Public Health and Healthy Communities of the Future

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Land Acknowledgment

- We gratefully acknowledge this land as the traditional, ancestral Indigenous territories of the Wahpekute, Anishinaabe, and Očeti Šakówiŋ (Sioux) tribes.
- I recognize the Indigenous knowledge that this land has seen, and encourage everyone to be respectful of the distinctive and permanent relationship that exists between Indigenous people and their traditional territories.

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To support public health, we need to stop gaslighting and start empowering communities.

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What is gaslighting?

- The phrase “to gaslight” refers to the act of undermining another person’s reality by denying facts, the environment around them, or their feelings.

- Targets of gaslighting are manipulated into turning against their cognition, their emotions, and who they fundamentally are as people.

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The history and meaning of “gaslighting”

- The phrase comes from the 1938 stage play “Gas Light” turned into a movie in 1944, where a husband is dimming the lights, and when his wife points it out, he denies it is happening.
- It breaks down a victim’s ability to trust their own perceptions.

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But we would never do that in public health!

- Or would we?

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Common “gaslighting” phrases

- You’re so sensitive!
- You know that’s just because you are so insecure.
- You are just paranoid.
- You are making that up.
- It’s no big deal.
- You’re imagining things.
- You’re overreacting.
- You are always so dramatic.
- Don’t get so worked up.
- That never happened.
- You know you don’t remember things clearly.
- Nobody believes you, why should I?

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It is time for a reckoning in public health. Do we do this?

- If so, how can we do better?
  - Listening
  - Learning
  - Giving up space, resources, opportunities so that others might experience their full potential (empowerment)

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What is empowerment?

- “the state of being empowered to do something**:** the power, right, or authority to do something”

- Isn’t that what communities really need?

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The public health focus on individual behaviors is gaslighting because it does not address social determinants of health or structural inequities.

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Even discussion of "social determinants of health" has an individual focus

- "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." – Healthy People 2020

- Can we focus on structural inequities to enhance the vitality of communities?

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How do we do better in public health?

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Listen to the wisdom of communities

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Shared power

- Strong, strategic, long-term, and trusting relationships with community partners are vital to advancing health equity and transforming public health practices. These relationships must recognize each other's strengths, be rooted in shared values and interests, share decision making, and allow for authentic participation by those facing inequities.

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Equity Manifesto

- "It begins by joining together, believing in the potency of inclusion, and building from a common bond…"

https://www.policylink.org/about-us/equity-manifesto

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Concrete steps we can and should take:

1. Stop calling resilient communities "vulnerable" and start recognizing strengths
2. Recognize our own power, and give it away
3. Ensure representation by community
4. Place resource control within communities, let decisions be made by those most affected
5. Center at the margins, question what is "normal"

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An example from my research

University of Minnesota Rural Health Research Center Mission

We conduct policy-relevant research

to **improve** the **lives** of rural residents and families,

to **advance** health **equity**, and

to **enhance** the **vitality** of rural communities.

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The Story of This Project…

- 18 million reproductive-age women live in rural US communities
- Half a million babies born in rural hospitals each year
- Declining access to obstetric services at rural hospitals
- And a group of women in rural Alabama asked their member of Congress if what they were seeing in their communities was unique or part of a broader pattern.

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But First, Why Do Rural Hospitals Close?

- Financial constraints
  - Fixed costs are constant, and revenue is variable and depends on volume
  - Payer mix and the role of Medicaid
- Workforce constraints
  - Yes, it's physician shortages, but also nursing and administration
- Patient safety concerns
  - When the clinical team is worried about the ability to provide safe care. (Remember rural folks are sicker.)
- Rural Hospital Closure Tracking http://bit.ly/ruralclosures
- Consequences may be mixed and are not well-documented

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Rural Obstetric Unit and Hospital Closures

- From 2004-2014, how many rural communities lost hospital-based obstetric services?

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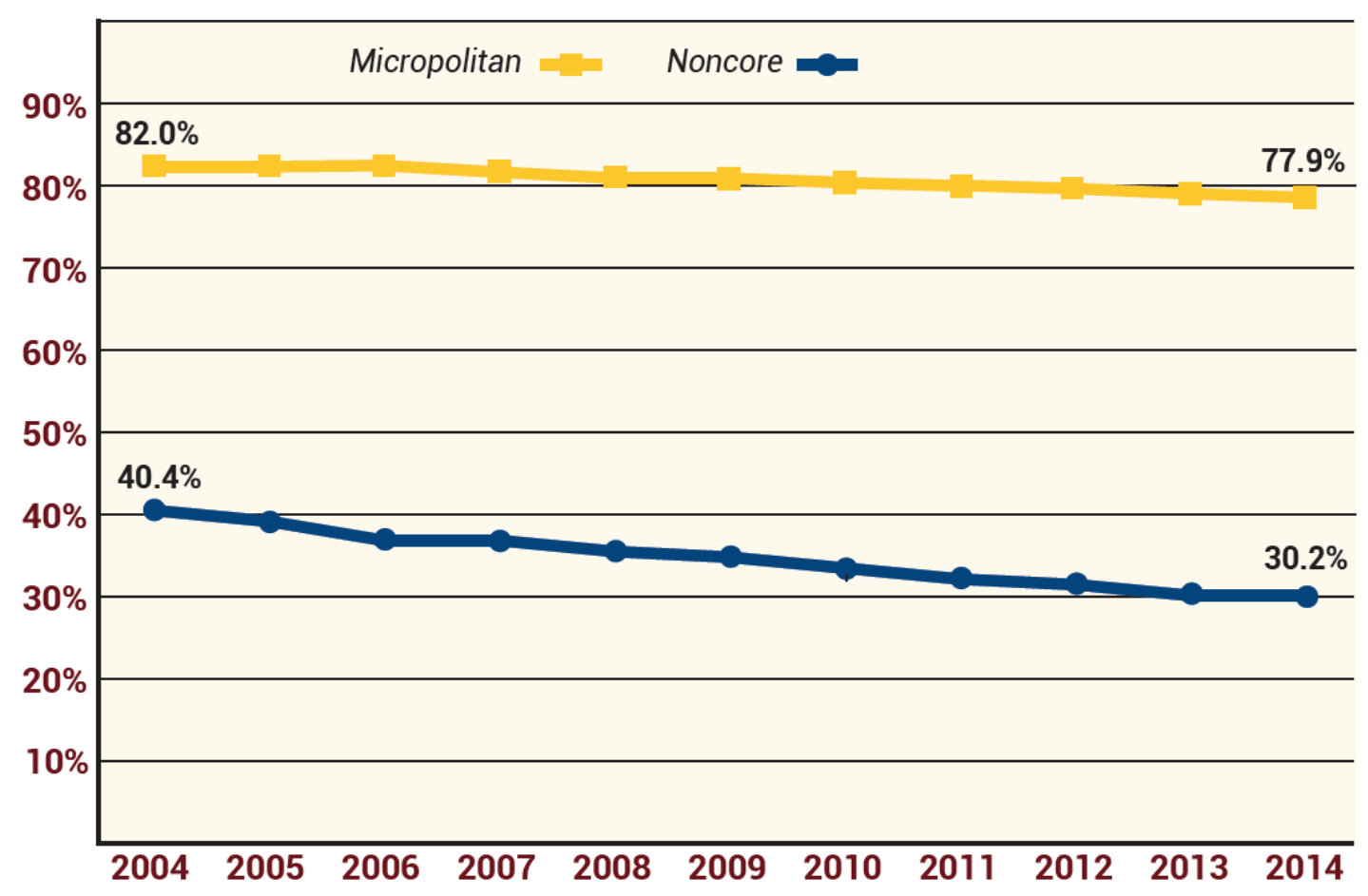
Percent of Rural Counties with Hospital OB Services, 2004-2014



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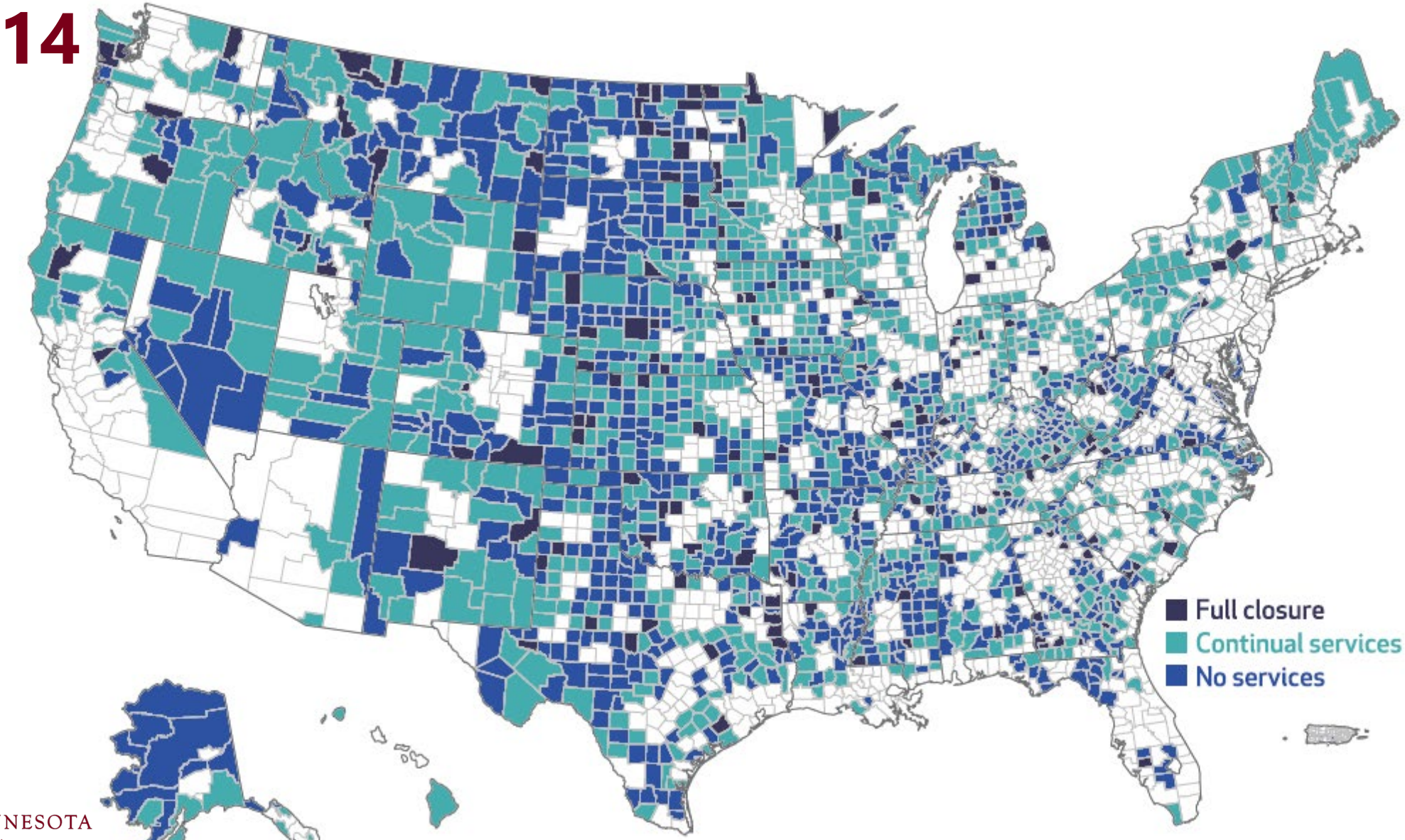
Hospital Obstetric Services in Rural Counties, 2004 - 2014



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Hung, P., Henning-Smith, C., Casey, M., & Kozhimannil, K. (2017). Access to obstetrics services in rural counties declining, with 9 percent losing services, 2004-2014. *Health Affairs, 36*(9), 1663-1671.

Key Findings on Closures

- More than half of rural counties have no hospital-based obstetrics services
  - 9% of rural counties lost OB services between 2004-2014
  - Most vulnerable communities: low-income, physician shortage areas, remote, black, less generous Medicaid programs
- The women in rural Alabama were exactly right – their communities were more deeply affected.

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What Are the Consequences of OB Unit Closures?

- For rural counties that lost hospital-based obstetric services between 2004-2014, what were the associated changes in birth location and birth outcomes?

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Key Findings on Changes in Birth Location and Outcomes

- After losing obstetric services, rural counties that are not adjacent to urban areas had higher rates of preterm birth, out-of-hospital birth, and births in hospitals without obstetric units.
- In rural counties next to urban areas, there was also an increase in births in hospitals without obstetric units, although this declined as time went on.

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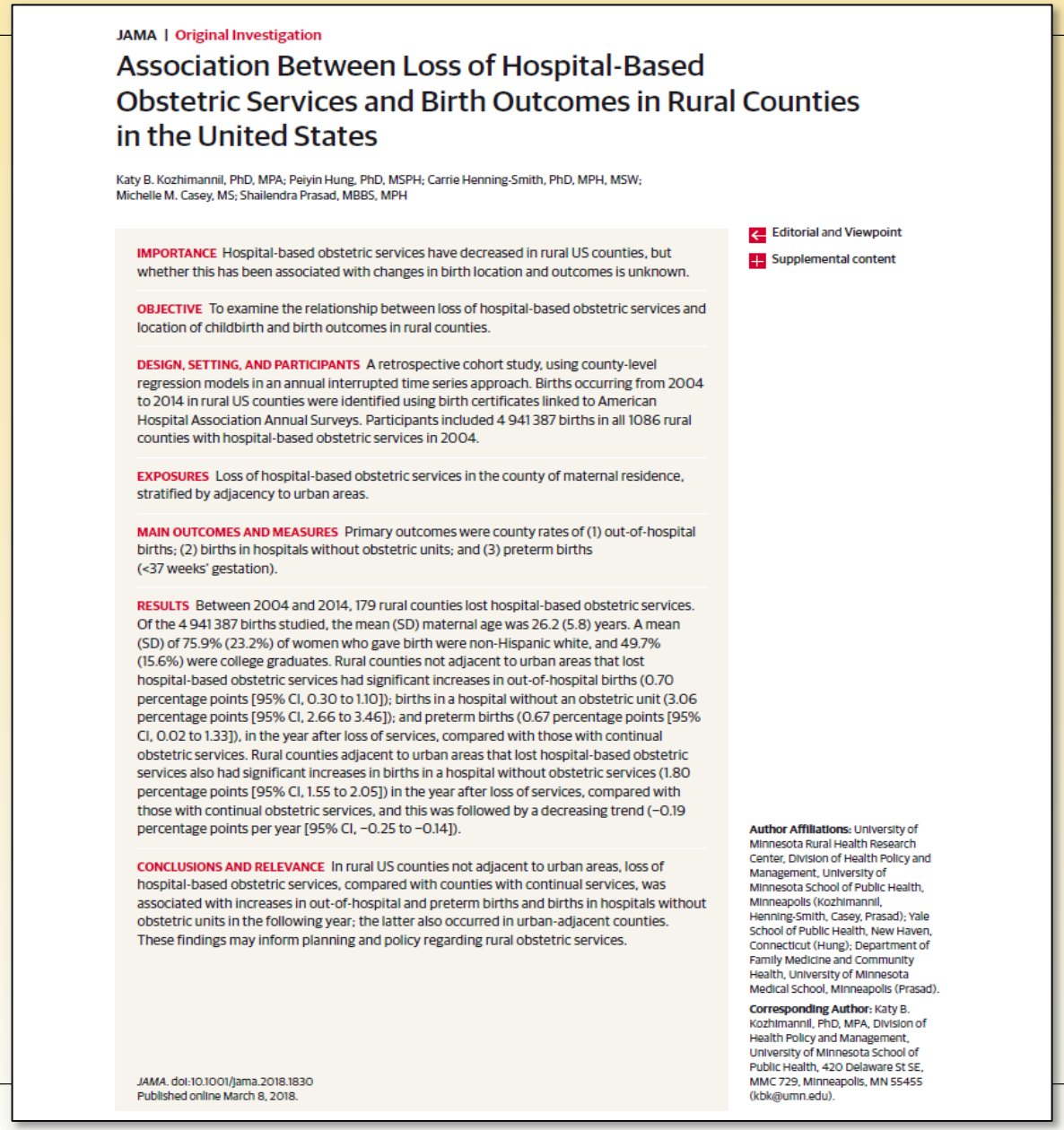

JAMA | Original Investigation

Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States

Katy B. Kozhimannil, PhD, MPA; Peiyin Hung, PhD, MSPH; Carrie Henning-Smith, PhD, MPH, MSW; Michelle M. Casey, MS; Shailendra Prasad, MBBS, MPH

IMPORTANCE Hospital-based obstetric services have decreased in rural US counties, but whether this has been associated with changes in birth location and outcomes is unknown.

OBJECTIVE To examine the relationship between loss of hospital-based obstetric services and location of childbirth and birth outcomes in rural counties.

DESIGN, SETTING, AND PARTICIPANTS A retrospective cohort study, using county-level regression models in an annual interrupted time series approach. Births occurring from 2004 to 2014 in rural US counties were identified using birth certificates linked to American Hospital Association Annual Surveys. Participants included 4 941 387 births in all 1086 rural counties with hospital-based obstetric services in 2004.

EXPOSURES Loss of hospital-based obstetric services in the county of maternal residence, stratified by adjacency to urban areas.

MAIN OUTCOMES AND MEASURES Primary outcomes were county rates of (1) out-of-hospital births; (2) births in hospitals without obstetric units; and (3) preterm births (<37 weeks' gestation).

RESULTS Between 2004 and 2014, 179 rural counties lost hospital-based obstetric services. Of the 4 941 387 births studied, the mean (SD) maternal age was 26.2 (5.8) years. A mean (SD) of 75.9% (23.2%) of women who gave birth were non-Hispanic white, and 49.7% (15.6%) were college graduates. Rural counties not adjacent to urban areas that lost hospital-based obstetric services had significant increases in out-of-hospital births (0.70 percentage points [95% CI, 0.30 to 1.10]); births in a hospital without an obstetric unit (3.06 percentage points [95% CI, 2.66 to 3.46]); and preterm births (0.67 percentage points [95% CI, 0.02 to 1.33]), in the year after loss of services, compared with those with continual obstetric services. Rural counties adjacent to urban areas that lost hospital-based obstetric services also had significant increases in births in a hospital without obstetric services (1.80 percentage points [95% CI, 1.55 to 2.05]) in the year after loss of services, compared with those with continual obstetric services, and this was followed by a decreasing trend (−0.19 percentage points per year [95% CI, −0.25 to −0.14]).

CONCLUSIONS AND RELEVANCE In rural US counties not adjacent to urban areas, loss of hospital-based obstetric services, compared with counties with continual services, was associated with increases in out-of-hospital and preterm births and births in hospitals without obstetric units in the following year; the latter also occurred in urban-adjacent counties. These findings may inform planning and policy regarding rural obstetric services.

Editorial and Viewpoint

Supplemental content

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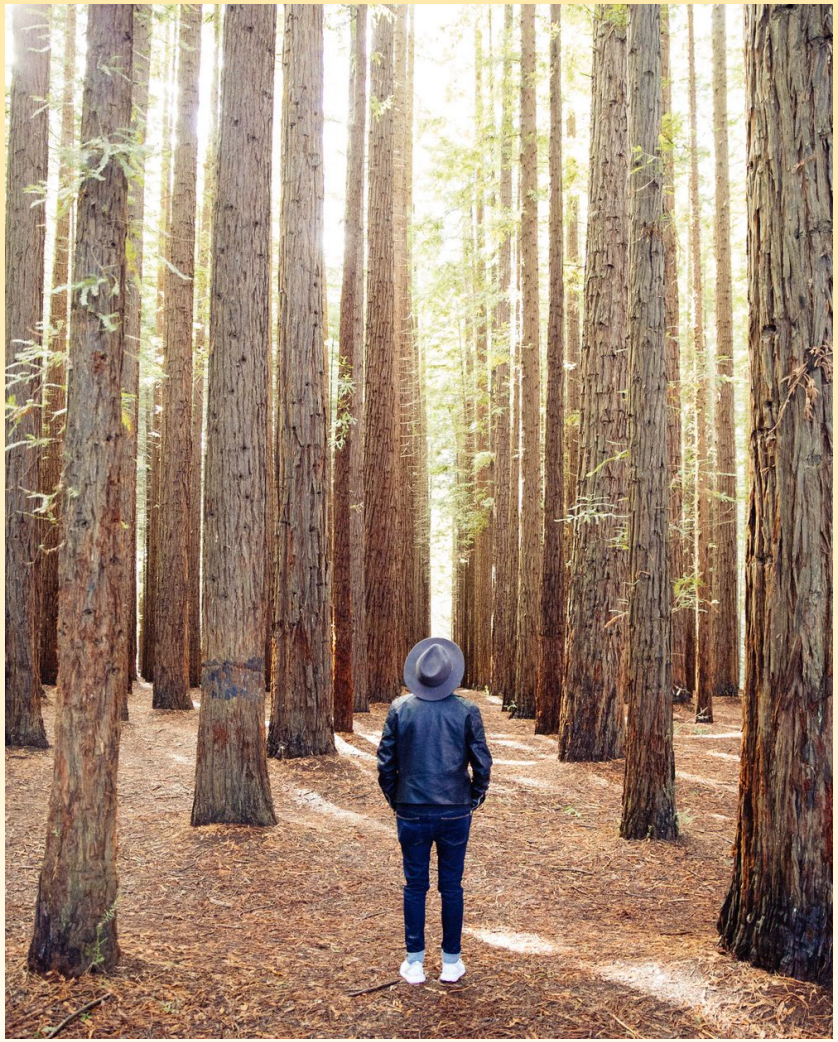
US Senate Briefing:
Improving Access to Maternity Care Act

- March 8, 2018, International Women's Day
- Sponsored by Sen. Baldwin, with ACOG, ACNM, Every Mother Counts
- Signed into law Dec 2018



Healthy communities require public health professionals that are humble, responsive, and deeply empathetic to their needs and experiences and honoring of the knowledge they possess.

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Thank you so much

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