HEALTH BEGINS

PROMISE, PERIL & OPPORTUNITY

An inflection point in the journey to improve population health and address the social arrangements that put people in harm's way

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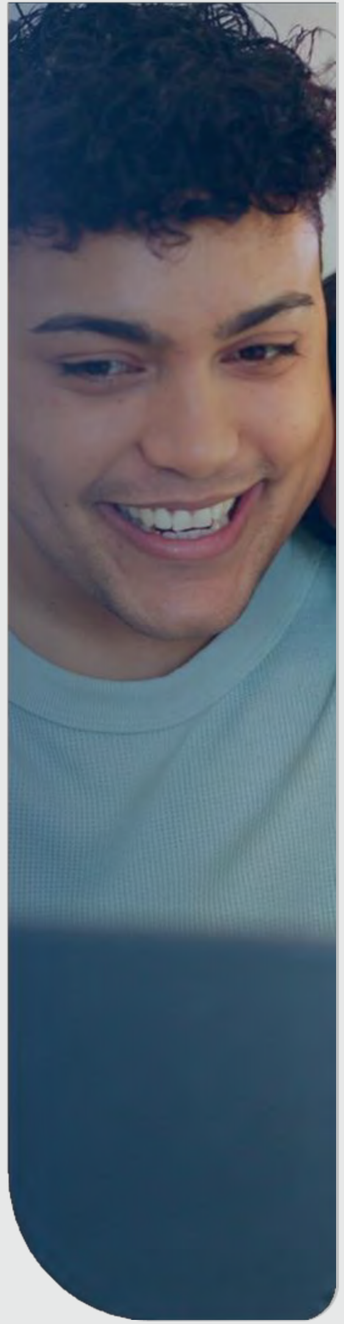
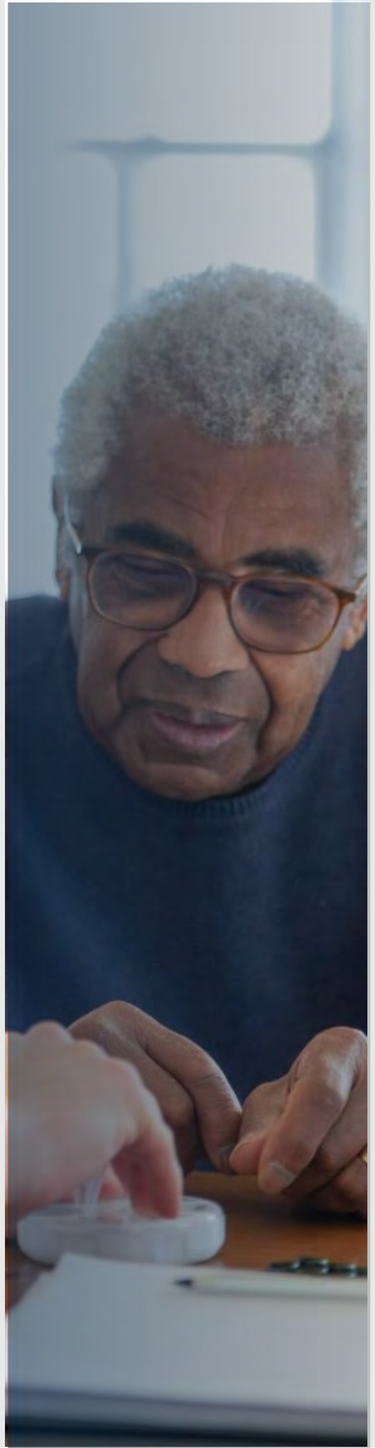
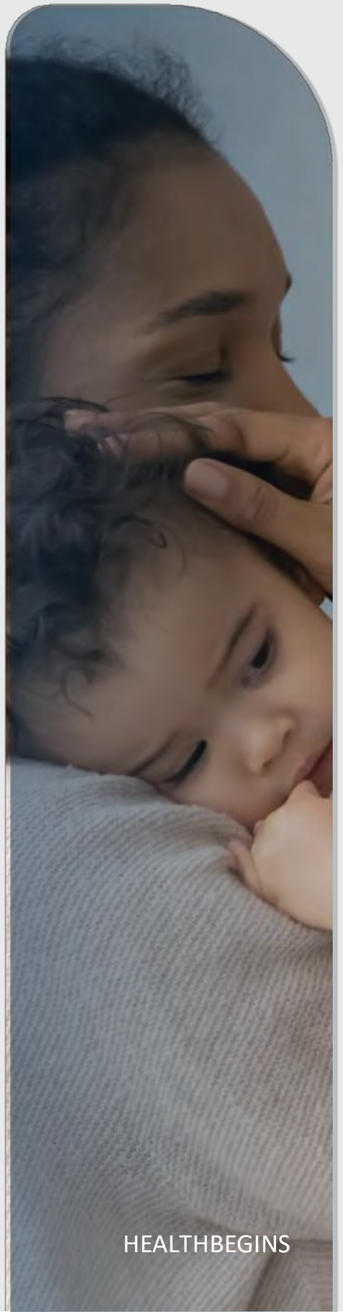
PHMI Statewide Learning Session Keynote
March 5, 2025



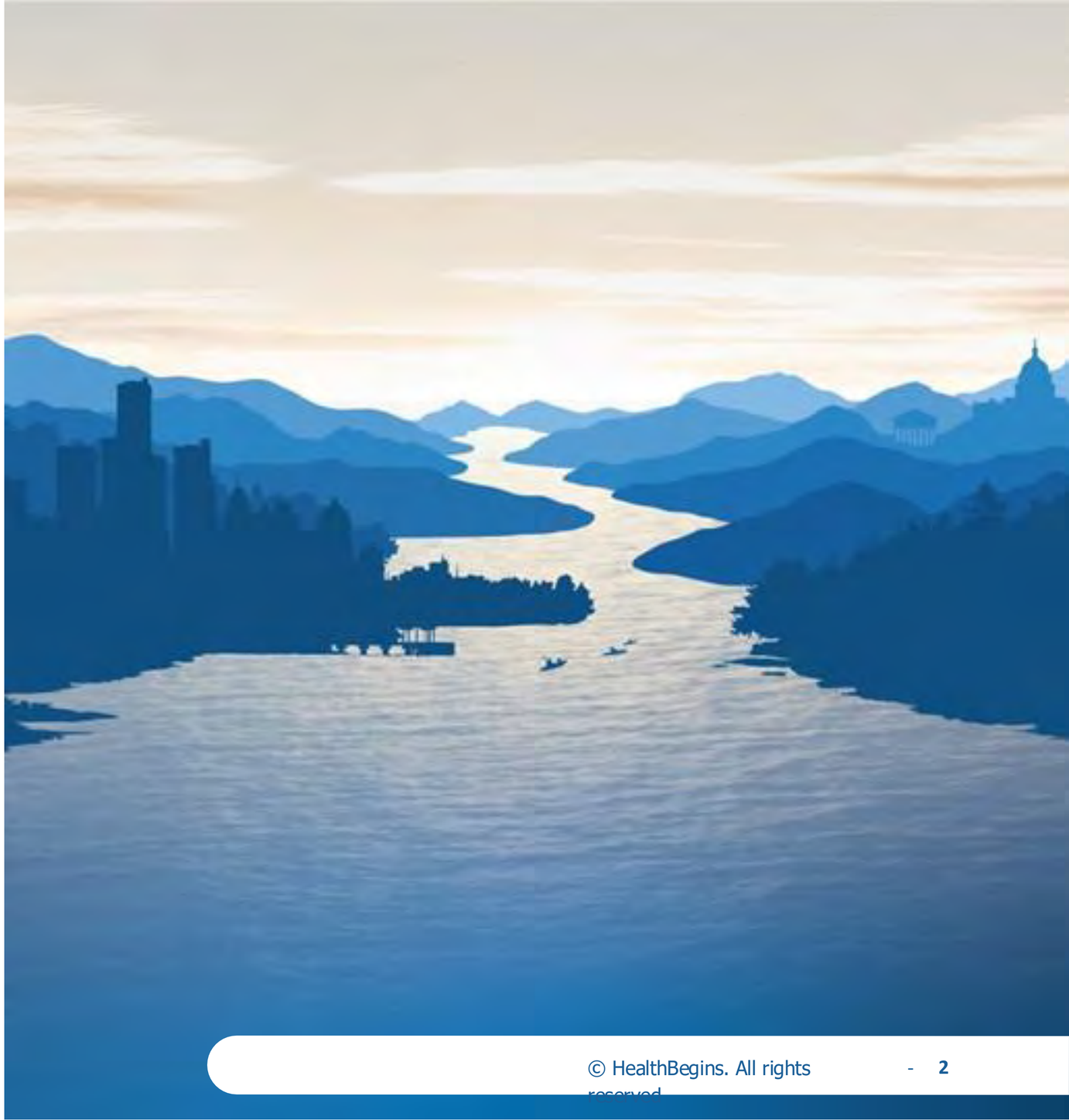




ABOUT US

HealthBegins is a national mission-driven strategy and implementation firm that helps Medicaid-serving health plans, health systems, and CBOs to exceed health care equity and social needs requirements and achieve long–term impact for people and communities harmed by societal practices.

To date, we've helped hundreds of courageous leaders and staff move upstream to improve health outcomes and advance health equity in over 350 communities across the country.



Objectives

By the end of this presentation, we will :

- **Celebrate accomplishments** in optimizing care and equity for patients and populations served by community health centers across California

- **Describe current risks and opportunities** for preserving, optimizing, and paying for equitable care

- **Identify at least two concrete ways** to improve care for all and advance health equity in this moment

Uncertainty in this moment facing community health centers

- How can we prepare and respond to policies that are creating uncertainty and fear among our patients and colleagues?

- What is the future of Medicaid?
  - Health centers care for more than 1 in 6 Medicaid beneficiaries nationally, and roughly half (49%) of health center patients are Medicaid beneficiaries.

Pop Quiz

What do these pictures have in common?

Mrs. M’s Story

- Mrs. M is in her early-60s. She loves her two adult children and her granddaughter, all of whom live in a neighboring state.
- She has a low-wage job and typically spends at least $2200 a year on out-of pocket healthcare costs.
- Mrs. M has type II diabetes and stage 3A chronic kidney disease.
- At the end of last month, Mrs. M nearly passed out at work and was admitted to the hospital.
- Diagnosis: low-blood sugar

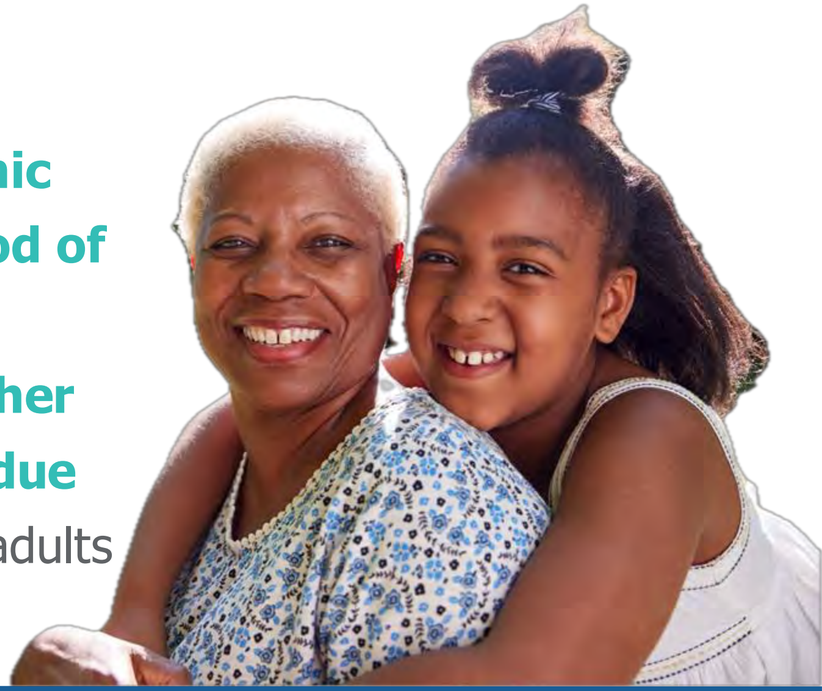
Mr. T’s Story

- Mr. T is in his late-70s. He adores his adult daughter and grandson, who live about an hour away,
- He’s retired, lives on a limited fixed income, and typically spends at least $1200 a year on out-of pocket healthcare costs.
- Mr. T has type II diabetes and stage 3B chronic kidney disease.
- At the end of last month, Mr. T nearly collapsed in his primary care doctor’s waiting room.
- Diagnosis: low-blood sugar

Food and nutrition insecurity puts people in harm's way

- **Diabetes prevalence rises** with increasing severity of food insecurity (10% for mild household food insecurity vs. 16.1 % for severe)
- **Diabetes risk was approximately 50% higher among adults in food-insecure households** than in food-secure households

- Among lower-income adults, food insecurity is associated with a **46% higher odds of chronic kidney disease** and a **38% higher likelihood of progression to end-stage kidney disease.**
- Adults with **very low food security had higher risk of all-cause mortality and mortality due to cardiovascular disease**, compared with adults with high food security.



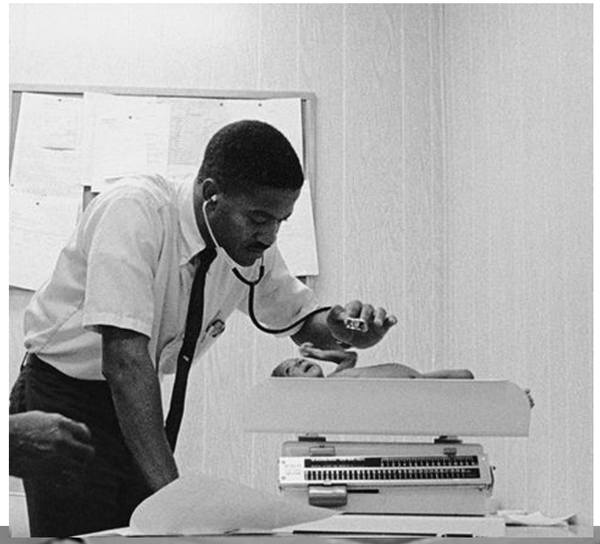
1. Seligman HK, et al. *Health Affairs*. 2014;33(1):116–23
2. Crews DC, Kuczmarski MF, Grubbs V, Hedgeman E, Shahinian VB, Evans MK, Zonderman AB, Burrows NR, Williams DE, Saran R, Powe NR; Centers for Disease Control and Prevention Chronic Kidney Disease Surveillance Team : Effect of food insecurity on chronic kidney disease in lower-income Americans. *Am J Nephrol* 39: 27–35, 2014
3. Sun Y, Liu B, Rong S, Du Y, Xu G, Snetselaar LG, Wallace RB, Bao W. Food Insecurity Is Associated With Cardiovascular and All-Cause Mortality Among Adults in the United States. J Am Heart Assoc. 2020 Oct

A Moment of Promise

Pholela Health Centre, Kwazulu-Natal, South Africa

Images courtesy of National Library of Medicine. Stories of Global Health
https://www.nlm.nih.gov/exhibition/makingaworldofdifference/collection-detail.html?imgid=11&imgName=OB9283-md

Delta Health Center, Mound Bayou, Mississippi, USA



Images courtesy of National Library of Medicine. Stories of Global Health https://www.nlm.nih.gov/exhibition/makingaworldofdifference/collection-detail.html?imgid=11&imgName=OB9283-md

https://www.nachc.org/resource/americas-health-centers-by-the-numbers/

Over the last decade, Medicare and Medicaid increased opportunities for healthcare to partner with communities to address social needs and advance health equity

Centers for Medicare & Medicaid Services (CMS)

Medicaid

- Medicaid section 1115 demonstrations
- Medicaid managed care in-lieu of services and supports

Medicare

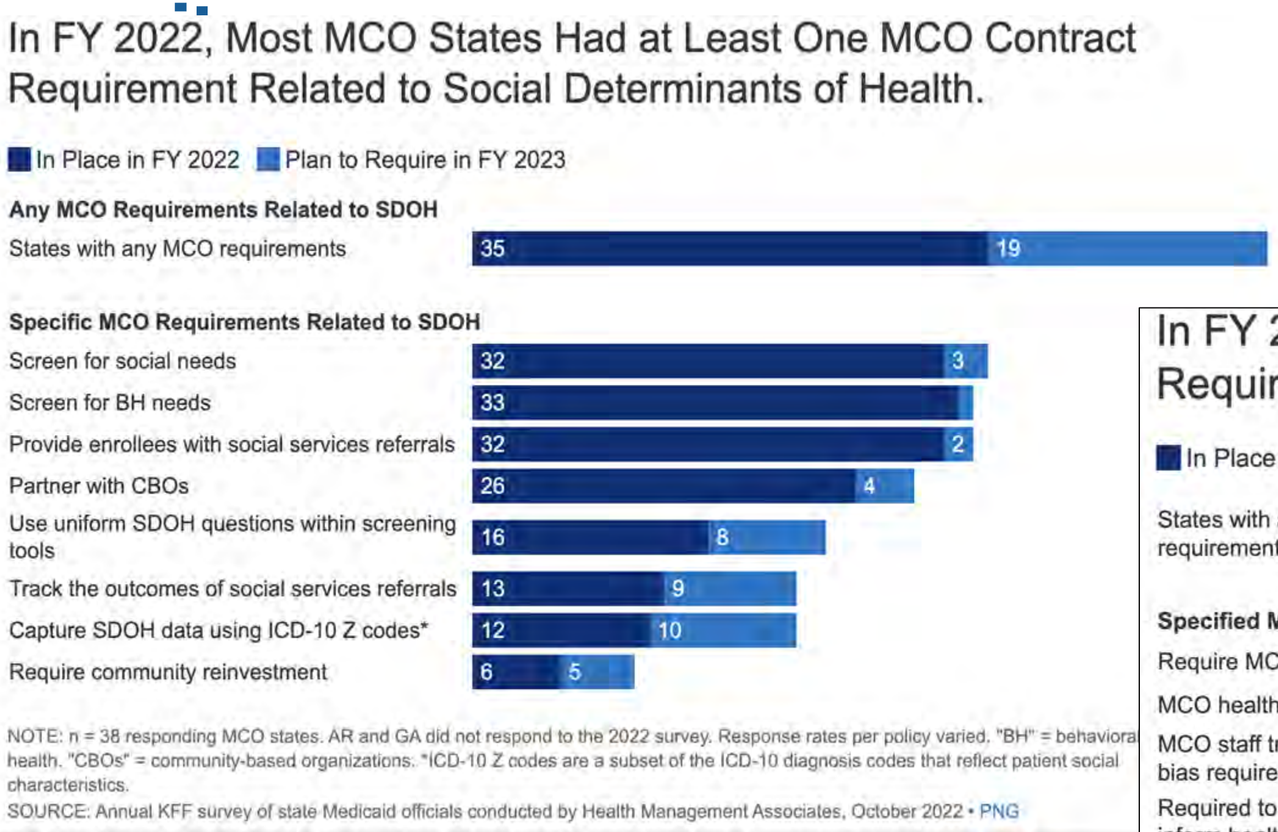
- Supplemental benefits in Medicare Advantage
- Merit-Based Incentive Payment System (MIPS) and the Medicare Shared Savings Program (MSSP) in the traditional Medicare program
- Under the 2024 Physician Fee Schedule final rule, Medicare separately pays for SDOH risk assessments

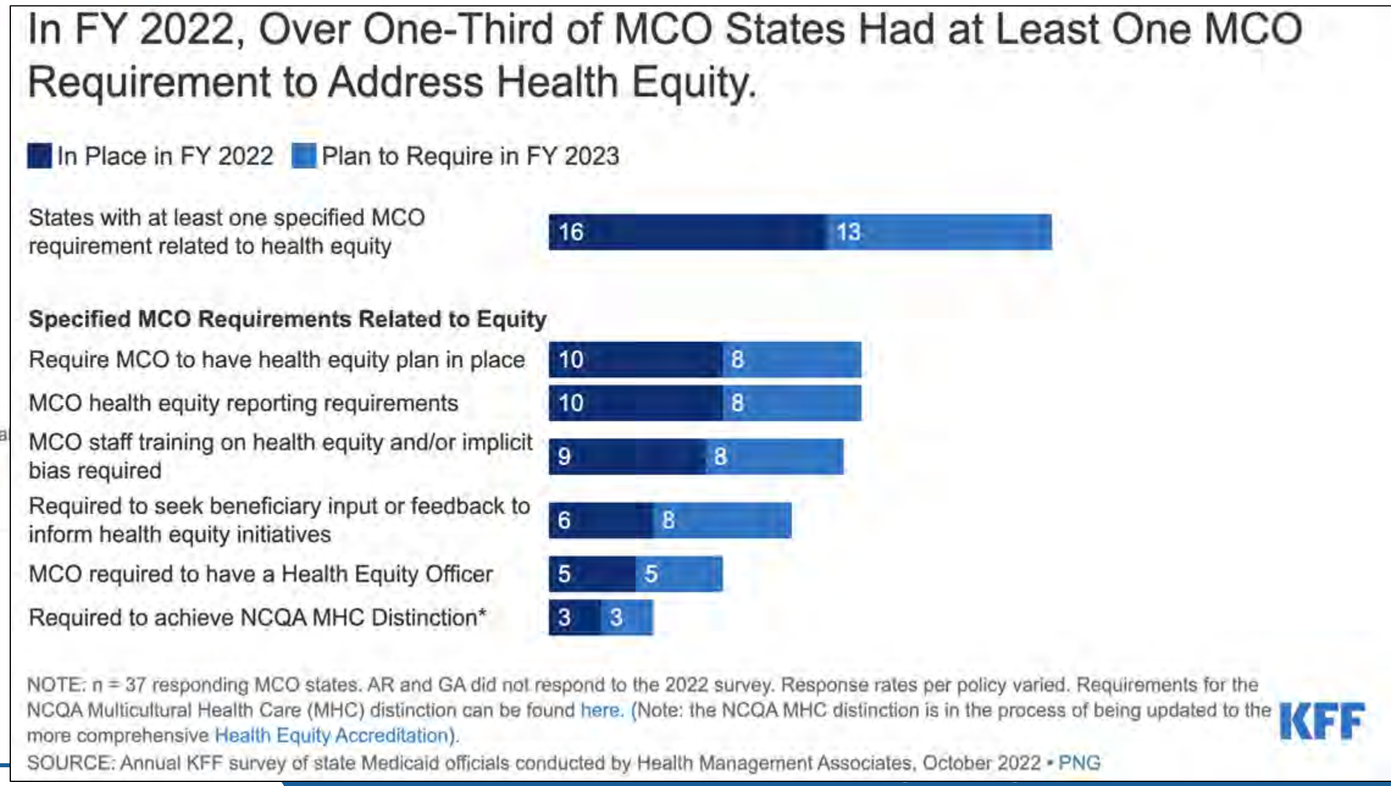
Administration for Community Living (ACL) & the Centers for Disease Control and Prevention (CDC)

- Awarded grants and provided training and technical assistance to communities that are building the infrastructure to connect the health and social care sectors

- CDC provided states with an SDOH module for the Behavioral Risk Factor Surveillance System to help assess SDOH at a population level

State Medicaid agencies are focusing on social needs and healthcare



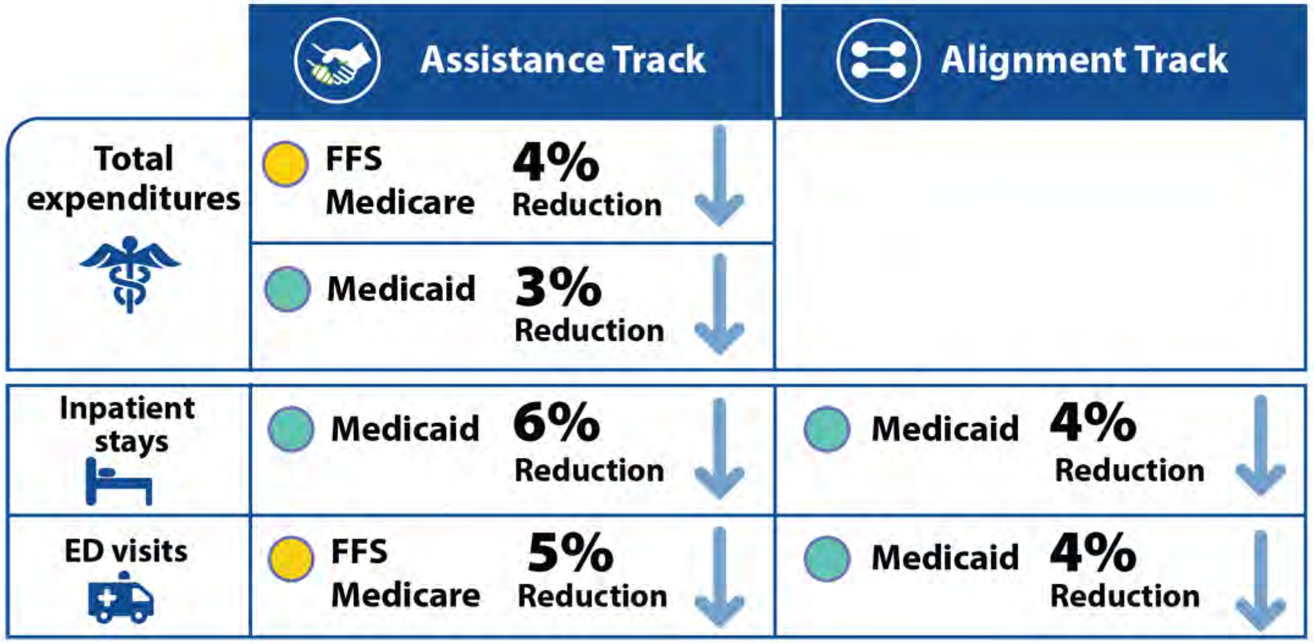


https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

Navigation and assistance connecting with social resources improved quality of care and lowered costs among Medicare and Medicaid beneficiaries

- The CMS Accountable Health Communities (AHC) Model was associated with **significant impacts on total expenditures and quality of care,** even though the model resulted in moderate increases in beneficiaries' connection to community services and HRSN resolution overall.

- "One possible explanation for these findings is that **navigators not only helped beneficiaries with [social needs] but also addressed tangible barriers to health care** (e.g., transportation to appointments) and helped them navigate the health care system generally."

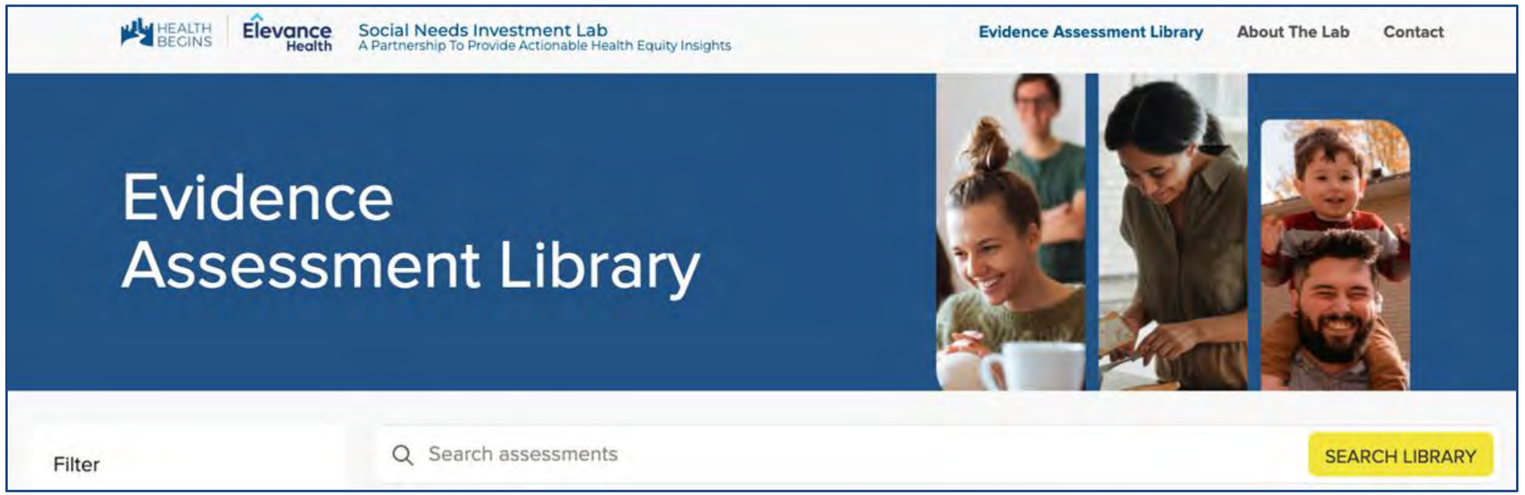


CMS Accountable Health Communities Model Evaluation of 2018–2023. https://www.cms.gov/priorities/innovation/data-and-reports/2024/ahc-3rd-eval-report-aag

The evidence of impact is growing

- Improving population health management and connecting patients to resources for their social needs can help avoid unnecessary hospitalizations, emergency department visits and significantly lower costs

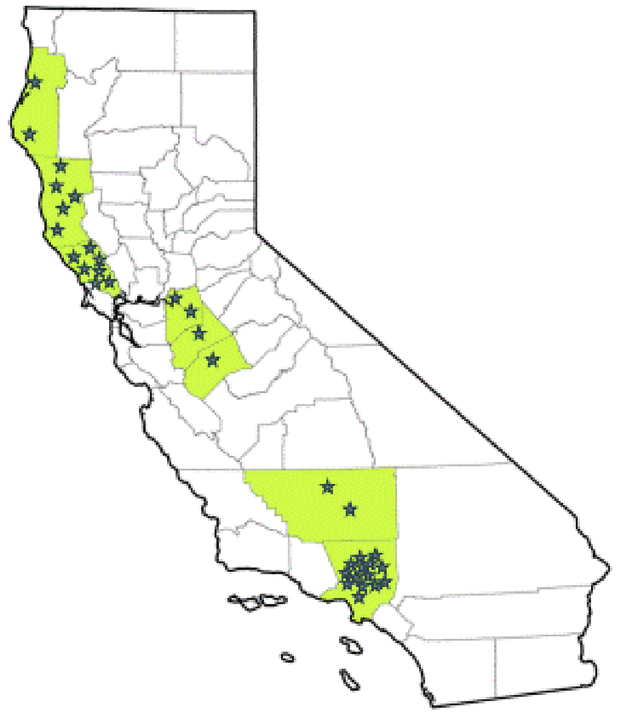
  - **Example:** Home-delivered, medically tailored meals for patients with chronic conditions have been found to significantly lower inpatient stays, 30-day readmissions, and overall medical costs.



https://www.socialneedsinvestmentlab.com/

Celebrating accomplishments

Community Health Centers involved in PHMI, California



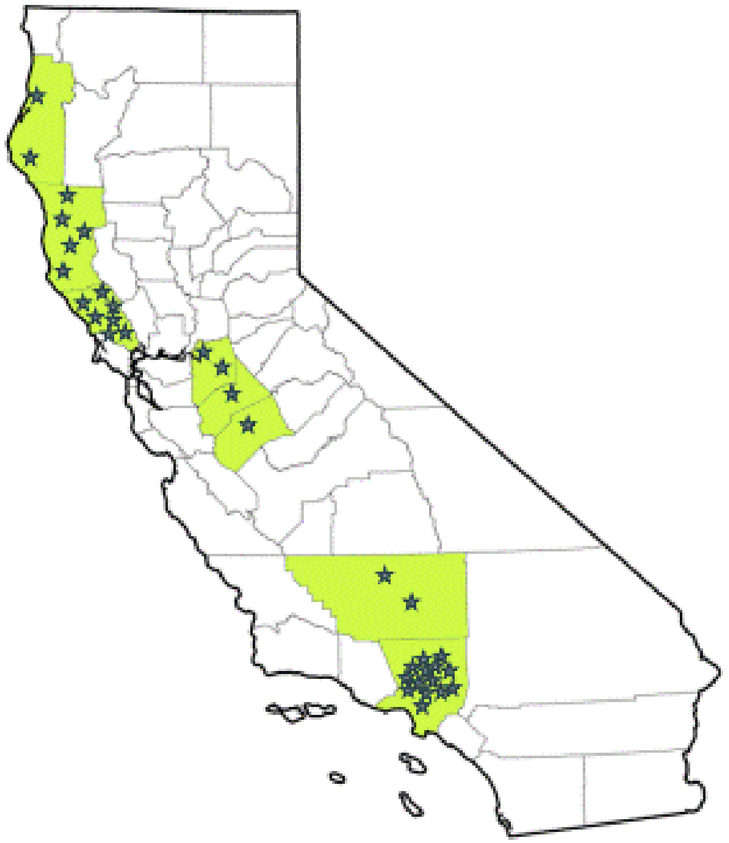
Regional Associations of California (RACs) Supporting the PHMI Cohort

RAC: North Coast Clinics Network
Anderson Valley Health Center
Long Valley Health Center
Mendocino Coast Clinics
Mendocino Community Health Clinics
Open Door
Redwood Coast Medical Services
Redwood Rural Health Center Inc.

RAC: Aliados Health
Alexander Valley Healthcare
Alliance Medical Center
Petaluma Health Center
Santa Rosa Community Health Centers
Sonoma County Indian Health Project
Sonoma Valley Community Health Center
West County Health Centers

RAC: Central Valley Health Network
Clinica Sierra Vista
Community Medical Center Inc.
Golden Valley Health Center
Omni Family Health

RAC: Community Clinic Association of Los Angeles County
APLA Health
Asian Pacific Health Care Venture Comprehensive Community Health Centers
East Valley Community Health Center
Eisner Health
Northeast Valley Health Corporation
ParkTree Community Health Center
Saban Community Clinic
San Fernando Community Health Center
UMMA Community Clinic
Universal Community Health Center
Valley Community Healthcare
Venice Family Clinic
Via Care Community Health Center



PHMI's Goals

Improve quality of care and equitable health outcomes of people served by CHCs

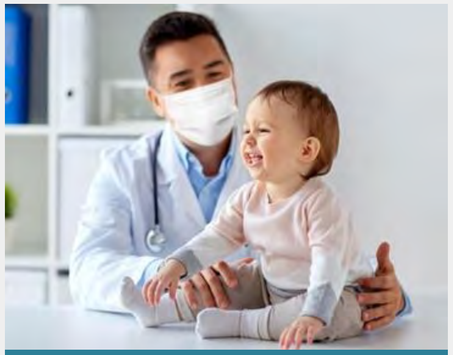
Enhance access through team-based care and care redesign at CHCs

Improve CHC patient engagement and experience of care

Improve CHC technology enablement to optimize population health capabilities

Populations of Focus

PHMI is focused on improving quality of care and equitable health outcomes for five high-priority populations.

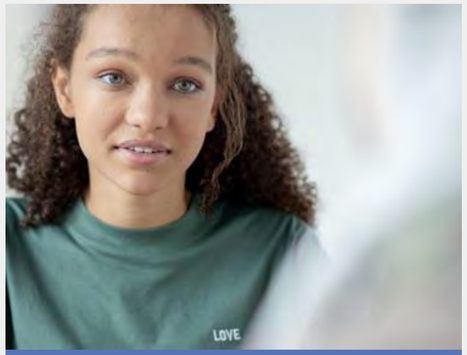


Children

Pregnant People

Adults with Preventative Care Needs

Adults Living with Chronic Conditions



People with Behavioral Health Conditions

PHMI Support for Food is Medicine

01 **PARTNERING WITH FIM PROVIDERS**

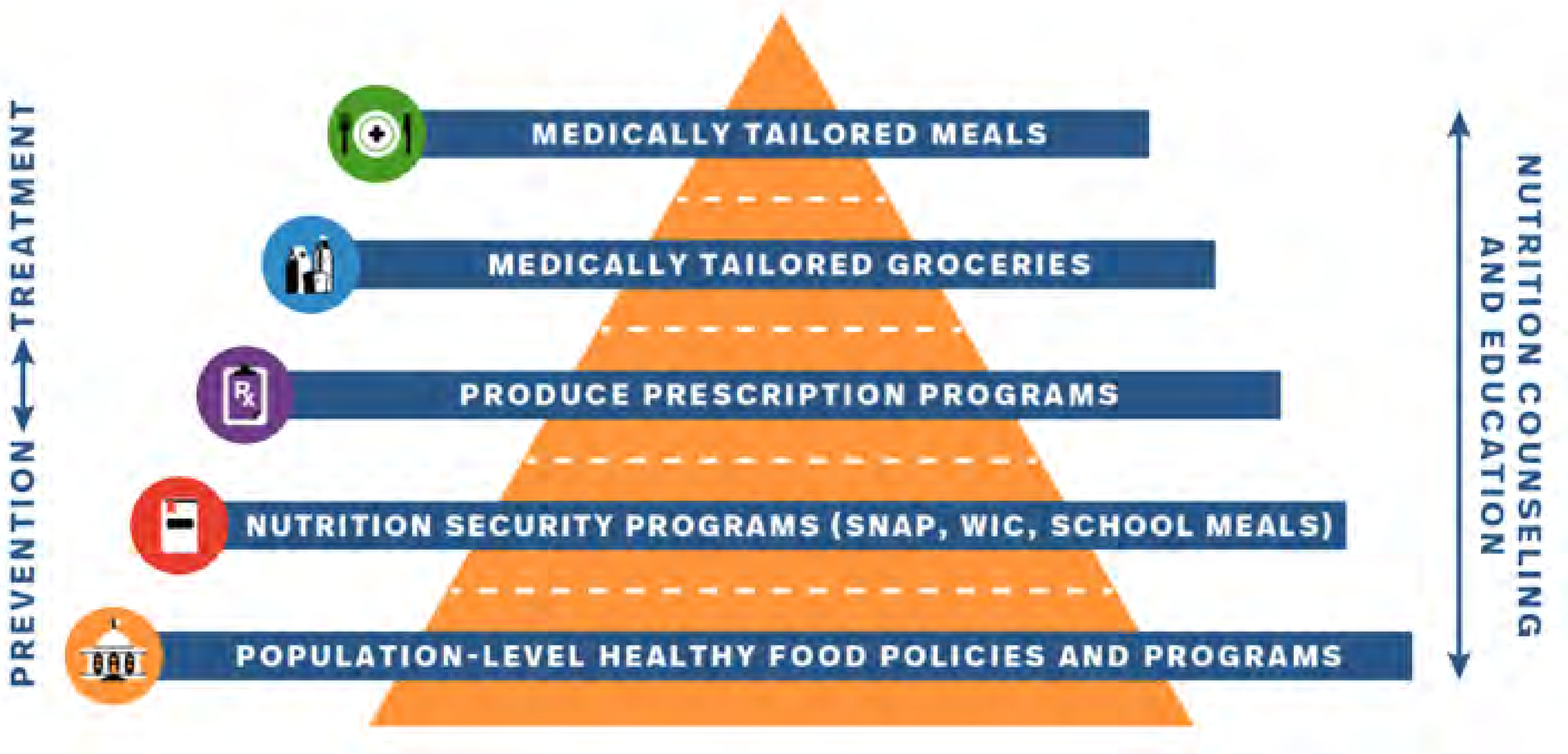
02 **INTEGRATING FIM INTO CLINICAL CARE**

03 **EDUCATING PATIENTS**

Outcomes of Interest

- Improve Food Security
- Reduce Blood Pressure
- Improve Diabetes Management
- Improve Depression Response & Remission

Food & nutrition interventions, including “Food is Medicine”, can reduce harm



1. Mozaffarian D, Blanck HM, Garfield KM, Wassung A, Petersen R. A Food is Medicine approach to achieve nutrition security and improve health. Nat Med. 2022 Nov;28(11):2238-2240. doi: 10.1038/s41591-022-02027-3.
2. Food is Medicine Fact Sheet, Tufts University, August 2023

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A Moment of Peril

When equity is not a priority, inequity persists

"many value-based payment programs have been regressive, which has hampered the pursuit of health equity.

For example, Medicare's Merit-Based Incentive Payment System (MIPS) has disproportionately penalized outpatient clinicians who care for poor adults.

Similarly, **all three of Medicare's hospital value-based programs** — the Hospital Readmissions Reduction Program, the Hospital Value-Based Purchasing Program, and the Hospital-Acquired Condition Reduction Program — **have transferred resources away from safety-net hospitals and potentially widened inequities in care**….

Value-based payment initiatives have failed to advance health equity in large part because equity wasn't prioritized during their design and implementation."

Risk of worsening structural and social arrangements that put people in harm's way

- **"Bridges to nowhere"**
  - Without equitable re-allocation of resources, underfunded social service providers may not be equipped to meet growing demand from healthcare
- **"Free-rider problem"**
  - Benefits of health & social care integration may not accrue to institutions that make initial investments
- **"Wrong-pockets"**
  - Accumulating benefits to healthcare without sharing benefits or reinvesting in the social or public health sectors

- **Extractive practices undermine health**
  - Profiteering (unfair, excessive profit-making) and other extractive practices contribute to and depend upon poverty, inequality, and dispossession.

T. Schrecker, A.-E. Birn, M. Aguilera. How extractive industries affect health: political economy underpinnings and pathways Health Place, 52 (2018), pp. 135-147, 10.1016/j.healthplace.2018.05.005

The limits of conventional ROI analysis for health interventions

- **ROI often lacks an equity analysis**
  - Is the estimated ROI for a health intervention truly meaningful if we haven't valued health equity, or at least identified the costs of inaction?
- **Asymmetry of power in ROI conversations**
  - ROI conversations between healthcare and community-based social service organizations can be distorted by the power differentials and structural inequities between them
- **"Leaving money on the table" ROI analyses may not reflect full value and impact**
  - The financial ROI models and methods often used to assess population health, health equity, and social needs investments often underestimate their full value and financial, economic, and social impact for institutions and communities

https://healthbegins.org/beyond-roi-understanding-value-on-investment-in-social-needs-partnerships/
https://healthbegins.org/finding-value-faster-a-new-roi-one-stop-shop-for-clinical-community-partnerships/

In a time of political turbulence and policy shifts, how can healthcare institutions and professionals maintain their mission, protect vulnerable patients, and mitigate risks?

A Moment of Opportunity

Thinking differently

“Give a man a fish and you feed him for a day; teach a man to fish and you feed him for a lifetime.”

But…

- why not teach a woman to fish?
- what if the pond close to home is polluted?
- what if their family and neighbors have been historically denied easy access to resources to fish (e.g. rods, tackle, permits) due to poverty, racism, sexism, homophobia and/or xenophobia?

See, feel and understand avoidable diseases, unmet social needs, and health inequities as **harm**

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Once we see and feel **health inequities as harm**,

we can do our part to address the upstream social and structural arrangements that put people in harm's way.

Mrs. M, a 63yo woman who self-identifies as Black, has diabetes and was recently hospitalized with hypoglycemia.

Takes meds as prescribed, never counseled about food insecurity

Worries about rent/eviction; Skips meals

Can’t afford & find healthy food at end of month

Works below living wage job ; rent burden jumps

“Let go” by employer

Sued by old hospital for medical debt, default judgment; wages garnished

Moves family to rental apt; unable to pay medical bill for stay in 2019

Home foreclosed in 2008; divorced 2014;

This flow diagram was inspired by Neff J et al. Structural Competency: Curriculum for Medical Students, Residents, and Interprofessional Teams on the Structural Factors That Produce Health Disparities. *MedEdPORTAL*. 2020;16:10888. Published 2020 Mar 13. doi:10.15766/mep_2374-8265.10888

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Mrs. M, a 63yo woman who self identifies as Black, has diabetes and was recently hospitalized with hypoglycemia

Takes meds as prescribed, never counseled about food insecurity

Worries about rent/eviction; Skips meals

Lack of integrated health & social care; de facto healthcare segregation

employer, state, federal policies that worsen broken food systems

lack of eviction protections; barriers to public benefits enrollment

low-wage labor markets; limited labor protections

"Let go" by employer

Works below living wage job ; rent burden jumps

Can't afford & find healthy food at end of month;

Predatory subprime lending; lack of community restitution

Lack of affordable housing; de facto housing segregation

criminalization of medical debt; harmful hospital financial practices

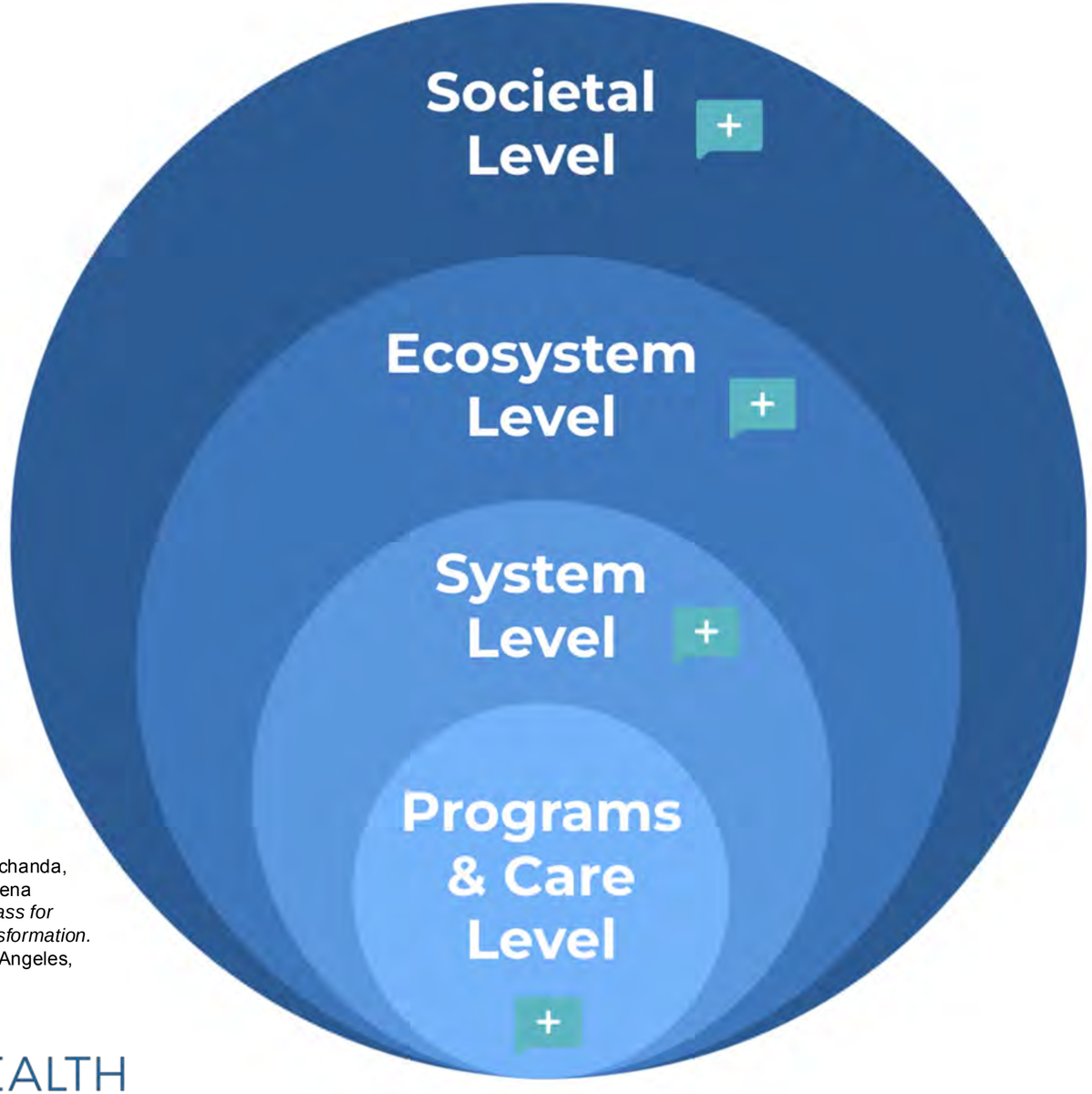
Sued by old hospital for medical debt, default judgment; wages garnished

Moves family to rental apt; unable to pay medical bill for stay in 2019

Home foreclosed in 2008; divorced 2014

This flow diagram was inspired by Neff J et al. Structural Competency: Curriculum for Medical Students, Residents, and Interprofessional Teams on the Structural Factors That Produce Health Disparities. *MedEdPORTAL*. 2020;16:10888. Published 2020 Mar 13. doi:10.15766/mep_2374-8265.10888

Advance health equity with multi-level strategies



GOAL

Help replace social policies and structures that cause ongoing harms, and support policies that promote healing and justice.

GOAL

Help build a high-performing, just, and equitable cross-sector ecosystem for health in your community

GOAL

Drive institutional transformation and culture change to create a more effective, just, equitable, and inclusive institution.

GOAL

Surpass performance goals for health care equity & social needs for patient populations

Citation: Rishi Manchanda, Kathryn Jantz, Sadena Thevarajah. *Compass for Health Equity Transformation*. HealthBegins. Los Angeles, May 2023.

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Compass for Health Equity Transformation

Moving upstream to address the social and structural arrangements that put people in harm's way

SOCIETAL

Food, nutrition and economic policy

Residential segregation: unjust laws & systems → racially & economically segregated neighborhoods

Food injustice

COMMUNITY

Food deserts: areas with limited access to nutritious foods

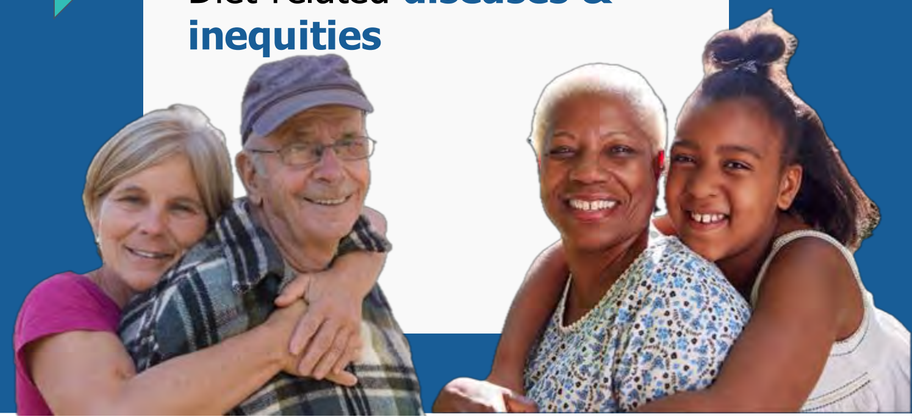
Food swamps: areas with excessive high-energy food sources

Broken **"community food systems"**

HOUSEHOLD/ INDIVIDUAL

Food & nutrition **insecurity**

Diet-related **diseases & inequities**



Communicating value

01 Understand your audience

02 Tell a Story About Why This Matters to You

03 Craft a Message Tailored for Your Audience

04 Share Salient and Appropriately Sized

05 Prepare a Menu of Opportunities to Take

Rishi Manchanda et al. Communicating the Value of Health Equity: Narrative Frames (HealthBegins, June. 2024).

Health Equity Narrative Frames

Core values of quality & safety

Patient satisfaction

Regulatory compliance

Employee recruitment & retention

Financial health & economic value

Adverse events & harm

Healthcare access & quality

Strategic investments

Rishi Manchanda et al. Communicating the Value of Health Equity: Narrative Frames (HealthBegins, June. 2024).

Stakeholders who value “quality” and “safety”

Narrative Focus: Integrating and aligning your work with Quality and Safety Standards

For stakeholders who prioritize quality and safety, you can emphasize how embedding diabetes interventions, social needs, and health equity into the organization's operations improves both quality and safety.

Example: A community health center that tracks patient quality data may find that addressing social needs (such as food insecurity) reduces emergency room visits among patients with diabetes, leading to fewer adverse events related to chronic disease mismanagement.

For example, you might say:

'When we address diabetes disparities, we create safer care environments for all patients with diabetes.

By focusing on equitable access to diabetes care, we reduce the risks of misdiagnoses, medication errors, and inadequate care for vulnerable populations, which in turn boosts our overall safety and quality metrics.'"

Rishi Manchanda et al. Communicating the Value of Health Equity: Narrative Frames (HealthBegins, June. 2024).

Stakeholders focused on financial health and economic value

Narrative Focus: Health Equity as a Driver of Cost Reduction and ROI

For stakeholders who are concerned with financial health, you can position diabetes interventions and health equity as an investment that saves money in the long term.

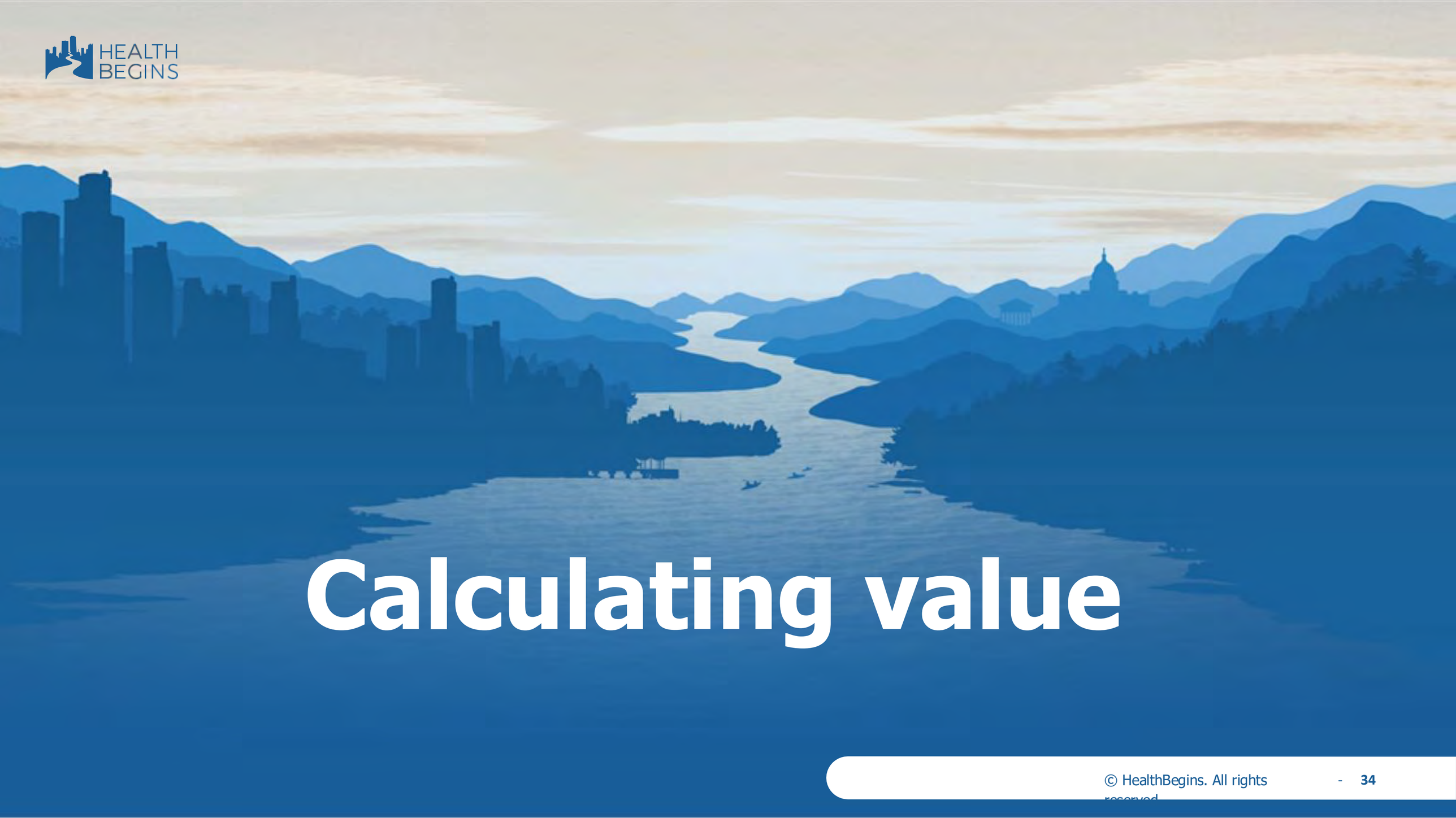
Example: A health plan that targets high-risk populations, including subgroups with relatively poorer outcomes, with proactive, wrap-around, culturally tailored care management programs can reduce emergency care utilization, leading to significant cost savings.

For example, you might say:

'Avoidable gaps in diabetes care or outcomes represent avoidable costs, in both fee-for-service and value-based payment models. Diabetes prevention initiatives are a cost-saving strategy.

By investing in preventive care and addressing the social drivers of these disparities among populations at risk of diabetes, we can reduce costs. For instance, providing DPP and food security resources for patients can reduce no-show rates, ultimately improving revenue cycle performance.'"

Rishi Manchanda et al. Communicating the Value of Health Equity: Narrative Frames (HealthBegins, June. 2024).



Calculating value

We need different ways to estimate and measure the value and impact of health investments and interventions

A “Blended value” approach reflects three measures of value

Return on Investment (ROI)

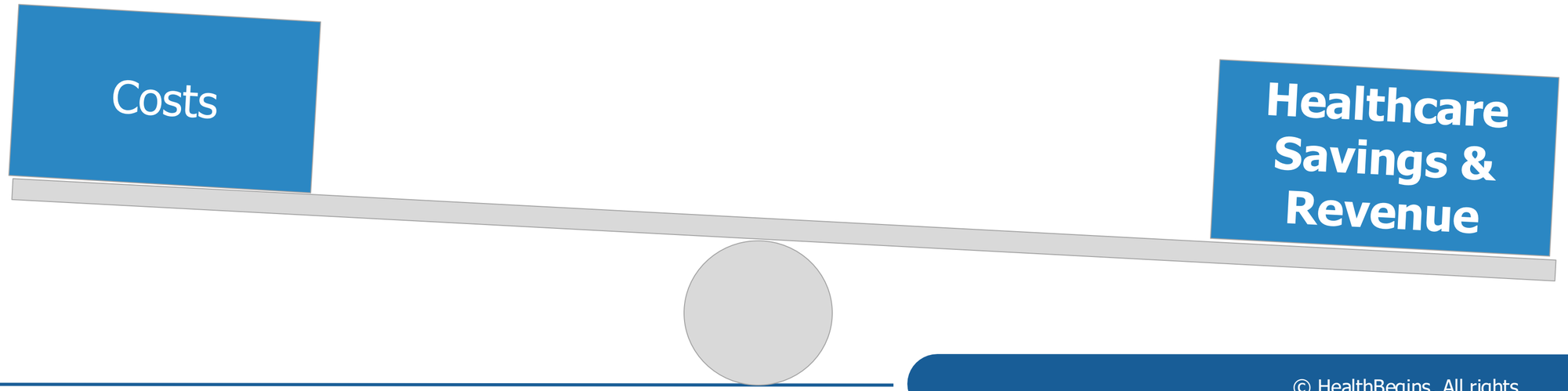
Value on Investment (VOI)

Social Return on Investment (SROI)

Return on Investment (ROI)

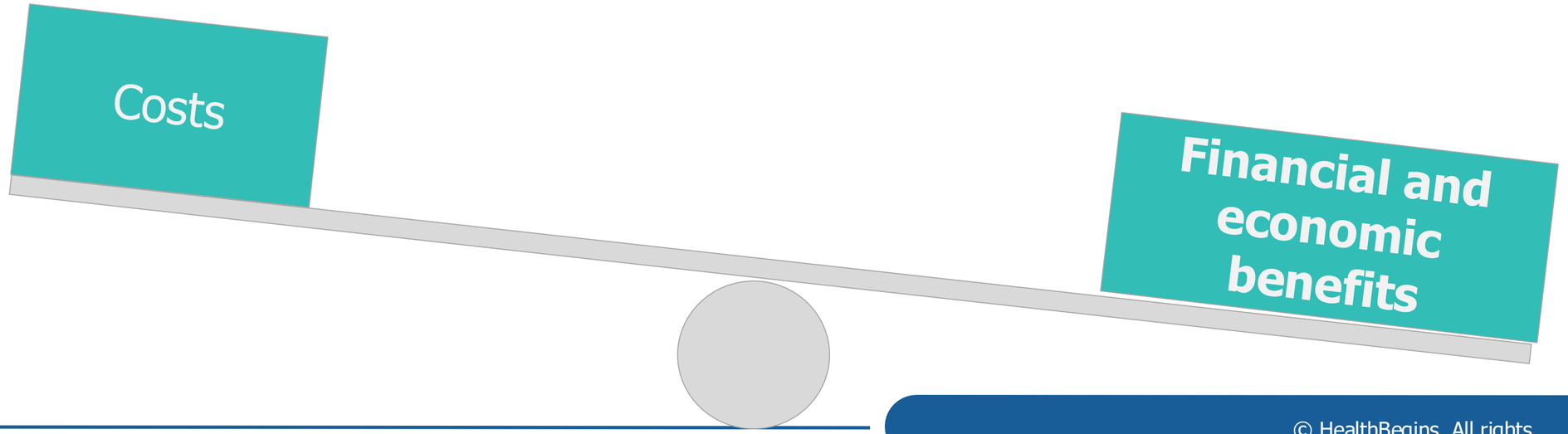
➔ Assesses financial performance

➔ It is the ratio of a program's net financial benefits to its costs



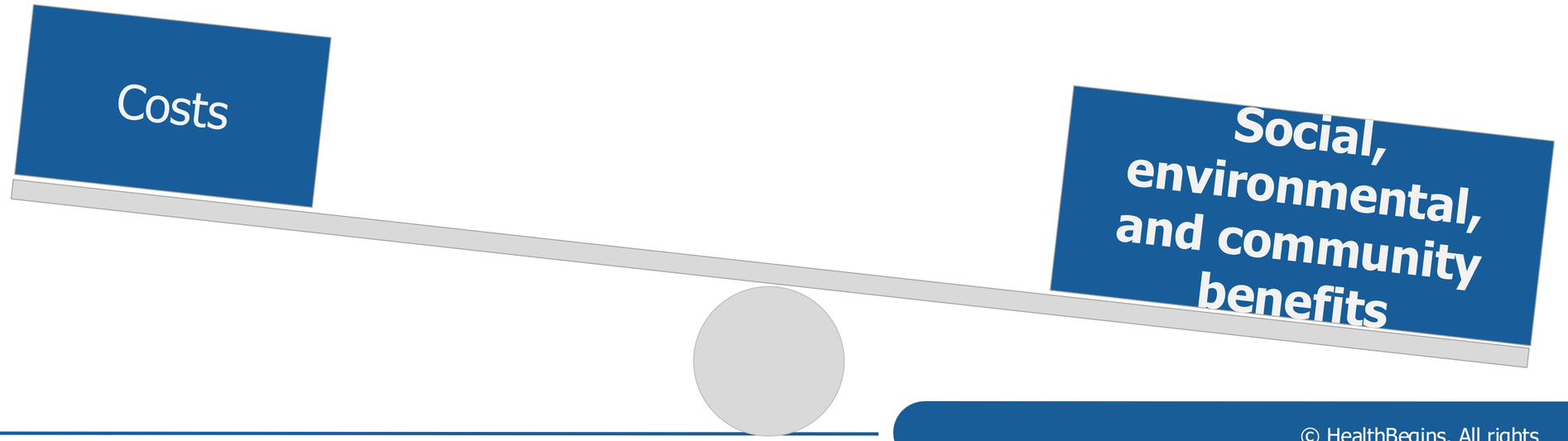
Value on Investment (VOI)

- ➔ Estimates overall economic value, considering both financial and non-financial benefits.
- ➔ Quantifies intangible economic benefits and longer-term outcomes.



Social Return on Investment (SROI)

- ➔ Measures social value or impact, typically across sectors
- ➔ Quantifies broader social, environmental, and community benefits relative to the resources invested.



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We can estimate and measure financial returns (ROI), economic value (VOI) and impact (SROI) for health equity and social needs investments

Blended value models can assess financial returns (ROI), economic value (VOI) and impact (SROI) for health equity and population health

Report Summary

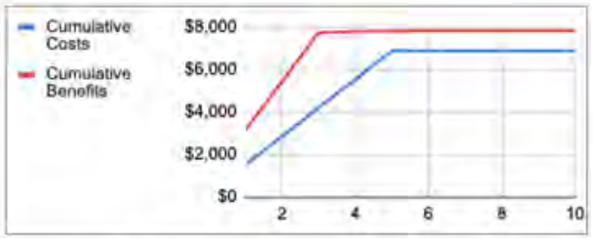
Participant Summary	
Target Population Size	1,400
People Engaged (%)	27%
Total Program Participants	380
Sub-Population Size	1,400
Sub-Population Engaged (%)	27%

Intervention ROI Estimate Summary	Gross	NPV	ROI %
ROI	-$285,490	$16,295	0%
VOI	$639,904	$891,033	15%
SROI	$934,319	$1,151,925	19%

Discount Rate 5%

Staffing Needs	FTEs Need	Avg. Salary
Health System - Management Staff	0.9	$250,000
Health System - Admin Staff	1.8	$75,000
Health System - Program Staff	3.2	$95,000.0
Partner - Management Staff	0.7	$150,000
Partner - Admin Staff	1.1	$50,000
Partner - Program Staff	6.5	$75,000.0

Intervention Financial Summary	Year 1	Year2	Year 3	Year 4	Year 5	Years 6+
Startup Costs	$150,000					
Fixed Annual Costs	$455,000	$455,000	$455,000	$455,000	$455,000	
Variable Costs	$889,643	$889,643	$889,643	$889,643	$889,643	
Total Cost of Program	$1,494,643	$1,344,643	$1,344,643	$1,344,643	$1,344,643	
Additional Revenue	$114,000	$114,000	$114,000	$114,000	$114,000	
Net Cost	$1,380,643	$1,230,643	$1,230,643	$1,230,643	$1,230,643	
Benefits	$3,135,738	$2,295,502	$2,292,678	$51,850	$27,205	$4,560



ROI Ranges

	Gross ROI			NPV			ROI%		
	Low	Base	High	Low	Base	High	Low	Base	High
ROI	-$5,110,714	-$285,490	-$5,614,286	-$3,065,753	$16,295	$5,255,249	-69%	0%	108%
VOI	-$4,957,992	$639,904	-$3,910,918	-$2,921,621	$891,033	$6,861,690	-66%	15%	141%
SROI	-$4,949,832	$934,319	-$3,769,558	-$2,876,673	$1,151,925	$7,331,234	-65%	19%	150%

Population Summary

Payer/Plan	Sub-Population	Population Size	Engagement Rt	Units/Month	Subpopulation Return			Return/Member		
					ROI	VOI	SROI	ROI	VOI	SROI
PHP Medicaid Standard	Black	500	30%	1.5	-17%	-4%	1%	-$790.3	-$165.5	$48.4
PHP Medicaid Maternal Bundle	Non-Specified	500	30%	1.5	16%	29%	34%	$762.0	$1,386.9	$1,581.2
BCBSMI Medicaid Maternal Bundle	Black	200	20%	1	2%	22%	27%	$76.0	$700.8	$842.7
BCBSMI Medicaid Maternal Bundle	Non-Specified	200	20%	1	2%	22%	27%	$76.0	$700.8	$842.7

HEALTH BEGINS

In a time of political turbulence and policy shifts, how can healthcare institutions and professionals maintain their mission, protect vulnerable patients, and mitigate these growing risks?

Assess risks to prevent harm

Precautionary Principle

The Precautionary Principle states that when there is uncertainty about potential harm, the burden of proof should fall on the proponent of an activity to prove that the activity is not harmful.

- Healthcare institutions should act proactively to prevent harm when there is a potential for harm, even in the absence of complete evidence.

HEALTH BEGINS

Assess threats and risks to your organization, employees, patients, and communities

https://bigpicture.one/blog/project-risk-assessment-examples/

Health Equity Policy Hub

Coming Soon

Health Equity Policy Tracker

Track executive policies that impact health equity.

NOTIFY ME

HEALTH BEGINS

Health Equity Policy Tracker

Monitoring and translating policies that impact health equity

Filters | Search | Sort by

Withdrawn — Last Updated: 02/11/25

Temporary Pause of Agency Grant, Loan, and Other Financial Assistance Programs

Office of Management and Budget · Memo

Cash or economic assistance | Social safety net | Children and families

Indefinitely and illegally pauses billions in congressionally approved funding that supports people and communities in every state in America.

Learn More →

Introduced — Last Updated: 02/11/25

U.S. Withdrawal from World Health Organization

White House · Executive Order

Global health | Public Health | Global health

Would end U.S. participation in global health initiatives and reduce access to vital health resources.

Learn More →

Introduced — Last Updated: 02/11/25

NIH Indirect Cost Rates Reduction

Department of Health and Human Services · Memo

Research and data | Healthcare delivery, services, and quality

Proposed reduction in NIH indirect cost rates could significantly impact research institutions.

Learn More →

Introduced — Last Updated: 02/11/25

Defending Women from Gender Ideology Extremism

White House · Executive Order

Introduced — Last Updated: 02/11/25

Federal Research Grant Restrictions

Department of Education · Memo

Challenged — Last Updated: 02/11/25

Common Sense Enforcement Actions in or Near Protected Areas

Department of Homeland Security · Agency Directive

Health Equity Policy Tracker About Us Resources Sign Up Get Involved

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Common Sense Enforcement Actions in or Near Protected Areas

Challenged | Agency Directive | Healthcare delivery, services, and quality | Immigrant Health

Department of Homeland Security

Last Updated: 02/11/25

Quick Translation

Rescinds previous guidelines limiting immigration enforcement actions in or
protected areas such as schools, hospitals, and places of worship.

Anticipated Impact

This policy change could significantly impact immigrant communities' acces
essential services, including healthcare and education. It may deter immigra
seeking necessary medical care or sending their children to school, potential
leading to negative public health outcomes and educational disparities.

Immigration Enforcement in Healthcare Settings: How to Prepare and Respond

HealthBegins

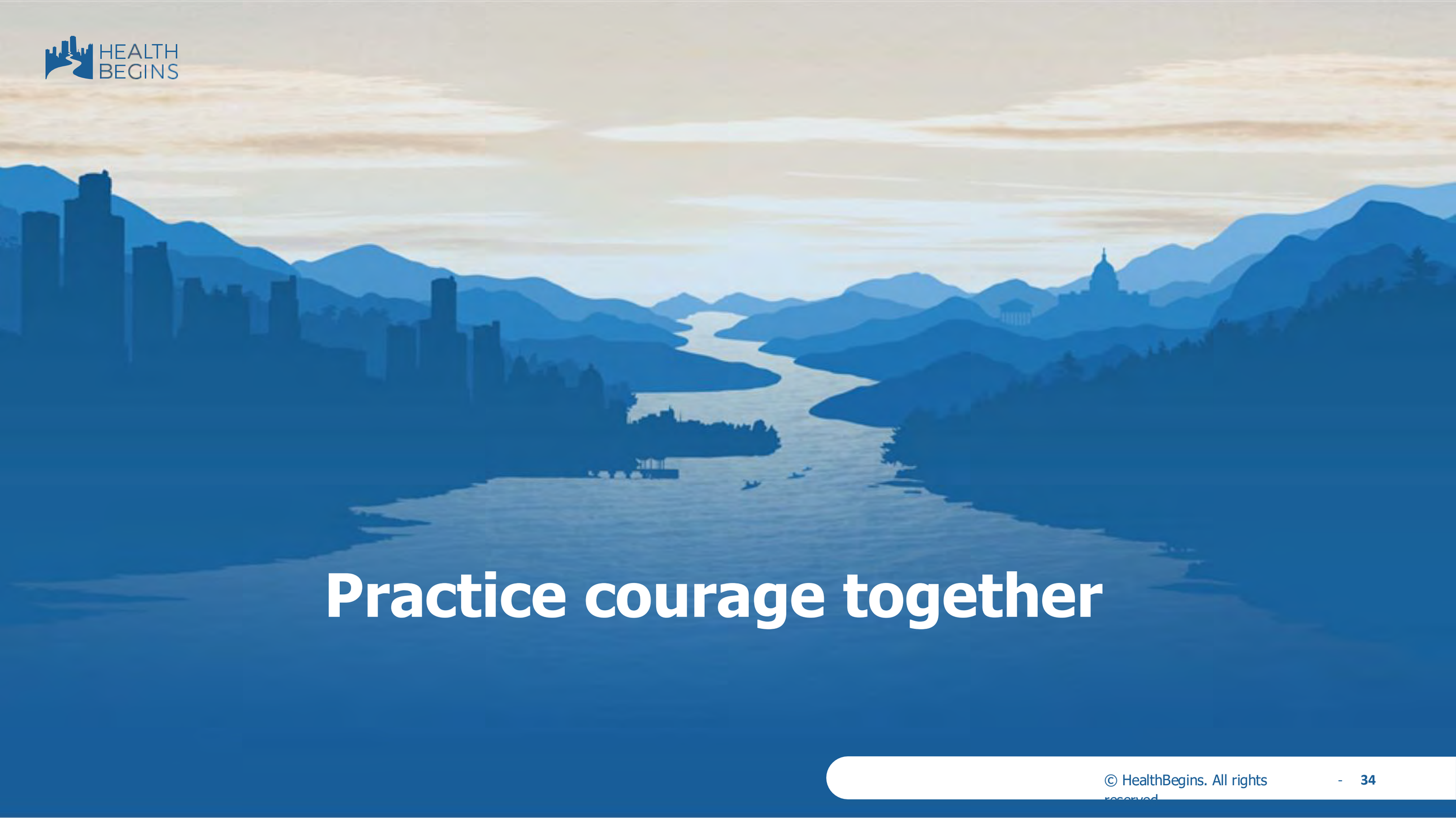
January 30, 2025

Collaborate to improve institutional policy readiness & response

Remember that decisions and policy responses are made based on moral judgments:

- **Rule-based:** Following established laws and regulations while ensuring compliance with health equity mandates.
- **Interest-based:** Aligning risk mitigation with financial sustainability, patient safety, and workforce retention.
- **Value-based:** Making decisions that reflect ethical commitments to justice, dignity, and equity.

Courtesy: Josh Hyatt, DHSc, MHL, CPHRM, Healthcare Risk Manager, ethicist, lecturer and professor



Practice courage together

HEALTH BEGINS

It takes courage to reduce harmful and inequitable exposures, vulnerability and consequences for communities and patients

"Health disparities arise from disparities in **exposure, vulnerability** (which is shaped by social advantage/ disadvantage), and c**onsequences**."
(Braveman p.14)

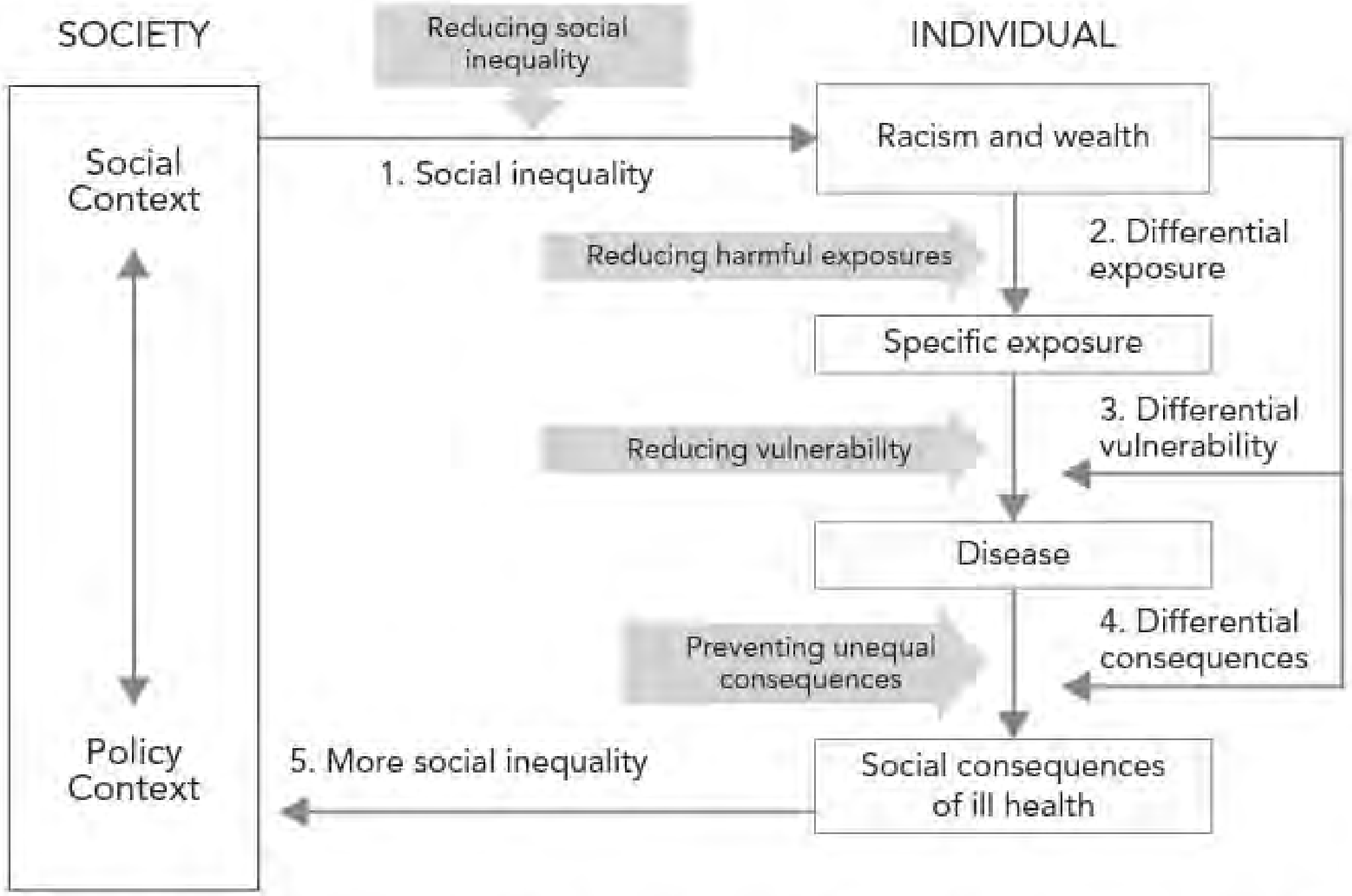


FIGURE 1.4 What produces health disparities across the life course and across generations? Adapted from Diderichsen (1998) [Google Scholar].

It takes courage to help address the upstream social and structural arrangements that put people in harm's way

SOCIETAL

Food, nutrition and economic policy

Residential segregation: unjust laws & systems → racially & economically segregated neighborhoods

Food injustice

COMMUNITY

Food deserts: areas with limited access to nutritious foods

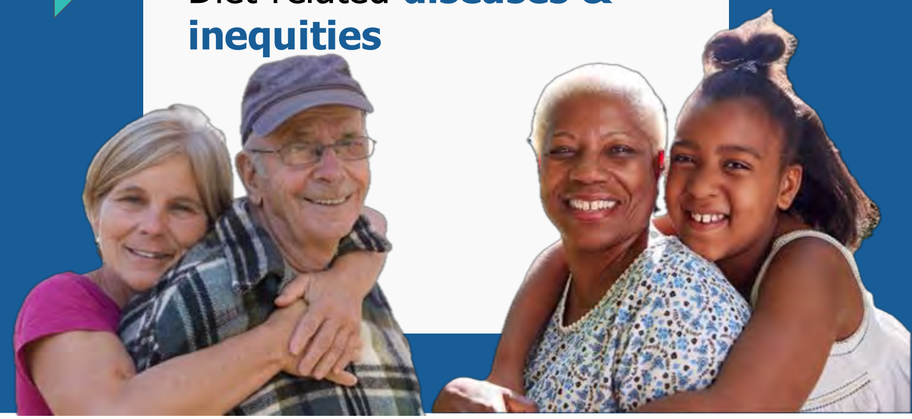
Food swamps: areas with excessive high-energy food sources

Broken **"community food systems"**

HOUSEHOLD/ INDIVIDUAL

Food & nutrition **insecurity**

Diet-related **diseases & inequities**



Courage as practice

"The ability to be courageous develops over time and includes efforts to fully accept reality, problem solve based on discernment, and push beyond ongoing struggles."

- reflective awareness
- practice vulnerability
- small courageous steps
- lead with integrity: "making choices that align with our deepest values and convictions, even when it's uncomfortable or risky to do so"

- Finfgeld DL. Courage as a process of pushing beyond the struggle. Qual Health Res. 1999 Nov;9(6):803-14.
- Yang, Y., Zhu, S., Wang, X., & Wang, L. (2024). Dare to be yourself: Courage promotes self-authenticity via sense of power. *The Journal of Positive Psychology*.
- https://positivepsychology.com/courage/

Lead with integrity

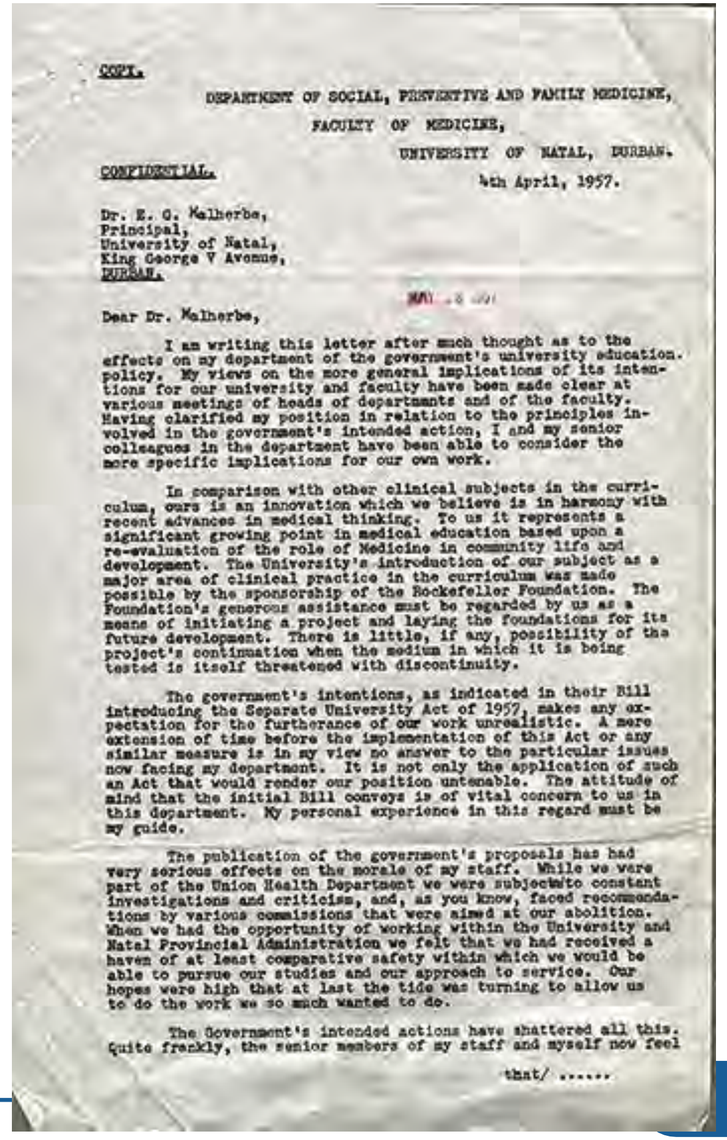
- Ethical leadership means making decisions that safeguard institutional viability, public health, and the dignity of the people we serve and work alongside.
- Align institutional risk management with values-based advocacy efforts on key policy issues (e.g., Medicaid access, tenant protections, workforce safety).
- **Maintaining integrity in chaos means choosing to act with foresight, courage, and unwavering dedication to health equity.**

Courtesy: Josh Hyatt, DHSc, MHL, CPHRM, Healthcare Risk Manager, ethicist, lecturer and professor

Community Health Centers have a rich history of practicing courage

Drs. Sidney and Emily Kark

Drs. Kark helped start the Pholela Health Centre in South Africa in the 1940s, calling their model "Community-Oriented Primary Care." That model inspired the creation of Community Health



COPY.

DEPARTMENT OF SOCIAL, PREVENTIVE AND FAMILY MEDICINE,
FACULTY OF MEDICINE,
UNIVERSITY OF NATAL, DURBAN.

CONFIDENTIAL.

4th April, 1957.

Dr. E. G. Malherbe,
Principal,
University of Natal,
King George V Avenue,
DURBAN.

Dear Dr. Malherbe,

I am writing this letter after much thought as to the effects on my department of the government's university education policy. My views on the more general implications of its intentions for our university and faculty have been made clear at various meetings of heads of departments and of the faculty. Having clarified my position in relation to the principles involved in the government's intended action, I and my senior colleagues in the department have been able to consider the more specific implications for our own work.

In comparison with other clinical subjects in the curriculum, ours is an innovation which we believe is in harmony with recent advances in medical thinking. To us it represents a significant growing point in medical education based upon a re-evaluation of the role of Medicine in community life and development. The University's introduction of our subject as a major area of clinical practice in the curriculum was made possible by the sponsorship of the Rockefeller Foundation. The Foundation's generous assistance must be regarded by us as a means of initiating a project and laying the foundations for its future development. There is little, if any, possibility of the project's continuation when the medium in which it is being tested is itself threatened with discontinuity.

The government's intentions, as indicated in their Bill introducing the Separate University Act of 1957, makes any expectation for the furtherance of our work unrealistic. A mere extension of time before the implementation of this Act or any similar measure is in my view no answer to the particular issues now facing my department. It is not only the application of such an Act that would render our position untenable. The attitude of mind that the initial Bill conveys is of vital concern to us in this department. My personal experience in this regard must be my guide.

The publication of the government's proposals has had very serious effects on the morale of my staff. While we were part of the Union Health Department we were subject to constant investigations and criticism, and, as you know, faced recommendations by various commissions that were aimed at our abolition. When we had the opportunity of working within the University and Natal Provincial Administration we felt that we had received a haven of at least comparative safety within which we would be able to pursue our studies and our approach to service. Our hopes were high that at last the tide was turning to allow us to do the work we so much wanted to do.

The Government's intended actions have shattered all this. Quite frankly, the senior members of my staff and myself now feel

that/ .....

"The government's intentions, as indicated in their Bill…,makes any expectation for the furtherance of our work unrealistic….

The publication of the government's proposals has had very serious effects on the morale of my staff…

Our hopes were high that at least the tide was turning to allow us to do the work we so much wanted to do.

The Government's intended actions have shattered all this."

- *Dr. Sidney Kark, 1957*

Images courtesy of National Library of Medicine. Stories of Global Health https://www.nlm.nih.gov/exhibition/makingaworldofdifference/collection-detail.html?imgid=11&imgName=OB9283-md

Images courtesy of National Library of Medicine. Stories of Global Health
https://www.nlm.nih.gov/exhibition/makingaworldofdifference/collection-detail.html?imgid=11&imgName=OB9283-md

Images courtesy of Joe Lee, Community Health Synergy

What can we do in this moment?

- **Think differently about the upstream arrangements** that place populations in harm's way
- Communicate value better using **narrative frames** based on stakeholder priorities
- Calculate value more effectively using **blended value** tools and methods
- Identity threats and assess risks to **prevent harm** to patients and communities

- **Practice courage together,** however you can

“We have made the world we are living in and we have to make it over again.

“There is never a time in the future in which we will work out our salvation. The challenge is in the moment, the time is always now.”

- James Baldwin