurses and Physicians: Toward New Horizons. Advancing Inter-professional Education in
  Academic Health Centers, June 2010

• Materials pertinent to each state on social determinants of health
  http://www.cdc.gov/socialdeterminants/Resources.html
More Resources and References

- Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century
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• Centers for Disease Control and Prevention. Principles of community engagement (1st ed.). Atlanta (GA): CDC/ATSDR Committee on Community Engagement; 1997

More Resources and References


- What is the Practical Playbook? 2015. Available at [https://www.practicalplaybook.org/about](https://www.practicalplaybook.org/about)

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