Maryland Office of Minority Health and Health Disparities
13th Annual Health Equity Conference
December 13, 2016

Achieving Health Equity through Community Engagement and Innovative Health Care Delivery

SHIRLEY NATHAN-PULLIAM HEALTH EQUITY LECTURE
****AWARD RECIPIENT & KEYNOTE ADDRESS****

Camara Phyllis Jones, MD, MPH, PhD, President, American Public Health Association
Senior Fellow, Satcher Health Leadership Institute and Cardiovascular Research Institute, Morehouse School of Medicine

Achieving Health Equity

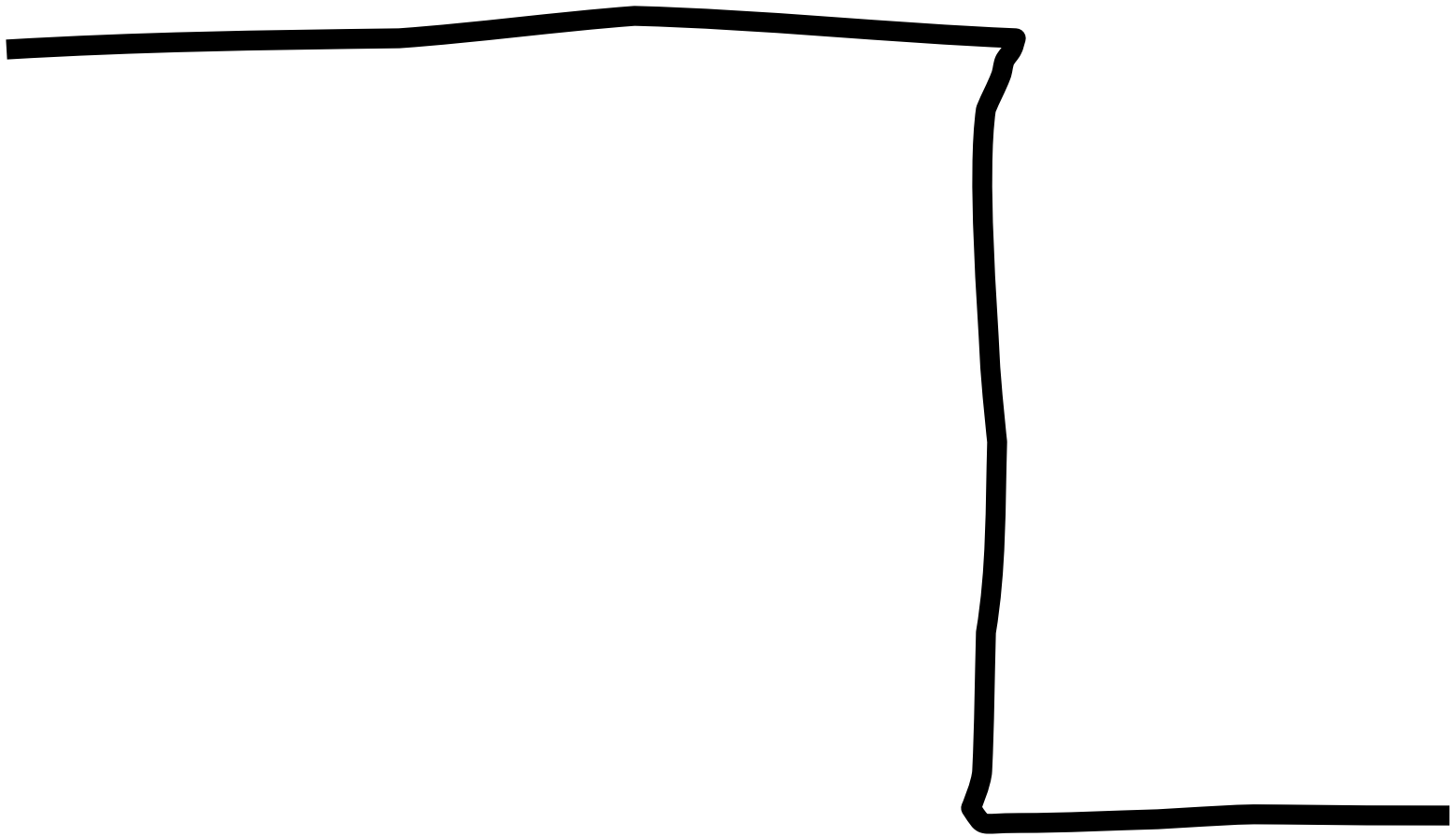
tools for a national campaign against racism

Camara Phyllis Jones, MD, MPH, PhD

Shirley Nathan-Pulliam Health Equity Lecture
MHHD's 13th Annual Health Equity Conference
Maryland Office of Minority Health and Health Disparities

Baltimore, Maryland
December 13, 2016

Levels of health intervention



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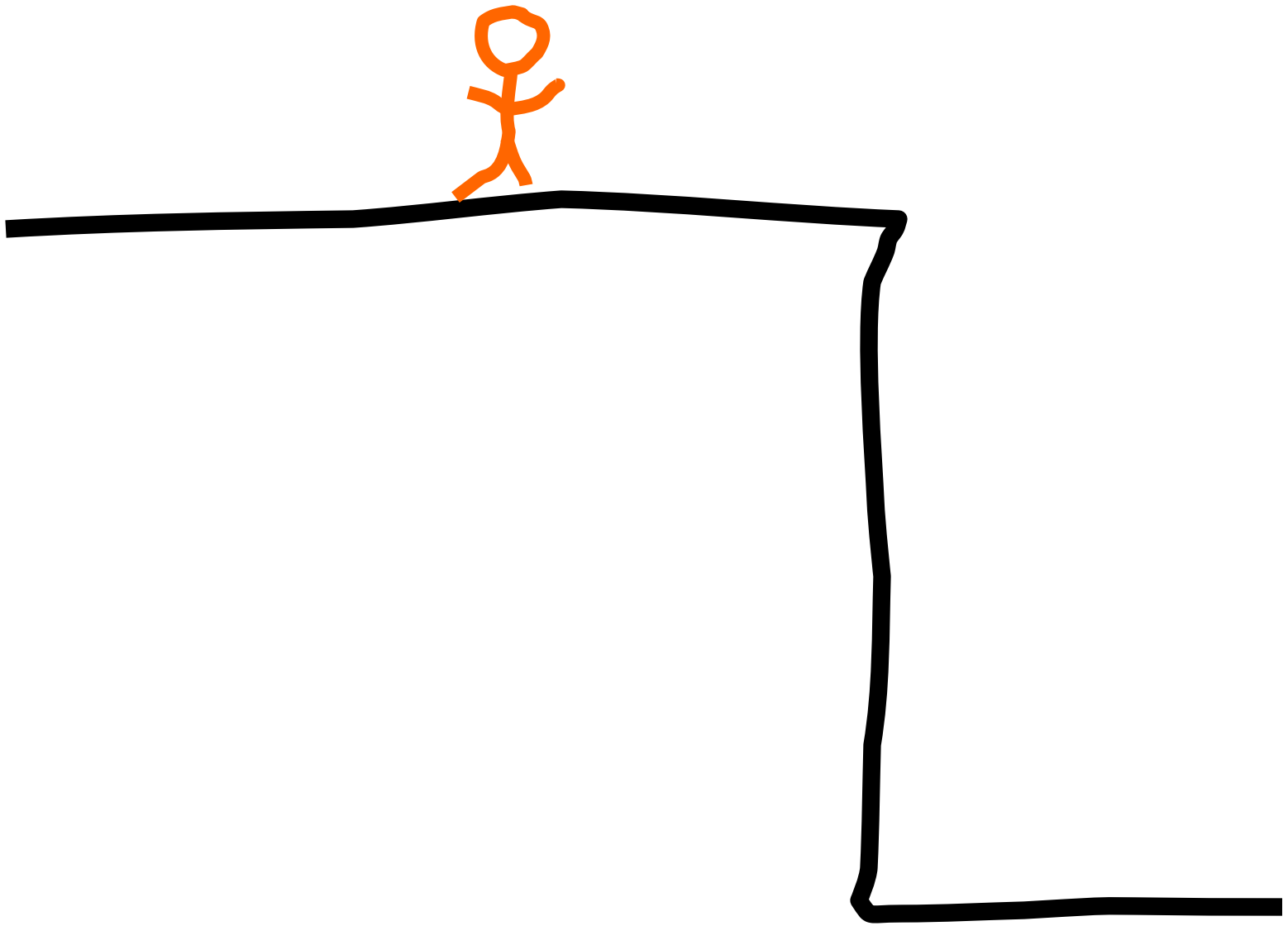

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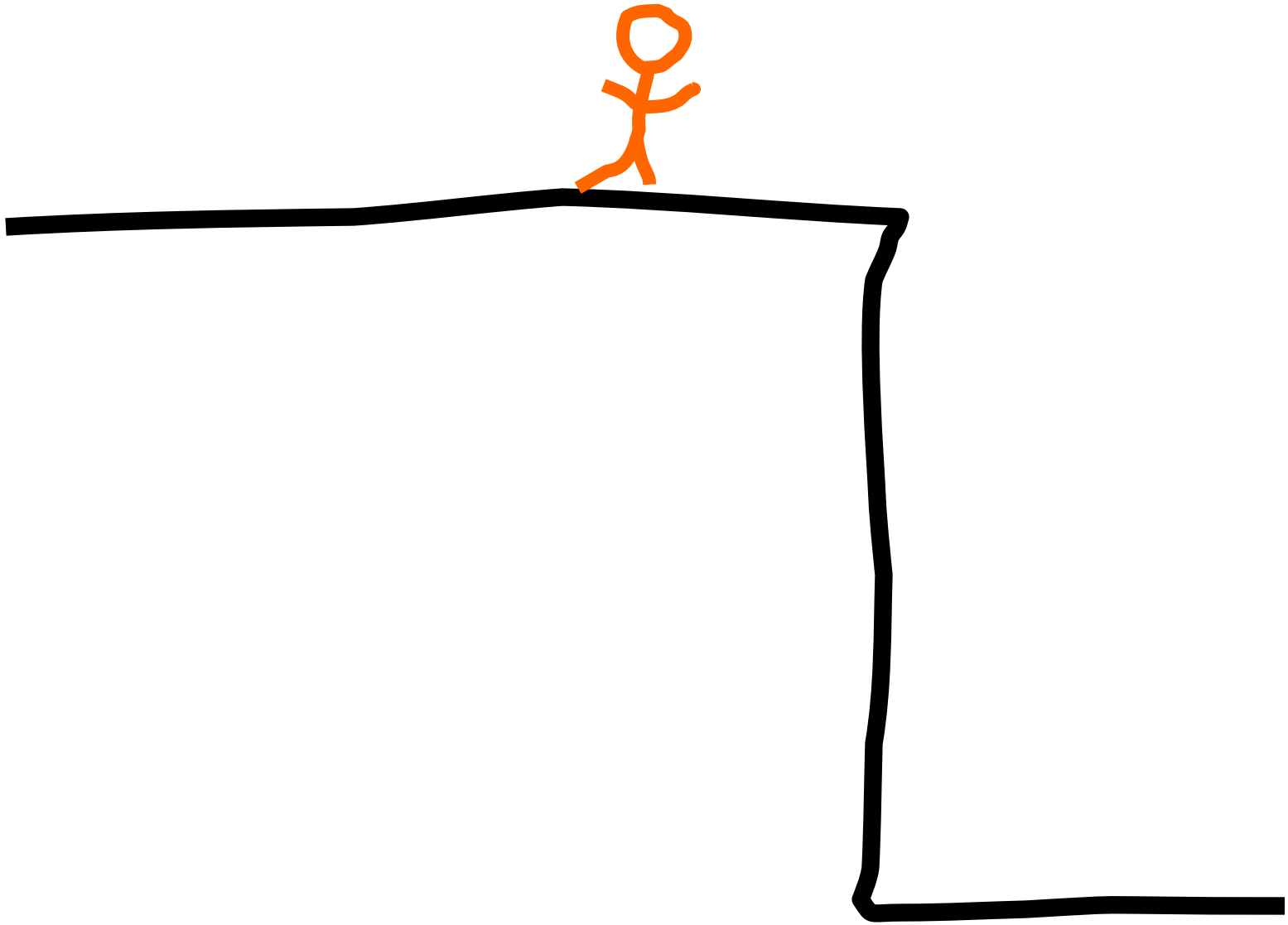

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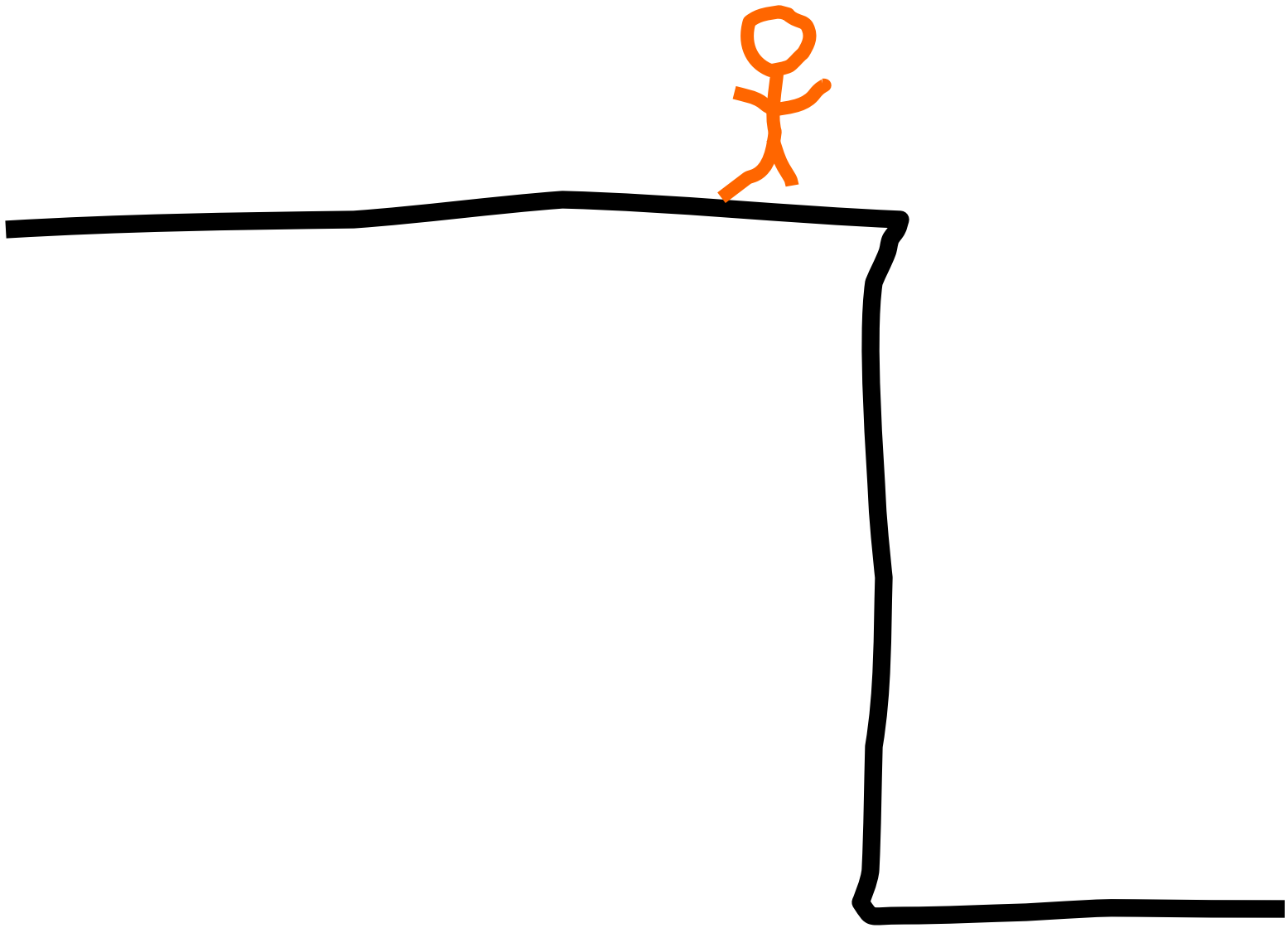

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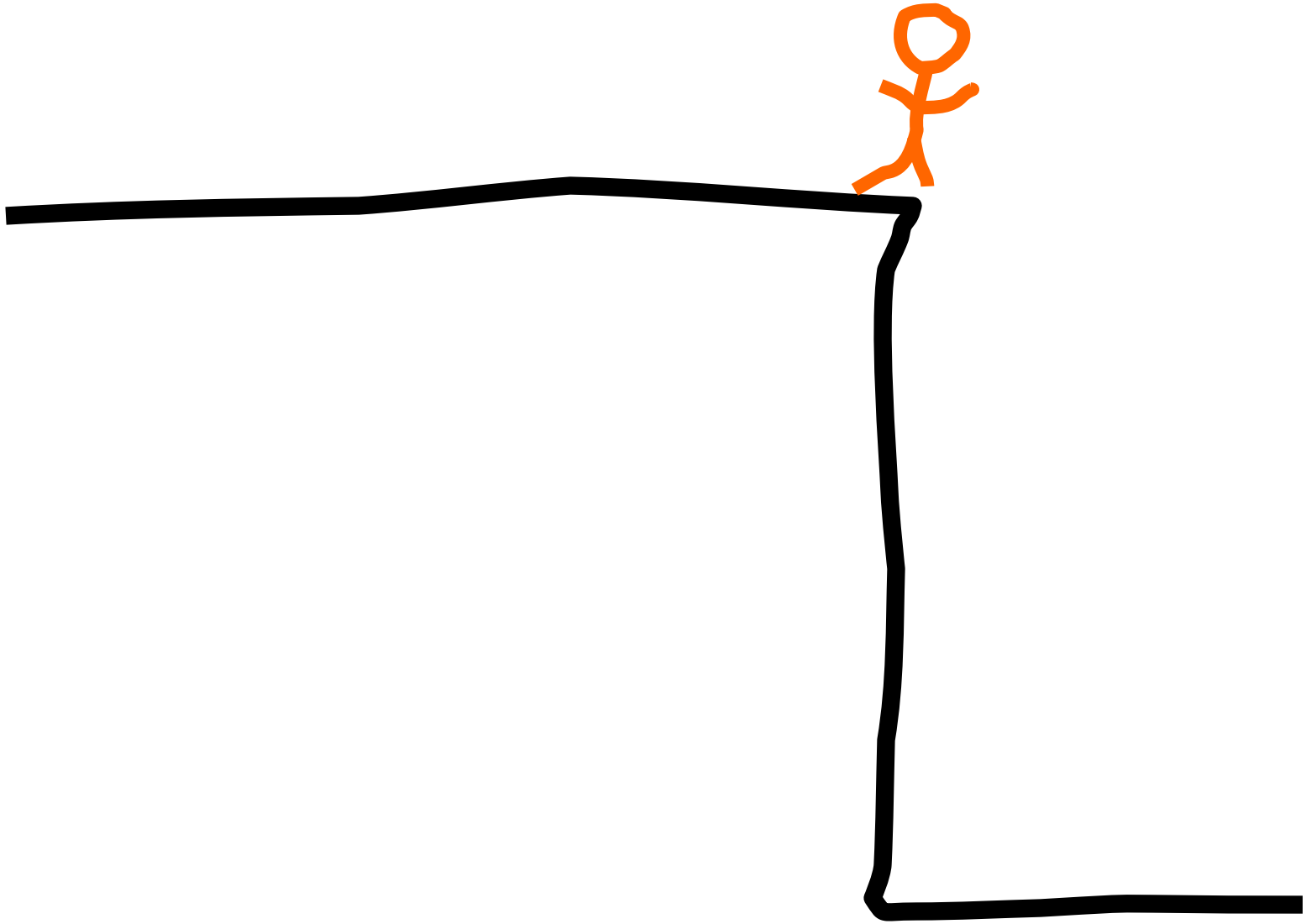

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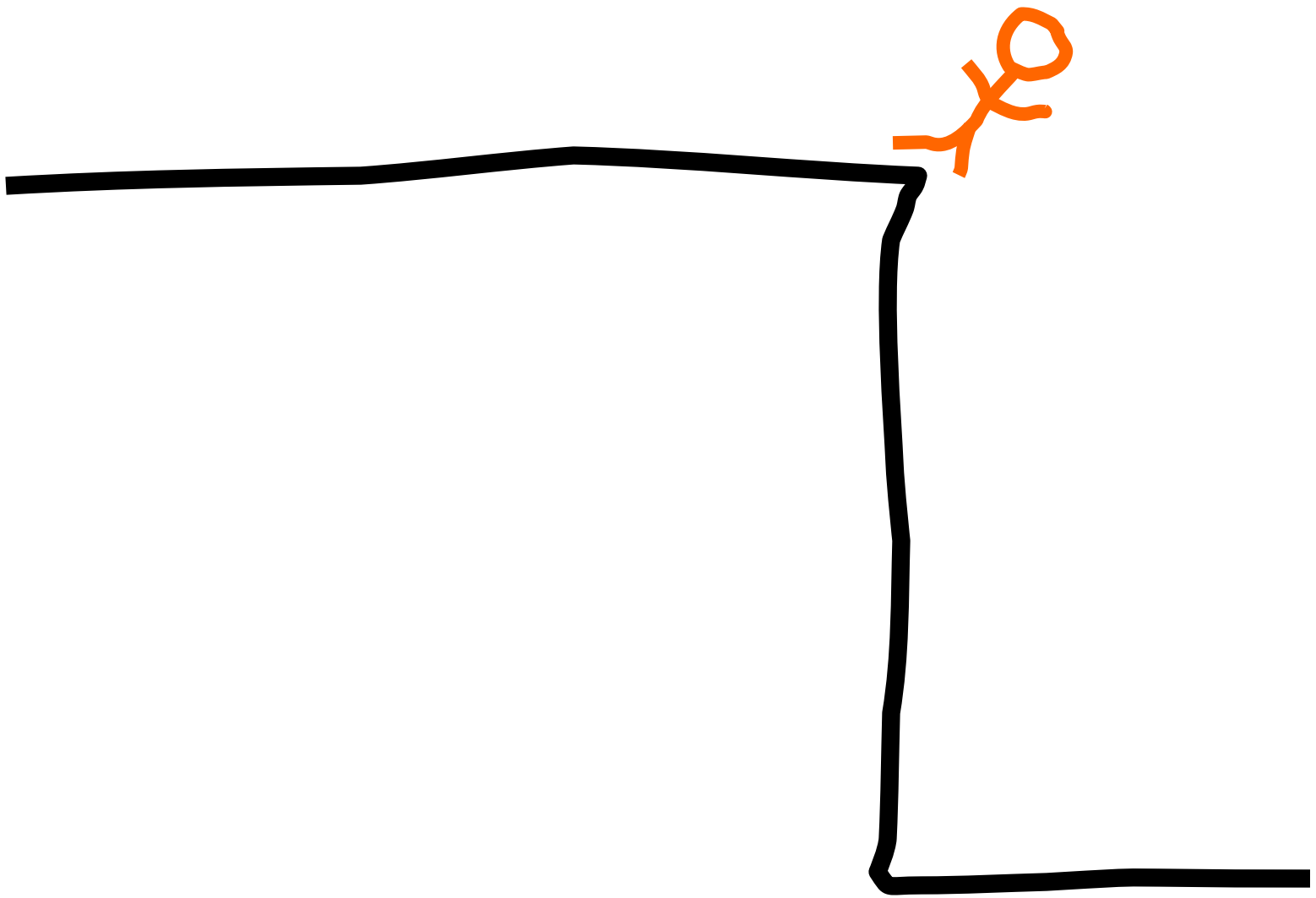

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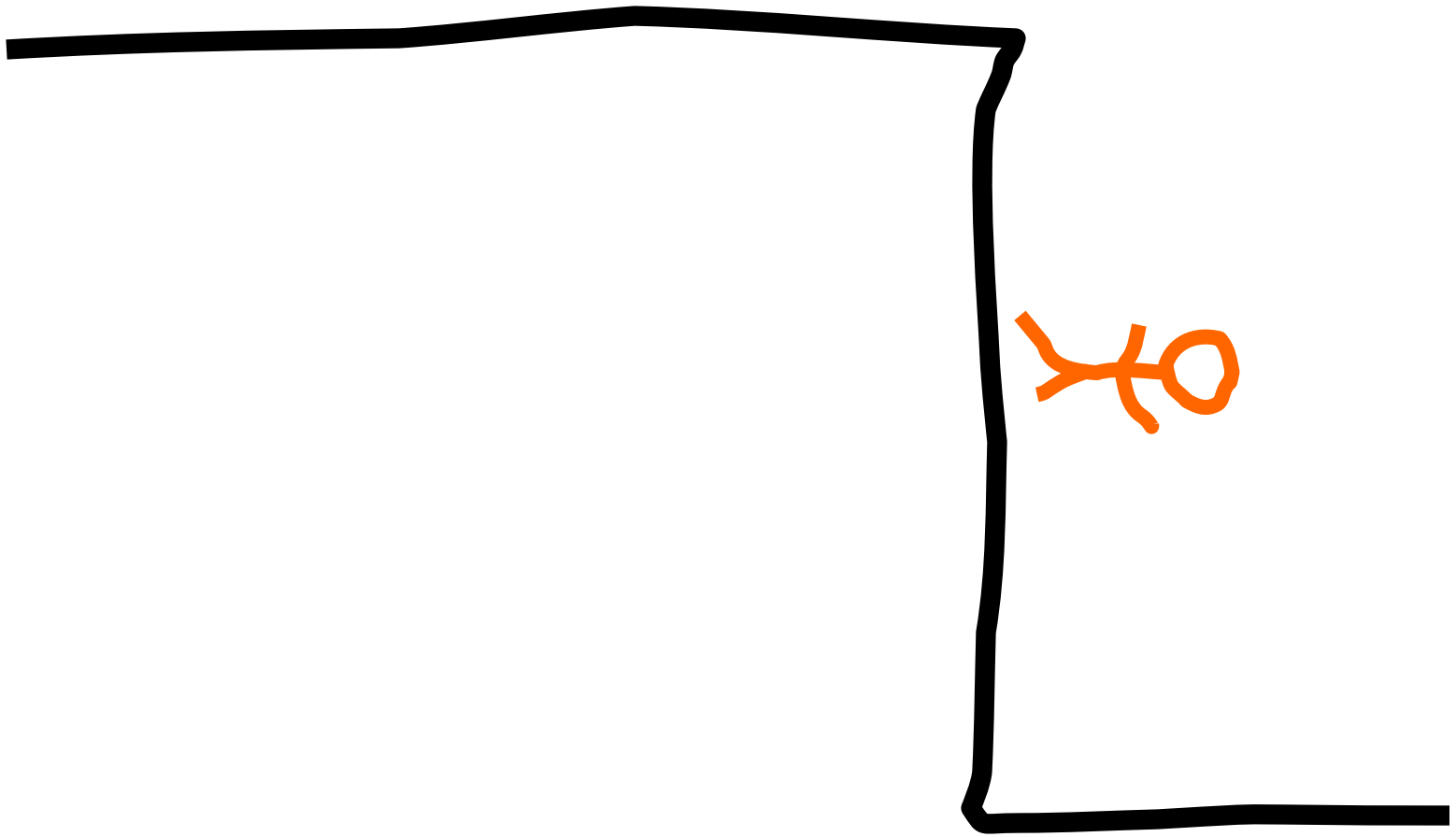

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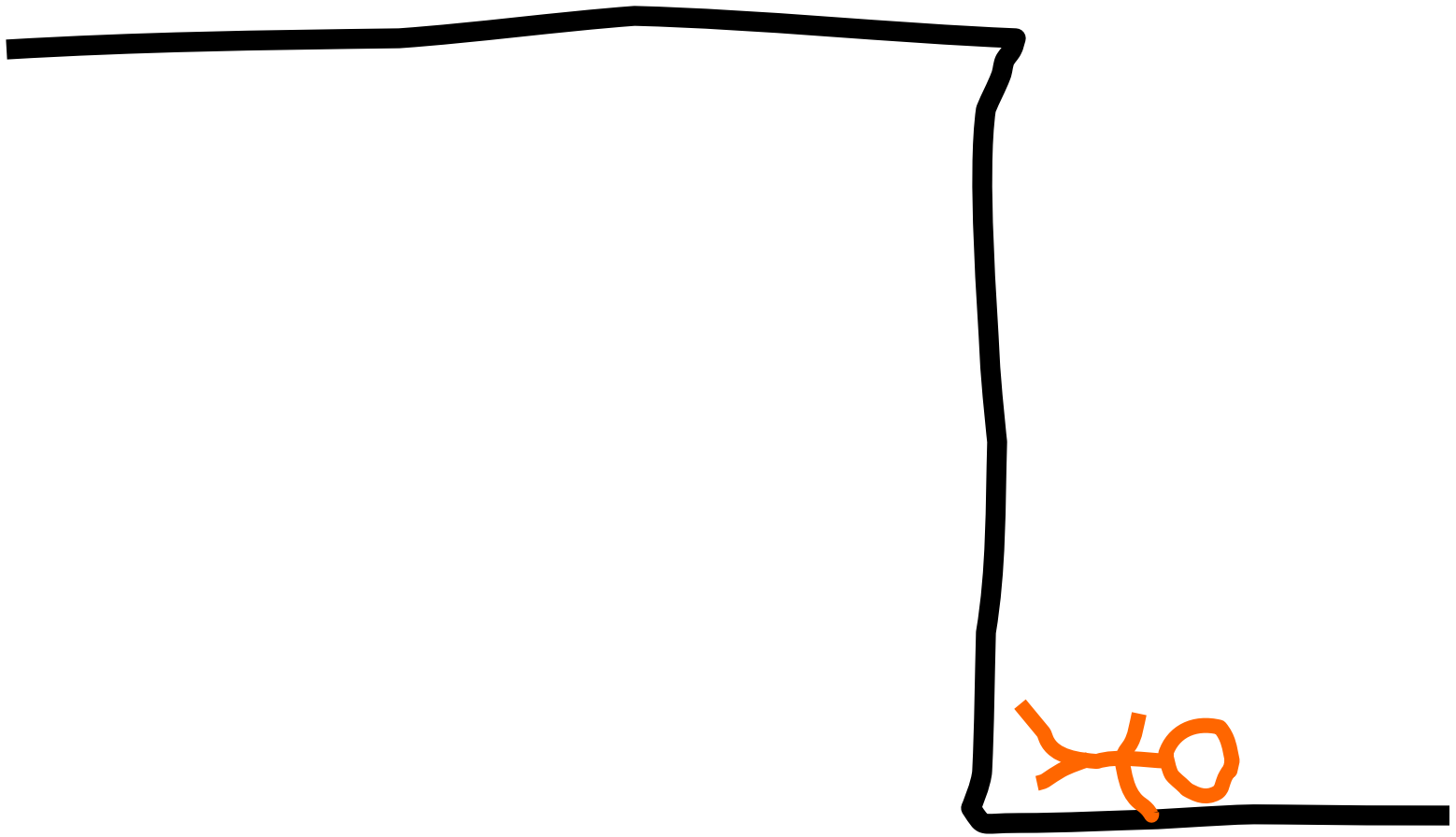

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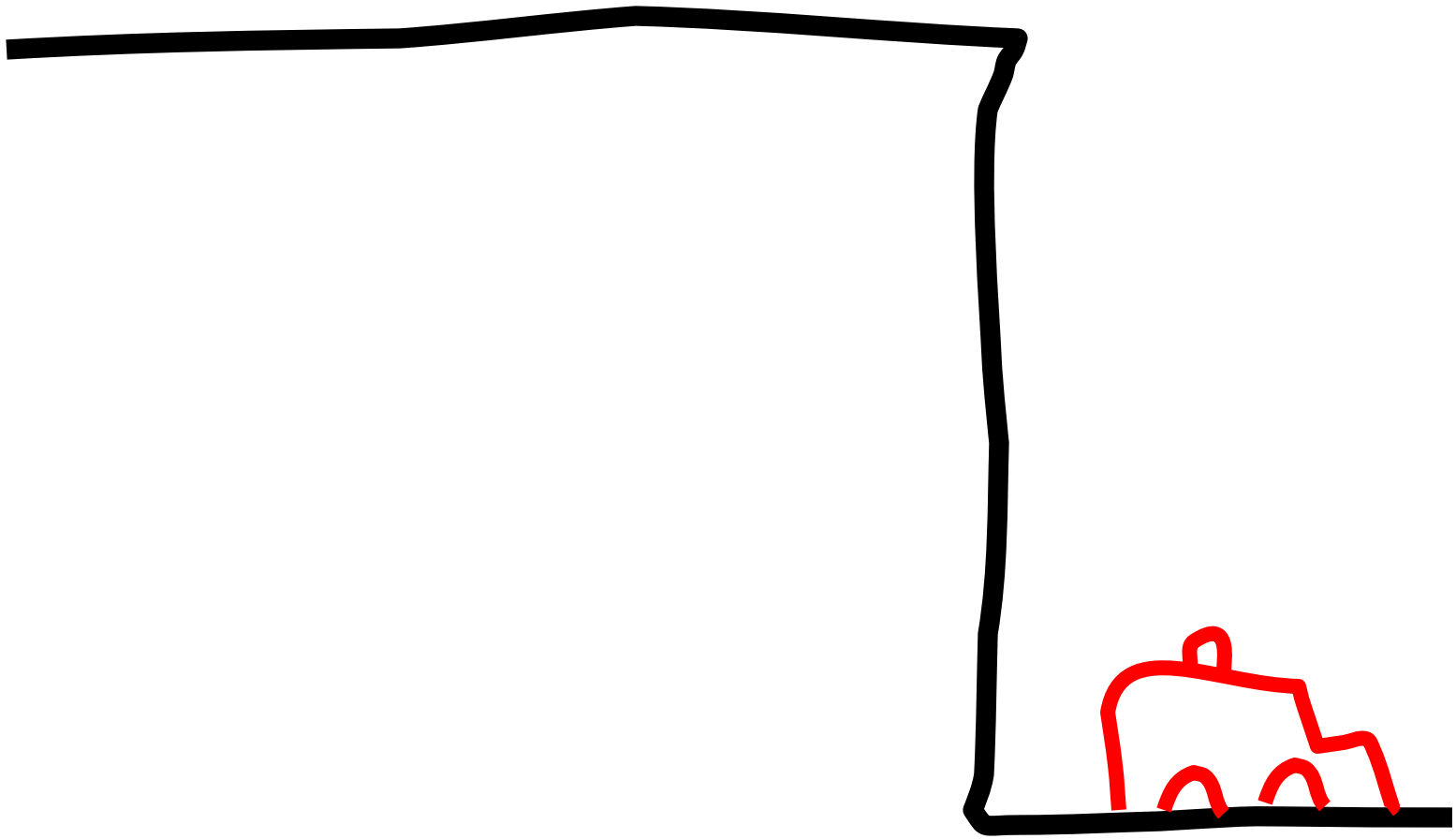

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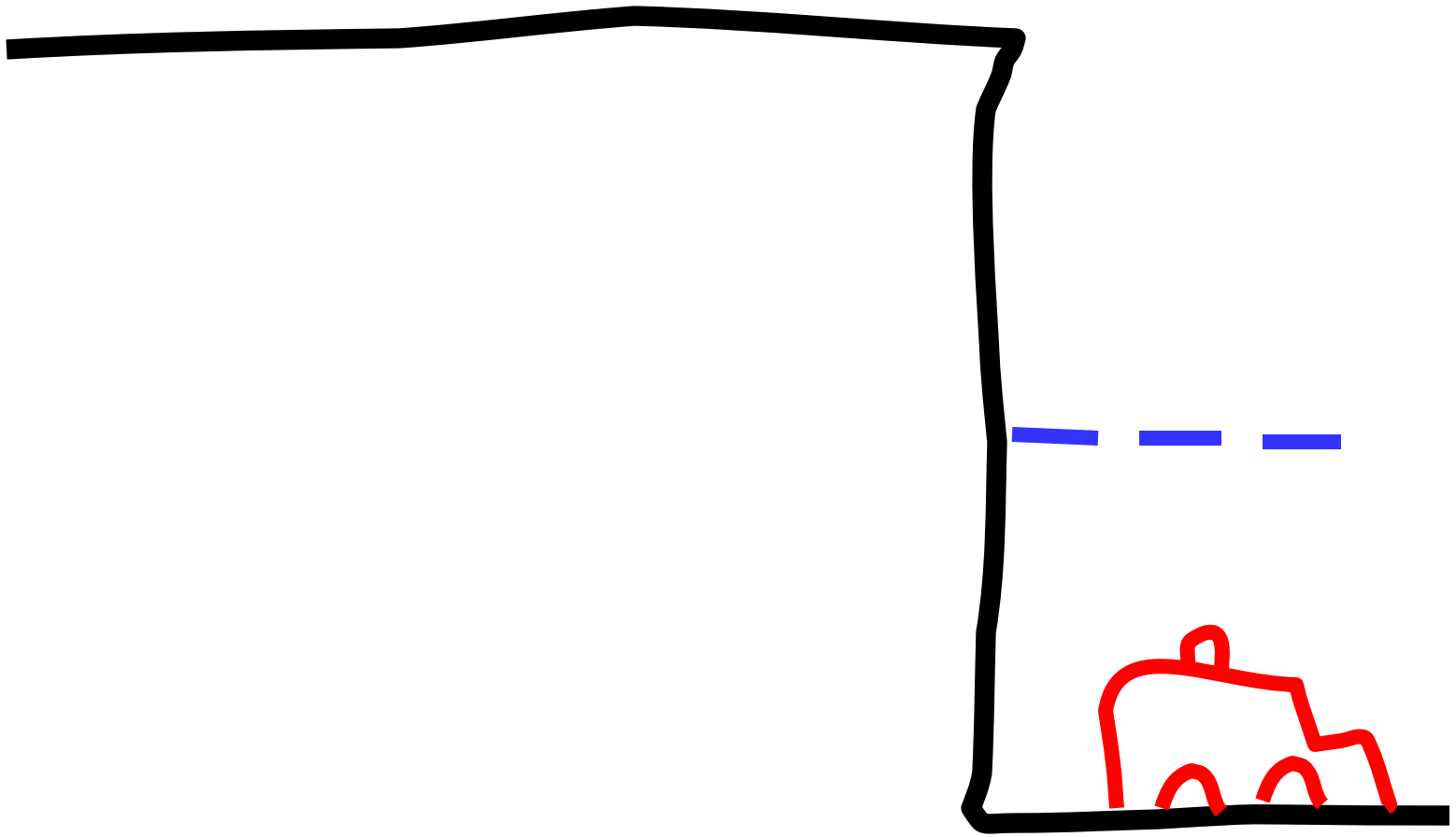

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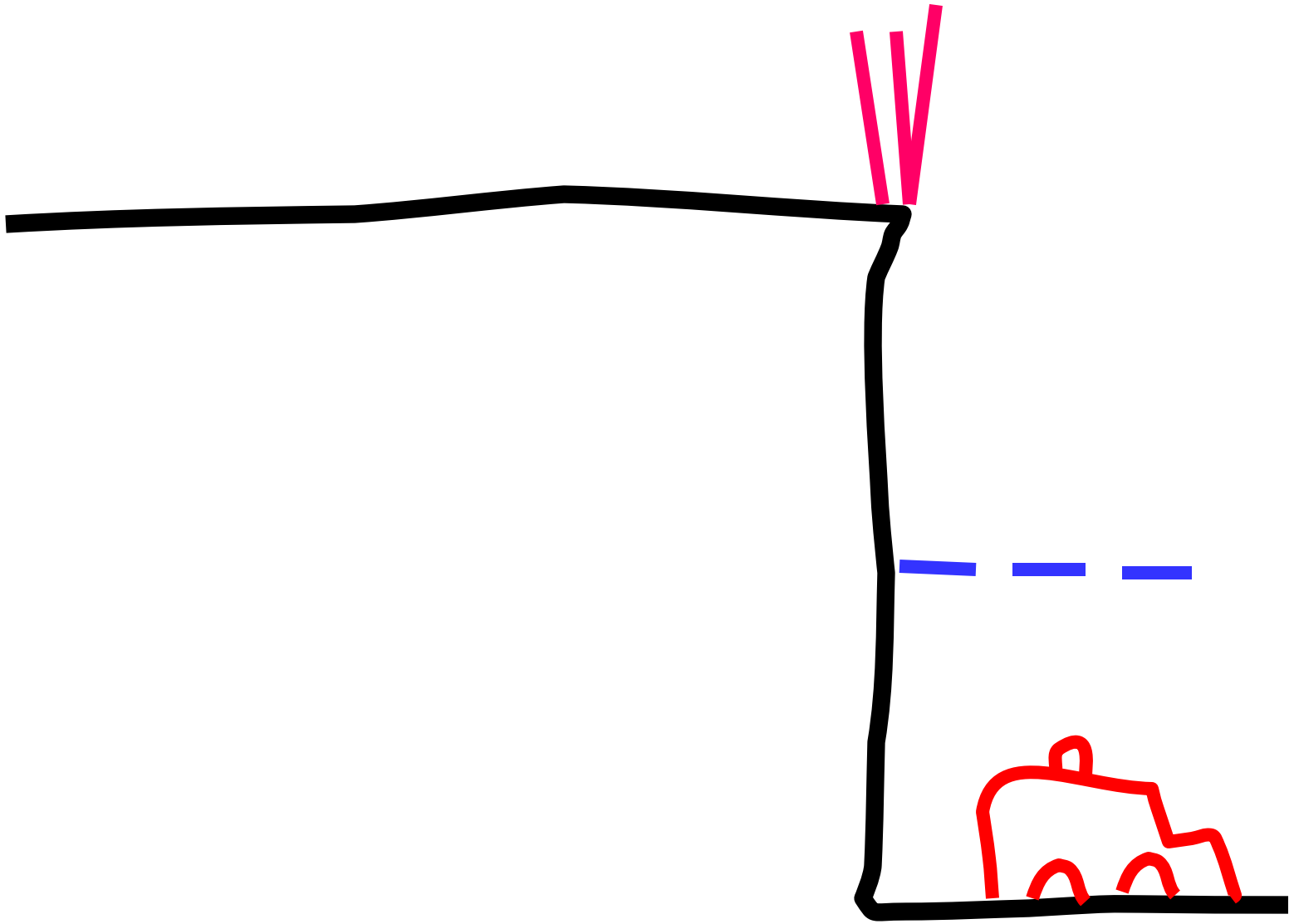

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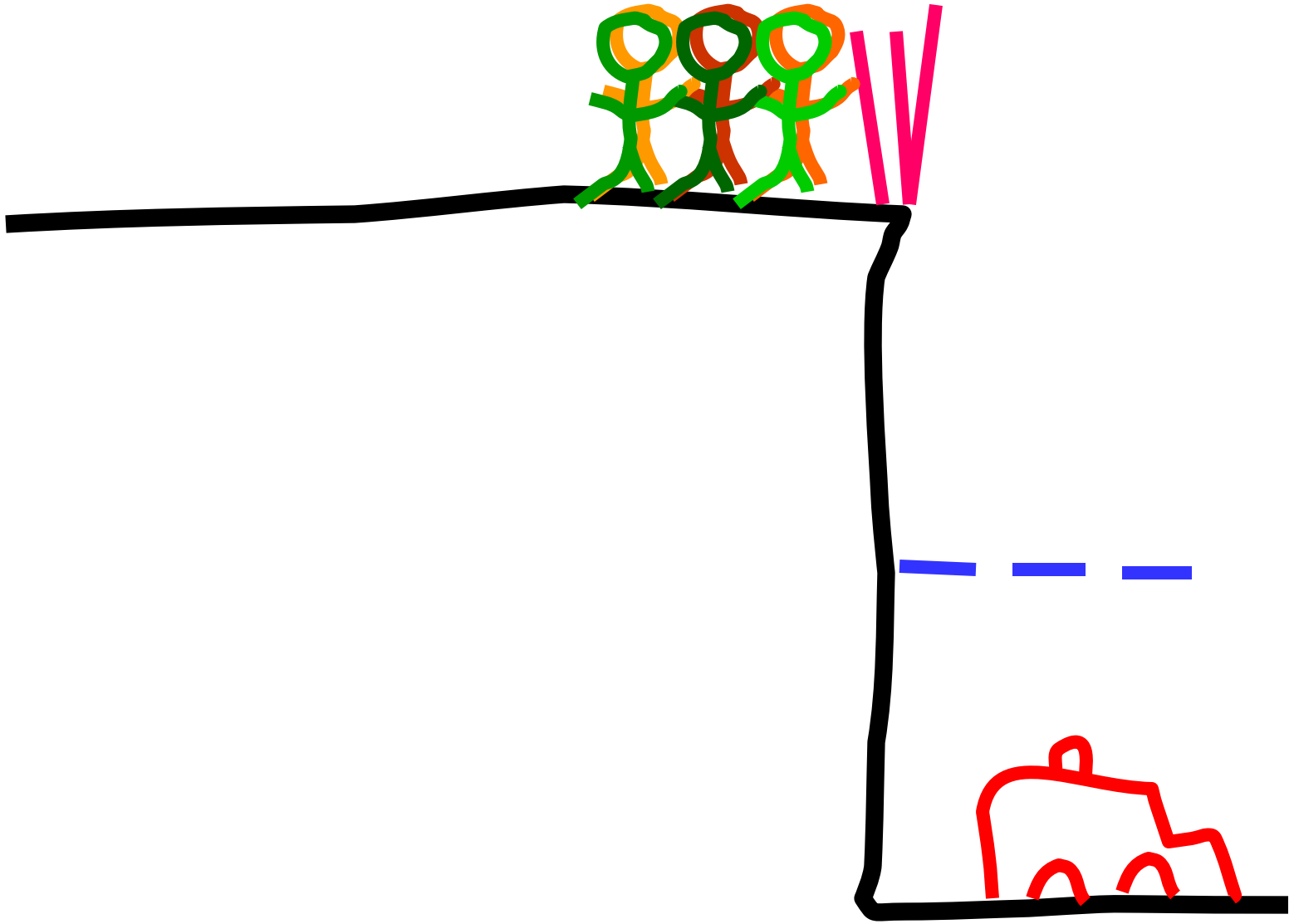

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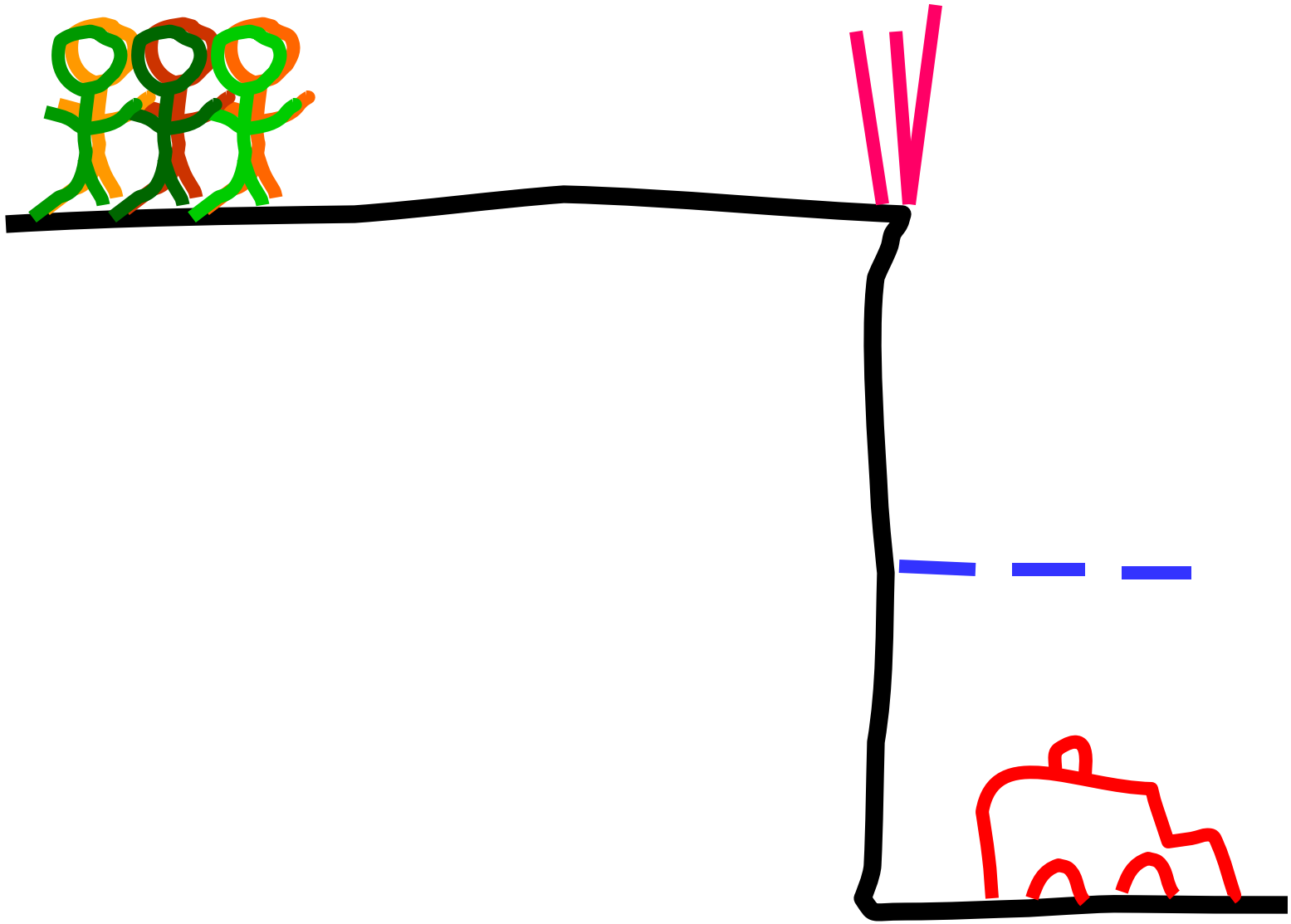

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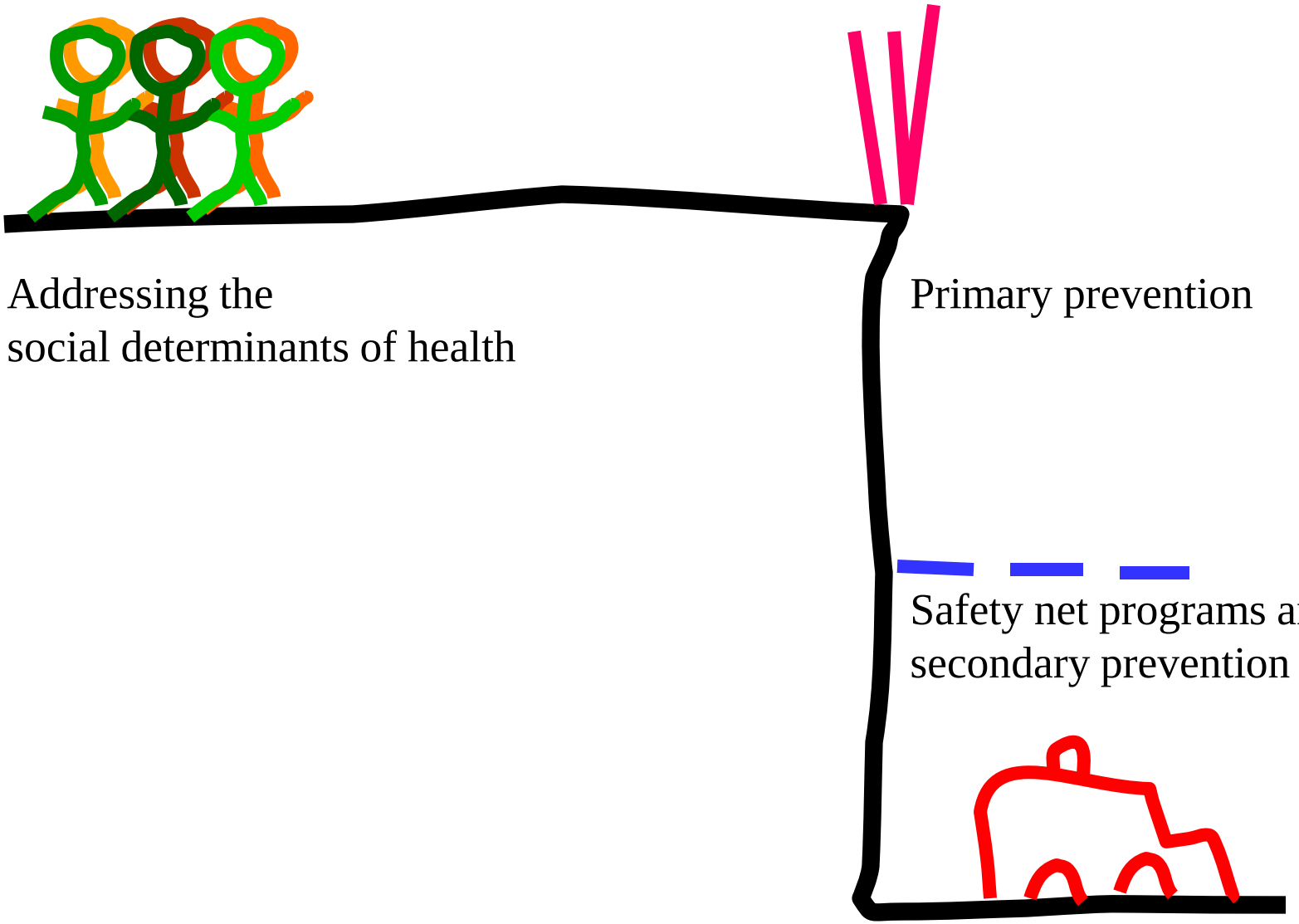


Jones CP *et al.* ***J Health Care Poor Underserved* 2009.**

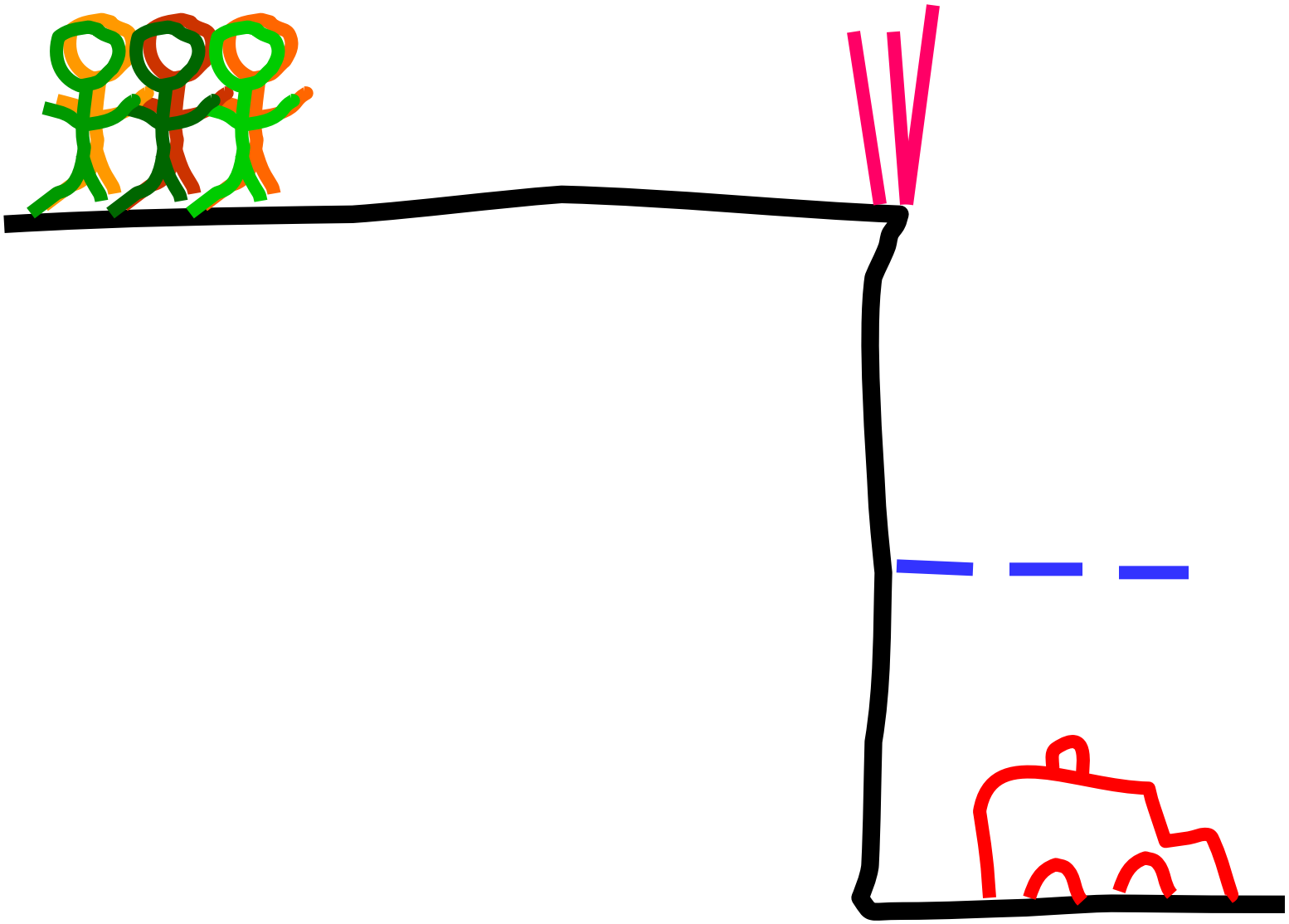
But how do disparities arise?

- **Differences in the quality of care received within the health care system**
- **Differences in access to health care, including preventive and curative services**
- **Differences in life opportunities, exposures, and stresses that result in differences in underlying health status**

Phelan JC, Link BG, Tehranifar P. Social Conditions as Fundamental Causes of Health Inequalities. ***J Health Soc Behav* 2010;51(S):S28-S40.**

Byrd WM, Clayton LA. ***An American Health Dilemma: Race, Medicine, and Health Care in the United States, 1900-2000.*** New York, NY: Routledge, **2002.**

Smedley BD, Stith AY, Nelson AR (editors). ***Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.*** Washington, DC: The National Academies Press, **2002.**



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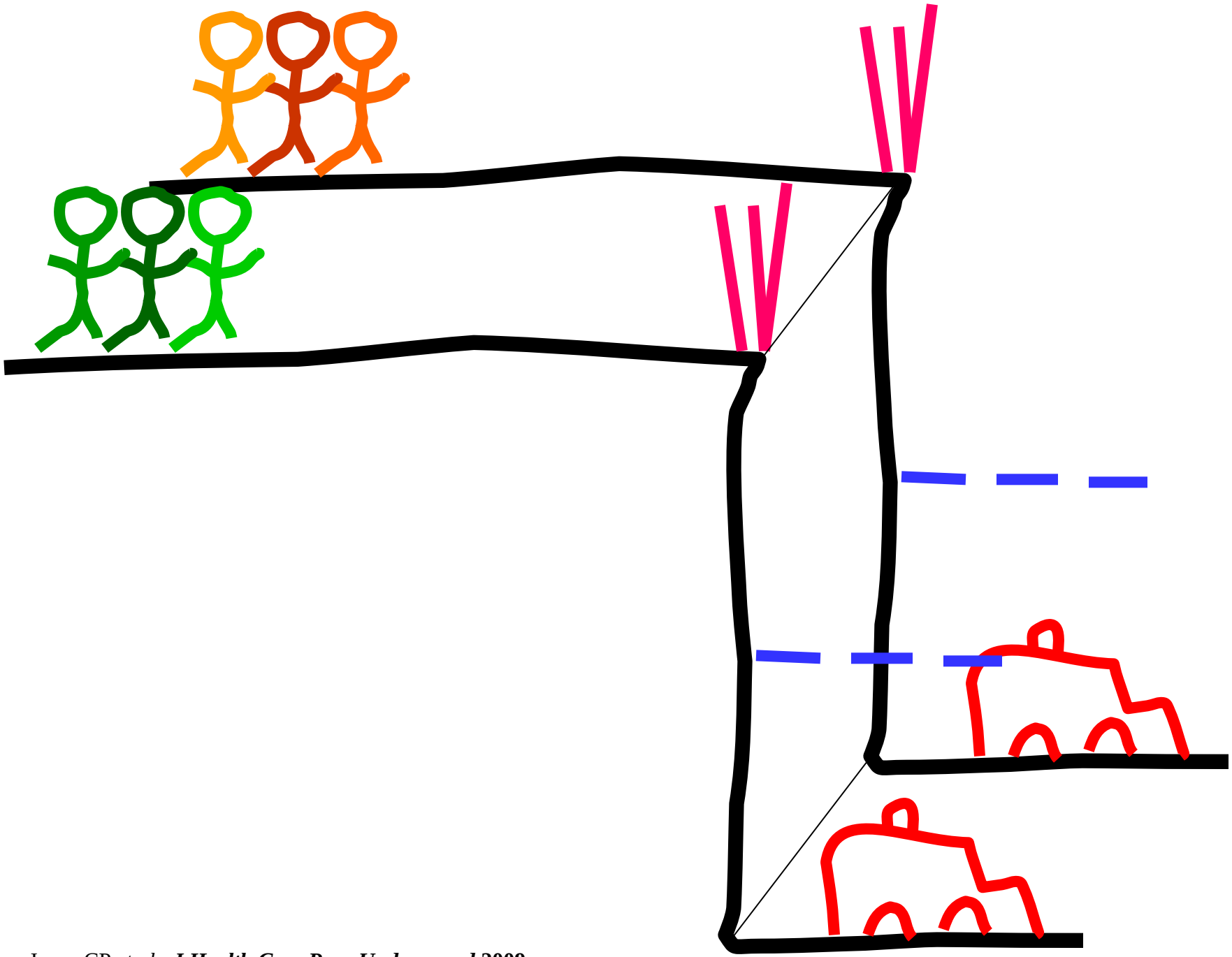

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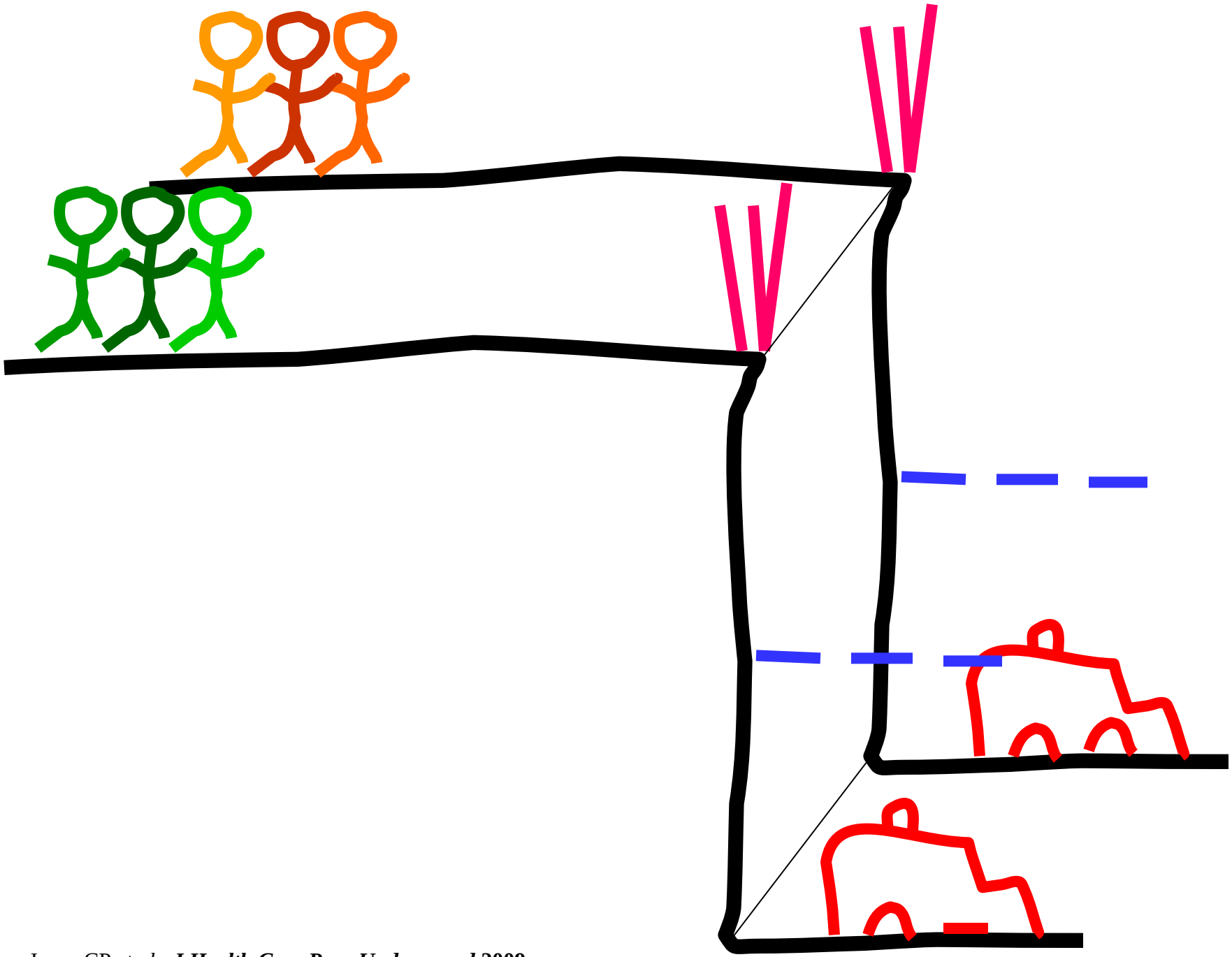

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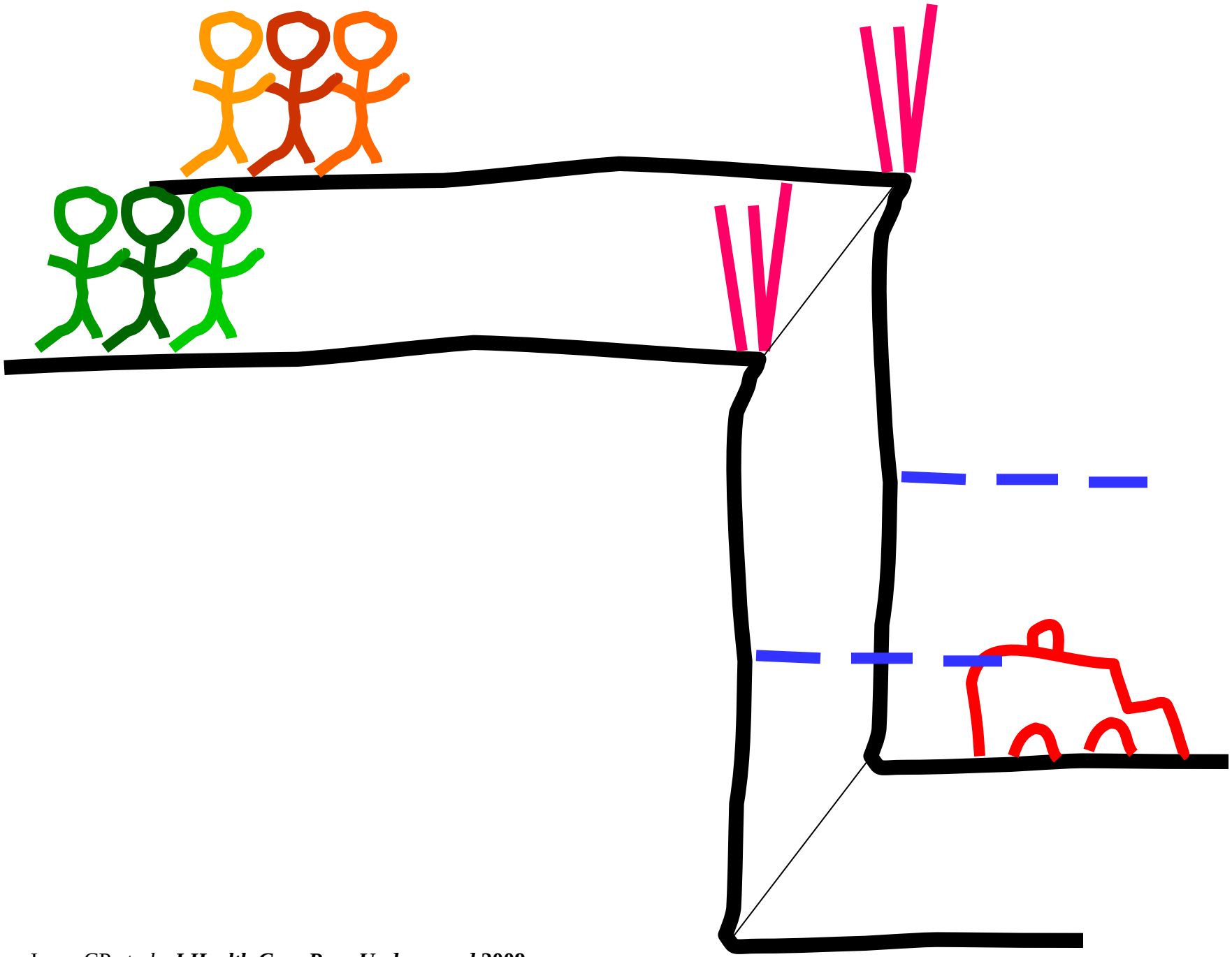

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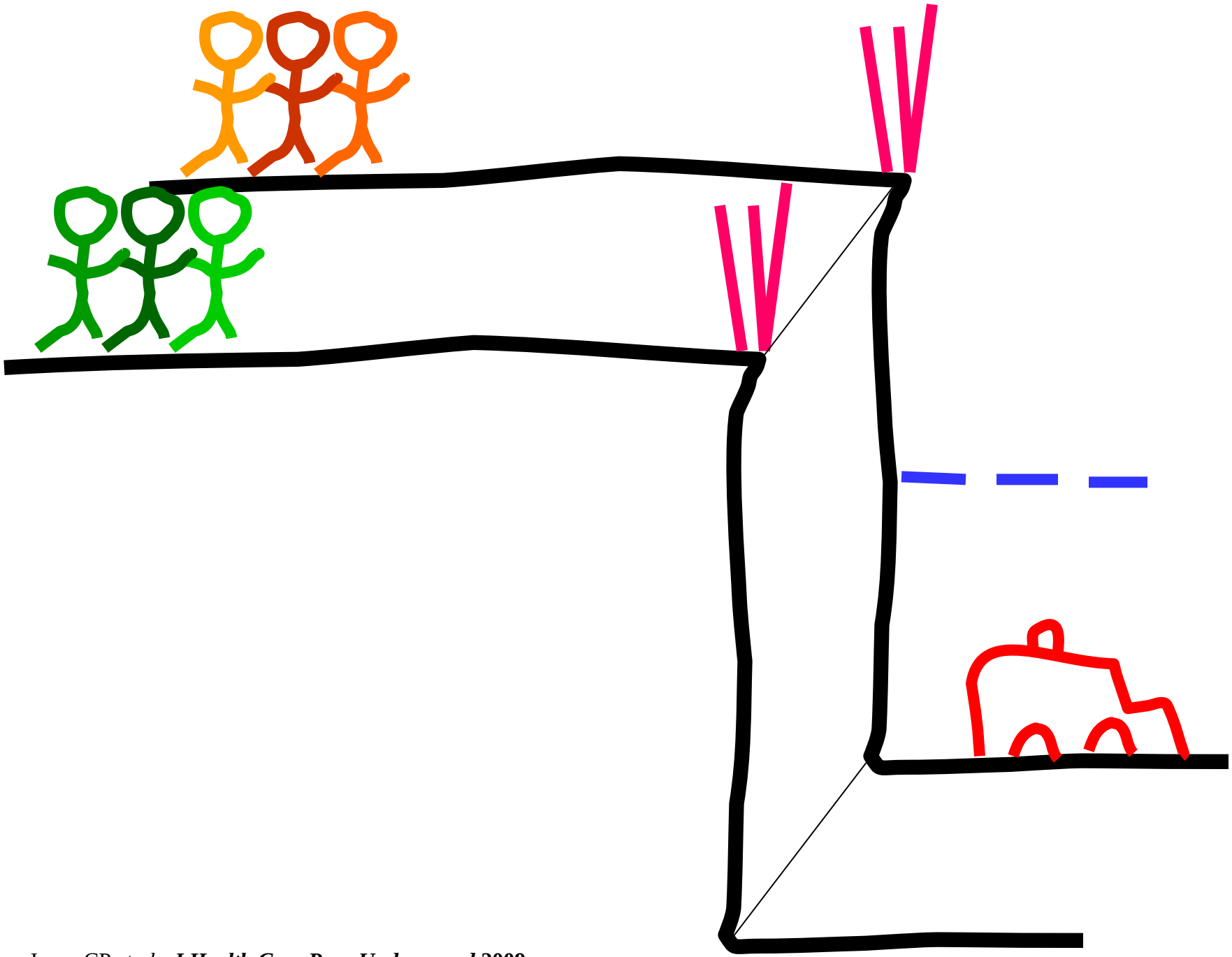

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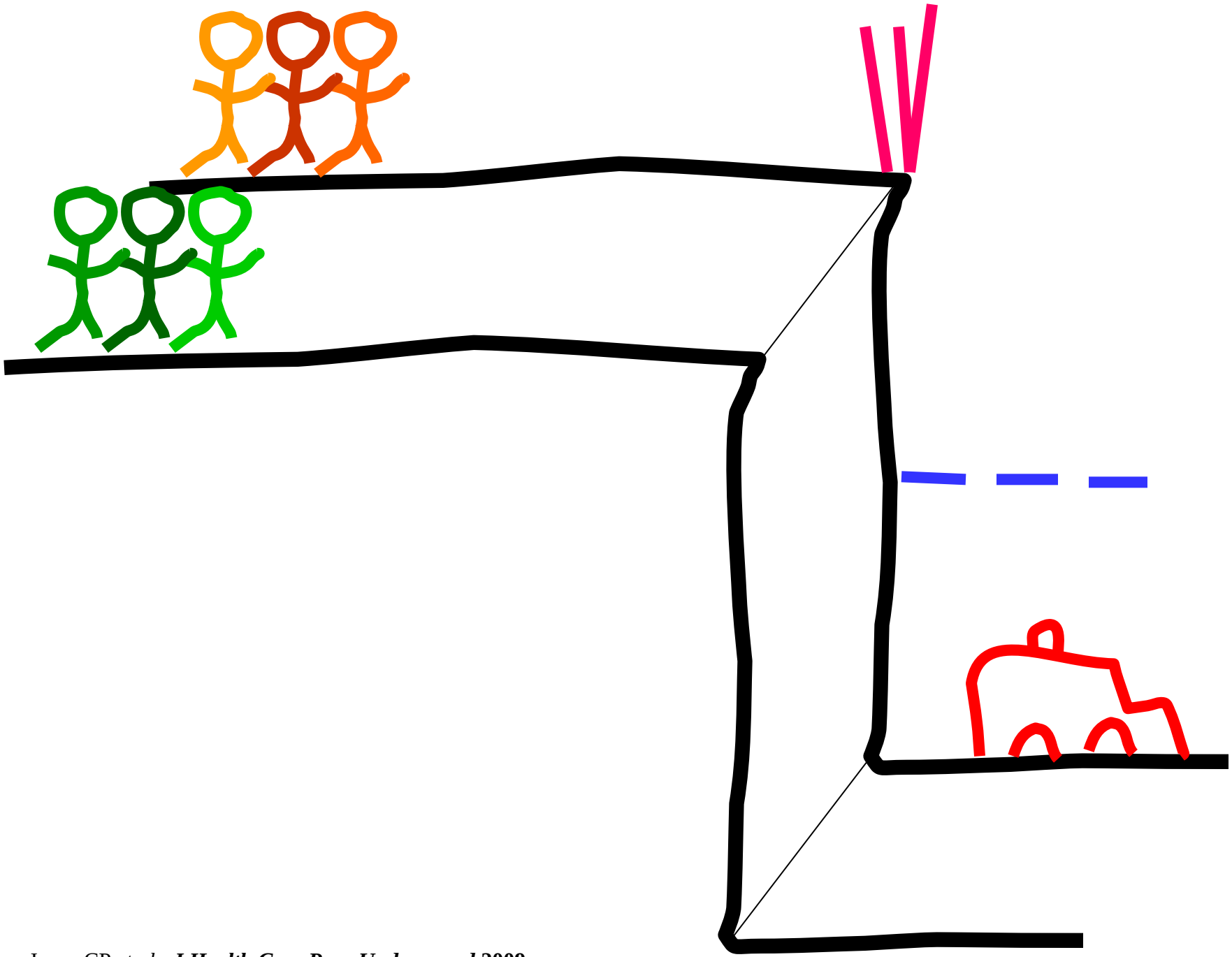

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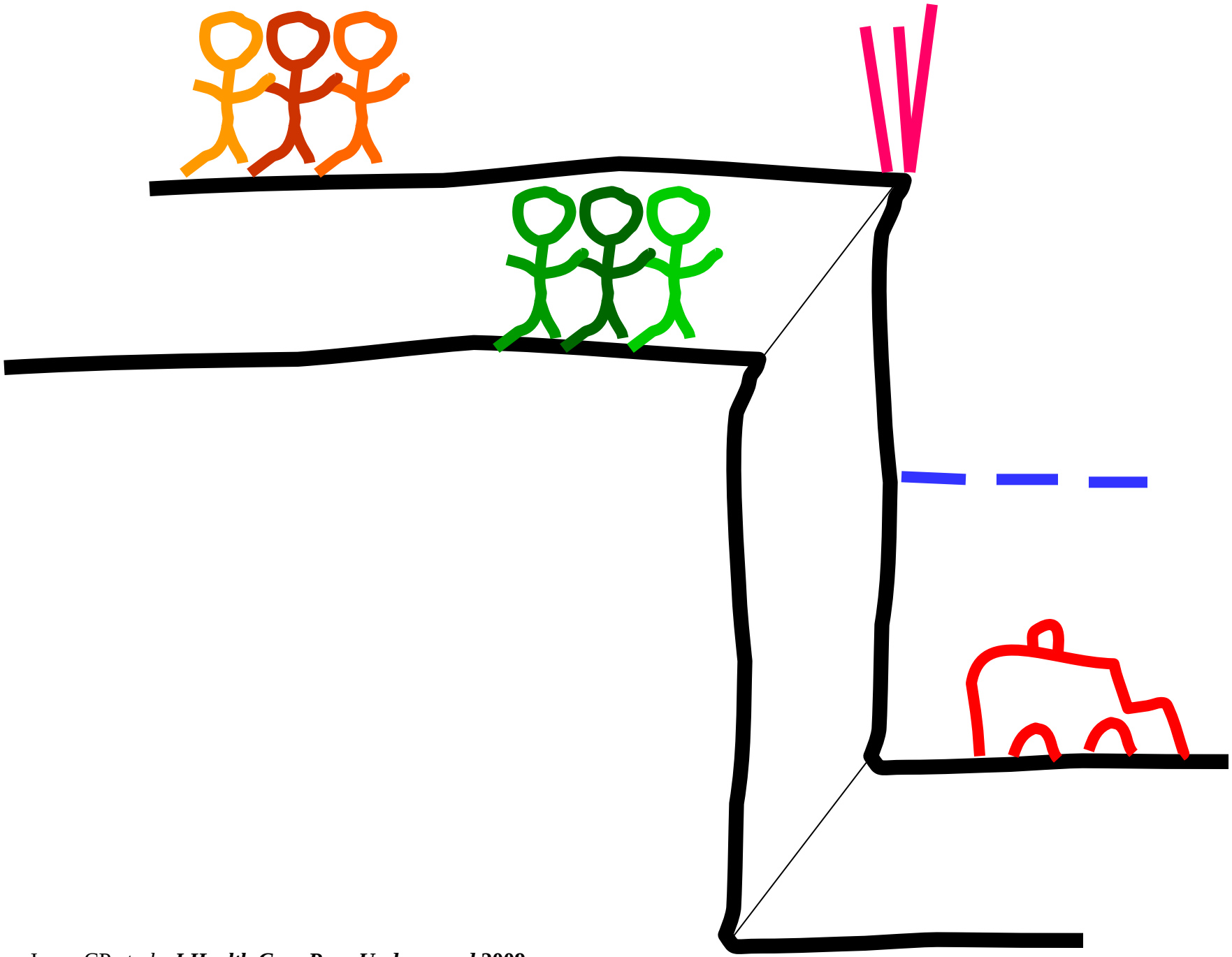

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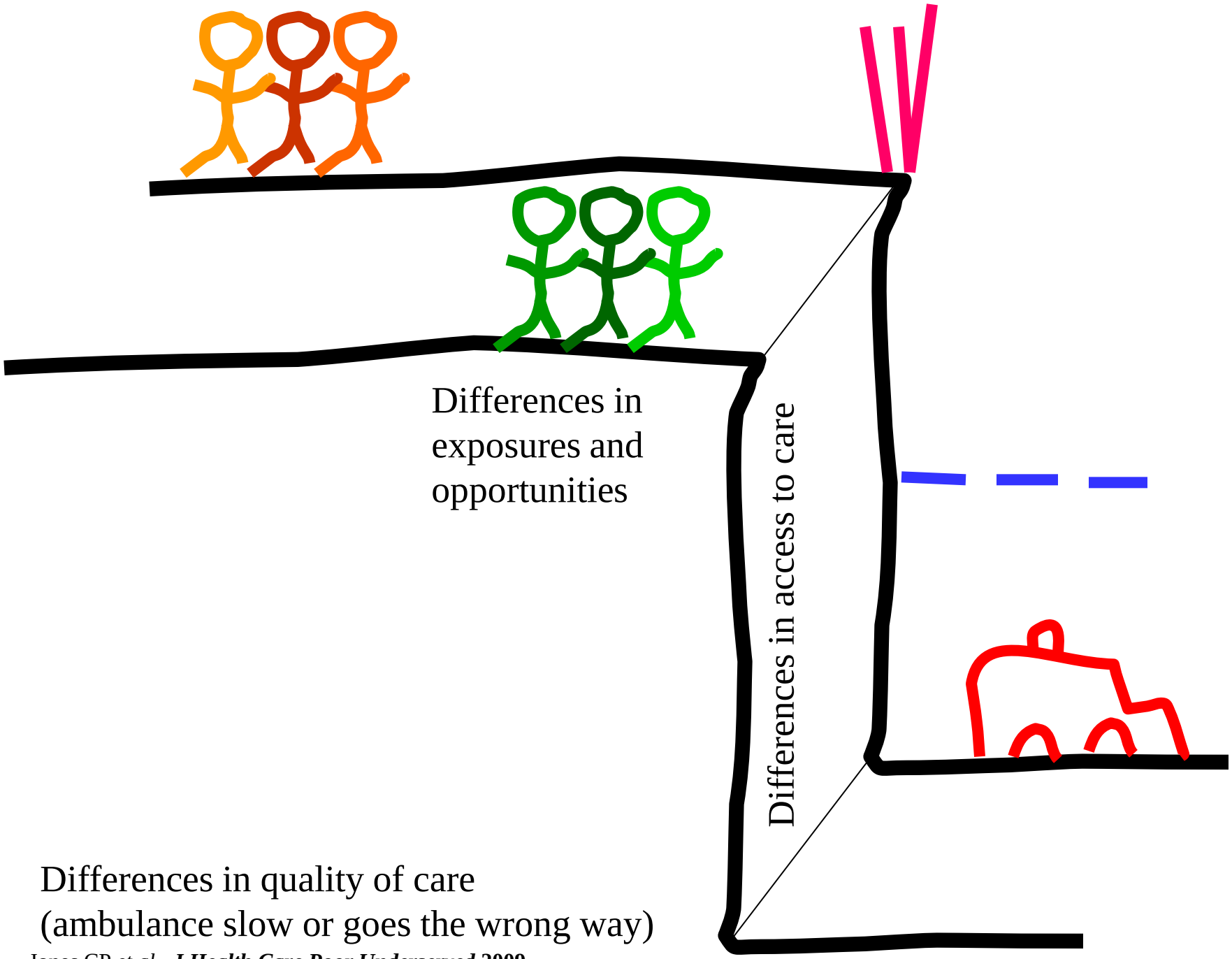

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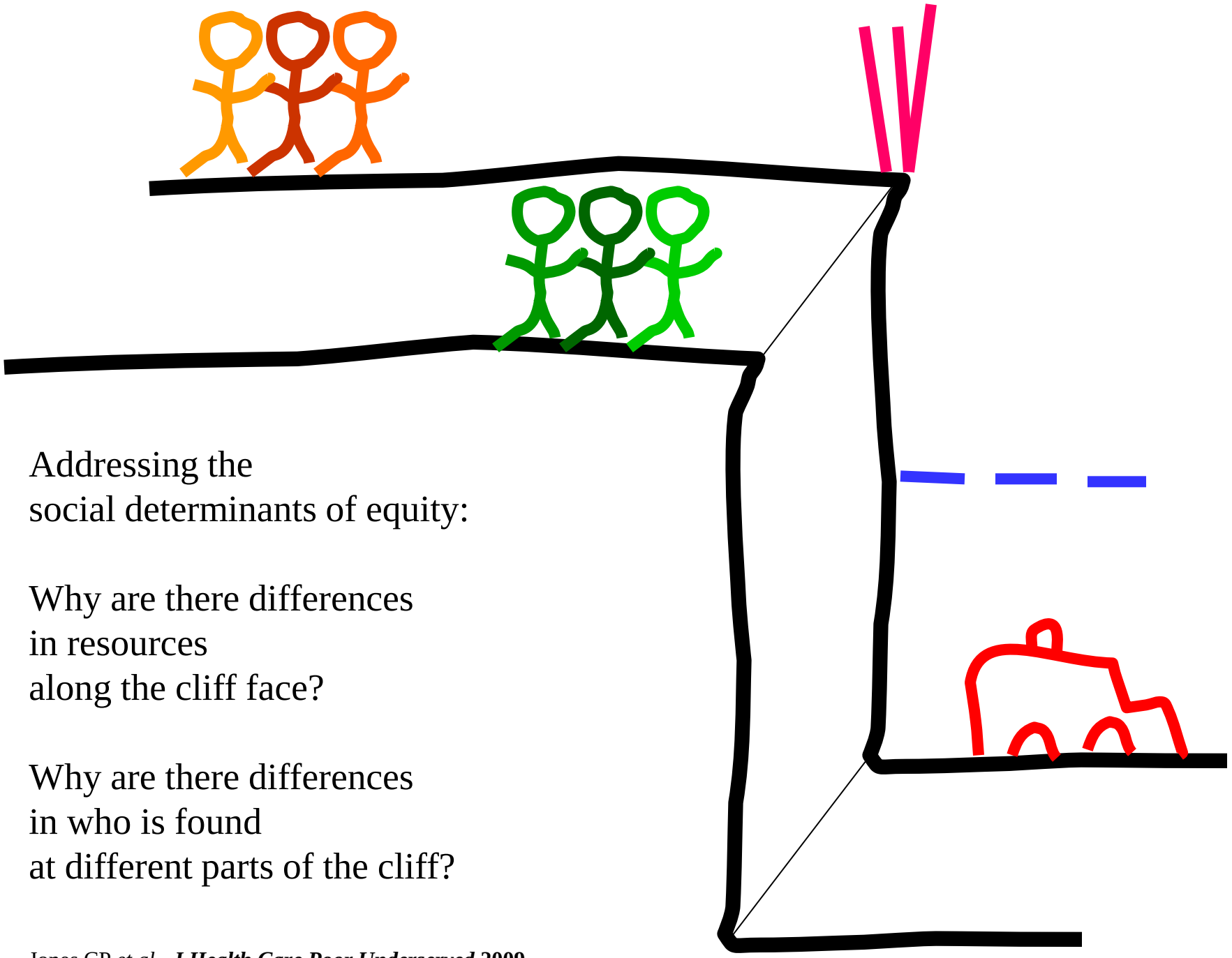


Addressing the
social determinants of equity:

Why are there differences
in resources
along the cliff face?

Why are there differences
in who is found
at different parts of the cliff?

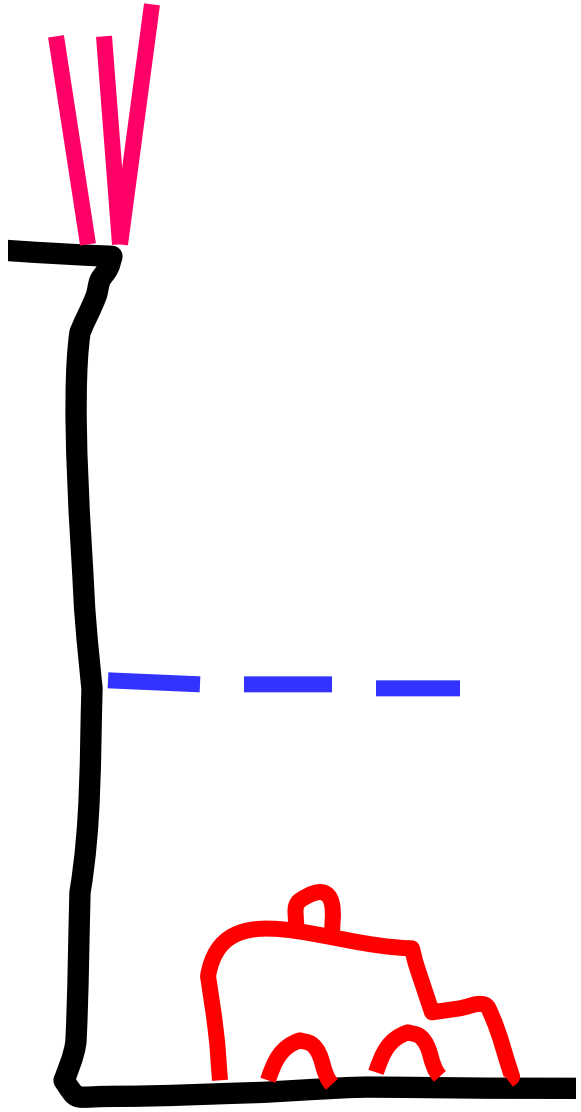
Jones CP *et al.* ***J Health Care Poor Underserved* 2009.**

3 dimensions of health intervention

Jones CP *et al.* ***J Health Care Poor Underserved*** **2009.**

3 dimensions of health intervention

Health services



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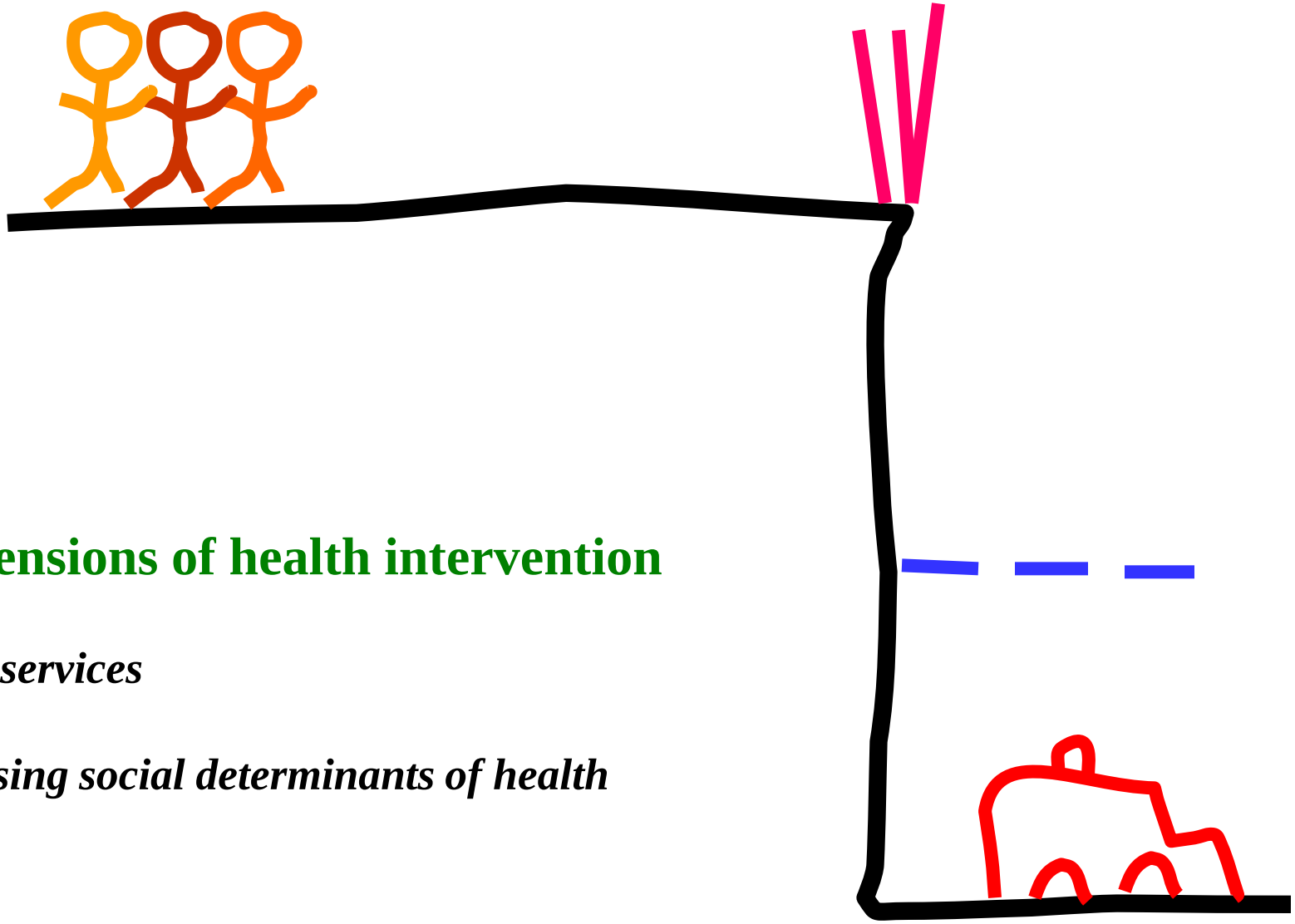

3 dimensions of health intervention

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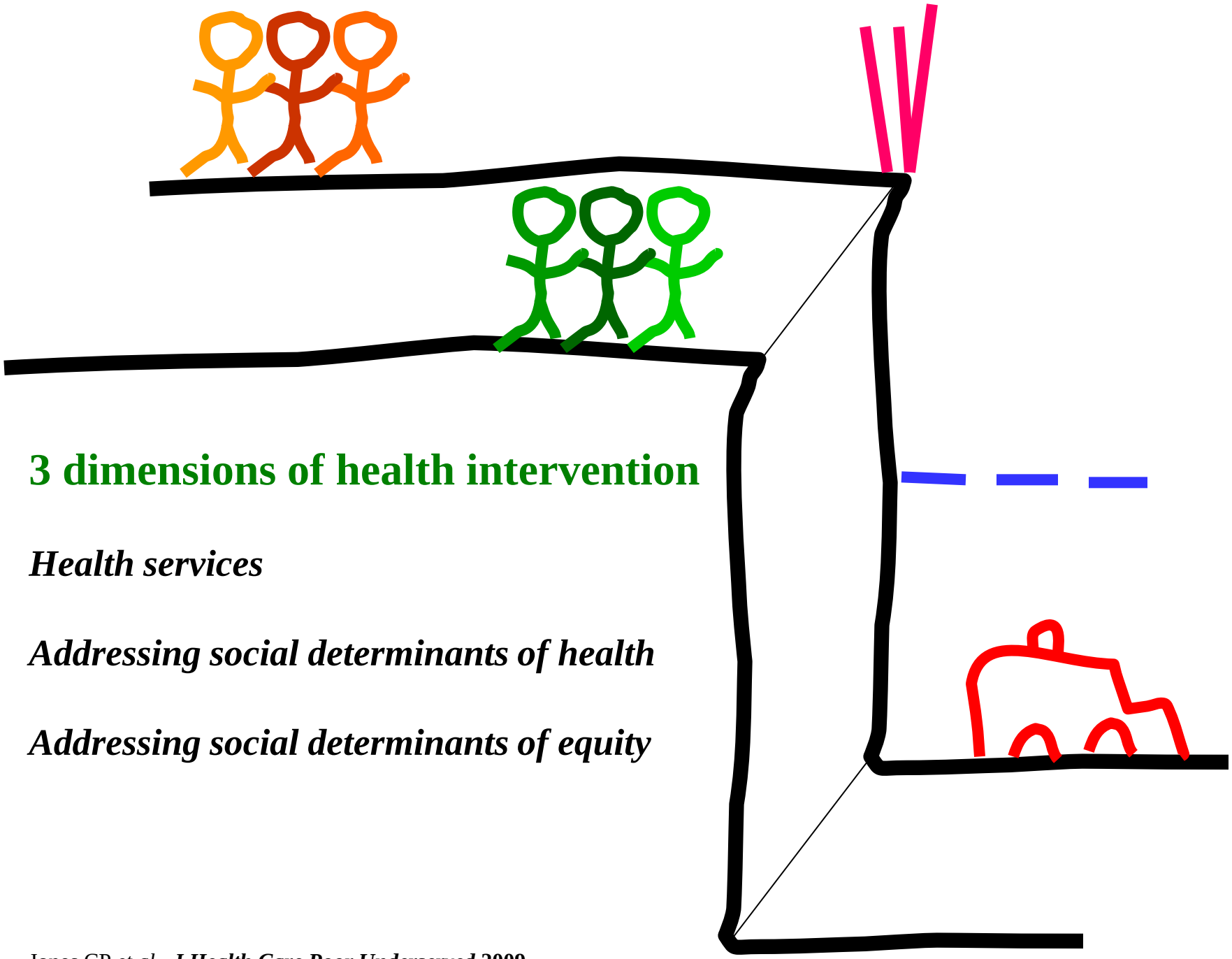

3 dimensions of health intervention

Health services

Addressing social determinants of health

Addressing social determinants of equity

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What is racism?

A system

Jones CP. Confronting Institutionalized Racism. *Phylon* **2003;50(1-2):7-22.**

What is racism?

A system of structuring opportunity and assigning value

Jones CP. Confronting Institutionalized Racism. *Phylon* **2003;50(1-2):7-22.**

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A system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race")

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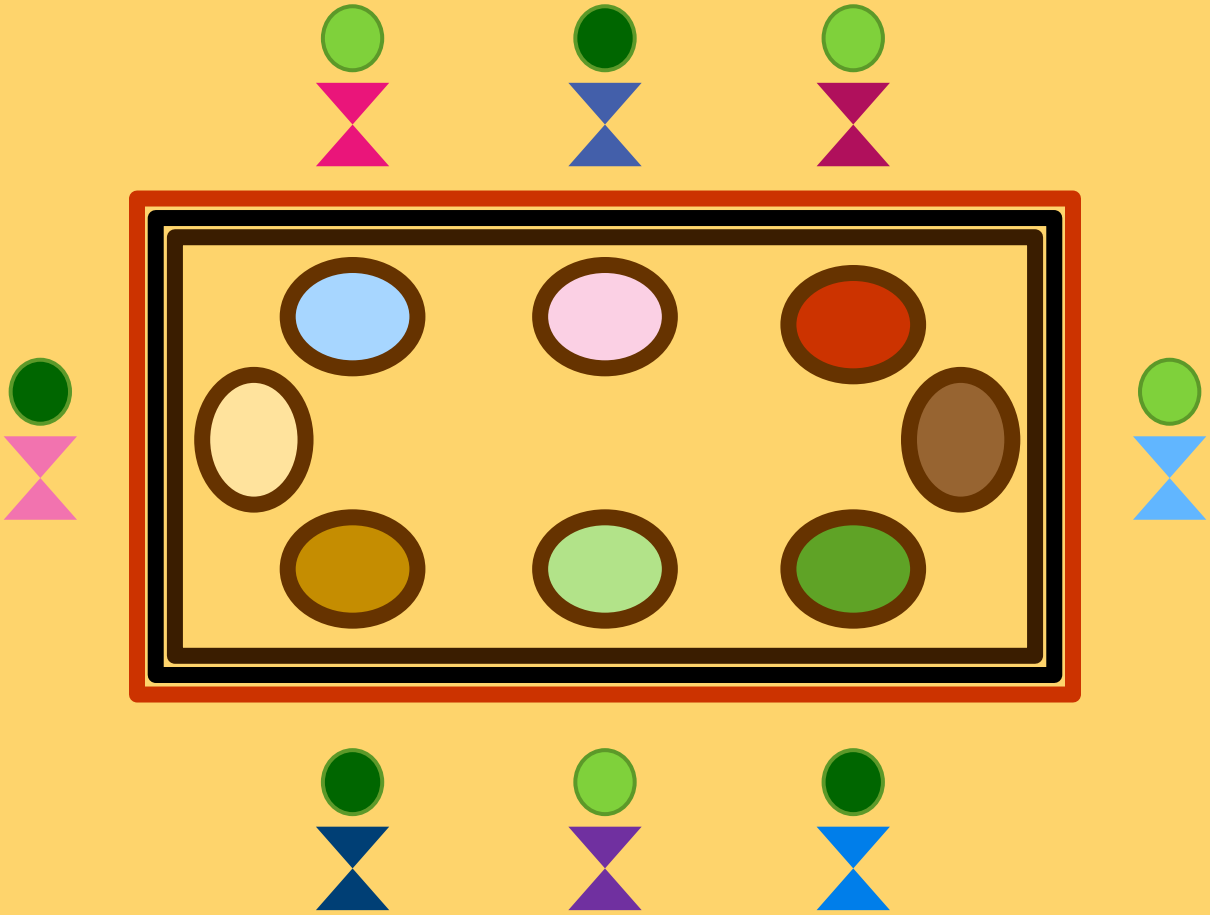
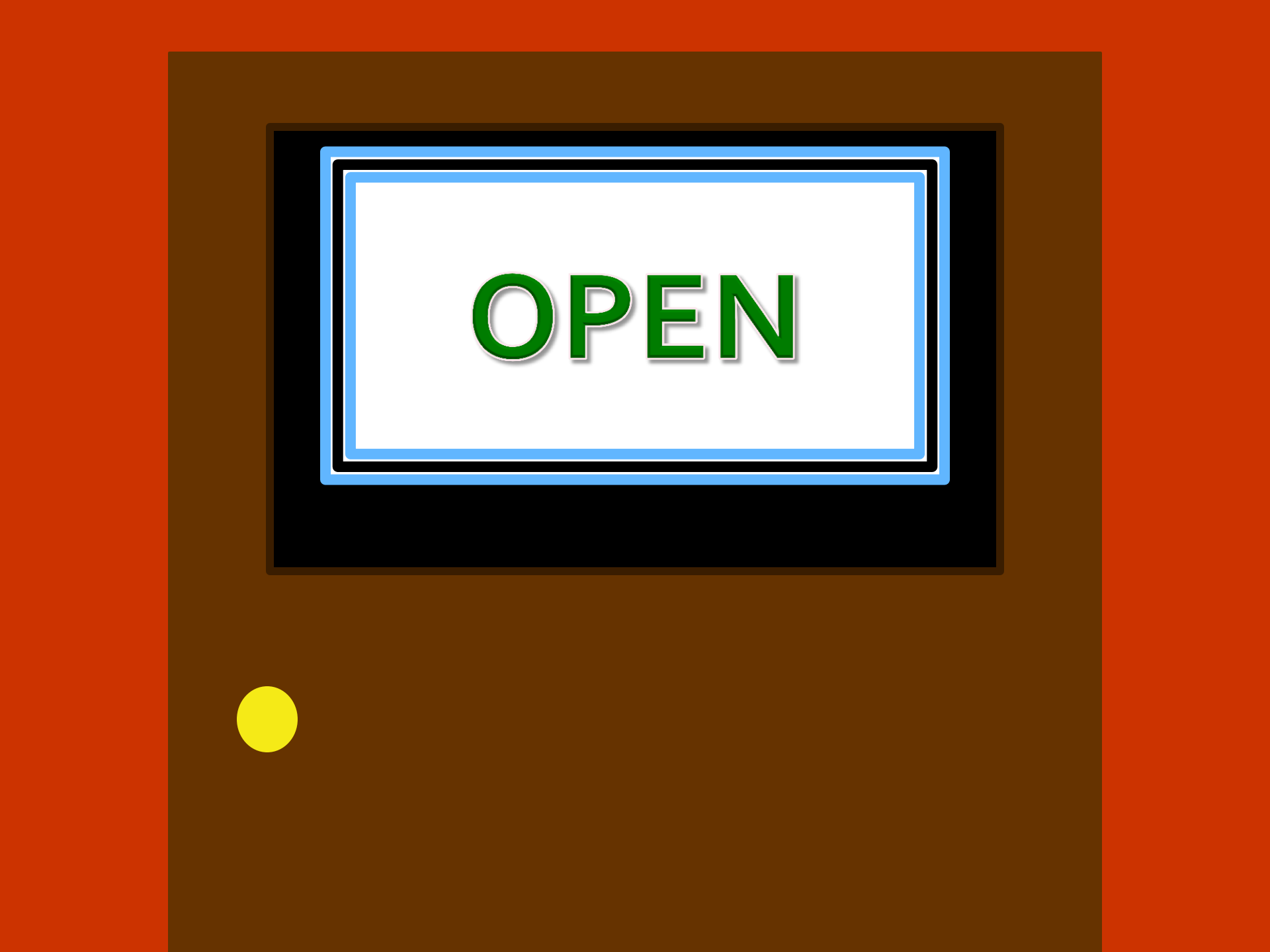
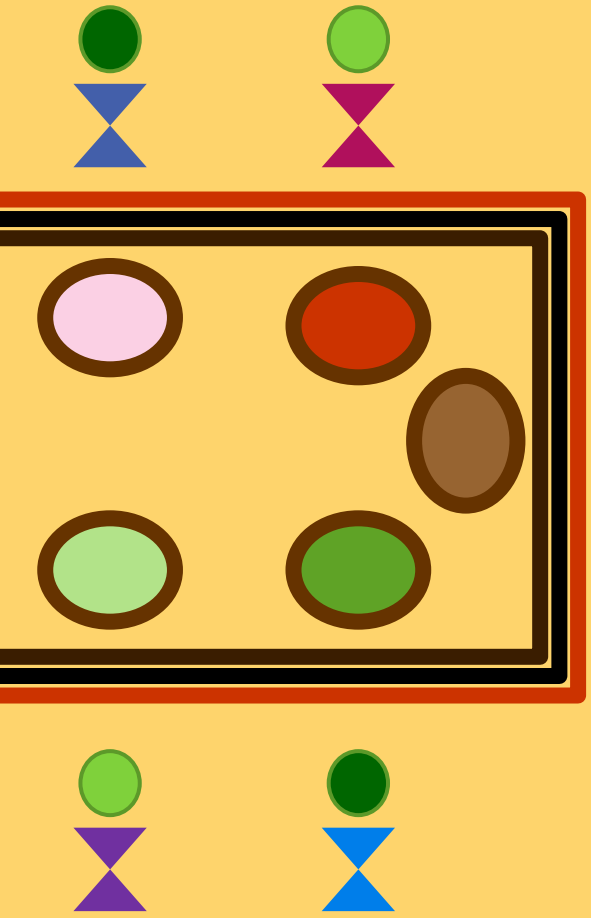
Dual Reality: A restaurant saga

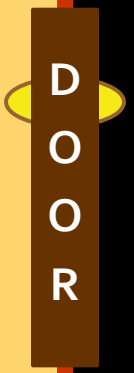


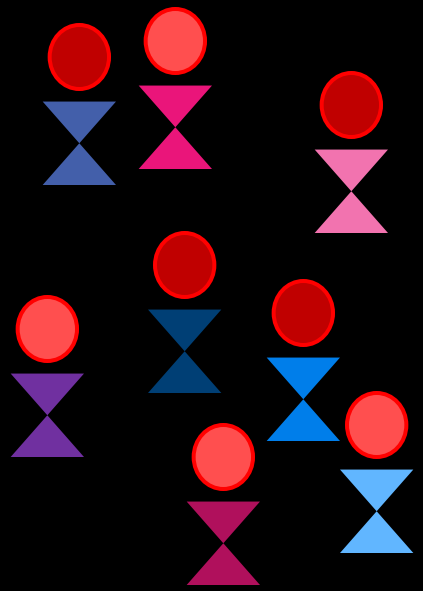
I looked up and noticed a sign . . .


OPEN

Racism structures “Open/Closed” signs in our society.

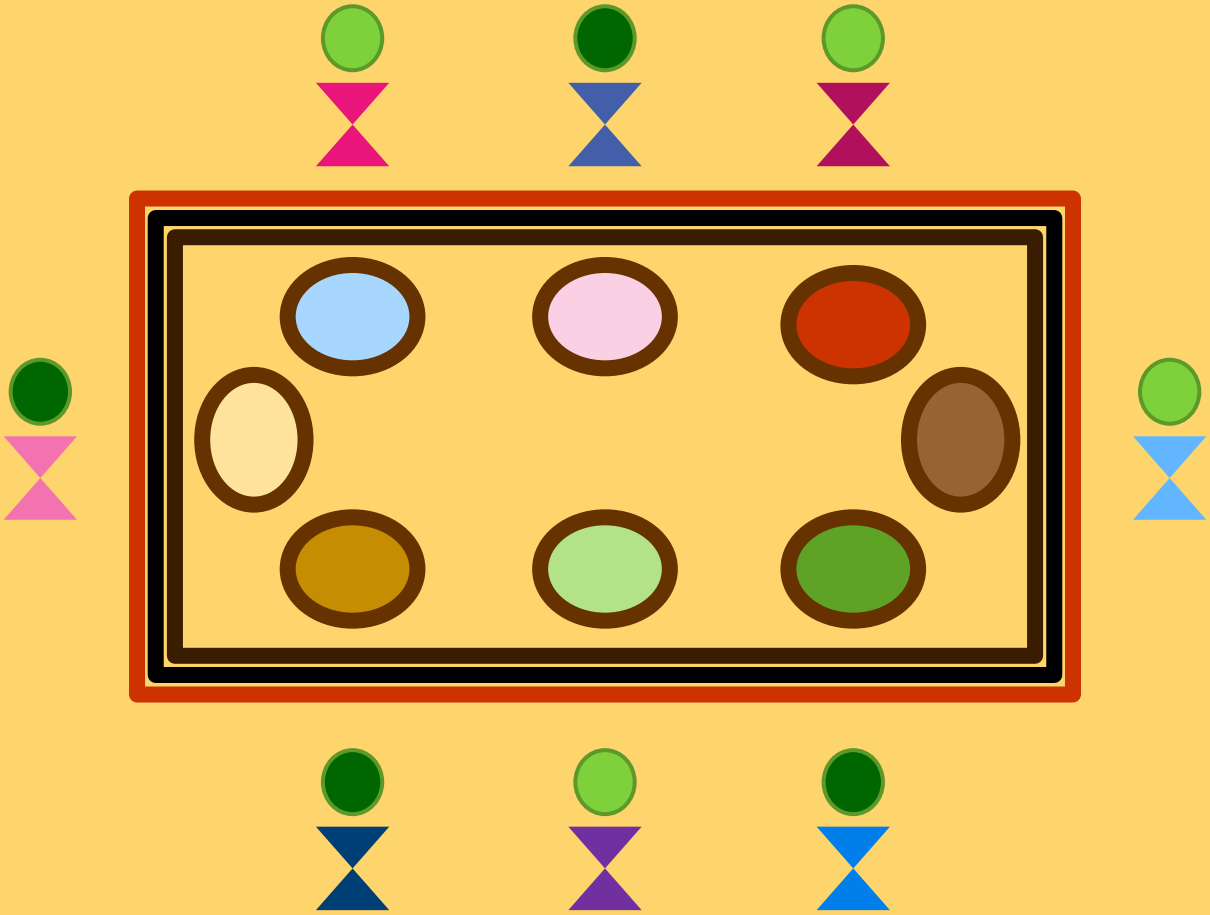






It is difficult
to recognize
a system of inequity
that privileges us.

Those on the outside
are very aware of the
two-sided nature
of the sign.



Is there really a two-sided sign?

Hard to know, when only see “Open”.
A privilege not to HAVE to know.
Once DO know, can choose to act.

Levels of racism

- Institutionalized
- Personally-mediated
- Internalized

Jones CP. Levels of Racism: A Theoretic Framework and a Gardener's Tale. *Am J Public Health* **2000;90(8):1212-1215.**

Institutionalized racism

- **Differential access to the goods, services, and opportunities of society, by "race"**

- **Examples**
  - Housing, education, employment, income
  - Medical facilities
  - Clean environment
  - Information, resources, voice

- **Explains the association between social class and "race"**

Jones CP. Levels of Racism: A Theoretic Framework and a Gardener's Tale. *Am J Public Health* **2000;90(8):1212-1215.**

Personally-mediated racism

- **Differential assumptions about the abilities, motives, and intents of others, by "race"**
- **Differential actions based on those assumptions**

- **Prejudice and discrimination**
- **Examples**
  - Police brutality
  - Physician disrespect
  - Shopkeeper vigilance
  - Waiter indifference
  - Teacher devaluation

Jones CP. Levels of Racism: A Theoretic Framework and a Gardener's Tale. *Am J Public Health* **2000;90(8):1212-1215.**

Internalized racism

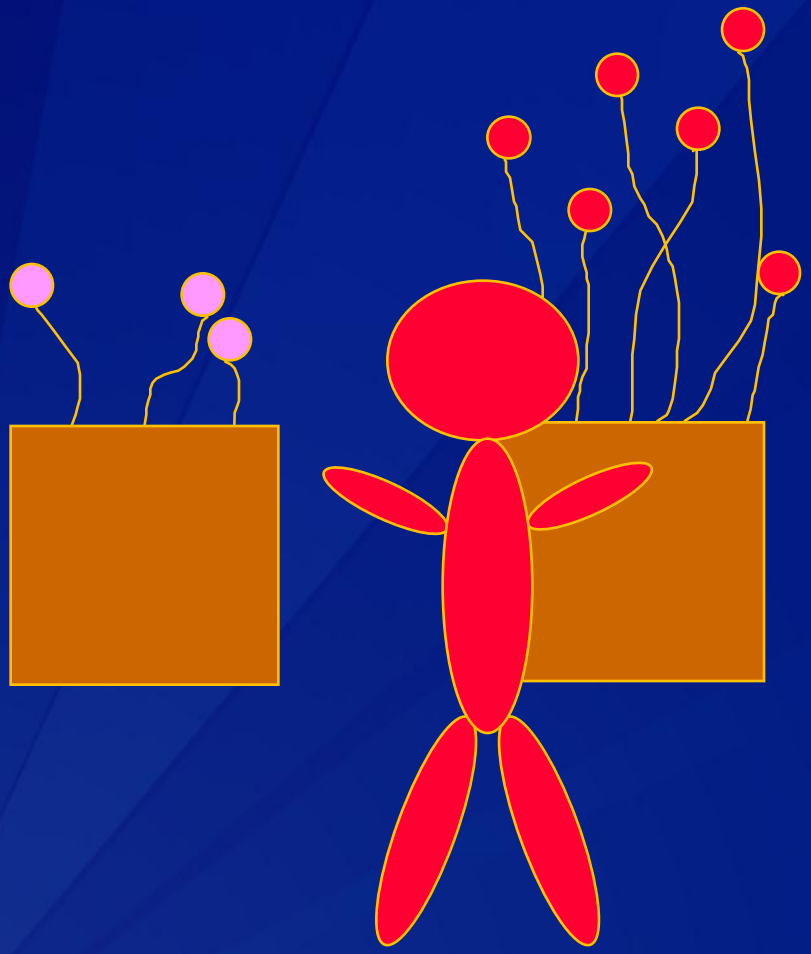
- **Acceptance by the stigmatized "races" of negative messages about our own abilities and intrinsic worth**
- **Examples**
  - Self-devaluation
  - "White man's ice is colder" syndrome
  - Resignation, helplessness, hopelessness
- **Accepting limitations to our full humanity**

Jones CP. Levels of Racism: A Theoretic Framework and a Gardener's Tale. *Am J Public Health* **2000;90(8):1212-1215.**

Levels of Racism: A Gardener's Tale

Jones CP. Levels of Racism: A Theoretic Framework and a Gardener's Tale. *Am J Public Health* **2000;90(8):1212-1215.**

Who is the gardener?



- Power to decide
- Power to act
- Control of resources

- **Dangerous when**
  - Allied with one group
  - Not concerned with equity

Jones CP. Levels of Racism: A Theoretic Framework and a Gardener's Tale. *Am J Public Health* **2000;90(8):1212-1215.**

"How is racism operating here?"

- **Identify mechanisms**
  - **Structures:** the *who?*, *what?*, *when?*, and *where?* of decision-making
  - **Policies:** the written *how?*
  - **Practices and norms:** the unwritten *how?*
  - **Values:** the *why?*

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What is *[inequity]* ?

A system of structuring opportunity and assigning value based on *[fill in the blank]*

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A system of structuring opportunity and assigning value based on *[fill in the blank]*, that

- Unfairly disadvantages some individuals and communities
- Unfairly advantages other individuals and communities
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Many axes of inequity

- "Race"
- Gender
- Ethnicity and indigenous status
- Labor roles and social class markers
- Nationality, language, and legal status
- Sexual orientation and gender identity
- Disability status
- Geography
- Religion
- Incarceration history

These are risk MARKERS

What is health equity?

- **"Health equity" is assurance of the conditions for optimal health for all people**

- **Achieving health equity requires**
  - Valuing all individuals and populations equally
  - Recognizing and rectifying historical injustices
  - Providing resources according to need

- **Health disparities will be eliminated when health equity is achieved**

Jones CP. Systems of Power, Axes of Inequity: Parallels, Intersections, Braiding the Strands. ***Medical Care*** 2014;52(10 Suppl 3):S71-S75.

Barriers
to achieving health equity

- **Narrow focus on the individual**
  - Self-interest narrowly defined
  - Limited sense of interdependence
  - Limited sense of collective efficacy
  - Systems and structures as invisible or irrelevant
- **A-historical culture**
  - The present as disconnected from the past
  - Current distribution of advantage/disadvantage as happenstance
  - Systems and structures as givens and immutable
- **Myth of meritocracy**
  - Role of hard work
  - Denial of racism
  - Two babies: Equal potential or equal opportunity?

Strategies
for achieving health equity

- **To change opportunity structures**
  - Challenge the narrow focus on the individual
  - Understand the importance of history
  - Expose the “myth of meritocracy”
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- **To value all people equally**
  - Break out of bubbles to experience our common humanity
  - Embrace ALL children as OUR children

ICERD

- *International Convention on the Elimination of all forms of Racial Discrimination*

  International anti-racism treaty adopted by the UN General Assembly in 1965

  http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx

- **US signed in 1966**
- **US ratified in 1994**

Current status

- 3rd US report submitted to the UN Committee on the Elimination of Racial Discrimination (CERD) in 2013

  http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fUSA%2f7-9&Lang=en

- 82 parallel reports submitted by civil society organizations
- CERD considered at its 85th session (13-14 Aug 2014)

CERD *Concluding Observations*

- **14-page document (25 Sep 2014) available online**
  http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fUSA%2fCO%2f7-9&Lang=en

- **Concerns and recommendations**
  - Racial profiling (paras 8 and 18)
  - Residential segregation (para 13)
  - Achievement gap in education (para 14)
  - Differential access to health care (para 15)
  - Disproportionate incarceration (para 20)

CERD *Concluding Observations*

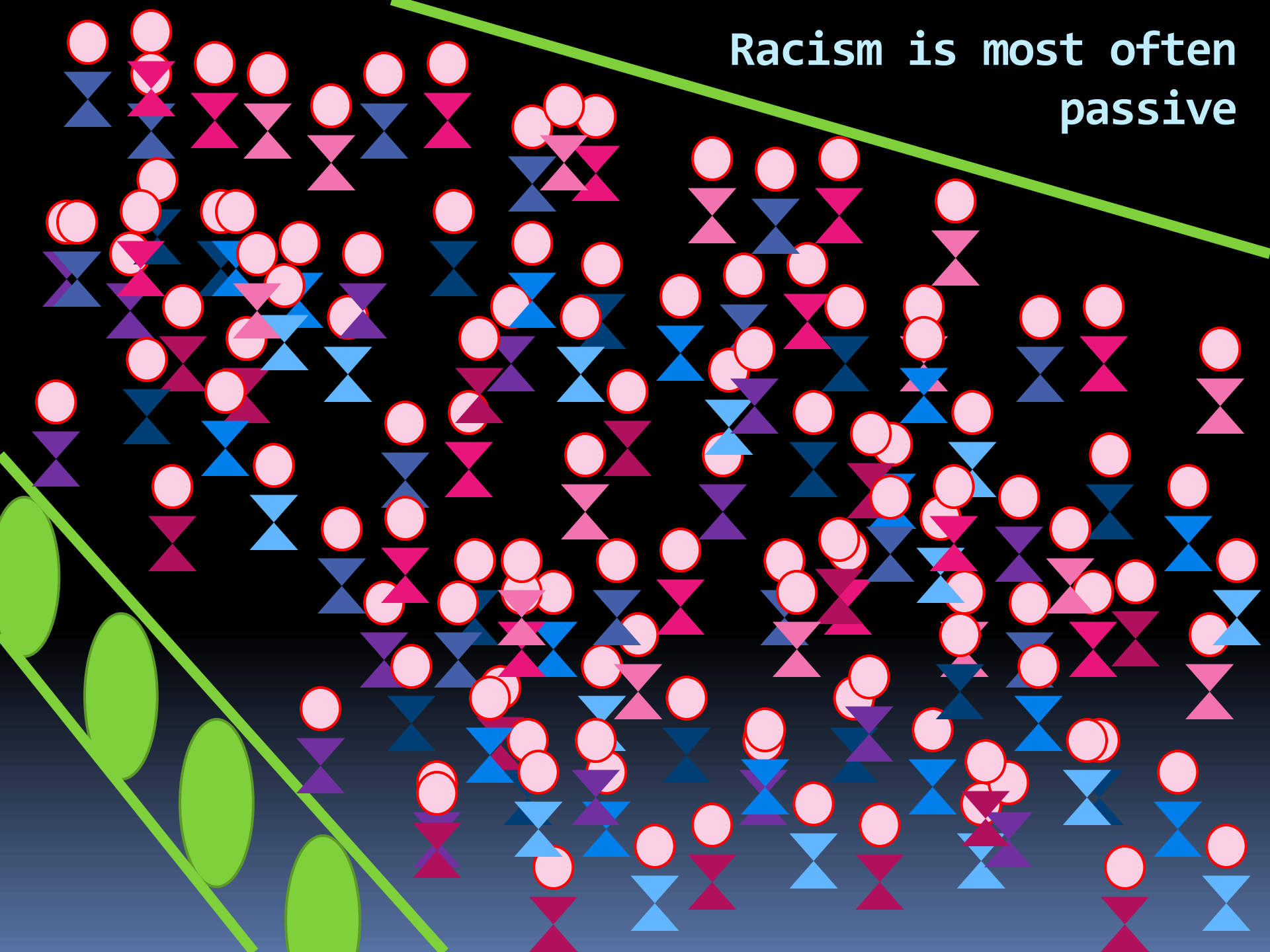
- **14-page document (25 Sep 2014) available online**
  http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fUSA%2fCO%2f7-9&Lang=en

- **Concerns and recommendations**
  - "The Committee recommends that the State party adopt a national action plan to combat structural racial discrimination" (para 25)
  - "The Committee recommends that the State party increase its efforts to raise public awareness and knowledge of the Convention throughout its territory" (para 32)

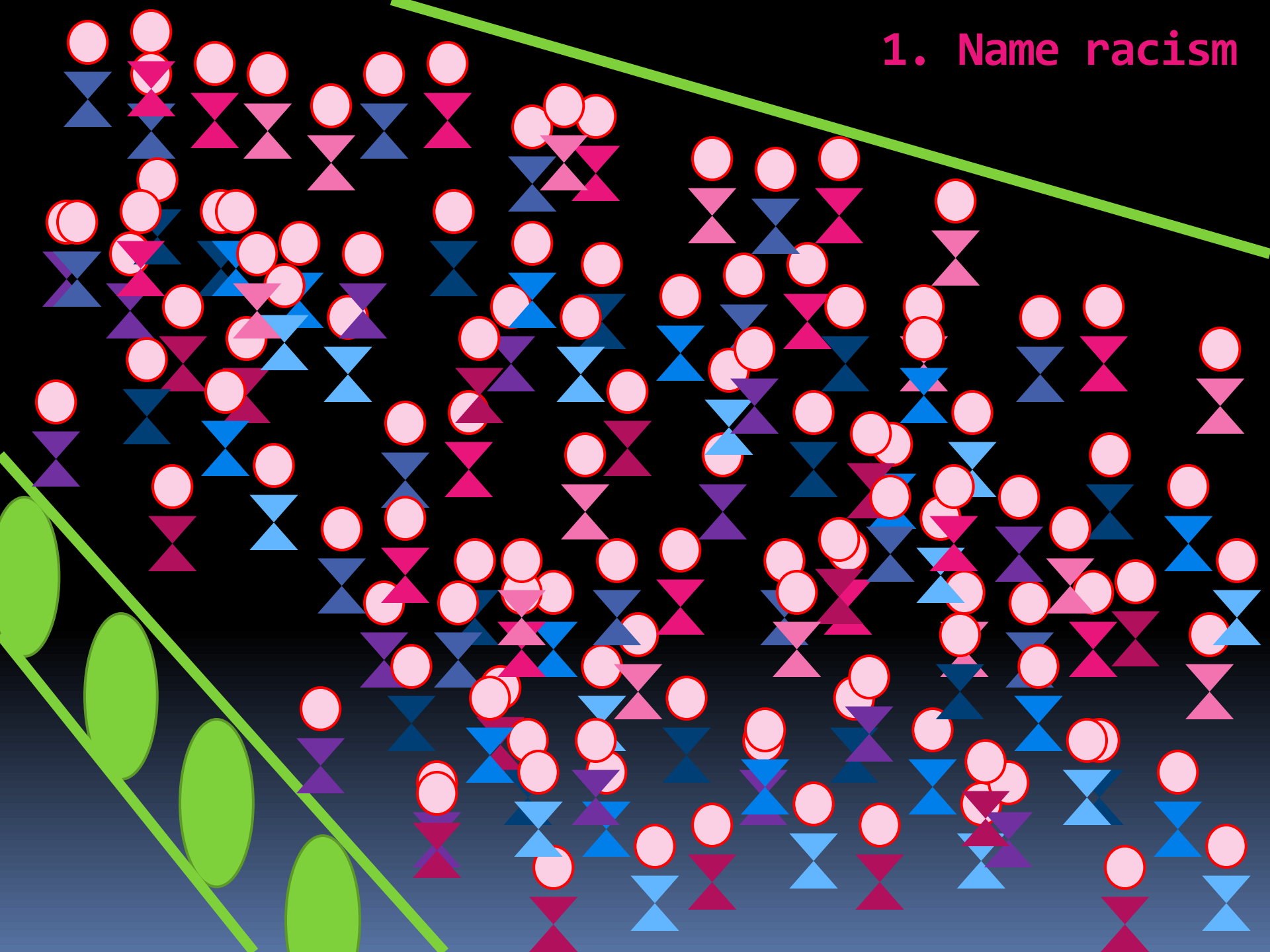
American Public Health Association
National Campaign Against Racism

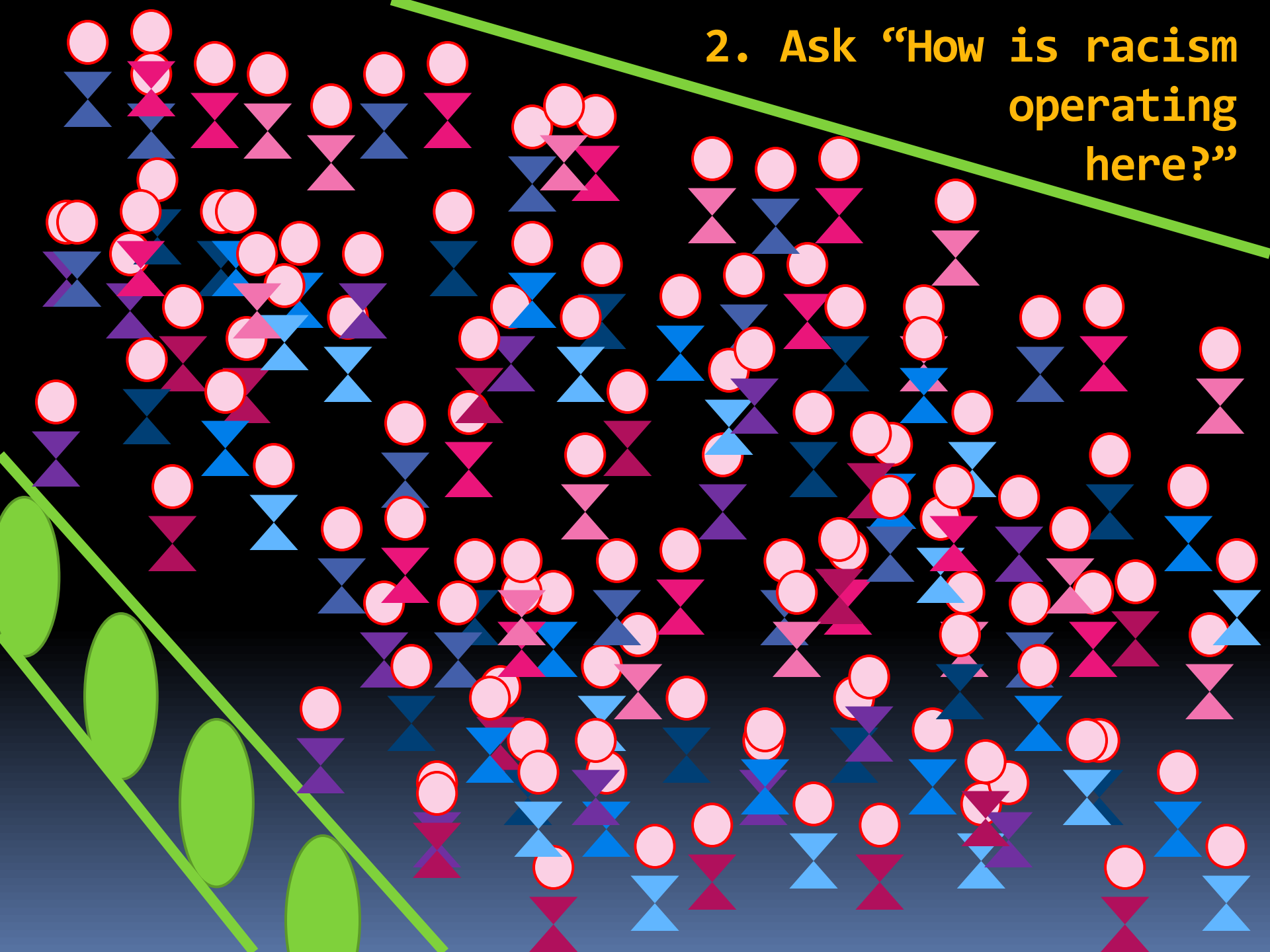
- **Active website: www.apha.org/racism**
- **Launching soon: Anti-Racism Collaborative with eight Collective Action Teams**
  - Communication and Dissemination
  - Education and Development
  - Global Matters
  - History
  - Liaison and Partnership
  - Organizational Excellence
  - Policy and Legislation
  - Science and Publications

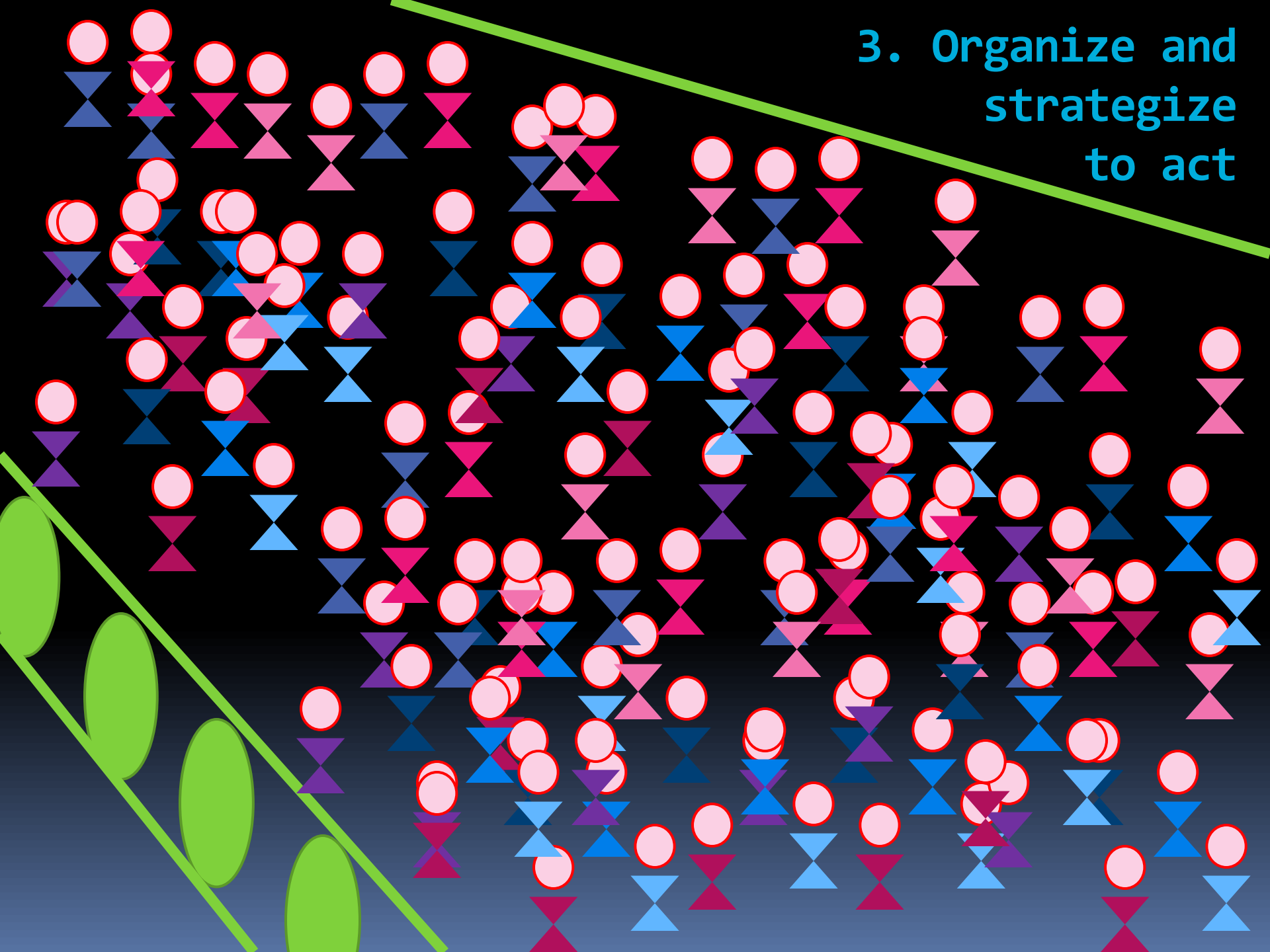
Life on a Conveyor Belt: Moving to action


Racism is most often
passive

1. Name racism




2. Ask “How is racism operating here?”


3. Organize and
strategize
to act

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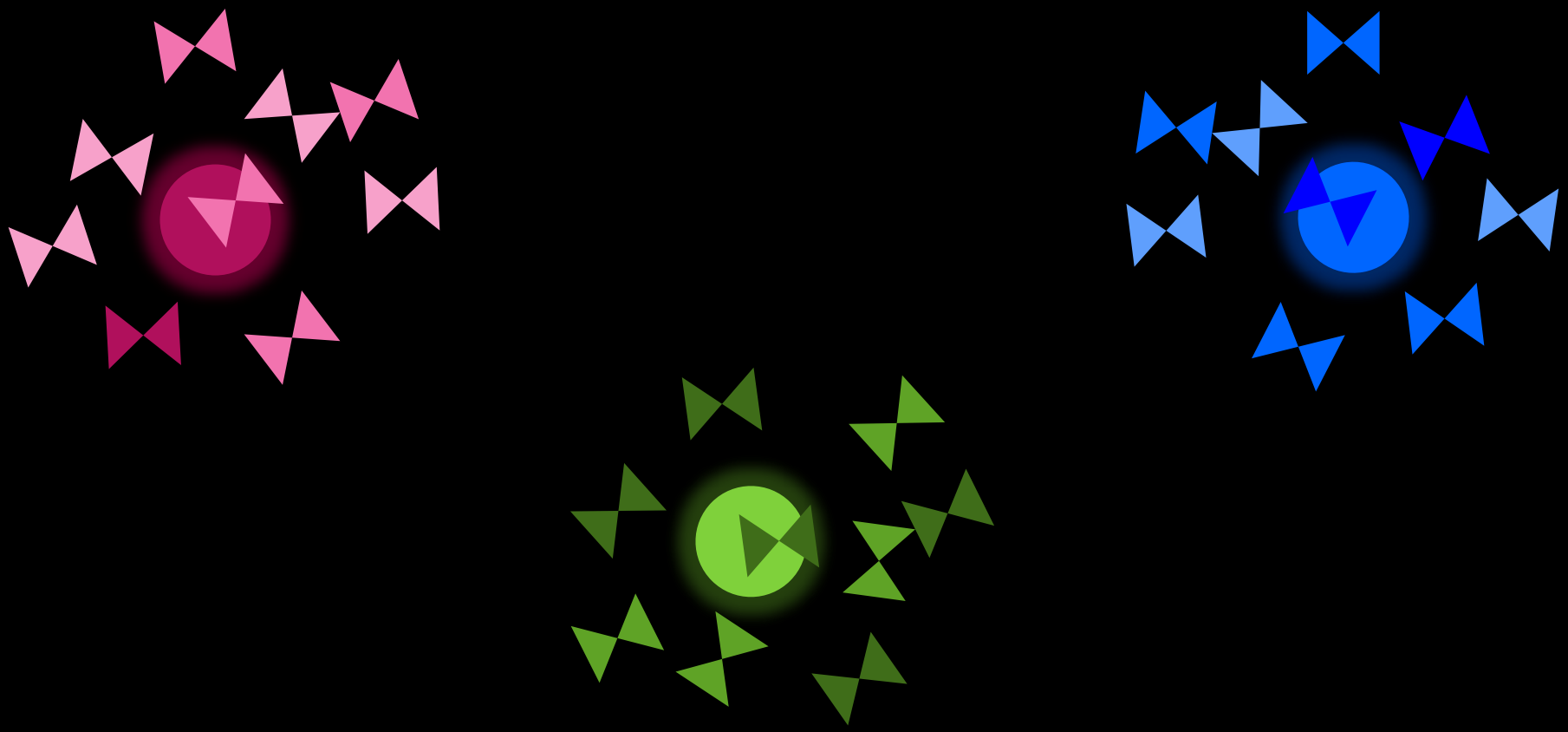
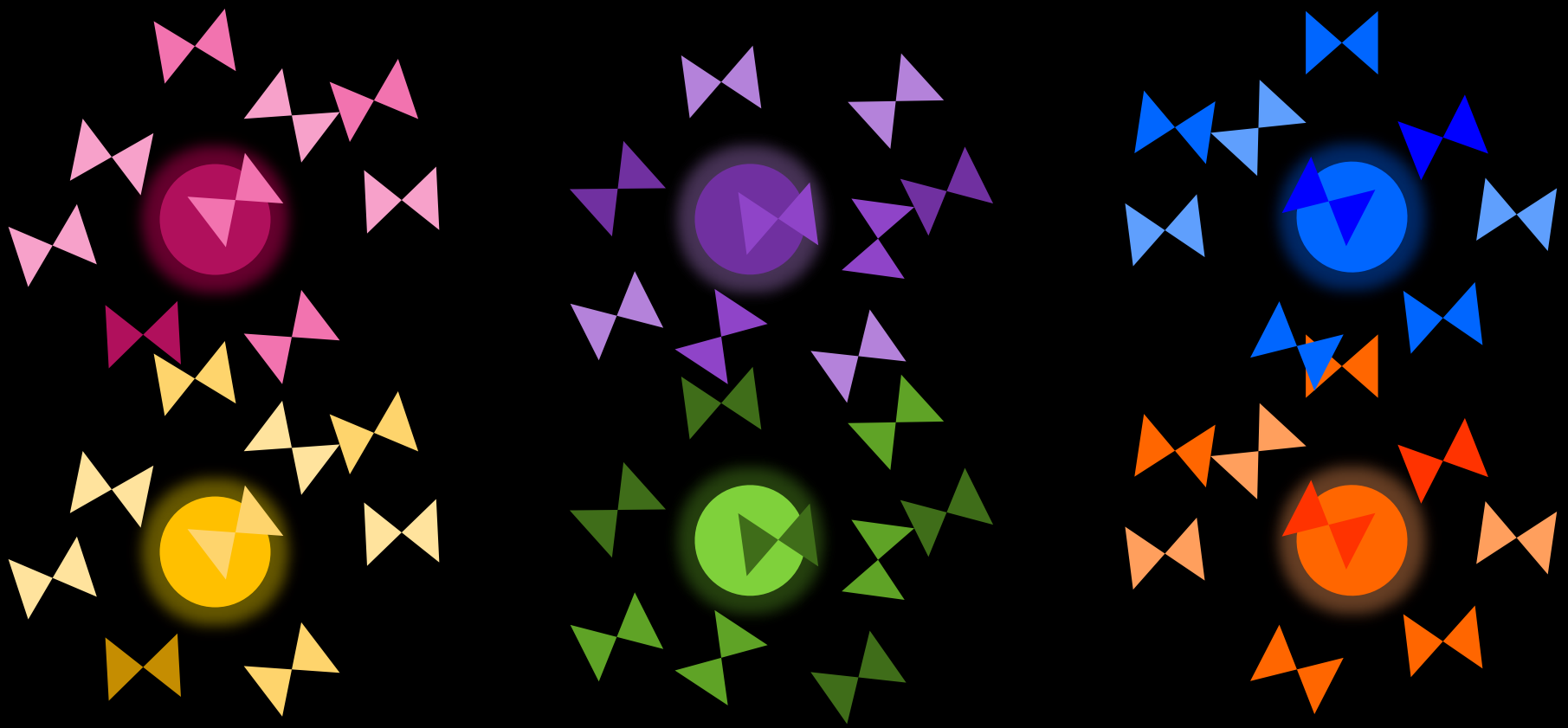
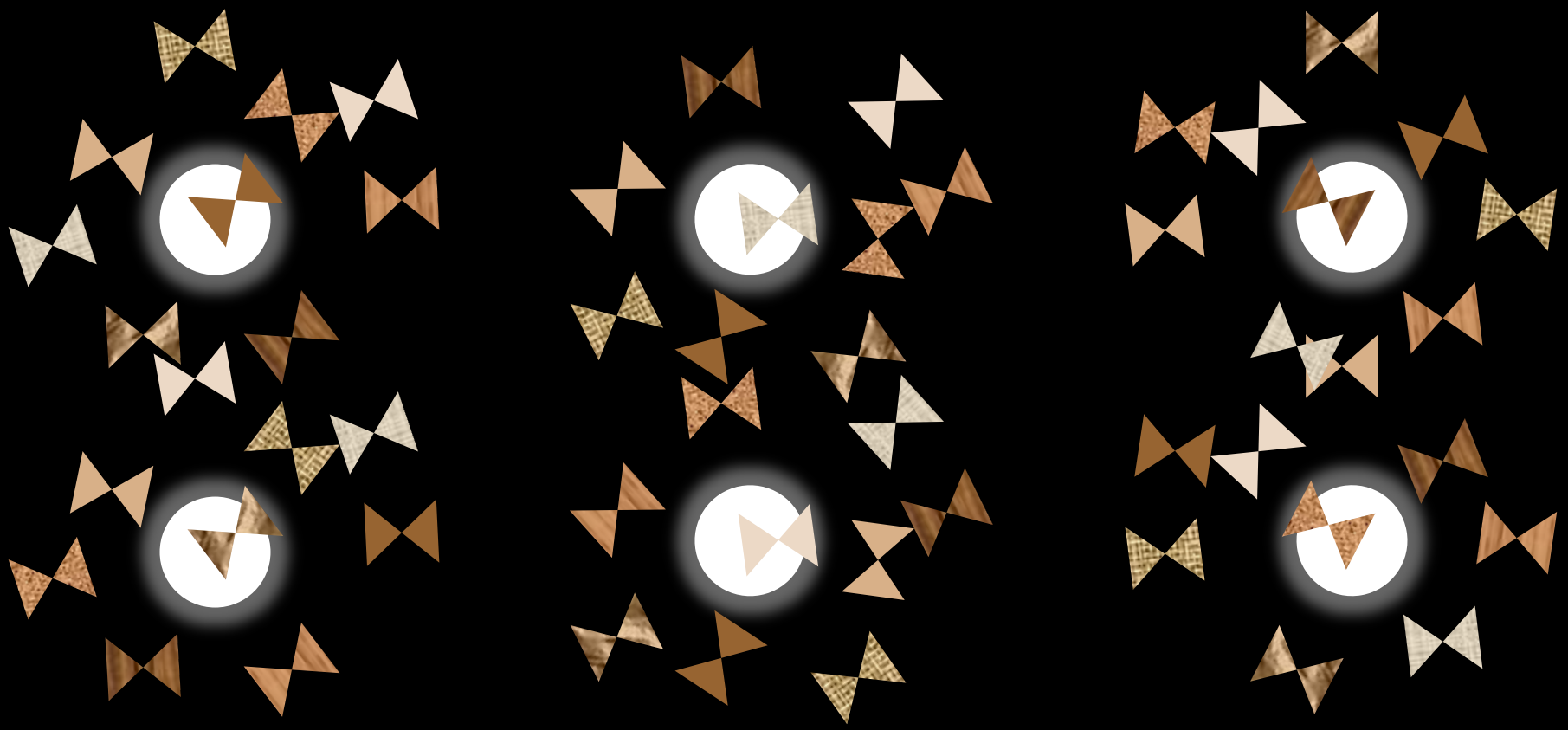
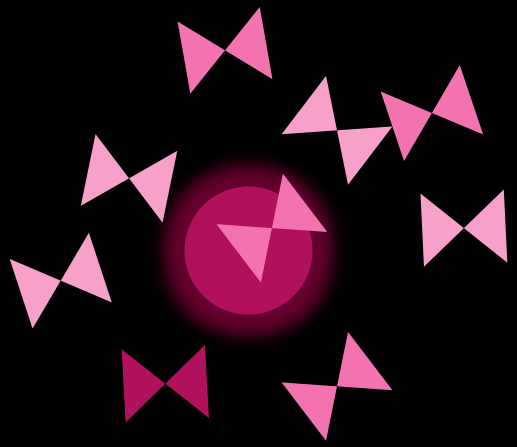
Japanese Lanterns: Colored perceptions

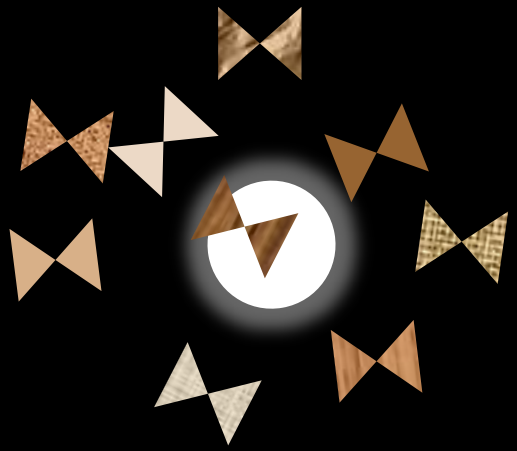






The colors we think we see are due to the lights by which we look.
These colored lights distort and mask our true variability.





What is “race”?

A social classification,
not a biological descriptor.
The social interpretation of how one looks
in a “race”-conscious society.

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Anti-Racism Collaborative
Communication and Dissemination

- **Guiding questions**
  - How can we support the naming of racism in all public and private spaces?
  - What tools and strategies are needed to start community conversations on racism?

Anti-Racism Collaborative
Education and Development

- **Guiding questions**
  - How can we support training around issues of “race”, racism, and anti-racism at educational institutions of all levels?
  - How does effective anti-racism curriculum look?

Anti-Racism Collaborative
Global Matters

- **Guiding questions**
  - How can we use the International Convention on the Elimination of all forms of Racial Discrimination (ICERD) to support anti-racism work in the United States?
  - What can we learn from anti-racism work in other nations?

Anti-Racism Collaborative
History

- **Guiding questions**
  - What is the history of successful anti-racism struggle in the United States and around the world? How can this history guide our anti-racism work today?
  - How can we institutionalize attention to history in all decision-making processes?

Anti-Racism Collaborative
Liaison and Partnership

- **Guiding questions**
  - What anti-racism work is happening at the community level?
  - What anti-racism work is happening in other sectors?
  - How can we create linkages?

Anti-Racism Collaborative
Organizational Excellence

- **Guiding questions**
  - How do we answer the question “How is racism operating here?” in each of our settings?
  - How do we examine structures, policies, practices, norms, and values?

Anti-Racism Collaborative
Policy and Legislation

- **Guiding questions**
  - What are current policy and legislative strategies to address and dismantle racism?
  - What new strategies should we propose?

Anti-Racism Collaborative
Science and Publications

- **Guiding questions**
  - What research has been done to examine the impacts of racism on the health and well-being of the nation and world?
  - What intervention strategies have been evaluated?
  - What are next steps?

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Maryland Office of Minority Health and Health Disparities
13th Annual Health Equity Conference
December 13, 2016

Achieving Health Equity through Community Engagement and Innovative Health Care Delivery

ACHIEVING HEALTH EQUITY: FROM THEORY TO ACTION

Moderator:

Shalewa Noel-Thomas, PhD, MPH, Director, Office of Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene

Panelists:

Edward Ehlinger, MD, MSPH, Commissioner of Health, Minnesota Department of Health

Stephen B. Thomas, PhD, Professor, Health Services Administration, University of Maryland School of Public Health and Director, Maryland Center for Health Equity, University of Maryland, College Park

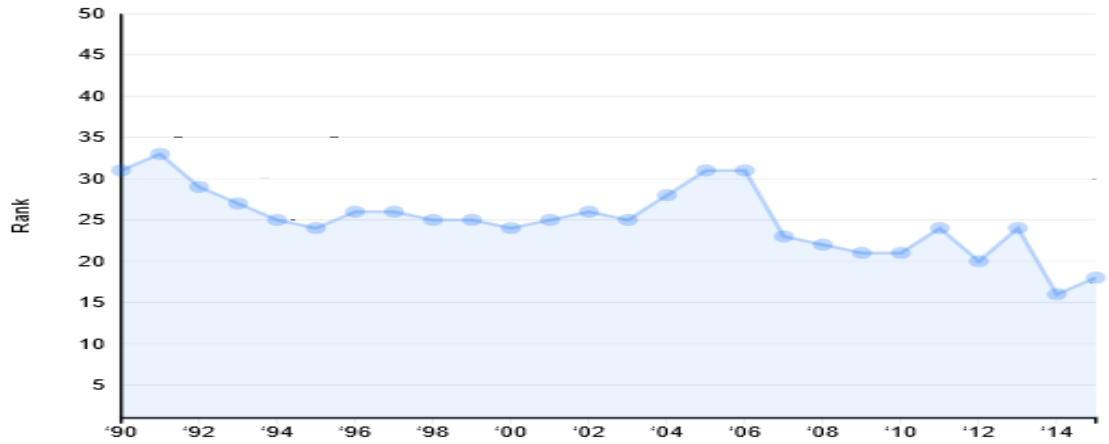
Advancing Health Equity and Optimal Health for All

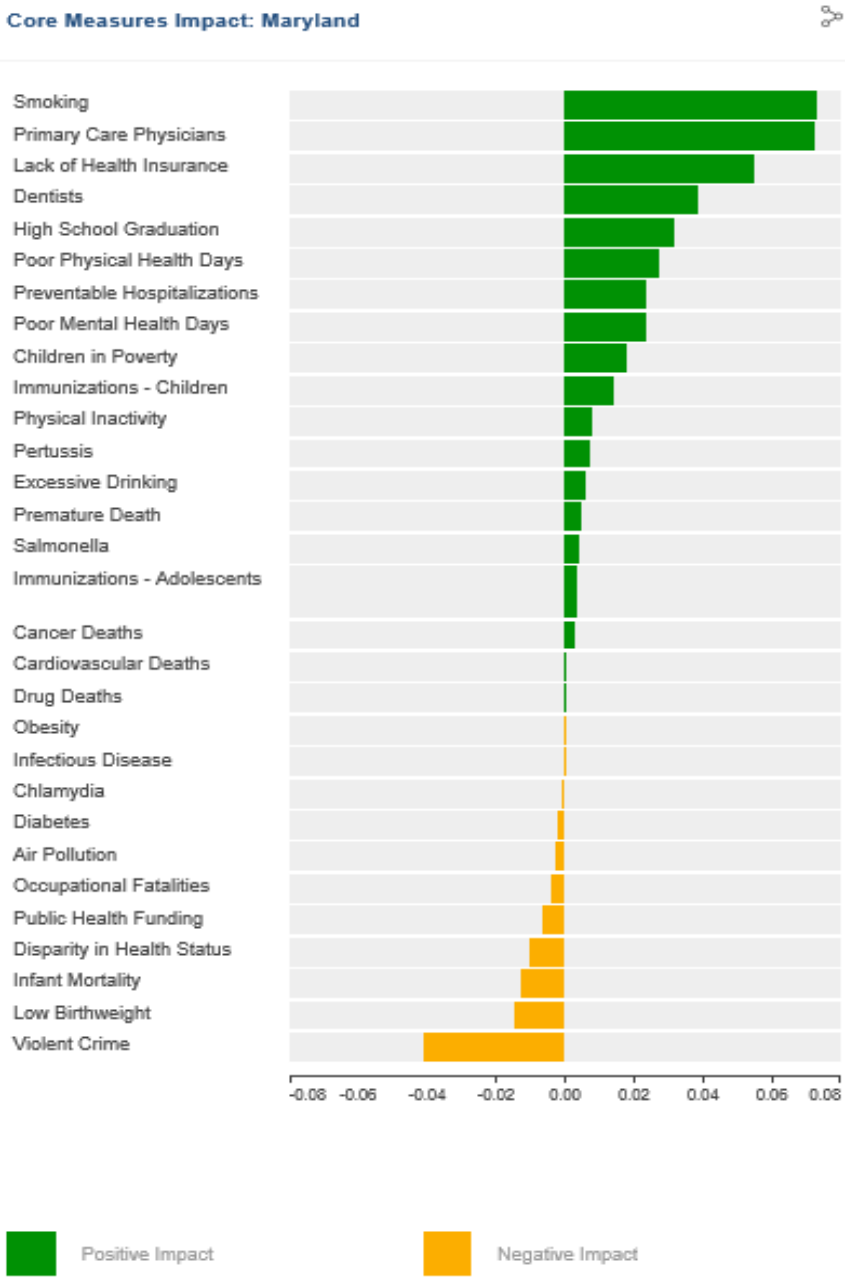
Edward P. Ehlinger, MD, MSPH
Commissioner, Minnesota Department of Health
Past President, Association of State and Territorial Health Officials (ASTHO)
December 13, 2016

MDH Minnesota Department *of* Health

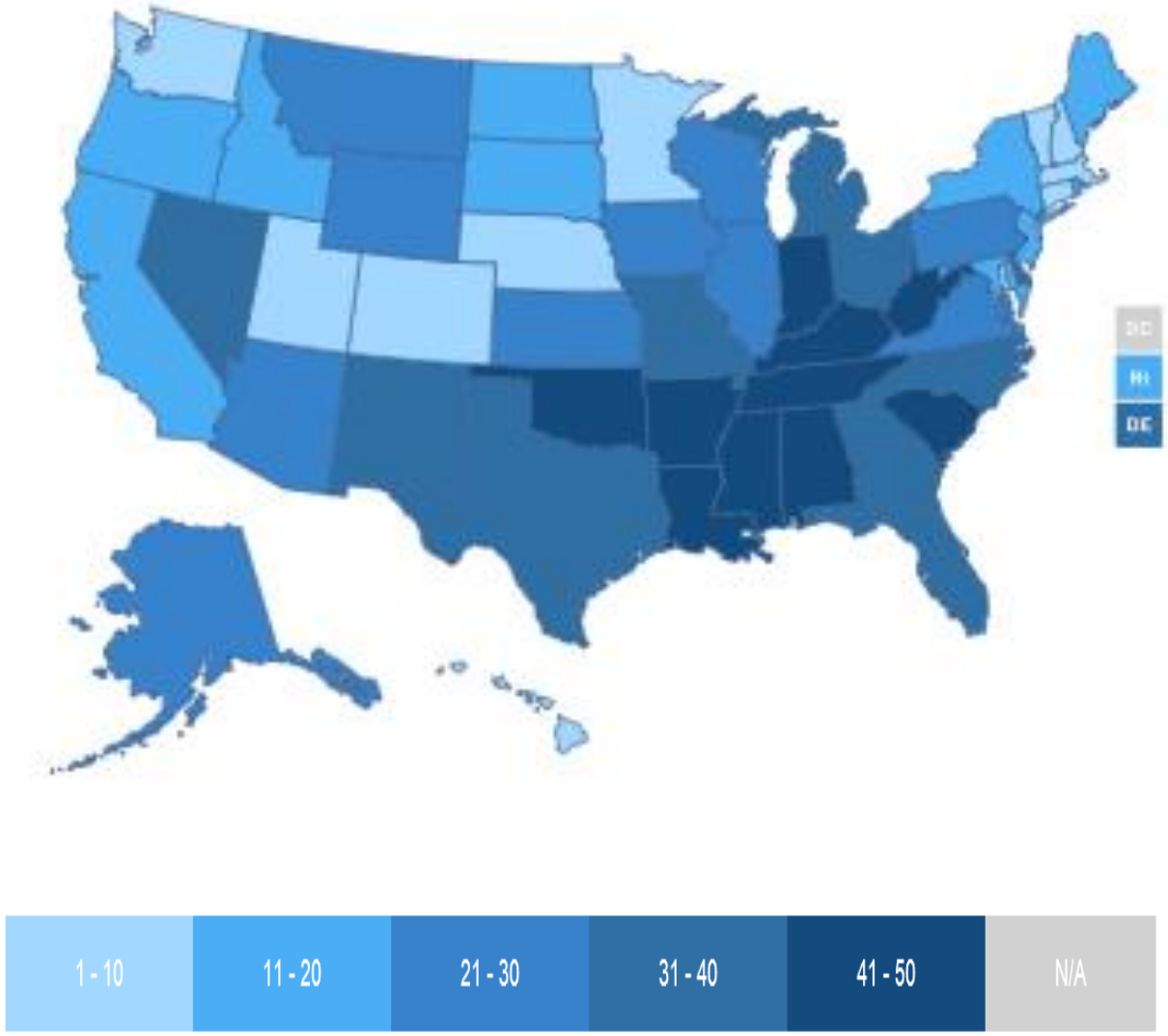
Maryland – 18th healthiest state

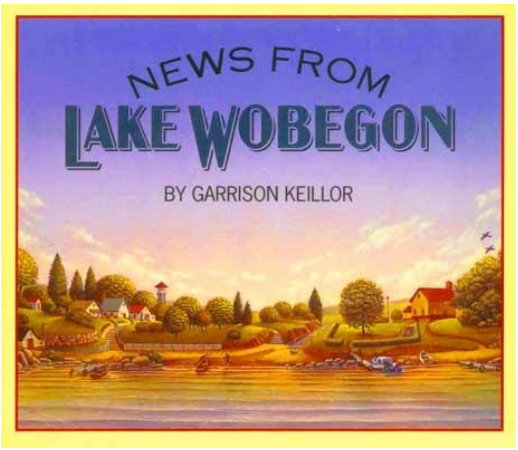
- America in Miniature, The *Free State*
- Birthplace of religious freedom in America
- Highest median family income
- Children in poverty – 9
- Income disparity – 13
- Disparity in health status – 42





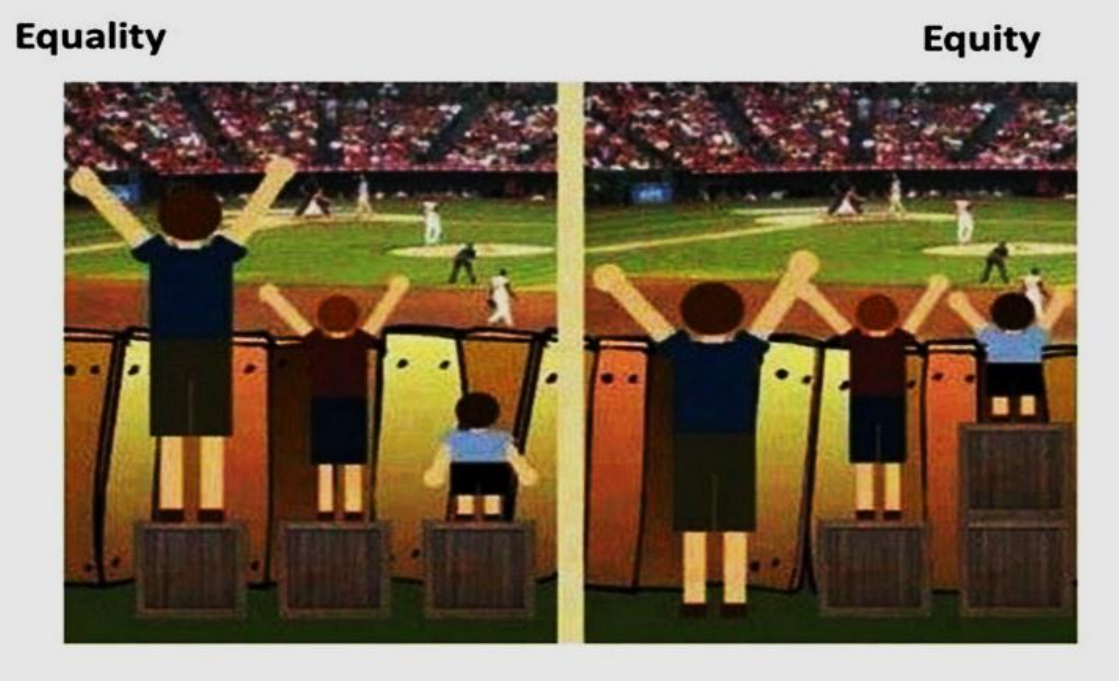
State Health Rankings





Minnesota (and Maryland)!
Where the women are strong,
The men are good looking,
And all our health statistics
are above average –
Unless you are
a person of color or
an American Indian.

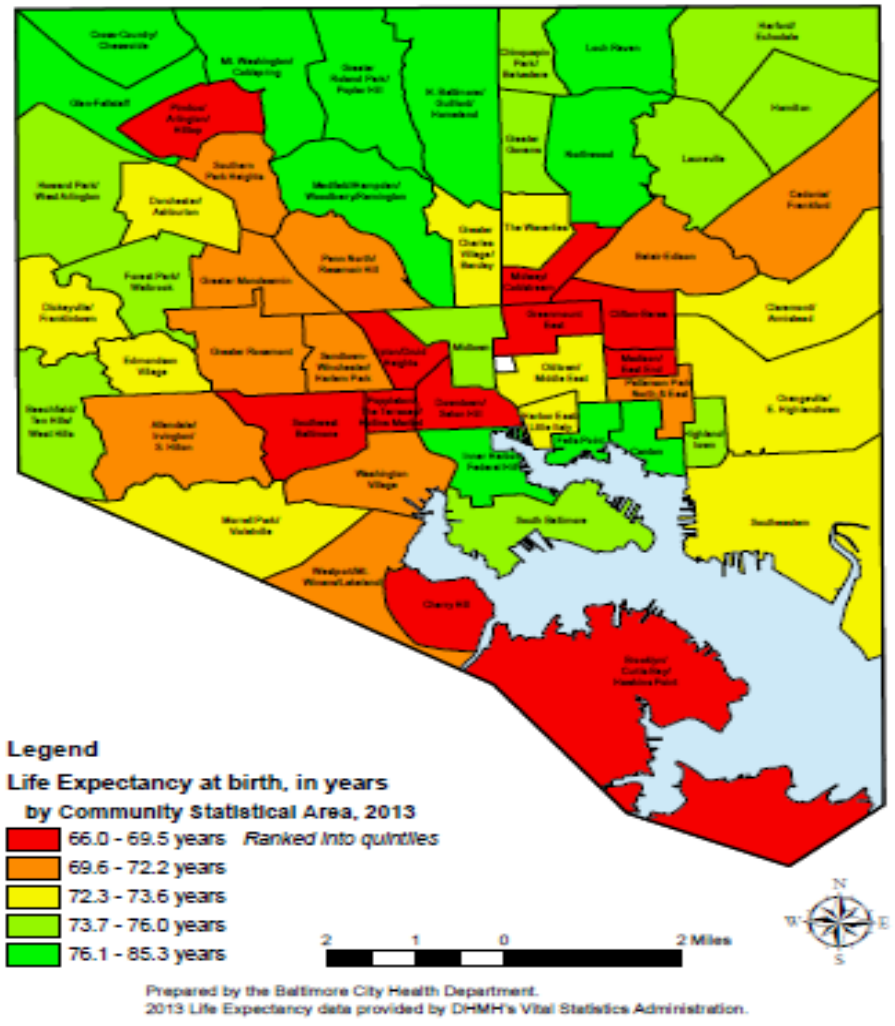
Advancing health and health equity is not about averages - It's about creating opportunities for everyone to be healthy

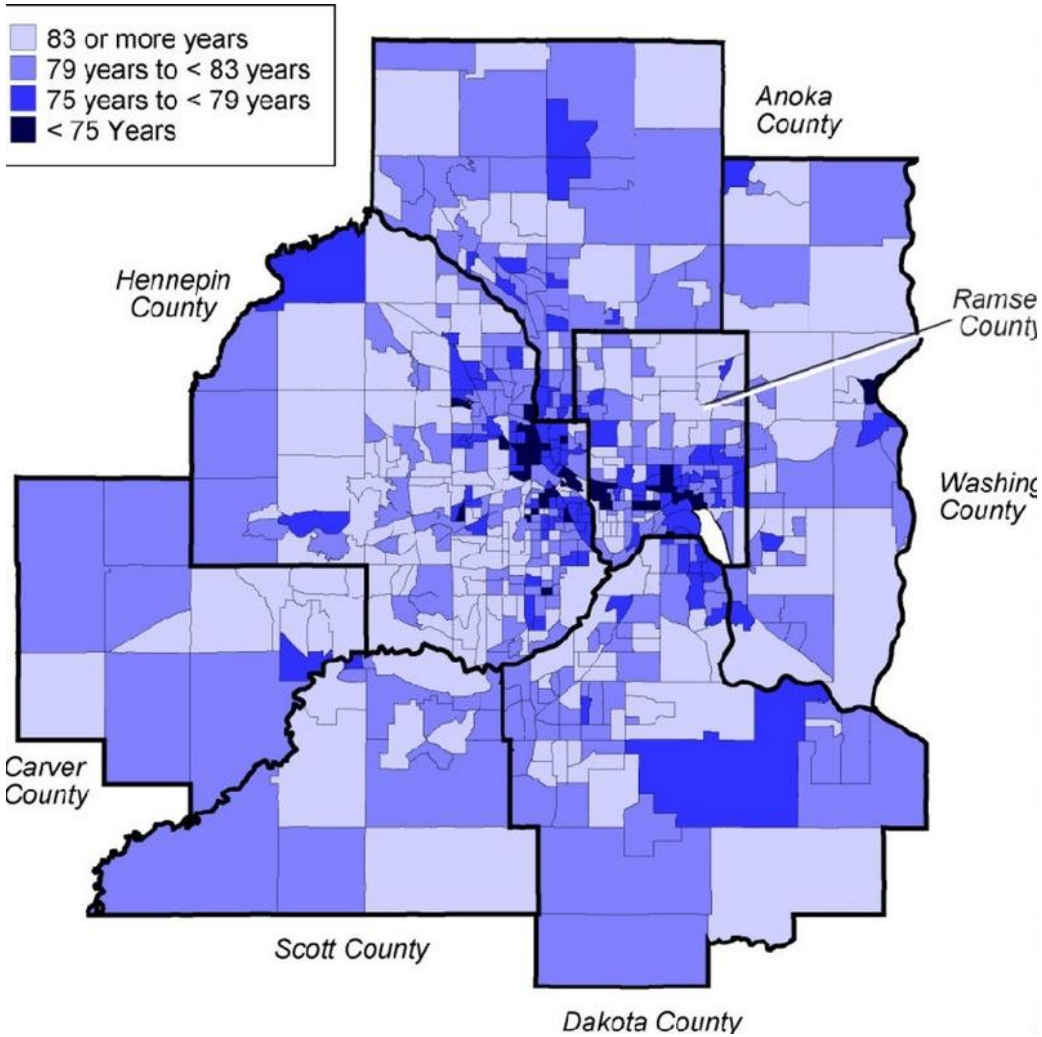


The opportunity to be healthy is not equally available everywhere or for everyone.

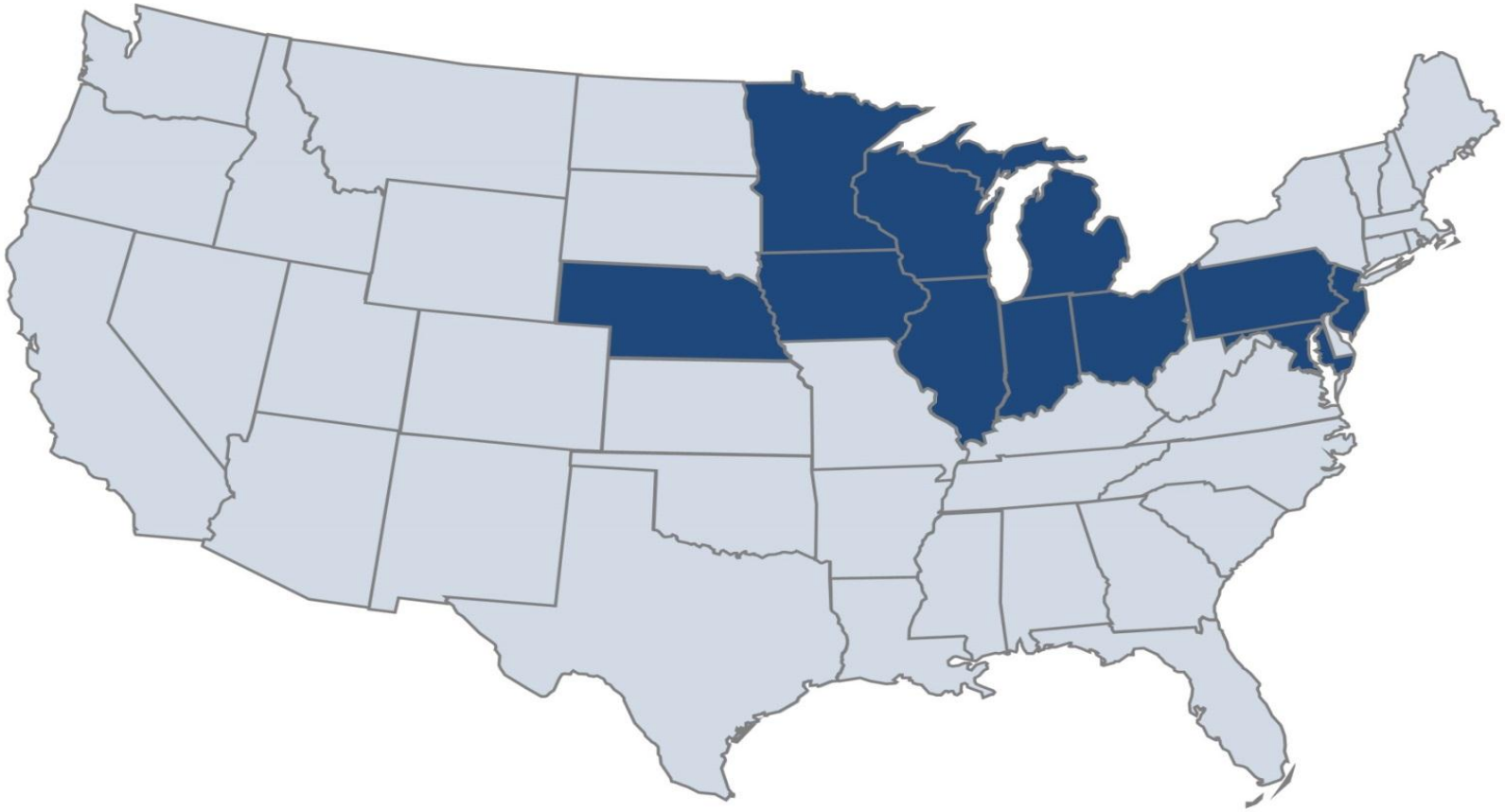
One way to measure opportunity

Life Expectancy: Baltimore and Minneapolis/St. Paul





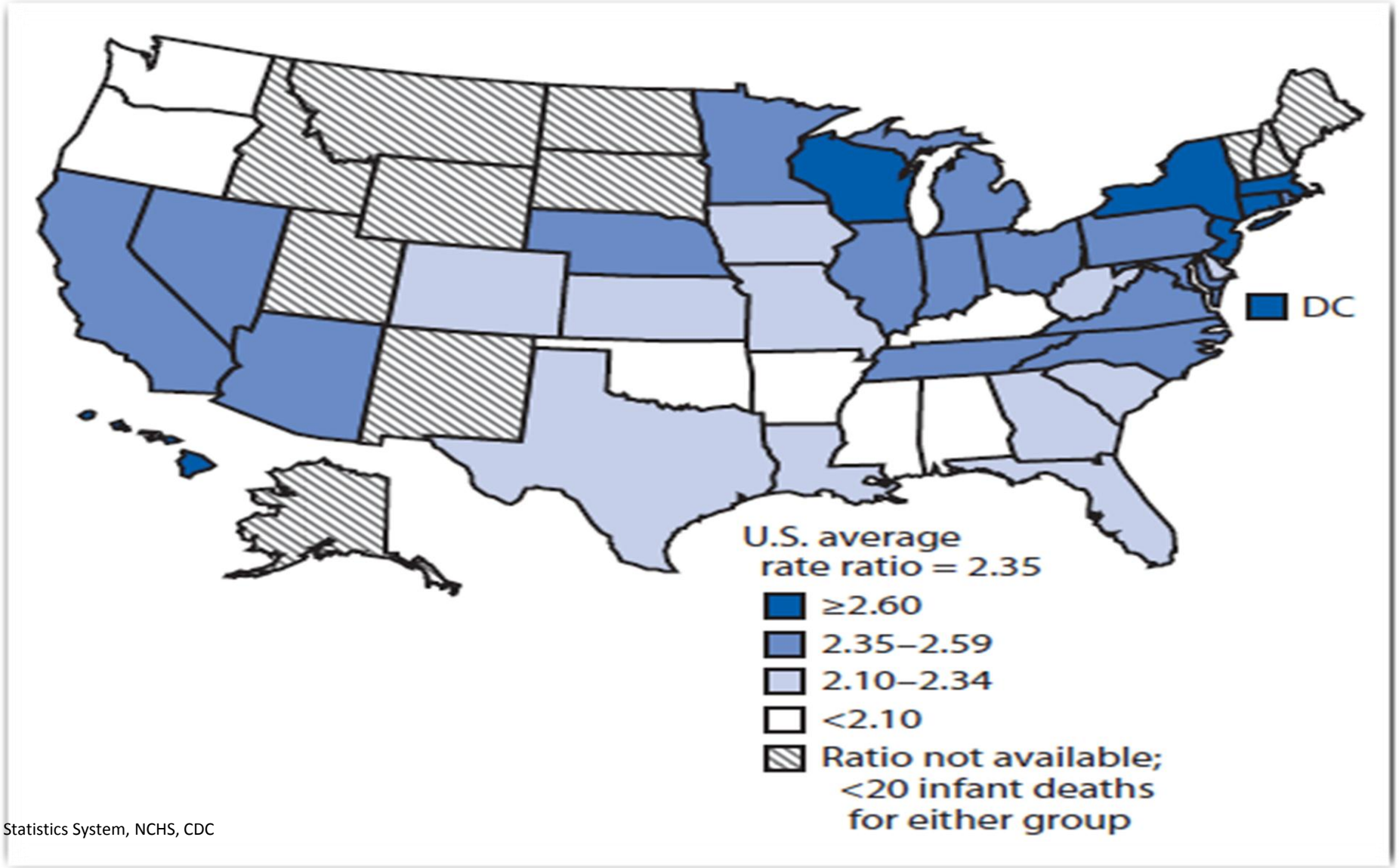
Big Ten Academic Alliance/State Health Department Health Equity Initiative



The mission of Land Grant Universities: focus on practical academic disciplines to **address issues created by changing economic conditions and social class.**

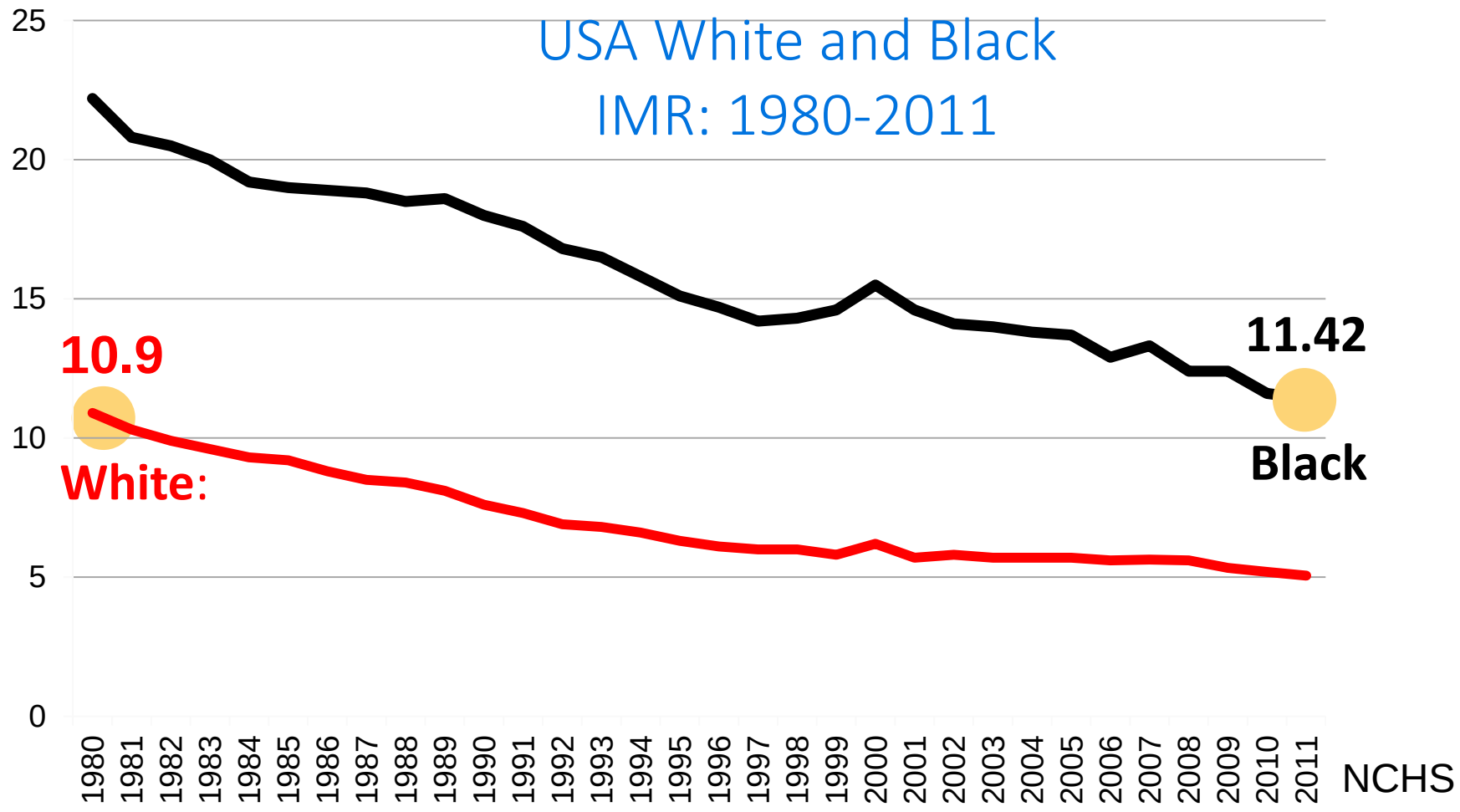
- **U of Wisconsin**
- **U of Minnesota**
- **U of Iowa**
- **U of Nebraska**
- **U of Illinois**
- **Northwestern U**
- **U of Chicago**
- **Indiana U**
- **Purdue U**
- **Michigan State U**
- **U of Michigan**
- **Ohio State U**
- **Penn State U**
- **Rutgers U**
- **U of Maryland**

Ratio of non-Hispanic black and non-Hispanic white infant mortality rates,* by state — United States, 2006–2008



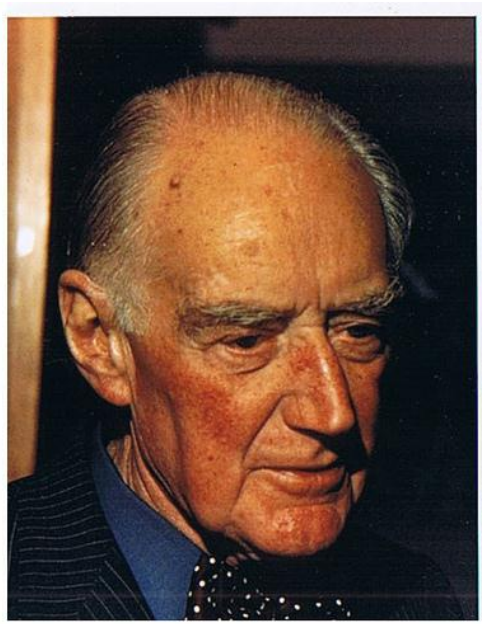
Source: National Vital Statistics System, NCHS, CDC

One Way to Measure Opportunity

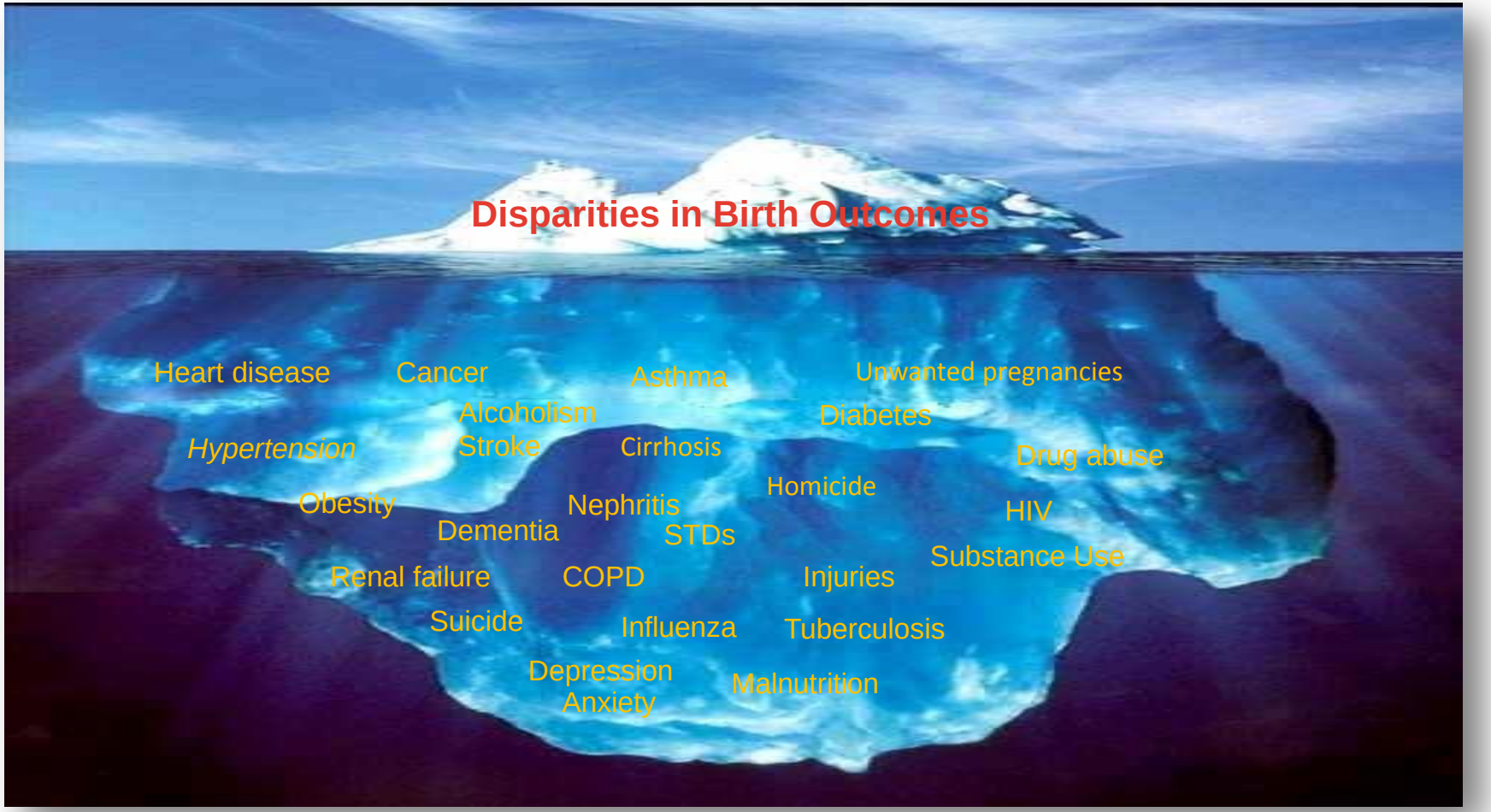


"What Sets the Goals of Public Health?"
Sir Geoffrey Vickers

"The landmarks of political, economic and social history are the moments when some condition passed from the category of the given into the category of the intolerable. I believe that the history of public health might well be written as a record of successive re-definings of the unacceptable."

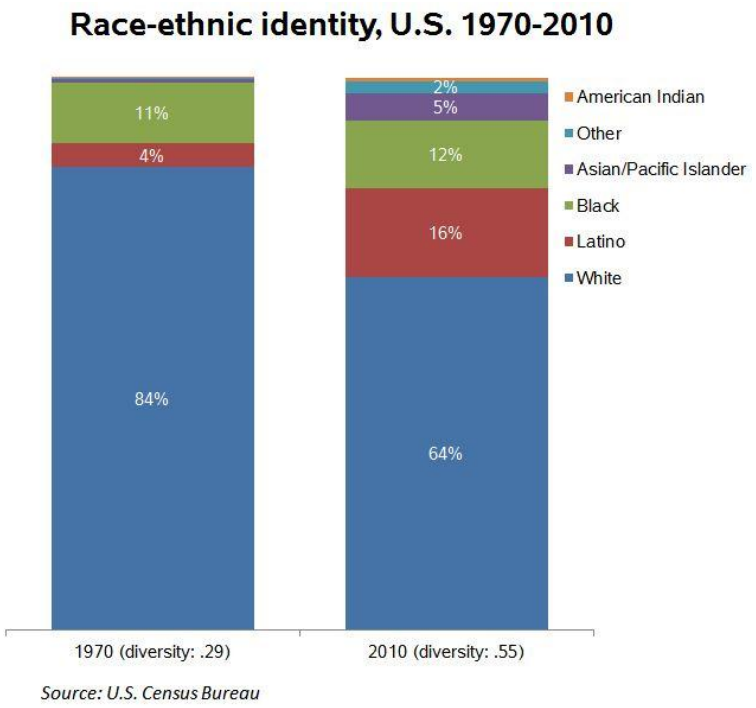


Disparities in Birth Outcomes are the tip of the health disparities iceberg

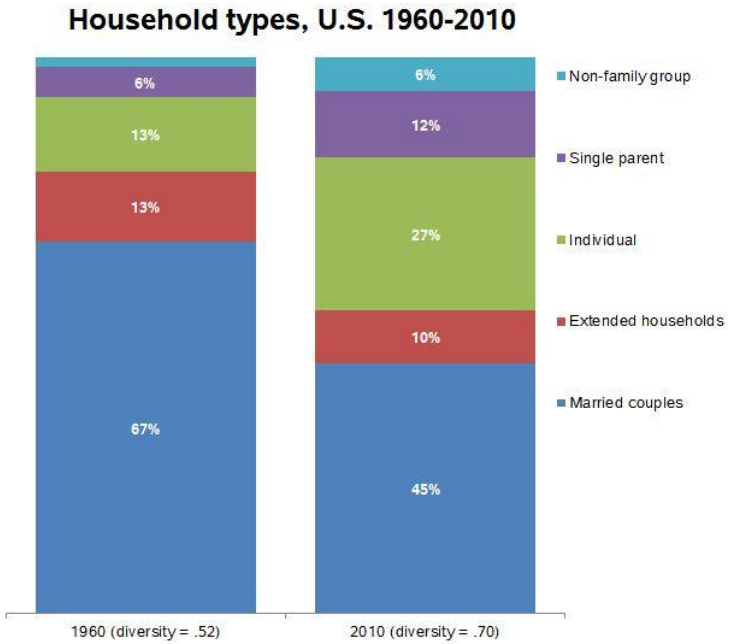


Disparities in health are the tip of the societal disparities iceberg

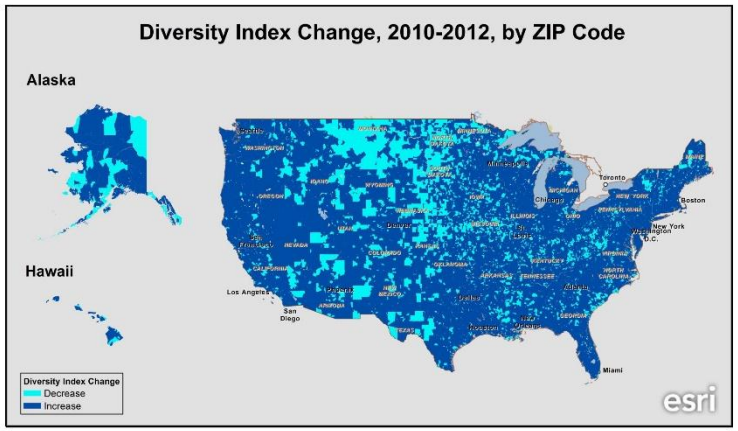
Why Should People Be Concerned About Equity



Source: U.S. Census Bureau



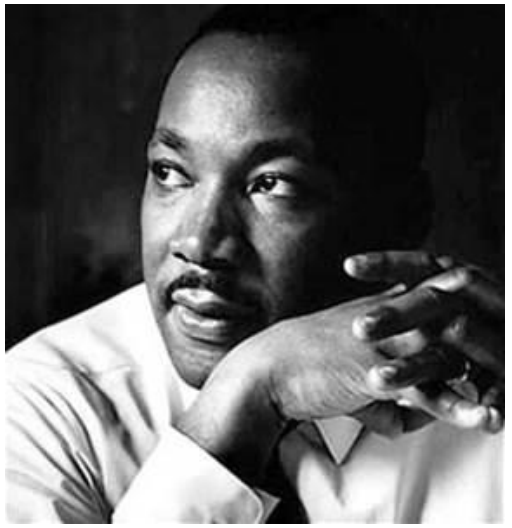
Source: My analysis of US Census data.



It's a math problem

It's a social justice problem…

"Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly."

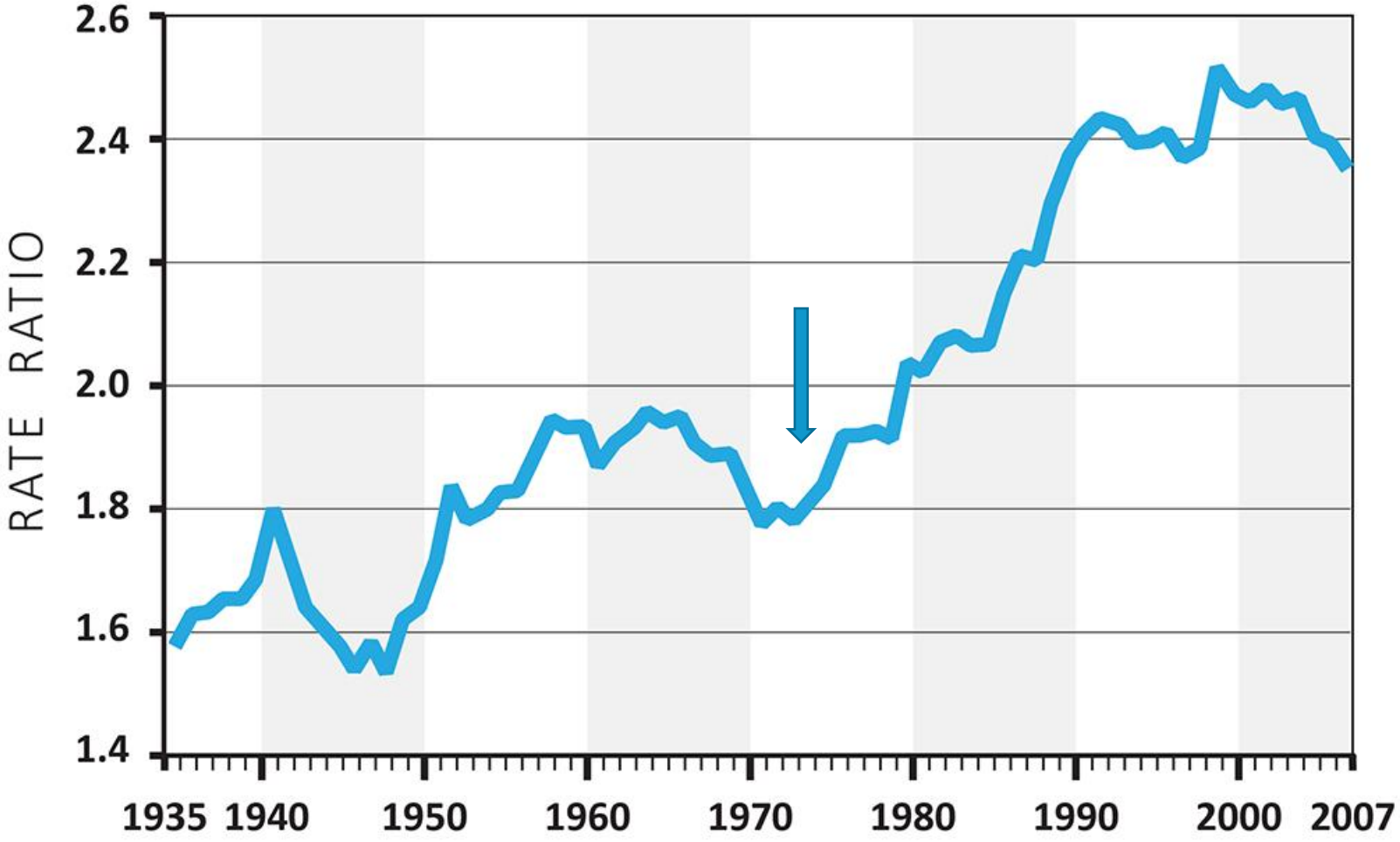


MLK, Jr, Letter from Birmingham Jail, April 16, 1963

Health Equity is the public manifestation of social justice

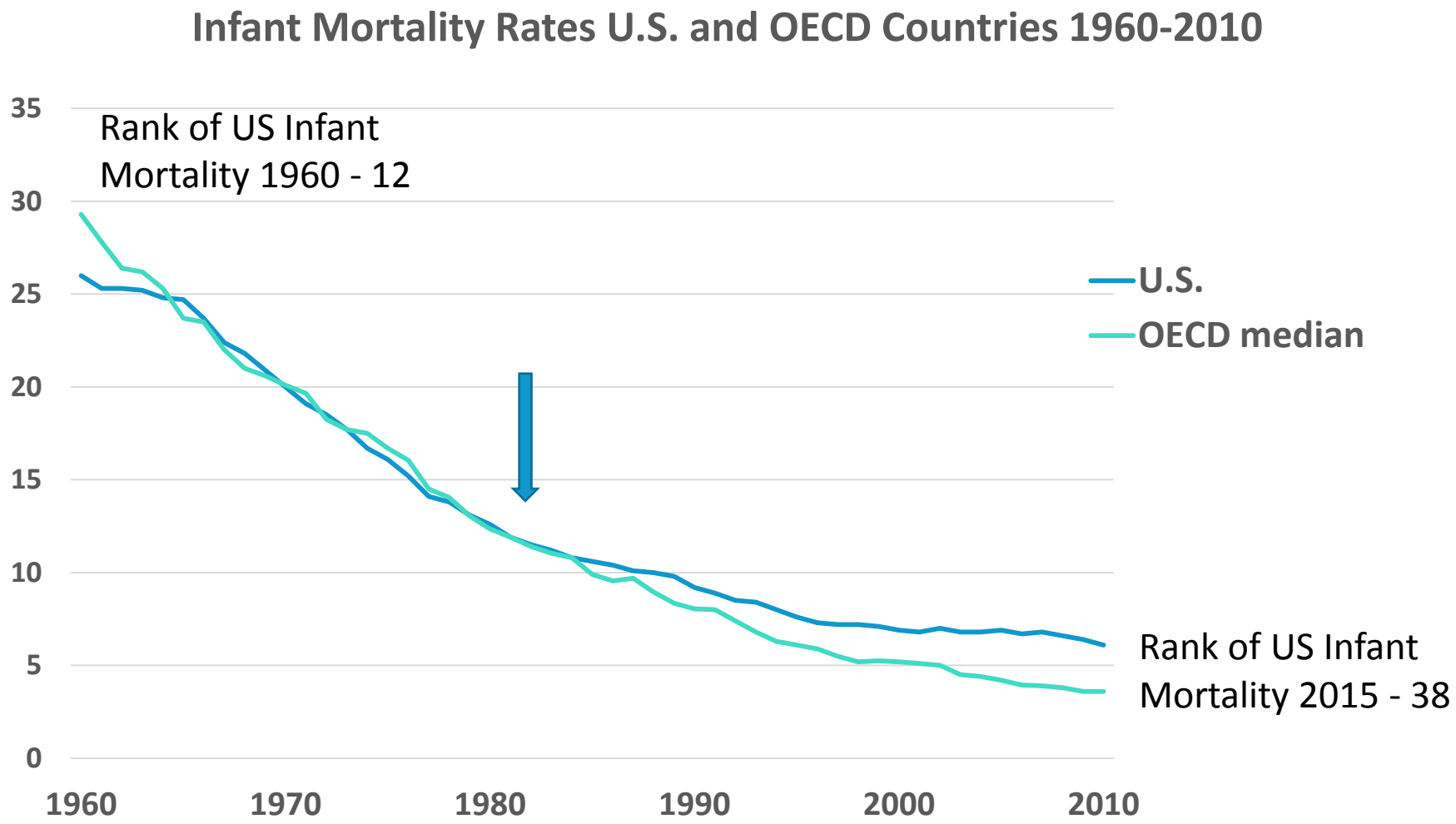
"Injustice anywhere…

Black/White Disparity in Infant Mortality Rates, US, 1935-2007



National Center for Health Statistics, Health United States, 2009 (updated)

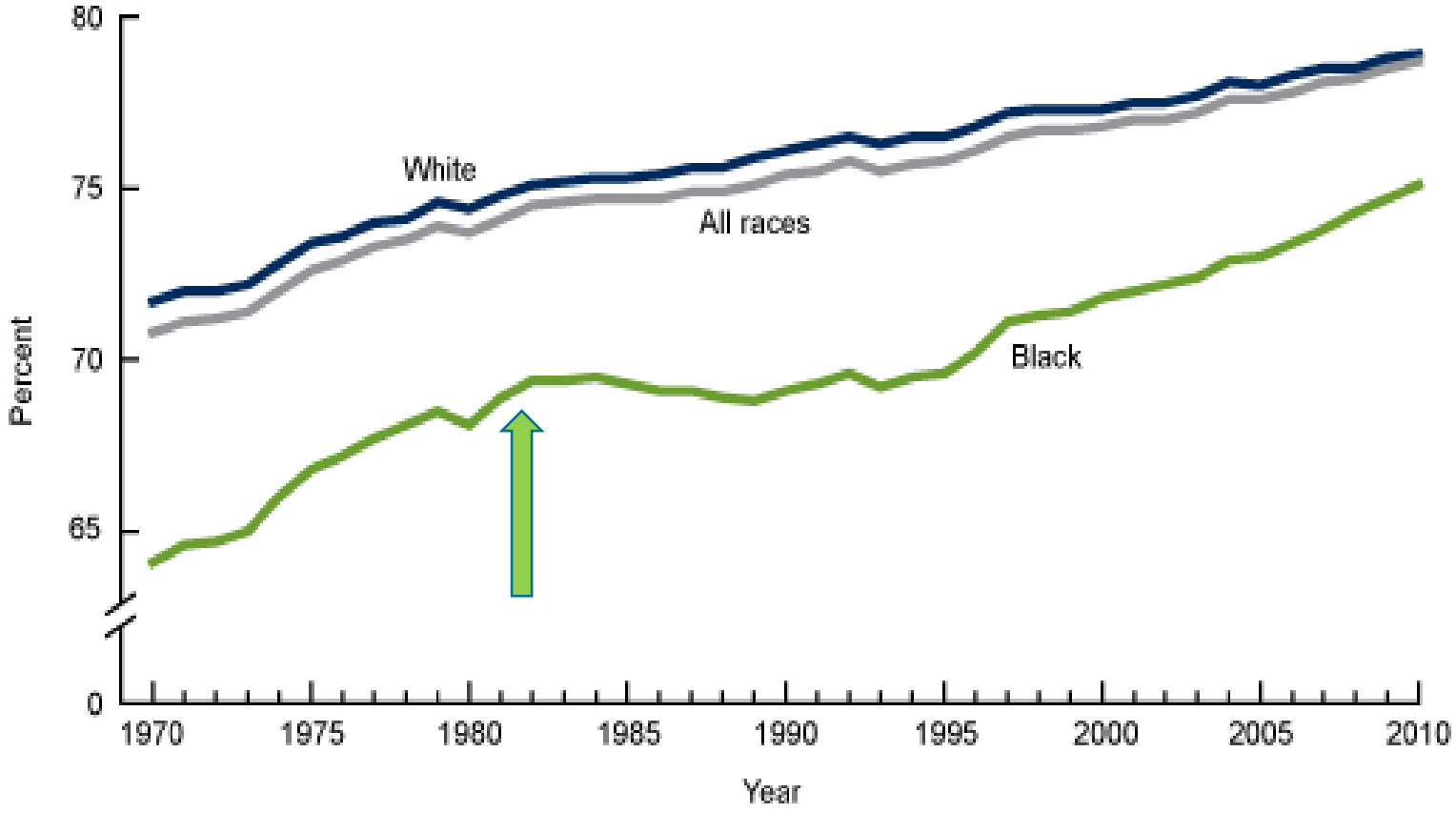
…is a threat to justice everywhere."



Source: http://stats.oecd.org, accessed 6-10-16

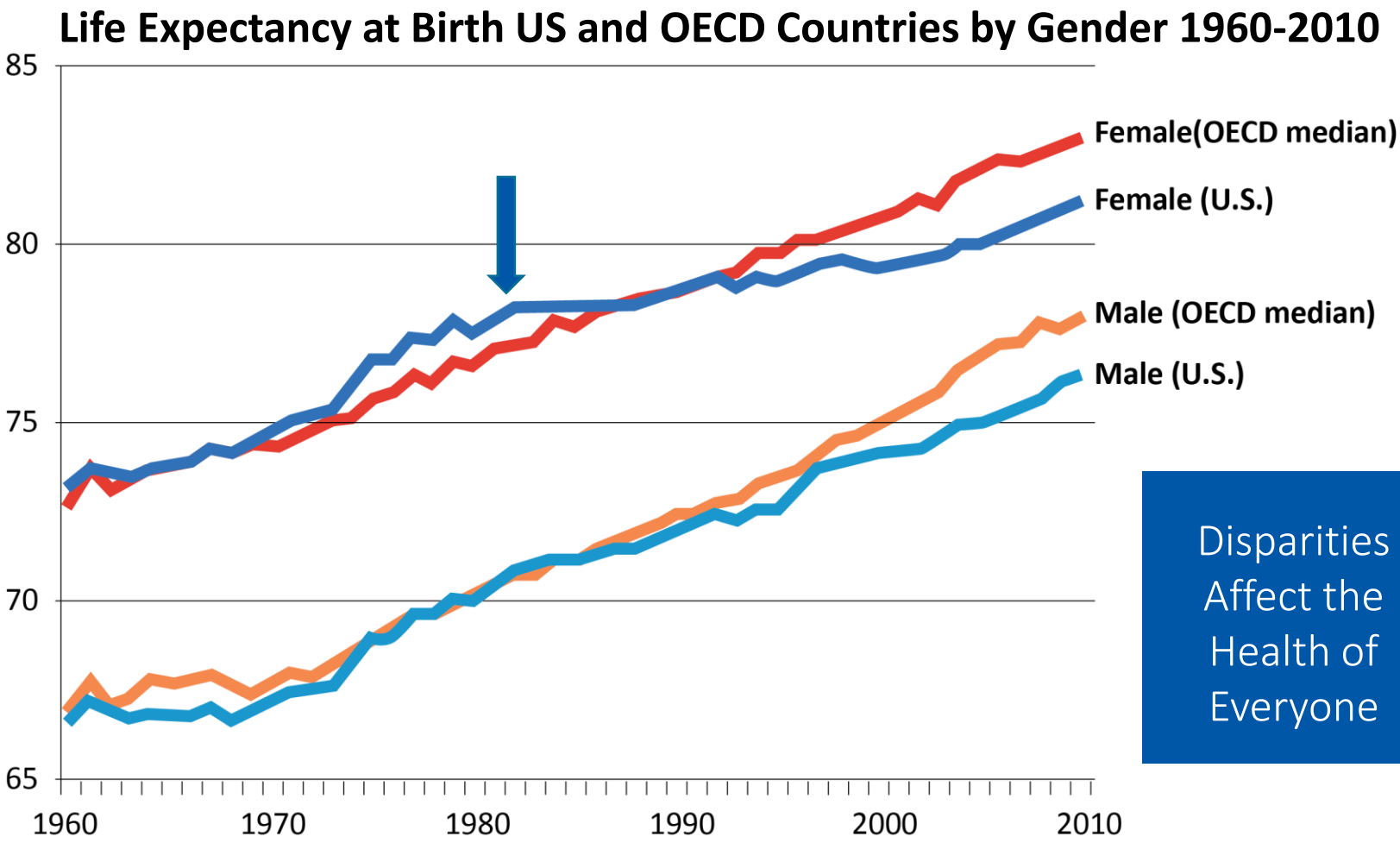
"Injustice anywhere…

Life Expectancy, by race: United States, 1970 - 2010



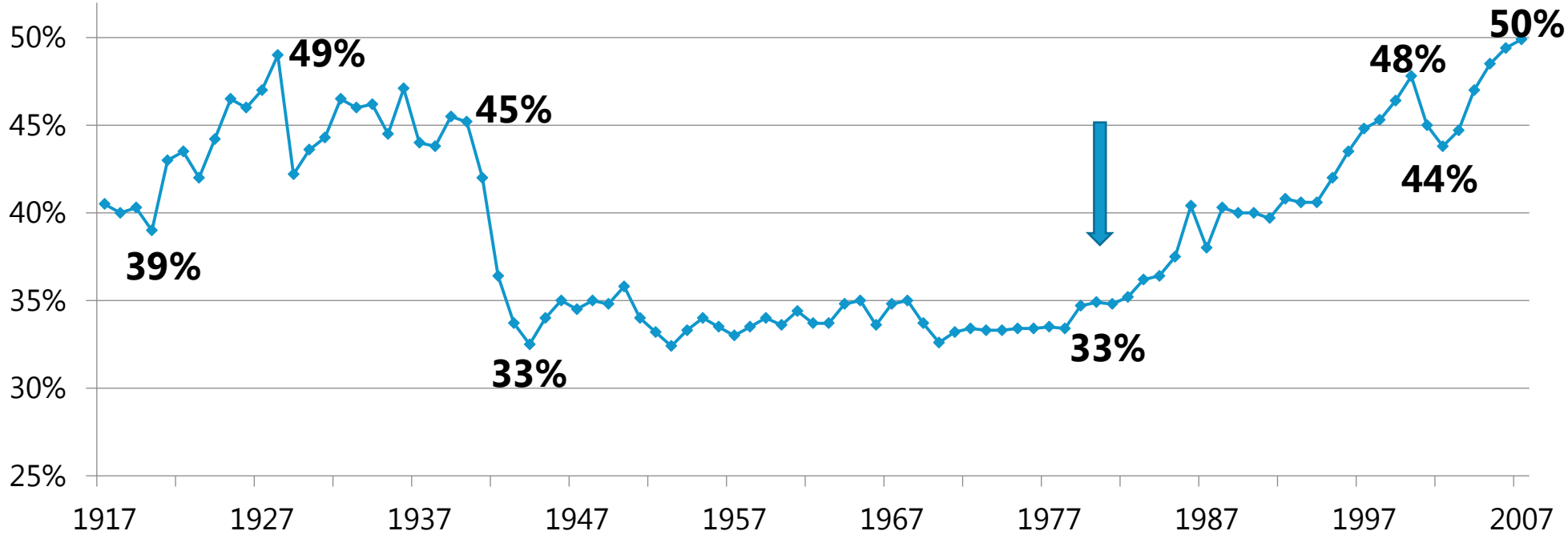
SOURCE: CDC/NCHS, National Vital Statistics System, Mortality.

…is a threat to justice everywhere.”



Disparities Affect the Health of Everyone

Top Decile Income Share in the United States, 1917-2007
Growing income disparity

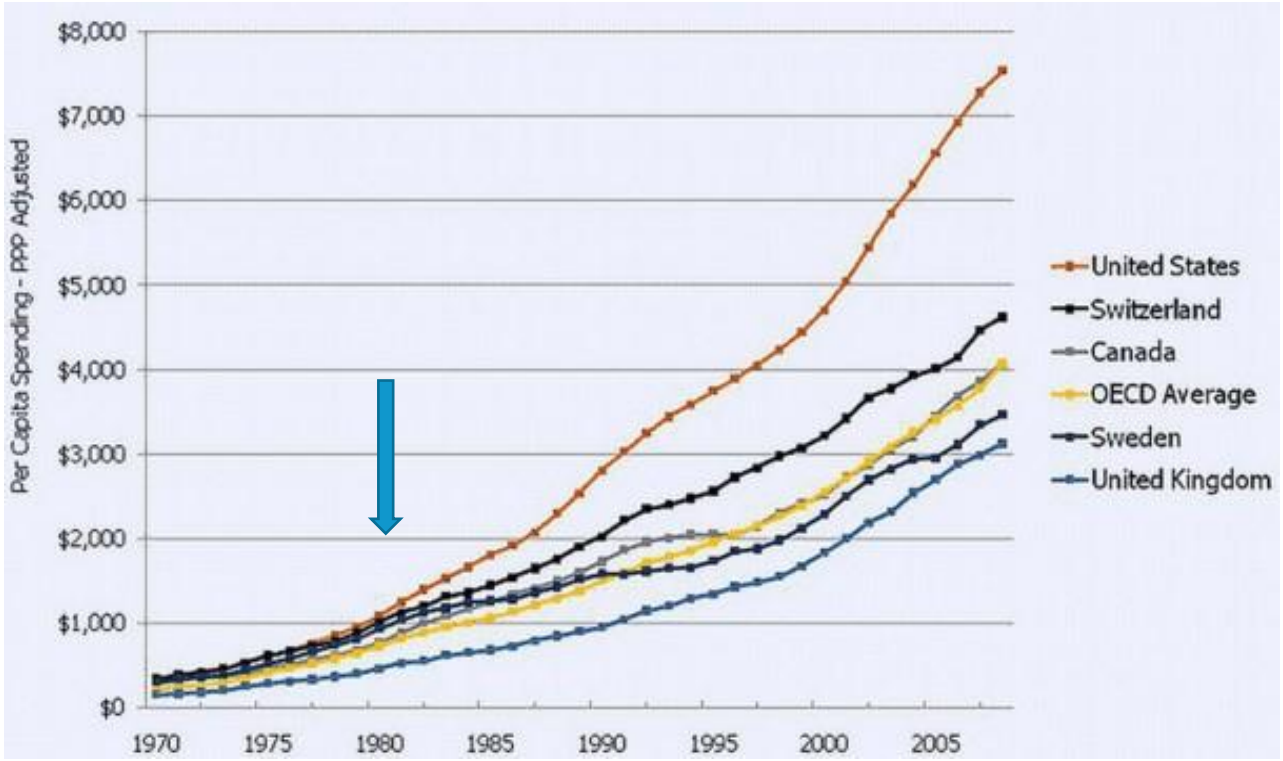


In 2007, top decile includes all U.S. families with annual income above $109,600.

Sources: *Piketty & Saez (2003), series updated to 2007, Journal of Economic Literature, Vol. XLIX (Mar -11)*

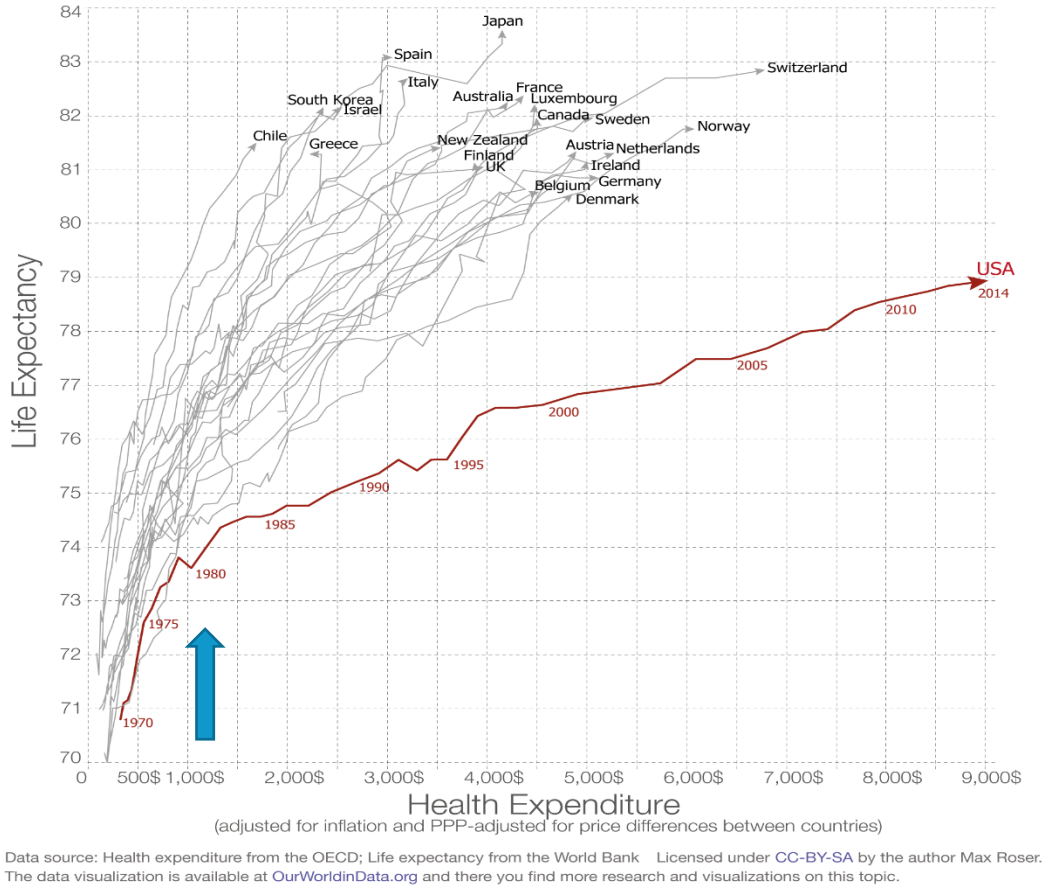
Average Health Care Spending per Capita, 1970-2009

(Adjusted for differences in cost of living)



Source: OECD Health Data 2011 (June 2011)

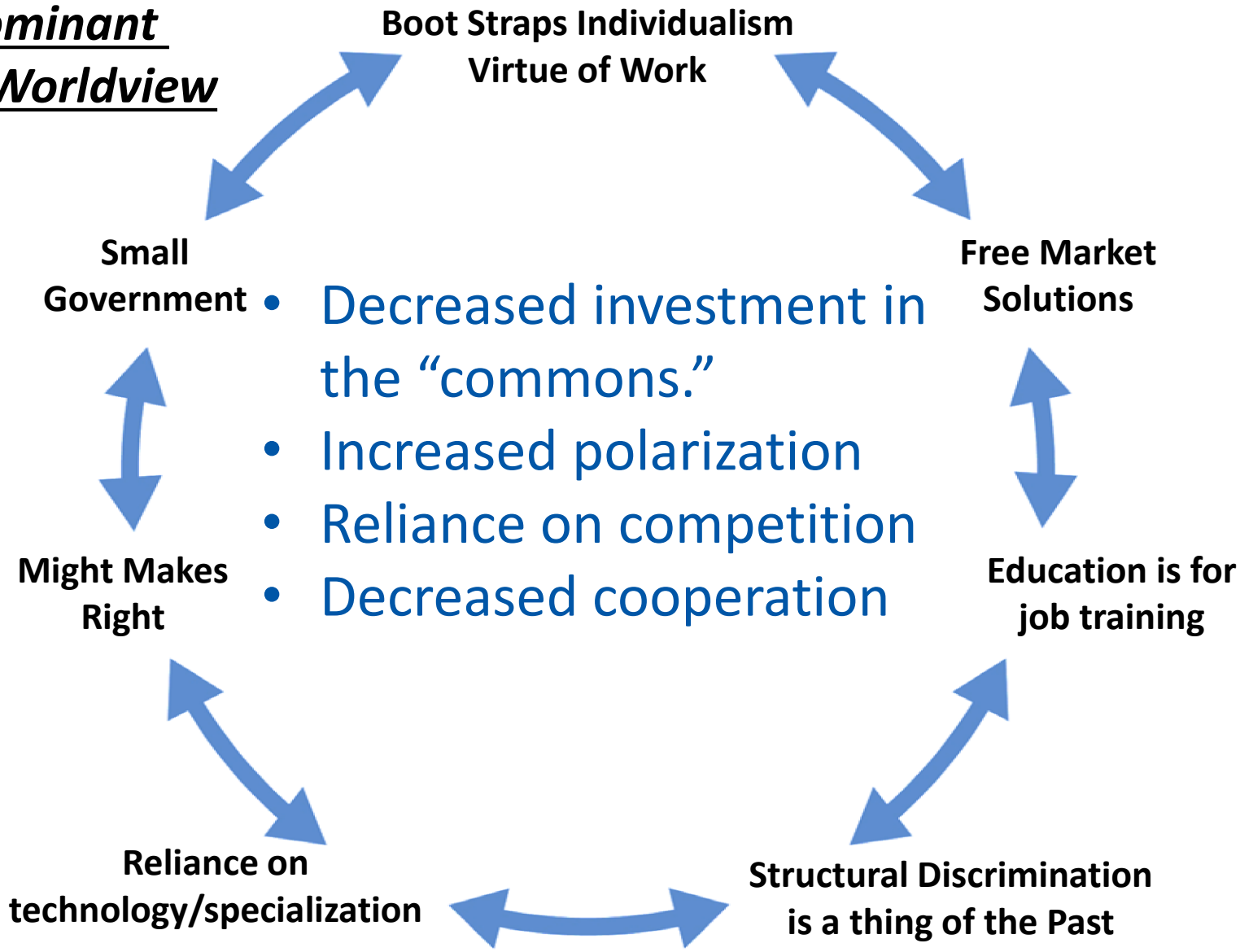
Life expectancy vs health expenditures 1970 -2014



Data source: Health expenditure from the OECD; Life expectancy from the World Bank Licensed under CC-BY-SA by the author Max Roser.
The data visualization is available at OurWorldinData.org and there you find more research and visualizations on this topic.

How did this happen?

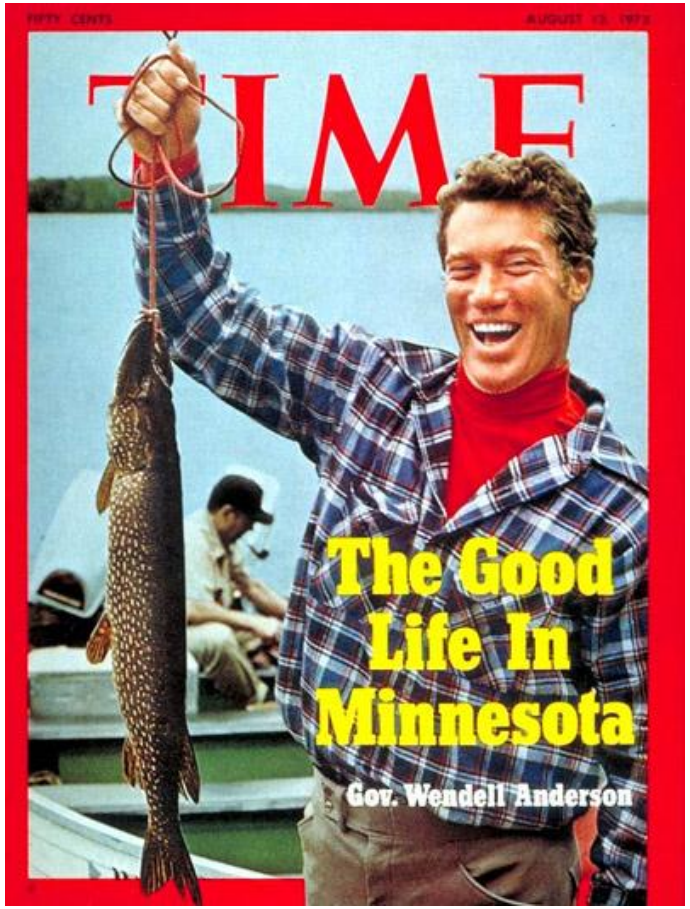
Predominant U. S. Worldview



December 13

- 1968: The journal Science published the classic essay **“Tragedy of the Commons”** by Garrett Hardin.
- 1994: Wall Street Journal published “**Mainstream Science on Intelligence”** co-signed by Hardin (in response to “**The Bell Curve**.”)
- *“Equity is determinable by law and custom; equality is determined by nature.”*
- *“Affirmative action implies that if we cannot guarantee equality, then we should legislate equity.”*

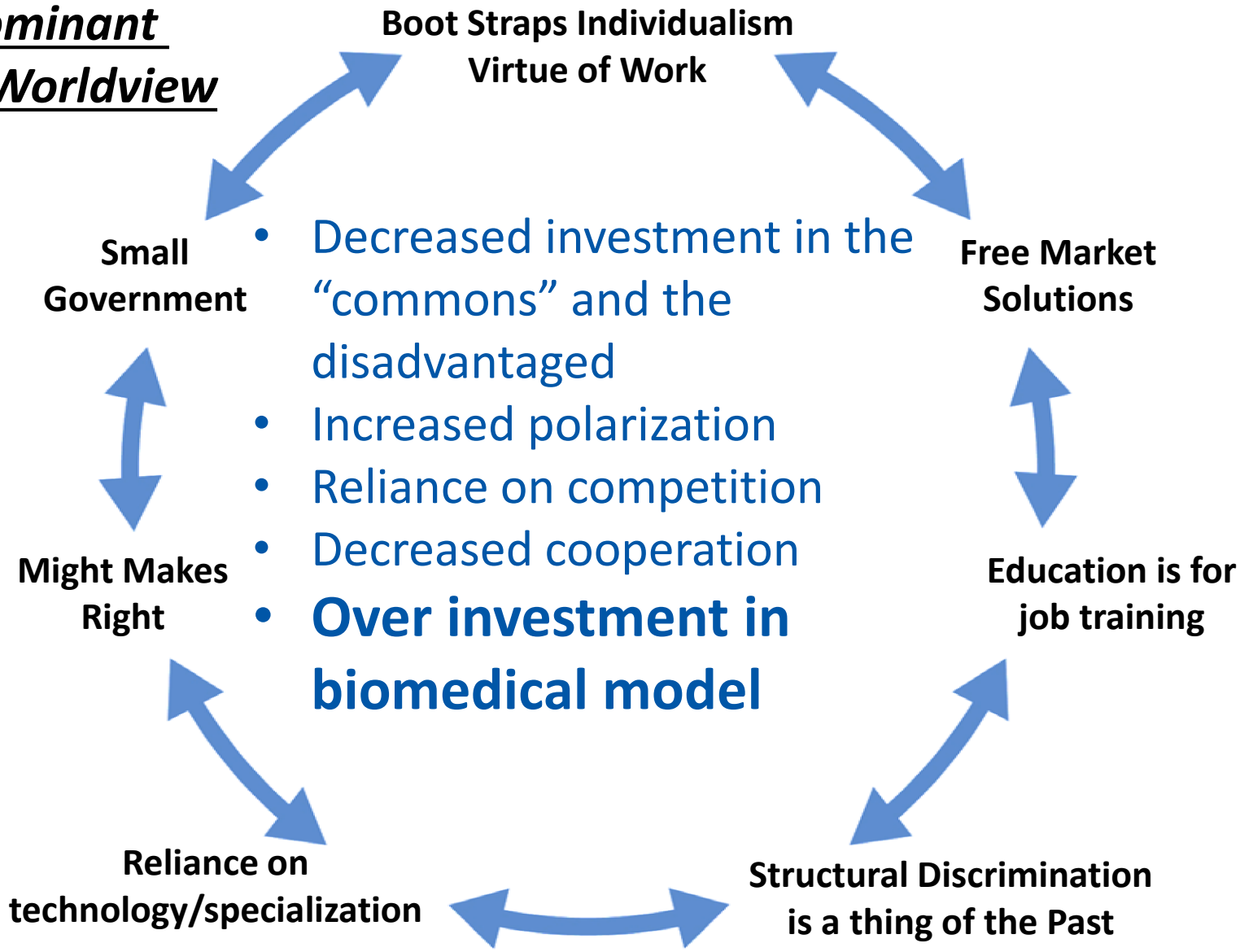
What Created “The Good Life In Minnesota”?



- “We had a social conscience.”
- “We invested in the “public good.” (The Commons)
- “We were civil and we cooperated.”

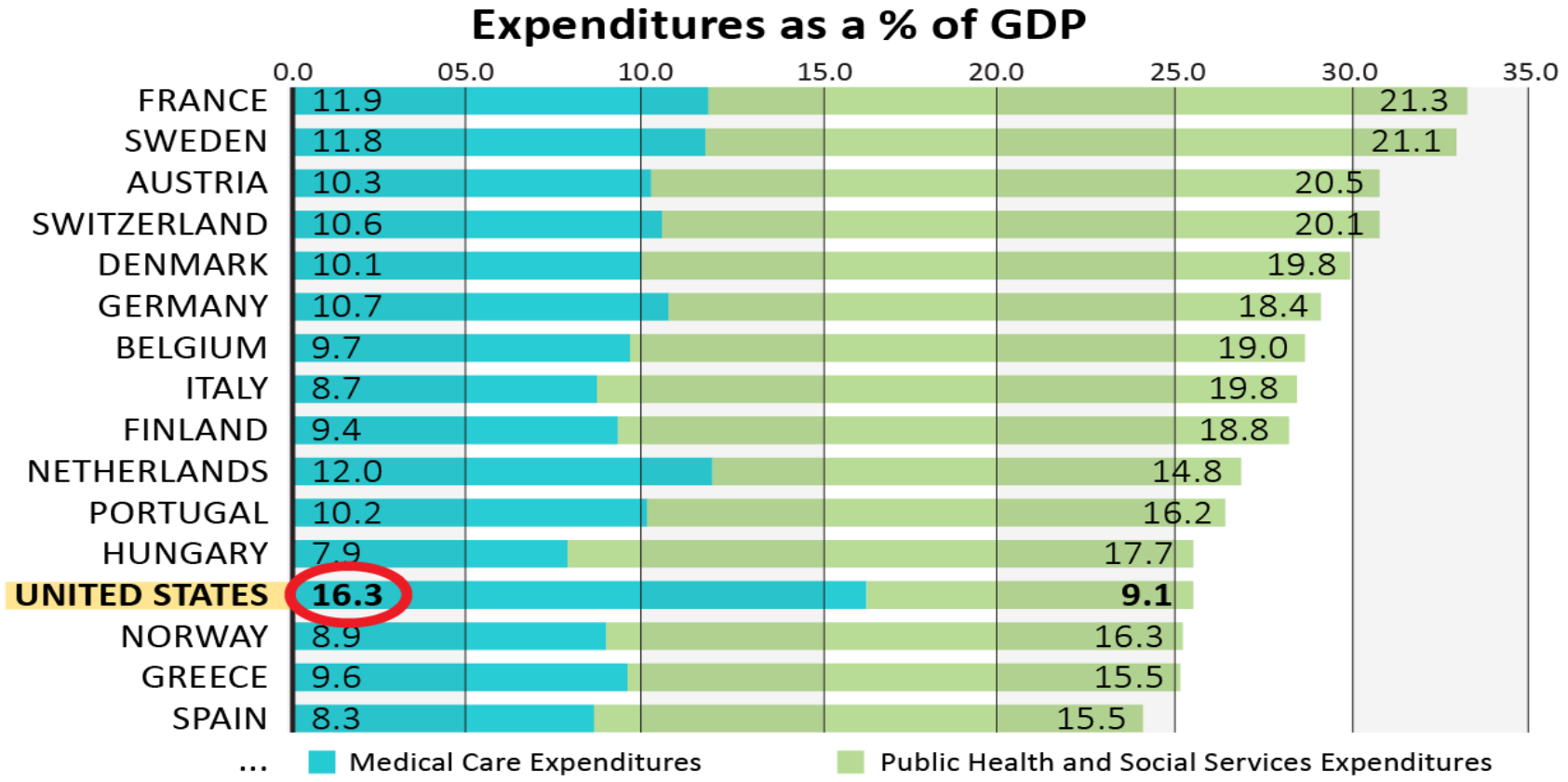
How did this happen?

Predominant U. S. Worldview



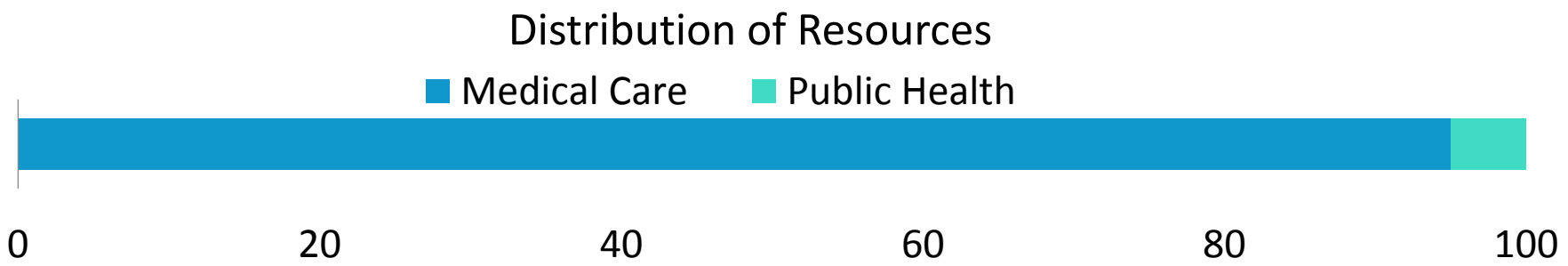
Re-defining the Unacceptable

Total Investment in Health and Human Services



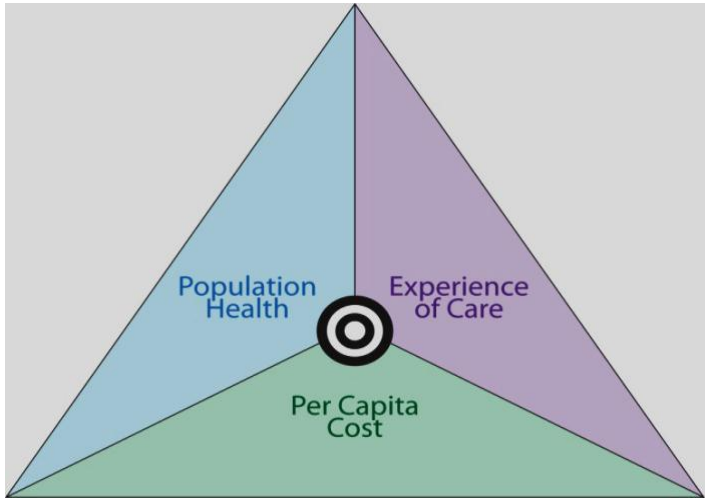
In OECD, for every $1 spent on health care, about $2 is spent on social services.

In the U.S., for every $1 spent on health care, about 55 cents is spent on social services.



Triple Aim of Healthcare

Institute *for* Healthcare Improvement



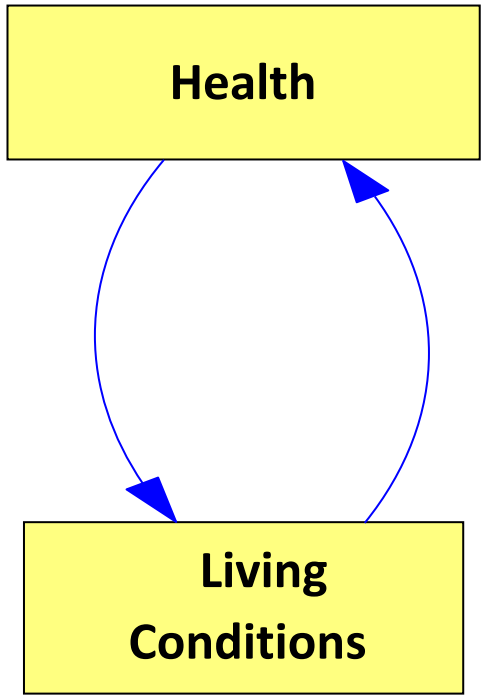
- Better care for individuals
- Lower per capita costs
- Better health for populations

To Advance Health Equity, We Need a Different Approach

"Public health is what we, as a society, do collectively to assure the conditions in which (all) people can be healthy."

The Future of Public Health
Institute of Medicine, 1988

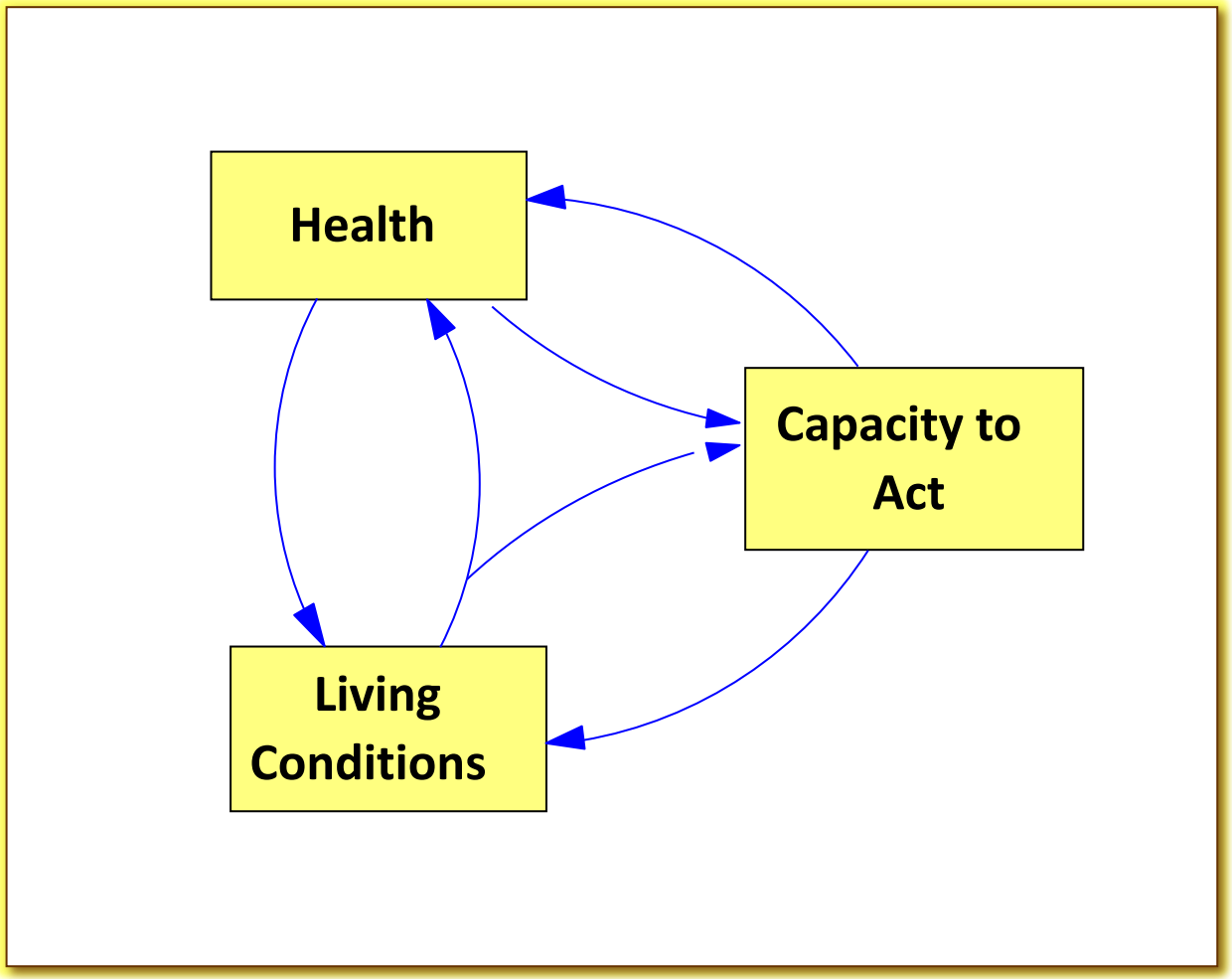
Living Conditions Impact Health



Social Determinants of Health

The conditions and circumstances in which people are born, grow, live, work, and age. These circumstances are shaped by a set of forces beyond the control of the individual: economics and the distribution of money, power, social policies, and politics at the global, national, state, and local levels.

Changing the Conditions that Affect Health Requires the Capacity to Act



Some populations have a more difficult time than others in impacting living conditions

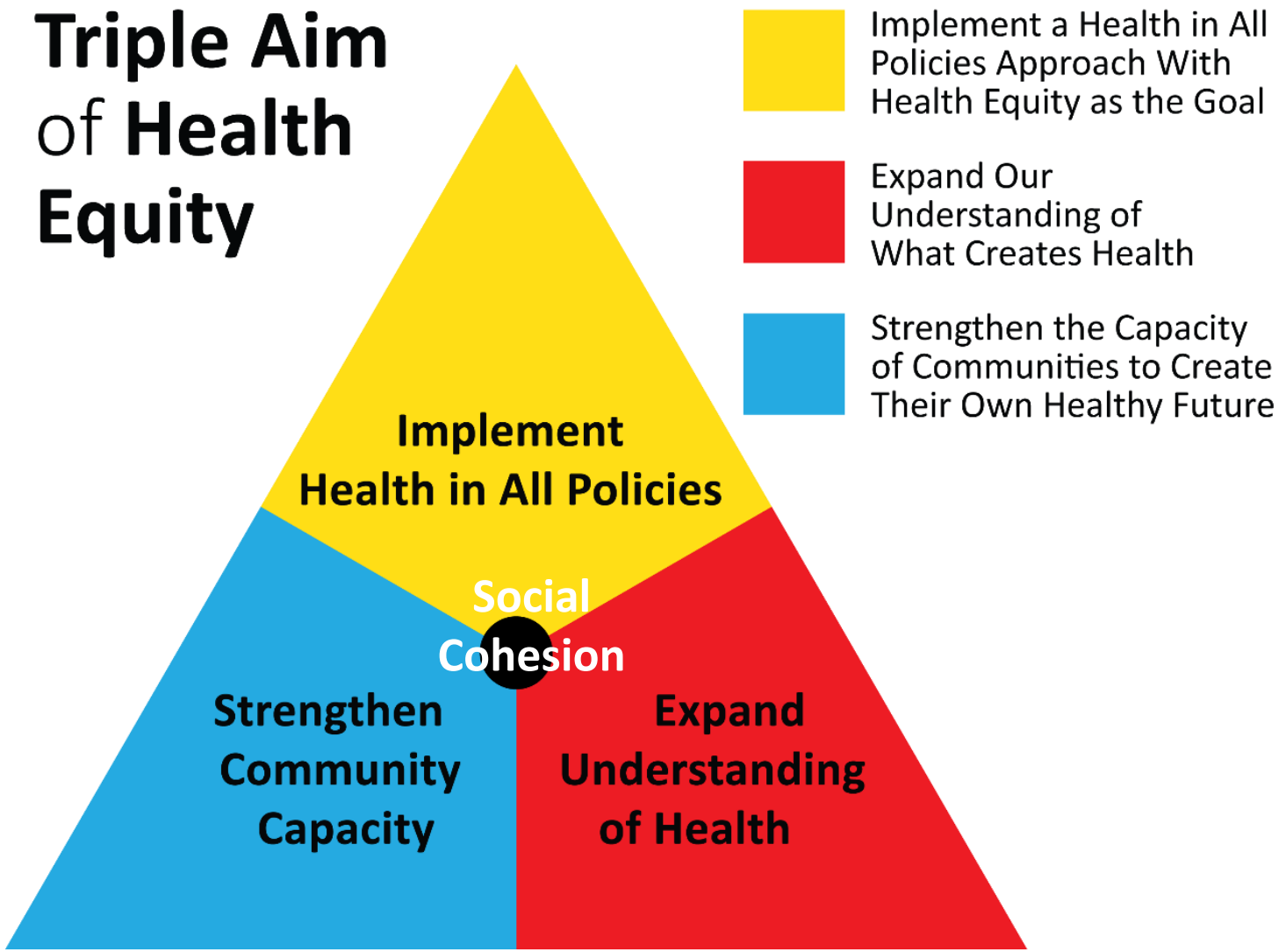
Public health has few skills in fostering the capacity to act

Structure Public Health work to achieve our overall aim: Create/Strengthen "**Capacity to Act**"

Organize the:

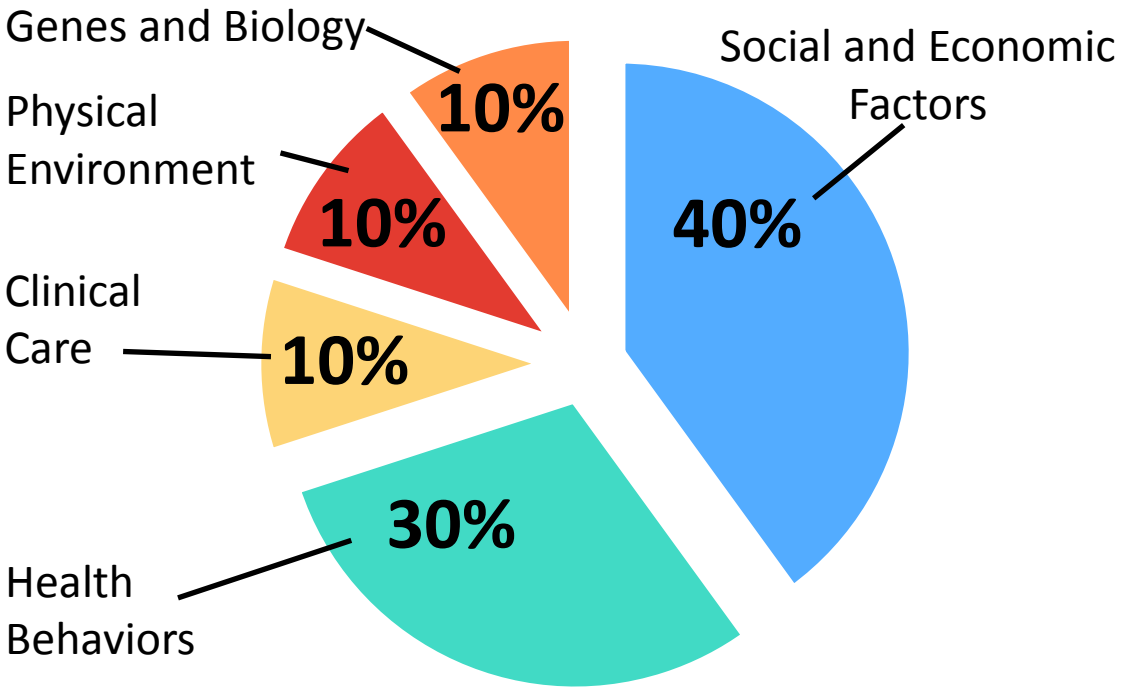
- **Narrative**: Align the narrative to build public understanding and public will.
- **Resources**: Identify/shift the resources-infrastructure-the way systems and processes are structured.
- **People**: Directly impact decision makers, develop relationships, align interests.

Advancing Health Equity and Optimal Health for All



Expand the Understanding of What Creates Health

Determinants of Health

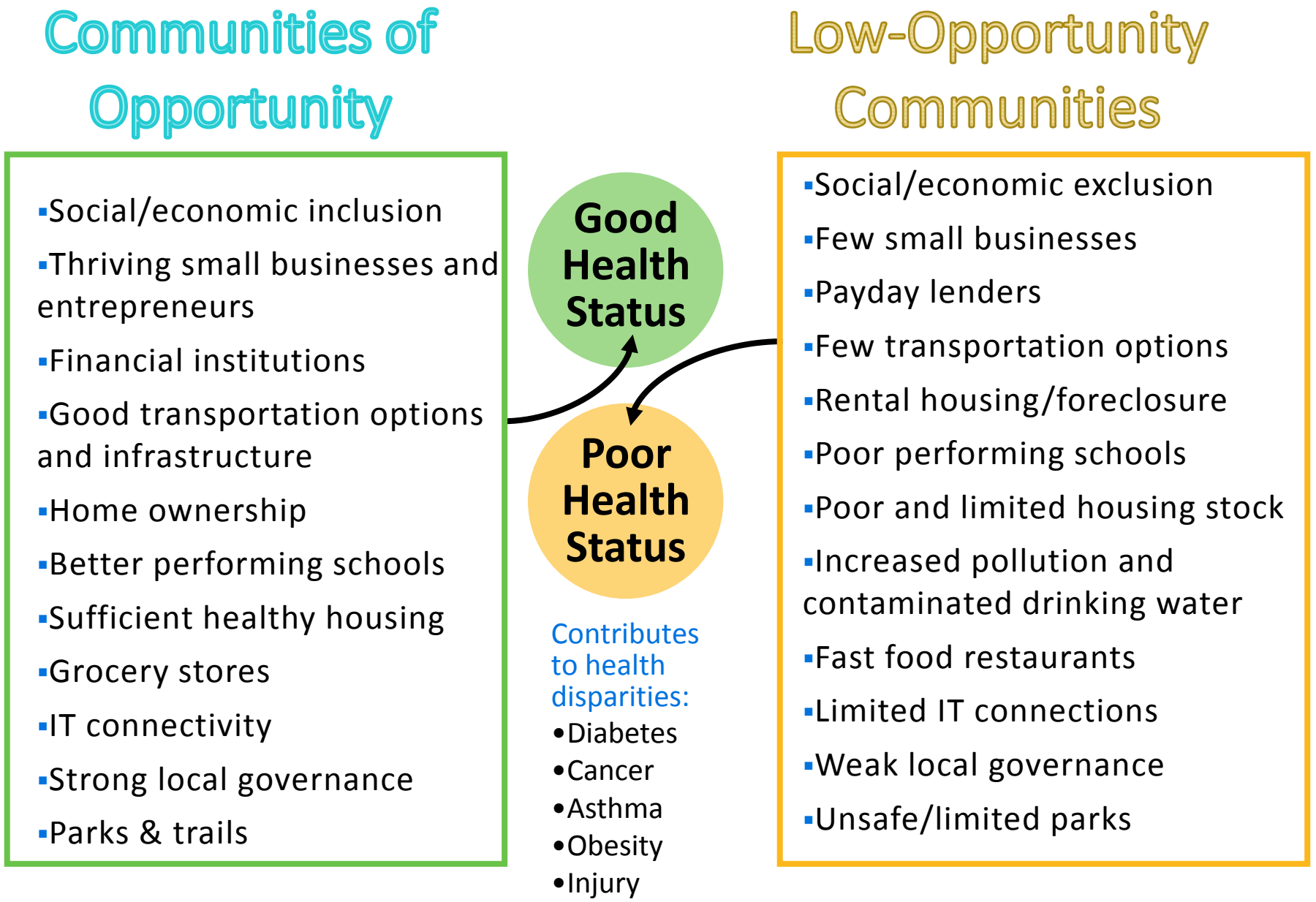


Necessary conditions for health (WHO)

- Peace
- Shelter
- Education
- Food
- Income
- Stable eco-system
- Sustainable resources
- Mobility
- Health Care
- Social justice and equity

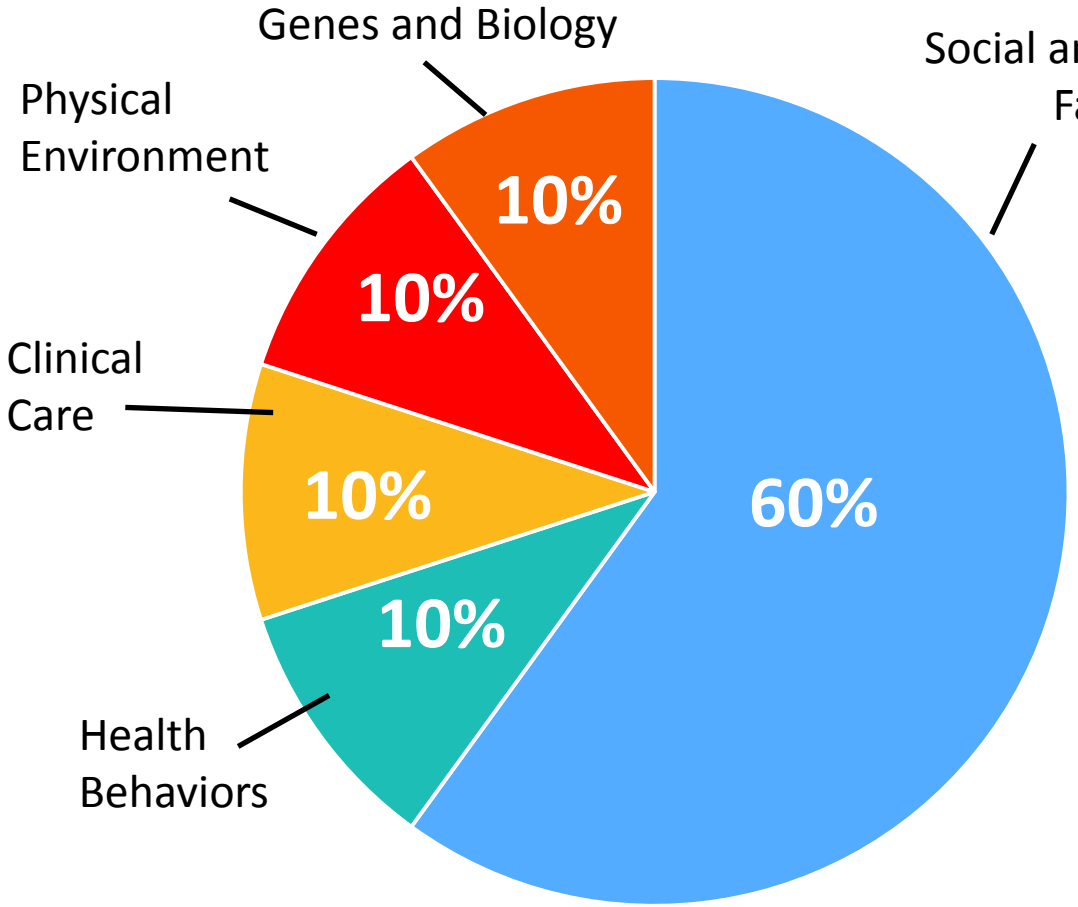
Determinants of Health Model based on frameworks developed by: Tarlov AR. *Ann N Y Acad Sci* 1999; 896: 281-93; and Kindig D, Asada Y, Booske B. *JAMA* 2008; 299(17): 2081-2083.

World Health Organization. Ottawa charter for health promotion. International Conference on Health Promotion: The Move Towards a New Public Health, November 17-21, 1986 Ottawa, Ontario, Canada, 1986. Accessed July 12, 2002 at http://www.who.int/hpr/archive/docs/ottawa.html.


Communities of Opportunity
▪Social/economic inclusion
▪Thriving small businesses and entrepreneurs
▪Financial institutions
▪Good transportation options and infrastructure
▪Home ownership
▪Better performing schools
▪Sufficient healthy housing
▪Grocery stores
▪IT connectivity
▪Strong local governance
▪Parks & trails
Good Health Status
Poor Health Status
Contributes to health disparities:
•Diabetes
•Cancer
•Asthma
•Obesity
•Injury
Low-Opportunity Communities
▪Social/economic exclusion
▪Few small businesses
▪Payday lenders
▪Few transportation options
▪Rental housing/foreclosure
▪Poor performing schools
▪Poor and limited housing stock
▪Increased pollution and contaminated drinking water
▪Fast food restaurants
▪Limited IT connections
▪Weak local governance
▪Unsafe/limited parks

Expand the Understanding of What Creates Health

Ehlinger's beliefs about the contributions to health determinants

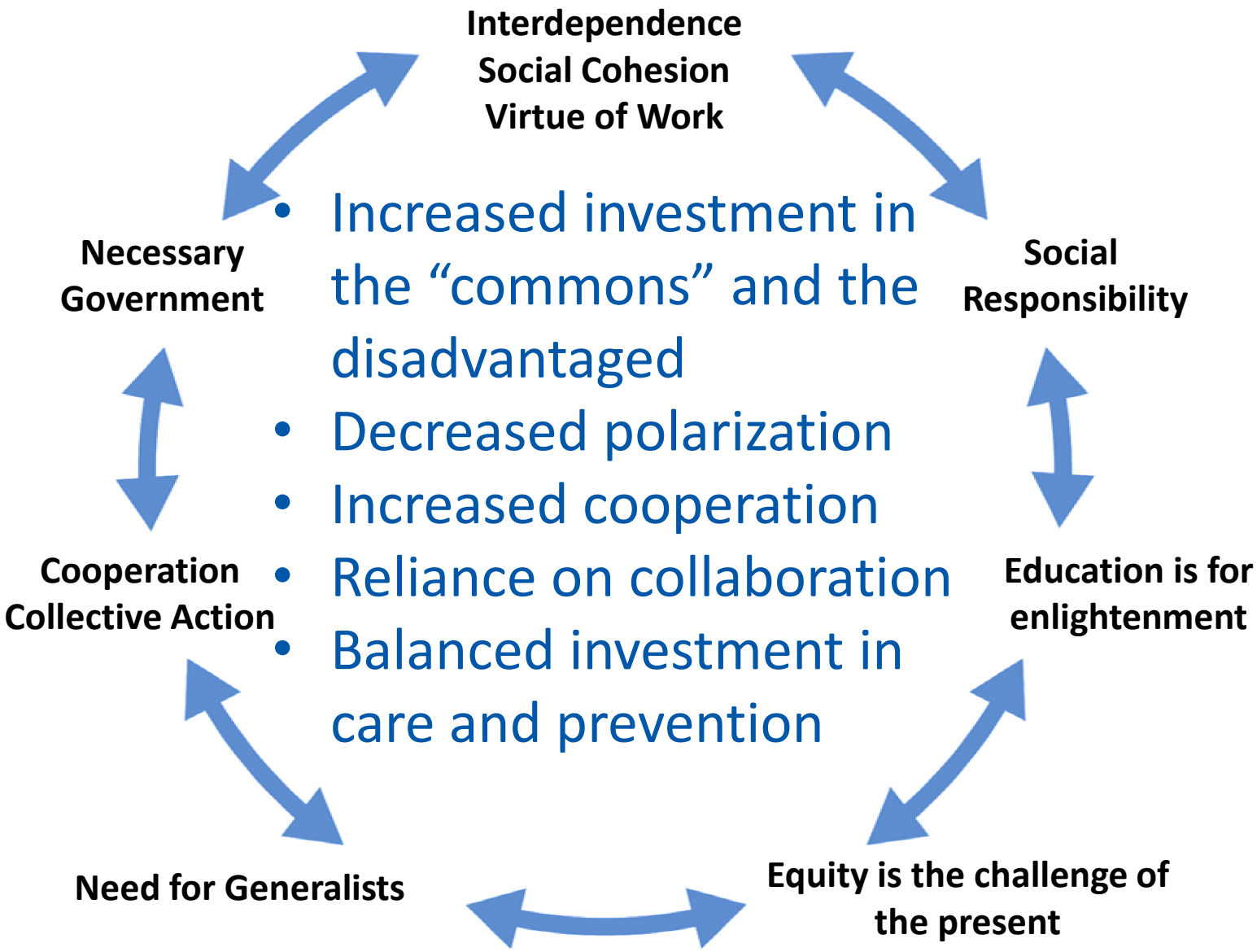


Determinants are created & enhanced mostly by policies and systems that impact the physical and social environment

And The Real Narrative of What Creates Health Inequities?

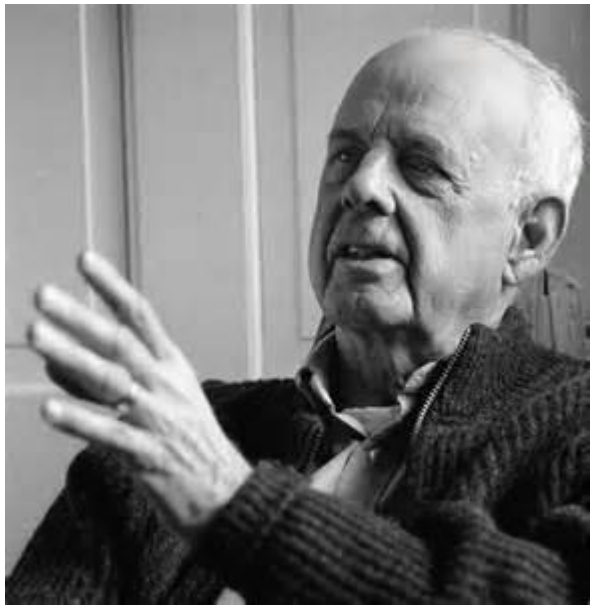
- Disparities are not just because of lack of access to health care or to poor individual choices.
- **Disparities are mostly the result of policy decisions that systematically disadvantage some populations over others.**
  - Especially, populations of color and American Indians, GLBT, immigrants, and refugees
  - Structural Racism

Change the Narrative about What Creates Health
Alternative Worldview



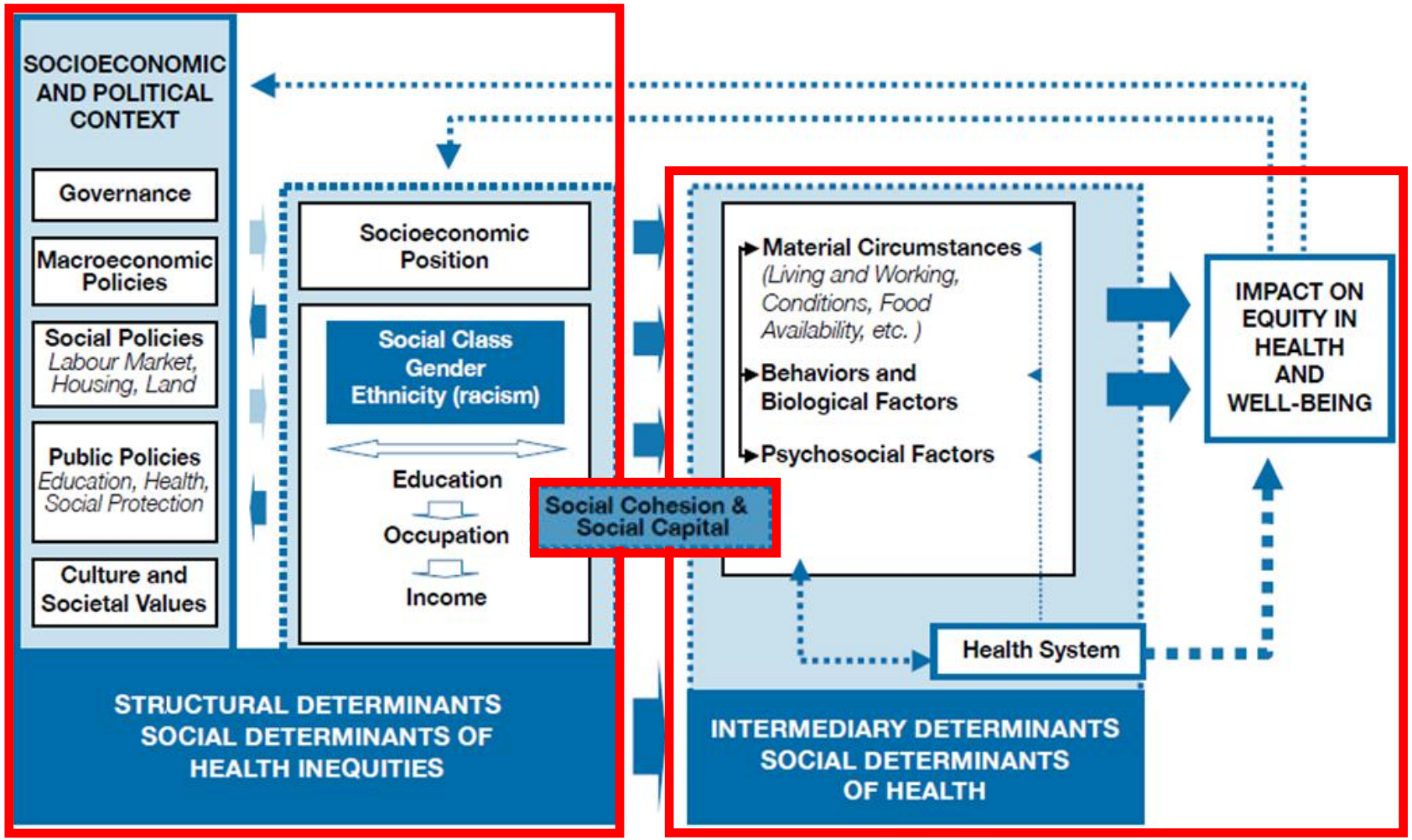
Alternative World View and Narrative

- *“We have lived by the assumption that what was good for us would be good for the world. We have been wrong. We must change our lives so that it will be possible to live by the contrary assumption, that what is good for the world will be good for us.”* Wendell Berry



Implement a Health in All Policies Approach with Health Equity as the Goal

Implement Health in All Policies Approach with Health Equity as a Goal

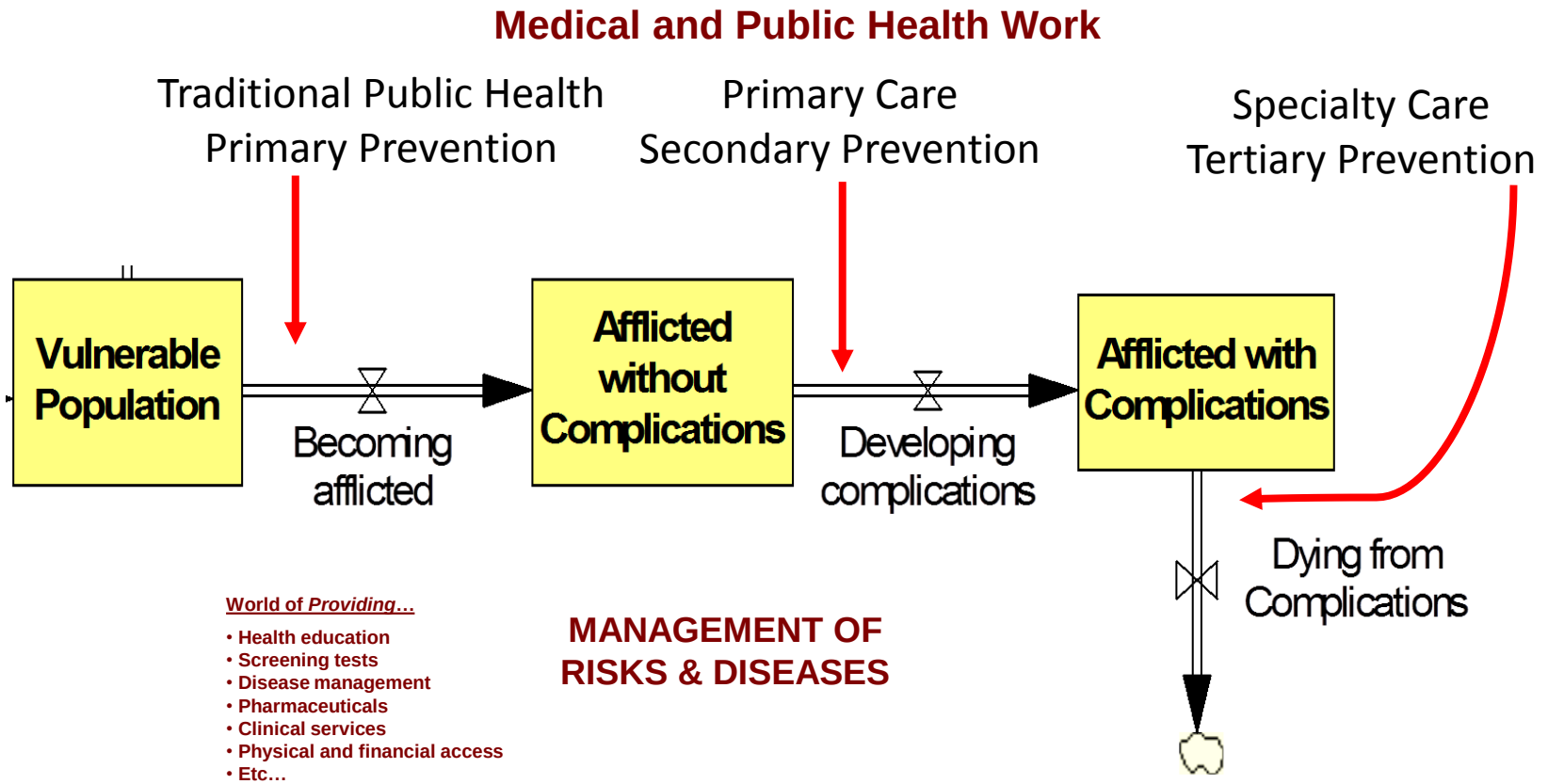


Commission on Social Determinants of Health. (2010). *A conceptual framework for action on the social determinants of health*. Geneva: World Health Organization.

Implement a Health in All Policies Approach with Health Equity as the Goal

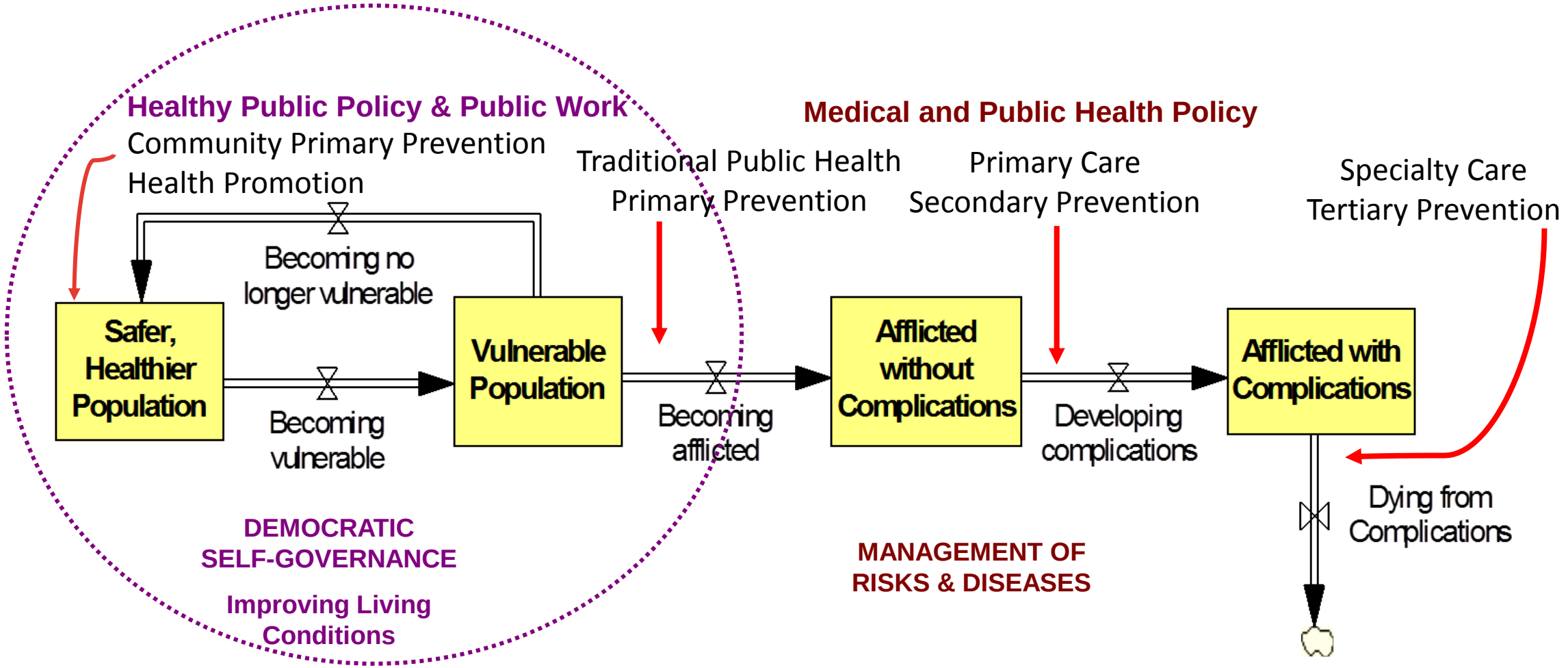
- Minimum Wage
- Paid Leave
- Income and Diabetes
- Incarceration and health
- Ban the Box
- Transportation Policy
- Broadband connectivity
- E-Health Policies
- Ag Buffer strips
- Marriage Equity
- Payday Lending
- Air/Water quality

Strengthen the Capacity of Communities to Create Their Own Healthy Future



Milstein B. Hygeia's constellation: navigating health futures in a dynamic and democratic world. Atlanta, GA: Syndemics Prevention Network, Centers for Disease Control and Prevention; April 15, 2008. Available at: http://www.cdc.gov/syndemics/monograph/index.htm

Strengthen the Capacity of Communities to Create Their Own Healthy Future



"…the community in the fullest sense is the smallest unit of health…to speak of the health of an isolated individual is a contradiction in terms."

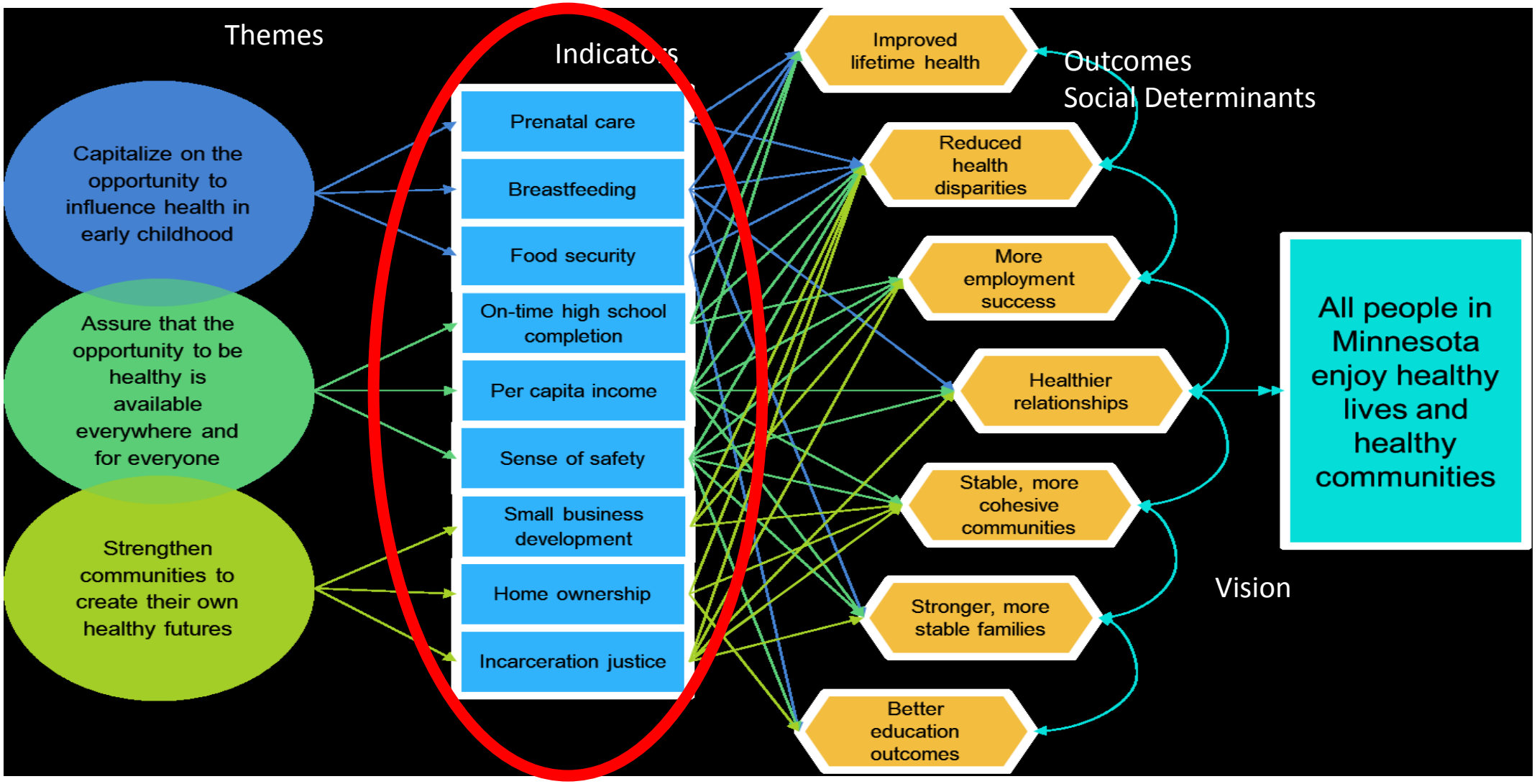
Wendell Berry in Health is Membership

Milstein B. Hygeia's constellation: navigating health futures in a dynamic and democratic world. Atlanta, GA: Syndemics Prevention Network, Centers for Disease Control and Prevention; April 15, 2008. Available at: http://www.cdc.gov/syndemics/monograph/index.htm

Social Cohesion

- *"A proper community, we should remember also, is a commonwealth: a place, a resource, an economy. It answers the needs, practical as well as social and spiritual, of its members - among them the need to need one another. The answer to the present alignment of political power with wealth is the restoration of the identity of community and economy.*
  - *Wendell Berry, The Art of the Commonplace: The Agrarian Essays*

Triple Aim of Health Equity in Action



Asking the Right Questions Can Advance Health Equity

Expand Understanding

- *What values underlie decision-making process?*
- *What is assumed to be true about the world and the role of the institution in the world?*

Health in All Policies

- *What are the health and equity implications of the policy/program?*
- *Who is benefiting and who is left out?*

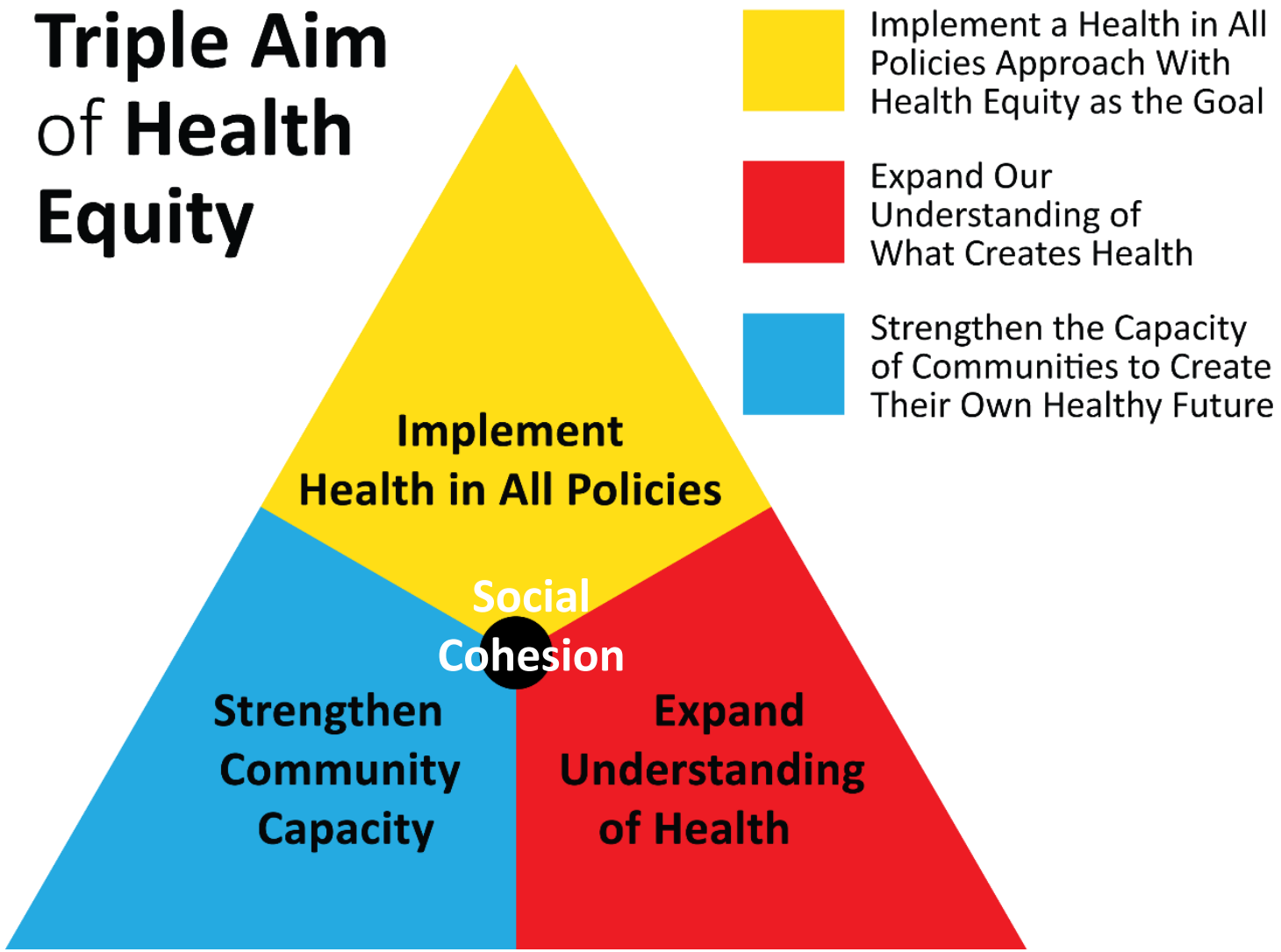
Support Community Capacity

- *Who is at the decision-making table, and who is not?*
- *Who is being held accountable and to whom?*

Asking the Right Questions Is a Path to Action for Change

- *What would it look like if equity was the starting point for decision-making?*
- *Our work would be different.*

Our work would be to Advance Health Equity and Optimal Health for All by:



Asking the Right Questions Is a Path to Action for Change

- *What would it look like if equity was the starting point for decision-making?*
- *Our work would be different.*
- ***But it would be going back to our roots***

"…the ***physician's function is fast becoming social and preventive,*** *rather than individual and curative…(do) not to forget that directly or indirectly,* ***disease has been found to depend largely on unpropitious environment…a bad water supply, defective drainage, impure food, unfavorable occupational surroundings…(these) are matters for 'social regulation,'*** *and doctors have the duty to promote social conditions that conduce to physical well-being."*

Abraham Flexner
1910 Flexner Report

C. E. A. Winslow - 1920

C.E.A. Winslow, Dean
Yale School of Public Health

Public health is the science and art of :

1. Preventing disease.
2. Prolonging life, and
3. Promoting health and efficiency through **organized community effort** for…

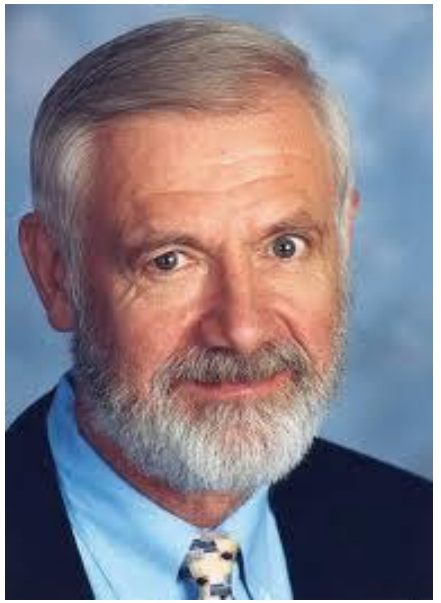
continued

Winslow – definition of public health continued

a. the **sanitation** of the environment
b. the control of **communicable infections**
c. the **education** of the individual in personal hygiene
d. the organization of **medical and nursing services** for the early diagnosis and preventive treatment of disease, and
e. the development of the **social machinery** to insure everyone a **standard of living** adequate for the maintenance of health, so **organizing these benefits** as to enable **every citizen to realize his birthright of health and longevity**.

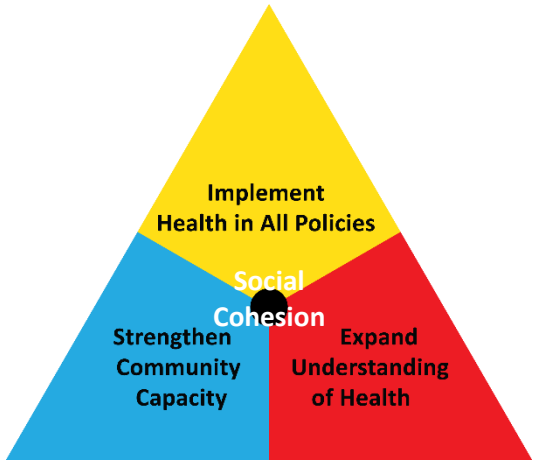
The Root of Public health is social justice

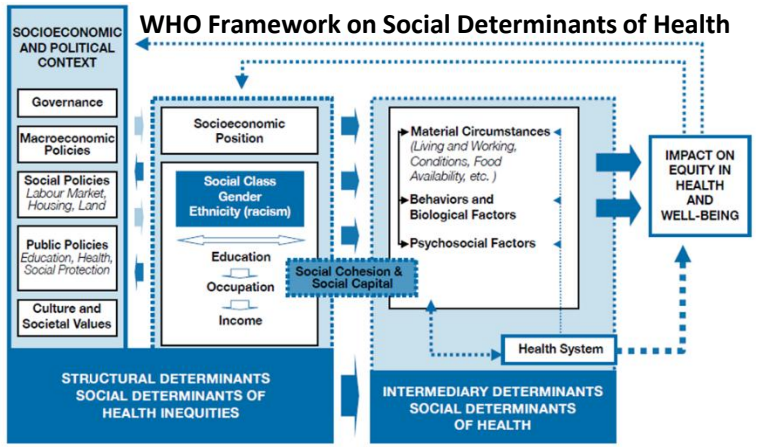
- *"The philosophy behind science is to discover truth.*
- *The philosophy behind medicine is to use that truth for the benefit of your patient.*
- *The philosophy behind public health is social justice."*
  - *William Foege – CDC director, 1977-1983*

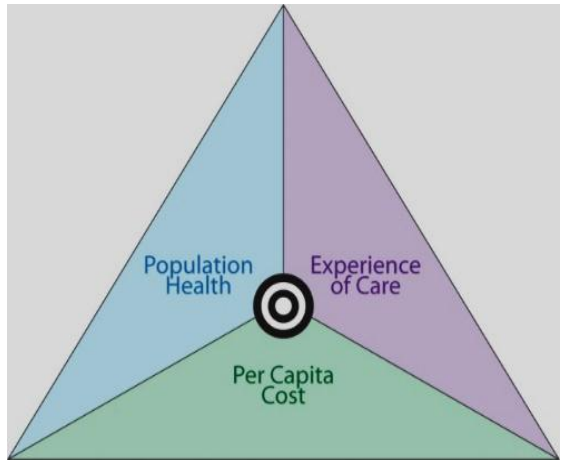


Public Policies – Community/Public Health – Healthcare

Essential in Advancing Health Equity and Optimal Health for All

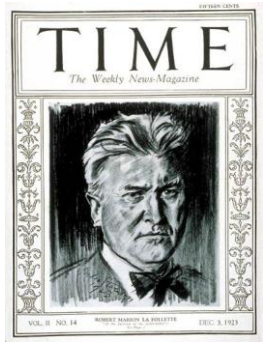






"There never was a higher call to greater service than in this protracted fight for social justice."

Robert M. (Fighting Bob) La Follette, Sr.



Less Talk More Action:

Join the Health Equity Movement

Stephen B. Thomas, Ph.D.
Professor Health Services Administration
Director, Maryland Center for Health Equity
School of Public Health
University of Maryland, College Park

Twitter: #umdhealthequity

Imagine two men, one Black & one White.

They meet at Metro Center in D.C. to go home. Can you predict their life expectancy by where the Metro Stops?

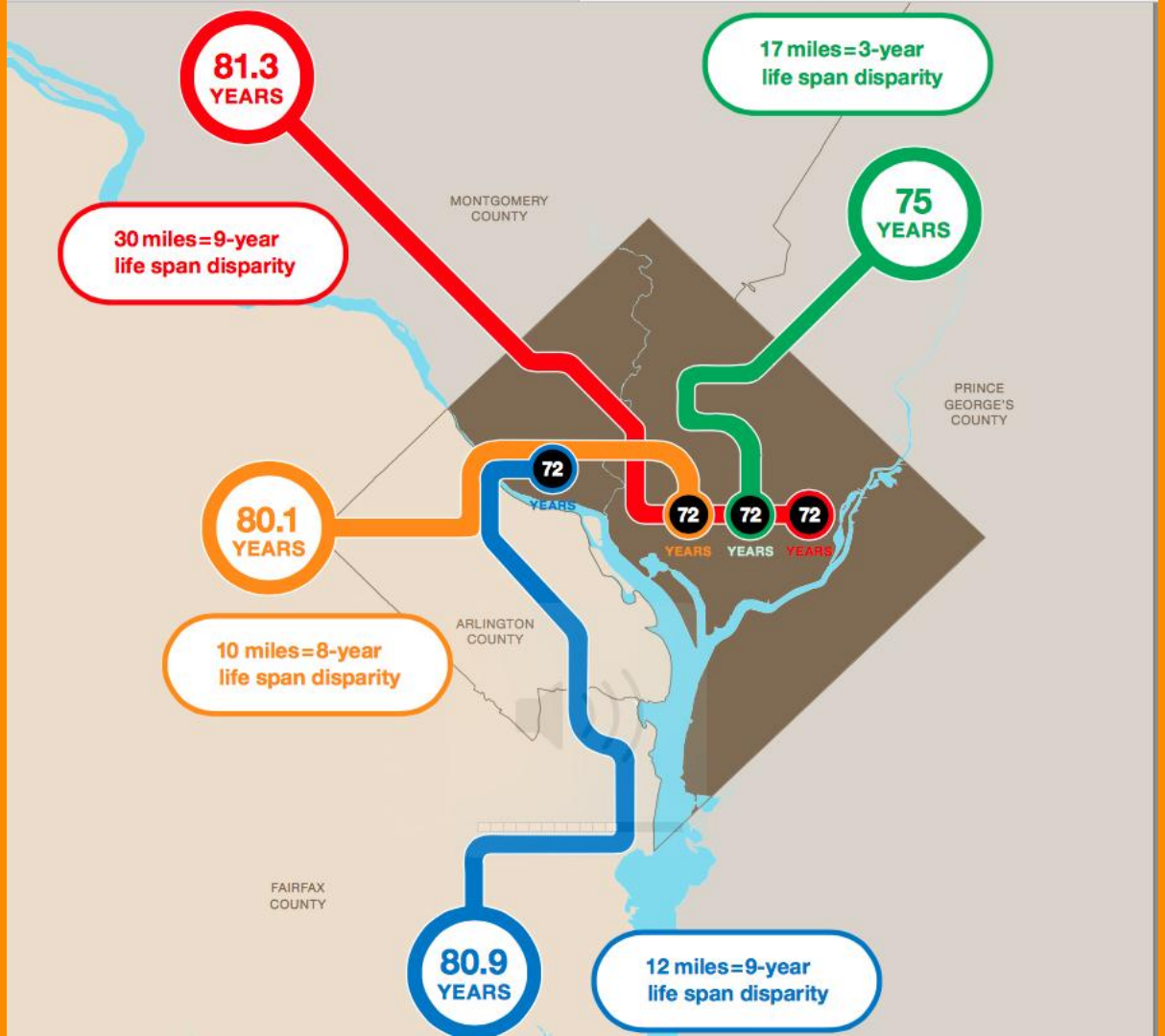
James

John

Meet James & John.

James gets on the **Green** Line.

John gets on the **Red** Line.


81.3 YEARS
17 miles=3-year life span disparity
MONTGOMERY COUNTY
30 miles=9-year life span disparity
75 YEARS
PRINCE GEORGE'S COUNTY
72 YEARS
72 YEARS
72 YEARS
72 YEARS
80.1 YEARS
ARLINGTON COUNTY
10 miles=8-year life span disparity
FAIRFAX COUNTY
80.9 YEARS
12 miles=9-year life span disparity


Social
Determinants
of Health


Social
Determinants
of Health

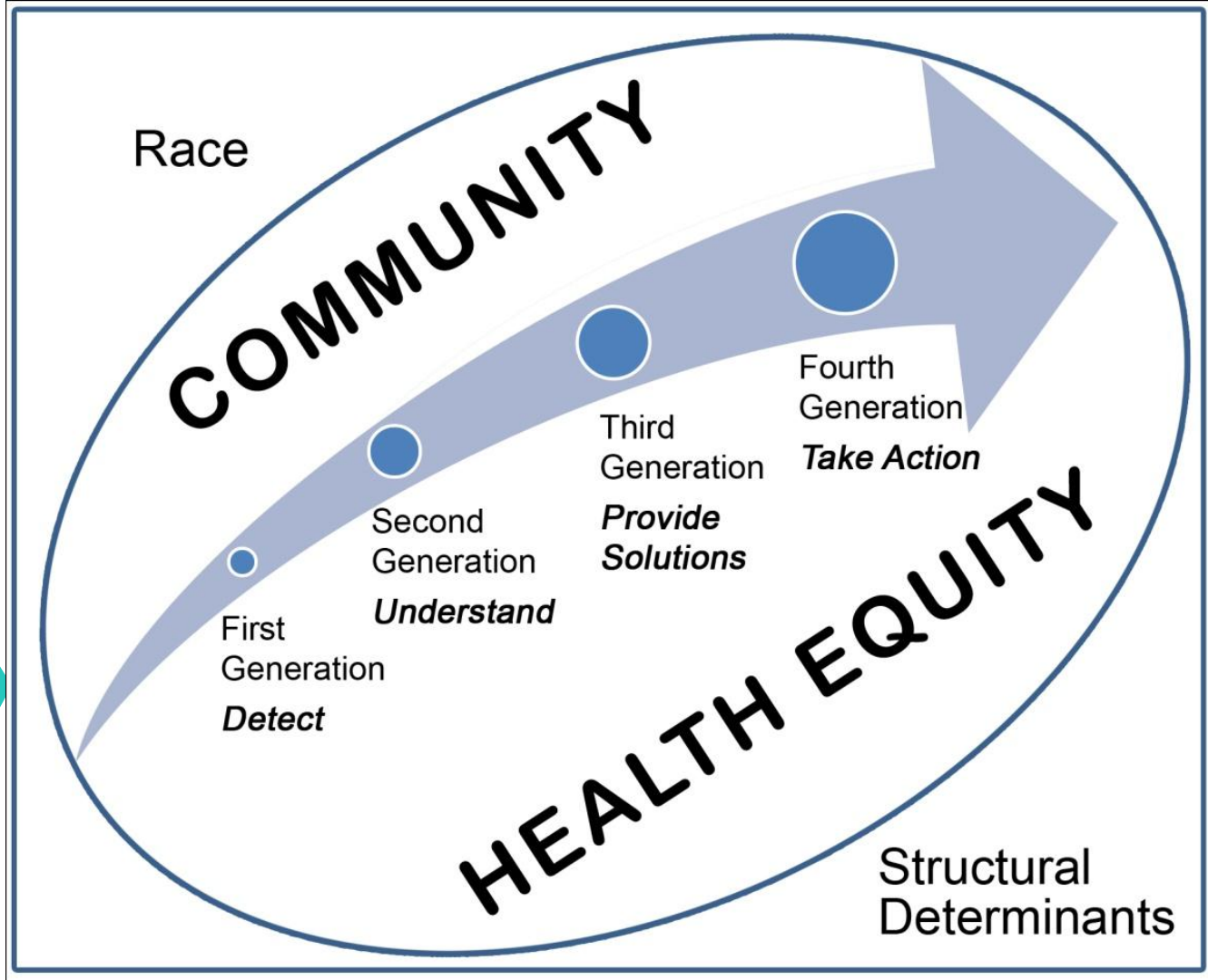

Burdens of
Race and
History

Racial and Ethnic Health Disparities

Join the Health Equity Movement!

The Health Equity Action Research Trajectory:

Toward a 4th Generation Disparities Research Agenda



Innovative Solutions to:

The “Wicked” Problem of Oral Healthcare

Over 1,000 people in line stretching as far as the eye could see

Many providers closed their private practice to volunteer at the 2014 Mid-Maryland Mission of Mercy


Mission Of Mercy
1,185 PEOPLE SERVED
#MissionofMercy
Oral Surgery
WASH

196 total media clips !

66 million impressions

publicity value $52,000

“Why Don't We Treat Teeth Like the Rest of Our Bodies?”

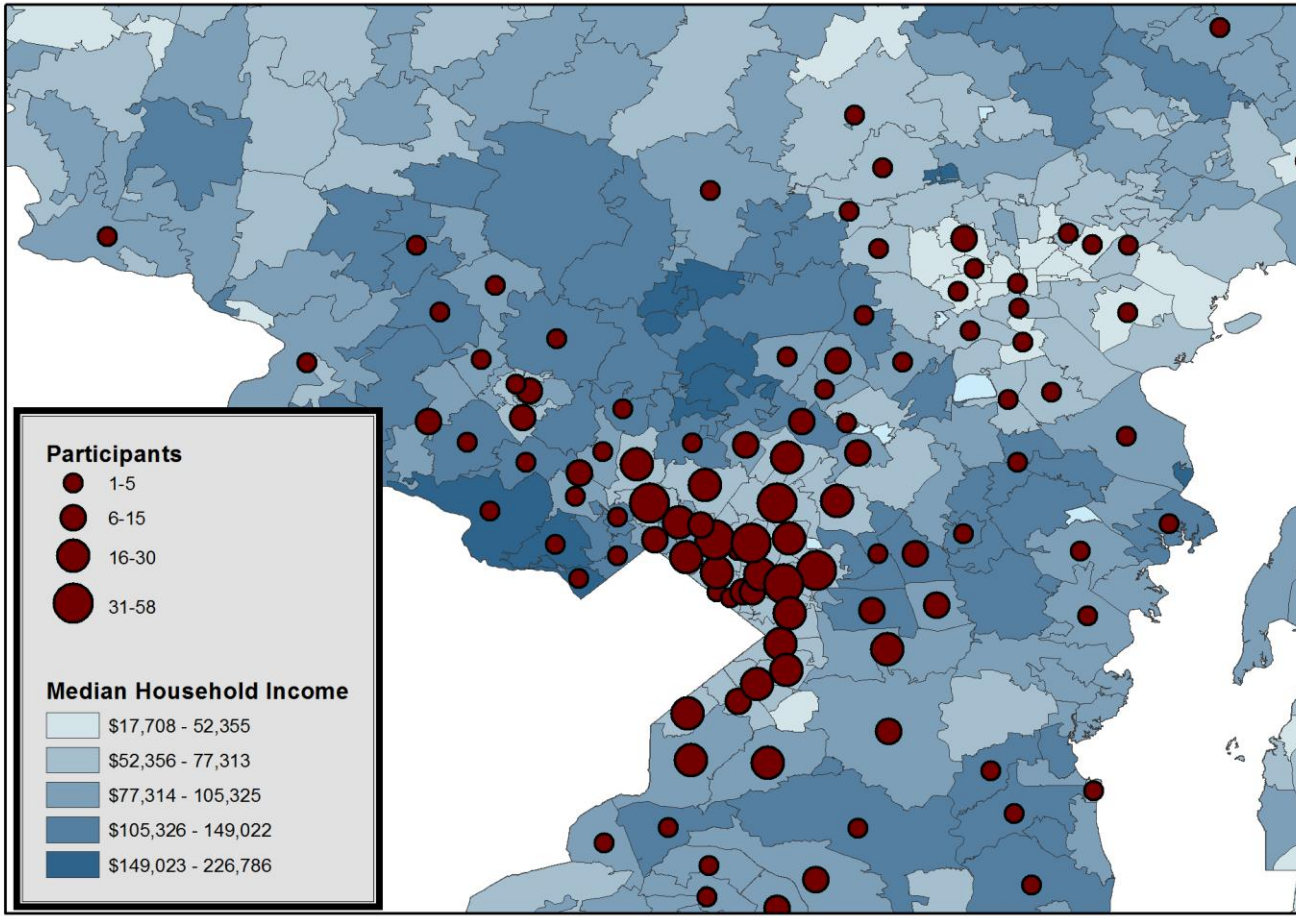
Awareness:

Political and Media Outreach

Education, Religious and Political Leaders

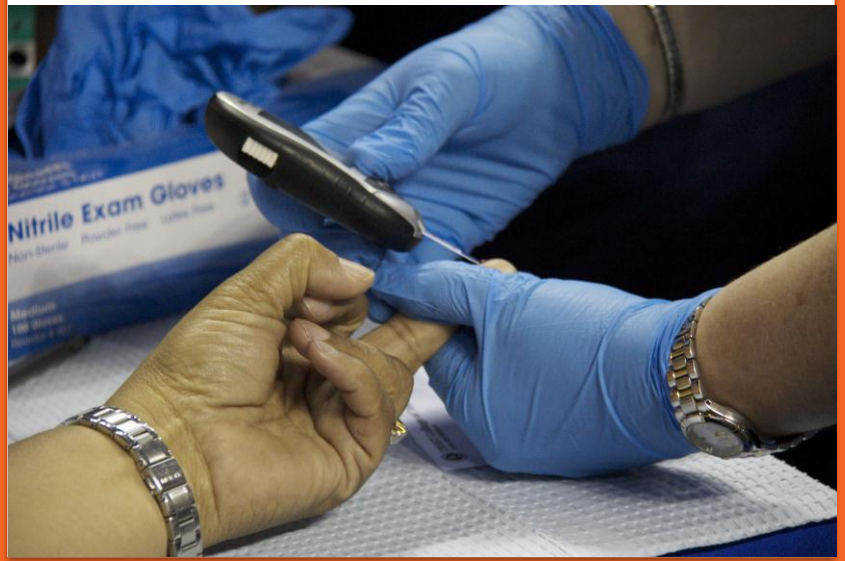
Sirus-XM Satellite Radio
Joe Madison
The Urban View

People Came From Across the Region



Screening

For Chronic Disease



We can help people like James & John together !

Acknowledgements & Funding Support:

NIH National Institute for Minority Health and Health Disparities which supports the Maryland Center for Health Equity as a Center of Excellence on Race, Ethnicity and Health Disparities Research (5P20MD006737, S. Thomas & S. Quinn M-PI);

Special THANK YOU to Tiffany Hu and the UMD Fearless Idea Team Members Steve Chen, Maaz Amjed, Areege Jendi, for creative and technical assistance with PowerPoint theme.

Twitter: #umdhealthequity

Join the Health Equity Movement!

Volunteer

2017 Mission of Mercy

Google = UMD Health Equity

Maryland Office of Minority Health and Health Disparities
13th Annual Health Equity Conference
December 13, 2016

Achieving Health Equity through Community Engagement and Innovative Health Care Delivery

THE CHANGING LANDSCAPE OF HEALTHCARE - HOSPITAL GLOBAL BUDGETS AND COMMUNITY ENGAGEMENT INITIATIVES

Moderator:

Michelle Spencer, MS, Associate Director, Bloomberg American Health Initiative and Associate Scientist, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health

Panelists:

Dianne Feeney, BSN, MS, Associate Director of Quality Initiatives, Health Services Cost Review Commission, Maryland Department of Health and Mental Hygiene

Kendra Thayer, RN, MSN, CDE, Chief Nursing Officer and Vice President of Patient Care Services, Garrett Regional Medical Center

Katherine Harton Talbert, MPA, RN, BSN, Care Management Program Manager, Howard County General Hospital

Jennifer Newman Barnhart, MPH, Director, Population Health Improvement, Maryland Department of Health and Mental Hygiene

Maryland Office of Minority Health and Health Disparities' 13th Annual Health Equity Conference

The Changing Landscape of Healthcare - Hospital Global Budgets and Community Engagement Initiatives

December 13, 2016

HSCRC
Health Services Cost Review Commission

Overview

- The Nation's Evolving Healthcare Landscape: Major Pressures Leading Shift to Value
- Unique Changes in Maryland's Healthcare Delivery System
- Model Progression

The Nation's Evolving Healthcare Landscape: Shifting to Value

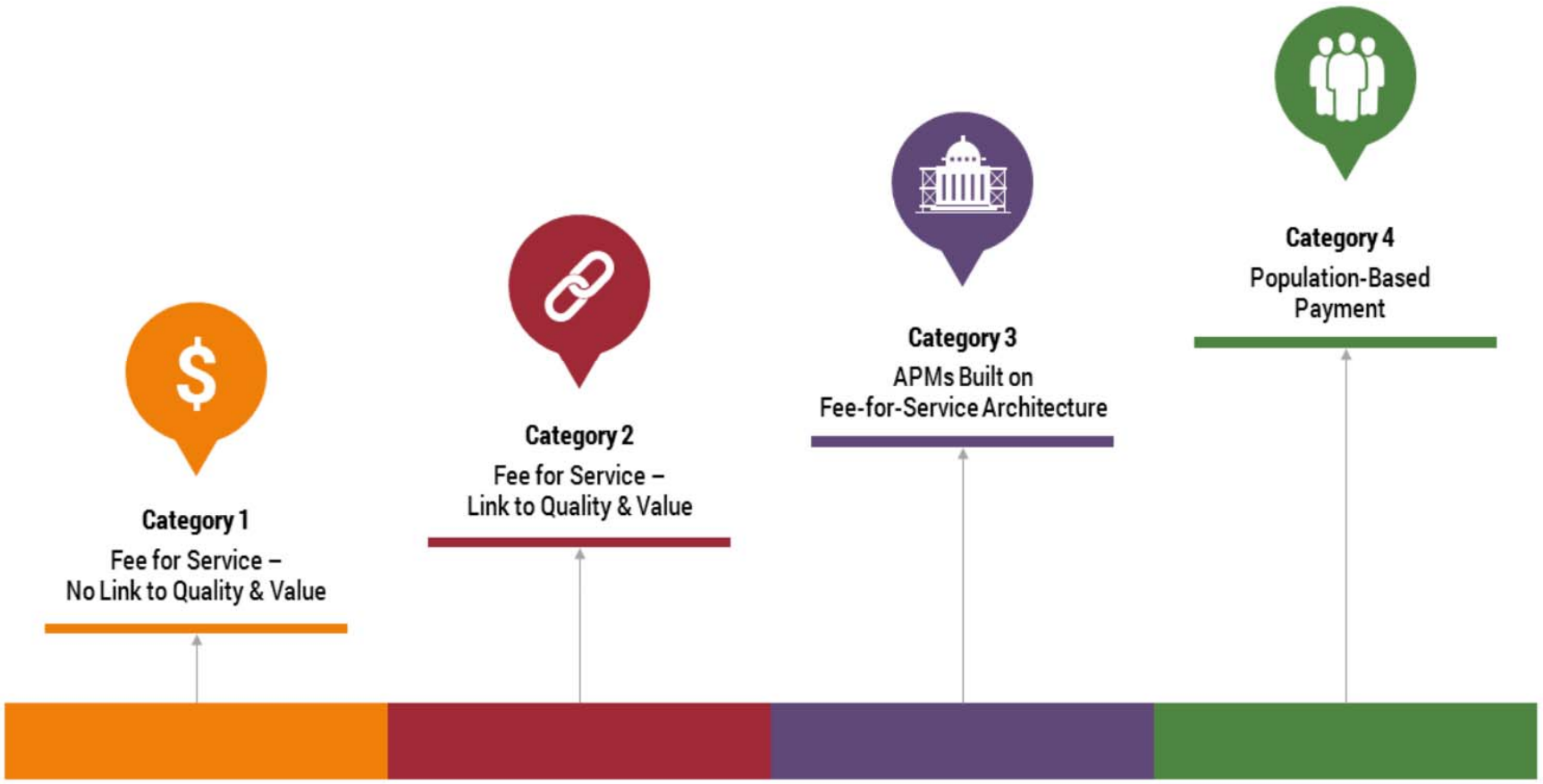
CMS and National Strategy--Change Provider Payment Structures, Delivery of Care and Distribution of Information

Focus Areas	Description
Pay Providers	• Increase linkage of payments to value • Alternative payment models, moving away from payment for volume (MACRA) • Bring proven payment models to scale
Deliver Care	• Encourage integration and coordination of care • Improve population health • Promote patient engagement
Distribute Information	• Create transparency on cost and quality information • Bring electronic health information to the point of care

Source: Summarized from Sylvia Burwell (US Secretary of Health & Human Services) presentation

CMS is Focused on Progression to Alternative Payment Models (APMs)

MACRA is expected to have extensive fee schedule effects on physicians in 2019 based on participation in APMs

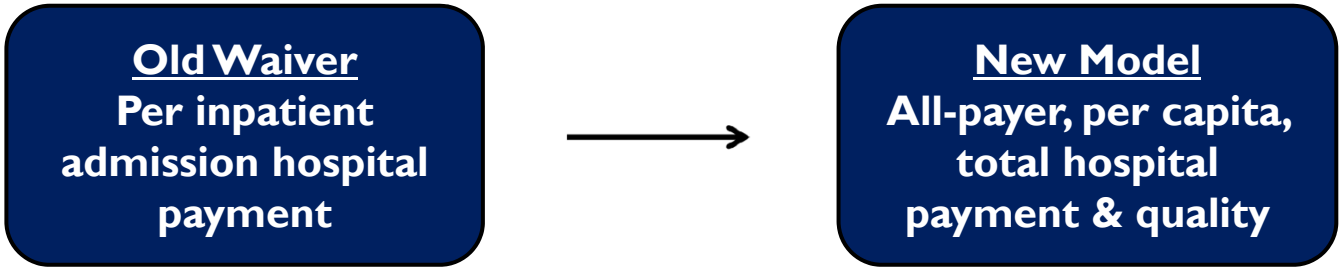


Source: Health Care Payment Learning & Action Network Alternative Payment Model (APM) Framework Final White Paper

Unique Changes in Maryland's Healthcare Delivery System

Unique New Model: Maryland's All-Payer Model

- Maryland is implementing an All-Payer Model for hospital payment
  - Approved by Centers for Medicare & Medicaid Services (CMS) effective January 1, 2014 for 5 years
  - Modernizes Maryland's Medicare waiver and unique all-payer hospital rate system
  - Health Services Cost Review Commission (HSCRC) is leading the effort



- HSCRC back drop:
  - Oversees hospital rate regulation for all payers
  - Rate setting authority extends to all payers, Medicare waiver
    - Granted in 1977 and renewed under a different approach in 2014
  - Provides considerable value
    - Limits cost shifting- all payers share in medical education, uncompensated care, etc.

Year 1 Accomplishments: Global Model Shifts Focus from Volumes

Former Hospital Payment Model: Volume Driven

Units/Cases

× **Rate Per Unit or Case**

↓

Hospital Revenue

- Unknown at the beginning of year
- More units creates more revenue

New Hospital Payment Model: Population and Value Driven

Revenue Base Year

× **Updates for Trend, Population, Value**

↓

Allowed Revenue for Target Year

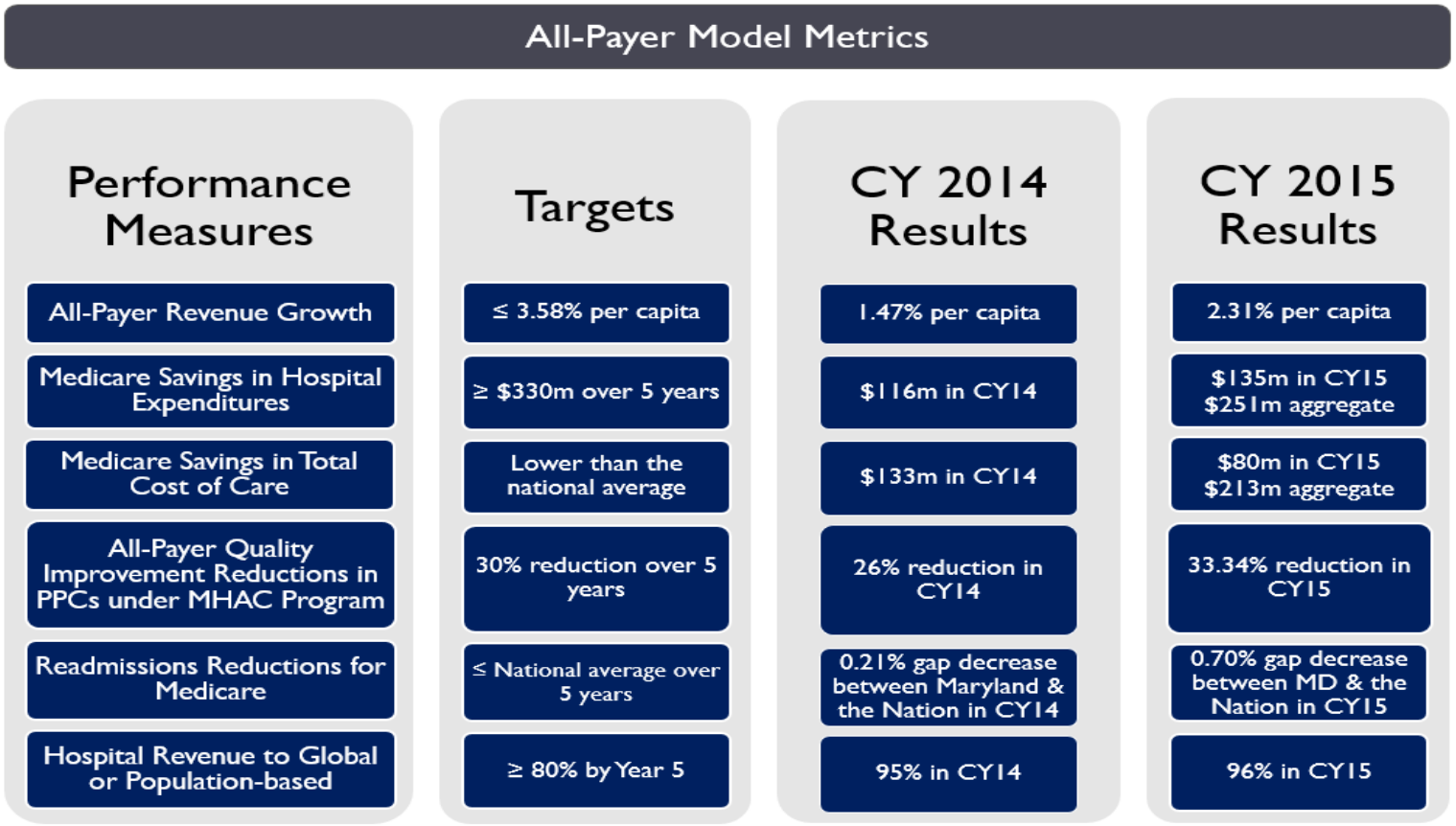
- Known at the beginning of year
- More units does not create more revenue

What do Global Budgets mean

- Hospitals:
  - Incentive to reduce potentially avoidable utilization
    - Readmissions
    - Complications
    - Ambulatory sensitive conditions
  - Prevent new admissions:
    - Spearhead prevention
    - Collaborate with community providers
    - Help to address social determinants
- Payers
  - Reduced utilization
  - Predictability in overall hospital costs
  - Control on growth in hospital charges
  - Consistent with PCMH type programs

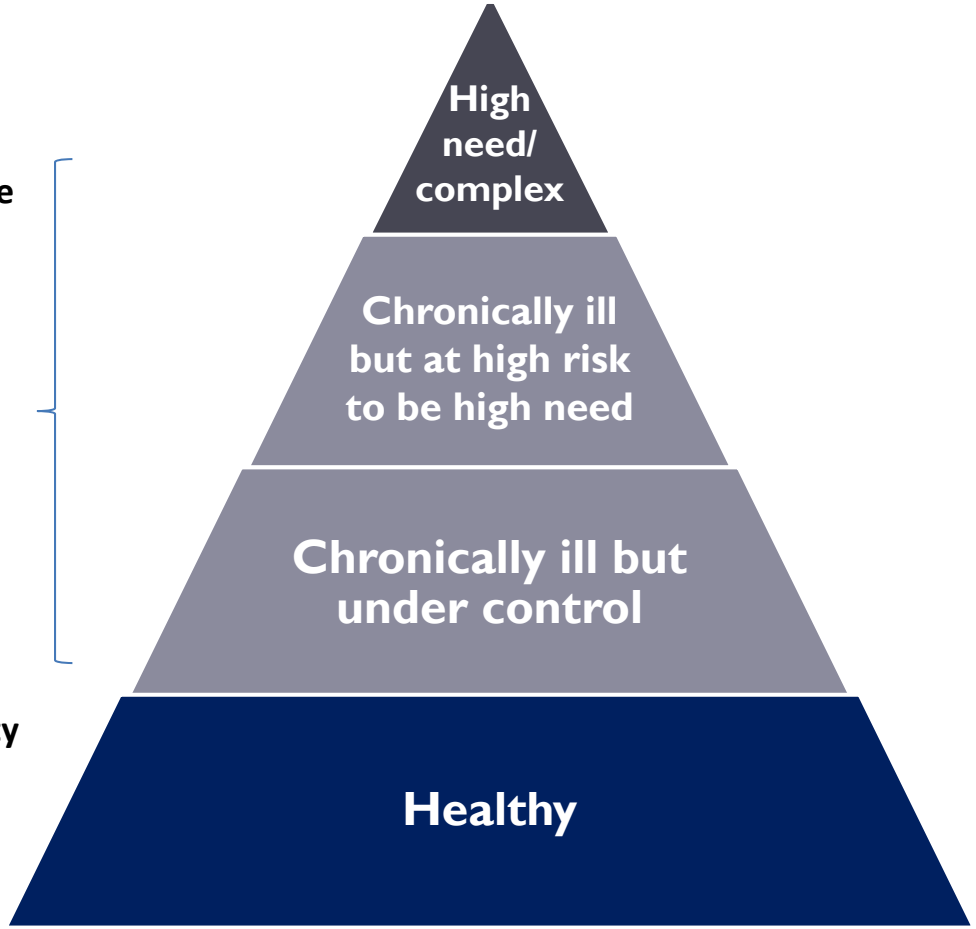
All-Payer Model Performance – CY 2014 and 2015

Maryland Year 1 & Year 2 Performance



Opportunities for Patients—Tailoring Care Delivery to Persons' Needs = Better Outcomes & Quality of Life, Fewer Hospitalizations

Utilizing EHRs, analytics, health information exchange, and care coordination resources to improve care and health.



B

Address modifiable risks and integrate and coordinate care, develop advanced patient-centered medical homes, primary care disease management, public health, and social service supports, and integrated specialty care

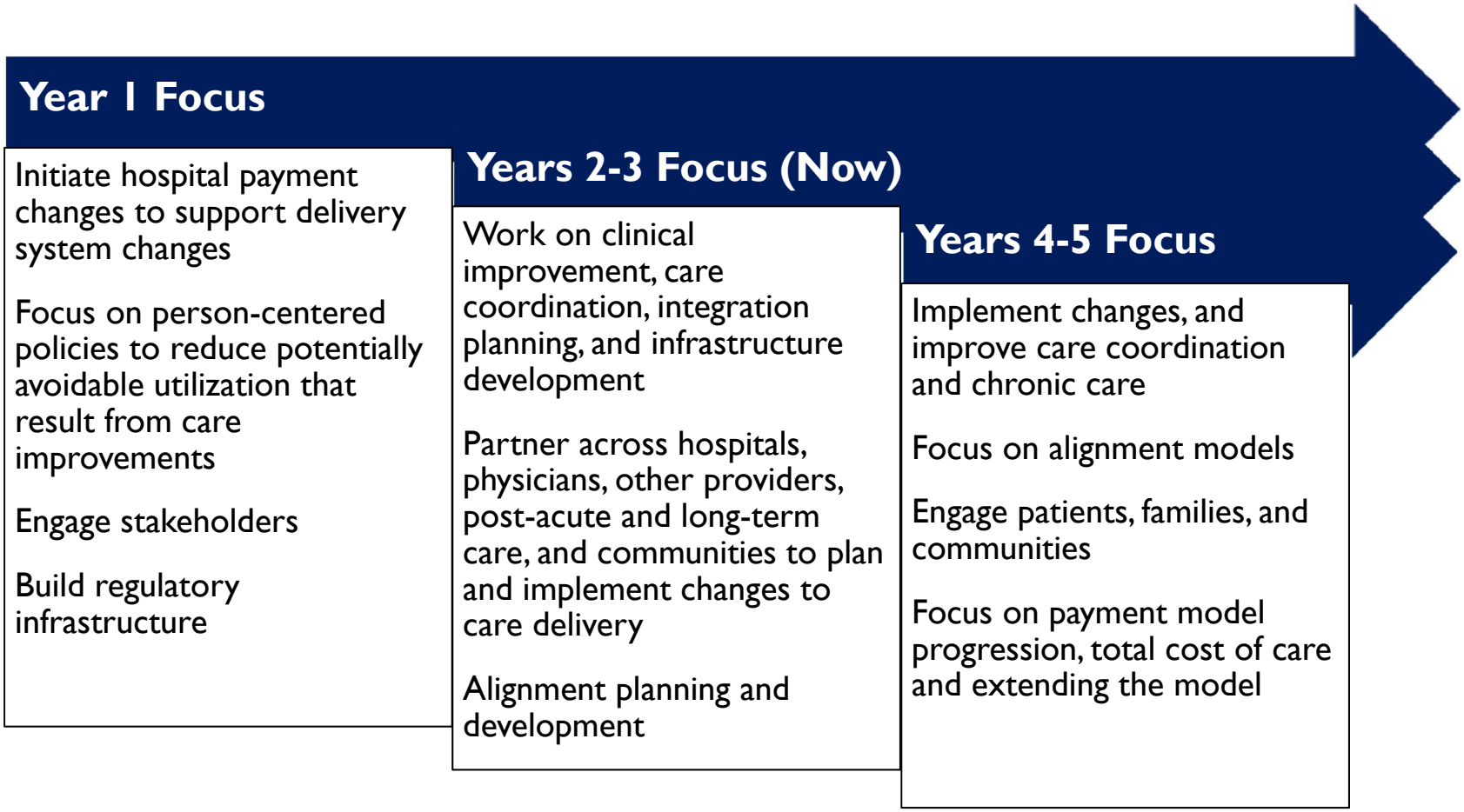
A

Care plans, support services, case management, new models, and other interventions for individuals with significant demands on health care resources

C

Promote and maintain health (e.g. via patient-centered medical homes)

Recap: Strategy for Implementing the All-Payer Model



Maryland's Strategy—Care Coordination for High Needs Patients

- Fully implement care coordination to scale, first for complex and high needs chronically ill patients
  - Organize and engage consumers, primary care, long-term care, and other providers in care coordination and chronic care management
  - Intense focus on Medicare, where models do not exist or are immature in Maryland
  - Build on growing PCMH and ACO models, global budgets and geographic areas, and Medicare Chronic Care Management (CCM) fee
- Develop financial alignment programs across hospitals and other providers, and get data and approvals needed for implementation

Care Redesign in Maryland

- The State of Maryland has proposed Care Redesign component to the All-Payer Model through a Model Amendment
  - Advisory Council, Physician Alignment work group, Care Coordination work group
- Gains the approvals (Safe harbors, Stark, etc.) and data needed to support activities for:
  - Creating greater engagement and outcomes alignment capabilities for providers practicing at hospitals and non-hospital providers
  - Engaging patients and families
  - Care coordination, particularly for patients with high needs
  - Understanding and evaluating system-wide costs of care
- Tools include:
  - Shared care coordination resources
  - Medicare data
  - Financial incentive programs for providers

Next Steps

Next Steps: Amendment and Model Extension

- Focus on gaining approvals from CMS
  - Awaiting Amendment approval – in process with CMS/CMMI
  - Provide TCOC data for providers
- Developed Model extension concepts with stakeholder input
- Submit plan hat expands focus on total cost of care (due at the end of 2016 for implementation in 2019 and beyond)
  - Best approach is to focus on care redesign to reduce avoidable hospitalization costs
  - Alignment of incentives across multiple settings
  - Maryland will not propose rate-setting for other providers

How Might All-Payer Model Developments Impact Patients and Providers?

- Improved data infrastructure/exchange/tools for care management, care coordination, and community health
- Increased focus on interoperability and connection with CRISP
- Increased collaboration and coordination among providers based on patient needs
- Increased programmatic efforts by hospitals and other providers to reduce potentially avoidable utilizations (PAUs)
- Increased focus on factors affecting patients in their homes (e.g. medication reconciliation, nutrition, transportation)
- Increased opportunities for shared savings arrangements, outcomes-based payment, and other incentives when care is improved and avoidable utilization is decreased

Opportunities for Patients and Physicians in Maryland

Get Connected

- Utilize CRISP encounter alerts, common care histories, and other care management tools
  - Address gaps in patients' health

Get Coordinated

- Coordinate your patients' care with other providers across clinical and community settings
- Work with case managers to address the medical and social needs of complex patients

Participate

- Use data and information to help improve outcomes and lower costs
- Join Accountable Care Organizations, medical homes, geographic initiatives, etc.
- Get involved in outcomes-based payment programs, etc.

Be Proactive

- Be a watchdog
- Contribute to the redesign of the state's healthcare delivery system

Thank you for the opportunity to work together to improve care and health.

Garrett Regional Medical Center

Population Health Workforce Support for Disadvantaged Areas
Peer Navigation Program

Demographics

- Garrett Regional Medical Center(GRMC) is the only medical center in our county.
- GRMC is a Medically Underserved Area (MUA).
- 45% of all county residents live at or below 200% of federal poverty guidelines.
- Very rural area with a population of 30,150 residents and limited transportation services.
- GRMC is the second largest employer in the county.
- High rates of chronic disease conditions including cancer, heart disease, diabetes, and lung disease.

Well Patient Program

- Program established to provide care coordination and navigation services for patients who require more intensive services and assistance.
- Program assists with setting up appointments, transportation, access to community resources, and help with social or living situations.
- Effort to decrease unnecessary visits to the Emergency Department or hospital if care could be provided in other settings such as with PCP or other agency.
- Use of peer navigators who are also living with a chronic condition and can help others navigate the health care system.

Peer Navigators

- Peer navigators were selected from various programs at our facility who have benefited from care coordination to effectively manage their disease condition.
- The Peer Navigators are enrolled in the Community Health Care Worker curriculum at Garrett College and will receive certification as a Community Health Care Worker.
- The Peer Navigators are employees of the Medical Center and work with our nurse navigators/Social Workers to manage the daily needs of participants in the Well Patient Program.

Program Benefits

- Improved health status for those living with chronic disease as they have assistance to manage their condition.
- Care being provided in the appropriate care settings versus utilization of the hospital as the primary source of care.
- Decreased ED utilization and hospital readmissions as participants will have access to the navigators every day to answer questions or arrange appointments.
- Program aligns with the HSCRC's population health initiative, care coordination, and managing health care needs within the global budget.
- Gainful employment opportunity for those who need a stable income or benefits.

Successes

- Physician support of the program as they see this as an adjunctive service to them from the medical center.
- Collaboration among community agencies as we work with them to link patients to needed services. Community engagement with the hospital has grown through this program.
- Qualified applicants have been hired and are in the training program.
- Appropriate utilization of our outpatient services such as cardiac and pulmonary rehabilitation, diabetes clinic, infusion center, and wound care center.

Kendra Thayer RN, MSN, CDE
Chief Nursing Officer
VP Patient Care Services
Garrett Regional Medical Center

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HOWARD COUNTY GENERAL HOSPITAL

JOHNS HOPKINS MEDICINE

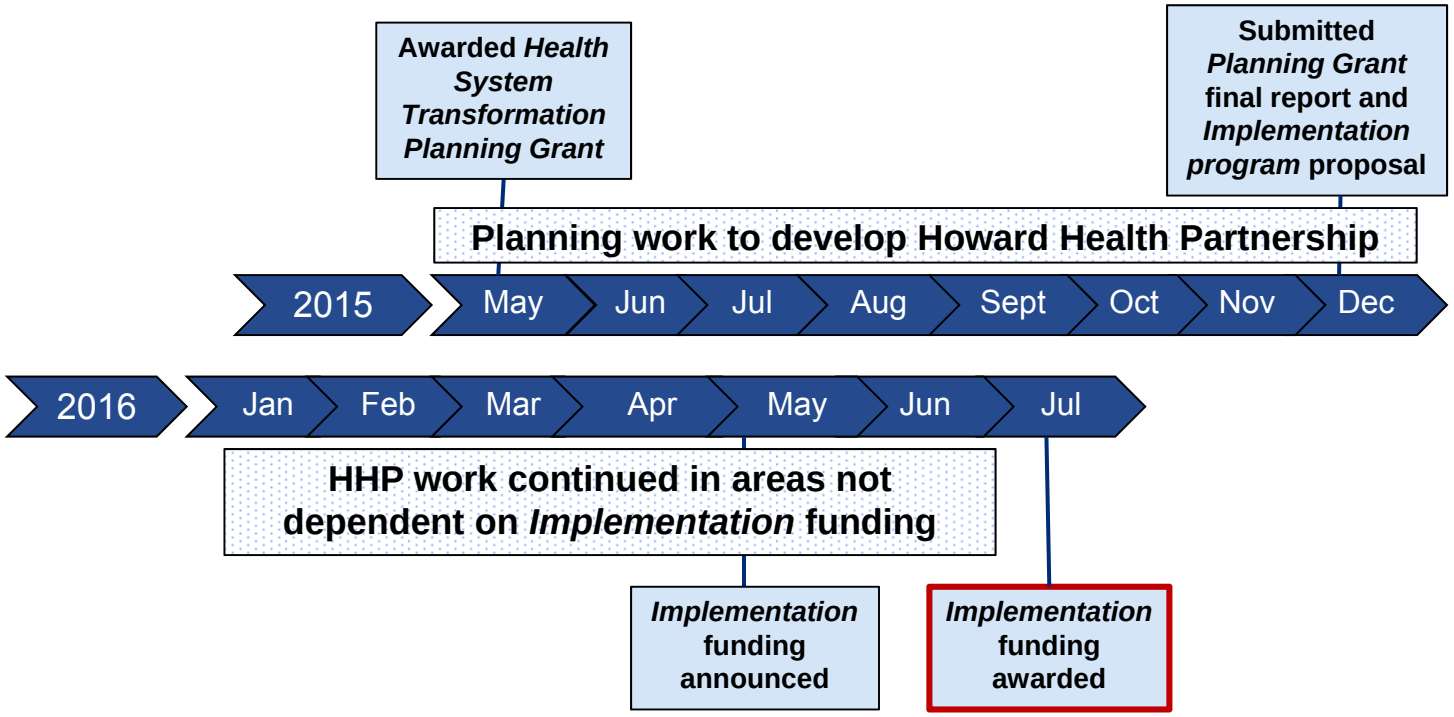
Howard Health Partnership (HHP) - Overview

Vision for Transformation

HOWARD COUNTY GENERAL HOSPITAL
JOHNS HOPKINS MEDICINE

- HSCRC provided competitive grant funding for hospitals to establish Regional Partnerships to manage health of a defined community (initial focus on Medicare)
- Realize the "Triple Aim"
  1. Improve the health of the population;
  2. Enhance the patient experience of care;
  3. Reduce the per capita cost of care.
- Focus on multidisciplinary care teams, coordination across settings, patient-centered care

HHP Timeline Recap



HHP Mission

To deliver an effective, community-based & financially sustainable model of care that improves health, achieves cost savings & offers an enhanced patient experience for our target population.

HHP Target Population

HOWARD COUNTY GENERAL HOSPITAL
JOHNS HOPKINS MEDICINE

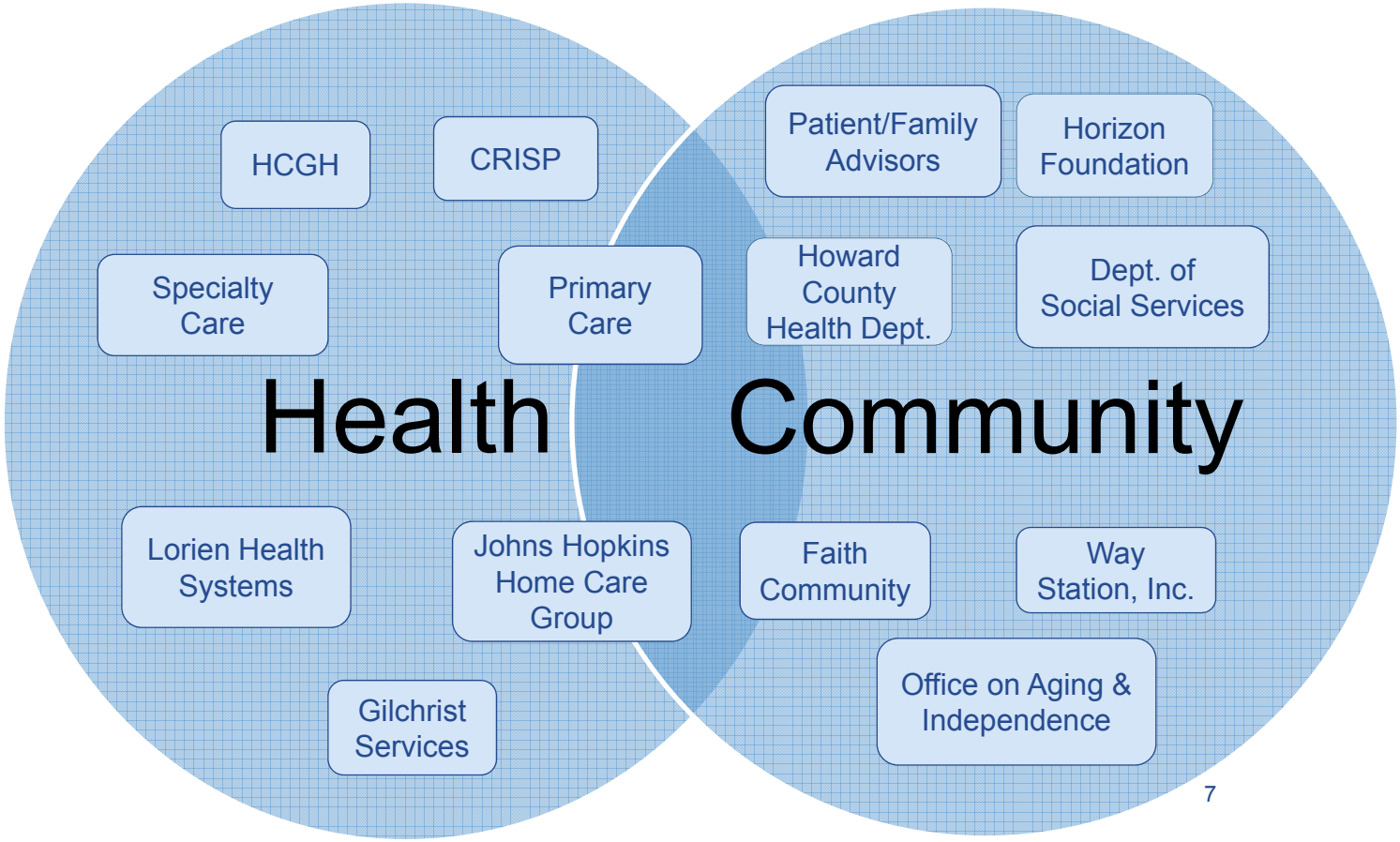
- Howard County Resident, ≥ 18 yrs
- Medicare or dual eligible
- At least 2 HCGH encounters in past 365 days (inpatient, observation or ED visit)

Initial focus on high utilizers. Population health improvement is long term goal.

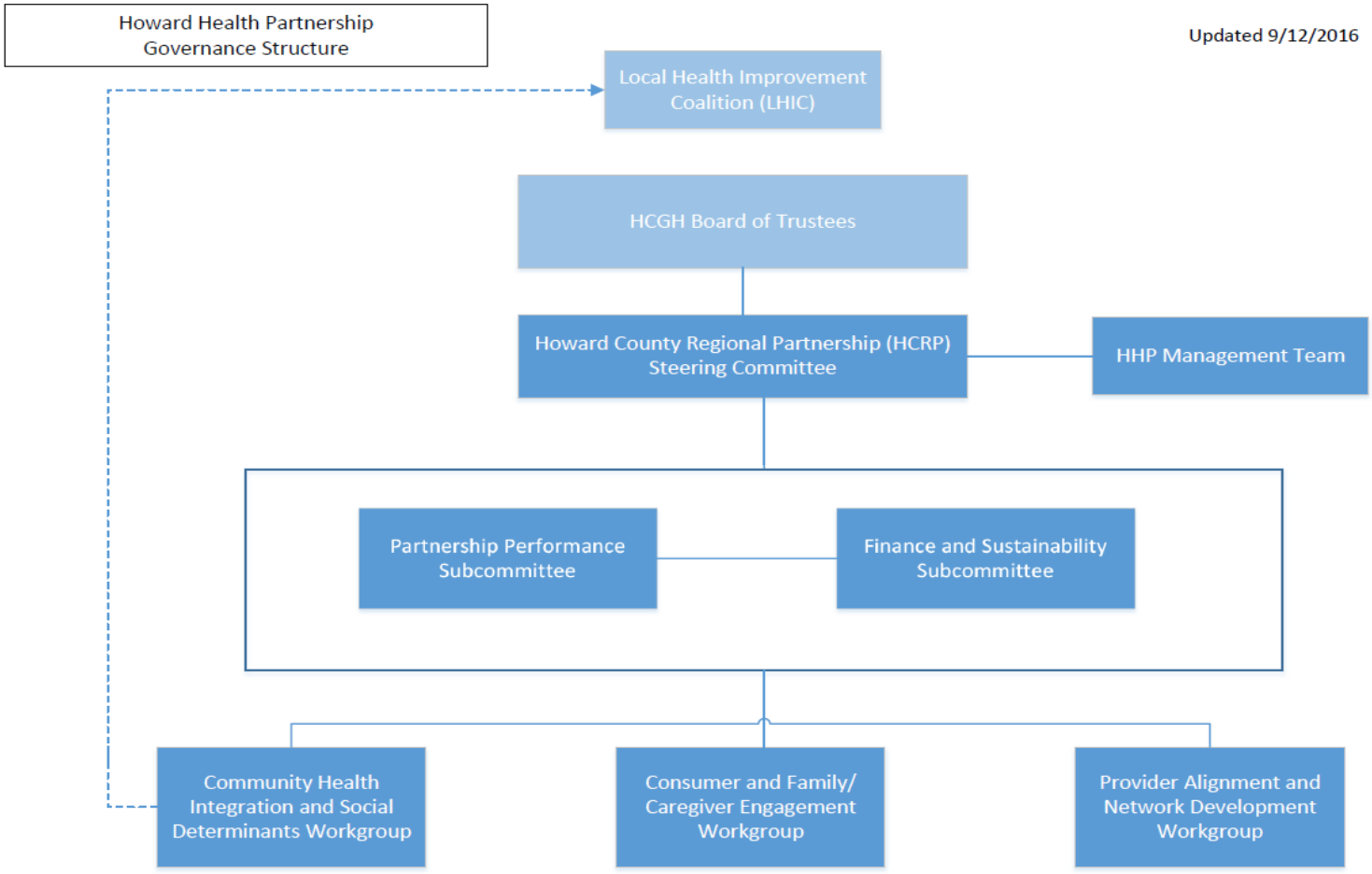
HHP Target Population (cont)

- Clustered in 5 zips: 21044, 21045, 21043, 21042 and 21075
- 80% are ≥ 65yrs + (51% are ≥ 80yrs)
- 66% have multiple chronic conditions
- 42% of visits are for chronic issues or conditions that could be managed outside of a hospital
- 54% have behavioral health condition listed on at least one encounter

HHP Partners



HHP Governance Structure



HHP Interventions

Complex Care Management	• **Community Care Team** • Support Our Elders *(Gilchrist Hospice Care)* • Remote Patient Monitoring *(Johns Hopkins Home Care Group)*
Seamless Care Transitions	• ED and PCP embedded Community Health Workers • Skilled Nursing Facility Collaborative *(Lorien Health Systems)* • Rapid Access Program for Behavioral Health *(Way Station, Inc.)* • Transitions & Care Choices programs *(Gilchrist Hospice Care)*
Self Management Supports	• Journey to Better Health • Powerful Tools for Caregivers *(Howard County Office on Aging & Independence)* • CAREApp *(Howard County Health Department)*

Community Care Team

HOWARD COUNTY GENERAL HOSPITAL
JOHNS HOPKINS MEDICINE

CCT empowers patients to better manage their chronic conditions outside of the hospital.

Program Objectives:

1. Determine and address social barriers to achieving good health outcomes.
2. Encourage the utilization of medical homes and community resources.
3. Produce overall cost savings by reducing preventable hospitalizations and ER visits.

Community Care Team (CCT)

HOWARD COUNTY GENERAL HOSPITAL
JOHNS HOPKINS MEDICINE

- Multidisciplinary team: Community Health Nurse (CHN), Community Health Worker (CHW), Licensed Clinical Social Worker (LCSW)
- Patients referred from acute care, ED, SNF, Primary Care, home care and community organizations
- Post-discharge: 30-90 day intervention with frequent home visits and telephone contact
- Connects patient to primary, behavioral and specialty care; coordinates with home care
- Focus on social determinants of health: transportation, housing, food, community services, social isolation

CHANGING
Maryland
for the Better

Maryland Comprehensive Primary Care Model

Minority Health and Health Disparities

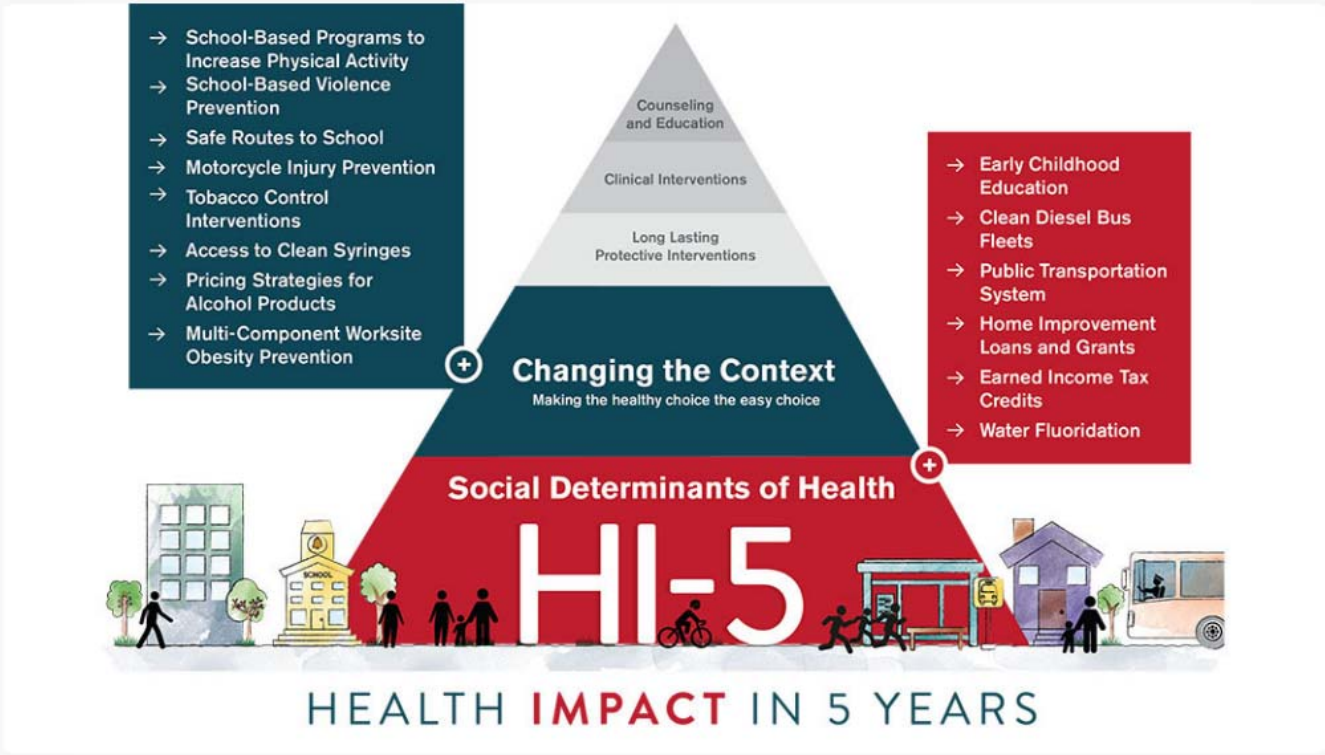
13th Annual Health Equity Conference

Jennifer Newman Barnhart, MPH
Director, Office of Population Health Improvement
Public Health Services
Department of Health and Mental Hygiene

December 13, 2016

Triple Aim of Health Equity: Population Health and Primary Care

Figure 4 | Health Impact in 5 Years



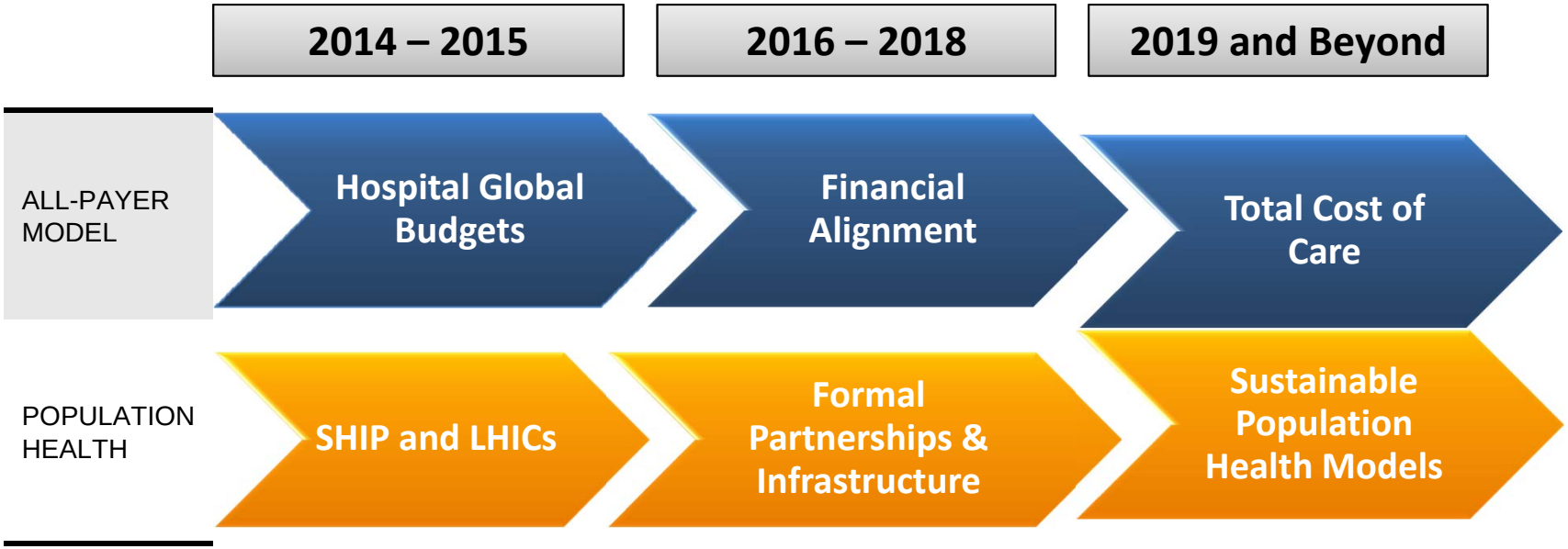
Source: U.S. Centers for Disease Control and Prevention, Health Impact in Five Years. http://www.cdc.gov/hi5

Goals of Primary Care Model

- **Improve the health of Maryland through:**
  - Person-centric healthcare
  - Team-based support
  - Evidence-based approach
  - Consistent quality and outcome metrics
  - Volume to Value
  - Reduce potentially avoidable utilization
  - Improve management of chronic illness
  - Alignment with Maryland All-Payer Model and Medicaid Duals ACO
  - Alignment with State Population Health Improvement Plan (due to CMMI: 12/31/2016)
- **Timeline:**
  - 12/31/2016: Submit Primary Care Model concept paper to CMMI
  - January / February 2017: Clearance process
  - 2017: Enhanced Infrastructure development begins:
    - Coordinating Entity
    - Care Transformation Organization / applications
    - Practice adoption/technical assistance
    - HIE Expansion, more primary care providers achieve connectivity
  - 2019 – 2023: Total Cost of Care

Sustainability achieved through long term Return on Investment

Transformation Progression



Dec 31, 2016

Submit designs of:
- Primary Care Model
- State Population Health Plan
- All Payer Model Progression Plan
- Duals ACO

2017

- All Payer Model Amendment, Population Health Plan – Design
- Primary Care Model – infrastructure development

2018

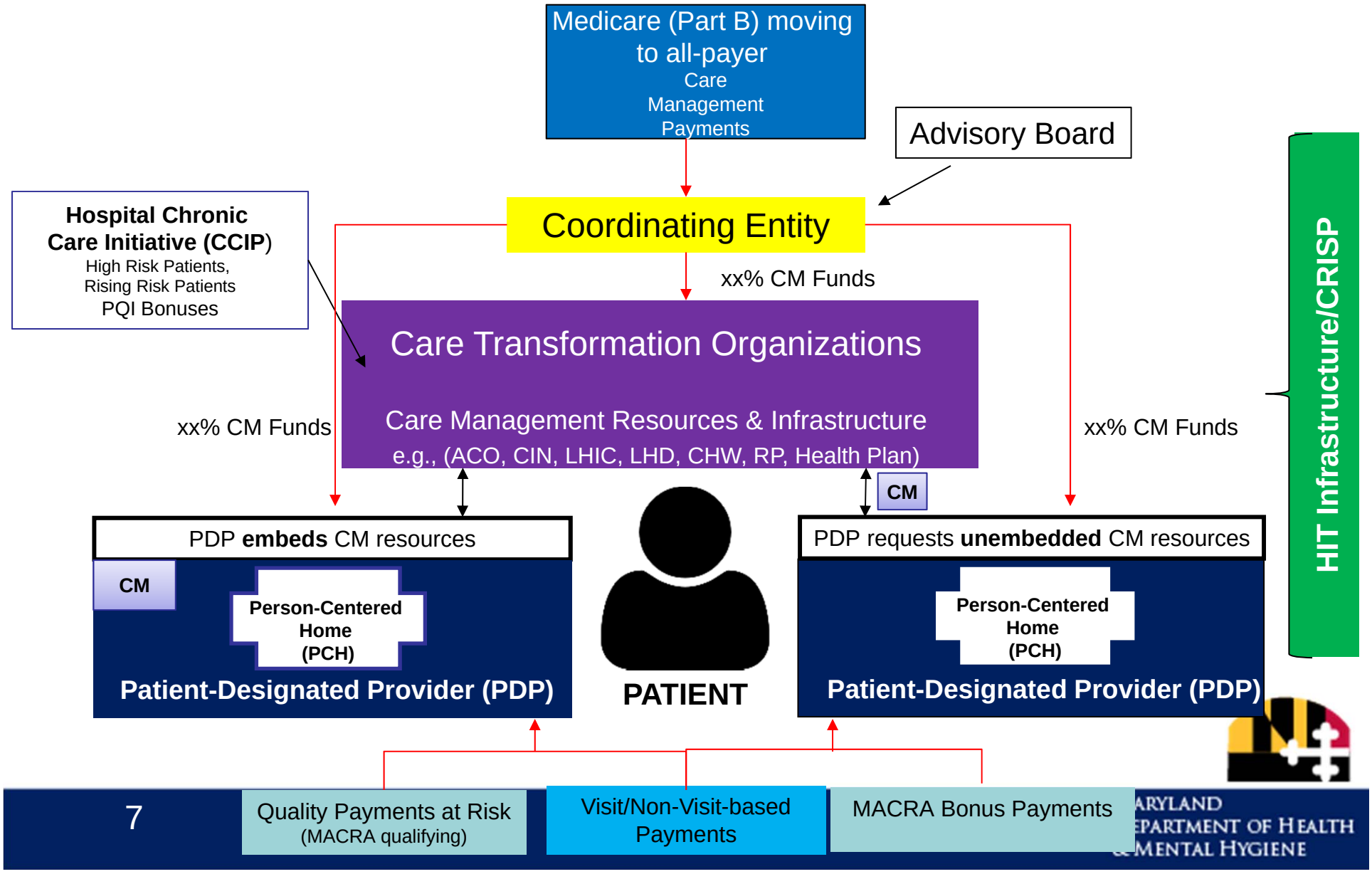
- Primary Care Model – Year 1 Operation
- Additional Population Health Plan and VBP - Planning

Relationship to All-Payer Model and Progression Plan

- The Primary Care Model will help sustain the early gains of the All-Payer Model as targets becoming increasingly reliant on factors beyond the hospital
  - Aligns incentives; important to design in a way that ensures hospitals are not responsible for risks they cannot control
- Complements the Care Redesign Amendment
  - Community-level alignment to CCIP
- Reduces avoidable hospitalizations and ED usage through advanced primary care access and prevention
  - Components include embedded care managers, 24/7 access to advice, medication mgt., open-access scheduling, behavioral health integration, and social services
- Enhanced version of CPC+ will complement and support hospital global budgets

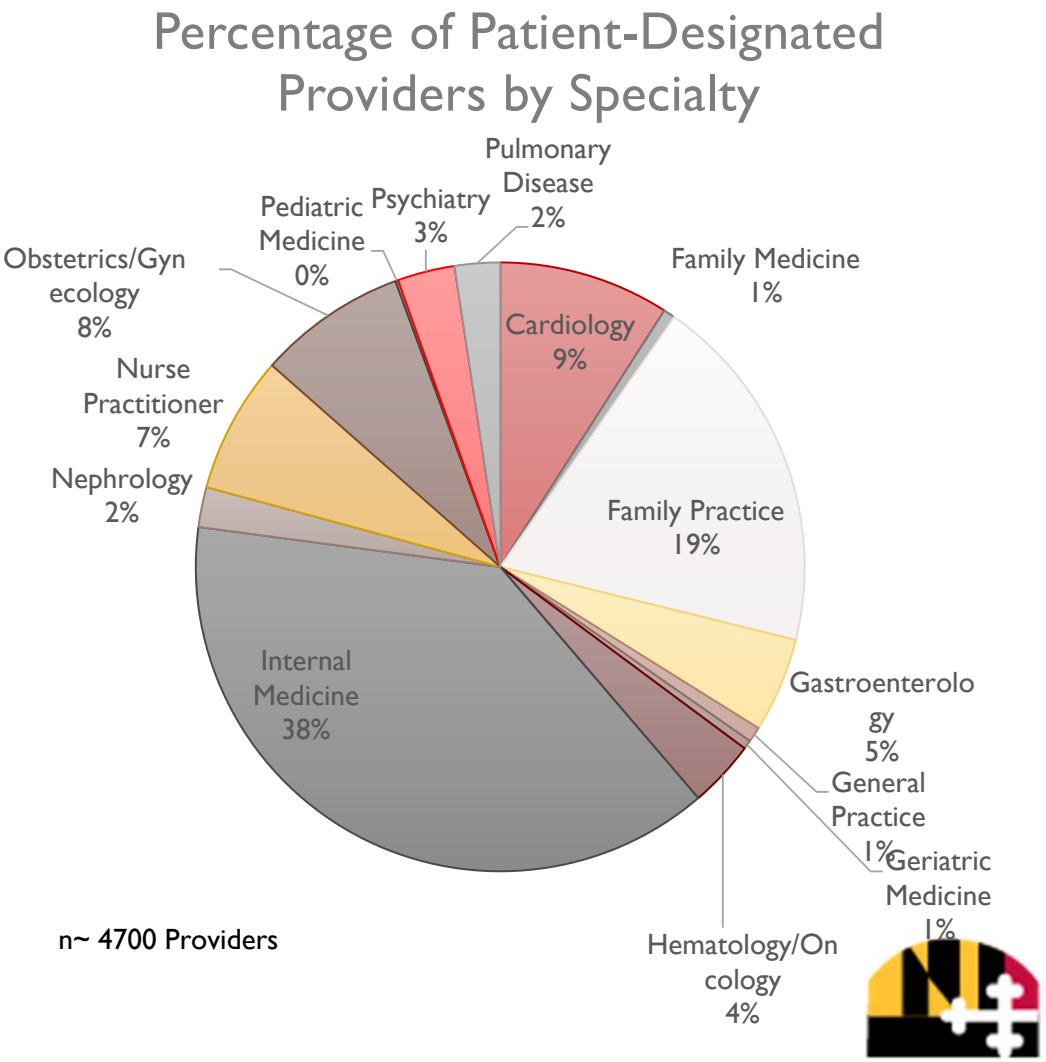
OVERVIEW OF PRIMARY CARE MODEL

Maryland Primary Care Model



Patient Designated Providers

- Patient Designated Providers (PDPs)
  - The most appropriate provider to manage the care of each patient
  - Provides preventive services
  - Coordinates care across the care continuum
  - Ensures enhanced access
  - Most often this is a PCP but may also be a specialist, behavioral health provider, or other depending on patients health needs



Person Centered Home

- Person-Centered Home (PCH)
  - An individual provider or group of providers that deliver care as a team to a panel of patients
  - The PCH must have at least one PDP
  - PCH practices must meet the requirements laid out by the Model – CPC+ like
  - Practices may span multiple physical sites in the community

Practice Transformation is Key

- Practices will **NOT** be expected to be transformed on day 1 or program start
- The State is designing a system to provide support for practice transformation:
  - Care Transformation Organizations (CTOs) will be approved to assist practices
  - Practices will choose the best CTO for them (*not required*)
  - CTOs will ensure that practices meet requirements under program by developing high functioning services including:
    - Care management resources and people
    - Technical assistance on practice transformation
    - HIE supports (CTO and CRISP)

The Role of Care Managers

- Care managers will work very closely with physicians, NPs, PAs, and other members of a primary care team
- They will assist the clinicians, patients, and family members in the development and implementation of Care Plans tailored to each patient's needs
- Care managers will arrange for services such as transportation, nutrition, and help smooth transitions of care
- Care managers are embedded in PDP practices; an alternative approach for the deployment of care managers to practices on an as-needed basis.

I am a Patient: What does a transformed practice look like to me?

- I am a Medicare beneficiary
- Provider selection by my historical preference
- I have a team caring for me led by my Doctor
- My practice has expanded office hours
- I can take advantage of open access and flexible scheduling:
  - Telemedicine, group visits, home visits
- My care team knows me and speaks my language
- My records are available to all of my providers
- I get alerts from care team for important issues
- My Care Managers help smooth transitions of care
- I get medication support and as much information as I need
- I can get community and social support linkages (e.g., transportation, safe housing)

I am a Provider: What does a transformed practice look like to me?

- Voluntary participation
- Able to spend more time with patients
- Patient care management support based on severity index
- Care managers embedded in my practice and part of my care team
- Practice incentives:
  - 5% MACRA participation bonus (lump sum); CPC+ participation
  - Quality and Utilization incentive bonus $2.50 or $4 PBPM (Track 1, Track 2, respectively) – Prepaid
  - Track 2 comprehensive payment – Prepaid
  - Care Management payment PBPM risk adjusted
  - Care management infrastructure
  - Practice transformation support
  - Healthier patient population
  - Reimbursement for non-office based visits

How do I become a Care Transformation Organization?

- Certification by external accrediting body
- Apply through Coordinating Entity (CE)
  - CE holds CTO accountable for requirements and outcomes
- Ability to provide following services includes:
  - Care management infrastructure
    - Nurses, pharmacists, nutritionists, Community Health Workers, LCSWs, Health educators
  - Technical assistance for 24/7 after-hours access
  - Social support connections – Community Health Workers
  - "Hot-spotting" areas with high and/or specific needs
  - Pharmacist support for medication management and consultations
  - Assisting practices in meeting Primary Care Model requirements
  - Physician training resources
  - CRISP connectivity

Next Steps

- Public Comment Period: December 1 through December 14th
- dhmh.pcmodel@maryland.gov
- December 15 – December 20th: Concept paper revision and stakeholder acknowledgement
- December 31st: Concept paper submission to CMMI
- 2017 is intended to be a transition year with model development and building the infrastructure of the CE, CTOs
- The plan is to fully "stand up," implement the Model in 2018