



## Enhancing the Health of **Every Community**

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@AlisahahMD





You do not have to be me in order for us to fight alongside each other. I do not have to be you to recognize that our wars are the same. What we must do is commit ourselves to some future that can include each other and to work toward that future with the particular strengths of our individual identities. And in order for us to do this, we must allow each other our differences at the same time we recognize our sameness."

-Audre Lorde



# goals

get  
informed

get  
inspired



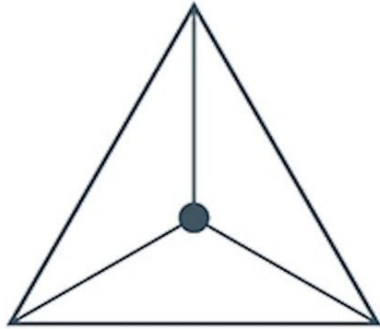
get  
uncomfortable

get  
activated

# population health evolution

## The IHI Triple Aim

Population Health



Experience of Care

Per Capita Cost



# population health evolution

## Quintuple Aim

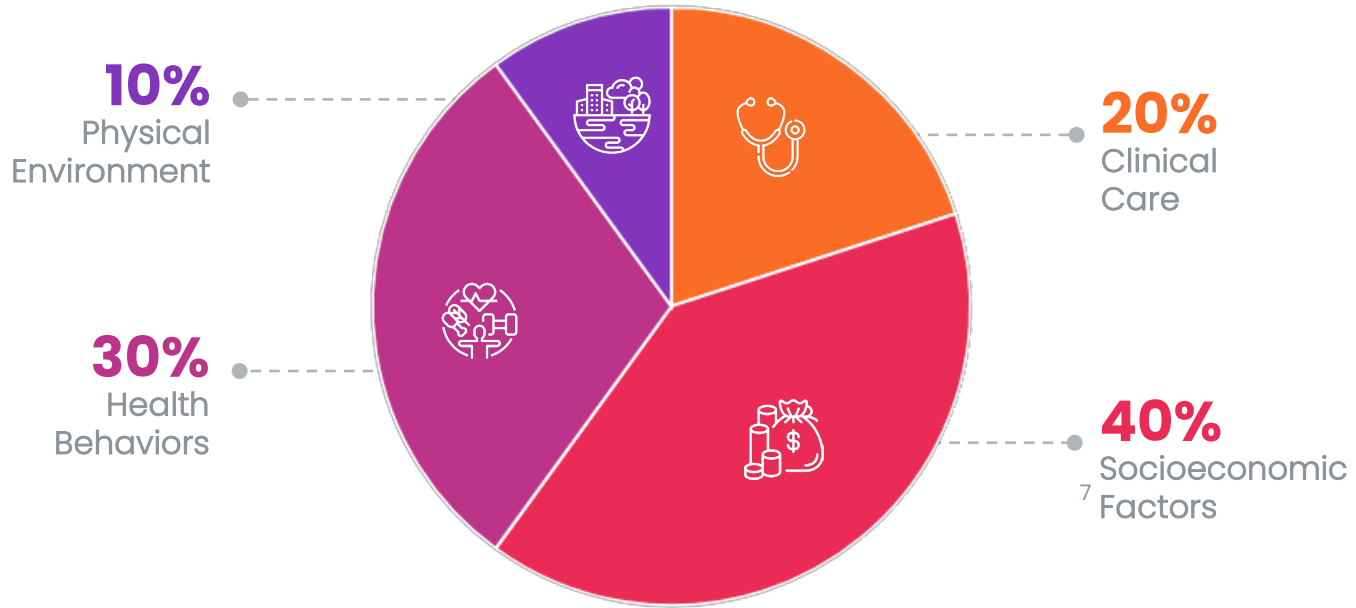
Population Health Management

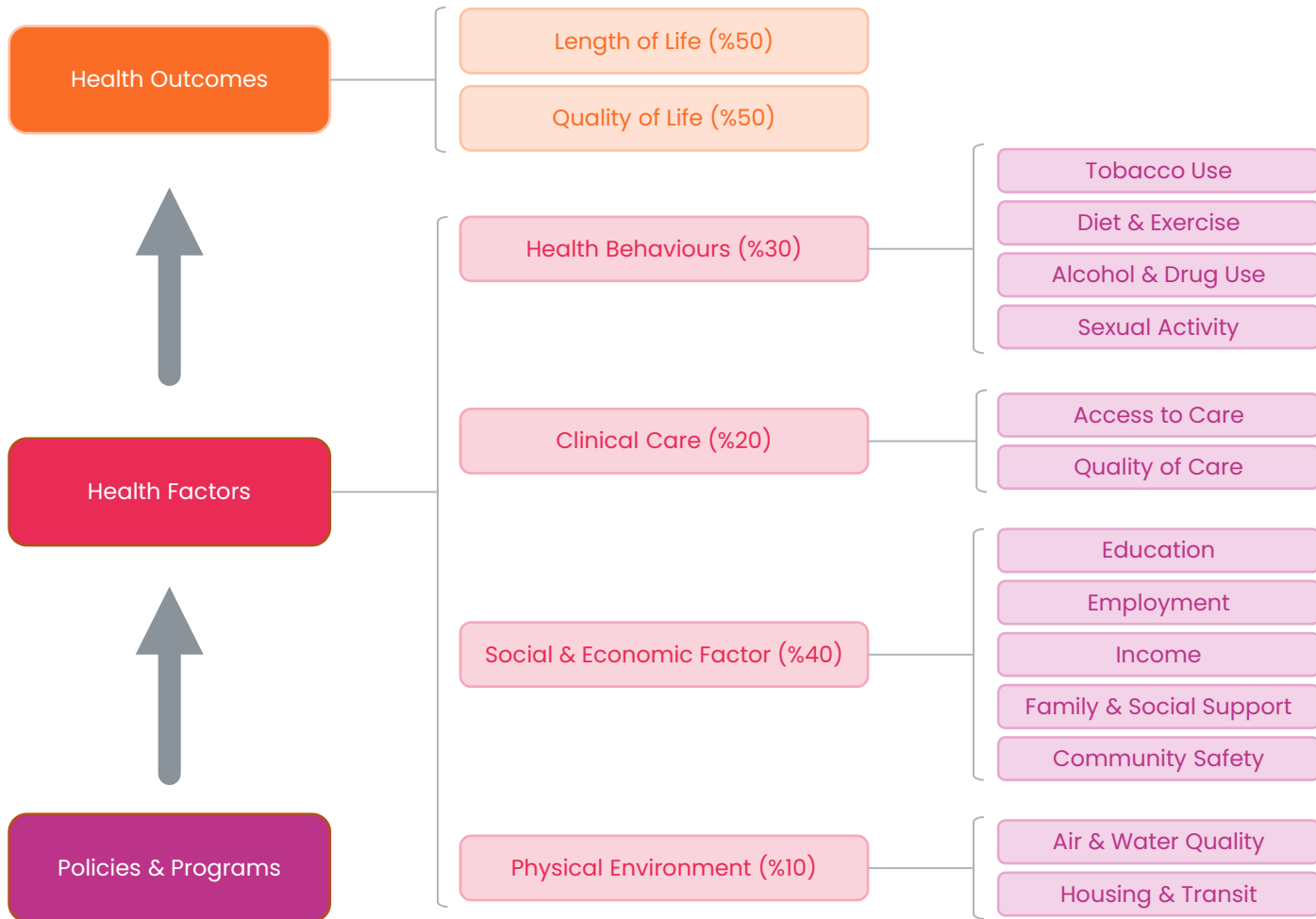






# know what affects **health**







# ready to get uncomfortable?

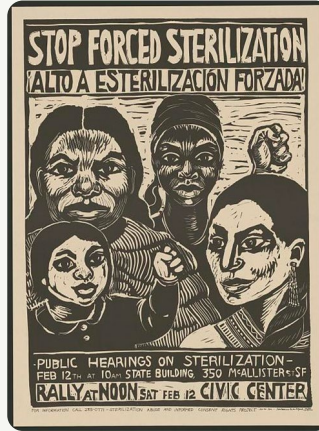


**“I suppose I’ll be the one  
to mention the elephant in the room.”**

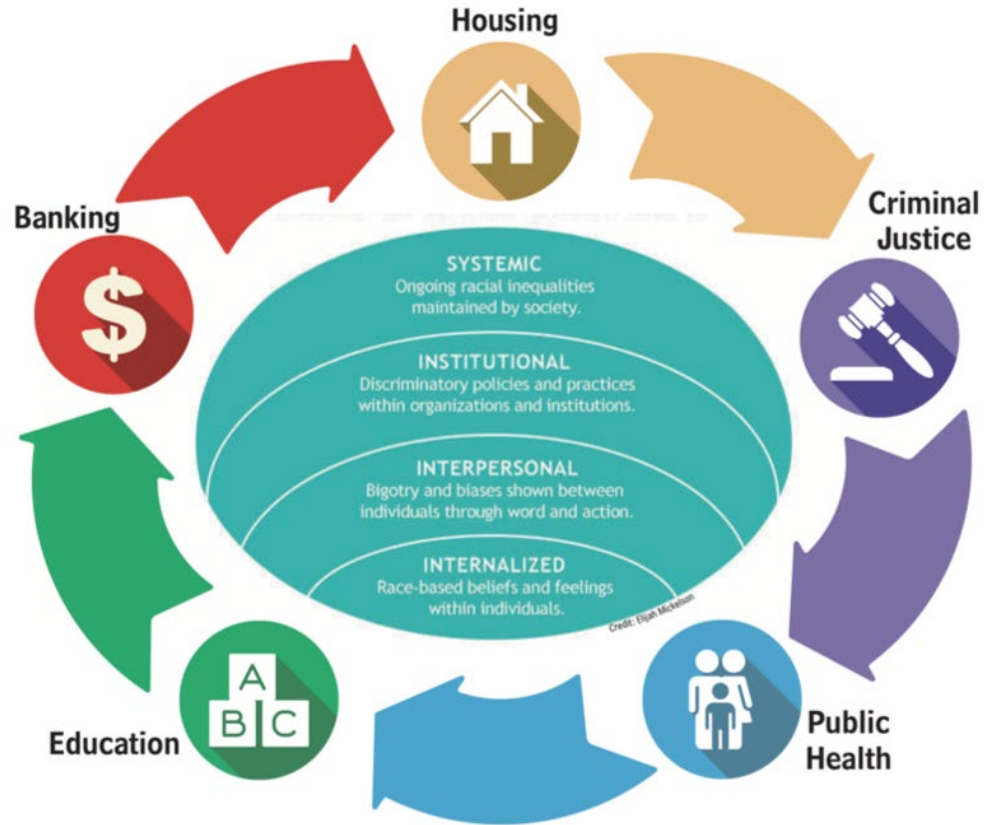
a comfort  
zone is  
a beautiful  
place but  
nothing  
ever grows  
there



# The “Ism’s” in Medicine



# racism explained



# home ownership

Mecklenburg County, 2017

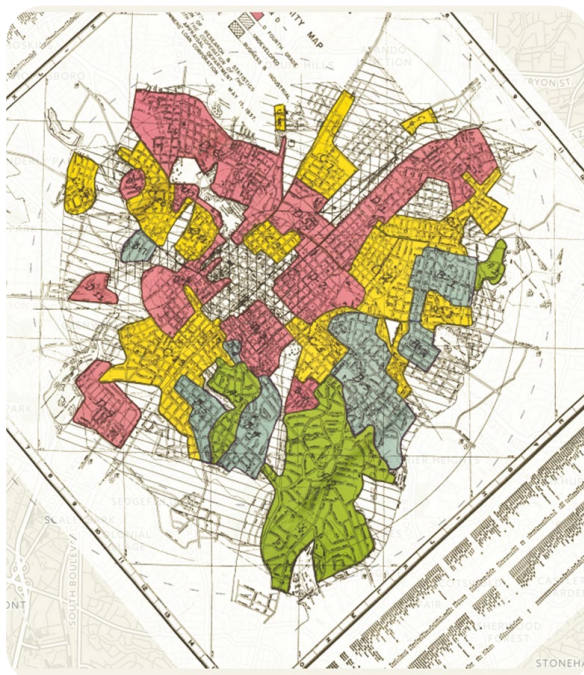
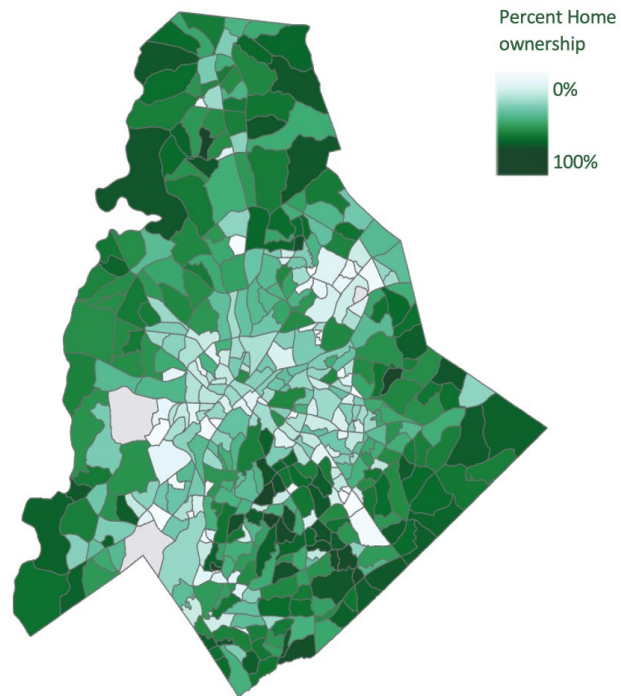


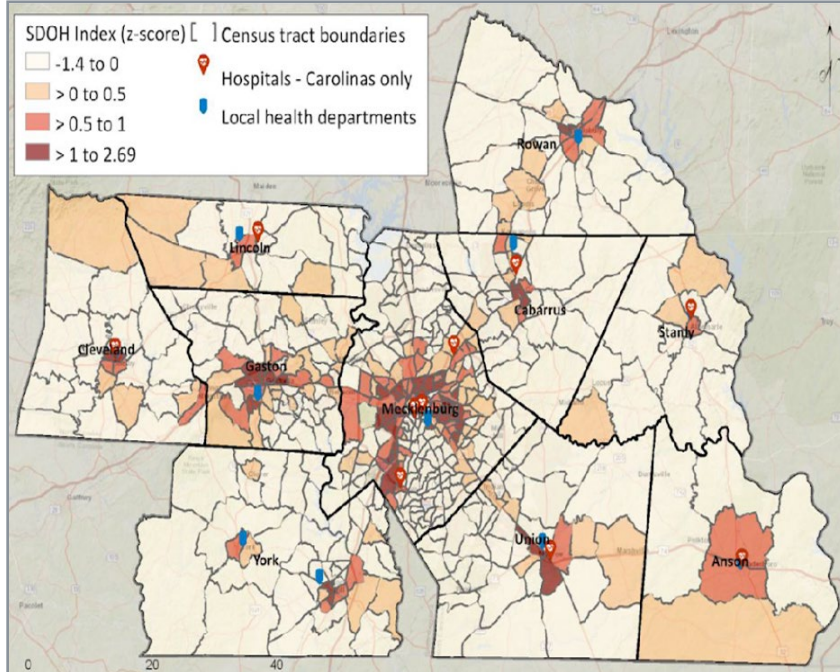
Photo credit: Home Owners Loan Corporation Risk Map, Charlotte (1937)



Source: Charlotte-Mecklenburg Quality of Life Explorer, 2017

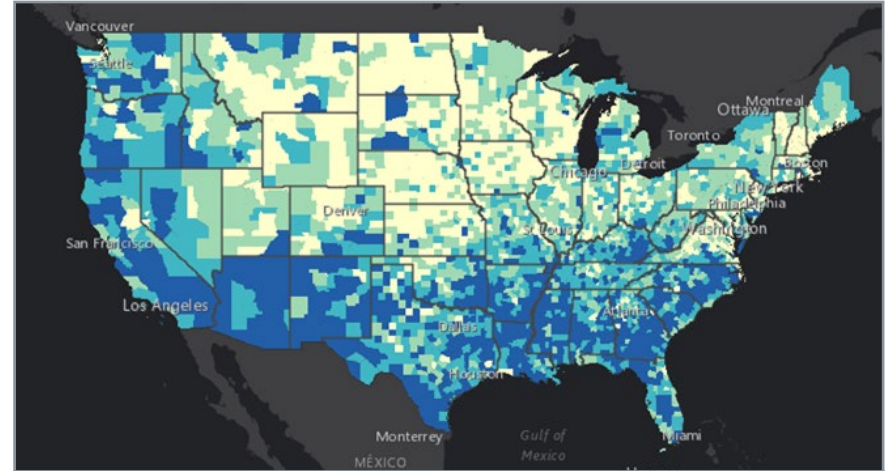


Figure 8. Social Determinants of Health Index Map, CHIS Region



High (red) values show neighborhoods with the highest disparities among the Social Determinants of Health.

<http://tinyurl.com/SDH-Story-Map>

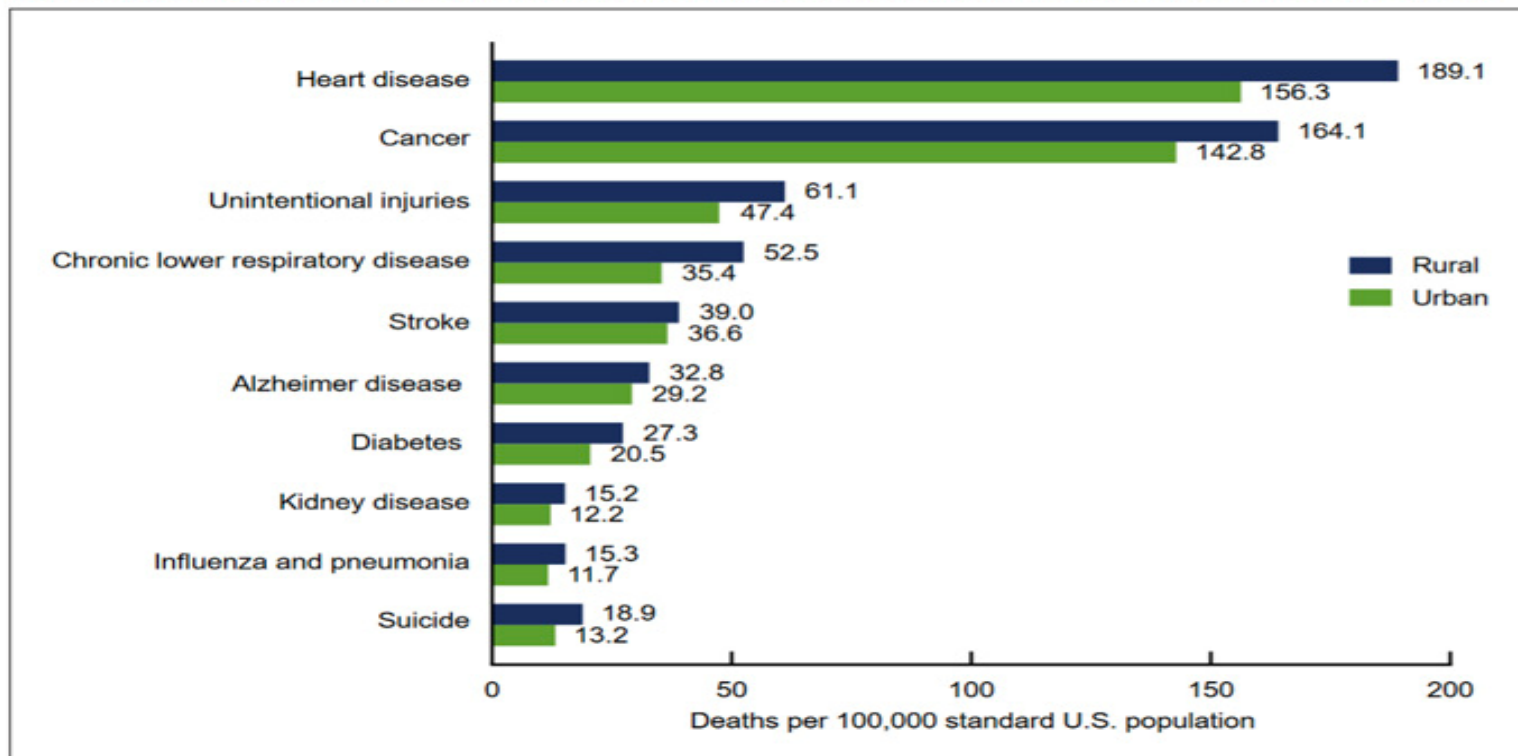


<https://www.atsdr.cdc.gov/placeandhealth/svi/index.html>

- Interactive web map
- 10-county region
- 12 SDH indicators at the neighborhood level (Census Tracts)
- Index summarizing indicators into a single variable

# rural health disparities

Figure 3. Age-adjusted death rates for the 10 leading causes of death, by urban-rural classification: United States, 2019



NOTES: Urbanicity of county of residence is based on the 2013 NCHS Urban-Rural Classification Scheme for Counties; see Data source and methods. Causes of death are ranked according to the number of deaths for the total population. Rates for all causes in rural areas were significantly higher than rates in urban areas ( $p < 0.05$ ). Access data table for Figure 3 at: <https://www.cdc.gov/nchs/data/databriefs/db417-tables.pdf#3>. SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.



# Another moment for discomfort: Operational Hesitancy

## Hospital Closures and Consolidation



Since 2005, **181 rural hospitals** have closed across the country.



**453** more are vulnerable to closure.



## Impact on Access

Rural hospital closures are often the result of **consolidation, provider shortages, and lower patient volumes**. Additionally, **lower reimbursement rates** impact hospital viability as rural populations are more likely to be covered by public insurance. Many of these challenges were **exacerbated by the pandemic**. This can **create a gap in services** that are accessible to the community. Residents in these areas are forced to **travel further to find available treatment**.



*Prior to closure, the average distance between patients and the nearest inpatient care was 3.4 miles...*



*After closure, the average distance was 23.9 miles.*

why should we care?



Moral Imperative

What if a 747  
crashed everyday in  
the US?



# financial imperative

## Joint Center Health Policy Institute

Found between 2003 & 2006 combined costs of health inequalities and premature death in US were **\$1.24 trillion**

## Urban Institute

Projects **\$337 billion** to be spent 2009–2018 on health care related disparities

FIGURE 3

### A glimpse of how health disparities can increase health care spending

Disease area	Health disparity	Annual cost of disease (in US\$ billions)	% of spending associated with disparity	Unnecessary spending associated with the disparity (in US\$ billions)
Diabetes	Black adults are <b>60%</b> more likely than white adults to be diagnosed with diabetes and are two to three times more likely to have complications	\$327	4.8%	<b>\$15.6</b>
Asthma	The asthma rate for those living under the FPL is <b>11%</b> compared to <b>~7%</b> for those that are <b>&gt;2x</b> the FPL	\$56	4.3%	<b>\$2.4</b>

Sources: Deloitte analysis of data from the US Department of Health and Human Services, Centers for Disease Control and Prevention, and American Diabetes Association.

Deloitte Insights | [deloitte.com/insights](https://deloitte.com/insights)

time to get inspired







# zipcode **statistics**

- Average age of death **is 7 years** younger than those who live in other surrounding zip codes
- Since grew up here, a poverty stricken area, her ability to move out of poverty as an adult is less than **10%**





“all black”  
neighborhood



- Raised by her mother in a single parent household
- Always wanted to be a doctor

23

# zipcode **statistics**

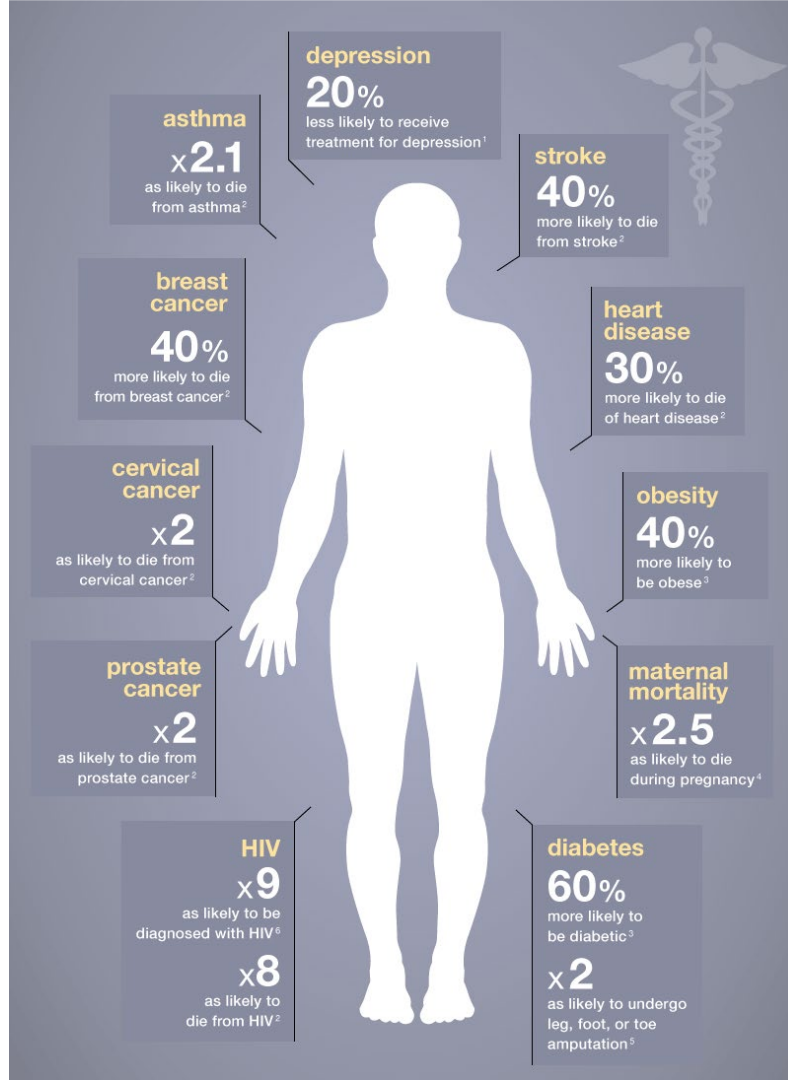
- Only 17% of 3rd graders are proficient in Math and Reading at End of Grade testing
- 63% of residents have HS diploma vs.86% in county





3x more  
prevalent

# black health disparities





# my journey

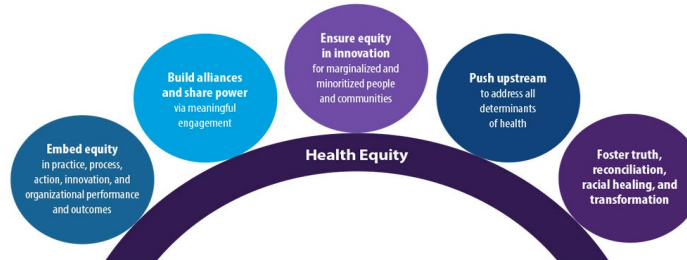


# How Can Boards Contribute?

- Population Health Strategy and Resources to support Quintuple Aim



## AMA Strategic Approaches to Advance Health Equity



### Value Based Strategies

- Care coordination:** Care coordination involves ensuring that patients receive the appropriate care at the appropriate time, with the goal of improving patient outcomes and reducing costs. Physician practices may implement care coordination programs that include case management, patient education, and communication with other providers involved in the patient's care.
- Population health management:** Population health management involves identifying and managing the health needs of a group of patients. Physician practices may implement population health management programs that focus on preventive care and chronic disease management to improve patient outcomes and reduce costs.
- Patient engagement:** Engaging patients in their care can improve outcomes and satisfaction. Physician practices may implement patient engagement strategies such as patient portals, patient education materials, and shared decision-making to help patients take an active role in their care.
- Quality measurement and reporting:** Physician practices may implement quality measurement and reporting programs to track their performance on quality measures and identify opportunities for improvement. Quality measures may include clinical outcomes, patient satisfaction, and healthcare utilization.
- Alternative payment models:** Physician practices may participate in alternative payment models (APMs) such as accountable care organizations (ACOs) or bundled payments, which tie reimbursement to quality outcomes and cost savings. APMs incentivize physicians to provide high-quality, cost-effective care and can help align financial incentives with patient outcomes.

[www.carnahangroup.com](http://www.carnahangroup.com)

Disclosure: Carnahan Group is neither a law or accounting firm. Appropriately qualified accounting and legal advisors should be consulted to help ensure compliance with regulatory, tax and legal requirements.

# How Can Boards Contribute?

- Endorse Partnerships to Address Healthcare Workforce Diversity

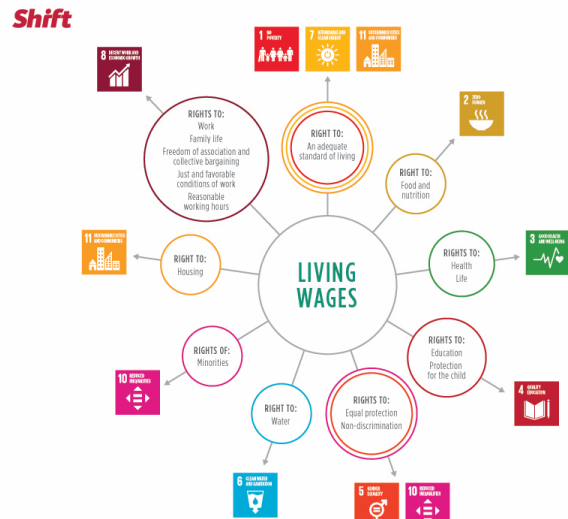
**St. Luke's Health-Memorial, Baylor College of Medicine establish new rural health residency program**

**Massachusetts General Hospital receives record gift from Kraft family benefitting community health and health equity**

\$50 million gift is largest in support of community health and health equity in 211-year history of MGH.

# How Can Boards Contribute?

- Understand staff and patients from a human perspective



**ProMedica’s “Market on the Green,” a full-service grocery store, offers fresh and affordable healthy food choices in a designated food desert**

# Core Social Need Domains

**Screening** for social needs is intended **to identify the impact** of structural and social determinants on the health of individuals and families and **to identify opportunities** to provide additional support for patients.

- **Food Insecurity**
- **Housing Instability**
- **Transportation Barriers**
- **Personal Safety Concerns**
- **Financial Challenges**
- **Social Isolation**
- **Gaps in Health Literacy**

**Structural and Social Determinants** (also called Social Drivers or Social Influencers) are conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. (Healthy People 2030)

Hospitals and clinics may include additional questions to address specific needs of the local populations served and resources available in the community.

# Food Insecurity & Health



Lower birth weights,  
higher rates preterm  
birth

Pregnancy



Increase risks of birth  
defects, anemia,  
cognitive problems,  
anxiety, depression

Children



Higher rates of DM,  
obesity, depression;  
poor sleep outcomes

Adults



Limitations in ADLs,  
lower nutrient  
intakes

Seniors

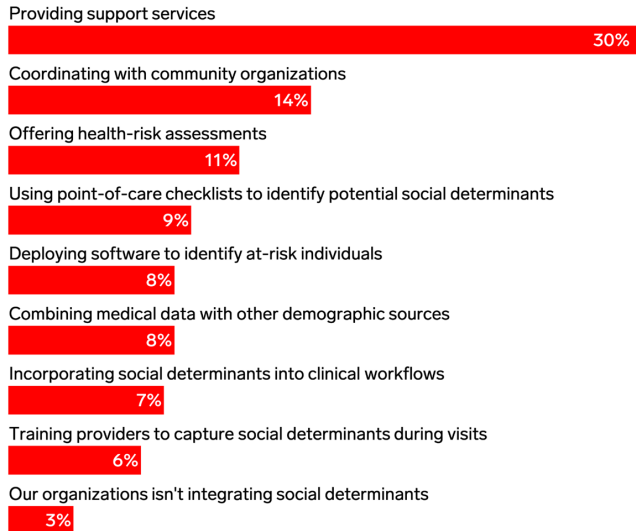




# Leveraging Technology

## Social Determinants of Health That Healthcare Organizations Are Addressing

Q: What social determinants of health does your organization capture at the member or patient level? Select all that apply.



Note: This survey was fielded prior to the coronavirus pandemic and does not take its impacts into account.

Source: Change Healthcare, "2020 Healthcare Industry Pulse Report," February 2020

Methodology: Online survey of 445 leaders at US providers and payer organizations conducted by Change Healthcare via InsightDynamo from October–December 2019.



get activated



# get activated: design new systems



Create the Strategy



Resource the Operations



Implement Accountability



Measure Outcomes

“

Every system is  
perfectly designed to  
get results it gets.

-W. Edwards Deming

# accelerate **research** to implementation

- Nurse Family Partnership Program
- Community Health Workers
- Diversifying the Healthcare Workforce (HCOP Program)
- Primary Care/Population Health
- Violence Intervention Programs
- Kindness, Compassion, Empathy, and Trust

requires...

motivation

collaboration

innovation

# call to **action**



In a racist society, it is not enough to be non-racist, we must be anti-racist.

-Angela Davis



# get activated: **build connection**

- Stop being “colorblind.”
- Educate yourself.
- Do not contribute to micro-aggressions and call out others when they do.
- Listen to other people’s experiences without questioning their validity.
- Expand your social circle to include those who don’t look like you.
- Commit to improving social determinants of health.
- Take ownership: Be an ally and use your voice.



what  
can you  
do?



Start where you are.  
Use what you have.  
Do what you can.

-Arthur Ashe

get  
informed

get  
uncomfortable

get  
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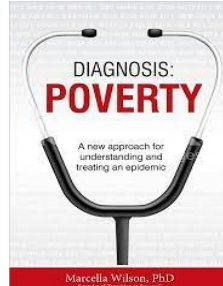
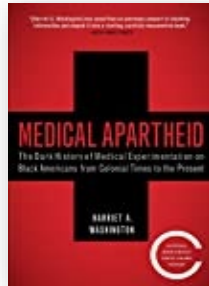
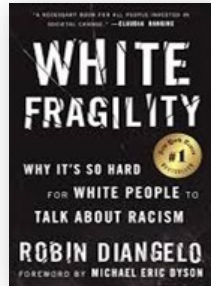
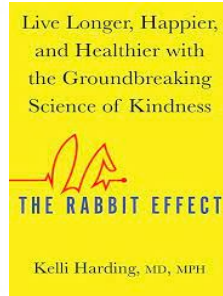
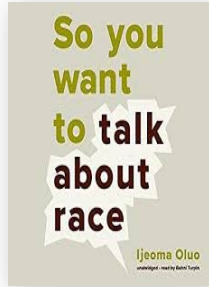
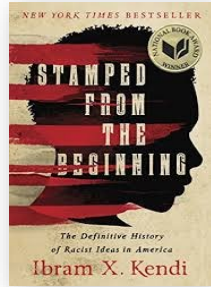
get  
activated



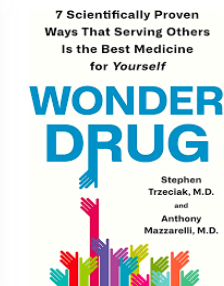
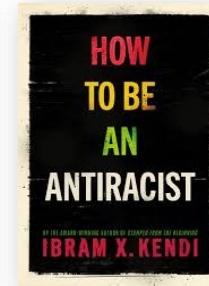
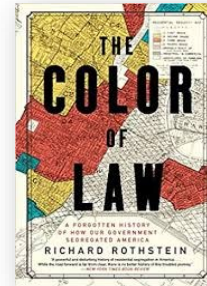
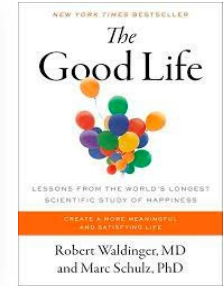
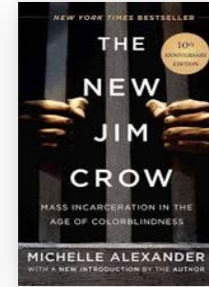
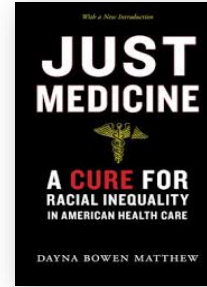
Questions?

# resources

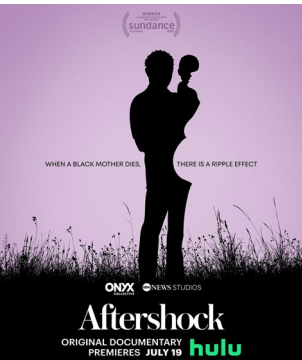
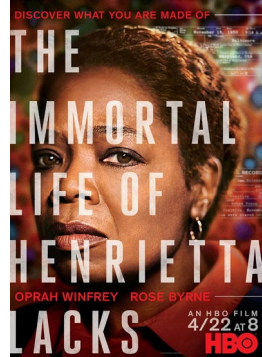
## Starter Level



## Intermediate Level



# resources





*whyhealth*  
matters