
Center for Health Innovation Project
ECHO Series Human Centered Design:

"Keeping people the focus while addressing services for opioid use disorder in non-urban communities of New Mexico."

**Session 6:**
**Systems Level Change**

**Anjali Taneja, MD MPH, FASAM**
Executive Director
Casa de Salud

# Goals

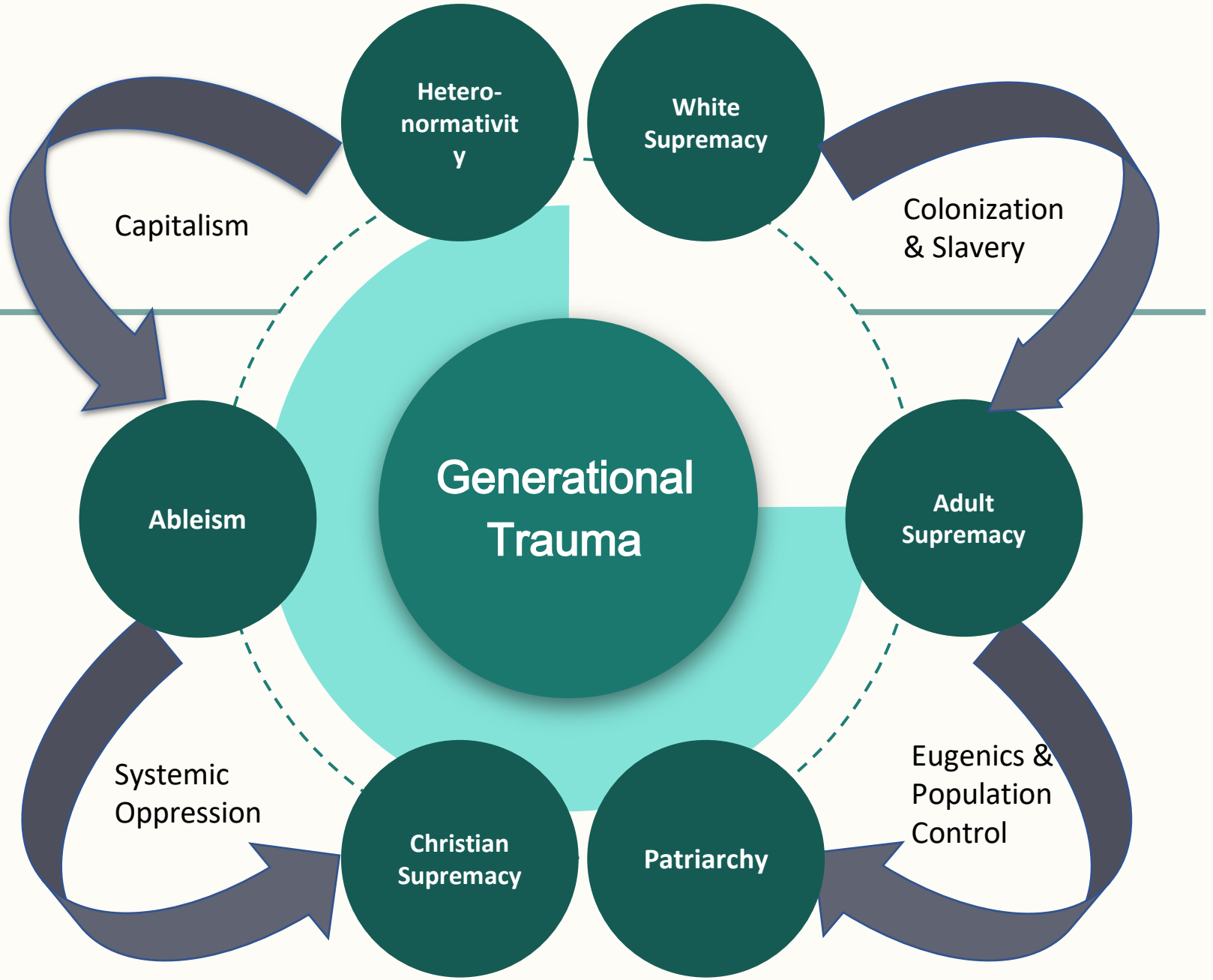
- Describe system level barriers
  - Context of structural issues including medical industrial complex, poverty, policies, racism, colonization
  - Current system issues
- Big picture policy approaches
- Exploration of what we can do in our own systems
  - Example of Casa de Salud's reflections and improvement process

# System level structural issues/barriers

Some examples:

- Effects of drug war, criminalization, incarceration, poverty, racism, colonization, generational trauma
- The medical industrial complex
- Medication assisted treatment (in community and in prisons/jails)
- Transitional housing and services post-incarceration
- Insurance/access barriers (Medicaid re-enrollment barriers, etc)
- Structural issues with health, behave health workforce
- Lack of harm reduction approach (vs stigmas; morality in the system)
- Lack of education and empowerment in community (family, community)

# The Medical Industrial Complex



# Does Diversity Matter for Health? Experimental Evidence from Oakland

Marcella Alsan, Owen Garrick, Grant Graziani

June 2018

- 1,300 black men from Oakland, CA. 14 black & non-black male doctors.
- Black people comprise approximately 13% of the U.S. population but only 4% of physicians and less than 7% of recent medical school graduates
- Upon interacting with their doctor, subjects assigned to black doctors increased screening services by 16 percentage points compares to non-black doctors

# Does Diversity Matter for Health? Experimental Evidence from Oakland

Marcella Alsan, Owen Garrick, Grant Graziani
June 2018

- Evidence pointed to better trust and communication between black subjects and black doctors than between black subjects and non-black doctors (based on subject feedback forms and doctor notes)
- Subjects were 29% more likely to talk with black male doctors about their health problems outside of offered screenings
- Black doctors were able to convince 26% of subjects to get the flu shot who initially declined the flu shot, even after an incentive was offered
- **It was calculated that increased screening could lead to a 19% reduction in the black-white male cardiovascular mortality and a 8% decline in the black-white male life expectancy gap**

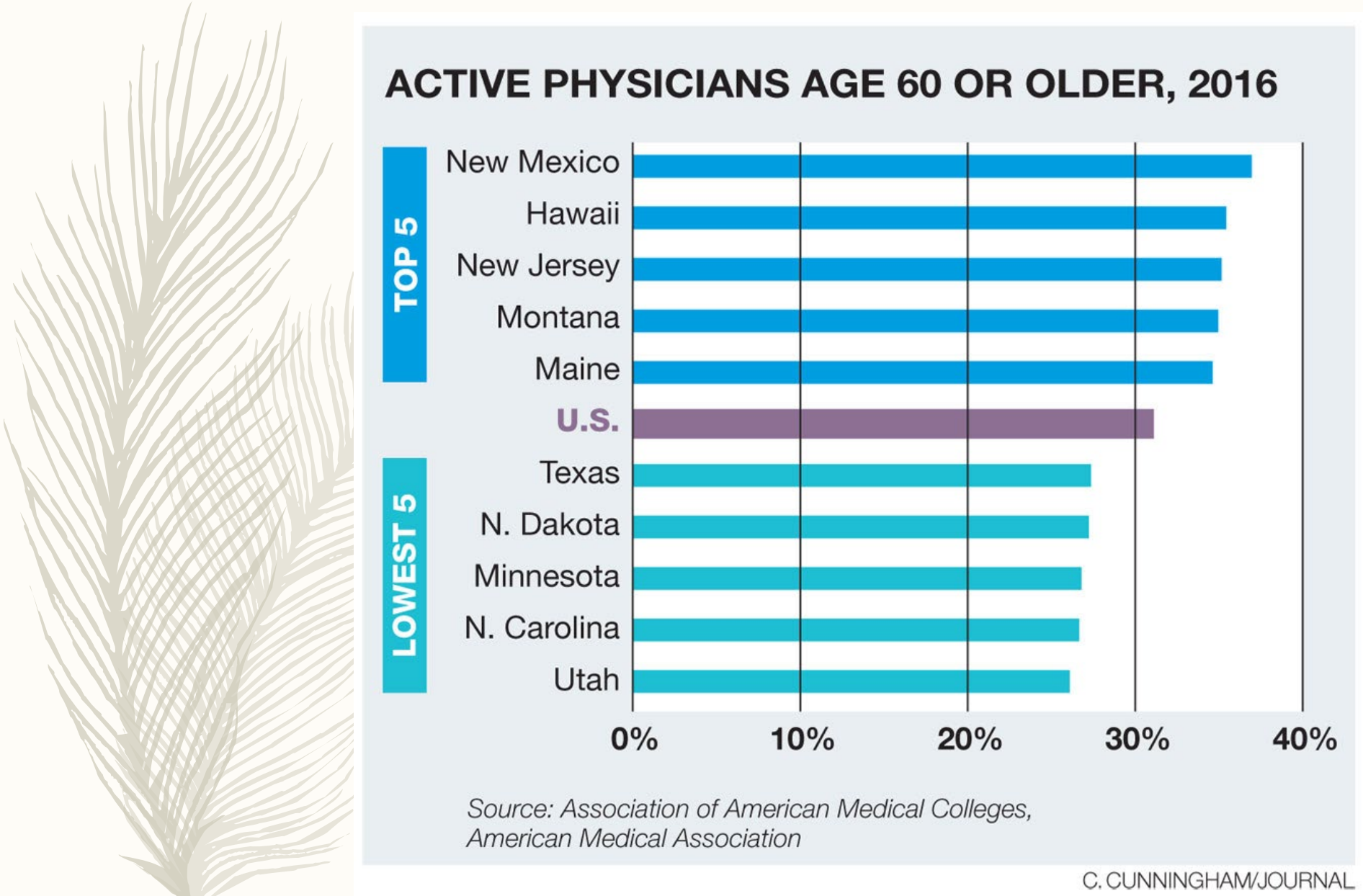
# Underrepresented Groups in Medical School, 1997 and 2017.*

| Underrepresented Groups in Medical School, 1997 and 2017.* | | | |
|---|---|---|---|
| **Variable** | **1997** | **2017** | **Percent Change** |
| No. of first-year medical school slots | 18,857 | 29,118 | 54 |
| No. of matriculants from underrepresented groups | 2850 | 3713 | 30 |
| Percent of matriculants from underrepresented groups | 15 | 13 | –16 |
| No. of people from underrepresented groups in U.S. population | 65,497,000 | 106,835,890 | 63 |
| No. of matriculants from underrepresented groups per 100,000 population | 4.3 | 3.5 | –20 |

* Underrepresented groups are defined as American Indians or Alaska Natives, blacks, and Hispanics or Latinos. Data are from the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the U.S. Census Bureau.

E Talamantes et al. N Engl J Med 2019;380:803-805.

The NEW ENGLAND JOURNAL of MEDICINE


ACTIVE PHYSICIANS AGE 60 OR OLDER, 2016
TOP 5
New Mexico
Hawaii
New Jersey
Montana
Maine
U.S.
LOWEST 5
Texas
N. Dakota
Minnesota
N. Carolina
Utah
0%
10%
20%
30%
40%
Source: Association of American Medical Colleges, American Medical Association
C. CUNNINGHAM/JOURNAL

# Statewide Youth Treatment Planning Grant – Workforce Mapping in Behavioral Health 2016

## Age: Which age category represents your current age?

| Response | Chart | Percentage | Count |
|---|---|---|---|
| Under 20 years old | | 0.6% | 11 |
| 20 to 29 years old | | 3.2% | 60 |
| 30 to 39 years old | | 15.2% | 290 |
| 40 to 49 years old | | 21.2% | 404 |
| 50 to 59 years old | | 24.9% | 473 |
| 60 to 69 years old | | 28.2% | 537 |
| Over 70 years old | | 6.7% | 128 |
| | | **Total Responses** | **1903** |

50 thru >70: 60%
60 thru >70: 35%

## Gender version 1.0

Gender

| Response | Count | |
|---|---|---|
| **Female** | 771 | 77.9% |
| **Male** | 219 | 22.1% |
| | *Total:* 990 | |



## Gender version 2.0

| Response | Chart | Percentage | Count |
|---|---|---|---|
| Female | | 76.8% | 1453 |
| Male | | 21.5% | 406 |
| Transgender (specify if desired) | | 0.4% | 7 |
| Prefer not to answer | | 1.2% | 23 |
| Self-Identify (specify if desired) | | 0.2% | 3 |
| | | Total Responses | 1892 |



## Culture findings 1.0

Are you Hispanic/Latino?

| Response | Count | |
|---|---|---|
| **Yes** | 262 | 26.8% |
| **No** | 715 | 73.2% |
| | *Total:* 977 | |

## Culture findings 2.0

### Do you identify with any of the following ethnic categories:

| Response | Chart | Percentage | Count |
|---|---|---|---|
| American Indian or Alaskan Native | | 6.5% | 123 |
| Black or African American | | 2.7% | 51 |
| White | | 63.4% | 1200 |
| Asian | | 0.8% | 16 |
| Native Hawaiian or other Pacific Islander | | 0.3% | 6 |
| Hispanic/Latino | | 27.1% | 513 |
| Do not identify with an ethnic category | | 2.5% | 47 |
| Prefer not to answer | | 4.1% | 77 |
| Other (specify if desired) | | 2.9% | 55 |
| | | Total Responses | 1894 |

## In what language(s) are you able to provide services?

| Response | Chart | Percentage | Count |
|---|---|---|---|
| Spanish | | 20.1% | 376 |
| Tewa | | 0.2% | 3 |
| Tiwa | | 0.3% | 5 |
| Keres | | 0.2% | 4 |
| Towa | | 0.2% | 3 |
| Zuni | | 0.2% | 4 |
| Navajo/Dine | | 1.5% | 28 |
| Apache (specify if desired) | | 0.1% | 2 |
| English | | 97.6% | 1827 |
| Other, (specify if desired) | | 3.3% | 61 |
| | | Total Responses | 1871 |



## Reflections…

- How do we recruit more males into our workforce?
- How do we recruit and retain bi-lingual providers?
- How do we support those individuals once recruited?



## Highest Degree Achieved

| Response | Chart | Percentage | Count |
|---|---|---|---|
| High School Diploma/GED | | 0.9% | 17 |
| Associates | | 1.1% | 21 |
| Bachelors | | 5.6% | 106 |
| Masters | | 76.8% | 1454 |
| Doctorate | | 15.3% | 289 |
| MD | | 0.1% | 1 |
| Juris Doctorate | | 0.2% | 4 |
| None | | 0.1% | 1 |
| | | Total Responses | 1893 |

## Licensure(s) / Certifications

(check all that apply)

| Response | Chart | Percentage | Count |
|---|---|---|---|
| LSAA | | 3.1% | 59 |
| LADAC | | 7.0% | 132 |
| LMHC | | 9.6% | 181 |
| LAMFT | | 0.3% | 5 |
| LMFT | | 4.4% | 83 |
| LPAT | | 1.4% | 27 |
| LPC | | 3.6% | 68 |
| LPCC | | 27.5% | 518 |
| LMSW | | 14.6% | 275 |
| LISW | | 8.1% | 153 |
| LCSW | | 21.2% | 399 |
| Clinical Psychologist (non prescribing) | | 9.1% | 171 |
| Clinical Psychologist (prescribing) | | 1.0% | 19 |

# Motivational Interviewing

Do you receive adequate supervision in this model?

| Response | Count | |
|---|---|---|
| **Expert Supervision** | 91 | *14.0%* |
| **Adequate Supervision** | 197 | *30.2%* |
| **Inadequate Supervision** | 83 | *12.7%* |
| **No supervision in this model** | 281 | *43.1%* |
| | *Total:* 652 | |

# Medication Assisted Therapy (MAT)

How familiar are you with this model?

| Response | Count | |
|---|---|---|
| **Very Familiar** | 119 | *15.9%* |
| **Somewhat Familiar** | 168 | *22.5%* |
| **Not At All Familiar** | 460 | *61.6%* |
| | *Total:* 747 | |

# Medication Assisted Therapy (MAT)

Do you receive adequate supervision in this model?

| Response | Count | |
|---|---|---|
| **Expert Supervision** | 43 | *16.3%* |
| **Adequate Supervision** | 87 | *33.0%* |
| **Inadequate Supervision** | 30 | *11.4%* |
| **No supervision in this model** | 104 | *39.4%* |

# Other Youth Centered Practices

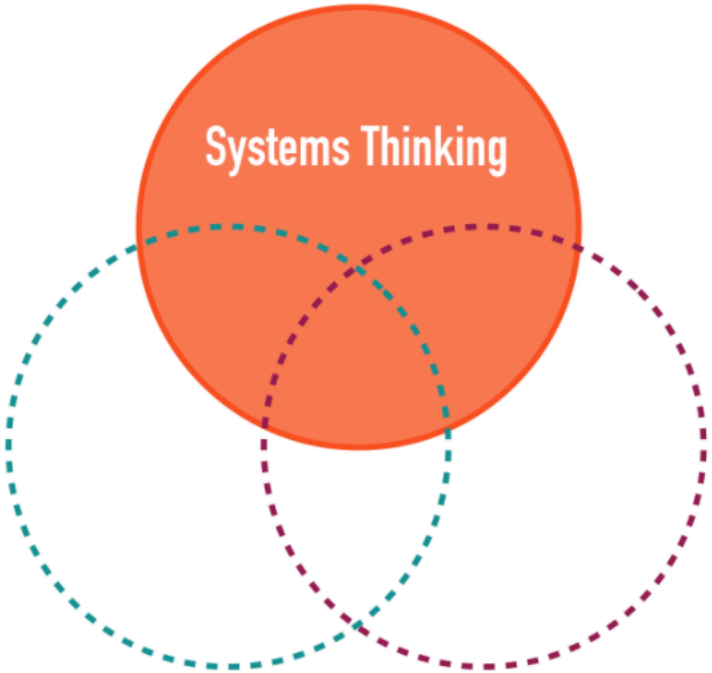
| Response | Count | |
|---|---|---|
| **Wraparound** | 275 | *38.8%* |
| **Youth Support Services** | 185 | *26.1%* |
| **Life Skills Training** | 342 | *48.3%* |
| **Collaborative Decision Making** | 296 | *41.8%* |
| **Experiential or Adventure Based Education** | 113 | *16.0%* |
| **Equine Therapy** | 68 | *9.6%* |
| **Youth Move** | 17 | *2.4%* |
| **None** | 187 | *26.4%* |
| **Other, please specify...** | 100 | *14.1%* |

Nationally recognized recovery program for opioid addictions:

# Raices Fuertes/ Strong Roots

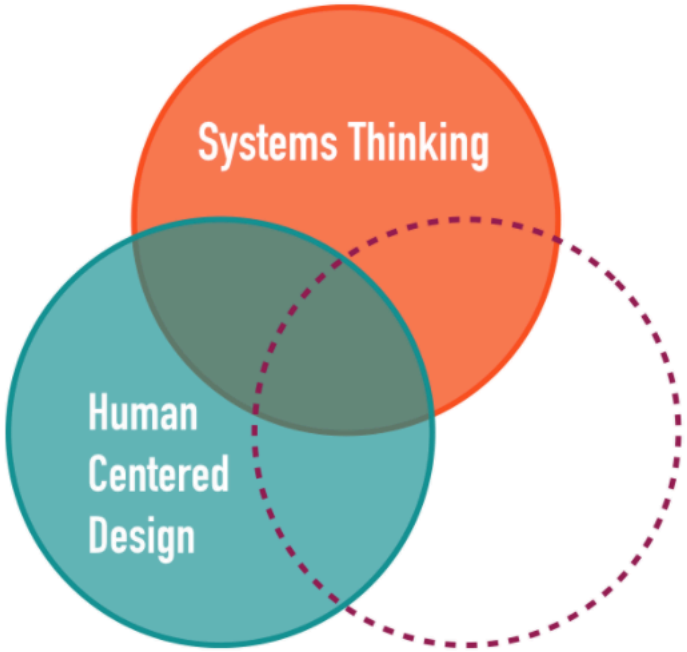
anjali@casadesaludnm.org


Healing mind, body, & soul



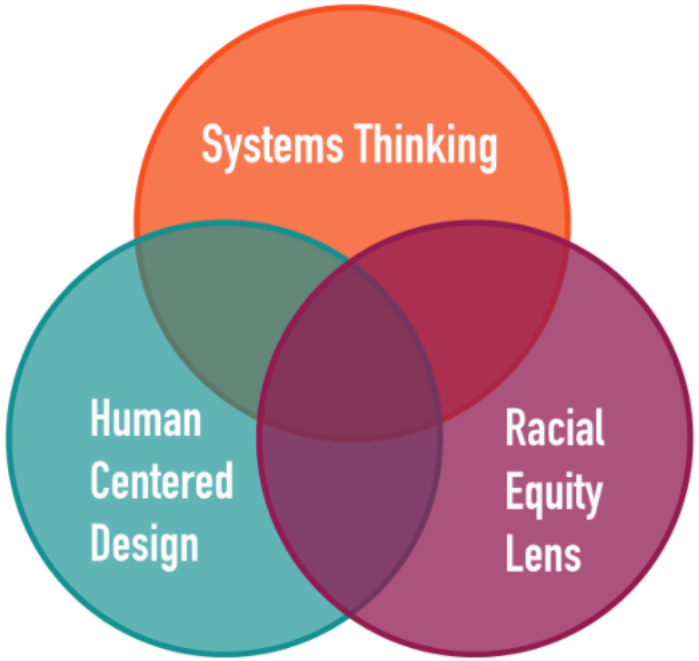

## Systems Thinking: Creating a Civic Space for Conversation

Through public-private partnership, bringing together people, process & policy to reimagine and redesign local government




## Human Centered Design: Improving Civic Engagement

CDL applies human centered design method to public sector problems, starting with the question: “Who are we designing this policy or service with and for?”

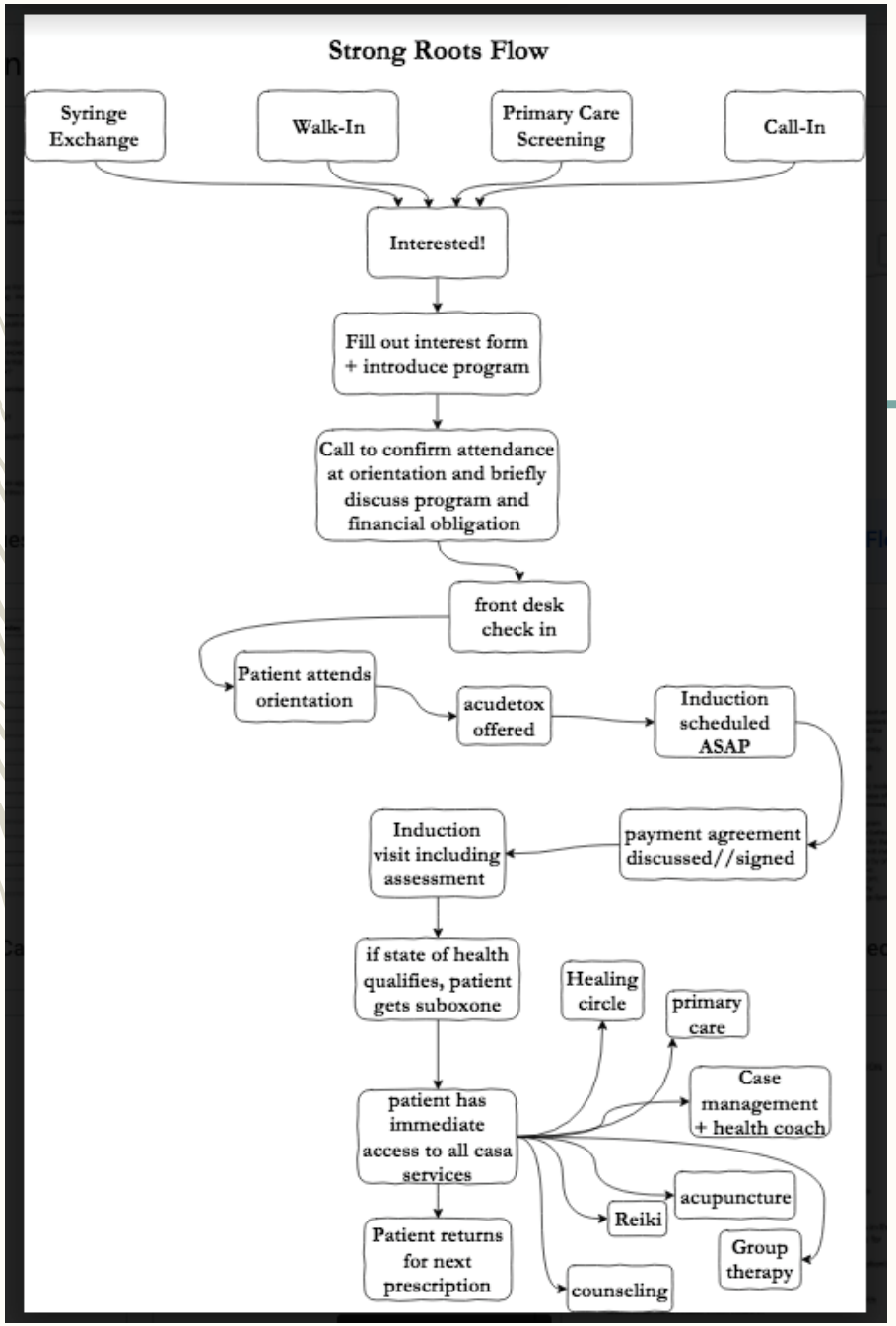



## Leading with Racial Equity Lens

CDL puts people first. By bringing the racial equity lens to the start of every challenge we tackle, we can better understand our stakeholders, including who is being served, and by extension, who is not, so that we can design inclusively and equitably.

| Principle | Definition | Approaches |
|---|---|---|
| 1. Humanism | • Providers value, care for, respect, and dignify patients as individuals.<br>• It is important to recognize that people do things for a reason; harmful health behaviors provide some benefit to the individual and those benefits must be assessed and acknowledged to understand the balance between harms and benefits.<br>• Understanding why patients make decisions is empowering for providers. | • Moral judgments made against patients do not produce positive health outcomes.<br>• Grudges are not held against patients.<br>• Services are user-friendly and responsive to patients' needs.<br>• Providers accept patients' choices. |
| 2. Pragmatism | • None of us will ever achieve perfect health behaviors.<br>• Health behaviors and the ability to change them are influenced by social and community norms; behaviors do not occur within a vacuum. | • Abstinence is neither prioritized nor assumed to be the goal of the patient.<br>• A range of supportive approaches is provided.<br>• Care messages should be about actual harms to patients as opposed to moral or societal standards.<br>• It is valuable for providers to understand that harm reduction can present experiences of moral ambiguity, since they are essentially supporting individuals in health behaviors that are likely to result in negative health outcomes. |
| 3. Individualism | • Every person presents with his/her own needs and strengths.<br>• People present with spectrums of harm and receptivity and therefore require a spectrum of intervention options. | • Strengths and needs are assessed for each patient, and no assumptions are made based on harmful health behaviors.<br>• There is not a universal application of protocol or messaging for patients. Instead, providers tailor messages and interventions for each patient and maximize treatment options for each patient served. |
| 4. Autonomy | • Though providers offer suggestions and education regarding patients' medications and treatment options, individuals ultimately make their own choices about medications, treatment, and health behaviors to the best of their abilities, beliefs, and priorities. | • Provider-patient partnerships are important, and these are exemplified by patient-driven care, shared decision-making, and reciprocal learning.<br>• Care negotiations are based on the current state of the patient. |
| 5. Incrementalism | • Any positive change is a step toward improved health, and positive change can take years.<br>• It is important to understand and plan for backward movements. | • Providers can help patients celebrate any positive movement.<br>• It is important to recognize that at times, all people experience plateaus or negative trajectories.<br>• Providing positive reinforcement is valuable. |
| 6. Accountability without termination | • Patients are responsible for their choices and health behaviors.<br>• Patients are not "fired" for not achieving goals.<br>• Individuals have the right to make harmful health decisions, and providers can still help them to understand that the consequences are their own. | • While helping patients to understand the impact of their choices and behaviors is valuable, backwards movement is not penalized. |

Hawk, M., Coulter, R.W.S., Egan, J.E. et al. Harm reduction principles for healthcare settings. Harm Reduct J 14, 70 (2017). https://doi.org/10.1186/s12954-017-0196-4




Shifts after putting feet in patients' shoes, observing data points, and asking patients:

- Shifts in flow, order of events
- Mandatory vs optional services
- Offered access to all modalities, offering autonomy and agency
- Warm intake process, work to meet pt's needs upon contact with the org


# Civic Engagement

Root Causes of Addictions – Popular Education Workshops

Leadership Survey of syringe exchange clients and patients in treatment/recovery

New Mexico in Focus: The Apprenticeship Program at Casa de Salud (2 segments): https://www.newmexicopbs.org/productions/newmexicoinfocus/tag/casa-de-salud/

Center for Health Innovation Project ECHO Series Human Centered Design:

**Session 6: Systems Level Change**

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**Email:** anjali@casadesaludnm.org

**Website:** casadesaludnm.org

**Facebook, twitter, Instagram:** @casadesaludnm (and @losanjalis)

**Address:** 1608 Isleta Blvd. SW. Albuquerque, NM 87105

**Phone:** 505-907-8311

How to Survive the End of the World Podcast episode on Casa de Salud: https://www.endoftheworldshow.org/

Fortification Podcast COVID-19 Series: https://auburnseminary.org/fortification/

# Sources


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