



Integration Optimization: Understanding Equity and What it Means to Provide Responsive Care

Presented by: So O'Neil, Eli Michaels, and
Shannon Lea

Today's Moderator



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About PCDC

Primary Care Development Corporation (PCDC) is a national nonprofit organization and a community development financial institution catalyzing excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity.

Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).



www.samhsa.gov

“Operationalizing Integration” Webinar Series Tip Sheets

MITIGATING BURNOUT THROUGH INTEGRATED HEALTHCARE

IMPACT OF BURNOUT

HOW INTEGRATION CAN MITIGATE THE IMPACT OF BURNOUT

Resources for Health Care Worker Well-Being: 6 Essential Elements

- Advance Organizational Commitment
- Strengthen Leadership Behaviors
- Conduct Workplace Assessment
- Examine Policies & Practices
- Enhance Workplace Efficiency
- Cultivate a Culture of Connection & Support

Remember that trans-disciplinary connections are protective. They improve patient care and support staff communication and relations.

Examples include:

- Daily huddles
- Weekly meetings
- Treatment planning sessions

The goal is to create space, collaborate, share information, and problem solve together, moving towards an integrated strengths based approach.

“Mitigating Burnout through Integrated Healthcare” tip sheet can be accessed here:
<https://www.pcdc.org/resources/operationalizing-integration-mitigating-burnout-through-integrated-healthcare-tip-sheet/>

COLLABORATIVE CARE MANAGEMENT 101

STEPPED STRATEGIES FOR INTEGRATION¹

Principles of Collaborative Care¹

- Patient-Centered Team.** The patient, primary care, and mental health providers collaborate effectively using shared care plans that incorporate patient goals.
- Population-Based.** A registry is used to facilitate engagement and outcome tracking in a defined group of patients at the caseload and clinic level.
- Measurement-based Treatment to Target.** Progress is measured regularly, and treatments are actively changed until clinical goals are achieved.
- Evidence-Based Treatments.** Providers use treatments that have research evidence for effectiveness.
- Accountable.** The care team is accountable to the patient and other care team members for quality of care and clinical outcomes, not just the volume of care provided.

COLLABORATIVE CARE FOR VARIOUS BEHAVIORAL HEALTH CONDITIONS¹

Established Evidence-Base

- Depression**
 - Adolescent Depression
 - Depression, Diabetes, and Heart Disease
 - Depression and Cancer
 - Depression in Women's Health Care
- Anxiety**
- Post Traumatic Stress Disorder**
- Chronic Pain**
- Dementia**
- Chronic Substance Use Disorder**
- Bipolar Disorder**

“Collaborative Care Management 101” tip sheet can be accessed here:
<https://www.pcdc.org/resources/operationalizing-integration-collaborative-care-management-foundations-tip-sheet/>

MATERNAL MENTAL HEALTH CONSIDERATIONS

Burden of Untreated Perinatal Mood and Anxiety Disorders (PMADs) in the United States

High-Level Solutions to Address the Burden of Untreated PMADs in the United States

Policy	Infrastructure	Health Care System
Support policies to expand insurance eligibility, enrollment, and provider and services covered	Incentivize providers to practice in low resource areas	Encourage the creation of multi-disciplinary teams and team based coordinated care processes
Provide patient navigation to insurance and alternative providers	Widen providers' care area potential	Have mental health providers consult with obstetricians
	Provide flexibility by offering extended hours or after-hours care	Screen for PMADs, report quality measures, and use maternity mental health safety bundles

“Maternal Mental Health Considerations” tip sheet can be accessed here:
<https://www.pcdc.org/resources/operationalizing-integration-system-level-opportunities-to-improve-maternal-mental-health-tip-sheet/>

"Integration at Work" Webinar Series Tip Sheets

TYPES OF INTEGRATION

Coordinated Care (off-site)
Level 1: Minimal Collaboration
 Patients are referred to a provider at another practice site, and providers have minimal communication.
Level 2: Basic Collaboration
 Providers at separate sites periodically communicate about shared patients.

Co-located Care (on-site)
Level 3: Basic Collaboration
 Providers share the same facility, but maintain separate cultures and develop separate treatment plans for patients.
Level 4: Close Collaboration
 Providers share records and some system integration.

Highly Integrated Care
Level 5: Close Collaboration
 Providers develop and implement collaborative treatment planning for shared patients but not for other patients.
Level 6: Full Collaboration
 Providers develop and implement collaborative treatment planning for all patients.

INTEGRATION CONTINUUM

Key Domains of Integrated Care	Preliminary	Intermediate I	Advanced
Screening, Referral to Care, Follow-Up (RU)	Response to patient self-report of general health condition or other chronic disease by when prompted.	Systematic screening for general health risk factors and proactive health education to a support intervention to address risk factors.	Analyze patient population to identify by severity of medical complexity and/or unique ability for proactive assessment/feedback.
Facilitation of referrals and FU	Referrals to external primary care, specialty and medical FU.	Formal collaborative agreement with external PCPs to facilitate referral that includes engagement and communication expectations.	Enhanced referral facilitation to create or closely integrated, share PCPs with automated data sharing and accountability for engagement.
Ongoing Care Management	None or minimal FU of patients referred to primary and medical specialty care.	Formal ability to operate FU of general health appointments, encourage medical adherence and engagement of appointments.	Use of tracking tool to monitor treatment response and outcomes over time at individual and group level, tracking and proactive FU.



START YOUR JOURNEY WITH THE PREVENTIVE SCREENING ROAD MAP:

1. Understand your patient population
2. Define your priorities and select screening tools
3. Define care team member roles and responsibilities
4. Operationalize the screening process
5. Provide education, training, and cross-training

TYPES OF REGISTRIES TO HELP MEET YOUR SCREENING GOALS:

- MANUAL:** Reports run by individuals using identified criteria
- ELECTRONIC:** Built into the electronic health record, but must be manually run
- AUTOMATED:** Reports are built into the system and automatically run at a selected frequency
- INTEGRATED:** Real-time population management platform that can be viewed by all care team members at any time

LABS AND HEALTH INDICATORS: AN INTEGRATED CARE OPPORTUNITY

Primary Care Providers (PCP):

- Provide information to BH colleagues about "red flag" symptoms a client may mention that should get a referral for labs or other health indicator testing such as: dizziness when standing, trouble breathing, excessive thirst, numbness, etc.
- Keep BH colleagues updated on fluctuations in client labs and health indicators.
- Convey acute and long-term implications of health behaviors that may be related to lab results in order to facilitate collaborative care planning and alignment on shared treatment goals.
- Follow through on care for referred clients and follow up with BH provider to correct around reasons for referral.

Behavioral Health Providers (BH):

- Refer clients for labs or other health indicator testing when "red flag" symptoms are expressed and provide a warm hand-off to PCP.
- Engage with clients about their experience receiving lab and health results. Offer supportive coping mechanisms if needed.
- Connect with PCP for updates on what client lab results indicate. Collaborate on care plans, modifying shared treatment goals to ensure client is comprehensively supported.
- Recommend ways PCP colleagues can supportively provide health guidance and information to clients.

Key ways Behavioral Health providers are critical partners within integrated care:

- Improve the skills of primary care providers to recognize behavioral disorders.
- Improve the skills of providers to recognize how behavioral health conditions may manifest as physical symptoms.
- Promote greater adherence to treatment regimens for chronic conditions.
- Help patients understand the ways that emotions can affect how they feel physically.
- Establishing responsive "person centered" goals to manage both physical and behavioral conditions.

POLICY CONSIDERATIONS

- Include details on specific task oriented staff activities
- Convene stakeholders from throughout organization to develop PC-BH policies and recommendations
- Incorporate feedback even after policies are drafted as input is key to understanding how a process gets carried out in real time
- Ensure all guidance is either broad enough for or can specifically account for differences between disciplines. For instance: PCP may focus on specific clinical markers; BH may focus on social and emotional markers. Good policy and directives would account for both.

Contact us to discuss how our services can help your care teams. Email: cap@pcdc.org
This resource was developed in partnership with the Center of Excellence for Integrated Health Solutions.



Considering Cost and Yield in Partnership Equations

Integrated care partnerships can be complex, with different organizations and team members holding different visions.

Part of taking an advanced lens on partnerships is determining the cost (input of time, energy and resources) and the yield (client impact, positive staff experience, increase in revenue, etc.) and understanding if shifting or transitioning a partnership is necessary.

When the cost is HIGHER than the yield, applying concepts on the wheel to the right can be supportive to recalibrate.

When the cost is LOWER than the yield, it is still critical to have methods in place, such as those within the wheel, to keep a forward trajectory where your partnerships remain in a low cost high yield equation.

All recordings and tip sheets from the "Integration at Work" webinar series can be accessed here: <https://www.pcdc.org/what-we-do/training-technical-assistance/integration-at-work-samhsa-webinar-series/>

Audience Demographics Poll

Do you work in a:

- Primary care setting
- Behavioral health setting
- Integrated care setting

Are you working primarily as a:

- MD/DO
- Nurse Practitioner/Registered Nurse
- Physician Assistant
- Medical Assistant
- Therapist
- Social Worker
- Care Manager
- QI Manager
- Informatics
- Other

Please rate your current skills and comfort with understanding the root causes and various aspects of how inequities perpetuate, embedding equity in healthcare, and delivering responsive care.

- Very Low
- Low
- Moderate
- High
- Very High

Today's Presenters



So O'Neil

Director, Health Philanthropy Portfolio
Mathematica



Eli Michaels

Health Equity Researcher
Mathematica

The road to equity in health care



Agenda

- Equity to the forefront
- Defining equity
- The road to inequities
- Beyond racial inequities
- Equity and responsive care
- Q and A

Objectives

- Provide context for current discourse around equity
- Understand root causes and various aspects of how inequities perpetuate
- Inspire participants to engage in discussions and reflection on how to embed equity in healthcare
- Define and discuss factors that impact the provision of responsive care



Equity to the Forefront





Source: Keyvan Shovir, Clarion Alley, Mission District, San Francisco, 2020

Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity

Updated Apr. 24, 2023

Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases ¹	1.6x	0.8x	1.1x	1.5x
Hospitalization ²	2.5x	0.7x	2.1x	1.8x
Death ^{3, 4}	2.0x	0.7x	1.6x	1.7x

Source: [National Center for Immunization and Respiratory Diseases \(NCIRD\), Division of Viral Diseases, 2023](#)



JANUARY 20, 2021

Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government



BRIEFING ROOM

PRESIDENTIAL ACTIONS

Section 1. Policy

Sec. 2. Definitions

Sec. 3. Role of the Domestic Policy Council

Sec. 4. Identifying Methods to Assess Equity

Sec. 5. Conducting Equity Assessments in Federal Agencies

Sec. 6. Allocating Federal Resources to Advance Fairness and Opportunity

Sec. 7. Promoting Equitable Delivery of Government Benefits and Equitable Opportunities

Sec. 8. Engagement with Members of Underserved Communities

Sec. 9. Establishing an Equitable Data Working Group

Sec. 10. Revocation

Sec. 11. General Provisions

Source: [White House](#), 2021



Defining Equity



What is Equity?

THE MEANS

Deep equity means working toward outcomes in ways that model dignity, justice, and love without re-creating harm in our structures, strategies and working relationships.

Change Elemental

THE ENDS

Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.

World Health Organization

What is Equity?

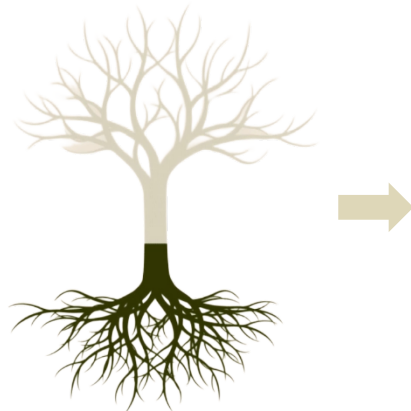


EQUALITY

EQUITY

Health equity framework

Structural determinants of health



Policies and institutional practices that determine the allocation of societal resources.

Social determinants of health



Conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.

Quality and use of services



The safety, effectiveness, patient-centeredness, timeliness, efficiency, and consistency of healthcare and other social resources that people use.

Health and wellness



Well-being experienced by various individuals and groups

Source: [Mathematica](#), 2021

Why do we care about equity?

Everyday narratives [and behaviors] that marginalize, minimize and disrespect people of color and those with less privilege should be replaced with ones that do not demonize individuals but understand the systemic and structural barriers that limit possibilities and the ability to thrive. They can instead lift-up the historical, contextual and powerful dynamics that create and sustain oppression and shed light on the strategies and solutions which can shift the 'rules of the game' so that equity is achievable.

– *Equitable Evaluation Initiative (EEI)*

The economic costs of not advancing health equity

\$320 billion

in annual health care spending today

\$1 trillion

in annual health care spending by 2040

Source: [Deloitte](#), 2022



How did we get here?



Segregated, underfunded, inaccessible care

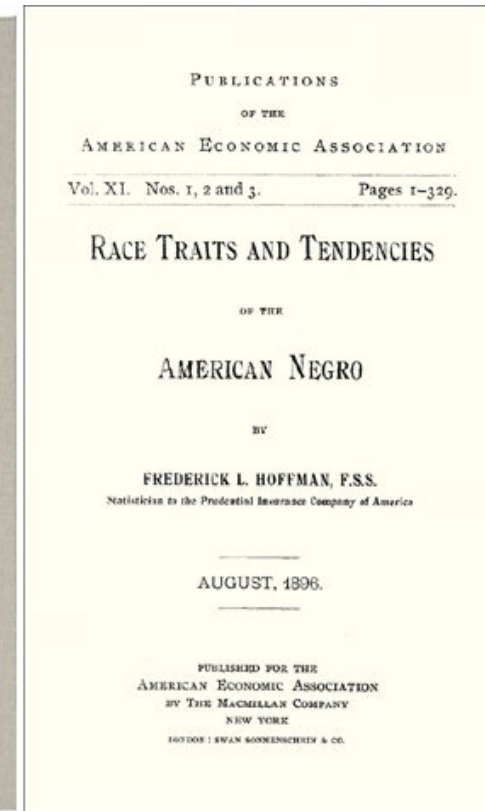
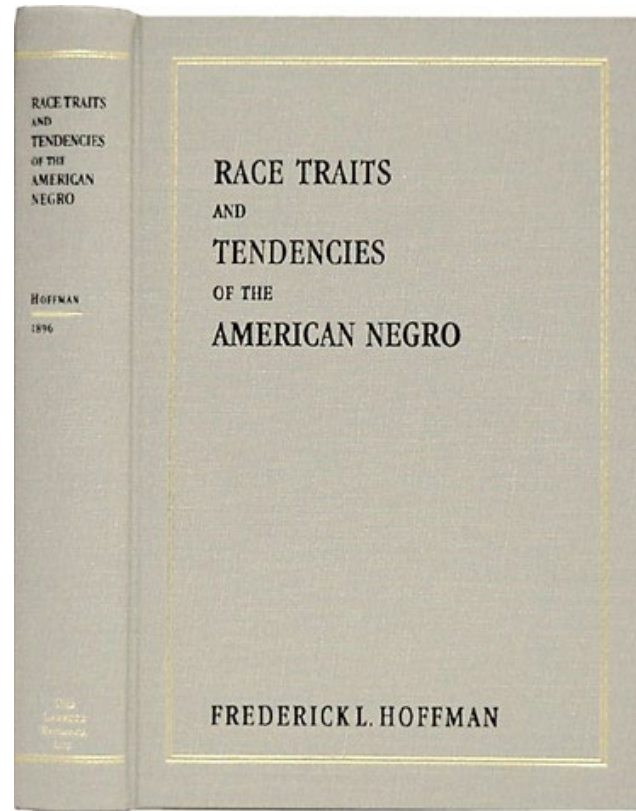
FREEDMEN'S BUREAU MEDICAL DIVISION

Freedman's Village, Arlington,
Virginia, ca. 1865

Source: Library of Congress
(LC-DIG-ppmsca-34829)



Inaccurate narrative of poorer health outcomes among Black Americans rooted in eugenics



Inhumane treatment by medical professionals

TUSKEGEE SYPHILIS STUDY
(1932-1972)



Source: National Archives

Exclusionary policies

1965 – Medicaid eligibility linked to Welfare eligibility

Excluding:

*Those not part of the formal workforce, therefore, ineligible for unemployment, who were **mostly people of color and living in poverty.***

1996 – Medicaid eligibility delinked from Welfare eligibility

Excluding:

***many people of color and living in poverty.** Because Medicaid eligibility was set to lower income levels, many people lost coverage.*

Medicaid expansion became optional under ACA and 10 states still have not expanded Medicaid, accounting for 92% of the coverage gap in adults

Source: [Health Affairs](#), 2020

HealthAffairs

HEALTH AFFAIRS FOREFRONT

RELATED TOPICS:

MEDICAID | ACCESS TO CARE | MEDICAID PROGRAMS | NURSING | HEALTH DISPARITIES | COVID-19

How Foundational Moments In Medicaid's History Reinforced Rather Than Eliminated Racial Health Disparities

[LaShyra T. Nolen](#), [Adam L. Beckman](#), [Emma Sandoe](#)

SEPTEMBER 1, 2020

10.1377/forefront.20200828.661111



Inequitable distribution of resources

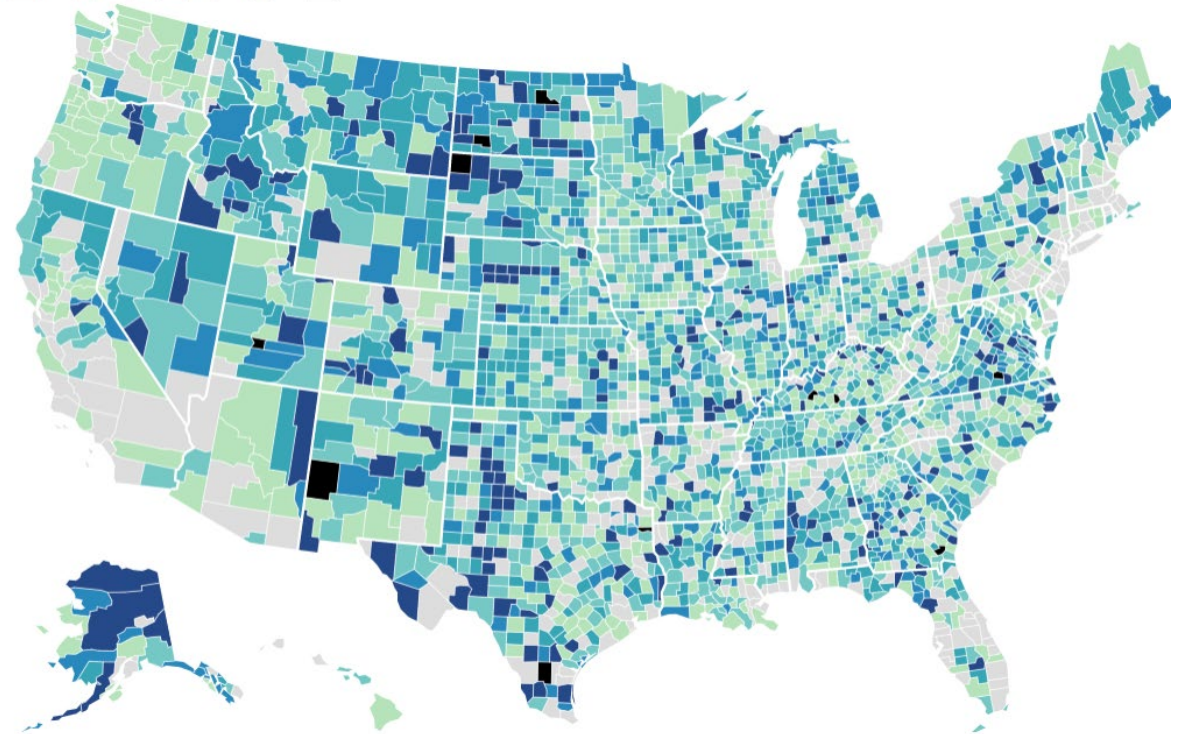
80% of counties lack adequate access to healthcare

- 45% low-cost health center
- 40% pharmacy deserts
- 20% hospital deserts
- 9% primary care provider deserts

570 counties across the United States have no psychologists, psychiatrists or counselors

Healthcare deserts in the United States by county

Number of healthcare deserts
1 2 3 4 5 6

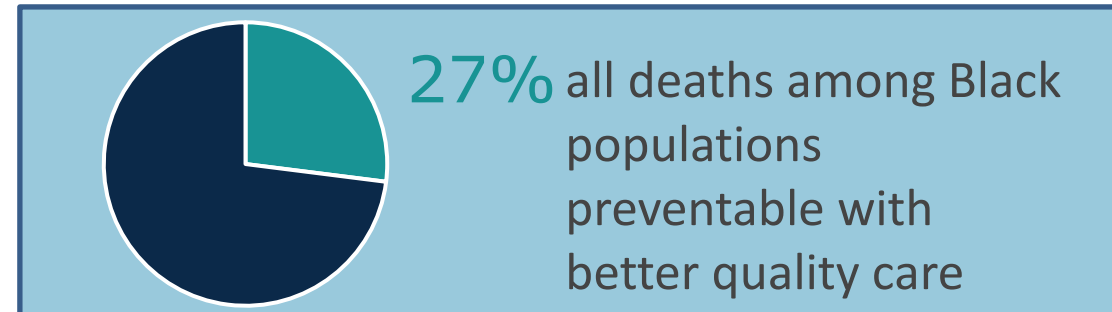


Source: [GoodRx Health](#), 2021

Implicit bias in organizations and individuals

“If you’re having a heart attack, there are very standardized protocols. If you’re African-American, you’re less likely to get those, even with the same health insurance, even with the same presentation.

—Ashish Jha, 2016, Harvard Gazette





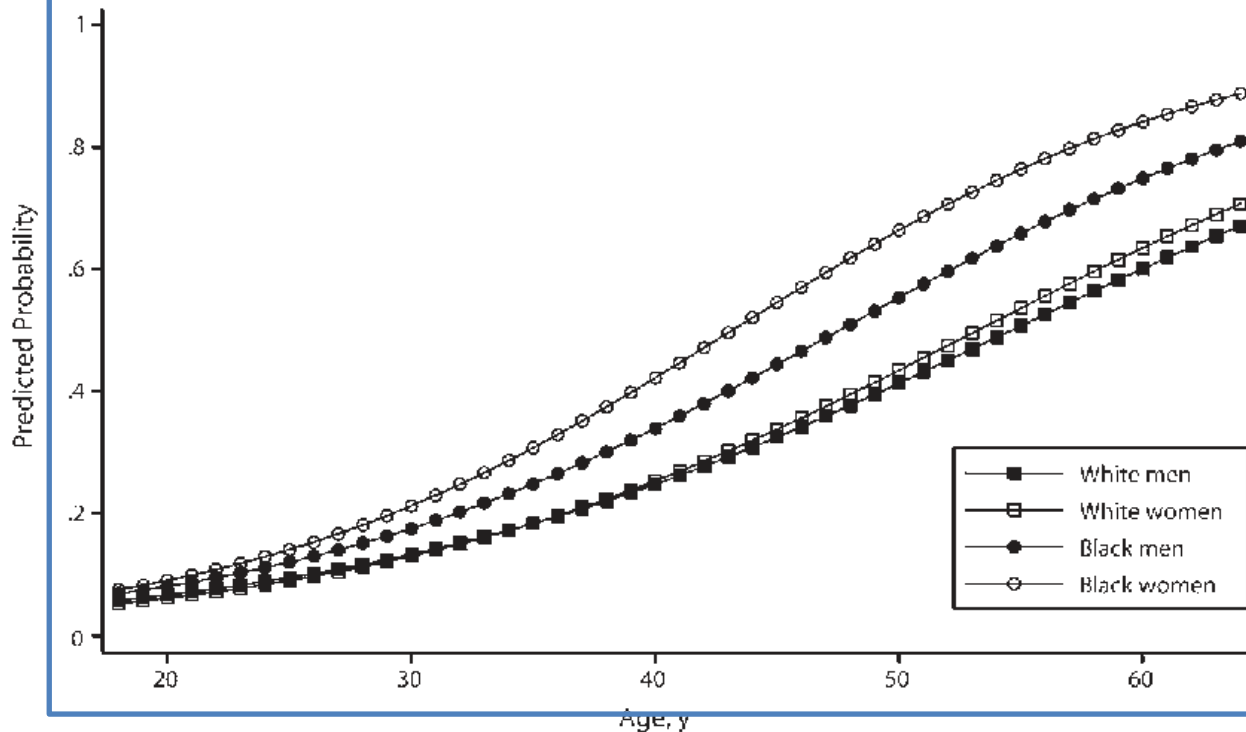
Expanding our understanding



Beyond race and ethnicity

- Communities experiencing poverty
- Immigrants
- LGBTQIA+
- People with disabilities
- People living in rural areas

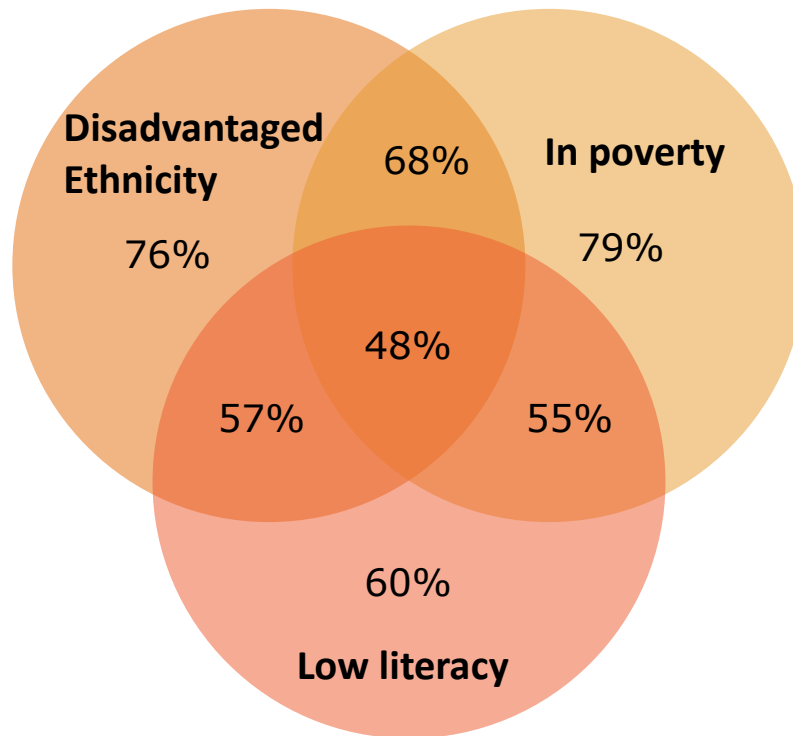
Accelerated aging at the intersections of race and gender: Black women show higher allostatic load at earlier ages, compared to white women and Black men (Geronimus et al., 2006, [AJPH](#))



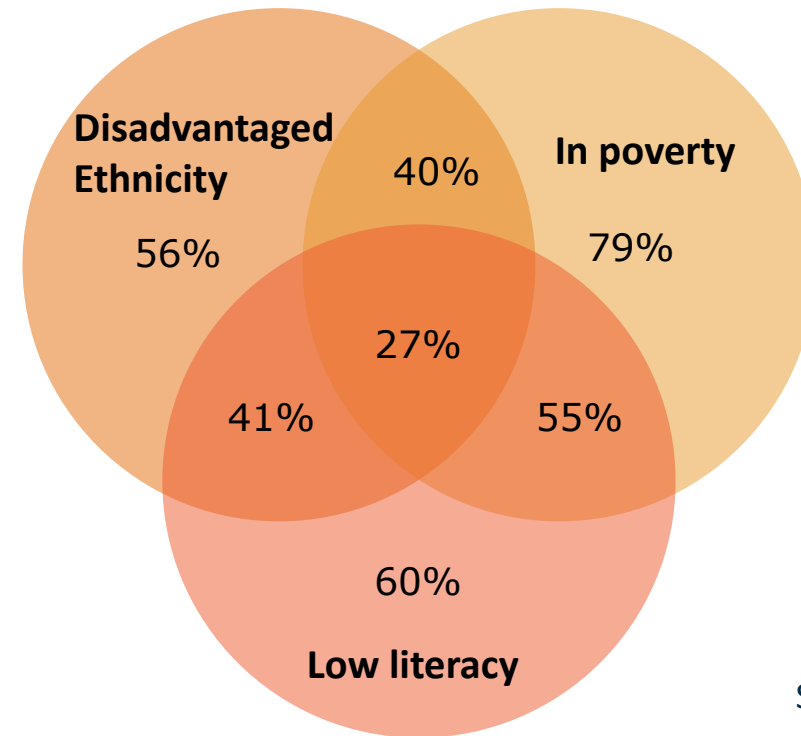
Health behaviors at the intersections of race/ethnicity and sexual identity: Smoking during pregnancy was more common among LGBTQIA+ people compared to heterosexual people, with the biggest gaps observed for Latina people compared to White people. Smoking may be used to **cope** with race- and sexuality-related stress (Hartnett, Butler, & Everett, 2021, [SSM – Population Health](#))

Coverage of maternal and newborn health services based on identities, Nepal 2016

Had 4 antenatal care visits

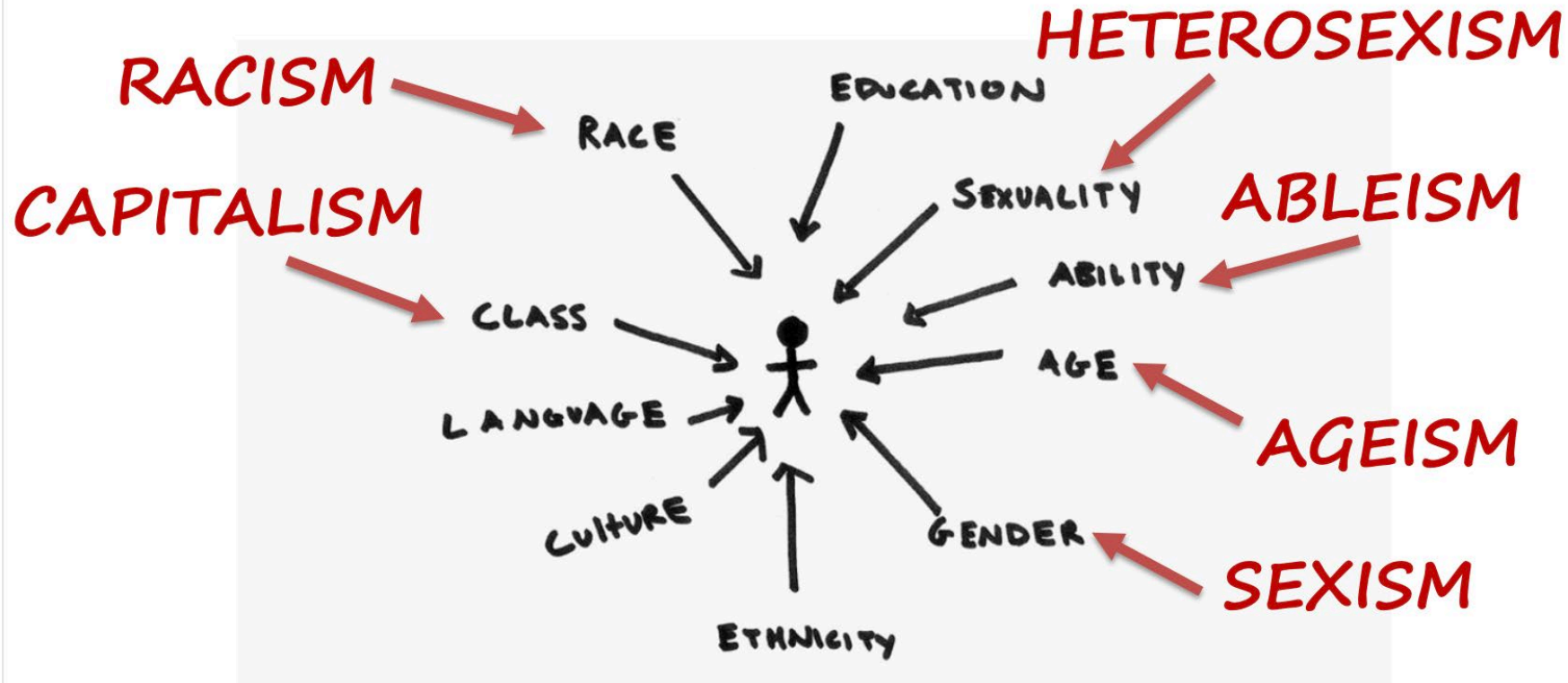


Had a postnatal care visit within 48 hours of delivery



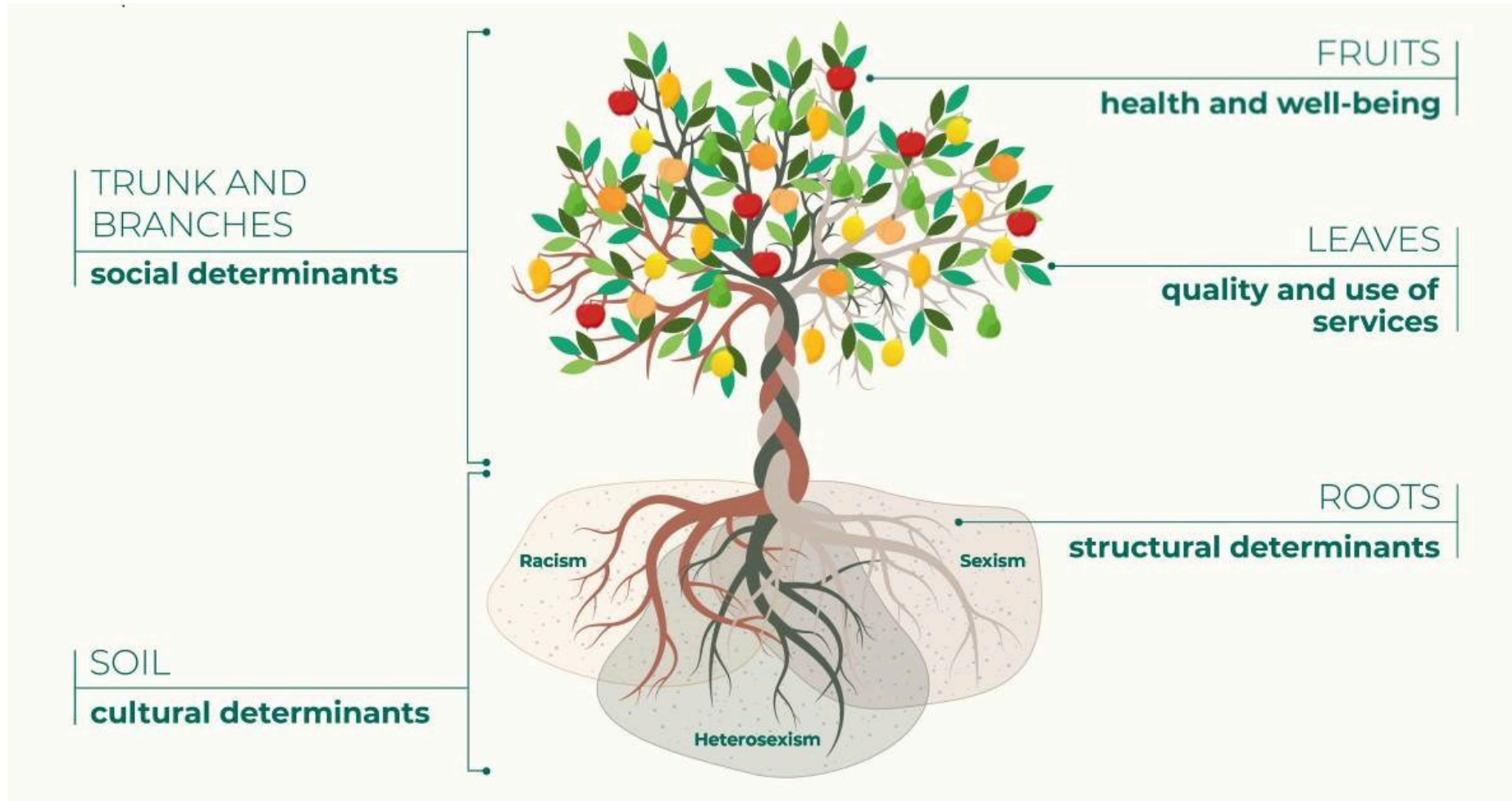
Source: [PLOS ONE](#)

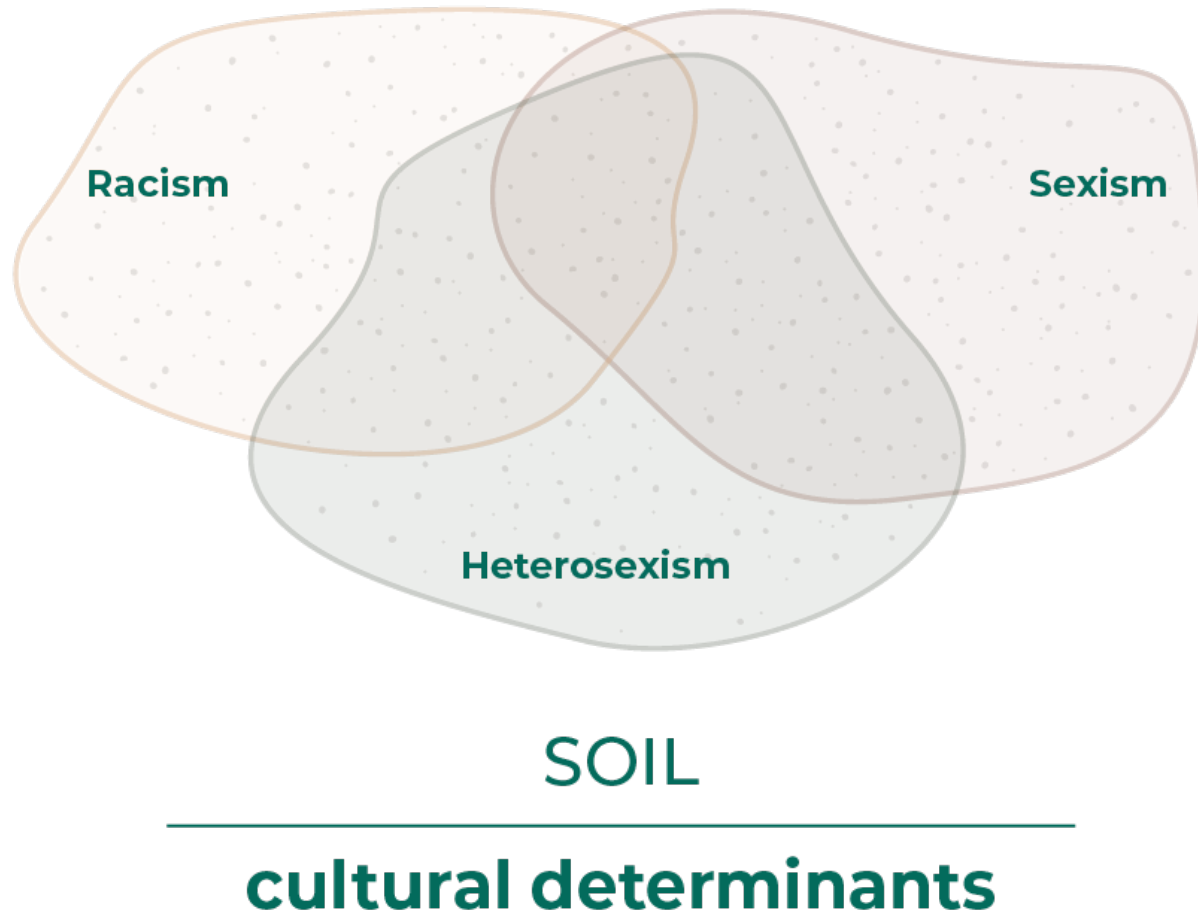
Intersectionality: How multiple social categories intersect at the **individual level** to reflect multiple interlocking systems of privilege and oppression at the **societal level**.



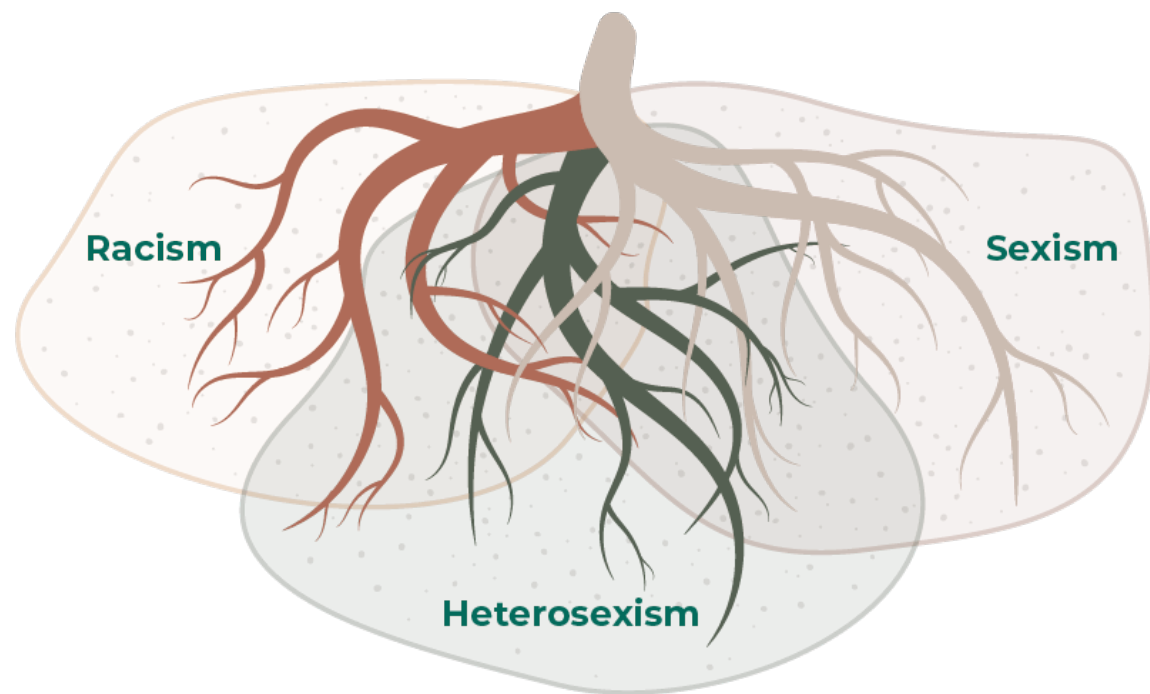
Bowleg, 2012, Crenshaw, 1989

Intersectionality at each level of the tree shapes health





- Collective ideologies and belief systems about which groups are most valued in society
- Reflected in the media, shape decision-making

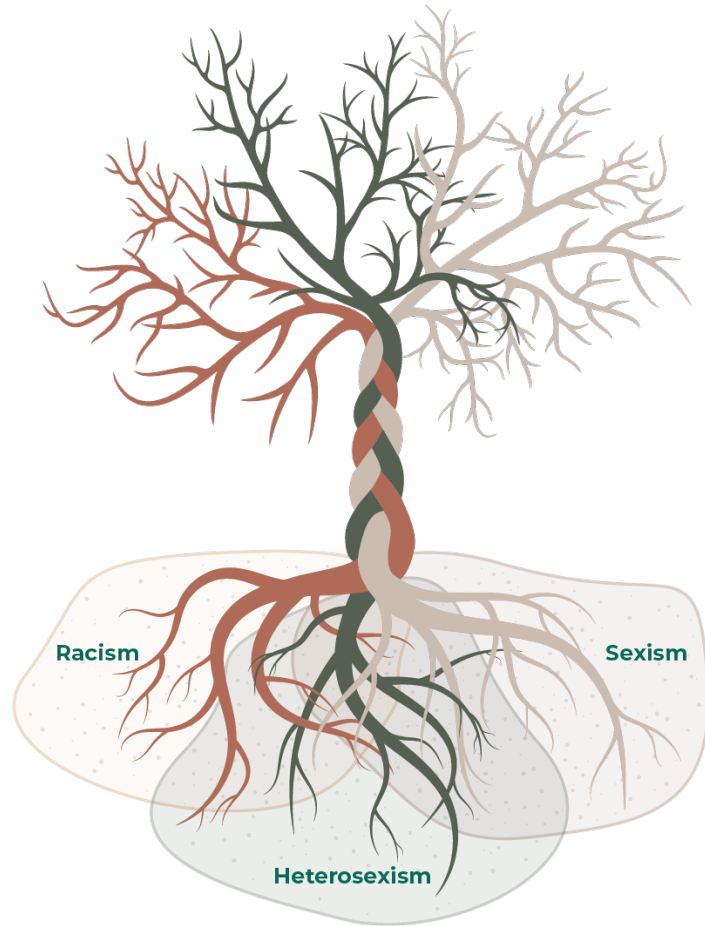


ROOTS

structural determinants

- Policies and practices that shape the distribution of resources in society
- Different forms of structural marginalization intersect to concentrate power and societal resources for privileged groups

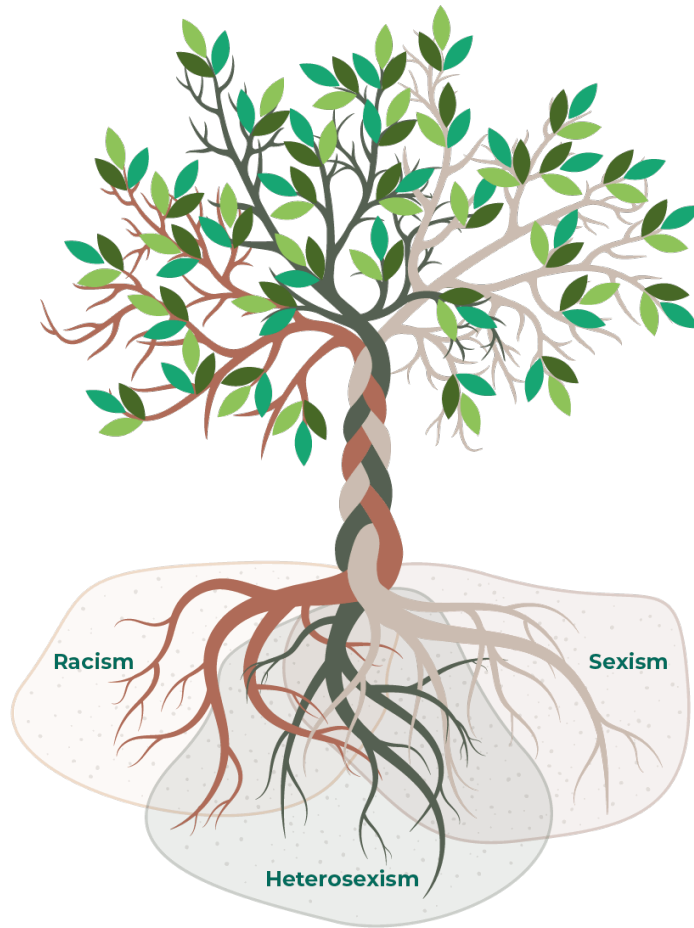
Intersectionality in the social determinants of health



TRUNK AND BRANCHES

social determinants

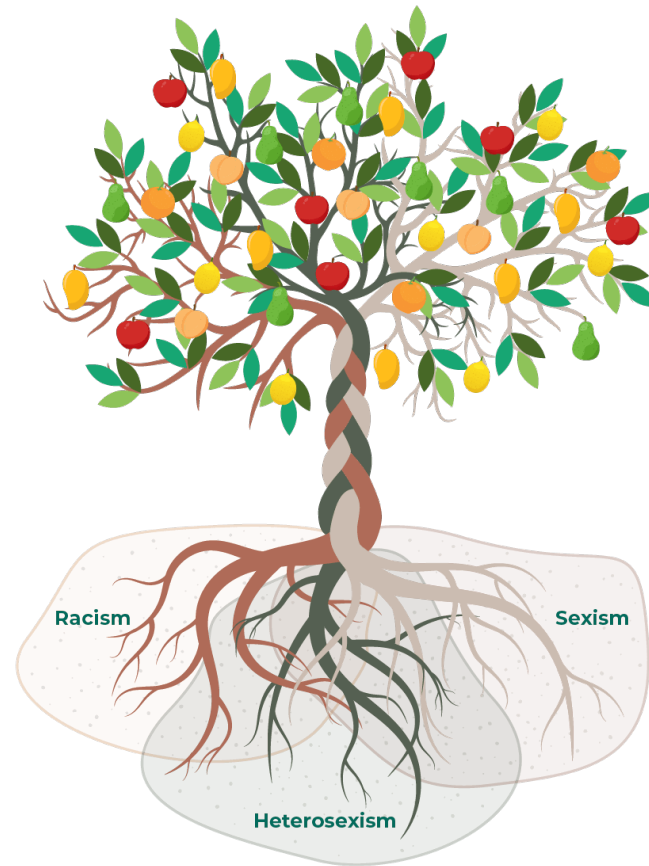
- Conditions in which people are born, live, learn, work, play, worship, and age
- Harmful conditions cluster and compound for communities facing multiple forms of marginalization



LEAVES

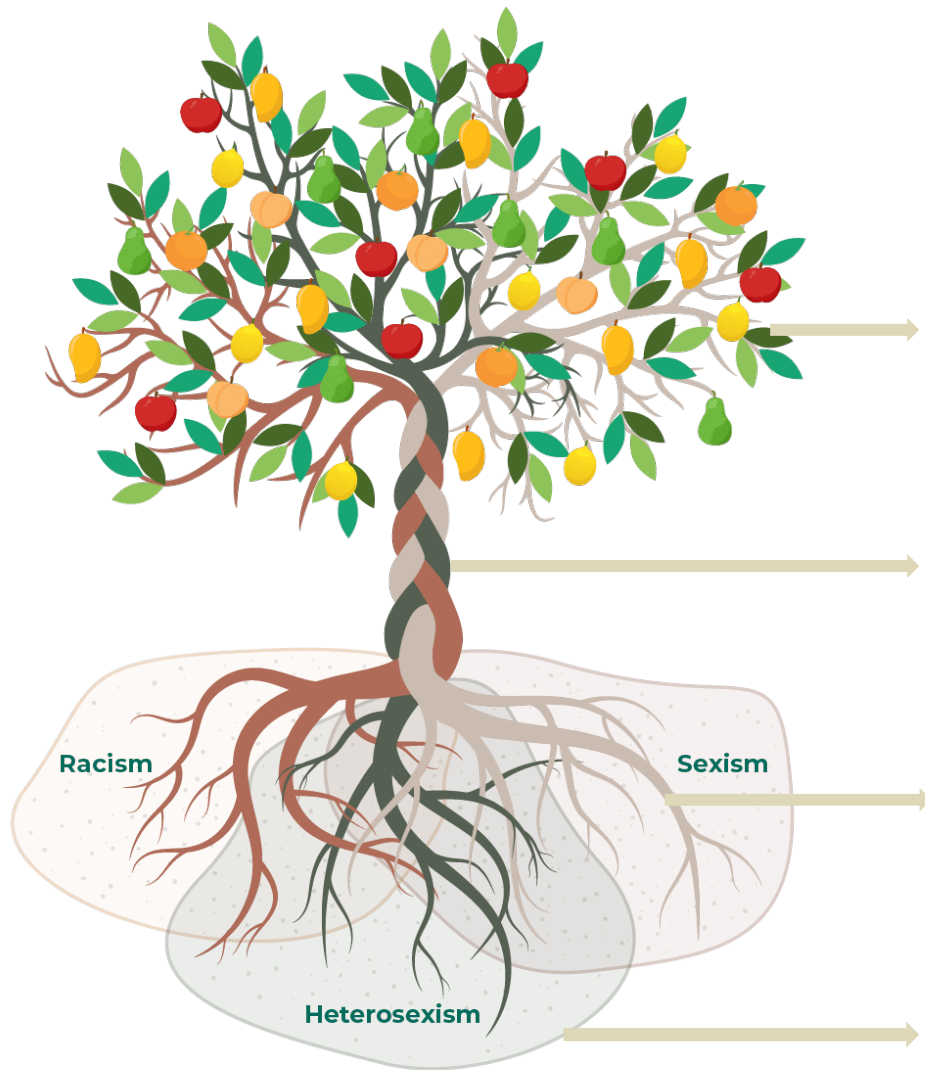
quality and use of services

- The safety, effectiveness, patient-centeredness, timeliness, efficiency, and consistency of health care
- Patients with intersectional identities face multiple barriers to quality health care



Well-being experienced by various individuals and groups

FRUITS
health and well-being



Intersectional interventions at each level

- **Health care** – deliver whole-person services
- **Social** – create resources to achieve optimal health
- **Structural** – reform policies and systems
- **Cultural** – change hearts and minds

Whole-person, person-centered service delivery

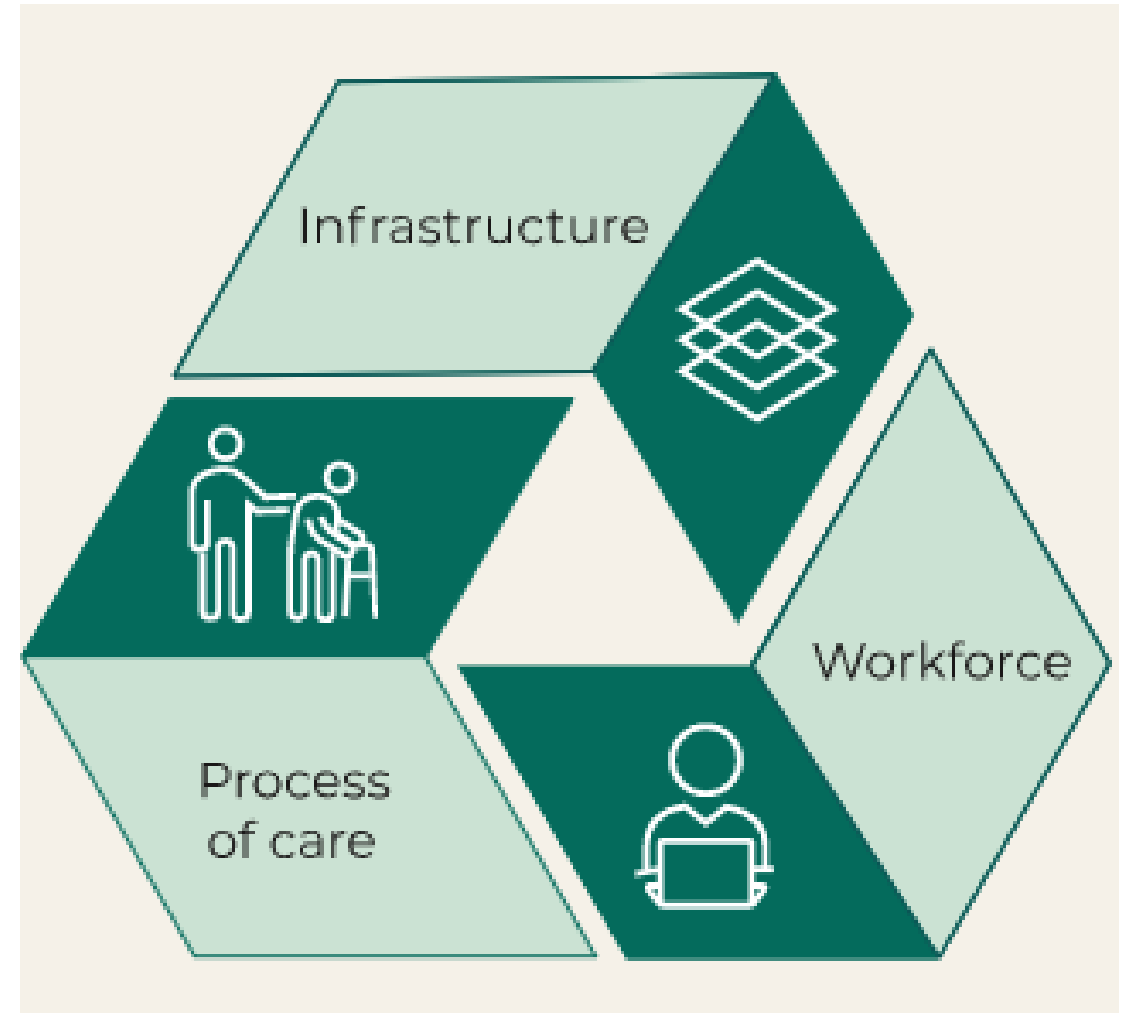
Diversify **workforce** and expand definition of health care workforce

Provide **affirming care** that is tailored to people's identities and needs

Implement processes to ensure **patient navigation** and care coordination

Increase accessibility of care **infrastructure** (e.g., satellite location, extended hours)

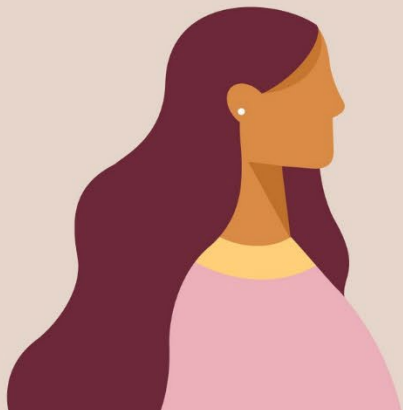
Capture multiple identities in **data** and leverage cross-sectoral data for insights



Addressing cultural determinants by examining mindsets

- Be aware of and **reflect on personal implicit biases** and their translation to external decisions
- Accept **pluralism** and **complexity**
- Engage in **transorganizational thinking**

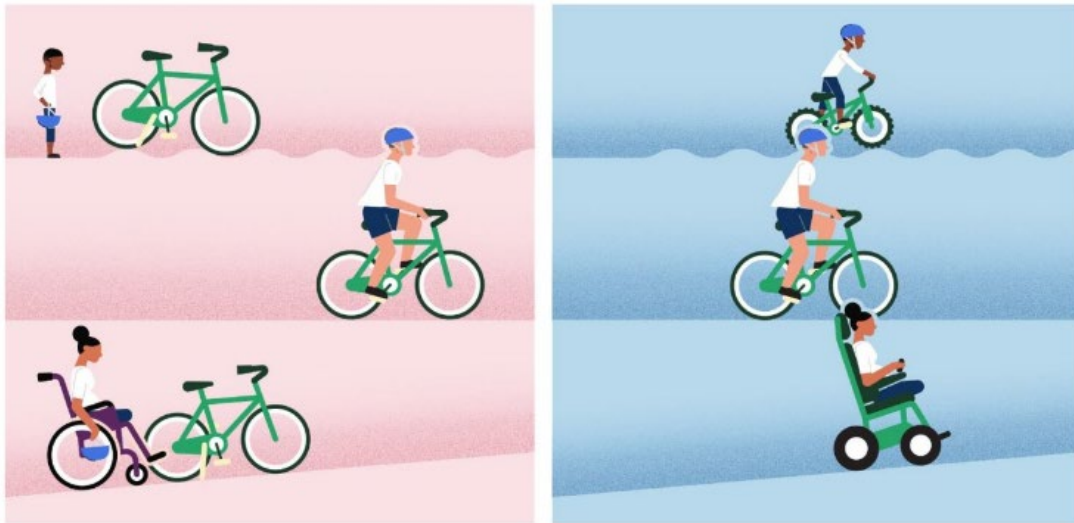




Equity and responsive care



Reflecting on Equity



Equality

- Everyone gets the same treatment, regardless of whether it is needed or right for them

Equity

- Everyone gets the treatment that is right for them
- Allows people to attain the highest level of health, regardless of cultural, demographic, or socio-economic status

Source: [Robert Wood Johnson Foundation](#), 2022

Responsive Care

Defined as:

- The intentional and consistent decision providers make to see, respect, and celebrate the aspects that make each person unique
- An acknowledgment of a patient's intersectional existence in the world and how this shapes their experiences

Source: [San Diego Foundation](#), 2023



Providing Responsive Care

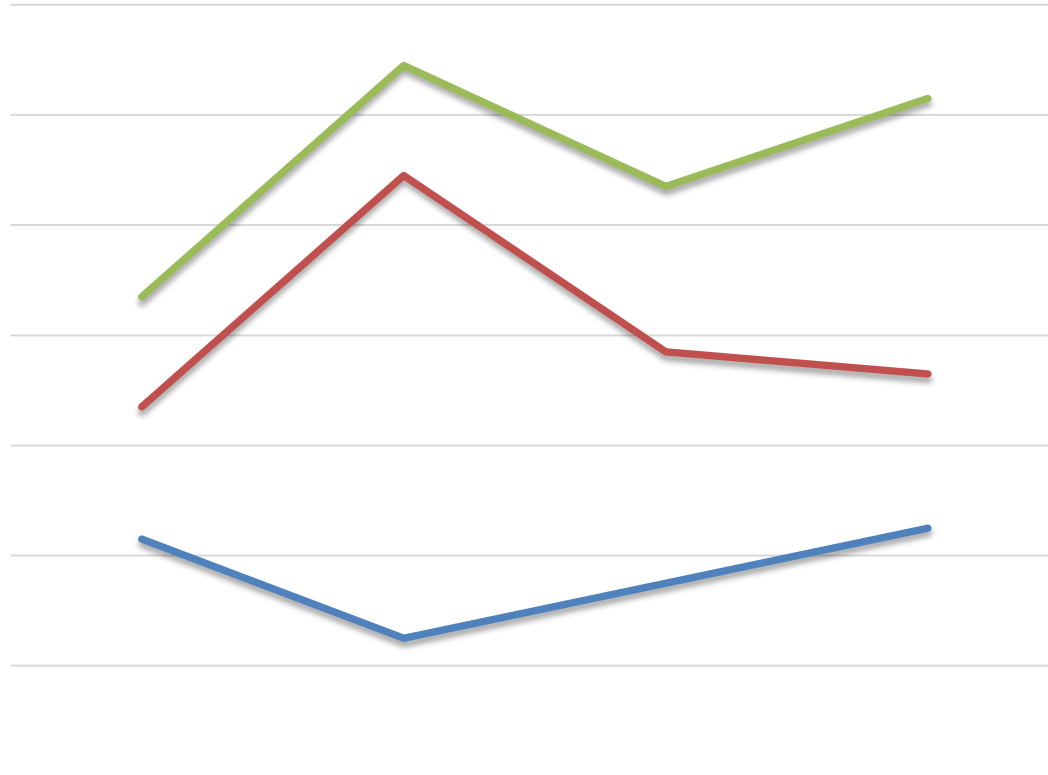
Point of care

- Patient-centered
- Present in the moment
- Treat an individual as an individual
 - One size doesn't fit all
- Recognize potential biases
- Seek to understand and look beyond differences

The organizational level

- Identify opportunities to optimize your structure
 - Evaluate integrated care models
- Foster collaboration pathways between interdisciplinary teams
- Assess complex patient and community needs
 - Social Determinants of Health
 - Right-size integrated care offerings

Patient Data



Risk Stratification

- Static Risk Factors
 - Language Barriers
 - Cultural Competencies
 - Number of Chronic Conditions
- Dynamic Risk Factors
 - Lack of PCP or Infrequent Visits
 - Housing Barriers
 - Transportation Barriers
 - Social Supports
 - Food Insecurity

Protocol for responding to and assessing patients' assets, risks, and experiences (PRAPARE)

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

Yes	No	I choose not to answer this question
-----	----	--------------------------------------

2. Which race(s) are you? Check all that apply

Asian	Native Hawaiian
Pacific Islander	Black/African American
White	American Indian/Alaskan Native
Other (please write): _____	
I choose not to answer this question	

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

Yes	No	I choose not to answer this question
-----	----	--------------------------------------

4. Have you been discharged from the armed forces of the United States?

Yes	No	I choose not to answer this question
-----	----	--------------------------------------

5. What language are you most comfortable speaking?
Family & Home

6. How many family members, including yourself, do you currently live with? _____

I choose not to answer this question

7. What is your housing situation today?

I have housing
I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
I choose not to answer this question

8. Are you worried about losing your housing?

Yes	No	I choose not to answer this question
-----	----	--------------------------------------

9. What address do you live at?
 Street: _____
 City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

Less than high school degree	High school diploma or GED
More than high school	I choose not to answer this question

11. What is your current work situation?

Unemployed	Part-time or temporary work	Full-time work
Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver)		
Please write: _____		
I choose not to answer this question		

12. What is your main insurance?

None/uninsured	Medicaid
CHIP/Medicaid	Medicare
Other public insurance (not CHIP)	Other Public Insurance (CHIP)
Private insurance	

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

I choose not to answer this question

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE® for Implementation as of September 2, 2016

14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write): _____
I choose not to answer this question					

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

Yes, it has kept me from medical appointments or
Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
No
I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

Less than once a week	1 or 2 times a week
3 to 5 times a week	6 or more times a week
I choose not to answer this question	

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

Not at all	A little bit
Somewhat	Quite a bit
Very much	I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

Yes	No	I choose not to answer this question
-----	----	--------------------------------------

19. Are you a refugee?

Yes	No	I choose not to answer this question
-----	----	--------------------------------------

20. Do you feel physically and emotionally safe where you currently live?


Yes	No	Unsure
I choose not to answer this question		

21. In the past year, have you been afraid of your partner or ex-partner?

Yes	No	Unsure
I have not had a partner in the past year		
I choose not to answer this question		

Source: [PRAPARE](#), 2022

The EveryONE Project

 AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

PATIENT FORM (short version)

Please answer the following.

HOUSING

1. What is your housing situation today?

I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

I have housing today, but I am worried about losing housing in the future

I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)

Bug infestation

Mold

Lead paint or pipes

Inadequate heat

Oven or stove not working

No or not working smoke detectors

Water leaks

None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.¹

Often true

Sometimes true

Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.¹

Often true

Sometimes true

Never true

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)

Yes, it has kept me from medical appointments or getting medications

Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need

No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

Yes

No

Already shut off

PERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?

Never

Rarely

Sometimes

Fairly often

Frequently

8. How often does anyone, including family, insult or talk down to you?

Never

Rarely

Sometimes

Fairly often

Frequently

9. How often does anyone, including family, threaten you with harm?

Never

Rarely

Sometimes

Fairly often

Frequently

The EveryONE Project
Advancing health equity in every community

10. How often does anyone, including family, scream or curse at you?

Never

Rarely

Sometimes

Fairly often

Frequently

ASSISTANCE

11. Would you like help with any of these needs?

Yes

No


Questions 1-10 are reprinted with permission from the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

REFERENCES

1. Biloux A, Verlander K, Anthony S, and Alley D. National Academy of Medicine. Standardized screening for health-related social needs in clinical settings: the accountable health communities screening tool. National Academies Press, Washington, D.C. <https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf>. Accessed November 14, 2017.

Source: [American Academy of Family Physicians](#), 2018

Accountable Health Communities – Health-Related Social Needs Screening Tool (AHC-HRSN)



The Accountable Health Communities Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.¹ We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

What's in the AHC HRSN Screening Tool?


In a National Academy of Medicine discussion paper,² we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs

¹ United States, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. <https://www.cms.gov/medicare/innovation/center-for-medicare-and-medicaid-innovation/2017-09-05-accountable-health-communities-model>

² Billow, A. MD, DPH, Vanderk, K., MPH, Anthony, S., DPH, & Alley, D., PhD. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. National Academy of Medicine Perspectives, 14. <https://www.nationalacademies.org/perspectives/2017/04/standardized-screening-for-health-related-social-needs-in-clinical-settings>

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AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. What is your living situation today?³
 - I have a steady place to live
 - I have a place to live today, but I am worried about losing it in the future
 - I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
2. Think about the place you live. Do you have problems with any of the following?⁴

CHOOSE ALL THAT APPLY

 - Pests such as bugs, ants, or mice
 - Mold
 - Lead paint or pipes
 - Lack of heat
 - Oven or stove not working
 - Smoke detectors missing or not working
 - Water leaks
 - None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.⁵

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.
 - Often true
 - Sometimes true
 - Never true

³ National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. <https://www.nacchc.org/research-and-data/prapare/>

⁴ Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327.

⁵ Hager, E. R., O'Leary, A. M., Black, M. M., Coleman, S. M., Heenan, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 125(1), 26-32. doi:10.1542/peds.2009-3146

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Source: [CMS](https://www.cms.gov)

Z Codes

Payers often deny the SDOH codes when used as primary diagnoses because they are classified in ICD-10-CM as “unacceptable principle diagnosis” codes.

- ICD-10 Z code categories Z55-65 are subsets of diagnosis codes that describe social drivers of health.

Code	Description
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances

Code	Description
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

Chart adapted from [CMS](#), 2022

Patient Voice



- Patients should always have a seat at the table.
- To ensure this, utilize the following:
 - Focus groups
 - Patient and Family Advisory Councils
 - Patient Satisfaction Surveys
 - Comment Boxes

Patient Voice

- Listening to your patients will help identify barriers to care, provide insight into needed resources, and can aid in the development of:
 - Updated processes
 - Culturally responsive educational materials
 - Expanded offerings or services related to additional supports
- Ensure that the services you provide are connected to the needs of the population you serve.

Community Voice

- Community needs assessment results should be integrated as a part of your ongoing commitment to quality services and outcomes.
- Ensure that the care you provide is culturally responsive and appropriate for the community at large.
- Inform the expansion of service offerings:
 - School-based health centers
 - Shelters for the unhoused
 - Domestic violence shelters



Care Team Insights



- Your care team is essential and can help determine the most effective ways to be responsive at the point of care and at the organizational level.
- Insight into:
 - Patients
 - Health risk appraisals
 - Clinical diagnoses
 - Personal knowledge
 - Social supports
 - Financial barriers
 - Mental status
 - Physical condition
 - Organization
- Trusted relationships

Additional Factors to Consider

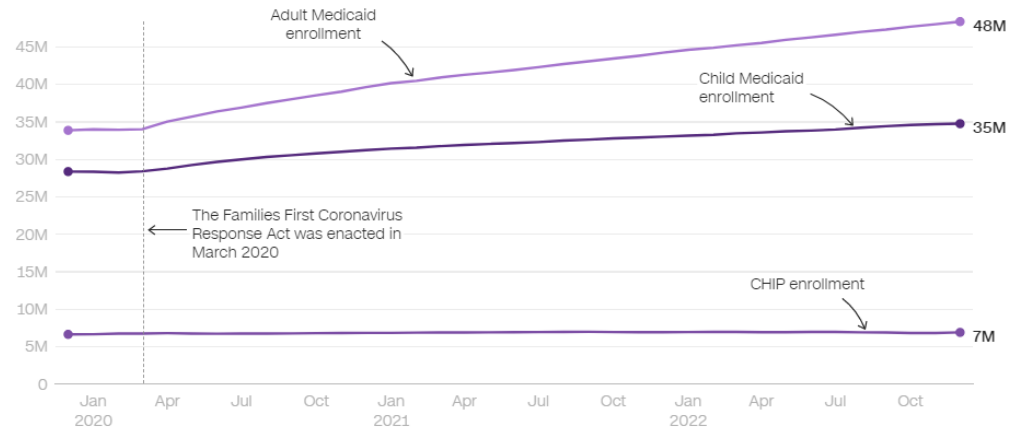
- Documentation requirements
 - When
 - What
 - Who
 - How
- Billing and reimbursement
 - Public health emergency flexibilities
- Virtual care delivery and policy changes
 - Modality requirements
 - Reimbursement



Medicaid Unwinding

Medicaid and CHIP enrollment increased during the pandemic

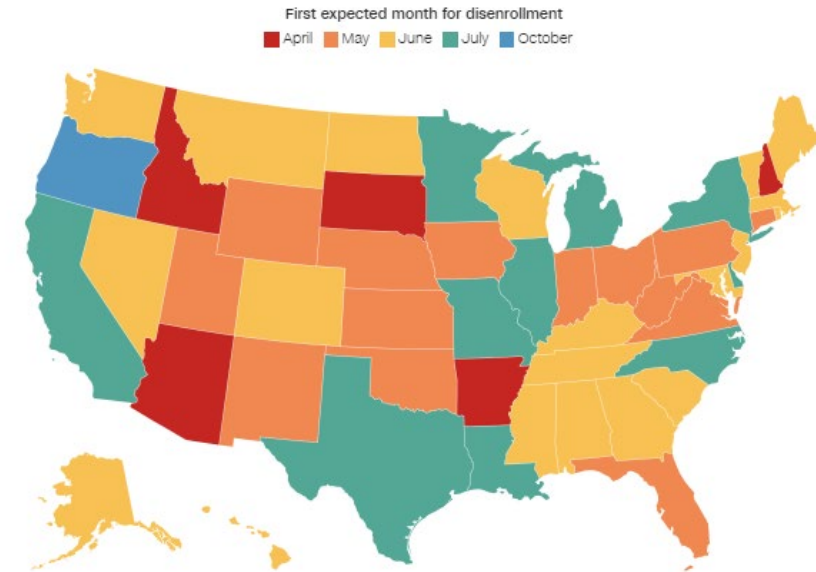
In December, 92.3 million people were enrolled in Medicaid and the Children's Health Insurance Program, an increase of 31% since February 2020, just before the Families First Coronavirus Response Act was enacted. Adult enrollment grew by 43% over the same period.



Note: Subcategories do not add up to 92.3 million because Arizona did not report breakouts for adult and child enrollment between February 2020 to November 2022 to CMS.

Source: Centers for Medicare & Medicaid Services
Graphic: Han Vu, CNN

Source: [CNN](https://www.cnn.com), 2023



Source: Center for Medicare & Medicaid Services
Graphic: Han Vu, CNN

Bridging the Gap

Responsiveness through the lens of equity may result in the following:

- Improving patient care outcomes
- Increasing buy-in from the care team
- New or revised:
 - Workflows
 - Policies
- Technology optimization
- Updating service offerings
- Expansion of the multi-disciplinary team
- Improving community partnerships



THANK YOU



DI·VER·SI·TY

All the ways in which people differ.

EQ·UI·TY

Fair treatment, access, opportunity, and advancement for all people. One's identity cannot predict the outcome.

IN·CLU·SION

A variety of people have power, a voice, and decision-making authority.

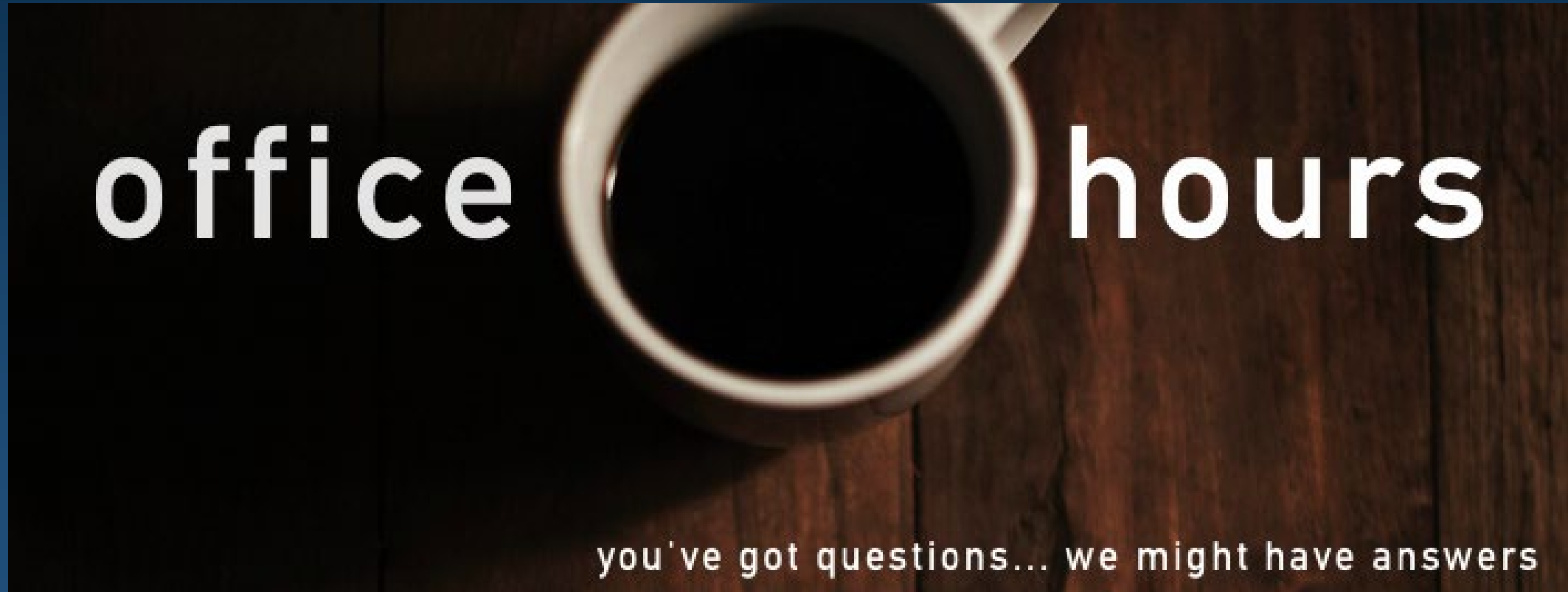
Source: Gesler, *Inclusion by Design: Insights from Design Week Portland*.

Post-presentation Skills and Comfort Poll

After attending this webinar, please rate your current skills and comfort with understanding the root causes and various aspects of how inequities perpetuate, embedding equity in healthcare, and delivering responsive care.

- Very Low
- Low
- Moderate
- High
- Very High

Office Hour



Upcoming CoE Events

Telehealth in Rural Integrated Care Part 3: Telehealth Programs to Support Agricultural Workers

[Register for the Webinar](#) on Thursday, June 22, 2-3pm ET

Meadowlark: Building a Team-based Approach to Integrated Perinatal Care

[Register for the Webinar](#) on Wednesday, June 28, 2-3pm ET

Interested in an individual consultation with the CoE experts on integrated care?

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CoE Resources

Population Health Management

- [Part 1: Introduction to Population Health](#)
- [Part 2: Measurement-informed Care](#)
- [Part 3: Clinical Pathways](#)
- [Part 4: Office Hour – Real-world Examples](#)

Social Determinants of Health

- [Part 1: Screening for Patient Social Risks in Integrated Care Settings](#)
- [Part 2: Integrated Care Screening Tools & Implementation Considerations](#)

Health Equity Office Hour

- [Understand Health Inequities, Health Disparities & Social Determinants of Health within Integrated Care Settings](#)

[Advancing Health Equity Toolkit](#)

NATIONAL
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for Mental
Wellbeing



Upcoming PCDC Events

**EXAMINING THE IMPACT OF RACISM ON
SEXUAL AND REPRODUCTIVE HEALTH**

June 28, 2023 | 12:30 - 2:00 PM ET




Nancy Morisseau, MPH
Senior Project Manager
PCDC


Linda Sloan Locke, CNM, MPH, LSW, FACNM

To register, please visit: <https://bit.ly/3Xh67kU>

Contact Us



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References

- Barlow, Joan. “Graphic on Equity.” *Robert Wood Johnson Foundation*, <https://www.rwjf.org/en/insights/blog/2022/11/we-used-your-insights-to-update-our-graphic-on-equity.html>
- Luhby, Tami. “These 5 States Will Be the First to Kick Residents of Medicaid Starting in April.” *CNN*, 1 Apr. 2023, <https://www.cnn.com/2023/04/01/politics/medicaid-termination-states/index.html>.
- National Technical Assistance and Evaluation Center for Systems of Care. “Cultural Competency: A Closer Look.” 1 Mar. 2009, <https://www.childwelfare.gov/pubPDFs/culturalcompetency.pdf>
- “Report: Adverse Childhood Experiences.” *National Conference of State Legislatures*, 23 Aug. 2022, <https://www.ncsl.org/health/adverse-childhood-experiences>.
- “Social Needs Screening Tool.” *American Academy of Family Physicians*, https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf.
- “The Accountable Health Communities Health-Related Social Needs Screening Tool.” *Centers for Medicaid and Medicare Services*, <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>.
- “The PRAPARE Screening Tool.” *The Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences*, <https://prapare.org/the-prapare-screening-tool/>.