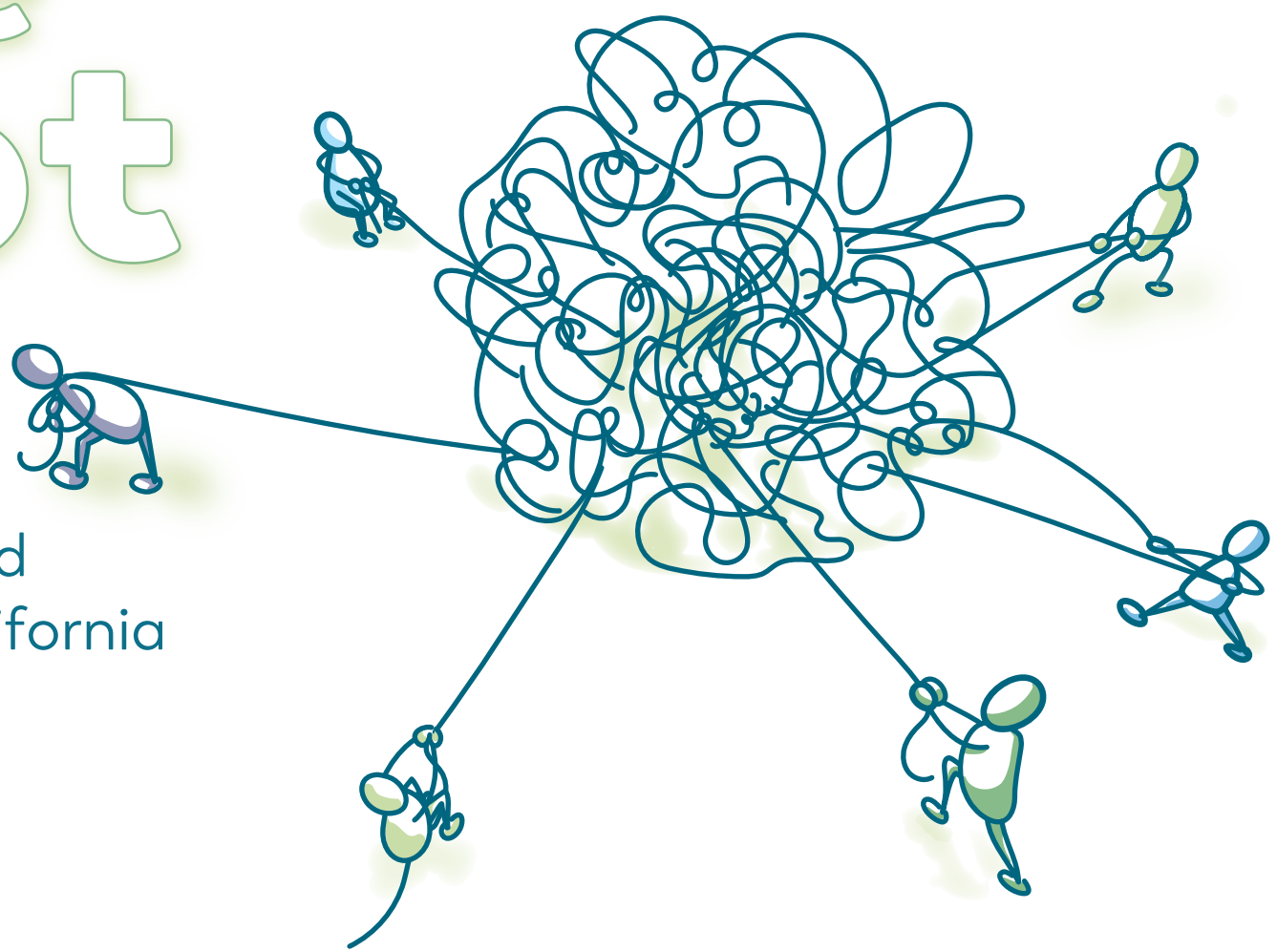
Untying the Knot



A Vision for Improved Health and Health Equity in California

JSI

Made possible with support from
Blue Shield of California Foundation

California is a leader and bellwether for social change and policy innovations that spread across the country. In many domains such as criminal justice reform and climate change, California is charting an ambitious and progressive path to the future. The same has been true for health in the past. From reducing tobacco use to dramatically expanding coverage through Medi-Cal, the state has taken bold steps forward.

Today, there are clear and pressing issues within California's health sector:

regions of the state with some of the ***poorest health outcomes in the country;***

unacceptable disparities in health outcomes across ***racial and economic groups;***

unsustainable costs and per capita spending that dwarfs what any developed country spends;

unmet chances to address drivers of illness and injury such as unsafe streets, unaffordable housing, and income inequality;

continued fragmentation of systems and funding streams despite on-going efforts to improve collaboration.

California has many opportunities for substantial progress if there is collective will and focus.

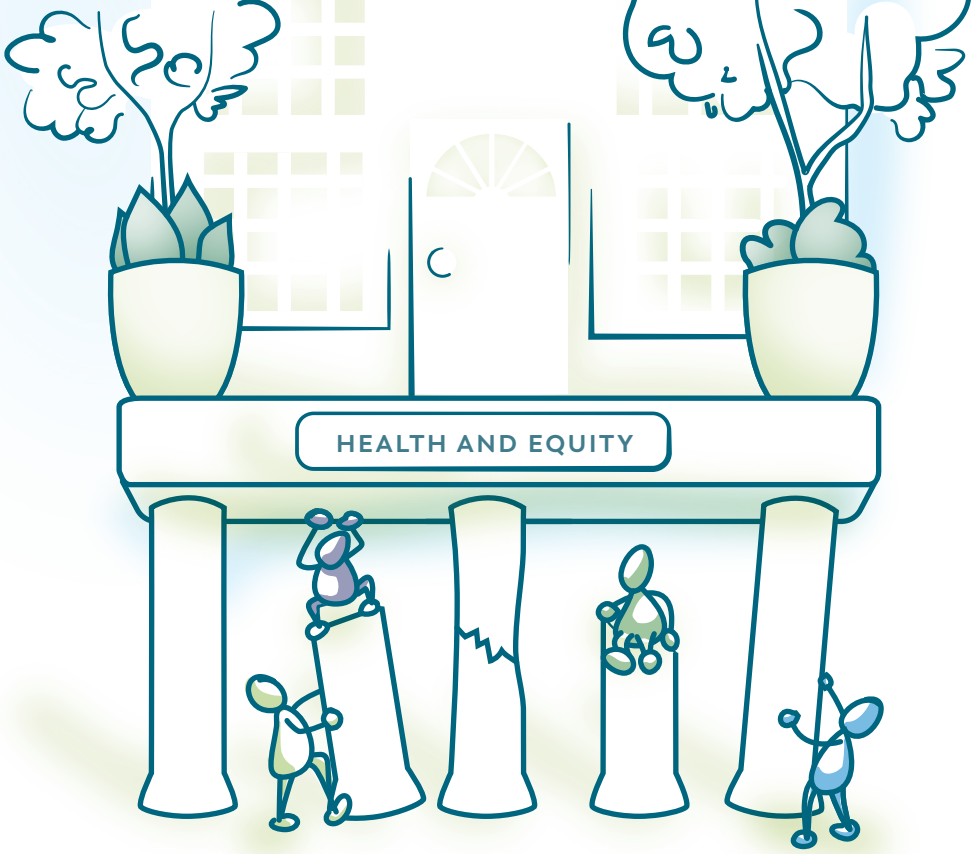
BACKGROUND:

What's our goal?

In the context of broad agreement that substantive change is necessary, multiple health initiatives underway, and a new administration in Sacramento, JSI set out to explore a Vision for Health Transformation for California. **Our inquiry was guided by the question:**

"How do we move from a health system that thinks about the individual and produces disparate outcomes toward one that thinks about populations and produces equitable opportunity and outcomes?"

During late 2018 and early 2019, JSI conducted a literature scan and talked to over 20 thought leaders across the state to get their insights on important trends and barriers and where they would put emphasis over the next 5–7 years to have the greatest impact on health and health equity in California. Our goal was not to create an inventory of ideas (for a partial list of ideas that did come up in our research, see Appendix B), but rather to focus on a practical yet ambitious vision that provokes discussion, followed by action, and is realistic about the pace and bandwidth necessary for change.



Health transformation requires building stronger supports for health and equity.

Even if the healthcare sector were 100% optimized in terms of resources, quality, and access to services, disparities and inequities would persist.[1] Healthcare can provide a step toward health and well-being and a support when individual health fails, but without other strong "pillars", the underlying patterns (inequities) that create disparities in health outcomes will remain in place.

ASSESSING TODAY:

What's Getting in the Way?

There is broad agreement at a high level on **goals for health system transformation**[2,3]:

1) **better health**
2) **better services**
3) **reduced costs**
4) **happier staff and stakeholders**
5) **increased equity**

However, progress has been slow, and in some cases, **indicators are heading in the wrong direction**.[4,5]

When we asked key informants about the barriers that are fundamental impediments to achieving better health and health equity, there was variation in emphasis but fairly consistent agreement on the following issues:

Power Imbalances & Structural Racism

Overlapping Jurisdictions & Authorities

Ineffective Incentives & Regulation

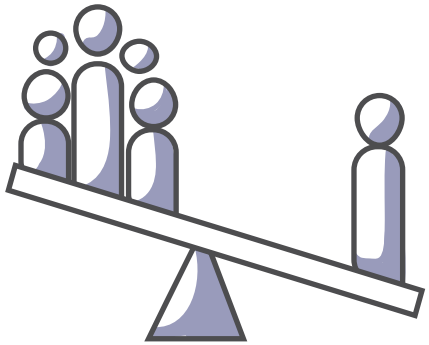
Escalating Complexity

Power Imbalances & Structural Racism

Across California and the United States, historical and ongoing discrimination and marginalization based on race, ethnicity, gender, sexual identity, immigration status, and other factors have led to policies and resource allocation that maintain and exacerbate health inequities.

For example, it is no coincidence that race-based redlining from the mid–20th century, which prevented homeownership and wealth building by non-white families, correlates with neighborhoods today that have comparatively under-resourced schools with less experienced teachers, higher rates of police misconduct, fewer parks and other recreational facilities, etc.[6,7,8] Similar patterns are evident in the correlation of communities of color with high levels of environmental exposures, limited economic investment, and high rates of chronic disease.[9,10] The legacy and continued impact of racism and discrimination is obvious when looking at health issues such as African American maternal mortality, diabetes rates among Latino adolescents, and exposure to violence in communities of color.

Patterns of racism and discrimination are also evident in expressions of political power; it is not arbitrary that freeways and garbage dumps are built in low-income communities of color .[11,12] Though community and consumer perspectives are manifest in political processes related to health, they are often overwhelmed by the influence of non-governmental organizations and private-sector interests.[13,14] In practice, institutional and professional players have the expertise and resources to define the terms and parameters of policy debate.



"Health inequities are a failure of democracy."

Rectifying this situation will require concerted effort to build power and efficacy in historically disempowered communities through organizing and other strategies to identify and truly respond to community priorities.

Ineffective Incentives & Regulation

Healthcare and public health are both highly regulated fields. Yet on the whole, regulation has most often focused on ensuring access to and delivery of healthcare services and improvement to healthcare operations and has rarely incentivized improvements in people's health.

The move toward value-based payment holds some promise for linking risks and rewards to outcomes. However, without conscious design of initiatives and incentives to focus on achieving health and equity outcomes, "value" may only equate to reduced costs and an increase in delivery of designated services.

One persistent challenge to aligning incentives is the "Wrong pocket" problem, referring to the mismatch between the investor in health improvements and beneficiaries. For example, California's tobacco control efforts had a dramatic impact on health and saved an estimated $134 billion in healthcare costs, yet there has been no systematic capture of these savings and reinvestment in the types of strategies that led to the savings.[15,16] Related issues exist around concerns such as housing: how to incorporate funding from health that is commensurate with the health benefits of housing homeless individuals.

Incentives, regulation, funding cycles, election cycles, and other planning timelines also largely emphasize short-term outcomes. As a result, longer-term strategies do not receive adequate investment. Outcomes such as reduced childhood adversity, healthy housing, or increased access to green spaces likely don't produce measurable impacts on health or other outcomes in one, two, or even five years. They may be, however, the most efficient strategies to improve health in the long-term. These "long pocket" and wrong pocket problems both require tailored incentive and regulatory responses.[17]

"The best way to herd cats is to move the food."

Overlapping Jurisdictions & Authorities

Across any given geography in California—county, city, neighborhood, region—there are multiple and fragmented systems and sectors that impact health.

For example, Medi-Cal, behavioral health, and public health are largely organized by county; police, parks, and schools are primarily organized by city; provider networks and health plans cross city and county boundaries and overlap within those boundaries; hospital districts have separate, distinct jurisdictions; and employers draw employees from across a region.

While people live, work, and play in communities, the decisions that produce health (both those around a healthy built and social environment and those that govern access to high-quality comprehensive services) are not generally made with locally-determined priorities in mind. In response to this reality, many foundations have launched initiatives in the past decade to advance a "place-based" approach to health. Yet it is a significant challenge to set a local table in light of such complex and overlapping authorities. Processes such as Community Health Needs Assessments do require community participation in priority setting but not resource allocation decisions. They also cover large geographic areas and have authority over limited healthcare resources.

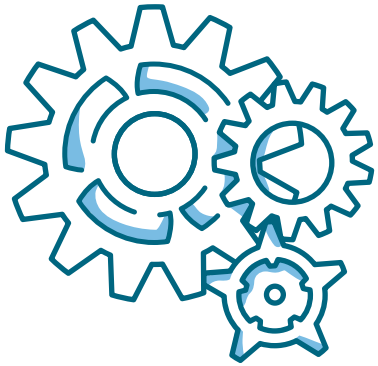
"[Unlike health] In education or housing, I know where to go locally."

Escalating Complexity

Health systems and regulation in California are remarkably complex.

Clinicians spend hours at night to complete required paperwork. School social workers struggle to figure out which versions of public insurance and benefits students are eligible for. Local public health leaders wrestle to align resources from myriad sources to keep people housed. Health researchers look through multiple data and quality measure sets and conduct qualitative interviews to try and understand what's happening on the ground. Individuals talk to multiple care coordinators to figure out how to access needed services or have to ask what network the doctor belongs to as they are being wheeled into the ER (to avoid surprise medical bills). And the list goes on. Health system complexity impedes effective decision-making, service provision, and community participation.

Conversations about value and whether health systems and investments are serving the public interest can quickly devolve into dissections of technical policy. There are also so many health entities and interests that it takes an extremely high degree of sophistication to participate meaningfully in policy development. The complexity of the healthcare system and the relative opaqueness and non-local nature of decision-making processes only serves to enhance the power of professional associations, trade groups, and corporations—all of whom have the resources for extensive policy and government relations staff. Finally, the complexity means that significant policy change discussions—such as negotiations about Medi-Cal waivers that can provide significant resources for transformation—often focus on the ways fragmentation effects big institutions as opposed to investment to address community needs.



"We have institutionalized our fragmentation."

Looking Forward:

TRENDS THAT WILL HAVE A GRAVITATIONAL PULL ON HEALTH

There are a number of large-scale trends that are likely to affect health and equity in California over the coming years. The trajectory of some of these trends may shift based on decision-making in the health sector while others are largely outside of health's formal purview. However, even trends that health leaders may feel are "in another lane" are important to consider in terms of the health effects and mitigation opportunities (e.g., work on structural racism and ageism in recognition of demographic change).

1) **Economic inequality and patterns of poverty:** **California has the highest poverty rate and among the worst income inequality in the nation; economic issues are particularly evident when comparing across communities and among children, the elderly, and people of color.[18,19,20,21,22,23] Automation is likely to continue to erode blue- and white-collar professions.[24] Poverty is increasingly a suburban issue as workers and families are forced out of urban cores by unaffordable housing.**

2) **Climate change:** **Fires, floods, drought, and extreme heat are predicted to become more commonplace features of life in California, resulting in direct health consequences such as increases in asthma and cardiovascular disease and secondary effects such as displacement.**

3) **Demographic change:** **The population of the state is changing, becoming older and more racially and ethnically diverse. As one of our interviewees noted, the state is in need of "a demographic doula" as a guide into the new reality. The implications range from changes to the necessary workforce and services to different strategies for community design and community participation in decision-making.**

4) **Healthcare reform policy:** **There are numerous efforts underway to expand coverage, control drug prices, train the workforce of the future, implement value-based payment, among others. In each case, the question about the potential impacts in terms of health and health equity need to be evaluated carefully.**

5) **Cooperation vs. competition:** **National rhetoric and policy continues to reflect divisiveness, regressive taxation, and an exclusionary stance on immigration. California is moving in the opposite direction, toward a more inclusive narrative and a set of ambitious and progressive policies that emphasize collective interests. Will that tension result in policy challenges for California and will support for a collective narrative and social contract remain strong?**

THE PIVOT:

Clear responsibility

New dollars and health policies may address specific issues or specific populations but also likely leave untouched or deepen underlying problems. Much the same as dealing with an individual patient, to have the right treatment plan for the health system, requires the right diagnosis. Otherwise we're putting Band-Aids on a broken arm, using duct tape to fix a broken system.

Reflecting on the status of health in California, the current barriers, and future trends, one unifying theme emerges: there is no true locus of responsibility for health at a population level. In this context, responsibility means being motivated, being accountable to multiple constituencies, having the necessary authority to make policy and regulatory changes, and controlling funding. On one hand, the lack of responsibility is understandable because so many factors are involved in producing health: from clean water and air to affordable housing, decreasing exposure to stress, and access to quality services. That breadth of factors leads to multiple fields such as primary care, public health, and behavioral health and disciplines and sub-disciplines within those fields. Each division leads to a separate set of tools and expertise designed to meet a subset of health needs of specific groups of people. There truly is no "health system." On the other hand, health is fundamental to individual well-being (what would anyone trade for their health?), underlies a functioning society (illness and injury impede work, civic activity, volunteerism, family relationships, etc.), and is the largest sector of the economy.

Not having clear responsibility and a focal point or venue for considering health comprehensively leads to:

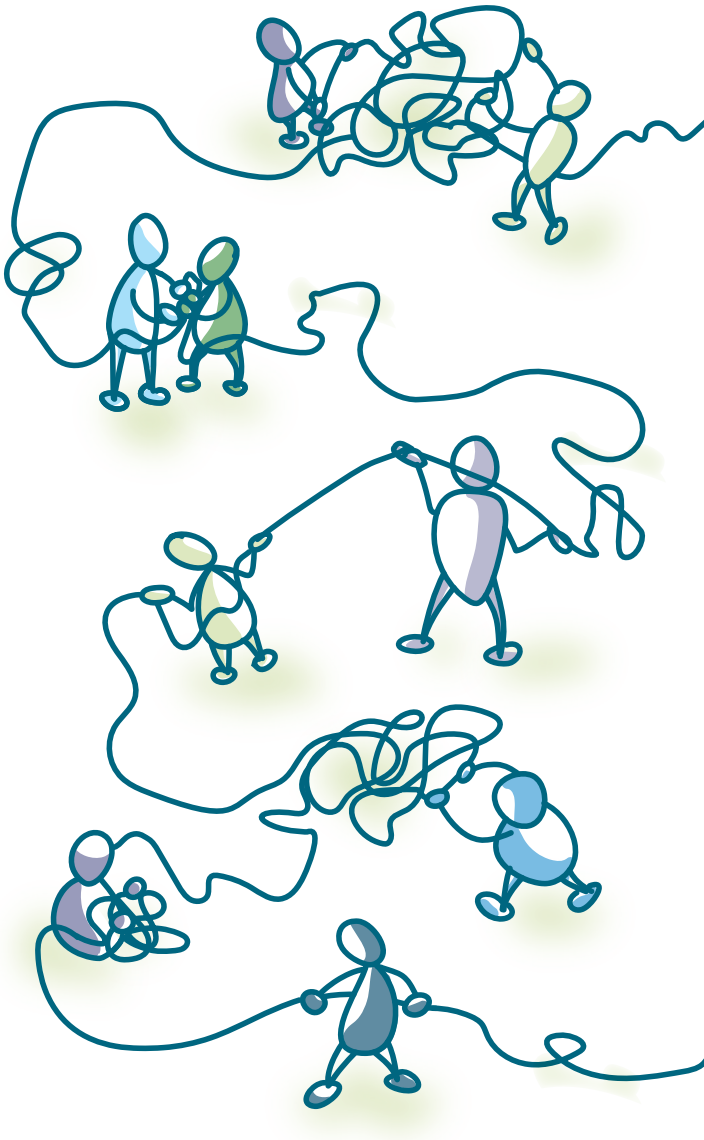
Ambiguity about high-level priorities: "What are California's health priorities?" The answers generally focus on the 5 goals at the beginning of this paper or some version of "it depends who you ask" (though the Newsom administration has been more vocal about priorities). Ask how to address the priorities, and there is an almost endless list of ideas (see Appendix B for a summary of the ideas from our research).

Inability to respond effectively to challenges and emerging crises: Imagine crime rates suddenly soared in a city or state. Elected officials and law enforcement would be expected to respond immediately. Now consider the opioid crisis, the slow response, and the lack of clarity about who could or should respond. There tends to be a lot of finger pointing in health (at the state, at health plans, at patients, at special interests, etc.), which is unsurprising given the complexity and fragmentation discussed above, but also a real problem when significant resources and effort need to be marshalled.

Competing factions: When there are too many interest groups fighting for influence from a specific perspective (one disease, one group of professionals, etc.), it can become very difficult to assess collective benefits. In a fragmented landscape, small but narrowly focused interests can carry disproportionate weight. Advocacy groups become very adept at winning small battles without addressing big system changes.

A vision for health and health equity in California has to center around creating venues and capacity to set and respond to shared priorities.

START PULLING IN THE SAME DIRECTION:
Where is the greatest leverage to increase responsibility?



Developing a strategy to improve health and health equity in California is akin to untangling a ball of yarn. There are so many different issues and constituencies simultaneously pulling on different threads with equal resolve. Sometimes it seems the knot is only tightening. One approach for this paper would have been to provide an extensive list of population health goals, paint a picture of an ideal future state, and provide a menu of many potential strategies. However, the underlying challenge is prioritization itself. Practitioners, advocates, and policymakers have limited bandwidth and attention span for innovation. In our discussions with health leaders, this notion came through crystal clear. Using a wide-angle lens to see the landscape of issues is insufficient: what is needed is boldness and agreement to work together on a small number of high-leverage opportunities rather than moving forward incrementally on numerous fronts.

As discussed above, what underlies all of the barriers is a profound lack of responsibility for population health and health equity. ***How could health advocates, decision makers, and policy experts work together in the next 5–7 years to increase clear responsibility and make progress toward significant improvements?***

The following are four possible directions that health stakeholders could choose to pursue together.

Our intent is not so much to land on one strategy but to suggest thinking critically about how best to answer that central question of increasing responsibility among stakeholders. Given that there are many paths to pursuing each strategy, the scores would vary depending on the specifics of implementation. The scores are subjective assessments and are not rooted in qualitative or quantitative data; they are intended as a conversation starter, not a conclusion. Each approach is scored likely, possible, or unlikely according to the extent to which it would address the key barriers to shared responsibility described above.

LIKELY ● POSSIBLE ◑ UNLIKELY ○

DIRECTION 1:

Solve a charismatic issue collectively to build momentum and muscle memory

In general, stakeholders and decision makers are motivated by problems that urgently need to be solved. Problems that have a human face, can be captured in one metric, and register as manifestly problematic or unjust are particularly motivating. For example, in 2010, Oklahoma City was dubbed the most overweight city in the country. Mayor Mick Cornett responded by initiating a campaign to lose a cumulative one million pounds. The effort started by focusing on individuals through a website, encouraging people to sign up and track their weight loss. Leaders quickly realized that a much broader effort was needed, involving community-based organizations, the business community, and multiple public agencies to focus on the built environment and policy and organizational practice changes to support healthy living. The city-wide initiative became a model of collective mobilization, engaging partners and strategies in a response equal to the scale of the problem.

Working collectively to address a "charismatic" health issue has value on its face, and if explicitly approached and framed as a demonstration of ability to take responsibility, can also serve as a model for future collective action.[25,26]

BARRIER	SCORE	EXPLANATION
 Power	◑	On its own will not significantly shift power structures, though if conducted in a way that ensures local leadership, could be an important example.
 Geography	○	Likely to lead to statewide focus and to operate within existing decision-making structures. It is unlikely that a new regional structure would be created to pursue the target goals.
 Incentives	◑	Would demonstrate the power of focusing attention and resources on a meaningful and measurable outcome, exactly what incentives are intended to do.
 Complexity	●	By elevating an issue that has clear implications for the well-being of Californians, would cut through complexity and look beyond existing systems.

In this context, a charismatic issue should have three key characteristics:

1) **Require a cross-sector response, touching multiple areas of public health and a variety of stakeholders.**

2) **The potential for substantial progress and success in the relative short-term.**

3) **Lend itself to framing as an inclusive issue, meaning everyone is affected by the status quo and would benefit from improvement.**

California is not short on potential issues that fit these criteria. Three examples include:

1) **Increase housing stability:**
Build 400,000 units of housing, half of which are for low- and moderate-income families.

2) **Achieve kindergarten readiness:**
95% of 5-year-olds are deemed kindergarten ready.

3) **Reduce exposure to violence:**
Decrease injuries and deaths from guns by 50% by 2025.

Those are ambitious goals. Are they impossible or just difficult? Each of those goals would require engagement across sectors and significant, focused resources and planning. They would also have positive implications for health. If such an effort was successful, it could serve as a proof point for similar cross-sector collaborations and as evidence of the value of shared responsibility.

DIRECTION 2:

Create new inclusive regional decision-making bodies

The current health system in California involves a dramatic mismatch: Health is largely the result of local factors (physical, social, economic environment; access to quality services and programs) yet few health resources are actually controlled locally. Moreover, there is little in the way of transparent and inclusive health decision-making in a local context. Boards of Supervisors have oversight of some Medi-Cal resources and public health in most jurisdictions, but health is just one of many issues they manage and public input is generally limited. Community Health Needs Assessment processes solicit community input on priorities but have only tenuous connection to the expenditure of a relatively small pool of community-benefit resources from non-profit hospitals. Public health has responsibility for monitoring health at a county level and responding to certain health crises but doesn't have significant influence on healthcare resources (or resources in other sectors that shape health outcomes).

BARRIER	SCORE	EXPLANATION
 Power	◑	**Driving decision-making closer "to the ground" should enhance local voice. However, there are many examples of attempts at inclusive processes that end up reinforcing existing power structures.**
 Geography	●	**With the right level of authority and inclusive decision-making, gets directly at the barrier as described.**
 Incentives	◑	**Depends largely on the extent to which the new entity has authority to set incentives and direct resources toward priorities.**
 Complexity	◑	**It is somewhat counterintuitive that adding an administrative body could reduce complexity. Ideally, however, a new body would set priorities and better monitor complex systems.**

More local decision-making may emerge organically out of some of the initiatives underway such as the California Accountable Communities for Health Initiative (CACHI) and Whole Person Care pilots, but it remains to be seen whether these structures will remain after funding has disappeared. It will take some specific mandate and design to engage the necessary stakeholders, determine how to measure progress, and set up necessary financing for a permanent structure.[27] A new regional body that combines resource control, effective long-term planning, and genuine inclusive decision-making will need to fit the unique California context. However, there are lessons that could be learned from other states' initiatives such as Oregon's Coordinated Care Organizations (CCOs) and Colorado's Regional Care Collaborative Organizations (RCCOs), which have established Regional Accountability Entities (RAEs) to coordinate activity, use resources flexibly to improve outcomes, and be accountable for regional health improvements through incentives and some level of risk taking. Additionally, efforts to establish regional oversight in other sectors such as housing and transportation offer useful learning about the interaction of regional bodies with state and city government, appropriate planning cycles, and community involvement strategies.

Three possible examples include:

1) **1) Start with a regional or county-based entity responsible for the maintaining and improving the health of all Medi-Cal enrollees. Examples from other states could guide California..**

2) **Establishing Multi-sector Wellness Funds that require collective decision-making about pooled resource and work to influence public and private sector resource allocations.[28]**

3) **Demonstrating effectiveness through a local pilot: Local government, the business sector, and philanthropy in a given region could work to test an alternative governance structure as an explicit, time-limited pilot.**

DIRECTION 3:

Use data to encourage investment in the health of communities

California is the world's tech innovation hub; how do we harness that capacity and skill in service of making better health- and health equity-driven decisions? The risk is that technological invention and big-data analytics are applied to health in the service of identifying profit opportunities or solving narrow precision-medicine questions. That approach could increase inequities and disparities as advances are most available to those who have access and resources.[29] Instead, technology and machine learning could be applied to understanding how upstream factors and social determinants shape health and well-being over the lifespan in ways that inform shared decision-making and incentivizing investment in the health of communities.

BARRIER	SCORE	EXPLANATION
 Power	◑	**If done well, clearer readily available data and data-driven decision-making could serve to balance power by shifting resources to places they are most needed.**
 Geography	◑	**Data can highlight geographic phenomena and correlations but won't necessarily lead to different decisions or decision-making structures.**
 Incentives	◑	**Incentives could potentially be influenced by new approaches to data or evidence could change "hearts and minds," leading to different decisions.**
 Complexity	◑	**The great hope for better, more inclusive, and well-analyzed data is that it focuses collective attention on a small, clear set of impactful drivers of health and equity.**

There is a "lake of existing data" that needs to be structured into models that expand understanding of what determines health and equity at a population level. One example of a project that has worked on this challenge of structuring data to better inform health and equity is The California Healthy Places Index (HPI). HPI, created by the Public Health Alliance of Southern California, compiles detailed local data and maps of a range of indicators that impact and shape health as well as two composite health scores: the CalEnviro Screen and Health Disadvantage Index. HPI has been used by public health departments, health systems and others to inform decision-making and action on issues ranging from transportation to preterm births.

Three potential approaches include:

1) **Creating a platform to radically expand community health needs assessment and accreditation processes to include other actors (beyond hospital community benefit and public health) and to broaden the influence of the reports and priorities priorities, including for instance, agreements from health plans and local government to align investments with needs assessment findings, for example.**

2) **Address the streetlight phenomenon (looking for solutions where we already have information/light) by identifying a small core set of measures that track health system progress on underlying predictors of health. Potential measures could include social isolation and loneliness, experience of trauma and adversity, ability to conduct the activities of daily living, and self-reported well-being.**

3) **Shift from disease-oriented monitoring to community-level comprehensive monitoring: build out the Healthy Places Index and composite scores to including health system data (Medi-Cal enrollment, etc.) and public sector spending. Create venues for reporting on the data and connect community-level indicators with health incentives and penalties.**

DIRECTION 4:

Leverage healthcare policy to increase investments in health and equity outcomes

It is a well-worn trope that health in the U.S. exists in a state of paradox: we spend far more per capita than any other nation yet achieve poor outcomes by comparison.[30] Healthcare transformation and movement toward value-based payment hold promise but need to be implemented effectively with a true focus on improved outcomes.[31] A single-payer system, for instance, is described as a way to control costs and improve quality. However, it is not clear that a single-payer system would automatically lead to improvements in health or equity (though it could reduce economic stress and the "wrong pocket" issues discussed previously by creating a single "pocket"). What would healthcare policies that demand value look like, which center on improvements in health and health equity in return for our vast investments?

BARRIER	SCORE	EXPLANATION
 Power	◑	There is some potential for policy changes to include requirements for inclusive decision-making and community oversight.
 Geography	○	Additional resources might be available locally but are not likely to alter decision-making structures.
 Incentives	●	Gets directly to the issue of incentives and could set an agenda for future action.
 Complexity	◑	In some ways, this approach could add complexity by creating new regulations and funding streams. However, it could also create some sense of focus and direction.

A few ideas for new policies, or tweaks to existing policy, that could drive both dollars and other resources toward innovative outcome-driven work include:

1) **Require upstream investment: A number of states have required health plans to make community investments as part of contracting (e.g., Arizona and Oregon). Others have put requirements in place for hospitals and health systems to invest in local communities through regulatory policy and/or as a requirement attached to major capital expenditures. A small (from healthcare's perspective), but mandatory, investment could provide the certainty and continuity to build significant capacity over time in non-healthcare entities.**

2) **Implement significant incentives focused on health and equity outcomes: The majority of high-stakes and value-based incentives remain focused on services and individuals. Tying value-based incentive dollars to a set of population level measures focused on outcomes (e.g. rates of chronic disease in an entire geographic area) or determinants of health (e.g. community level body-mass index or opioid use) could serve to break down concerns among healthcare payers about churn and focus collective efforts.**

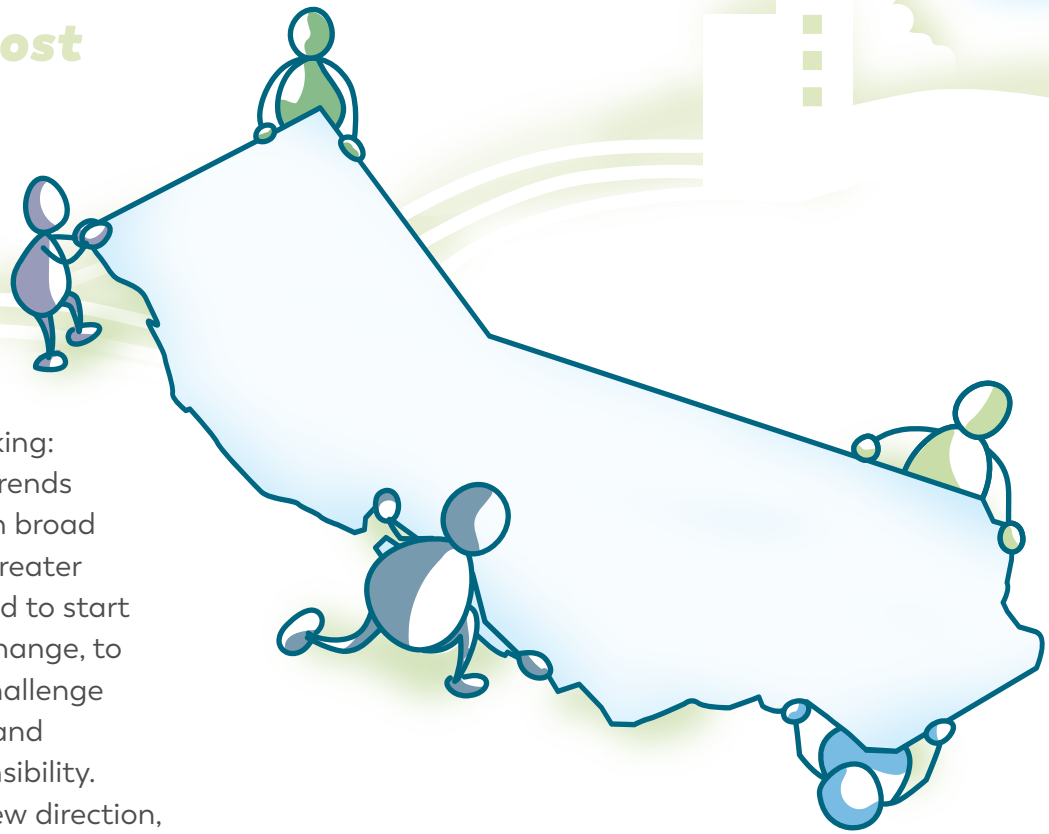
3) **Modify rate-setting process: The current way rates are set for Medi-Cal managed care plans perversely disincentivizes innovative investments that improve health through a focus on social determinants. Rate setting could potentially encourage innovation by sharing the risk of up-front investments between plans and the state, allowing for sharing of any savings, and/or accounting for social factors and risks in patient populations.**

4) **Dramatically expand the health workforce: An expansive community health worker (CHW) program could serve to address significant staff shortages (particularly in behavioral health); provide economic opportunities (so long as living wages and local hiring are required); create a functional interface between clinical institutions and the communities they serve; and bolster care coordination and systems and policy change work (so long as CHWs are encouraged to organize around community health priorities).**

CONCLUSION

Which of the four directions is most likely to catalyze real change?

Which sub-strategy will have the greatest impact?



Part of the answer lies in who is involved in the decision-making: different constituencies will prioritize different barriers and trends and any bold direction and/or strategy will only succeed with broad buy-in. There is some irony in calling for movement toward greater responsibility and accountability since that is what is required to start such movement. However, there is a strong motivation for change, to do things differently for moral and economic reasons. The challenge is to focus California's vast and diverse health stakeholders and expertise to create even a temporary sense of shared responsibility. Once a large object or complex system starts moving in a new direction, it can pick up momentum.

Appendix A: KEY INFORMANTS

The authors are grateful to the individuals listed below who contributed their expertise and insights to this project. Titles and affiliations listed reflect positions at the time of our interviews.

CALIFORNIA

Elizabeth Baca, MD, MPA
Deputy Director, governor's office of planning and research

Renae Badruzzaman, MPH
Program Manager for Health Equity Investments, Bay Area Regional Health Inequities Initiative (BARHII)

Alex Briscoe, MA
Principal, California Children's Trust

David Carlisle, MD, PhD
President and CEO, Charles R. Drew University of Medicine and Science (CDU)

Sarah de Guia, JD
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Tracy Delaney, PhD, RD
Executive Director, Public Health Alliance of Southern California

Caroline Fichtenberg, PhD
Managing Director, UCSF Social Interventions Research & Evaluation Network (SIREN)

Jonathan Heller, PhD
Co-Director, Human Impact Partners

Lisa Hershey, MPH
Executive Director, Housing California

Jim Hickman, MBA
Principal and Chief Catalyzer/ Interim CEO, Hickman Strategies; Center for Youth Wellness

Tony Iton, MD, JD, MPH
Senior Vice President, The California Endowment

Melissa Jones, MPA
Executive Director, Bay Area Regional Health Inequities Initiative (BARHII)

Doug Jutte, MD, MPH
Executive Director, Build Healthy Places Network

Rishi Manchanda, MD, MPH
President and CEO, Health Begins

Xavier Morales, PhD, MRP
Executive Director, Praxis Project

Tyler Norris, MDiv
Chief Executive, Well Being Trust

Karen Smith, MD, MPH
Director, California Department of Public Health (CDPH)

Sadena Thevarajah, JD
Managing Director, Health Begins

Micah Weinberg, PhD
President, Bay Area Council Economic Institute

JSI INTERNATIONAL DIVISION

For more discussion of the process and input from leaders of JSI's International Division, see the commentary here: https://medium.com/@JSIhealth/an-international-perspective-on-californias-population-health-challenges-8d89daecb8ec

KumKum Amin, MBA, MFA
Associate Director

Craig Burgess, MD, MBA, MS
Senior Technical Officer

Heather Danton, MS
Project Director

Penny Dawson, MD
Senior Technical Advisor

Carolyn Hart, MSPH
Vice President

Sean Maher, MBA
Senior HIV Advisor

Tanvi Pandit-Rajani, MPH
Senior Technical Advisor

Amanda Pomeroy-Stevens, MS
Project Director

Appendix B: STRATEGY MATRIX

Below are specific strategies for health improvement that came up in our research process but that did not fit into the framework that emerged. They are shared here, in relatively raw form, in the hope that they may be provocative and/or provide affirmation for those who work on these issues.

Healthcare Structure and Funding

STRATEGIES

- Single-payer healthcare
- Managed competition as a healthcare financing system
- Primary Care and Behavioral Health Integration
- Whole Child Care initiative(s)
- Mandatory Health Plan to support/ funding for SDOH and health equity
- Leadership programs and faculty investments for community health workers
- Social, peer-to-peer models in physical and behavioral health

Data and Measurement

STRATEGIES

- Elevate health equity in measurement and accountability
- Clinical integration and tech: meeting people where they are, tailoring "precision public health"
- Mandated de-identified data release from healthcare institutions
- Measures for quality of democracy and participation (beyond voting)
- Data infrastructure to create a data lake for health information exchange
- Community-level data collection (finer level than zip code)
- Family stability as key, value-based metric (ACEs, incarceration)
- Leading causes of Life indicators
- Focus tech ingenuity on big, complex problems through government partnerships
- Community-driven indicator selection and monitoring

Innovative Financing

STRATEGIES

- Public sector "housing pools" that purchase properties during market downturns
- Expanded participatory budgeting processes
- County-level "Wellness Trust" to pool funding from multiple sources
- Statewide Universal Basic Income pilot
- "Children's Trusts" to pool resources across child welfare, juvenile justice, behavioral health
- Outcomes-focused investments that reflect community priorities and equity
- Incentivized social-impact business models

Health In All Policies

STRATEGIES

- Affordable housing becomes a right/entitlement
- Criminal Justice reform and reduced incarceration
- Truly affordable post-secondary education
- Social mobility strategies (e.g. Trust Funds for Kids from low-income families)
- Treat loneliness as a health epidemic
- Family-sustaining employment (e.g. Pay a living wage to formerly incarcerated people to case manage people reentering communities)

Leadership, Infrastructure, Partnerships

STRATEGIES

- Many more pilots funded to test innovation
- Regional Health Governance Councils
- Narratives that emphasize shared destiny
- Capacity building for CBOs (contracting, negotiation)
- Training for community residents to feel empowered to serve on boards and commissions
- Public Health Accreditation
- Certification for regional public health collaboratives

ENDNOTES

1 Woolf S. Necessary But Not Sufficient: Why Health Care Alone Cannot Improve Population Health and Reduce Health Inequities. Annals of Family Medicine, May/June 2019. http://www.annfammed.org/content/17/3/196.full

2 Feeley D. The Triple Aim or the Quadruple Aim? Four Points to Help Set Your Strategy. Institute for Healthcare Improvement, November 2017. http://www.ihi.org/communities/blogs/the-triple-aim-or-the-quadruple-aim-four-points-to-help-set-your-strategy

3 California Health and Human Services Agency, California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Guiding Principles. October 2019. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf

4 Greene J, Badley E, & Nguyen T. Peterson A & Oldham R. County Health Status Profiles 2019. California Department of Public Health, April 2019. https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CountyProfiles_2019.pdf

5 Perrone C. New Study Shows Lagging Quality Improvement in Medi-Cal Managed Care. California Health Care Foundation, September 2019. https://www.chcf.org/blog/new-study-shows-lagging-quality-improvement-medi-cal-managed-care/

6 Mitchell B. HOLC "Redlining" Maps: The Persistent Structure Of Segregation And Economic Inequality. *National Community Reinvestment Coalition*. March 20, 2018. https://ncrc.org/holc/

7 Charles J. Federal Housing Discrimination Still Hurts Home Values in Black Neighborhoods. *Governing: The States and Localities*. April 30, 2018. https://www.governing.com/topics/transportation-infrastructure/gov-redlining-race-real-estate-values-lc.html

8 Green M. How Government Redlining Maps Pushed Segregation in California Cities [Interactive]. KQED News. April 27, 2016. https://www.kqed.org/lowdown/18486/redlining

9 Public Health Alliance of Southern California. The California Healthy Places Index (HPI). https://healthyplacesindex.org/

10 Advancement Project California. Healthy city. https://www.healthycity.org/

11 Miller J. Roads to nowhere: how infrastructure built on American inequality. The Guardian. February 21, 2018. https://www.theguardian.com/cities/2018/feb/21/roads-nowhere-infrastructure-american-inequality

12 Sanchez T, Stolz R, Ma J. Moving to Equity: Addressing Inequitable Effects of Transportation Policies on Minorities. June 1, 2003. https://civilrightsproject.ucla.edu/research/metro-and-regional-inequalities/transportation/moving-to-equity-addressing-inequitable-effects-of-transportation-policies-on-minorities

13 Hacker J. & Pierson P. Winner-Take-All Politics: Public Policy, Political Organization, and the Precipitous Rise of Top Incomes in the United States. *Politics and Society*. 2010; 38(2):152-204. https://journals.sagepub.com/doi/abs/10.1177/0032329210365042

14 Gilens M. & Page B. Testing Theories of American Politics: Elites, Interest Groups, and Average Citizens. *Perspectives on Politics*. September 2014; 12(3):564-581. https://www.cambridge.org/core/journals/perspectives-on-politics/article/testing-theories-of-american-politics-elites-interest-groups-and-average-citizens/62327F513959D0A304D4893B382B992B/core-reader#

15 Fernandez E. California's Tobacco Control Program Generates Huge Healthcare Savings: UCSF Study Examines Impact of Statewide Anti-Smoking Campaign Over Nearly 20 Years. UCSF. February 13, 2013. https://www.ucsf.edu/news/2013/02/13533/californias-tobacco-control-program-generates-huge-health-care-savings

16 Iton A. & Cohen L. Closing the Loop: Why We Need to Invest—and Reinvest—in Prevention. National Academy of Sciences, 2014. https://nam.edu/wp-content/uploads/2015/06/closingtheloop.pdf

ENDNOTES ...continued

17 Freedman D. Healthcare's 'upstream' conundrum. *Politico*. January 10, 2018. https://www.politico.com/agenda/story/2018/01/10/long-term-health-nation-problems-000613

18 Renwick T & Fox L The Supplemental Poverty Measure: 2015. The U.S. 61 Census Bureau. September 2016.

19 Nichols C. TRUE: California has the nation's highest poverty rate, when factoring in cost-of-living. *PolitiFact California*. January 20th, 2017. https://www.politifact.com/california/statements/2017/jan/20/chad-mayes/true-california-has-nations-highest-poverty-rate-w/

20 United Health Foundation. Annual Report: Income Inequality — Gini Index. https://www.americashealthrankings.org/explore/annual/measure/gini/state/CA

21 Bohn S, Danielson C, & Thorman T. Child Poverty in California. Public Policy Institute of California. July 2019. https://www.ppic.org/publication/child-poverty-in-california/

22 Cubanski J. et al. How Many Seniors Live in Poverty? Kaiser Family Foundation. Nov 19, 2018. https://www.kff.org/medicare/issue-brief/how-many-seniors-live-in-poverty/

23 Levin M. Income gap growing in California's poorest regions. *San Francisco Chronicle*. Aug 14, 2016. https://www.sfchronicle.com/news/article/Income-gap-growing-in-California-s-poorest-9142062.php

24 Mason M. Millions of Californians' jobs could be affected by automation — a scenario the next governor has to address. *Los Angeles Times*. Oct 14, 2018. https://www.latimes.com/projects/la-pol-ca-next-california-work/

25 Let's Get Healthy California. https://letsgethealthy.ca.gov/

26 Quinn M. The Walking Cure: How Oklahoma City Lost 1 Million Pounds. *Governing: The States and Localities*. January 2017. https://www.governing.com/topics/health-human-services/gov-oklahoma-city-walking-obesity.html

27 Briggs A, Alderwick H, & Fisher E. Overcoming challenges to US payment reform: could a place-based approach help? *JAMA*. April 2018; 319(15):1545-1546. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5944326/

28 Cantor J, Powers P, & Masters B. Establishing a Local Wellness Fund: Early Lessons From The California Accountable Communities For Health Initiative. CACHI. July 2019. https://blueshieldcafoundation.org/sites/default/files/publications/downloadable/Establishing-a-Local-Wellness-Fund_Issue-Brief_FINAL_7-10-19.pdf

29 O'Neil C. *Weapons of Math Destruction: How big data increases inequality and threatens democracy*. Crown Random House; 2016. https://weaponsofmathdestructionbook.com/

30 Bradley EH, Sipsma H, & Taylor LA. American healthcare paradox—high spending on healthcare and poor health. *QJM: An International Journal of Medicine*. February 2017; 110(2):61–65. https://academic.oup.com/qjmed/article/110/2/61/2681813

31 Giron N, Kirui T, Tobey R, & Cantor J. Moving Toward Value: Medi-Cal Managed Care Plans and the Social Determinants of Health. JSI Research & Training Institute, Inc. September 2019. www.jsi.com/movingtowardvalue

Authors:

Jeremy Cantor, MPH

Kiely Houston, MSPH

Mia Bladin, BA

Design:

Molly McCoy Graphic Design

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