Starfield Summit II: Health Equity Summit
Curriculum Toolkit

Communities Working Together to Improve Health and Reduce Disparities

IGNITE presentation by J. Lloyd Michener, MD

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Community Health Improvement Plans and Patient-Centered Primary Care Homes as Tools to Address Health Disparities

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Appropriate Audience Advanced learners

Related Modules

- Community Vital Signs: Achieving Equity through Primary Care Means Checking More than Blood Pressure.
- Identifying and Addressing Patients' Social and Economic Needs in the Context of Clinical Care.
- Understanding Health Experiences and Values to Address Social Determinants of Health.

Learning Objectives

After participating in this learning module, the participant will be able to:

1. Explain the importance of the following components in effective community health interventions: clinical data, patient-centered primary care, and community organizations.
2. Describe the movement towards community health improvement plans (CHIPs) and key stakeholders involved.
3. Identify at least one multi-sector partnership in her/his state working to improve community health.
4. Make an argument for and against primary care clinics acting as intermediaries between patients and community-based organizations.

Background

Most illnesses are now chronic conditions, and more heavily influenced by social determinants rooted in communities, rather than biological determinants addressed in healthcare.[1] Communities – such as those defined geographically or by race/ethnicity—offer significant expertise in, and lived experience with, these health-harming factors. While these conditions are not easily addressed through narrow clinic- or systems- based interventions,[2] approaches grounded in the community offer great promise.

Emerging developments in health information technology, such as clinical data, patient-reported social determinants of health (SDoH), and community vital signs within electronic health records (EHRs) provide the ability to better understand the multi-dimensional contributions of both medical conditions and SDoH, enabling much greater precision in identification of at-risk groups, as well as provider awareness of social barriers prevalent in their patients' communities. Parallel efforts to identify and catalog—in the EHR or other database—community-based resources that are better equipped to address socioeconomic determinants rooted out in the community presents an opportunity for better coordinated interventions designed by the community. Advancements in health information technology (HIT) enable primary care and health systems to better partner with community-based organizations already offering effective interventions to address the SDoH. These partnerships encourage health systems to respond to community-specific needs, as well as co-create solutions that build upon existing resources, thereby improving outcomes in community- and culturally- responsive ways.[3,4,5,6] There are now more than 400 such partnerships across the country, with the number expanding rapidly as evidence grows on the value and impact of these programs.[7]

Successful models for developing community-primary care partnerships build on communities' strengths, expertise, and use processes that reflect cultural considerations.[8] They are based upon principles that lead to transformative changes in power, equity and justice.[9] In these models, clinician and other professional partners listen to communities and offer the expertise that is asked for, such as health-related data and policy advocacy. Created in 2012 by the Oregon state legislature as part of a comprehensive statewide strategy for health system transformation, Oregon's Coordinated Care Organizations (CCOs) are networks of healthcare providers partnering with local community organizations to better provide preventive services and address chronic conditions. CCOs serve as one model of healthcare/community partnerships that has reduced health expenditures for its state while improving health outcomes for Medicaid beneficiaries. One of the fundamental strategies of CCOs is combining health related data with the needs identified by communities through state-mandated community health assessments (CHAs).[10] CHAs directly inform the development of community health improvement plans (CHIPs), community-driven strategic plans coordinating health systems, public health departments, and community organizations to collectively address health and social issues prioritized by the community.

Patient-centered primary care homes (PCPCHs) represent the primary care unit within Oregon CCOs and have increased care coordination and access to primary care for Oregonians at high-risk for poorer medical outcomes and increased healthcare utilization. The model has subsequently been associated with significant improvements statewide across the Triple Aim (improving patient experience and population health while reducing cost).[7] Thus, PCPCHs offer a unique and timely opportunity to better develop community-primary care partnerships, and understand how primary care can participate in identifying assets and resources already existing in communities, and collaborating with local organizations to better address their most pressing needs through individual, community, and policy interventions. These learnings could

inform ongoing efforts nationally for community-primary care partnerships to address health disparities and advance health equity for all.

Ignite Video

- Please follow the link below to view the full talk given by J. Lloyd Michener, MD (~7 minutes): https://www.youtube.com/watch?v=3DxZv3t5iGI
- Please follow the link below to view the full talk given by Elizabeth Steiner Hayward, MD (focus on first 2 minutes; full talk is ~6 minutes): https://www.youtube.com/watch?v=orKZnBYtCcA

Accompanying Slides

- The full slides by J. Lloyd Michener, MD: http://www.starfieldsummit.com/s/13-Michener-Presentation.pdf
- There are no slides that accompany Dr. Elizabeth Steiner Hayward's presentation.

Questions for Group Discussion

After watching the talks, consider splitting your learners into smaller groups and facilitate discussion on the following questions.

1) What does "community engagement" mean to you? How much agency and power does the community have in that definition? What are existing or imagined examples of a community engagement model that involves empowerment and activation of communities?
2) What systemic inequities prevent marginalized communities from having a leadership role in implementing interventions to reduce health disparities? How could these be mitigated to give communities a greater role in effecting change?
3) What is the role, or could be the role, of primary care in community engagement and community partnerships? What does each partner bring to the collaboration?
4) What is the role of policy-makers in effecting social change? How can communities and healthcare systems influence policy in a way that is mutually beneficial?
5) What skills do you need to develop to be an effective collaborator? What steps can you take to foster and sustain trust with partners?
6) What processes can be implemented by healthcare systems (e.g., clinics, hospitals) to ensure they respect communities' expertise in identifying health/social priorities, and co-creating interventions?
7) How can payment models be re-structured to support the development and cultivation of community partnerships?
8) Both IGNITE presentations discuss "effective" interventions based on a certain set of metrics. Should community partnerships be assessed on their ability to decrease healthcare utilization? Improve health outcomes? Both together? How do we design patient- and community- centered outcomes? What work remains for healthcare

systems and payers to ensure better alignment of the metrics that the healthcare system uses to define success with outcomes that matter to patients and communities?

9) What community-level data would impact your clinical care, if any? How? What community-level data would impact your (or your clinic's/health system's) community engagement efforts? How?

Applying an Equity Lens in Professional Practice

As you reflect on the material in this module consider how you will apply it in your professional practice by asking questions based upon the Equity and Empowerment Lens' 5Ps:

PURPOSE:

- How do clinicians engage with patients and communities to ensure that interventions meant to improve health are effective and desirable by the population for whom the interventions are intended?
- How do we ensure that the data we are using to inform these interventions reflects the values of communities?

PEOPLE:

- Who are the stakeholders that need to be included in a multi-sector partnership?
- Who benefits most from this partnership and who benefits least?

PLACE:

- Where do the community partnerships convene? Do the spaces advantage one set of participants over another?
- What is the data revealing about the distribution of investments geographically in communities?

PROCESS:

- How do we honor patients' and community partners' efforts and expertise and join their existing efforts?
- What is the consent process for sharing data collected about individuals *between* partners, even if the data are de-identified and aggregated?
- How do we address inequities arising from socioeconomic, geographic or cultural factors without reinforcing them?

POWER:

- How do we integrate voices, elevate priorities, and avoid "tokenizing" community partners?
- Which partners hold historical and societal power, and what steps can we take to reduce these power dynamics and elevate traditionally marginalized partners?
- How are resources distributed between healthcare and community partners? Who ultimately "owns" the project, and how is this decided?

For more in depth discussion read and refer to:

- Geiger H J. The first community health center in Mississippi:Communities empowering themselves.Am J Public Health. 2016 October; 106(10): 1738–1740..
    - Dr. Jack Geiger is one of the founders of the community health center (CHC) model that persists today. He explains that community organizing, partnerships with community organizations, and patient engagement were fundamental to the original CHC movement in a way that they no longer are today.
- Givens M, Kindig D, Tran Inzeo P, Faust V. Power: The Most Fundamental Cause of Health Inequity? Health Affairs Blog. Health Affairs website.https://www.healthaffairs.org/do/10.1377/hblog20180129.731387/full/. Published February 1, 2018. Accessed May 15, 2018.
    - This blog post outlines the need to consider power as a fundamental determinant of health, with patient empowerment and community capacity building promoted as one of the most upstream approaches to addressing health inequities. It underscores the power of measurement and data reporting to advance health equity.
- Jones, C. P., Jones, C. Y., Perry, G. S., Barclay, G., & Jones, C. A. Addressing the social determinants of children's health: a cliff analogy. Journal of Health Care for the Poor and Underserved, 2009: 20(4), 1-12.
    - A foundational paper describing the need for interventions that address direct services of biological determinants of health, the social determinants of health, and the social determinants of equity.
- Stojicic P, Auchincloss, E. Exploring Resident Engagement for Health System Transformation.Resident Engagement Blog Series. ReThink Health website. . https://www.rethinkhealth.org/the-rethinkers-blog/exploring-resident-engagement-for-health-system-transformation. Published February 13, 2018. Accessed on May 15, 2018.
    - This blog post is the first part of a 4-part series outlining key findings from a national review of patient- and community- engagement efforts in the U.S. The authors found that the emerging interest in “community engagement” manifested across a spectrum of patient awareness —from patient feedback, to patient activation, with the latter being the most effective yet least implemented model due to a wide array of barriers.
- Willard WR. Family practice. *JAMA.* 1966;197(12):985-988. doi:10.1001/jama.1966.03110120091021
    - The Willard Report—alongside the Folsom Report and Millis Commission—represents one of the founding documents of the specialty of family medicine that emphasizes the need to develop community-oriented providers who are attuned to upstream, preventive approaches that address the social determinants of health and equity.

Resources for Further Exploration

Macro:

- Franklin S, Edwards D. It takes a neighborhood: Purpose built communities and neighborhood transformation. Investing in What Works for America's Communities website. http://www.whatworksforamerica.org/ideas/it-takes-a-neighborhood-purpose-built-communities-and-neighborhood-transformation/#.W7POD3tKiUk. Accessed October 2, 1018.
    - This article outlines the efforts of Purpose Built Communities, a non-profit organization that started in Atlanta's predominantly African-American East Lake district. Purpose Built Communities approached this community due to its disproportionately higher levels of poverty, crime, unemployment, and poor school conditions. Multiple community-based organizations collaborated to develop mixed-income housing, early child development programs, and employment support—leading to significant improvements in crime, housing, employment, and education.
- Nicholas SW, Jean-Louis B, Ortiz B, et. al. Addressing the childhood asthma crisis in Harlem: the Harlem Children's Zone Asthma Initiative. Am J Public Health. 2005 Feb;95(2):245-9.
- Reducing childhood asthma through community-based service delivery--New York City, 2001-2004. MMWR Weekly. 54(1):11. CDC website.https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5401a5.htm. Published January 14, 2005. Accessed October 2, 2018.
    - These two articles detail the Harlem Children's Zone Asthma Initiative, a geographically-targeted community partnership involving a community-based organization, the local public health department, and the local hospital system, to decrease childhood asthma-related morbidity and mortality. This partnership was formed after community-level data showed high levels of pediatric asthma in Harlem, with hospitalizations and morbidity disproportionately impacting African-American families. Interventions target both medical (e.g., increased screening for tobacco use, increased asthma education) and social determinants of health and equity (e.g., legal advice for housing conditions, parenting skills classes).

Meso:

- Kaufman A, Powell W, Alfero C, et. al. . Health extension in New Mexico: An academic health center and the social determinants of disease. Ann Fam Med. 2010 Jan 1;8(1):73-81.
    - The University of New Mexico pioneered the Health Extension Rural Offices (HERO) model, in which community-based, culturally-responsive agents are hired by academic health centers (AHCs) in underserved rural areas to create a bidirectional relationship that brings the resources of AHCs to the community, and build community capacity to address health and social issues in that process.

Micro:

- Doherty WJ, Mendenhall TJ. Citizen health care: A model for engaging patients, families, and communities as coproducers of health. Fam Syst Health. 2006;24(3): 251.

  - This article describes a community organizing-based model used in a primary care clinic in Minnesota to engage patients, families, and communities as equal co-producers in delivering improved health by "flattening the hierarchy" of the traditional "top-down" healthcare model. This model requires minimal time from clinical staff, but persists today as a model that has produced several patient- and community- led interventions.
- DeVoe JE, Bazemore AW, Cottrell EK, et. al.. Perspectives in primary care: A conceptual framework and path for integrating social determinants of health into primary care practice. Ann Fam Med. 2016 Mar;14(2):104-8. doi: 10.1370/afm.1903.
  - This article outlines how both individual- and community- level data on the SDH in the primary care setting could hypothetically inform clinical decision making at the point-of-care (e.g., considering barriers to accessing nutritious foods for patients living in food deserts) and the panel management level (e.g., exploring community-oriented solutions if a cluster of clinic patients from the same zip code are experiencing higher rates of poorer HbA1cs). Multiple pilots are underway to explore integration of this data into clinical care and population health management, but a knowledge gap persists.

Words and Concepts Used in this Module that are Defined in the Guidebook

- Community
- Community Engagement
- Community Health
- Community Vital Signs
- Community Health Improvement Plan (CHIPs)
- Power

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3. Minkler M, Wallerstein N, eds. *Community-Based Participatory Research for Health: From Process to Outcomes.* San Francisco, CA: Jossey-Bass; 2008.
4. Beresford P. Beyond the usual suspects: towards inclusive user involvement. Shaping our Lives. INVOLVE website. http://www.invo.org.uk/beyond-the-usual-suspects-towards-inclusive-user-involvement Accessed October 2, 2018.

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6. Davis S. Understanding health experiences and values to address social determinants of health. In: Edgoose J. (ed) *Health Equity Curricular Toolkit.* Parkway Leawood, KS: Health Equity Team for Family Medicine for America's Health; 2018. URL. Accessed Date.
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8. Minkler M, Garcia AP, Rubin V, Wallerstein N. Community-based participatory research: A strategy for building healthy communities and promoting health through policy change. Oakland, CA: PolicyLink; 2012.
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