RI DIABETES HEALTH EQUITY CHALLENGE

Supporting the community during the COVID-19 pandemic

Welcome! Please chat in your:

- Name & affiliation

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

ANA P. NOVAIS, MA

DEPUTY DIRECTOR, RHODE ISLAND DEPARTMENT OF HEALTH

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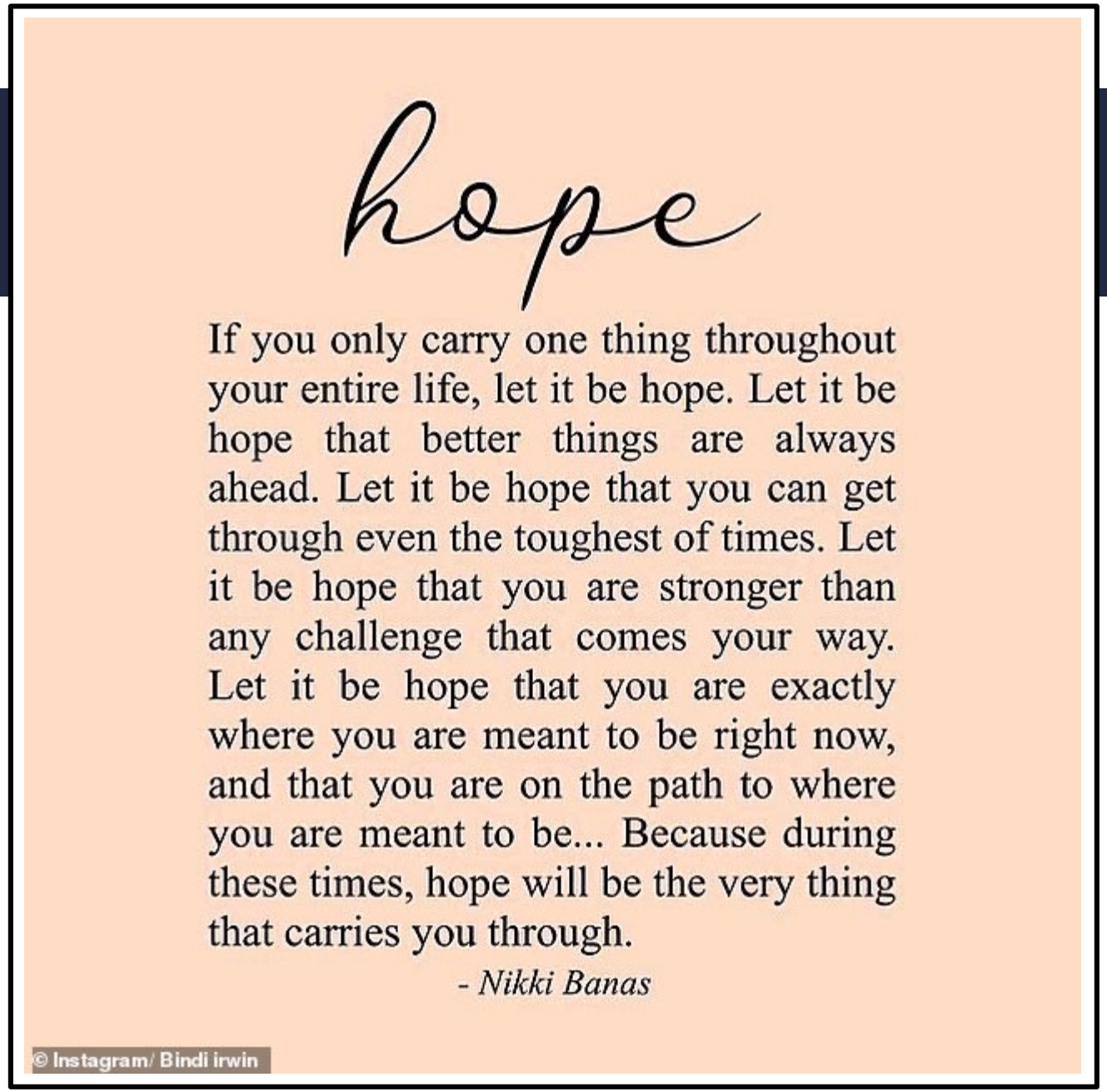
WELCOME

- What word/phrase stands out to you? Why?



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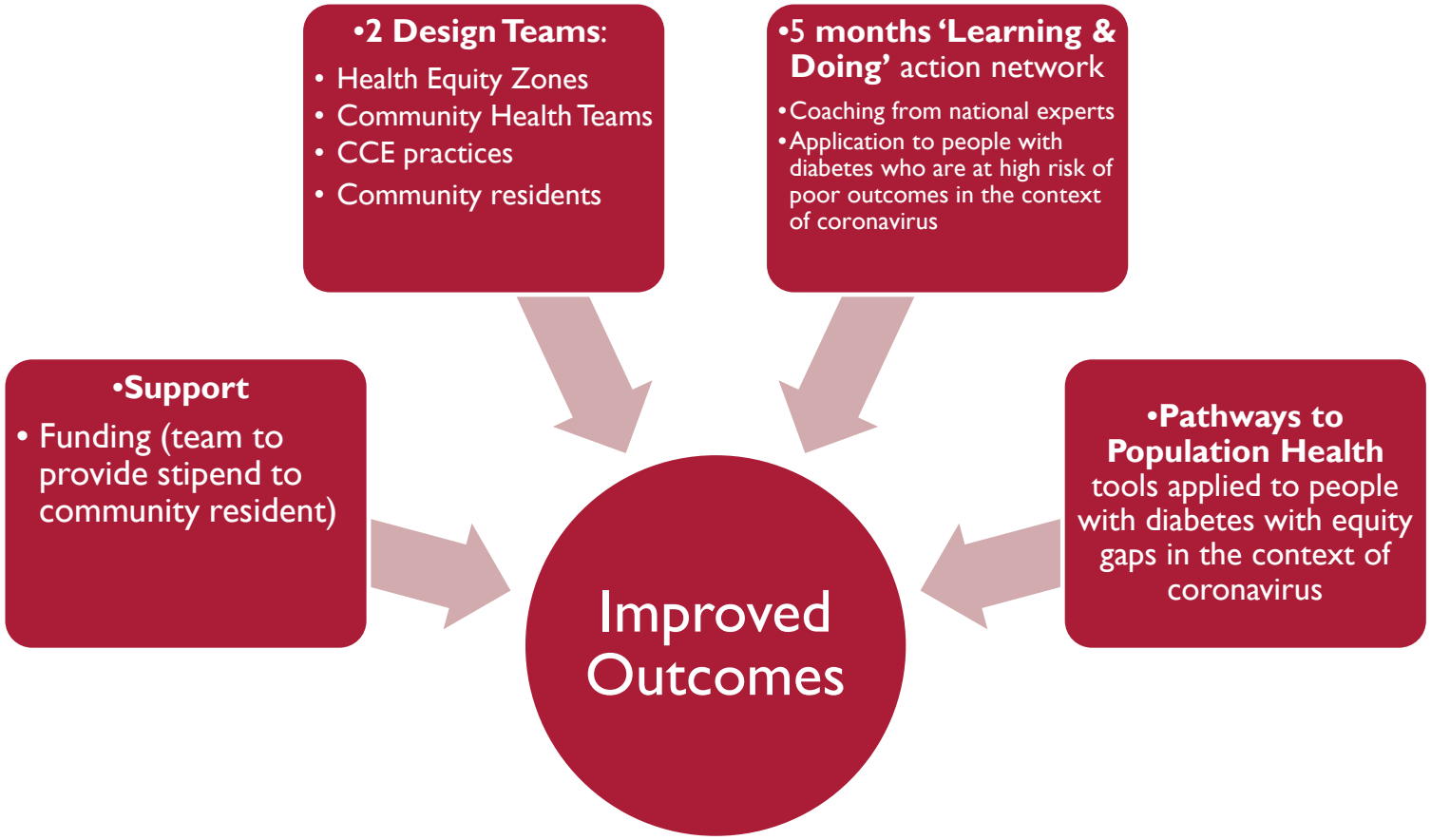

TODAY'S AGENDA

All Participants
11am – 1pm

- Approaching population health with an equity lens
- Activity: Assess the needs of those most affected
- Tools and Resources for the journey

Health Equity Challenge Teams
1 pm – 3pm

- Assess the needs of those most affected
- Asset Mapping/Exploring Partnerships
- Understand the action planning process
- Planning the next steps in the journey

RANDI BELHUMEUR, MS RD LDN CDOE

Special Projects Administrator: Health Equity Institute / Diabetes, Heart Disease, & Stroke Program, Rhode Island Department of Health

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Geographic focus:	Pawtucket/Central Falls
AE:	Integra Community Care Network
CBO:	Progreso Latino
CHT:	Family Service of RI
HEZ:	Pawtucket/Central Falls HEZ: LISC
Practice:	CNEMG Internal Medicine Center
Lived experience:	Glenit Palacios

integra
Belong. Be Well.

PROGRESO Latino

LISC RHODE ISLAND

Pawtucket | Central Falls Health Equity Zone

FSRI Family Service OF RHODE ISLAND
healthy families · strong communities

Care New England

RI DIABETES HEALTH EQUITY CHALLENGE

Supporting the community during the COVID-19 pandemic

Susanne Campbell, RN, MS, PCMH CCE

Pano Yeracaris, MD, MPH

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RI DIABETES HEALTH EQUITY CHALLENGE

Supporting the community during the COVID-19 pandemic

Geographic focus: **East Providence**
Person w/experience: TBA

east bay community action program
50 Years of Service 1965-2015
THE BRIDGE to SELF-RELIANCE

RI DIABETES HEALTH EQUITY CHALLENGE

Supporting the community during the COVID-19 pandemic

Debra Hurwitz, MBA, BSN, RN,
Executive Director

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WELLBEING AND EQUITY (WE) IN THE WORLD TEAM

Marta Kuperwasser
Director of Operations

Seth Fritsch
Project Manager and Coach

Fany Flores-Maldonado
Project Coordinator

Somava Saha
Founder and Executive Lead

WE IN THE WORLD

WE IN THE WORLD FACULTY/ACCOMPANIERS

Yolanda Roary

Kirsten Meisinger

Laura Brennan

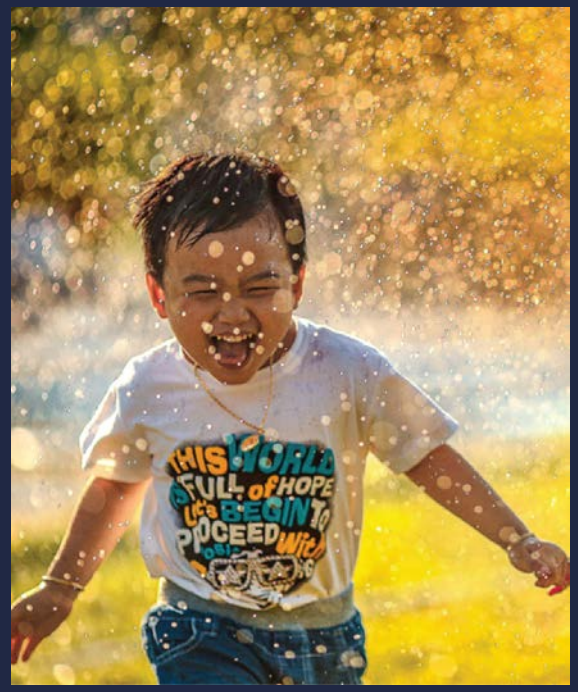
Shemekka Ebony

Somava Saha, MD MS

-Executive Lead, Well Being In the Nation (WIN) Network
-Executive Lead, Well-being and Equity (WE) In The World
-Former Vice President, Institute for Healthcare Improvement and Exec Lead, 100 Million Healthier Lives
-Primary Care Doctor and Public Health Practitioner for >15 years
-Faculty, Harvard Medical School

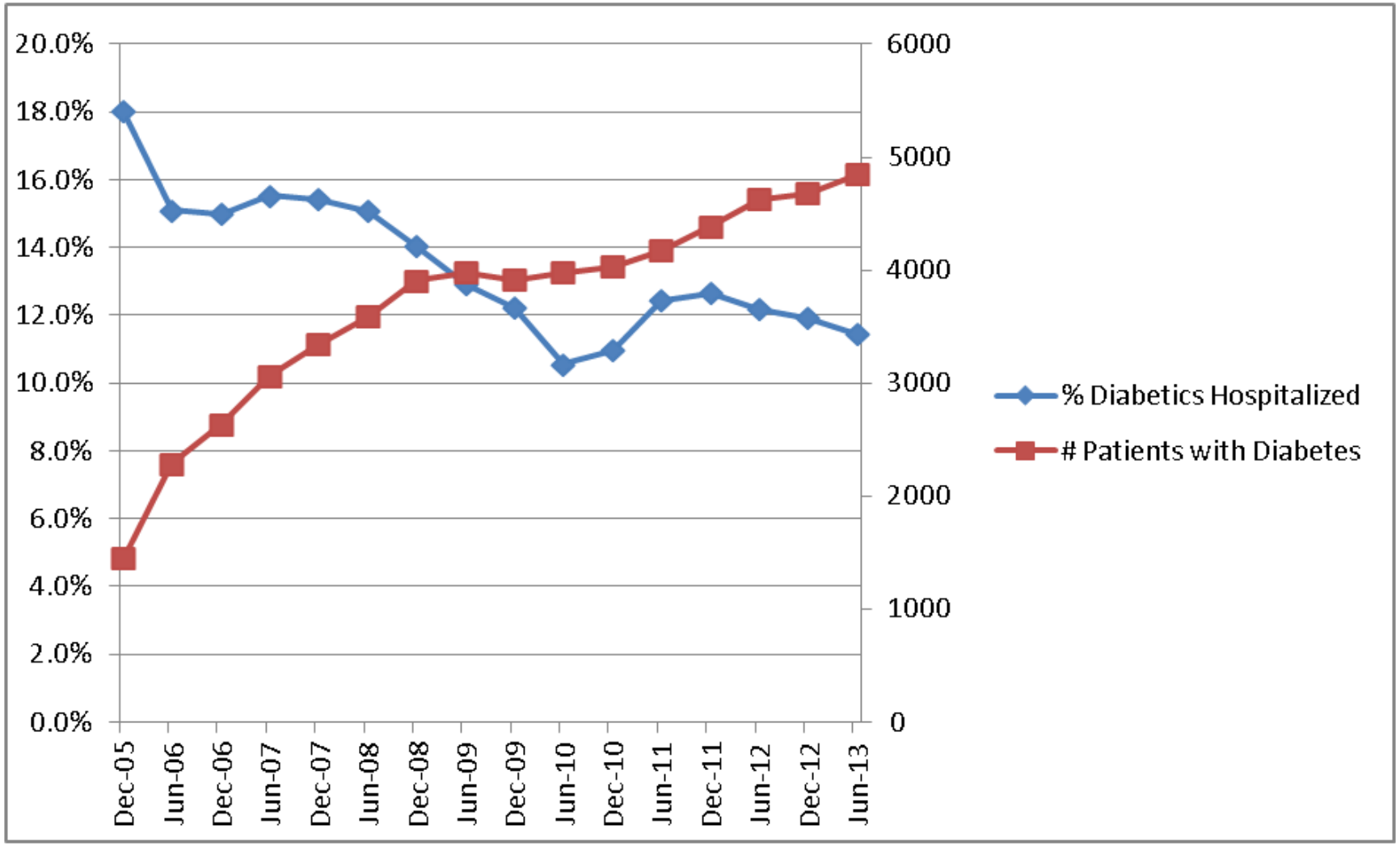
LEANING INTO THIS MOMENT TO CREATE REAL HOPE: PATHWAYS TO POPULATION HEALTH

SOMAVA SAHA, MD MS, FOUNDER AND EXECUTIVE LEAD, WELL-BEING AND EQUITY (WE) IN THE WORLD

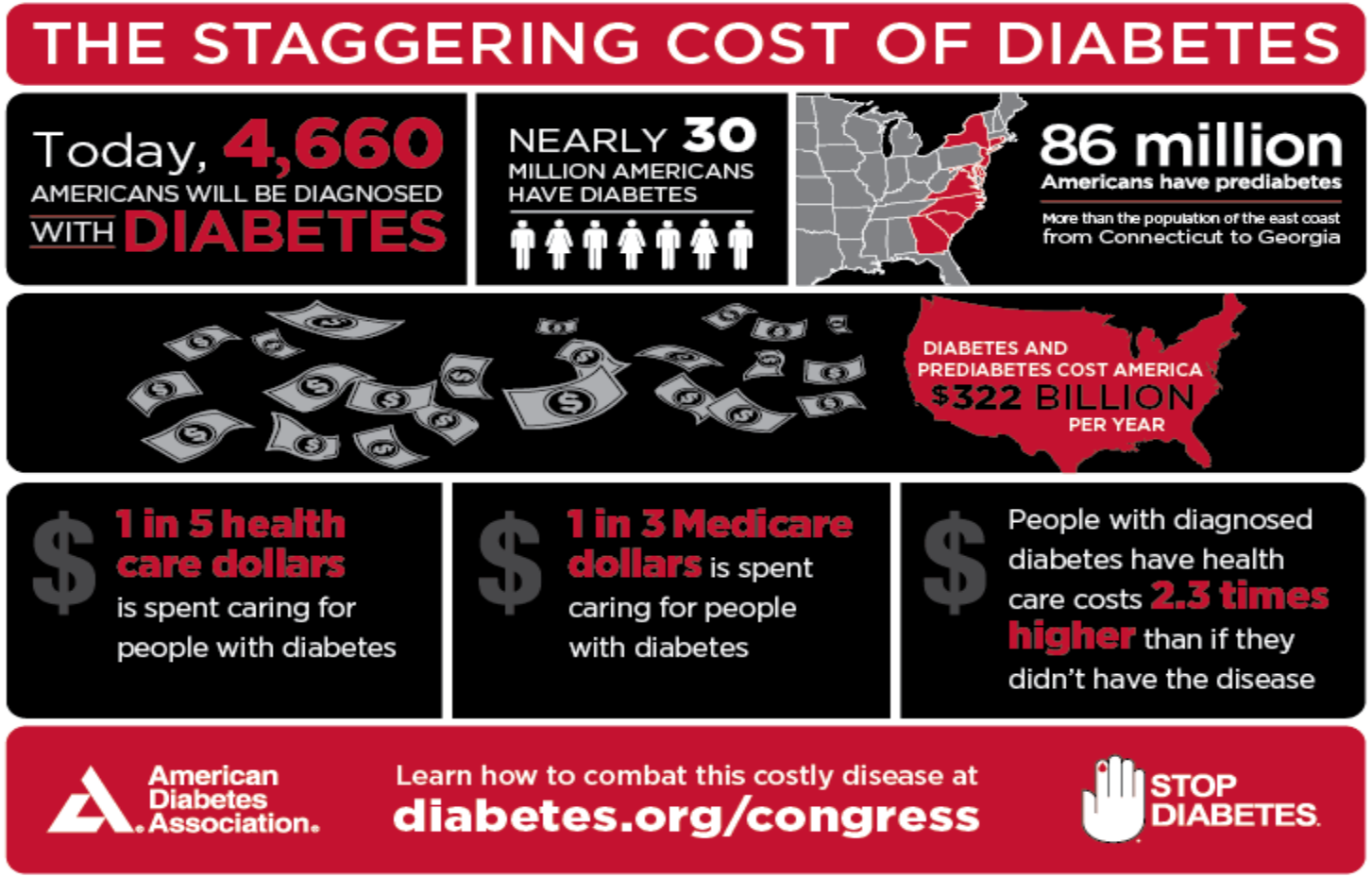


WE IN THE WORLD

WHY WE NEED TO CHANGE OUR FRAME



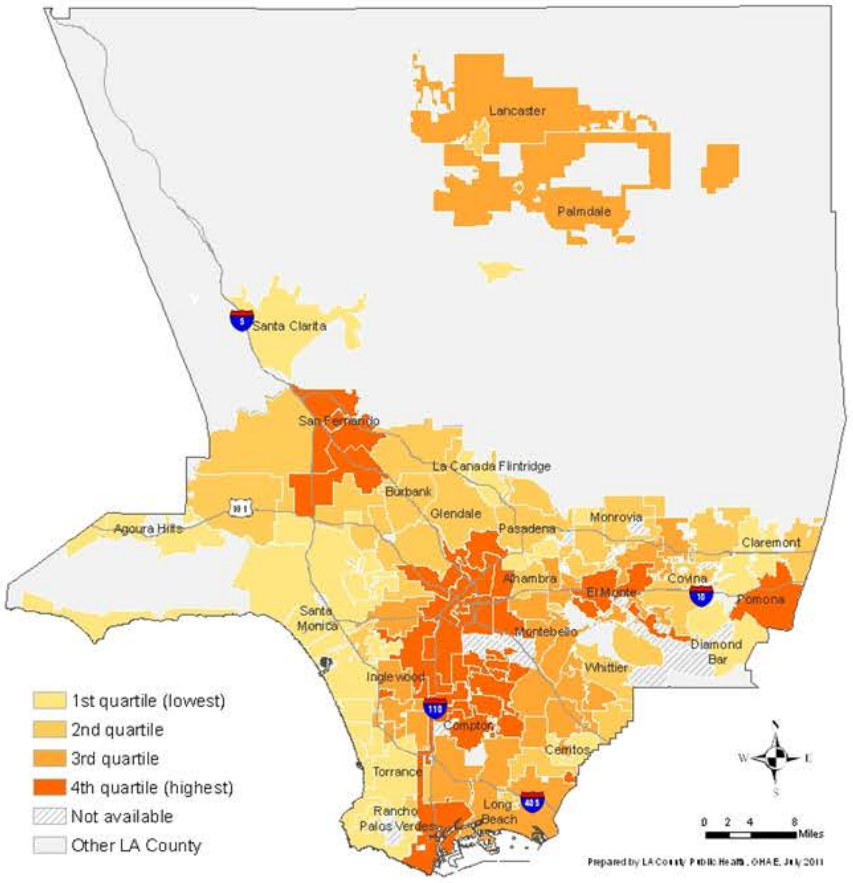
COST OF INEQUITY AND ITS IMPACT ON CHRONIC DISEASE IS UNSUSTAINABLE



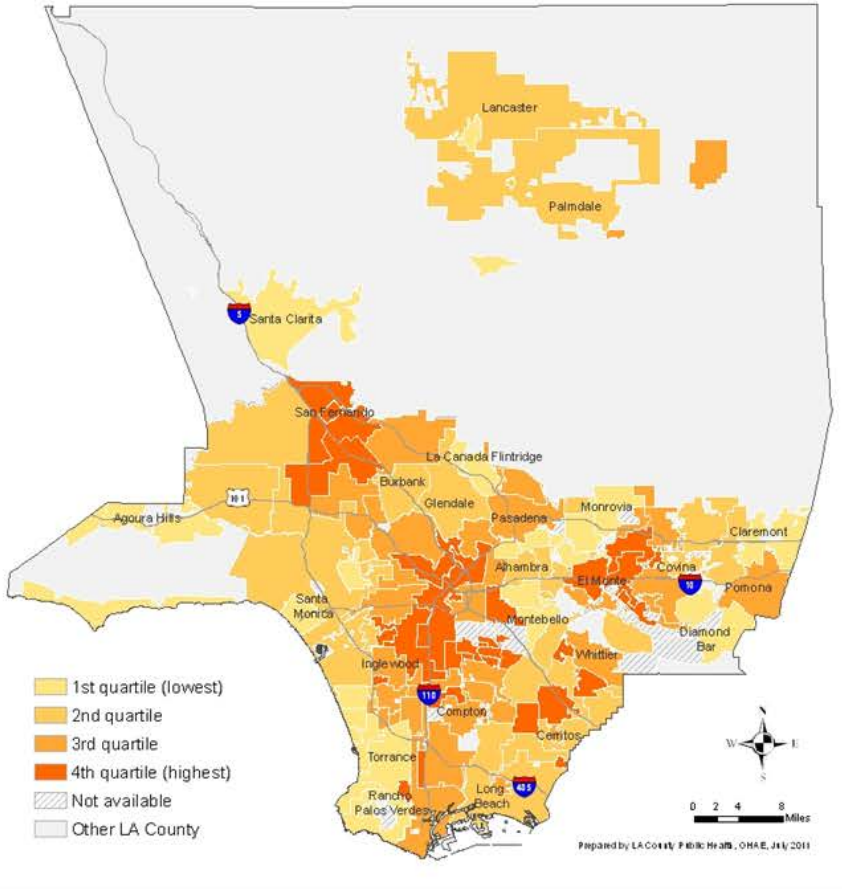
20% by 2020

RELATIONSHIP BETWEEN THE HEALTH AND WELL-BEING OF PEOPLE, PLACES AND EQUITY

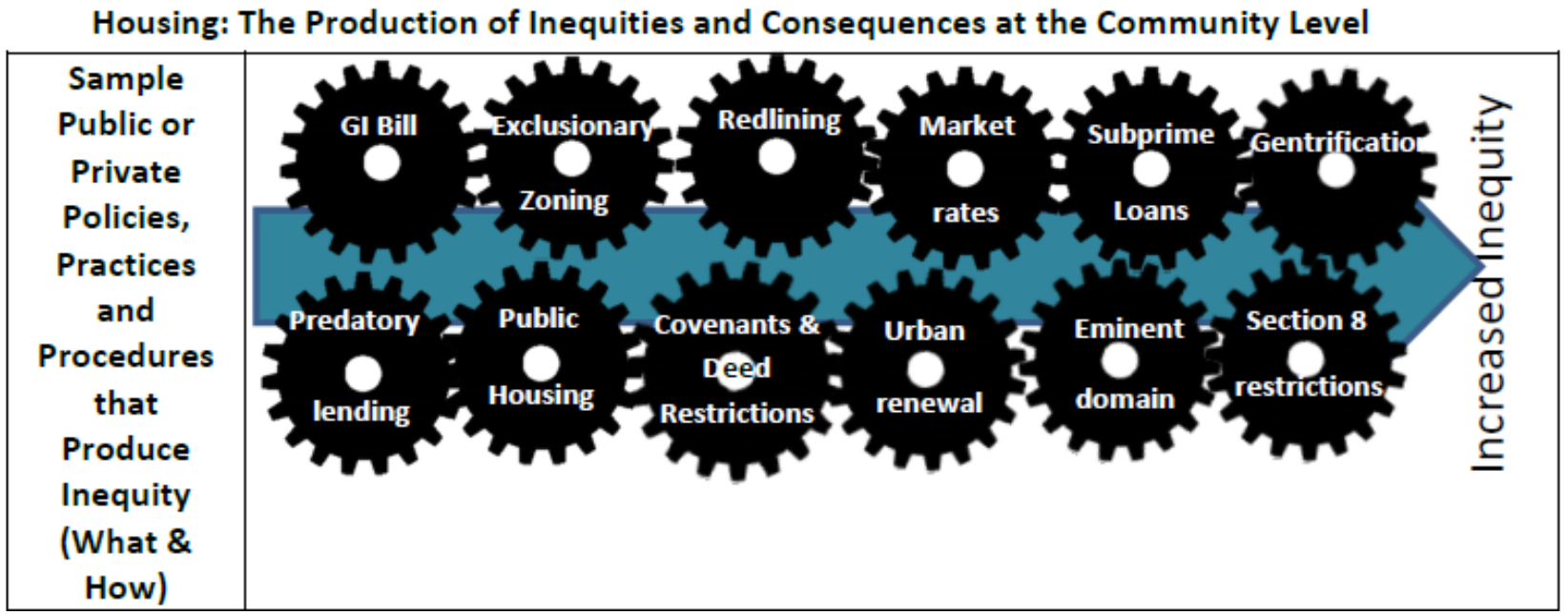
Economic Hardship Index by City/Community, Los Angeles County, 2000



Prevalence of Childhood Obesity by City/Community, Los Angeles County, 2005



CHRONIC PLACE-BASED INEQUITIES ARE NOT ACCIDENTAL – THERE IS A SYSTEM IN PLACE THAT PROPAGATES THEM



"Countering the Production of Health Inequities" Report from the Prevention Institute

A TALE OF TWO BOYS

https://wsvn.com/news/us-world/color-blind-boys-scheme-to-get-same-haircut-to-trick-teacher/

INTERRELATIONSHIP BETWEEN THE HEALTH, WELLBEING AND EQUITY OF PEOPLE, PLACES AND THE SYSTEMS OF SOCIETY

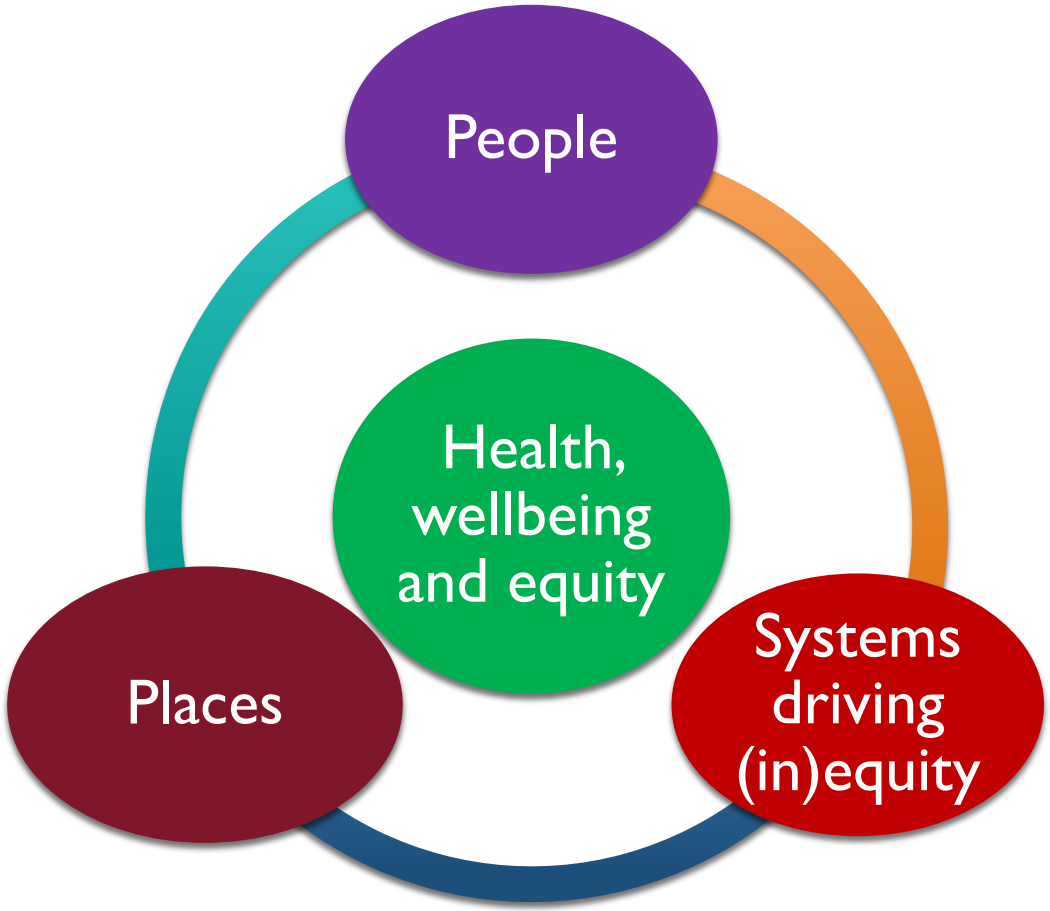
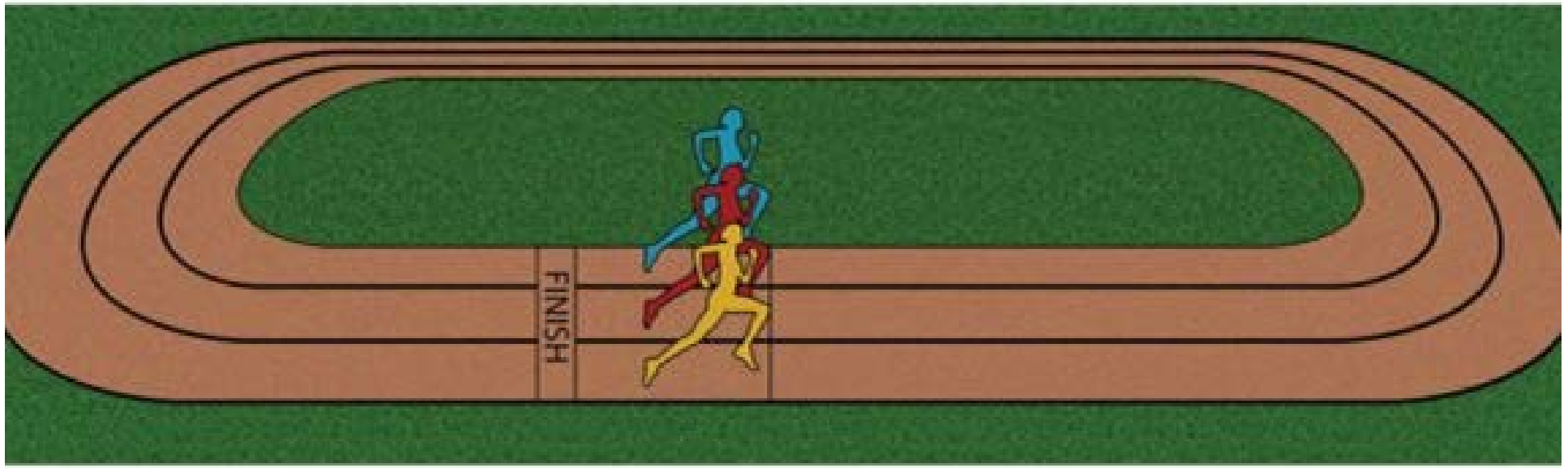
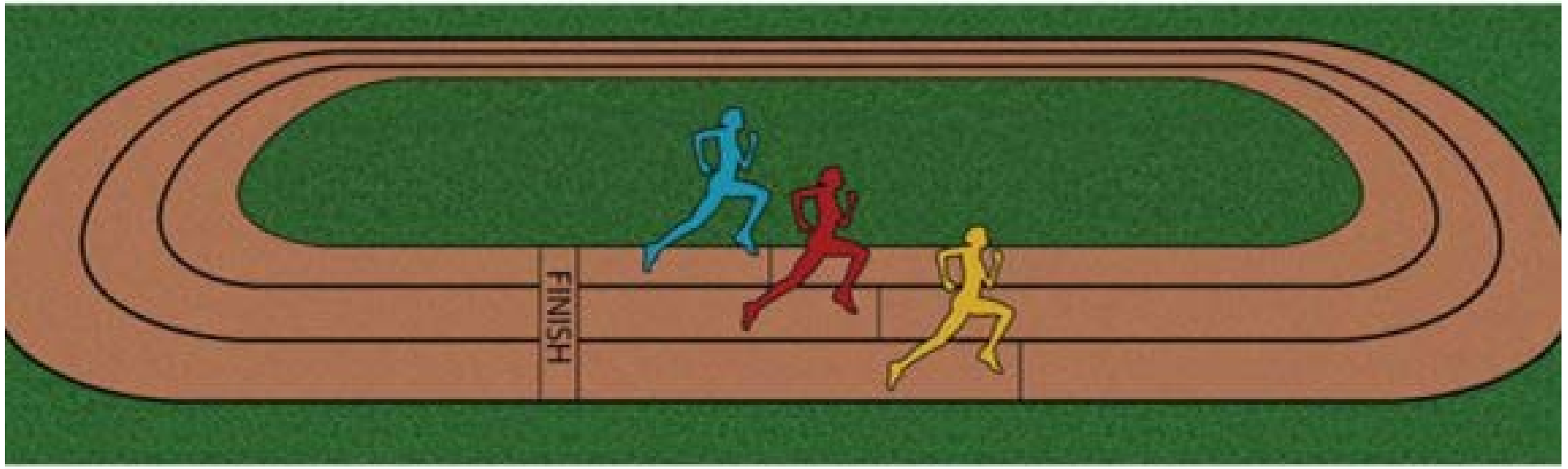


Photo courtesy of Kaique Rocha. Metaphor courtesy of Camara Jones and Natalie Burke.

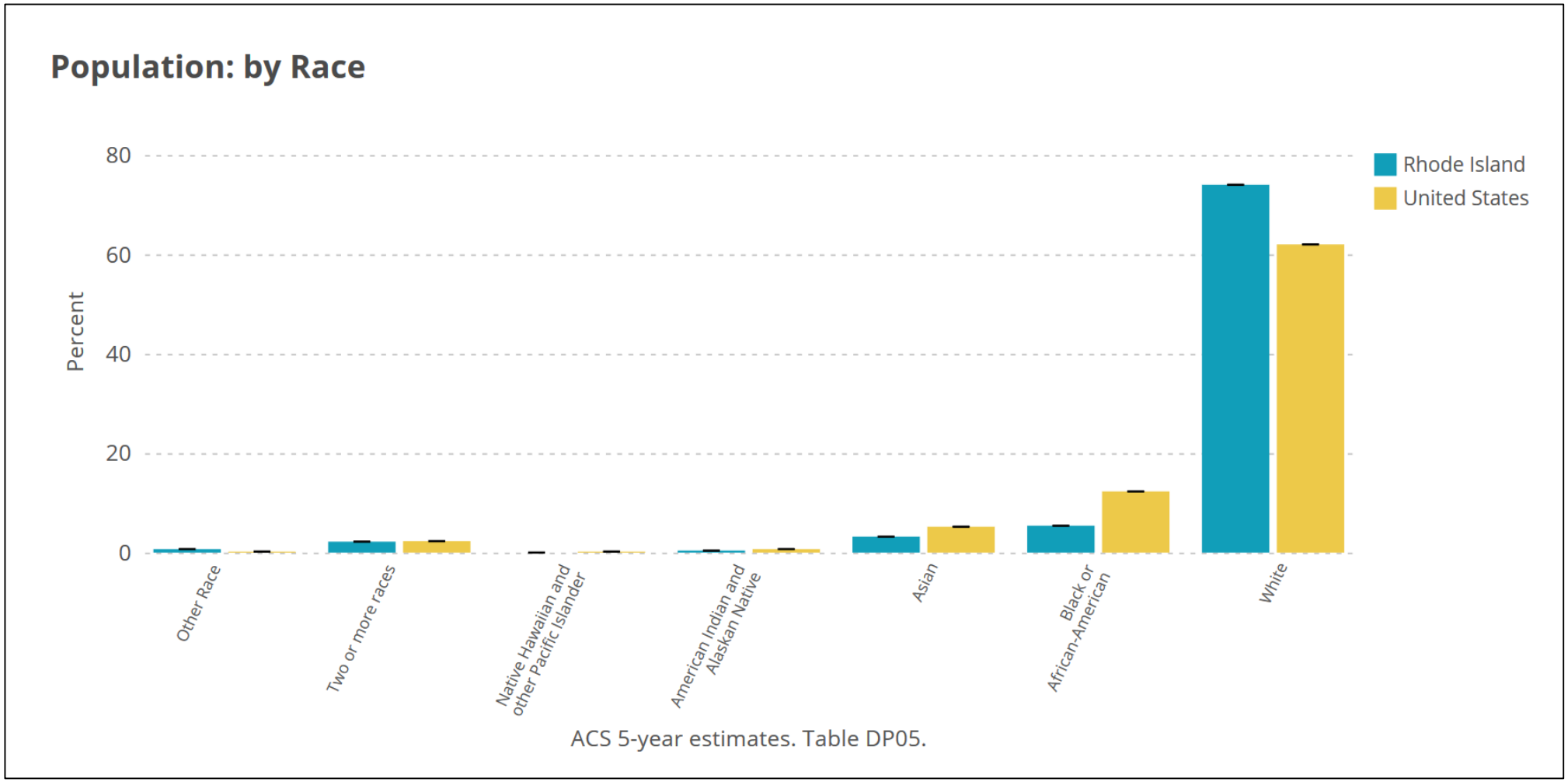


EQUALITY



EQUITY

A DISPROPORTIONATE BURDEN OF POOR HEALTH ON RACIAL AND ETHNIC GROUPS IN RHODE ISLAND



BRFSS data 2015, Rhode Island Department of Health

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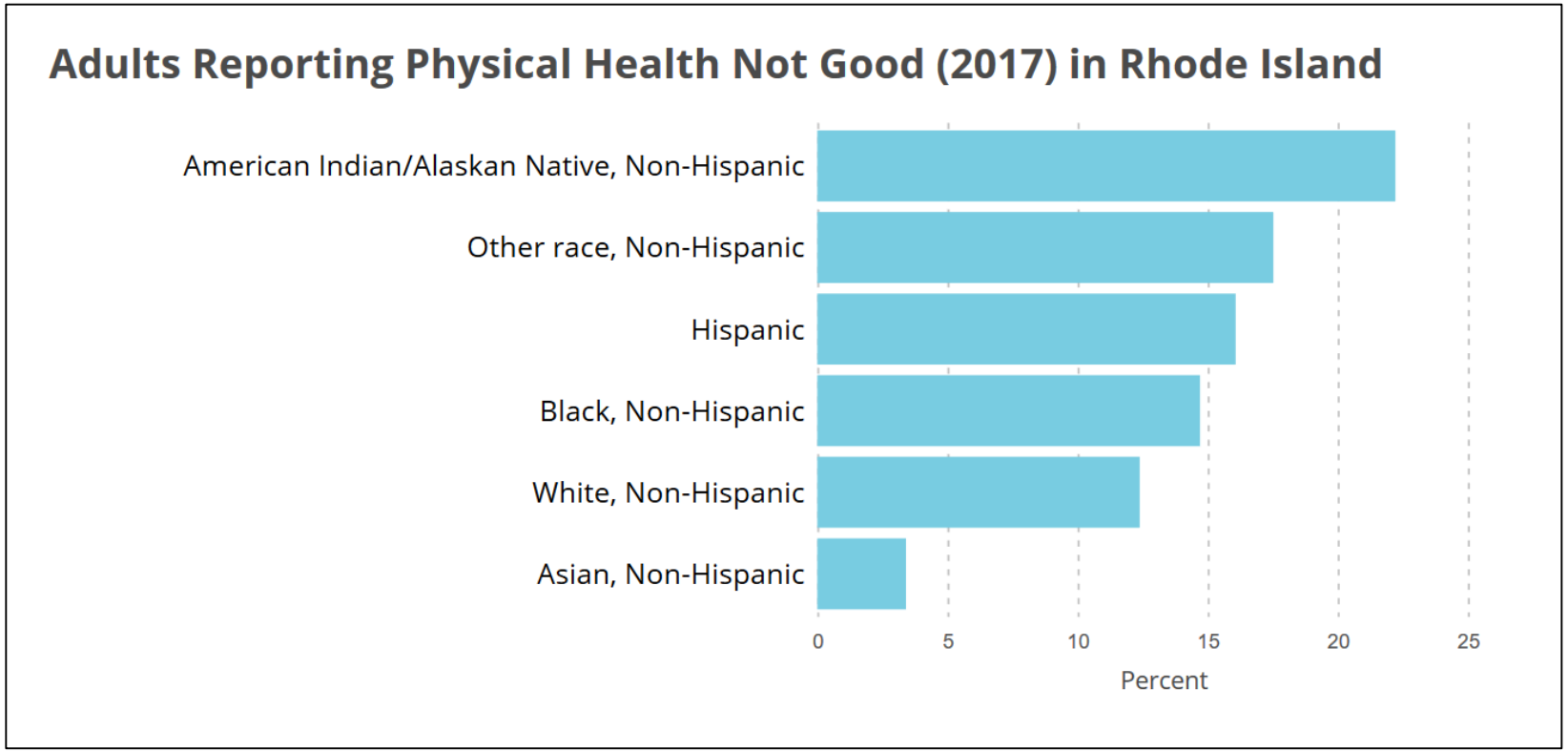
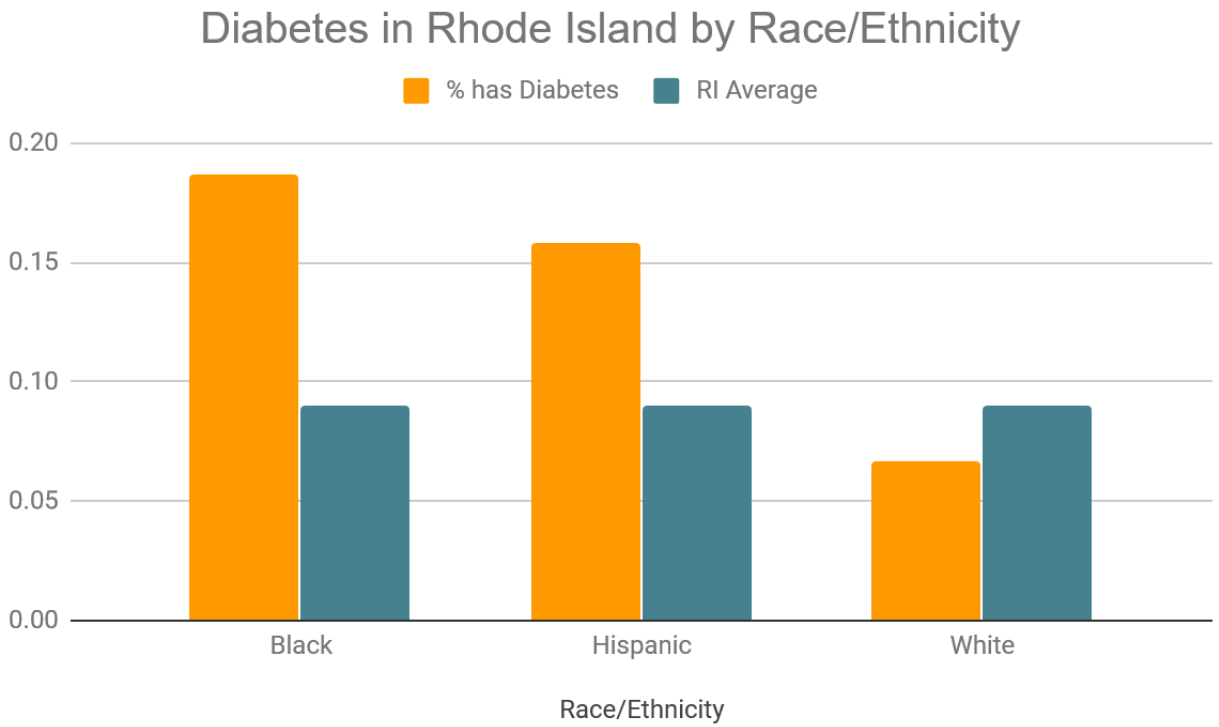
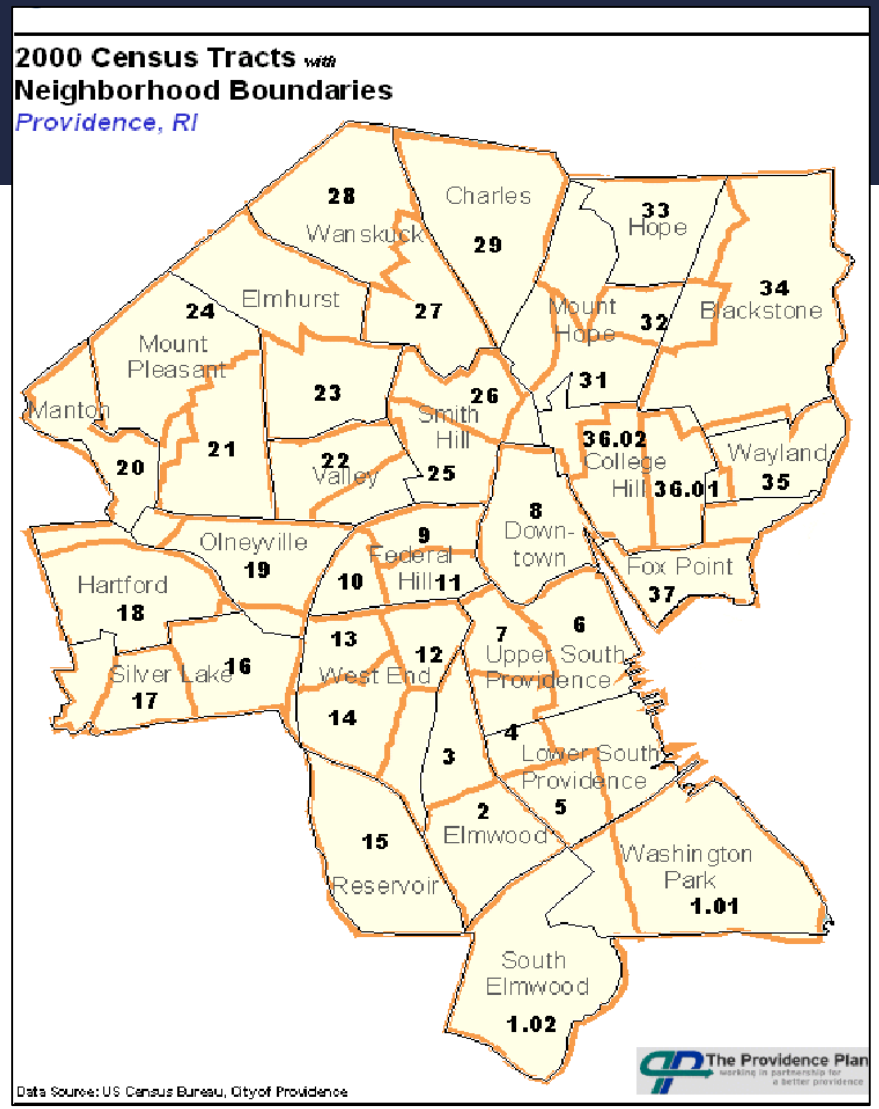


www.winmeasures.org

DIABETES IN RHODE ISLAND

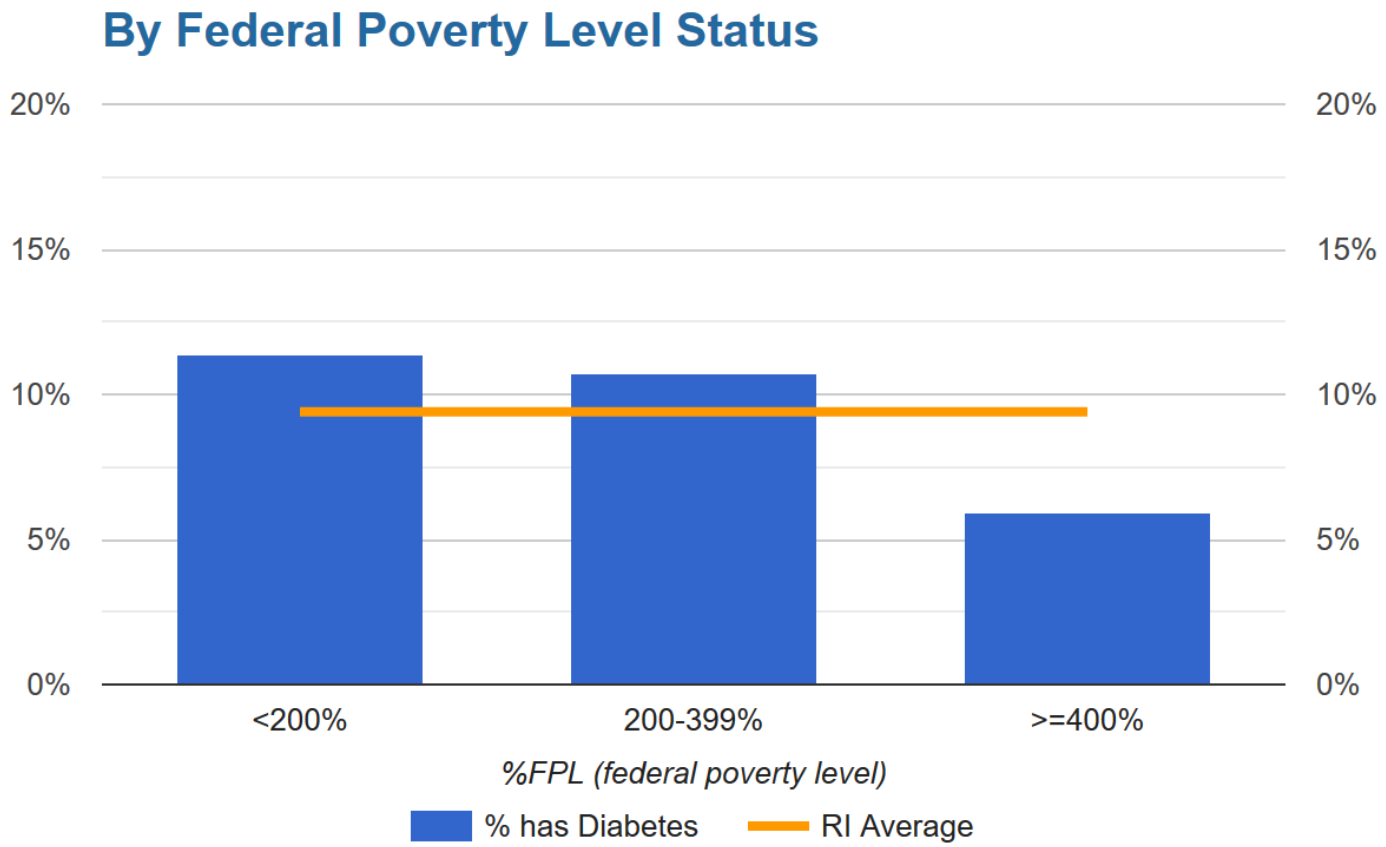




Published in Rhode Island medical journal 2013

The link between poverty and type 2 diabetes in Rhode Island. Yongwen Jiang, Deborah N. Pearlman

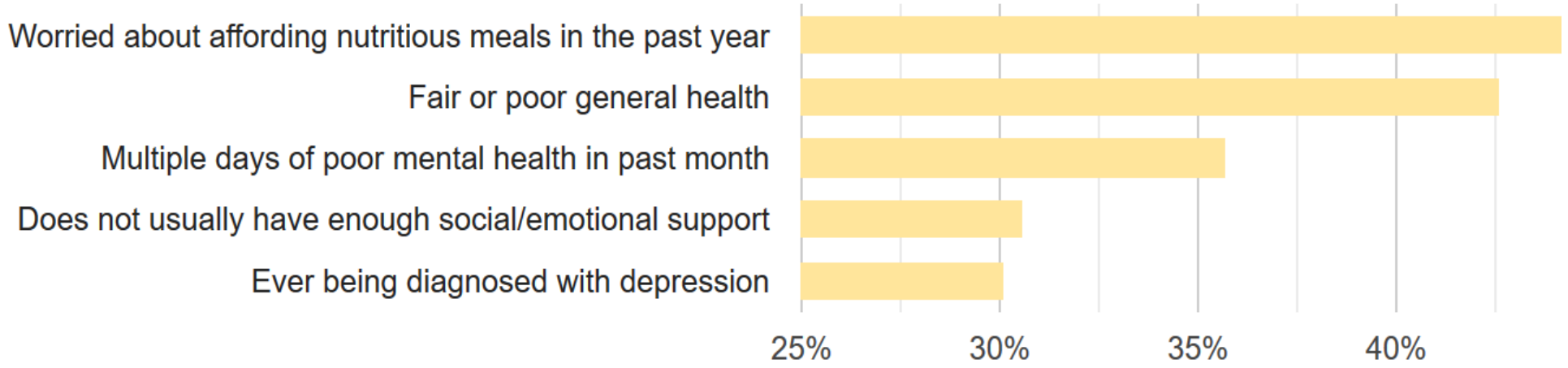
PEOPLE WITH DIABETES IN RHODE ISLAND WHO ARE ECONOMICALLY INSECURE



BRFSS data 2015,
Rhode Island Department of Health

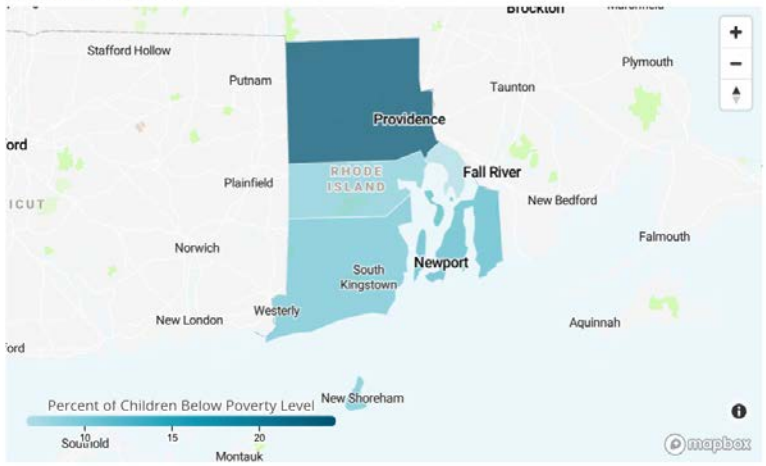
THE IMPACT OF POVERTY ON PEOPLE WITH DIABETES IN RHODE ISLAND

Percentage of RI Adults with diabetes who ...



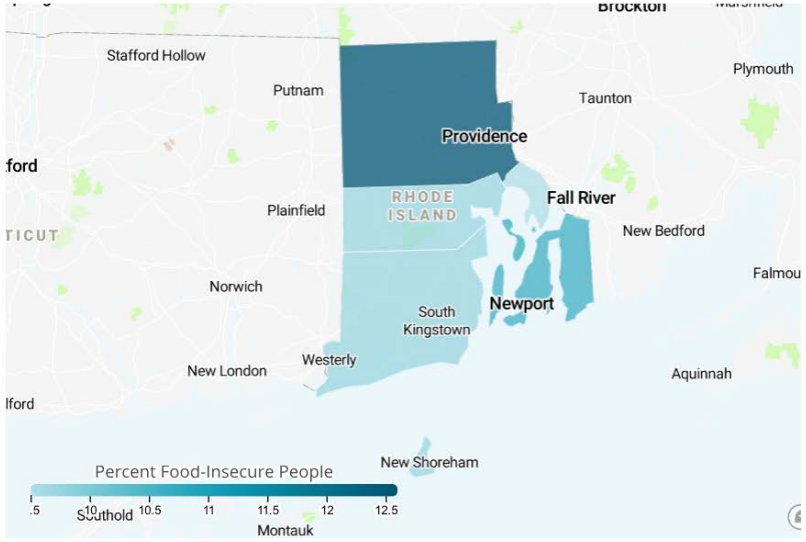
PATTERNS BY PLACE IN RHODE ISLAND

Child Poverty (2013-2017)
Children: Children Under 18

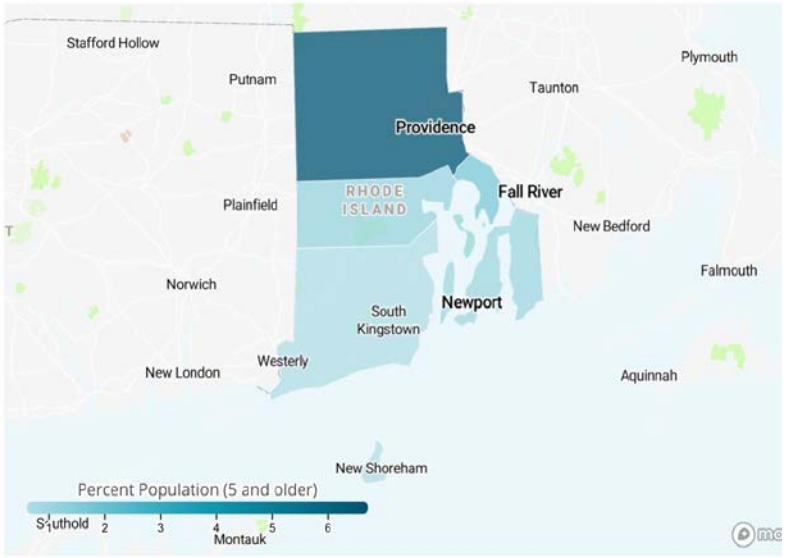


Gini Index of Income Inequality (2013-2017)

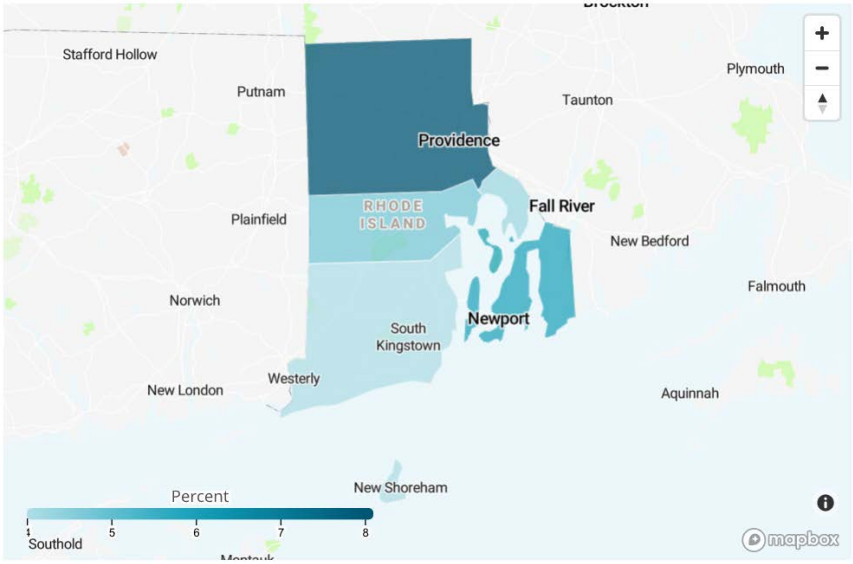
Food Insecurity (2017)



Population Who Do Not Speak English Well (2013-2017)



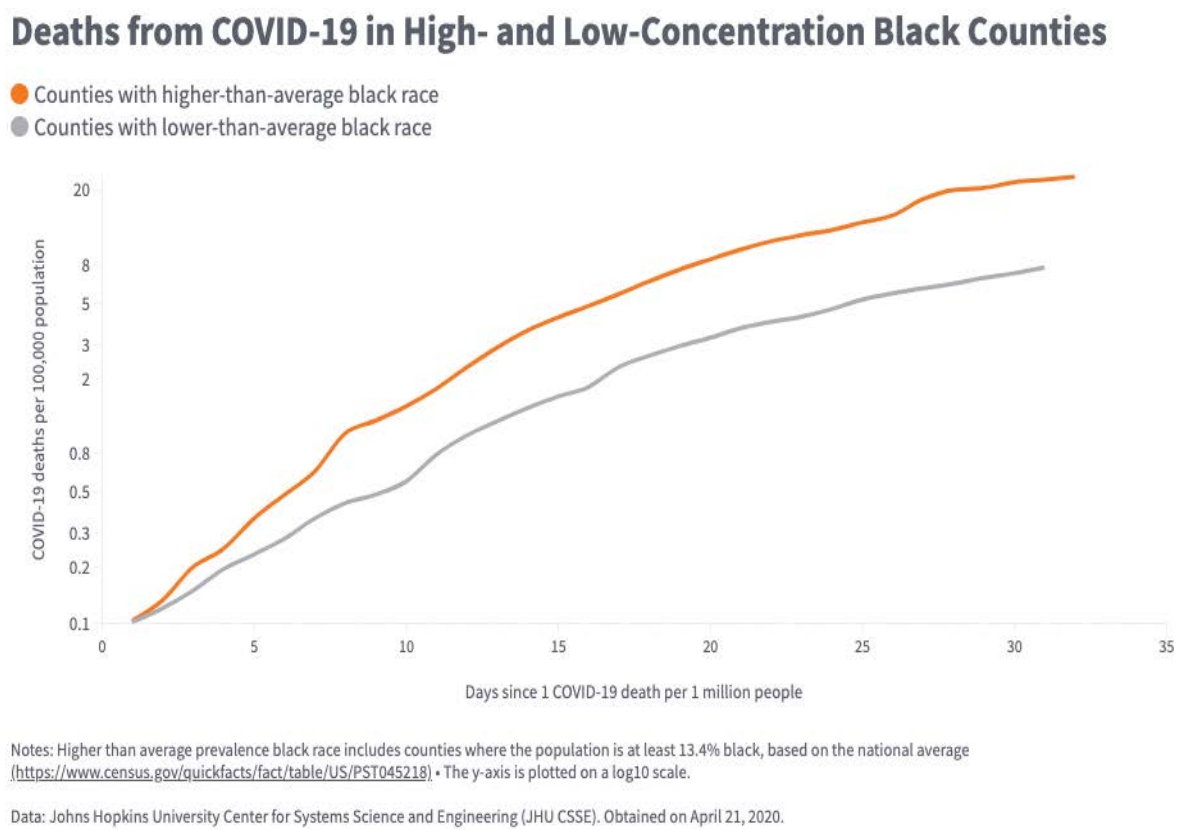
No Health Insurance Coverage (2013-2017)
Coverage Status: Uninsured



https://www.winmeasures.org

HOW INEQUITIES ARE SHOWING UP IN THE CONTEXT OF COVID-19

UNDERSTANDING INEQUITIES IN THE CONTEXT OF COVID-19

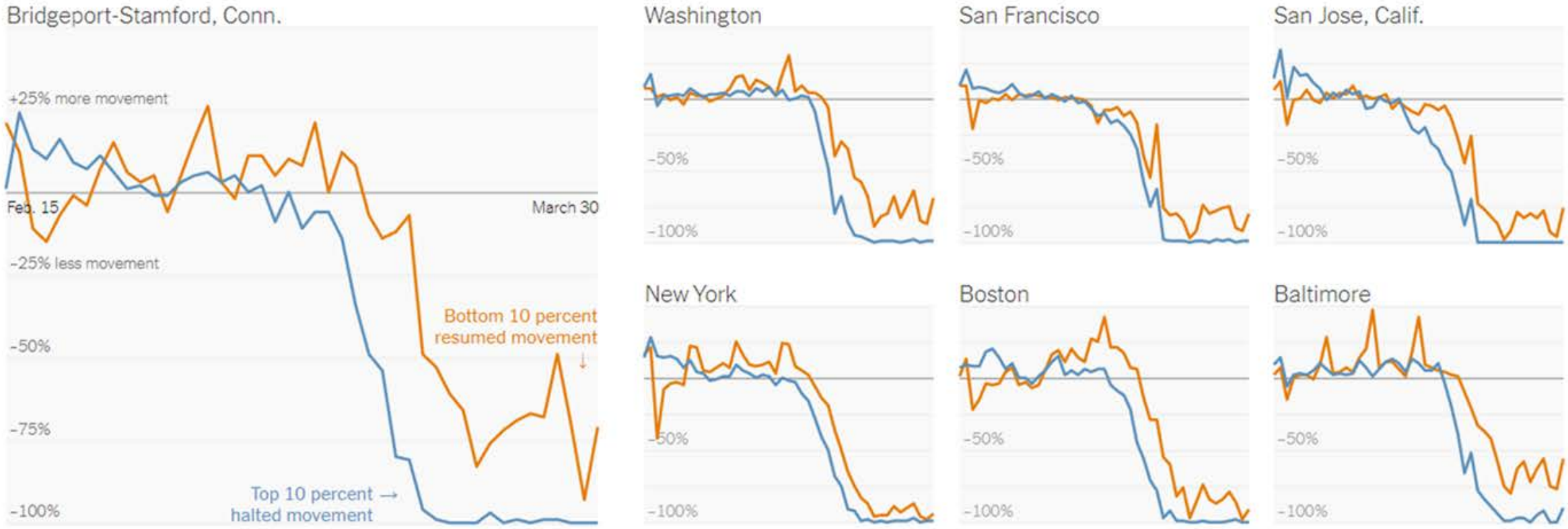


- Deaths from COVID-19 far higher among African-American, Hispanic and Native American populations across the country
- Related to underlying conditions of place (clean water, environmental pollution, access to health care) and underlying prevalence of chronic illness

Commonwealth Fund, April 2020

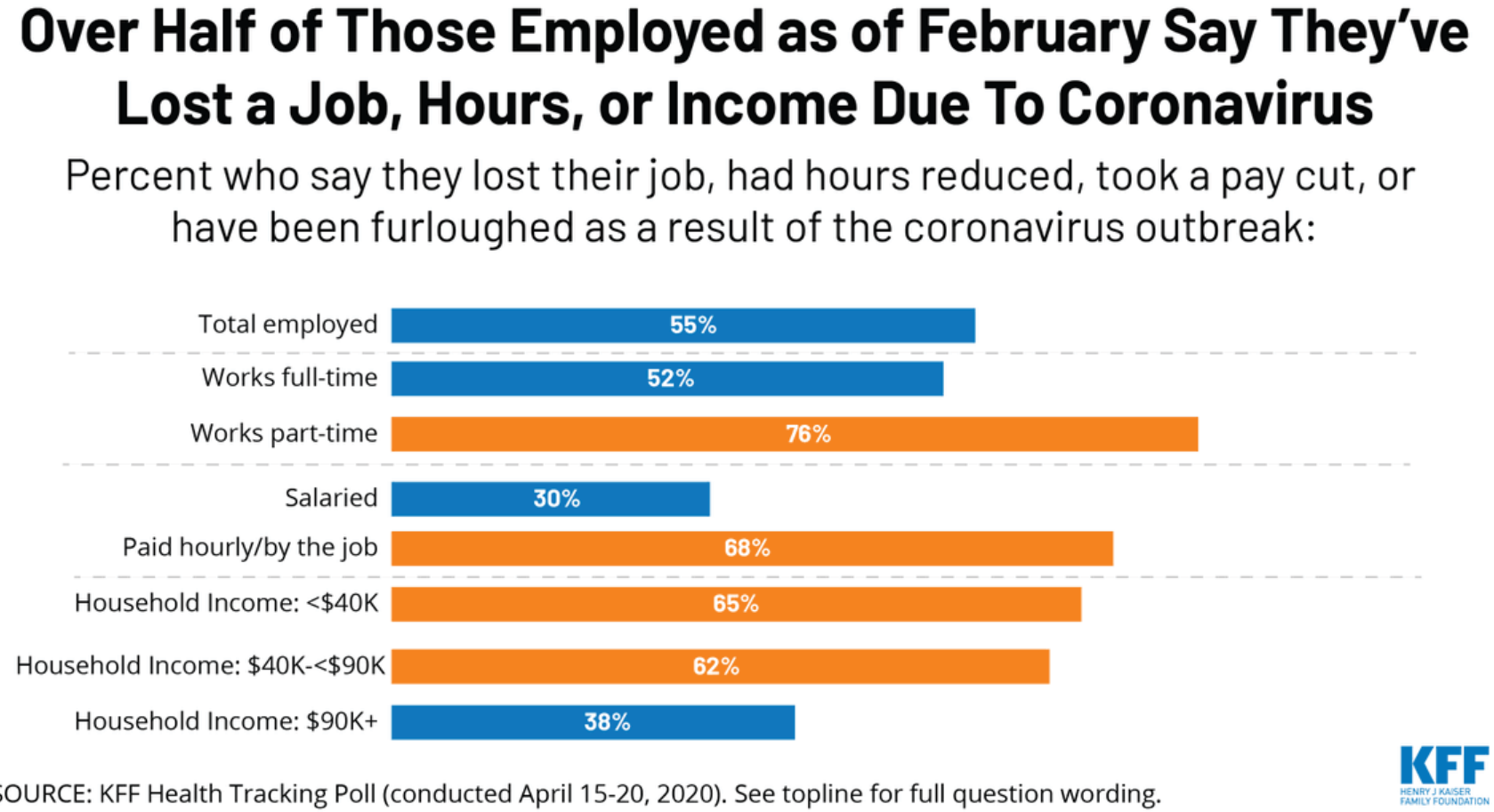
Income Disparities in Response to COVID

Change in movement in metro areas with high income disparity



top 10 percent **bottom 10 percent**

https://www.nytimes.com/interactive/2020/04/03/us/coronavirus-stay-home-rich-poor.html



Rhode Island snapshot

- Unemployment – 91,604 applications for unemployment in 3 weeks
- Disability – 7,274 applications for disability due to COVID-19

IN THE CONTEXT OF COVID-19 HOW MIGHT RACIAL, INCOME AND OTHER INEQUITIES PLAY OUT?

Community and belonging

- Mistrust of "the other"
- Cloth bandannas in communities of color
- Perceptions of who is clean and unclean
- Social isolation

Basic needs for health and safety

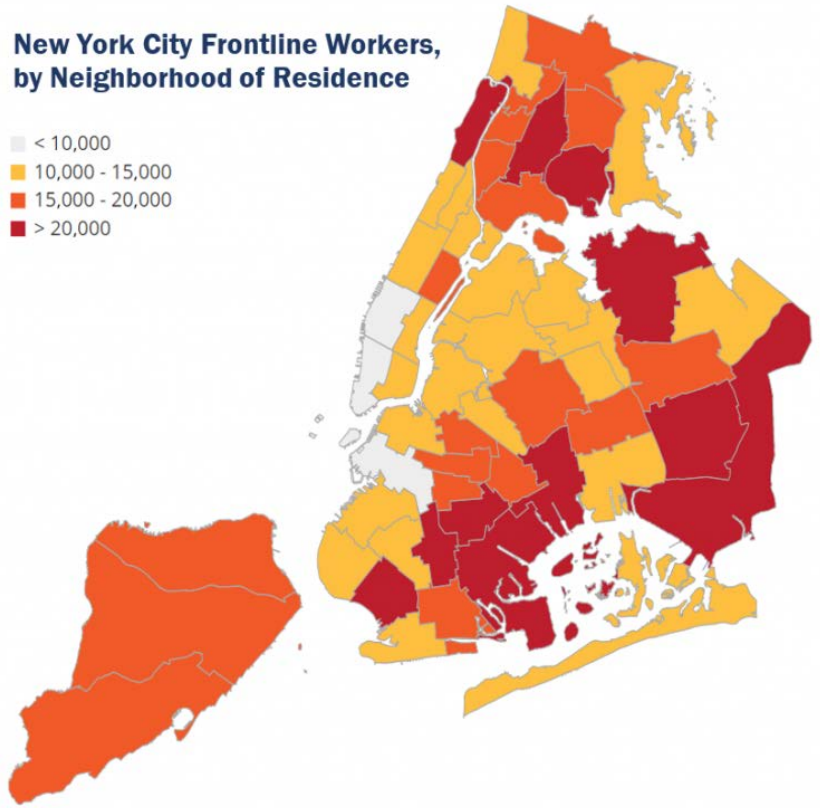
- Who has access to health insurance?
- Who still has access to affordable health care?
- Who has access to COVID-19 testing?
- Who has access to clean water to wash their hands?
- Who feels safe getting help? (public charge)
- How does increased stress, isolation, etc affect their physical and mental health and risk behaviors?

Conditions of housing

- Are people housed?
- Housing density

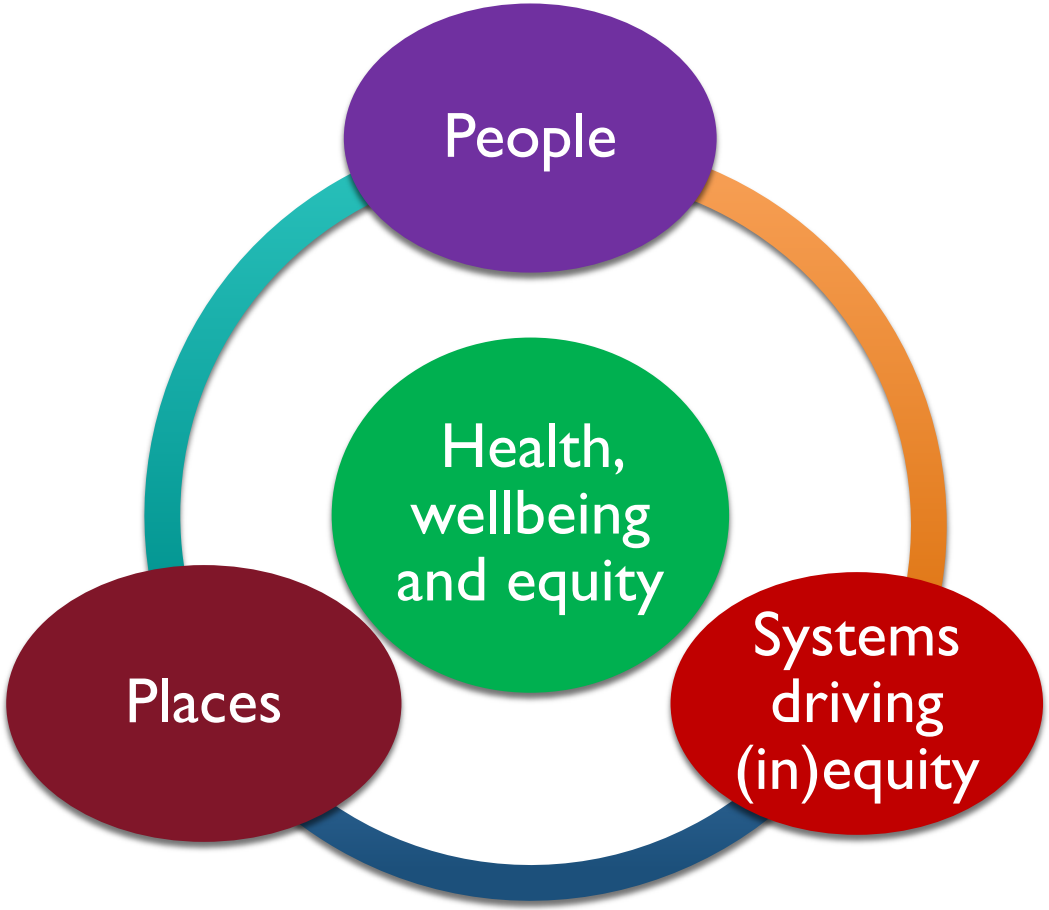
COVID-19 AND ECONOMIC INEQUITY

- Who has to work?
- What protection do they have in terms of working conditions in general?
- What protective equipment do they have for COVID-19?
- Can they afford to be quarantined or to care for a family member?
- Who can't work or has reduced work?
- What are the conditions of work?
- How much wealth do they have to ride out a downturn?
- What benefits do people have when they are unemployed?



HOW CAN WE ADDRESS THIS?

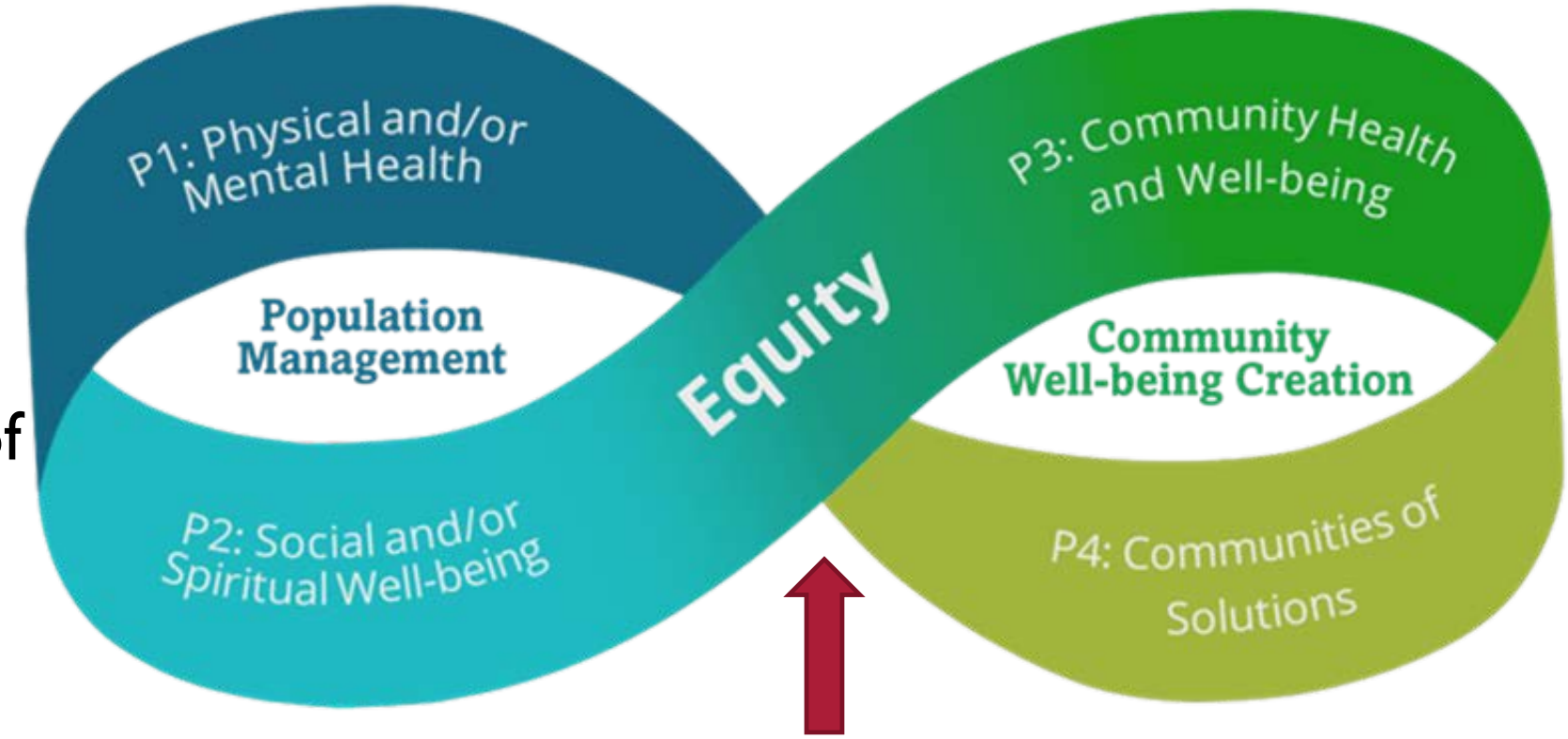
1. Understand the population through data, story and partnership
2. Stratify the population – who is at highest risk of not thriving?
   - People
   - Places
   - Systems driving inequities
3. Make it easy to care for the whole person
4. Work to address the underlying conditions in the community that would solve the problem for everyone
5. Apply a current day and historic equity lens



FOUR PORTFOLIOS OF POPULATION HEALTH ACTION

PATHWAYS TO POPULATION HEALTH

Improving the health and wellbeing of people



Improving the health and wellbeing of places

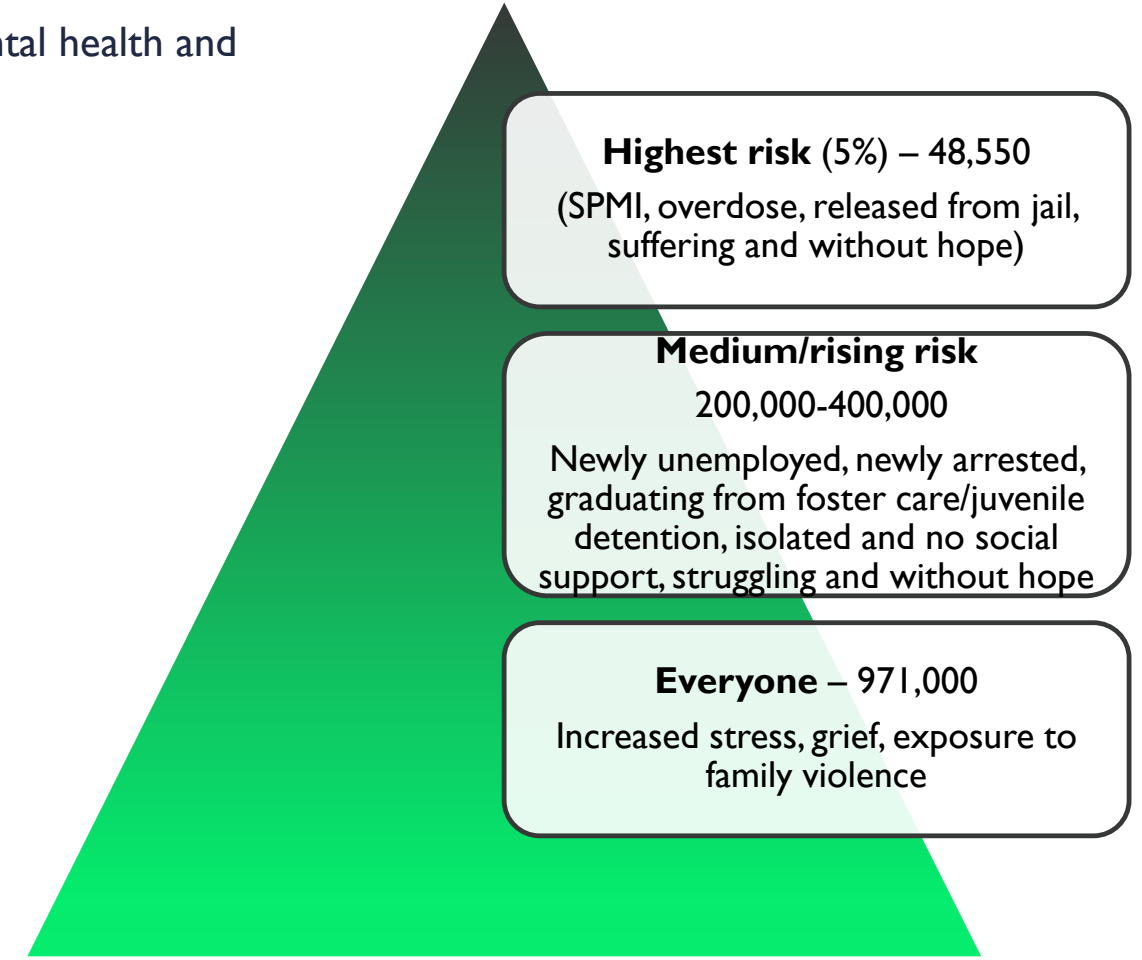
Improving the systems that drive (in)equity

Source: Pathways to Population Health, 2018

pathways2pophealth.org

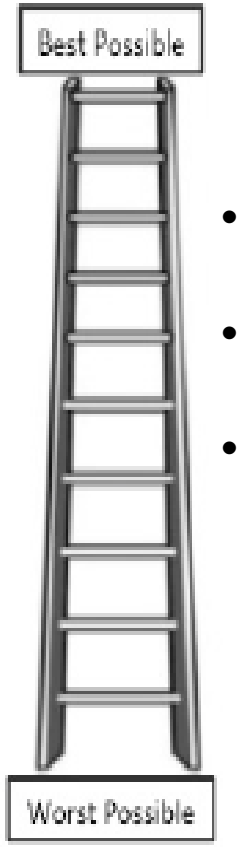
RESPONDING TO CORONAVIRUS IN DELAWARE: UNDERSTANDING THE POPULATION

- Impact: Greatly expand the number of people who need help for their mental health and addiction needs in the context of
  - Increased anxiety in the population
  - Social isolation (especially among the elderly)
  - Increased loss from people who are hospitalized or who die
  - Massive levels of job loss
  - Increased trauma
  - Loss of access to basic needs for life and health
  - Loss of caregivers and peer supports
  - High prevalence of legal needs and housing instability; loss of social connection
  - Need to address physical and mental health needs together



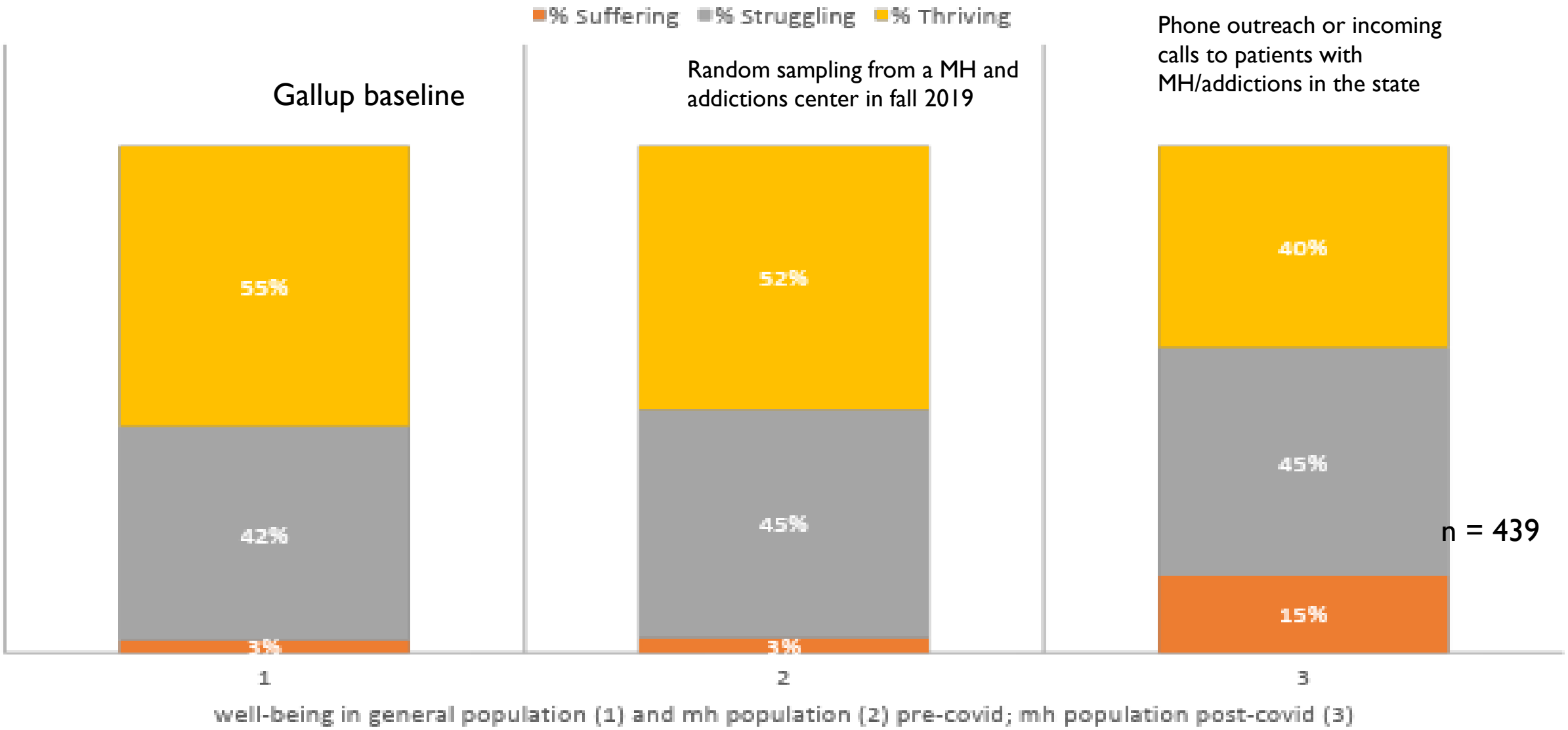
ORGANIZING YOURSELF TO IMPROVE THE WELL-BEING OF PEOPLE: DELAWARE

1. Understood who might be in the highest risk, rising risk, and "everyone" categories
2. Used a few simple questions to risk stratify and rapidly assess needs
    1. Overall well-being and hope
    2. Financial well-being
    3. Loneliness
    4. Social supports
    5. Housing, legal needs
    6. COVID symptoms
3. Planned for what happens to anyone who screens positive including "outreach failures"
4. Care managers outreach to people who a at highest or rising risk; part of all in-reach
5. Connect people reliably to needed suppo whether they be around primary care, behavioral health or social needs through integration with 2-1-1 and community providers
6. Follow up to assure they get the help they need using team-based care
7. Big White Wall implementation and warm for anyone – with back end integration int state telehealth support systems

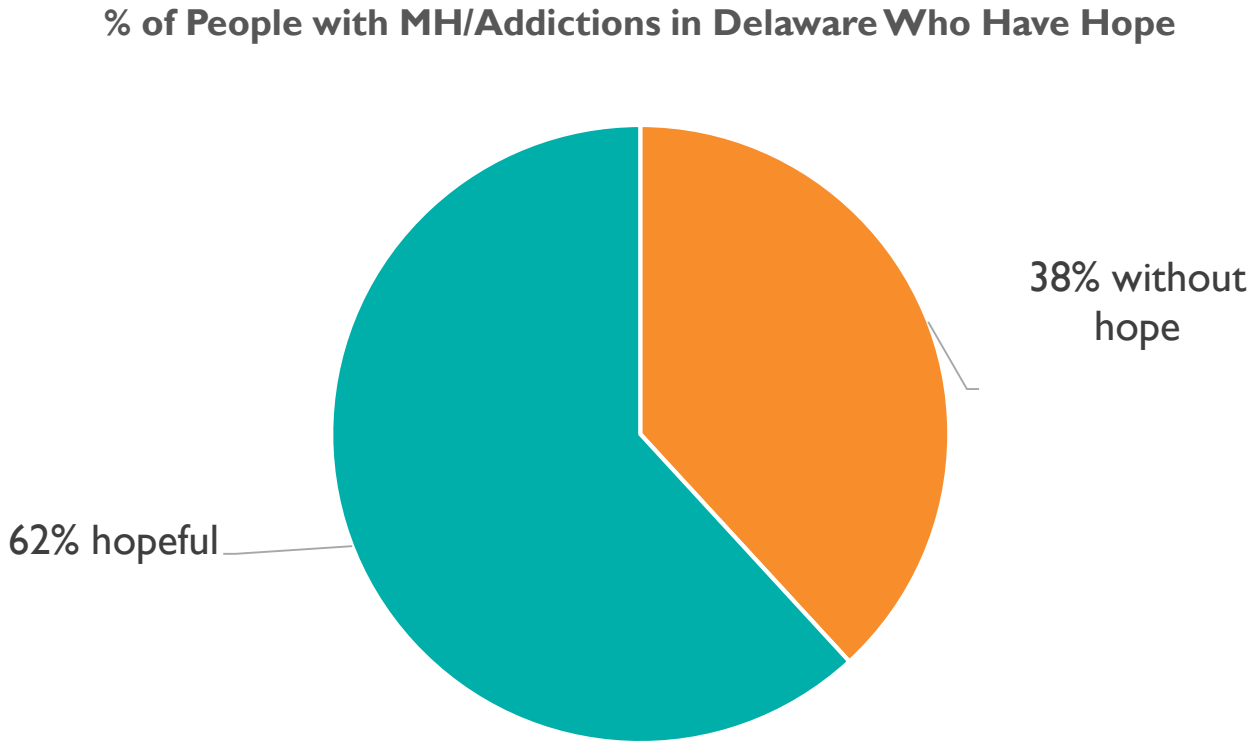


- % people thriving
- % people struggling
- % people suffering

Change in Well-being in Delaware Before COVID-19 and Today



% OF PEOPLE WITH MENTAL HEALTH AND ADDICTIONS IN DELAWARE WHO HAVE HOPE



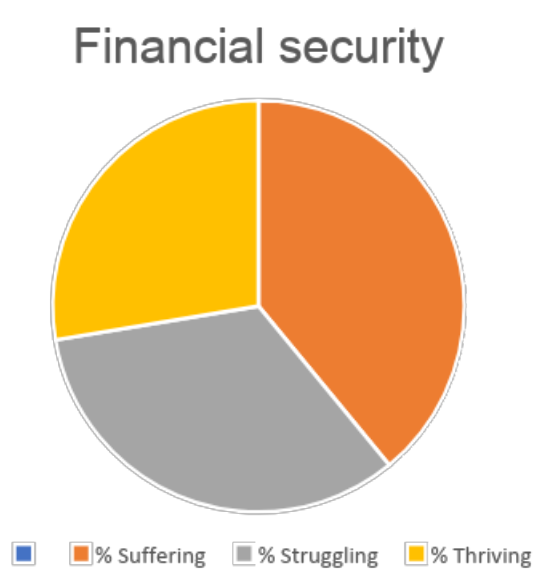
N = 448

100 Million Healthier Lives

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health

WE IN THE WORLD

CONTRIBUTORS TO POOR WELL-BEING IN PEOPLE WITH MENTAL HEALTH AND ADDICTIONS IN DELAWARE POST-COVID-19



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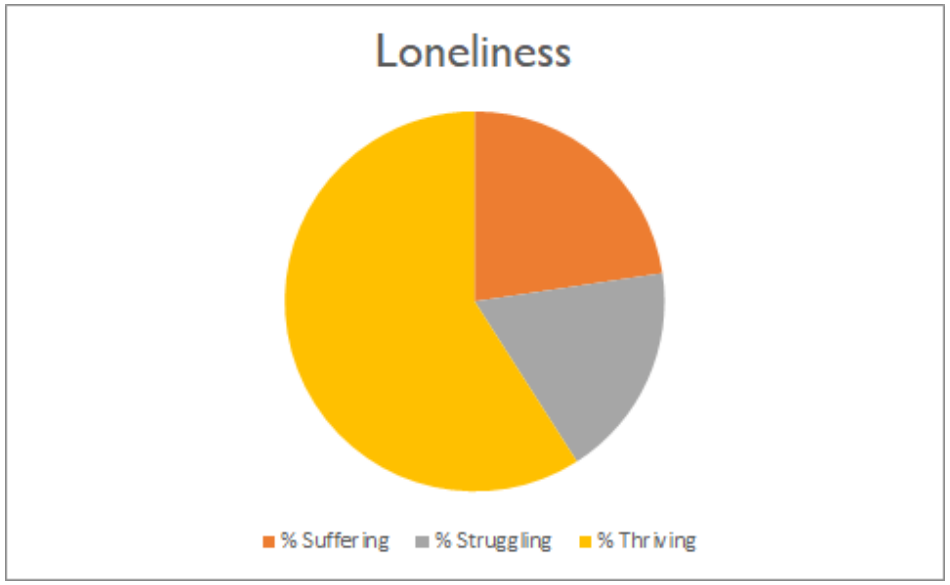

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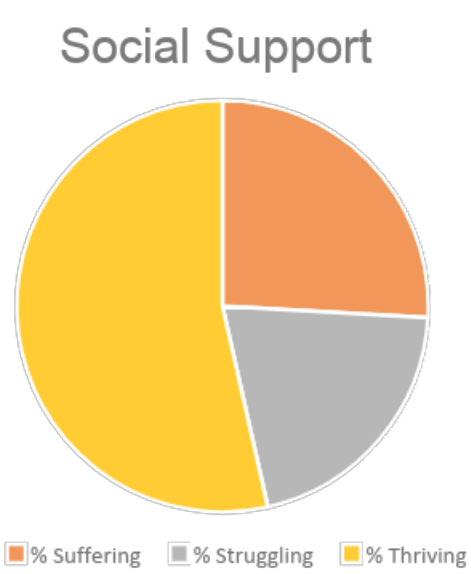


n = 454

WE IN THE WORLD

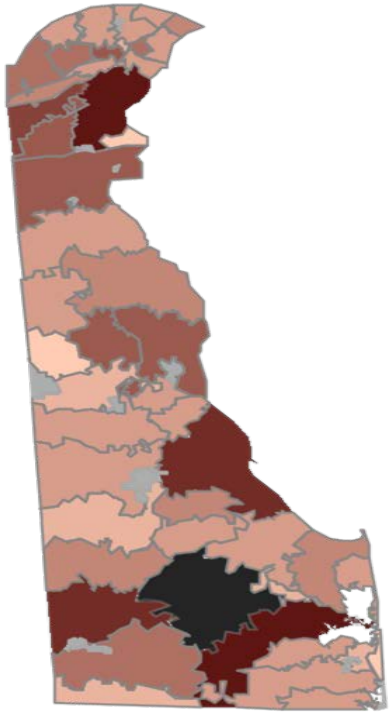
DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health

100 Million Healthier Lives

CLINICAL-COMMUNITY CONNECTIONS

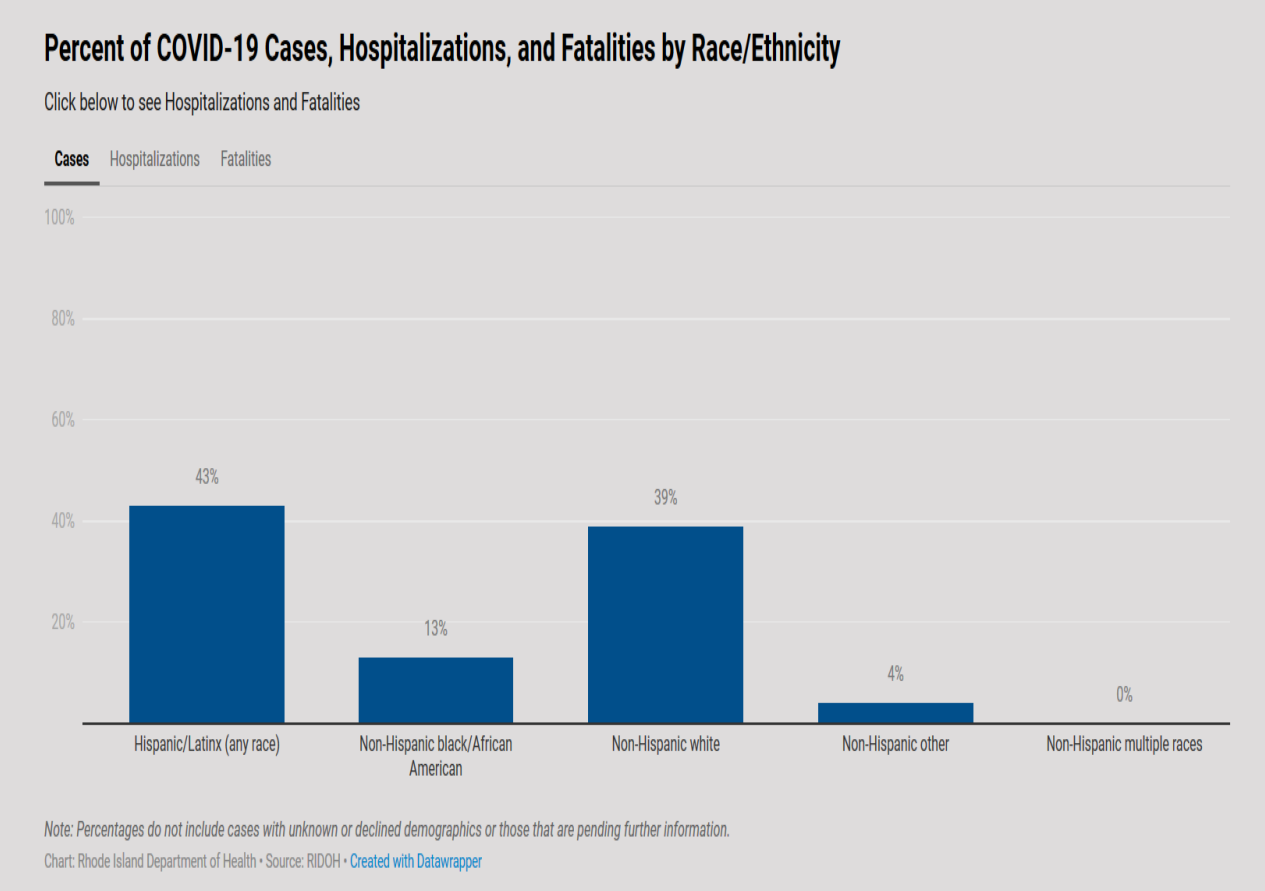
- Partnerships between ERs, mental health system, primary care, police, and corrections
- Diversion by police and corrections to mental health and addictions crisis stabilization for anyone with an overdose or charges related to mental health or addiction
- Rapid facilitation to get people with mental health and addictions who need to be hospitalized out of the EDs
- Warm handoff and coordinated transition from anyone coming out of jail or prison with policies in place to support transfer
- Coordinated transitions for anyone in the state graduating from foster care and juvenile detention
- Connection to social needs (housing, peer support, education/employment, etc) and peer supports

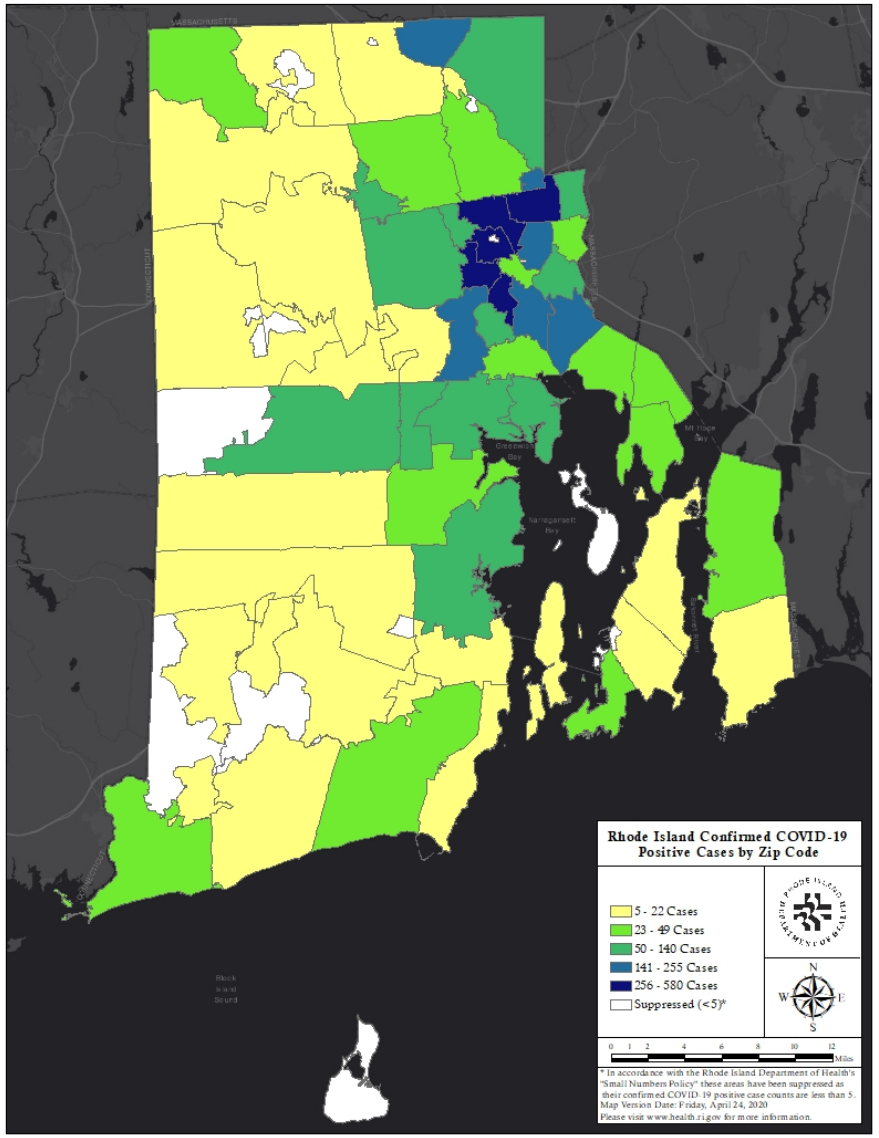
IDENTIFYING COVID-19 DISPARITIES BY PLACE



- Hotspots related to Haitian immigrants working in chicken farms and nursing homes
- Crowded working conditions, no social distancing, no PPE
- Poverty → crowded housing conditions for workers
- Health literacy low
- Low trust in government, fear of public charge
- Mental health stigma
- Besides shutting down the plant and assuring financial support for the workers, the state is engaging in a peer supported outreach strategy in the community through the DPH
- Policies to support everyone who is unemployed and at risk

COVID-19 IN RHODE ISLAND





https://ri-department-of-health-covid-19-data-rihealth.hub.arcgis.com/

COVID-19 AND DIABETES IN RHODE ISLAND – HOW WOULD YOU RISK STRATIFY THIS POPULATION?

Physical	Mental health	Economic and social needs	Loneliness and social support	Place-based risk	Underlying factors
Poorly controlled diabetes (A1C>8)	Active mental health/addictions	Unemployed or financially insecure	Caregiver support	High levels of environmental pollution	Underlying poverty and h/o redlining
Poorly controlled CV conditions, tobacco use	Past history of mental health and addictions	Low education or language barrier	Recovery/peer support	Neighborhood safety and access to green spaces	Underlying trauma in the community
COVID-19+	Low access to mental healthcare	Housing instability	Caregivers who become COVID+	High COVID prevalence area	Lack of access to health care
No health insurance	Low levels of hope	Poor conditions of work	Older adults in nursing homes	Lack of access to affordable housing	Lack of access to broadband
No access to medications, supplies etc	Safety in the home	Food insecurity	People in jails or prisons	Food desert	Exclusionary zoning

FOR MORE INFORMATION

Rhode Island demographics:

- https://health.ri.gov/data/covid-19
- www.winmeasures.org

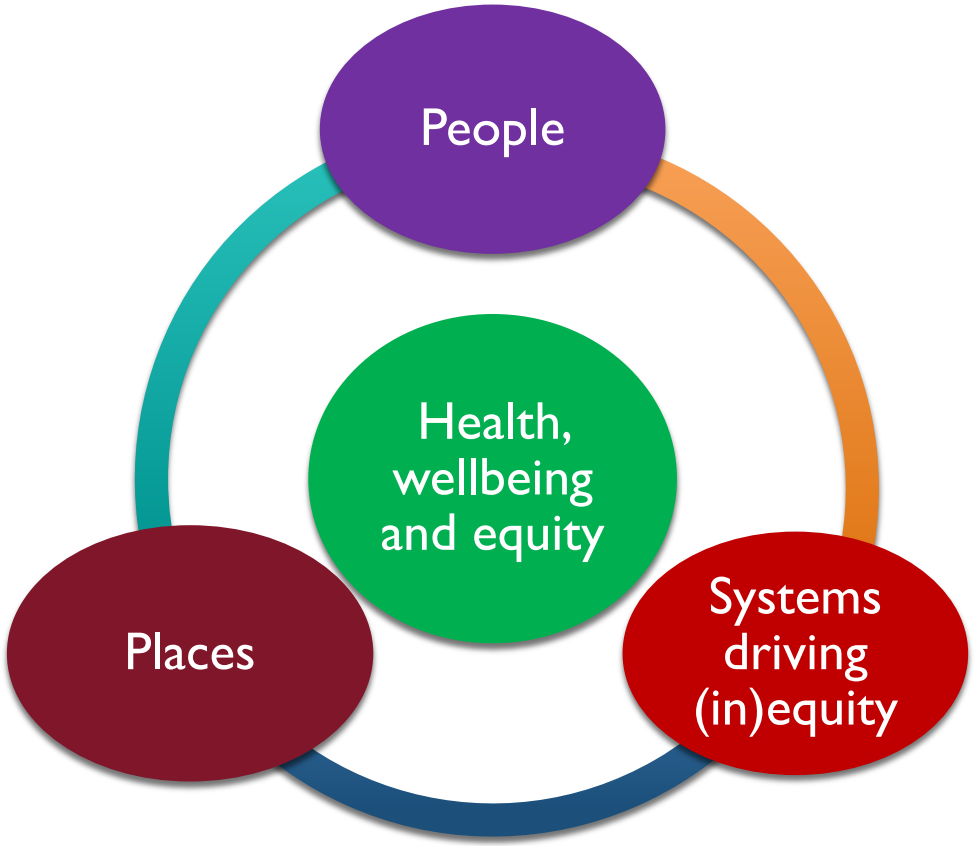
Health Equity and COVID-19: https://conta.cc/34WoYav

Well-being and Equity (WE) in the World

- we@weintheworld.org
- Somava Saha – somava.saha@weintheworld.org
- www.weintheworld.org

KEY TAKEAWAYS

1. Understand the population through data, story and partnership
2. Stratify the population – who is at highest risk of not thriving?
   - People
   - Places
   - Systems driving inequities
3. Make it easy to care for the whole person in the context of their mental, physical, social and spiritual well-being and place
4. Work to address the underlying conditions in the community that would solve the problem for everyone
5. Apply a current day and historic equity lens



LET'S START BY UNDERSTANDING THE POPULATION! CASE STUDY INSTRUCTIONS (ABOUT 30 MIN)

- Read your assigned case study carefully
- Facilitators will lead a group discussion about questions 1 & 2
- Individually choose one question (3-7) and type in your answer below
- Facilitators will lead a group discussion about the responses

NEXT STEPS

Just joining us for this morning

- Change package, including slides and case studies will be sent out after this meeting
- Will receive notice of additional optional webinars on managing COVID-19 in this period in primary care and community
- Next gathering on June 19th (Registration to be sent in the follow up to this meeting)

Health Equity Challenge Teams

- We will continue and meet as teams for the next two hours
- Will meet with your coaches and set up times with them
- Begin to asset map and find connections between clinic and community, using the portfolios of population health!

POLL

I feel more prepared to think about how to improve health equity in my population.

POLL

I have a better understanding of how COVID-19 might affect my community and how we might be able to work together to address their needs.

THANK YOU!

RI DIABETES HEALTH EQUITY CHALLENGE

Supporting the community during the COVID-19 pandemic

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

WE'LL RETURN IN…

WAYS OF BEING AND DOING

Share your experience

Practice "Yes…and vs. "Yes…but"

Stay curious

Respect Time

Expect to experience varied emotion

Show up, CHOOSE to be present

BREAKOUT SESSION

Time with your team and facilitators

- TEAM 1: Yolanda, Kirsten, Seth
- TEAM 2: Shemekka, Laura, Somava

3 Activities

- Deepen relationships
- Schedule weekly huddle time
- Choose a team name

ASSET MAPPING TO NEEDS / EXPLORING CLINICAL-COMMUNITY PARTNERSHIPS

1. Introduce yourself by sharing you name and a priority need for people with diabetes you are working with or in your community who are already experiencing equity gaps. Think about what they might need to improve outcomes in the context of COVID-19.
2. Choose one need to focus on that could benefit from clinical-community partnership.
3. Identify your assets across clinic and community to address this need.
4. Identify a potential partnership and, if you can, a quick win for advancing the partnership.
5. You will be using this form as a team over the next month as you get to know your population and understand their needs. The purpose of this exercise is to help you get familiar with the worksheet and the process and to begin to see the assets you have together.
6. Your action plan should include a balanced portfolio of activities across the portfolios of population health improvement and have an equity lens.

BREAKOUT SESSION

Time with your team and facilitators

- TEAM 1: Shemekka, Laura, Somava
- TEAM 2: Yolanda, Kirsten, Seth

- 3 Activities
  - Form/deepen relationships
  - Schedule weekly huddle time
  - Choose a team name

THE NEXT STEPS IN THE JOURNEY

Now

- Schedule weekly team huddles (if not done already)
- Complete the P2PH Compass (if not done already)
- Get to know your coaches (huddles, open coachings)
- Get familiar with the RI Health Equity Challenge Change Package
- Begin to engage key stakeholders in this process – check out the Stakeholder Engagement Plan in your change package!

Between now and May 14th

- Begin to understand your population and partner with them to identify needs and assets
- Begin to stratify your population based on risks, needs and assets
- Identify opportunities for clinical-community partnerships
- We will use these to develop an action plan on May 14th
- Attend coaching session on engaging people with lived experience of inequities in your work – May 12th at 2pm ET

MAY 14TH

- Building your driver diagram for the challenge
- Planning action to advance health equity in your population using a balanced portfolio approach
- Identifying measures and tools to create change

APPRECIATIONS

- Health Equity Challenge Teams
  - Community members
  - Front-line health care workers
- CTC, RIDOH, WE in the World accompaniers

REFLECTION – CIRCLE, TRIANGLE, SQUARE

What's still circling around for you?

What do you have squared away "I've got it"?

What are 3 take-aways that you can put into practice now?