RI DIABETES HEALTH EQUITY CHALLENGE

Supporting the community during the COVID-19 pandemic – WAVE 2

WHAT IS SOMETHING IN 2021 THAT HAS BROUGHT YOU JOY?

RHODE ISLAND DEPARTMENT OF HEALTH

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

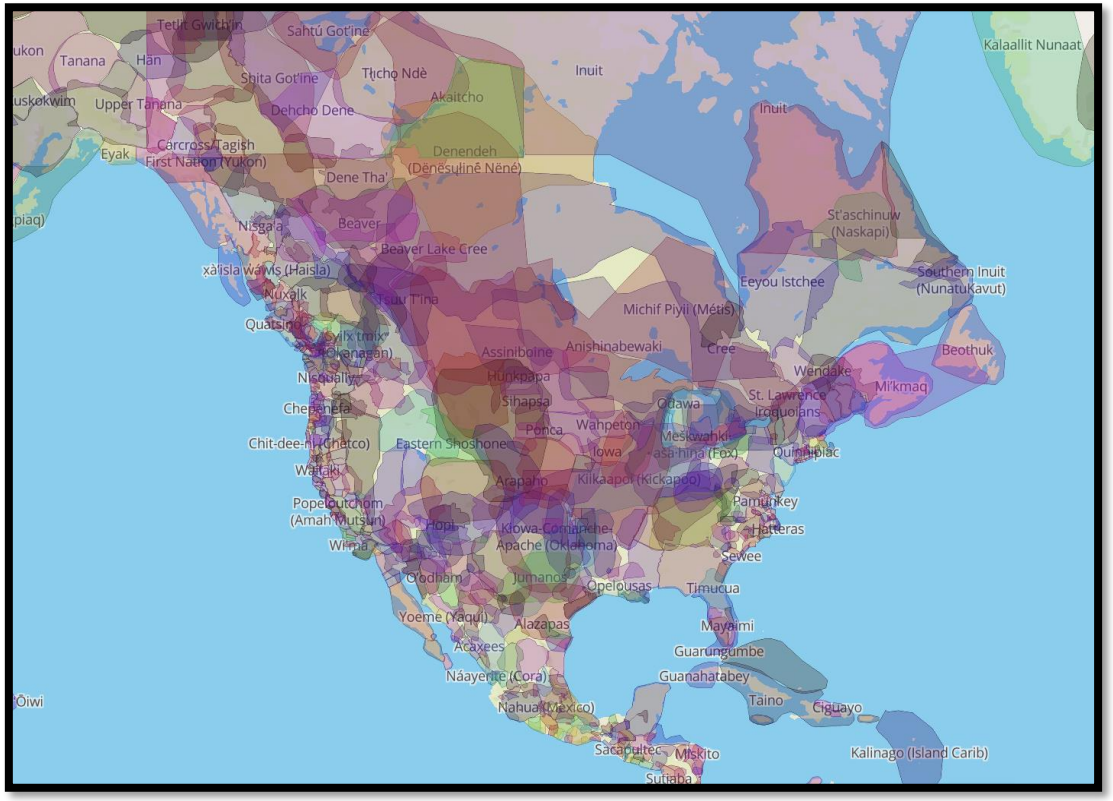
100 Million Healthier Lives

WE IN THE WORLD

LAND ACKNOWLEDGEMENT

Together, we acknowledge indigenous peoples, on whose ancient and sacred land we live, work, and play. As a community, we recognize the ever-present systemic inequities that stem directly from past wrongdoings, and we commit ourselves indefinitely to respecting and reconciling this long history of injustice.

https://native-land.ca/



AGENDA

1. Welcome / Review of Wave 2
2. EBCAP update progress
    1. Compass improvement plan
    2. Project updates
3. Stratify Risk to ensure Population Equity
4. What's your Risk Stratification Plan?

RI DIABETES HEALTH EQUITY CHALLENGE WAVE 2

Wave 1
- March-Sept 2020

Wave 2
- Dec-June 2021

Rhode to Equity
- June 2021

A SPIRAL OF TRANSFORMATION

- Apply the concepts we learned in Wave 1 with greater depth and at scale

PHOTO BY JULIANA MALTA ON UNSPLASH

OUR WORK TOGETHER RI DIABETES HEALTH EQUITY CHALLENGE WAVE 2

KEY MILESTONES

Milestone document

- Dates of meetings
- Due Dates for deliverables (in Participative agreement)
- Change package will be updated to reflect this

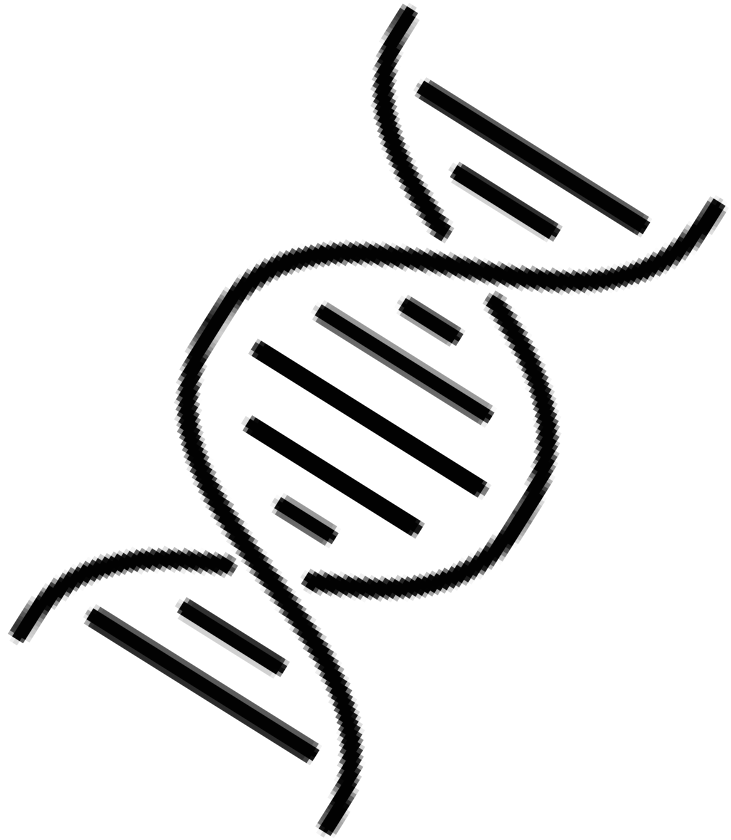
Rhode Island Diabetes Health Equity Challenge
Wave 2 Milestones

Deliverable	Purpose	Timeframe / Due Dates	Notes / Roles
Complete/submit the Participative Agreement	To confirm engagement and commitment to Wave 2	December 10, 2020	Signed Agreements from Wave 2 Teams due back to CTC: December 10, 2020
Teams notified of acceptance into Wave 2	To prepare teams for participation in Wave 2	December 10, 2020	Teams notified of their acceptance and level of participation by CTC-RI
Attend Wave 2 Kick off meeting • All team members	• Orientation to Wave 2 • Learn how to apply P2PH to improve your services during COVID-19 and beyond (Compass/balanced portfolio)	December 11, 2020	1.5 hours Prep: • Individual team members review previous P2PH Compass scores, consider gaps, bring ideas of what could be action areas • Consider what a deepened strategy could look like for a balanced portfolio During:

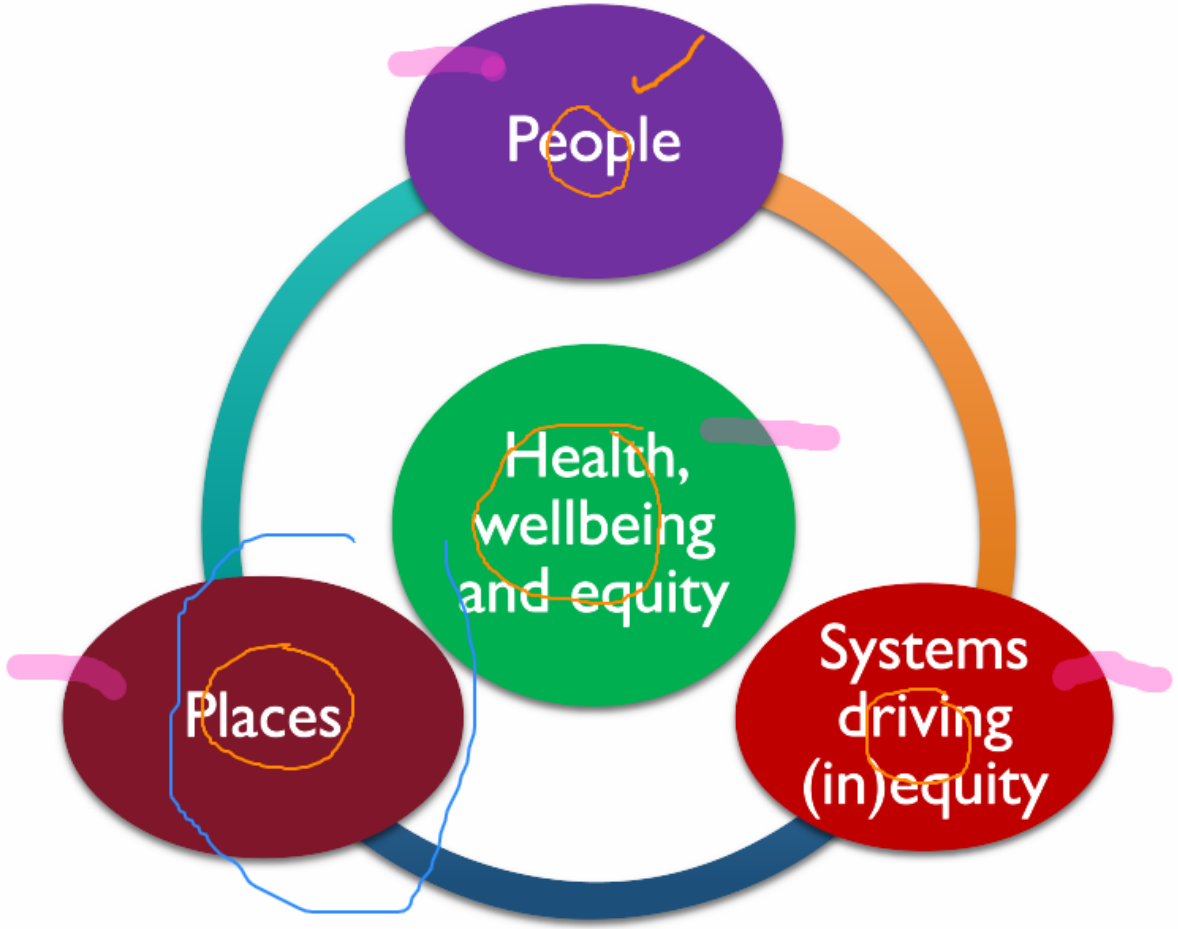
EXPECTATIONS FOR WAVE 2

Double helix approach

- Population health equity: Improving the health and well-being of people and places that aren't thriving
- Long-term system change (inside your policies, relationships and processes and those in the community)



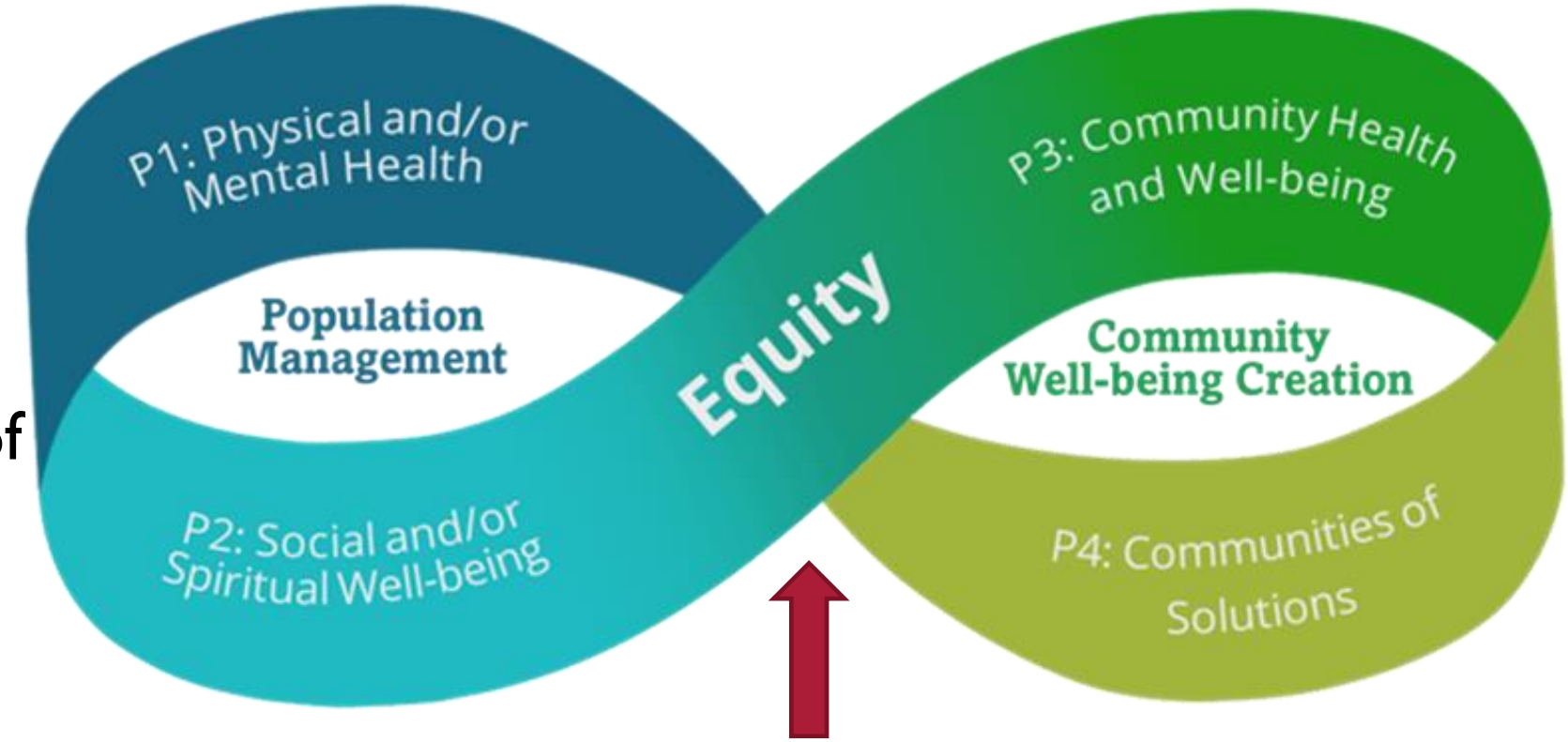
PEOPLE, PLACES, SYSTEMS OF SOCIETY



FOUR PORTFOLIOS OF POPULATION HEALTH ACTION

PATHWAYS TO POPULATION HEALTH

Improving the health and wellbeing of **people**



Improving the health and wellbeing of **places**

Improving the systems that drive (in)equity

Source: Pathways to Population Health, 2018

pathways2pophealth.org

Produce to People
January 2021

EAST PROVIDENCE
HEZ
HEALTH EQUITY ZONE

Community Health Team

Overview

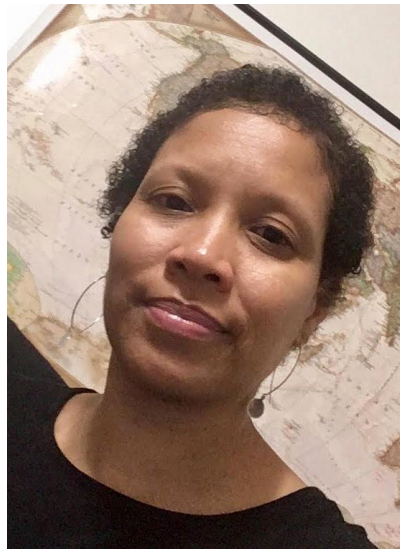
- Our Vision
- Our Team
- Short Term Goals
- Long Term Goals
- Compass Tool
- Questions

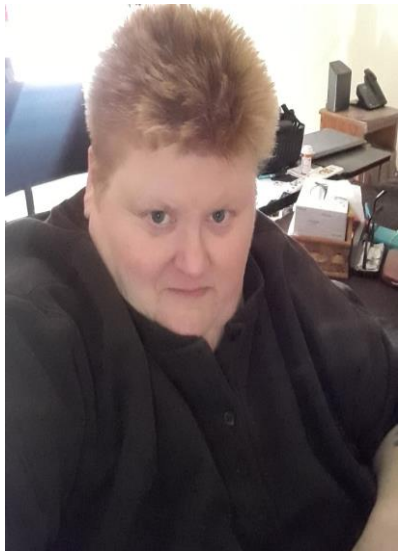
Produce to People

Greens, beans, and healthy in-betweens!

Our Team:

- Albert Whitaker - HEZ
- Carla Whanon - CHT
- Caroline Burns – NCM, RN
- Jamie Douglas - PLE
- Maddy Maher – NCM, RN





Our Vision

By January 31st, 2021, twenty community members managing diabetes who utilize the EBCAP food pantry will have increased access to fresh fruits and vegetables as a first step toward a healthier diet and a sustainable community solution.

Short Term Goals

- Complete training in Eagle Dream risk stratification system by 1/31/2021
  - Caroline, Maddy, Carla
- Share Eagle Dream with the team and review for larger use throughout agency
- Speak with Angie regarding SNAP policy changes regarding maintaining increased COVID-related benefits and expanding online capacity for SNAP benefit use
  - Albert
- Draft one-sheet summarizing program and it's needs
  - Caroline and Carla
- Transportation coordination with East Providence Senior Center
  - Albert and Angie
- Finalize list of community partners and participant waiting list
  - Caroline

One Sheet


PRODUCE TO PEOPLE
We need your help. Produce to People is a grassroots organization based in East Providence, Rhode Island aiming to build sustainable avenues to distribute fresh foods to people living with diabetes and other chronic health conditions.
Do you want to be a part of our team?
We are looking for a student / volunteer who would:
Complete pre and post surveys via telephone
Organize pick-ups and deliveries of food
Distribute participant incentives
?
If interested, please contact...

Community Partners

McCoy Farm	•Lisa Culton: 401-680-0281, will add Produce to People to the list of receiving orgs, will contact us in spring 2021
RI Food Bank	•Erica Hanson: ehanson@rifoodbank.org, has “an abundance” of produce available
Farm Fresh RI	•Sherri Griffin: 401-480-0102, beginning new project to donate fresh produce, can include Produce to People
Barrington Community Garden	•Cyndee Fuller: 401-323-9571, can donate if team can help pick/transport foods
Hope’s Harvest	•Al has a contact, meeting being scheduled
Fox Point Community Garden	•No response yet
Ample Harvest	•Not yet contacted

AmpleHarvest.org

FARM FRESH RI

HOPE'S HARVEST RI

RHODE ISLAND COMMUNITY FOOD BANK

Participant Waiting List

- Current waitlist of qualifying patients: 19
- Eagle Dream risk stratification tool
- Referrals from CDOE staff, Behavioral Health, Nurse Care Managers, Food Pantry staff, etc.
- Expansion agency wide once programming is operational

Long Term Goals

- Equity Goal: Internet access
- Increase delivery per month
- Add meal guides and customize produce bags
- Nutritionist access for enrollees (facilitated discussions)
- Program staffing
- PLE Advisory Group
- Expansion to General Population
- EBCAP community garden

Compass Tool

The Team thinks we have improved on equity within our organization and would like to focus on building even greater equity within it.

Equity

As you consider your organization's efforts to improve **equity**, please select the description that best represents the attitudes, behaviors, or actions currently underway.

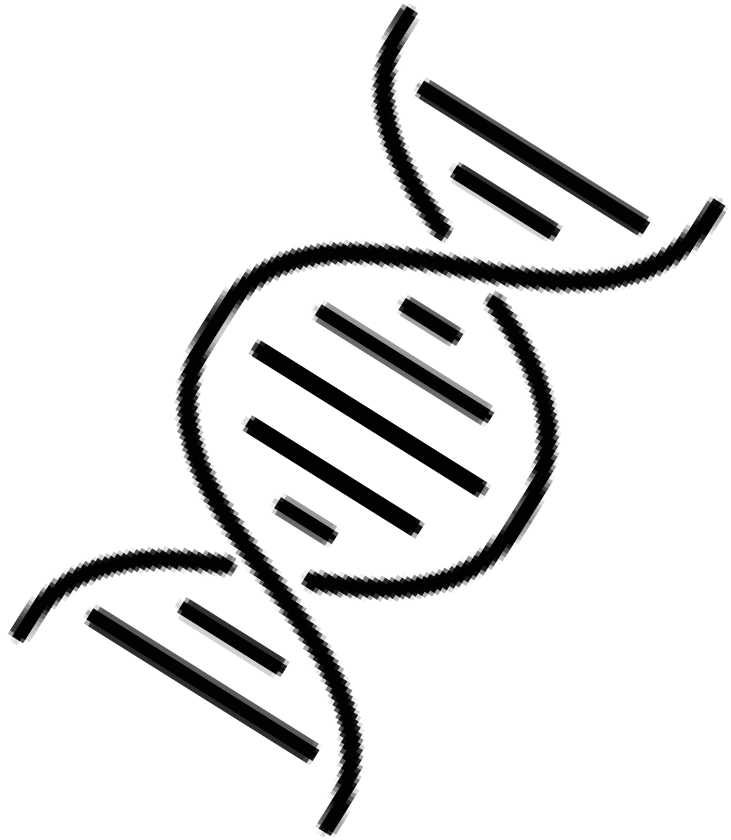
We do not discuss health equity in our organization.	We've had some discussions or educational sessions related to health equity but have not taken any action to address equity issues.	We routinely collect data on race, ethnicity, language, and SES and have active improvement efforts underway to address health equity gaps.	We stratify community data based on key sociodemographic factors and work with community partners to close equity gaps.	We work with community partners to implement, evaluate, and improve programs and policies to address the root causes of inequities.
At the beginning 0	**Making initial progress 1**	**Making moderate progress 2**	**Making substantial progress 3**	**Implementing broadly 4**

Questions?

EXPECTATIONS FOR WAVE 2

Double helix approach

- Population health equity: Improving the health and well-being of people and places that aren't thriving
- **Long-term system change**



DOUBLE HELIX APPROACH

System Transformation:

P2PH Compass

- Review compass scores
- Choose priority improvement areas
- Plan for the next 6 months

Population health equity:

- Stratify your population to address needs of people / places with an equity lens
- *Clinic/CHT*: develop and implement a plan to understand and meet the needs of people who are highest and rising risk in partnership
- *Community/HEZ*: develop a plan to address the underlying conditions of people and places at highest risk together with people with lived experience of inequities
- Joint equity plan to address groundwater issues

P2PH COMPASS

- **Stewardship**
- **Equity**
- **Payment**
- **Partnerships with People with Lived Experience**
- **Portfolio 1:** Physical and/or Mental Health (Data, Team-Based Care, Behavioral Health Integration, Care Management)
- **Portfolio 2:** Social and/or Spiritual Well-Being (Data, Social Determinant Screening/Referrals)
- **Portfolio 3:** Community Health and Well-Being (Data, Community Partnerships, Community Benefit)
- **Portfolio 4:** Communities of Solutions (Data, Leveraging Nontraditional Roles, Policy)

USING YOUR COMPASS SCORE TO DESIGN SYSTEM CHANGE

1. Look at where there is variation in your scores. Engage in a dialogue about why that might be.

2. Identify areas of strength and opportunities for improvement.

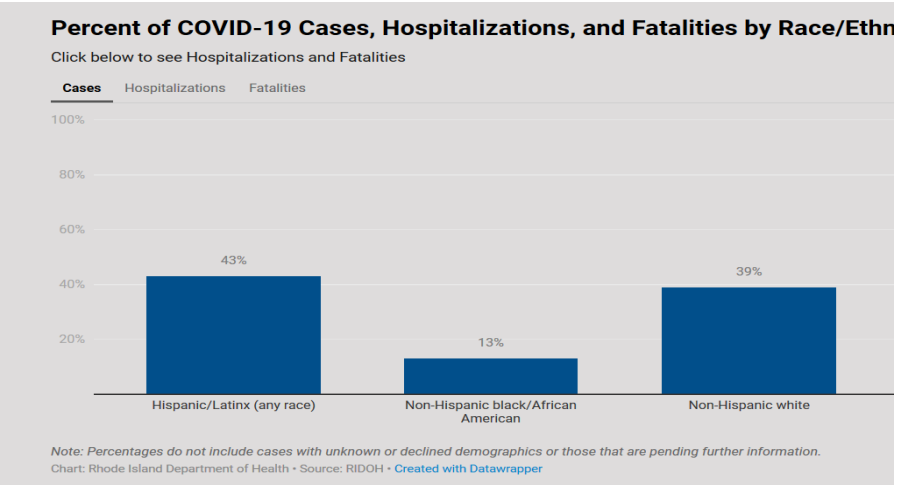
3. Develop an aim and a specific workplan for where you might want to be by the end of this initiative.

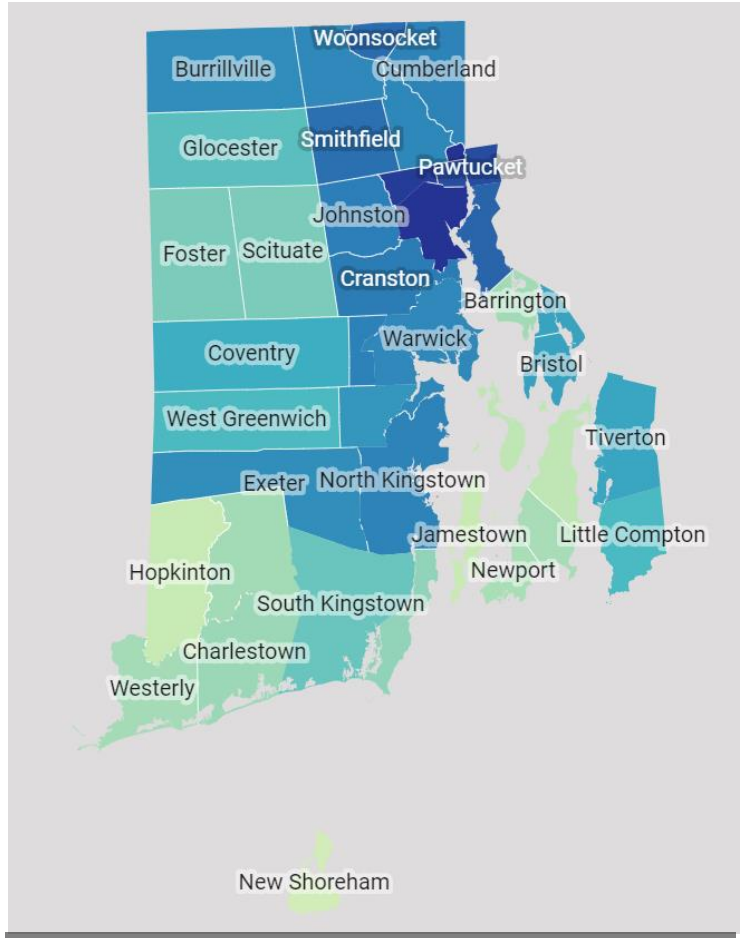
STRATIFYING YOUR POPULATION BY RISK FACTORS

HOW CAN WE IMPROVE POPULATION HEALTH WITH AN EQUITY LENS?

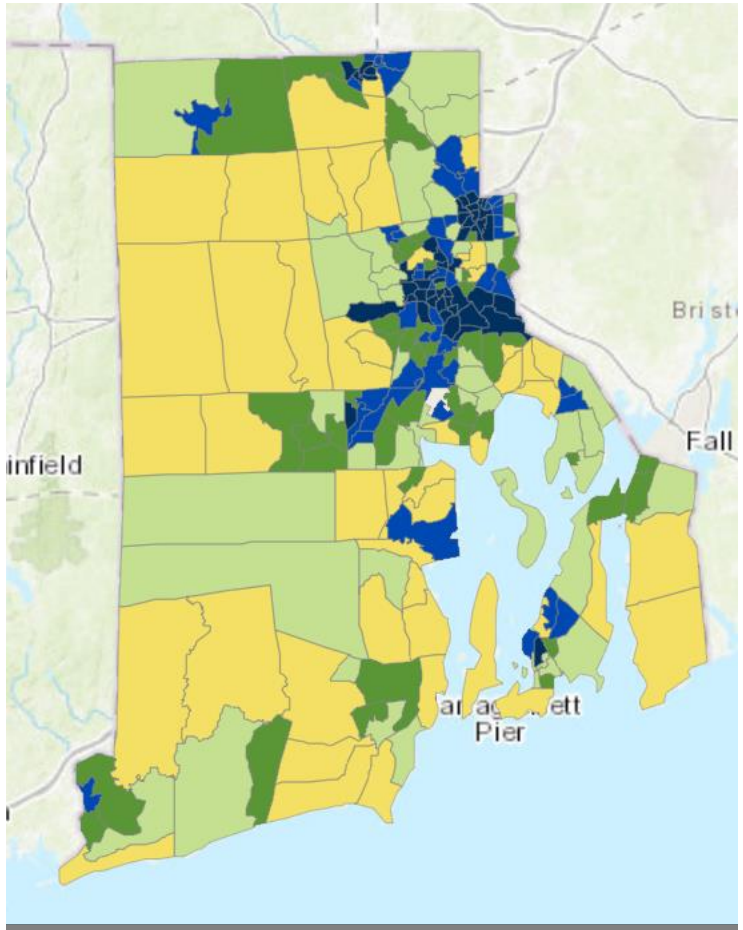
1. Understand the population through data, story and partnership (learn from the person, plan for the population)
2. Stratify the population – who is at highest risk of not thriving?
   - People, Places, Systems driving inequities
3. Develop and implement a strategic plan for equity that includes a balanced portfolio of upstream, midstream, downstream, and groundwater clinical and community actions
   - Care for the whole person – scaled to all the people who are at risk of not thriving
   - Work to address the underlying conditions in the community that would solve the problem for everyone
4. Apply a current day and historic equity lens to acknowledge and address root causes.

COVID-19 AND SOCIAL VULNERABILITY: RACE, PLACE, HEALTH, WEALTH, AND BELONGING





COVID-19 CASES



SOCIAL VULNERABILITY

OPTION 1 - WELL-BEING OF PEOPLE

MEDICAL RISK

- High risk (3 points)
  - A1C > 9 OR
  - Hospitalized in last 6 months
- Medium risk (2 points)
  - A1C >7 and not hospitalized
- Low risk (1 point)
  - A1C < 7

WELL-BEING (social risk)

- High (3 points)
  - Suffering and hopeless – if they feel life today <= 4 and future <= 4
- Medium (2 points)
  - Struggling - Everyone else
- Low risk (1 point)
  - Thriving – 7 or higher today and hopeful (8 or higher in the future)

EQUITY

- High (3 points)
  - Black/Hispanic/immigrant and poor and/or have less than a high school education (any two factors
- Medium (2 points)
  - Black/Hispanic/immigrant /other at-risk OR poor OR less than a high school education
- Low if anyone else – 1 point

WE IN THE WORLD

Potential risk stratification table – Diabetes and COVID

Physical	Mental health	Economic and social needs	Loneliness and social support	Place-based risk	Underlying structural factors
Poorly controlled diabetes (A1C>8), hospitalized	Active mental health/addictions	Unemployed or financially insecure	Poor caregiver or social support	High levels of environmental pollution	Area of significant child poverty
Other significant medical conditions, active tobacco use	History of mental health and addictions	Poor conditions of work (high levels of exposure to people, low social distancing, no or poor PPE access, underlying health harms)	Loss of recovery/peer supports	Food scarcity or lack of green spaces	Place with history of redlining or current practices of exclusionary zoning
COVID-19+	Not connected to mental healthcare or poor access	Homeless	Caregivers who become COVID+	Lives or works in high COVID prevalence area	History of community trauma
No health insurance	Low levels of hope that things will get better	Housing insecure or lives in conditions of high housing density (many people in the home)	Older adult in nursing home or other residential facility	Lack of access to affordable housing in the community	Lak of access to health care facilities, pharmacies, etc. in the community
Poor access to healthy food	Low sense of purpose and meaning	Low education level, poor health literacy or language barrier	People in jails or prisons	Poor sense of belonging in a community/ perception of discrimination	Lack of civic infrastructure with significant resident engagement
Poor access to medications, testing supplies, etc.	Unsafe in the home	Lack of access to internet or low digital literacy	Black, Hispanic or immigrant	Low neighborhood safety/high levels of crime	Lack of broadband access

HOW WILL YOU STRATIFY YOUR POPULATION TO ENSURE EQUITY?

THE PATH FORWARD

System Transformation

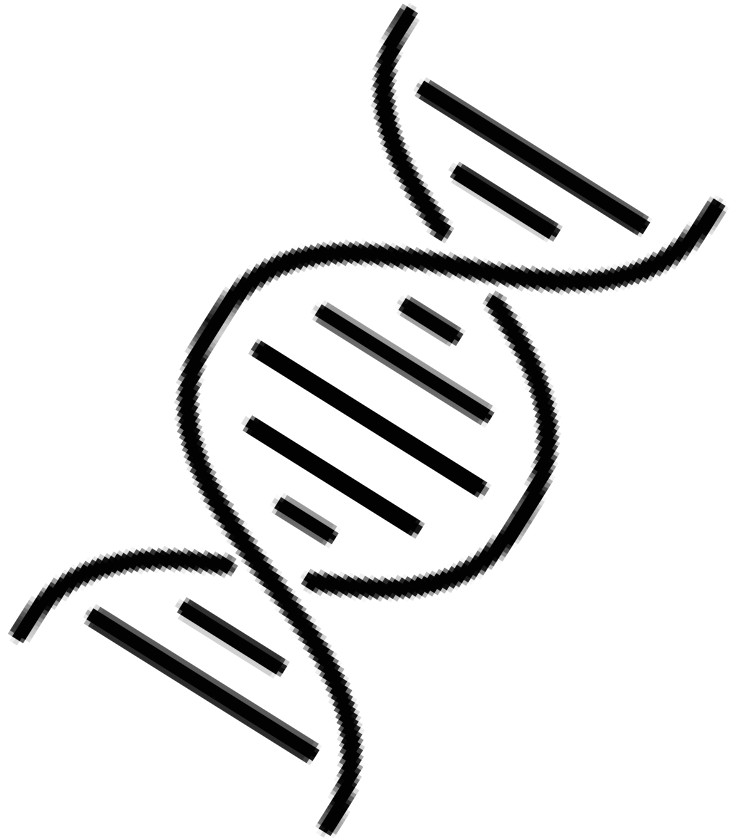
- Compass Improvement Plan

Population Health Equity

- Risk Stratification Plan by 1/31

Additional Support

- Milestone Document
- Coaching session
- Offer of a longer Design workshop



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THANK YOU!

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