Communities in Action: Pathways to Health Equity

May 5, 2017

#PromoteHealthEquity

Community Driven
The committee

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- Lisbeth Schorr
- Nick Tilsen
- William Wyman
The Robert Wood Johnson Foundation asked the committee to:

- Review the state of health disparities in the United States and explore the underlying conditions and root causes contributing to health inequity and the interdependent nature of the factors that create them.

- Identify and examine a minimum of six examples of community-based solutions that address health inequities, drawing both from deliberate and indirect interventions or activities that promote equal opportunity for health, spanning health and non-health sectors accounting for the range of factors that contribute to health inequity in the US (e.g., systems of employment, public safety, housing, transportation, education).

- Identify the major elements of effective or promising solutions and their key levers, policies, stakeholders, and other elements that are needed to be successful.

- Recommend elements of short- or long-term strategies and solutions that communities may consider to expand opportunities to advance health equity.

- Recommend key research needs to help identify and strengthen evidence-based solutions and other recommendations as viewed appropriate by the committee to reduce health disparities and promote health equity.
The report in brief
9 chapters, 15 recommendations

A. Health equity is crucial for the wellbeing and vibrancy of communities. Chapter 1 & 2

B. Health is a product of multiple determinants. Chapter 3

C. Health inequities are in large part a result of poverty, structural racism, and discrimination. Chapter 3

D. Communities have agency to promote health equity. Chapters 4 & 5

E. Supportive public and private policies (at all levels) and programs facilitate community action. Chapter 6

F. The collaboration and engagement of new and diverse (multi-sector) partners is essential to promoting health equity. Chapter 7

G. Tools and other resources exist to translate knowledge into action to promote health equity. Chapter 8
Report conceptual model

Context—May be equal but not equitable

Key elements of community-based solutions/COH

Causes of Inequity—Non-Linear

 Desired outcome

Structural Inequities and Biases, Socioeconomic and Political Drivers

Community Driven Solutions

Transportation

Education

Employment

Health Systems & Services

Housing

Income & Wealth

Social Determinants of Health

Community Driven Solutions

Making health equity shared vision and value

Fostering multi-sector collaboration

Healthier more equitable communities in which individuals and families live, learn, work, and play

Increasing community capacity to shape outcomes
Vital Directions for Health and Health Care Priorities From a National Academy of Medicine Initiative

The vision
A health system that performs optimally in promoting, protecting, and restoring the health of individuals and populations and helps each person reach his or her full potential for health and well-being

Core goals
- Better health and well-being
- High-value health care
- Strong science and technology

Health Equity
- Action priorities
  - Pay for value
  - Activate communities
  - Empower people
  - Connect care
- Essential infrastructure needs
  - Measure what matters most
  - Accelerate real-world evidence
  - Modernize skills
  - Advance science

Achieving the vision of the Vital Directions for Health and Health Care requires focusing on 3 core goals—better health and well-being, high-value health care, and strong science and technology—and pursuing the action priorities and infrastructure needs required for their achievement.
Preface

Our founders wrote, that all people are created equal with the right to

“life, liberty and the pursuit of happiness.”

Equality and equal opportunity are deeply rooted in our national values, wherein everyone has a fair shot to succeed with hard work.
## Health inequities in the U.S.

**Infant mortality rates, 2013 select examples**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Infant Mortality Rate (per 1,000 live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Americans</td>
<td>11.1</td>
</tr>
<tr>
<td>Native Americans</td>
<td>7.61</td>
</tr>
<tr>
<td>Puerto Ricans</td>
<td>5.93</td>
</tr>
<tr>
<td>Whites*</td>
<td>5.06</td>
</tr>
</tbody>
</table>

*In 2012, IMR was 7.6 per 1,000 for white infants in the Appalachian region.  
*Children’s Defense Fund, 2016*

**Note:** Infant mortality is one of the indicators of overall health.
Health inequities in the U.S.

Disparities in life expectancy have increased alongside the rise in income inequality.

- 2001-2014, life expectancy for top 5 percent of income earners rose by 3 years, while the bottom 5 percent saw no increase.
- Gap in life expectancy between richest 1 percent and the poorest 1 percent:
  - 14.6 years for men
  - 10.1 years for women

(Chetty et al., 2016)
Health inequities in the U.S.

Geography Matters

Life expectancy disparities in New Orleans, LA and Kansas City, MO


Note: Age adjusted death rates and life expectancy are indicators of overall health
Health inequities in the U.S.

Conclusion

Health disparities and health inequity have profound implications for the country’s overall health, economic vitality, and national security. Addressing health inequity is a critical need that requires this issue to be among our nation’s foremost priorities.

• The Urban Institute projects from 2009-2018: Racial disparities in health cost approximately $337 billion. Reducing such disparities would save $229 billion.

• 75% or 26 Million Americans (ages 17-24) cannot qualify to serve in the Military: due to persistent health problems (drugs, prescription and non prescription, poorly educated, convicted of a felony, obesity).
Recommendations
Funders should support:

(a) **health disparities research** re: the multiple effects of structural racism and implicit/explicit bias across different categories of marginalized status on health and health care delivery

(b) **strategies to mitigate the effects** of explicit and implicit bias

(c) **multidisciplinary research teams** that include non-academics to:

(1) understand the cognitive and affective processes of implicit bias and

(2) test and learn from interventions that disrupt and change these processes toward sustainable solutions
# Communities promoting health equity

<table>
<thead>
<tr>
<th>Name</th>
<th>Primary Social Determinant(s) of Health Targeted, Data on outcomes *</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blueprint for Action</strong></td>
<td><strong>Public safety 2007-2015</strong></td>
</tr>
<tr>
<td><em>Minneapolis, MN</em></td>
<td><em>Preventing youth violence: Results = Reductions reported</em></td>
</tr>
<tr>
<td></td>
<td><em>62% in youth gunshot victims; 36% youth victim crimes; 76% youth</em></td>
</tr>
<tr>
<td></td>
<td><em>arrest with guns</em></td>
</tr>
<tr>
<td><strong>Delta Health Center</strong></td>
<td><strong>Health systems and services</strong></td>
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<tr>
<td><em>Mound Bayou, MS</em></td>
<td><em>From 2013-2015</em></td>
</tr>
<tr>
<td></td>
<td><em>Low birth weight babies decreased from 20.7% to 3.8%</em></td>
</tr>
<tr>
<td><strong>Dudley Street Neighborhood</strong></td>
<td><strong>Physical environment 2014-2015</strong></td>
</tr>
<tr>
<td><em>Initiative</em></td>
<td>% HS students at or above grade level:</td>
</tr>
<tr>
<td><em>Boston, MA</em></td>
<td><em>Math from 36% to 63%</em></td>
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<tr>
<td></td>
<td><em>Graduation Rate 51% to 82%</em></td>
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<tr>
<td></td>
<td><em>Percent enrolled in college 48% to 69%</em></td>
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<tr>
<td><strong>Eastside Promise Neighborhood</strong></td>
<td><strong>Education</strong></td>
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<tr>
<td><em>San Antonio, TX</em></td>
<td><em>Child care available 80% to 100%</em></td>
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<td></td>
<td><em>Work with others to improve neighborhood 58% to 83%</em></td>
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<tr>
<td></td>
<td><em>Safe places for Kids 48% to 67%</em></td>
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*Data as reported by the communities*
## Communities promoting health equity

<table>
<thead>
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<th>Name</th>
<th>Location</th>
<th>Primary Social Determinant(s) of Health Targeted, Data on outcomes*</th>
</tr>
</thead>
</table>
| Indianapolis Congregation Action Network                            | Indianapolis, IN | Employment; Public safety  
76% more civic duty than avg. resident  
Reduction in incarceration and increased jobs                          |
| Magnolia Community Initiative                                       | Los Angeles, CA | Social environment 2016  
57% children 0-5 had access to place vs ER  
78% graduated from H.S.; 45% College  
75.7% report feeling safe, to and from school                         |
| Mandela Marketplace                                                  | Oakland, CA    | Physical environment  
641,000 lbs. of produce; 76% consumption  
$5.5 M new revenue; 26 + job ownership opportunities---sustainability |
| People United for Sustainable Housing                               | Buffalo, NY    | Housing  
Regional mapping process: # of employed workers, # housing units for redeveloped, carbon emission reduction; utility bills          |
| WE ACT for Environmental Justice                                   | Harlem, NY     | Physical environment  
New policies around air quality, use of harmful chemicals, pesticides, flame retardants                                      |

*Data as reported by the communities*
Guiding principles for communities

• **Leverage existing efforts** whenever possible
• Adopt strategies for authentic **community engagement, ownership, involvement, and input**
• **Nurture** the next generation of leadership
• Foster **flexibility, creativity, and resilience** where possible
• Seriously consider **non-traditional** community partners
• Commit to **results**, systematic **learning**, cross-boundary **collaboration, capacity building, and sustainability**
• **Partner** with public health agencies
Communities are able to take action on the factors that shape health. But they can’t do it alone.

Community-based solutions rely on multi-sectoral collaborations ensuring varied approaches to improving community health equity and well-being.
Using evidence to drive action

Recommendation
A public–private consortium should create a publicly available repository of evidence and provide technical assistance to inform and guide efforts to promote health equity at the community level.

The report provides existing models and examples.
Partners in promoting health equity

Top 1%
21.4% of pop ~ ($88K per yr.)
Disproportionately socially disadvantaged
Bundled Payment initiative

Recommendation

• Government/non-government payers and providers should expand policies aiming to improve the quality of care, improve population health, and control health care costs to include a specific focus on improving population health for the most vulnerable and underserved.

• The Centers for Medicare & Medicaid Services could undertake research on payment reforms that could spur accounting for social risk factors in value-based payment programs it oversees.

Vital Directions for Health and Health Care

The National Academies of
SCIENCES • ENGINEERING • MEDICINE
Partners in promoting health equity

Recommendation
Anchor institutions* should make expanding opportunities in their community a strategic priority. This should be done by:

• Addressing multiple determinants of health on which anchors can have a direct impact or through multi-sector collaboration; and

• Assessing the negative and positive impacts of anchor institutions in their communities and how negative impacts may be mitigated.

*Anchor institutions include: health care organizations, universities, and businesses based in a communities, employing residents, etc.
Policies to support community solutions

Recommendation

Hospitals and health care systems should focus their community benefit dollars to pursue long-term strategies to

• build healthier neighborhoods
• expand access to housing
• drive economic development and
• advance other upstream initiatives aimed at eradicating the root causes of poor health
Community Driven!

Bryant market mural, 2011, community mosaic project designed by Bharra Frank. Blueprint for Action, Minneapolis, MN.

Two of WE ACT’s rallying in 1988 to protest the North River Sewage Treatment Plant. WE ACT, West Harlem, NY.

For the full report, slides, and related resources, visit nationalacademies.org/promotehealthequity

Contact: Amy Geller, Study Director, ageller@nas.edu
Backup Slides
Health inequities in the U.S.

Conclusion
The evidence is that health inequities are the result of more than individual choice or random occurrence.

They are the result of the historic and ongoing interplay of inequitable structures, policies, and norms that shape lives.

Ecological model
SOURCE: IOM, 2003
Partners in promoting health equity

Recommendation

• Health sector organizations should build internal capacity to effectively engage community development partners and to coordinate activities that address the social and economic determinants of health.

• Play a convening or supporting role with local community coalitions to advance health equity.