

*Center for Medicine & Public Health
FSU College of Medicine*



Achieving Health Equity Through Real-World Research

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Progress We've Made

- Whole people in real-world community context
- From One-Disease at a Time to Clinical Complexity (MCC)
- From Clinical Complexity to Triple Complexity
- From Disparities to Equity
- Multi-Dimensional Interventions
- Dynamic interventions
- Learning Organizations
- Prioritizing Primary Care (?)

Treat Whole People in Context

Clinical Complexity
(MCC)

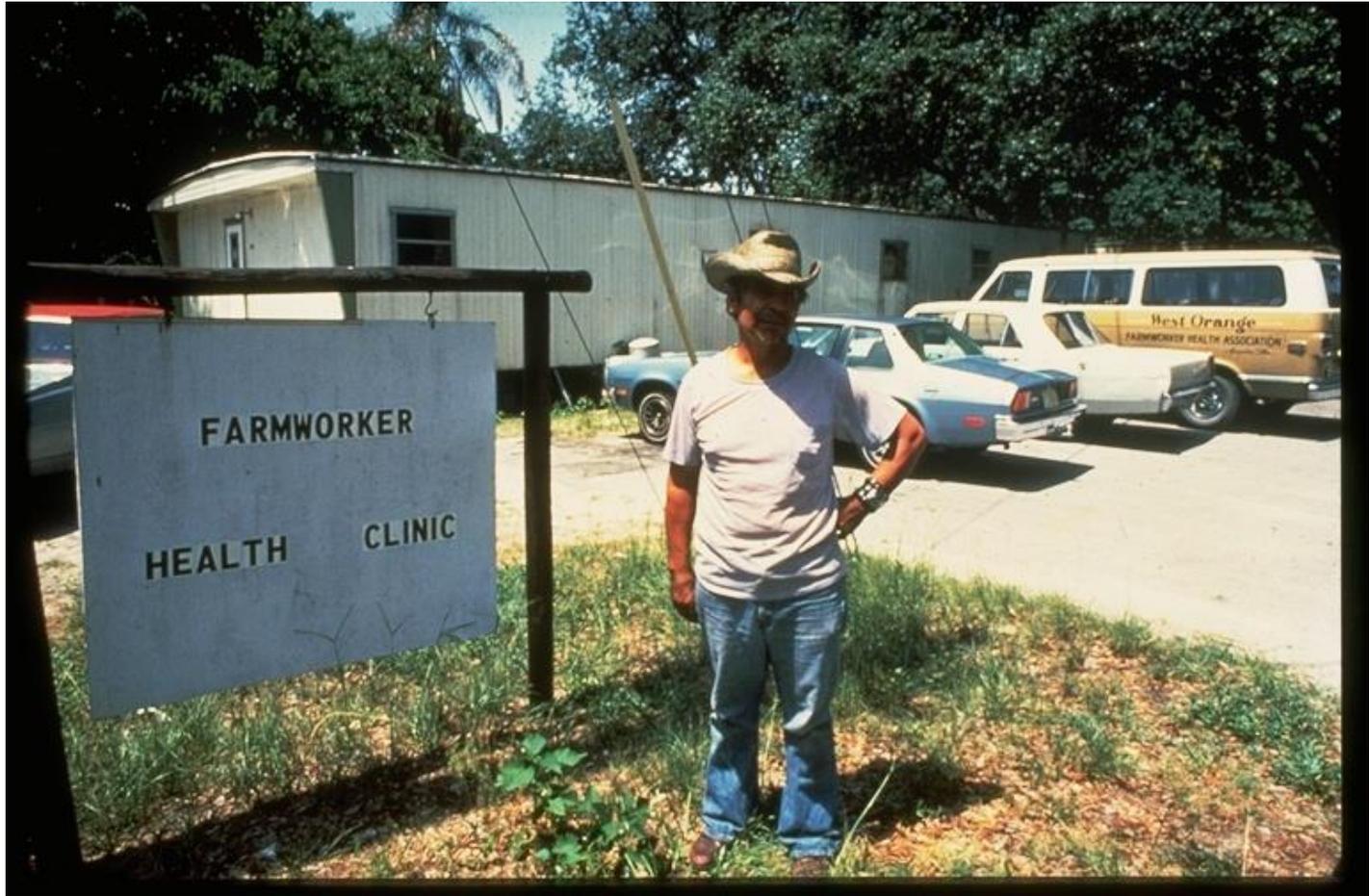
Behavioral Complexity

Social Complexity

Complex People Require
Sophisticated and
MultiDimensional Care:

- **Care Mgt Teams**
(physician, nurse, social worker, psychologist, community health workers)
- **Peer Support**
- **Social Services**
- **Behavioral Health**
- **Community Partnerships**

“Muddy Boots” Research



If we can make it work here, we can make it work in higher-resource settings.

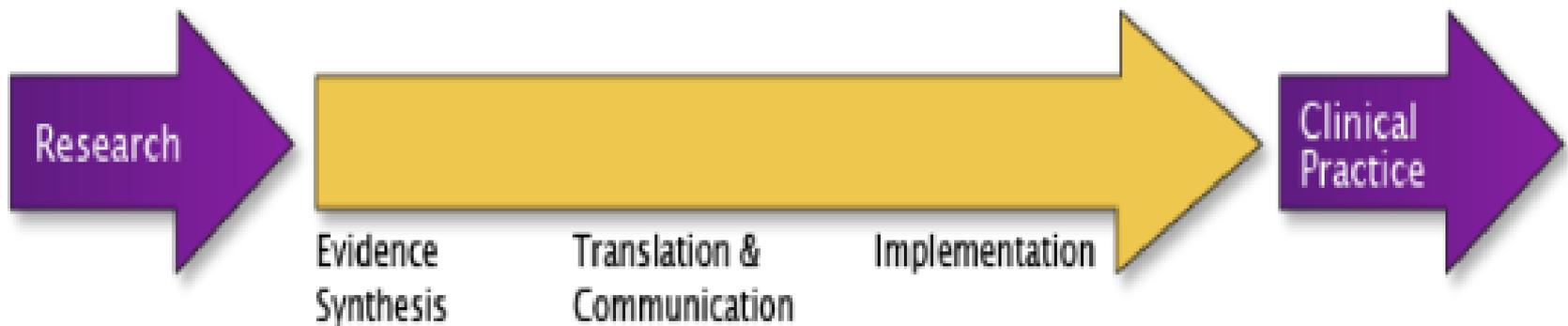
AHRQ Embracing (?) Its Role as the Center for Primary Care
Research and Practice-Based Research: *(especially Primary Care Clinicians in Underserved Settings Serving High-Disparity Populations with Limited Resources)*



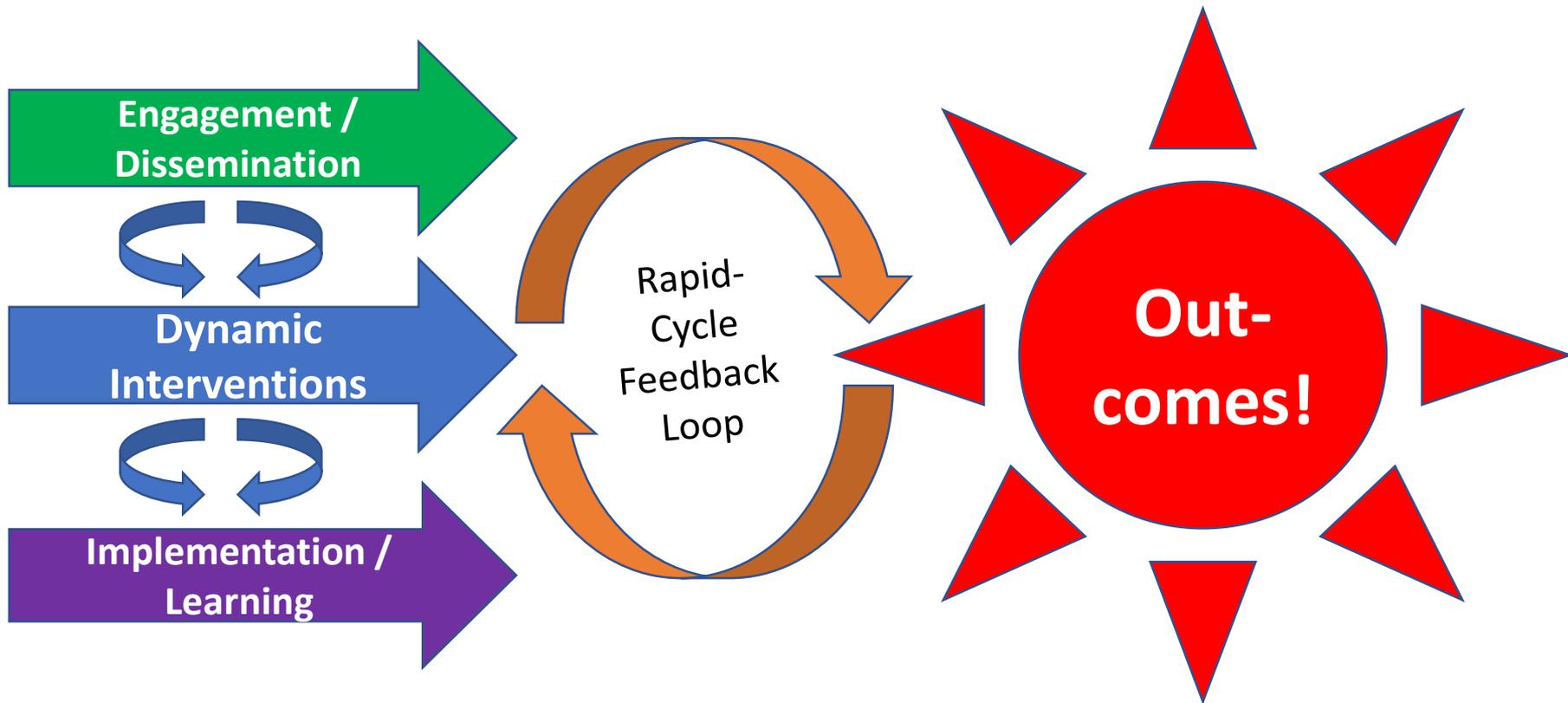
*Real-World
Primary Care*

Remaining Gaps:

- We still have a linear, step-wise view of translation, dissemination, and wide-scale implementation.
 - *An approach that is guaranteed to take years or decades to achieve wide-scale adoption and implementation.*



Re-Engineering Translation / Dissemination at Real-World Scale



Remaining Gaps:

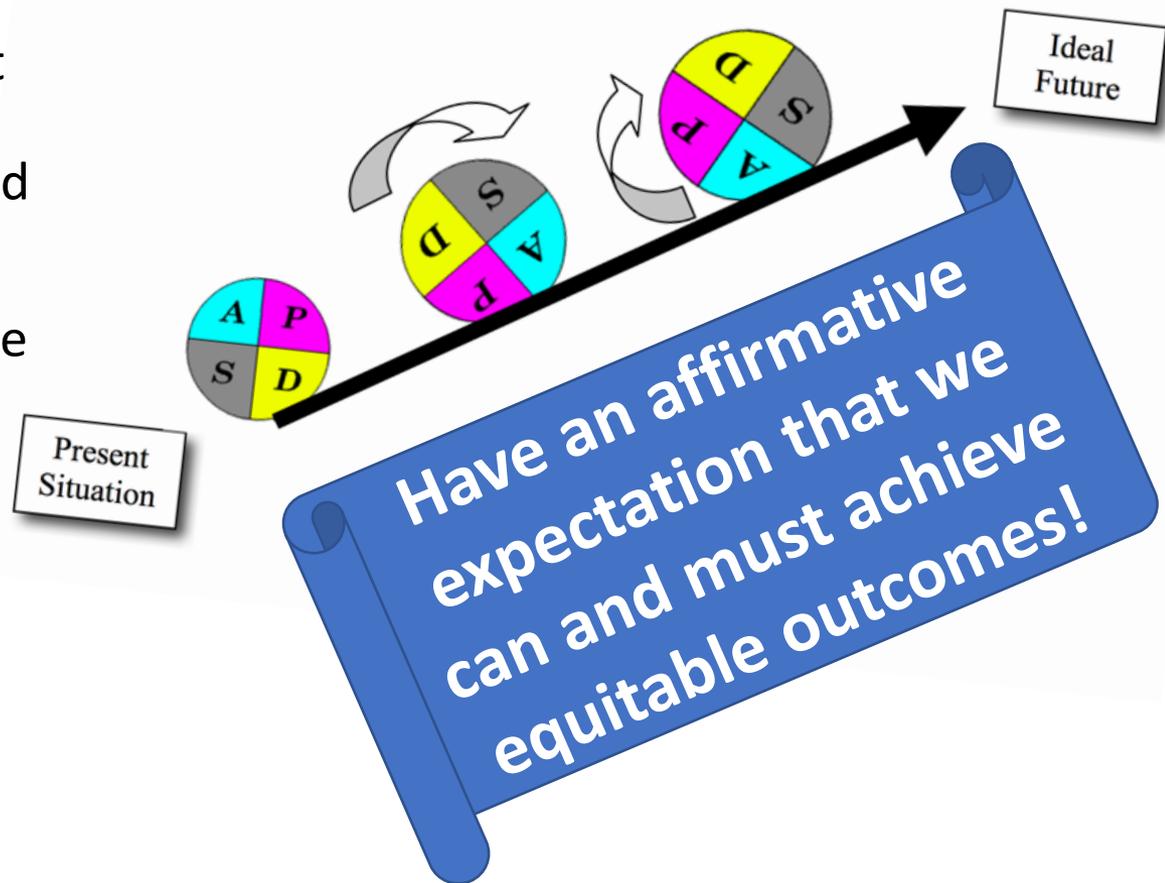
- We still lack the data we need where we need it when we need it.
 - Open access, democratized data
 - Real-time or rapidly-refreshed
 - Geographically Granular
 - Racially / ethnically granular
 - Clinically detailed
 - Focused on health outcomes

Examples:

- Medicaid Population Health Management Program
- CDC Covid Pulse Survey

Actionable, Timely, and Granular Data to Drive Rapid-Cycle Change

- Data to Support Rapid-Feedback Loops with Repeated Measures of Actionable Information At the Local Level for Granular Demographic and Clinical Strata
- Engage in PDSA rapid-cycle improvement processes at patient-level and community level.
- **Fail Fast!
Fail Forward!!!**



Remaining Gaps:

- We still lack vertically proportionate diversity in our research agencies, investigators, and institutions.

Vertically-Proportionate Diversity

-- *minority leadership and power driving the health equity research agenda*



Ruth Shim

*Professor in Cultural Psychiatry
University of California at Davis*

Remaining Gaps:

- We still think community engagement is enough.
 - *True partnership is rare.*
 - *The problem is not community trust; the problem is in our own trustworthiness.*

Partnership not “Engagement”

Real partners . . .

- . . . Share the vision
- . . . Share the power
- . . . Share the money
- . . . Share the future



*Nothing about us
without us!*

Guiding Principles



Community Values

1. Policies and programs should be based on mutual respect and justice for all people, free from discrimination or bias.
2. All people have a right to political, economic, cultural and environmental self-determination.
3. The community has the right to participate as an equal partner at every level of decision-making including needs assessment, planning, implementation, enforcement and evaluation.
4. Principles of individual and community informed consent should be strictly enforced.
5. The community repudiates the targeting of people of color and lower socioeconomic status for the purpose of testing reproductive and medical procedures and vaccinations.
6. Present and future generations should be provided an education that emphasizes social and environmental issues, based on our experience and an appreciation of our diverse cultural perspectives.
7. Research processes and outcomes should benefit the community. Community members should be hired and trained whenever possible and appropriate, and the research should help build and enhance community assets.
8. Community members should be a part of the analysis and interpretation of data and should have input into how the results are distributed.
9. Productive partnerships between researchers and community members should be encouraged to last beyond the life of the project. This will make it more likely that research findings will be incorporated into ongoing community programs and therefore provide the greatest possible benefit to the community from research.
10. Community members should be empowered to initiate their own research projects, which address needs they identify themselves.

Community Health as Community Development

- Leadership Development
- Economic Development
- Health Development
- Educational Empowerment
- Political Empowerment

H. Jack Geiger (L), John W. Hatch (b1928)^(R)
construction of Delta Health Center, Bayou Mound,
Mississippi 1968



John Hatch: Head of community organizing Delta CHC; first African-American endowed chair UNC School of Public Health.

Jack Geiger: used “health care as an instrument of social justice and empowerment for those oppressed by racism and poverty.”

“The Flint Disaster: Why Doesn’t Black Health Matter?” (Geiger, Feb 3 2016 physiciansforhumanrights.org/blog)

Photo: Dan Bernstein

Collaborative For Health Equity Cook County WHERE PEOPLE PLACE AND POWER MATTER

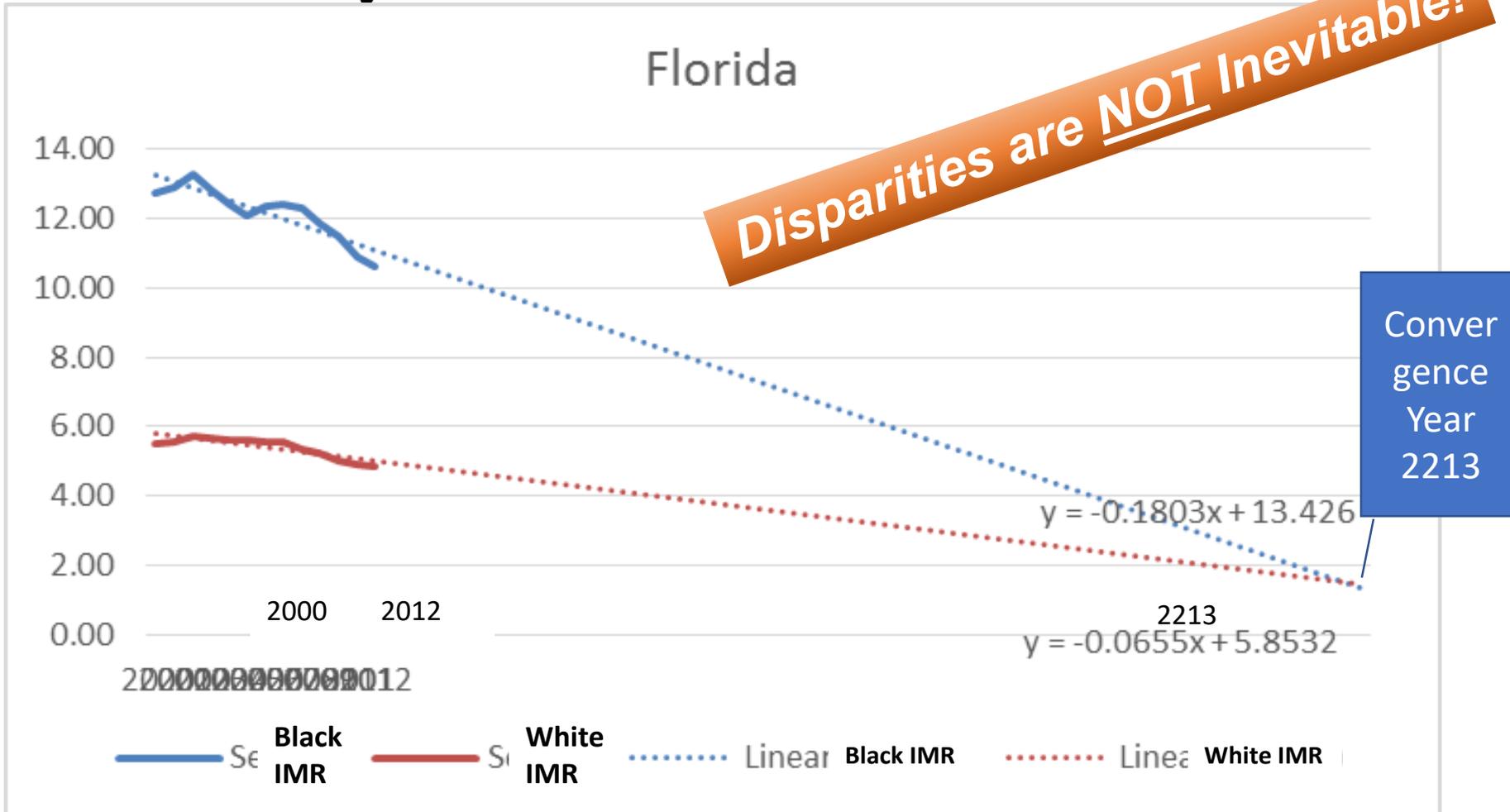
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<https://www.slideshare.net/JimBloyd/physicians-health-reform-and-health-equity-when-we-fight-we-win>

Remaining Gaps:

- We still have disparities.
 - *Few projects explicitly expect to move the needle on health outcome disparities, and even fewer actually achieve it.*

Create an Affirmative Expectation of an Equitable Outcome



Florida Forecast for Achieving Racial Equality in Infant Mortality

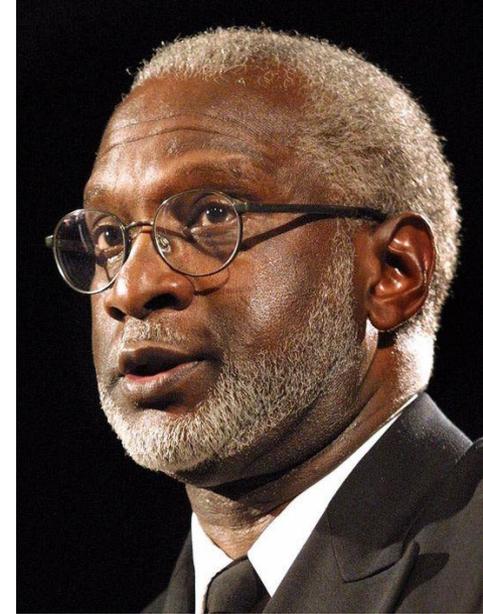
Hold Ourselves Accountable for Moving the Needle on Disparities

- Benchmark all progress against an ultimate outcome of optimal and equitable health for all with an affirmative expectation that equity will/must be achieved.

Example: Breast Cancer Survival Disparities eliminated -- Cone Health in South Carolina

- The question is not “How could we achieve a little bit of progress toward health equity?”, but rather *“How could we speed up our progress toward achieving the health equity we are holding ourselves accountable to achieving?”*

An Affirmative Expectation of Achieving Equity



“Living through the Civil Rights movement showed me that I could be a part of change. I realized then that you don’t have to accept things the way they are.”

-- David Satcher, MD, PhD



Own the Challenge:

- We have disparities.
- Disparities are real and unfair and kill people and hurt people.
- I am (and my institution is) part of the problem.
- I can (and my institution can) be part of the solution (if we are willing to spend our privilege)
- *The choices we make now and every day will determine whether we become more or less a cause of the problem and more or less a source of the solution*

Paths to Health Equity and Justice



- **Equity => Justice**
in institutions, processes, systems, care and context that result in optimal and equitable health outcomes and experiences for all.