HEALTH EQUITY LEARNING SERIES
Solutions for Health Equity
The Patient-Centered Medical Home: A Path Toward Health Equity?

Winston Wong, Kaiser Permanente; Karen M. Anderson, Institute of Medicine; Irene Dankwa-Mullan, National Institutes of Health; Melissa A. Simon, Northwestern University; and William A. Vega, University of Southern California*

September 2012

*Participants in the activities of the IOM Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

The views expressed in this discussion paper are those of the authors and not necessarily of the authors’ organizations or of the Institute of Medicine. The paper is intended to help inform and stimulate discussion. It has not been subjected to the review procedures of the Institute of Medicine and is not a report of the Institute of Medicine or of the National Research Council.

ALTHOUGH THEIR NUMBERS ARE GROWING IN COLORADO AND THE NATION, RACIAL AND ETHNIC MINORITIES ARE STRONGLY THE MINORITY IN THE HEALTH CARE WORKFORCE. For instance:

- Nationally, people of color make up 14 percent of physicians, 9 percent of dentists, 14 percent of nurses, and 17 percent of city and county public health officials.
- Almost all (98%) senior managers in health care organizations across the nation are white.

This situation does not match the evolving racial and ethnic makeup of the nation or Colorado. People of color make up more than 30 percent of Coloradans and 35 percent of the U.S. population. Given that communities of color experience a disproportionate burden of morbidity and mortality, increasing workforce diversity is vital to eliminating health disparities. Studies show providers of color are more likely to practice in underserved areas with greater racial and ethnic minority populations and serve patients of color who are uninsured or underinsured.

The Colorado Trust, Health Equity and Financial Well-Being: How to Address the Shortage of Racially and Ethnically Diverse Health Professionals

INSTITUTE OF MEDICINE
Advising the nation • improving health

"There is a comfort level that is almost immediately apparent when [patients] are served by someone like them. It makes a phenomenal difference."

—Kerry Buttsman, Chief Executive Officer, Inner City Health Center, Denver
Viewing Parties

- Alamosa
- Colorado Springs
- Durango
- Eagle
- Fort Collins
- Frisco
- Grand Junction
- Gunnison
- Lamar
- Leadville
- Montrose
- Monte Vista
- Pueblo
- Rifle
- Steamboat
- Telluride
- Yuma
Today’s Presenters

Anthony Iton, MD
Senior Vice President
The California Endowment

Winston Wong, MD
Medical Director
Kaiser Permanente
Health is political

“The struggle over the allocation of scarce and precious social goods”
Argument

1. Where you live influences how long you live
2. Policy/politics shapes neighborhood design & resources- (inner cities, Chinatowns, barrios)
3. Living in a resource deprived community is chronically stressful
4. Chronic stress produces chronic disease
5. Medical care is a necessary but insufficient tool
ZIP CODE 94301 LIFE EXPECTANCY 86

Your ZIP Code shouldn’t predict how long you’ll live.

health happens here
Policy/Politics Shapes Neighborhoods

and resources.....
II

That plaintiffs are the owners of lots or parcels of land within and being a portion of Tract 597, Washington Township, Alameda County, California, as said tract is delineated and so designated on map thereof recorded in the office of the County Recorder, Alameda County, California, in Book 17 of Maps, page 95. That plaintiffs are the owners of record and in fact respectively of the following lots in said tract:

1. Melton Matthews and Florence Mathews, his wife, lot 28;
2. Louise W. Nielsen and Isabel E. Nielsen, his wife, lot 29;
3. E. A. Miller and Marybelle Miller, his wife, lot 18.

III

That under date of April 7, 1941, Frank E. Clarke, Wabel S. Clarke, Ada E. Rowe, E. W. Stenhammer, and Esther Stenhammer, did execute and thereafter cause to be recorded on the 30th day of April, 1941, in Book 4028 of Official Records, at page 611, in the office of the County Recorder of Alameda County, California,

"(5) no person or persons of the Mexican race, or other than the CAUCASIAN race shall use or occupy any building or any lot, except that this covenant shall not prevent occupancy by domestics or servants of a different race domiciled with an owner, tenant or occupant thereof.

at which time said covenants and restrictions shall terminate.

"(10) if the parties hereto, or any of them, or their heirs, successors or devisees, executors or administrators or assigns, shall violate, or attempt to violate, any of the covenants or restrictions herein contained before January 1, 1961, any owner or owners of the remainder of the premises herein described, or of
The FHA and Covenants

- Federal Housing Administration recommended racially restrictive covenants to receive mortgage guarantees.

“*It is necessary that properties shall continue to be occupied by the same social and racial groups*” - Federal Housing Administration Underwriting Manual 1938.

- 30 year mortgages, 10% down payment.
- Without FHA, 33%-50% down payment. Far shorter mortgages (higher monthly payments).
Exclusionary Policies & Legacy

- Redlining, racially restrictive covenants
- School segregation, funding
- Health insurance
- Transportation priorities
- Predatory lending
- Affordable housing, sub prime lending
- Immigration
- Marriage
- Legacy-Social Security, GI Bill
How Does Your “Neighborhood” Get Under Your Skin?
Actual Causes of Death

A bridge between genotype and phenotype—a phenomenon that changes the final outcome of a locus or chromosome without changing the underlying DNA sequence.

PERSONAL RESPONSIBILITY!!

Lifestyle 51%
Smoking
Obesity
Nutrition
Alcohol Use

Epigenetics

Biology 20%

Health Care 10%

Environment 19%

When the external becomes internal: How we internalize our environment

Allostatic Load

- Inadequate Transportation
- Long Commutes

- Housing

- Lack of social capital

Stress

- High Demand-Low Control Jobs

- Lack of access to stores, jobs, services

- Crime
Stressed vs. Stressed Out

**Stressed**
- Increased cardiac output
- Increased available glucose
- Enhanced immune functions
- Growth of neurons in hippocampus & prefrontal cortex

**Stressed Out**
- Hypertension & cardiovascular diseases
- Glucose intolerance & insulin resistance
- Infection & inflammation
- Atrophy & death of neurons in hippocampus & prefrontal cortex
### Equal Postsecondary Attendance Rates for Low-Income, High Achievers and High-Income Low Achievers

<table>
<thead>
<tr>
<th>Achievement Level (in quartiles)</th>
<th>Low-Income</th>
<th>High-Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>First (Low)</td>
<td>36%</td>
<td>77%</td>
</tr>
<tr>
<td>Second</td>
<td>50%</td>
<td>85%</td>
</tr>
<tr>
<td>Third</td>
<td>63%</td>
<td>90%</td>
</tr>
<tr>
<td>Fourth (High)</td>
<td>78%</td>
<td>97%</td>
</tr>
</tbody>
</table>

Source: NELS: 88, Second (1992) and Third Follow up (1994); in, USDOE, NCES, NCES Condition of Education 1997 p. 64
A Framework for Health Equity

Medical Model

- Adapted by ACPHD from the Bay Area Regional Health Inequities Initiative, Summer 2008
A Framework for Health Equity

Socio-Ecological

Medical Model

Upstream

Downstream

Health Inequities

Risk Factor Behavior

Health Disparities

Mortality

Health Status

Adapted by ACPHD from the Bay Area Regional Health Inequities Initiative, Summer 2008
A Framework for Health Equity

Socio-Ecological

Medical Model

UPSTREAM

Discriminatory Beliefs (ISMS)
- Race
- Class
- Gender
- Immigration status
- National origin
- Sexual orientation
- Disability

Institutional Power
- Corporations & other businesses
- Government
- Schools

Social Inequities
- Neighborhood conditions
- Social isolation
- Racial segregation
- Workplace conditions

DOWNSTREAM

Individual Health Knowledge

Risk Factors & Behaviors
- Smoking
- Nutrition
- Physical activity
- Violence
- Chronic Stress

Disease & Injury
- Infectious disease
- Chronic disease (intentional & unintentional)

Health Status
- Infant mortality
- Life expectancy

Healthcare Access

Inequities

Disparities

Adapted by ACPHD from the Bay Area Regional Health Inequities Initiative, Summer 2008
A Framework for Health Equity

Socio-Ecological

UPSTREAM

Family & Culture

DOWNSTREAM

Medical Model

Conditions

Consequences

- Adapted by ACPHD from the Bay Area Regional Health Inequities Initiative, Summer 2008
Inclusion & Sustainability
Health in All Policies
Resilient & Transformed Communities
Behavior
Disease
Death

Change the Narrative
Policy Advocacy
Building in Place
Health Education
Clinics
Emergency Rooms

Socio-Ecological (society)
Medical Model (individuals)
US spends two-and-a-half times the OECD average

Total health expenditure per capita, public and private, 2010 (or nearest year)

USD PPP

1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Total expenditure excluding investments.
Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

Source: OECD Health Data 2012.
Argument

1. Where you live influences how long you live
2. Policy/politics shapes neighborhood design & resources- (inner cities, Chinatowns, barrios)
3. Living in a resource deprived community is chronically stressful
4. Chronic stress produces chronic disease
5. Medical care is a necessary but insufficient tool
Contact Information

Tony Iton, MD, JD, MPH
Senior Vice President
The California Endowment

Aiton@calendow.org
(510) 271-4310
The Colorado Trust

November 15, 2013

Winston F. Wong, MD, MS
Medical Director, Community Benefit
Director, Disparities improvement and Quality Initiatives
Many Factors Shape Health

- Health is driven by multiple factors that are intricately linked – of which medical care is one component.

Drivers of Health

- Personal Behaviors: 40%
- Family History and Genetics: 30%
- Environmental and Social Factors: 20%
- Medical Care: 10%

Source: Determinants of Health and Their Contribution to Premature Death, JAMA 1993
We Must Address Health At All Levels
Total Health Framework

Social & Economic Factors (40%)
- Education
- Employment
- Income
- Family & social support
- Community safety
- Culture

Physical Environments (10%)
- Built environment
- Food environment
- Media/information environment
- Environmental quality

Clinical Care and Prevention (20% +)
- Access to care
- Quality of care
- Clinic-community integration

Health Behaviors & Other Individual Factors (30%)
- Diet & activity
- Tobacco use
- Alcohol use
- Unsafe sex
- Genetics
- Spirituality
- Resilience
- Activation

Health Outcomes And Wellbeing
- Physiology
- Disease and injury
- Health and function
- Wellbeing

Programs and Policies

Settings: Home Work at Place School Neighborhood Clinic Virtual

Richmond Area

- KP members have:
  - Some higher than average asthma prevalence
  - Higher hypertension prevalence
  - Higher obesity prevalence
  - Higher diabetes prevalence
Join the discussion...

- Q & A from the audience
- Submit questions via Twitter: #healthequityTCT
Health Equity
Our vision is that all Coloradans have fair and equal opportunities to lead healthy, productive lives regardless of race, ethnicity, income or where we live.

- HEALTH EQUITY LEARNING SERIES
- POLICY & ADVOCACY
- DATA & INFORMATION
- COMMUNITY-BASED GRANTMAKING

HEALTH EQUITY means ending inequalities that affect racial, ethnic low-income and other vulnerable populations, so that all Coloradans have fair opportunities to achieve good health.

GOOD HEALTH DEPENDS ON MORE THAN MEDICAL CARE. It is affected by where we live, the education we receive, the work we do, the wages we earn and by our opportunities to make decisions that improve our own and our family’s health.

CommunityConnections Blog
- 11/13/13 Increasing Empathy to Improve Patient Outcomes
- 11/04/13 Things Have (Slightly) Improved
Feedback Survey
November 15, 2013 Learning Lunch

Please take a moment to give us your feedback on the event today. Your responses will help us to plan future events like this one. You may leave your completed survey on the table before you leave.

1) What type of organization are you from?
   □ Community organization
   □ Policy/Advocacy organization
   □ Direct service provider - Health
   □ Research/Evaluation
   □ Academic Institution/University
   □ Government
   □ Media
   □ Business
   □ Community member
   □ Foundation
   □ Other: _________________________

2) What is the primary reason you chose to attend this event today?
   □ The topic was of interest to me
   □ The speaker was of interest to me
   □ Networking with community members
   □ My relationship with The Colorado Trust
   □ I’m here for the free lunch
   □ Other: _________________________

3) How relevant did you find the topic discussed today to your work?
   □ Highly relevant
   □ Somewhat relevant
   □ Neither relevant or irrelevant
   □ Not very relevant
   □ Not at all relevant

6) Are you interested in attending future events like this?
   □ Yes   □ No  Why not? _________________________
   If yes, I would prefer to attend:
   □ In person □ Stream online □ I would like to have both options

7) After attending this event today, do you feel more inclined to take action to promote health equity?
   □ Yes   □ No
   If not, why not?
   □ I already take action to promote health equity in my work; this has not changed
   □ It is not a high priority for me/my work, but I hope that others address it
   □ I do not feel that it is an important issue to address
   □ Other: _________________________

8) Will you take any action based on this event?
   □ I will take the discussion materials provided by The Trust back to my organization
   □ I will share the recording of this event with others in my organization (available shortly on The Trust’s website)
   □ I will encourage others to attend future events like this one
   □ Other: _________________________
   □ It is unlikely that I will take any action

9) Prior to this event, were you aware of the option to stream this event online?
   □ Yes   □ No

10) Please rate your level of satisfaction with the following:
Thank you for joining us!