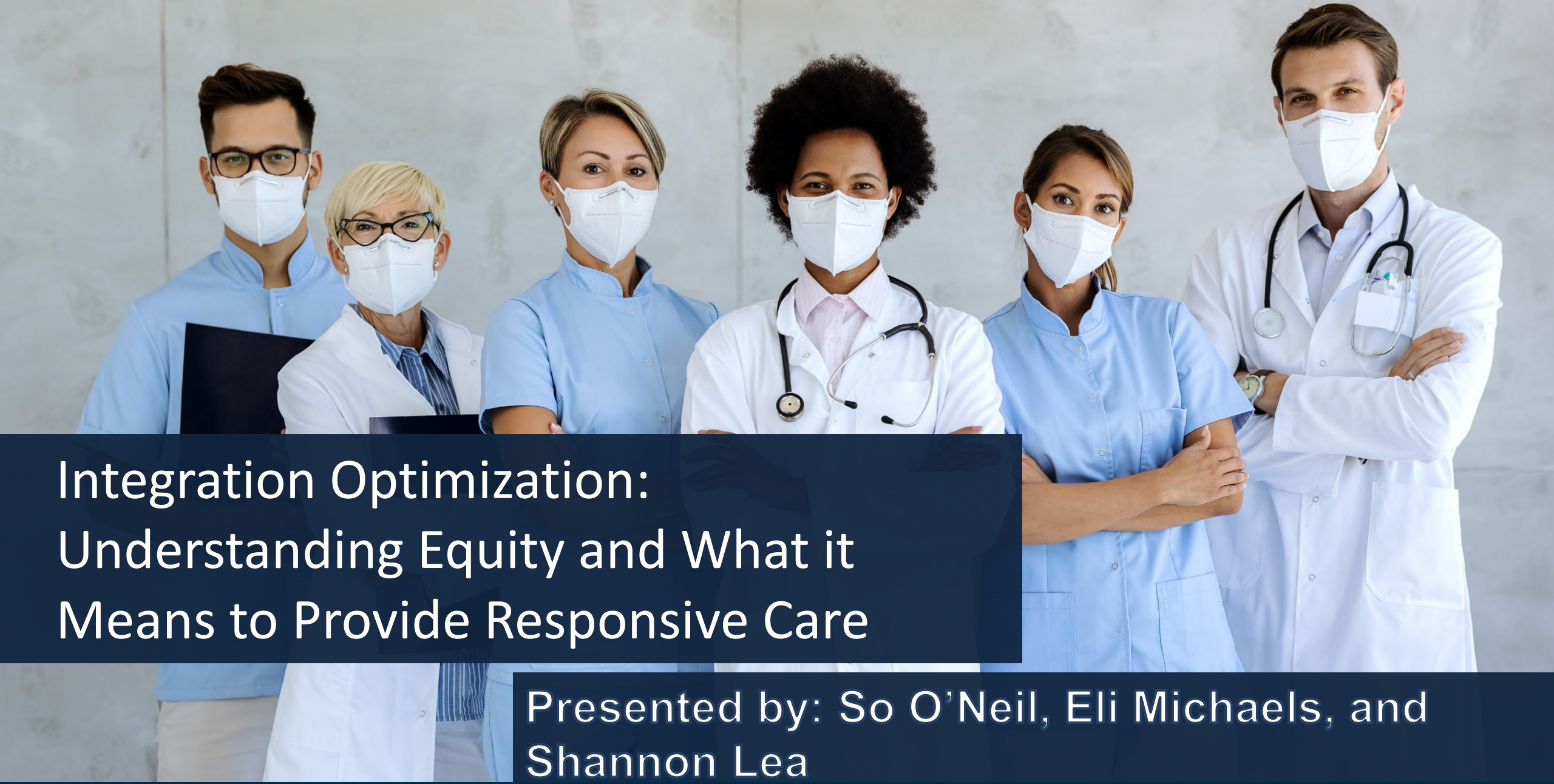


Integration Optimization: Understanding Equity and What it Means to Provide Responsive Care

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

PRIMARY CARE DEVELOPMENT CORPORATION

CENTER OF EXCELLENCE for Integrated Health Solutions
Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

Today's Moderator

Shannon Lea
Senior Program Manager
Primary Care Development Corporation

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.

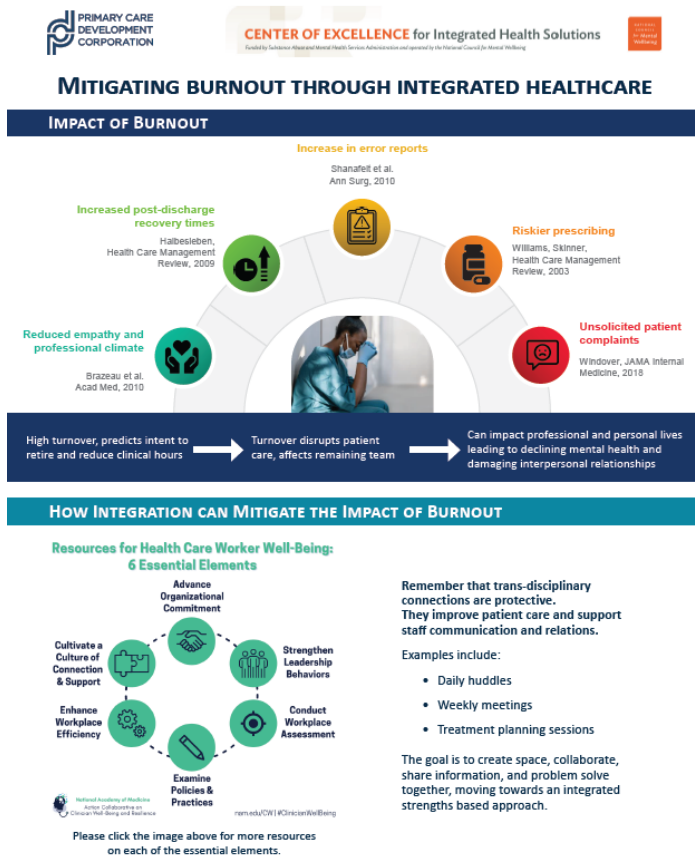
Disclaimer

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).

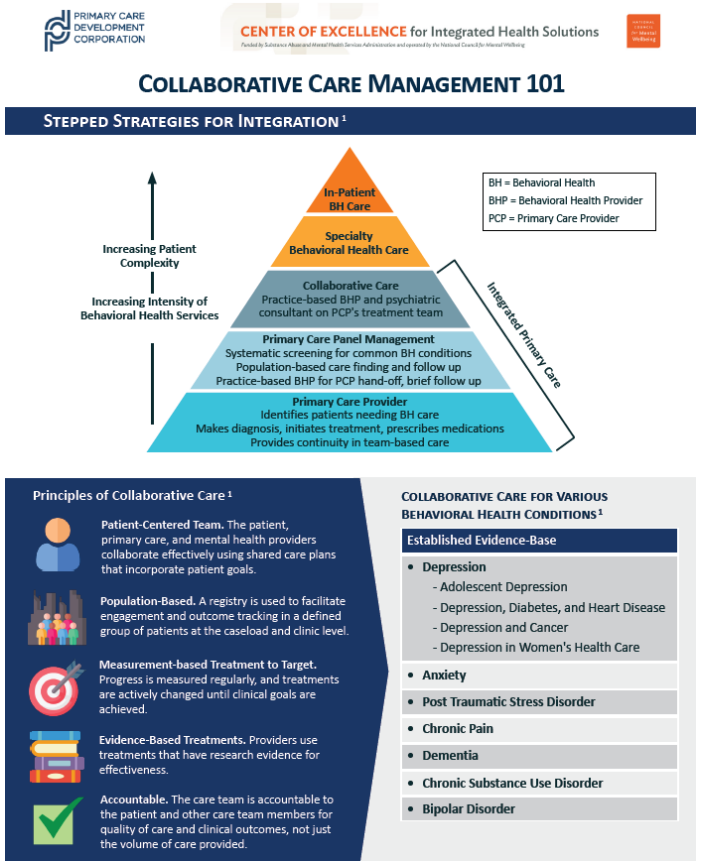
SAMHSA
Substance Abuse and Mental Health Services Administration

www.samhsa.gov

"Operationalizing Integration" Webinar Series Tip Sheets



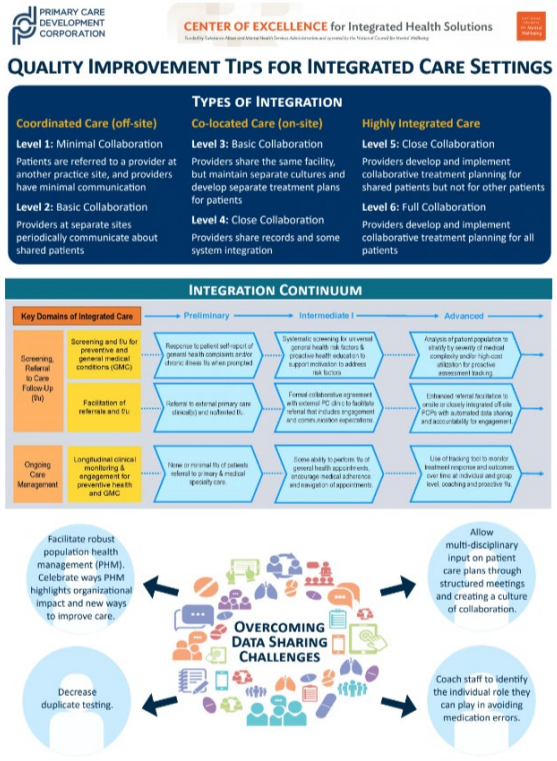
"Mitigating Burnout through Integrated Healthcare"
tip sheet can be accessed here:
https://www.pcdc.org/resources/operationalizing-integration-mitigating-burnout-through-integrated-healthcare-tip-sheet/

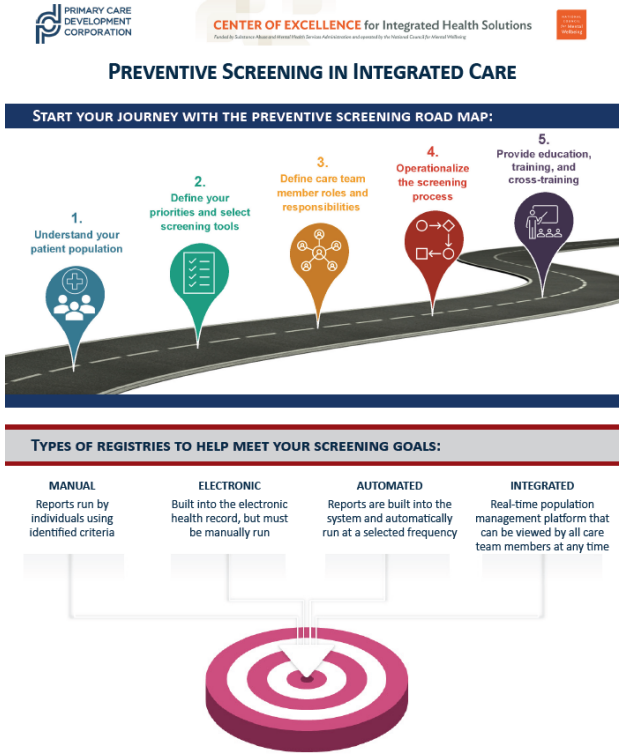


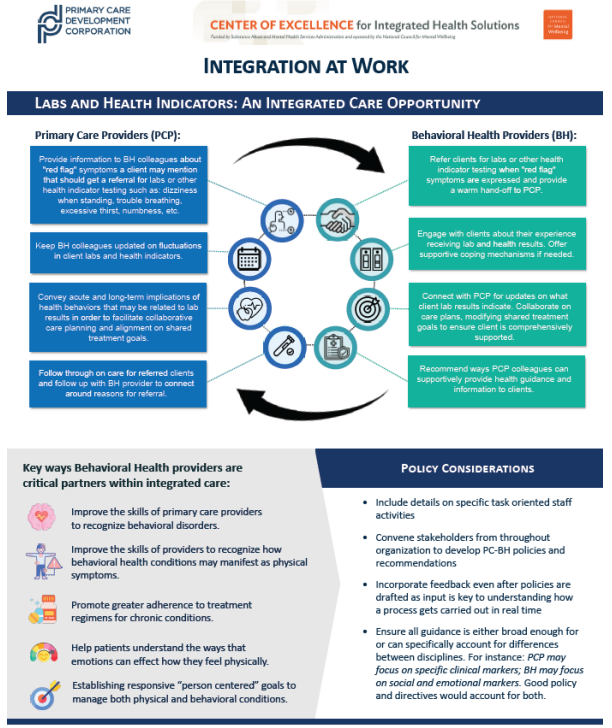
"Collaborative Care Management 101"
tip sheet can be accessed here:
https://www.pcdc.org/resources/operationalizing-integration-collaborative-care-management-foundations-tip-sheet/

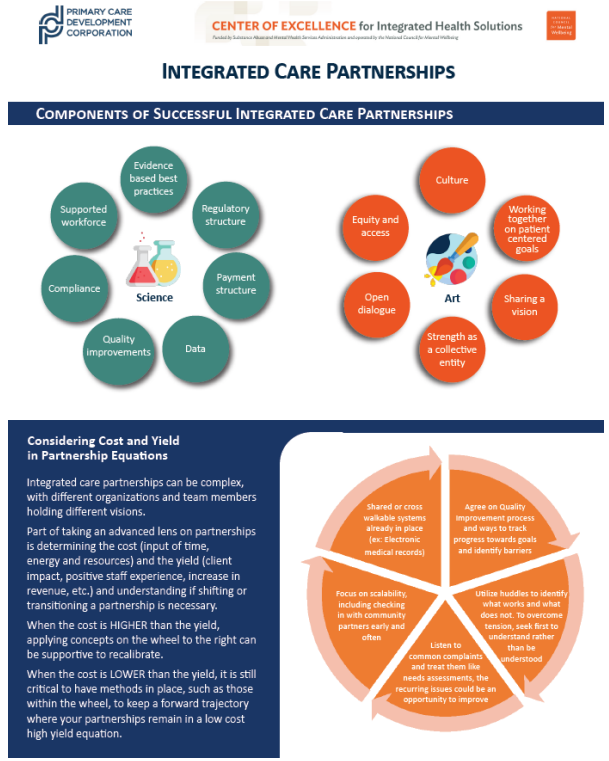
"Maternal Mental Health Considerations"
tip sheet can be accessed here:
https://www.pcdc.org/resources/operationalizing-integration-system-level-opportunities-to-improve-maternal-mental-health-tip-sheet/

"Integration at Work" Webinar Series Tip Sheets









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

PRIMARY CARE DEVELOPMENT CORPORATION

CENTER OF EXCELLENCE for Integrated Health Solutions
Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

The road to equity in health care

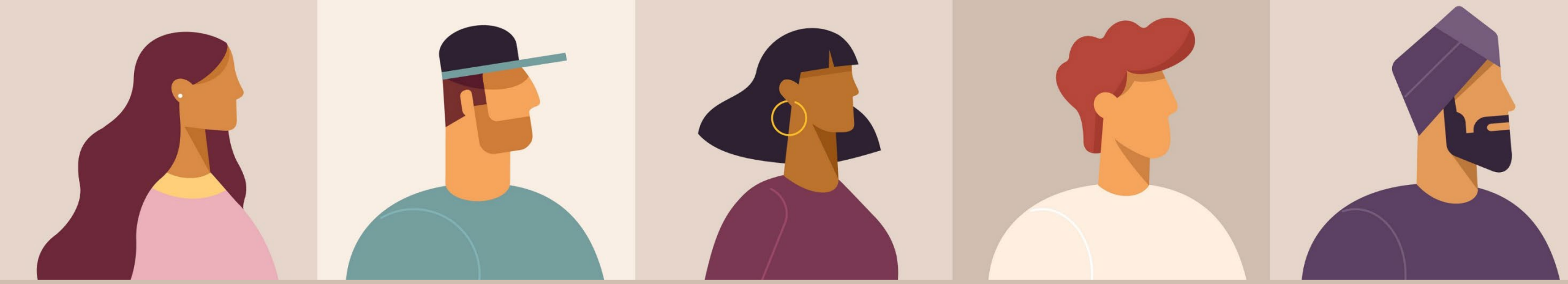
PRIMARY CARE DEVELOPMENT CORPORATION

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

Rise in collective consciousness

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

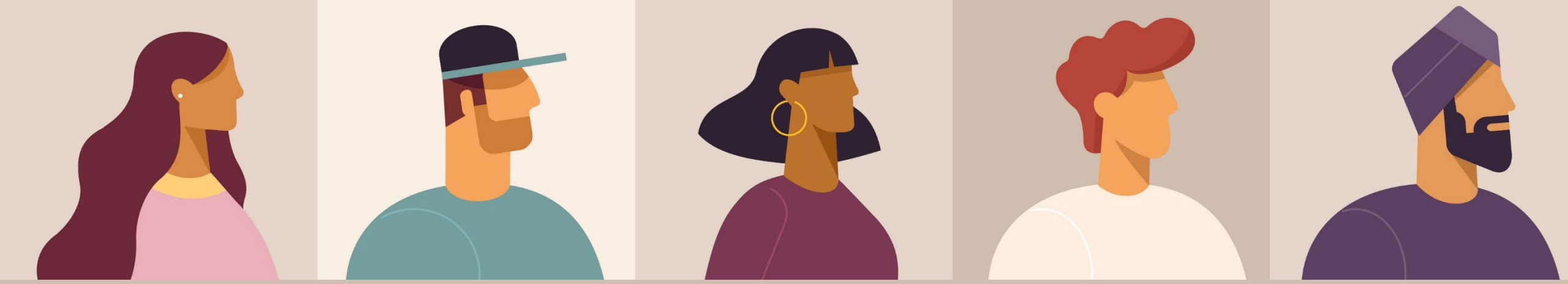
Rise in collective consciousness

JANUARY 20, 2021

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

BRIEFING ROOM › PRESIDENTIAL ACTIONS

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.

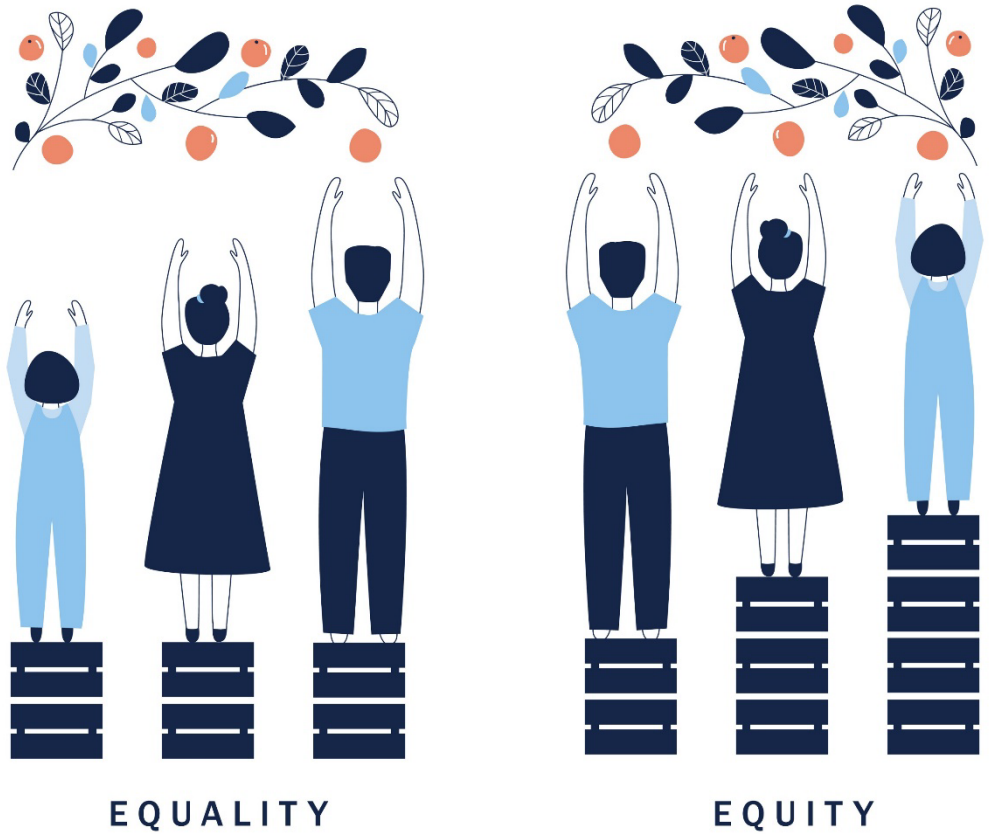
Change Elemental

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.

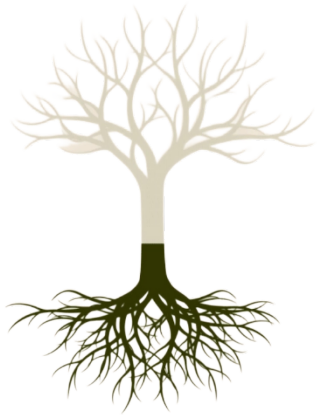
World Health Organization

What is Equity?



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

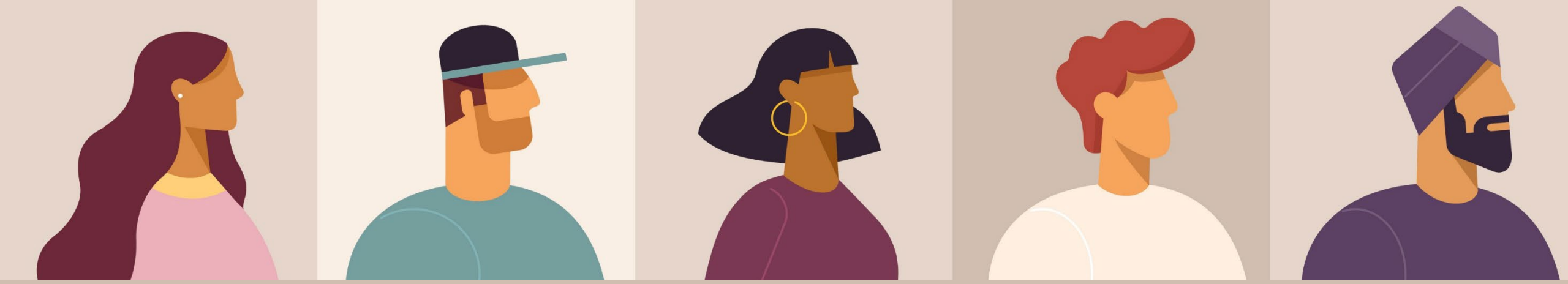
$320 billion

in annual health care spending today

$1 trillion

in annual health care spending by 2040

Source: Deloitte, 2022



How did we get here?

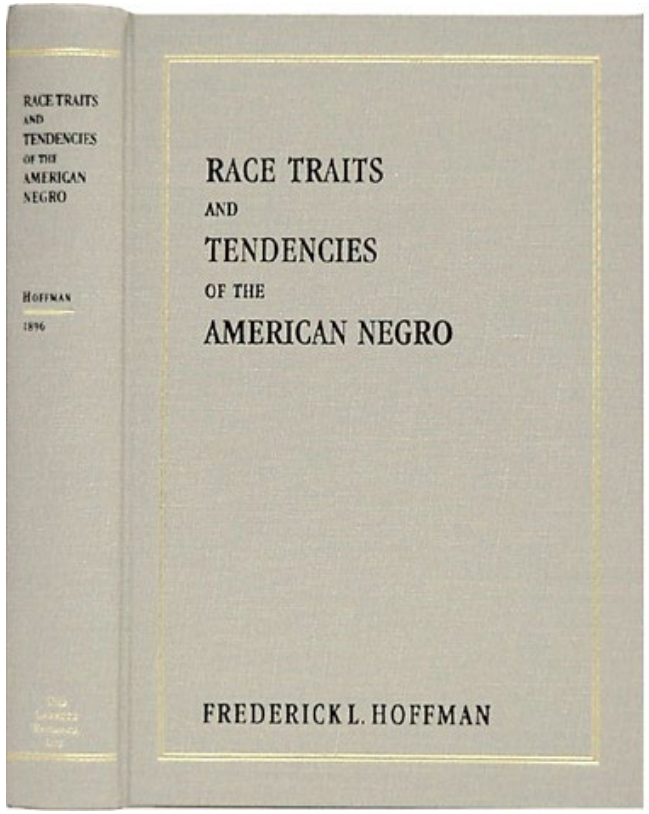
Segregated, underfunded, inaccessible care

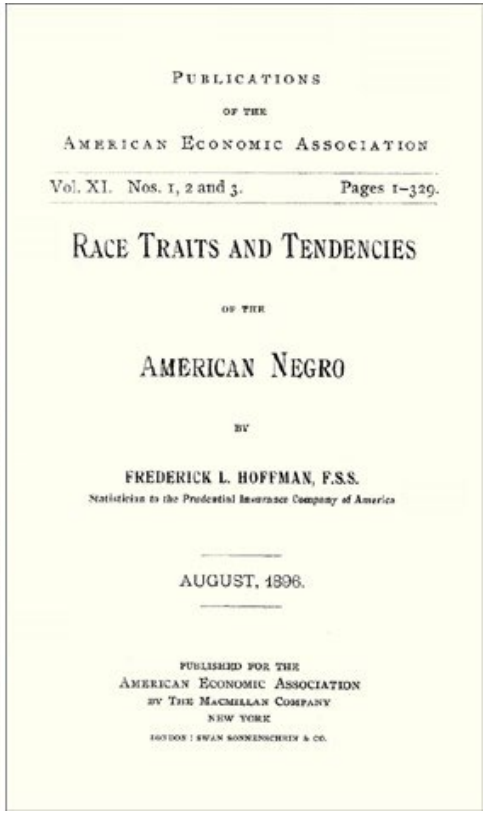
FREEDMEN'S BUREAU
MEDICAL DIVISION

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

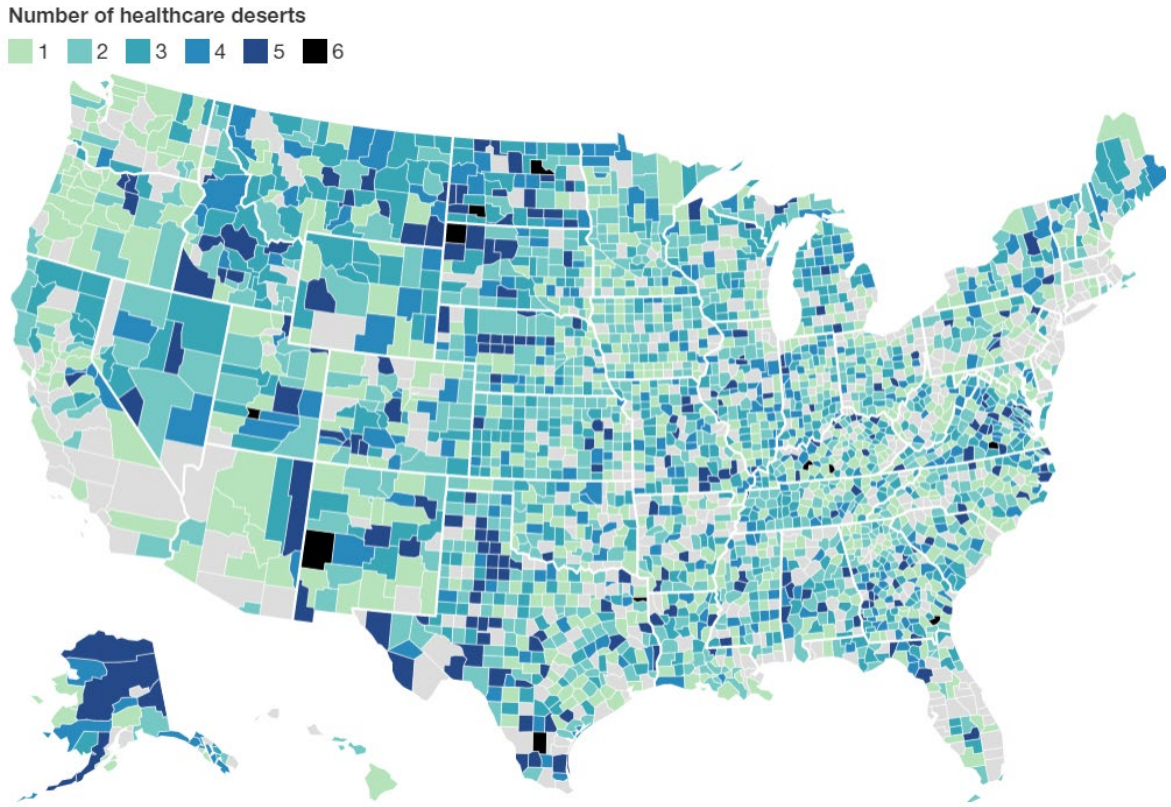
Inequitable distribution of resources

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

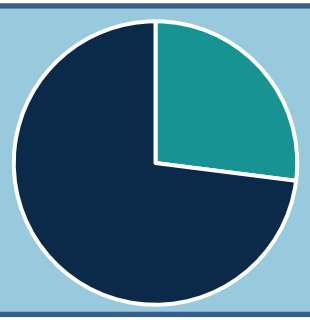
Healthcare deserts in the United States by county



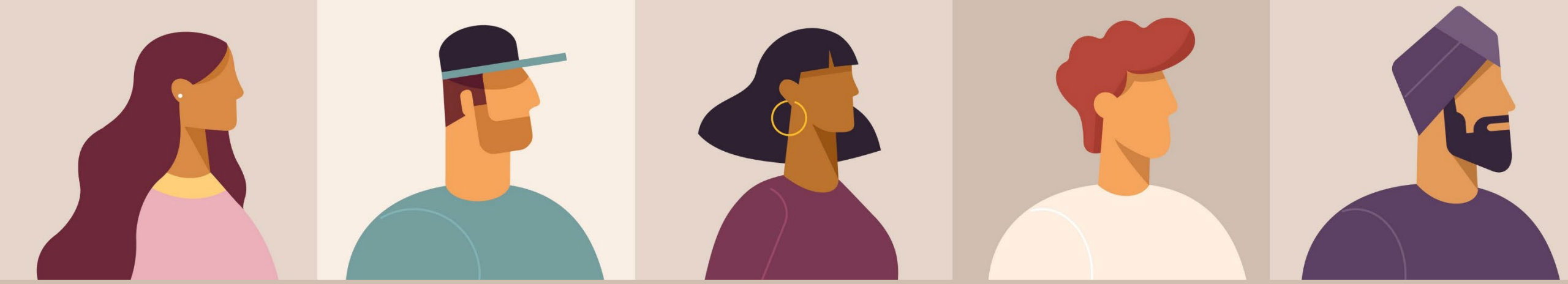
Source: GoodRx Health, 2021

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*



27% all deaths among Black populations preventable with better quality care



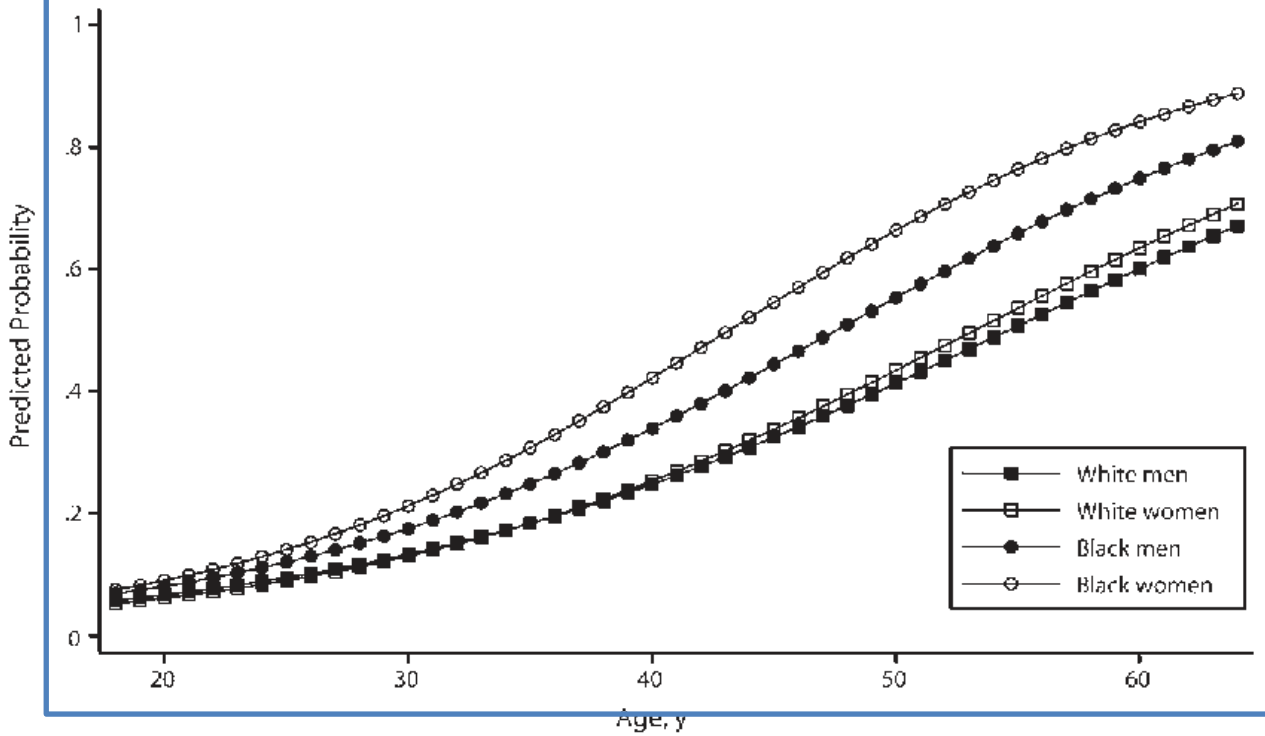
Expanding our understanding

Beyond race and ethnicity

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

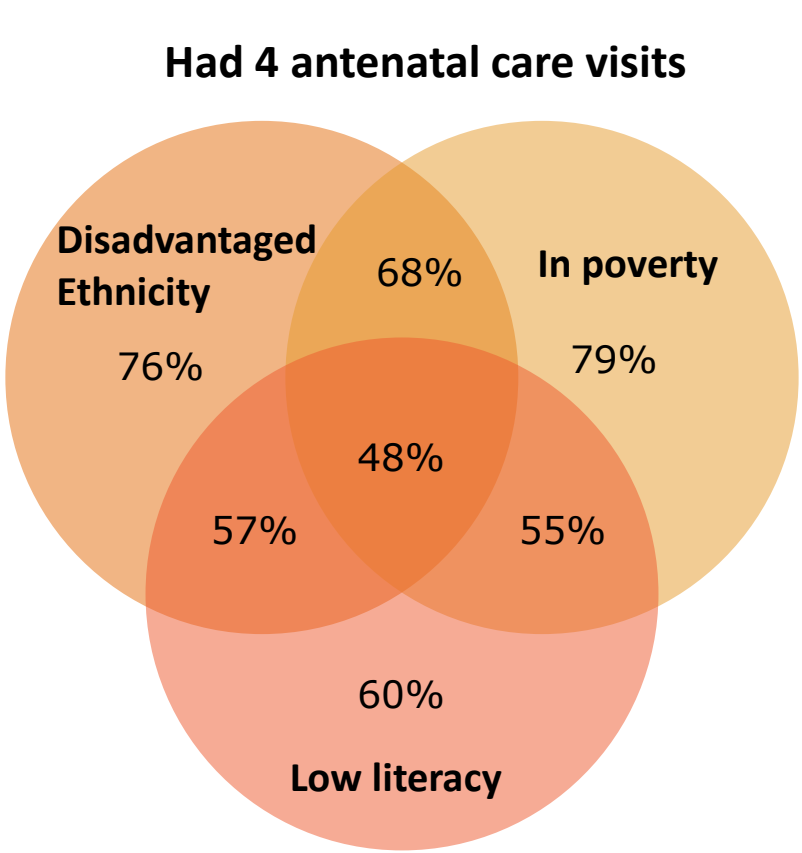
Compounding inequities

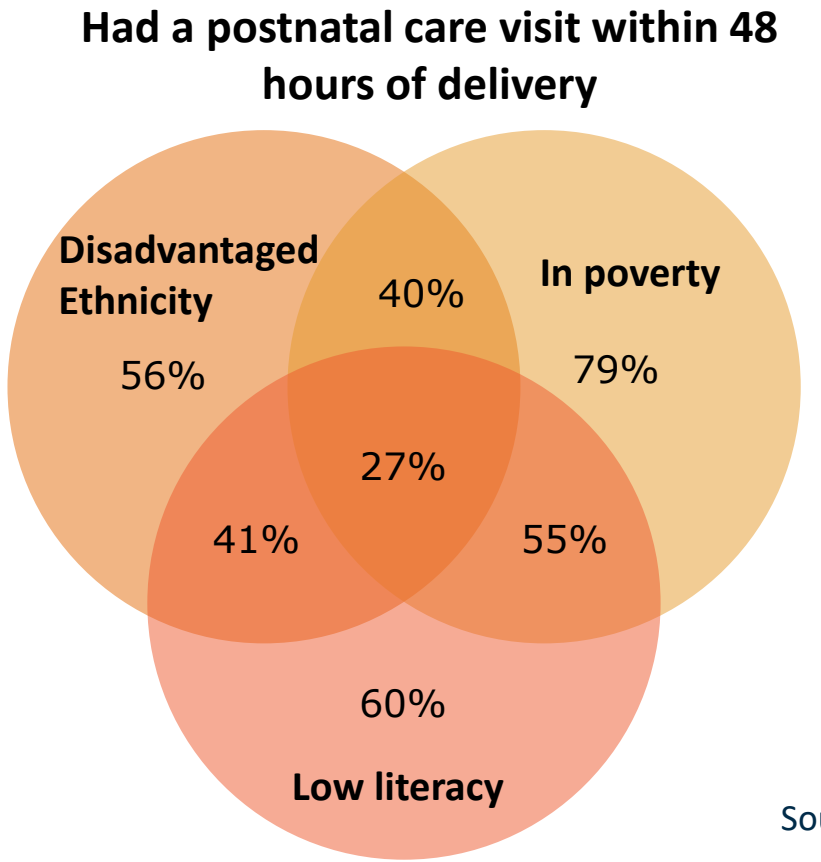
Accelerated aging at the intersections of race and gender: Black women show higher allostatic load at earlier ages, compared to white women and Black men (Geronimus et al., 2006, *AJPH*)



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

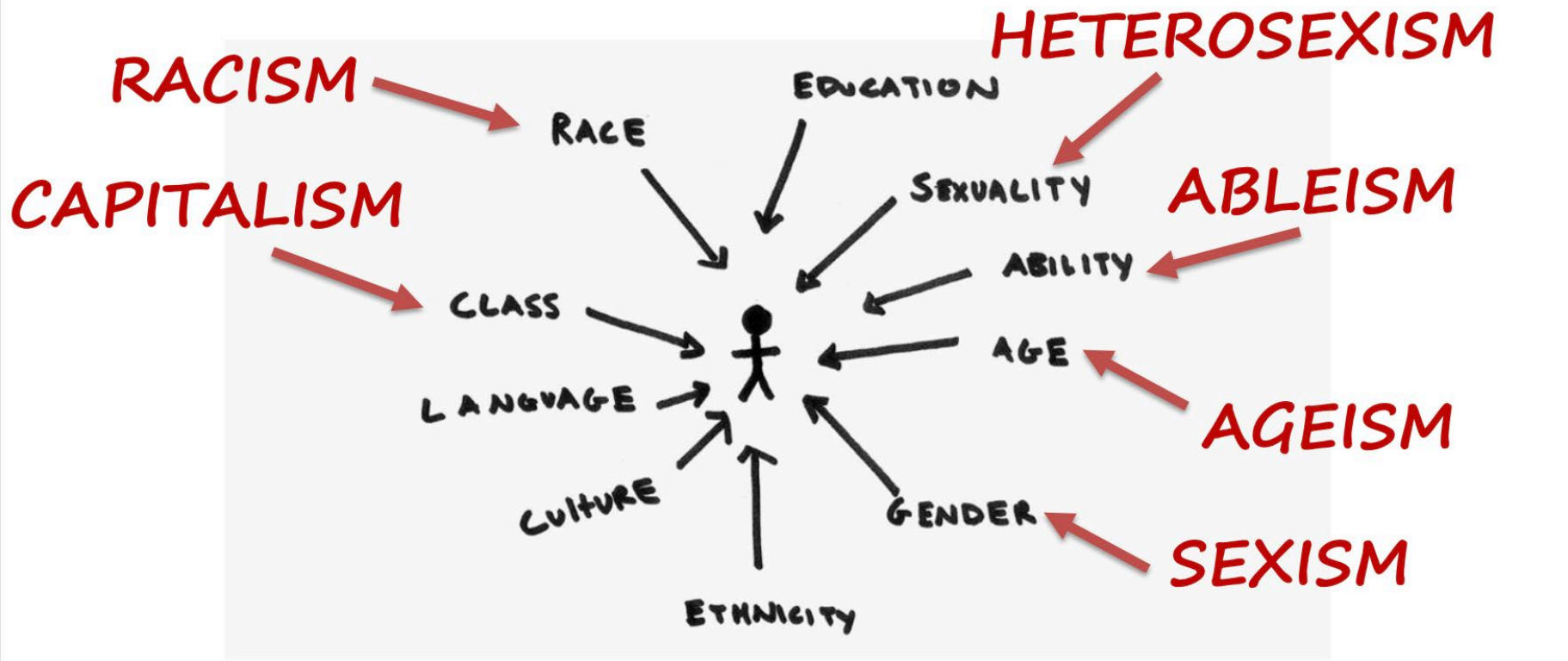




Source: PLOS ONE

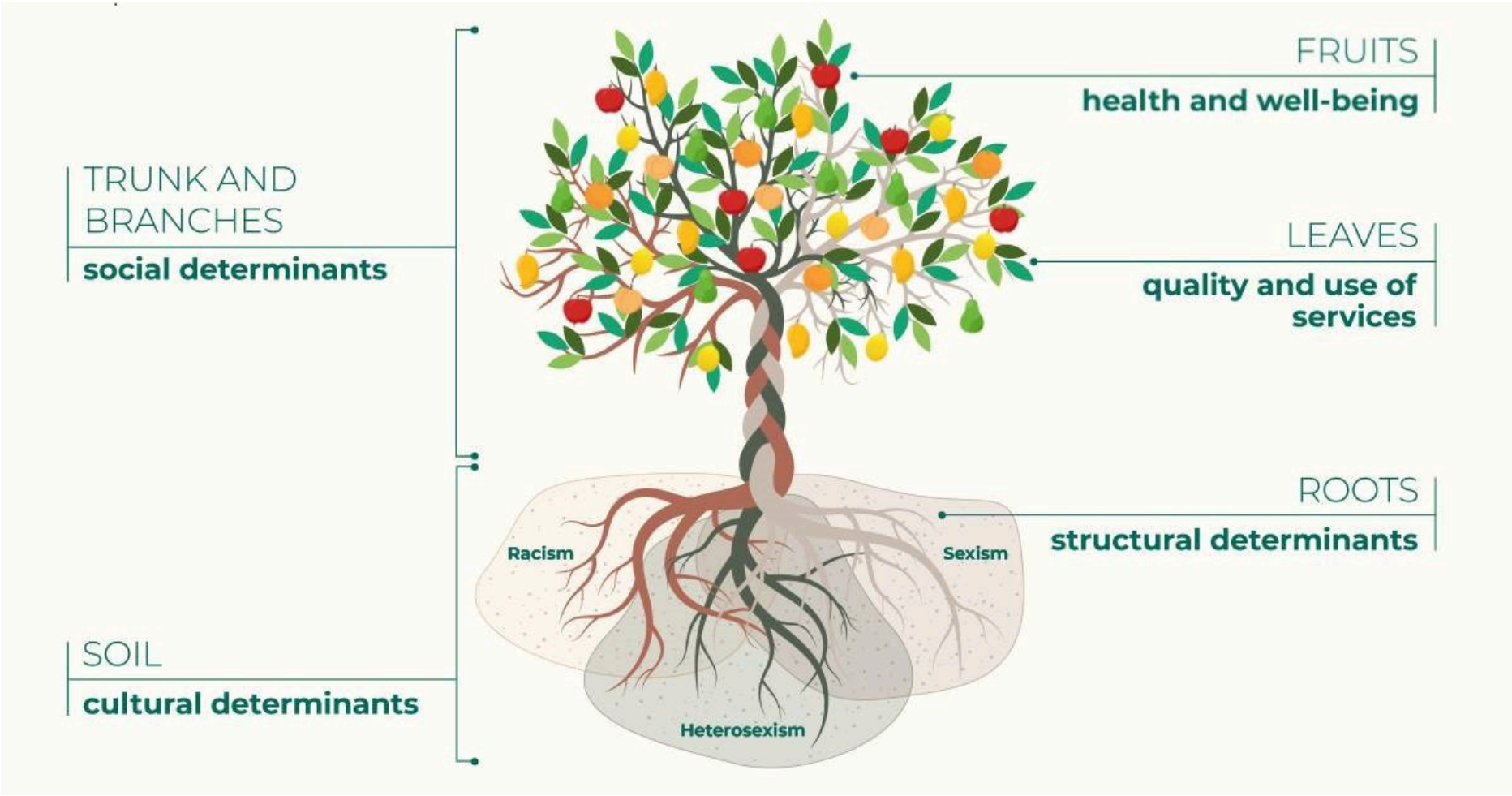
Expanded understanding

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

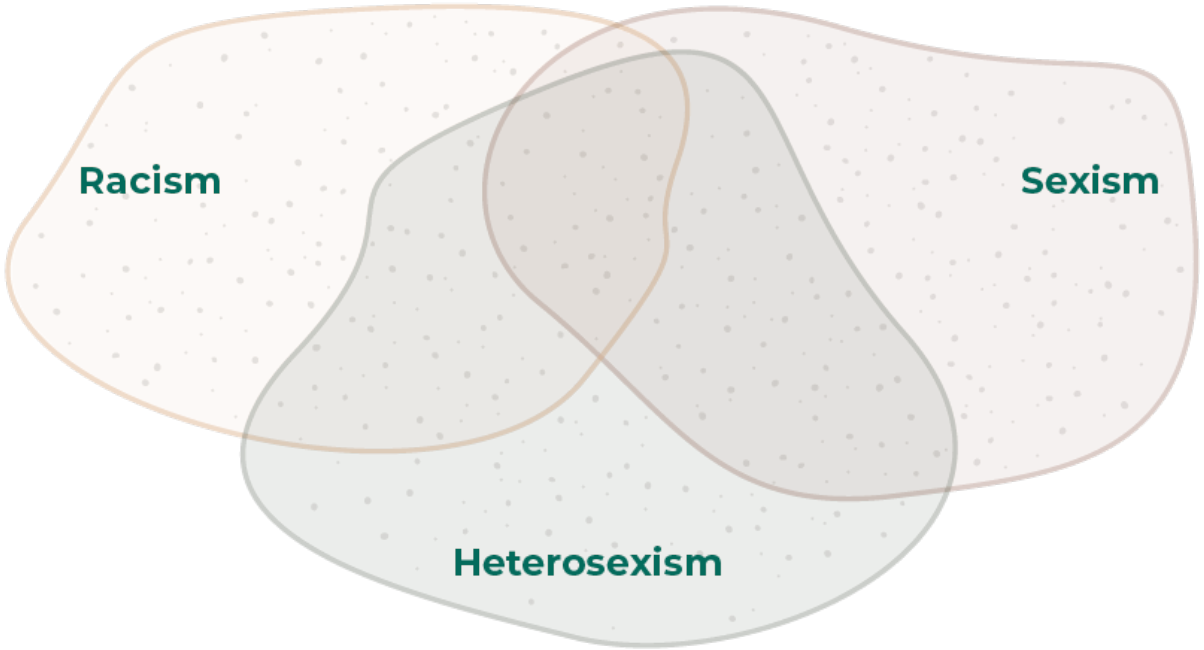


Bowleg, 2012, Crenshaw, 1989

Intersectionality at each level of the tree shapes health



Intersectionality in the cultural determinants of health

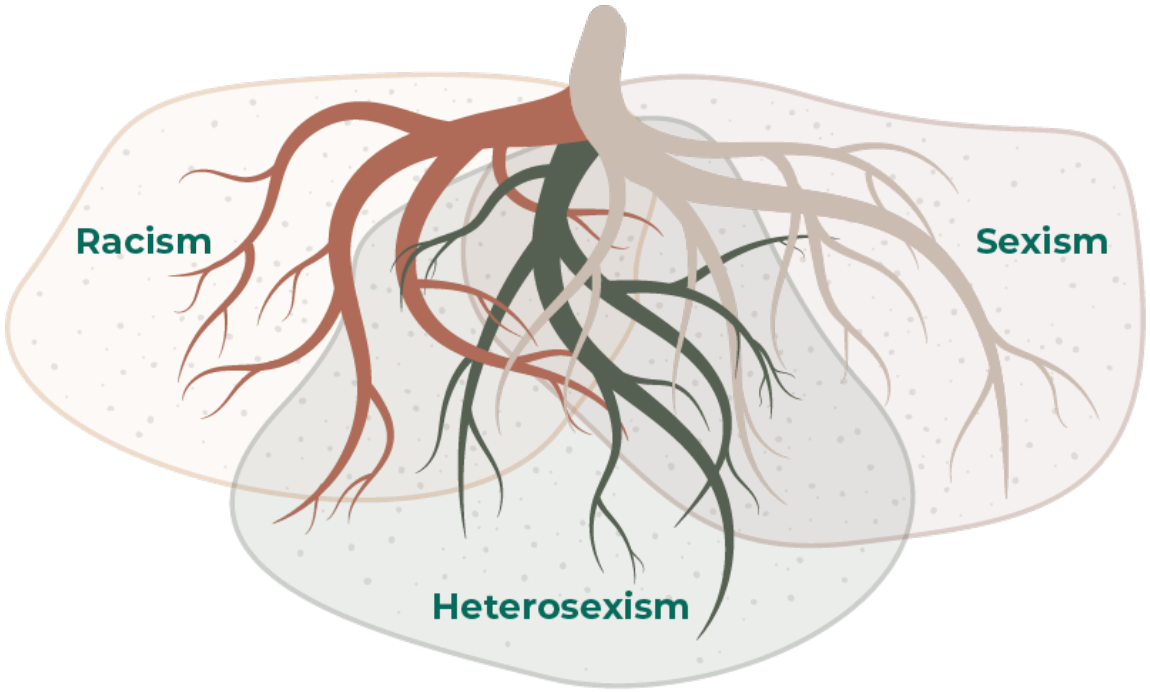


SOIL

cultural determinants

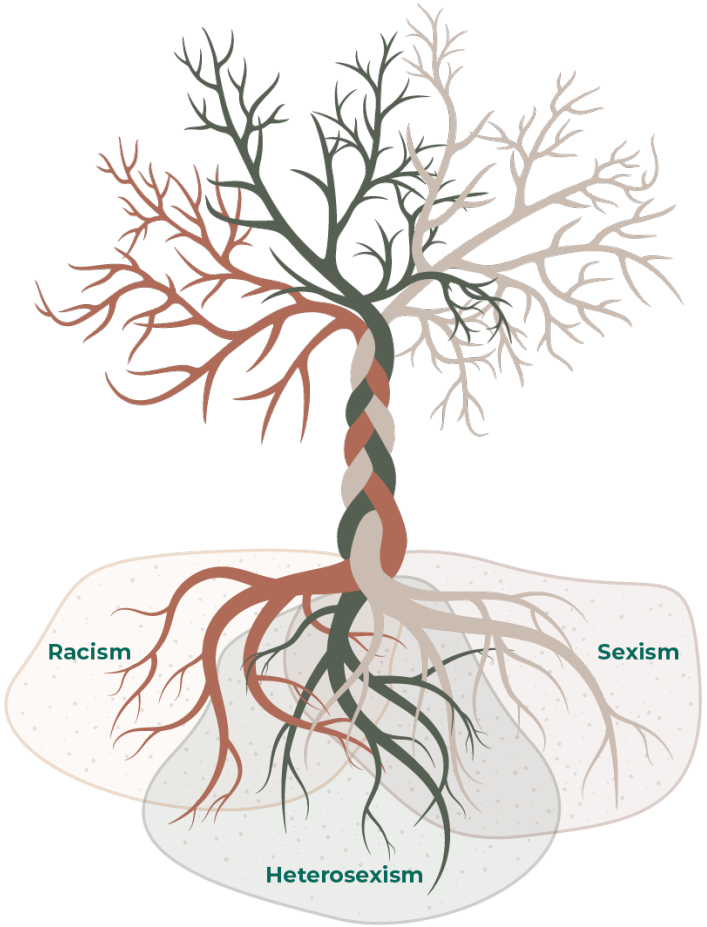
- Collective ideologies and belief systems about which groups are most valued in society
- Reflected in the media, shape decision-making

Intersectionality in the structural determinants of health



- 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

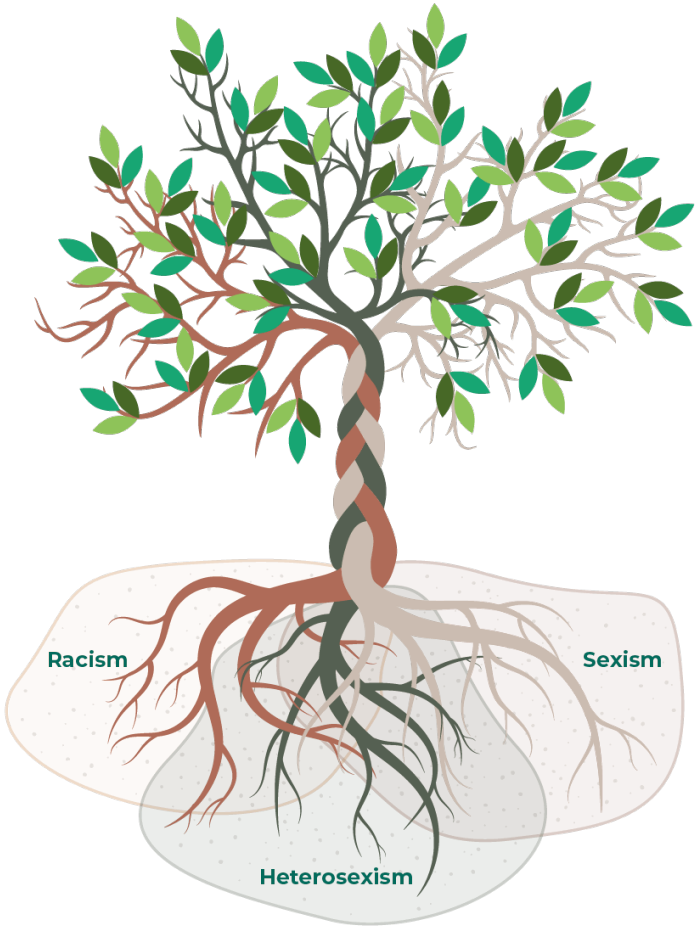


TRUNK AND BRANCHES

social determinants

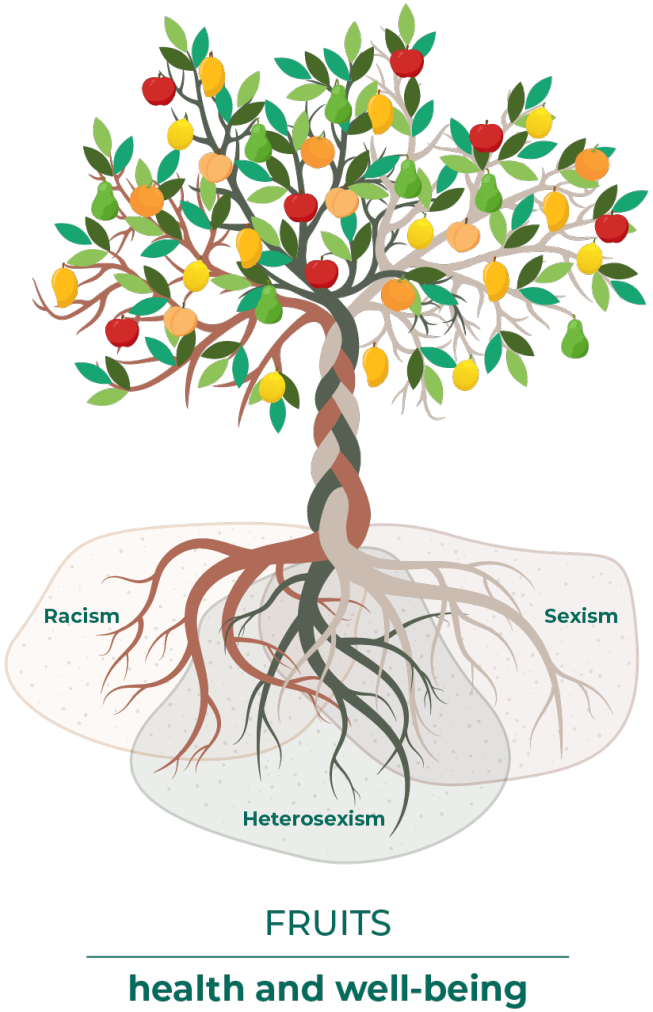
- Conditions in which people are born, live, learn, work, play, worship, and age
- Harmful conditions cluster and compound for communities facing multiple forms of marginalization

Intersectionality in the quality and use of health services



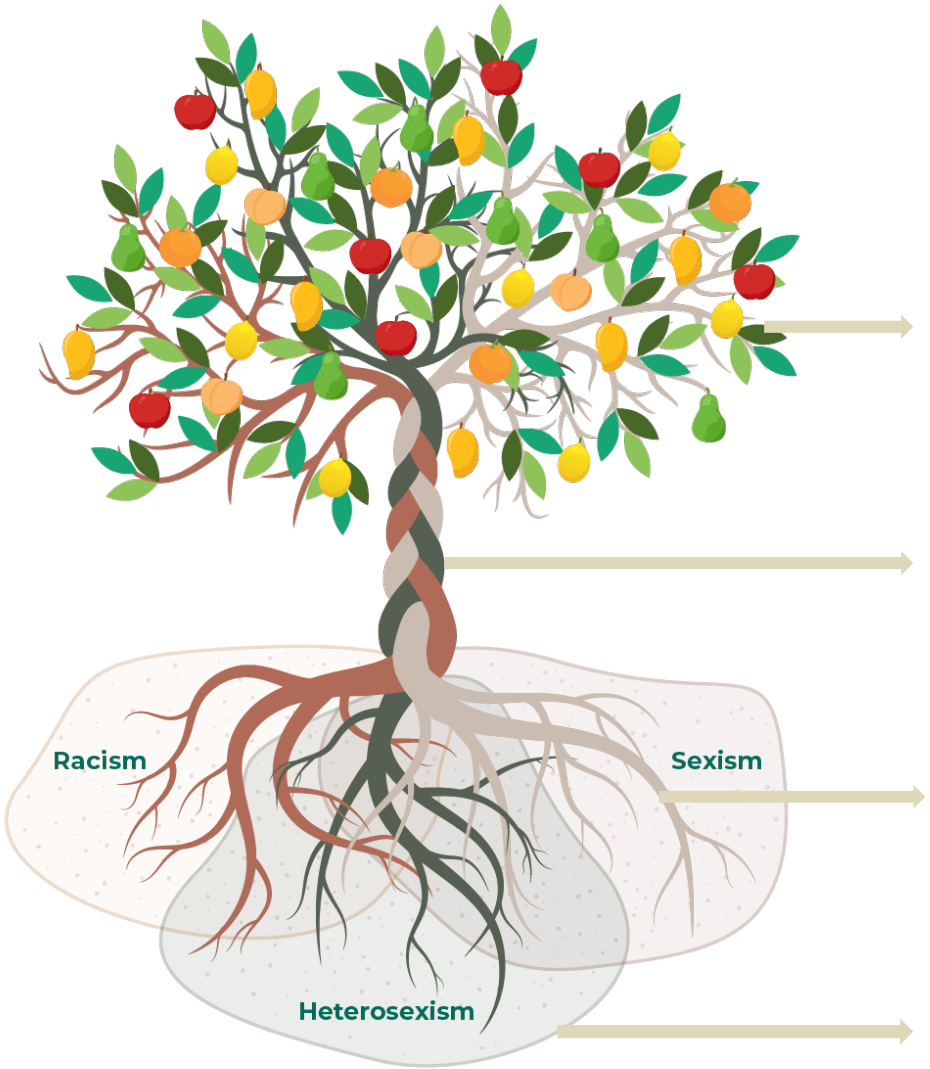
- The safety, effectiveness, patient-centeredness, timeliness, efficiency, and consistency of health care
- Patients with intersectional identities face multiple barriers to quality health care

Intersectionality in health outcomes



Well-being experienced by various individuals and groups

Implications for policy and practice



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

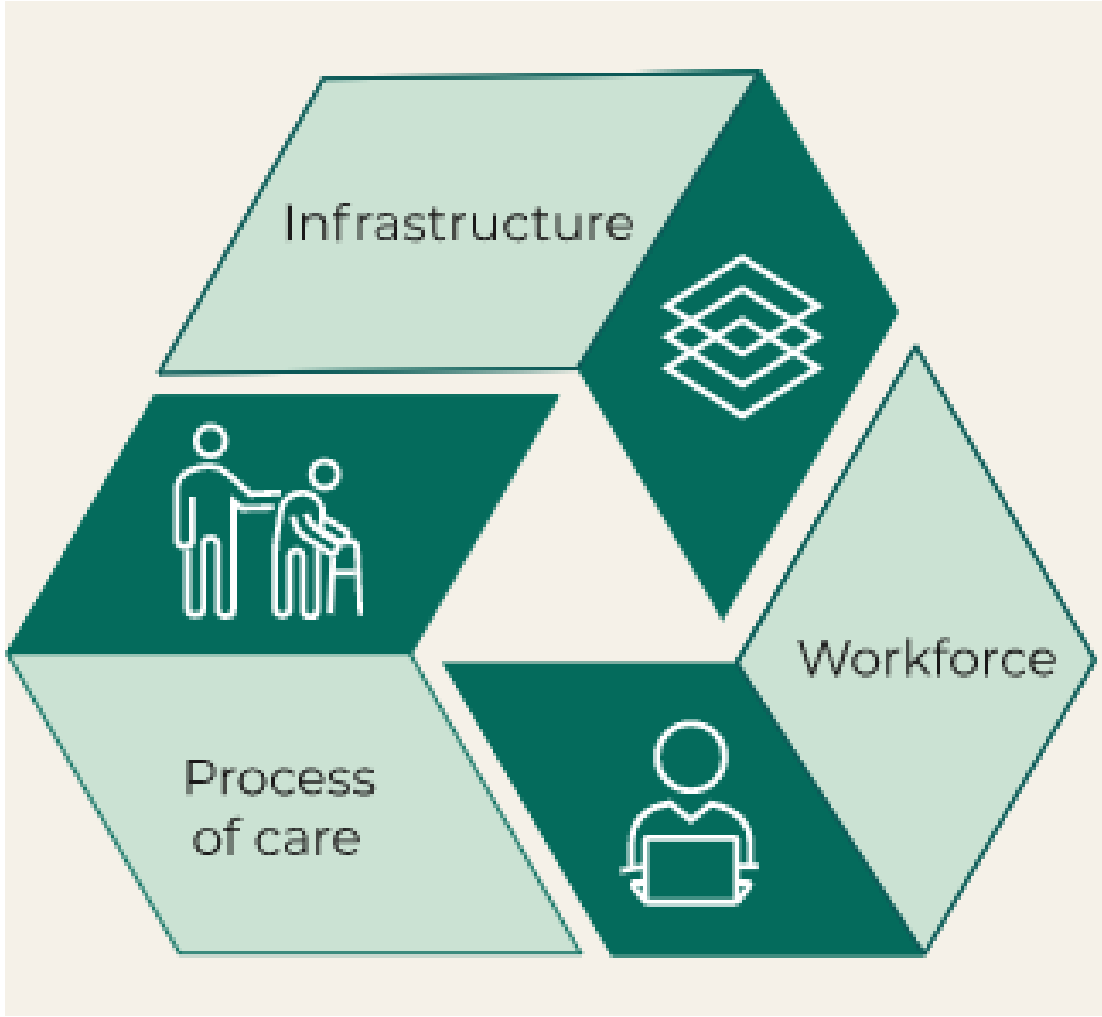
Diversify **workforce** and expand definition of health care workforce

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

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

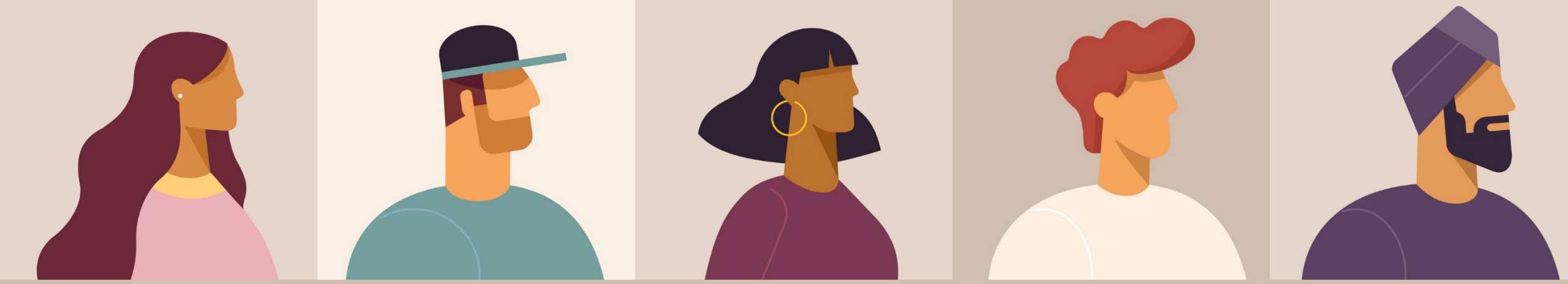
Increase accessibility of care **infrastructure** (e.g., satellite location, extended hours)

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

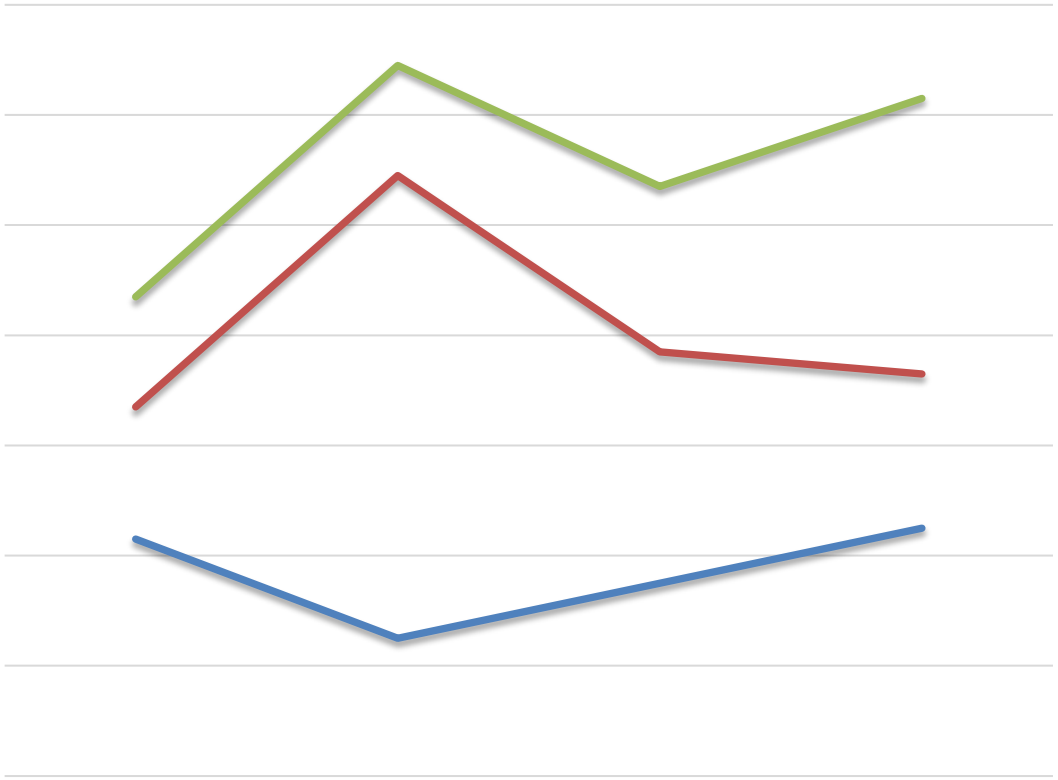
Point of care

- 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

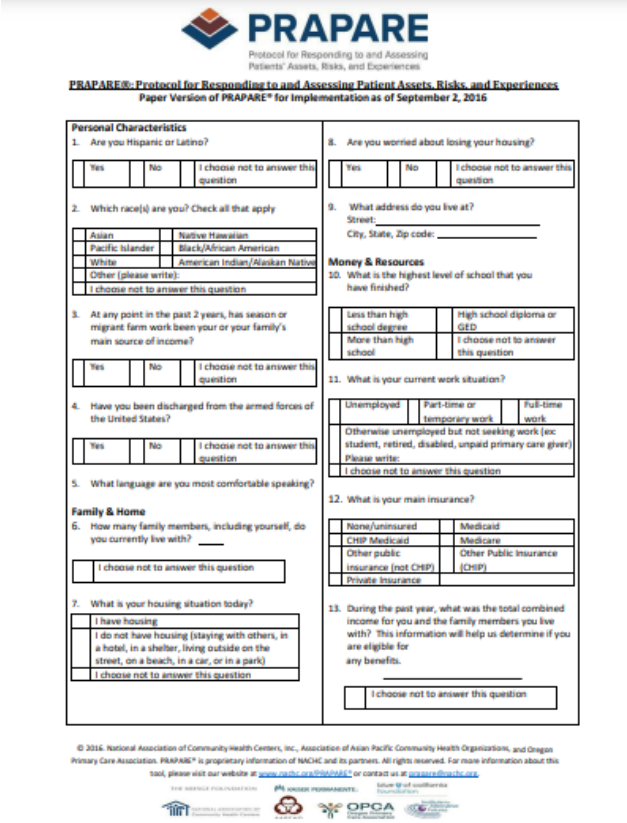
Patient Data



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 Patients' Assets, Risks, and Experiences

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

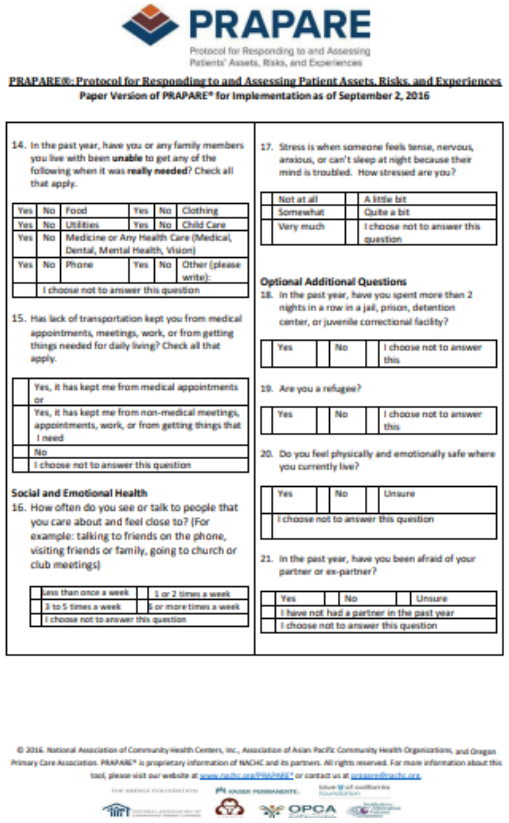
1. Are you Hispanic or Latino?
   - Yes | No | I choose not to answer this question
2. Which race(s) are you? Check all that apply
   - Asian | Native Hawaiian
   - Pacific Islander | Black/African American
   - White | American Indian/Alaskan Native
   - Other (please write):
   - I choose not to answer 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 Patients' Assets, Risks, and Experiences

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

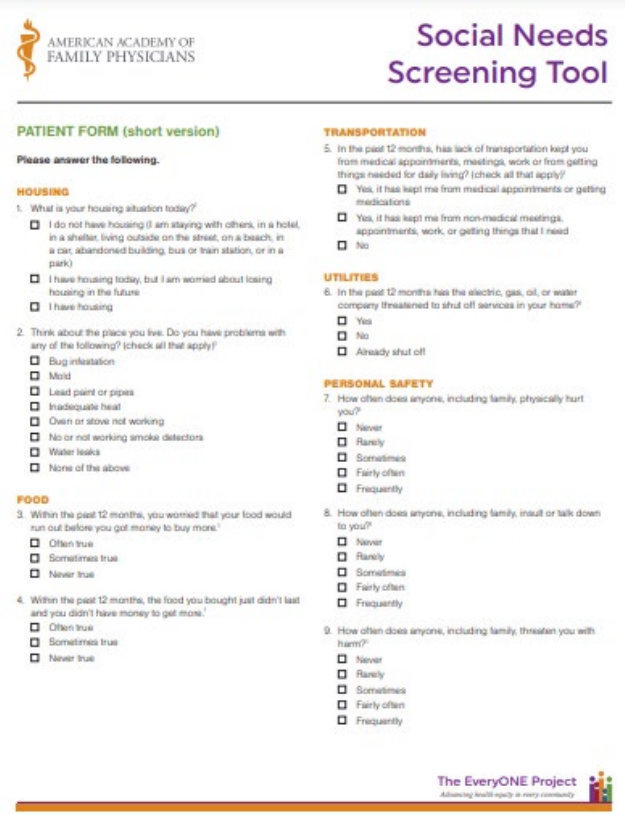
16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)
    - Less than once a week | 1 or 2 times a week
    - 3 to 5 times a week | 6 or more times a week
    - I choose 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
19. Are you a refugee?
    - Yes | No | I choose not to answer this
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.
   - ☐ 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.
   - ☐ 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

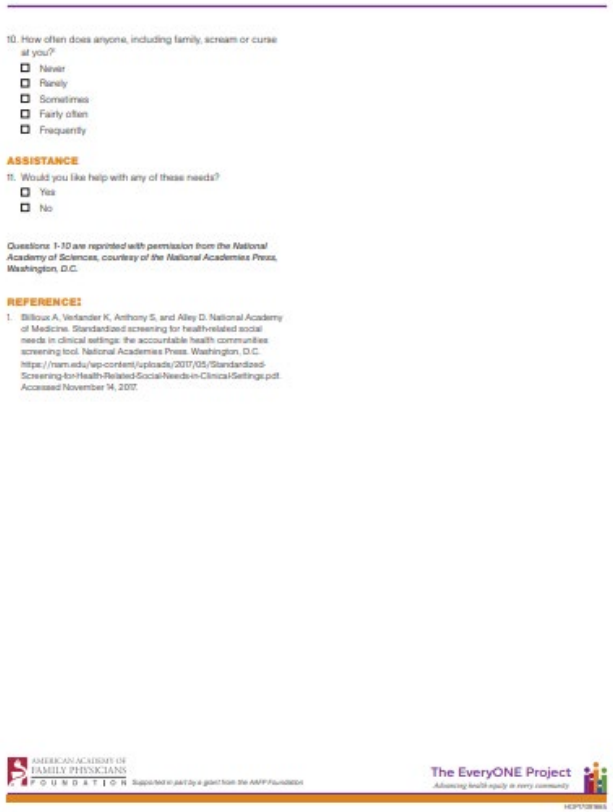
UTILITIES

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.

REFERENCE:

1. Billioux 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.

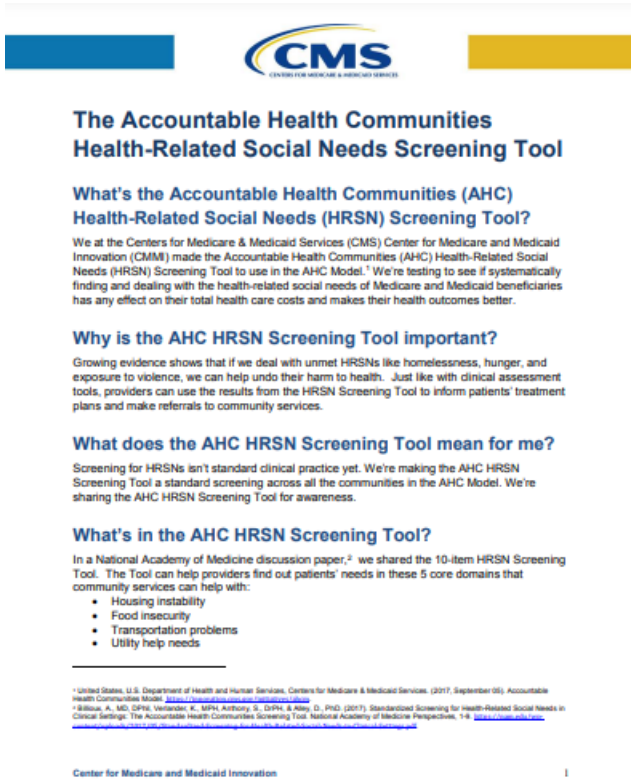
AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION

Supported in part by a grant from the AAFP Foundation

The EveryONE Project
Advancing health equity in every community

Source: American Academy of Family Physicians, 2018

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



CMS

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?

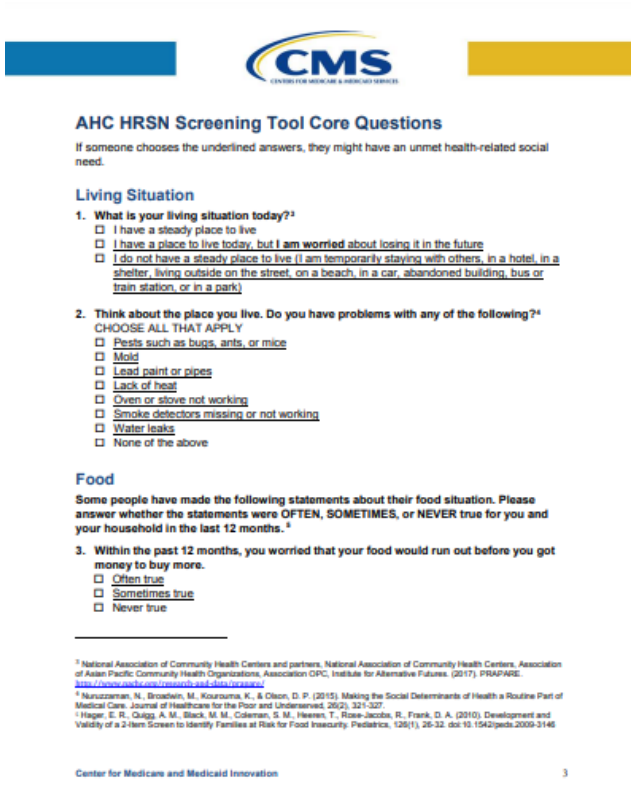
In a National Academy of Medicine discussion paper,[2] we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

- 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://innovation.cms.gov/initiatives/ahcm

[2] Billioux, A., MD, DPH, Verlander, K., MPH, Anthony, S., DrPH, & 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, 1-9. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf

Center for Medicare and Medicaid Innovation 1



CMS

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.nachc.org/research-and-data/prapare/

[4] Nurtzzaman, 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., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, 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, 126(1), 26-32. doi:10.1542/peds.2009-3146

Center for Medicare and Medicaid Innovation 3

Source: CMS

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

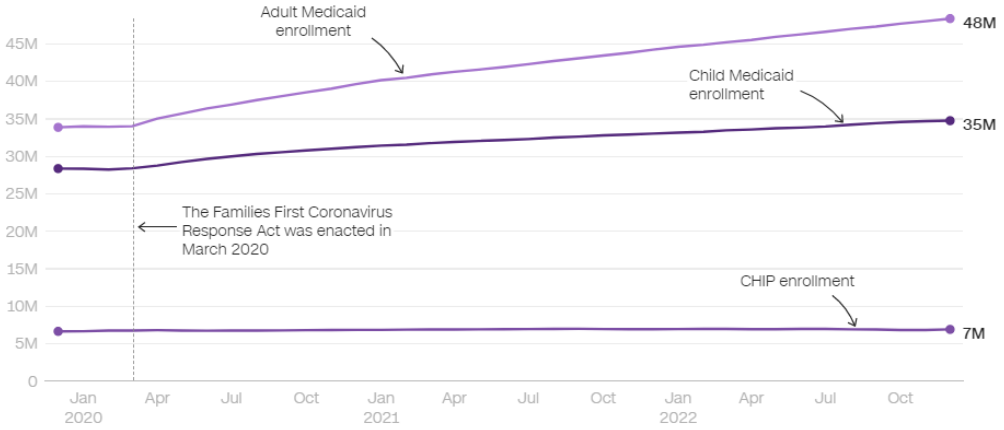
Additional Factors to Consider

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

Medicaid Unwinding

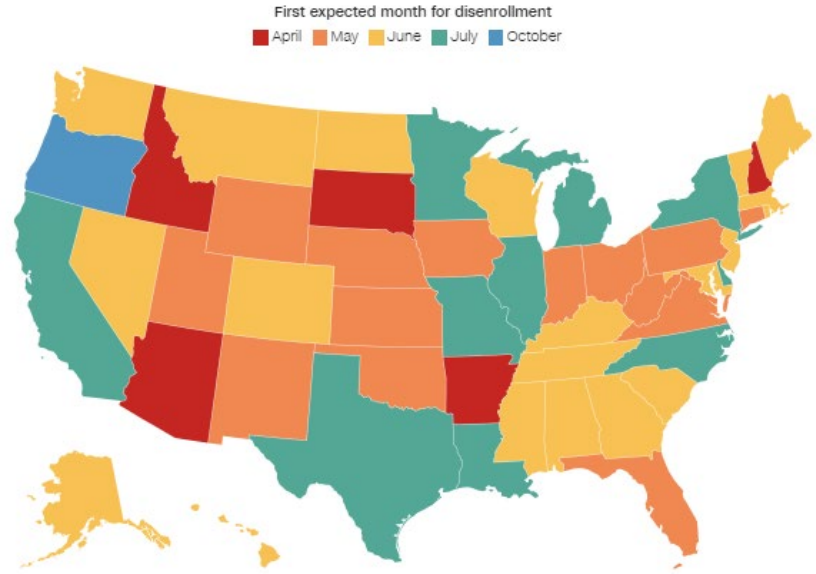
Medicaid and CHIP enrollment increased during the pandemic

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

Source: CNN, 2023

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?

Contact us through this form here!

Looking for free trainings and credits?

Check out integrated health trainings from Relias here

Subscribe for Center of Excellence Updates

Subscribe here

NATIONAL COUNCIL for Mental Wellbeing

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 COUNCIL for Mental Wellbeing

Upcoming PCDC Events

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

Contact Us

Shannon Lea, MPH

slea@pcdc.org

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/.