Equity’s role in SDOH
Interventions: Implementation

April 7, 2020
12:00pm – 1:00pm ET
The Q&A function is located on the bottom right-hand side of the screen
  - If you experience technical issues, please private message the **Event Producer**
- Send all questions and feedback through the Q&A function
- We will share a poll at the end
- The webinar is being recorded and will be shared afterwards
OUR VISION: Health, well-being and dignity for every person in every community.

OUR MISSION: We partner with communities and health systems to address systemic causes of inequity and disease. We do this by removing barriers that keep people from identifying, accessing and choosing the resources everyone needs to be healthy.
### Examples of Why the Equity Discussion is Important in the COVID-19 Era

<table>
<thead>
<tr>
<th>Racism and discrimination exhibited towards Asian/Pacific Islander community</th>
<th>Higher % of deaths within African American community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients currently within the safety net have even more difficulty obtaining the essential resources needed to be healthy</td>
<td>Impact following shelter in place is expected to hit historically underinvested communities harder</td>
</tr>
</tbody>
</table>
Objectives for today

• This webinar will provide direct insight into the approaches used to ensure that screening and navigation promote equity within social determinants of health/social risks interventions.

• This webinar will delve into how integrating social care into clinical care can be used to explicitly address disparities and inequities present within the health care system.

• This webinar will create a space for inquiry and dialogue to discuss ways equity can be further advanced as stakeholders seek to develop new or improve upon existing interventions focused on social determinants of health/social risks.
Panelists

Leticia Reyes-Nash
Director of the Office of Programmatic Services and Innovation
Cook County Health

Moraya Moini
Director of Programs and Operations, Women’s Health Programs and Innovation
Los Angeles County Department of Health Services

Nimisha Patel
Associate Vice President of Management Services
Duke Health | Private Diagnostic Clinic, PLLC

Tigee Hill
National Director of Partnerships & Initiatives
Health Leads

Artair Rogers
Manager of West Coast Partnerships
Health Leads
Equity’s Role in SDOH
Interventions: Implementations

Screening

Tigee Hill & Nimisha Patel
Why enroll community voices in screening development process?

People can best define what health means to them and should have control over the decision making process that affects their health.

Building strong relationships results in trust. Trust is part of the critical path for building a successful and sustainable social care model.

Direct input from people leads to a more equitable design.

Leads to creating a program that is highly adopted and utilized because it meets the specific needs of that community in a particular place.
Bring the community into the design of the screening

“Historically underinvested communities understand their needs more than we do.”

Scope of Screening

- What are the relevant needs?
- What are the gaps in the resource landscape?
- What needs are easy/challenging to navigate?

Framing the Introduction

- Asking permission and stating the purpose of the conversation
- For example: Response to the word “need”

Presentation of Questions

- Elementary grade reading level or lower
- Use preferred language
- Limit jargon
- Who is asking the questions?
How do we ensure that patients/community members can comfortably engage with the questions?

Provide training for **ALL** staff involved in screening

- Cultural Humility
- Implicit Bias
- Trauma Informed Care
- Empathic Inquiry

Creating a safe space
### At what level & how do you involve community input?

<table>
<thead>
<tr>
<th>Community Representation</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Advisory Council</td>
<td>Level 1 + Community Stakeholders (Professionals, CBOs, Public Health Depts, Cross-Sector Orgs)</td>
<td>Level 1 + Level 2 + Residents with Lived Experiences (Community Action Network or Coalition)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Power Structure</th>
<th>Organization-led</th>
<th>Co-led</th>
<th>Community-led</th>
</tr>
</thead>
</table>

| Progression of Becoming Community Led | | |
|---------------------------------------|---|
| • Project based | • Project based or developing cultural norm |
| • Organization facilitates community input & solution design | • Collaborative facilitation of community input & solution design |
| • Community time volunteered | • Community time volunteered |
| | • Entrenched cultural norm & standard practice |
| | • Community facilitates community input & solution design |
| | • Community time paid for, role formalized & expertise acknowledged |
In your experience or from what you have seen in your community, what is impacting the health, quality of life, and well-being of women who identify as black in the city of Boston?

Missed the mark: the word racism doesn’t appear in the question at all.

Do you feel that racism in Boston has affected your well-being or the well-being of other black women in your community? If so, how? Can you share a story?

Getting closer: Racism appears in the question, but racism is phrased as a possibility rather than a known barrier.

How has racism in Boston affected your well-being or the well-being of other Black women in your community?

On track: Racism is noted in the first three words, and the question is phrased in a manner that acknowledges racism as a known barrier.
Thank You!
Cook County Health

Leticia Reyes-Nash
Cook County Health

Health Plan

Provider

Correctional Health

Public Health
Center for Health Equity and Innovation: Health Equity Strategies*

Make Health Equity a Strategic Priority

Develop structure and processes to support health equity work

Deploy specific strategies to address the multiple determinants of health

Decrease institutional racism within the organization

Develop partnerships with community organizations to improve health and equity

*(IHI, 2016)
Current CCH Activities

To provide care for historically underinvested populations, we must design programs and push for change in policies that tackle inequities and root causes of disparities in health.

<table>
<thead>
<tr>
<th>Social Inequities</th>
<th>Opioid Overdose Epidemic</th>
<th>Food Insecurity and Food as Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cook County minimum wage ordinance, addressing stigma</td>
<td>Opposing SNAP changes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Institutional Inequities</th>
<th>Opioid Overdose Epidemic</th>
<th>Food Insecurity and Food as Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult probation policies</td>
<td>Good Food Purchasing Program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living Conditions</th>
<th>Opioid Overdose Epidemic</th>
<th>Food Insecurity and Food as Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expanding access to MAT</td>
<td>Screening and referral to Fresh Trucks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Behaviors</th>
<th>Opioid Overdose Epidemic</th>
<th>Food Insecurity and Food as Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual provision of MAT, naloxone</td>
<td>Individual health education</td>
</tr>
</tbody>
</table>
We lean on existing community partnerships to quickly respond to the needs of the community.

In partnership, we can quickly identify needs. For example, unhoused patient population* top needs are:

1. Linkage to temporary housing resources for those needing to self isolate;
2. Wellness kits for those given temporary housing;

New, flexible strategies are created due to community engagement to meet the new needs of these patients.

*8,857 households in Chicago are experiencing homelessness and an estimated 7,351 households are CCH patients.
Navigating Resource Connections post COVID-19

1. **We are behind:** Disparities have existed before this crisis; COVID-19 has exacerbated the disparities and inequities more. Equity is now a requirement.

2. **We need a comprehensive approach to address resource landscape.** Our approach to address social needs must intersect at the individual, community, government, and policy level.

3. **We need alignment.** Community coordination and partnership must receive investment.
Thank You
MAMA’S NEIGHBORHOOD

Los Angeles County Department of Health Services

Moraya A. Moini, MPH
Director of Programs and Operations
Women’s Health Programs and Innovation
How Structural Oppression Looks in Healthcare: Place Matters

Preterm Births by Mother’s Service Planning Area: Los Angeles County, 2013

<table>
<thead>
<tr>
<th>Service Planning Area</th>
<th>Preterm Births : Between 17 and 36 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>1. Antelope Valley</td>
<td>620</td>
</tr>
<tr>
<td>2. San Fernando</td>
<td>2,240</td>
</tr>
<tr>
<td>3. San Gabriel</td>
<td>1,865</td>
</tr>
<tr>
<td>4. Metro</td>
<td>1,161</td>
</tr>
<tr>
<td>5. West</td>
<td>518</td>
</tr>
<tr>
<td>6. South</td>
<td>1,945</td>
</tr>
<tr>
<td>7. East</td>
<td>1,572</td>
</tr>
<tr>
<td>8. South Bay</td>
<td>1,691</td>
</tr>
<tr>
<td>Unknown</td>
<td>76</td>
</tr>
<tr>
<td>Total</td>
<td>11,688</td>
</tr>
</tbody>
</table>
### Preterm Births by Mother’s Service Planning Area: Los Angeles County, 2013

<table>
<thead>
<tr>
<th>Mother’s Race/Ethnicity</th>
<th>Preterm Births : Between 17 and 36 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>11,688</td>
</tr>
<tr>
<td>African American</td>
<td>1,189</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1,465</td>
</tr>
<tr>
<td>Hispanic</td>
<td>6,838</td>
</tr>
<tr>
<td><strong>Native American</strong></td>
<td><strong>26</strong></td>
</tr>
<tr>
<td>White</td>
<td>1,801</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>182</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>187</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11,688</strong></td>
</tr>
</tbody>
</table>

- **African American**: 1,189 (12.8%)
- **Asian/Pacific Islander**: 1,465 (7.4%)
- **Hispanic**: 6,838 (9.4%)
- **Native American**: 26 (16.4%)
- **White**: 1,801 (7.8%)
- **Two or More Races**: 182 (9.5%)
- **Other/Unknown**: 187 (10.6%)
# How the Results of Structural Oppression Show Up in Our System

<table>
<thead>
<tr>
<th></th>
<th>Percent preterm births</th>
<th>Percent low birth weight infants</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>10.8%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>11.4%</td>
<td>7.4%</td>
</tr>
<tr>
<td>DHS deliveries</td>
<td>16.9%</td>
<td>13.0%</td>
</tr>
<tr>
<td>DHS SPA 6 and 8 deliveries</td>
<td>19.2%</td>
<td>14.0%</td>
</tr>
</tbody>
</table>
Mother-Centered Care Model: An Approach to Directly Confront Structural Oppression

- Maternity
- Assessment
- Management
- Access and
- Service synergy throughout the Neighborhood for health

Figure 1. Los Angeles County Department of Health Services, Moraya Moini, MPH and Erin Saleeby, MD, MPH, 2017. Adapted from Mother Centered Care Conceptual Model, Mother Friendly Childbirth Initiative Consortium. PHP Consulting, Moraya A. Moini, MPH, November 2012.
An Equity Orientation Causes a Shift in Care

Traditional
- Episodic Care
- Prescriptive Care
- Social Determinants
- Highlight Deficits
- Cultural Competency
- Referral for Community Services
- Individual-Focused

Equity Oriented
- Life Course Planning
- Shared Decision Making
- Social Contributors
- Leverage Protective Factors
- Cultural Humility
- Linked Connections to Services
- Neighborhood-Focused
Referrals to Assessed Service Needs, n=2,289 Patients

- Transportation: 14%
- GED/Job Training: 22%
- Food Banks: 11%
- Food Stamps/TANF: 18%
- Housing Services: 14%
- MH: 30%
- IPV/DV: 15%
- Substance Abuse Treatment: 15%
- Emergency Needs: 18%
- Parenting Class: 2%
- Breastfeeding Assistance: 52%
- Prenatal Educ Classes: 63%
- Oral Health: 27%
- WIC: 81%
Gestational Age at Birth, n=702

- Very Preterm (32-33 weeks): 3%
- Late Preterm (34-36 weeks): 2%
- Preterm (37-38 weeks): 9%
- Early Term (39-40 weeks): 26%
- Full Term (41 weeks): 10%
- Late Preterm (42 weeks): 10%
- Postterm (43 weeks): 0%
- Unknown Gestation: 1%

Newborn Weight, n=702

- Very Low Birth Weight (VLBW) <1500 gms: 3%
- Low Birth Weight (LBW) 1200-<2500 gms: 7%
- Normal Weight 2500-<4500 gms: 87%
- Macrosomia 4500+ gms: 2%
- Unknown Weight: 1%
On the Forefront…

- Trauma Informed Care Model
- Measuring Racism
- More Investment in Public Private Partnerships
- Social Care Community Connectors
Panel Discussion

• What are the opportunities for advancing health equity in SDOH interventions in the time of COVID-19?

• What are the risks in not advancing health equity in SDOH interventions in the time of COVID-19?
Q&A

• Send questions through the Q&A function on the right side of the screen

• If you wish to come off mute to ask your question, simply click the **Hand Raise** icon on the right side of your screen so we can unmute you
Join Us!

**Health Leads Forum**: How social need programs are shifting during the pandemic to meet significant increases in demand for essential resources

- **Date**: Friday, April 17
- **Time**: 12pm ET / 9am PT
- Information on how to register will be shared after the webinar

**Part Two of Intentionally Integrating Equity Into SDOH Interventions**: Equity’s Role in SDOH Interventions: Evaluation

- **Date & Time**: More information coming soon!
Thank you!

Questions?

Send to:
Network@healthleadsusa.org

https://healthleadsusa.org/network/