# DSRIP 2.0

## PERSPECTIVES ON PREVENTION, ACCESS, CULTURAL COMPETENCE

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# Overview of Presentation



- Define disparity, inequity and equity
- Demonstrate integration of health equity and cultural competency
- Highlight opportunities to address the social determinants of health
- Ensure a culturally competent workforce
- Identify strategies for community engagement and transparency

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# Definition of Health Disparities



**Health and mental health disparities:**

Differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.

Notes: California Department of Public Health, Office of Health Equity, Health and Safety Code 131019.5

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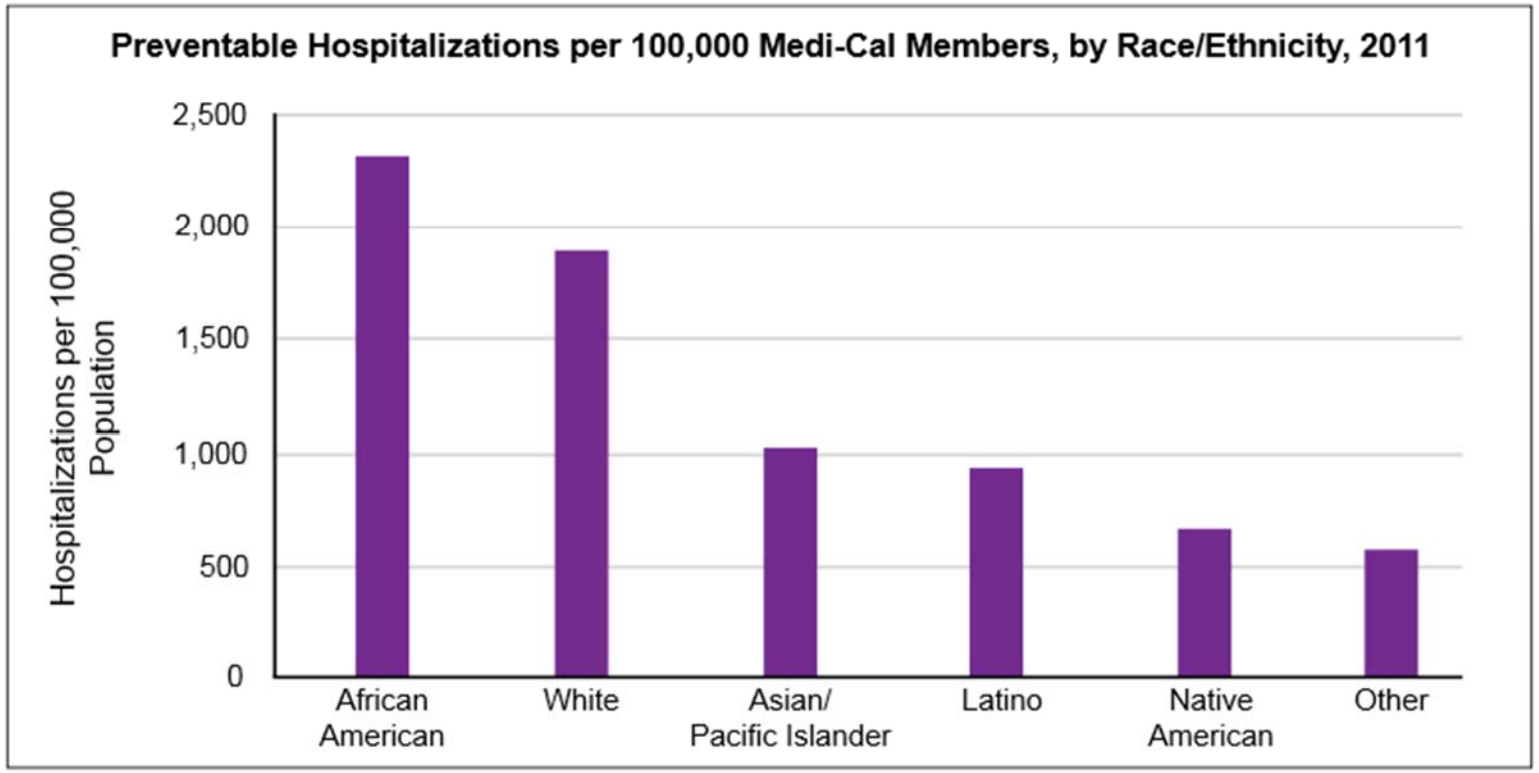
# Example of Health Disparities

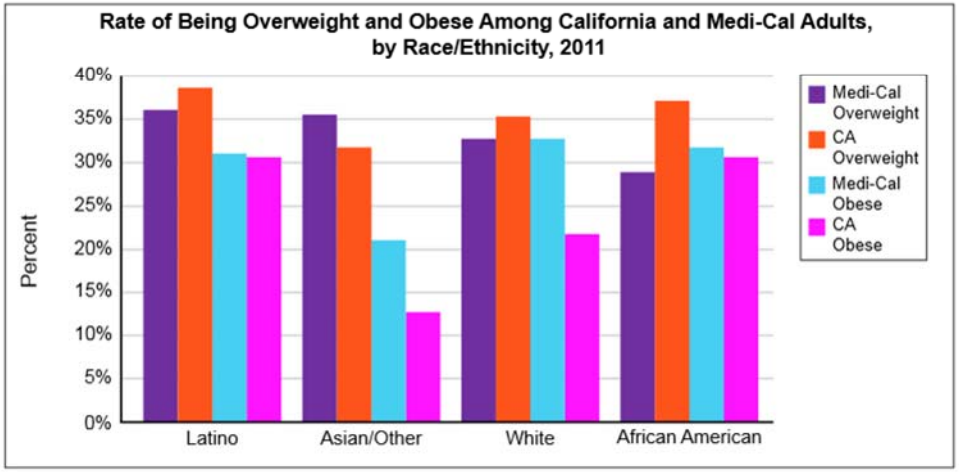





Source: Numerators: Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data, 2011; Denominators: Medi-Cal MIS/ DSS, 2011.
Note: Rates produced from the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators Composite, Version 4.4. Members eligible for both Medicare and Medicaid were excluded.

# Examples of Health Disparities






Source: Behavioral Risk Factor Surveillance Survey, 2011 - California Data File.

**Latinos and Asians in Medi-Cal are more likely to be overweight.**

**Persons that speak English not well or at all are more likely to be diagnosed with heart disease.**

Source: 2011 - 2012 California Health Interview Survey
**95%** confidence intervals are displayed in table

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| | How well does respondent speak English | | | |
|---|---|---|---|---|
| Ever diagnosed with heart disease | Very well *Sort by this* | Well *Sort by this* | Not well / not at all *Sort by this* | All |
| Has heart disease | 3.4%<br>(1.5 - 5.2)<br>35,000 | 4.3%<br>(2.9 - 5.7)<br>41,000 | 6.6%<br>(5.2 - 8.0)<br>173,000 | 6.3%<br>(5.6 - 7.1)<br>443,000 |
| Doesn't have heart disease | 96.6%<br>(94.8 - 98.5)<br>1,019,000 | 95.7%<br>(94.3 - 97.1)<br>909,000 | 93.4%<br>(92.0 - 94.8)<br>2,453,000 | 93.7%<br>(92.9 - 94.4)<br>6,563,000 |
| **Total** | 100.0%<br>1,054,000 | 100.0%<br>950,000 | 100.0%<br>2,627,000 | 100.0%<br>7,006,000 |

# Defining Health Inequity



- **Health and mental health inequities:** means disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.

Notes: California Department of Public Health, Office of Health Equity, Health and Safety Code 131019.5

# Example of Health Inequities



- Uninsurance rates
- Lack of cultural/linguistic providers
- Lack green space
- Lack of transportation
- Segregated housing

# Youth Access to Parks and Communities of Color


- HIGH % Communities of Color & LOW Youth Access to Parks
- HIGH % Communities of Color & HIGH Youth Access to Parks
- LOW % Communities of Color & LOW Youth Access to Parks
- LOW % Communities of Color & HIGH Youth Access to Parks

**Data Source:** 2009 California Health Interview Survey (CHIS)
**Classification:** Counties with values higher than the median are included in the "high" category, while those with values at or below the median are included in the "low" category. The medians for Communities of Color and Youth Access to Parks are 47% and 85% respectively.
**Geographies:** CHIS groups some counties with smaller populations together into 3 regional groupings.

**Youth Access to Parks & Playgrounds**
(% with a park or playground walking distance from home)

High
Low
High

**Communities of Color**
(% of Population)

84% of California youth, aged 1-17, had a park or playground within walking distance of their home in 2009.

Nevada County had the smallest percentage of youth with access to parks at 49%, while Santa Barbara County had the largest percentage at 95%.

# Social Determinants of Health



- The biological, behavioral, economic, physical, environmental, and political factors that shape the health of individuals, communities, and jurisdictions.
- "Determinants of equity" means social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society.

Notes:

- Health in All Policies: A Guide For Local Governments. Available: http://www.phi.org/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf
- California Department of Public Health, Office of Health Equity, Health and Safety Code 131019.5

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# Definition of Health Equity



- **Health equity:** means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Notes: California Department of Public Health, Office of Health Equity, Health and Safety Code 131019.5

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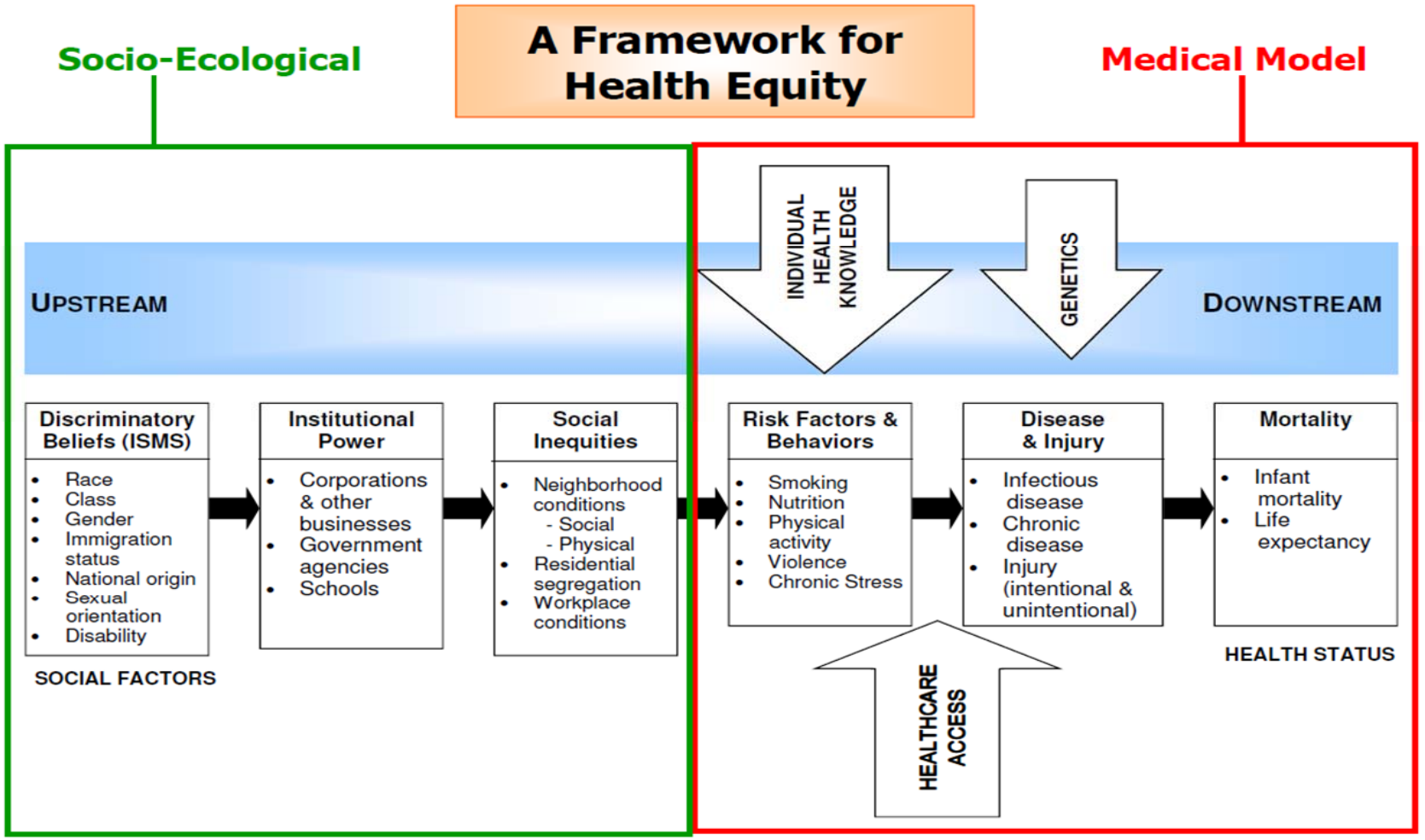
# Framework for Health Equity






- Adapted by ACPHD from the Bay Area Regional Health Inequities Initiative, Summer 2008

# Recommendations



- Integrate data collection and analysis into all domains
- Focus efforts on the identification and reduction of health disparities
- Ensure health systems are providing culturally and linguistically appropriate services
- Better integrate identification and addressing of social determinants of health

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# Integrating Data and Reducing Disparities



1. Create and support systems to identify health disparities
2. Implement health disparities reduction initiatives
   a) PCMH 6A4: Performance data stratified for vulnerable populations
   b) PCMH 6D7: Set goals and address at least one identified disparities in care/service for identified vulnerable population

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# Ensure Culturally and Linguistically Appropriate Services



1. Ensure providers are providing culturally and linguistically appropriate care
   a) Adhere to language assistance standards
   b) Hire and recruit volunteers from communities of color
   c) Connect with community leaders
   d) Engage community members in delivery system reform

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# Example: Medical Home for Boys and Young Men Of Color



Commit to thinking about how to serve boys and young men of color and take a step towards improving those services :

- **Get input from current young male patients of color:** Focus groups, surveys, analyze data from health assessments, patient satisfaction surveys, ask questions during visits .
- **Get Input from the community:** Form a Youth Advisory Board
- **Actively recruit young men of color** to your facility: Use outreach materials, social media, nearby schools, mobile clinics, technology
- **Hire men of color as providers**, recruit volunteers from the community, or hold male-only clinic hours.
- **Address Trauma and violence:** Know the signs of trauma and respond by integrating procedures to address impacts of trauma; Educate staff.
- **Integrate other services** into your program: legal, job training, father training and support, youth programs, etc.

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# Integrate Social Determinants



- Integrate questions about the social determinants of health in patient assessments
  - PCMH Element 4A4: A process for identifying patients based on social determinants of health.
- Work with California's Health in All Policies Task Force
- Align with Let's Get Health California Task Force Indicators

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# Coordinate with Community



- Establish coordination efforts to link patients to resources to improve health
- Coordinate with local health departments to share community level data
  - Ask a local health department or community organization to conduct a Healthy Community Report Card (next slide)

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# Health Community Report Card



Community Report Card for "Bridgewater", California, 2010

| Healthy Community Domain | Icon | Description of Indicator | Indicator Result* | State Average Comparison |
|---|---|---|---|---|
| Meets Basic Needs of All |  | Food affordability for female-headed household with children under 18 years | 29 | |
| |  | Modified retail food environment index | 12 | |
| |  | Percent of Population within ½ Mile of Park, Beach, Open Space, or Coastline | 82 | |
| |  | Percent of population within 1/2 mile of major transit stop# | 38 | |
| |  | Annual number of fatal road traffic injuries per 100,000 population | 5 | |
| |  | Percent of residents taking public transportation to work | 7 | |
| |  | Percent of population aged ≥ 16 years whose commute to work includes ≥ 10 minutes of daily walking | 3 | |
| |  | Percent of households spending more than 30% of monthly household income on monthly gross rent or selected housing costs | 43 | |
| |  | Percent of household overcrowding (> 1.0 person per room) | 7 | |

| Legend | |
|---|---|
| Less (better) than the state average | |
| 1-1.5 times (poorer than) the state average | |
| 1.6 or more times (poorer than) the state average | |

# Access Integration and Equity



- Strong and competitive safety net crucial to the success of the ACA in California
  - Over 80% in Medi-Cal Managed Care
  - High numbers of remaining uninsured
  - Building on foundational Bridge to Reform
  - California's Public Health Systems
    - Anchor the safety net
    - Focus of DSRIP 2.0

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# Embracing Our Diversity

- California Context
  - One of four majority person of color states
    - Latinos outnumber Whites

# DSRIP 2.0 GOALS



- Delivery System Transformation
  - To achieve improvements in clinical quality & population health
- Care Coordination for High Risk, High Utilizing Populations
  - Addressing care across sectors
- Prevention
  - To reduce morbidity & mortality
- Resource Utilization Efficiency
  - Choosing Wisely Campaign
- Patient Safety
  - Culture and inappropriate surgeries

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# DSRIP 2.0 GOALS

# Patient Safety: Workforcep erspective



- Worker safety strongly correlated with patient safety and clinical outcomes (directly or indirectly)
  - **Gap:** Workers not referenced in Domain 5: Promoting a Culture of Patient Safety
  - **Solutions:**
    - Make becoming High Reliability Organizations (HROs) a DSRIP goal
    - Incorporate worker health and safety into Domain 5 goals/objectives and core components
    - Include worker safety and satisfaction as indicators under project metrics
    - Incorporate input from patients, families, and where appropriate, communities

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# DSRIP 2.0 GOALS



- Delivery System Transformation
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# Role of Frontline Workers



- **Expanded Access to Care**
  - Team-based care: Increase panel size by offloading appropriate tasks to workers, freeing up more time for provider visits/exams
  - Patient Navigation: Teach newly covered or assigned patients how to use heath care
  - Conduct home visits and provide frequent follow up and support
  - Accompaniment: attend clinical visits with the patient, and understand and reinforce care plan.



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# Role of Frontline Workers



- **Improved Health Equity**
  - Hired from the communities served, e.g. promotoras, peer counselors, community health workers
  - Provide culturally competent health coaching
  - Inform development of the care plan to ensure it fits with the patients' cultural perspective and community

# Role of Frontline Workers



- **Better Care Integration**
  - Build bridges from PCMHs to Health Homes
  - Integrate and coordinate health services for mental health and substance use disorders
  - Telemedicine: Monitor health indicators at home (e.g. IHSS workers), use/teach telemedicine tools such as smartphones and tablets
  - Assist with care transitions
  - Advocate for improved housing and other environmental conditions that affect health

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# Role of FrontLine Workers



- **More Efficient Care**
  - Assigned to work with high cost complex care patients as part of a multidisciplinary care team in PCMH, Health Home, or specialty care team
    - Evidence of frontline workers' effectiveness in preventing and controlling chronic diseases (IOM)
  - Prevent avoidable care such as unnecessary hospitalizations and emergency department visits
  - Improve patients' self-management and engagement

Source: National Center for Chronic Disease Prevention and Health Promotion Community Health Worker Policy Evidence Assessment Report

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# Recommendations



- **What is needed in DSRIP 2.0?**
  - Clearer commitment to culturally and linguistically appropriate workforce grounded in communities served
  - More consistent commitment to workforce training and engagement in planning
  - Support shift to team-based care delivery models
  - Expand the role of the IHSS worker through enhanced IHSS workers as members of the care team

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# Example:
# High Risk, High Utilizing Populations



- **Culturally & Linguistically Appropriate Services Essential**
  - Behavioral Health Integration
  - Foster children
  - Post incarceration
  - Advanced Illness Planning and Care

# Example: Domain 1



- DOMAIN 1: Delivery System Transformation
  - Requires more team-based care models:
    - PCMH
    - Team-based approaches to specialty care management
  - Requires more patient engagement
    - DSRIP project planning
    - Individual care plans
  - **Gaps:**
    - Frontline staff engagement in planning specialty care and addressing social determinants of health
    - Investment in staff training for incumbent or new staff
    - Crucial role of frontline workers

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# Considerations



- Data, Communication and Trust
- Need to test and develop new coordination models
  - Care management and coordination have many meanings
- Communication with other entities (plans, other providers, etc) to avoid unnecessary duplication of services
- Care coordination at the provider-level

# Strategies for Community Engagement and Transparency

- Community Needs Assessments:
  - These should follow minimum standards in terms of what measuring (social determinants and stratification by demographics)
  - Results should be transparent (+translate as necessary) to impacted communities and stakeholders
- Transparency via Dashboarding (this is well tested in certain counties & across the nation)

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# Community Needs Assessment: Best Practices for DSRIP Domains

1. Describe population to be served
   a) Meet *all* data specifications (standards defined by state)
   b) Include non-Medicaid population & uninsured
2. Assess health status & clinical care needs & social determinants indicators AND
3. Assess health care and *community-based resources available to address those needs (including SDH )*

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# Community-Based Services to Account for

## as part of NEEDS ASSESSMENTS (Note Ties to SDHs)

- Housing services for homeless
- Food banks, community gardens, farmers markets
- Clothing & furniture banks
- Specialty educ. programs for special needs
- Transportation services
- Religious service orgs
- Non profit health & welfare agecnies
- Youth development programs
- NAMI, peer supports & self advocacy resources
- Alternatives to incarceration
- Libraries with computer labs

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# Searchable Social Determinants

## Economy

### Employment

| | |
|---|---|
| Unemployed Workers in Civilian Labor Force NEW | Comparison: U.S. States |

### Government Assistance Programs

| | |
|---|---|
| Households with Cash Public Assistance Income | Comparison: U.S. States |
| Kansas Medical Assistance Programs - Adults per 1000 Population, 20-64 Age-Group | Comparison: KS State Value |
| Kansas Medical Assistance Programs - Children per 1000 Population, 0-19 Age-Group | Comparison: KS State Value |
| Students Eligible for the Free Lunch Program | Comparison: U.S. Counties |

### Homeownership

| | |
|---|---|
| Homeowner Vacancy Rate | Comparison: U.S. States |
| Homeownership | Comparison: U.S. States |

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# Maximize Regional Data Sources



- The *County Health Rankings & Roadmaps* project. County rankings include information on health outcomes and factors influencing health, and the roadmaps show how communities can become healthier.
- The *Scorecard on Local Health System Performance* (Commonwealth Fund) tracks 43 indicators across 4 categories (access, prevention and treatment, costs and potentially avoidable hospital use, and health outcomes) and identifies how improved performance on various measures could save lives, reduce costs, and improve quality of and access to care.
- The *Healthy City* project, is the largest free, California-specific, interactive, online resource that contains actionable information including data, maps, and service referrals. Users can access various demographic, economic, health and safety, and housing data on the site and also contribute their own data that are then available to other users.

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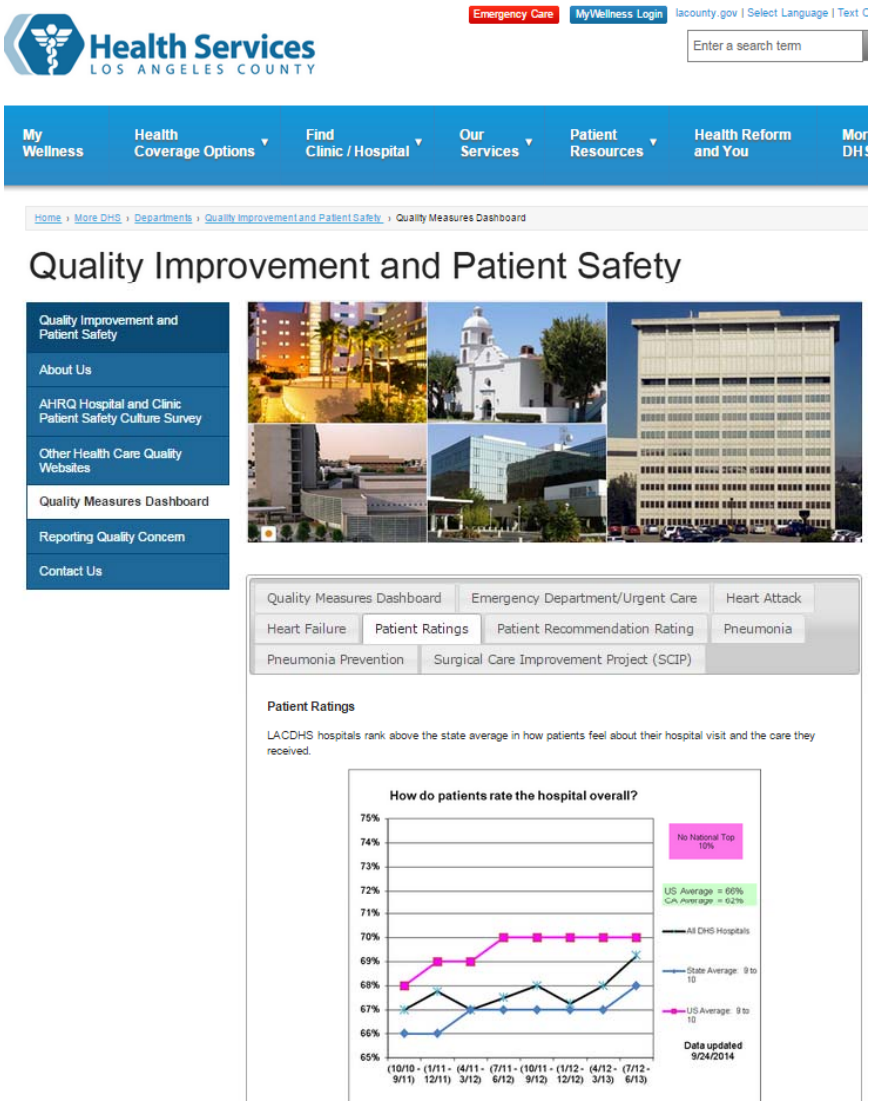
# DashBoarding Example: Los Angeles

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# Conclusion



- Cornerstones of a strong safety net delivery system
  - Anchored in the communities served
  - Builds on our strengths
    - DSRIP 1.0 experience
    - Invests in workforce training
  - Stretch
    - New care models
    - Big challenges
  - Patient, family and community-centered
    - Health Justice!
    - Transparency and accountability to communities

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