STARFIELD SUMMIT

...where primary care research inspires policy and practice

STARFIELD HEALTH EQUITY SUMMIT ISSUE BRIEF

Theme: Social Determinants of Health in Primary Care

Title of IGNITE Presentation Topic: Communities Working Together to Improve Health and Reduce Disparities

Partnerships between health care, public health and communities are underway across the country, delivering striking results through shared data and coordinated efforts building on community strengths. Family medicine, and primary care more broadly, have the opportunity to work with this broad movement, reshaping our methods of providing care and our training programs so that we provide community-responsive care that improves outcomes and reduces disparities.

Why This Is an Important Topic to Address (brief description):

Most illness is now chronic, with roots in the community, and is not easily affected by office - or health system-based interventions. At the same time, data from electronic health records provides the ability to understand and see patterns of illness and risk within our communities, allowing much greater precision in identification of groups at risk. Add detailed information on community resources, and the opportunity arises for coordinated, partnered interventions designed by and with the community, that provides services in ways that are responsive to community needs and improves outcomes in ways the community values. There are now more than 400 such partnerships across the country, with the number expanding rapidly as evidence grows on the value and impact of these programs. Unfortunately, family medicine and primary care are often absent from these partnerships, reflecting our overly busy lives, as well as our long-standing focus on the office and hospital. The opportunity exists now to find, connect with, and participate in these partnerships, adding in our insights and perspectives, and gaining insights and perspectives on the needs, strengths, and resources of the community.

What We Think We Know (Bulleted evidence + Seminal references):

- Most Illness is chronic
- Chronic Illness has its roots in the community.
- Communities vary – across the country, within states, and within cities.
- Community partnerships to improve health are numerous and growing rapidly.
- Coordinated interventions can be highly effective – and cost effective.
- Family Medicine is sometimes an active participant in these partnerships– but not always.
- There is an opportunity to connect with programs in our own communities, learning the skills of partnership, and the techniques of community engagement and outcomes improvement
- This is a new skill set – and our learners are often the leaders within our systems.

References:

- Practical Playbook (PPB) website: www.practicalplaybook.com
- The Practical Playbook. Public Health and Primary Care together. Edited by J. Lloyd Michener, Denise

Koo, Brian C. Castrucci, and James B. Sprague, Oxford University Press 2016

- Vital Directions for Health and Health Care: Priorities from a National Academy of Medicine Initiative

Questions for Group Discussion

Questions to Address in Group Discussion:

Our model of change is based on incremental improvement and consensus-based change, with expertise passed from the experienced to the novice. But the movement to community-based health improvement has its roots outside medicine, broad bipartisan support, and is 'in play' in states and cities across the country. How do we effectively connect to this accelerating political and social movement?

What do we need to be teaching our students and residents about the role of communities in health, and how to use data and partnerships to improve health outcomes – inside and outside the office?

What do we need to be doing in our practices to role model the partnerships that are proving effective in improving health – even before payment models have aligned with them?

Implications for Action (In Research, Education, Policy, Practice and Organizational and Community Action):

- What are the opportunities for states to realign funding streams to use data to target and support cost effective interventions?*
- What are the key 'packages' of reforms that states should consider if/when block grants become an important option?*
- What role can state chapters play in bringing policy ideas across state lines, so that successful programs can quickly scale?*

*Indicates that this idea is already under discussion across states

Important Unanswered Questions:

- What are the roles of primary care/family medicine in successful partnerships? It is NOT always leadership – is it advocacy, funding, linking with at-risk patients…?
- What are the methods of helping eager students and residents learn these skills, given curricula are already overburdened?
- How do we learn ourselves, since these programs are based in and one of the community?