RI DIABETES HEALTH EQUITY CHALLENGE

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

WELCOME!

02/12/2021

RHODE ISLAND DEPARTMENT OF HEALTH

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

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THINKING ABOUT YOUR WORK, WHAT IS ONE THING THAT MOTIVATES YOU?

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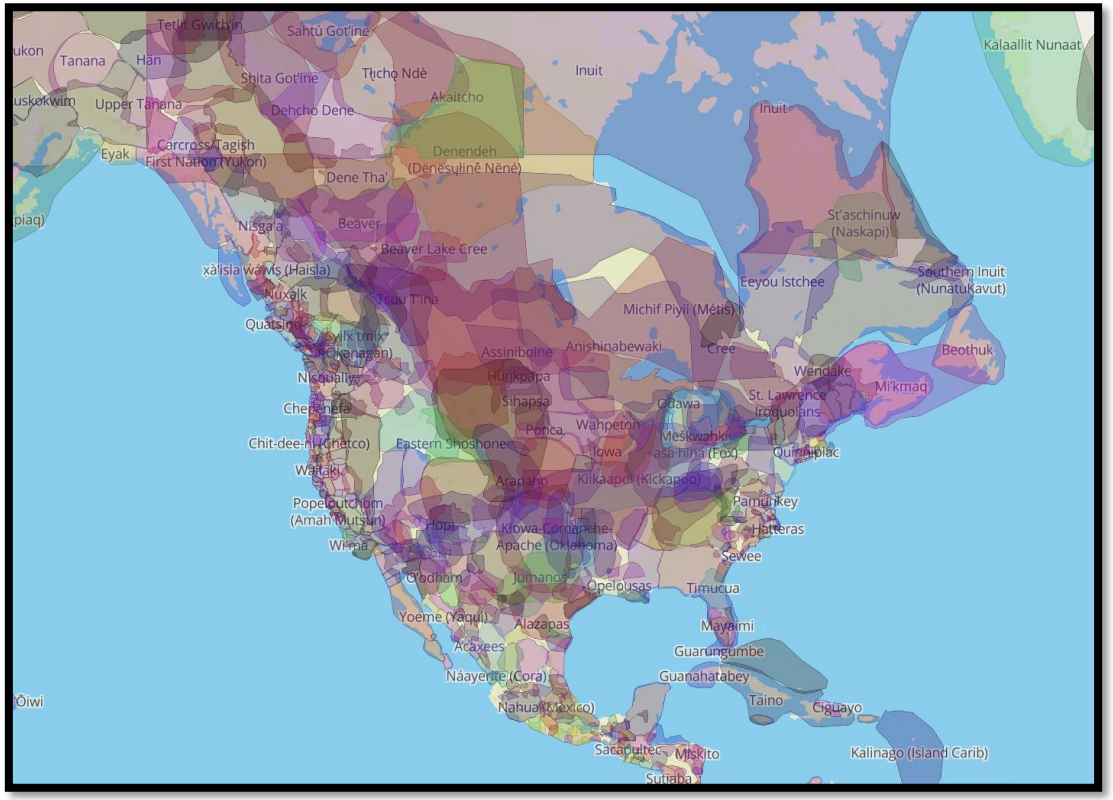
LAND ACKNOWLEDGEMENT

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 / Grounding
2. Team updates
    1. Project updates / Compass improvement plan
    2. Current Risk Stratification plan
3. Stratify Risk to ensure Population Equity

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

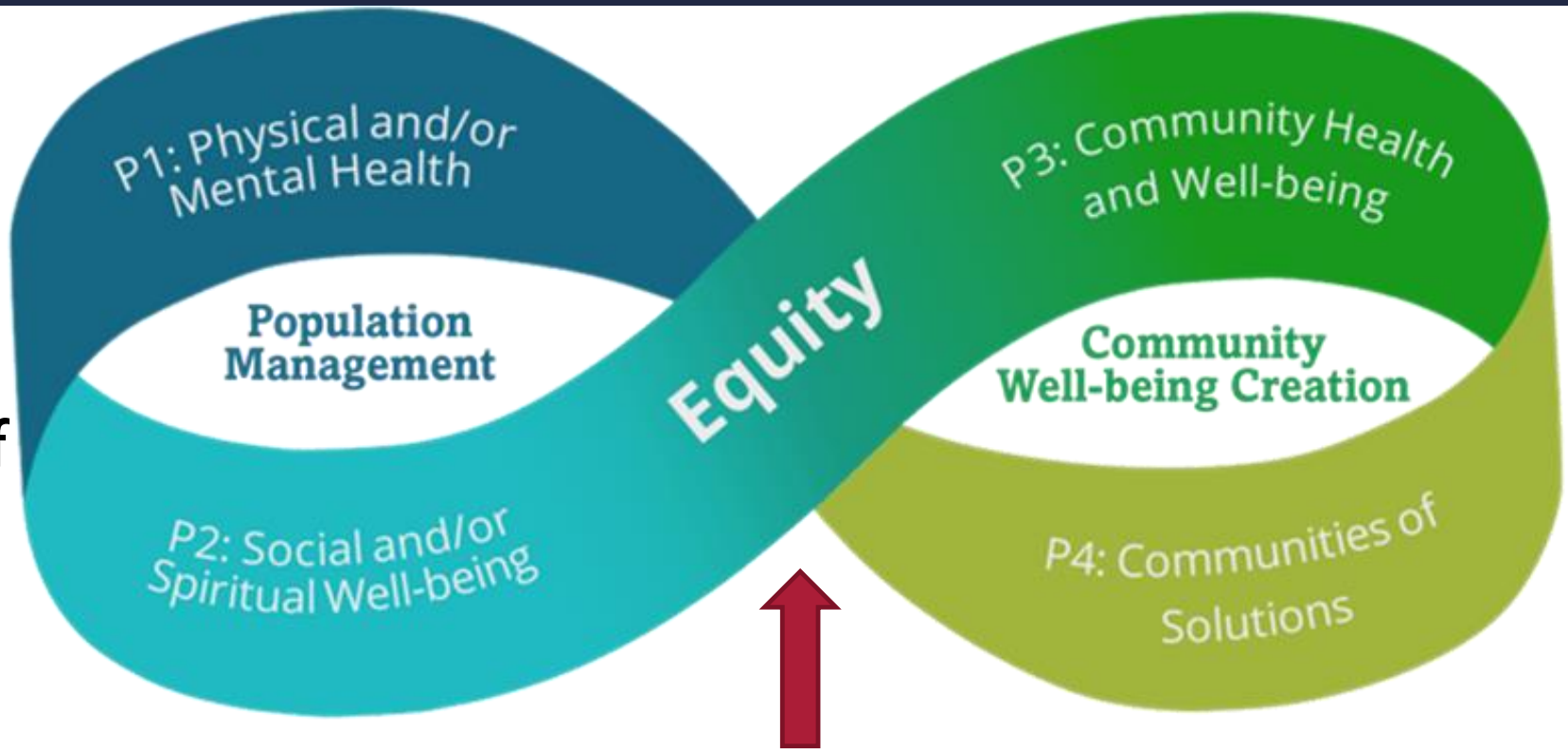
- Apply the concepts we learned in Wave 1 with greater depth and at scale

PHOTO BY JULIANA MALTA ON UNSPLASH

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

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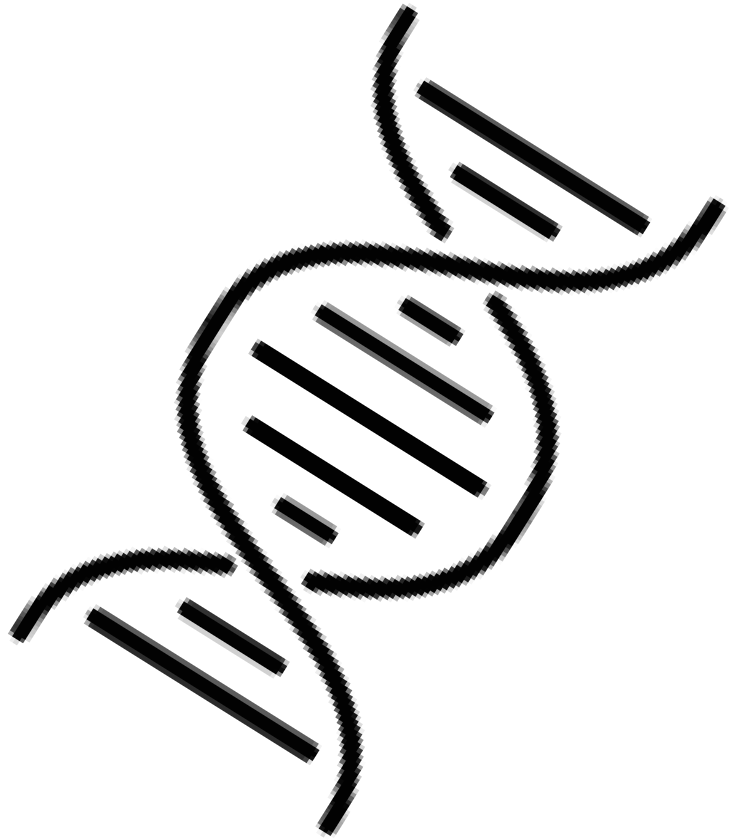
Source: Pathways to Population Health, 2018

pathways2pophealth.org

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

OUR WORK TOGETHER RI DIABETES HEALTH EQUITY CHALLENGE WAVE 2

Pawtucket/ Central Falls Team

February 12, 2020

Community Health Team

EAST PROVIDENCE HEZ HEALTH EQUITY ZONE

EBCAP Team Update 02-12-20

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? What would it take for that to change?
   - 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.

WHY STRATIFY THE POPULATION?

- Because everyone doesn't need the same help – some people need more help than others because of the conditions of their lives, the conditions of their communities, and the conditions of their communities
- Equity is about creating systems that reliably identify and give people the support they need
- To plan for that support, you need to see the whole picture
- You can use the information that is revealed about underlying determinants (housing, food, etc) to plan your broader community strategy
- To go from thinking of the person in front of you to being able to see and plan for the whole picture

Photo by Gift Habeshaw on Unsplash

Referred from: First Connections

Brief Client Description:

- Patient referred by FC nurse due to multiple concerns and risk factors
- Patient is a female in her late twenties with an infant son
- Patient lives with parents

Family Care Team Case study

Risk Drivers Identified:

- History of Substance Use Disorder, currently on methadone
- Uncontrolled chronic infectious disease
- Poor follow-through with primary care
- Lack of employment; Educational/Vocational needs
- No driver's license
- DCYF involvement
- Recently transitioned to home from residential placement
- Family conflict and poor natural supports

Interventions:

- Patient was referred to the CHT **Behavioral Health clinician** for counseling services and to the CHT Certified **Peer Recovery Specialist** (CPRS) who connected her to meetings (online/in-person)
- Assisted patient to **reinstate her license**; helped complete application and provided transportation to DMV.
- CCHW assisted patient in **completing resume and applying for jobs**
- CCHW assisted patient in **completing housing applications**

Family Goals:

- Finishing Medical Assistant schooling
- Secure employment
- Behavioral health counseling
- Peer Recovery services
- Family Therapy sessions
- License reinstatement for transportation

Care Team:

- Community Health Worker (CCHW)
- Behavioral Health Clinician (LMHC)
- Certified Peer Recovery Specialist (CPRS)

Other Partners/Services:

- Residential treatment center
- DCYF—Now closed
- Opioid Treatment Program—for medication assisted treatment and psychiatric care
- Early Intervention
- Healthy Families America
- Recovery Center

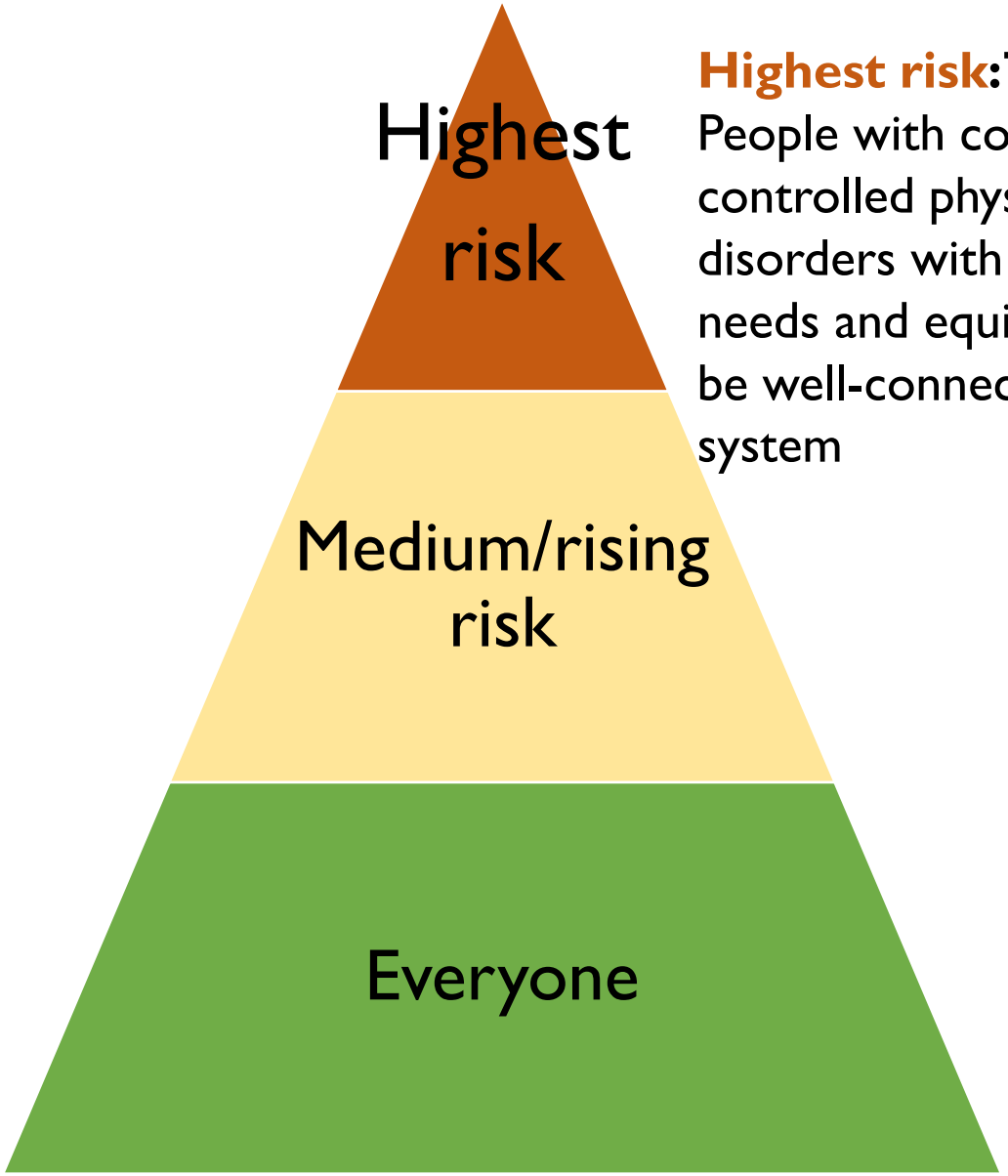
Outcomes:

- Actively attending online recovery meetings/ maintaining sobriety
- Baby is stable, attending all peds appointments, and mother is connected to recommended community providers
- Reporting a decrease in anxiety and improvement in sleep for parent
- Stable housing and relationship with family
- Chronic medical conditions are in control
- Patient has an active license, has been attending all appointments for child and herself
- Actively seeking employment
- DCYF has closed services
- Actively engages in an Early Intervention program.

RISK STRATIFICATION

Example / Poll

- Is this patient:
  - High risk
  - Medium risk
  - Low risk



Who is in this group?

Highest risk: Top 5%
People with combined poorly controlled physical, mental health disorders with compounding social needs and equity gaps) who may not be well-connected to primary care system

PT IS 52 YEARS OLD AND LIVES IN LOWINCOME HOUSING WITH HER 15 Y.O. DAUGHTER AND 10 Y.O. ADOPTED GRANDDAUGHTER. SHE IS DISABLED, HAS POORLY MANAGED DIABETES AND CHF. PT EXHIBITS POOR JUDGEMENT, HAS POOR ADLS AND POOR SUPPORTS. PT IS A FALL RISK AND STRUGGLES TO AMBULATE. PT HAS BEEN HOSPITALIZED RECENTLY FOR FALL RESULTING IN FRACTURED HIP AND SORE ON FOOT. PT CALLS THE AMBULANCE FOR SUPPORT IF SHE FALLS. PT DOES NOT HAVE TRANSPORTATION.

SCH CHT Case Study 2020

Risk Drivers

Utilization: Pt has been hospitalized several times for fall and Diabetes and COPD related symptoms
Health Conditions/Literacy: Diabetes, CHF, broken shoulder, fractured hip, eye problems. Pt is poor historian and has little insight.
Care Coordination: none prior to CHT
Social/Emotional Support: Pt has sister and older daughter who live in the state; somewhat supportive.
Functional Limitations: Pt struggles with ambulating and is a fall risk. Struggles w/ judgement, following through on referrals, memory and organizational skills-forgets appts, etc..
Social/Familial/Environmental:
Family: Pt care for 2 children, her daughter, 15 and adopted granddaughter, 10.
Food Security: SNAP and utilizes food banks.
Housing: Lives in subsidized housing. Sleeps on couch. 2 br apt.
Transportation: Pt takes public transportation or relies on sister.
Insurance: NHP access/ Medicaid
Financial: SSDI $1500/ month.
Behavioral Health: Pt has depression, displays flat affect and apathetic demeanor.
RISK DRIVERS IDENTIFIED FOR OTHER FAMILY MEMBERS:
- Counseling advised for children.
- In home family therapy advised for parenting skills; lack encouragement.

Intervention

Utilization: Pt has in home supports through HH and CHT support. Pt has BH support with BHCM.
Health Conditions/Literacy: has VNA, OT and PT currently and CHT support.
Care Coordination: Coordinated HH diabetes coaching. Pt has 2/x week wound care and meets with OT & PT.
Social/Emotional Support: BHCM meets with pt for weekly support.
Functional Limitations: CHT suggested pt use calendar and phone for scheduling appointments.
Social/Familial/Environmental:
Family: Daughter registered with Big Sister for mentoring and will have intake.
Housing: Pt on waitlist for larger apt. Assisted living advised.
Transportation: no changes
Insurance: no changes
Financial: no changes
Behavioral Health: suggested in home counselor- pt struggles with follow through. Suggested inpatient at Butler to address Depression symptoms.
INTERVENTIONS BENEFITTING OTHER FAMILY MEMBERS
- A Big Sister referral for 10 y.o.
- B FCCP referral; kids did not qualify
- C Seeking in home family therapy

RISK STRATIFICATION

Example / Poll

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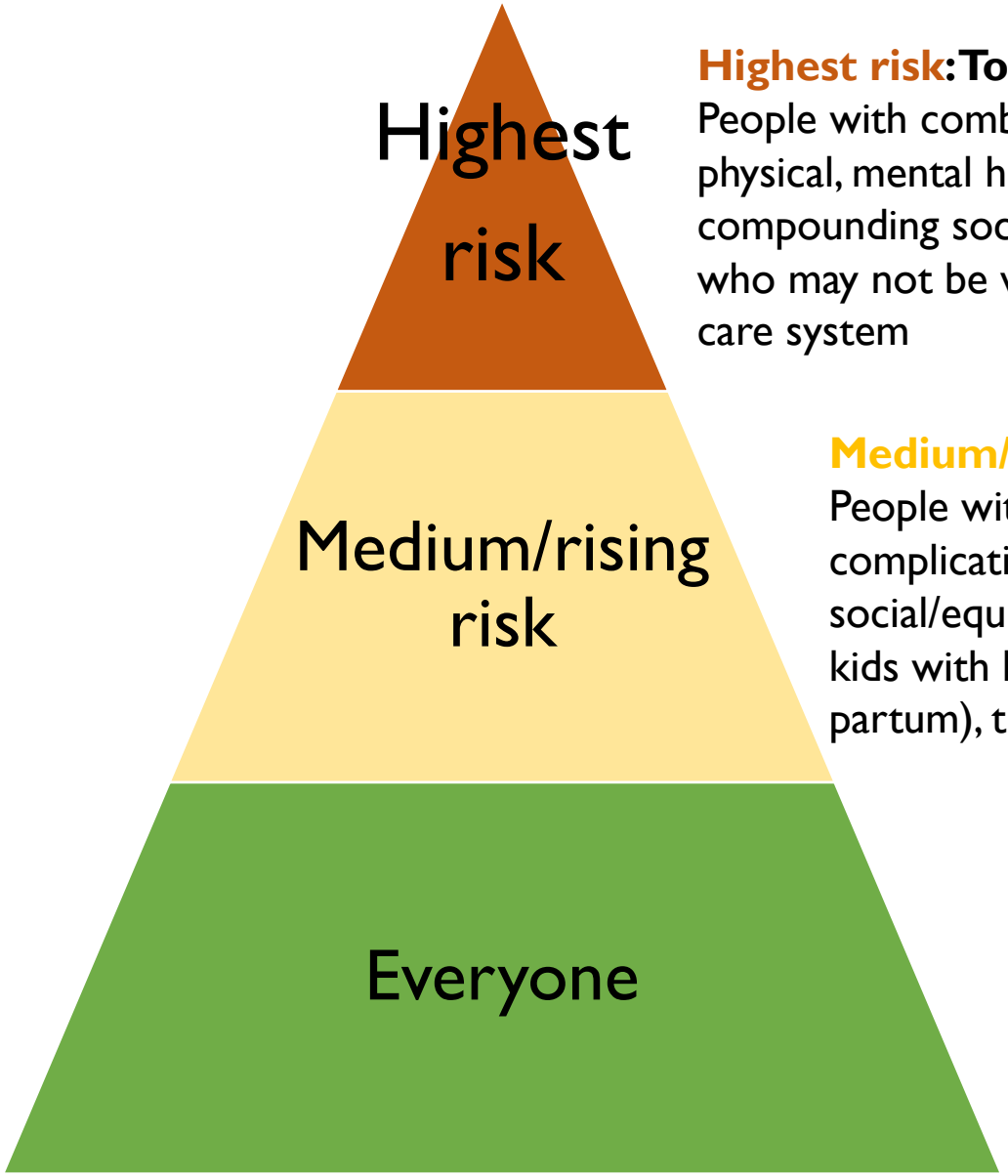
  - Low risk



Who is in this group?

Highest risk: Top 5%
People with combined poorly controlled physical, mental health disorders with compounding social needs and equity gaps) who may not be well-connected to primary care system

Medium/rising risk: (20-30%)
People with controlled chronic medical conditions, complicating behavioral health (eg, addiction) OR social/equity gap (people who are housing insecure, kids with high ACE scores, black mothers post-partum), those who are not connected to PC

HOW CAN YOU STRATIFY YOUR POPULATION TO IDENTIFY WHO MIGHT NOT BE THRIVING?

DIMENSIONS OF RISK STRATIFICATION

- Medical risk
- Social risk
- Place-based risk
- Equity risk

RISK STRATIFICATION BASED ON PEOPLE AND EQUITY

1. 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

2. 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)

3. 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

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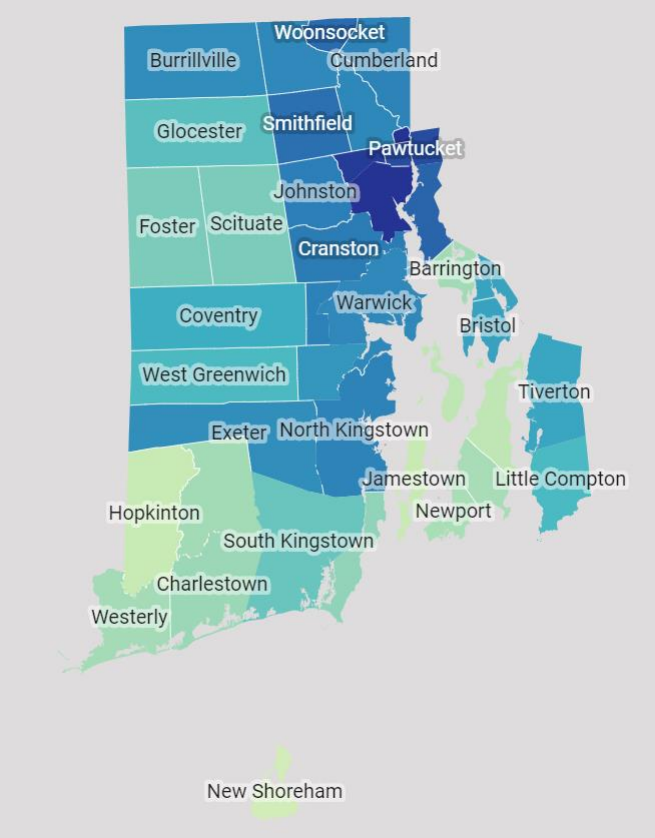
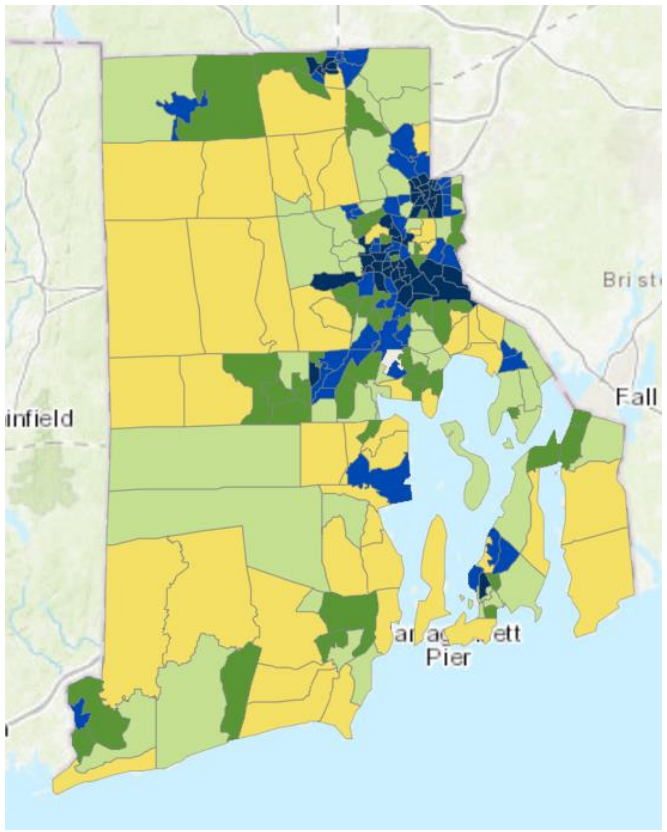
4. PLACE-BASED RISK



COVID cases/100,000 pop in RI



SOCIAL VULNERABILITY

- HIGH (3 points each)
  - COVID – DARK BLUE
  - SOCIAL VULN.

    > 0.8
- MEDIUM (2 points each)
  - COVID – LIGHTER BLUE
  - SOCIAL VULN – 0.4-0.8
- LOW (1 point each)
  - COVID – YELLOW AND GREEN
  - SOCIAL VULN - <0.4

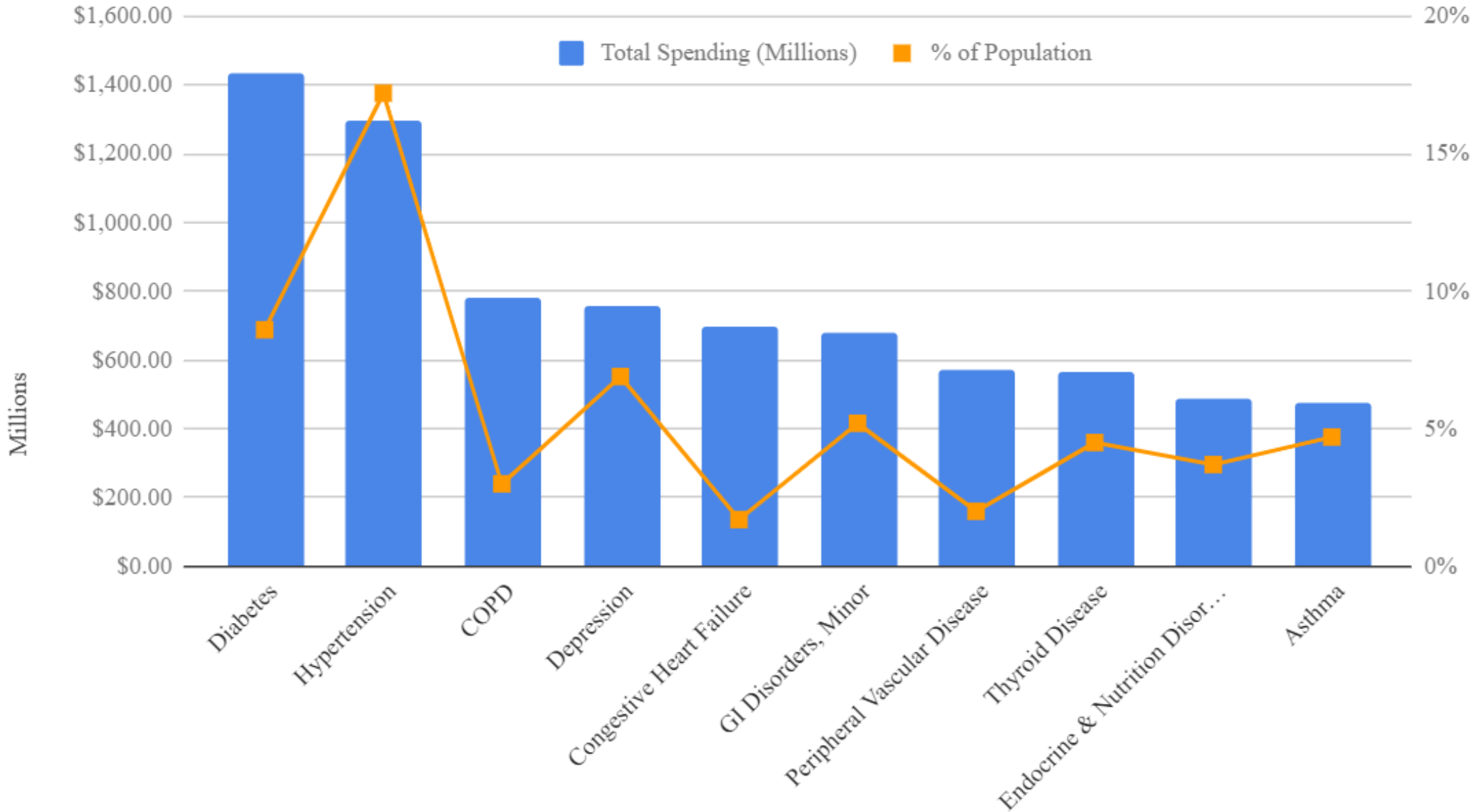
Potential risk stratification table – Diabetes and COVID

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

RISK STRATIFICATION

Practice Stratifying Medical / Social Risk /

Total Spending (Millions) for Patients with Each Condition and Percent of Population with Each Condition



Spending on chronic conditions in Rhode Island

https://health.ri.gov/data/chronicconditions/

PEDRO IS ONE OF OVER 30,000 UNDOCUMENTED IMMIGRANST IN RHODE ISLAND. HE IS FROM GUATEMALA AND WORKS IN A FACTORY. A LOT OF PEOPLE HE KNOWS HAVE BEEN SICK WITH COVID. HE HAS HEARD ABOUT A VACCINE BUT IS AFRAID HE AND HIS DAUGHTER (WHO CAME WHEN SHE WAS 1) WILL BE DEPORTED OR REPORTED FOR PUBLIC CHARGE. HE USES THE EMERGENCY ROOM SEVERAL TIMES WHEN HE NEEDS TO.

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Example / Poll

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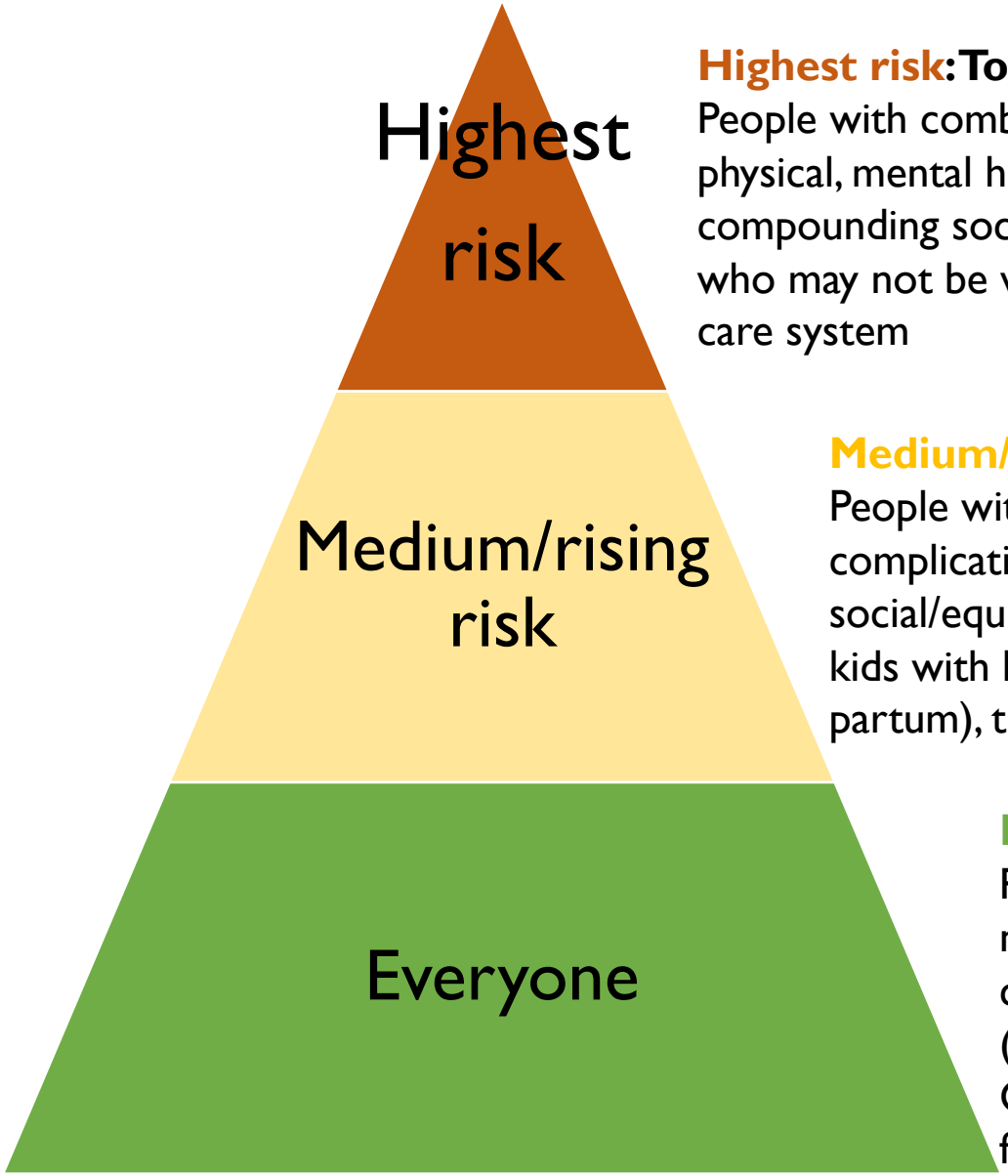

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Medium/rising risk:
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Everyone
People who would benefit from navigation for routine care and connection to social/equity needs (eg, immigrants who do not seek COVID testing or vaccination due to fear of public charge)

1. HOW DO YOU STRATIFY YOUR POPULATION CURRENTLY?

2. HOW WILL YOU STRATIFY YOUR POPULATION TO ENSURE EQUITY GOING FORWARD?

THANK YOU!

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