HEALTH MANAGEMENT ASSOCIATES

Advancing and Codifying Health Equity and Wellness for Medicaid Populations

An HMA Webinar in Partnership with the Arthur Ashe Institute for Urban Health (AAIUH), NYC and the Disability Policy Consortium (DPC), Boston

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TODAY'S PRESENTERS

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HMA'S PARTNERS ON THIS WEBINAR TODAY

Mission Statements

Arthur Ashe Institute for Urban Health

The Arthur Ashe Institute for Urban Health utilizes a model of community health empowerment and engagement to promote health equity and social justice through strategic partnerships, innovative community-based health promotion & research programs, and the preparation of a more diverse and inclusive workforce of health professionals.

Disability Policy Consortium

DPC. About Us. By Us.

Redefining the role of government as it affects the lives of people with disabilities.

WEBINAR LEARNING OBJECTIVES

1. How CBOs can advance health equity and wellness goals

2. How New York supported CBO engagement in its Delivery System Reform Incentive Payment (DSRIP) plan

3. Challenges CBOs have experienced in healthcare reform and how these resonated with CBOs in Massachusetts

4. Why we need a collective call to action to Advancing Health Equity

INTRODUCTION

WHY A FOCUS ON HEALTH EQUITY IS ESSENTIAL?

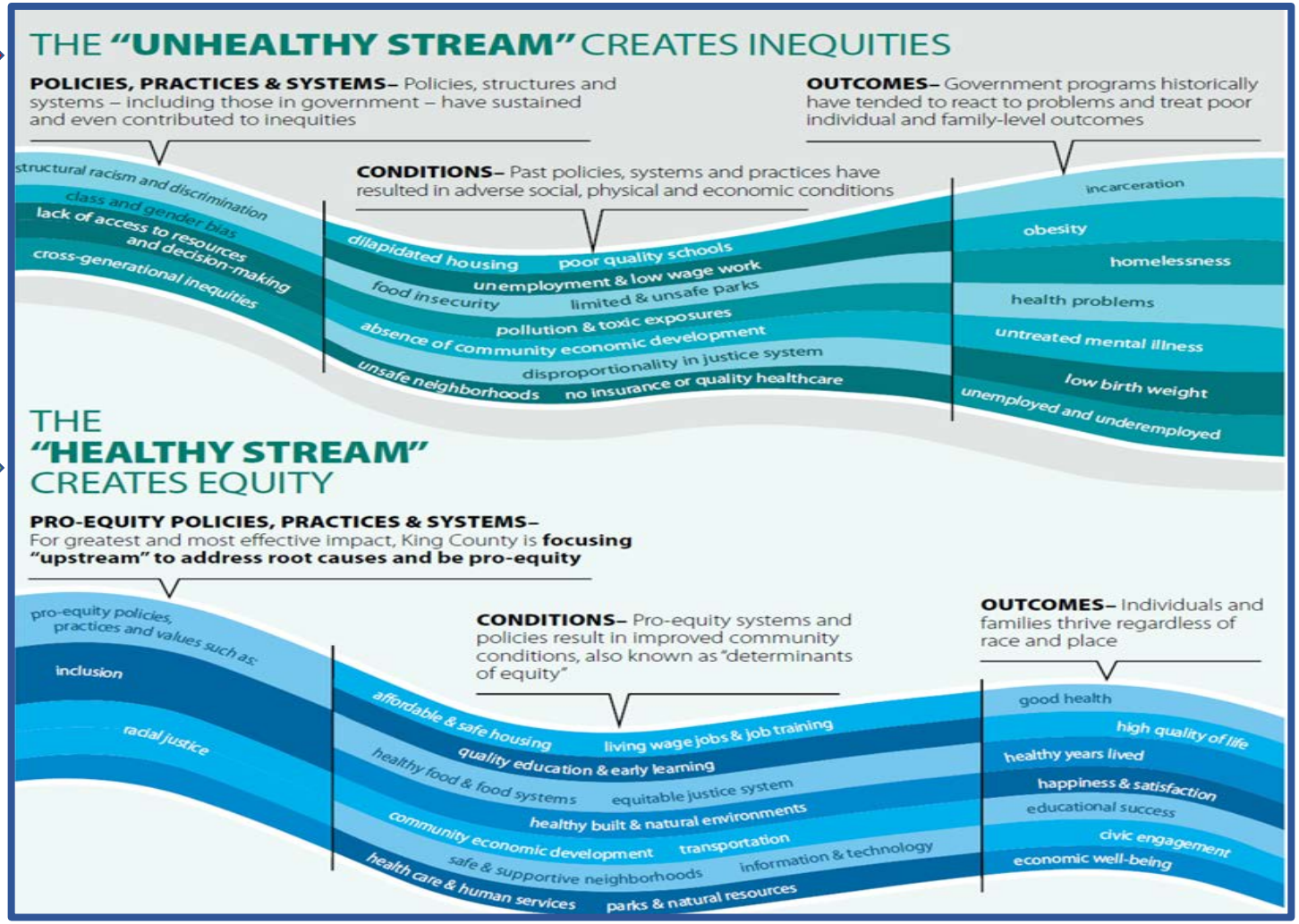
What is Health Equity?

In a 2017 report published by the RWJ Foundation, the foundation concludes that there is no common understanding of what health equity means, while offering their definition:

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

Source: Robert Wood Johnson Foundation
https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

HOW INEQUITIES CREATE HEALTH DISPARITIES



Source: King County
https://www.kingcounty.gov/elected/executive/equity-social-justice/vision.aspx

INEQUITY DRIVES HEALTH DISPARITIES

- **Health disparities are well documented and are an outcome of inequity.**

YES.

- Do Medicaid populations experience health disparities?
- Do certain racial and ethnic groups experience worse health outcomes than other groups?
- Do persons with disability experience worse health outcomes than persons without disabilities?

GROUPS EXPERIENCING HEALTH DISPARITIES

Race

Certain racial and ethnic groups experience worse health outcomes than other groups.

Disability

Persons with disabilities experience worse health outcomes than persons without disabilities.

Health disparity measures include higher rates of mortality, chronic conditions and disabilities, etc.

Source:
Minnesota Department of Human Services.
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7834-ENG

CBOs BRING AN INTERSECTIONAL LENS

"An intersectional lens is a critical tool that CBOs use to identify and understand the multiple factors that affect the quality of the person's life. This means all factors, be they gender, race, sexual orientation, location of residency, employment status, history of incarceration, and may more. Understanding the whole person serves as a pathway to designing interventions that address the needs of people in a holistic manner, and ultimate to social justice."

Source: AAIUH staff and members of Communities Together for Health Equity (CTHE) including Humberto Brown and Dr. Tenya Blackwell, October 2018.

SYSTEMS OF OPPRESSION

"Oppression is an interlocking system that involves ideological control as well as domination and control of the social institutions and resources of the society, resulting in a condition of privilege for the agent group relative to the disenfranchisement and exploitation of the target group(s)"

Source: Consciousness-in-Action, Raul Quinones Rosado, PhD

SDOH → SYSTEMS OF OPPRESSION

Achieving health equity requires that the health care delivery system address the systems of oppression that leads to health disparities.

- We cannot have a conversation focused on health disparities, interventions, and collaboration between community-based organizations (CBOs) and the health care system without addressing systems of oppression.
- We must name the systems of oppression that lead to health disparities (e.g. racism, medicalizing disability).
- Within the scope of the health care system there are opportunities for the health care system to address oppression.

- What are systems of oppression?
- Why do we want to start the conversation here?
- Why is it useful to talk about systems of oppression?
- How do systems of oppression lead to health disparities?
- How can we address systems of oppression to advance health equity?

EXAMPLES OF DISCRIMINATION AND STIGMA IN HEALTH (1)

How do these situations lead to health disparities?

We must make a commitment to take practical steps to address identified forms of oppression that perpetuate disparities at the systems level.

Health Disparities and Race

- White male physicians are less likely to prescribe pain medication to black patients than to white patients.
- Doctors assume their black or low-income patients are less intelligent, more likely to engage in risky behaviors, and less likely to adhere to medical advice.
- Women presenting with cardiac heart disease (CHD) symptoms are significantly less likely than men to receive diagnosis, referral and treatment, due to misdiagnosis of stress/anxiety.
- Pregnant women face discrimination from healthcare providers on the basis of their ethnicity and socioeconomic background.

EXAMPLES OF DISCRIMINATION AND STIGMA IN HEALTH (2)

Health Disparities and Disability

- A man with a physical disability has depression, but the doctor assumes that the depression is related to the physical disability.
- A blind woman asks the doctor for birth control. The doctor asks: “Why do you need birth control? You’re blind.”
- Hispanics or Latinos and non-Hispanic blacks with Intellectual/Developmental Disabilities (I/DD) were less likely to have received recent preventive care than non-Hispanic whites with I/DD.
- A person with lived experience of psychiatric diagnosis goes to the emergency department (ED) complaining of abdominal pains. The medical providers assume that the abdominal pains the person is experiencing are symptoms of the person’s condition. What should have been a routine appendectomy and quick hospital stay becomes a 10-day hospital stay, the result of an infection caused by a ruptured appendix because the ED staff waited two hours to perform a physical on the person until a psychiatrist can arrive on the scene to assess the situation.

PREREQUISITES TO ACHIEVING HEALTH EQUITY

A PREREQUISITE FOR ADDRESSING HEALTH EQUITY

Reinforcing the status quo will not change the systems of oppression. Community engagement and partnerships with CBOs are prerequisites for addressing health equity.

Requires:

- **Humility; there are unknowns that healthcare cannot learn in isolation**
- **Respect for community voices and CBO participation**
- **Balancing power dynamic**
- **Cross-system collaboration**
- **Agreed health equity goals**

CBO KEY LESSONS FROM NEW YORK

FIVE KEY LESSONS FROM NEW YORK

Lesson 2.

Bridging the Cultural Gap Between Health Care Organizations (HCOs) and Community-Based Organizations (CBOs) Requires A Paradigm Shift.

Lesson 3.

Successful Reform Requires Engagement and Expertise from Community-Based Organizations that Represent their Communities.

Lesson 1.

Delivery System Reform Must Be Rooted in Health Equity and Wellness Goals.

Lesson 4.

Community-Based Organizations Must Build Capacity to Level the Playing Field.

Lesson 5.

Community-Based Organizations Must Come Together as a Collective to Participate in Delivery Reform.

FIVE KEY LESSONS FROM NEW YORK

Lesson 1. Delivery System Reform Must Be Rooted in Health Equity and Wellness Goals.

Working for equity requires cross sector interventions at the community level. Beyond housing, education, and safety, efforts to achieve health equity must address racism and resulting racial disparities that ensue in the form of health inequities. Without a commitment to health equity and wellness, efforts to reform the health care delivery system will achieve only limited success.

Lesson 2. Bridging the Cultural Gap Between Health Care Organizations (HCOs) and Community-Based Organizations (CBOs) Requires a Paradigm Shift

NYC CBOs found that many HCOs had not taken Social Determinant of Health (SDOH) factors into consideration and were not aware of the contributions CBOs can offer.

FIVE KEY LESSONS FROM NEW YORK

Lesson 3. Successful Reform Requires Engagement and Expertise from Community-Based Organizations that Represent Their Communities.

CBOs believe that successful reform is tied to having a “seat at the table” and being fully engaged as equal partners in delivery reform.

Lesson 4. Community-Based Organizations Must Build Capacity to Level the Playing Field.

Building capacity is critical for CBOs to level the playing field between CBOs and HCOs.

Lesson 5. Community-Based Organizations Must Come Together as a Collective to Participate in Delivery Reform.

CBOs need a network for coordinating CBO planning for engagement in health reform.

A COLLECTIVE CALL TO ADVANCING HEALTH EQUITY

COLLECTIVE CALL TO ACTION

We want to ensure CBOs are recognized and engaged as integral stakeholders in health transformation. This is not only necessary to bring about better health, but also to create a more just society.

Join us in this critical and timely conversation:

- Many efforts to promote access to services that address the SDOH and integrate local CBOs are underway.
- Leaders are generating and codifying best practices to promote community-led health equity goal-setting, cross-sector CBO engagement, and collective planning to address the root "causes of the causes" of poor health.
- The lessons from NY are from one set of thought leaders but we need other thought leaders from around the country to inform a roadmap for effective community activation.
- **Healthcare leaders have an opportunity to get it right.**

Achieving Health Equity and Wellness for Medicaid Populations: A Case Study of Community-Based Organization (CBO) Engagement in the Delivery System Reform Incentive Payment (DSRIP) Program

AcademyHealth in partnership with Health Management Associates (HMA) and the Disability Policy Consortium (DPC)

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HMA Health Management Associates

DPC

AcademyHealth

Achieving Health Equity and Wellness for Medicaid Populations: A Case Study of Community Based Organization (CBO) Engagement in the Delivery System Reform Incentive Payment (DSRIP) Program

This issue brief provides five key lessons from New York City CBOs and reactions to those lessons from CBOs in Massachusetts.

Source: https://www.academyhealth.org/publications/2019-04/engagement-community-based-organizations-key-achieving-health-equity-wellness-medicaid-populations

RESOURCE PAGE: MORE ABOUT CTHE

BOX 3. COMMUNITIES TOGETHER FOR HEALTH EQUITY (CTHE)

In 2016, New York City's small, non-profit community-based social and human services organizations advocated for, and were granted, $2.5 million New York State (NYS) Community Based Organization (CBO) Planning Grants from the NYS Department of Health. The grants were intended to support the development of CBO consortia able to build CBO readiness for partnerships with Health Care Organizations (HCO), develop infrastructure for collective CBO planning, and complete strategic plans to facilitate CBO engagement in the transformed care delivery system. Called Communities Together for Health Equity (CTHE) and led by the Arthur Ashe Institute of Urban Health (AAIUH), the New York City (NYC) CBO consortium has a steering committee and lead organizations supporting members to convene as "hubs" organized for each of NYC's five boroughs. CTHE's member organizations provide a range of services to address SDOH across a diverse array of sectors, including economic stability, education, social, family and community, and neighborhood and environmental.[12]

Source: https://www.academyhealth.org/publications/2019-04/engagement-community-based-organizations-key-achieving-health-equity-wellness-medicaid-populations

RESOURCE PAGE: MORE ABOUT THE DSRIP PROGRAM

BOX 5. WHAT IS DSRIP?

Delivery System Reform Incentive Payment (DSRIP) programs are officially authorized under Section 1115 of the Social Security Act, under which the Medicaid program is also authorized. DSRIP programs are approved as "1115 Demonstration Waiver" agreements between the state and federal government. They are also known as Section 1115 Waiver programs or DSRIP waivers. States must secure approval from the Centers for Medicare and Medicaid Services (CMS) to proceed with their program and to receive funds to invest in and incentivize delivery reform. DSRIP programs provide states with significant Medicaid funding to support "qualifying" organizations, such as hospitals and other providers, to implement care delivery reforms. Key conditions of DSRIP waivers are: (1) investments made with DSRIP funding must create cost savings that meet or exceed the expenses; and, (2) funds to providers are tied to meeting performance metrics, such as those related to system redesign, clinical health, and population-based improvements. The funds are approved by CMS on a time-limited basis. When the federally-approved DSRIP period ends, the funds end, after which time CMS expects the state's Medicaid program to be able to sustain the achievements of delivery reform. The time-limited nature of DSRIP funds certainly raises the stakes for states, which is why states must be diligent in assessing their DSRIP programs throughout the implementation period and in taking steps to adjust the program as needed. DSRIP offers a vehicle for states to provide Medicaid payments to providers for carrying out infrastructure and care transformation activities that support state and federal health care delivery system reform goals. State programs intend to transform the care delivery system for their Medicaid members in ways that lead to better care, better health, and lower costs.[17]

Source: https://www.academyhealth.org/publications/2019-04/engagement-community-based-organizations-key-achieving-health-equity-wellness-medicaid-populations

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