

Advancing Health Care Through the Lens of History, Equity

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Madam Speaker, Madam President, members of the Board, delegates, and guests:

Welcome to Chicago ... a city known for its architecture, museums, restaurants and rich music scene.

Chicago is a place where anything is possible ... even time travel.

Here in downtown Chicago, it's 2019, and life expectancy for those living here is 82 years.

But if we hop on the train and ride just 20 minutes south to Fuller Park ... life expectancy is only 65 years – that's less by 17 years.

That's right ... just a few miles south, a person loses 17 years of life.

How far back in time would we have to travel for the average American to lose this much life expectancy – to expect to die at age 65?

The answer is from the 1930s to the 1940s ... a period overlapping with the Great Depression ... Prohibition ... the infamous Chicago Stockyards.

All it takes to revisit that distant era – from a health standpoint – is a short trip south. Or a short drive west for that matter, as life expectancy in a number of Chicago neighborhoods is far below the national average.

How can that be?

How ... in a country and in a city as dynamic, rich in educational assets, and affluent as ours ... can there be such an enormous difference in life expectancy from one neighborhood to the next?

A difference akin to time-traveling back the major part of a century?

One answer is found in what we now refer to as the social determinants of health.

Food insecurity, housing insecurity, income inequality, limited access to health care and transportation, and other circumstances ... all conspire to erode a person's prospects for a healthy life. They're determinants of health and life.

Here in Chicago and, indeed, in much of the country – including rural America – these inequities are barriers to optimal health.

That's to say, there is an absence of health equity.

I'm sure all of you can recite the three arcs of our long-range strategic plan. A plan that rests upon the policy portfolio created by this House.

The first strategic arc is reimagining medical education and lifelong learning. This began with our consortium of medical schools, now numbering 37, and has produced a number of innovations such as the creation of the third medical science – health system science – as well as a shift to measured competencies.

Our second arc ... confronting the challenge of chronic disease. This includes our focused work on pre-diabetes and better control of hypertension; with the latter, for example, now targeting 22 million hypertensive Americans in our program by the end of 2021. It also includes our work to end the opioid epidemic.

Ambitious aspirations.

And the third strategic arc is attacking the dysfunction in health care..... by improving the environment of the patient-physician setting. Work here includes our web-based StepsForward practice improvement modules, our work to right-size prior authorization ... and work which promises to improve the flow of clinical data, using the product of the first company spun out of Health2047 in Silicon Valley.

That new company is Akiri (A-K-I-R-I) - whose product is a clinical data liquidity solution. Check it out at Akiri.com.

As indicated by those examples, we've gained considerable traction in each of our strategic arcs ... garnering national attention and expanding the AMA's reputation in leadership and innovation.

But what has become clear is that the inequities that persist throughout health care are obstacles to achieving our goals in each of our strategic areas.

That's to say, while we can be proud of our progress in the three arcs over the last seven years, we now have yet another call to action.

As a nation, and as an association, we need to ensure that when solutions to improve healthcare are identified, that positive impacts are recognized by all.... that one shared characteristic of such solutions is that they also bend toward health equity.

Addressing inequities will require an enormous cooperative effort by our nation ... the AMA will be a leader, positioned at the tip of this effort.

Not surprisingly, this House has recognized the importance of work toward health equity.

So, let me briefly touch on our emerging work in this area.

First, we're in the early launch phase of the AMA Center for Health Equity. Our founding Chief Health Equity Officer is now on board.

Dr. Aletha Maybank, a prominent national figure in health equity, has joined us from the New York City Department of Health. Aletha's first task is to lead the planning phase for our work on health equity ... which will critically impact the breadth of our work at the AMA.

A springboard for this effort was our Health Equity Task Force chaired by **Dr. Willarda Edwards**, a long-standing member of this House and a current AMA Board member. Thanks Willarda and thanks to all members of that Task Force.

Improving health equity will take time ... it will take patience ... and it will take perseverance. It will also require new technological tools to facilitate rigorous analyses of underlying factors.

For example, currently there is a lack of a structured hierarchy to capture social determinants in a normalized and exacting fashion.

Lacking such tools impedes progress in understanding how social determinants impact health, and thus without these tools our ability to study, modify, and improve health equity is compromised.

In previous presentations, I have discussed a tool and approach that will aid the work of our three strategic arcs by improving the organization of, and extracting better meaning from, clinical data.

That tool - the Integrated Health Model Initiative, or IHMI - fills gaps in the current health data models to create better and more useful clinical data objects. This is an effort that was birthed in AMA Health Solutions and has now been launched as a unit led by Dr. Tom Giannulli, who I briefly introduced last fall.

Tom is a physician, an engineer, and a seasoned entrepreneur in the health data space.

Let me give an example of recent work of IHMI and you will see how it can carry over to work on social determinants.

Over the past year, the IHMI team created a software-based approach allowing a previous gap to be filled – in this instance it's the ability to capture accurate remote blood pressure measurements ... and to both incorporate and organize those measurements in the medical record without paper shuffling by physicians.

Remotely monitored blood pressures ... captured and coded in an organized electronic fashion ... filling a critical gap in our work on chronic disease.

Similarly, and related to today's theme, this approach also provides a blueprint to more precisely capture, define and code for social determinants of health.

In collaboration with others, our IHMI team has begun work toward filling this need in social determinants ... another example of how health equity penetrates all of our work, including cutting-edge innovation and technology.

At the Interim, I'll provide a more thorough update on our strategic arcs ... and there's lots to say. I am compelled to at least provide you a taste.

Earlier this week we announced the eight medical schools, residency programs and health systems that will launch our 15 million dollar "Reimagining Residency" initiative.

Three of these eight institutions have innovative projects that relate to health equity or social determinants of health, better training our physicians of tomorrow to deliver more effective and equitable health care.

This initiative will bridge our work of reinventing medical school to the residency programs. The goal is to make a more seamless handoff from med school to residency while also placing GME on a 21st century footing.

Another taste: in coordination with our work on pre-diabetes, Health2047 has spun out a second company. FirstMileCare creates a new path to the prevention of chronic disease by taking a personal care approach and harnessing the gig economy – check it out FirstMileCare.com.

There're so many exciting things happening across the three arcs that I find myself verging on a tangent.

So, let me return to where we began -- time travel.

This nation can't afford to travel backward when it comes to health care and life expectancy.

We need to work creatively, and collaboratively, to move forward; to create a health care system that deserves a place in the 21st century.

But how can we accomplish this considering the current contentious national health care debate?

How do we improve conditions for patients and physicians today, while also working to create the health system for the mid-21st century?

Our approach, as discussed in a prior address, is to focus on what I call pre-competitive needs ... needs that are vast and unmet, but have to be filled for any health system to function optimally..... regardless of its structure.

For example, any future health system will have these needs:

The need for better organized clinical data ... true interoperability as a physician would define it, clinical data liquidity, and data technology that, overall, takes less time and expense - not more;

Also needed: physicians trained for the 21st century ... not the 20th; for team-based care, analytics, population health, defined competencies including cultural competencies, and ... the need to define new solutions to handle the tsunami of chronic disease.

Collectively, these are the needs addressed by our strategic arcs ... and related to each of them are the challenges that come from system inequities related to social determinants of health.

To reach our ambitious goals, we need a mixed portfolio of activity ... a balance between the needs of today, and the long-term pre-competitive needs that will make health care much better in the future.

Until then, let's focus on time-travel...but time-travel that is forward-looking.

Is a future with a well-sculpted health system an aspiration that seems too distant?

As was once said about time-travel: "Nothing is as far away as one minute ago."

Our future can, and should be, more accessible than our past.

Thank you.

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