“Taking clinical continuum-of-care into neighborhoods and homes”

Lisa Graves MD, Associate Dean, WMEd
Clinical Equity Consultant

MDHHS Minority Health Grant Program
Overview

• Capacity Building grant from MDHHS – Minority Health

• Goal to eliminate racial and ethnic health disparities through implementing culturally appropriate, evidence-based approaches

• 1 of 6 awardees across the state
Overall Program & Evaluation

- Purpose of this grant is to support the overarching health equity goal of Cradle Kalamazoo: ensuring health equity and cultural competency of programs, policies, and providers.

- Partnering with 3 clinical sites (Ascension Borgess, Bronson, Family Health Center) to improve cultural competency of clinical processes and procedures that impact maternal and infant health.

- Dr. Joia Crear-Perry and Dr. Lisa Graves are consultants supporting the implementation of this work.
## IHI (Institute for Healthcare Improvement) Framework To Achieve Health Equity

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Actions</th>
</tr>
</thead>
</table>
| 1.   | Make health equity a strategic priority | • Demonstrate leadership commitment to improving equity at all levels of the organization  
• Secure sustainable funding through new payment models |
| 2.   | Develop structure & processes to support health equity work | • Establish a governance committee to oversee and manage equity work across the organization  
• Dedicate resources in the budget to support equity work |
| 3.   | Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact | • Health care services (CLAS, CHW, co-design processes)  
• Socioeconomic status (fair pay & opportunity for employees)  
• Physical environment  
• Healthy behaviors |
| 4.   | Decrease institutional racism within the organization | • Physical space: Buildings & design  
• Health insurance plans accepted by the organization  
• Reduce implicit bias within organization policies, structures & in patient care |
| 5.   | Develop partnerships with community organizations | • Leverage community assets to work together on community issues related to improving health & equity |

Overall Program & Evaluation

Phase 1:
• Identified 3 clinical sites

• Assessed cultural competency of policies and procedures that impact maternal/infant health (*pre-assessment*)

• Met with sites to review assessment & talk about needs

• Drafted recommendations
Overall Program & Evaluation

Phase 2:

• **Reviewed recommendations** (universal intake process, earlier access to care, equity trainings, substance abuse trainings, HR practices)

• **Implement recommendations** (training evaluations)

• **Assess after 1 year** (post-assessment, consultant evaluation, summary/process report)

• Plan for next steps
Current Work

• **Phase 2: Early Access to Care**  
  • Updated and documented intake processes & workflow  
  • Created reports with entrance to care data  
  • Updated intake process for first prenatal visit  
  • Working to create & implement unified SDOH questionnaire  
  • Offered trainings  
  • Post Assessment and review in September

• **Sustainability:**  
  • Processes and procedures incorporated into each clinic  
  • Connecting with partner agencies for continued training needs  
  • Incorporate into internal QI processes
Successes & Challenges

Successes

• Engagement from clinical partners
  • Unified approach to SDOH across Kalamazoo

• Changing culture around access to care
  • Support for early access to care
  • Median first prenatal visit occurring in first trimester

• Interest in trainings
  • 7 events completed
  • 3 planned

Challenges

• Finding a consultant

• Consistent follow-up with multi-sector partners
Next Steps

Streamlining the ASK (screening) & ACT (response)...

1. Developing an SDOH continuum of care

2. Standardizing validated screener (example attached)

3. Levelled response (printout of services, CHW referral, MSW consult)

Continue to look for opportunities e.g. postpartum period
# Example Standardized Validated Screener

## Population
- income & race/ethnicity
- Do you have Medicaid insurance, private insurance or no insurance (*Medicaid or no insurance = low SES*)
- Which racial group(s) do you belong to (open-ended, multi-response) (*Categorize into White only versus of color-non-White*)

## Do you have concerns about... [14 items]

### Material Domain (Y,N)
1. Running out of food before you have money or food stamps to buy more
2. Having a stable, healthy place to live
3. Having enough money to pay your bills (*like utility or medical bills*)
4. Having a primary care or regular general doctor
5. Getting mental health care for yourself or someone in your home?
6. Reliable transportation
7. Legal issues (*immigration, child support, custody, CPS, criminal charges, lawsuit*)

### Social Domain (Y,N)
8. Safety in your neighborhood
9. Having help from friends or family when you need it
10. Being hurt (*hit, kicked, punched, pushed*) by someone in your life (*during your childhood, as a teen, now*)
11. Being regularly treated with less respect than other people

### Psychosocial screener
12. During the last 3 months, have you...
   a. Have 4 or more drinks in one day?
   b. Take/use meds that were not prescribed to you?
   c. Use any street/recreational drugs (*pot/weed, heroin, cocaine, crack, meth, ecstasy, steroids, inhalants, etc*)
13. In the last year, how often did you feel down, depressed or hopeless?
   Dichotomize response into: (*risk*) Always, often, sometimes and (*no/low risk*) rarely, never
14. In the past year, has your partner or former partner... (*score 7+=risk*)
   a. Physically hurt you
   b. Insulted or talked down to you
   c. Threatened you with harm
   d. Screamed or cursed at you
   d. Forced you to have sexual activities

RESPONSE SCALE:  Never(1), rarely(2), sometimes(3), fairly often(4), frequently(5)... *score 7+=risk*
Thank You!