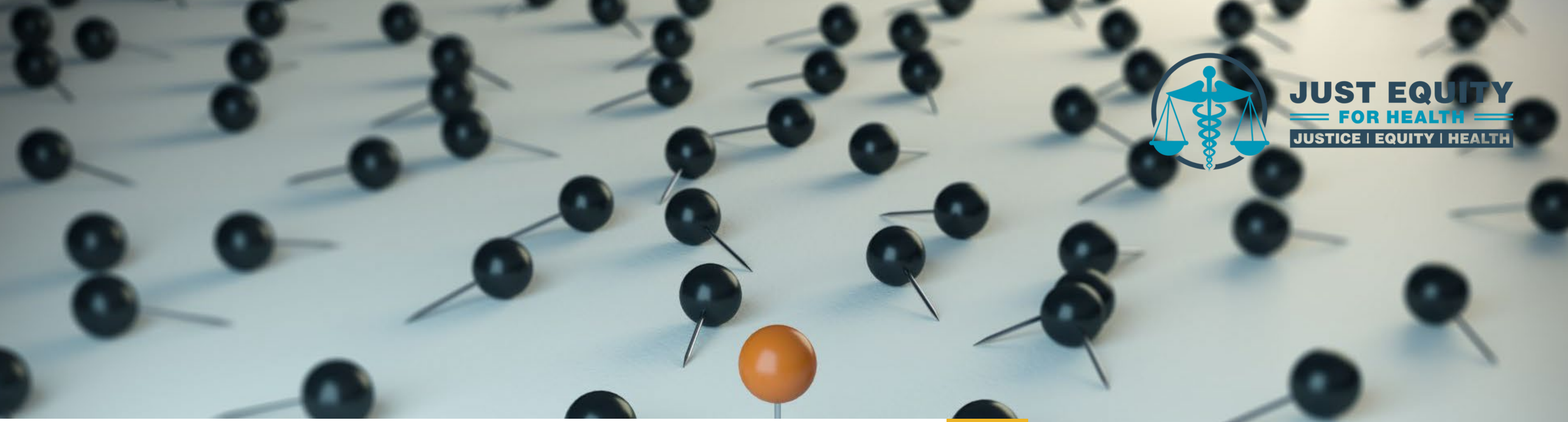

“Forward Together “

Community and Health System Partnerships to Center Health Equity

Stella Safo, MD MPH
Just Equity for Health, Founder & CEO
Assistant Professor Mount Sinai
December 2023

CAPH & SNI

- 2023 -

My Perspectives

Clinician

Board certified primary care physician with active panel of HIV and adult medicine patients

Designer

Experience in systems design as lead in Mount Sinai and Premier Inc.

User

Experience as a patient with a chronic medical disorder

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Learning Objectives

1. Outline the urgency of health equity in the context of current healthcare opportunities and challenges

2. Share frameworks and approaches to how equitable care can be delivered in various settings, with an understanding of potential backlash

3. Provide future solutions for applying a health equity lens to create lasting health system-community alliances and partnerhsips

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Bright Spots and Yellow Lights

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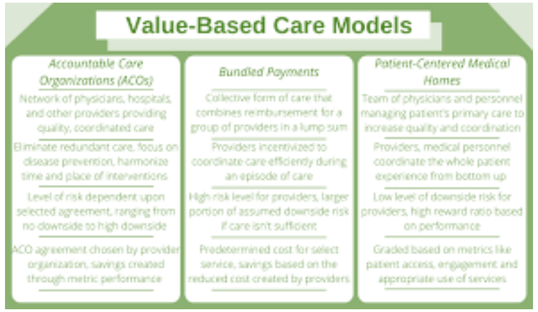
Progress in Significant Areas of Healthcare Delivery

- Access to healthcare

- Innovative value-based models



- Supportive technology

- Attention to structural inequities

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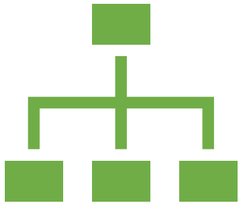
Clinical and Systems Design Perspective Suggests More is Needed

- In providing care or creating care models in various environments, what we are consistently missing is end-user voices and the intersectional perspectives they offer

Experience of healthcare workforce in providing **clinical care** and using services

Experience of health systems in **designing care models** and delivery protocols



Experience with **life science** companies from designing research and innovation

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Healthcare design often misses diverse frontline staff and patient voices in what and how we innovate

- “Nearly 64 percent of active physicians were White, 20.6 percent were Asian, 6.9 percent were Hispanic, and 5.7 percent were Black or African American.” – AAMC (Association of American Medical Colleges)

- Lack of engaging end-user voices means we lack the varied perspectives needed to inform good care model design and clinical delivery work

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Conundrum

- We take steps forward that could be transformative, but we are consistently hampered by inequitable outcomes→ we are on a fast moving forward journey with multiple yellow lights that are slowing our progress

- Our task now is to learn from these design challenges and apply them as we move forward in improving healthcare innovation

The Case For Health Equity

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Why an Equity Lens is Needed: What We've Known

- Health access, outcomes and quality are unequal across different intersectional characteristics (e.g. race, sexuality, gender, geography, etc.)

Category	Non-Hispanic White (%)	Black (%)	Latine (%)
Insurance status: Uninsured	5.7	9.6	17.7
Chronic disease: Diabetes Mellitus II	7.5	12.5	11.5
Service Access: Receiving mental health services	48	31	31
Birth Outcomes: Infant deaths	4.6 deaths/1000 births	10.8 deaths/1000 births	5.0 deaths/1000 births

Sources: https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Diverse-Populations.pdf
https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm

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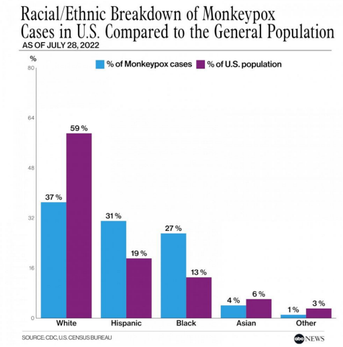
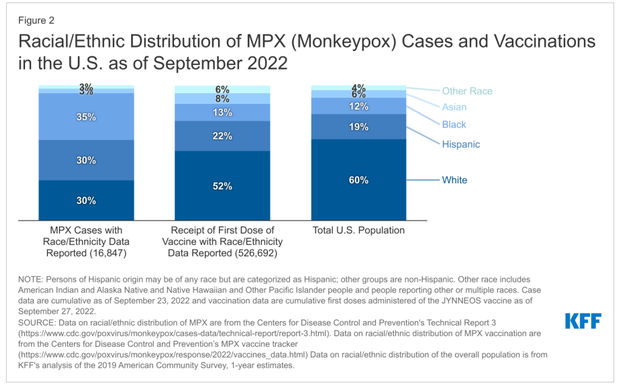
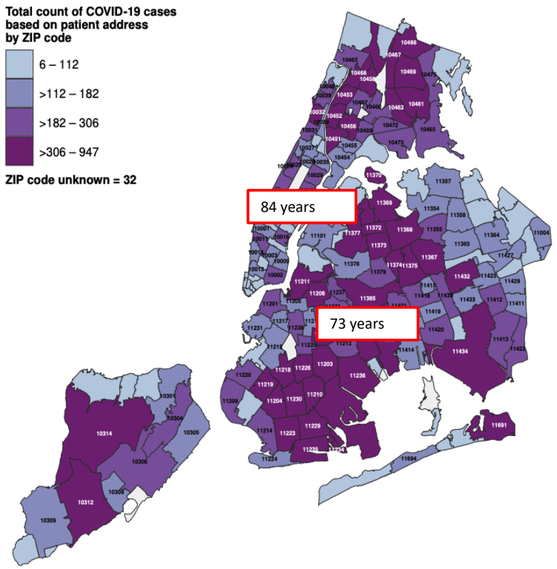
Why an Equity Lens is Needed: What We've Learned

- These differences are not immutable, but are seen even in disease states that are completely novel, like Covid-19 + Mpox

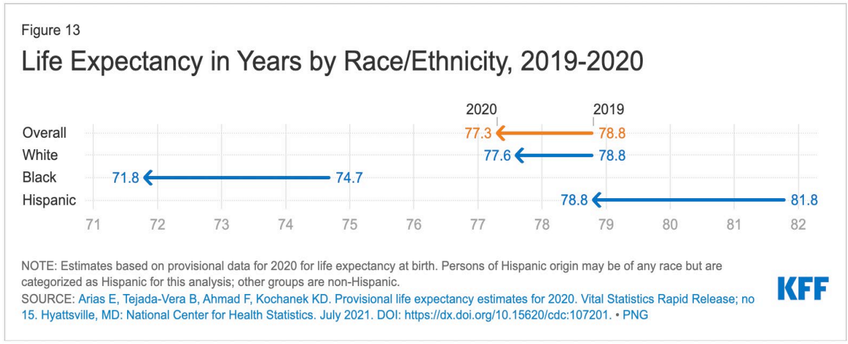


MPox





Covid-19



6.6 years

Decline in life expectancy for American Indian, Alaskan Natives since 2019

Sources: https://www.kff.org/global-health-policy/issue-brief/assessing-monkeypox-mpx-vaccine-eligibility-across-the-united-states/
https://ncdp.columbia.edu/ncdp-perspectives/racial-disparities-and-covid-19/covid-19-in-nyc_compare_hr/
https://tinyurl.com/mux2cuhv

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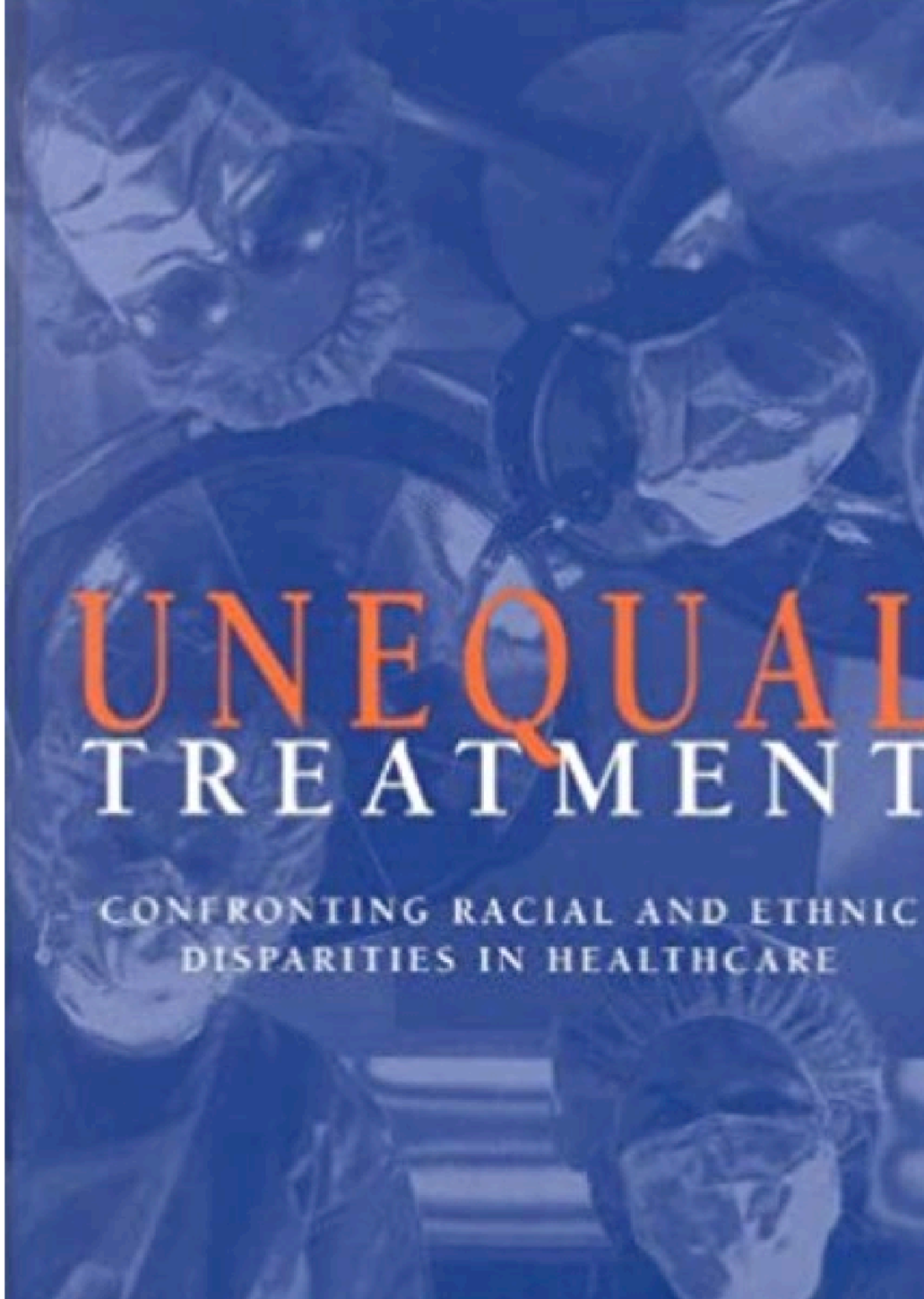
Biases and Clinical Care

- Healthcare workers have the same biases of the general public and this results in differences in how patients of intersectional identifies are perceived
- Implicit bias has an impact on clinician treatment of acute myocardial infarction, cancer care and pain management. IB also impacts treatment plans, patient satisfaction, and likelihood to continue to utilize healthcare services. (Maina et al, Hall et al.)
- Implicit bias is one of many forms of discrimination in healthcare

- Addressing bias has been an explicit focus of medical care delivery since the seminal 2003 Institute of Medicine's *Unequal Treatment* report which documents how racial and ethnic discrimination impacts healthcare outcomes



Sources: https://pubmed.ncbi.nlm.nih.gov/25032386/

https://pubmed.ncbi.nlm.nih.gov/28532892/

Inequities Are Baked Into How We Deliver Medical Care

- Diagnostics: Wearables, Equipment
  - Example: Pulse ox measures miss occult hypoxemia in those with more melanin, delaying access to life-saving care during early days of Covid-19 pandemic

- Treatment Plans: Algorithms for care (eGFR, PFTs, VBAC)
  - Example: Estimated glomerular filtration rates fail to recognize early signs of kidney disease in Black patients, leading to delays in care

- Delivery Platforms: EHRs, Virtual Medicine
  - Example: Telehealth may improve access but it is unevenly available to populations with a high Social Vulnerability Index and those who live in rural settings

- This may worsen as large corporations + Big Tech acquire sectors of delivery space

Sources: https://www.healthaffairs.org/do/10.1377/forefront.20210909.961330/
https://onlinelibrary.wiley.com/doi/abs/10.1111/1468-0009.12509
https://www.bmj.com/content/378/bmj-2021-069775

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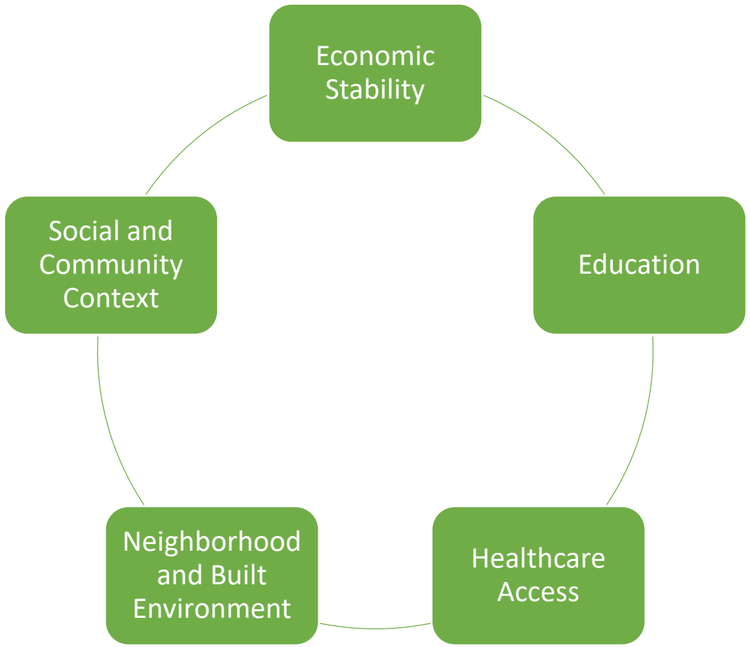
Recognizing the Impact of Social Drivers of Health



- Growing focus on impact of SDOH- all non-medical factors influencing health outcomes

- Healthcare delivery is rightly focused on more equitable care for all populations.
  - Population health – value-based payments ensure focus on high utilizers and *whole* population
  - Societal consciousness – Covid-19 + 2020 racial reckoning
  - Healthcare costs- 60-80% health tied to SDOH, up to $320 million excess dollars yearly

- CDC: Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances

- Equity vs. Disparities: Disparities describe the differences in outcomes, while inequity highlights the societal causes for these differences

Sources: https://www.cdc.gov/socialdeterminants/index.htm
https://www.cdc.gov/chronicdisease/healthequity/index.htm

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"You cannot solve a problem at the level on which it was created"
A. Einstein

- A focus on health equity requires us to name the causes, because **you cannot solve for what you will not name**

- Causes of health inequities are the underpinnings of our society- structural racism, classism, sexism, capitalism and work exploitation, ableism, and so much more

- A focus on health equities requires us to ask two questions:
  1. What caused it to be this way?
  2. How do we solve the problem without reinforcing these structural inequities?

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What I hear…

- “Is queer offensive or ok?”
- “Can I say Indian or Native American? What should I say instead?”
- “Are people still using the term BIPOC? What about Black and brown?”
- “Someone said touching a coworker’s hair is a microaggression? So is saying certain individuals are articulate?... I feel like I’m going to do or say something wrong”
- “Is it Latinx, Latine or Latino/a?”
- “Why are people offended by terms like HIV-infected or drug addict; what should I say instead?”
- “I wrote “Blacks” in a tweet and someone told me I should never say that- what did I say wrong?”

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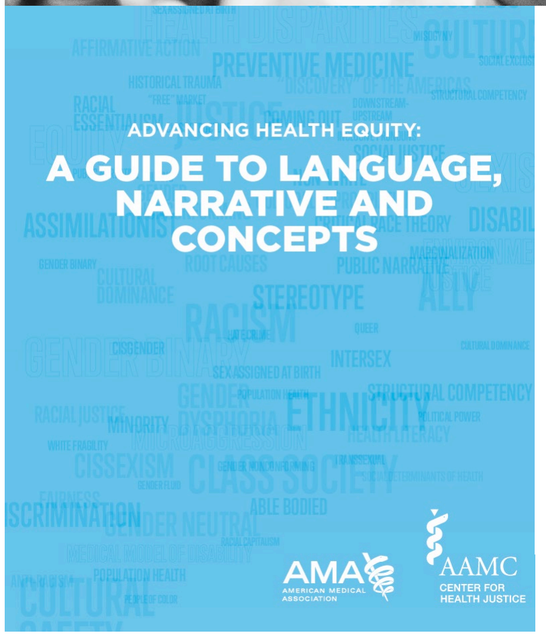
Laying a Foundation

- Multiple guides exist to teach person-first and inclusive language
- Terms are constantly changing and improving
- Matters not so much that you're getting terms perfectly correct each time, but that you're mindful of language use and how terms and actions impact real people
- Foundational work started with National Equity Project Collaboration



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https://www.cdc.gov/healthcommunication/Health_Equity_Lens.html

Direct Solutions to Levels of Inequities

- To apply a health equity lens, one must be clear on which level (Interpersonal, Institutional, Structural) the inequity exists.

Interpersonal

- **Interpersonal bias** describes discriminatory actions between individuals e.g. a provider and patient

Institutional

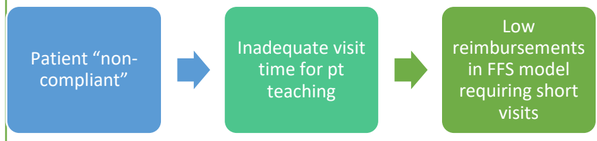
- **Institutional bias** describes the forms of discrimination that an institution like a health system may purposefully or inadvertently have (for example, the existence of racially segregated medical facilities in the Jim Crow South or lack of language services for non-English speakers)

Structural

- **Structural bias** refers to the societal levels of discrimination that impact individuals or populations, often through legislation (for example, historic restrictions on gay marriage in certain states)

<u>A Challenge</u>

Every time you design a healthcare solution, ask yourself: what level of inequity am I addressing and can I move up one level to address the root cause?



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Applying Health Equity Frameworks

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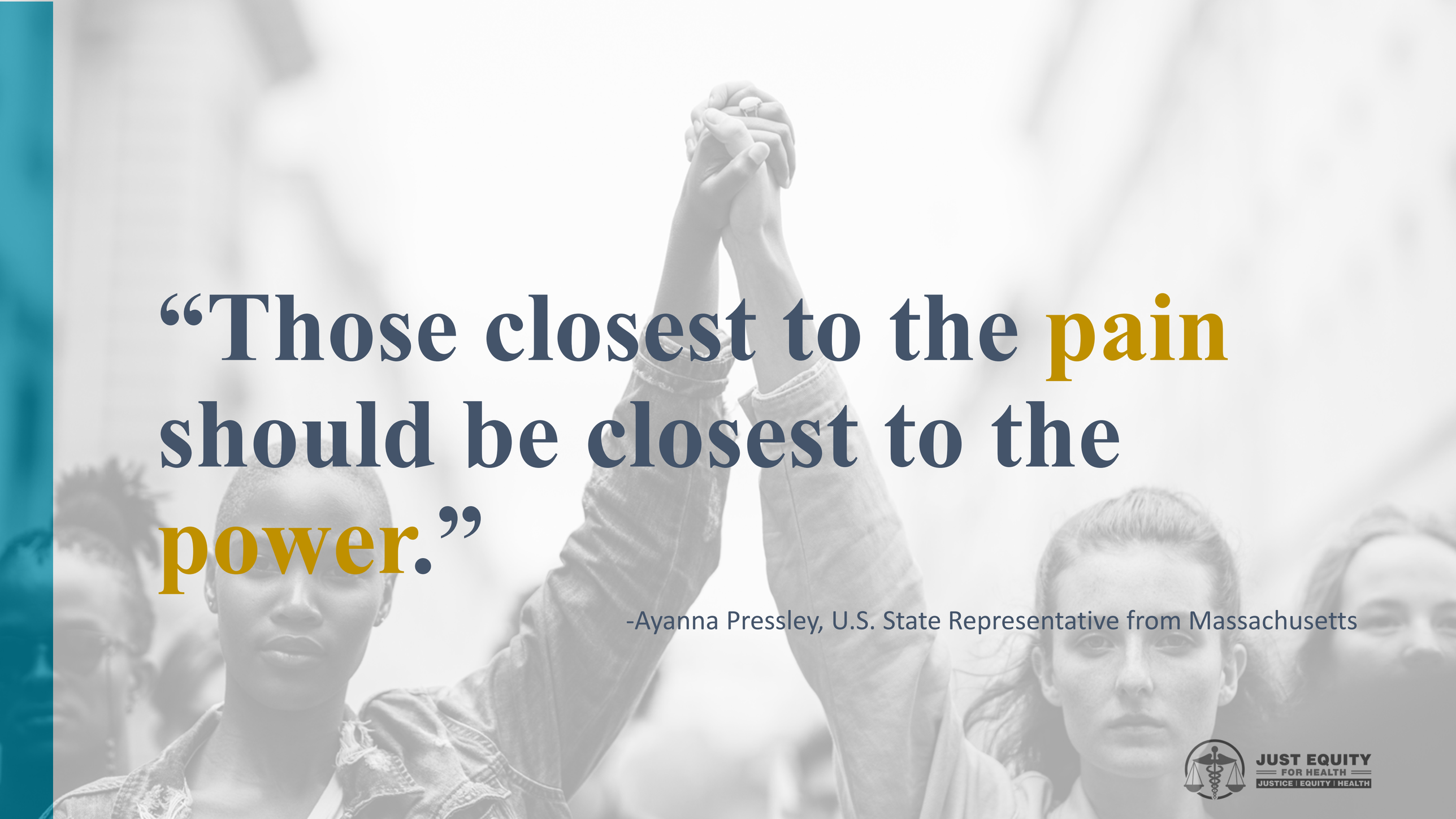

“Those closest to the pain should be closest to the power.”

-Ayanna Pressley, U.S. State Representative from Massachusetts

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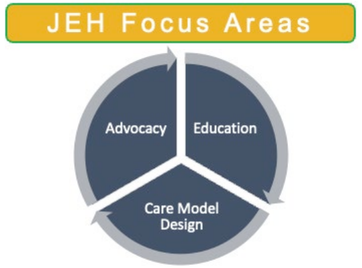
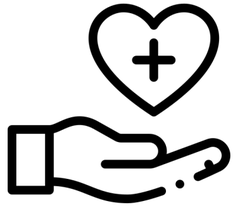
OUR COMMITMENT



Just Equity For Health operationalizes equitable healthcare delivery.

Advocates, educates and implements care founded on equity



Care co-designed by populations who will utilize it

Activated healthcare workforce with social determinants of health focus

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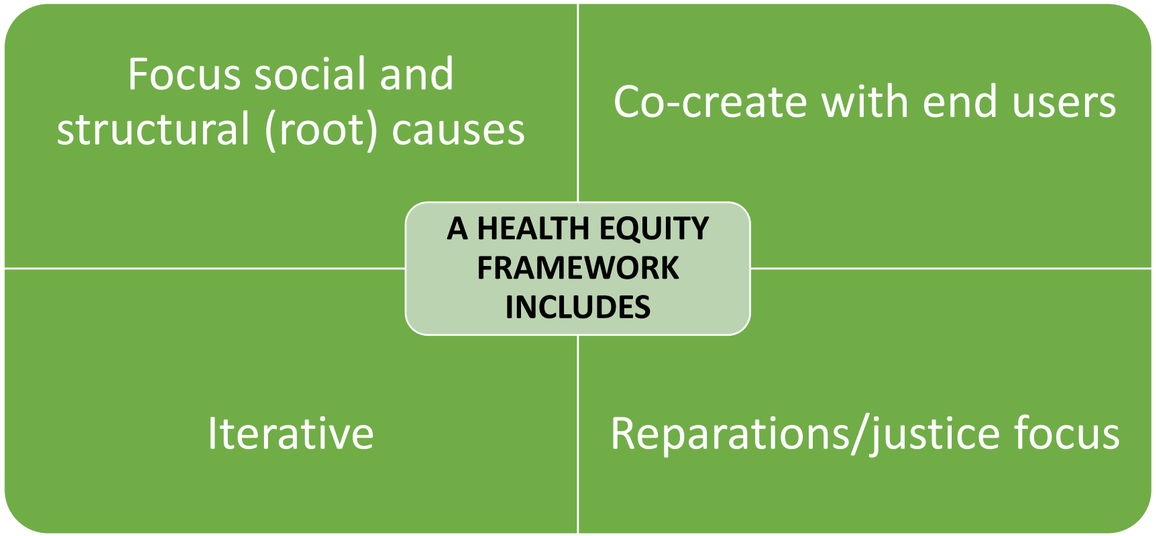
What Do We Mean By Applying a Health Equity Approach?

- Current design of care delivery is done by unspoken drivers:
  - Population health centers quality improvement, financial savings
  - Drivers of health inequities which are embedded into our way of doing things persist unbounded→ need for an active process

- Bringing in a health equity framework centers achieving improvements in healthcare for historically marginalized groups

- Loosely, a focus on health equity includes:



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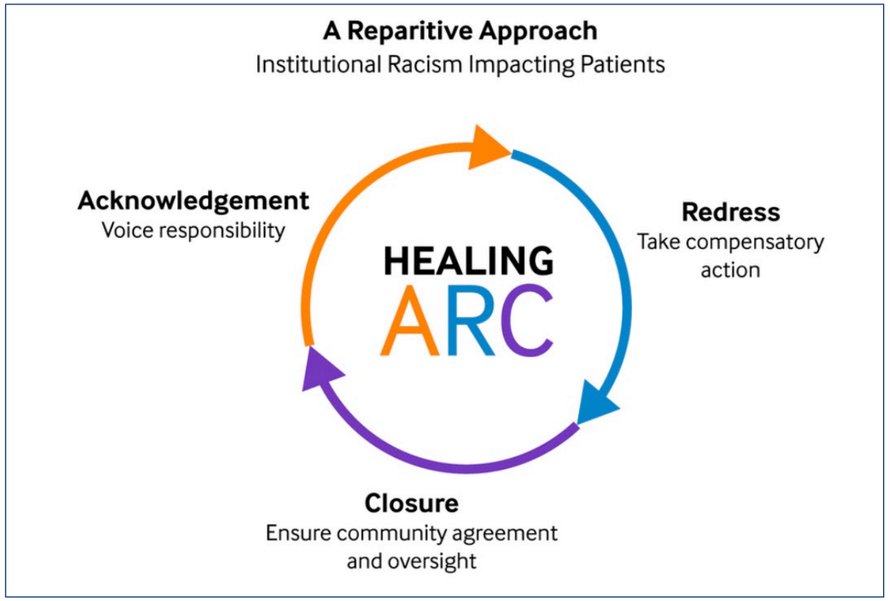
Frameworks Guiding Application

- DEVS (from Just Equity for Health) + Healing ARC (Applied at BWH by Morse and Wispelwey) provide theoretical frameworks for how an equity lens can be applied

AREA OF FOCUS: DEVS	GUIDING QUESTIONS
Designers	• Who is doing the care model design work? • Who will utilize the models? • Are these two groups overlapping?
Environment	• How have you accounted for historical and contemporary systemic inequities?
Value	• How do you measure success, taking into account usual population health measures while capturing equity metrics across different groups?
Scale	• How do you co-design the intervention using a scaled approach e.g. testing with pilot site/cohorts to allow for iteration and improvement before scaling?



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https://justequityforhealth.com/

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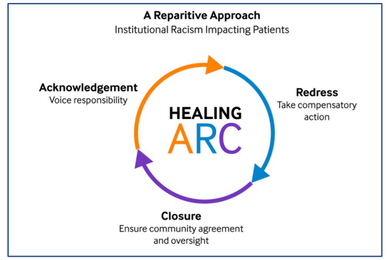
Use Case: The Healing ARC Model Applied

- The Healing ARC framework outlines an approach to implement health equity into care model design to close race-driven gaps in quality and performance outcomes
  - Heart failure care in Boston
  - Race based-clinical algorithms in New Yorl
  - Vaccine prioritization nationally
  - And more

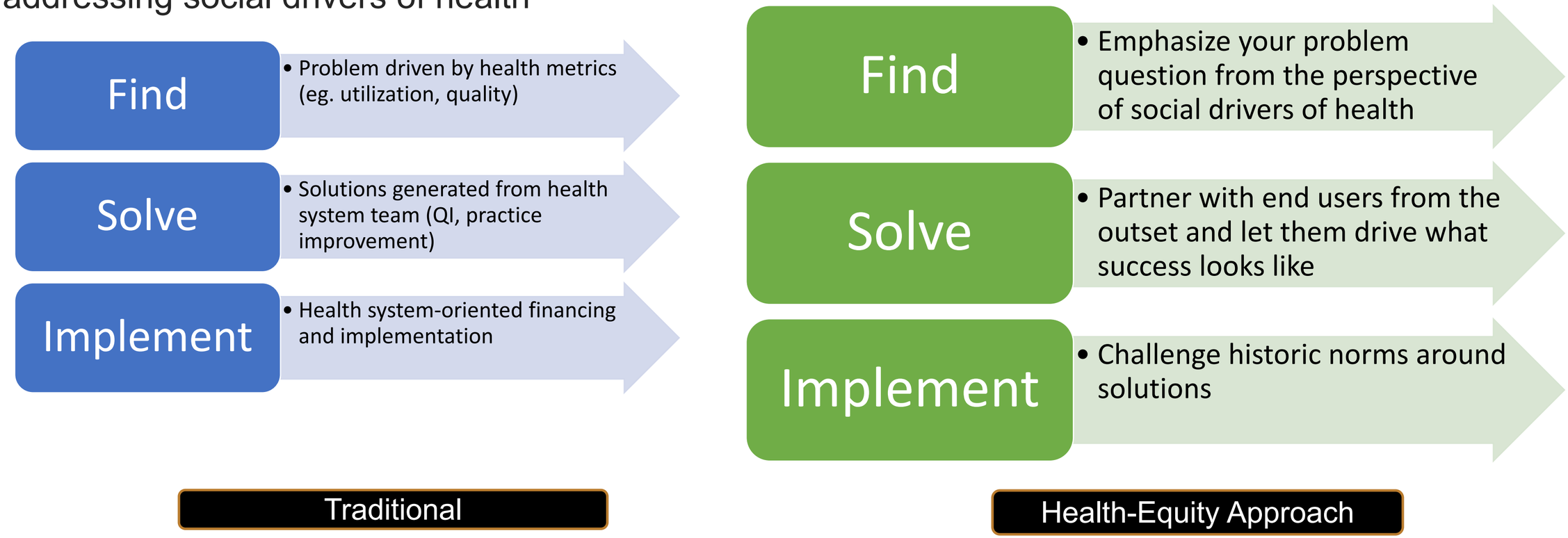


Healing ARC Framework Applied To NYC Analysis Of Racism In Clinical Algorithms Impacting Patient Care And Treatment

Source(s): https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0076

How to Apply an Equity Lens

- Population health presents a unique opportunity to rethink how care models are designed and rolled out to populations
- An equity lens moves from traditional ways of creating new care systems to ones focused on addressing social drivers of health



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Application: Equity-based Care Model Design

Find

- People with uncontrolled HIV need care- Instead of “how to get them to come into clinic more,” focus on understanding non biomedical causes for this lack of engagement.
- Ask “How do we reach them where they are best served and what do we need to provide within the clinical setting to meet this population’s needs?”

Societal drivers of inequities centered in question generation

Solve

- The design team will include members of the classic practice redesign team, but should be heavily influence—and if possible—led by those who identify with the affected group.
- If members of this group cannot sit on the design team, initial prototypes are workshopped with these individuals before finalizing for pilot implementation.

End users and those most impacted at the design table

Implement

- Solutions include providing onsite care (at events, online, locale geographics, etc.) or paying people to come in for services. Anticipate pushback to the financing of these solutions and small pilots to prove value before larger scale.

Financing those most proximate to delivering solutions

Creating a Future With More Bright Spots

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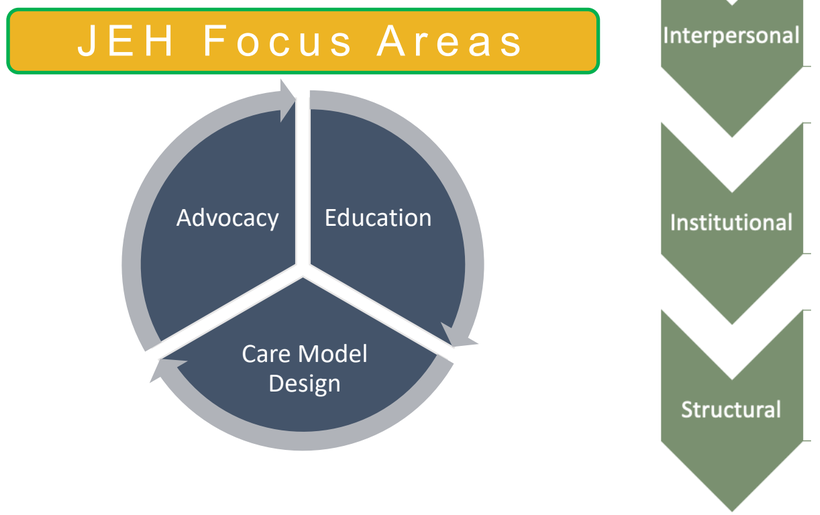
Healthcare suffers, not from lack of innovation, but lack of effective implementation

Create Spaces for Co-Design

Create a Customized Framework

Support Movements



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Create Spaces for Co-Design with Communities

INTERPERSONAL

- Reach community members **where they are**:
  - Note the intersectional roles community members hold
  - Use real-time feedback tools
  - Join CBOs at their sites
  - Assess how the community views your input (partner, supporter, etc.)
  - *As a reflex, ask "Are we (as an institution) taking up space that could/should belong to a CBO?"*

- Create **circumstances favorable** to continued participation:
  - Pay for time
  - Use non-traditional scheduling
  - Expand short timelines or create expectation for iterative design

- Real-world Application (JEH):
  - Care model design lever: partnering with community groups as trusted messengers for HIV prevention and Covid-19 vaccine campaigns

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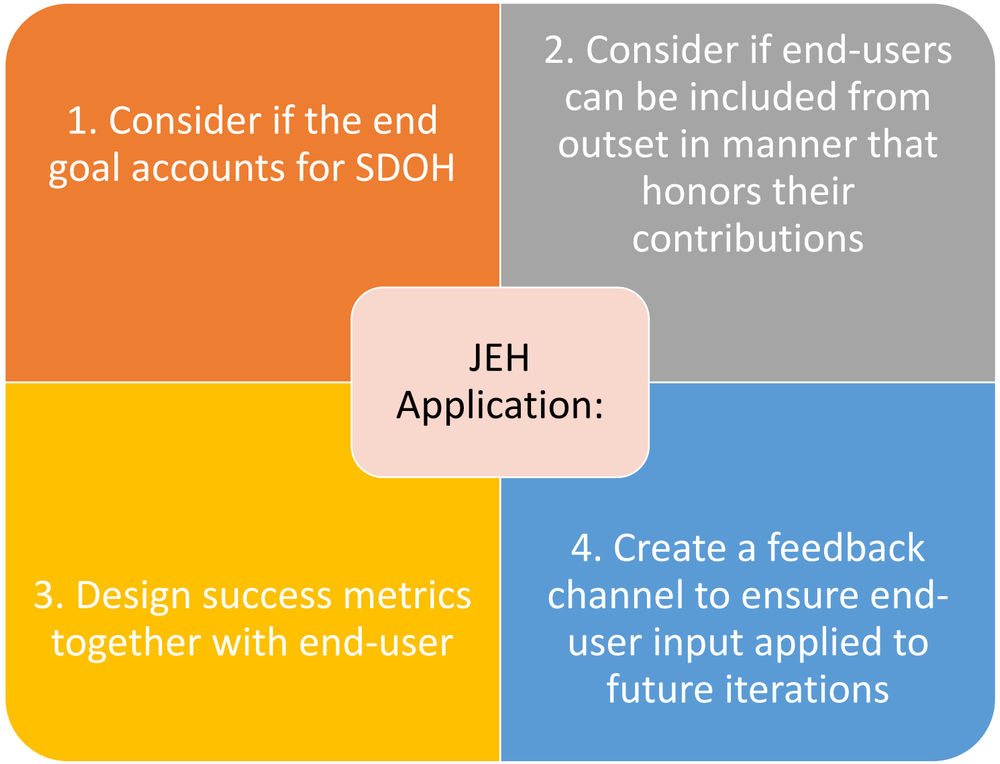
Create a Customized Health Equity Approach

INSTITUTIONAL

What it includes? → How it's styled? → Who it impacts? → How it's measured?

- **What includes**: Elements of a strong equity approach ensures end-user input is present and uses a reparative lens that acknowledges both remote and current history
- **How styled**: Clarity and ease of any equity approach is important to ensure uptake
- **Who impacts**: Building it stakeholders who will permission (e.g. c-suite) and use it (e.g. frontline staff) will make it more likely to be successful
- **How measured:** Measures of success are crafted to what matters to community members



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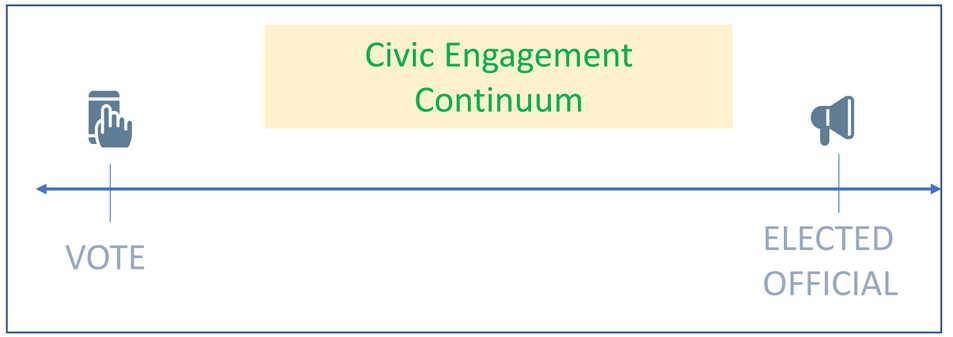
STRUCTURAL

Support Movements That Shift Power to Communities

- Using **collective power** of this group, consider support for
  - Establishment of **Anchor Models** for large healthcare systems to invest in workforce of their communities
  - Investment in **decentralized clinical trials**, which have been shown to increase the diversity of patients who can access trials by overcoming health-centered delivery
- CBOs can increase **weight of accountability** by seeking non-health system points of power
  - These include local city councils and state representatives
- Real-world Application (JEH):
  - Advocacy lever: Organizing communities, health systems and healthcare workers around gender and racial equity efforts and civic engagement movements
    - Equity Now- Gender/Race Equity Legislation with NYC Council
    - Civic Health Alliance- national focus



We define **civic engagement** as encompassing the variety of ways individuals and groups participate in their communities and public life, in service of addressing issues of public concern and/or improving community conditions

CIVIC HEALTH ALLIANCE

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Our Way Forward

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Our Way Forward

- The **urgency of centering health equity** is reflected in the differences in health outcomes by race, gender, geography, sexual identity and other intersectional characteristics
- To address these gaps, we must invest in building **approaches and frameworks** which consider interpersonal, institutional and structural approaches in how we design equitable interventions
- Frameworks like DEVS and Healing ARC may be **adapted for application** to each health system and institution's unique context, with an expectation for pushback
- Investing in **customized frameworks, spaces for co-design, and collective action around key movements**, we can create the kind of future where healthcare improvements benefit those who are historically left behind

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“

Medicine should be viewed as social justice work in a world that is so sick and riven by inequities.

Paul Farmer

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THANK YOU!

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