Transforming Child Health Care Through Anti-Racist, Family-Driven Approaches: Three Perspectives on the Need for Acceleration

August 25, 2021, 1:30 – 2:45pm ET

Made possible through support from the Robert Wood Johnson Foundation
Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.
Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

- **Effective models for prevention and care delivery** that harness the field’s best thinking and practices to meet critical needs

- **Efficient solutions for policies and programs** that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.

- **Equitable outcomes for people** that improve the overall wellbeing of populations facing the greatest needs and health disparities.
Agenda

• Accelerating Child Health Transformation Initiative & Introductions
• The Role of Dignity in Child Health Care Transformation
• Promoting Anti-Racism in Child Health Care from a Pediatrician’s Perspective
• Benefits of Co-Creating Equitable Partnerships with Patients, Families, and Medical Care Teams
• A Systems Approach to Identifying Strengths and Addressing Health-Related Social Needs
• Questions & Answers
ACHT is convening leading experts, pediatric providers, and family advisors across the nation to accelerate child health care transformation by:

• Creating a national learning community to promote the adoption of key strategies to child health care transformation;

• Identifying accountability measures and financing structures that support and accelerate widespread adoption; and

• Developing, testing and disseminating comprehensive and adaptable resources to support an effective practice transformation.

This initiative is led by CHCS and made possible through support from the Robert Wood Johnson Foundation.
Accelerating Child Health Transformation

Key strategies to transform child health care, beyond medical care:

- Adopting **anti-racist practices and policies** to advance health equity.
- Co-creating **equitable partnerships** with patients, families, and providers.
- Identifying **family strengths and** addressing health-related social needs to promote resilience.
Meet Today’s Presenters

Renee Boynton-Jarrett, MD, ScD
Boston Medical Center and Vital Village Networks

Ben Danielson, MD
University of Washington Medicine

Hala Durrah, MTA
Patient and Family Engagement Advocate

Carey Howard, MPH
Center for the Urban Child and Healthy Families at Boston Medical Center
The Role of Dignity in Child Health Care Transformation

Renee Boynton-Jarrett, MD, ScD
Boston Medical Center & Vital Village Networks
Dignity and Abundance
In the Anti-Racism Journey

Ben Danielson  August 2021
Ignore Honor Difference
Building our ability to understand each other’s experiences
The appearance of equity
The appropriation of equity
The pitting of equity
The delaying of equity
The selling of equity
**Equity Bill of Rights**

- **Article I**
  - Right to dignity

- **Article II**
  - Freedom of full expression of identity

- **Article III**
  - Right to quality, culturally relevant healthcare

- **Article IV**
  - Right to appropriate diversity

- **Article V**
  - Right to equity accountability

- **Article VI**
  - Freedom from tokenization

- **Article VII**
  - Right to one’s story

- **Article VIII**
  - Freedom from erasure

- **Article IX**
  - Community centered decision-making

- **Article X**
  - Freedom from denigration
Assuming Brilliance

You already possess everything necessary to become great.
We Are All On The Same Team- The Value of Family Partnerships and Patient/Family Engagement

Accelerating Child Health Transformation (ACHT) Webinar
August 25, 2021
Hala Durrah, Patient Family Engagement Consultant, ACHT Core Faculty and Family Advisory Team Lead
Level Setting-
What is Patient Family Centered Care?

• **Patient- and family-centered care** is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families.

• It redefines the relationships in health care by placing an emphasis on **collaborating** with people of all ages, at all levels of care, and in all health care settings.

• In patient- and family-centered care, patients and families define their “family” and determine how they will participate in care and decision-making.

Institute for Patient Family Centered Care  www.ipfcc.org

Also visit AAP website for more information-  [https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/youth-family-centered-care.aspx](https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/youth-family-centered-care.aspx)
Level Setting- What is Patient Family Engagement?

Patient and family engagement:

• Is an important component of patient- and family-centered care.

• Creates an environment where patients, families, clinicians, and staff all work together as partners to improve the quality and safety of care.

Involves patients and family members as:

• Members of the health care team.

• Advisors working with clinicians and leaders to improve policies and procedures.

Agency for Healthcare Research and Quality (AHRQ), www.ahrq.gov
Nothing About Me Without Me

• Not FOR patients, families, and communities BUT WITH patients, families, and communities

• Not one-way communication but two-way communication

• Not a one-size fits all approach; meet people where they are at and want to be, no assumptions. Equity versus equality

• Co-design and co-creation- patients, families, and communities are part of the care team, are equal and equitable partners from A-Z

• Measuring what matters- Patient Centered Measurement
Value of Partnerships

- Empowerment of patients, families and communities to participate in their care to support better outcomes and to establish a relationship with the practice
- Inclusion and respect for patients and families’ experiences and perspectives
- Undermining inequitable systems by creating a partnership whereby the entire care team, which is inclusive of patients and families, will meaningfully communicate and exchange information (i.e., shared decision making)
Examples of Partnerships in Practice

• CHCS ACHT Family Advisory Team

• Parents and medical staff having open, honest, two-way discussions on what is working and what is not in treating a child – Parents of children with disabilities/special health care needs do not have to argue to have their opinion, perspective and expertise regarding their child heard.

• Fathers are welcomed and made to feel like an important part of the decision-making process regarding the care of their child

• Thinking “outside” of the practice when designing outreach opportunities into the community (i.e., partnerships with barbershops)

• Multi-generational approaches in practice (i.e., home visitation models, maternal depression screening, etc.)
Partnering with Families to Identify Strengths & Address Health Related Social Needs

Carey Howard
Program Director
Center for the Urban Child and Healthy Family
Background: Disturbing Trends in Child Poverty

• Rates of children living in poverty in the US are astronomically high and increasing with the COVID pandemic
  • More children live in poverty than people in any other age group
  • Child poverty rate predicted to increase above 20% with pandemic
  • Health related social needs related to poverty include food insecurity, housing insecurity, and so many others

• Experiences with poverty and the accompanying health-related social needs have been associated with a wide range of adverse physical health, emotional health and educational outcomes for children over time
Deficit vs. Dignity Lens

- **BUT** using a deficit framework to address health-related social needs is not getting to the root causes
  - Inequities persist
  - Families and communities are made up of strengths and assets that are key to identifying solutions
  - Partnering with families to understand and address their goals and priorities is key
- **Must recognize and name role of structural racism**
Standard of Care: SDOH Screening

- Many health systems have adopted a standardized “social determinants of health” screening tool
- Responses are recorded in the patient medical record
- Often coupled with referral and/or connection to resources (e.g. WIC, SNAP, etc.)
- Some health systems have access to support staff, such as CHWs who help facilitate these resource connections
At Boston Medical Center, Pediatrics is piloting a new model of primary care that was co-created with families and is driven by four guiding principles:

- **Care team embraces the knowledge that a family’s wellness is defined by cultural, environmental, and community factors beyond physical health.**
- **Families in the driver’s seat, understanding that they are the experts in setting priorities and goals for their families’ wellbeing.**
- **Over time, care continuously builds on the strengths and progress of families through a family wellness plan.**
- **Care transcends episodic, need-based encounters.**
Co-Creating Tools that Illuminate Families Strengths and Priorities for Care

Family Eco-Mapping:

- Family-driven process to provide a comprehensive picture of a family’s ecosystem at a given time
- Allows family to define what their family looks like, and what they view as priority services, programs, and supports
- Illuminates areas of strength and support within a family that are not always reflected in healthcare (family supports, community, church, etc.)
- Opens a conversation between the care team and family to identify together areas of strength, support, and stress
Co-Creating Tools that Illuminate Families Strengths and Priorities for Care

• Family Visit Agenda:
  • Explicitly centers the visit around the goals and priorities of the family
  • Provides a grounding at the start of the visit for the family and team to check in about how things are going
  • Shifts the dynamic of power to a collaborative model where both priorities of the family and the care team can be discussed and agreed upon
Future Steps and Challenges

• Future steps as a field include moving towards assessment of health-related social needs in a way that engages families, leads with and celebrates strength, holds the medical team accountable for follow-through, and focuses on families’ priorities for change.

• Aspiration is simple, execution complex
  • Requires systems change (teaming)
  • Payment reform
  • Field focusing on anti-racism efforts at multiple levels
  • Continued partnership of families with their voices leading to tangible changes
Question & Answer
Questions?

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