RI DIABETES HEALTH EQUITY CHALLENGE
Supporting the community during the COVID-19 pandemic – WAVE 2

WELCOME!
02/12/2021
THINKING ABOUT YOUR WORK, WHAT IS ONE THING THAT MOTIVATES YOU?
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/
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

- 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
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
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
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

Photo by Gift Habeshaw on Unsplash
### 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

### 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

### 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

### Outcomes:
- Actively attending online recovery meetings/maintaining sobriety
- Baby is stable, attending all pediatrics 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.
Example / Poll

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

Who is in this group?

- **Highest risk:** Top 5%
- **Medium/rising risk:**
- **Everyone:**
PT IS 52 YEARS OLD AND LIVES IN LOW INCOME 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.
**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.

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**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
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.

**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
4. PLACE-BASED RISK

- **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

**COVID cases/100,000 pop in RI**

**SOCIAL VULNERABILITY**
## Potential risk stratification table – Diabetes and COVID

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

- Is this patient:
  - High risk
  - Medium risk
  - Low risk
Who is in this group?

**Highest risk:** Top 5%
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**Medium/rising risk:**
People with controlled chronic medical conditions, complicating behavioral health (e.g., 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

**Everyone**
People who would benefit from navigation for routine care and connection to social/equity needs (e.g., 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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100 Million Healthier Lives
RI DIABETES HEALTH EQUITY CHALLENGE
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