Reducing Disparities in Cardiovascular Care

Tuesday, December 14, 2021 | 4:30pm-6pm

Part of *Bridging the Gap from Healthcare Disparities to Anti-Racist Clinical Encounters,* a healthcare equity learning series

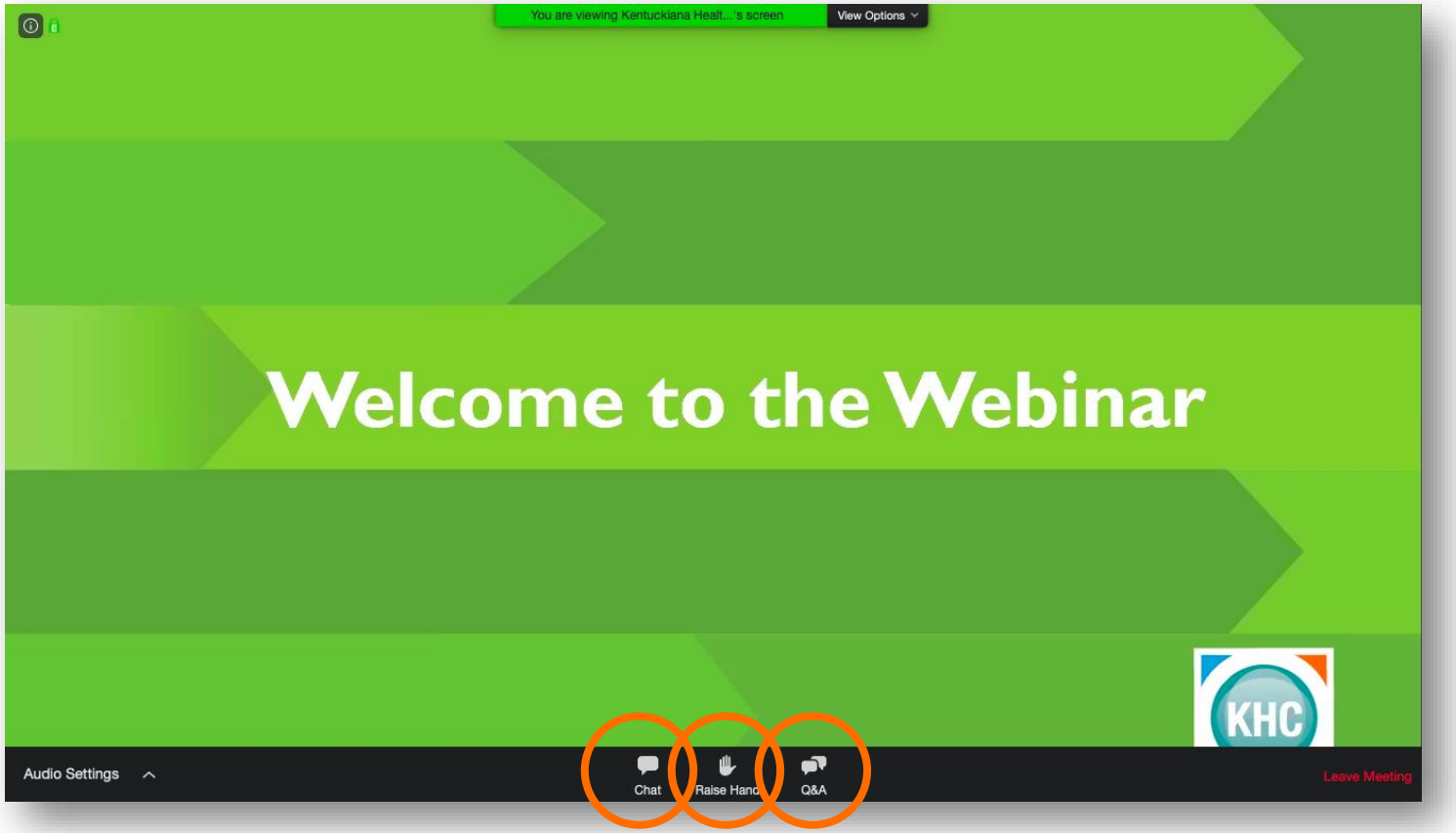
Kentuckiana Health Collaborative
Building a Bridge to Better Health, Better Care and Better Value

Have a Heart Clinic

American Nurses Association Kentucky

LOGISTICS

Select "Q&A" to type a question and ask it to the speaker.



SOCIAL MEDIA

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#KHC

AGENDA

- ***Cardiovascular Disease (CVD) Disparities in Kentucky***
- ***Closing Gaps in Cardiovascular Care***
- ***Panel: Stakeholder Priorities in Advancing CVD Equity***

THANK YOU TO OUR SPONSOR

Cardiovascular Disease (CVD) Disparities in Kentucky

Stephanie Clouser

Data Scientist

Kentuckiana Health Collaborative

What are we talking about today?

Cardiovascular Disease (CVD)

Heart Disease

Coronary Artery Disease

Heart Attacks

Stroke/TIA

Hypertension

Atrial Fibrilation

Heart disease is the **leading cause of death** for men, women, and people of most racial and ethnic groups in the United States.

659,000 deaths each year

One person dies every 36 seconds in the United States from cardiovascular disease.

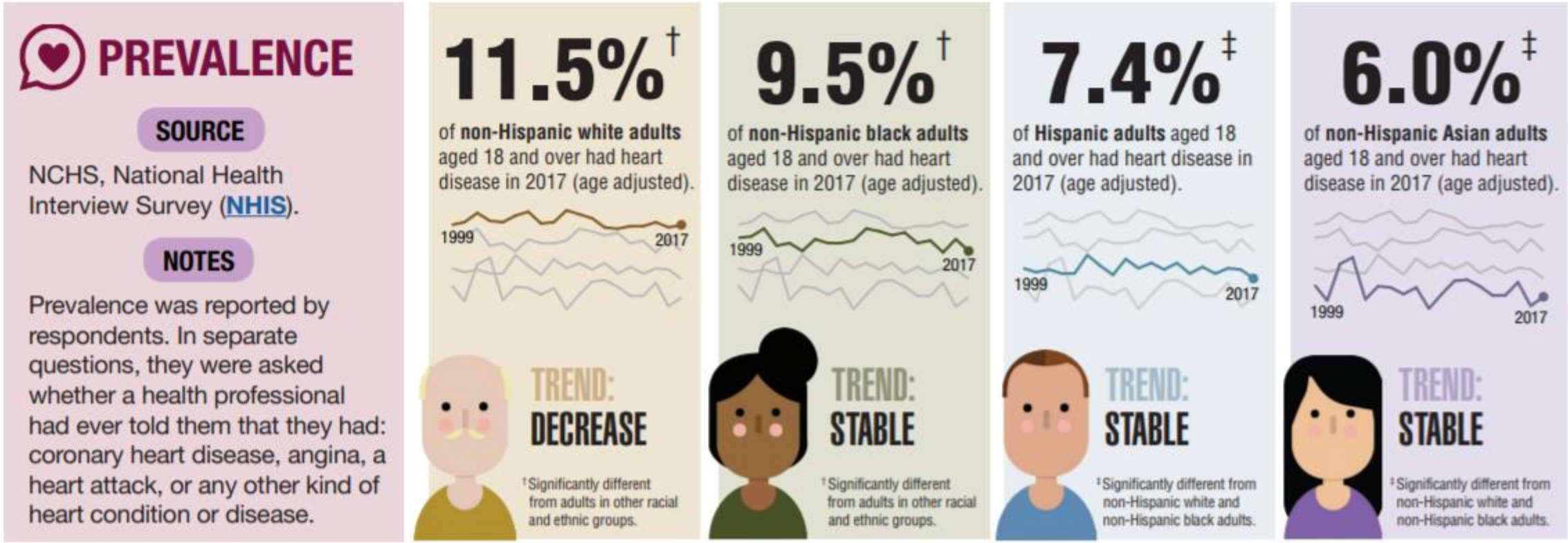
Cost the United States about **$363 billion** each year from 2016 to 2017.

Data Source: CDC

1. **HEART DISEASE**
2. Cancer
3. Chronic Lower Respiratory Diseases
4. Accidents
5. Stroke
6. Alzheimer's Disease
7. Diabetes
8. KIDNEY DISEASE
9. Septicemia
10. Influenza/Pneumonia

Leading cause of death in Kentucky

Data Source: CDC



Data Source: CDC

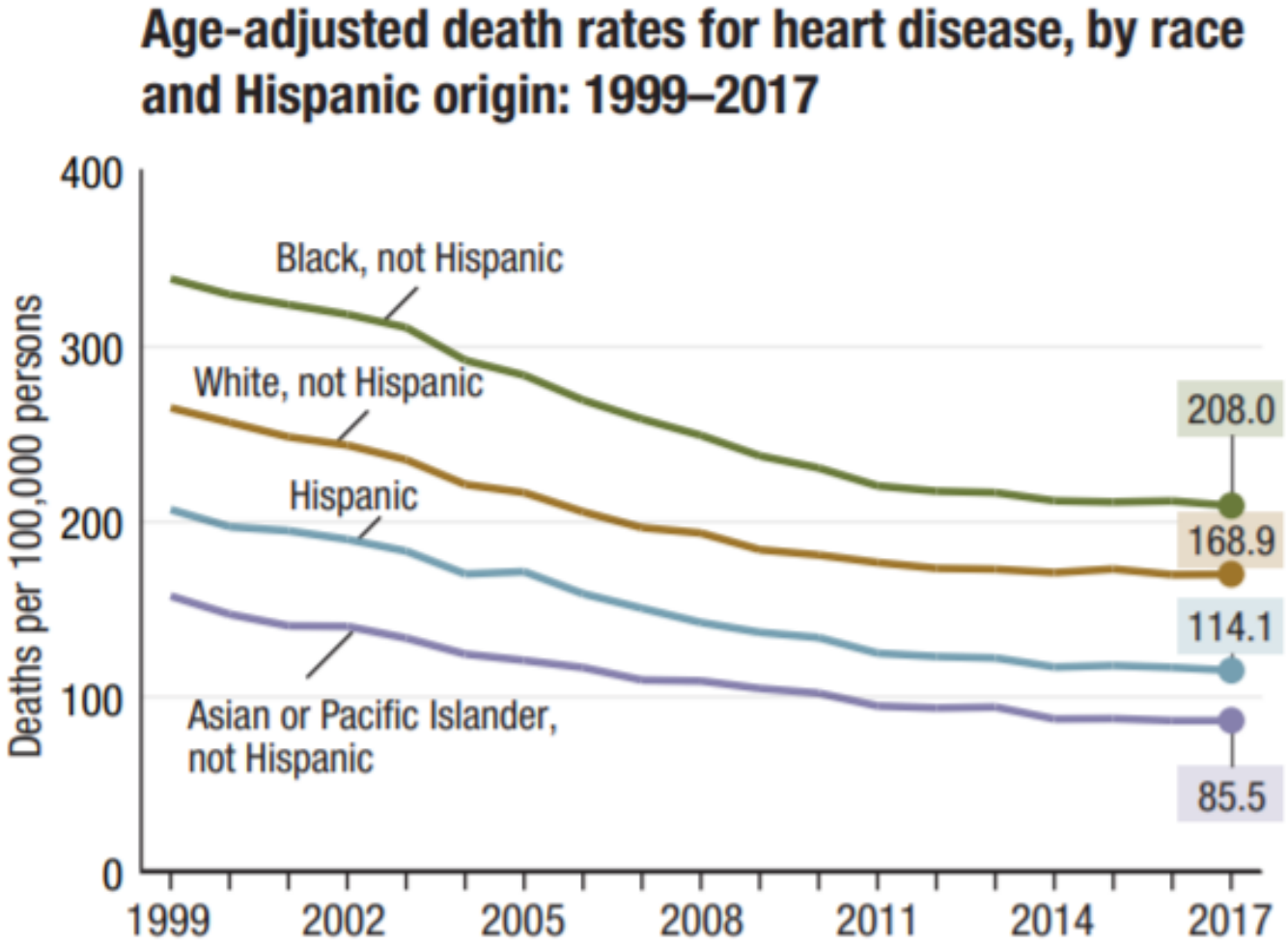
DEATHS

SOURCE

National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS).

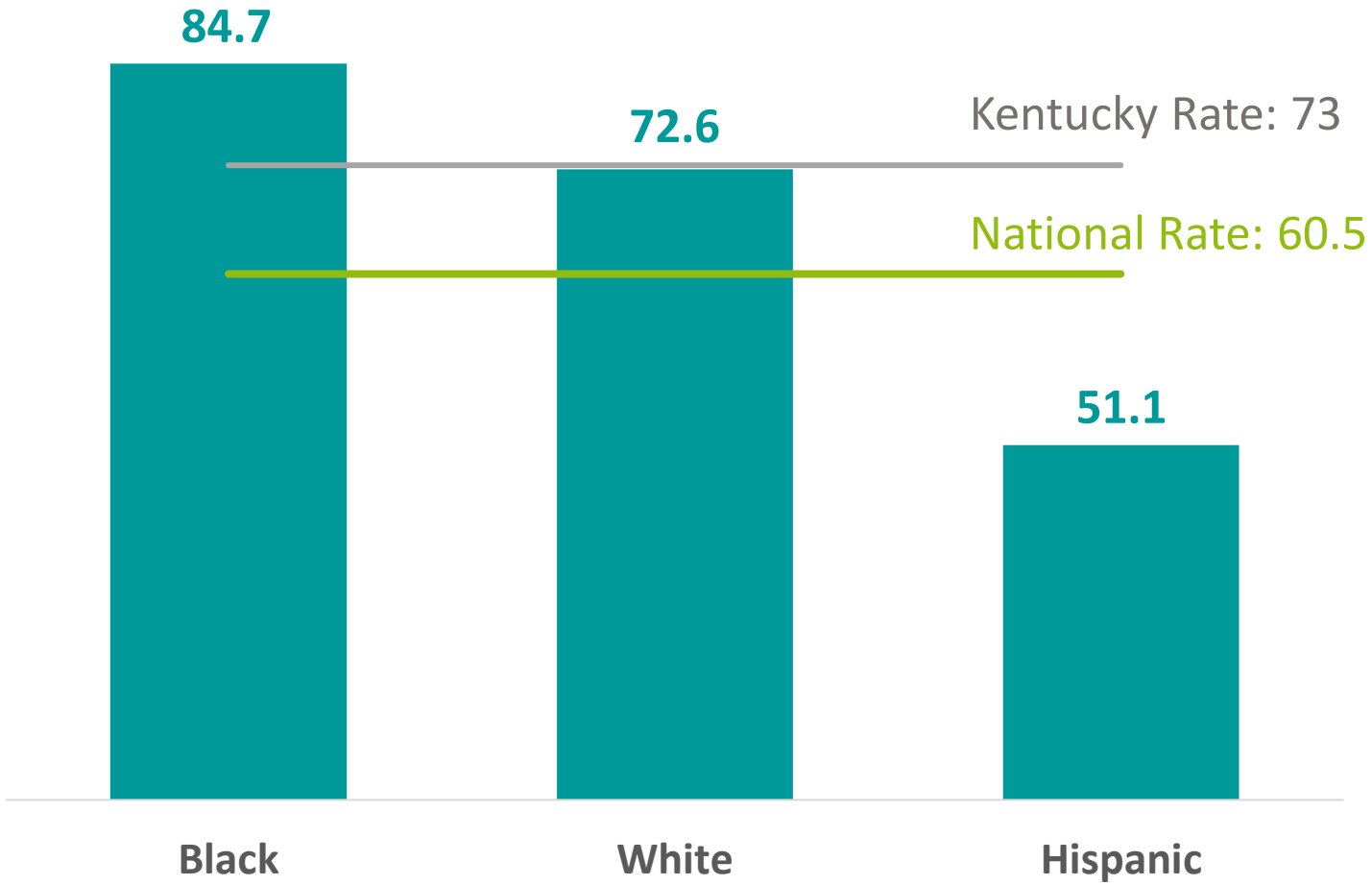
NOTES

Data for racial and ethnic groups, other than non-Hispanic white and non-Hispanic black, are subject to inconsistencies in reporting on the death certificate. However, misclassification is generally minor for Hispanic and non-Hispanic Asian or Pacific Islander groups.



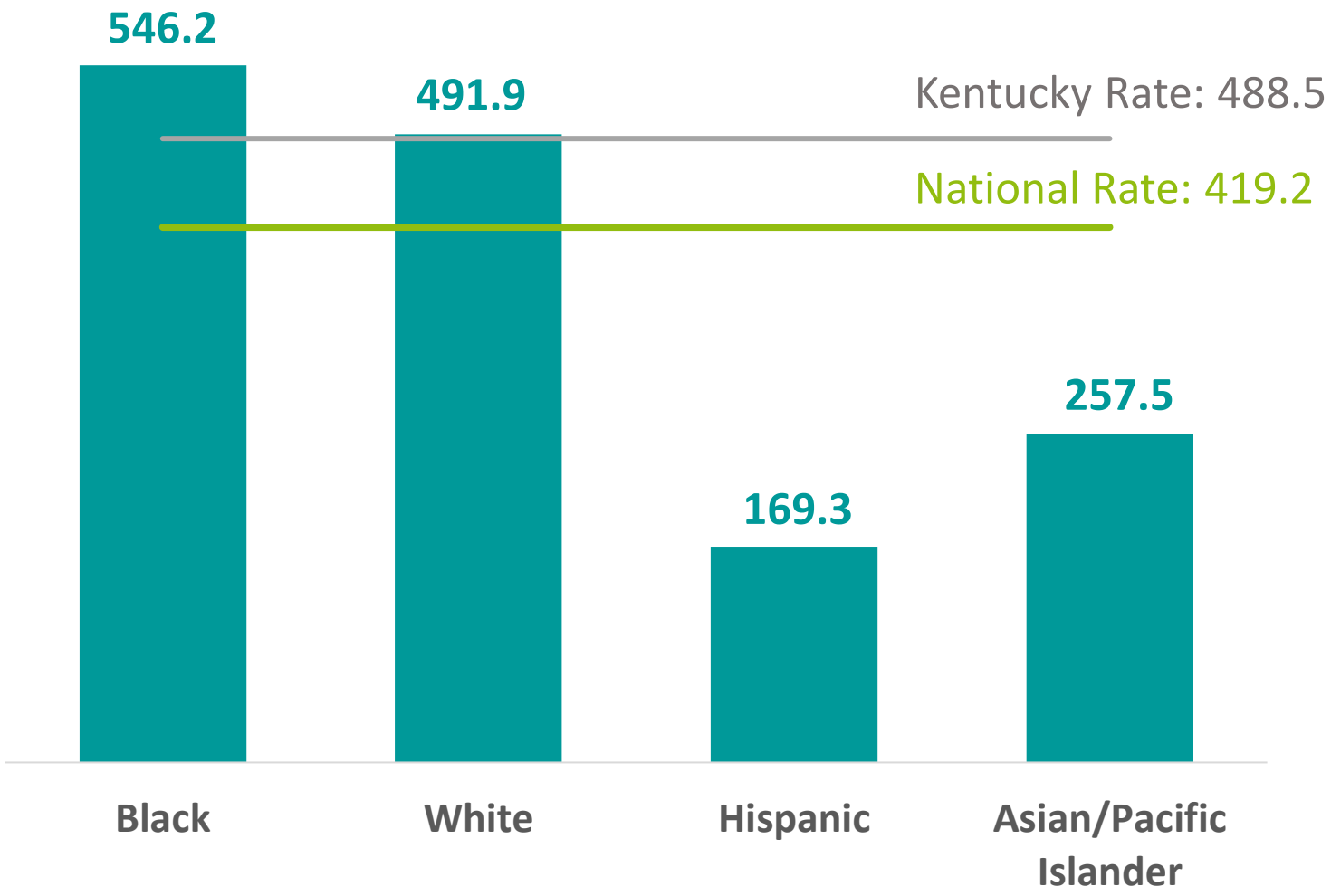
Data Source: CDC

In Kentucky, Black Medicare beneficiaries (ages 65+) are hospitalized at a higher rate for cardiovascular disease per 100,000 persons.



Data Source: CDC

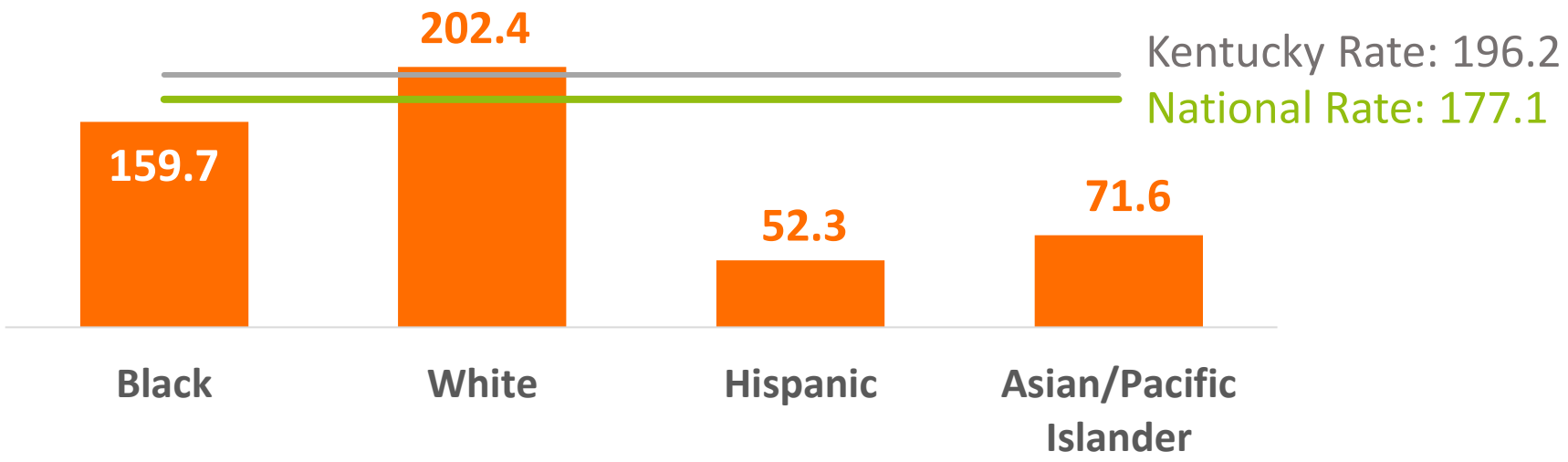
Black individuals in Kentucky die at a higher rate per 100,000 persons (ages 35+) from cardiovascular disease.



Data Source: CDC

Kentucky Death Rates – Coronary Artery Disease

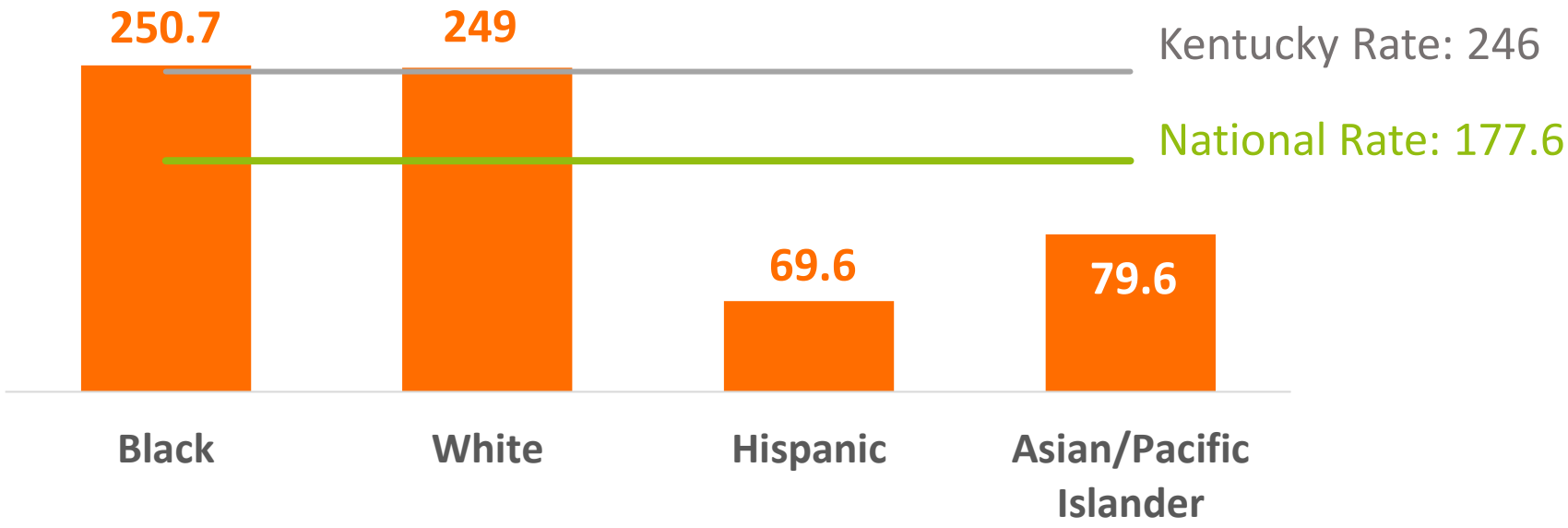
(per 100,000 persons)



Data Source: CDC

Kentucky Death Rates – Heart Failure

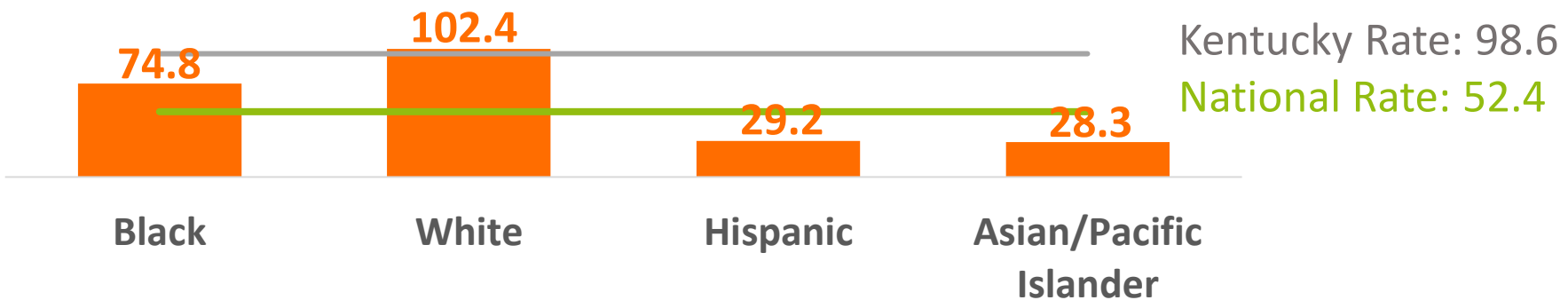
(per 100,000 persons)



Data Source: CDC

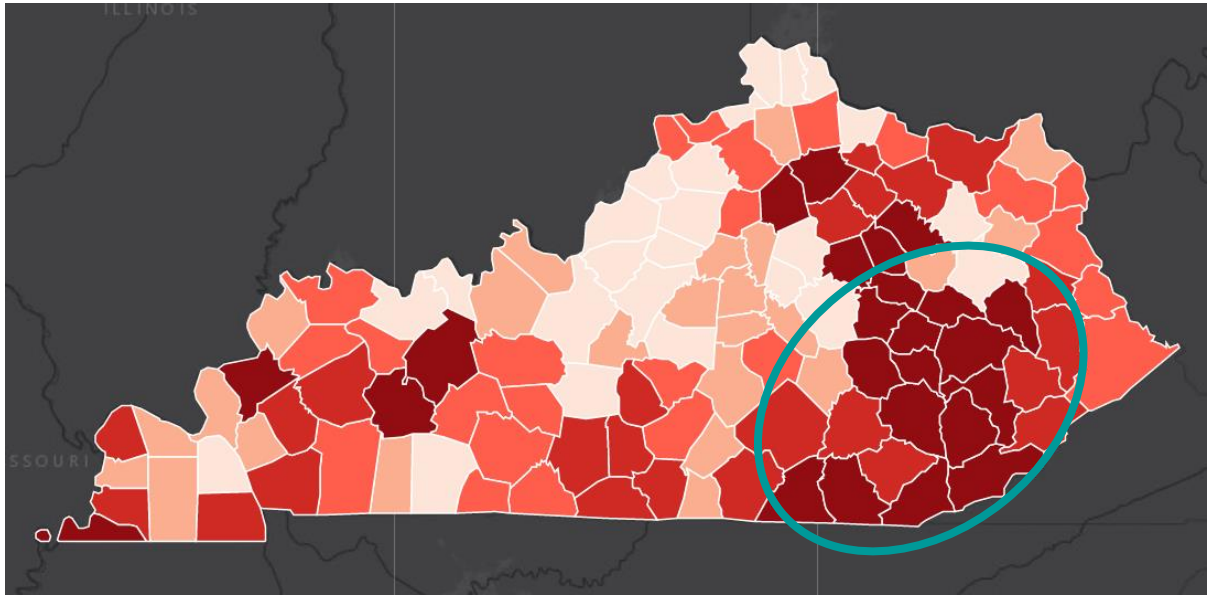
Kentucky Death Rates – Heart Attack

(per 100,000 persons)

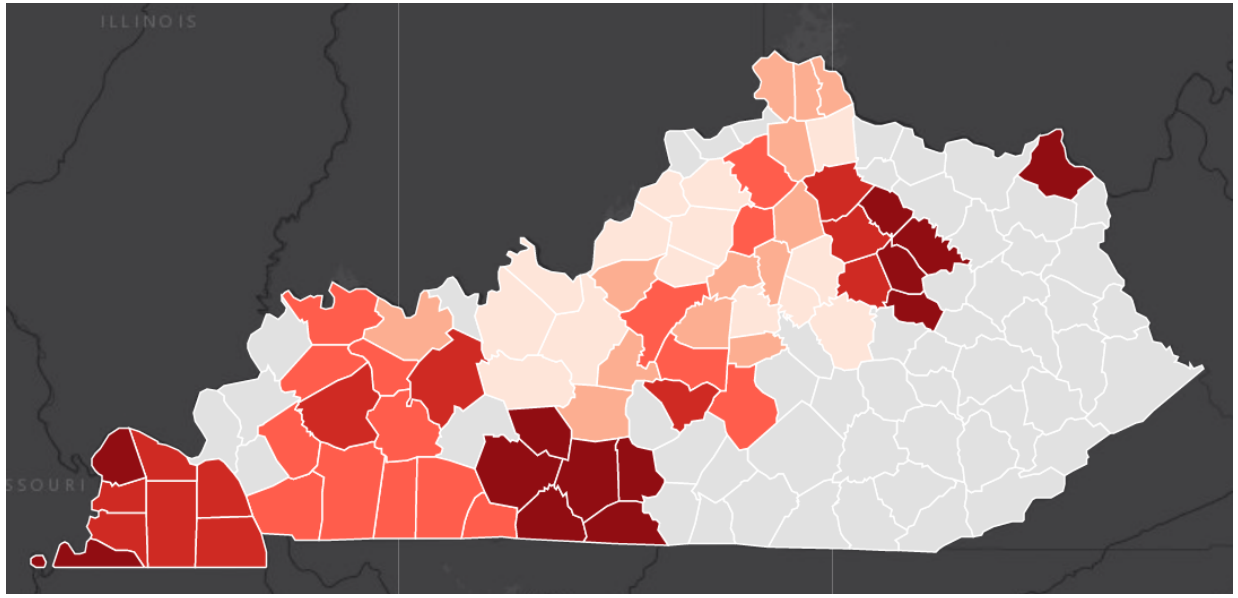


Data Source: CDC

Death Rates – Coronary Artery Disease



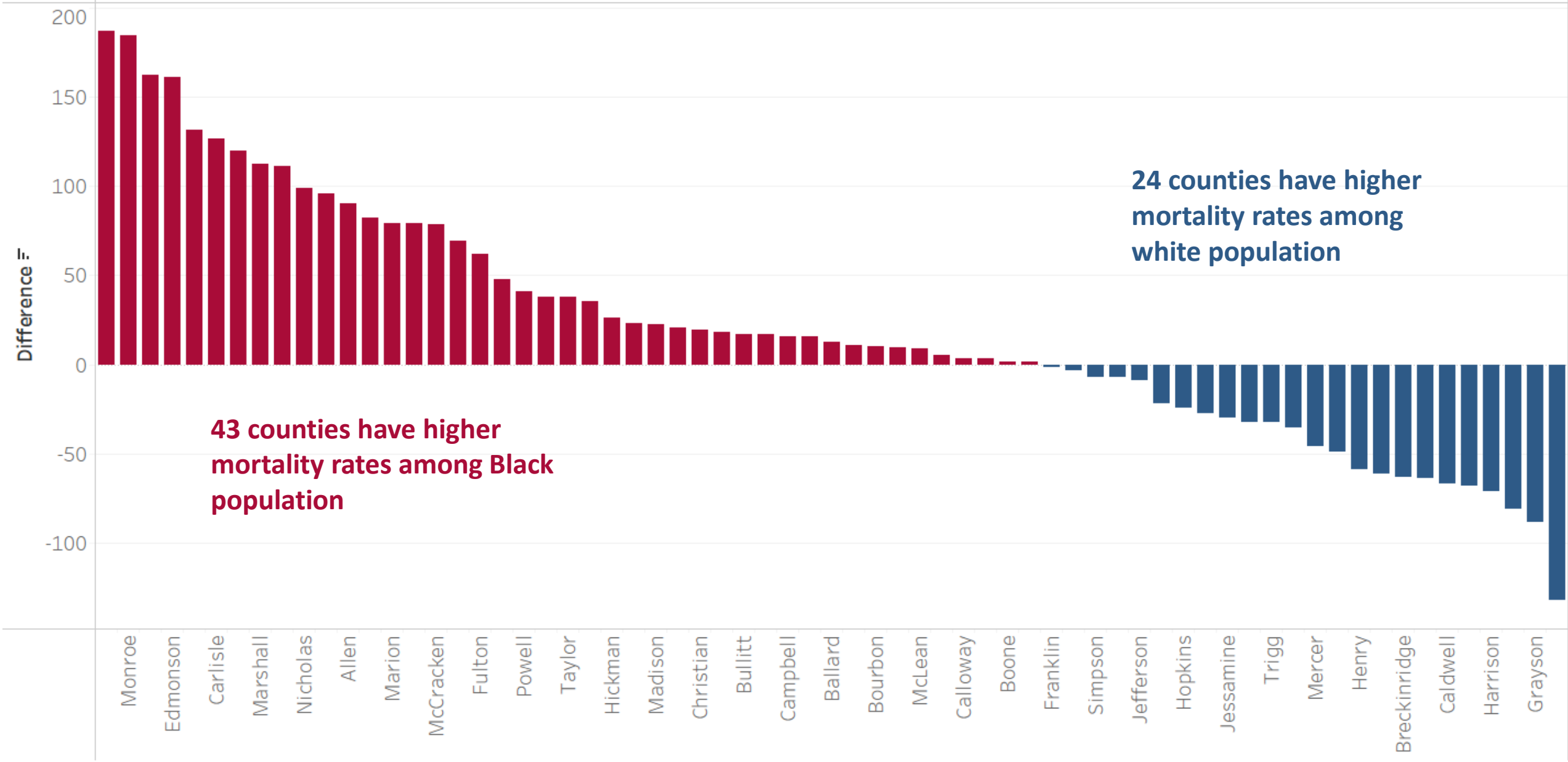
White, non-Hispanic



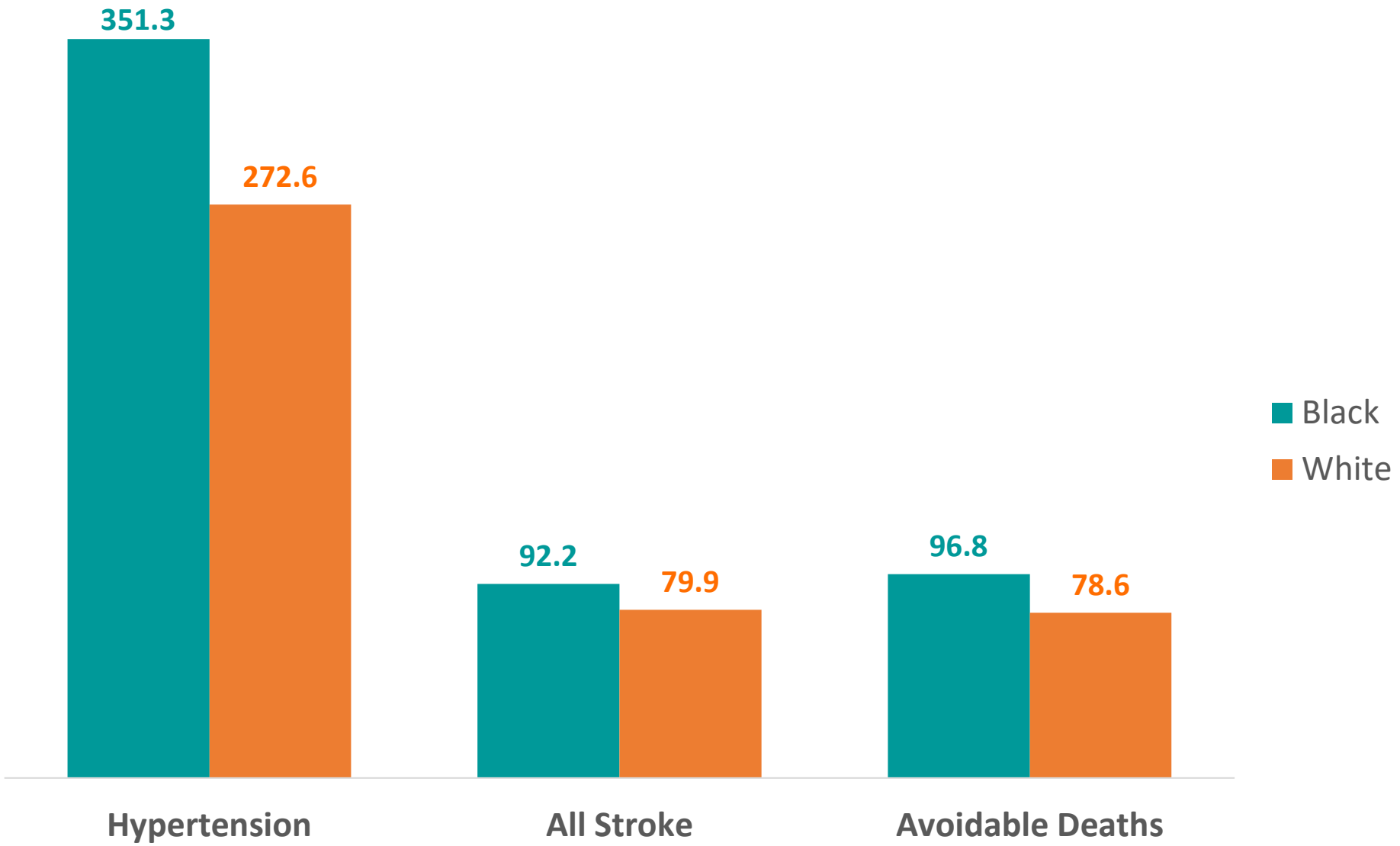
Black, non-Hispanic

Data Source: CDC

Death Rates – Coronary Artery Disease



What is driving the overall gap?



Closing Gaps in Cardiovascular Care

Michael Imburgia

Founder
Have a Heart Clinic

Reducing Disparities in Cardiovascular Care

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Patient One

Hispanic/Nonenglish Speaking

45 yo Gentleman

CP for months

Legal Immigrant

Echocardiogram reveal inferior hypokinesis

Sent to ER

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Patient Two

50 yo Gentleman

AntiPhospholipase Syndrome

Pulmonary Emboli

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Patient Three

58 yo Gentleman

Hypertension/heart failure/aortic insufficiency

In and out of the hospital since 2018

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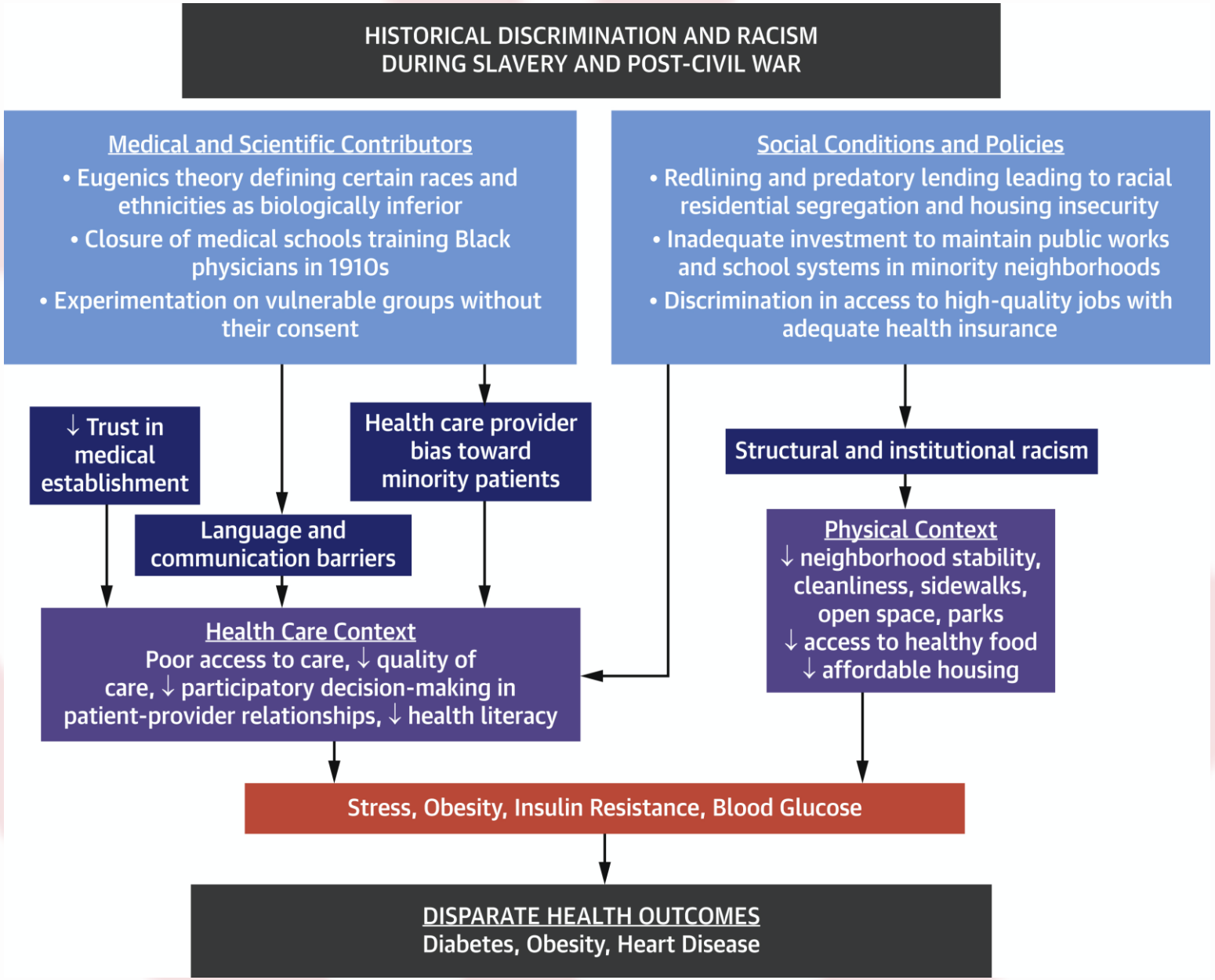
JACC Dec 14, 2021;
Vol78.Number24



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HEART DISEASE

Health Outcomes

Heart Disease Deaths Total 2011 - 2015

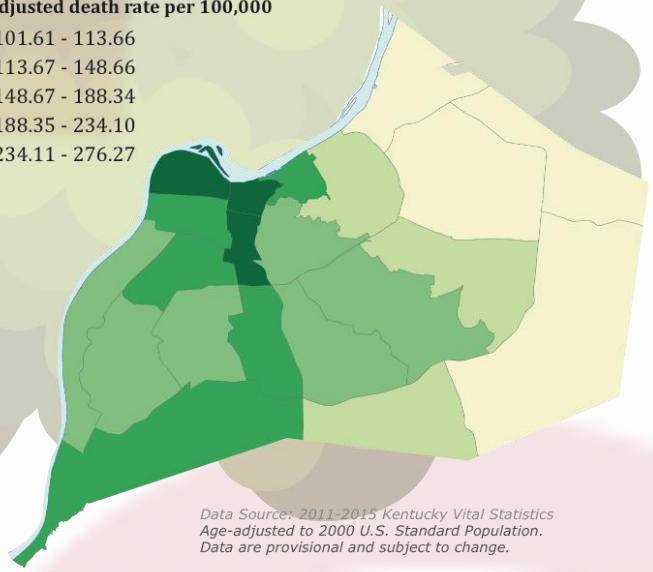
	Count	Age-adjusted rate (per 100,000)
Black Male	699	257.84
White Male	3,129	214.16
Louisville Metro	**7,400**	**166.43**
Black Female	605	154.98
White Female	2,874	123.61
Other Male	31	122.25
Hispanic Male	27	80.43
Other Female	18	69.92*
Hispanic Female	17	53.99*

Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to the 2000 U.S. Standard Population.
**The CDC defines rates as statistically unreliable when the numerator is less than 20.*
Racial categories are non-Hispanic.

Heart Disease

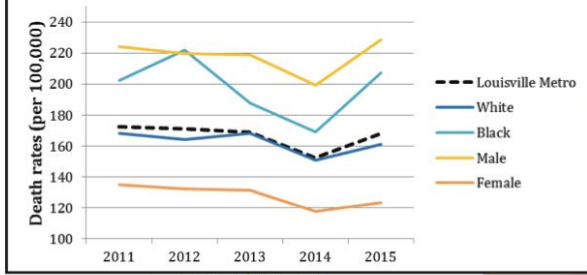
Age-adjusted death rate per 100,000

- 101.61 - 113.66
- 113.67 - 148.66
- 148.67 - 188.34
- 188.35 - 234.10
- 234.11 - 276.27



Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to 2000 U.S. Standard Population.
Data are provisional and subject to change.

Heart Disease Death Rates, 2011-2015



Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to the 2000 U.S. Standard Population.

Heart disease is the second leading cause of death in Louisville Metro. Men die from heart disease at higher rates than women, and Black people die at higher rates than their White counterparts. Heart disease death rates are higher in the downtown core, Old Louisville and the Northwest core.

The median age of those who died from heart disease in Louisville Metro from 2011-2015 was 79.

Root Causes

- HOUSING
- EARLY CHILDHOOD DEVELOPMENT
- FOOD SYSTEMS

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Prognostic Impact of Race in Patients Undergoing PCI Analysis From 10 Randomized Coronary Stent Trials. JACC: CARDIOVASCULAR INTERVENTIONS VOL. 13, NO. 13, 2020

Compared with White patients:

- Black and Hispanic patients had higher rates of adverse clinical events
- Black patients had a higher risk of death.

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JACC: HEART FAILURE VOL. 6, NO. 5, 2018. African Americans Are Less Likely to Receive Care by a Cardiologist During an Intensive Care Unit Admission for Heart Failure

- African Americans Are Less Likely to Receive Care by a Cardiologist During an Intensive Care Unit Admission for Heart Failure

JACC: HEART FAILURE VOL. 6, NO. 6, 2018

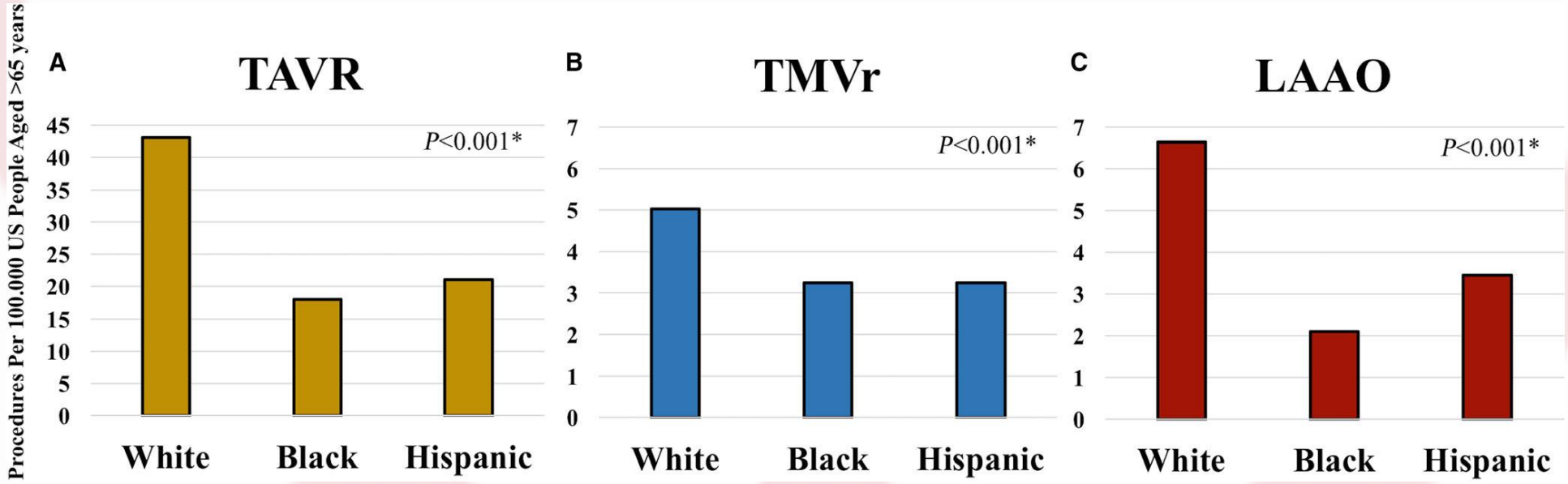
- Heart Failure with poor LV function in outpatient clinical practice, women, Blacks and Hispanics, and lower-income patients had statistically significantly worse HF-specific health status.

Circulation: Heart Failure. Oct 2019

- Among nearly 2000 patients, Black and Hispanic patients had lower rates of admission to the cardiology service than white patients
- Admission to the cardiology service was independently associated with decreased readmission within 30 days, independent of race.

Racial Disparities in the Utilization and Outcomes of Structural Heart Disease Interventions in the United States. J Am Heart Assoc. 2019;8:e012125. DOI: 10.1161/JAHA.119.012125.

- The Nationwide Inpatient Sample (NIS) November 2, 2011 to December 31, 2016.
- Total 106, 119 patients with TAVR, TMVr, LAAO



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Association of Race/Ethnicity With Oral Anticoagulant Use in Patients With Atrial Fibrillation Findings From the Outcomes Registry for Better Informed Treatment of Atrial Fibrillation II. JAMA Cardiology November 2018.

- First, Black patients were less likely to use any anticoagulation than White patients and were particularly less likely to use newer safer anticoagulants.
- Second, while we expected to see the difference in race mediated by socioeconomic status, differences between Black and White patients largely persisted despite inclusion of socioeconomic markers.
- Third, anticoagulation quality was poorer in Black patients and Hispanic patients.

Sex and Race/Ethnicity Differences in Implantable Cardioverter-Defibrillator Counseling and Use Among Patients Hospitalized With Heart Failure

Circulation. Volume 134, Issue 7, 16 August 2016, Pages 517-526

- The GWTG-HF program.
- AICD's result in a 31% and 23% reduction in the hazard of death in comparison with conventional medical therapy.
- Eligible race/ethnic minority group patients were less commonly counseled than their White counterparts (White patients 24.3%): Black patients 22.6%, Hispanic patients 18.6%, and other race/ethnic minority patients 14.4%
- Race/ethnic minority group patients received or were prescribed an ICD less commonly than White patients (White patients 65.3%): Black patients 58.0%, Hispanic patients 56.3%

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Heart
Clinic

Patient Demographics

Patient Visits	> 2500 in 2021			
Age	15 –96 yrs	48.6 yrs (mean)		
Gender	50% Male	50% Female		
Race	40% Black	21% Hispanic	4% Other	35% White
Language	17% Spanish	3% Other	80% English	
FPL	82% ≤ 200%	18% > 200%		
Referring Clinics	75% FQHC	17% Non for profit	8% other	
Chronic Illness	40 % < 2	60% ≥ 2		

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Cardiovascular Guideline Based Therapy (Threshold ≥ 85%)

CHF	Black	Hispanic	White
Beta Blocker	93%	75%	93%
ACE/ARB	88%	88%	93%
AICD	100%	100%	100%
CAD			
Beta Blocker	89%	88%	94%
Anti platelet	93%	100%	98%
Statin	95%	80%	93%
Atrial Fib			
Anticoagulation	100%	100%	100%

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Preventive Cardiology and Health Equity Center

	Black pts (Initial)	Black pts (6 months)	White pts (initial)	White pts (6 month)	Hispanic pts (Initial)	Hispanic pts (6 month)	Total Initial	Total 6 month
Statin at Goal								
	59%	78%	69%	80%	50%	67%	61%	77%
BP at Goal								
	39%	48%	52%	100%	40%	100%	42%	60%
Exercise at Goal								
	14%	15%	12%	20%	20%	33%	14%	17%
Diet at Goal								
	25%	44%	21%	60%	50%	67%	26%	49%
Medication Compliance								
	74%	74%	98%	80%	90%	67%	81%	74%

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Health equity: is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

Equal Access to Healthcare
Equal Quality and Outcome Healthcare
Address Social Determinants of Health
Solve Racism and Bias in Healthcare

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Addressing the Problem

Expand the Collection, Reporting, and Analysis of Standardized Data

Equal Access to Healthcare.

- Expand Health insurance coverage
- Regardless of Type of insurance coverage

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Equal Quality and Outcome Healthcare

- Establishing accountability frameworks such as equity Dashboards/scorecards.
- Review clinical algorithms that rely on race.

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Address Social Determinants of Health

- **Need structure within systems to evaluate and then address those needs.**
- Break down barriers and create partnerships.
- New policies are needed to increase economic empowerment.

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Address Racism and Bias in Healthcare

- Investing in scholarships for students of color interested in health professions.
- Train leadership and staff in diversity, equity, inclusion, and antiracism principles.
- Listen to and learn from patients and health care professionals of color.

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Panel: Stakeholder Priorities in Advancing CVD Equity

Yolanda Reed
Founder
Yokie!

Gretchen Leiterman
Chief Operating Officer
Baptist Health

Tony Linares
RVP Medical Director
Anthem National Accounts

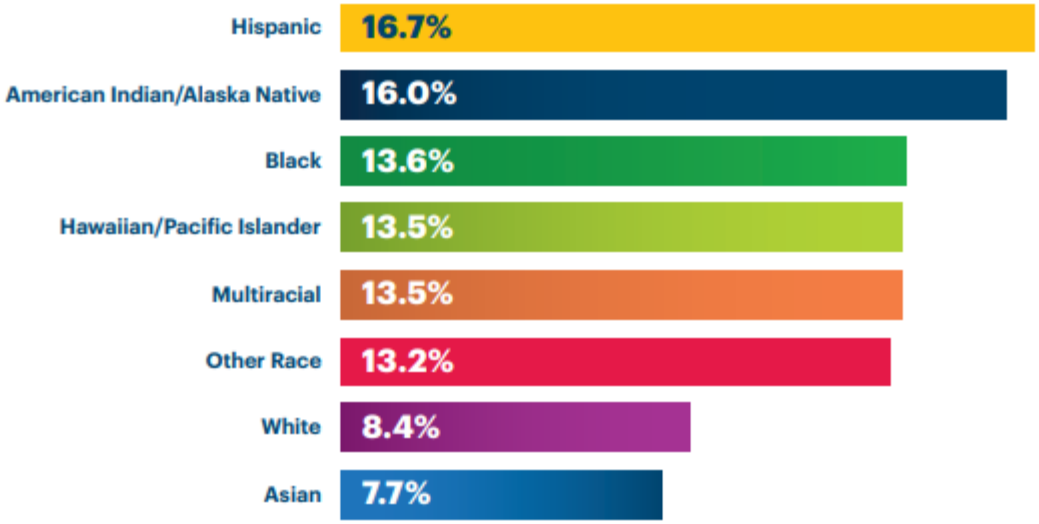
Ranna Parekh
Chief Diversity and Inclusion Officer
American College of Cardiology

Anne Stake
Head of Strategy, Innovation, & Technology
Medtronic

Reducing Disparities in Cardiovascular Care

Priorities in Advancing Health Equity at Baptist Health Louisville

Impact of the Pandemic:
Avoiding care due to cost was 2x higher among Hispanic and Black adults



Note: Hispanic is an ethnicity. All race groups are non-Hispanic.

ANNUAL REPORT www.AmericasHealthRankings.org

Health Equity at Baptist Health Louisville

- Community Investment
  - Mental Health Services
  - Maternal/Child Health
  - Opioid Reduction
  - Heart Disease
  - Health Screening
- Workforce diversity
- All staff, leadership and provider training
- Data-driven decision making

Reducing Disparities in Heart Disease

- Clinical Support
  - Partner with community providers
  - Expand screenings for cardiovascular disease
- Direct to Consumer
  - Online Risk Assessments and Follow Up
  - Community Education & Events
- Next Steps
  - Future additional partner investment
  - Primary data analysis of outcomes by determinants of health
  - National data sharing partnerships to allow benchmarking to best practice

Anthem Foundation - Mission – Vision- Values

OUR MISSION

As the philanthropic arm of Anthem, Inc., the Anthem Foundation promotes the organization's commitment **to improving lives and communities**. Through strategic partnerships and programs, we are addressing the disparities and social determinants that will help create a healthier generation of Americans.

OUR VISION

Be the most innovative, valuable and **inclusive partner** to our stakeholders and communities.

Anthem Foundation

OUR VALUES

Leadership: Redefining social responsibility through best-in-class program solutions.

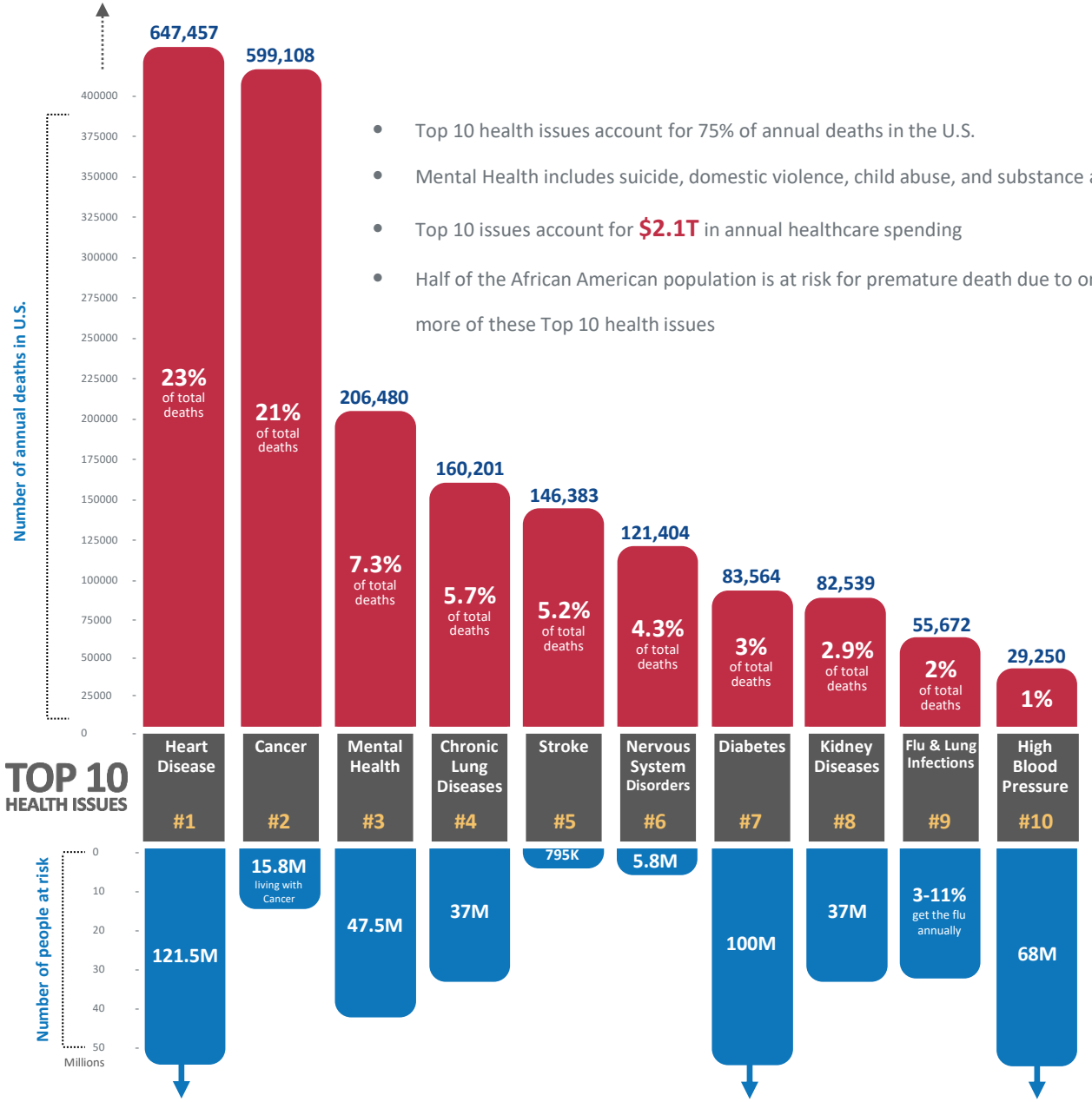
Community: Committed, connected, invested.

Integrity: Doing the right thing; being a good corporate citizen.

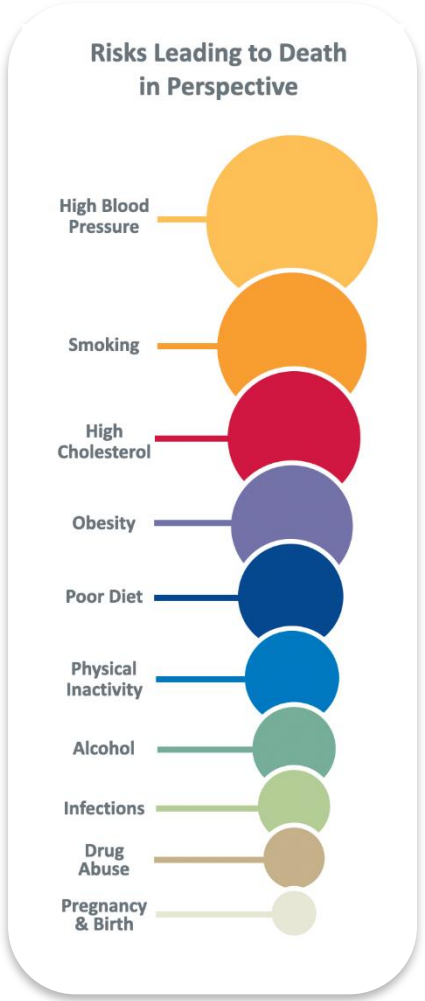
Agility: Adapting and transforming our work today to provide a safer tomorrow for our communities.

Diversity: Expanding access for those most in need; inherently addressing health disparities through our Healthy Generations strategy.

Leading Health Issues in the U.S.



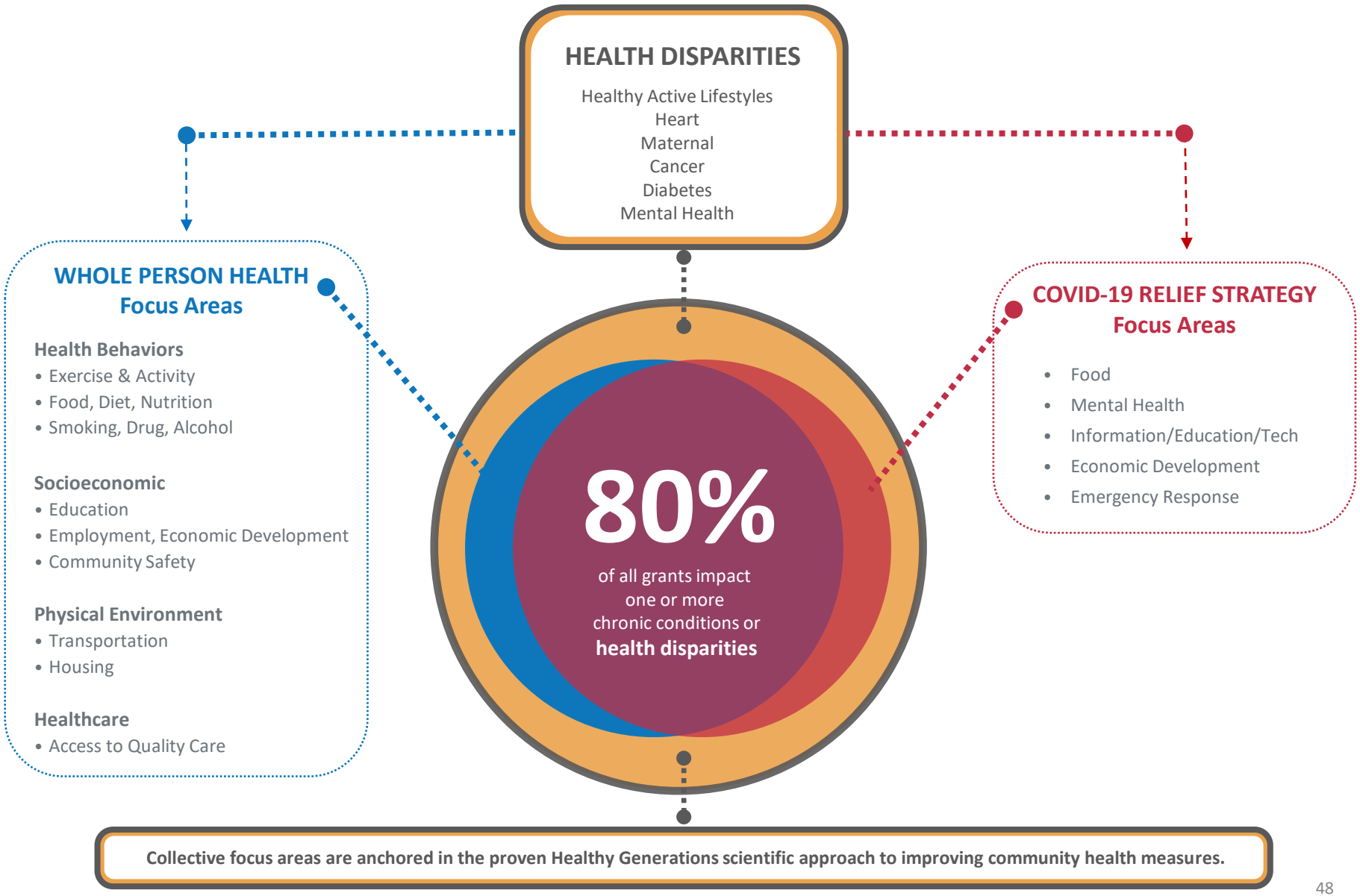
- Top 10 health issues account for 75% of annual deaths in the U.S.
- Mental Health includes suicide, domestic violence, child abuse, and substance abuse
- Top 10 issues account for **$2.1T** in annual healthcare spending
- Half of the African American population is at risk for premature death due to one or more of these Top 10 health issues



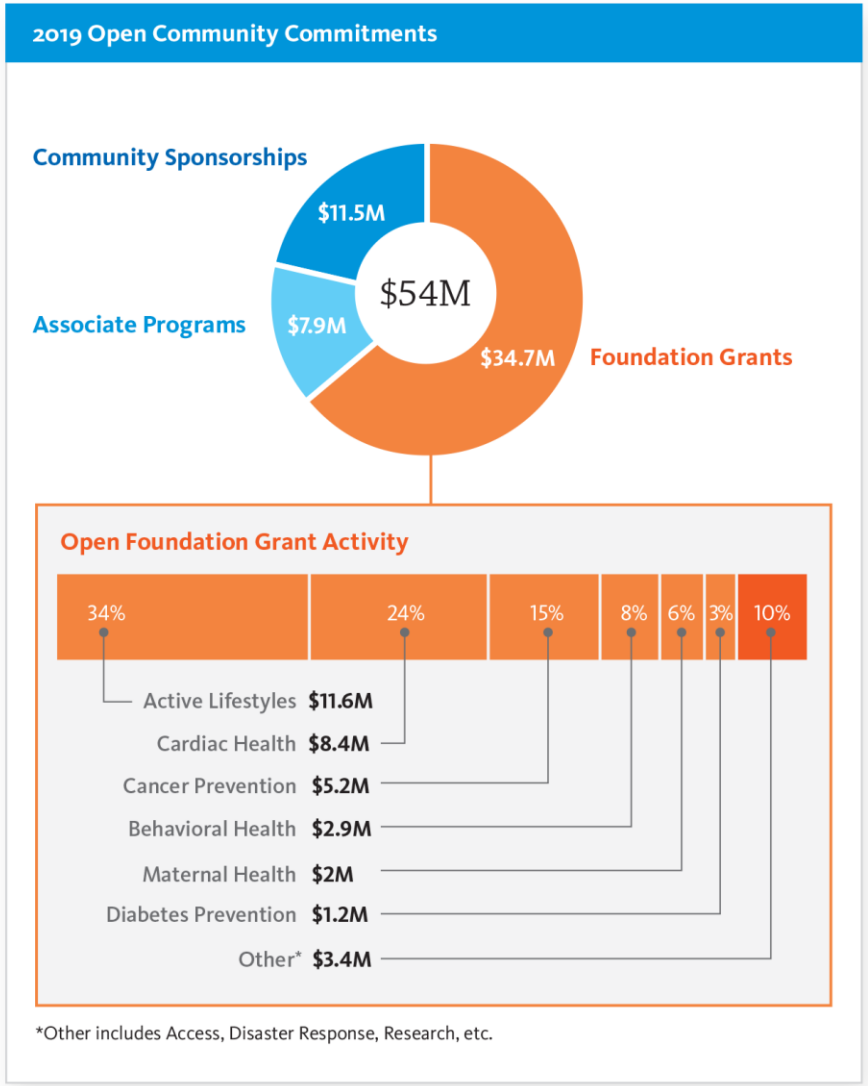
*Data estimated by the Centers for Disease Control and Prevention and the National Institutes of Health.

Anthem 2020 Strategy anchored in Health Disparities

The **Healthy Generations** strategy enables us to consistently and directly improve measures for the most critical health issues including those exacerbated by COVID-19.



Anthem Foundation: Open Community Commitments



Responding to the Research.

For 20 years, Anthem Foundation has been committed, connected, and invested in communities across the country through our Healthy Generations Program - a multigenerational initiative to improve public health. Through strategic partnerships and programs, our approach is inherently addressing the social drivers that are barriers to health and COVID-19 recovery within underserved communities.

Most Pressing Community Health Issues in the U.S.

HEART DISEASE	CANCER	MENTAL HEALTH
COVID-19 COMPLICATIONS		
• Coronary Artery Disease • Heart Failure • Blood Thinners • Congenital Heart Disease	• Cancer • Immunosuppressant medications • Cancer Treatment • Organ Transplant	• Isolation/Anxiety • Domestic Violence • Substance Abuse • Suicide
WHOLE PERSON HEALTH		
• **Smoke-free environment** • **Physical Activity**	• **Access to Healthy Food Options** • **Access to Stress Support Systems**	• **Health Literacy** • **Access to Healthcare**
Healthy Generations		
$7M in programming to support vulnerable individuals affected by heart disease. Trained more than 10.5M Americans in Hands-Only CPR, increasing the likelihood of people performing it by 7%.	$6.8M in programming to bring SDOH solutions to vulnerable individuals predisposed or affected by cancer. Efforts include providing education/awareness, prevention programs, and support for families impacted.	$3.5M in programming supporting individuals predisposed or affected by mental health challenges. Efforts include mental health screening and support, substance abuse prevention and youth programming.

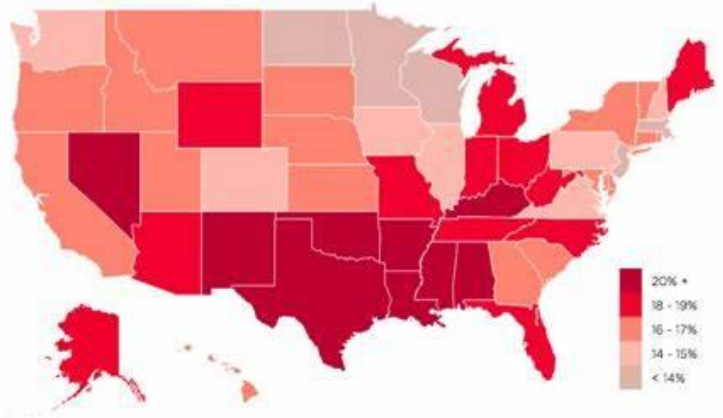
*Estimated by the Centers for Disease Control and Prevention and National Institute for Health

Food Insecurity and Heart Disease: Consequences

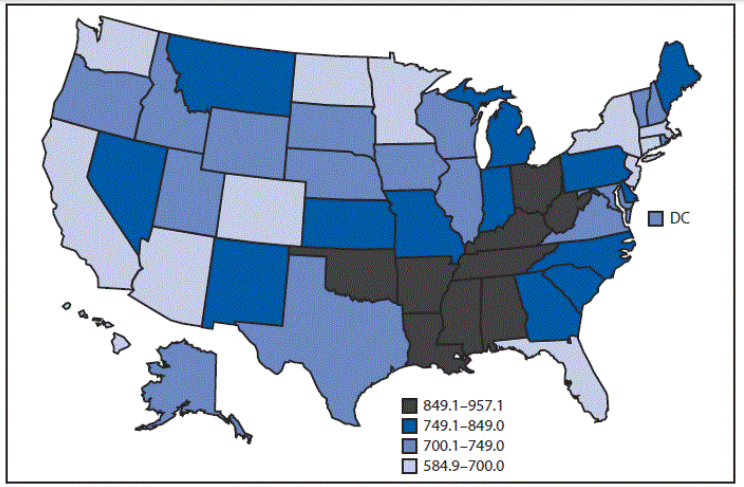
- Increased number of chronic conditions (1)
- Comorbidities included CAD, DM, HT, Stroke, CHF, Cancer and Asthma (2)
- Increase in all cause cardiovascular mortality (3)
- Increased mortality remained prominent even when correcting for health conditions, lifestyle factors, race and ethnicity (3)

1- Liu, et al
2 – Palakshappa et al
3- Sun et al

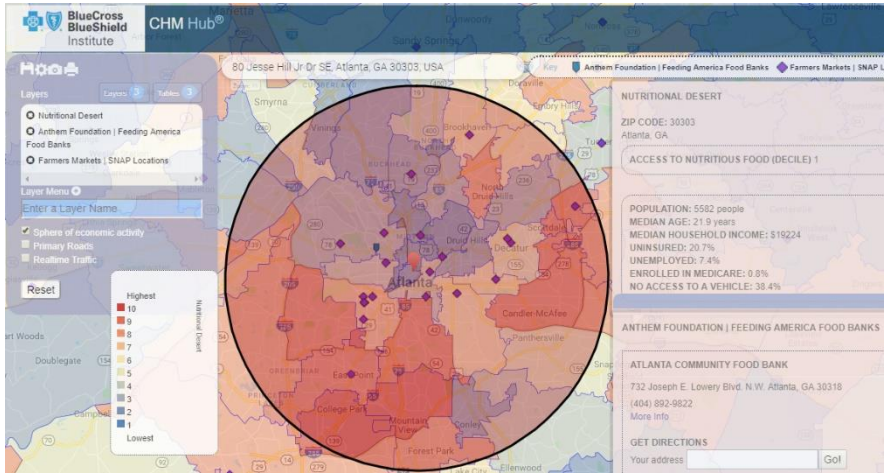
Food Insecurity Overall Population



Age Adjusted Mortality US



Food is Medicine (partnership with Feeding America food banks and Essential Hospitals)



- Example: Atlanta Community Food Bank and Grady Hospital
- Over 40% of Grady patients screened positive for food insecurity vs. 13% in the Metro Atlanta area
- Grady serves a largely low-income population with high rates of chronic disease due to health disparities
- Provide healthy food based on individuals' needs at the site of care

- Expand from 7 to 14 markets; increase food insecurity screening, programming, and SNAP/WIC enrollment
- Advance access to nutritious food at the site of care
- Innovate and disseminate best practices

Pre-Program

STEP 1: SCREENING

Patients are assessed for food insecurity and chronic disease

STEP 2: LOW-INTENSITY INTERVENTIONS

Based on results, patients are referred to SNAP enrollment, local food pantries, or nutrition education and Grady Nutrition Services

STEP 3: ENROLLMENT

Grady Nutrition Services enrolls eligible patients in Fruit & Vegetable (FVRx) Program: Eat Well, Live Well

Eat Well, Live Well Program

Grady

Patients participate in monthly group nutrition class where Grady providers write prescriptions and track health outcomes

wholesome wave GEORGIA

Patients redeem prescriptions for fresh, local fruits and vegetables weekly at Grady or partner farmers market

OPEN HAND

Patients learn how to make healthier choices, prepare nutritious meals and maximize food resources through six-week Cooking Matters course

Post-Program

SHORT-TERM IMPACT

Food Security

Fruit and Vegetable Consumption, Health Knowledge & Cooking Confidence

CONTINUED ENGAGEMENT

Health Tracking

Alumni Network Support

Referrals to Community Resources

LONG-TERM IMPACT

Improved Clinical Health Outcomes (i.e., A1C & Blood Pressure)

Healthcare Cost Savings

Consumer-facing tools to address heart disease

These free, **interactive websites** are focused on eliminating health disparities in African American/Black and Hispanic/Latino communities across **heart disease, prediabetes, chronic kidney disease, cancers** and **depression-risk**

TakeActionforHealth.org

TakingActionforOurHealth.org *(in English and Spanish)*

Created in collaboration with leading national organizations, including 100 Black Men of America, the National Urban League, Golden State Medical Association, and the National Hispanic Medical Association, they help individuals:

LEARN about their increased risks and how to protect their health and well-being
ACT by getting screened (*with searchable tools to find help for addressing barriers to getting screened*)
MONITOR their progress
SHARE their results with their healthcare providers and family

Share these websites with your patients and empower them to TAKE ACTION

Whole Health Index: Framework

Framework is adapted from the National Academy of Medicine's Vital Signs

Provider Resources on Health Disparities:
www.MyDiversePatients.com

Four domain areas

- **Social drivers**: e.g., socio-economic status, housing, transportation, food insecurity (25%)
- **Affordability:** e.g., % of out-of-pocket spending over household incomes (25%)
- **Global health:** e.g., number of chronic health conditions (25%)
- **Clinical quality**: e.g., screening, appropriateness of care, secondary prevention, well-child and maternity care (25%)

Anthem

Reducing Disparities in Cardiovascular Care

Kentuckiana Health Collaborative

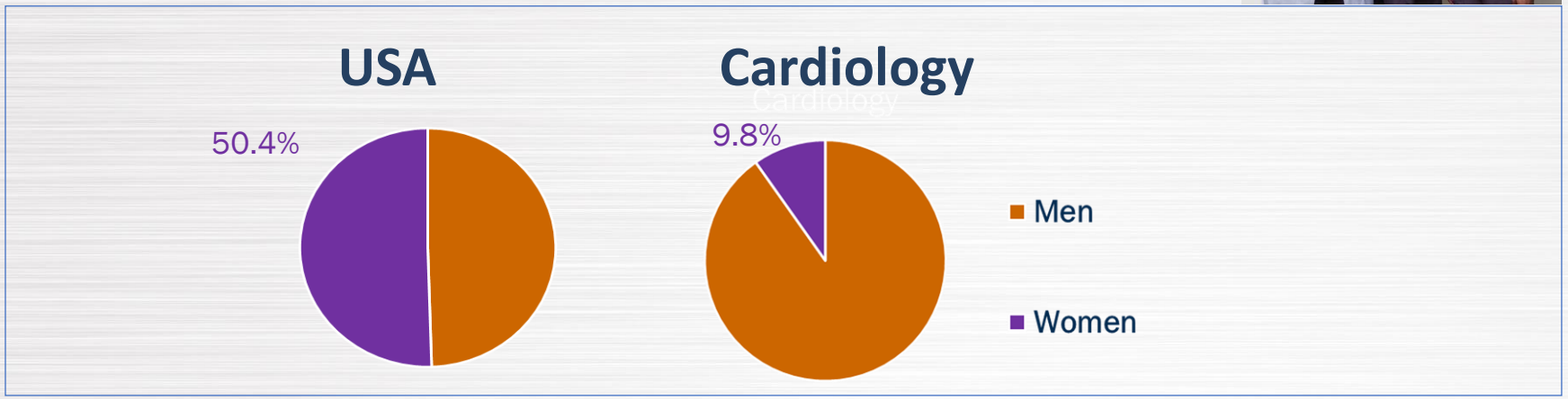
December 14, 2021

Ranna Parekh, MD, MPH

Chief Diversity and Inclusion Officer

AMERICAN COLLEGE of CARDIOLOGY

In comparison to U.S. medicine, adult cardiology is far less diverse.



- In 2015, only 9.8% of FACCs who are U.S. board certified in adult CV are women
- About half of IM residents are women, compared with 13% adult cardiologists and 21% of adult cardiology fellows. Even so, women are underrepresented in CV fellowships compared to almost every other specialty in the House of Medicine

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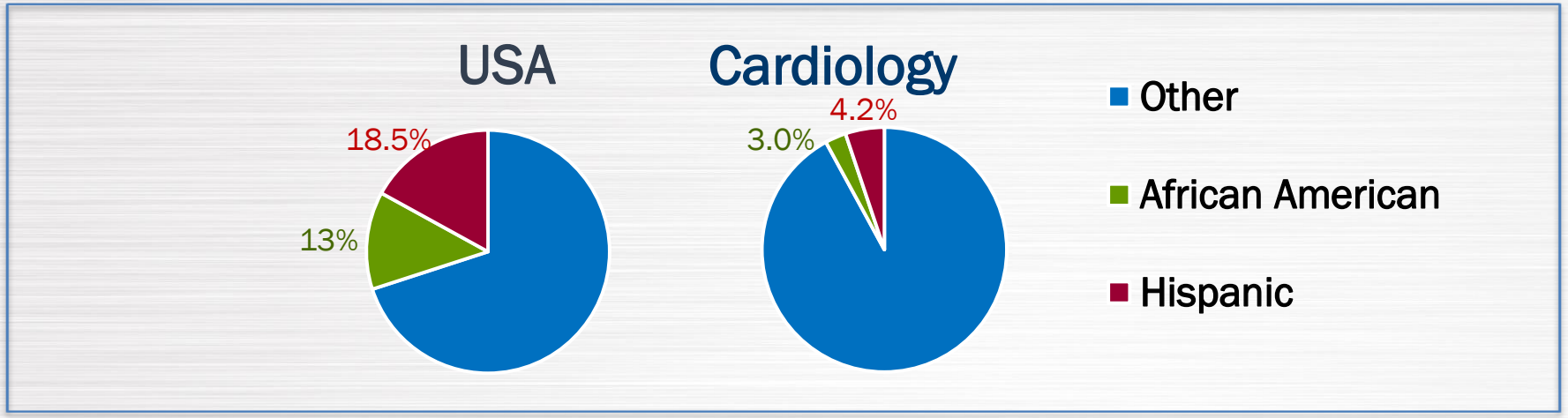
In comparison to the U.S. population,

Adult cardiology has fewer African Americans and Hispanics…



Source: Racial Diversity Among American Cardiologists: Implications for the Past, Present, and Future (Circulation, June 2021)

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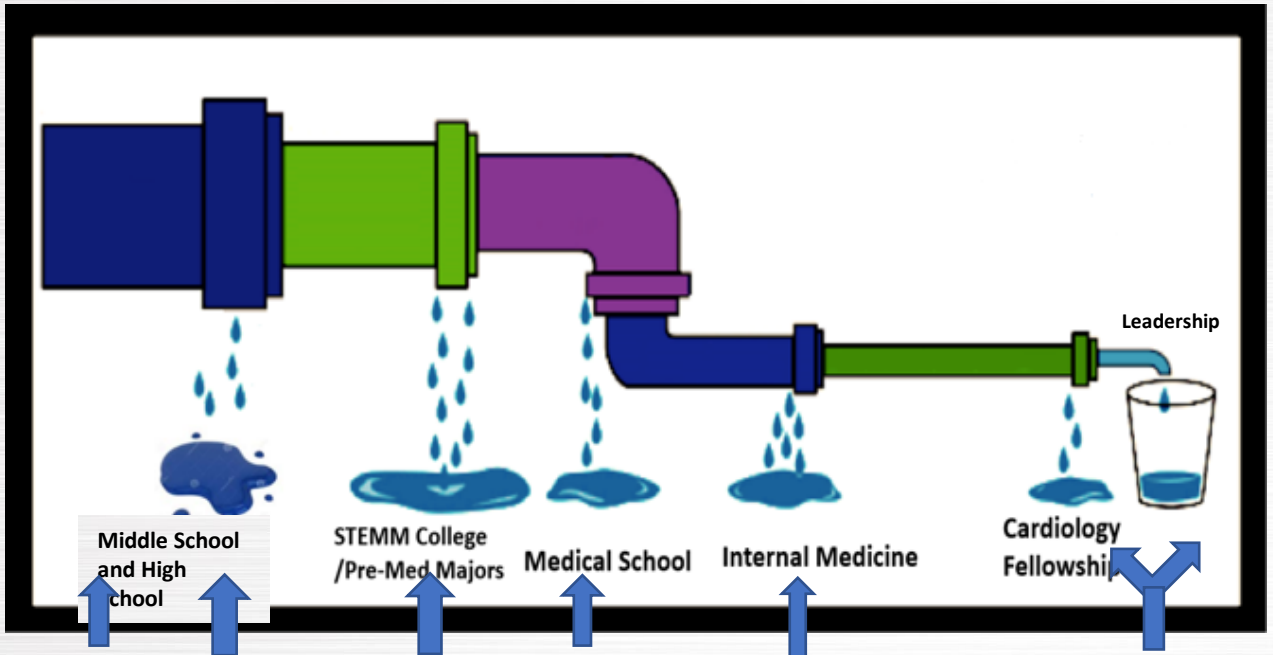
ACC's Programs to address the Leaky Pipeline for Underrepresented in Cardiology (URCs)



Program 1
ACC Middle School and High School Pipeline strategies

Program 2
ACC Young Scholars Program – late high school and early college

Program 3
ACC Pre-Med Pipeline Strategies

Program 4
ACC Medical Student Strategies

Program 5
ACC Medical Resident Pipeline Strategies

Program 6
ACC Cardiology Fellow and Leadership Programs

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Implicit Bias Training and Workshops

- Led by member workgroup
- BOT first group trained in January 2020
- Goal to train 2,000 ACC Member Leaders
- Virtual Train the Trainer Sessions in 2021 with plans for in person in 2022

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Joint Statement May 2020

Release Date: May 30, 2020

American Heart Association.

ABC
Association of Black Cardiologists, Inc.
Saving the Hearts and Minds of a Diverse America

AMERICAN COLLEGE *of* CARDIOLOGY

Dear Members, Friends and Concerned Citizens,

The Association of Black Cardiologists and our cardiovascular partners know that these are difficult and disturbing times for you, your families, patients and our communities. We know that at the forefront of your distress are concerns about preventable causes of death, illness and disease. Like cardiovascular disease, acts of violence and racism are core causes of psychosocial stress that promote poor well-being and cardiovascular health, especially for communities of color. Given that heart disease and stroke are the leading causes of death for communities of color, particularly African-Americans who have the lowest life-expectancy of all racial/ethnic groups living in the United States, we are extremely disturbed by violent acts that cut to the core of the lives of our community. Therefore, along with other leading health organizations, we DENOUNCE incidents of racism and violence that continue to ravage our communities.

Health equity is our mission. George Floyd and other black men and women who remain nameless and faceless are "At the Heart of the Matter" for the ABC and our cardiovascular partners. Mr. Floyd's death comes on the heels of other recent incidents caught on camera. In another 2020 incident, Ahmaud Arbery was shot and killed while jogging in his hometown of Brunswick, Georgia. Christian Cooper is fortunately alive and well to speak to the Memorial Day incident in New York's Central Park where he was accused of threatening the life of a woman while bird watching. Although the woman apologized for calling 911 to make this false claim, justice does not always follow these filmed incidents. Another senseless death involves officers entering the Louisville, Kentucky home of emergency medical technician Breonna Taylor.

The profound grief and stress triggered by these events, as well as the consequences for black lives, contribute significantly to cardiovascular risk. Each episode has emotional and physiological effects on individuals and **all** communities. ABC and our partners have been at the forefront of addressing cardiovascular disparities in our communities for decades and it is crucial, now more than ever, that our efforts help to mitigate the unacceptable disparities among our most vulnerable populations. We have the unprecedented opportunity to address these issues through policy and by working with affected communities and the healthcare providers who serve them.

Thus, we stand and link arms in solidarity with efforts to dismantle systems that maintain excess morbidity and mortality, especially among vulnerable populations and those historically oppressed. Indeed, our collective vast membership, many of whom are at the frontlines of clinical healthcare, has taken an oath to decisively and with kindness, compassion and grace act to relieve suffering related to ***"I can't breathe"*** in order to preserve life.

Stay safe, healthy and connected,

Michelle A. Albert, MD, MPH
President, Association of Black Cardiologists

Robert A. Harrington, MD
President, American Heart Association

Athena Poppas, MD
President, American College of Cardiology

The Business Case for Health Equity

Health disparities are costly and there would be a positive economic impact if health equity is better implemented

$135 BILLION
total economic gain per year if health disparities removed

$42 BILLION
untapped productivity due to health disparities

$93 BILLION
excess health care costs due to health disparities

$175 BILLION
economic impact of shortened life spans

3.5 MILLION
lost life years associated with premature deaths

$230 BILLION
projected economic gain per year if health disparities eliminated by 2050

https://altarum.org/sites/default/files/uploaded-publication-files/WKKellogg_Business-Case-Racial-Equity_National-Report_2018.pdf
https://cmelearning.com/resources/the-case-for-health-equity/#business
https://www.astho.org/Programs/Health-Equity/Economic-Case-Issue-Brief/
https://link.springer.com/article/10.1007/s11606-016-3604-7

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MEDTRONIC LABS

Perspectives on Health Equity from Medtronic LABS

Global Health, Local Solutions

December 2021

A bold approach to last-mile healthcare delivery

Our mission is to expand access to healthcare for underserved patients, families, and communities across the world.

Our work at Medtronic LABS

We design and implement tech-powered healthcare delivery models that strengthen and extend health systems into local communities, delivering sustainable outcomes for underserved patients worldwide.

Our current focus is transforming care for chronic diseases including hypertension, diabetes, mental health, and disabilities.

Why chronic disease?

5B+ low- and middle-income people lack access to healthcare globally.

Urbanization and standard-of-living improvements are driving an epidemiological shift towards Non-Communicable Diseases (NCDs) which now account for >70% of mortality in this population.

Our programs at-a-glance

Our team of **130+** field operations experts, health coaches, clinicians, technologists, and designers support **200+** sites across 5 countries

Coming soon…

Bhutan, Sierra Leone, Tanzania, Cambodia, Rwanda, USA

Impact (Since 2014)

PEOPLE SCREENED
1M+

LIVES IMPROVED
37K

HEALTH WORKERS TRAINED
2,400

Partners (*not a comprehensive list)

GOVERNMENTS
Ministry of Health, Kenya
County Governments, Kenya
Government of Kerala
Government of Bhutan

FUNDERS
GIZ
World Diabetes Foundation
Novo Nordisk
Novartis

HEALTH SYSTEMS
Christian Hospital Association of Ghana (CHAG)
Christian Hospital Association of Sierra Leone (CHASL)

NGOs
Path
Red Cross
Kenya Defeat Diabetes Association (KDDA)

Our approach integrates 3 core elements

We deliver health outcomes in low-resource settings by leveraging cutting-edge digital technologies to enable last mile healthcare delivery.

Software solutions designed for patients, community health workers, and healthcare providers operating in low-resource settings

Community-based teams integrated with health systems to expand screening, diagnosis and treatment; and direct patient engagement

Implementation-focused partnerships with health systems, governments, local innovators, multi-nationals and funders to drive sustainable system-level transformation

Build trust with **integration** with community-based structures

Medtronic LABS programs are fully integrated into the public health system in partnership with Ministries of Health and local governments.

At the community level, we engage with local structures, like churches, social support groups, NGOs, and other organizations.

Our community health programs are driven through robust community health worker networks. We equip and train community health workers and provide support through our hyper-local operations teams.

- Who holds trust in the communities where you work?
- How are you engaging with community-based organizations?

Design with **proximity** to population served

We design programs with and for the communities we are serving. Over 95% of our team are based in and are from the places where we operate. Our design and product teams are embedded directly in the community and work alongside stakeholders at every level, from the government to the clinicians to the patients and families we serve. We often employ human centered design and co-creation methods to ensure that all voices are heard.

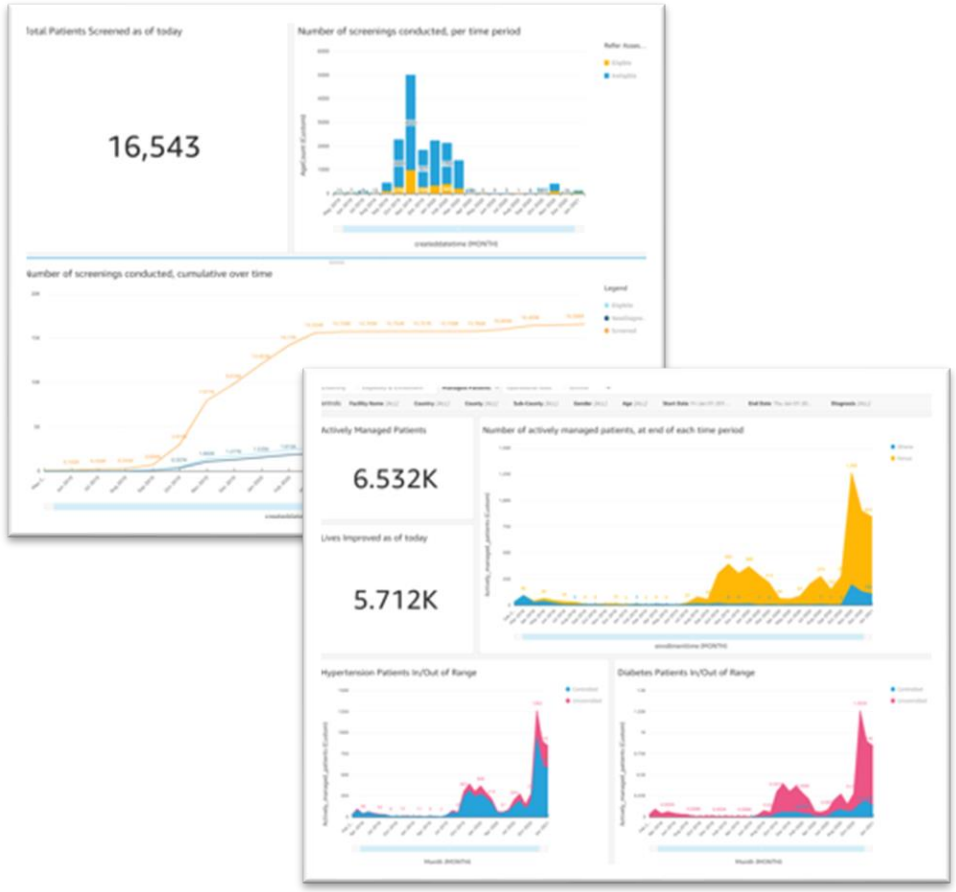
- Does your team in the organization represent the population served?
- How proximate are you to the problems or challenges in the daily lives of the beneficiaries or those being served?
- Could design based methods or design principles apply to health equity work?

Expand the definition of “healthcare” to focus on **health**

We design programs that address the social determinants at the root of poor health. We leverage telecounselors and health coaches to provide personalized feedback and strategies based on real time data. (e.g. transportation, healthy eating, exercise, mental health, stress…)

- What are the social determinants in the US context for the populations you are serving?
- How might partnerships with social services or local organizations enhance healthcare delivery?

Measure outcomes that matter to patients and stakeholders



Each stakeholder values different outcomes. At Medtronic LABS we track longitudinal clinical outcomes in real time and align with specific Ministry of Health standards. However, we also focus on what patients care about: quality of life, healthy days, etc.

- What do clinicians care about
- Patients?
- Administrators?
- Payors?

Medtronic LABS

Global Health, Local Solutions

Closing

Natalie Middaugh

Community Health Program Manager
Kentuckiana Health Collaborative

UPCOMING KHC EVENTS

The Quest for Value and Equity

KHC 8th Annual Conference

April 12-13, 2021

https://khcollaborative.org/2022-conference/

Reducing Disparities in Cardiovascular Care

Thank you for attending!

Kentuckiana Health Collaborative
Building a Bridge to Better Health, Better Care and Better Value

Have a Heart Clinic

AMERICAN NURSES ASSOCIATION KENTUCKY