From Programs to Portfolios

Charting a Path for Health Equity in Health Systems Transformation

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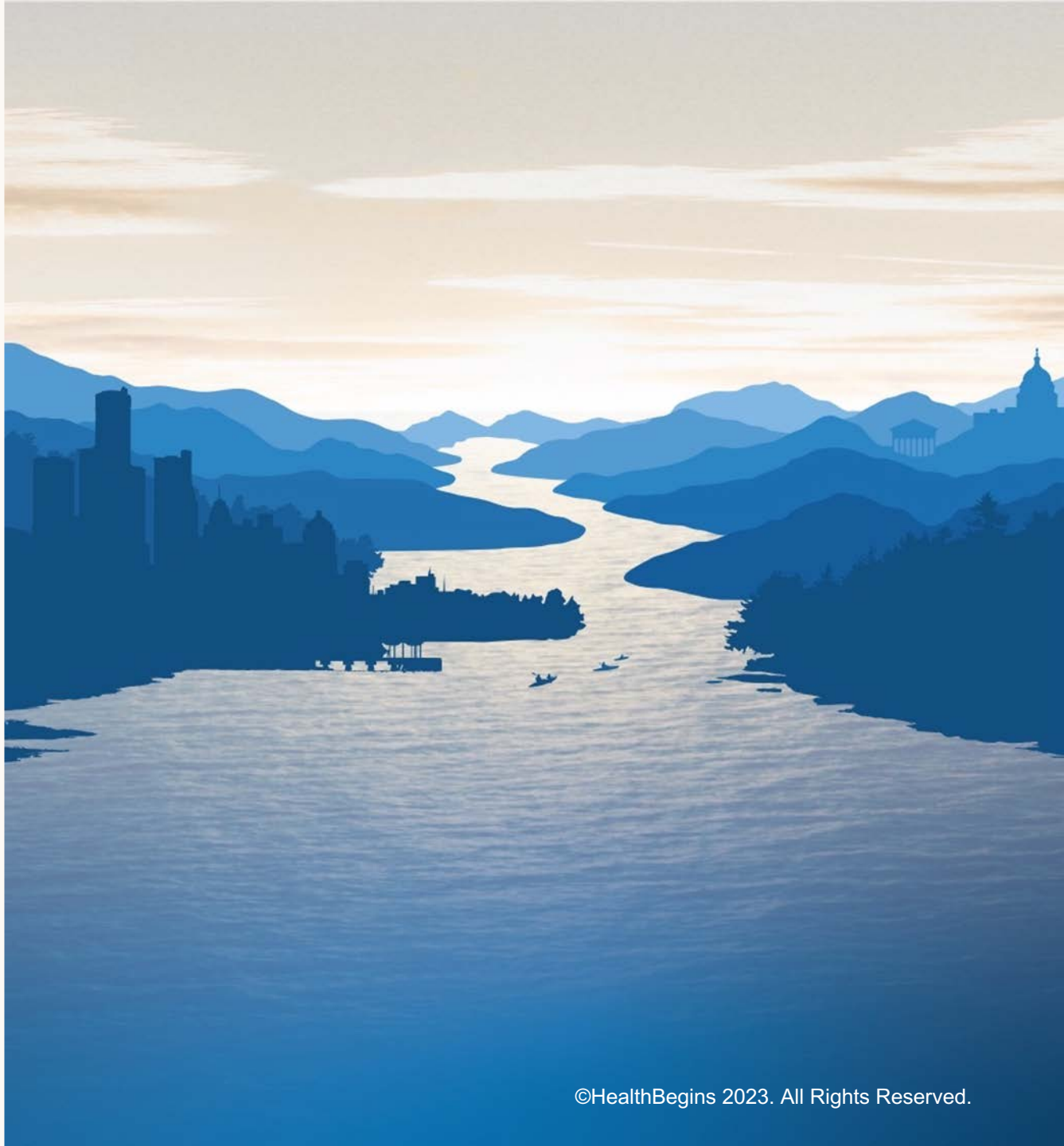
Annual CCO convening on OHA Medicaid spending initiatives

September 2023

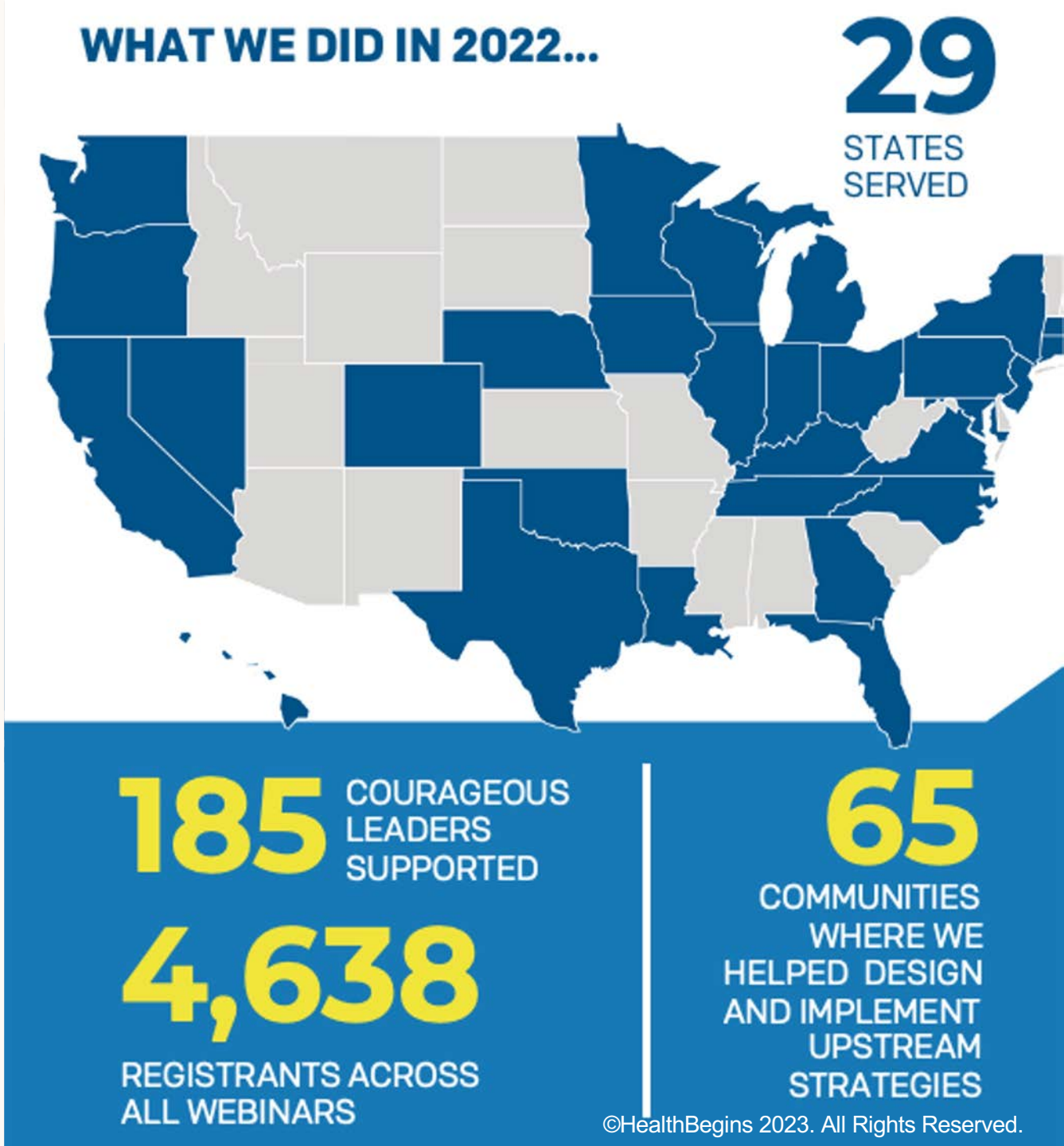


Who we are

HealthBegins is a national mission-driven strategy and implementation firm that helps Medicaid-serving health plans, health systems, and CBOs to exceed health care equity and social needs requirements and achieve long–term impact for people and communities harmed by societal practices.

Our goal is to improve health & social outcomes and advance health equity with 250 communities across the country by 2025.

www.healthbegins.org



Our work is informed by key observations

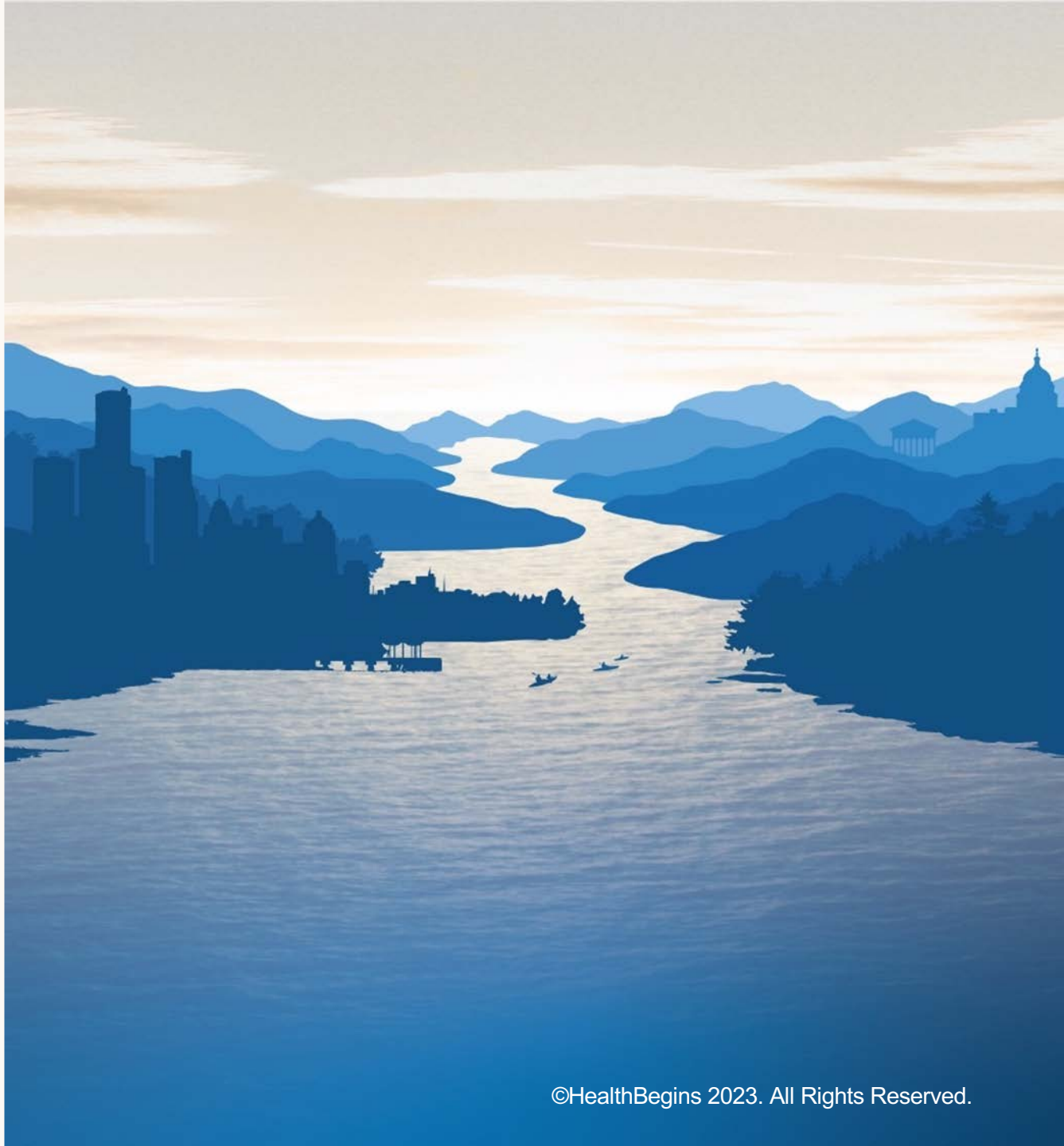
Health and social inequities are experienced as harm.

Social arrangements, including structural racism, put some people in harm's way.

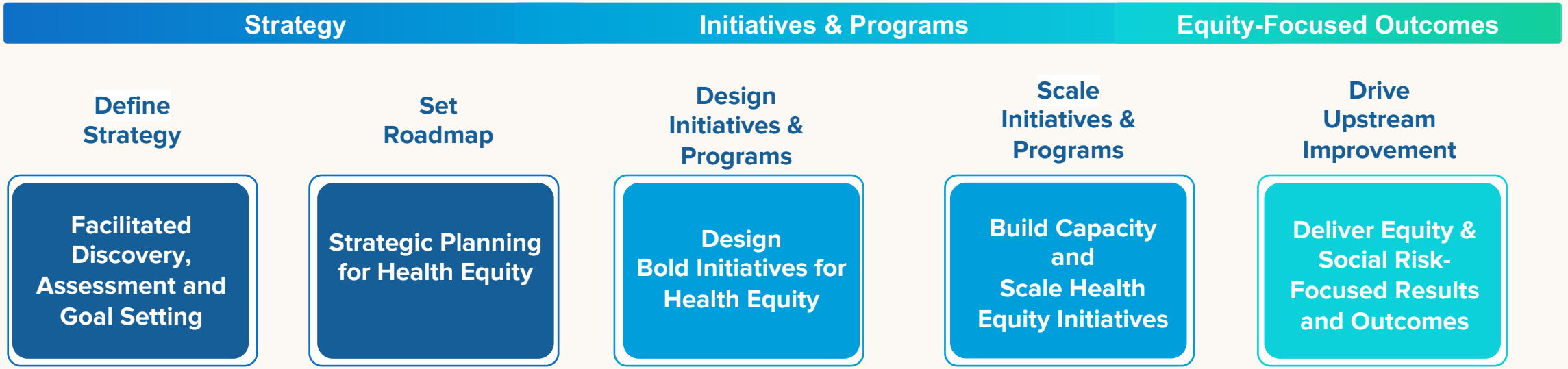
Equity is not just the absence of harm or unjust differences, it's the presence of systems that promote and preserve healing, opportunity, and justice.

Since structural violence and harm is spatialized, institutions need a portfolio of strategies to advance health and social equity that is place-based, outcomes-focused, and works across levels of change.

Courageous leaders need support and solidarity to implement these strategies, and to transform their institutions, relationships, communities and themselves in the process.



HealthBegins' services drive equity with strategy, scale, and success we can see



Areas of Expertise

Optimizing Services

- Health & Social Care Partnerships & Integration
- Equity-focused, Upstream Quality Improvement
- Racial Health Equity in Primary Care
- Accreditation, Regulatory & Performance Requirements
- Defining Value of Investment (VOI) for Health Equity
- Institutional Culture & Accountability for Health Equity
- Social Risk Analytics & Insights

Advancing Community Health

- Multi-sector partnership and network development
- Place-Based strategies for Health Equity
- Upstream Investment Planning
- Maturity Model & Portfolio Development
- Upstream Policy Learning Action Networks
- Core Competencies for Upstreamists

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A question:
How can CCOs and partners continue scaling efforts to advance equity and move upstream?

Supporting Hubs: How will CCOs help build infrastructure for social needs integration across CBOs and health systems, including supporting CBO “hubs” and reducing the administrative burden and financial costs of CBOs to provide social services?

Supporting Place-Based Collaboratives: How will CCOs harness the power of cross-sectoral collective impact models and support coordinated efforts that promote equity?

- **Building Strategic Portfolios**: As we consider Medicaid spending programs like HRS, SHARE, and ILOS, how will CCOs organize individual spending programs into a cohesive, multi-level strategic portfolio to improve health and health equity?

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We are at an inflection point in our health equity journey

Promise

We've come a long way in the last few years in centering equity and pursuing health & social care integration, with advances in systems, standards, policy, and some notable innovation

Peril

Health equity & "SDOH" strategies face risks, including the risks of whitewashing & perpetuating social arrangements that put people in harm's way

Opportunity:

We can take steps to **ensure equity efforts remain focused on reallocating power and resources** and dismantling structures that drive health and social inequities

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Promising advances in
health care equity and
integration of health & social care
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Mrs. M's story

- Mrs. M is 44 years old. She loves and cares for her two adorable children, and her wise, frail mother, who lives with her.
- Mrs. M has type II diabetes and mild atherosclerotic heart disease.
- She has a low-wage job, is enrolled in Medicaid, and typically spends at least $1500 a year on out-of-pocket healthcare costs.
- At the end of last month, Mrs. M was admitted to the hospital after nearly passing out at work.
- Diagnosis: low-blood sugar

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Understanding health and social inequities as harm

- Lower-income diabetic adults have a **27% higher rate of hospital admissions** at the end of the month **due to food insecurity,** compared with higher-income diabetics.[1]
    - About **1 in 7 US adults with** atherosclerotic **CVD experience food insecurity**.[2]

- Adults with **very low food security had higher risk of all-cause and CVD mortality**, with multivariable-adjusted HRs of 1.32 (95% CI, 1.07–1.62), and 1.53 (95% CI, 1.04–2.26), respectively, compared with those with high food security.[3]

- Approximately 30% of the mortality difference between Black and White men and 40% of the difference between Black and White women is driven by disparities in CVD outcomes.[4]

1. Seligman HK, et al. *Health Affairs.* 2014;33(1):116–23
2. Mahajan S at al. Scope and Social Determinants of Food Insecurity Among Adults With Atherosclerotic Cardiovascular Disease in the United States. J Am Heart Assoc. 2021 Aug 17;10(16):e020028.
3. Sun Y, Liu B, Rong S, Du Y, Xu G, Snetselaar LG, Wallace RB, Bao W. Food Insecurity Is Associated With Cardiovascular and All-Cause Mortality Among Adults in the United States. J Am Heart Assoc. 2020 Oct 20;9(19):e014629.
4. Gillespie CD, Wigington C, Hong Y; Centers for Disease C and Prevention . Coronary heart disease and stroke deaths—United States, 2009. MMWR Suppl. 2013; 62:157–160.

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Recent advances in **health care equity** standards

Health Equity Requirements Across Organizations

	NCQA	CMS	NQF	IHI	RWJF
Equity Focused Data Collection/Analysis	✔	✔	✔	✔	✔
Evidence-Based Solutions to Address Health Disparities	✔	✔	✔	✔	
Community Partnerships	✔	✔	✔	✔	✔
Expand Equitable Payment Models and Coverage		✔	✔	✔	
Culturally Tailored Services	✔	✔			
Equity in Organization Policies	✔	✔	✔	✔	✔
Address Systemic Racism				✔	✔

NCQA - National Committee for Quality Assurance
CMS - Center for Medicare and Medicaid Services
NQF - National Quality Forum
IHI - Institute for Healthcare Improvement
RWJF - Robert Wood Johnson Foundation

Source: https://healthcare.rti.org/insights/comparing-major-health-equity-frameworks-measures

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Recent advances in social care standards

Quality measures

NCQA HEDIS Social Need Screening and Intervention (SNS) measure*

% of members screened via a pre-specified instrument at least once for unmet needs related to Food, Housing, Transportation

% members who screen positive receive a corresponding intervention.

CMS value-based payment and quality reporting programs

acute care hospitals— Inpatient Quality Reporting (IQR)**

outpatient providers— Merit-based Incentive Payment System (MIPS)

Regulations, Standards & Models

CMS MA SNPs

HRAs must include at least one question about a social need (food, housing, transportation)

The Joint Commission

New requirement for hospitals to screen for social needs & provide resources to those who screen positive*

Health Care Equity Certification Program**

NCQA Health Equity Accreditation Plus

focuses on collecting data on community social risk factors and patients' social needs; establishing CBO partnerships, etc

CMS ACO REACH

ACOs will receive bonus points for collecting social needs data

* pairs social risk screening with subsequent **interventions**

** requires attestation of specific social risk-related capabilities

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"Developing National Social Care Standards", Health Affairs Forefront, February 22, 2023

https://innovation.cms.gov/innovation-models/aco-reach

Advances in social care standards: interventions

Interventions Framework

This is an updated draft (31 August 2020) of the framework for intervention data element concepts. Thank you to everyone who submitted comments on the initial version!

#	Gravity Term	Gravity Definition
1	**Assistance/Assisting**	To give support or aid to; help
2	**Coordination**	Process of organizing activities and sharing information to improve effectiveness.
3	**Counseling**	Psychosocial procedure that involves listening, reflecting, etc., to facilitate recognition of course of action/solution.
4	**Education**	Procedure that is synonymous with those activities such as teaching, demonstration, instruction, explanation, and advice that aim to increase knowledge and skills, change behaviors, assist coping and increase adherence to treatment.
5	**Evaluation of eligibility (for <x>)**	Process of determining eligibility by evaluating evidence.
6	**Evaluation/Assessment**	Determination of a value, conclusion, or inference by evaluating evidence.
7	**Provision**	To supply/make available for use.
8	**Referral**	The act of clinicians/providers sending or directing a patient to healthcare professionals and/or programs for services (e.g., evaluation, treatment, aid, information etc.)

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The Gravity Project
https://confluence.hl7.org/display/GRAV/Food+Insecurity

Advances in state Medicaid focus on equity

- 66% of states are using strategies to improve REL data
- ~ 25% of states are tying MCO financial incentives to health equity
- Some states are beginning to leverage MCO contract requirements to promote health equity
- 46% of states reported requiring MCOs to participate in PIPs focused on health disparities in FY 2022

Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023, Kaiser Family Foundation (KFF) and Health Management Associates (HMA), in collaboration with the National Association of Medicaid Directors (NAMD).

Exhibit 2: State Strategies to Improve Completeness of Medicaid Member Race, Ethnicity and Language (REL) Data, as of July 1, 2022

n = 45 states

	# of States	States
State requires MCOs and/or other applicable contractors to collect REL data	16	AL, AZ, IA, IL, IN, KY, LA, ME, MO, MS, NY, OH, OR, PA, RI, TN
Eligibility and/or renewal materials explain how REL data will be used and/or why reporting data are important	12	CA, CO, DC, LA, MA, ME, NC, NY, OH, OR, WI, WY
Medicaid agency links enrollment data with public health department vital records data	9	AL, AZ, MN, MS, NC, OH, OR, WV, WY

Exhibit 3: Financial Incentives Tied to Health Equity, FYs 2022-2023

n = 44 states

	FY 2022		FY 2023	
	# of States	States	# of States	States
MCO financial incentive	11	CA, CO, IA, IL, MI, MN, NJ, OH, OR, PA, WI	4	LA, MA, NC, TN
FFS financial incentive	2	CT, MN	2	MA, ME

NOTE: MCO = managed care organization. FFS = fee-for-service.
SOURCE: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2022 • PNG

KFF

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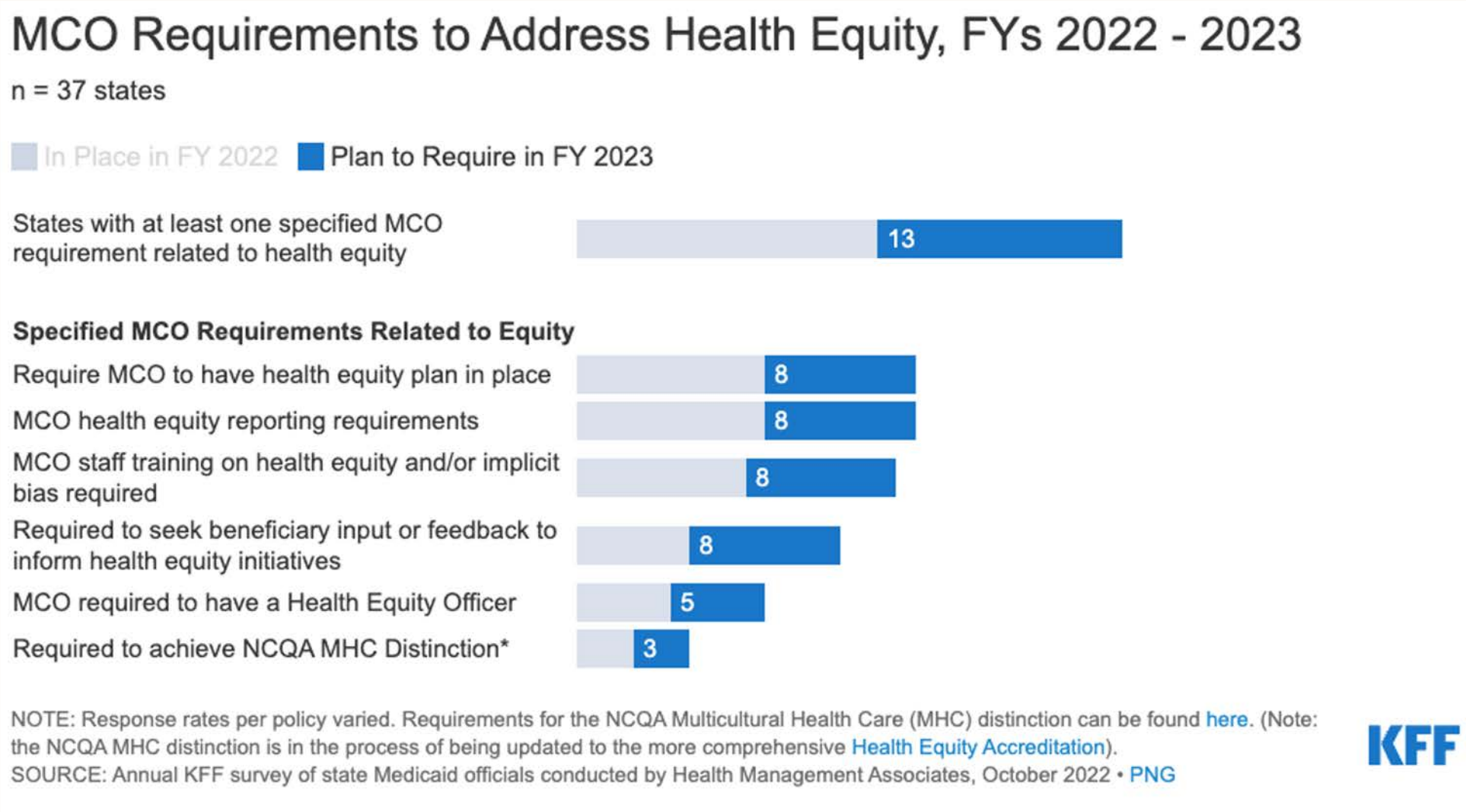
State Medicaid agencies are increasing health equity requirements



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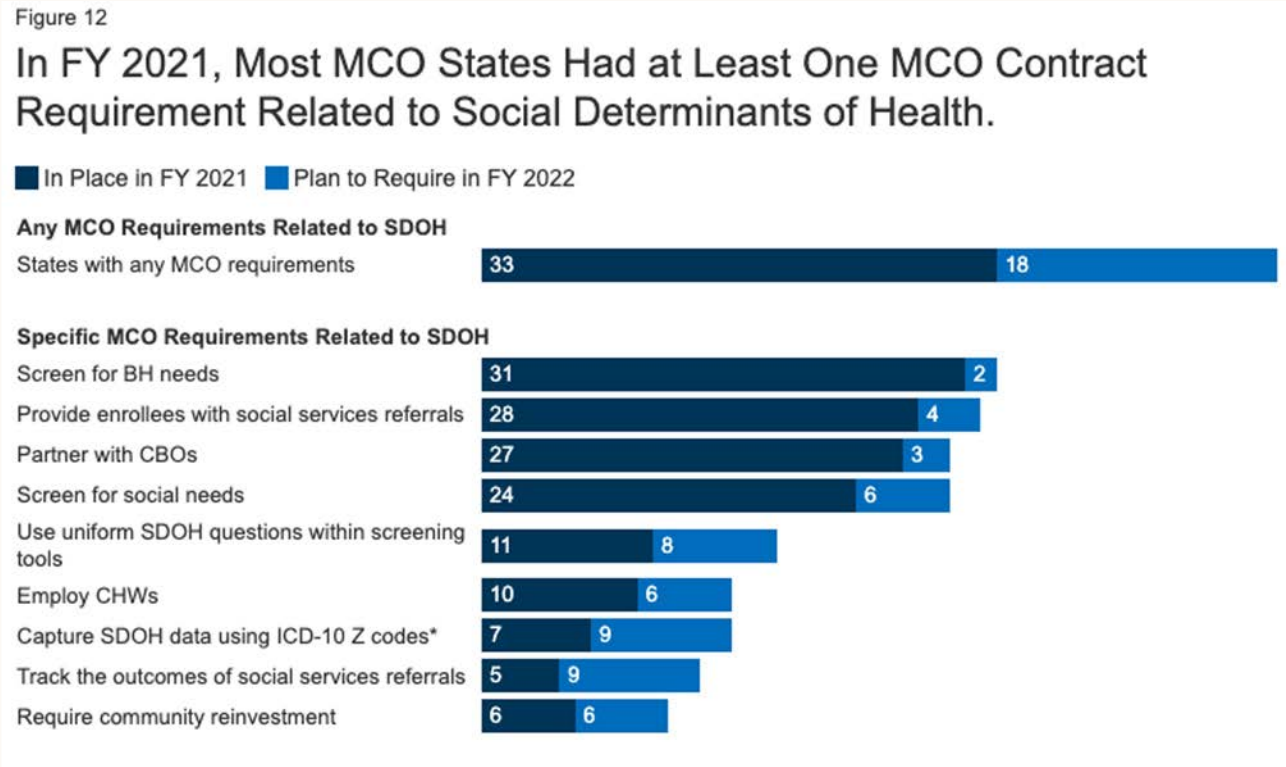
Advances in state Medicaid focus on social needs

More than half of responding states reported requiring MCOs to screen enrollees for social needs.

- About half reported requiring or planning to require uniform SDOH questions
- Fewer states reported requiring MCOs to track the outcomes of social service referrals or requiring MCO community reinvestment compared to other strategies

*States contracted with a total of 282 Medicaid MCOs as of July 2019

Figure 12



https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

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Advances in health & social care: Value

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https://healthbegins.org/partnership-resources/

Advances in health & social care: Impact

ROI Calculator for Partnerships to Address the Social Determinants of Health

Evidence Review

The Commonwealth Fund

Affordable, quality health care. For everyone.

HOUSING

There is strong evidence that providing people who are homeless, or at risk of becoming homeless, with supportive housing can significantly lower expensive forms of heath care, thereby reducing costs. We found several studies that provided supportive housing — both with and without case management services — to homeless individuals with a medical need like a chronic condition or behavioral health problem. These studies consistently found that housing reduces ED visits, admissions, and inpatient days and results in large decreases in health care costs. Some studies also found significant increases in the receipt of preventive primary care services among those provided housing compared to their counterparts.

A few studies looking at the impact of providing housing to the elderly found — in addition to reductions in hospitalizations and ED visits — large decreases in skilled nursing facility and long-term-care days, which resulted in significant cost savings to Medicare and Medicaid.

Several of the studies found housing can generate an ROI. For example, one study estimated an ROI of $2,249 per person per month, and another estimated for every $1 spent, savings of $1.57.

Study	Target population	Intervention summary	Type of evidence	Intervention cost	Results on utilization and costs of care
Basu et al., 2012	Homeless adults with chronic medical illnesses in Chicago	The housing and case management intervention was based on the Housing First model and offered three components: interim housing at a respite center after hospital discharge, stable housing after recovery from hospitalization, and case management based in study hospital, respite, and housing sites. Study participants were followed for 18 months.	Randomized control trial (n=201 intervention group, 206 usual care group) Strong evidence	Not given	Compared to usual care, the intervention group generated an average annual cost savings of $6,307 per person. Chronically homeless participants in the intervention group generated the highest per person annual cost savings ($9,809).
Sadowski et al., 2009	Homeless adults with chronic medical illnesses in Chicago	Study looked at the effectiveness of a case management and housing program. Intervention group was offered transitional housing after hospital discharge followed by placement in long-term housing. Case	Randomized control trial (n=201 intervention group, 206 usual care group) Strong evidence	Not given	For every 100 homeless adults offered the intervention, the expected benefits over the next year would be 49 fewer hospitalizations, 270 fewer hospital days, and 116 fewer ED visits.

SDOH category

Summary of findings

Author/ link

Pop focus

Study description

Study design

Costs (if available)

Impact on costs and utilization

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https://www.commonwealthfund.org/publications/2019/jun/roi-calculator-evidence-guide

Advances in health & social care: Impact

Preliminary evidence:
Hospitals with more robust SDOH programs have higher patient experience scores and lower mortality rates for key cardiovascular conditions

Each additional SDOH strategy was associated with lower 30-day mortality for hospitalized patients with certain cardiovascular conditions

Each additional SDOH strategy was associated with a 3.42 percentage point higher rate of hospitals receiving the highest patient experience scores

David E. Velasquez and Jose F. Figueroa, MD, MPH Learning from Massachusetts Hospitals on Programs to to Address Social Determinants of Health NEJM Catalyst Innovations in Care Delivery 2023; 04

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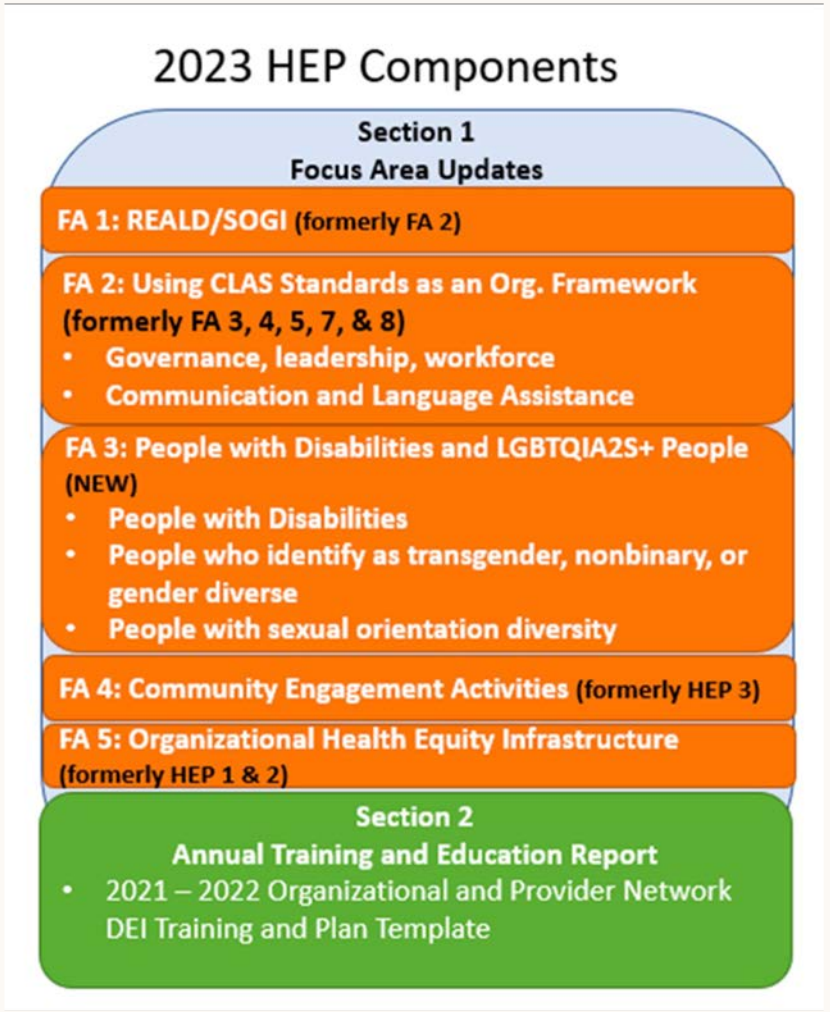
Advances in Oregon

- Upcoming 1115 Waiver → health-related social needs for transitions populations
- Healthier Together Oregon (statewide health improvement plan) focused on social determinants of health
  a. 5 priorities include institutional bias, adversity trauma and toxic stress, behavioral health, economic drivers of health and access to preventative care
- CCOs have submitted new more robust Health Equity Plans
- CCOs developed plans for traditional health workers, ensuring people with shared, lived experience are serving members:
- CCOs are making plans to screen all members for social needs
- The SHARE initiative prioritizes housing, which has resulted in many housing investments



Oregon Health Authority https://www.oregon.gov/oha/EI/Pages/Health-Equity-Plan-Process.aspx Accessed 9/1/23

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Medicaid Spending Programs in Oregon: ILOS, HRS & SHARE

In Lieu of Services (ILOS)
(alternative to covered service)

CCOs may offer certain pre-approved, evidence-based services in lieu of covered services.

- must be medically appropriate and cost effective services, and any ILOS must be available to all members for whom the service applies.
- Utilization and costs associated with an ILOS will be used in development of future CCO capitation rates.

Health Related Services (HRS)
(complementary to covered service)

CCOs may use their global budget to fund flexible services and community-based initiatives to address members' health-related social needs, alleviate disparities, and improve community health, as a supplement to covered services.

Flexible Services: cost-effective services offered to an individual member to supplement covered benefits

Community Benefit Initiatives (CBI): community-level interventions focused on improving population health and health care quality.

Spending counts favorably towards CCOs' medical loss ratio calculation. and is also reflected in the performance-based reward component of CCOs' capitation rates.

Designated role for CACs*

SHARE
(complementary to covered service)

CCOs shall dedicate a portion of their previous year's net income or reserves to SDOH-E spending.

Neighborhood and Built Environment,
Economic Stability,
Education, and
Social and Community Health

Must align with a shared Community Health Improvement Plan (CHP)

A portion of SHARE dollars must go directly to SDOH-E Partner(s) for the *delivery of services or programs, policy, or systems change.*

Designated role for CACs*

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Source: OHA SHARE, HRS and ILOS comparison. Updated Feburary 2022.
*CCOs must designate a role for CACs (Community Advisory Councils) in directing, tracking, and reviewing spending on the SHARE Initiative and Health-Related Services (HRS)


Peril:
Equity and “SDOH” efforts face risks, including whitewashing &
accommodating social arrangements that put people in harm’s way
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Risks

Failing to center equity

When equity is not a priority, inequity persists
Lack of structural competency and analysis

Quick fixes vs long-term impact

“ROI blinders”
“Techno-solutionism”

Perpetuating structural inequities

“Bridges to nowhere”
“Wrong-pockets”
“SDOH” cooptation
”Extractive models undermine equity”

Lack of accountability

to stakeholders (including people and places most harmed by structural violence)
to reinvest in place-based upstream interventions, rather accumulate advantage for those who already have it

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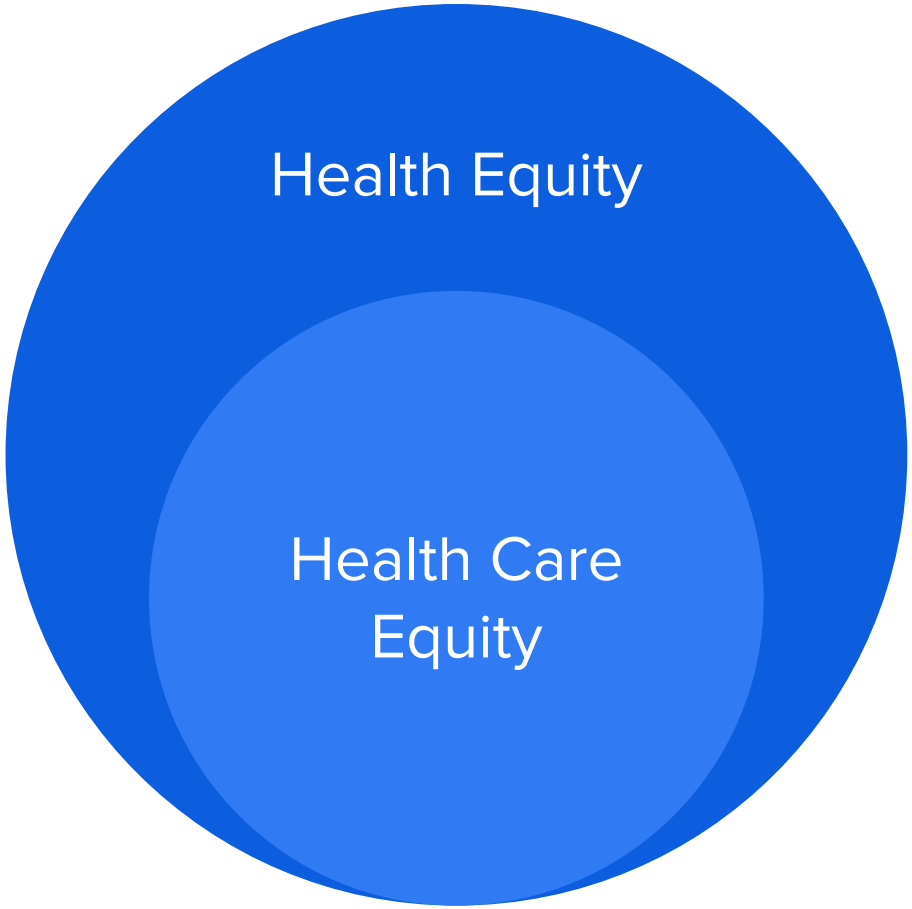
Health equity is the attainment of the highest level of health for all people.

- It means that everyone has the opportunities and resources they need to be as healthy as possible and that **no one is disadvantaged due to social circumstances or policies**.



Health care equity

"more narrowly describes equity in the experience of accessing and interacting with the health care system and its organizations.

- Ma et al. Distinguishing Health Equity & Health Care Equity: A Framework for Measurement, NEJM Catalyst. March 7, 2023

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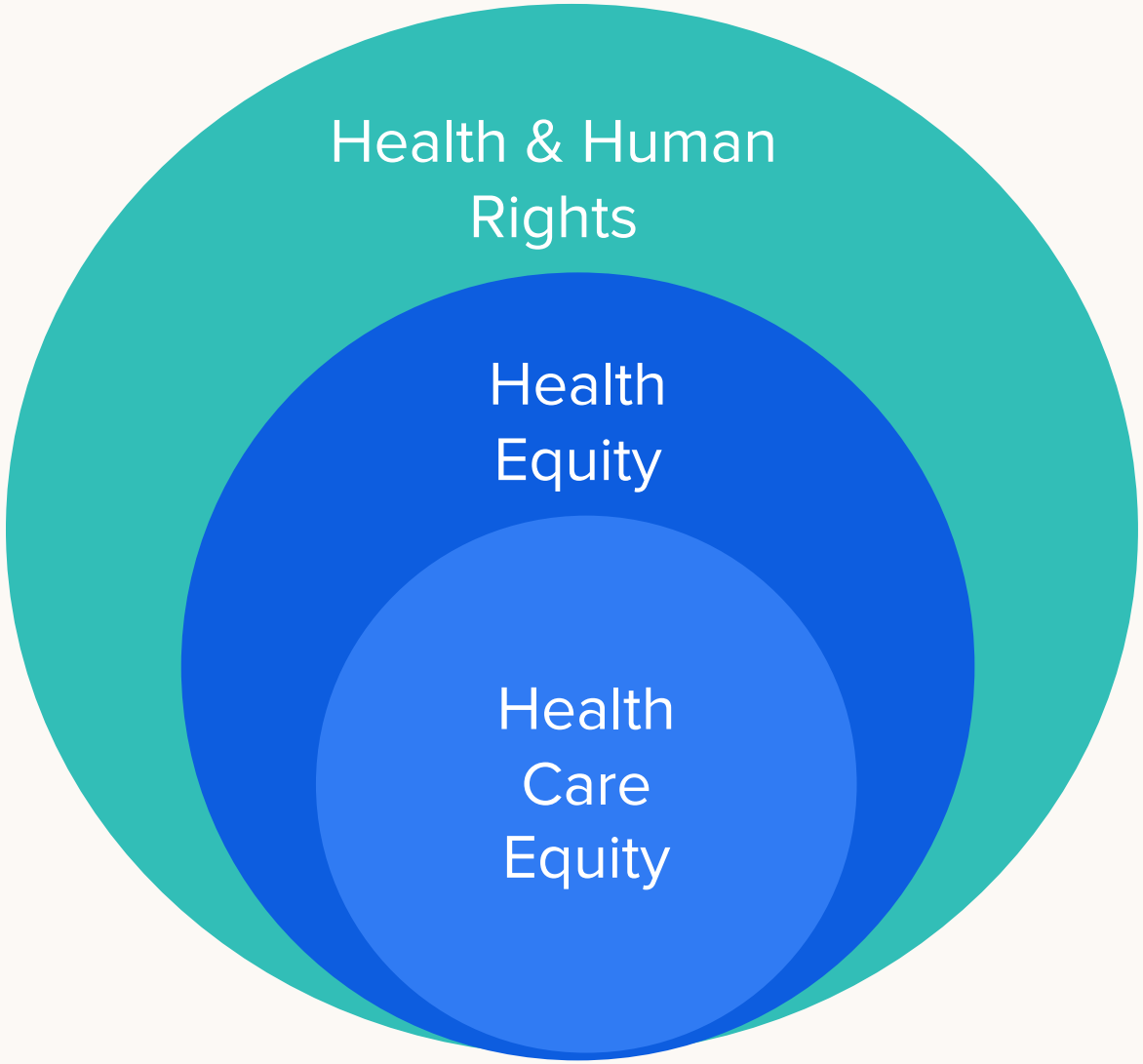
Contextualizing health equity efforts

- Align health care equity improvement efforts with broader place-based organizing efforts
- Review institutional relationships with movements & power-building organizations
- Apply structural analysis and competency to equity efforts



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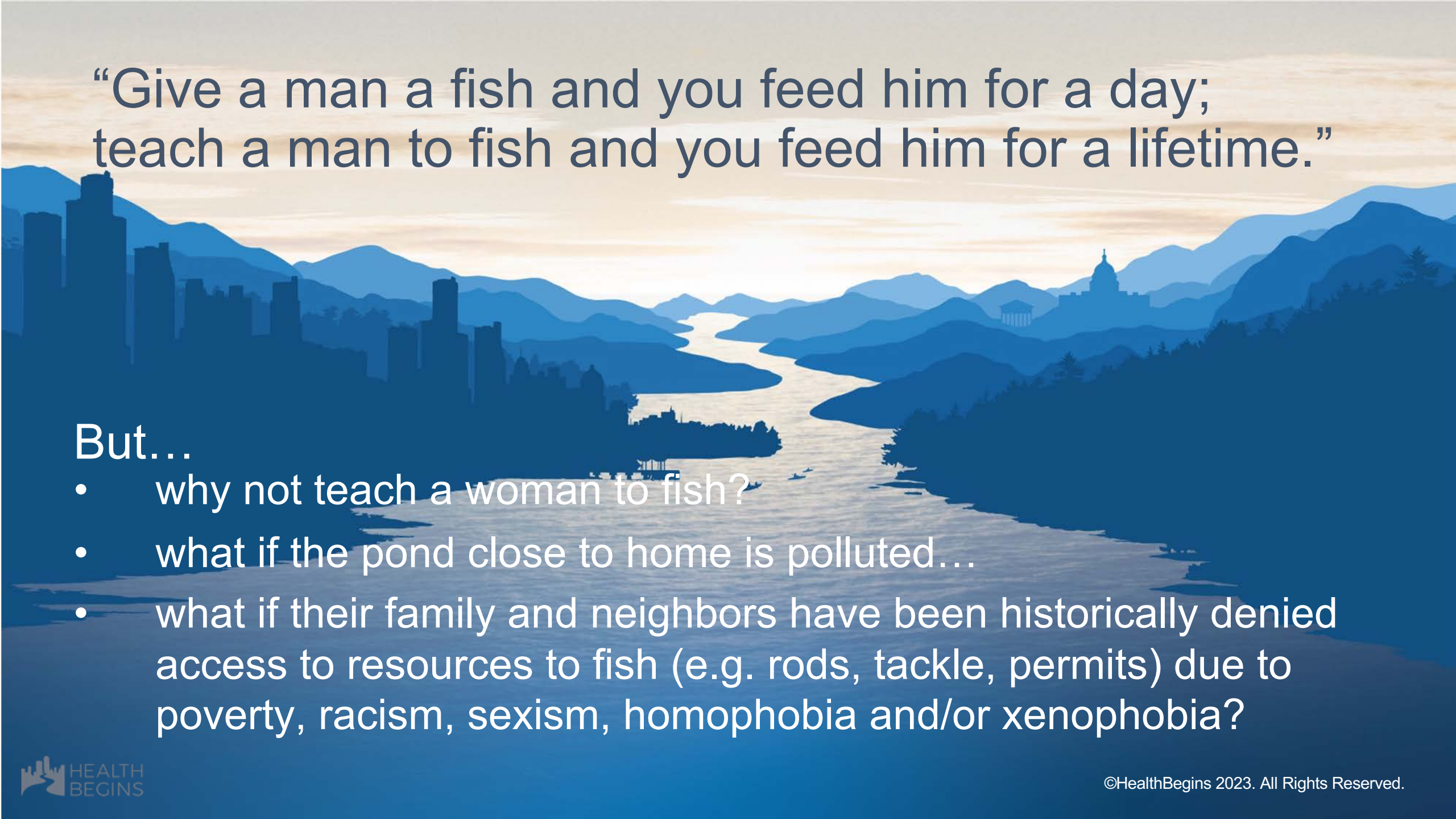

“Give a man a fish and you feed him for a day; teach a man to fish and you feed him for a lifetime.”

But…

- why not teach a woman to fish?
- what if the pond close to home is polluted…
- what if their family and neighbors have been historically denied access to resources to fish (e.g. rods, tackle, permits) due to poverty, racism, sexism, homophobia and/or xenophobia?

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As we get proximate,

we can see and feel
health inequities as harm

and better understand
the social, institutional
and structural
arrangements
that put some groups of
people in harm's way

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Mrs. M, a 44yo woman, identifies as biracial (Black & Asian), has diabetes and was recently hospitalized with hypoglycemia.

Takes meds as prescribed, never counseled about food insecurity

Worries about rent/eviction; Skips meals

Can't afford & find healthy food at end of month

Works below living wage job; rent burden jumps

"Let go" by employer

Sued by old hospital for medical debt, default judgment; wages garnished

Moves family to rental apt; unable to pay medical bill for stay in 2019

Home foreclosed in 2008; divorced 2015;

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This flow diagram was inspired by Neff J et al. Structural Competency: Curriculum for Medical Students, Residents, and Interprofessional Teams on the Structural Factors That Produce Health Disparities. *MedEdPORTAL*. 2020;16:10888. Published 2020 Mar 13. doi:10.15766/mep_2374-8265.10888

Mrs. M, a 44yo woman, identifies as biracial (Black & Asian), has diabetes and was recently hospitalized with hypoglycemia.

Takes meds as prescribed, never counseled about food insecurity

Worries about rent/eviction; Skips meals

Lack of integrated health & social care; de facto healthcare segregation

employer, state, federal policies worsen "food apartheid"

lack of eviction protections; barriers to public benefits enrollment

racialized low-wage labor markets; limited labor protections

"Let go" by employer

Works below living wage job ; rent burden jumps

Can't afford & find healthy food at end of month;

Racialized predatory subprime lending; lack of community restitution

Lack of affordable housing; de facto housing segregation

criminalization of medical debt; harmful hospital financial practices

Sued by old hospital for medical debt, default judgment; wages garnished

Moves family to rental apt; unable to pay medical bill for stay in 2019

Home foreclosed in 2008; divorced 2015

HEALTH BEGINS

Adapted from Neff J et al. Structural Competency: Curriculum for Medical Students, Residents, and Interprofessional Teams on the Structural Factors That Produce Health Disparities. *MedEdPORTAL*. 2020;16:10888. Published 2020 Mar 13. doi:10.15766/mep_2374-8265.10888

Misuse of “SDOH” makes it harder to identify and counteract social arrangements and structures that cause harm and inequities

Individual-level

Social Risk Factors & Social Needs:

Social risk factors are specific individual-level adverse social conditions (i.e., adverse material and psychosocial circumstances) that are associated with poor health. Behavioral risk factors are not social risk factors. Social needs are the social risk factors that individuals (e.g., patients, clients, beneficiaries) identify and prioritize. **Example: Food insecurity**

Community-level

Social Determinants of Health:

Underlying community-wide social, economic, and physical conditions in which people are born, grow, live, work, and age. These conditions shape the distribution, chronicity, and severity of individual social risk factors and social needs. **Example: Food desert**

Societal-level

Structural Determinants of Health Equity:

The societal norms; macroeconomic, social & health policies; and the structural mechanisms that shape social hierarchy and gradients (e.g., power, racism, sexism, class, and exclusion), and, in turn, the distribution, quality, and chronicity of social determinants of health and individual social needs.
Example: Supermarket redlining → Structural racism

Source: HealthBegins Upstream Communications Toolkit. February 2022.

Oregon's helping lead the way

"(A) SDOH-E encompasses three terms:

(i) The **social determinants of health** refer to the social, economic, and environmental conditions in which people are born, grow, work, live, and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities;

(ii) The **social determinants of equity** refer to systemic or structural factors that shape the distribution of the social determinants of health in communities;

(iii) **Health-related social needs** refer to an individual's social and economic barriers to health, such as housing instability or food insecurity.

(B) **SDOH-E initiatives may involve interventions that occur outside a clinical setting**, and may pursue mechanisms of change including:

(i) **Community-level interventions** that directly address social determinants of health or social determinants of equity;

(ii) **Interventions to address individual health-related social needs**"

OAR 410-141-3735 Social Determinants of Health and Equity; Health Equity
https://oregon.public.law/rules/oar_410-141-3735

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Opportunity:
Remain focused on reallocating power and resources and dismantling structures that drive health and social inequities
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Let's revisit our question:

How can CCOs and partners scale efforts to advance equity and move upstream?

Supporting Hubs: As CCOs help build infrastructure for health equity and social needs integration, support and reallocate power and resources to CBOs that provide HRS via CBO "hubs" and other SDOH-E partners

Supporting Place-Based Collaboratives: CCOs can harness and reallocate resources and power to place-based, cross-sector efforts, including those that support policy and system changes (e.g. via SHARE)

- **Building Strategic Portfolios**: CCOS can organize individual spending programs into a cohesive, multi-level strategic portfolio to improve health and health equity for members and communities.

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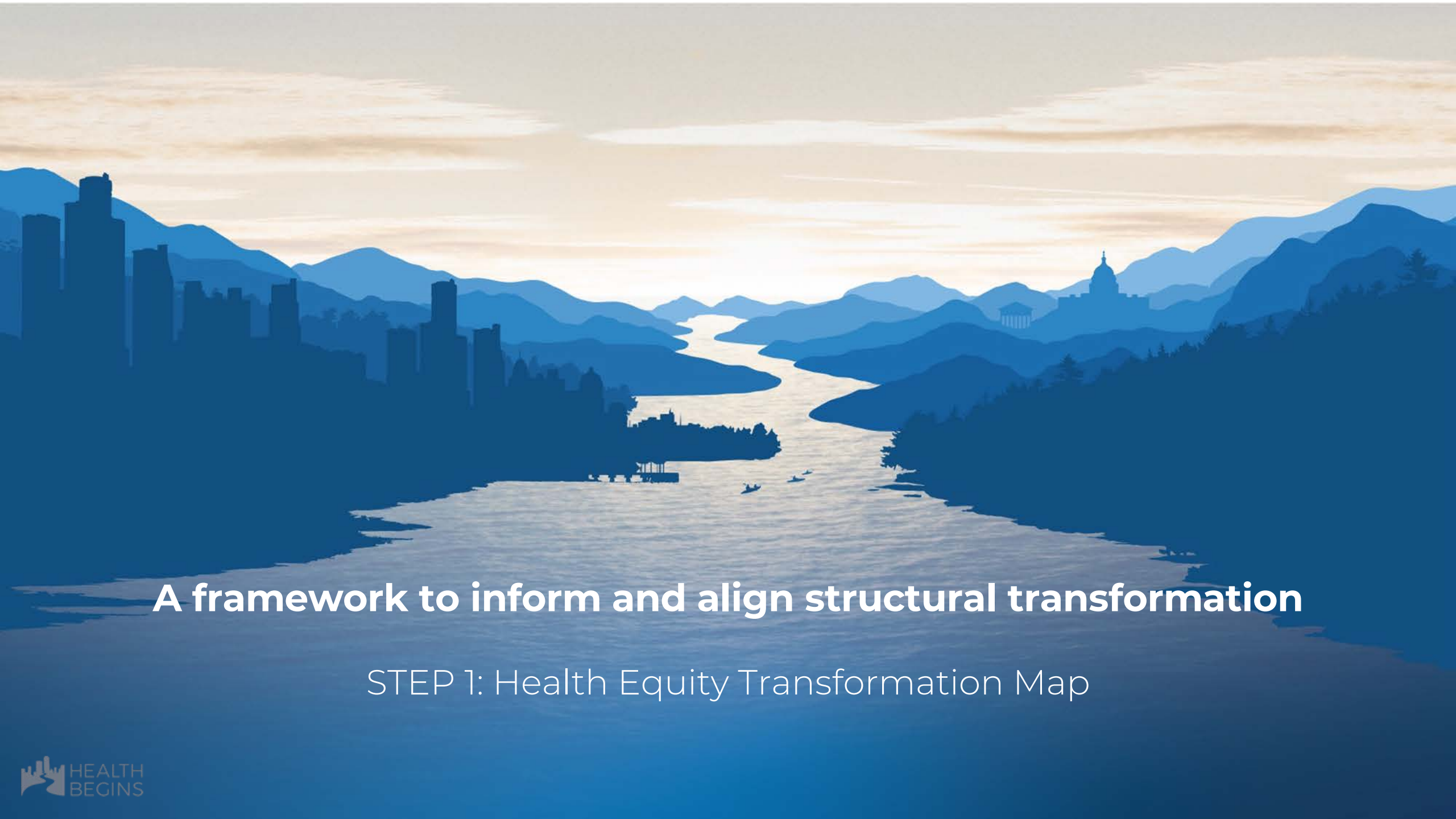

A framework to inform and align structural transformation

STEP 1: Health Equity Transformation Map

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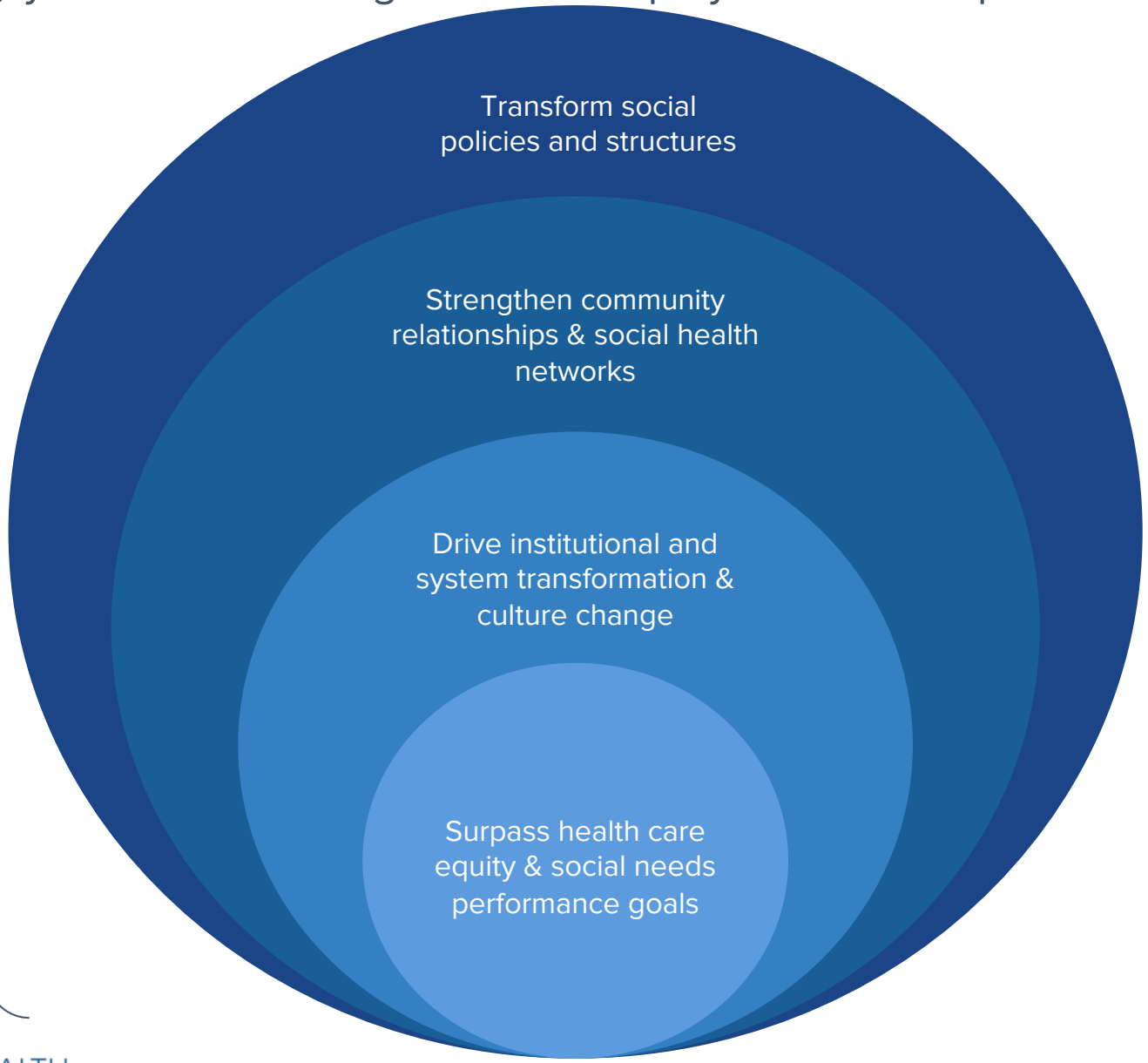
How is your CCO building its health equity investment portfolio over the next 3 years?

Advance health & social equity



Structural

Ecosystem

System

Programs & Care Delivery

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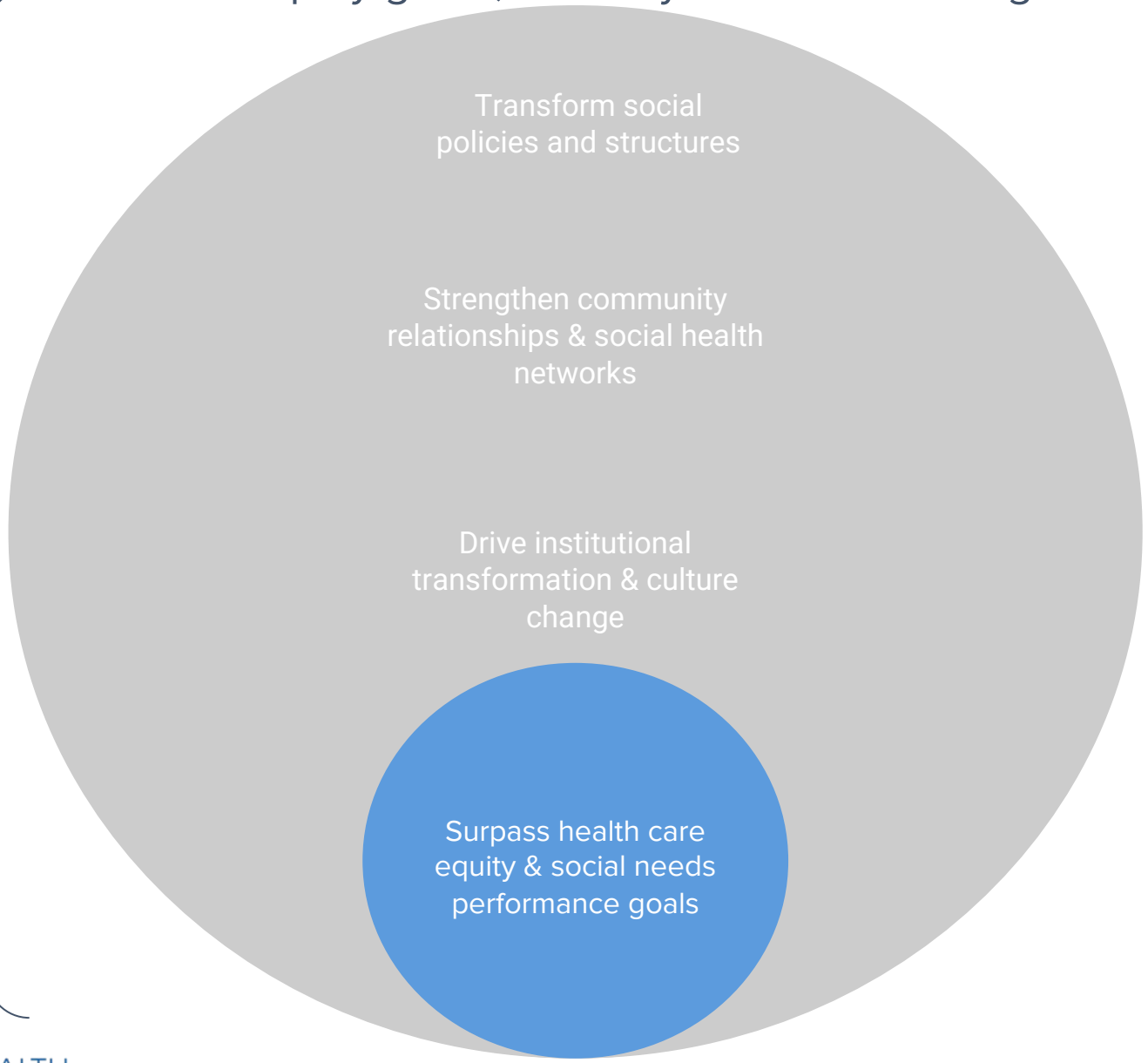
HealthBegins Health Equity Transformation Map

Suggested citation: Rishi Manchanda, Kathryn Jantz, Sadena Thevarajah. *Health Equity Transformation Map. HealthBegins. Los Angeles, May 2023.*

To achieve health equity goals, how is your CCO working to improve current programs?

Advance health & social equity



Aims

- Improve ***program & care delivery*** effectiveness, clarify goals, and achieve key performance measures to reduce health care inequities and associated social inequities by:
  - Improving completeness and quality of demographic **data** (REaL, SOGI, social needs, ability, income, geography) and then use that data to **disaggregate and stratify outcomes by populations and by place**
  - Improving equity-focused care models and **integration of care** (health, social services, behavioral health) to address social drivers of health care inequities
  - ***Identifying*** **institutional drivers** of health care inequities

*Achieve these aims using HealthBegins' *Upstream Quality Improvement Approach* & Performance Improvement Tools

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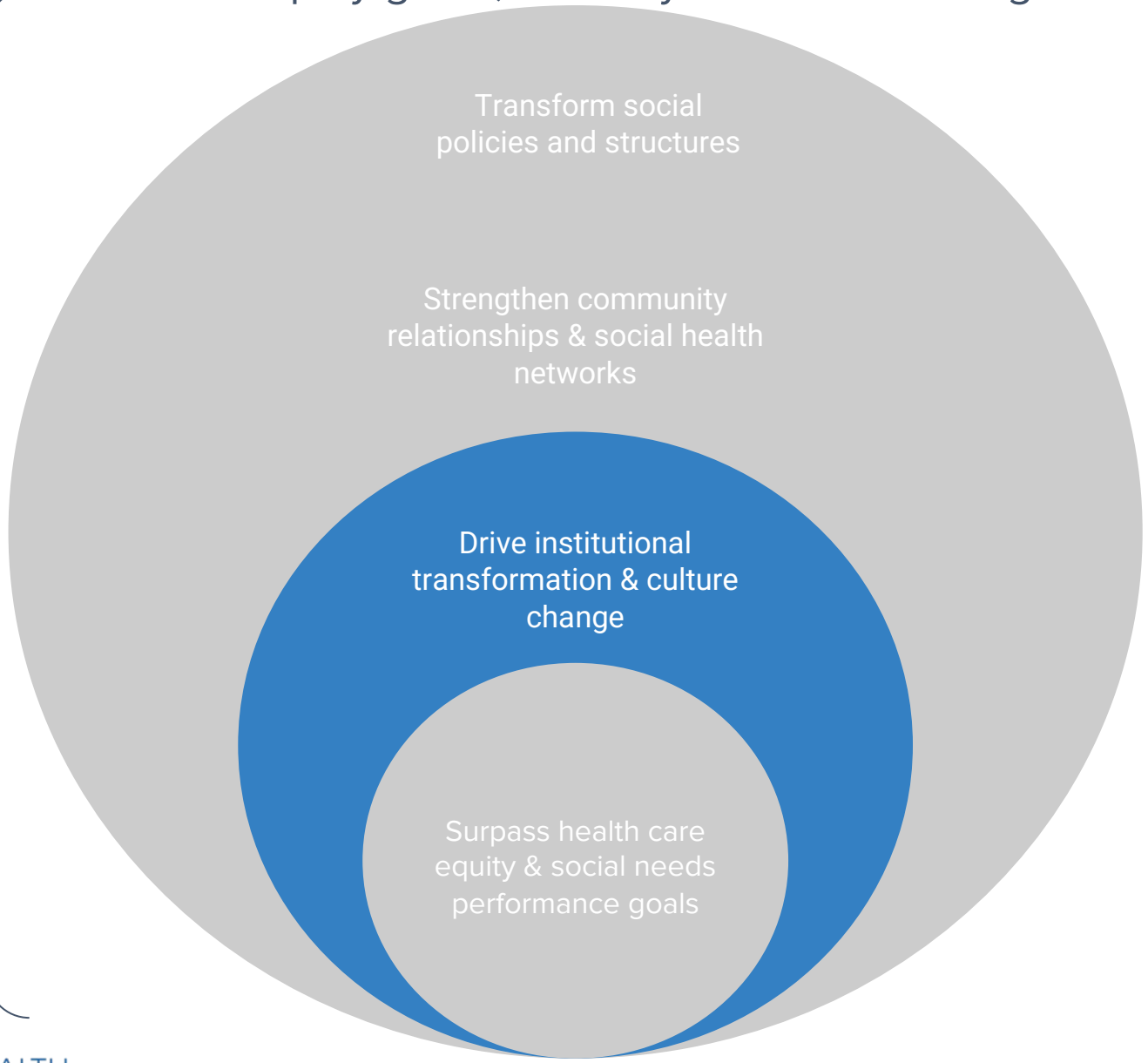
HealthBegins Health Equity Transformation Map

Suggested citation: Rishi Manchanda, Kathryn Jantz, Sadena Thevarajah. *Health Equity Transformation Map. HealthBegins. Los Angeles, May 2023.*

To achieve health equity goals, how is your CCO working to drive system transformation?

Advance health & social equity



Aims

- Create effective, just, equitable, and inclusive ***institutions and systems*** by:
  - Improving **culture** of justice, equity, diversity and inclusion
  - Improving shared knowledge, understanding, **motivation and accountability** for health equity
  - Developing workforce and leadership **competencies** to guide institutional transformation & culture change
  - Strengthening **organizational capabilities** (internal leadership, governance structures & data systems) for health & social equity
  - ***Removing*** **institutional drivers** of healthcare and social inequities *impacting patients and employees*

*Achieve these aims with HealthBegins E=AMC^2 Measurement Framework for Institutional Transformation & Culture Change

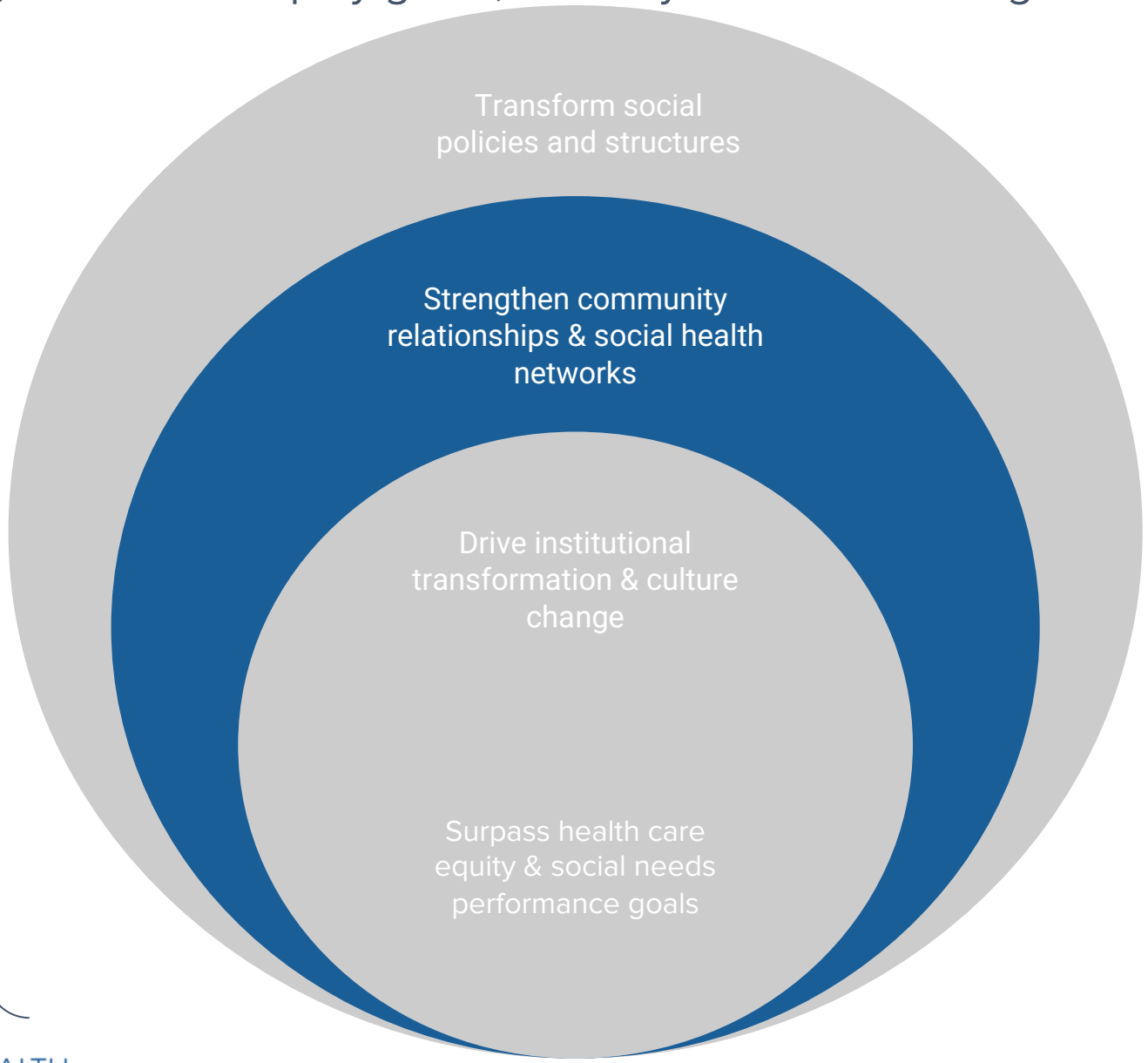
HEALTH BEGINS

HealthBegins Health Equity Transformation Map

Suggested citation: Rishi Manchanda, Kathryn Jantz, Sadena Thevarajah. *Health Equity Transformation Map. HealthBegins. Los Angeles, May 2023.*

To achieve health equity goals, how is your CCO working to strengthen local ecosystems?

Advance health & social equity



Aims

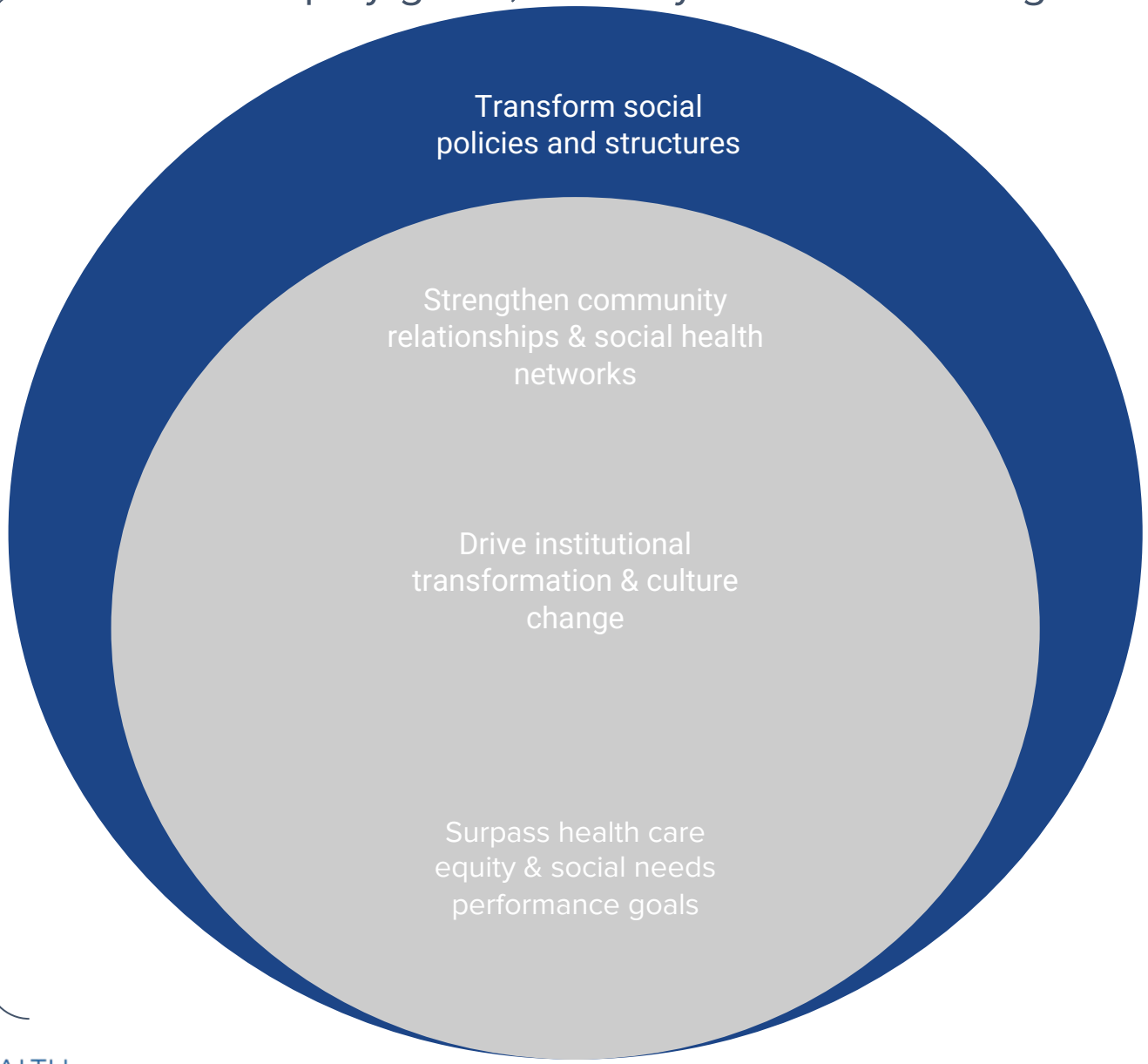
- Help build a high-performing, just, and equitable cross-sector and multi-level health ***ecosystem*** in your community by:
  - Improving **adequacy and performance of networks** supporting health & social care integration
  - Shifting to an **impact investment** approach to manage your spend
  - **Pooling and equitably reallocating resources** and rewards among organizational partners
  - Improving cross-sector **data** sharing, infrastructure and governance
  - **Removing drivers of healthcare, health, and social inequities** *among residents in a given geography*

*Achieve these aims using HealthBegins' Upstream Strategy Compass™ and Upstream Investment Planning services

Suggested citation: Rishi Manchanda, Kathryn Jantz, Sadena Thevarajah. *Health Equity Transformation Map. HealthBegins. Los Angeles, May 2023.*

To achieve health equity goals, how is your CCO working to transform policies & structures?

Advance health & social equity



Aims

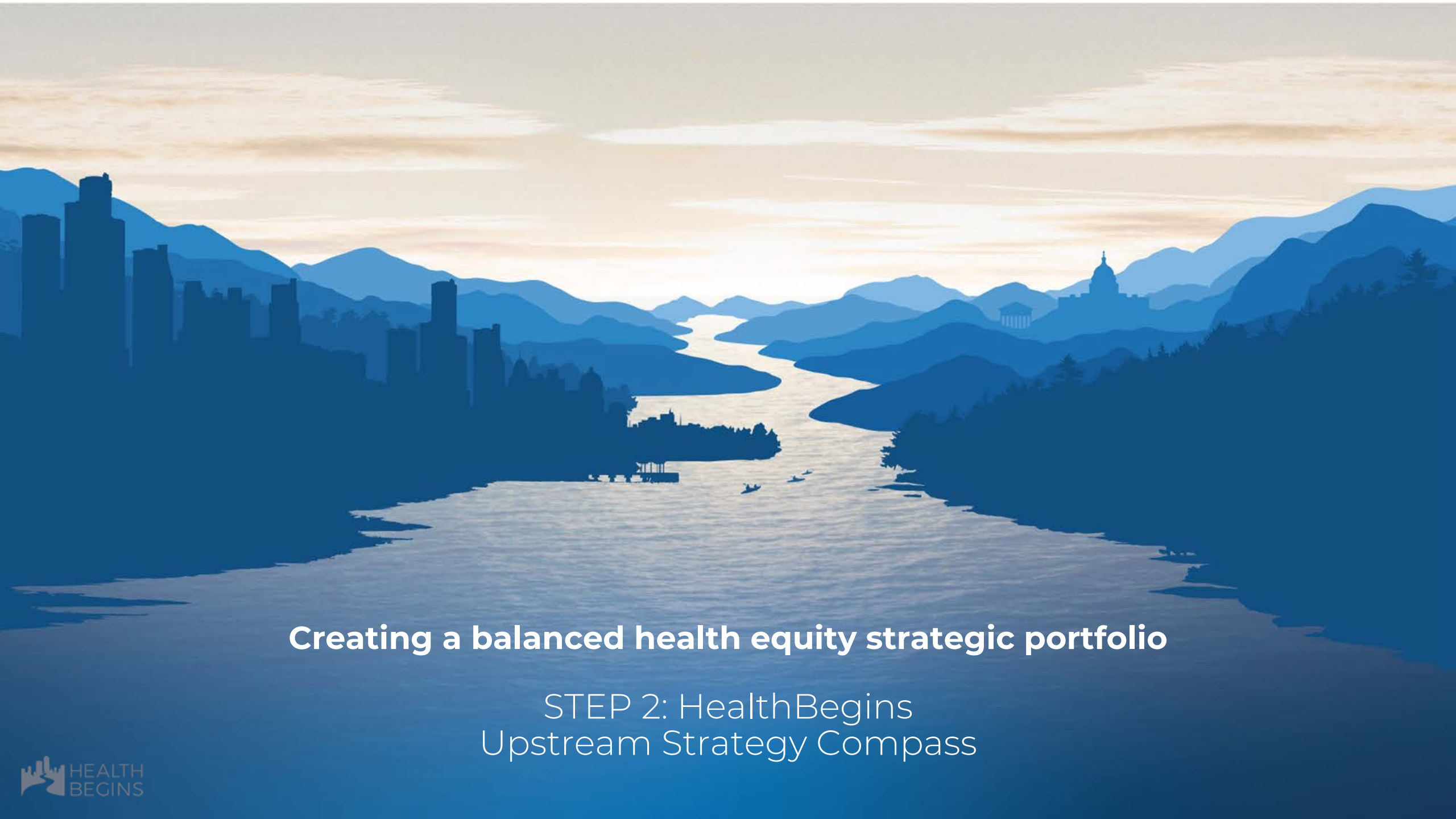
- Replace and counteract social policies and ***structures*** that cause ongoing harms, *and* support policies that promote healing and justice.
    - Expand **investments and support for structural interventions** and coalitions to reduce health and social inequities
    - Strengthen **community-centered governance** and equity-focused accountability for healthcare institutions
    - **Improve civic engagement** and enfranchisement among marginalized employees, patients, and residents.
    - **Advocate for** local, state and federal laws and policies that promote health equity and racial justice.

*Achieve these aims using HealthBegins' Structural Interventions Guide & Network

HEALTH BEGINS

HealthBegins Health Equity Transformation Map

Suggested citation: Rishi Manchanda, Kathryn Jantz, Sadena Thevarajah. *Health Equity Transformation Map. HealthBegins. Los Angeles, May 2023.*



Creating a balanced health equity strategic portfolio

STEP 2: HealthBegins
Upstream Strategy Compass

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How can we align investments to reduce health and health care inequities for specific populations in defined places?

Define a population: Adults with diabetes who visit the ER or are admitted frequently

Identify a pattern of inequity: Racial health care inequities in quality measures that disproportionately impact and harm adults who identify as Black

- **Identify places most impacted by inequities :** 01214, 01245, 01248

Identify social drivers of the inequity: Food and economic insecurity

HEALTH BEGINS

Condition: Diabetes
Inequity: Racial
Social Driver(s): Economic & food insecurity
Place(s): 01214,01245, 01248

How can we design & align program and care delivery investments to reduce health care inequities?

(Illustrative example: Reduce food insecurity to help reduce inequities in diabetes outcomes among residents in high-need zip codes)

Upstream strategy compass	**Program & Care Delivery** Level of intervention
Primary prevention	Connect low-income individuals and families experiencing food and nutrition insecurity to financial literacy, support & nutrition resources
Secondary prevention	Conduct food insecurity screening and connection, application assistance for state benefits and connection to community resources
Tertiary prevention	Provide medically-tailored meals for low-income patients with diabetes to close health care inequities

← What potential solutions or opportunities can improve current programs and advance equity for groups of patients?

HEALTH BEGINS

Upstream Strategy Compass™. Manchanda R. HealthBegins. 2014. Updated 2022
Adapted from Chokshi and Farley (2012); Gottlieb et al. (2013); Cohen and Swift (1999); and Leavell and Clark (1965). Abbreviations: DM, diabetes mellitus.

Condition: Diabetes
Inequity: Racial
Social Driver(s): Economic & food insecurity
Place(s): 01214,01245, 01248

How can we design and align structural investments to reduce inequities in health and health care?

Upstream strategy compass	What potential solutions or opportunities can help reform or support policies, laws, regulations that impact structural drivers of health equity? ➔	**Structural** Level of intervention
Primary prevention		Support local community-led coalitions increase minimum wages and reduce economic hardship for people with lower-incomes
Secondary prevention		Advocate to increase SNAP and WIC benefit amounts and reduce barriers to enrollment to ensure low income individuals receive adequate food assistance.
Tertiary prevention		Support Medicaid policy change to provide sustainable fund Medically tailored Meals for individuals with diabetes and pre-diabetes

HEALTH BEGINS

Upstream Strategy Compass™. Manchanda R. HealthBegins. 2014. Updated 2022

Condition: Diabetes
Inequity: Racial
Social Driver(s): Economic & food insecurity
Place(s): 01214,01245, 01248

How can we design & align system investments to reduce inequities in health and health care?

Upstream strategy compass	What are potential solutions or opportunities to reform **internal institutional practices or policies** to improve social and structural drivers of health equity? ➔	**System** Level of intervention
Primary prevention		Increase wages internally so that no staff are experiencing food insecurity
Secondary prevention		Incorporate the DPP into benefits plan for lower-wage employees with prediabetes
Tertiary prevention		Reduce or eliminate medical debt burden for lower-income patients with diabetes

HEALTH BEGINS

Upstream Strategy Compass™. Manchanda R. HealthBegins. 2014. Updated 2022

Condition: Diabetes
Inequity: Racial
Social Driver(s): Economic & food insecurity
Place(s): 01214,01245, 01248

How can we design & align ecosystem investments to reduce inequities in health and health care?

Upstream strategy compass	**Ecosystem** Level of intervention
Primary prevention	Invest in and support local food policy council; assess for and promote livable wages with vendors and partners
Secondary prevention	Subsidize vouchers to a farmer's market and market to lower-income residents and employees
Tertiary prevention	Coordinate with local banks, collectors, lenders, to reduce debt burden for people with diabetes and lower incomes

← What are potential solutions or opportunities to to improve social and structural drivers of health equity by reforming or supporting **relationships among two or more institutions**?

HEALTH BEGINS

Upstream Strategy Compass™. Manchanda R. HealthBegins. 2014. Updated 2022

Upstream Strategy Compass™

A balanced health equity strategic portfolio includes coordinated investments across multiple levels of intervention and prevention

Condition: Diabetes
Inequity: Racial
Social Driver(s): Economic & food insecurity
Place(s): 01214,01245, 01248

Upstream Strategy Compass	Program/ Care Delivery Level of intervention	System Level of intervention	Ecosystem Level of intervention	Structural Level of intervention
Primary prevention	Connect low-income individuals and families experiencing food and nutrition insecurity to financial literacy, support & nutrition resources	Increase wages internally so that no staff are experiencing food insecurity	Invest in and support local food policy council; assess for and promote livable wages with vendors and partners	Support local community-led coalitions increase minimum wages and reduce economic hardship for people with lower-incomes
Secondary prevention	Conduct food insecurity screening and connection, application assistance for state benefits and connection to community resources	Incorporate the DPP into benefits plan for lower-wage employees with prediabetes	Subsidize vouchers to a farmer's market and market to lower-income residents and employees	Advocate to increase SNAP and WIC benefit amounts and reduce barriers to enrollment to ensure low income individuals receive adequate food assistance.
Tertiary prevention	Provide medically-tailored meals for low-income patients with diabetes to close health care inequities	Reduce or eliminate medical debt burden for lower-income patients with diabetes	Coordinate with local banks, collectors, lenders, to reduce debt burden for people with diabetes and lower incomes	Support Medicaid policy change to provide sustainable fund Medically tailored Meals for individuals with diabetes and pre-diabetes

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Upstream Strategy Compass™. Manchanda R. HealthBegins. 2014. Updated 2022

At this inflection point in our journey,
let's move from programs to portfolios
to help ensure that equity efforts remain focused on:

- reallocating power and resources upstream,
- counteracting structures and policies that drive harmful health and social inequities, and
- reimagining ourselves and our institutions

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“There is never a time in the future in which we will work out our salvation. The challenge is in the moment, the time is always now.”

- James Baldwin

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Thank you

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