Conference on
Practice Improvement

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

- Viviana Martinez-Bianchi, MD, FAAFP
- Bonzo Reddick, MD, MPH, FAAFP
- Lloyd Michener, MD, FAAFP

Conference on
Practice Improvement

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

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Karen Smith, MD, FAAFP; (Payment Team rep)

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ADDITIONAL HEALTH EQUITY PROJECT LEADERS/ADVISORS
Brian Frank, MD
Ronya Green, MD
Laura Gottlieb, MD, MPH
Lloyd Michener, MD

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
Laura Gottlieb, MD, MPH
Joedrecka Brown Speights, MD
Jewell Carr, MD
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STFM Emerging Leader Fellow: Ronya Green, MD, MPH.
Member of Summit Advisory Panel: Kim Yu, MD, Lloyd Michener, MD
Summit lead note taker: Brian Park, MD MPH, PGY-3

http://www.starfieldsummit.com/

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

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

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

The Devine Soluti

- Non-black adults can be motivated to increase their awareness of bias against blacks, their concerns about the effects of bias and to implem were effective in producing subst bias that remained evident three
- Implicit biases viewed as de habits that can be replaced b prejudice-reducing strategie stereotype replacement, cou imaging, individuation, pers increasing opportunities for

Devine, P. G., Forscher, P. S., Austin, A. J., & C

management

- 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

Portland, Oregon – April 22-25, 2017

STARFIELD SUMMIT

IGNITE Theme 1: Social Determinants of Health in Primary Care

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

- **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*

Portland, Oregon – April 22-25, 2017

STARFIELD SUMMIT

IGNITE Theme 2: Vulnerable Populations

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

- **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*

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

Portland, Oregon – April 22-25, 2017

STARFIELD SUMMIT

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?

Boelen C. Why should social accountability be a benchmark for excellence in medical education? *Educ Med*.2016;17(3):101-105.

Table 1 The social obligation scale.

	Responsibility →	Responsiveness →	Accountability
Social needs identified	Implicitly	Explicitly	Anticipatively
Institutional objectives	Defined by faculty	Inspired from data	Defined with society
Educational programs	Community-oriented	Community-based	Contextualized
Quality of graduates	«Good» practitioners	Meeting criteria of professionalism	Health system change agents
Focus of evaluation	Process	Outcome	Impact
Assessors	Internal	External	Health partners

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**.

Boelen C. Why should social accountability be a benchmark for excellence in medical education? *Educ Med*.2016;17(3):101-105.

DUKEAHEC PROGRAM
AREA HEALTH EDUCATION CENTER
Partners in Learning & Teaching

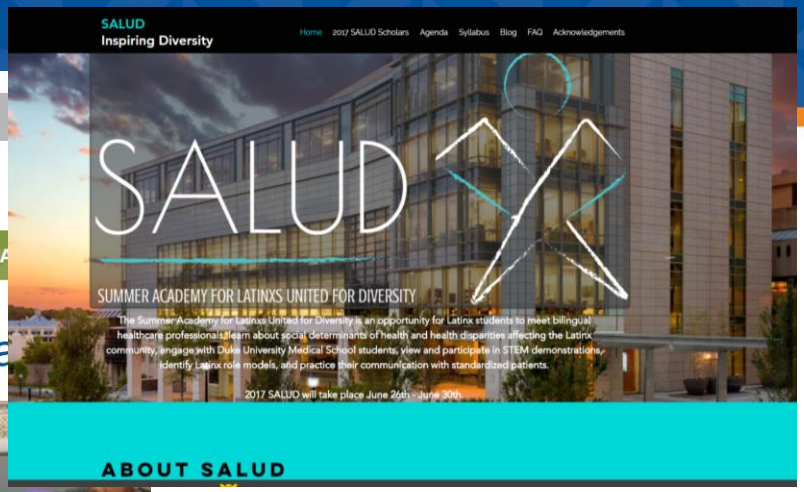
Search

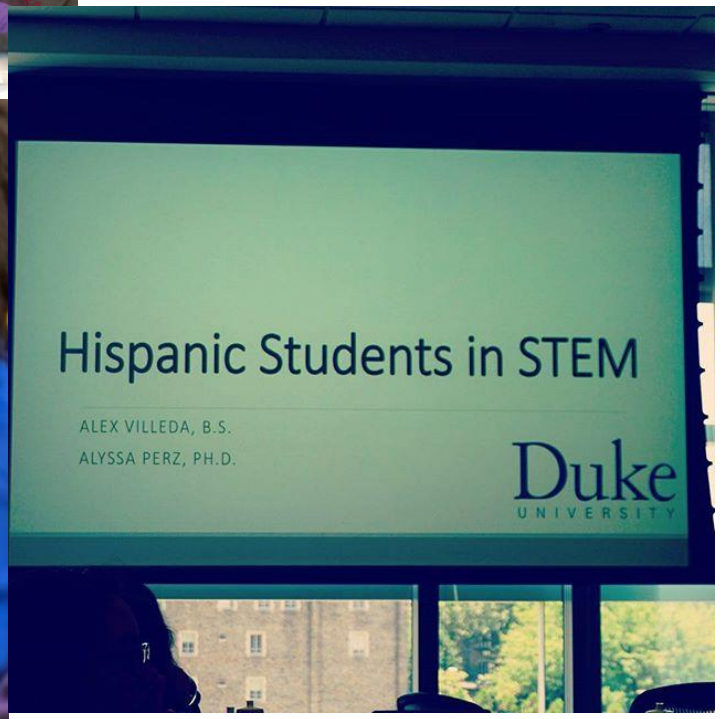
Continuing Education | Health Careers | Spanish Language Resources | Lamaze Program

- Awareness Programs
- City of Medicine Academy Programs
- Summer Programs
- College Readiness Resources

City of Medicine Academy Progra

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





Collaborative Learning

“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

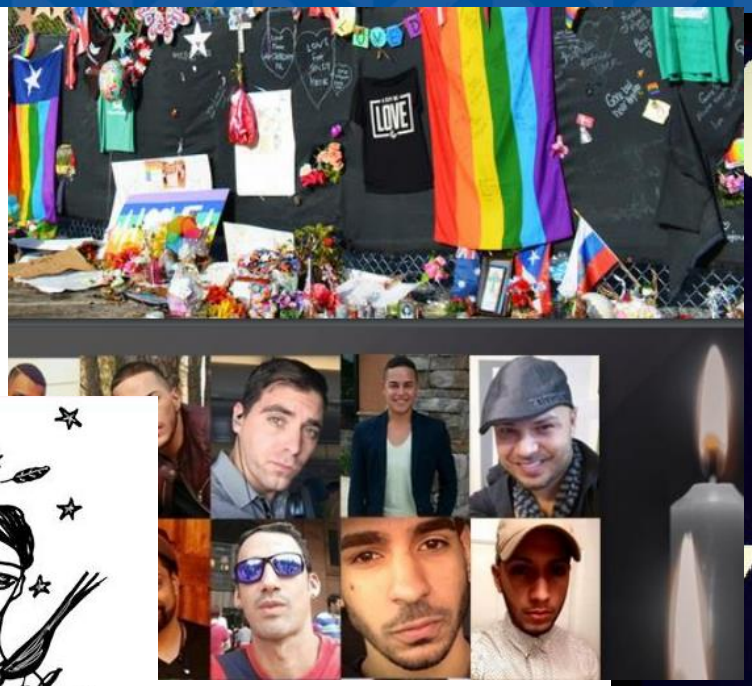
Portland, Oregon – April 22-25, 2017

STARFIELD SUMMIT

Health disparities

preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations


RACISM

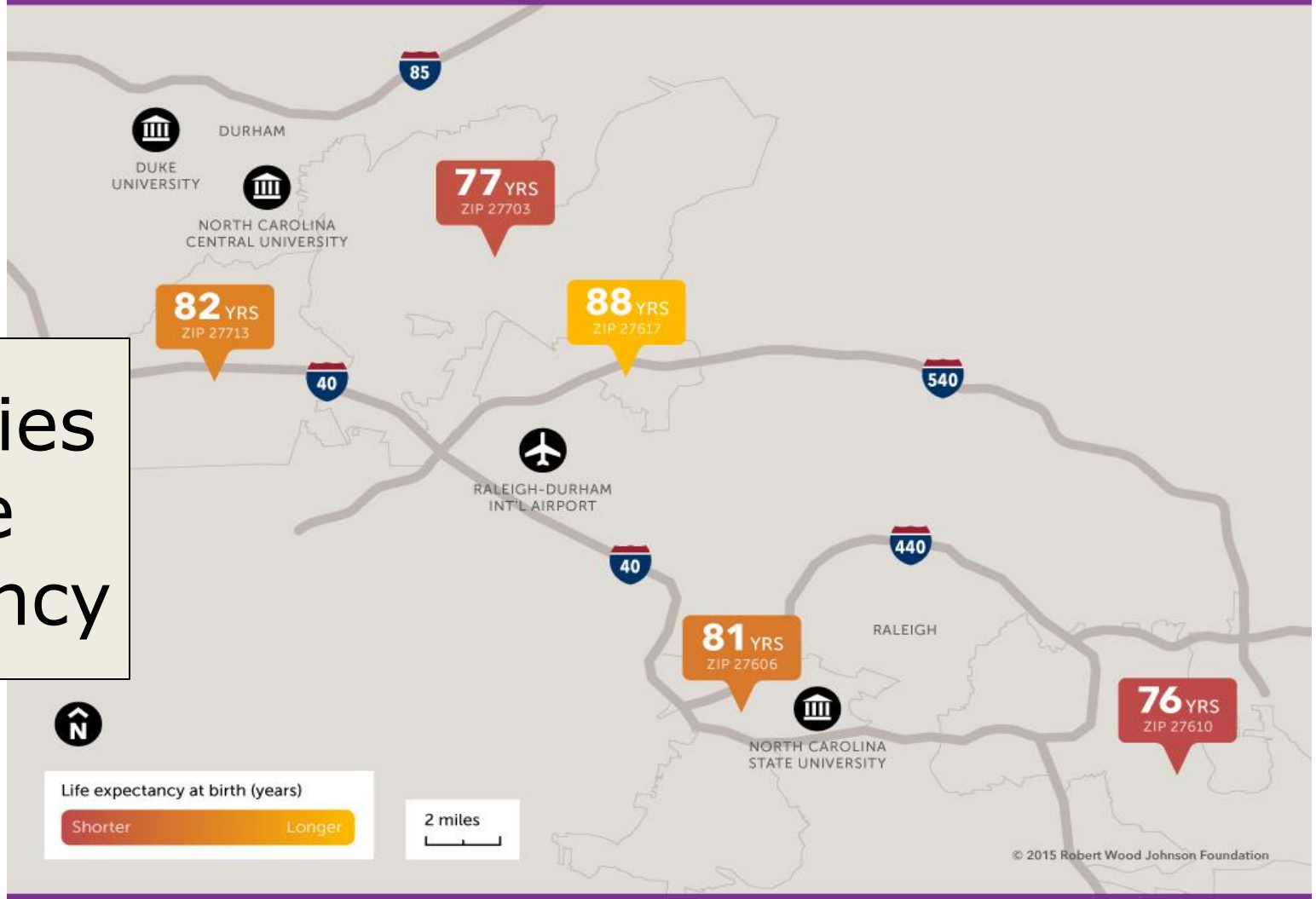

LOVE


Cuando ser pobre te condena
15 años


Braille


Raviolandia

Disparities in Life Expectancy

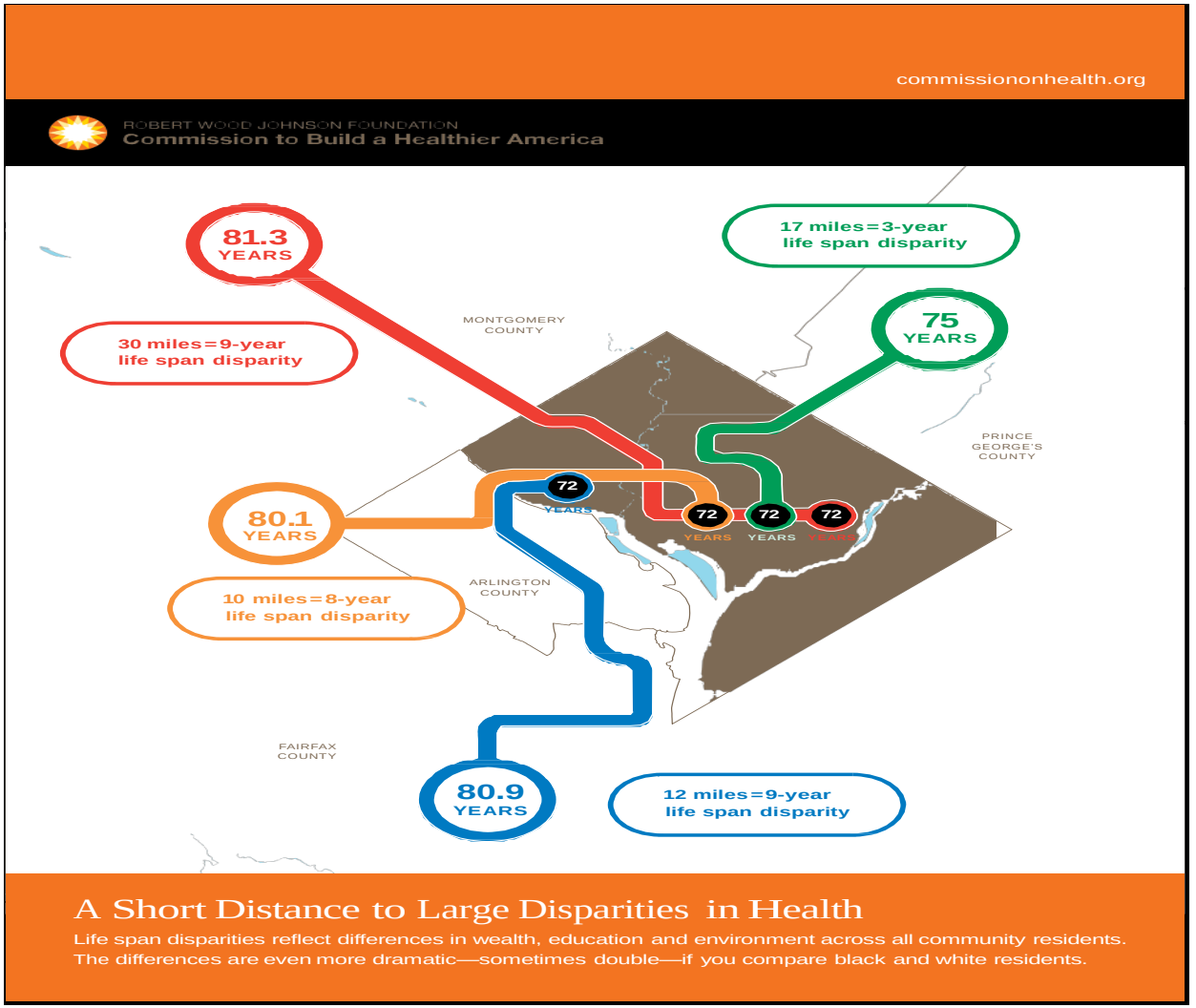


VCU Virginia Commonwealth University
Center on Society and Health
Robert Wood Johnson Foundation

Where people live matters more than the healthcare they receive.

Your zip code can be more important than your genetic code

RWJ
commissiononhealth.org



Let’s go to your city!

https://www.cdc.gov/500cities/

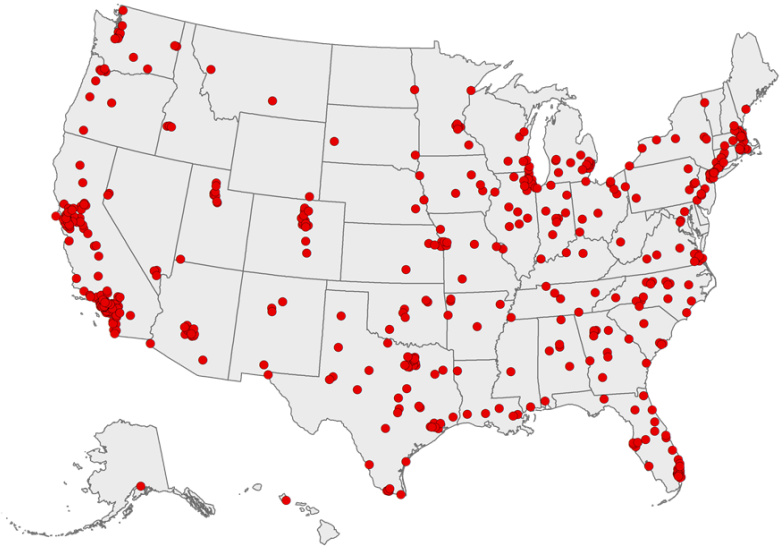
Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

500 Cities: Local Data for Better Health

The 500 Cities project is a collaboration between CDC, the Robert Wood Johnson Foundation, and the CDC Foundation. The purpose of the 500 Cities Project is to provide city- and census tract-level small area estimates for chronic disease risk factors, health outcomes, and clinical preventive service use for the largest 500 cities in the United States. These small area estimates will allow cities and local health departments to better understand the burden and geographic distribution of health-related variables in their jurisdictions, and assist them in planning public health interventions. Learn more about the 500 Cities Project.

500 Cities: Local data for better health

View data across the United States for the largest 500 cities



Select a State ▾ Go

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 DNA of Family Medicine

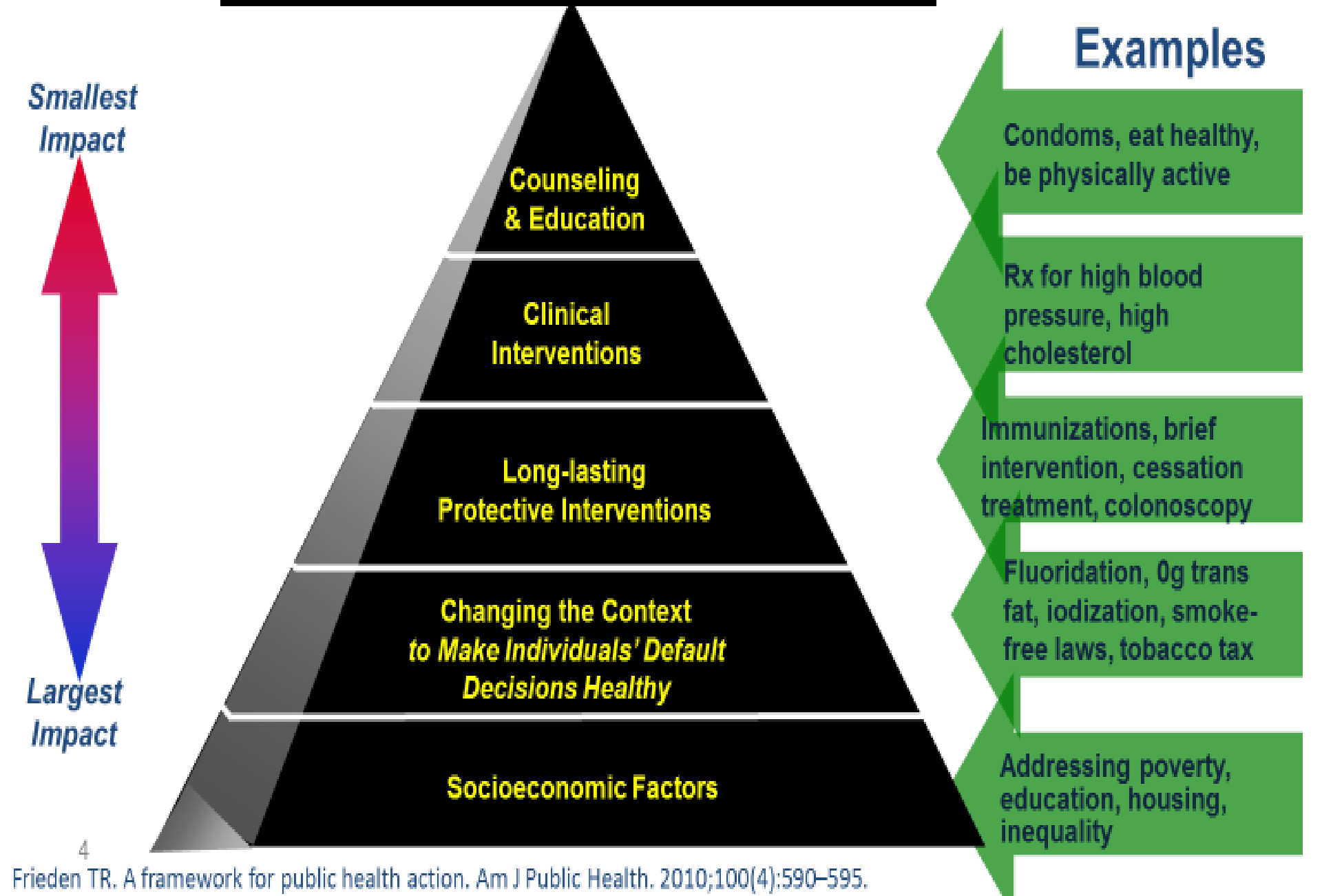
"The principle of health equity attracted many of us to medicine, and in particular to family medicine. In our DNA runs the desire to be person-centered, to take care of people of all ages and all life circumstances, to be accountable to our communities , to improve community and population health, to 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

Drawing “Equidad”, by Fernando Miguez, Argentina

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?

Factors That Affect Health

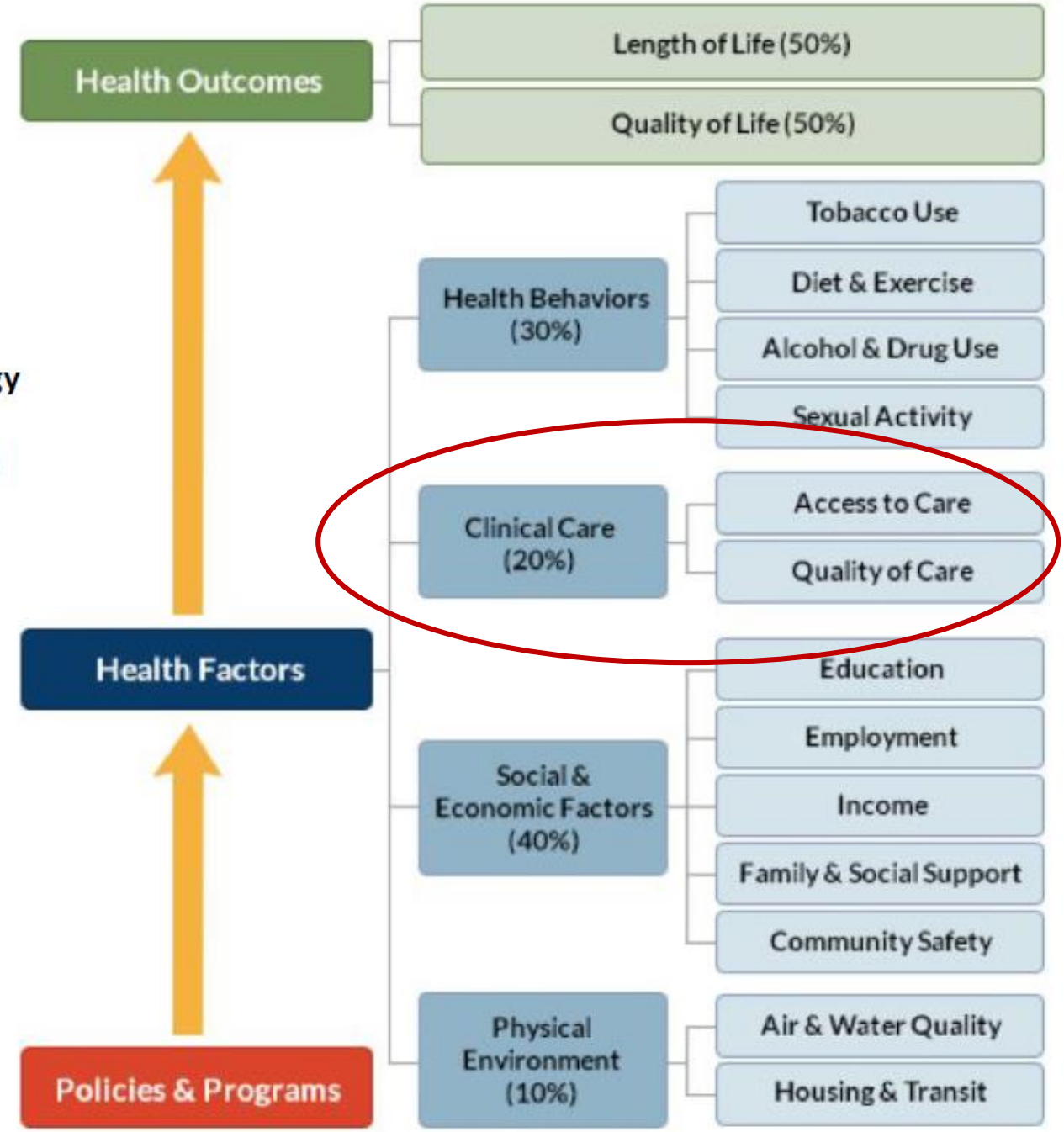


Frieden TR. A framework for public health action. Am J Public Health. 2010;100(4):590–595.

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?

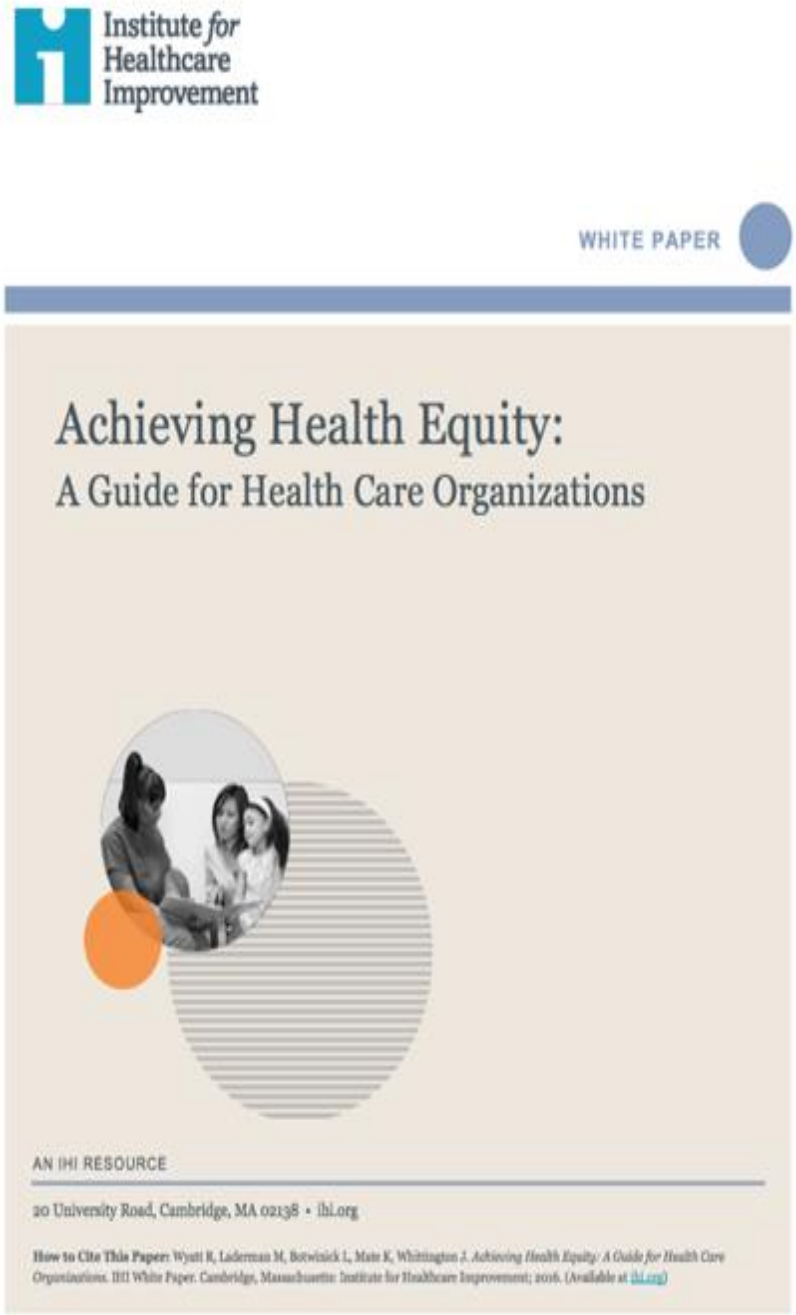
Multiple frameworks and requirements for addressing the social determinants of health

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.

Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

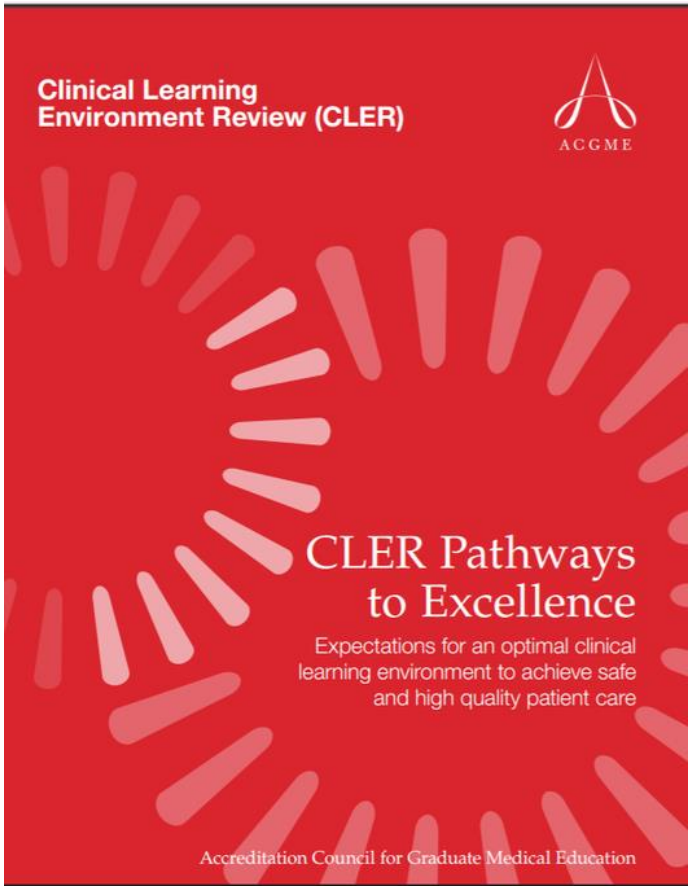
HQ Pathway 5: Resident/fellow and faculty member education on reducing health care disparities

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



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

ober 2015

Version 10/2015

PROF-3 Demonstrates humanism and cultural proficiency					
Has not achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	Consistently demonstrates compassion, respect, and empathy Recognizes impact of culture on health and health behaviors	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 Elicits cultural factors from patients and families that impact health and health behaviors in the context of the biopsychosocial model Identifies own cultural framework that may impact patient interactions and decision-making	Incorporates patients' beliefs, values, and cultural practices in patient care plans Identifies health inequities and social determinants of health and their impact on individual and family health	Anticipates and develops a shared understanding of needs and desires with patients and families; works in partnership to meet those needs	Demonstrates leadership in cultural proficiency, understanding of health disparities, and social determinants of health Develops organizational policies and education to support the application of these principles in the practice of medicine
☐	☐	☐	☐	☐	☐
Comments:					

AAMC Association of American Medical Colleges

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Subscribe to the Health Equity Research Update

Receive updates about new resources, upcoming conferences, and funding announcements.

First Name:
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Job Title:
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Submit

AAMC AHEAD

The AAMC Accelerating Health Equity, Advancing through Discovery (AHEAD) initiative seeks to identify, evaluate, and disseminate effective and replicable AAMC-member institution practices that improv community health and reduce

Health Equity Research and Policy

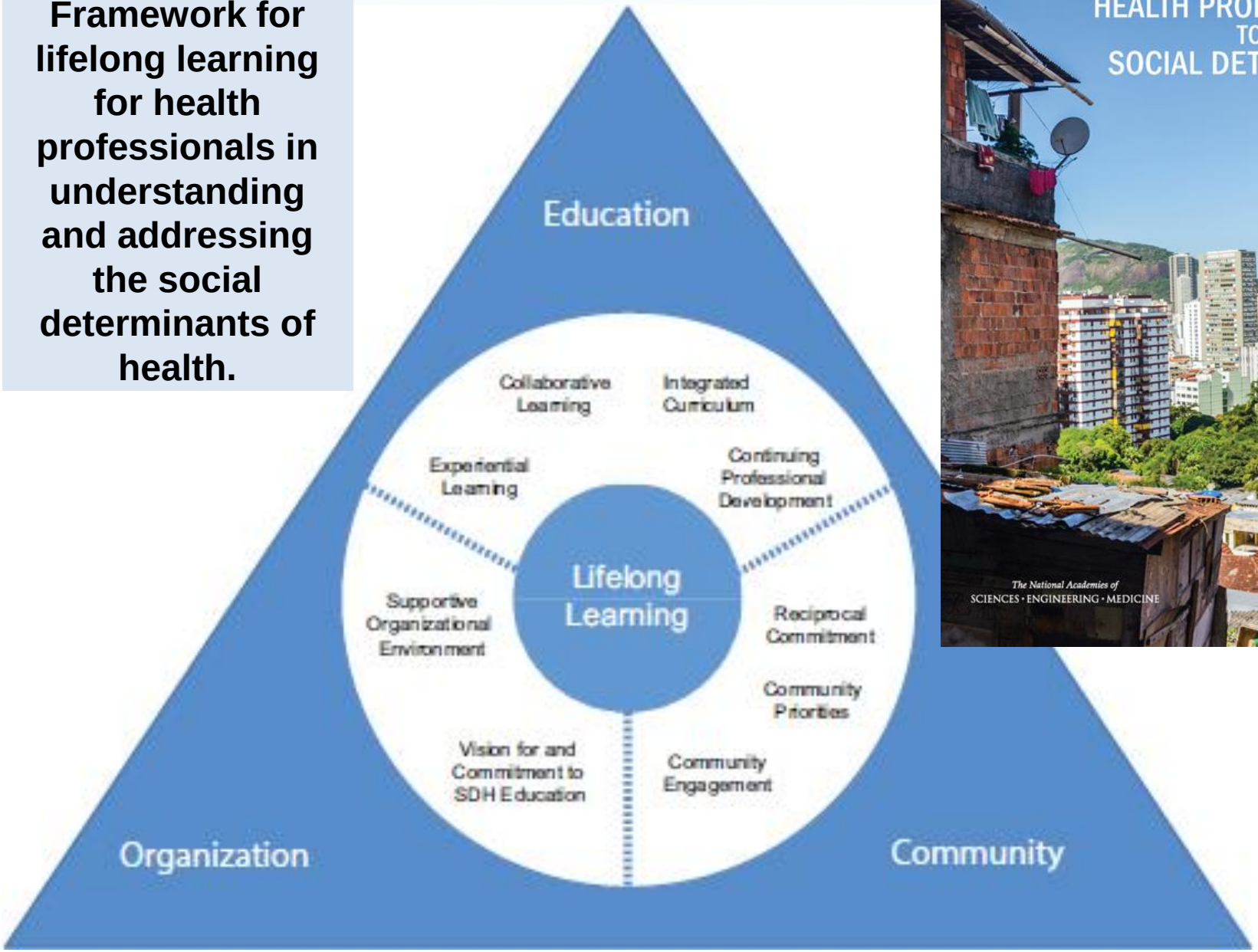
Toolkit: *Communities, Social Justice and Academic Medical Centers*

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

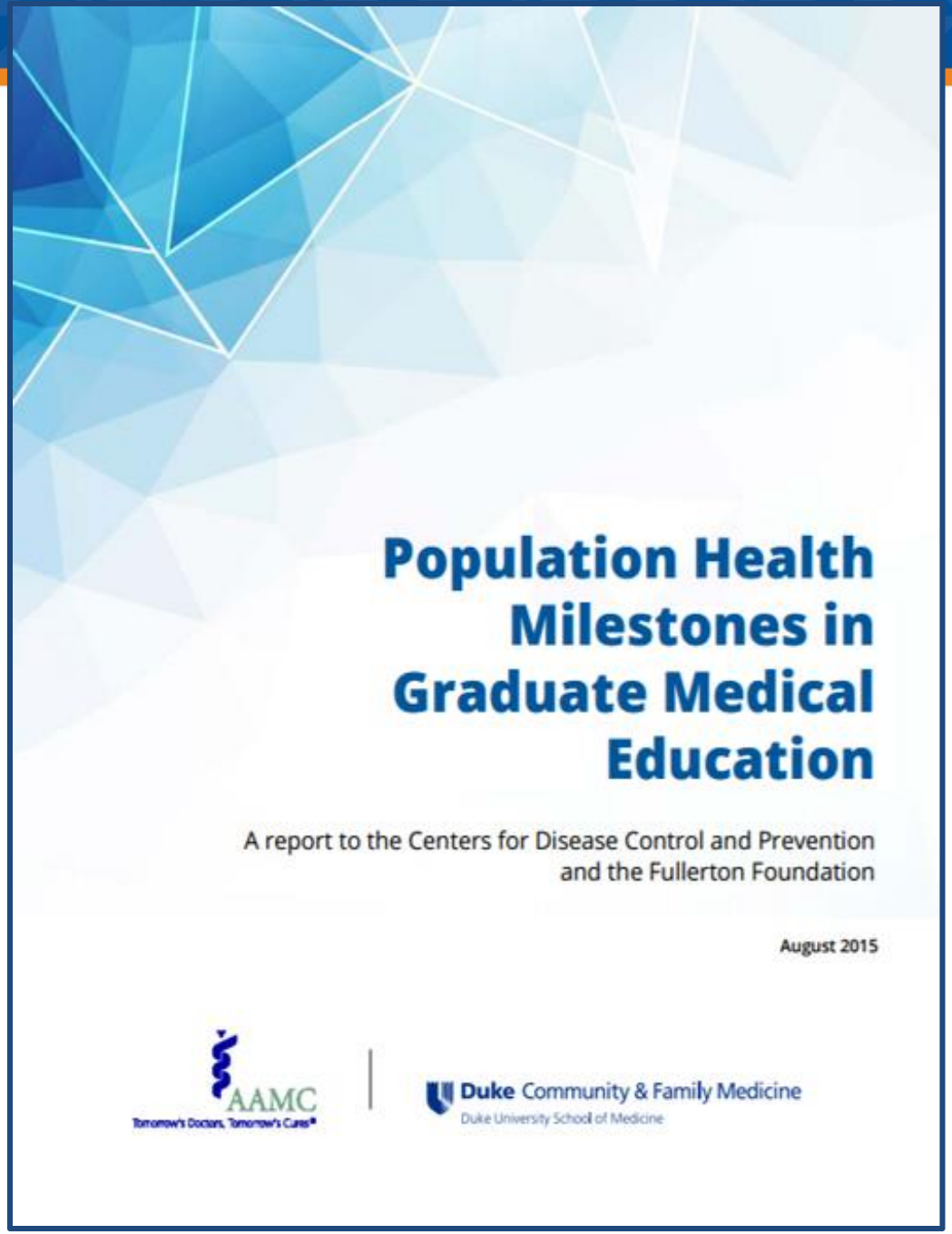
Finding Answers: Disparities Research for Change

Finding Answers:
Disparities Research for Change

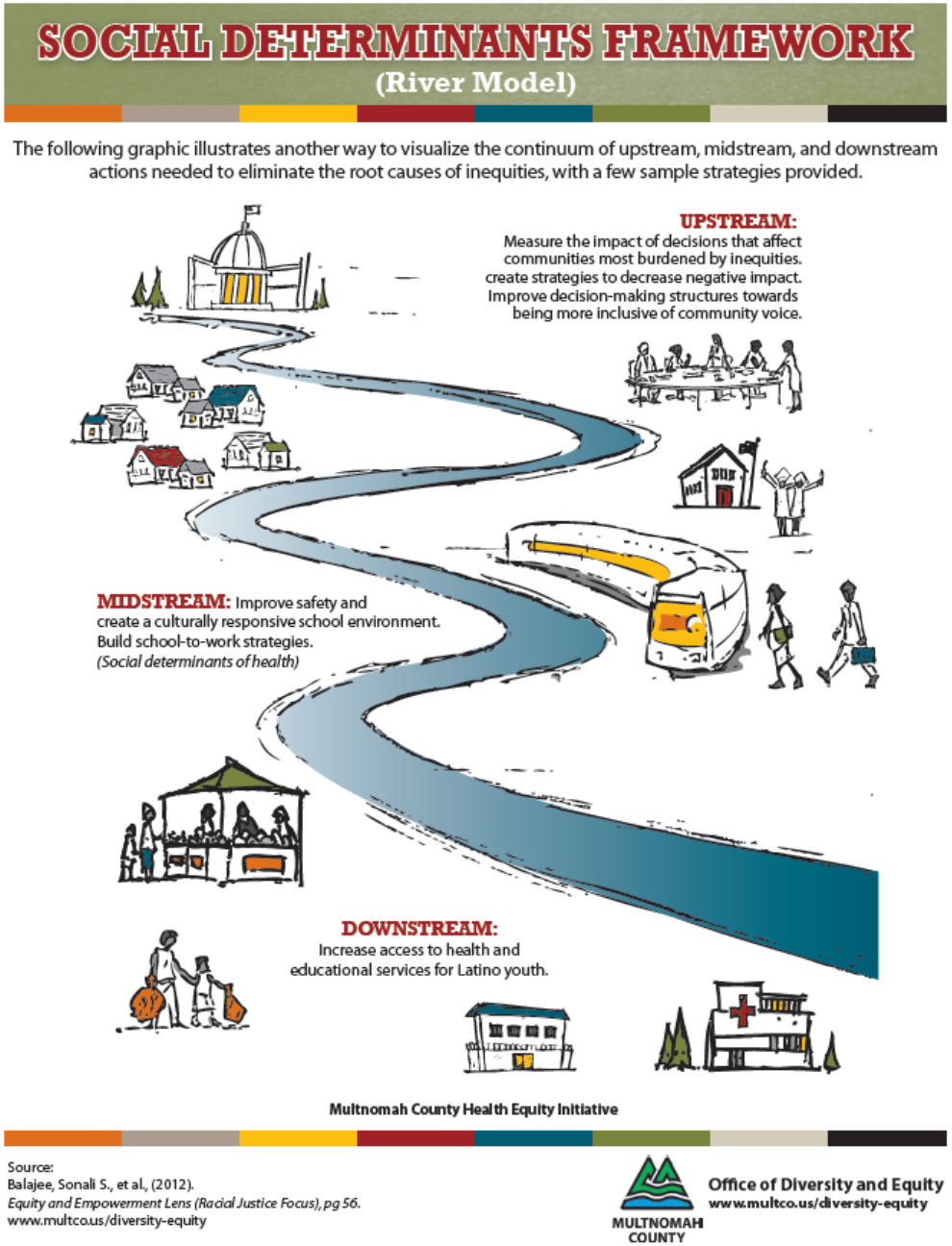
Robert Wood Johnson Foundation

Practice	Rationale	Possible Strategies	Outcome
Collect and stratify race, ethnicity, and language (REL) data in tandem with other equity efforts	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.	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.	Disparities efforts are not stalled. The organization is primed to address disparities once REL-stratified data is available.
Foster a culture of equity	Success is more likely if staff recognize that disparities exist within the organization and view inequality as an injustice that must be redressed.	Share feedback with providers and incentivize disparities reduction. Include equitable health care as a goal in mission statements. Build a work force that reflects the diversity of the patient population. Institute a Community Advisory Board and develop ties with community-based organizations.	Staff, patients, and community members share a definition of equitable care and value equity in health care delivery.
Appoint staff and protect their time for equity programs and hold them accountable for results	Without staff time and effort, equity programs are unlikely to reach their full potential.	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.	Staff is not overtaxed and remains committed to the program over time.
Target multiple levels and players across the care delivery system	The causes of disparities are complex; solutions need to address multiple factors.	Avoid focusing exclusively on patients - design programs that intervene with providers, organizations, community groups, and policies, as well as patients.	Programs effectively address the multiple causes of disparities. Improvements are systematic and comprehensive.

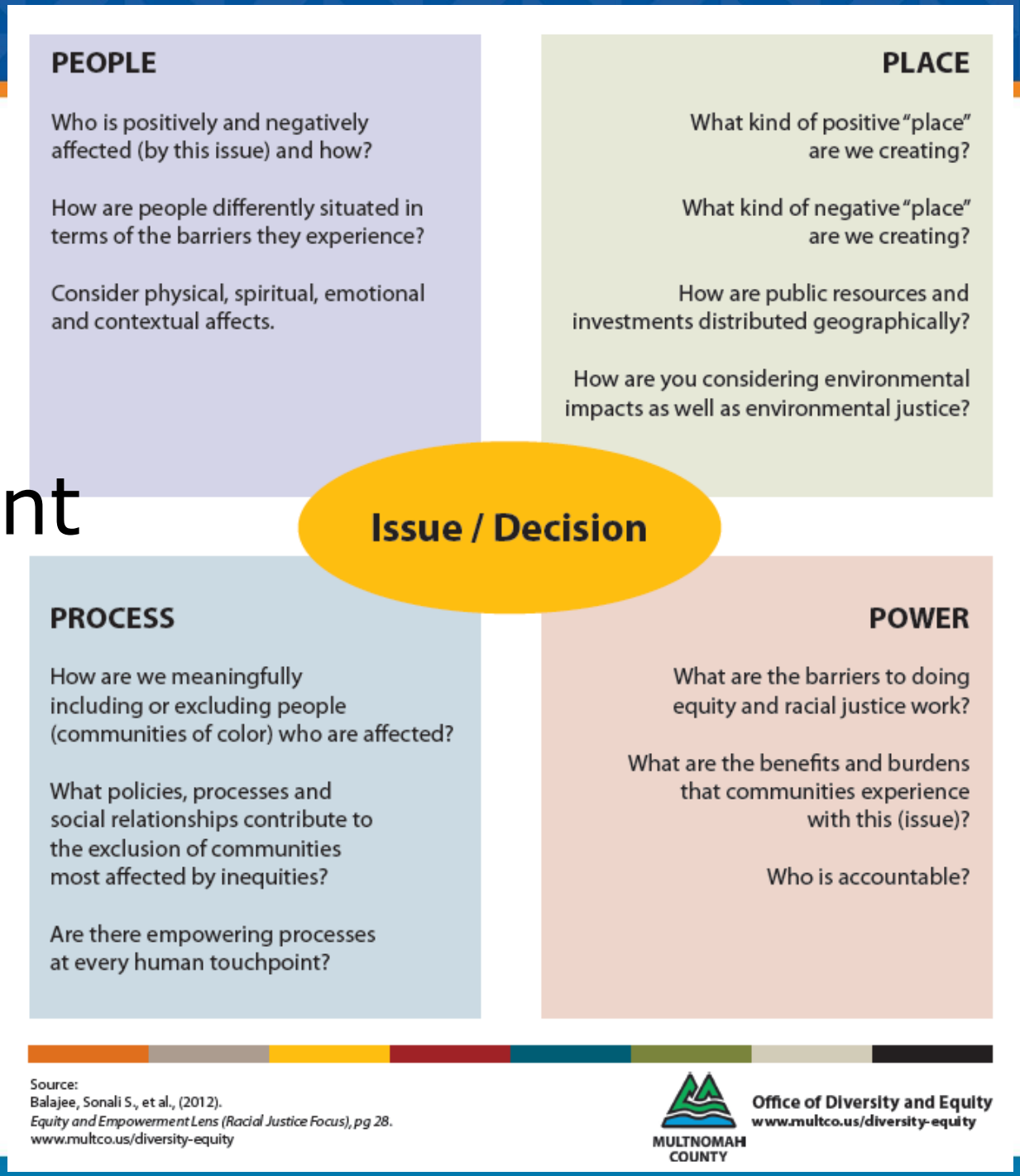
Population Health Milestones address health equity, social determinants of health



Accountability requires a social determinants framework



Equity and Empowerment Lens



SAMPLE METRICS WE USE TODAY IN PRIMARY CARE

HEDIS® & Performance Measurement

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.

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

Table 1. Summary of IOM Recommended Social and Behavioral Domains for Inclusion in all EHRs

Domains
Individual-level (patient-reported)
Race/ethnicity[a]
Education
Financial resource strain
Stress
Depression[a]
Physical activity
Tobacco use and exposure[a]
Alcohol use[a]
Social connections and social isolation
Exposure to violence: intimate partner violence
Community-level (geocodable)
Neighborhood and community compositional characteristics (residential address[a]; census tract-median income)

IOM recommended Social and Behavioral Domains for inclusion in EHRs

Source. Table copied from: Bazemore A, et al. J Am Med Inform Assoc 2016;23:407–412. doi:10.1093/jamia/ocv088, Perspective

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.

Housing code violation density associated with emergency department and hospital use by children with asthma. *Health Affairs* November 2014;33(11) 1993-2002.

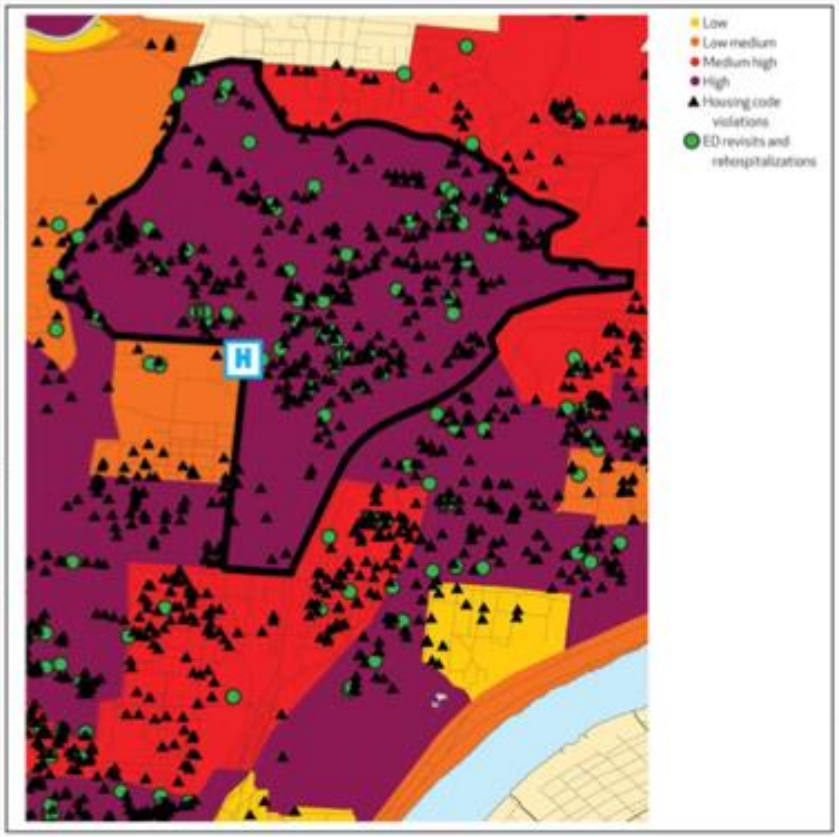


EXHIBIT 3
Cincinnati's Avondale Neighborhood With Asthma-Related Housing Code Violations, 2008–12, And Asthma-Related Emergency Department (ED) Revisits And Rehospitalizations Within Twelve Months Of the First (Index) Hospitalization For Children Hospitalized, 2009–12

SOURCE Authors' analysis of data from the Cincinnati Children's Hospital Medical Center and the Cincinnati Area Geographic Information System. **NOTES** All of the Avondale neighborhood (the area within the thick black line) has a high level of violations—that is, more than 23.8 violations per 1,000 units. Volume levels are defined in the notes to .

Housing Code Violation Density Associated With Emergency Department And Hospital Use By Children With Asthma
Health Aff (Millwood). ;33(11):1993-2002.

Table 2: Indicators selected for ADVANCE Pilot by Community VS Type

Community VS	Indicators	Data Source
Built environment	Fast food restaurants per 100 000 population; liquor stores per 100 000 population; population density	American Community Survey
		US Census Bureau, county business patterns
		US Census Bureau, ZIP code business patterns
Environmental exposures	Median housing structure age; number of person-days with maximum 8-h 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	American Community Survey
		Center for Disease Control and Prevention (CDC), Environmental Public Health Tracking Network
		Environmental Protection Agency, Safe Drinking Water Information System
Neighborhood economic conditions	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	Agency for Toxic Substances and Disease Registry
		American Community Survey
		Department of Housing and Urban Development, Neighborhood Stabilization Program
Neighborhood race/ethnic composition	Count and percent by race; residential segregation (dissimilarity and exposure)	American Community Survey
Neighborhood resources	Low access tract at 1 mile and at ½ 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 ½ mile of a park; recreation facilities per 100 000 population; Urban Classification Code—rural, urban cluster (>10 000 population, <50 000 population), urban area (>50 000 population)	Center for Disease Control and Prevention, Environmental Public Health Tracking Network
		US Census Bureau, county business patterns
		US Census Bureau, ZIP code business patterns
		USDA Food Access Research Atlas
		USDA, Economic Research Service
Neighborhood socioeconomic composition	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	American Community Survey
Social Deprivation Index	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.	Robert Graham Center[32]

Source. Table copied from: Bazemore A, et al. J Am Med Inform Assoc 2016;23:407–412. doi:10.1093/jamia/ocv088, Perspective

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.

Population Health

Two questions:

What is it?

Why is it important?

Population Health is…

… the study of health in a meaningful group.

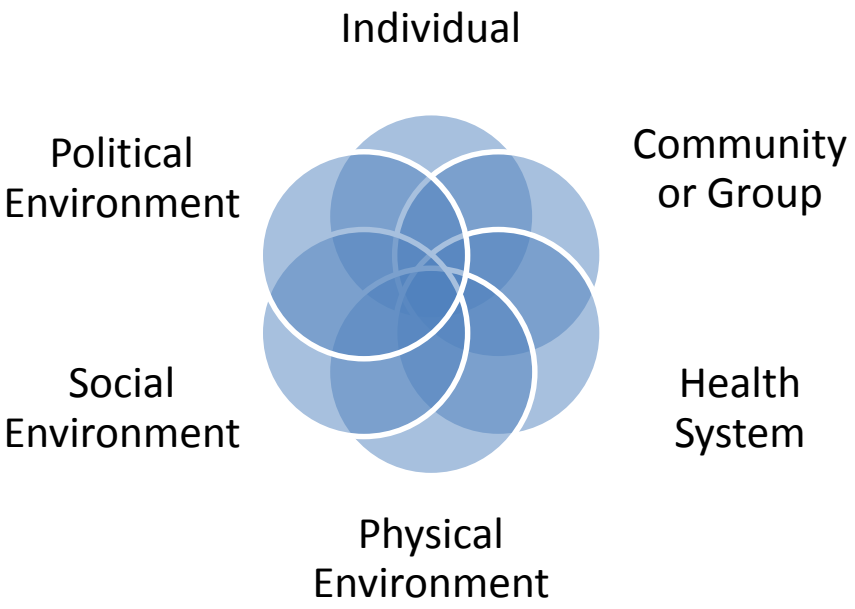
This includes:

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

Kindig D and Stoddart S (2003). What is population health?
AJPH 93 (3): 380-383.

Another way to view Population Health

Health is determined by the interaction between:



In population health we study these interactions

Stokols D. Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion* 1996;10(4):282-298.

Population Health – Why Teach This?

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

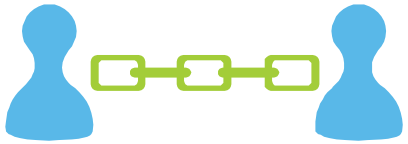
Family doctor – patient dyad
Family doctor- Family relationship

- 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

Linking Primary Healthcare and Public Health



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

Article

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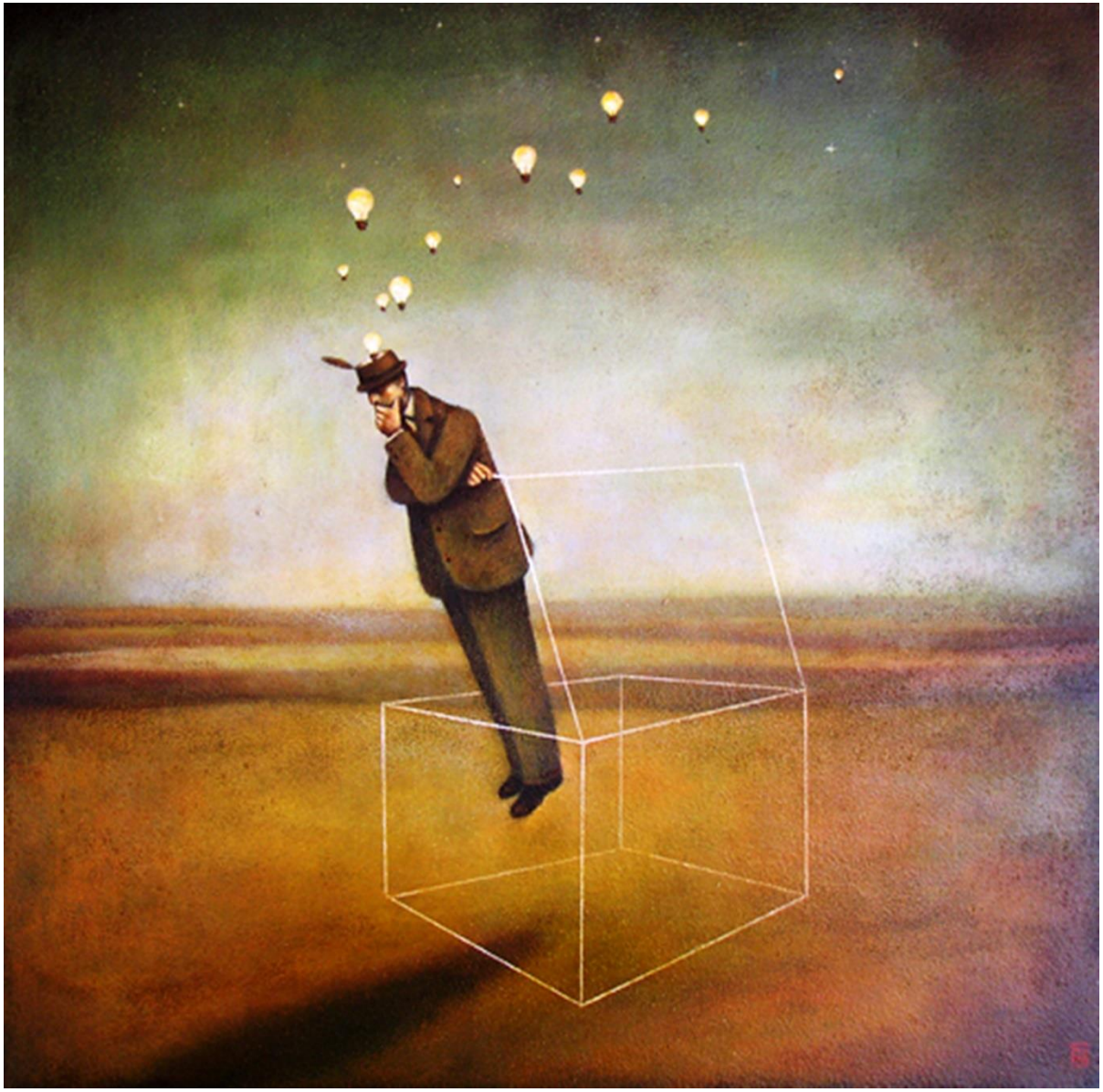
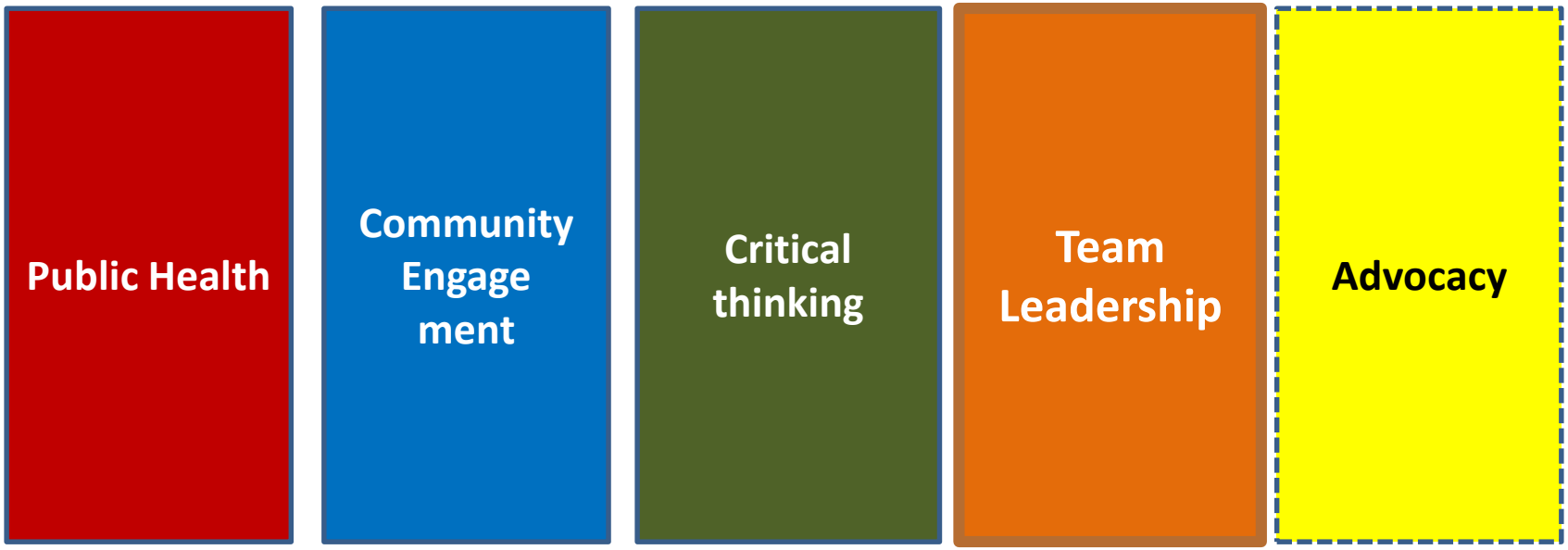


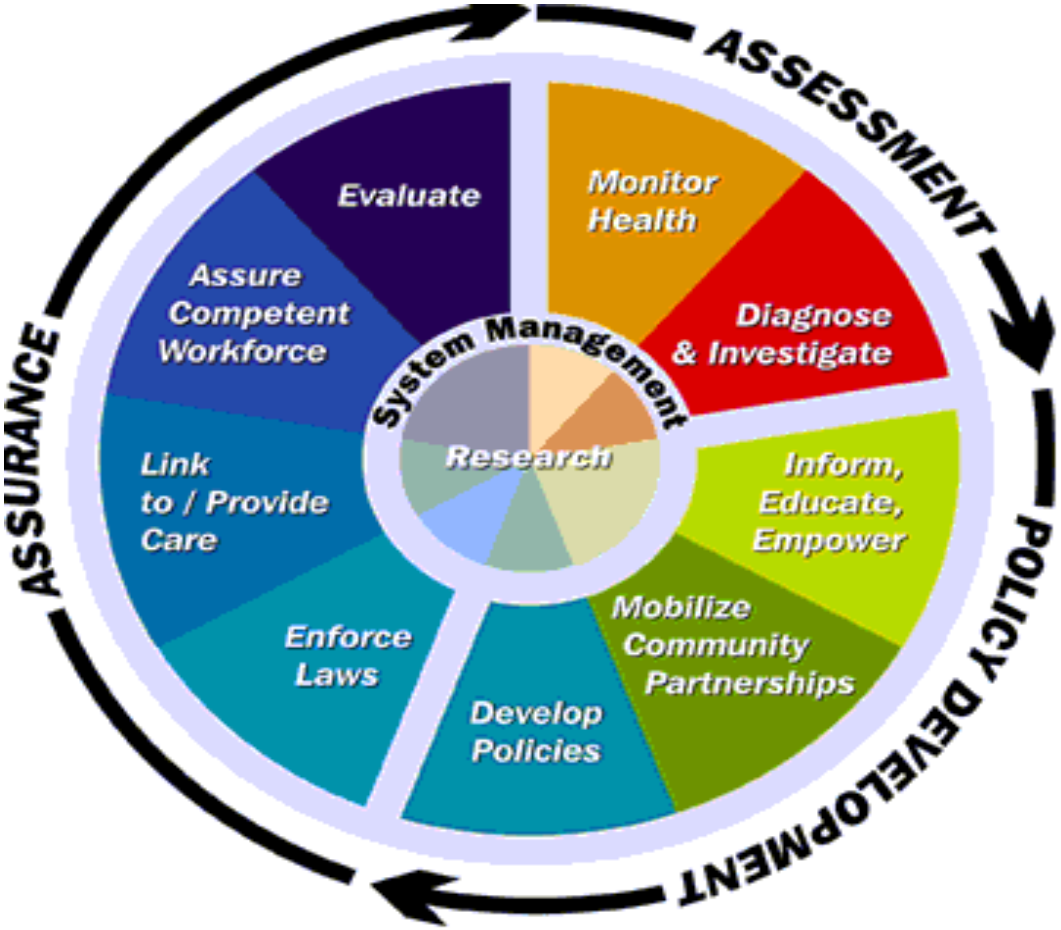
Population Health Competencies



Public Health

Public Health

10 Essential Services



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

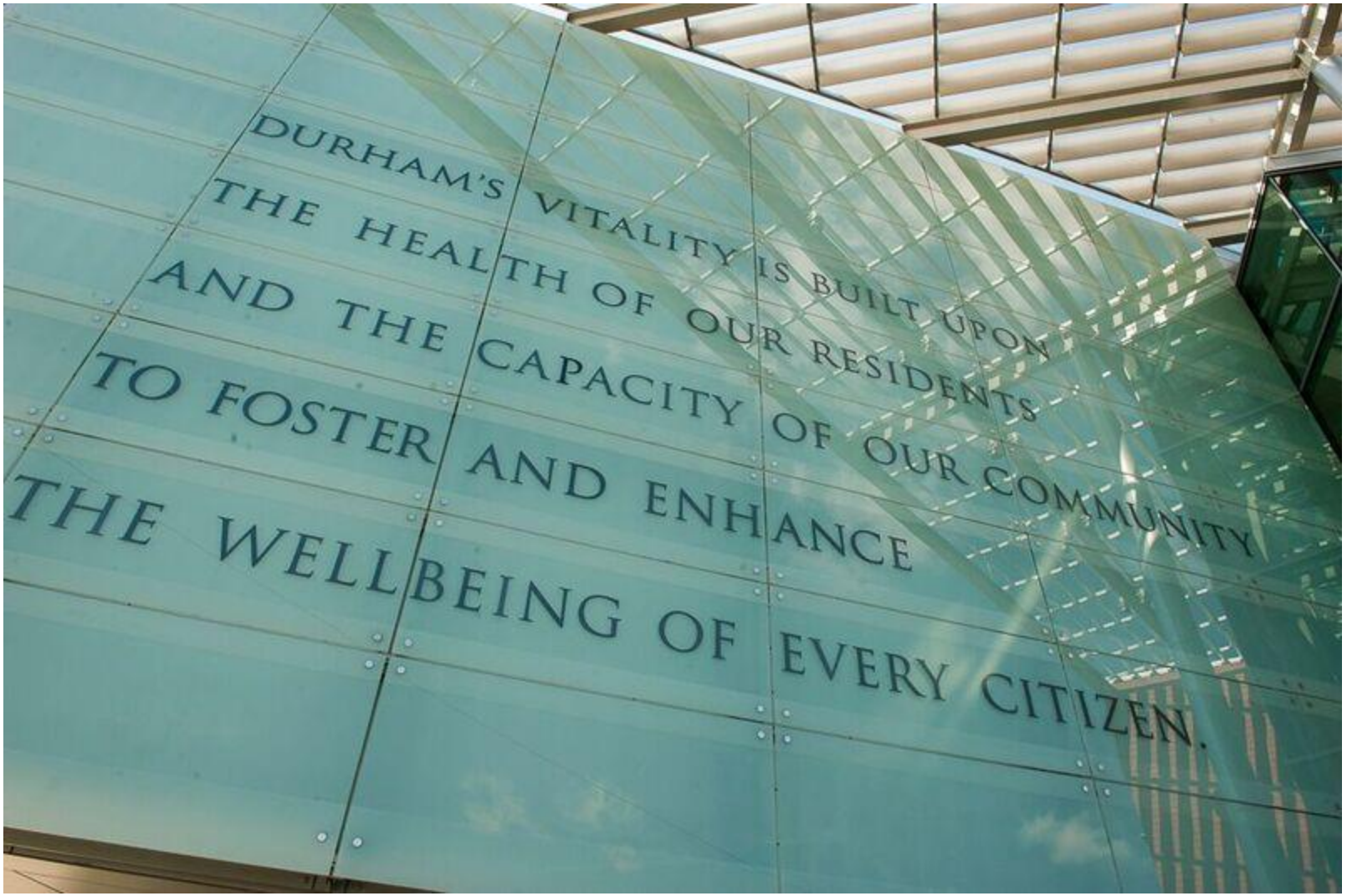
Medicine

- 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

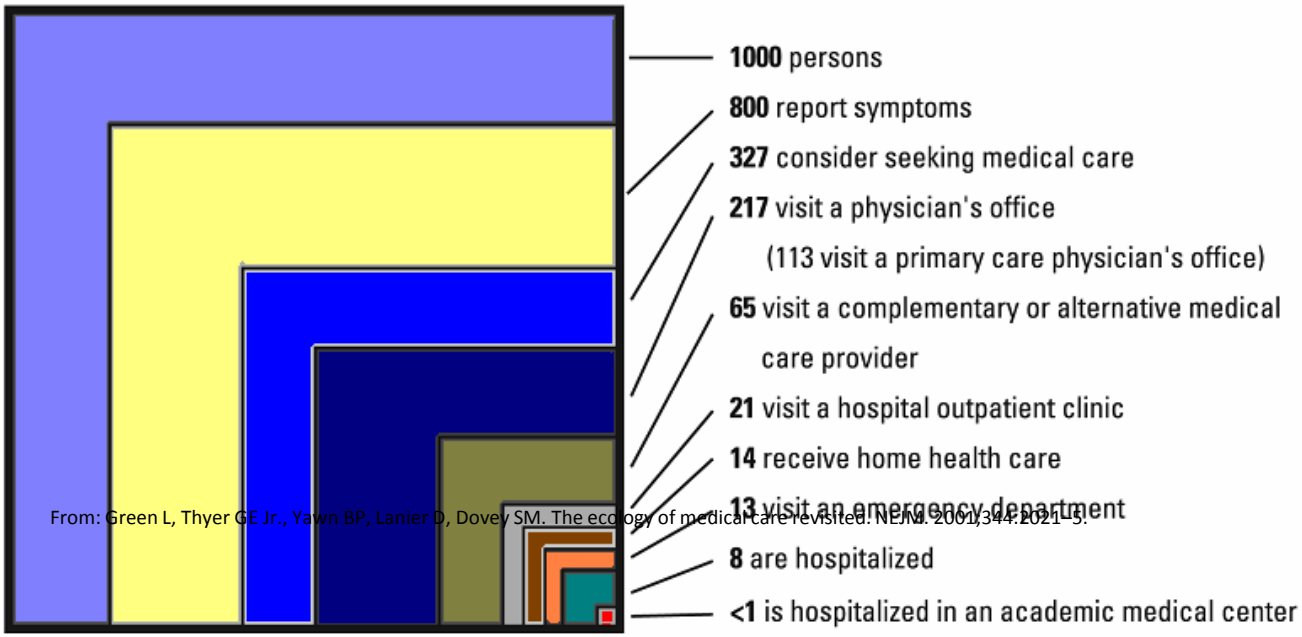
- Focus on populations
- Prevention & health promotion
- Environment & human behavior interventions
- Diverse workforce, variable education & certifications
- Social sciences integral; clinical sciences peripheral to education
- Observational studies: case control & cohort studies

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



From: Green L, Thyer GE Jr., Yawn BP, Lanier D, Dovey SM. The ecology of medical care revisited. NEJM. 2001;344:2021-5.

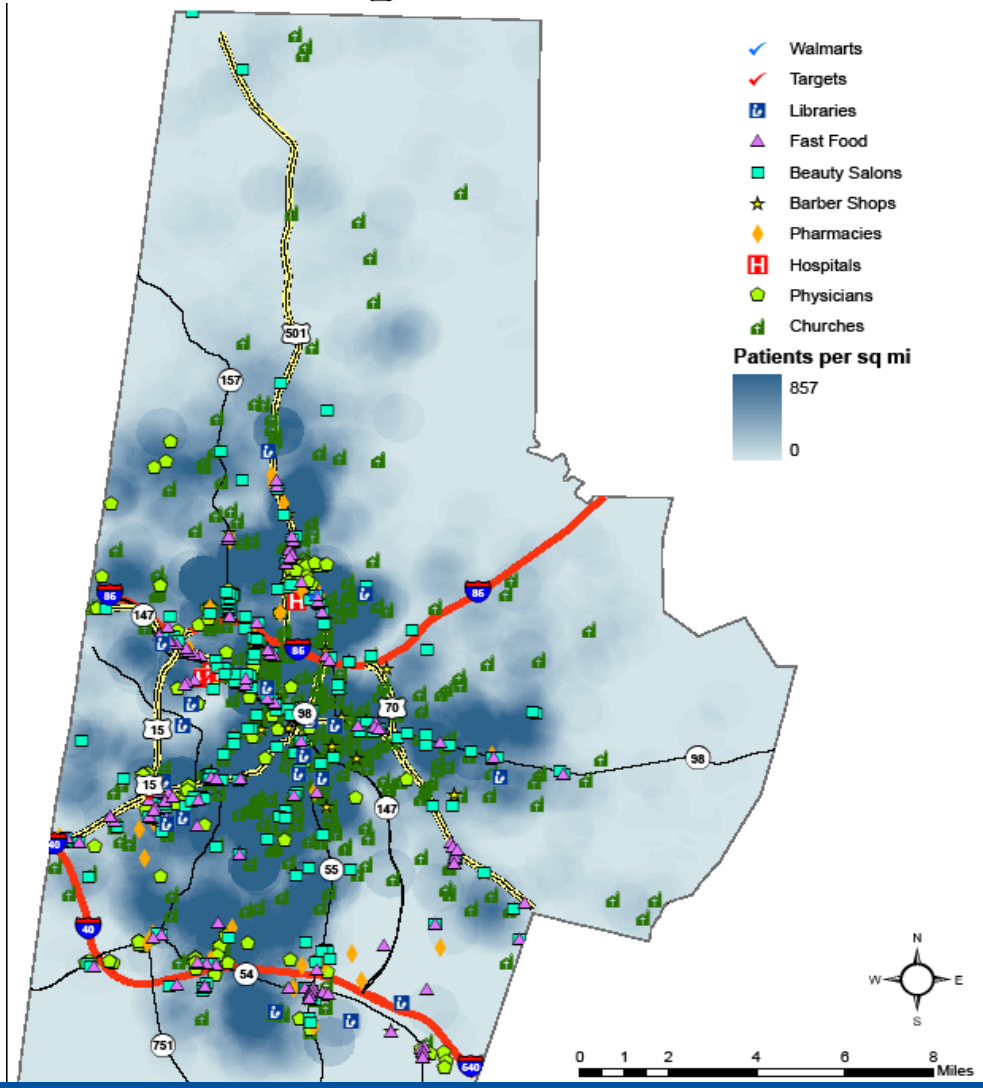
Most illness and care occur in the community

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

Research/Analytical Skills

Conference on
Practice Improvement

Join the conversation on Twitter: #CPI17

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.

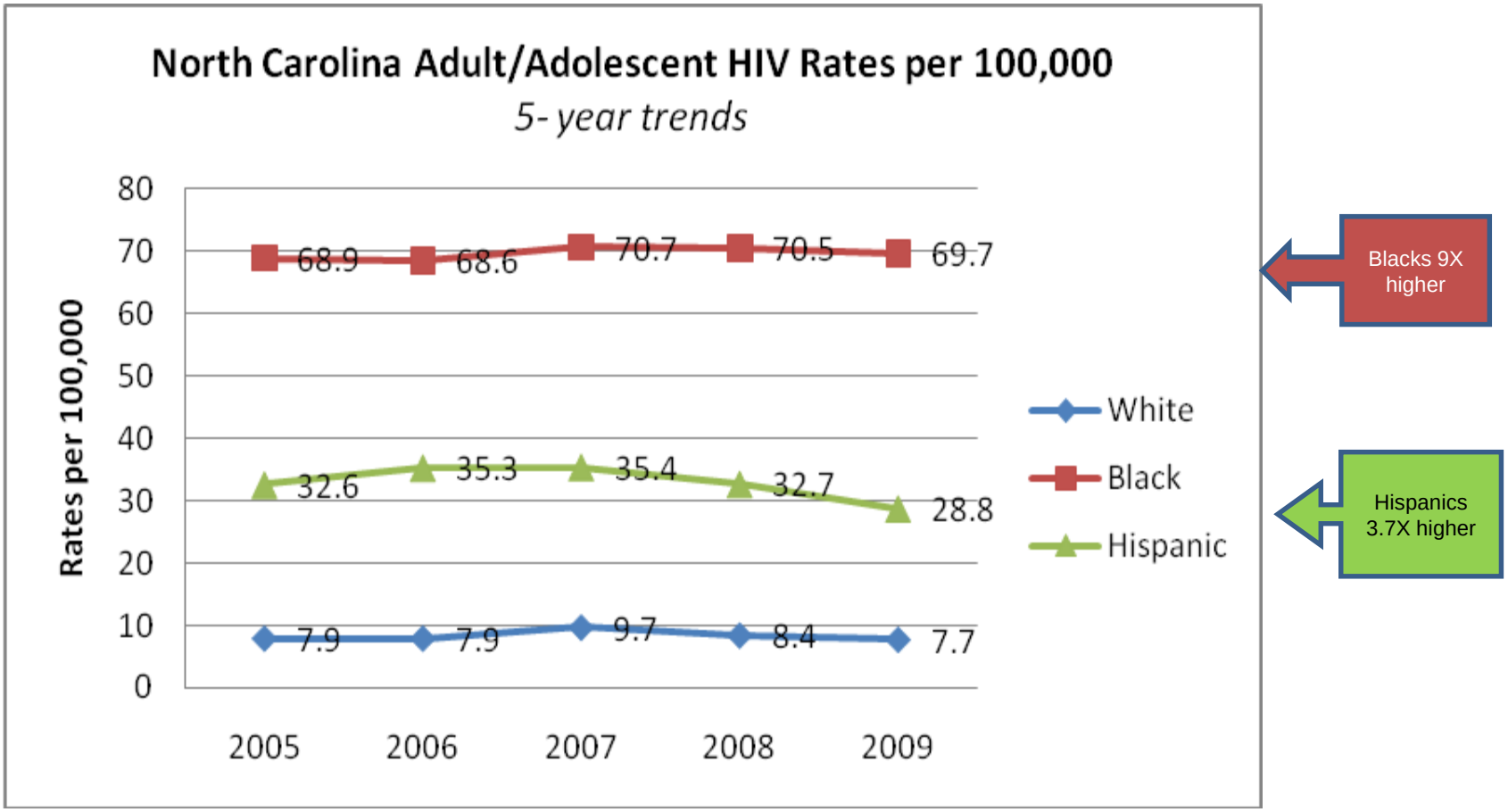
- **Quality and Equity Improvement (QEI)** related specifically to health equity includes knowledge and skills to improve care for underserved populations.

Zuckerberg San Francisco General

STEP UP

Training and Education Programs for Underserved Populations

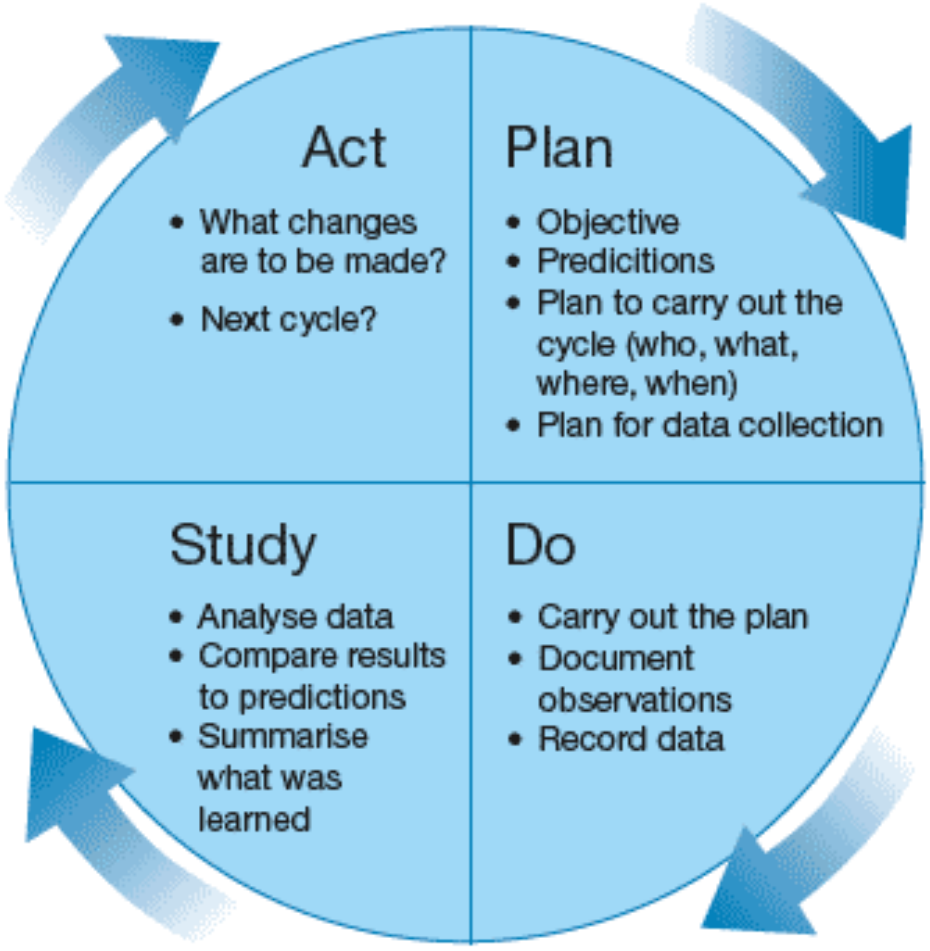
HIV



2011 Durham County Community Health Assessment. Durham, NC: Durham County Health Department; 2012. http://www.healthydurham.org/docs/CHA%202011%20-%20key%20findings.pdf

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


Act
• What changes are to be made?
• Next cycle?
Plan
• Objective
• Predicitions
• Plan to carry out the cycle (who, what, where, when)
• Plan for data collection
Study
• Analyse data
• Compare results to predictions
• Summarise what was learned
Do
• Carry out the plan
• Document observations
• Record data

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.”

Centers for Disease Control and Prevention. *Principles of community engagement* (1st ed.). Atlanta (GA): CDC/ATSDR Committee on Community Engagement; 1997.

Leadership and Team Skills

Conference on
Practice Improvement


Patient-Centered, Team-Based Care

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

Advocacy

Conference on
Practice Improvement

Advocacy


DUKE


RESIDENT
CONGRESS
AAFP


RESI
Microphone
#1


Visitors | Educators and Students | Media | Doing Business with the House | Employment
Search: GO
UNITED STATES HOUSE of REPRESENTATIVES
FIND YOUR REPRESENTATIVE
Enter your zip code
GO
112th Congress, 2nd Session · The House is not in session
REPRESENTATIVES LEADERSHIP COMMITTEES LEGISLATIVE ACTIVITY THE HOUSE EXPLAINED
Find Your Representative
Your member's website and contact form are available around the clock. Identify your member and let your opinion be heard.
Find Your Representative
Watch HouseLive
Congress Honors Suu Kyi
Congress Honors Palmer
Legislative Activity
Schedule
Floor Proceedings
Votes
Bills & Reports
Upcoming Events
Watch Most Recent House Floor Activity
Time (EST)
Session
11/28 10:00 am
Hearing: National Priorities for Solar and Space Physics Research and Applications for Space Weather Prediction
Committee on Science, Space, and Technology: Subcommittee on Space and Aeronautics
11/29 10:00 am
Hearing: Legislative Hearing on H.R. 511
Committee on Natural Resources:
11/29 10:00 am
Hearing: Clean Air Act Forum Part III
Committee on Energy and Commerce: Subcommittee on Energy and Power
12/4 2:00 pm
Hearing: Wading through Warehouses of Paper: The Challenges of Transitioning
House Overview
Public Disclosure
Financial Disclosure Reports

Population Health
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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.

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

Competency and training level	Foundational (basic): awareness*	Applied (intermediate): skilled participation†	Proficient (advanced): independent practice‡
Public health (PH)	*Learners will be able to …*	*Learners will be able to meet all basic objectives, plus …*	*Learners will be able to meet all basic and intermediate objectives, plus …*
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	• Define community • Discuss the role of community in health • Define a meaningful population for health improvement purposes	• Assess unifying characteristics of a population • Consider how these characteristics can help or hinder a proposed intervention • Identify the characteristics of communities and groups that are associated with disproportionate burden of disease	• Assess the characteristics of communities and groups that are associated with disproportionate burden of disease • Describe key disease states that demonstrate disproportionate burden of disease within specific populations
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	• Describe population-level determinants of health • Discuss how these factors influence health status and health care delivery	• Explain population-level determinants affecting the health of a population • Discuss potential strategies for addressing population-level determinants of health	• Collaborate with stakeholders to design and implement strategies to address population-level determinants of health • Report on the social and economic determinants of the burden of disease in specific populations
PH-3: Use community assets and resources to improve health at the individual and population levels	• List potentially helpful community assets and resources • Refer individual patients to resources that can assist in meeting their health needs	• Describe relevant assets and resources for population health improvement within a specific community • Discuss potential collaborations with community resources to improve	• Analyze gaps in community resources • Develop partnerships and programs to fill these gaps • Demonstrate leadership skills

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

Conference on Practice Improvement




INVEST IN YOUR COMMUNITY

4 Considerations to Improve Health & Well-Being *for All*

WHAT — Know What Affects Health

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

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.

Four ACTION Areas

VISIT **www.cdc.gov/CHInav** FOR TOOLS AND RESOURCES TO IMPROVE YOUR COMMUNITY'S HEALTH AND WELL-BEING

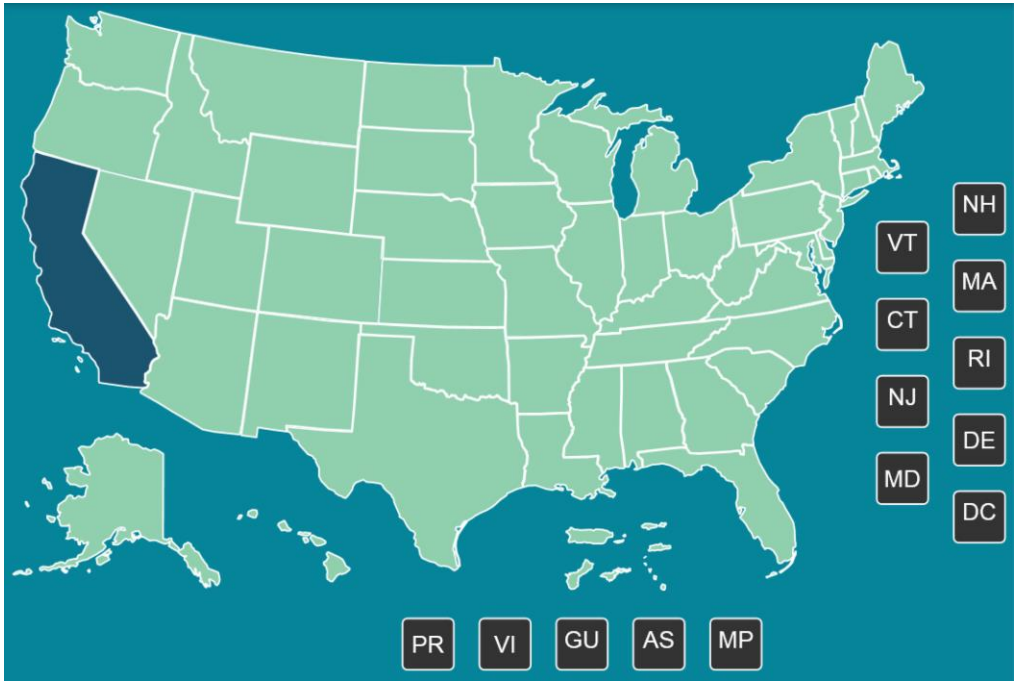
CDC · NATIONAL PREVENTION STRATEGY · Robert Wood Johnson Foundation

MARCH 2015

Join the conversation on Twitter: #CPI17

Now more than 500 known partnerships across the US

PRACTICAL PLAYBOOK®
Public Health. Primary Care. Together.®



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

POPULATION HEALTH
and your role as a family doctor

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

Conference on
Practice Improvement


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?

Viviana Martinez-Bianchi, MD, FAAFP
viviana.martinezbianchi@duke.edu

Resources and References

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Conference on
Practice Improvement

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