FOUNDATION FOR Health Care Quality

Home to complementary improvement communities…

CARE OUTCOMES ASSESSMENT PROGRAMS	BREE COLLABORATIVE	WASHINGTON PATIENT SAFETY COALITION	SMOOTH TRANSITIONS

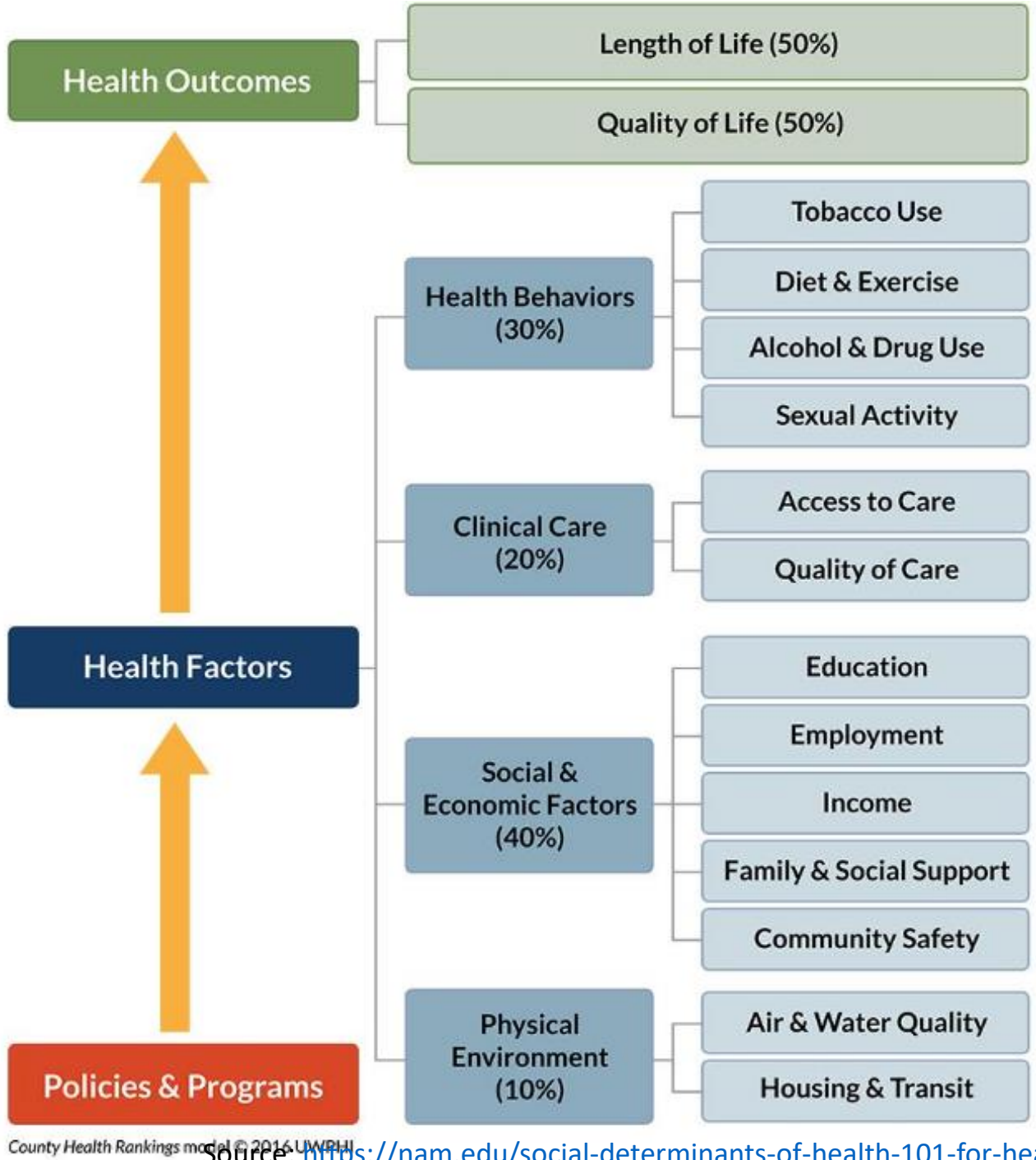
CARDIAC
CARE OUTCOMES ASSESSMENT PROGRAM (CARDIAC COAP)

SURGICAL
CARE OUTCOMES ASSESSMENT PROGRAM (SURGICAL COAP)

SPINE
CARE OUTCOMES ASSESSMENT PROGRAM (SPINE COAP)

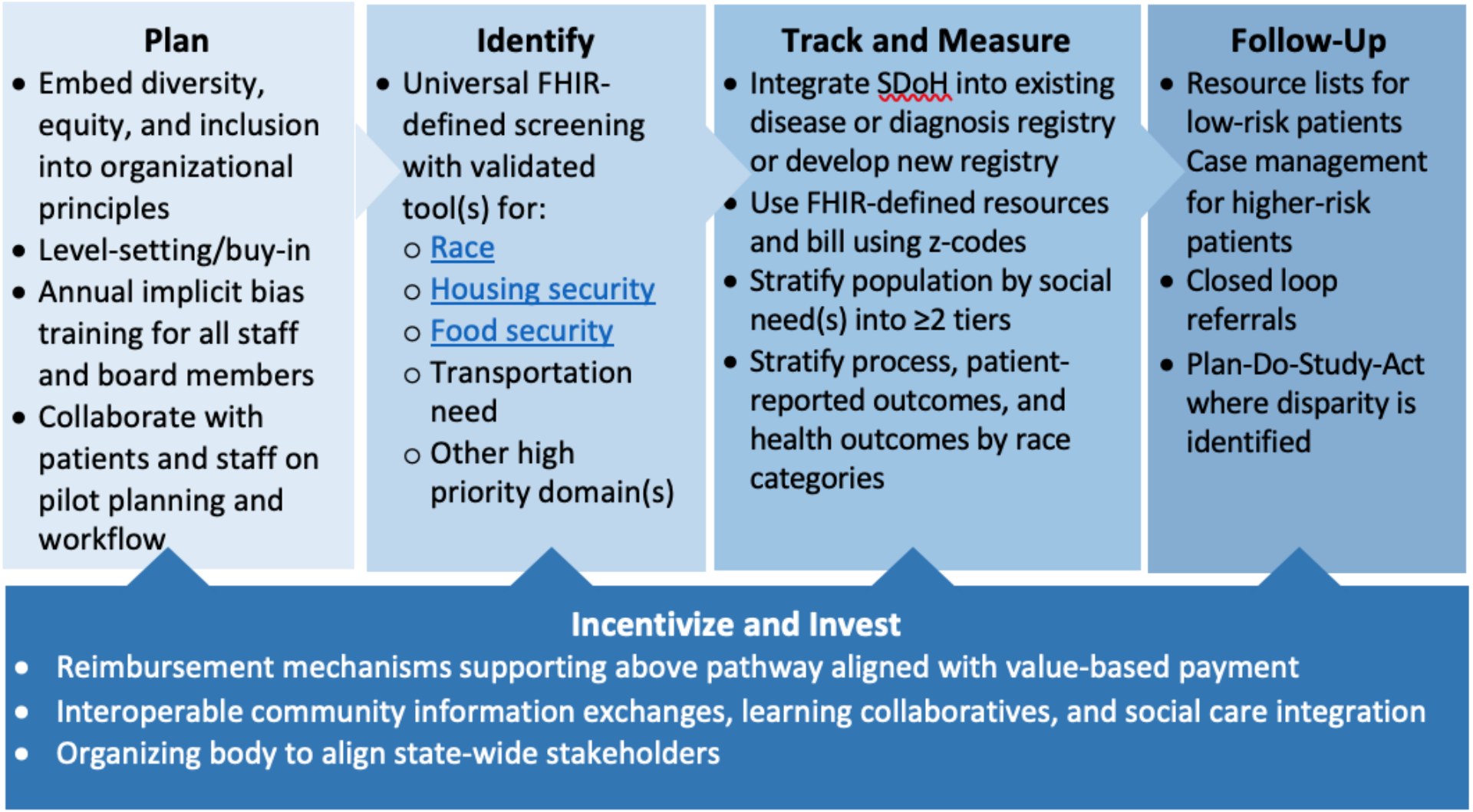
OBSTETRICAL
CARE OUTCOMES ASSESSMENT PROGRAM (OB COAP)

- Each sets own clinical priorities
- Using unique structure
- All to improve health of our population



Source: https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

Our 2021 Social Needs Guideline Framework



2021 Framework for Action Webinar Series

A Framework for Action Webinar Series
Brought to you by Bree Collaborative & Washington Health Alliance

From Impossible to Implementation:
Mobilizing Collective Action Around Social Determinants of Health

January 21, 2021 | 11:00 am -12:30 PM

Framework for Action Webinar Series
Brought to you by Bree Collaborative & Washington Health Alliance

Interoperability: Removing Barriers to Value-Based Success
(Why Don't We All Talk to Each Other?!)

April 15, 2021
10:00 am - 11:30 am PT

Framework for Action Webinar Series
Brought to you by Bree Collaborative & Washington Health Alliance

Aligning Quality Measures:
Can We Measure What Matters More Efficiently?

Thursday July 15, 2021
11:00 am - 12:30 pm PT

Bree Collaborative & Washington Health Alliance
Framework For Action Webinar

Falling Into Place: Aligning Payer Strategies for Population Health

Thursday October 14, 2021
10:00 am - 11:30 am PT

Addressing Social Need to Build Competent Care Systems

Value-Based Care Change in Action Webinar Series

January 27, 2022 | 10:00 – 11:30am

Source: NASA via Unsplash

Change in Action

WSHA's Pilot Group and Early Learnings

Abby Berube, Director Safety & Quality, WSHA

1.27.22

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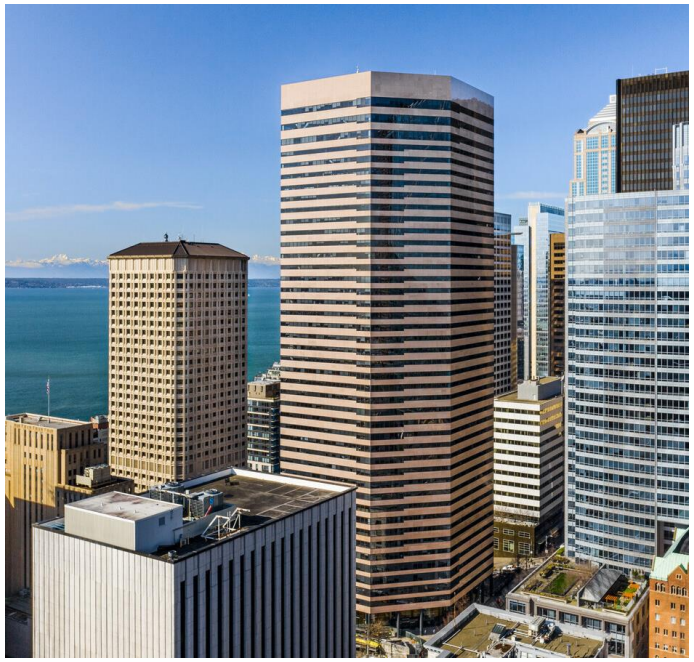


Washington State Hospital Association

About WSHA

Mission Statement

The Washington State Hospital Association advocates for and provides value to members in achieving their missions.

Vision Statement

WSHA will be the trusted voice and indispensable resource that leads, challenges and assists hospitals and health systems to improve the health of the communities they serve.

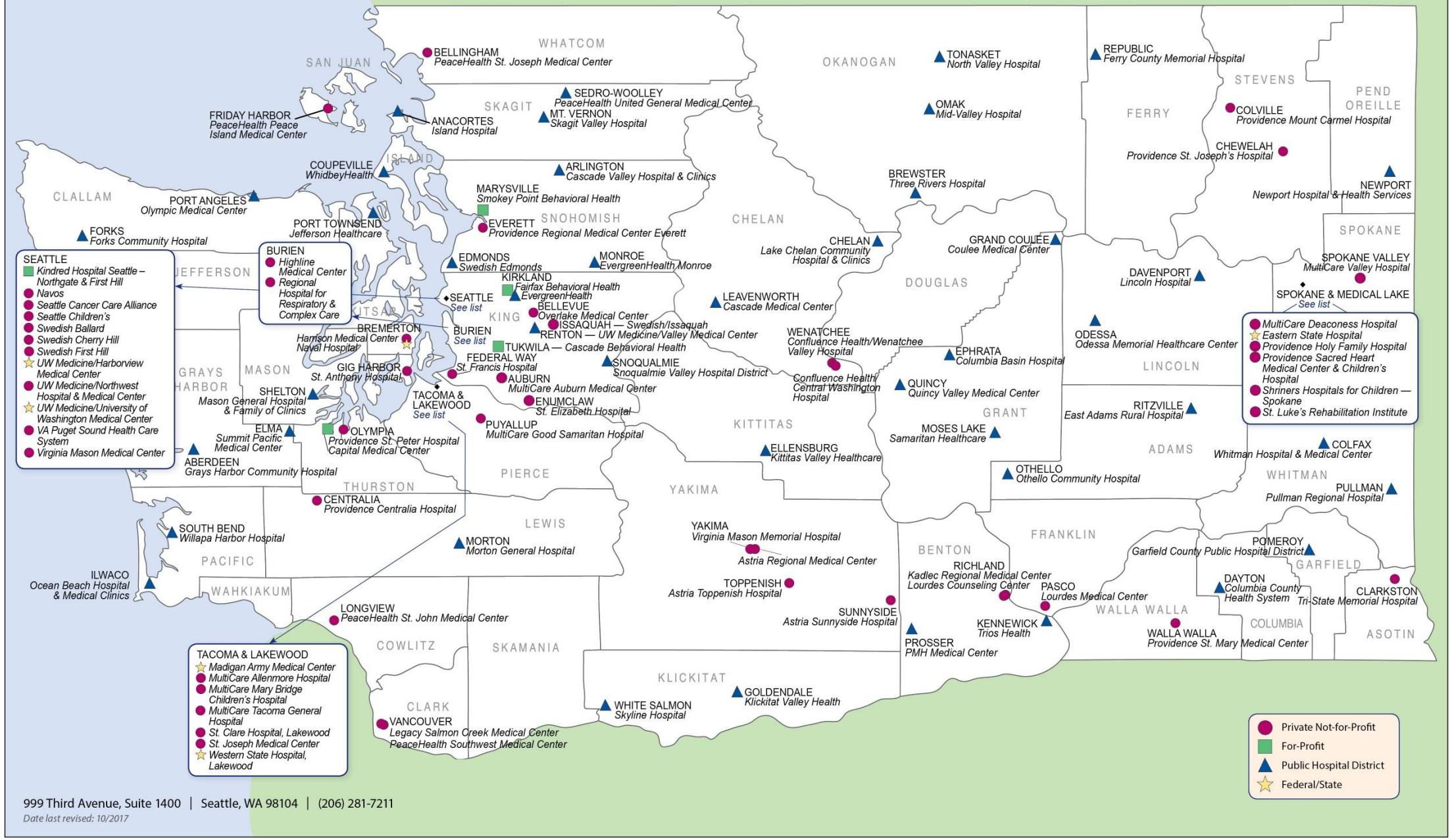
Values

Service: We are a member-led association committed to providing servant leadership.
Integrity: We are honest in our work and operate with transparency and accountability.
Collaboration: We act cooperatively, incorporate diverse perspectives and use the power of the collective to achieve our mission.
Innovation: We are agile and drive continuous quality improvement.

Strategic Goals

Goal 1: Create ambitious public policy to support access to health care and a strong delivery system.
Goal 2: Partner with hospitals across the Northwest to enhance their performance as high reliability organizations and optimize care for patients in all settings.
Goal 3: Be a leader in defining and supporting new directions for patients, hospitals, the health care system and for our society.
Goal 4: Enhance the strength of WSHA's people and financial performance ensuring the association's future viability.

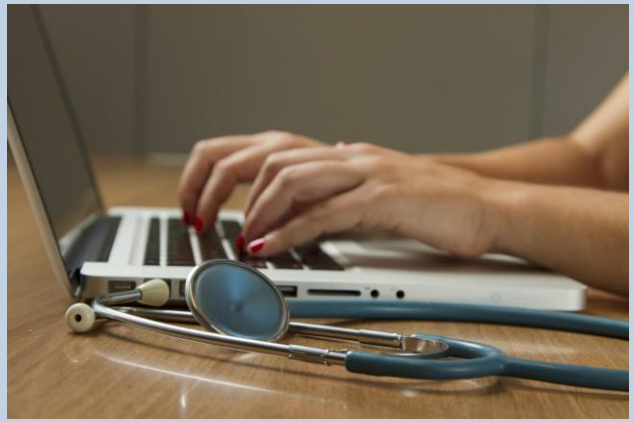
WSHA Member Hospitals



WSHA Safety and Quality Team

Purpose

The WSHA's Safety and Quality Team believes in challenging and supporting hospitals to provide safe, high-quality, accessible, culturally competent, and equitable care for all Washingtonians.



Who We Are

The Safety and Quality Team is experienced in designing data-informed programs to achieve state and regional safety and quality priorities. We draw from previous experience working in hospital systems including nursing, clinical leadership, perinatal, population health, patient safety and quality management. To inform our work across specialized fields, we maintain our clinical and quality credentials.

WSHA Safety and Quality Team

What We Do

WSHA's Safety and Quality professionals provide content expertise to hospitals participating in WSHA-led clinical quality and patient safety improvement programs. Individual consultation is provided to member hospitals to enhance clinical programs or troubleshoot implementation challenges. Team members actively participate in state level emerging healthcare issues impacting hospital members, such as COVID-19, and partner with WSHA's Government Affairs team to translate legislation into hospital implementation of new requirements.

As a trusted leader in healthcare quality, the WSHA Safety and Quality team convenes hospitals in learning collaboratives and rapid cycle improvement workshops. Our unique position as a non-regulatory organization with a system level view of hospital performance across the state, allows us to work with member hospitals transparently to identify and address root causes of safety and quality issues.

Health Equity

What is Health Equity?

Equitable care does not vary in quality because of personal characteristics such as gender identity, race, ethnicity, preferred language, geographic location and socioeconomic status. Quality care cannot be achieved without equity.

Despite decades of evidence showing persistent health disparities impacting populations made vulnerable by racism and discrimination, progress is slow to close the gaps. Quality initiatives measuring only outcomes of general populations may conceal widening gaps in care or disparate outcomes of minority groups. Focused efforts are needed to collect and stratify data to uncover health disparities within health systems, train staff to better understand root causes of inequities in healthcare and partner with communities to address social needs.

Topic Overview Today:

Medicaid Quality Incentive (MQI)-2020, 2021

Health Equity Collaborative-launched July 2021

Medicaid Quality Incentive (MQI)

What is the Medicaid Quality Incentive Program?

- Included in the legislation creating the new Hospital Safety Net Assessment program (originally passed in 2010).
- All Non-Critical Access Hospitals in WA State may earn one percent increase to inpatient Medicaid payments if they meet specific quality and reporting requirements. Critical Access Hospitals (CAH) are not eligible for incentive payments.
- The payments are funded by quarterly assessments paid to the state by hospitals and federal matching funds.
- Oversight by the Washington State Health Care Authority (HCA)
- WSHA supports the quality and performance guidelines and data submission

Additional background on MQI: http://www.wsha.org/wp-content/uploads/2021_05_14_WSHA-Medicaid-Quality-Incentive_powerpoint.pdf

2021 MQI Metrics

1. Pressure Ulcer (Skin Assessment Policy; Clinical Staff Education)
2. Falls with Injury (Falls with Injury / 1000 Patient Days; Post-Fall Huddle)
3. Surgical Site Infection (SSI Prevention Policy)
4. Catheter Associated Urinary Tract Infection (CAUTI Prevention Policy)
5. Patients with Five or More Visits to the ED (Care Guideline in EHR)
6. Safe Sleep (Patient education and Safe Sleep Discharge Instructions)
7. ED Triage "Are you currently pregnant /been pregnant within the past year?" (Perinatal Consult)
8. Behavioral Health Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths
9. Behavioral Health Transition Record with Four Specified Elements Received by Discharged Patients
10. SDOH Screening for housing stability, food insecurity, and transportation needs (Screening questions, policy, workflow)
11. Communication of critical lab result and/or radiology test (Counts of lab and radiology tests)
12. Number of Workplace Violence Events (RCA and REaL data collection)

Additional MQI Metric Specifications: http://www.wsha.org/wp-content/uploads/2021-WSHA_MQI-Guidelines_09162021_Updated-Final.pdf

Social Determinants of Health

Inpatient Screening for Social Determinants of Health (SDOH)

Measure eligibility: All hospitals who wish to participate in MQI are eligible to complete this metric. Critical Access Hospitals (CAH) are not eligible to receive the incentive payment.

Clinical Rationale:

Screening patients is the first step in addressing social needs, a key determinant of health. SDOH account for at least 80% of health outcomes. This SDOH metric promotes screening and identification of three core patient social needs: housing instability, food insecurity, transportation. Future MQI metrics may focus on linkage to community-based resources and achieving universal screening.

Social Determinants of Health

Inpatient Screening for Social Determinants of Health (SDOH)

Metric:

- Does your hospital conduct inpatient screening for housing stability, food insecurity, and transportation needs in at least one unit or defined patient group?
- Response options: Answer Yes/No.

Fields to be reported:

If screening for all three core SDOH (housing, food, transportation) is in place for at least one unit or a defined patient population, then enter Yes. Can enter Yes anytime during the time period of measurement.

In QBS, upload a copy of the SDOH screening protocol inclusive of the workflow and screening questions.

Only an answer of Yes *and* upload of all required documents will allow eligible hospitals to receive credit toward the incentive.

(Note: the 2021 SDOH screening metric does not require reporting use of standard coding in medical records, however this is recommended to support data analytics and allows for better understanding of population health needs)

2021 SDOH Participation

Facilities	Participated in MQI SDOH	Responded “yes” to screening
Large (250+ beds)	20	16 (80%)
Mid-size (99-249 beds)	16	14 (88%)
Small (25-99 beds)	8	7 (88%)
CAH*	23	15 (65%)
Total	67	52 (78%)

*CAH not eligible for MQI payment incentive
Data collection still underway, closes Jan 31, 2022

Themes

- **Many large/mid-size hospitals are using the Epic SDOH Wheel**
  - Each category has multiple questions

The SDoH factors of the wheel are listed below:

• *Financial Resource Strain*	• *Intimate Partner Violence*	• *Physical Activity, Stress*
• *Food Insecurity*	• *Depression*	• *Social Connections*
• *Transportation Needs*	• *Housing Stability*	• *Tobacco and Alcohol Use*

- **Use of flowsheets, need to document in several places**
  - Patient StoryBoard
  - Document SDOH assessments through History tab
  - History tab, accessible to multiple caregiver workflows
  - SmartPhrase to pull SDOH info into progress note
  - Case management workflow “intake assessment score summary” with recommended follow-up intervals
  - Ambulatory end users can view SDOH info in SnapShot report or Longitudinal Plan of Care Report (LPOC)
  - Some links to directory of community resources; may add to After Visit Summary using SmartPhrase

- Green = Not at risk
- Yellow = Moderate risk
- Red = High risk

Themes

- **Protocols vary; may be part of Admission, During Stay, or Discharge Planning**

c. All personnel performing or supervising discharge planning evaluations, including Registered Nurses and Social Workers, must have knowledge of clinical, social, insurance/financial and physical factors that must be considered when evaluating how a patient's expected post-discharge care needs can be met.

The behavioral health needs and social determinants of health impacts are included in the psychosocial needs assessment of the patient in order to address readmission risk and determine other supportive community needs

Case management documents assessment and discharge plan in the electronic medical record (EMR) and utilizes case management software for referrals to community partners.

- **All** patients admitted to the unit with patient class of "Inpatient" will be screened on admission by attending nurse for all 3 SDOH elements of Food, Transportation and Housing Stability.
- SDOH is hardwired into the Epic EHR ***required documentation*** Admission navigator/activity in the patient chart (required documentation = all 3 SDOH elements must be completed before an admission is flagged as completed in the chart). If a patient converts from Observation to Inpatient, the required documentation will update and become required after the patient class is changed.
    - When an SDOH response is documented as "Yes" for Housing and/or "Often True" for Food, a Best Practice Advisory (BPA) pop-up will prompt the nurse to place a Social Work (SW) Consult order.*

Themes

- **Small/CAH hospitals more likely to use short forms, check boxes and paper forms**

HOUSI - HOUSING DESCRIPTION:____
MODE - MODE OF PERSONEL TRANSPORTATION:____
DO YO - DO YOU HAVE ACCESS TO NUTRITIOUS FOOD:__

Date: 102921 Time: 0956 Patient Name:

Acct Number: MR #: DOB: Gender: Room #:

Admitting Physician: Primary Physician: Pt Stay Type:

Core Determinants of Health Screening (any one or more "Yes" answers refer for assistance/more assessment)

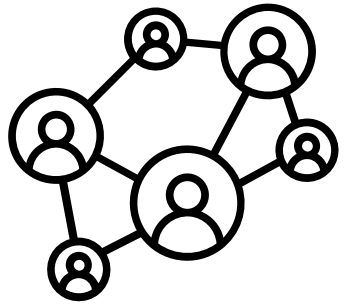
1. Do you/your family worry about whether your food will run out and you won't be able to get more? ☐ Yes ☐ No
2. Are you worried about losing your housing, or are you homeless? ☐ Yes ☐ No
3. Are you curently having issues at home with your utilities such as heat, electric, gas or water? ☐ Yes ☐ No
4. Has a lack of transportation kept you from attending medical appts, work, or getting things you need daily? ☐ Yes ☐ No

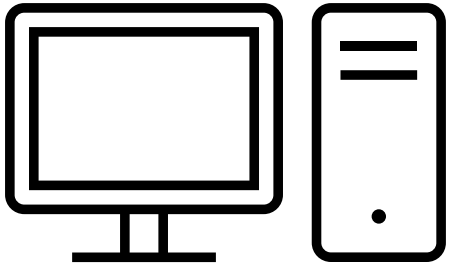
Assistance provided/type:

INITIAL	NAME/TITLE	INITIAL	NAME/TITLE

Challenges

- Staff reluctance to screen without solutions
- Limited community resources and networks
- EHRs and documentation, move to structured data





WSHA Health Equity Collaborative

Moving from Pledge to Performance

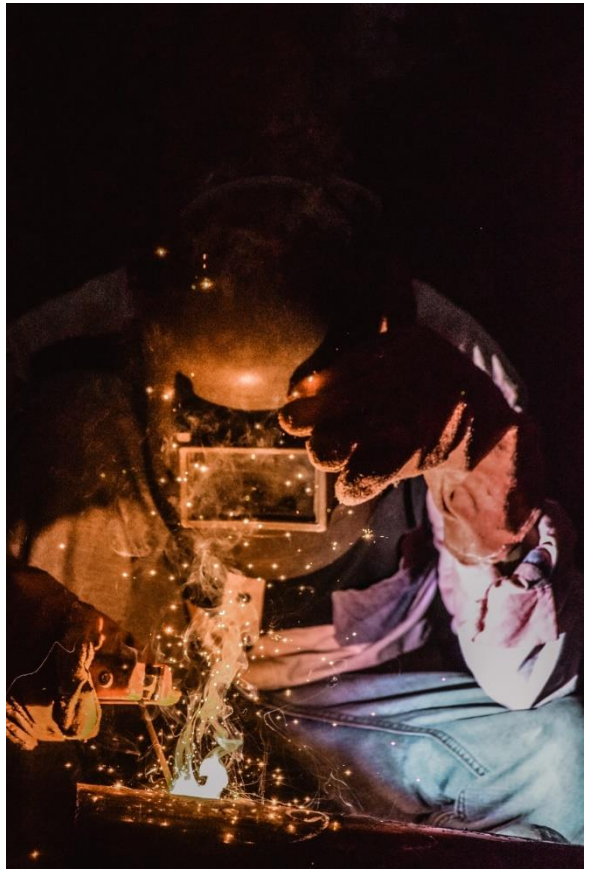
1. Collection and use of race, ethnicity, language preference and other socio-demographic data
2. Cultural competency training
3. Diversity in leadership and governance
4. Community partnerships

Design of WSHA Health Equity Collaborative

Goal: Catalyze action within diverse hospitals to identify and remove inequities; leverage the experience of peers and use data to guide planning.

- Reviewed equity frameworks (AHA, IHI, RWJF, DSC, others)
- Interviewed 15 hospitals and health systems
- Participate in state workgroups and topic focused collaboratives
- Aligned new/proposed legislation
- Pared down to areas with relatively faster implementation or timely focus

- Built Health Equity Gap Assessment (NQF, C-CAT, HIIN, others)
- Mapped Driver Diagrams
- Populated Change Package with resources and toolkits



How does the Collaborative work?

What: Commit to implementing quality improvement projects in three health equity domains, guided by Health Equity Gap Assessment results and peer coaching.

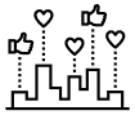
Complete Equity Gap Assessment

Review Baseline Data

Learn and Action Plan

Implement in Three 90-day Sprints

Receive Peer Coaching



Share Lessons Learned

Each team will have a private dashboard for viewing Gap Assessment results, storing Action Plans and tracking PDSA Cycle progress.

All events are virtual

WSHA Health Equity Collaborative Calendar

July Kick-off	**August** Learning & Action Planning	**September** Peer coaching	**October** Peer coaching	**November** Peer coaching
	December	**January** Virtual report out	**February** Learning & Action Planning	**March** Peer coaching
	April Peer coaching	**May** Peer coaching	**June** Learning & Action Planning	**July**
	August Virtual report out	**September** Peer coaching	**October** Peer coaching	**November** Peer coaching

Sprint

Sprint

Sprint

December
Close

Health Equity Domains

Leadership and Culture of Equity

Data Collection and Analytics

Addressing Social Determinants of Health

	Leadership and Culture	Data and Analytics	SDOH
Basic	• CLAS standards • Bias training • PFAC	• Self-report collection of REaL • Categories roll up to OMB • Patient messaging	• Screen for core SDOH • Provide resource listing • Community benefit
Intermediate	• Leadership accountability • Patient inclusion in QI • Equity strategic planning	• Data validated at multiple points • Less than 5% coded as “unknown” • Stratify quality metrics by REaL • Implement interventions	• Warm handoff to services • Closed-loop referral system • Deliver services onsite
Advanced	• Board diversification • Equality Leader designation • Community partnerships	• Collect SOGI and disability data • Equity Dashboards • Share data with community	• Community investments • Healthcare Anchor designation • Advocacy

Equity Gap Assessment

Leadership and Culture of Equity

Language Access

The following questions ask about language access for patients at your hospital or health system. Does your hospital/health system:

Perform a learning needs assessment on each patient which considers the patient's cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, or barriers to communication?

○ Yes ○ No ○ Sometimes

Provide comprehensive language assistance and communications services for individuals with limited English proficiency?

○ Yes ○ No

Provide comprehensive language assistance and communications services for blind, deaf, hard of hearing and non-verbal individuals?

○ Yes ○ No

Does your hospital have a policy for staff to ask patients if they need an interpreter?

○ Yes ○ No

Is interpretation often done by untrained interpreters (e.g., untrained staff members or patients' family or friends)?

○ Yes ○ No

Equity Gap Assessment

Data and Analytics

Data Collection

The following questions are specific to collection, validation and storage of patient demographic data.

Does your hospital / health system use a patient self-reporting methodology to collect data on the following (check all that apply):

- ☐ Race
- ☐ Ethnicity
- ☐ Disability
- ☐ Other (please specify)
- ☐ Sexual orientation
- ☐ Gender identity

Is it your hospital / health system policy to have staff ask patients their preferred language?

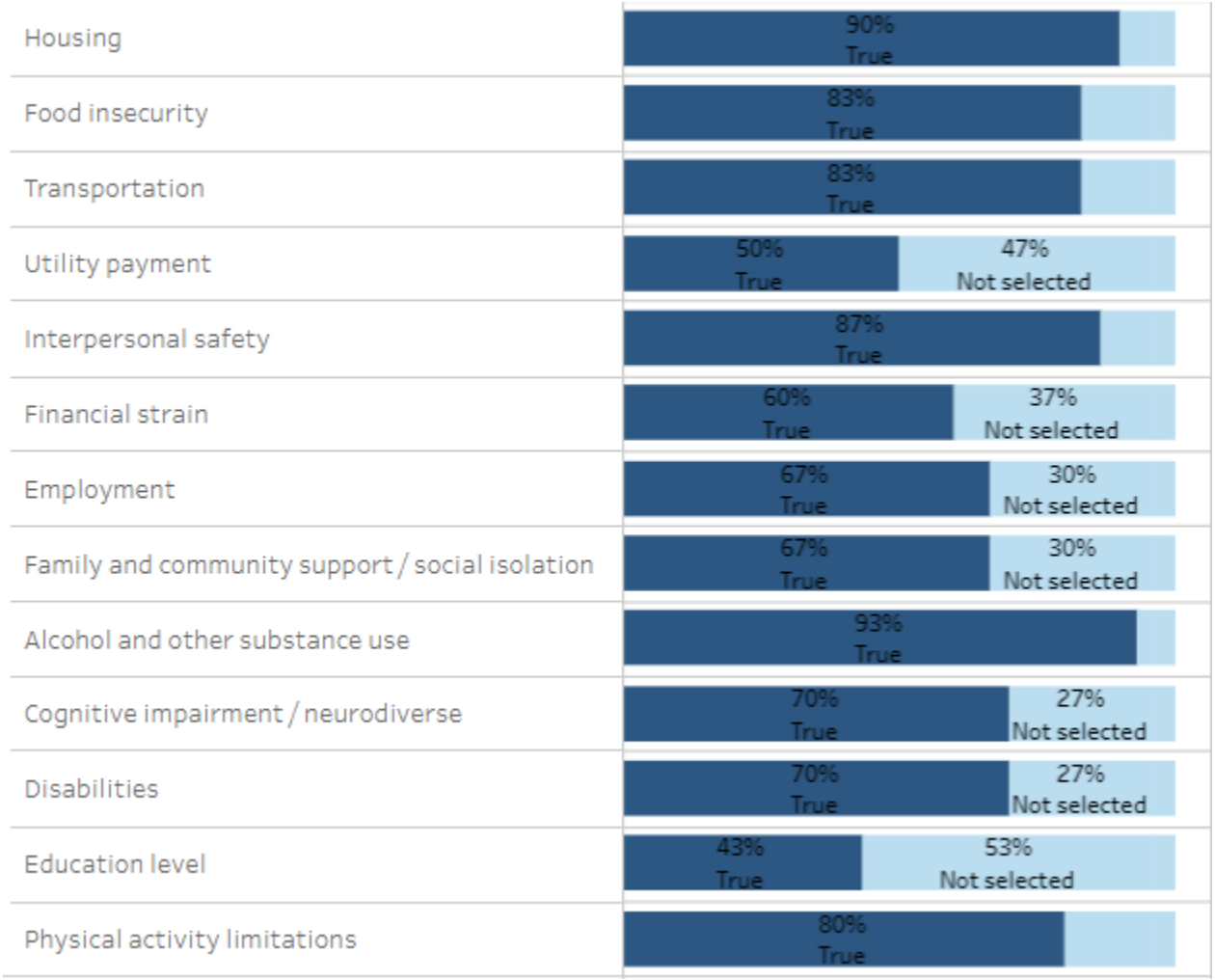
○ Yes ○ No

Is it your hospital / health system policy to document a patient's preferred language?

○ Yes ○ No

2021 Gap Assessment Results

Does your hospital/health system screen for the following health-related social needs (check all that apply):



2021 Gap Assessment Results

How widespread is the screening for health-related social needs in your hospital / health system?	Universal (all patients)	13% True / 83% Not selected
	ED	33% True / 63% Not selected
	Inpatient (some units)	33% True / 63% Not selected
	Inpatient (all units)	27% True / 70% Not selected
	Outpatient	27% True / 70% Not selected
Are social risk factor assessments (SDOH screenings) documented in the medical record?		53% Yes / 43% Sometimes
Does the hospital / health system inform staff about resources for patients that are available in the community?		77% Yes / 23% No
Do you use community health workers, navigators and/or promotoras to address social needs among patients?		53% Yes / 43% No
Does your hospital provide warm hand-offs to community-based services?		33% Yes / 67% Sometimes
Do you use a referral management system to direct patients with social needs to community-based services?		30% Yes / 67% No
Has the hospital invested in non-clinical programs delivered on-site or nearby to address health related social needs (e.g. food pantry, supportive housing, transportation)?		57% Yes / 43% No

Washington State Hospital Association

Ariel Singer | MPH

About Projects Collaborative Screening Contact Me

COLLABORATIVE SCREENING

Guidance for Person-Centered Inquiry

In the system-centered culture of health care, it takes determination and skill to offer person-centered services. Collaborative Screening offers concrete guidance for designing a partnership-based and trauma-informed approach to asking about people's lives.

https://arielsinger.com/collaborative-screening

Collaborative Screening Training Sessions

3 half-day virtual training sessions (9 hours total)

By the end of this training, participants will:

- **Consider the incentives and impacts of conducting social needs, demographic, and health behavior screenings, as well as the connections between screening and value-based health care, population management and health equity.**
- **Discuss core design principles and skills for person-centered screening and referral.**

- **Explore person-centered workflow and organizational design.**
- **Practice person-centered screening and referral.**
- **Develop next steps in creating a more person-centered and equity-focused approach at your organization.**

Design Principles

Person-Centered Screening Conversations

- Recognize and reduce differences in power
- Prioritize transparency
- Demonstrate respect
- Focus on strengths
- Let the client lead

Person-Centered Organizational Systems

- Raise awareness about personal and organizational contexts and power dynamics
- Create a welcoming environment
- Make internal and external partnership foundational to your strategy
- Demonstrate listening
- Commit to consistency

Success

- Very high participation and engagement
- Role play excellent for skill building
- Design principles helpful for tailoring implementation

Challenges

- Staff relationships with patients may be a barrier
- SOGI similarities, respect privacy create safe environments
- Ability to keep up training and refreshing skills/turnover

Thank you!

abigailb@wsha.org

Pediatric Primary Care and Social Determinants of Health

Addressing Social Need to Build Competent Care Systems

Phyllis M. Cavens, MD

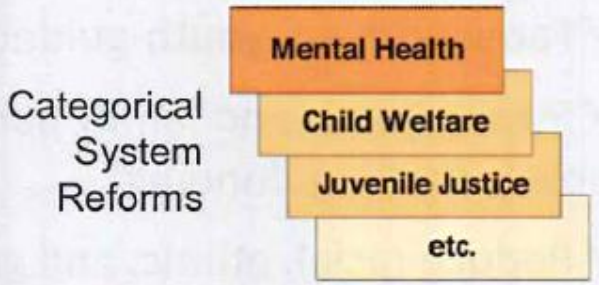
January 27, 2022

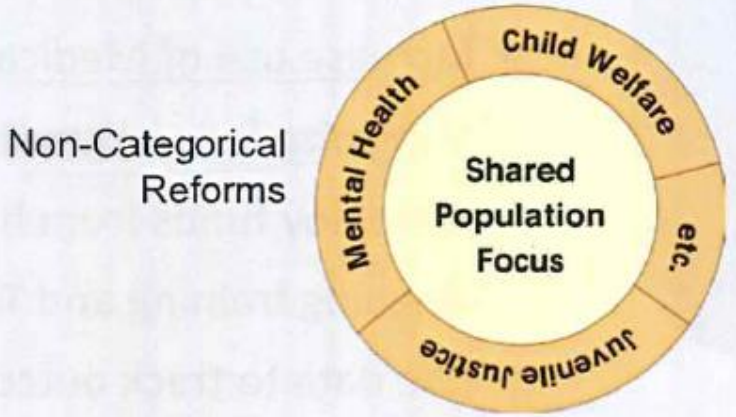
Let's begin by talking about children and families ....and why they need a system designed for them.

System of care is, first and foremost,

a set of values and principles that provides an organizing framework for systems reform on behalf of children, youth and families.

- Family-driven and youth-guided
- Home and community based
- Strengths-based and individualized
- Trauma-informed
- Commitment to health equity through cultural and linguistic competency
- Connected to natural helping networks
- Resiliency-and recovery-oriented
- Data-driven, quality and outcomes oriented
- Coordinated across providers and systems
- Takes a population focus across child-serving systems





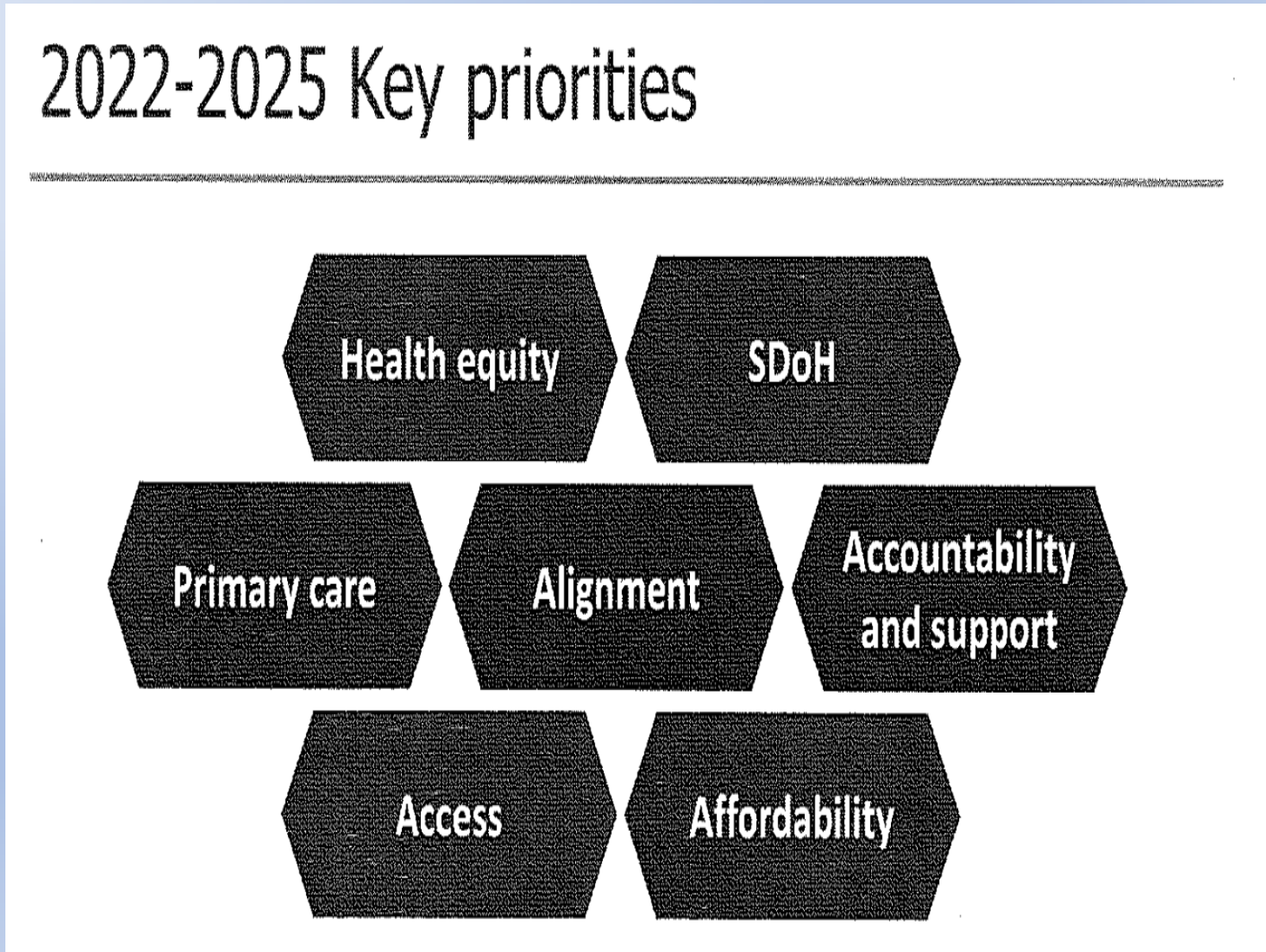
Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

Primary Care Innovations

- Identify and Address Social Needs
- Integrate Behavioral Health Care
- Coordinate Care
- Promote Health Equity
- Enhance Team-Based Care
- Use Technology to Improve Access
- Advance PCMH

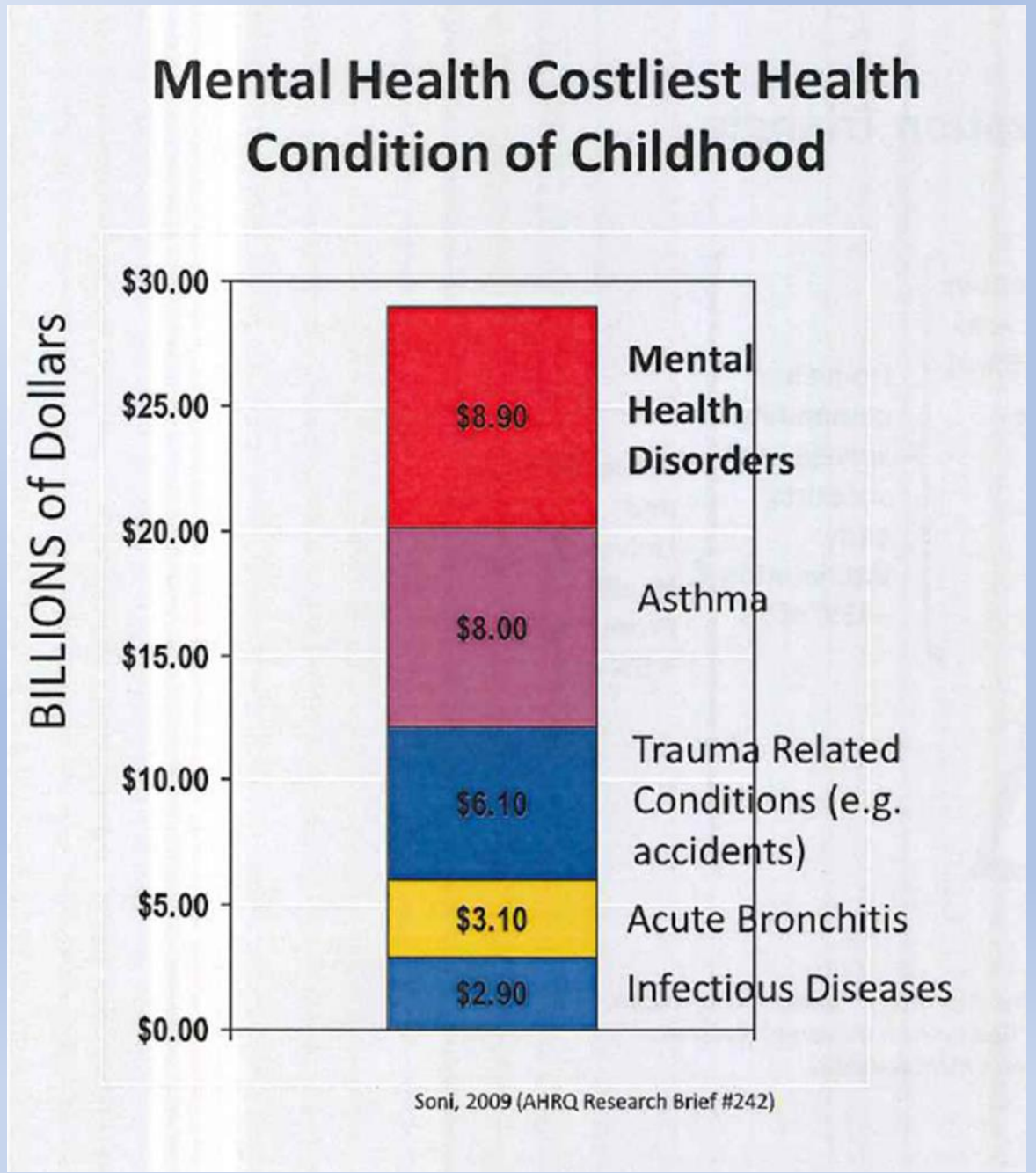
Center for Health Care Strategies, “Advancing Primary Care Innovation in Medicaid managed Care: A Toolkit for States”

Health Care Authority



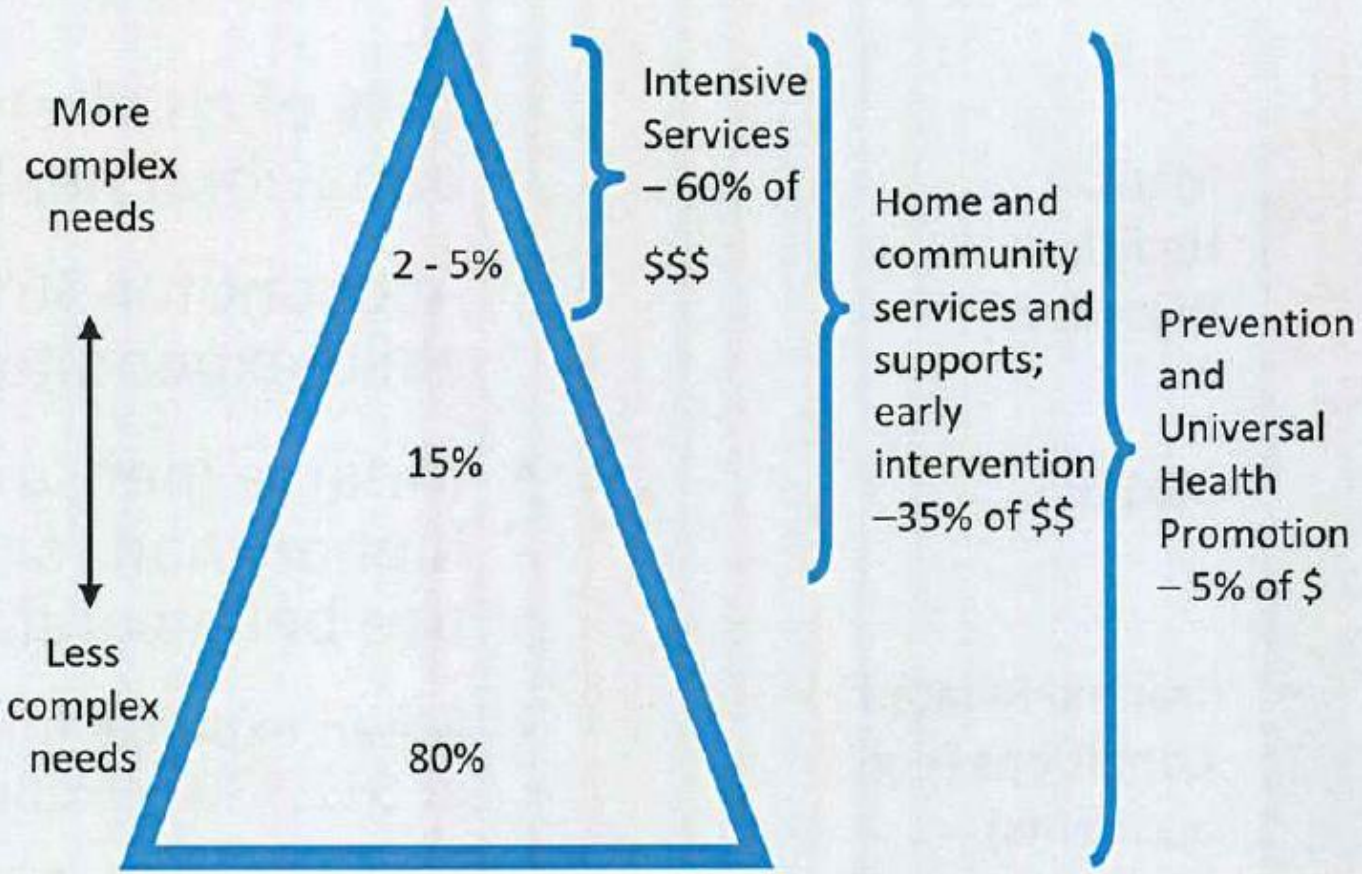
WA Health Care Authority, Sue Birch and Judy Zerzan-Thul, “Where Are We Now? HCA’s Value-based Purchasing” 2021.

Mental Health Costliest Health Condition of Childhood



Soni, 2009 (AHRQ Research Brief #242)

Prevalence/Utilization Triangle



Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

Role of Pediatric Primary Care

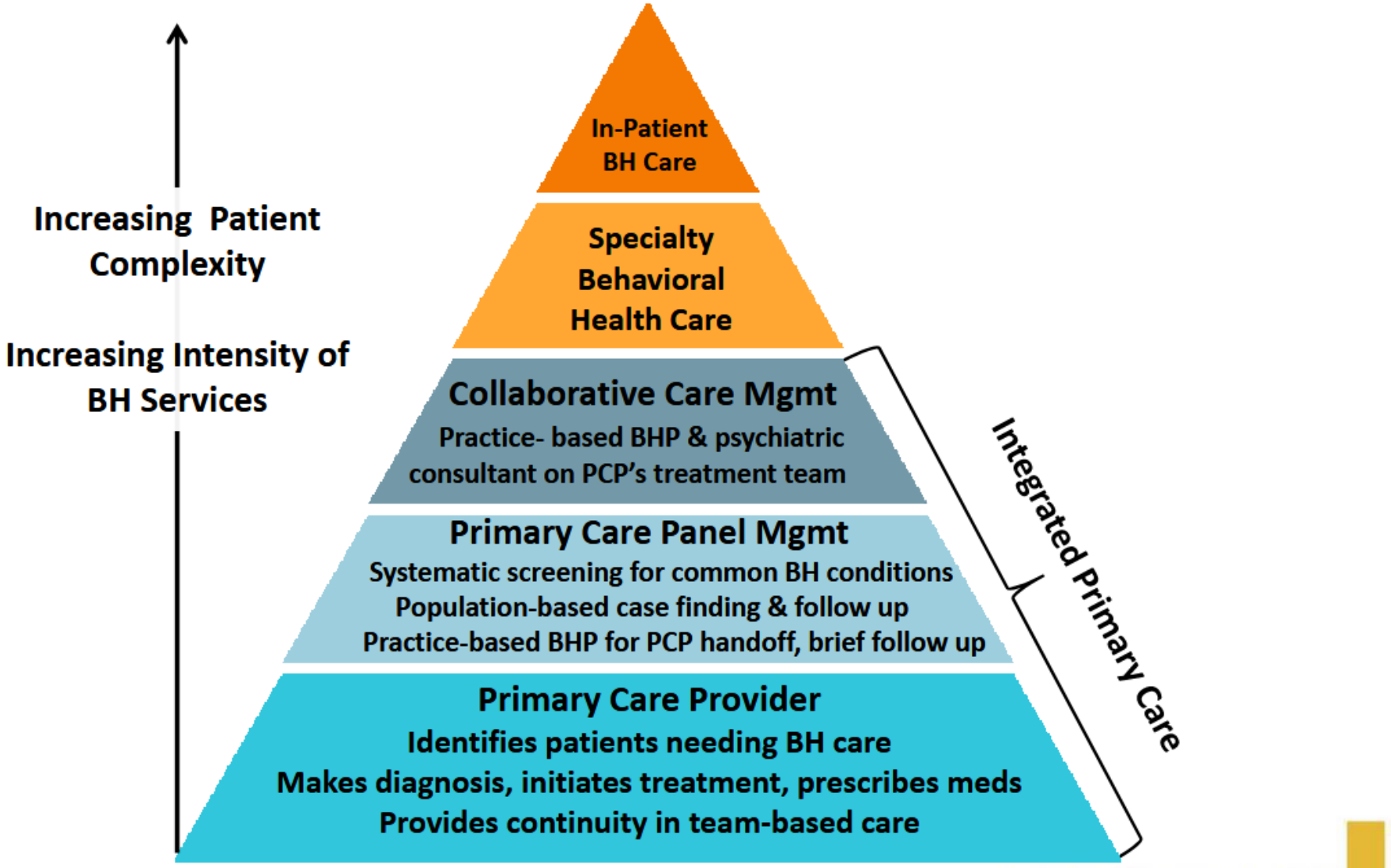
- Address prevention and wellness care
- Address behavioral health
- Address social determinants of health
- Address equitable health and health disparities
- Collaborate to achieve whole child care

Pires, S. Fields, S. et al., 2018 Care Integration Opportunities in Primary Care for Children, Youth and Young Adults with Behavioral health Challenges: Expert Convening. National Technical Assistance Network for Children's Behavioral Health.

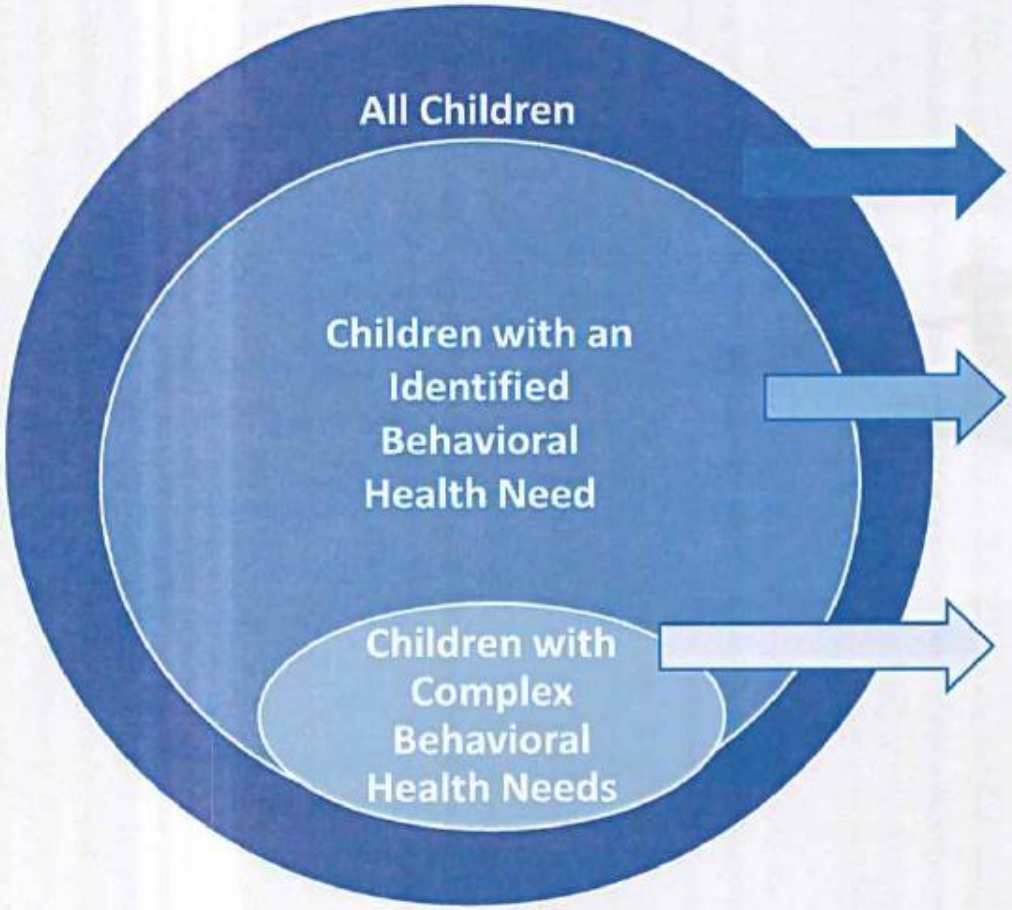
Levels of Primary Care Integration

Bree Collaborative 2017

Stepped Strategies for Integration



Care Coordination Continuum – What Belongs Where?



Screening, Information and Referral on an as Needed Basis/ During Well Child Visits

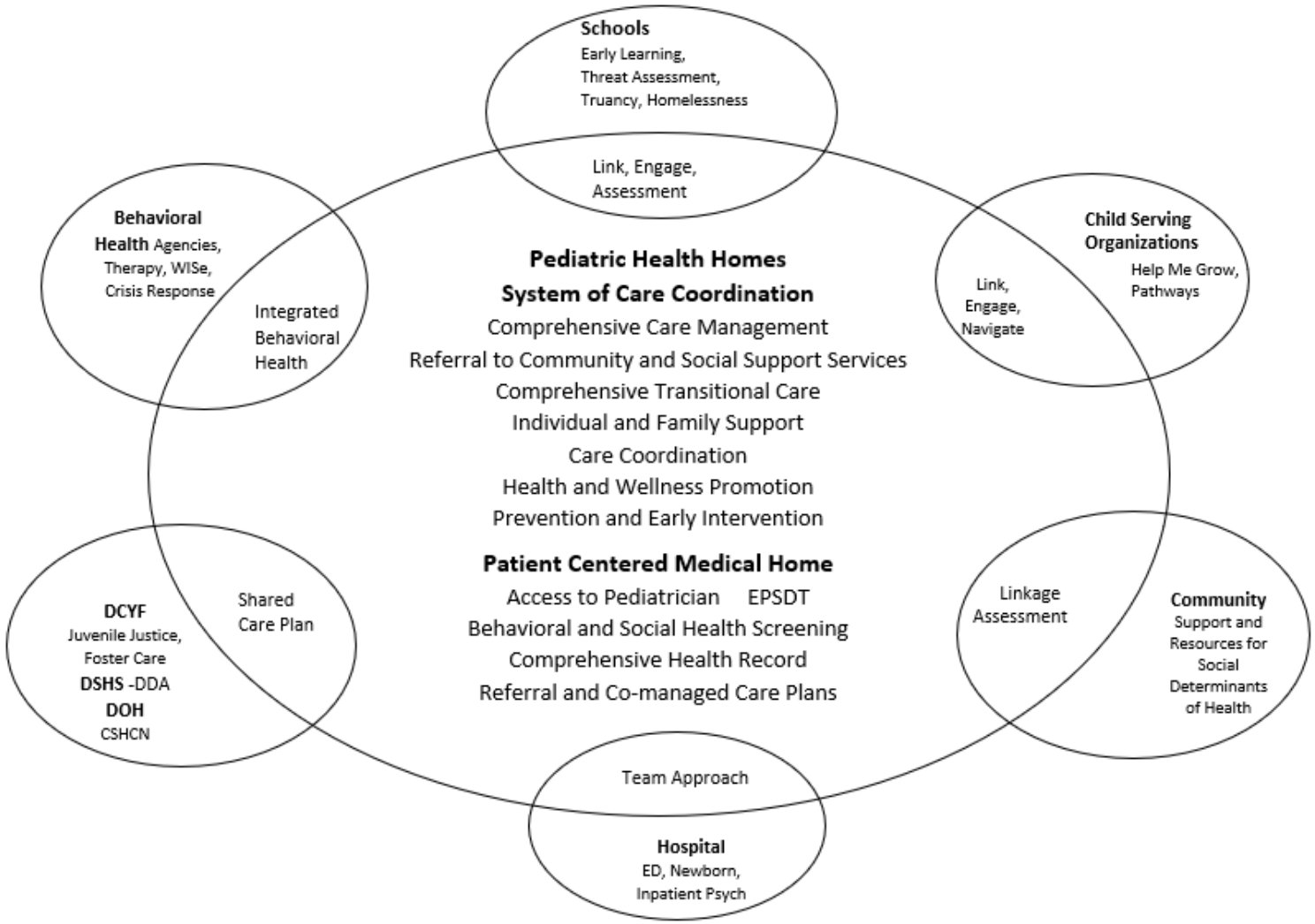
Service Coordination and System Navigation To Support Effective Response to Identified Need

Intensive Customized Care Coordination To Provide Extended Support To Multi-Modal Needs

Unmet need for care coordination is high for children and youth with mental health conditions

American Academy of Pediatrics (Brown, N. et al, 2013)

Care Coordination
Ensuring Community Clinical Linkages
The Role of the Health Navigator



The New Social Determinant Imperative

The importance of the social determinants is now well known. But, doing something to employ that knowledge in a meaningful and sustainable way is still elusive. The SDOH panel discussed the intersection between the delivery system and community, and the lessons learned from ACH work to connect the two to improve conditions where we live, work, and play.

The Social Equities Panel noted that the social determinants are primary drivers of one's health status. They also acknowledged that those influences are not evenly spread across geography or demography. The presentation explored what was known about that uneven spread, and discussed strategies to bring about greater equity in how we address social factors in health.

State of Reform, Social Determinants of Health and Health Equities presentations, January 2022.

Accountable Communities of Health Medicaid Transformation Projects, 2016-2022

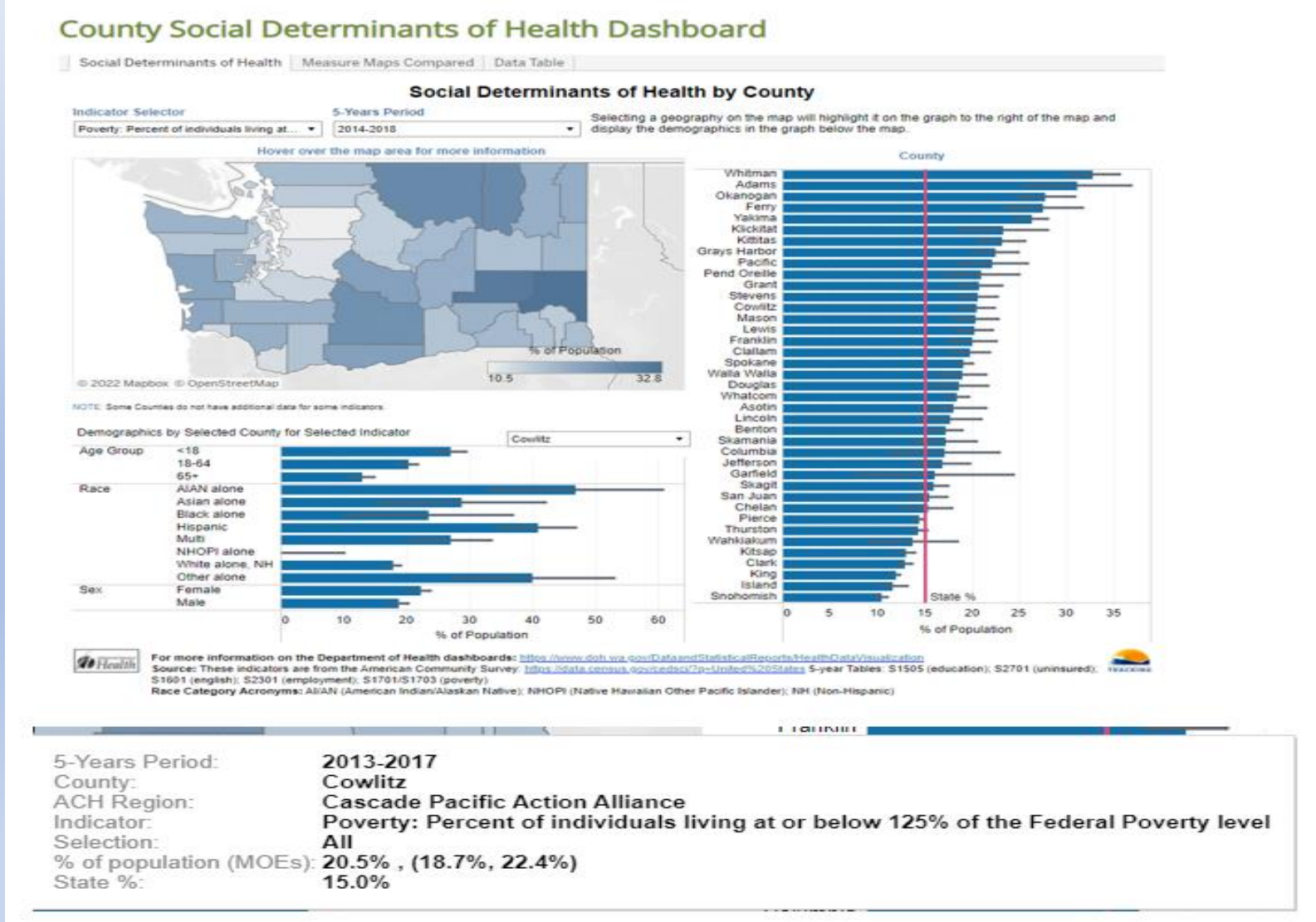
- Maternal and Child Health
- Integrated Behavioral Health
- Social Determinants of Health
- Health Equity
- Care Coordination
- Pathways Health Navigators
- Community Health Workers

Taking Action on the Social Determinants of Health in Clinical Practice and the Community

- Data registry
- Screening
- Referral
- Access and engagement
- Partnership

Annie Andermann, MD, PhD, CMAJ Podcast, “Taking Action on SDOH: A Framework for Pediatric Primary Care” 2016. DOI:M.1503/cmaj.160177.

Cowlitz County Social Determinants of Health



Social Determinants of Health Screening Universal / Every Patient Every Visit

August 1 to December 31, 2021

- 85,995 visits for 28,828 patients (3 visits per pt)
- 875 referrals for 785 people (1% of visits)
- 295 of referrals were homeless (34% of referrals)
- 54 patients spoke a language other than English (7% of referred pts)
- 283 patients were from under-represented racial or ethnic groups (36% of referred pts)

CPAA Health Equity Mini-Summit Learning Collaborative, Jan 2022, Partner Data Presentation regarding SDOH Screening

Social Determinants of Health Clinical Community Linkage

- Screening
- Funding
- Staffing
- Workflow
- Data collection
- Partnership

Annie Andermann, MD, PhD, CMAJ Podcast, “Taking Action on SDOH: A Framework for Pediatric Primary Care” 2016. DOI:M.1503/cmaj.160177.

Community Partners
Cross-Sector Collaboration

- $1 million Grant to Help SW WA Nonprofit with COVID-19 Outreach (The Columbian, Vancouver, WA)
- Behavioral Health Access in Rural Primary Care (Cascade Pacific ACH)
- Kaiser award $514,000 to 21 SW WA Non-Profits (The Daily News, Longview, WA)
- Unite Washington (UniteUs.com)
- Health and Nutrition for Homeless Students (Longview, McKinney-Vento)

Senate Bill 5894

- Senator Frockt introduced SB5894 at the 2022 Regular Session to be enacted by the Legislature of the State of Washington.
- The legislature finds that whole-person care that includes access to behavioral health, care coordination, and social supports at the point of entry is essential for families.
- The legislature intends to invest in primary care transformation, accomplished through a multipayer primary care transformation model developed by the health care authority in consultation with stakeholders across the health delivery system.
- By January 1, 2023, managed care organizations shall make reimbursement for care coordination services performed by non-licensed staff acting in the role of a health navigator available to primary care clinics.
- Health Navigators become a member of the health care team to help individuals overcome barriers and facilitate their access to services.

https://app.leg.wa.gov/billinfo/

Thank you for listening!

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Child & Adolescent Clinic
SPECIALIST CARE FOR EVERY CHILD

Panel

Source: NASA via Unsplash

Area Deprivation Index

https://www.neighborhoodatlas.medicine.wisc.edu/

Based on a measure created by the Health Resources & Services Administration over two decades ago for primarily county-level use

Refined, adapted, and validated to the Census block group/neighborhood level by Amy Kind, MD, PhD and her research team at the University of Wisconsin-Madison

Allows for rankings (groupings) of neighborhoods by socioeconomic disadvantage in a region of interest, e.g., statewide or nationally

Includes domains of **income, education, employment, and housing quality**

Can be **used to inform health delivery and policy**, especially for the most disadvantaged neighborhood groups

Has been **correlated with health outcomes** including all-cause cardiovascular, cancer, and childhood mortality; cervical cancer prevalence; etc.

Value-Based Care Change in Action 2022 Webinar Series

- April 7 | Interoperability
- July 7 | Quality Measures
- October 6 | Multi-Payer Initiatives

Source: Alexander Sinn via Unsplash