The Integrated Care for Kids (InCK) Model and Health Equity

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Of all the forms of inequality, injustice in health care is the most shocking and inhumane.
Webinar Agenda

1. About InCK Model and InCK Marks
2. What the InCK Model (NOFO) says and requires in applications
3. Framing SDOH and equity
4. How can applicants focus on TWO ACES and building community resilience
5. What child health and health equity champions can do
6. Next Steps for InCK Marks

Purpose of Federal InCK Model

The Integrated Care for Kids (InCK) Model will test whether combining a local service delivery model coordinating integrated child health services and a state-specific alternative payment model (APM) to support coordination of integrated services reduces health care expenditures and improves the quality of care for pediatric Medicaid and CHIP beneficiaries.
Basics – Federal InCK Model

• Provides up to $16 million in funding over 7 years to eight states in competitive application model ($128 million total)

• Applications described in Notice of Funding Opportunity (NOFO) are due June 10, 2019

• Funds to plan and design and implement an alternative payment model and integrated service delivery models for children prenatal to 21 within a specific, sub-state geographic area

• State Medicaid agency must be involved and partner with a Lead Organization (key to local level implementation) to develop an integrated community model.

• Emphasis is on reducing and preventing unnecessary out-of-home placements and hospitalizations of children, preference given to “two generation” approaches.

What are the MUSTs in the InCK Model?

• **Risk stratify child population** into service integration levels (SILs) based upon child conditions/risks and multiple service system involvement.

• Conduct **root cause analysis** for out-of-home placements.

• Provide **care coordination** for risk stratified populations and care coordination and team-based care for children in out-of-home or at risk of out-of-home placements/hospitalizations.

• Focus on a set of **core services** and establish mobile crisis response teams as part of core services.

• Provide health outcomes and cost savings projections and data.
InCK Marks: Purpose and Disclaimer

• InCK Marks developed under funding from the Robert Wood Johnson Foundation and the Perigee Fund to:

provide resources and supports to child health advocates and experts, practitioner champions, family and community leaders, state administrators, and policy makers regarding reviewing and developing applications for the InCK model

• InCK Marks has no affiliation with CMS, produces only nonproprietary information, and does not claim to be an authoritative source for developing a competitive grant proposal
Focusing on Equity to Improve InCK and Child Health

Kay Johnson, Johnson Group Consulting
InCK Marks National Advisory Team Chair

Child Health and Health Equity Defined

Child health (birth to 21)

- “The extent to which an individual child or groups of children are able or enabled to a) develop and realize their potential; b) satisfy their needs and c) develop the capacities to allow them to interact successfully with their biological, physical and social environment.” (Institute of Medicine, 2004)

- Child health is the “full range of health constructs, including physical health, developmental, social, emotional and behavioral health, oral health, nutrition, and physical activity.” (U.S. DHSS; U.S. DOE; InCK Model Notice of Funding Opportunity)

Health equity is achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices. (Healthy People 2020)
Interface of disparities, SDOH, and equity

- Not all health differences are disparities.
- Health disparities are systematic, avoidable health differences reflecting racism, classism, ableism, or other factors related to social disadvantage.
- Disparities—reflecting both biomedical and social determinants of health (SDOH)—are the metric for assessing health equity.
- Health equity is the principle underlying a commitment to reducing disparities in health and its determinants.
- Health equity is social justice in health.

Beyond documenting disparities

- In 1985, HHS Secretary Heckler issued report on persistence of racial disparities in health, including infant mortality and child health.
- In 2002, IOM study *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* focused our attention on bias, inequity in care.
- Healthy People 2010: an overarching goal on eliminating health disparities.
- Healthy People 2020: overarching goals to achieve health equity, eliminate disparities, and create social and physical environments that promote good health for all (SDOH).
- Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people."
- Leaders today focusing on ACTION to ensure equity.

Diversity, Equity and Children: Basic Facts

**Children are the age group with most racial/ethnic diversity**

Percent of Age Group that is Non-white or Hispanic

<table>
<thead>
<tr>
<th>Age Group</th>
<th>0-4</th>
<th>5-17</th>
<th>Adults 18-64</th>
<th>Seniors 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Children are the age group most likely to live in poverty**

Percent of Age Group with Income Below Federal Poverty Level

<table>
<thead>
<tr>
<th>Age Group</th>
<th>0-4</th>
<th>5-17</th>
<th>Adults 18-34</th>
<th>Adults 35-64</th>
<th>Seniors 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td>20%</td>
<td>25%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: Census Bureau. American Community Survey.
Concentrated disadvantage

Among young children, 38% of African Americans, 32% of Native Americans, and 29% of Hispanics live in census tracts where the poverty rate is >40%, compared to 8% of White, Non-Hispanics.

Poorest census tracts are:
- “rich” in the proportion of young children,
- highly racially segregated,
- separated from many sources of economic opportunity, and
- in need of community building.

Inequities and their Consequences

- Exposure to effects of structural racism.
- Disproportionate number of children of color in foster care, special education, and juvenile justice.
- Disparities by race/ethnicity in:
  - Health outcomes (infant mortality, asthma, obesity, ACEs, PTSD, etc.)
  - Participation in preschool, preventive care, and developmental services
  - Exposure to environmental hazards and unsafe environments
- Results in reduced life expectancy, general well-being, and likelihood of being “middle class by middle age”.

Medicaid and Health Equity

- Medicaid covers most low-income children and therefore most children of color.
- Medicaid financing should support health services and systems that focus on achieving health equity.

Looking at InCK NOFO with SDOH and equity lens

- Preventive measures delivered during the earliest years of life can mitigate the effects of adverse childhood experiences (ACEs)... (NOFO p.8)
- Applicants must include all Medicaid- and CHIP-covered children residing in the model service area in their attributed population 0-21. (NOFO p.15)
- Applicants must submit ‘before’ and ‘after’ care maps that demonstrate how access to and coordination of Core Child Services will change the experience of care for children. (NOFO p.19)
- Root case analysis should provide detailed information on the size and characteristics of at least 80% of pediatric Medicaid (and, if applicable, CHIP) population in model service area … should include any significant needs that impact the population’s health, and details on any subpopulations with special health needs. (NOFO p.29)
InCK Marks view on opportunities to address health equity within federal InCK Model

• While the InCK NOFO itself does not reference health equity or disparities by race/ethnicity, language, and ability, the InCK Marks framework emphasizes that achieving InCK objectives are not possible without doing so.

• States and lead organizations can and should include specific reference and strategies.

NOFO language for grounding an equity lens

• Lead Organization will be responsible for improving population-level care quality and outcomes (p. 11)

• The Partnership Council must include … community stakeholder representatives (p.12)

• Level 2 features integrated care coordination across Core Child Services to facilitate individualized, family- and child-driven, and ethnically, culturally, and linguistically appropriate care delivery… Awardees must ensure that children in Level 3 receive the integrated care coordination services provided at Level 2 (p. 22)

• Applicants must identify health conditions that are the root causes of out-of-home placements of their attributed population (to include any institutional or residential setting of care, foster care, and juvenile detention) (p. 29)

• In their population scan and root cause analysis, applicants should provide background population level demographic information of the target community (p. 47)
Root Cause Analysis – Getting to Health Equity

• **Cause for children currently in or at imminent risk of placement:**
  - Lack of options for keeping child safe and receiving care without placement
  - Absence of crisis response team and capacity for triage and stabilization without placement
  - Lack of coordinated services or services lacking racial/ethnic, cultural, and linguistic competence

• **Cause for children with conditions getting to the point of being at imminent risk**
  - Child conditions (physical, social, emotional, developmental) not identified or responded to, resulting in worsening severity of behaviors or conditions or episodes placing child at imminent risk (e.g., parent substance use, depression, neglect). Describe insufficient responses for children of color.

• **Cause for children developing conditions in the first place**
  - Childhood ACES and/or other social determinants of health such as family stress, economic insecurity, and family instability and lack of nurturing, including failure to address impacts of racism on parental/child health and resiliency

• **Cause for families being in compromised positions that can lead to trauma/stress**
  - Discrimination, unsafe neighborhoods, and segregation leading to more barriers to providing a safe, stable, home environment

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Equity & Child Core Services

• Children of color are disproportionately and inequitably represented in the InCK Model core service areas.

• Lead Organizations must coordinate the systematic integration of Core Child Services within model service area for the purposes of integrated care coordination and case management.

• How can Lead Organizations and community partners coordinate these services to advance equity?
Building Community Resilience

May 7, 2019

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Learn More: go.gwu.edu/BCR

Cincinnati, OH
Washington, DC
Oregon
Alive & Well Communities (MO-KA)
Dallas, TX

Word 8 Health Council
The Pair of ACES

Adverse Childhood Experiences

Maternal Depression
Physical & Emotional Neglect
Emotional & Sexual Abuse
Divorce
Substance Abuse
Mental Illness
Domestic Violence
Incarceration
Homelessness

Adverse Community Environments

Poverty
Discrimination
Community Disruption
Lack of Opportunity, Economic Mobility & Social Capital
Violence
Poor Housing Quality & Affordability


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Theory of Community Resilience

Components of Community Resilience

Information & Communication
Skills & Infrastructure
Trusted Sources of Information
Narratives of the Community

Community Competence

Community Action
Collective Action & Efficacy
Political Partnerships
Critical Reflection & Problem Solving Skills

Social Capital

Received & Perceived Social Support
Organizational Linkages & Cooperation
Citizen Participation, Leadership & Roles
Attachment to Place
Sense of Community

Level & Diversity of Economic Resources
Equity of Resource Distribution

Economic Development

Community Resilience Networked Capacities
Source: Norris, et al. (2007)
Systems Driven Adversity

Population Health & Community Outcomes

Policies & Systems

Trauma

Equity

Resilience

The Power of Collaboration

Building Community Resilience:
Process of Assessment, Readiness, Implementation & Sustainability

Shared Understanding

State of Readiness

Community

Cross-Sector Partners

- ACEs
- Resilience
- Narratives of the Community

- Provider Capacity/ Capability
- System Capacity/ Capability
- Policy Supports

- Organizational Linkages
- Citizen Leadership
- Social Supports
- Attachment to Place

- How to Connect
- Resource Distribution
- Community & Political Partnerships
- Collaboration

BCR : Changing Program, Practice & Policy

Building Community Resilience Mapping Assets Guide: This guide will help you sort through the types and sources of data to assemble when mapping assets. The data collected can be visually placed on a map of the service area to demonstrate the current infrastructure of services that can be built upon, as well as to identify gaps and where resources overlap. It can ultimately be used to strengthen health and community-based systems’ readiness, capacity, and linkages to address and mitigate the impacts of ACE’s.

<table>
<thead>
<tr>
<th>Sample Types of Data</th>
<th>Source</th>
<th>Who to Contact</th>
<th>Who will lead outreach</th>
<th>Data Available</th>
<th>Data Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Children under 18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty rate</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Children poverty rate</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known ACEs/ Child maltreatment rates</td>
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</tbody>
</table>
BCR Coalition Building & Communications Guide

- Defines key terms and concepts
  ACEs, community resilience, SDH, trauma-informed care

- Talking points
  “ACEs are an American public health problem.”
  “Every system or organization that touches an aspect of a child’s life and family can contribute to community resilience.”

Download the tools at go.gwu.edu/BCR

What’s in our soil?

Adverse Community Environments

Rate of violent crimes (per 100,000 ppl)
- St. Louis County: 298 crimes
- St. Louis City: 1,703 crimes
- Jackson County: 823 crimes
- Clay County: NA

% children living in poverty
- St. Louis County: 13%
- St. Louis City: 38%
- Jackson County: 23%
- Clay County: 11%

% severely unaffordable or unsafe homes
- St. Louis County: 14%
- St. Louis City: 23%
- Jackson County: 17%
- Clay County: 12%

% low-income families with limited access to a grocery store
- St. Louis County: 6%
- St. Louis City: 3%
- Jackson County: 7%
- Clay County: 6%

Rate of drug overdose deaths (per 100,000 ppl)
- St. Louis County: 516
- St. Louis City: 287
- Jackson County: 336
- Clay County: 15

Go to go.gwu.edu/bcrsnappcite for data source information.
What Does Resilience Look Like?

BCR is working to transform programs, practices, and policies across systems to improve the health and life outcomes of children, families, and communities.

- Fewer children in foster care
- Fewer youth in mental health crisis
- Fewer justice-involved youth
- Supported families & healthy households
- Reduced crime
- Families drawing on their strengths
- Steady employment
- Connected systems & supports

BCR Policy and Advocacy Guide

The guide can help your team:

- Answer FAQs about policy
- Identify top policy priorities
- Choose target offices
- Craft messages to target offices
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Opportunities for Equity Advocates to Improve InCK

Maxine Hayes, MD, MPH, FAAP
InCK Marks National Advisory Team Co-chair

Opportunities for Advocacy within InCK Model

**Content**
- Root cause analysis should address pair of ACEs
- Care coordination and care teams should reflect diversity of community and be culturally and linguistically responsive
- Outcome analysis should look at racial and other disparities

**Process**
- Diverse leaders and advocates should be part of the planning, design, and implementation process, including:
  - Medicaid work on designing alternative payment mechanisms (APMs)
  - Lead Agency selection and oversight
  - Partnership Council membership
  - Care mapping and community asset mapping
Roles for Equity Advocates – Ask to InCK Planners

• **Be specific and actionable:** Recognize the importance of addressing issues of disparities and equity in InCK planning.

• **Apply what we know:** Develop supportive data and information related to child health disparities and equity.

• **Use expertise:** Invite us/others to share knowledge about strategies to improve equity as part of the planning process AND include diverse community members in InCK Partnership Council.

• **Use networks:** Identify others at the state and community level who can contribute to planning and implementation.

• **Think community:** Include adverse community experiences in the root cause analysis and address in project design.

Talking Points – Advocates Making Marks for InCK Health Equity

• **Medicaid is part of the solution.**
  • Medicaid can and must play a key role in improving health equity for children and reducing health disparities.

• **We know enough to act.**
  • More relational, and two generation primary health care responses are key to reducing health disparities for children – ones that are culturally, linguistically, and socio-economically responsive and aligned.
  • Clinical and public health practitioners are effective as advocates and leaders in ensuring health equity is addressed as part of any health reform activities.

• **We must build upon what we know.**
  • Community health equity leaders, child health practitioner innovators, public health activists, child health advocates, and families and children most affected by health disparities are essential to guiding Medicaid reforms to improve child health.
Other Webinars:

- InCK Model Overview *(March 5 on website)*
- InCK Model and the Medicaid EPSDT Benefit *(March 19 on website)*
- InCK Model and Family Engagement *(April 2 on website)*
- InCK Model, Prevention, and Building a Culture of Health *(April 9 on website)*
- InCK Model, Two Generation Strategy the First 1000 Days *(April 30 on website)*

InCK Marks Commissioned Resource Briefs:

- Guiding Framework *(includes appendices by ages/stages of development)*
- The InCK Model, Adolescents, and Behavioral Health *(with Mental Health America)*
- The InCK Model, Medicaid and Child Welfare Coordination *(with Center for the Study of Social Policy)*
- The InCK Model and Risk/Strength Stratification *(with Child and Adolescent Health Measurement Initiative)*
- The InCK Model and Maternal and Infant Health
- The InCK Model and the Prevention of Obesity

- Key Issues Sections on *[www.inckmarks.org]*
- Medicaid and EPSDT
- Value-Based Care, Risk Stratification, and Preventive Health
- Exemplary Early Childhood Primary Care Practices
- Opioids, Foster Care and Behavioral Health

Next Steps: Champions

- Complete Survey on Webinar
- Sign up for and participate in future webinars
- Visit *[www.inckmarks.org]*
- Share state experiences
- Provide ideas for InCK Marks activities

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