

PRESIDENT'S COLUMN

The Cutting Edge for Achieving Health Equity

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SGIM members are driven by a sense of social mission. Caring for the underserved and attempting to reduce health disparities have been long-standing hallmarks of the organization. For example, of scientific abstracts submitted to the 2016 SGIM Annual Meeting, by far the most abstracts were received in the Health Disparities/Vulnerable Populations category. The health disparities field has moved beyond purely documenting disparities and explaining their causes. We are now immersed in the solutions phase. I'd like to highlight three areas that I believe represent the cutting edge of solutions for achieving health equity and link those to SGIM's ongoing efforts in these areas. These three frontier areas are: 1) implementing payment reform to enable and incentivize reduction of disparities, 2) addressing the social determinants of health, and 3) improving our training of clinicians about how to reduce disparities.

Aligning payment and delivery system reform to reduce disparities is crucial. At the University of Chicago, we have experienced first hand the challenges of caring for our predominantly working class South Side African-American patients under the current reimbursement system. Like many academic medical centers in fee-for-service markets, a relatively small percentage of patients, roughly 5%, accounts for the profit that subsidizes the remaining clinical, research, and educational activities. These patients are recipients of tertiary/quaternary care—for example, organ transplantation, orthopedic surgery, gastrointestinal procedures, and cancer chemotherapy. Therefore,

for many years our hospital's strategic plan, similar to many other medical centers, prioritized increasing its market share of these complex specialized patients. The medical center has simultaneously sought to improve the health of the South Side of Chicago community, such as with an Urban Health Initiative that considers how clinics, community hospitals, and the academic medical center can best coordinate their care. However, these community and prevention-oriented efforts have received relatively fewer resources as governmental and private reimbursement systems have continued to incentivize tertiary and quaternary care.

Today the landscape for health equity is transitioning in Chicago and across the nation. Our current dean, who is also in charge of the medical center's operations, was brought in five years ago, and he and his team have launched intensive initiatives to increase diversity, inclusion, and equity in the medical center and improve the health of the South Side's African-American population. In fact, population health is a cornerstone of the new strategic plan. Why did this transformation occur? The dean deeply understands the importance of achieving health equity. He grew up in South Africa during the apartheid era and saw first hand the human costs of health disparities and social inequities. And the marketplace is changing. While Chicago still is mostly a fee-for-service health care market, global and bundled payment schemes are growing. The governmental payers Medicaid and Medicare are increasingly shifting to capitated at-risk contracts. Tax laws

require a community needs assessment and the demonstration of community benefit to justify non-profit status of medical centers. The University of Chicago and other Chicago-area medical centers realize that they must develop expertise in population health to survive. These new pressures are palpable and have penetrated to frontline clinicians and staff.

However, current changes in the marketplace that raise the importance of reducing disparities are not sufficiently powerful. In a 2016 commentary in *JGIM* titled "Creating the Business Case for Achieving Health Equity," I outline six key steps payers can take to achieve equity. These steps are requiring health care organizations to stratify clinical performance data by race, ethnicity, and socioeconomic status; incentivizing preventive and primary care; explicitly incentivizing the reduction of disparities; implementing the same equity performance measures across all payers; assisting safety-net providers; and conducting more payment demonstration projects designed to reduce disparities. Payers can do much more to achieve health equity.

Addressing the social determinants of health disparities is another cutting edge issue. We have tended to focus on health system factors that contribute to health disparities—clearly an important lever. However, social determinants such as poverty, poor education, inadequate housing, and crime drive most health inequities. Addressing these social determinants of health has gone from a distant aspirational goal to a priority policy and business issue. A key

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question is how to integrate initiatives to improve social determinants with efforts to reduce disparities in the health care system. The recent call for proposals from the Center for Medicare and Medicaid Innovation for Accountable Health Communities is emblematic of the importance of this issue and the strong interest by public and private funders to catalyze innovative models. That initiative provides funds for community-based organizations and health care organizations to address health-related social needs of patients. The Robert Wood Johnson Foundation's new emphasis on a Culture of Health is another prominent example of the emerging focus on social determinants of health.

The SGIM Disparities Task Force is currently developing a toolkit for measuring social determinants of health. The Disparities Task Force has finalized a conceptual framework for social determinants of health, identifying more than 60 instruments that measure economic, cultural, health system, sociodemographic, and psychological factors. The task force is aiming to create a searchable tool on the SGIM website and write articles about these efforts for dissemination. In addition, the 2016 SGIM Annual Meeting theme of population health will help us learn more about social determinants of health and ways to integrate health care-community solutions to reduce disparities.

Determining the best way to train learners and practicing clinicians how to reduce disparities remains an excit-

ing growing field. In last month's column, I described the seminal work of the SGIM Disparities Task Force in creating recommendations for health disparities courses that are crucial for moving the field beyond a sole focus on cultural competency training. Some challenging ongoing issues include how to: 1) incorporate health disparities curricula longitudinally across the four years of medical school, 2) teach students about population health and social determinants of health, 3) incorporate advocacy training into curricula, and 4) determine what curricula and teaching methods are most effective for reaching a broad audience rather than only those self-selected students particularly interested in disparities, and 5) combine didactic instruction with active experiential learning about how to reduce disparities.

Cultural competency is a field that is also evolving. One of our University of Chicago research team's current projects examines how to improve shared decision making between clinicians and lesbian, gay, bisexual, transgender, and queer (LGBTQ) racial and ethnic minority patients. Our team has members experienced in racial/ethnic disparities and LGBTQ health. However, we were rapidly humbled by how complex the issues are for multiple identity patients working at the intersection of race, ethnicity, sexual orientation, and gender identity. This project has given us additional insight into the issues of all of our patients as everyone has multiple identities that are not immediately ob-

vious but that impact care. Our team has written four initial articles from this LGBTQ racial/ethnic minority shared decision making project that will be published in *JGIM* in 2016.

Key lessons include that clinicians should be aware of these multiple identity or so-called intersectional issues as they approach patients and that clinics can improve their organization, procedures, and culture to make high-quality shared decision making more likely for their LGBTQ racial and ethnic minority patients and other multiple identity patients.

Advocacy is also essential for advancing health equity. Disparities are health and social justice issues. It will require advocacy to get policymakers to devote more attention and resources to payment reform that reduces disparities as well as initiatives to address social determinants of health. On a local level, advocacy is necessary to increase the breadth and depth of health disparities training for our medical students and house officers, including state-of-the-art training in culturally competent communication, shared decision making, behavior change, patient empowerment, and systems' solutions for achieving health equity.

Today's opportunities to improve health equity are the best in my lifetime. SGIM's strengths in research, education, clinical care, health policy, and advocacy will all contribute to these exciting advances. We look forward to working with you as we advance health equity along all these fronts.

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