FAMILY MEDICINE DEPARTMENTS AS CORE MEMBERS OF PARTNERSHIPS FOR HEALTH AND HEALTH EQUITY

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PI, The Practical Playbook

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Nothing To Disclose

Goals

- Clarify language around ”social determinants”
- Share work underway in communities across the US
- Discuss federal efforts to support community coalitions for health
- Outline steps FM Departments can take to productively engage in local partnerships for health and health equity

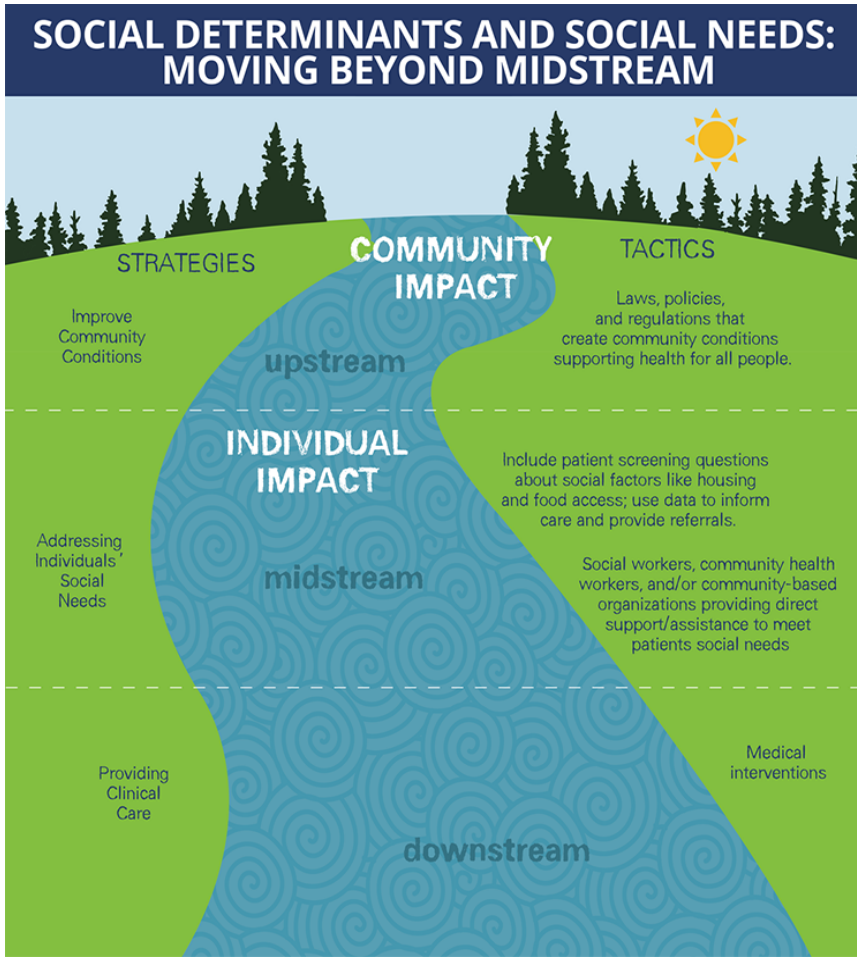
The language around social determinants of health is evolving

Social needs are social conditions of individuals that help determine if and how they become ill.
A homeless person needs housing.

Drivers are upstream community factors that influence health.
Food deserts and absence of parks drive obesity rates.

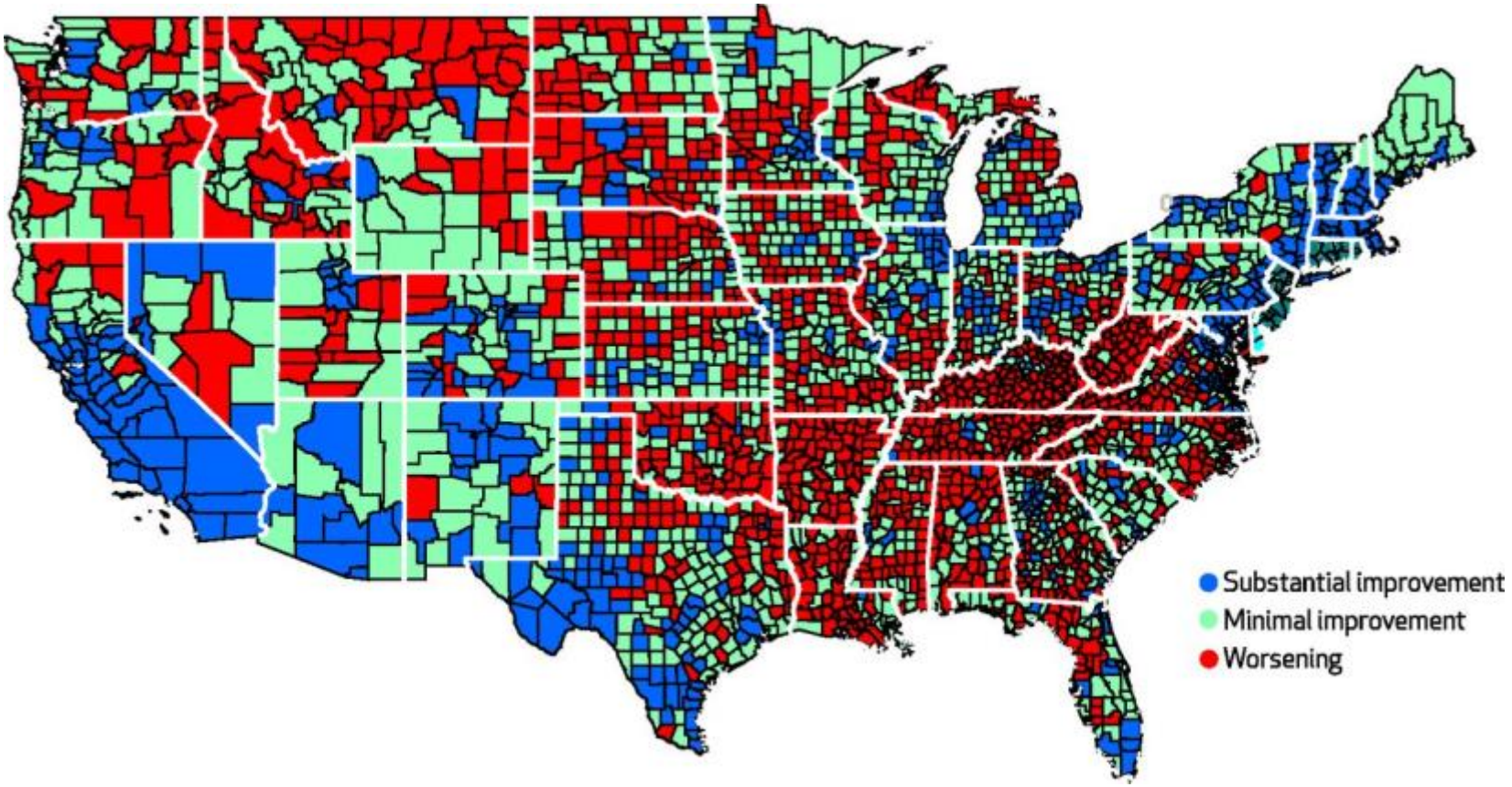
Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health
Brian C. Castrucci John Auerbach
HEALTH AFFAIRS JANUARY 16, 2019

"**Vital Conditions**" is preferred terminology



Actionable Data is Increasingly Available

Change In Female Mortality Rates From 1992–96 To 2002–06 In US Counties.



Kindig D A , and Cheng E R Health Aff 2013;32:451-458

HealthAffairs

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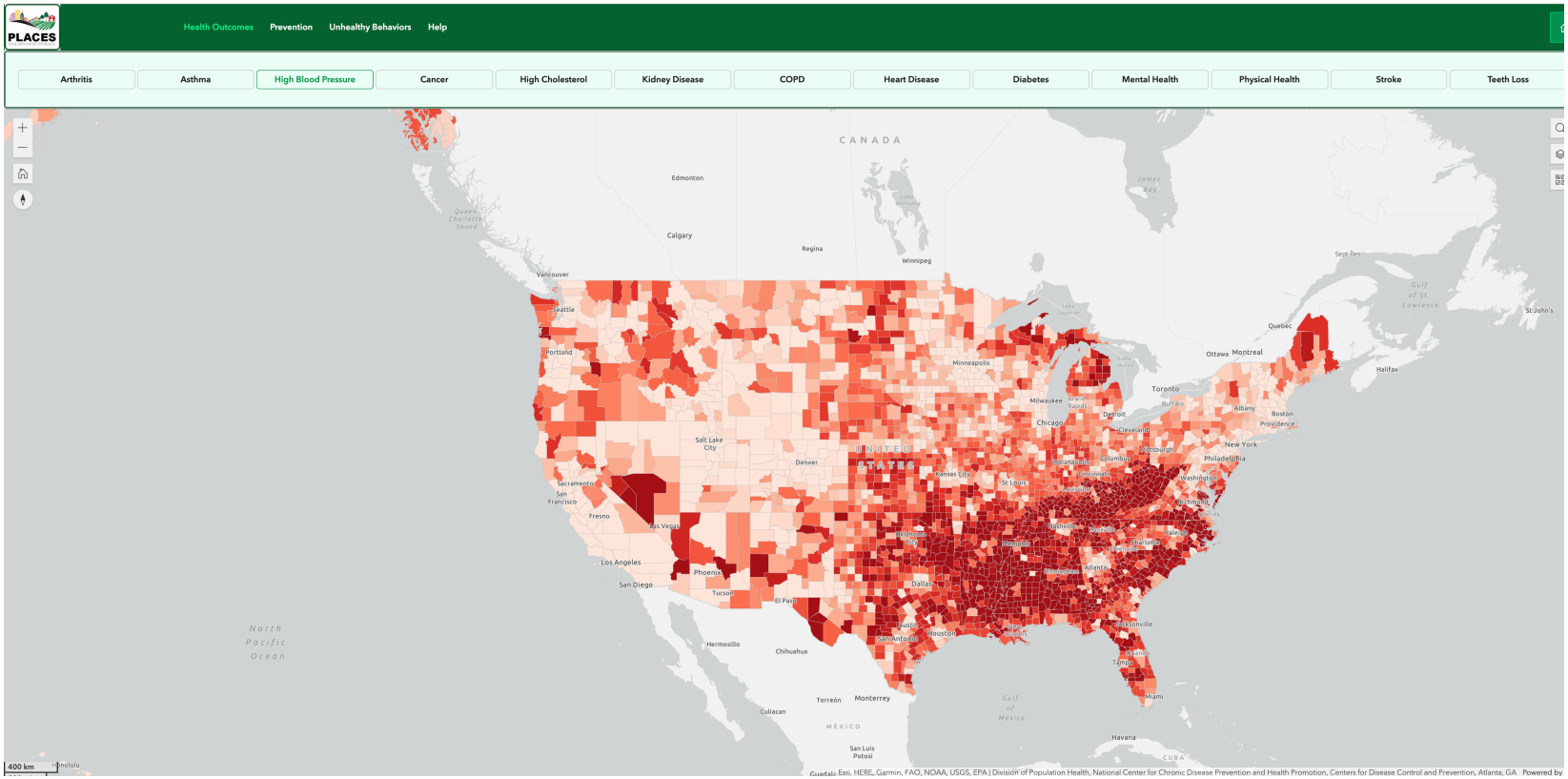
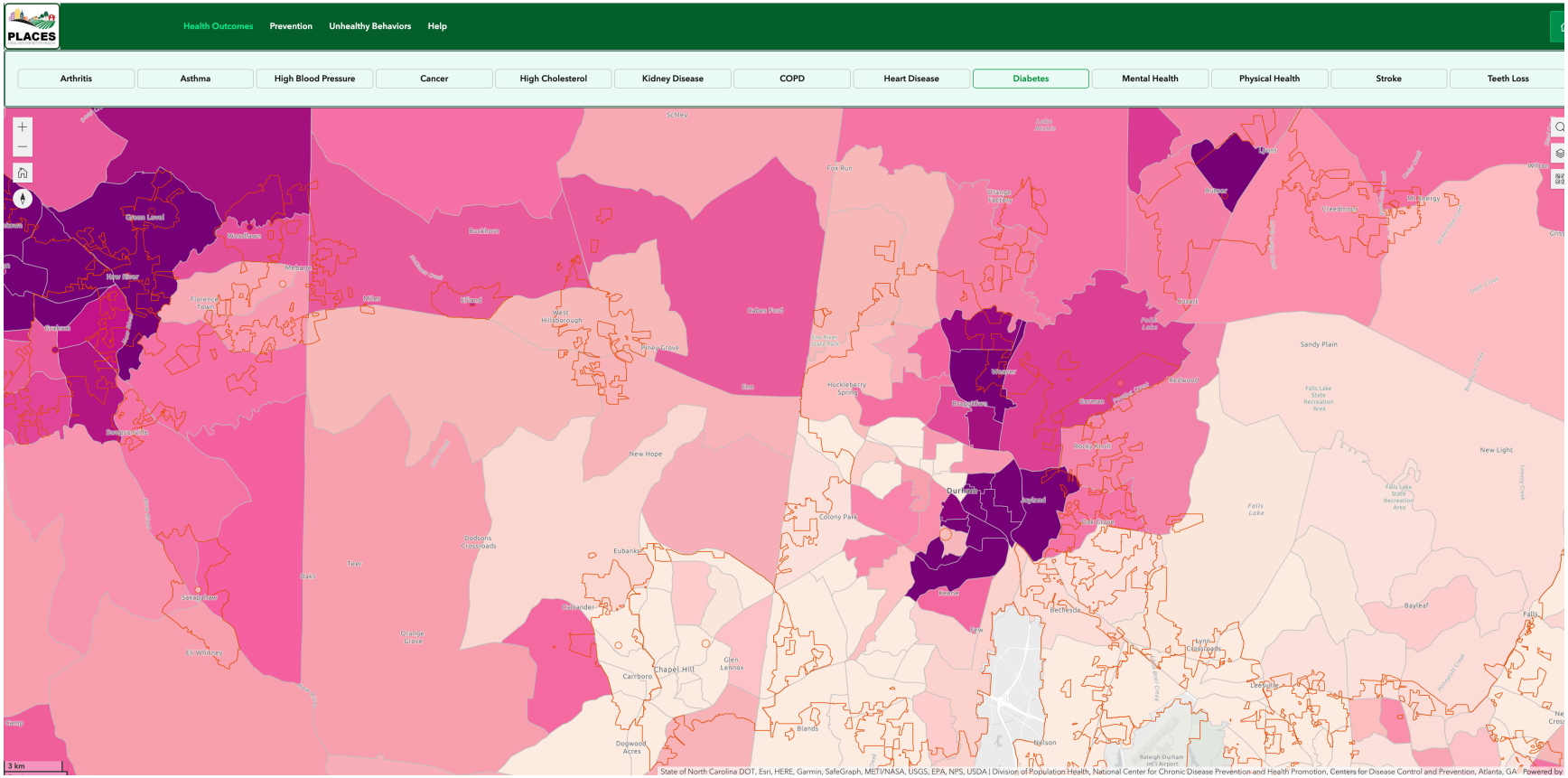
New Source of Health Data at Zipcode Level

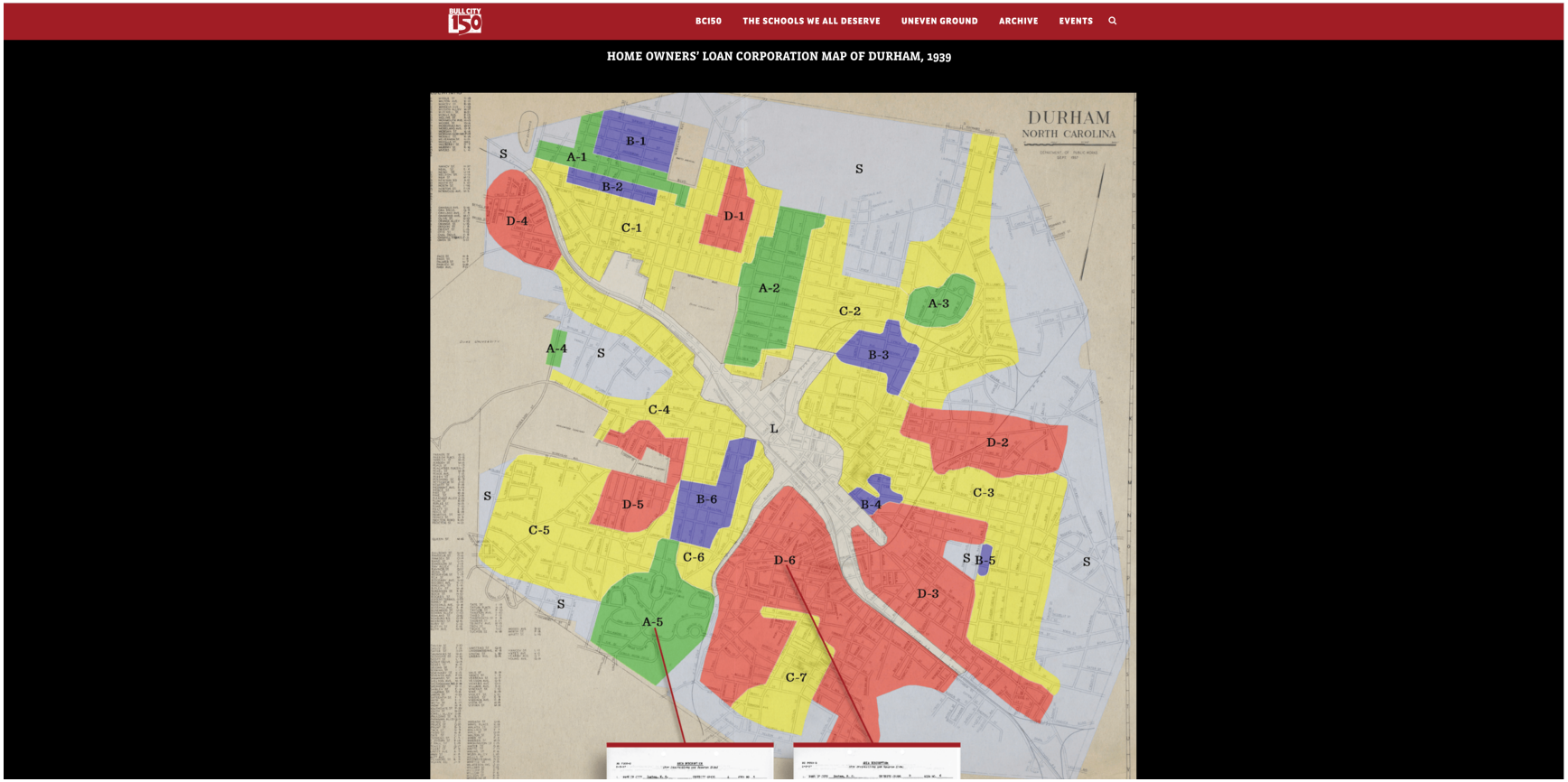
https://www.cdc.gov/places/index.html



Prevalence of Diabetes by Zip code, Durham NC



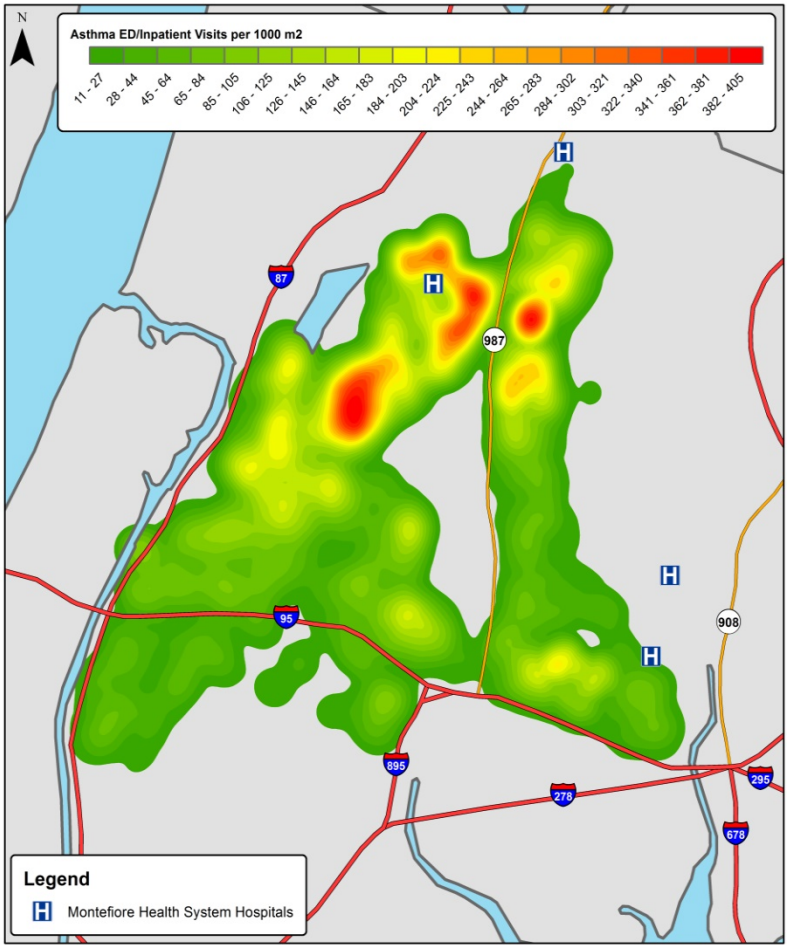
Neighborhood Redlining – Durham NC 1939



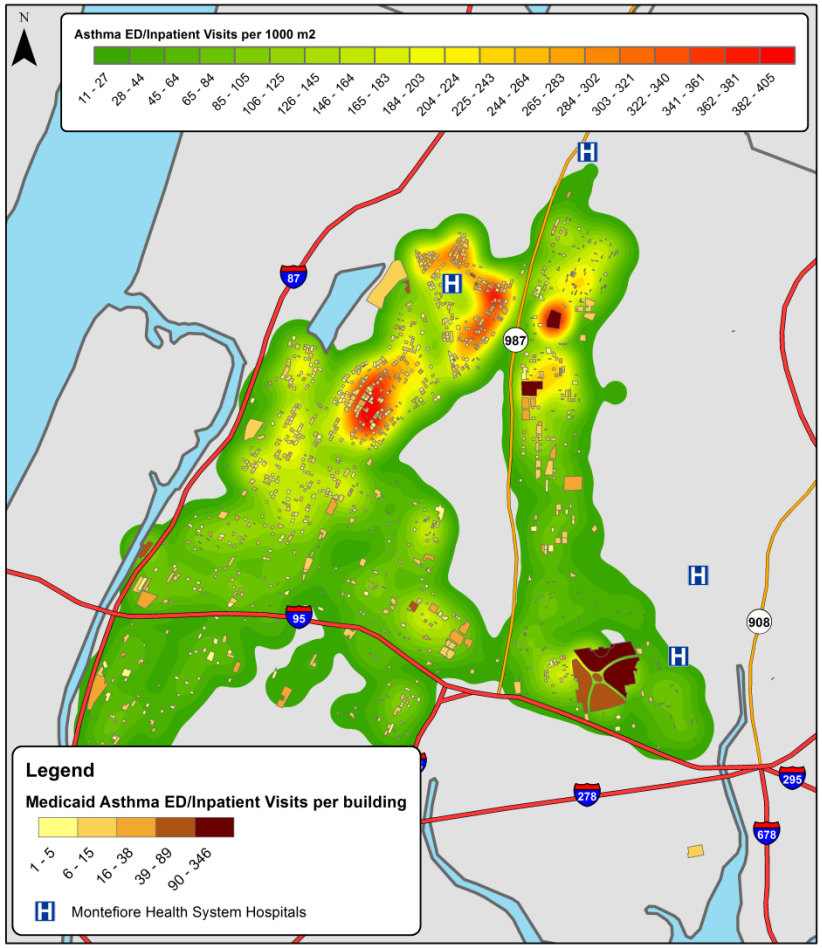
The Model
Multi-Sector, Multi-Stakeholder Partnerships are Developed

Adapted from countyhealthrankings.org

Communities acting on data:
Asthma visits among Medicaid patients - Bronx



Red areas have higher density of asthma visits



Some mismatch between “areas” with more asthma visits and “buildings” with most asthma

Notes: Visits are from 2012-7/2016. Does not include visits to non-Bronx Montefiore Health System locations.

What if a Team had been Working to Strengthen the Social Determinants of Health for over a Decade in the most Vulnerable Communities…

and a Pandemic Happened?

www.the-mhi.org

Media Supporters:

Alix Redmond SNN News; Charles Clapsaddle METV; Bobeth Wallace; Ed James ABC Ch7; Heidi Godman Health Check at WSLR radio 98.9; Susan Burns/Sarasota Magazine; The Nilon Report

Collaborations with:

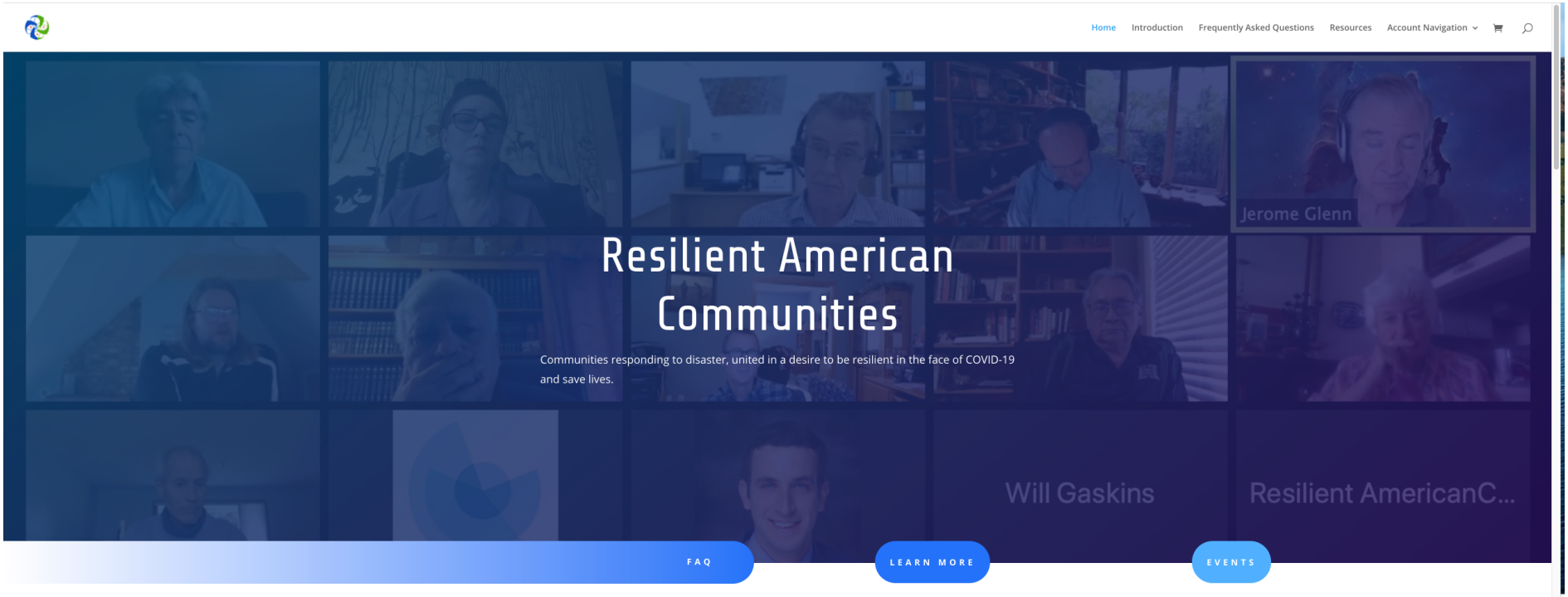
1st Step; 2nd Chance Last Opportunity; AHEC; All Faiths Food ...tion; ASALAH; Bay haven, Booker High, Booker Middle, ...ville Elementary, ODA; Boule; Boys & Girls club... ...ter of Sarasota; Center for Building Hope; City of Sarasot... ...stitute; Community Foundation of Sarasota; Children 1st; Cl... ...y Redevelopment Agency; Designing Women; Depart... ..., Dollar Dynasty; Education Foundation; East West Colle... ...ter Seals of Southwest; Florida Blue; Florida Diversity Council; Fl... ...Genesis; Goodwill Manastoa; Group homes; HANS; Health Equities Res... ...tute (HERI); Health Equities Leadership Network; Healthy Start; Howard Club; Jewish Family & Children Services; Journey to Success; KOMEN Foundation; Latin Chamber; Laurel Civic Center; LECOM; Layne Klabfliesch's 2E Consults; The LINKS; Manatee Rural Health Services; Men Educating Men; Moffitt; Morehouse; New College of Florida; Newtown Centennial Celebration; Newtown Wellness; Newtown Biz & Professional Women; Neuroscience; Neuropsych Associates; Numerous Faith-Based Communities including Truevine,

They would have TRUST in the community...
Addressing Health Disparities takes all of us!

Gatekeepers of Community Health
Crush COVID
With Their **Multicultural Action Team** Partners

Masks	Hand Sanitizer	Families Receiving Food	Health Information& Linkage to Care
30,752	3,759	6,020	9,305

31,763 People Impacted



COMMUNITIES

What We Do Together

The RAC is dedicated to collapsing the SARS-CoV-2 pandemic and reducing the devastating COVID-19 syndemic impacts on American communities, with a special focus on the most vulnerable communities. RAC partners with and provides support for community partners, empowering local leaders and community members to enact change in their community.

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100+

Dashboards Developed

125+

Maps Created

Panama City/ Bay County

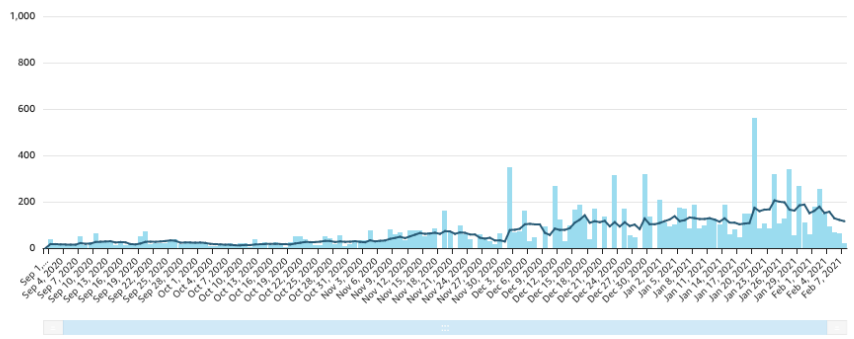
RAC is working with LEAD Coalition of Bay County, whose mission is to work

Sarasota and Manatee Counties

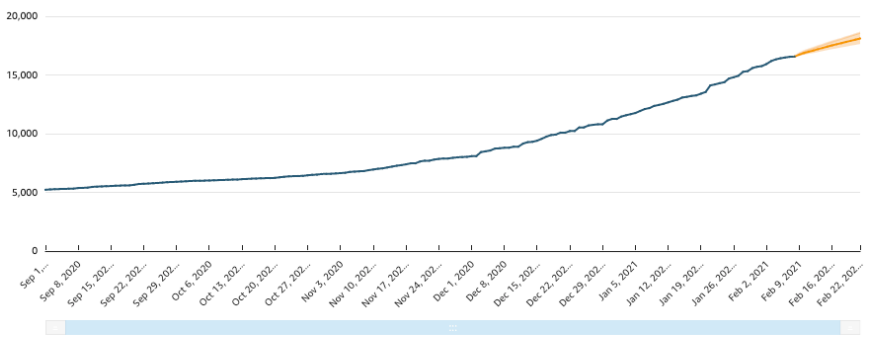
RAC is working with the Multicultural Health Institute (MHI) which seeks to level the healthcare playing field by promoting, educating, and ensuring equal healthcare

County Dashboard

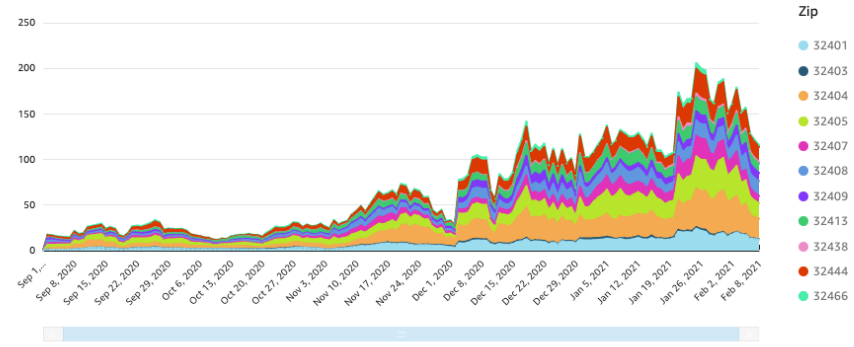
Selected County: New Cases (w/ 7-day Average Line) (source: FDOH zipcode data)



Selected County: Cumulative Cases + Case Forecast (source: FDOH zipcode data)



Selected County: New Cases by Zip Code over Time - 7d avg (source: FDOH zipcode data)



Selected County: Total Cases and Growth by Places tags (source: FDOH zipcode data)

Zipcode	Places	Total Cases	% WoW Case Growth
32404	Panama City|Orlando|Parker|Callaway	3,674	-38.4%
32405	Panama City	2,960	-40.4%
32444	Lynn Haven	2,256	-14.9%
32401	Panama City Beach|Hialeah|Panama City	1,843	-21.1%
32408	Panama City Beach|Panama City|Winter Park	1,527	35.3%
32407	Panama City Beach|Panama City	1,341	-50.5%
32413	Inlet Beach|Watersound|West Panama City Beach|S...	1,323	6.0%
32409	Southport|Panama City	887	10.9%
32466	Youngstown|Bayou George	406	0.0%
32438	Fountain	211	-11.8%
32403	Tyndall Air Force Base|Panama City	138	-57.1%

Powered by QuickSight

MPHISE ANALYTICS

Resilient American Communities

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Family Medicine Departments can be key partners with communities in pursuing health equity

LATIN-19

Salud y bienestar para nuestra comunidad Latina

Health and wellness for our Latina community

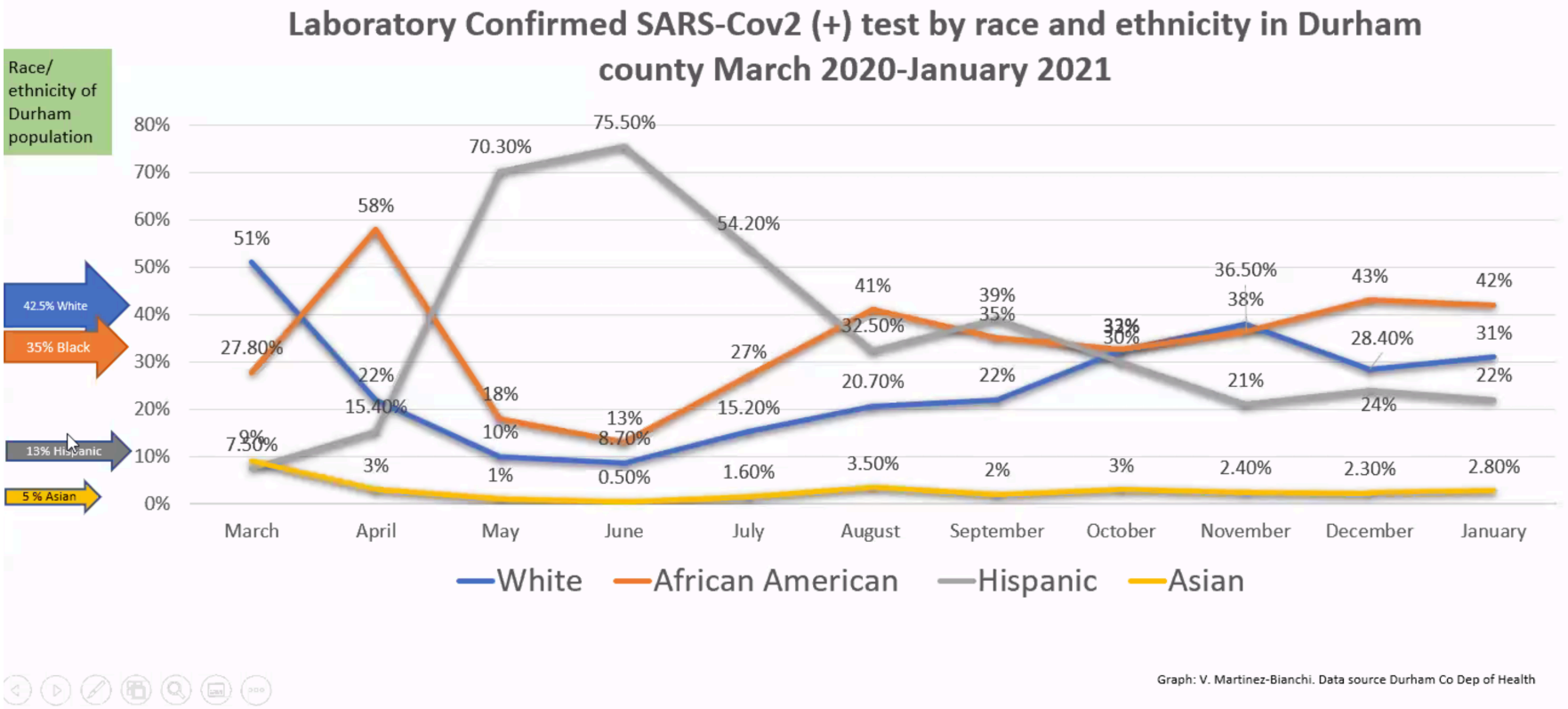
"When the world is burning, I have to put out the fire"

Testing sites: Durham

Dr. Alex Cho takes at the drive-up COVID testing site at Holton Welln in Durham on 7/23/20. Picture by Shawn Rocco/Duke Health

Slide courtesy of Dr Andrew Flynn

Durham County cases



Graph: V. Martinez-Bianchi. Data source Durham Co Dep of Health

The EveryONE Project

Neighborhood Navigator

The EveryONE Project™
Advancing health equity in every community

neighborhood navigator

The EveryONE Project offers you screening tools to identify patients' social needs and address health equity in your practice. The Neighborhood Navigator is the next step for you to improve social determinants of health among your patients.

Use this interactive tool at the point of care to connect patients with supportive resources in their neighborhoods. It lists more than 40,000 social services by zip code.

- Food
- Housing
- Transportation
- Employment aid
- Legal aid
- Financial

Want to see how the Neighborhood Navigator tool works?

Watch the training videos now.

Find Services in Your Community

Enter your ZIP code SEARCH

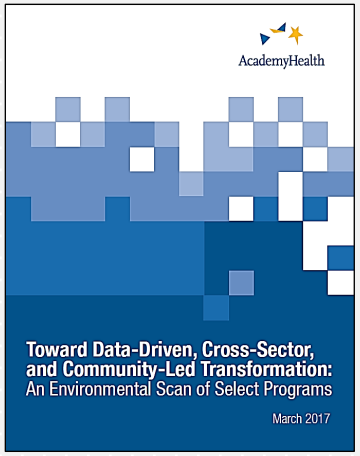
The movement is growing

A New "Movement": Over **1000** local initiatives awarded or soon to be awarded

Program Duration: **8 months** to **5 years**

Spread and Scale: Neighborhoods, counties, Multicounty, cities

Find a Partnership:
www.practicalplaybook.org/page/find-partner

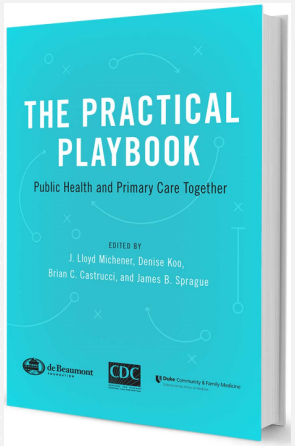


John D. and Catherine T. MacArthur Foundation

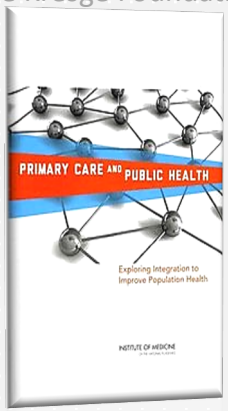
W.K. Kellogg Foundation

Robert Wood Johnson Foundation

The Kresge Foundation



Trinity Health



Rippel Foundation

The Pew Charitable Trusts

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The Colorado Health Foundation

The BUILD HEALTH Challenge

Bloomberg Philanthropies

Vital Directions for Health and Health Care
A National Academy of Medicine Initiative

de Beaumont Foundation

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The Practical Playbook - Content

1 . Introduction: Accelerating Partnerships for Health

2. Collaboration

3.Data

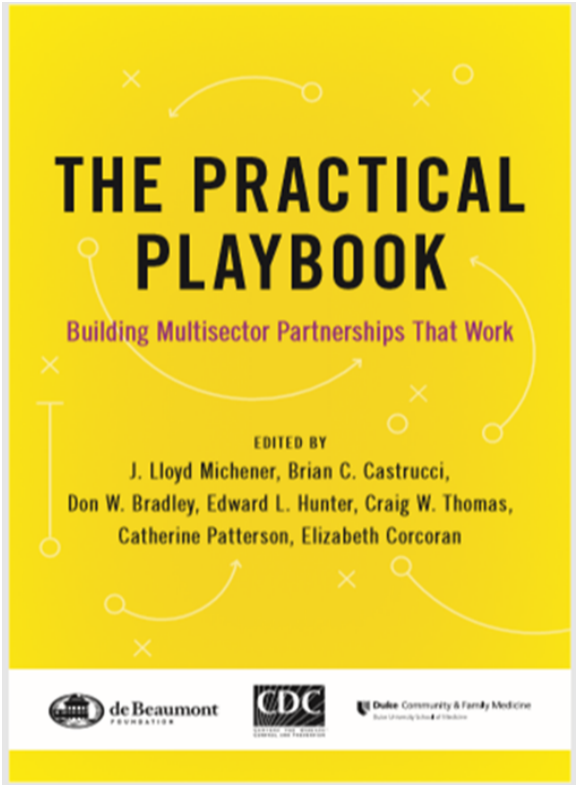
4. Innovation

5. Sustainability & Finance

6. Policy

7. Training & Workforce

8. Conclusion: The Next Steps Toward Population Health



All chapters online (and free) at www.practicalplaybook.org

Executive Order on Ensuring an Equitable Pandemic Response and Recovery

The COVID-19 pandemic has exposed and exacerbated severe and pervasive health and social inequities in America. For instance, people of color experience systemic and structural racism in many facets of our society and are more likely to become sick and die from COVID-19. The lack of complete data, disaggregated by race and ethnicity, on COVID-19 infection, hospitalization, and mortality rates, as well as underlying health and social vulnerabilities, has further hampered efforts to ensure an equitable pandemic response..

The Task Force shall provide specific recommendations to the President…for mitigating the health inequities caused or exacerbated by the COVID-19 pandemic and for preventing such inequities in the future.

The Task Force shall submit a final report ..addressing any ongoing health inequities faced by COVID-19 survivors that may merit a public health response, describing the factors that contributed to disparities in COVID-19 outcomes, and recommending actions to combat such disparities in future pandemic responses.

Recommendations

- Review (new) data on health outcomes in your community
- Learn about partnerships that are already underway in your community
  - Ask your staff
  - Go to community meetings
  - Listen / share
  - Ask how you can help
- Involve students and residents in community projects – with training and oversight

- DON'T over plan

Conclusions

- Partnerships for health are growing rapidly across the US., supported as part of COVID response, and as a key element in achieving health equity.
- Key elements are community leadership, data, targeted interventions, and designing for sustainability.
- Partnerships for health are a journey that involves mutual trust, new ways of working together, and shared success.
- Family Medicine departments can have key roles in these partnerships, serving their communities, their learners, and their health systems.

To close with Jack Geiger, founder of the FQHCs

Chris Koller, President of the Milbank Memorial Trust, writing about Jack Geiger, founder of the FQHCs:

> "Finally, in a time of massive societal health care spending for diminishing life expectancy, health care leaders have a responsibility to think beyond the needs of their own organizations, institutions, or professions and use their authority and influence to communicate about the systemic challenges we face and in Dr. Geiger's words, "to do something.""

And to close with Jack himself:

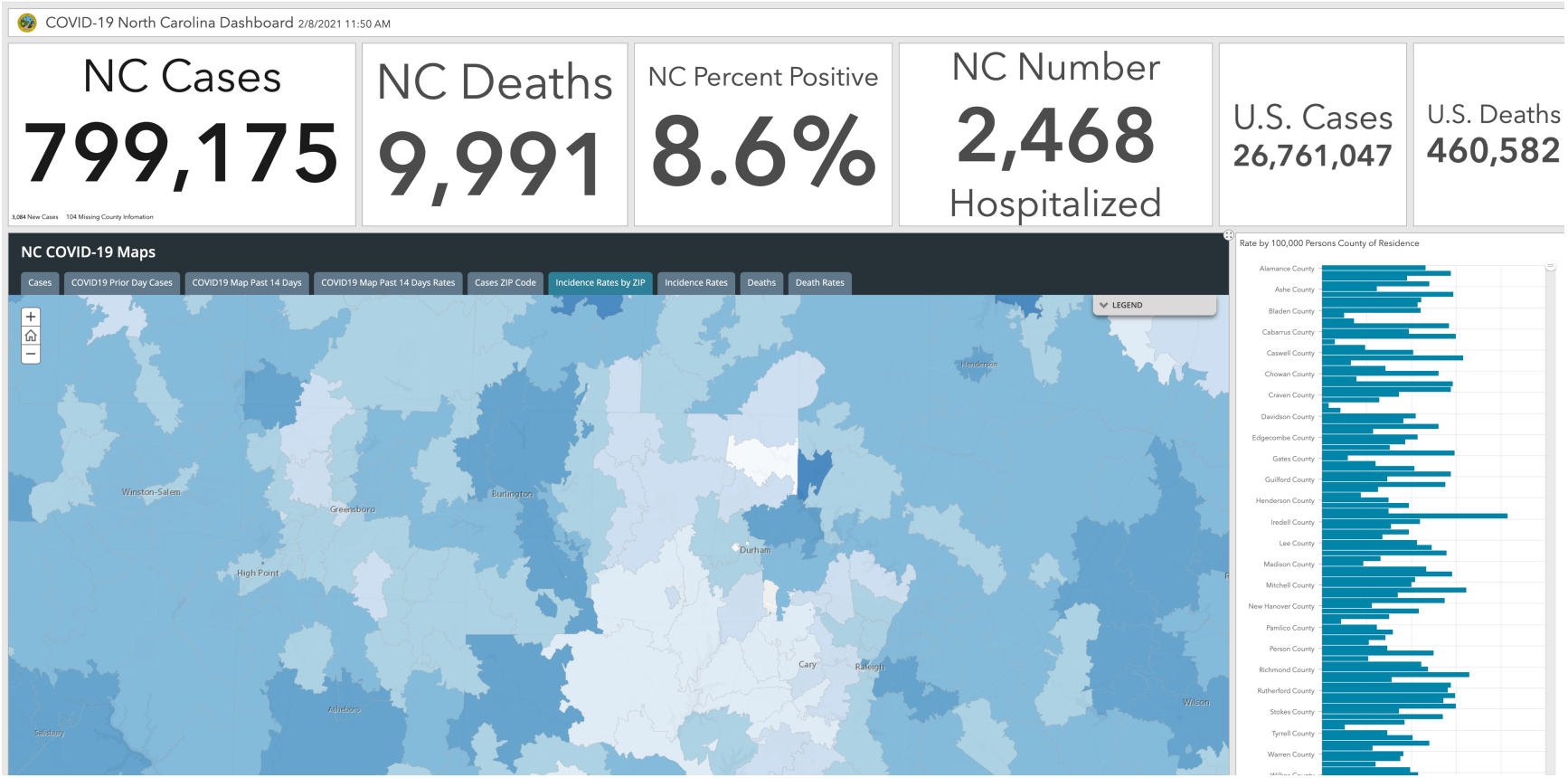
"There is just no point in treating rat bites — and ignoring the rats."

Thoughts and questions?

Time for a new model of targeted data driven care that prevents progression of disease

Three Buckets of Prevention

Auerbach J. The 3 Buckets of Prevention. *J Public Health Manag Pract*. 2016;22(3):215–218.



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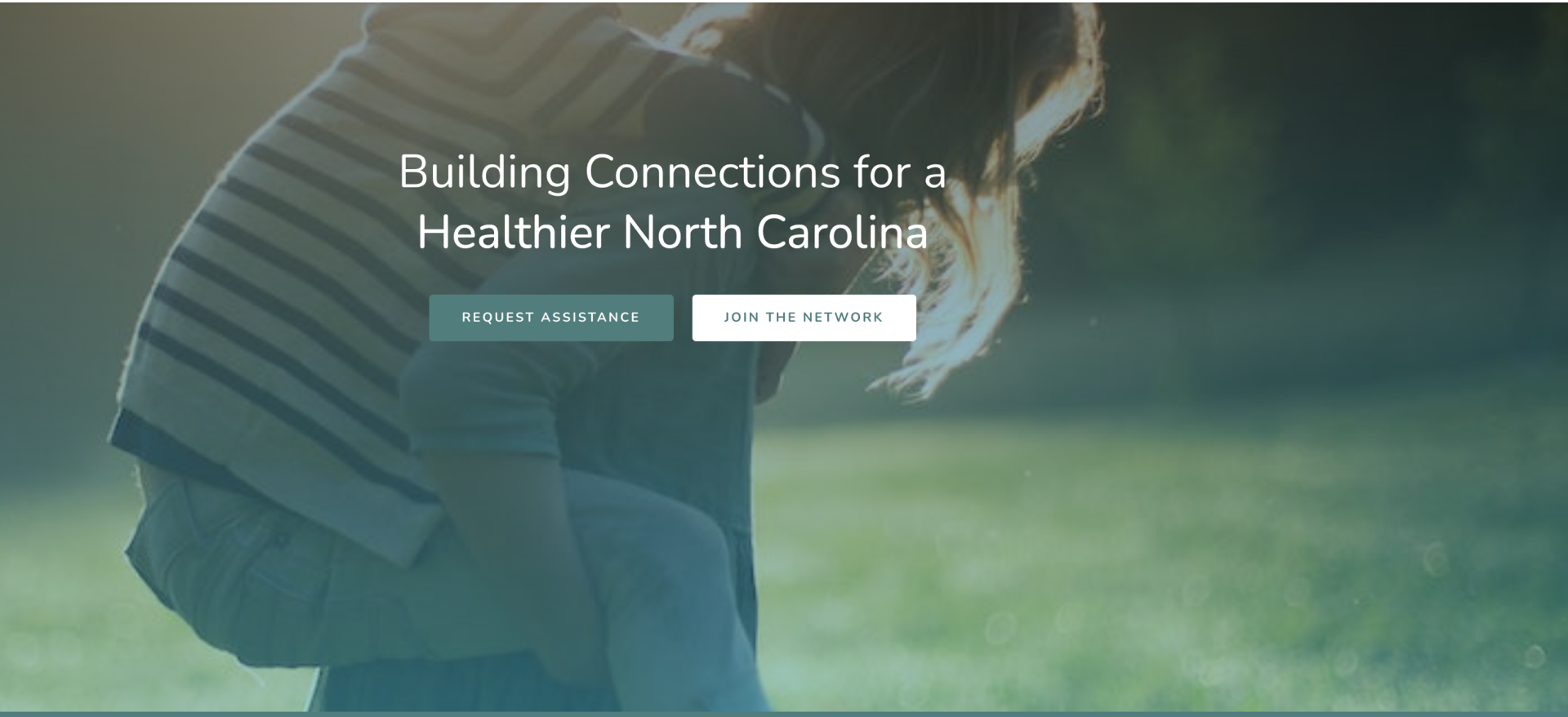
NCCARE360

About News & Events For Network Partners For Individuals



Building Connections for a Healthier North Carolina

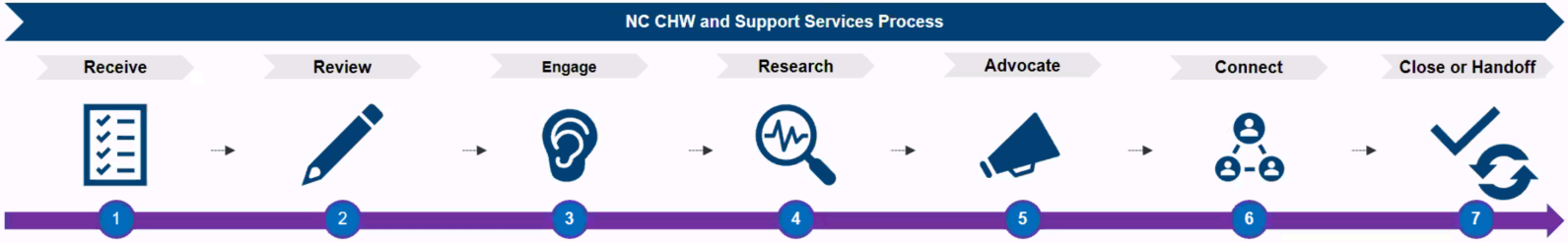
REQUEST ASSISTANCE JOIN THE NETWORK

Last updated: February 28, 2020

100	2,200+	36,980+
Counties Activated	Organizations Onboarded	Users Onboarded

Community Health Worker and Support Services Workflow

Scenario: How an individual who needs to quarantine or isolate gets connected to Support Services



1 — Receive

CHW picks up assigned patients from a variety of channels:

- Testing sites
- Contract tracers
- LHDs
- PCPs
- Outreach workers
- CBOs
- Self referrals
- Also receives patient lists from contact tracing tool (CCTO)

2 — Review

CHW performs a needs assessment, determines the person's eligibility for support services through a standardized attestation form, and makes a support plan. The CHW triages high priority cases first.

3 — Engage

Patient Engagement: CHW asks clarifying questions and presents options

4 — Research

CHW researches available resources using NCCARE360 DHHS sites (Check My Symptoms, Find My Testing Place), and primary care provider list

5 — Advocate

CHW conducts additional research and advocacy

6 — Connect

CHW sends referrals to Support Service Vendors and subcontractors through NCCARE360 or other mechanism and includes the individual's eligibility attestation form.

The CHW continues to be the individuals' point of contact throughout their isolation/quarantine if they need additional supports. CHWs may call vendors on behalf of the patient and continue to communicate directly with the patient.

7 — Close or Handoff

Support Service Vendors deliver services to individuals and note that their needs have been met in NCCARE360 or with CHW.

Support Service Vendors conduct ongoing invoicing, reimbursement, and reporting (to be discussed in more detail).

Community Health Workers serve as the connection between the individual requiring services and the Support Services vendors

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

National COVID Cohort Collaborative (N3C)
Social Determinants of Health (SDoH)
January 2021

Scaling Up-CDC