Translating life course theory to clinical practice to address health disparities

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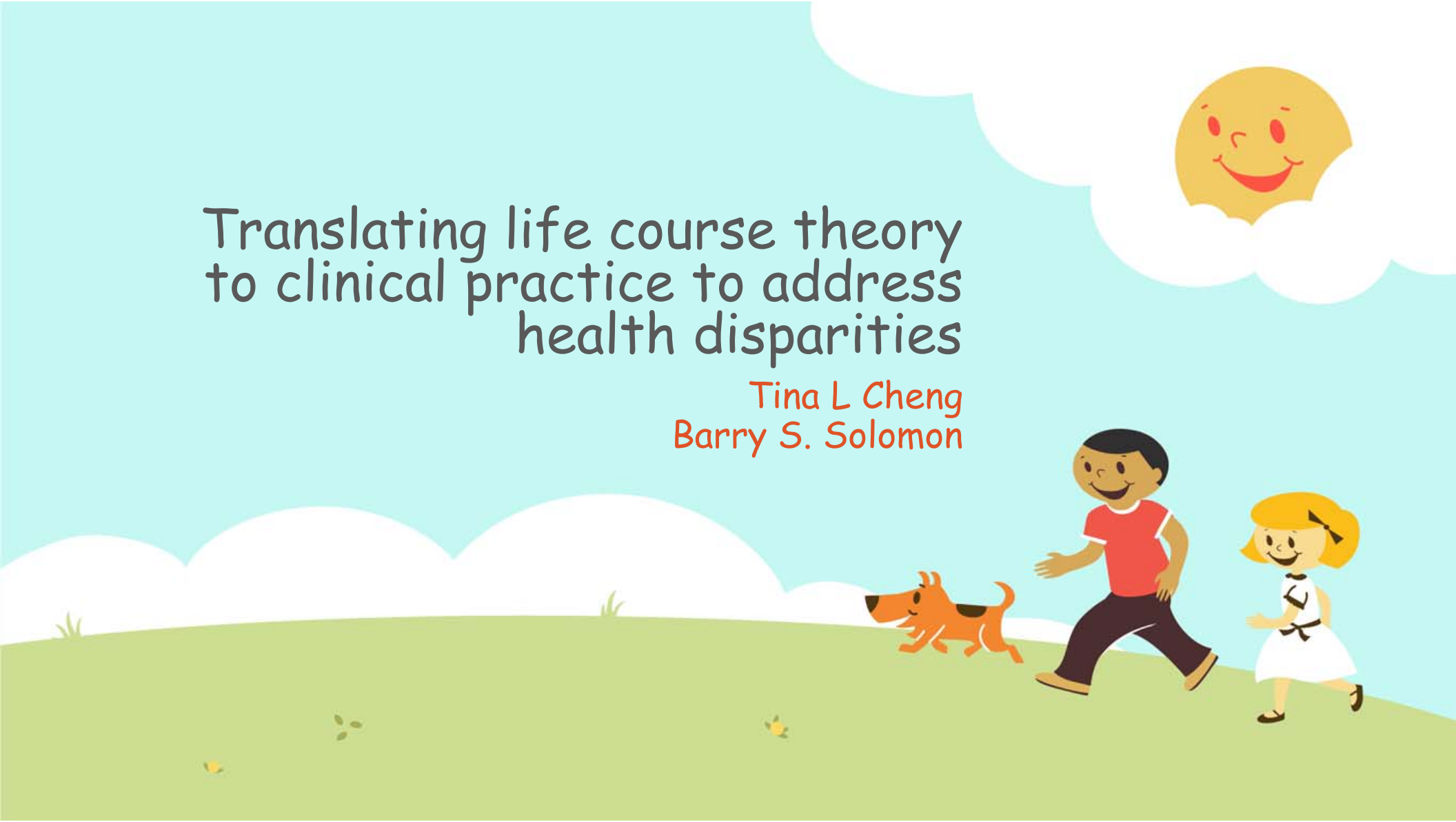


In response to Fine and Kotelchuck's paper, clinical practice innovations in three areas -

- Recognition of context and the whole person, whole-family, whole-community systems approach –
  - Addressing social influences on health in clinical practice
- Longitudinal approach with greater emphasis on early determinants of health
  - Longitudinal and vertical integration of clinical services
- Need for integration and "developing integrated, multi-sector service systems that become lifelong pipelines for healthy development"
  - Horizontal integration with community services and resources
- Life course theory translation requires integration of population health and disease-specific strategies and the recognition of the multiple influences on health

Whole person, family and community

- Critical community contributes to setting priorities and developing approaches
  - e.g., Danis et al found residents; priorities included health insurance, housing vouchers, dental care, job training, adult education, counseling, health behavior incentives and job placement
- Increase comprehensiveness of services provided in primary care or medical home
  - e.g., JH children's Center Harriet Lane Clinic
  - Evaluation promising
  - Obstacles include cultural and structural barriers (disciplinary boundaries; requires collaboration and teamwork)

Upstream intergenerational approach – longitudinal and vertical integration

- Early antecedents to adult disease; critical to ensure prenatal and child health to avoid or delay on set of adult disease (e.g., diabetes, cvd, depression)
- Vertical service integration – spans primary, secondary and tertiary care and different health disciplines
- Horizontal service integration – involves merging of health services with other service sectors
- Longitudinal service integration – across the age span with attention to transition points
- Intergenerational service span – interdependence of health across generations

Future life course theory paradigm for health care delivery

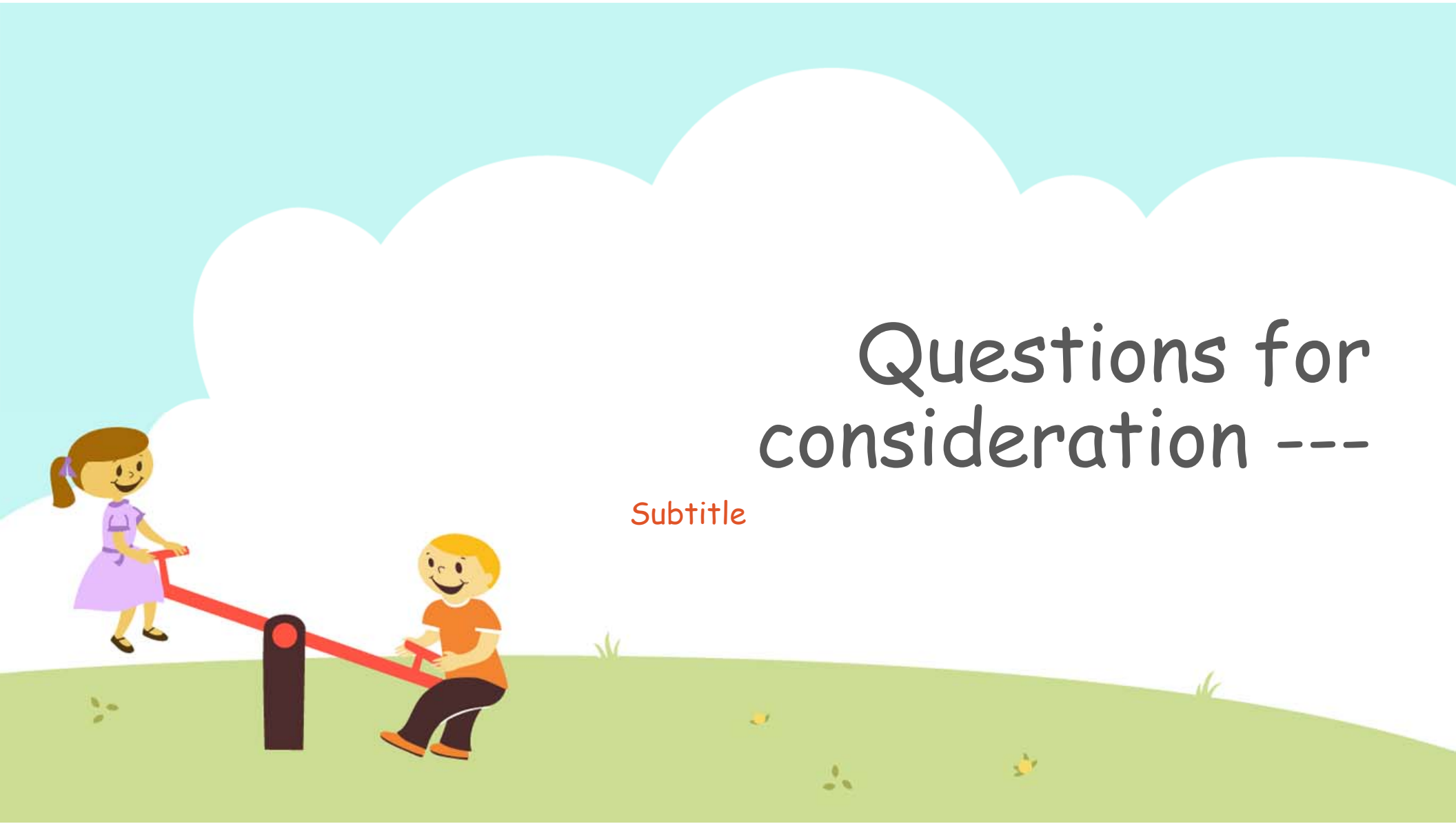
Current medical system	Life course theory concept	Life course theory paradigm for clinical care
Organized by age: Ob-gyn, pediatrics, Internal medicine, geriatrics (exceptions: family medicine, internal medicine-pediatrics)	"Emphasis on early ("upstream") determinants of health" "Lifelong development/lifelong intervention" "Whole-family" approach	*Longitudinal* and *intergenerational Integration*
Organized by setting: Primary care, emergency medicine, hospital medicine, intensive care, specialty care, long-term care	"Development of referral/linkage services to assure timely linkage to a range of needed services within...the health system..."	*Vertical Integration* across health settings
Organized by specialty organ system: Cardiology, gastroenterology, nephrology, neurology, etc.	"Whole-person" approach	*Vertical Integration* across health disciplines
Medical sector focus	"Whole-community systems approach" "Developing integrated, multi-sector service systems that become lifelong "pipelines" for healthy development."	*Horizontal integration* across sectors influencing health
Individual focus	"Population focused and firmly rooted in social determinants and social equity models"	*Individual, family and population focus*

Service sector integration – horizontal integration

- Horizontal service integration involves merging health services with other service sectors including health, social and civic sectors
- Health Impact Assessment (HIA)- way to consider effects policies may have on health of population
- Integration example – England's Sure Start Program

Questions for consideration ---

Subtitle



But first… a story

"You know,' he said, 'sometimes it feels like this. There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying breathing, and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in."

-JB McKinlay, 1974

Question for discussion 1 -

- Is clinical care – by practice – downstream?
  - Why or why not?
  - If it is, can it be made more upstream?
  - If it is, should we be trying to make it upstream?

Question for discussion 2 -

- Given the length of time it takes to observe exposure – outcome relationships intergenerationally and over the life course
  - What information do we need to begin tracking / documenting if we want to understand the causes of – and ultimately impact - human health?
  - What systems need to be in place?
  - What improvements in causal inference methods?

Question for discussion 3 -

- In the authors' final (non-conclusion) paragraph, they note that this "…integrated approach requires a culture change in medicine and its traditional disciplines segmented by age, setting and specialty. It also requires a change in financing structures that currently do not incentivize an integrated approach.

- Name one thing that we can do today to support the suggested culture change
- How can we support financial incentivization for an integrated approach?