Equity’s role in SDOH Interventions: Implementation

April 7, 2020

12:00pm – 1:00pm ET

Health Leads

Housekeeping slide

- 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

Racism and discrimination exhibited towards Asian/Pacific Islander community

Higher % of deaths within African American community

Patients currently within the safety net have even more difficulty obtaining the essential resources needed to be healthy

Impact following shelter in place is expected to hit historically underinvested communities harder

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

Health Leads

Private Diagnostic Clinic
THE PHYSICIAN PRACTICE OF DUKE HEALTH

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

Direct input from people leads to a more **equitable design**

WHY ENROLL COMMUNITY IN SCREENING DEVELOPMENT PROCESS ?

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

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?

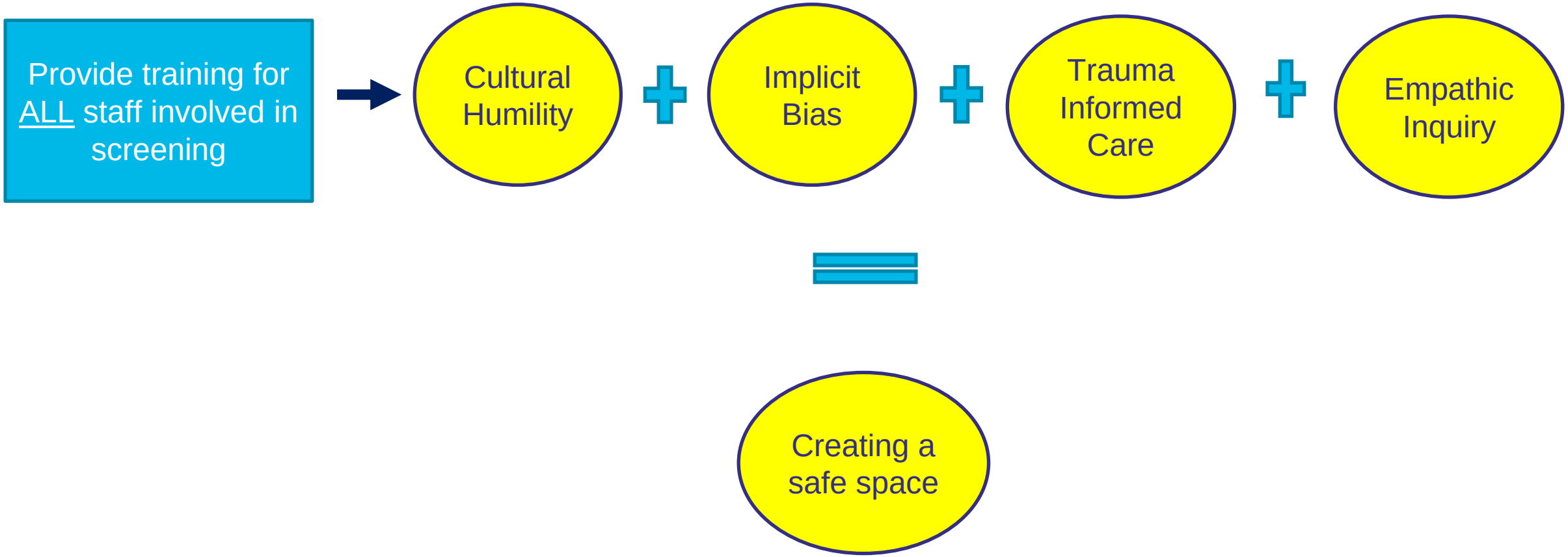
Framing the Introduction

- 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?



At **what level** & **how** do you involve community input?

	Level 1	Level 2	Level 3
Community Representation	Patient Advisory Council	Level 1 + Community Stakeholders (Professionals, CBOs, Public Health Depts, Cross-Sector Orgs)	Level 1 + Level 2 + Residents with Lived Experiences (Community Action Network or Coalition)
Power Structure	Organization-led	Co-led	Community-led
Progression of Becoming Community Led	• Project based • Organization facilitates community input & solution design • Community time volunteered	• Project based or developing cultural norm • Collaborative facilitation of community input & solution design • Community time volunteered	• Entrenched cultural norm & standard practice • Community facilitates community input & solution design • Community time paid for, role formalized & expertise acknowledged

Evolution of a question

Version 1: Based on best assumptions from discussions w/ community members
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.

Version 2: Based on one direct community feedback session
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.

Version 3: Based on second direct community feedback session
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 know barrier.

Thank You!

Health Leads

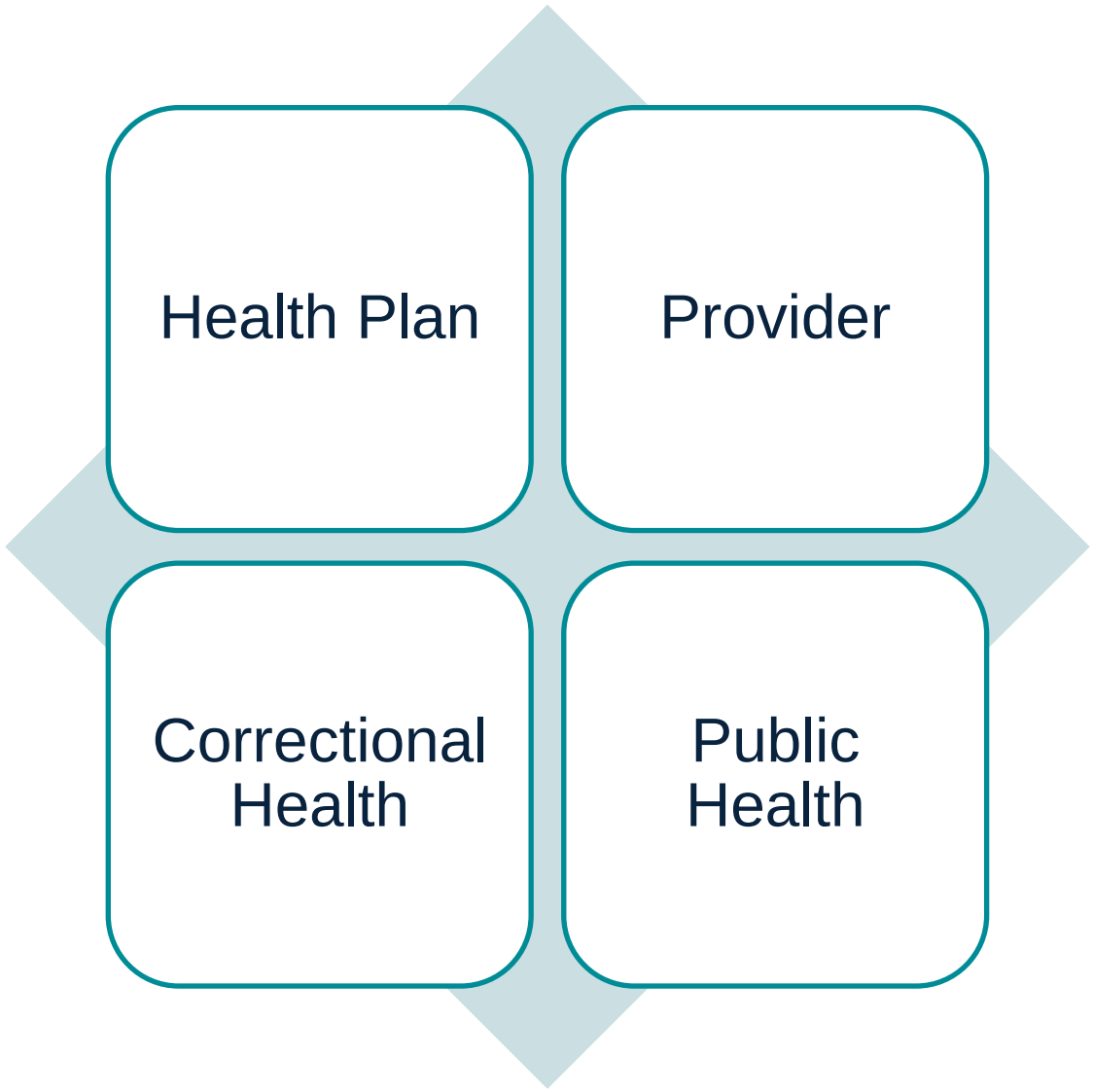
Private Diagnostic Clinic
THE PHYSICIAN PRACTICE OF DUKE HEALTH

Cook County Health

Leticia Reyes-Nash

COOK COUNTY HEALTH

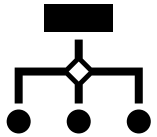
Cook County Health



COOK COUNTY HEALTH

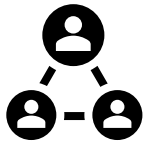
Center for Health Equity and Innovation: Health Equity Strategies*

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

COOK COUNTY HEALTH | Cook County Department of Public Health

*(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.

	Opioid Overdose Epidemic	**Food Insecurity and Food as Medicine**
Social Inequities	Cook County minimum wage ordinance, addressing stigma	Opposing SNAP changes
Institutional Inequities	Adult probation policies	Good Food Purchasing Program
Living Conditions	Expanding access to MAT	Screening and referral to Fresh Trucks
Risk Behaviors	Individual provision of MAT, naloxone	Individual health education

Cook County Health COVID-19 Response

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; (3) monitoring covid-19 cases within shelter

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.**

COOK COUNTY HEALTH

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.

COOK COUNTY HEALTH

Thank You

COOK COUNTY HEALTH

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		
	Preterm Births : Between 17 and 36 weeks	
Service Planning Area	Total	%
1. Antelope Valley	**620**	**11.0**
2. San Fernando	2,240	9.2
3. San Gabriel	1,865	7.5
4. Metro	1,161	9.0
5. West	518	7.5
6. South	**1,945**	**11.0**
7. East	1,572	9.2
8. South Bay	1,691	9.2
Unknown	76	14.4
Total	11,688	9.1%

How Structural Oppression Looks in Healthcare: Race/Ethnicity Matters

Preterm Births by Mother's Service Planning Area: Los Angeles County, 2013		
	Preterm Births : Between 17 and 36 weeks	
Mother's Race/Ethnicity	Total	%
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
Total	11,688	9.1

How the Results of Structural Oppression Show Up in Our System

	Percent preterm births	**Percent low birth weight infants**
California	10.8%	6.9%
Los Angeles County	11.4%	7.4%
DHS deliveries	**16.9%**	**13.0%**
DHS SPA 6 and 8 deliveries	19.2%	14.0%

Mother-Centered Care Model: An Approach to Directly Confront Structural Oppression

- **M**aternity
- **A**ssessment
- **M**anagement
- **A**ccess and
- **S**ervice synergy *throughout the*
- **Neighborhood** for health

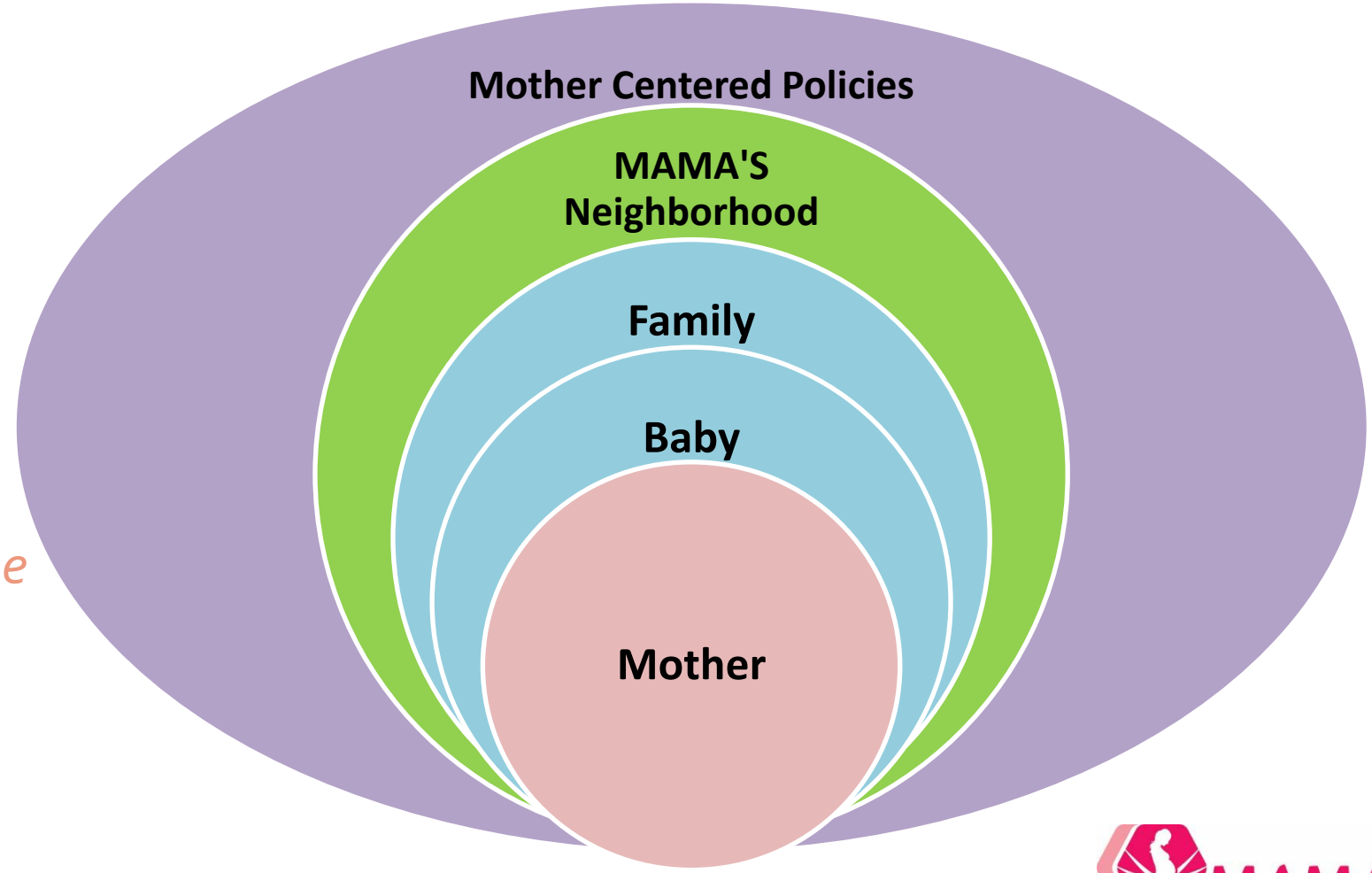


Figure 1. Los Angeles County Department of Health Services, Moraya Moini, MPH and Erin Saleeby, MD, MPH, 2017. *Adapted from Mother Centered Care Conceptual Model, Mother Friendly Childbirth Initiative Consortium. PHP Consulting, Moraya A. Moini, MPH, November 2012.*

MAMA's NEIGHBORHOOD a Strong Start for Families

An Equity Orientation Causes a Shift in Care

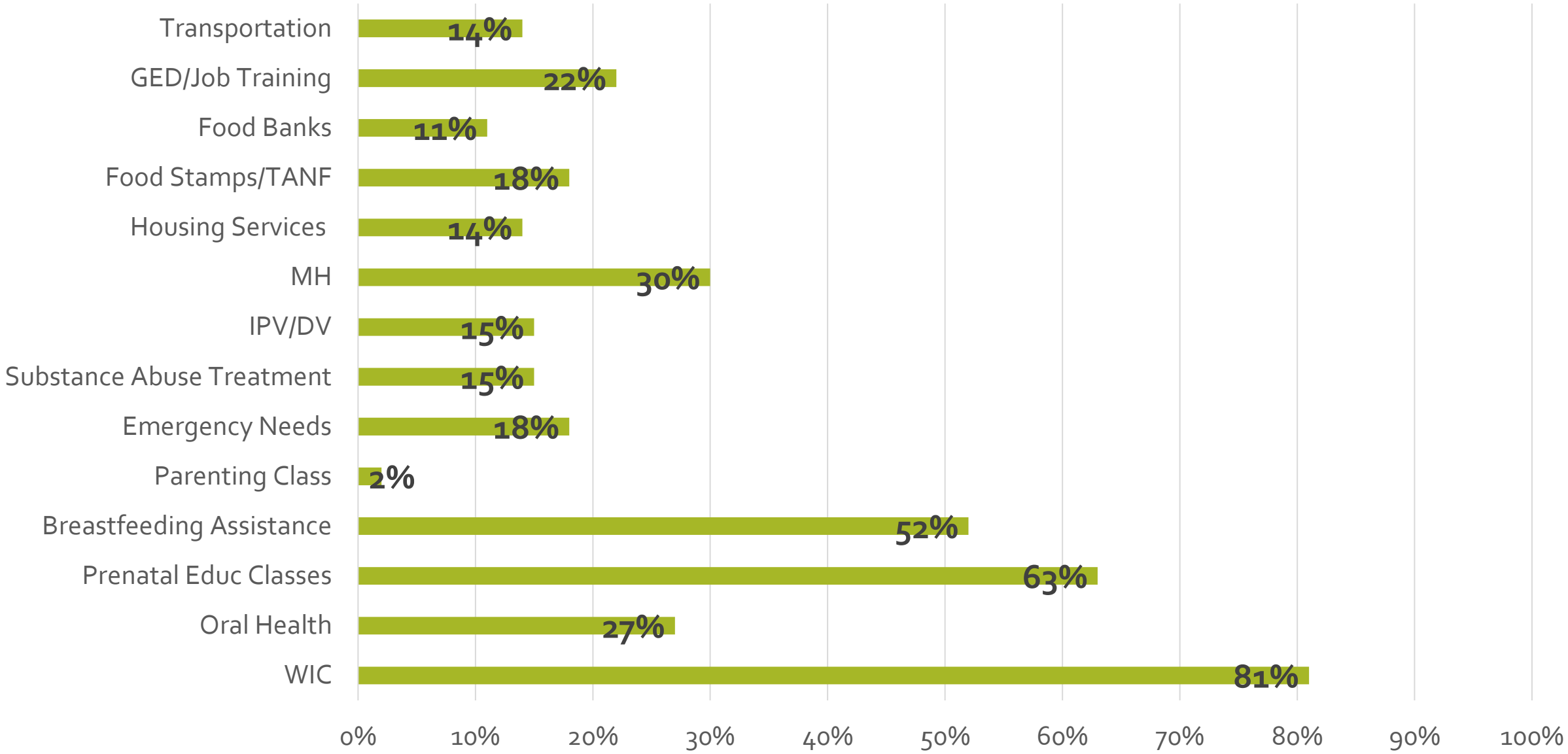
Traditional

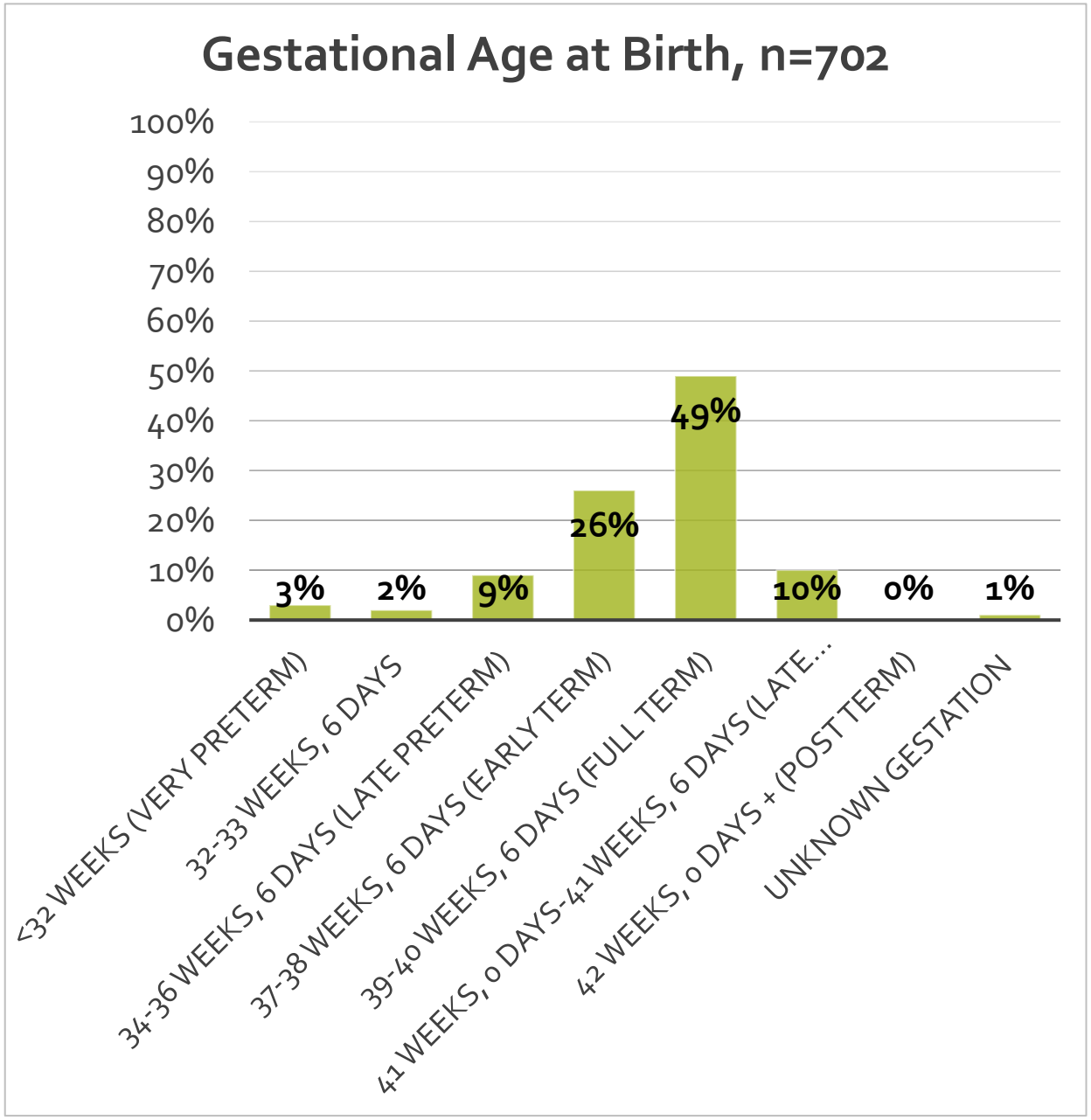
- Episodic Care
- Prescriptive Care
- Social Determinants
- Highlight Deficits
- Cultural Competency
- Referral for Community Services
- Individual-Focused

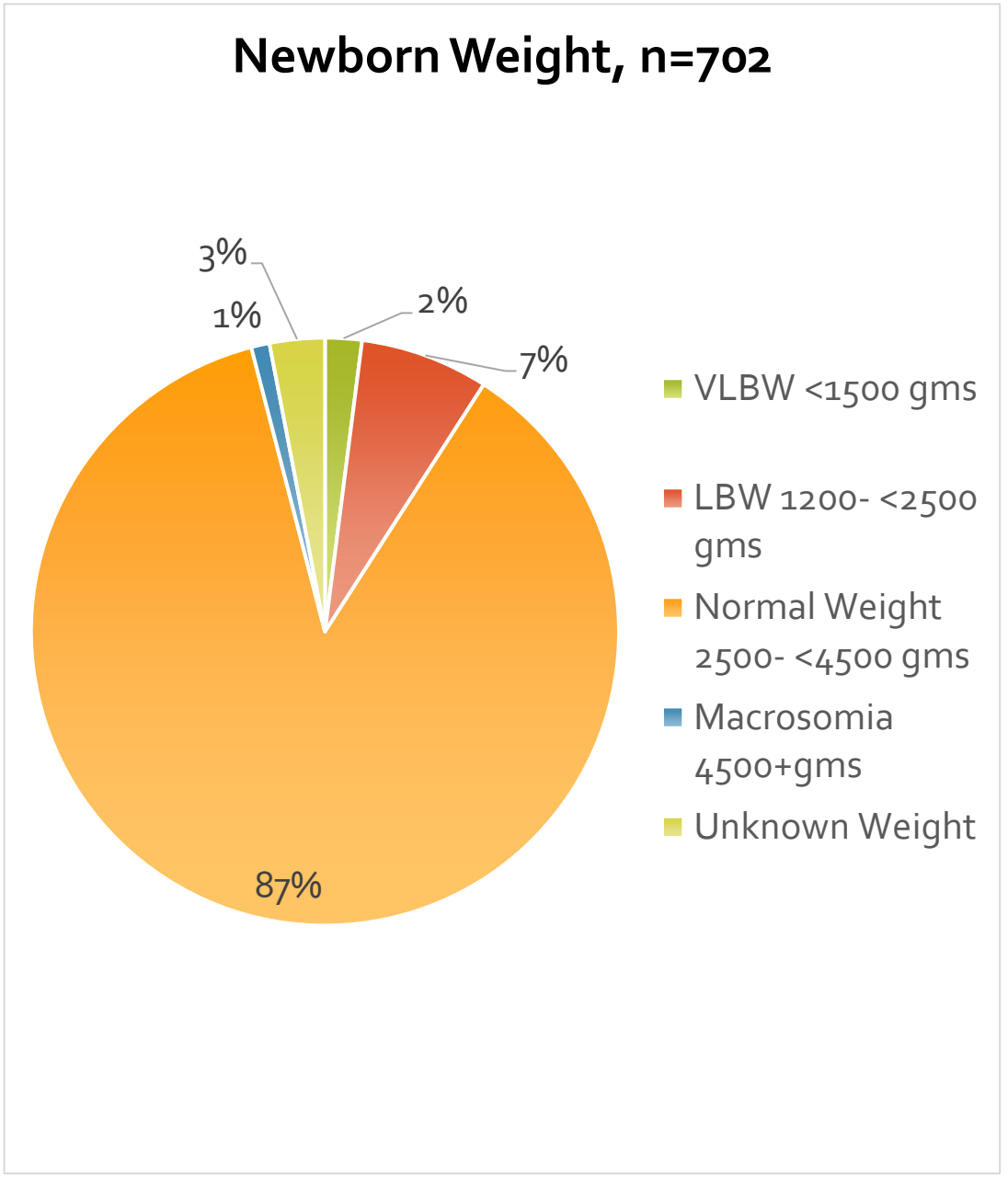
Equity Oriented

- 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




Gestational Age at Birth, n=702
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3%
2%
9%
26%
49%
10%
0%
1%
<32 WEEKS (VERY PRETERM)
32-33 WEEKS, 6 DAYS
34-36 WEEKS, 6 DAYS (LATE PRETERM)
37-38 WEEKS, 6 DAYS (EARLY TERM)
39-40 WEEKS, 6 DAYS (FULL TERM)
41 WEEKS, 0 DAYS-41 WEEKS, 6 DAYS (LATE...
42 WEEKS, 0 DAYS + (POST TERM)
UNKNOWN GESTATION


Newborn Weight, n=702
3%
1%
2%
7%
87%
VLBW <1500 gms
LBW 1200- <2500 gms
Normal Weight 2500- <4500 gms
Macrosomia 4500+gms
Unknown Weight

On the Forefront…

MAMA's NEIGHBORHOOD
a Strong Start for Families

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/

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