Family Medicine for America's Health:

What Can Program Directors Do to Increase Health Equity?

AMERICAN ACADEMY OF FAMILY PHYSICIANS

We are members of the FMAH-Health Equity team

https://fmahealth.org/health-equity-cross-tactic-team/

- Viviana Martinez-Bianchi, MD, FAAFP – Team Leader; Family Medicine Residency Program Director, Duke Department of Community and Family Medicine
- Jewell Carr, MD (Technology Team rep); Family Physician, Carolinas Medical Center
- Jane Weida, MD, FAAFP; (FMAHealth Board Liaison to the Team); Associate Residency Director, Family Medicine, College of Community Health Sciences, The University of Alabama

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Disclosures

- We are members of the Health Equity Team with Family Medicine for America's Health
- No links to Pharma to disclose

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
  - Creating a health equity toolkit
- 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

The Health Equity Team is working closely with the AAFP's Center for Diversity & Health Equity….

- Following the August 2017 Working Party, Danielle Jones, MPH - Manager of the AAFP's CDHE - was invited to and has joined the Health Equity Core Team.
- Glen Stream, Julie Wood, Jane Weida, Viviana Martinez-Bianchi & Danielle Jones are working together regularly on how best to align and integrate their work.
- The Health Equity Team and CDHE staff are working together to align efforts on the following projects…
    - Continuing the work launched at Starfield II
    - Health Equity Toolkit
    - Developing the Business Case for Health Equity
    - Rural Health Equity Project
    - Working with Family Medicine organizations on increasing social accountability
    - Health Equity Fellow

What can FMAH–Health Equity team do to work with AFMRD?

http://www.starfieldsummit.com/

STARFIELD II: HEALTH EQUITY SUMMIT

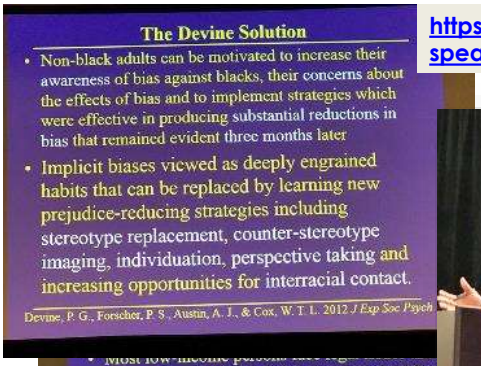
Primary Care's Role in Achieving Health Equity

...

PORTLAND, OREGON — APRIL 22-25, 2017

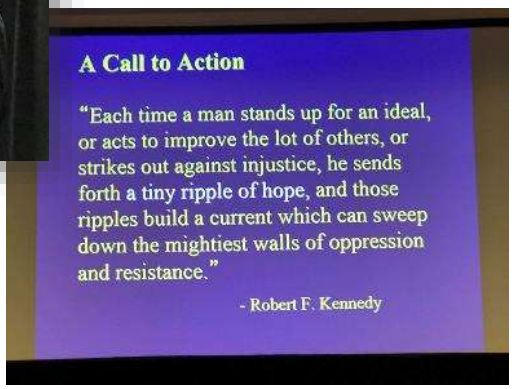
"In its most highly developed form, primary care is the point of entry into the health services system and the locus of responsibility for organizing care for patients and populations over time. There is a universally held belief that the substance of primary care is essentially simple. Nothing could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

—Barbara Starfield, MD, MPH



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

Keynote Address
David Williams, PhD, MPH



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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 Disparit**
  - *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*

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

IGNITE Theme 2: Vulnerable Populations

Link: 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

Link: 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*

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Family Medicine for America's Health:

What Can Program Directors Do to Increase Health Equity?

Viviana Martinez-Bianchi, Jane Weida, Jewell Carr
FMAH Health Equity Team

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Drawing “Equidad”, by Fernando Miguez, Argentina

YSICIANS

Can we develop a plan towards equity in health?
And what should that plan be?

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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.

When talking about health equity

We need to talk about
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.

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

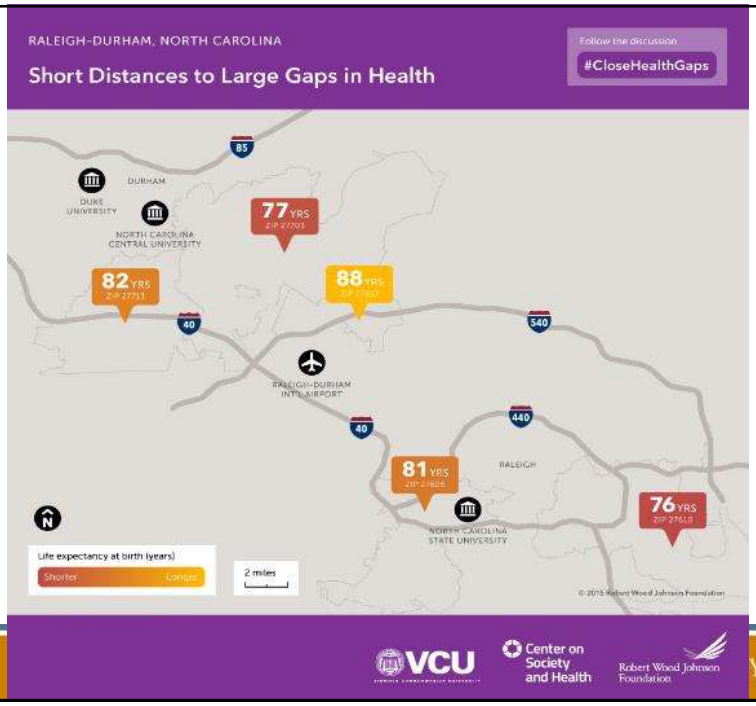
Healthcare institutions are generally **socially responsible** (being aware of their duty to respond to society's needs) and some can be seen being **socially responsive** (implementing interventions to address these needs). But few are wholly **SOCIALLY ACCOUNTABLE**.

Boelen C. Why should social accountability be a benchmark for excellence in medical education? *Educ Med J*. 2016;7(3):101-105.

Health disparities

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

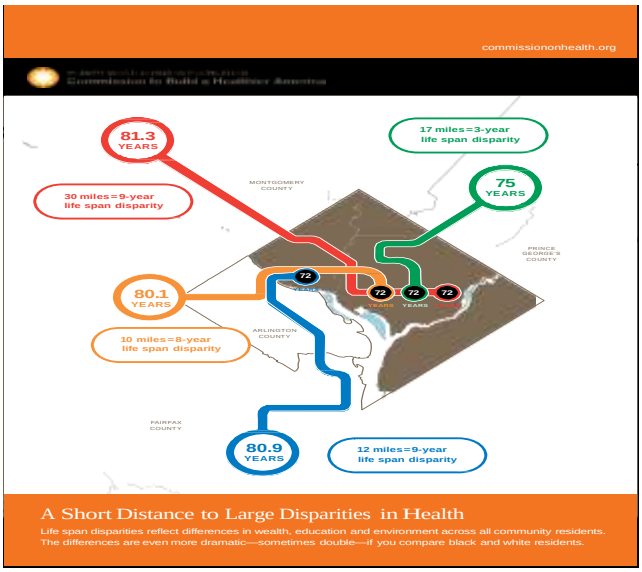
Disparities in Life Expectancy



Where people live matters more than the healthcare they receive.

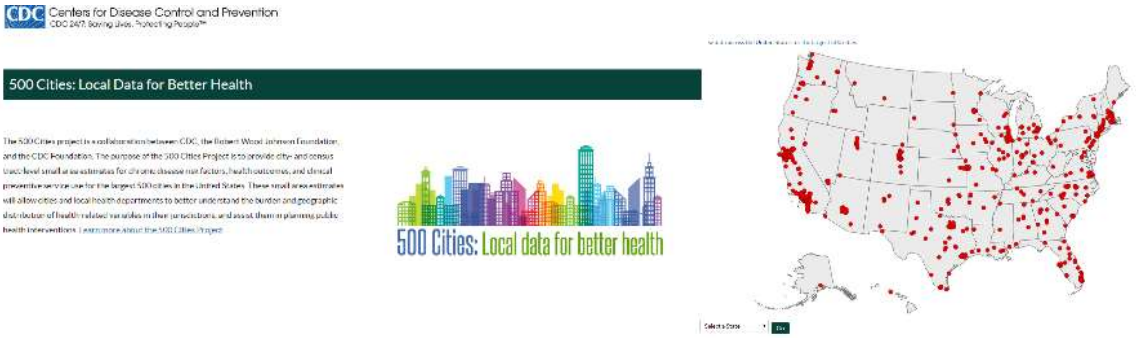
Your zip code can be more important than your genetic code

RWJ
commissiononhealth.org

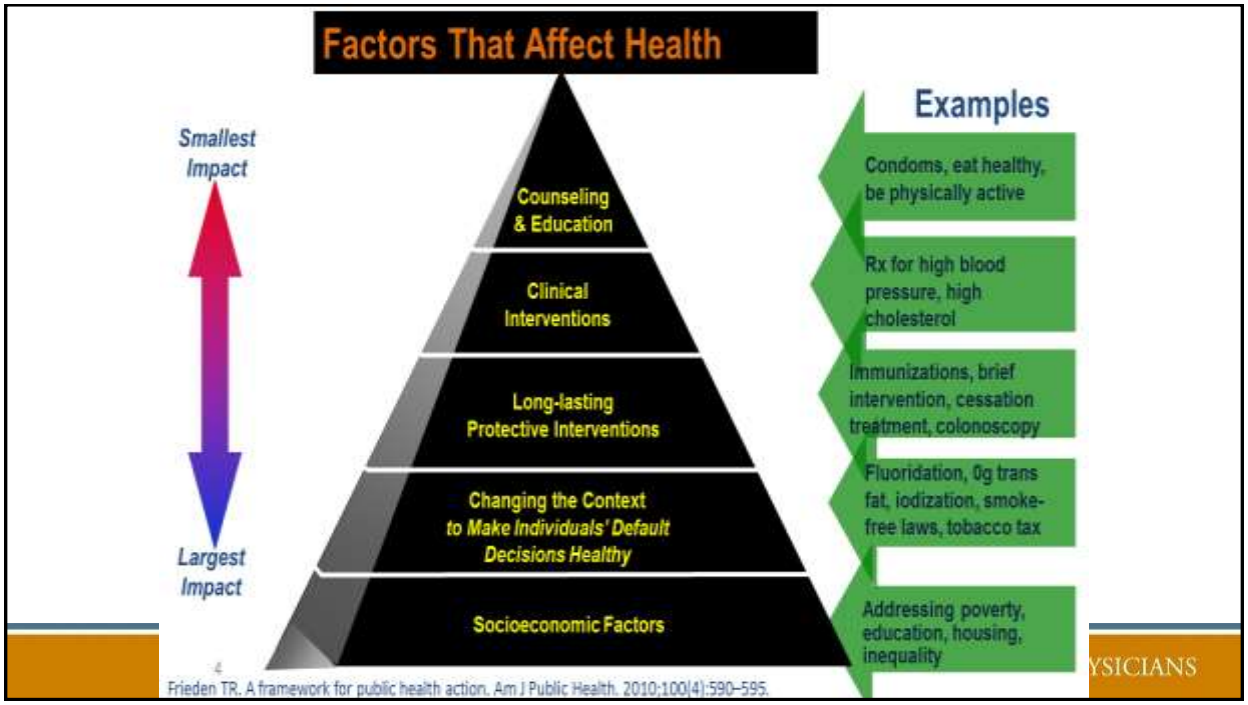


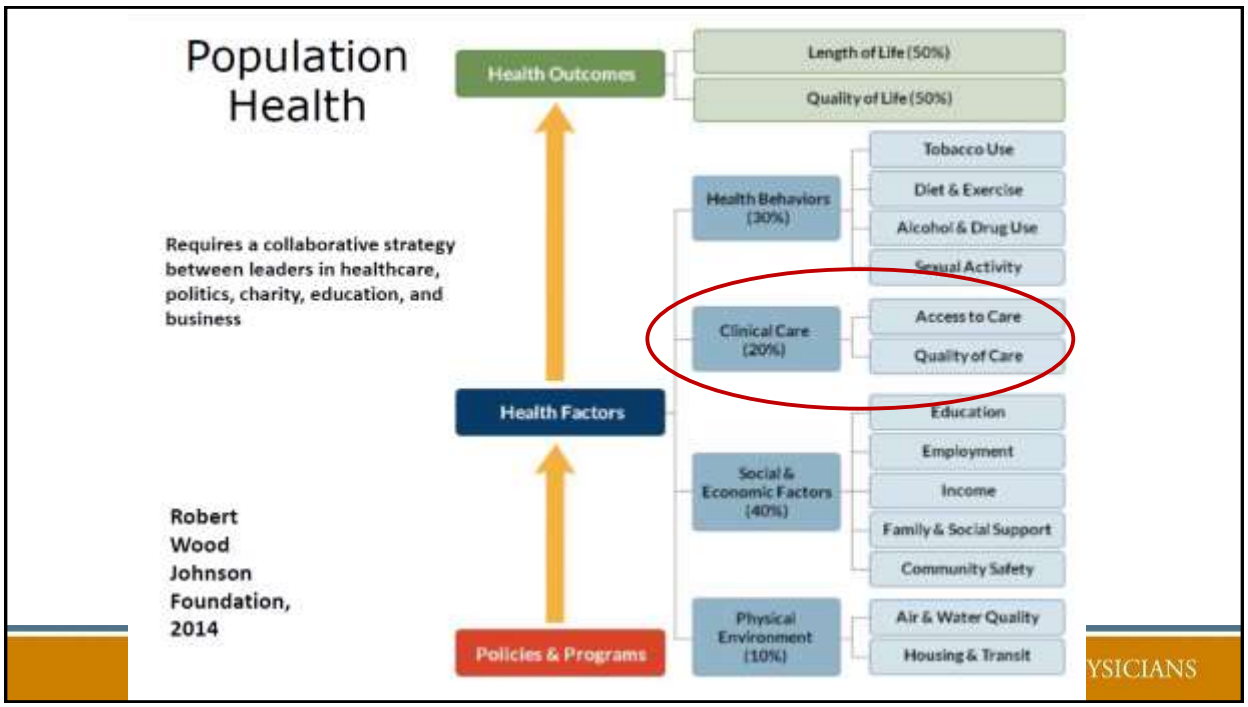
Let's go to your city!

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



Drawing "Equidad", by Fernando Miguez, Argentina


Factors That Affect Health
Smallest Impact
Largest Impact
Counseling & Education
Clinical Interventions
Long-lasting Protective Interventions
Changing the Context to Make Individuals' Default Decisions Healthy
Socioeconomic Factors
Examples
Condoms, eat healthy, be physically active
Rx for high blood pressure, high cholesterol
Immunizations, brief intervention, cessation treatment, colonoscopy
Fluoridation, 0g trans fat, iodization, smoke-free laws, tobacco tax
Addressing poverty, education, housing, inequality
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
Health Outcomes
Length of Life (50%)
Quality of Life (50%)
Health Factors
Health Behaviors (30%)
Tobacco Use
Diet & Exercise
Alcohol & Drug Use
Sexual Activity
Clinical Care (20%)
Access to Care
Quality of Care
Social & Economic Factors (40%)
Education
Employment
Income
Family & Social Support
Community Safety
Physical Environment (10%)
Air & Water Quality
Housing & Transit
Policies & Programs

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

Pursuing health equity requires

- 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

Pursuing health equity requires

that we STOP tolerating inequity

Any ideas on what you are doing or would want to do?

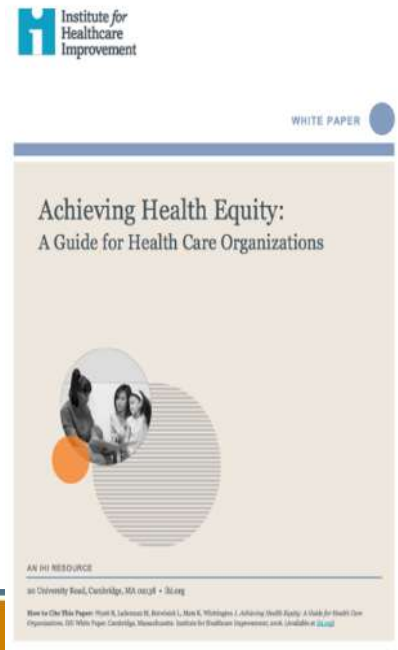
Multiple frameworks and requirements for addressing the social determinants of health

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)

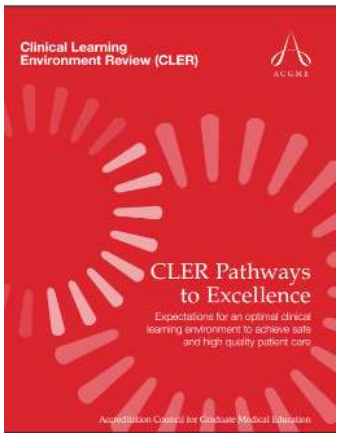
HQ Pathway 5: Resident/fellow and faculty member education on reducing health care disparities

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

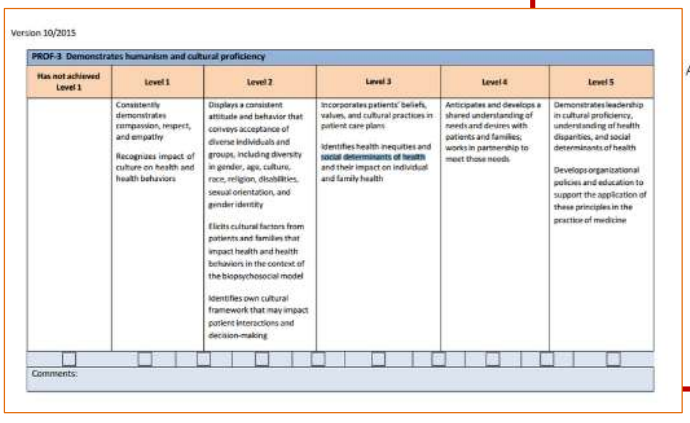
Properties include:

- 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



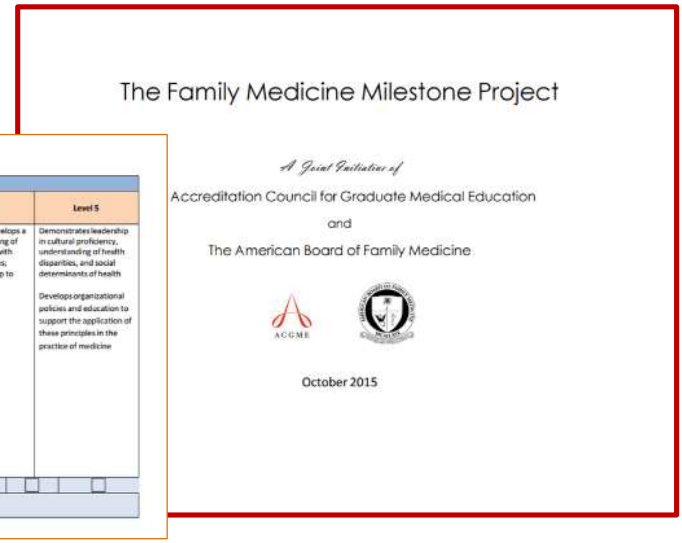
ACGME CLER visits



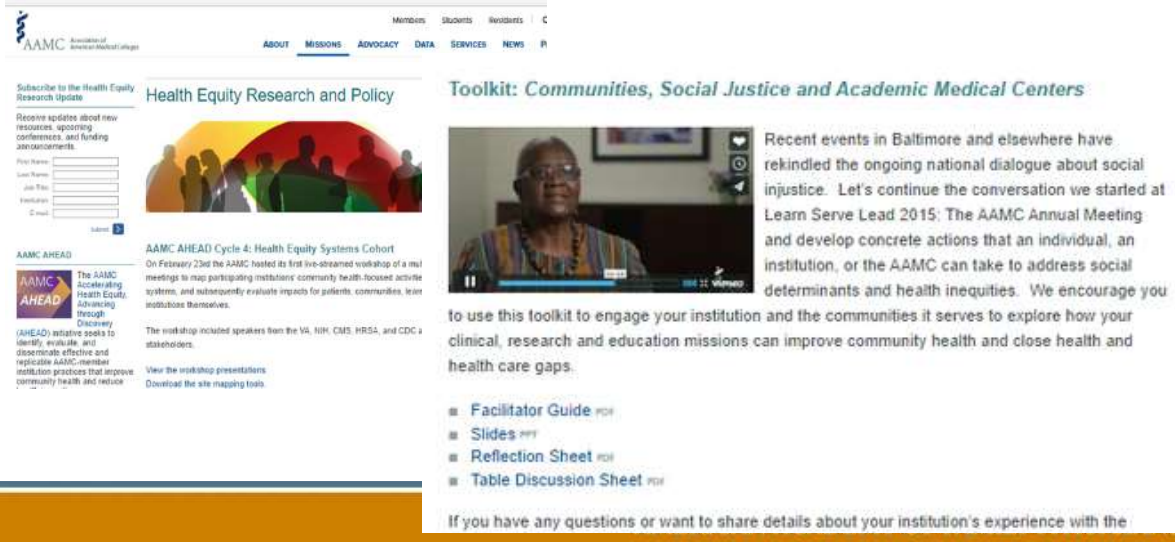
Version 10/2015

PROF-3 Demonstrates humanism and cultural proficiency

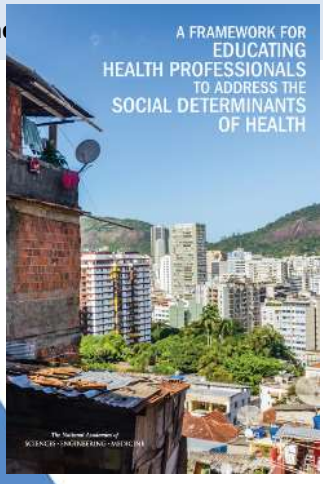
Has not achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Consistently demonstrates compassion, respect, and empathy Recognizes impact of culture on health and health behaviors	Displays a consistent attitude and behavior that conveys acceptance of diverse individuals and groups, including diversity 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:					

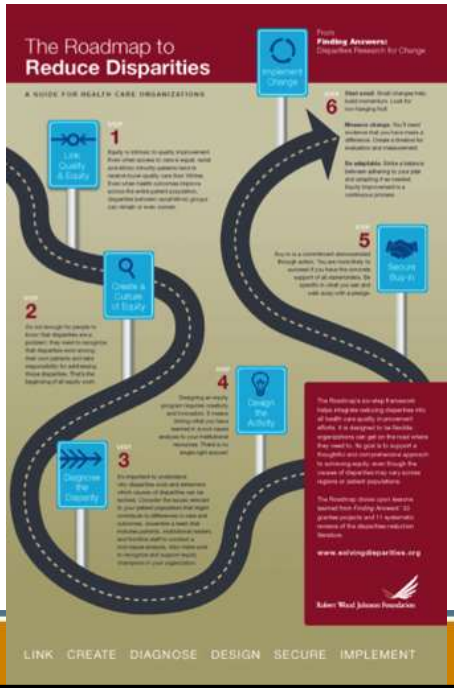


AAMC



2016 Institute of Medicine: Framework for lifelong learning for health professionals in understanding and addressing the social determinants of h





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

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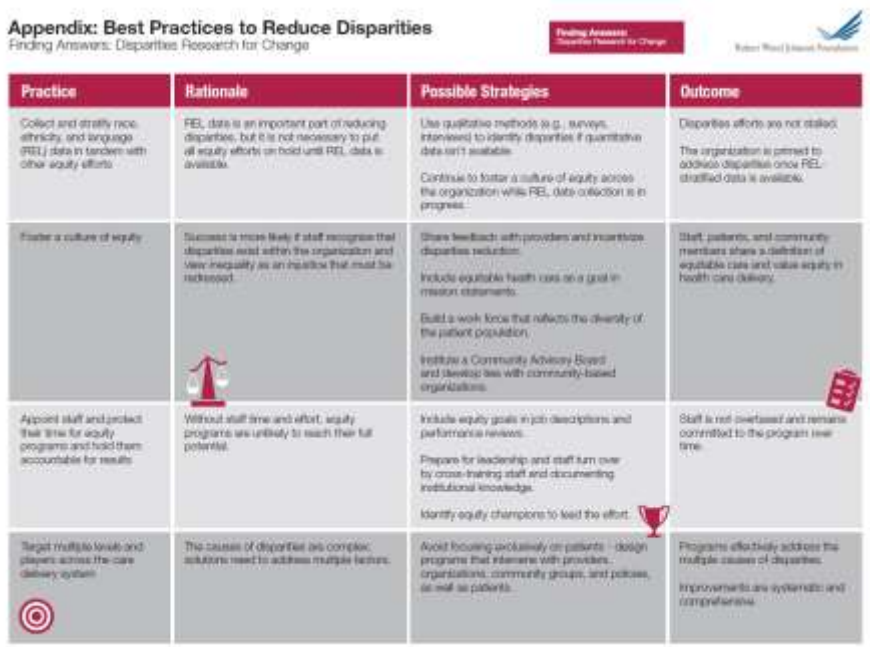
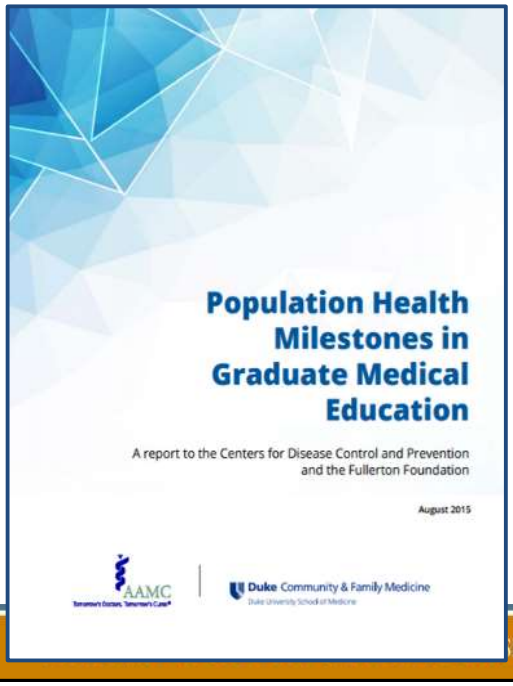


Appendix: Best Practices to Reduce Disparities
Finding Answers: Disparities Research for Change

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.

YSICIANS

Population Health Milestones address health equity, social determinants of health



Accountability requires a social determinants framework

Equity and Empowerment Lens

Source:
Balajee, Sonali S., et al., (2012).
Equity and Empowerment Lens (Racial Justice Focus), pg 28.
www.multco.us/diversity-equity

MULTNOMAH COUNTY
Office of Diversity and Equity
www.multco.us/diversity-equity

PHYSICIANS

Equity and Empowerment Lens

PEOPLE

Who is positively and negatively affected (by this issue) and how?

How are people differently situated in terms of the barriers they experience?

Consider physical, spiritual, emotional and contextual affects.

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Equity and Empowerment Lens

PLACE

What kind of positive "place" are we creating?

What kind of negative "place" are we creating?

How are public resources and investments distributed geographically?

How are you considering environmental impacts as well as environmental justice?

Equity and Empowerment Lens

Issue /

PROCESS

How are we meaningfully including or excluding people (communities of color) who are affected?

What policies, processes and social relationships contribute to the exclusion of communities most affected by inequities?

Are there empowering processes at every human touchpoint?

Equity and Empowerment Lens

POWER

What are the barriers to doing equity and racial justice work?

What are the benefits and burdens that communities experience with this (issue)?

Who is accountable?

Equity and Empowerment Lens

Source:
Balajee, Sonali S., et al., (2012).
Equity and Empowerment Lens (Racial Justice Focus), pg 28.
www.multco.us/diversity-equity

MULTNOMAH COUNTY
Office of Diversity and Equity
www.multco.us/diversity-equity

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

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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

Housing code violation density associated with emergency department and hospital use by children with asthma.

Beck AF, Huang B, Chundur R, Kahn RS.
Health Affairs November 2014;33(11) 1993-2002.

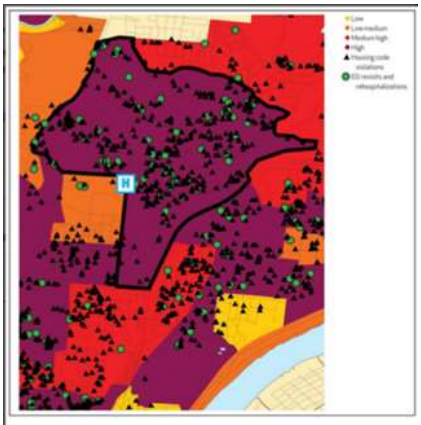


EXHIBIT 3
Cincinnati's Avondale Neighborhood With Asthma-Related Housing Code Violations, 2009–12, And Asthma-Related Emergency Department (ED) Revisits And Rehospitalizations Within Twelve Months Of the First (Index) Hospitalization For Children Hospitalized, 2009–12

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

Does your residency program have…

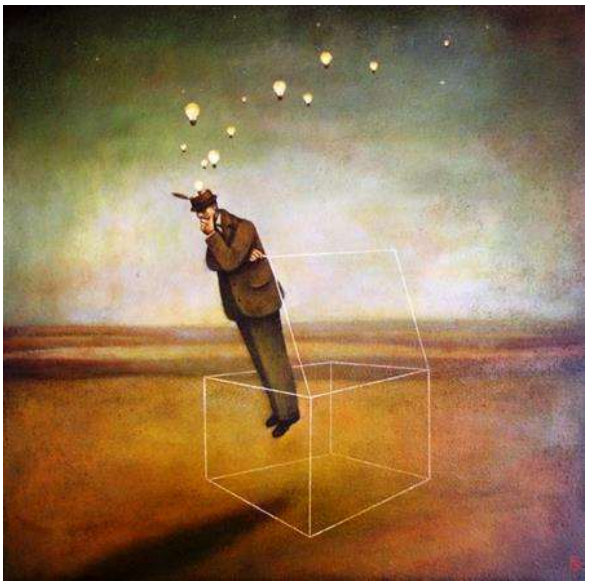
- A health equity champion?
- A lead community health faculty?
- Involvement with the community?
- A health equity curriculum?
- A population health curriculum?

Share

- What Can Program Directors Do to Increase Health Equity?

Obstacles

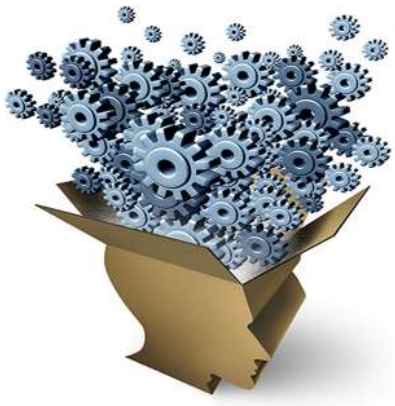
- What gets in the way?



Addressing health equity is tied to achieving population health competencies

Health equity and your program

- What will you do next?



The DNA of Family Medicine

Drawing "Equidad", by Fernando Miguez, Argentina

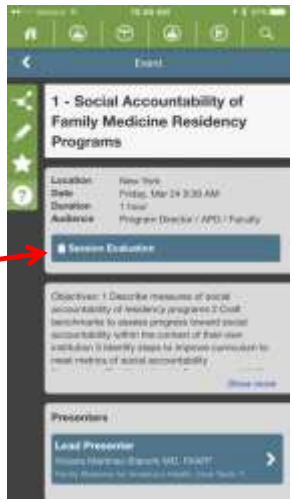
Health professionals who can see the river of disease that flows into our clinics and hospitals and will go to identify what happens upstream

Questions/ comments?

Please

complete the

session evaluation.

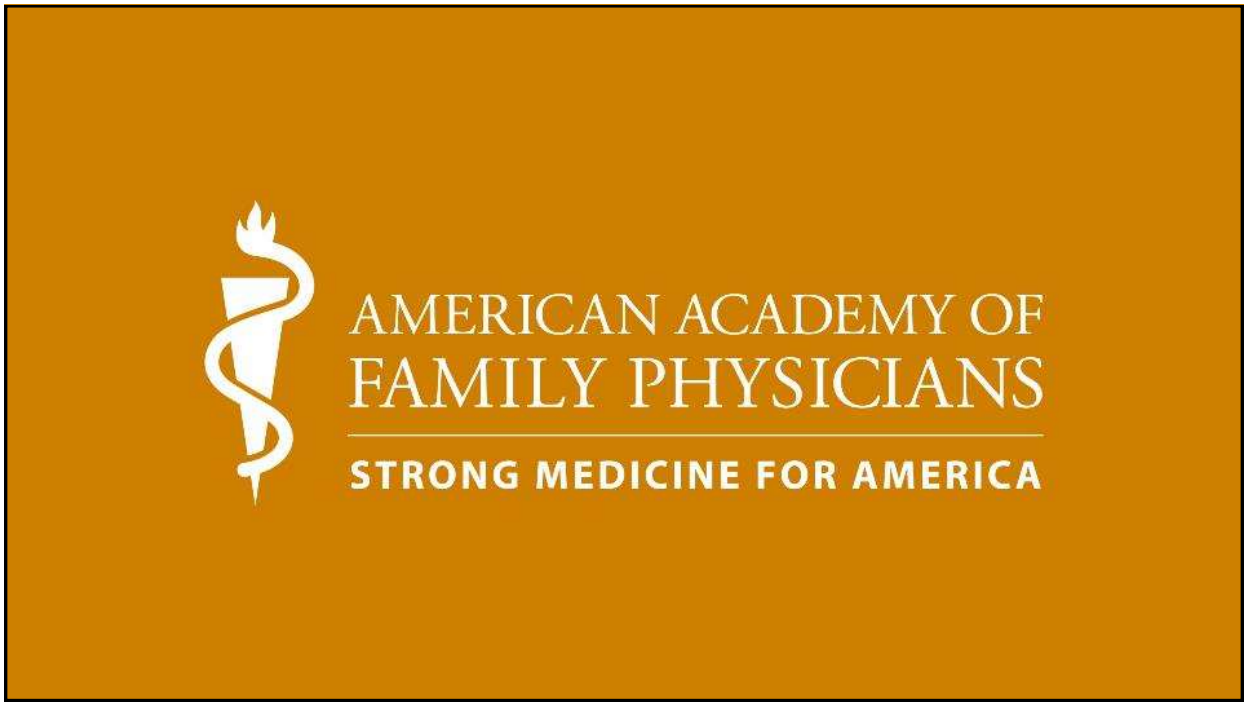


Thank you.

- **FAMILY MEDICINE FOR AMERICA'S HEALTH CORE TEAM MEMBERS**

- Viviana Martinez-Bianchi, MD, FAAFP – Team Leader; Family Medicine Residency Program Director, Duke Department of Community and Family Medicine
- Bonzo Reddick, MD, MPH, FAAFP; Associate Dean, Diversity & Inclusion at Mercer University School of Medicine
- Jennifer Young Choe Edgoose, MD, MPH; Faculty, University of Wisconsin School of Medicine and Public Health
- Kim Yu, MD, FAAFP; Director for Quality and Performance, Ambulatory and Urgent Care, CEP America and Past Board Chair of Michigan Academy of Family Physicians
- Jewell Carr, MD (Technology Team rep); Family Physician, Carolinas Medical Center
- Danielle Jones, MPH; Manager, AAFP Center for Diversity and Health Equity
- Christina Kelly, MD, FAAFP (Workforce Team rep); Faculty, Savannah Family Medicine Residency and Director, Mercer University School of Medicine Primary Care Accelerated Track
- Jay Lee, MD, MPH, FAAFP; (Practice Team rep); Chief Medical Officer, Venice Family Clinic
- Ronna D. New, DO (Research Team rep); Geriatrician, Johnston Memorial Hospital
- Karen Smith, MD, FAAFP; (Payment Team rep); Owner and Practicing Physician, Family Medicine Practice of Karen L. Smith, MD
- Laura Gottlieb, MD, MPH; Associate Professor-in-Residence, Department of Family and Community Medicine & Director, Social Interventions Research and Evaluation Network (SIREN), Center for Health & Community University of California, San Francisco
- Jane Weida, MD, FAAFP; (FMAHealth Board Liaison to the Team); Associate Residency Director, Family Medicine, College of Community Health Sciences, The University of Alabama

- ADDITIONAL HEALTH EQUITY PROJECT TEAM LEADERS/ADVISORS
- Brian Frank, MD
- Ronya Green, MD
- Lloyd Michener, MD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