HEALTH EQUITY CAN’T WAIT.
ACT NOW
IN YOUR COMMUNITY

“Creating a healthier community has to be the collaborative work of justice by diverse social, civic, political and spiritual groups ensuring wide involvement of all members of the community.”

- Sister Peg Murphy

A Conversation Starter about Health Equity in Pierce County
Distributed May 28th, 2015 at the Health Equity Summit
In 2011, the Carol Milgard Breast Center Board of Directors commissioned the Tacoma-Pierce County Health Department to assess how the organization could best target under-served and at-risk populations in Pierce County with outreach and mammography services. The analysis showed that there is significant variation in the incidence of breast cancer, the use of mammography, and socioeconomic barriers to care throughout Pierce County.

Specifically the study found that African American women are almost twice as likely to die from Breast Cancer than white women.

- African American women diagnosed at a regional or distant stage are more likely to die of breast cancer than other women diagnosed at the same stage.
- African American women are more likely to die at a younger age from breast cancer than any other race of women.
- Breast cancer death rates and premature death from breast cancer were higher in Tacoma, than any other city within Pierce County, despite relatively high rates of mammography screening.

Breast cancer incidence, hospitalization and death increased dramatically with age in Pierce County, as elsewhere in the nation.

These findings support national statistics, but for the first time, local data were interpreted and validated. The Carol Milgard Breast Center Board of Directors then directed staff to dig further, to learn more about the cultural and behavioral patterns that may play a role in the diagnosis and occurrence of breast cancer in African American women. The Carol Milgard Breast Center engaged the Northwest Leadership Foundation consultants to convene and facilitate a series of listening sessions which eventually engaged 6 churches, two civic groups and 79 participants.

From this work emerged the Leaders in Women’s Health – an amazing group of 25 volunteers deeply committed to changing the narrative for African American women regarding breast health. The group comprises a former Senator, 3 PhDs, and representatives of esteemed community groups like the Ebony Nurses Association. After one year of convening, the group has a framework, established goals and a subcommittee structure.

Leaders in Women’s Health is committed to:

- Developing innovative ways to reach this under-served population to access screenings early.
- Identify and address the barriers that African American women face as it relates to their health.
- Ensure that any work/effort this task force takes on is embedded in the African American community by using churches and community organizations as its anchor institution.

On Thursday, May 28, 2015, Leaders in Women’s Health held a special community conversation about health and how we take ownership of our own health agenda in Pierce County.

How can I get involved?

Please contact Patricia Talton, President & CEO, Northwest Leadership Foundation about attending one of our monthly meetings or more information at: ptalton@northwestleadership.org.
An estimated 43% of people with safe places to walk within 10 minutes of their home get the minimum recommended level of daily activity. For people living in less walkable areas, that number decreases to 27%. 1

Low-wage jobs provide paid sick leave compared to 81% of high-wage jobs, discouraging low-income populations from seeking health care.1

Rates of violent crime, child abuse, and domestic violence are higher in Pierce County than the state.6

The number of Black children living in families with economic hardship compared to the state average of 39%. 3

In Pierce County, teen birth rates are higher for American Indian/Alaska Native and Hispanic populations compared to Whites. 4

People in the United States live more than a mile from the nearest supermarket. Wealthy areas have twice the number of supermarkets as poor ones. 1

The Affordable Care Act (ACA) includes both general and explicit provisions that could narrow these gaps.

Disparities occur in the quality of care received even when income, health insurance and access to care are taken into account. Patients from racial and ethnic minorities often fare far worse than their white counterparts on a range of health indicators: life expectancy, infant mortality, prevalence of chronic diseases and insurance coverage, among others.

How can we transform

COMMUNITY PARTNERSHIPS?

One of the great opportunities is to identify new partners who are already working to improve community well-being. Addressing the social factors of health puts us into conversation with partners in housing, transportation, education, agriculture, public health, economic development and business. Health care providers do not need to carry the freight of solving complex social issues on their own, but they can strategically align their resources and efforts with those of others who specialize in these areas.

Call to Action

KEY RECOMMENDATIONS to Health Systems

The case for transformative community partnerships to improve individual and community health—as well as the health of the bottom line—is increasingly compelling. Respected national medical and quality organizations, public health at all levels, the academic community, and foundations know this. Health systems are learning it, and many are sharing successes with demonstrated, replicable outcomes based on the population health model.

Health systems today face pressing needs to increase access to prevention and primary care, and develop person-centered, place-based care models to lessen the load on emergency departments and reduce readmissions. Each high-leverage clinical priority opens new doors for transformative community partnerships that return the health systems’ investment of time and money many times over—and result in sustainable health improvement empowered by the common good. With these challenges and opportunities at hand, we are asking our health systems to make a shared commitment to the following actions:

• To approach our community health work collaboratively, as one steward among many others with a responsibility to improve the health of our communities.

• To proactively invest a percentage of what we currently spend on charity care, with a focus in neighborhoods where there is clear opportunity to achieve substantial measurable improvements.

• To monitor our proactive investments, our finance departments will work together to develop new, standard financial metrics and accountability processes, and to share them broadly within the health care community.

• To identify and address potentially preventable readmissions that may indicate problems with quality of care. To do this we will develop, benchmark, and validate new practices in population health management. In the process, we will jointly seek to share in the financial gains produced which would otherwise only flow to the payers.

• To develop shared-outcome metrics and accountability measures to capture the impact of collaboration among government, private payers and community partners. We will invite vendors to create IT products that build capacity and connectivity in the complex partnerships at the heart of our new opportunities.

• To engage and collaborate with governmental partners, foundations and non-traditional partners, to leverage their mission with ours to favorably impact our communities and become economic engines within our settings. When possible, we will work even with our competitors to achieve the common good—healthier people in healthier communities.

• To better understand our diverse communities through the lens of race/ethnicity, linguistics/literacy and socioeconomics to ensure we are equipped to meet their needs in culturally appropriate ways.

What is the MEMPHIS MODEL?

Tackling a Racial Gap in Breast Cancer Survival

While survival rates have generally risen dramatically among U.S. women, the same is not true for African American women. Memphis, Tennessee topped the list for this disparity. Funded by the Susan G. Komen Foundation, Teresa Cutts, Director of Research for Innovation at the Methodist Le Bonheur Healthcare system, conducted extensive research that led to engaging key people in Memphis to explore solutions.

The reasons for the gap include poverty, distrust of the health system from years of discrimination, and lack of insurance. As a result, Black women often arrive at the hospital with cancers so advanced, they rival the late-stage disease that doctors see among women in developing nations.

After deliberations, the group decided to focus on getting women breast cancer screenings. Teresa Cutts along with Gary Gunderson, Vice President of FaithHealth at Wake Forest Baptist Medical Center and co-leader of the Stakeholder Health Secretariat is credited with designing a new health partnership approach informally called the “Memphis Model”. The effort turned into a powerful partnership between MLH, the Congregational Health Network that includes more than 500 area congregations, the Avon and Komen foundations, Dr. Kurt Tauer of the West Cancer Clinic, and others.

The “Memphis Model,” is a health network that serves as a partnership between local hospitals, congregations, community health centers, as well as faith-based and community organizations. The objective is to show that through engaging faith communities in collaborative partnerships, health providers can not only build capacity in local communities, but also to map viable health assets.

The Congregational Health Networks (CHN), employ “health navigators” that identify congregations to participate in the program. To date there are nearly 500 congregations signed up as part of the Memphis Model. Each congregation then chooses 2 to 3 liaisons to work with the navigators on public health outreach.

Through these volunteer liaisons, individuals and families within the CHN are connected to additional healthcare guidance and support. “The volunteers think of it as faith work not health work,” added Gary Gunderson. Along with the liaisons, each congregation in the network enters into a “covenant” with the hospital.

Results: The CHN helps about 4,000 patients per year. Early CHN patient data shows that there is a 50% reduction in mortality, a 20% reduction in hospital readmissions, and a savings of over $4 Million dollars to the hospital in costs. On all patient diagnoses, the average CHN patient showed approximately 120 days longer between readmissions to the hospital, compared to patients out of network.
5 Steps to get involved in your community

Here are a few ideas for addressing health disparities to get you started. These potential strategies build on the five goals of the National Stakeholder Strategy for Achieving Health Equity.

1. **INCREASE AWARENESS About Health Disparities**
   - Blog or tweet about health disparities in your community, or share information via Facebook.
   - Contact the media with stories about health disparities in your community.
   - Write a letter to the editor or an opinion-article for your local newspaper.
   - Speak at health fairs, PTA and school board meetings, civic meetings, faith-based events and other community gatherings.

2. **BECOME A LEADER for Addressing Health Disparities**
   - Educate others about disparities and share stories about model programs with local organizations or community leaders.
   - Start a petition to get local citizens to support policy recommendations and submit the petition to the appropriate elected officials.
   - Organize a meeting of local organizations representing diverse sectors and work together to ensure health equity is on the local and state health agenda.
   - Form coalitions with local organizations representing diverse sectors and leaders from different racial, ethnic and other groups affected by health disparities to address common barriers and join the NPA.

3. **SUPPORT HEALTHY AND SAFE BEHAVIORS In Your Community**
   - Be a role model and serve nutritious foods at work or social functions.
   - Involve your employees in a group physical activity or challenge. Participate in National Health Observances—such as AIDS Awareness Days—by sponsoring local health events or encouraging loved ones and colleagues to take action to address their health.
   - Host seminars in your local library, school, workplace or other venue to discuss health disparities in your community. Topics could include reducing asthma triggers in the home, managing obesity and chronic illnesses, or how to enroll in public health insurance programs.
   - Join the First Lady’s Let’s Move! initiative to raise a healthier generation of kids, the President’s Challenge and other similar initiatives.

4. **IMPROVE ACCESS to Health Care**
   - Partner with a local health care provider or employer to offer free health screenings in your workplace or place of worship.
   - Ask local health care providers to translate health and health care information or connect them to an individual or organization who can provide translation services.
   - Establish a Community Health Worker or Promotoras de Salud program in your community.

5. **CREATE HEALTHY NEIGHBORHOODS**
   - Advocate for more sidewalks, bike lanes and recreation facilities in your neighborhood.
   - Encourage local schools, workplaces and assisted living facilities to provide healthier lunch and snack options.
   - Ask your neighborhood supermarket to provide fresh fruit and vegetables to the local foodbank, ask local restaurants to provide healthy menu options, or organize a farmers’ market that accepts food stamps.
   - Work with your local government and organizations in your community to collect and track data about health disparities and monitor changes over time.

Source: the National Partnership for Action: Toolkit for Community Action 2014
Most community assessments focus on needs. Indeed the government now mandates a “community needs assessment” and fines hospitals that do not do them and do not show some evidence of paying attention to them. We are not currently required to do what really matters: assess the assets, discern what we have to work with and animate the energy, vision and moral purpose to push to the very edge of what they make possible. The focus on needs inevitably highlights: diseases and pathologies, focusing our fears, not our hopes or intelligence.

A focus on assets does the opposite. It holds us accountable to the strength and possibility. But in every case those assets are not found merely on the margins of what is left over after we do our main separate work. “Community benefit” in the law is confined roughly to the amount that a non-profit might pay in taxes, if they were profitable; so if you have no margin, you owe no benefit. Focusing on assets, not margin, brings the whole organizational body into view and asks a more radical question worth asking.

When you get the question right, the scale of the assets, not the problem becomes the organizing opportunity. There are too many things that matter, too many languages governing too many different ways of turning the energy of the complex systems called communities in the direction of life and wholeness. Nobody can possibly be in charge of it. But many of us can lend our voice, budget and logic and hands to influence. The prophet Amos spoke of justice rolling down like mighty waters, an image more like the springtime floods of thawed rivers than the garden hose our timid committees think about.

Read the full article at: www.stakeholderhealth.org

Can you name at least six community/health assets in your neighborhood?
A MAMMOGRAM
Could Save Your Life

Most health insurance plans must cover Breast Cancer Mammography screenings for women over 40.

DON'T HAVE INSURANCE? We have financial assistance available. Please call our toll-free 1-855-824-2622, option 1, Monday-Friday, 8:00 a.m.-5:00 p.m. Interpretive services are also available.

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