



# Human-Centered Design as a Mindset and Toolkit for Building Health Equity

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# *Upstream* Health Innovations

**Our Vision** is a world where all people have equal opportunity to live healthy lives - regardless of race, ethnicity, income, neighborhood or social condition.

**Our mission** is to remove barriers to health such as poverty, discrimination, lack of access to reliable transportation, and housing instability, resulting in the delivery of true, person-centered health care.

**Our approach** is grounded in human-centered design and the belief that those most effected by health inequities are the experts we must involve in designing new ways forward.

## Equality



## Equity

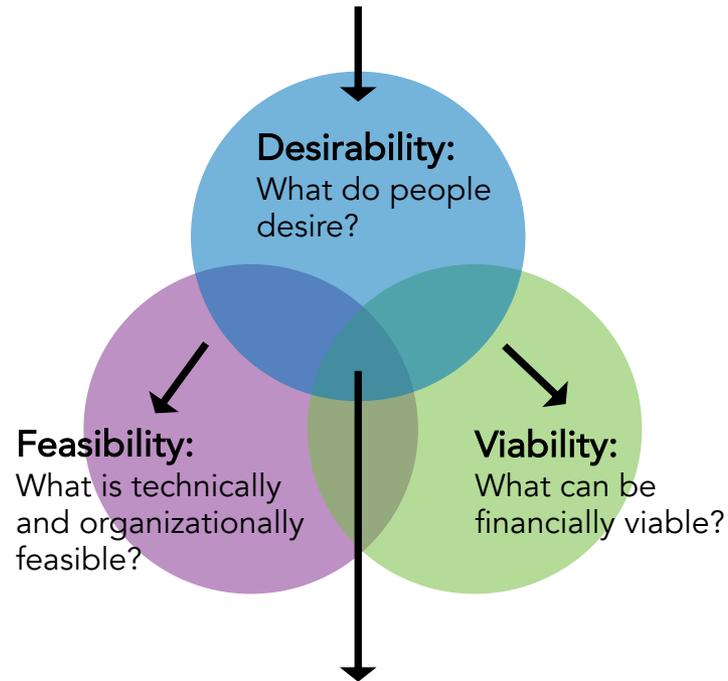


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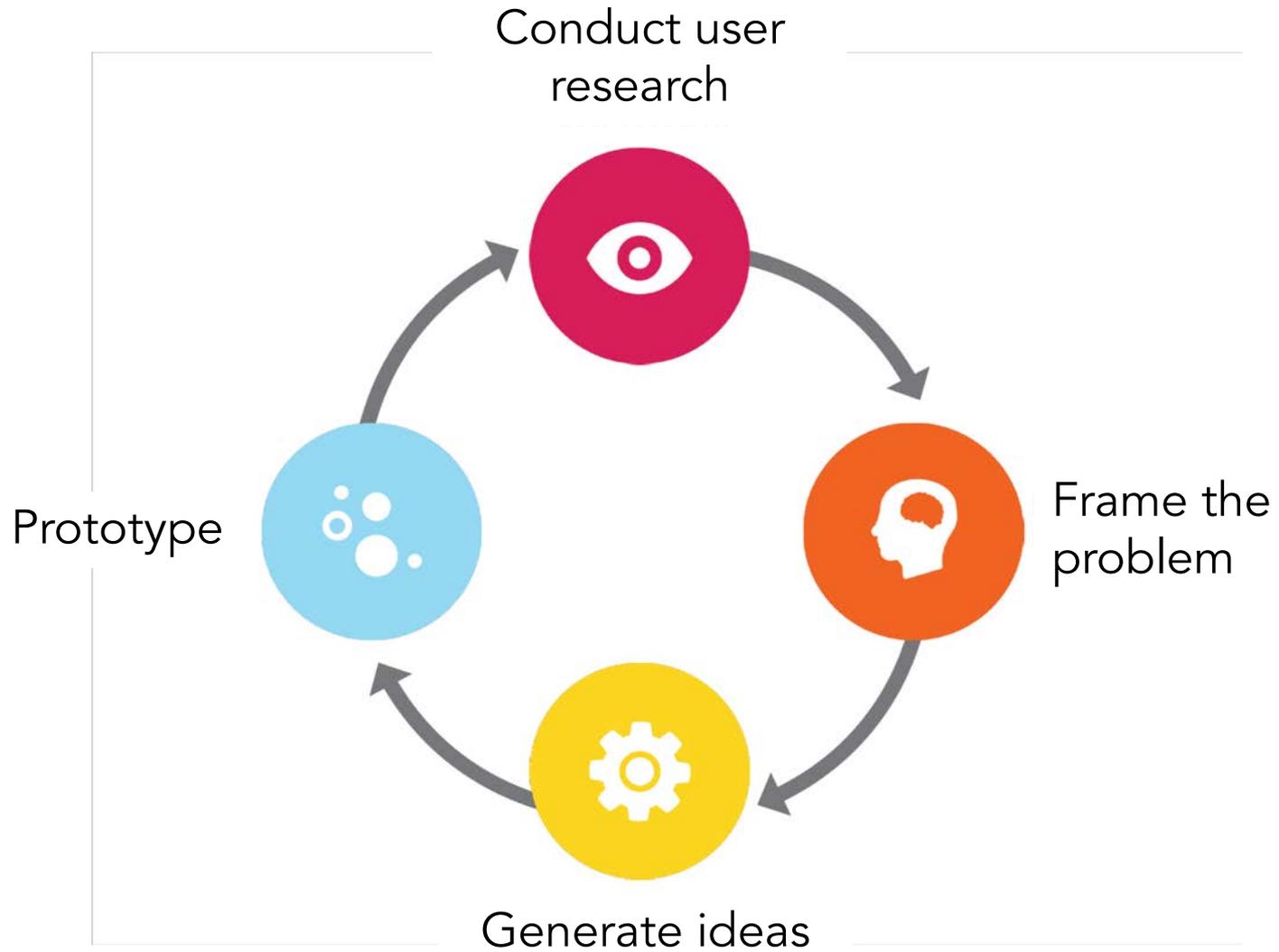
# Human Centered Design

# A human-centric problem-framing and problem-solving methodology

Start here.



Lasting solutions  
are desirable,  
feasible and viable.





# Conduct user research



# Frame the problem





**PATIENT FOCUSED**



# Generate Ideas



Medical CTM referral clarity & Hot hand off to FST



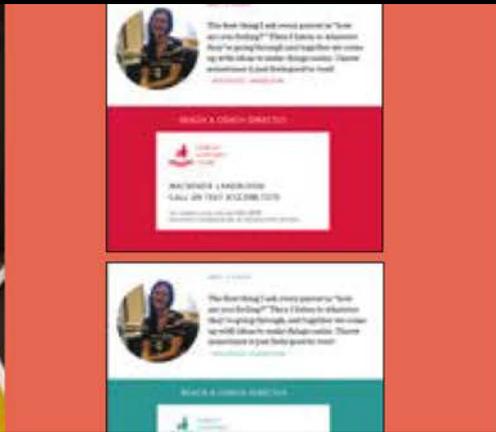
Non-medical CTM referral clarity

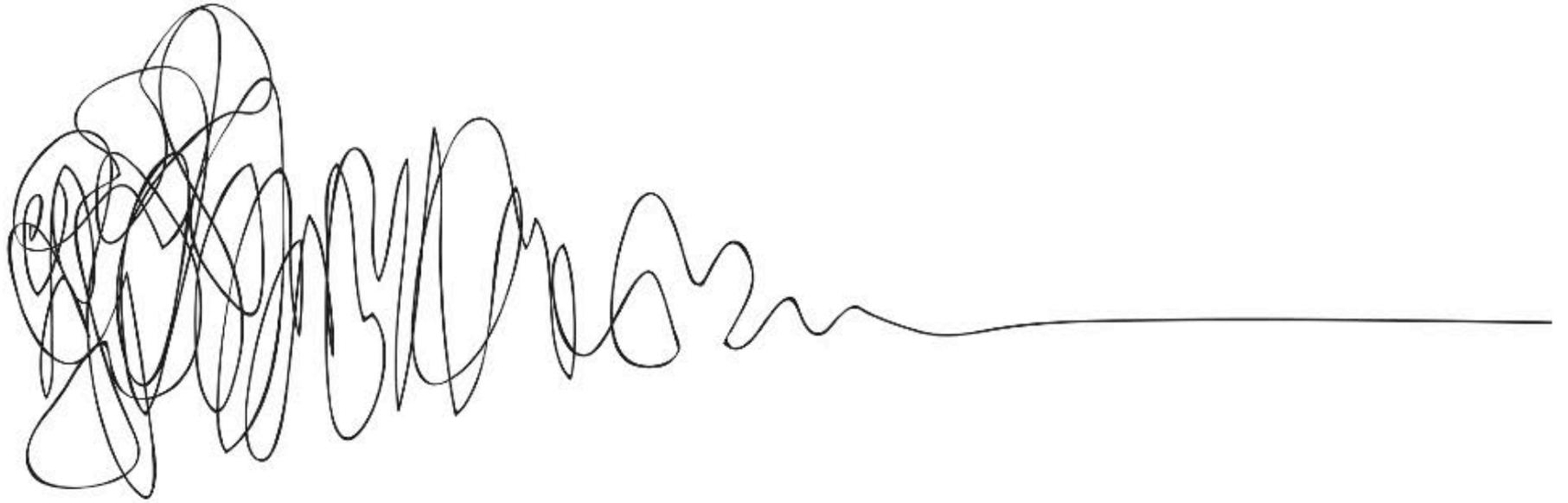


Support across the patient journey



# Prototype & Evolve





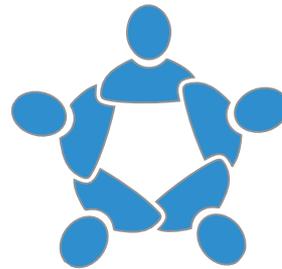
# Mindset



Optimism +  
Appetite for  
Change



Embrace  
Ambiguity



Radical  
Collaboration



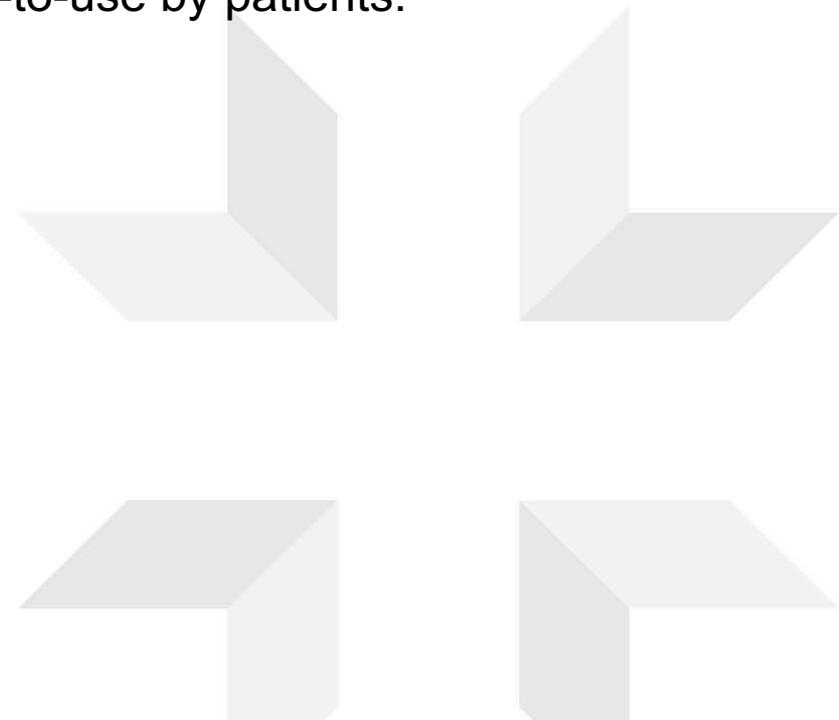
Systems  
Thinking

# Twin Cities Community Resource Finder



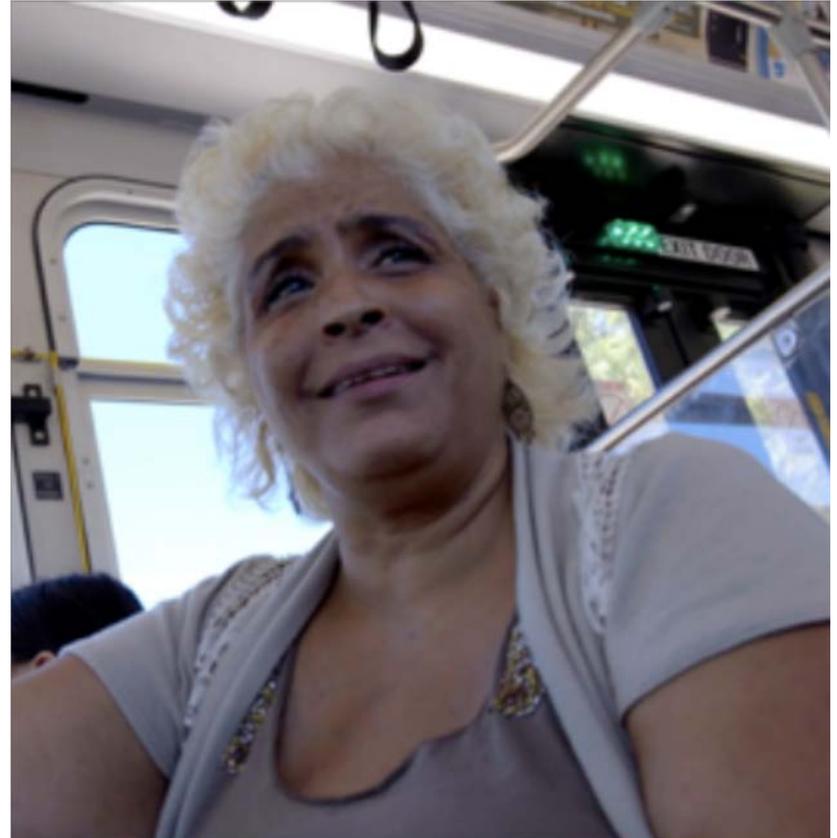
## The Need:

Many patients need support with the social determinants of health, but social health professionals cannot meet the demand. Other self-service tools like 2-1-1 are neither considered up-to-date nor easy-to-use by patients.





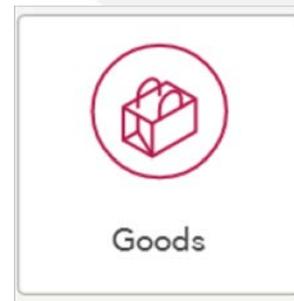
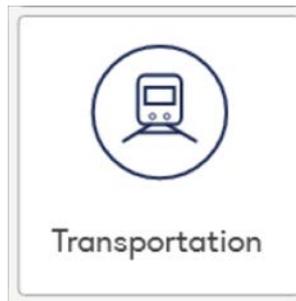
*“Some patients have unrealistic expectations about what a doctor can do for them. One patient told me they needed a bigger apartment.”* - Dr. Sara Champlin, Medicine Clinic



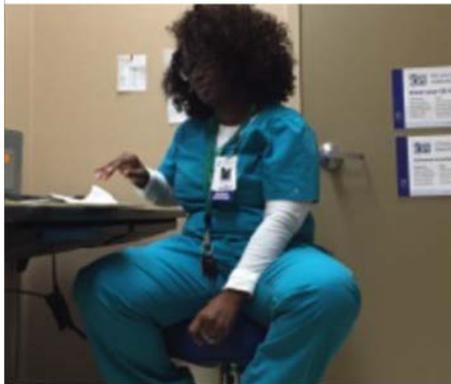
*“The doctor keeps telling me to soak in the tub, but I don’t have a tub where I’m at.”*  
Paula, HCMC Patient

## The Challenge:

How might we increase HHS' capacity to offer more patients holistic care where the social determinants of health are addressed?



# Testing and Iterating



**A conversation tool for medical assistants**

*“It’s cool, but it isn’t listed in our standardized MA job description. I feel like I’m taking on someone else’s role.” – Medical Assistant*



**Text messaging with HHS about social needs**

*“HCMC has a reason to send me a text... it’s not just random. I would expect they know my health history” – Patient*



**Mobile website**

*“[The screen] view is better. I can see multiple things and I know I can pick one, then go back and see if I can find another” – Patient*



**Public Kiosk**

*“I thought it was an iPad giveaway.” – Patient*

## Understanding the Opportunity



Andrew, 52

**Patients and SHP like the idea of allowing patients to help themselves.**

*“Sometimes I want to call myself instead of them looking it up on their screen. I like to take initiative and do it myself sometimes - so I can show that I’m responsible.” - Patient*



Christa, 40

**A self-service tool will only help patients who are already motivated to address SDOH needs.**

*“You have to be willing to help yourself. You have to try [...] In MN, help is everywhere. All you have to do is want the help.” – Patient*



**A self-service tool cannot address all SDOH needs because the processes for addressing some of these needs involve complex systems and people may need customized guidance.**

*“I definitely think for those who know what they want, they would use it more. But for others who don’t know where to start, or might have more barriers, more of them might need to come in and figure out stuff with me.” – CHW*

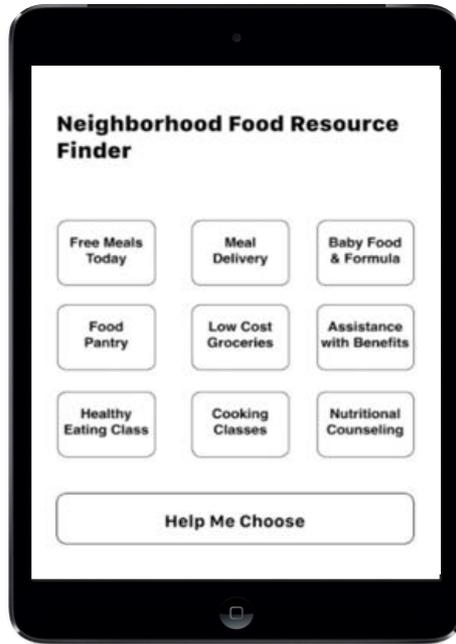
# Twin Cities Community Resource Finder

## Evolving Faster with a Digital Tool

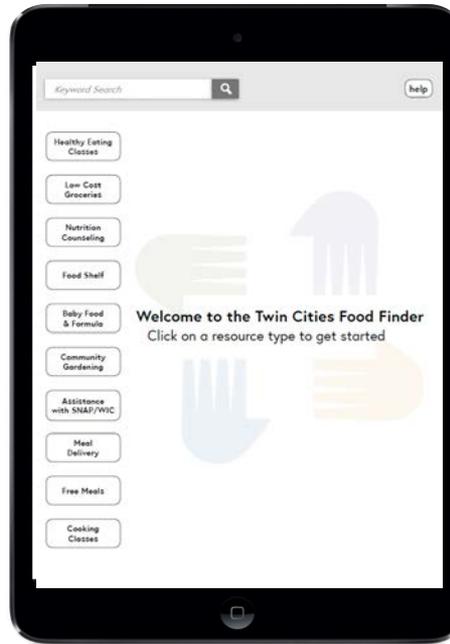
Splash Page



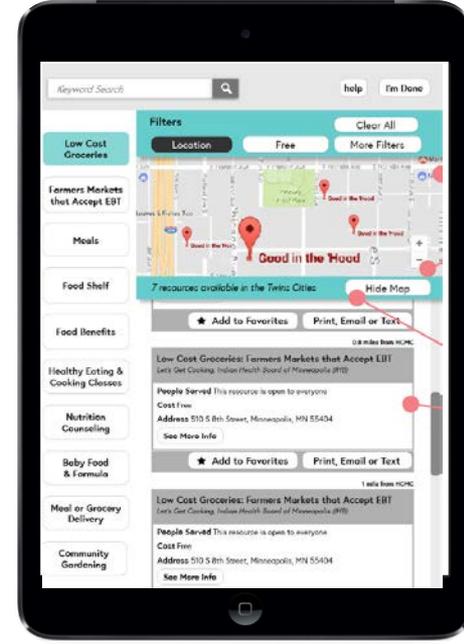
Guided Flow



Get to the Resources



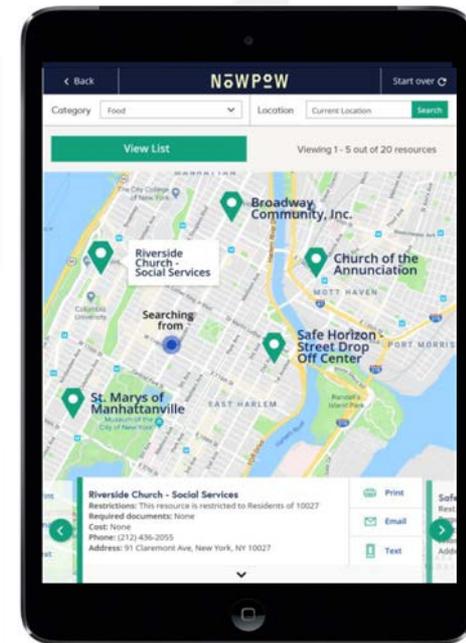
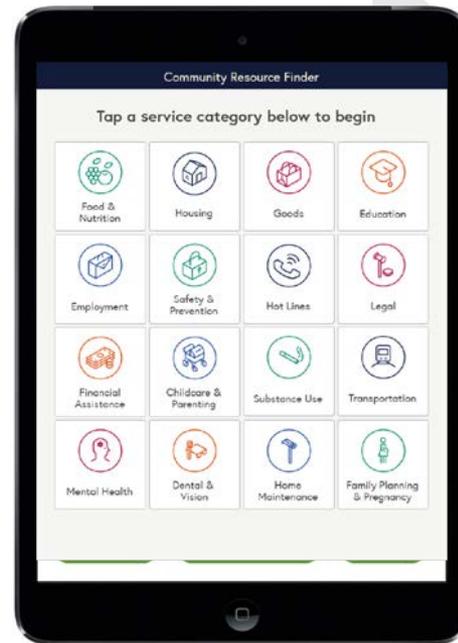
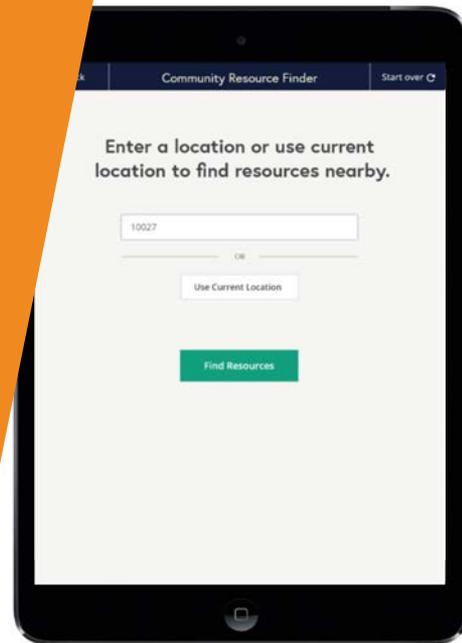
Add a Map



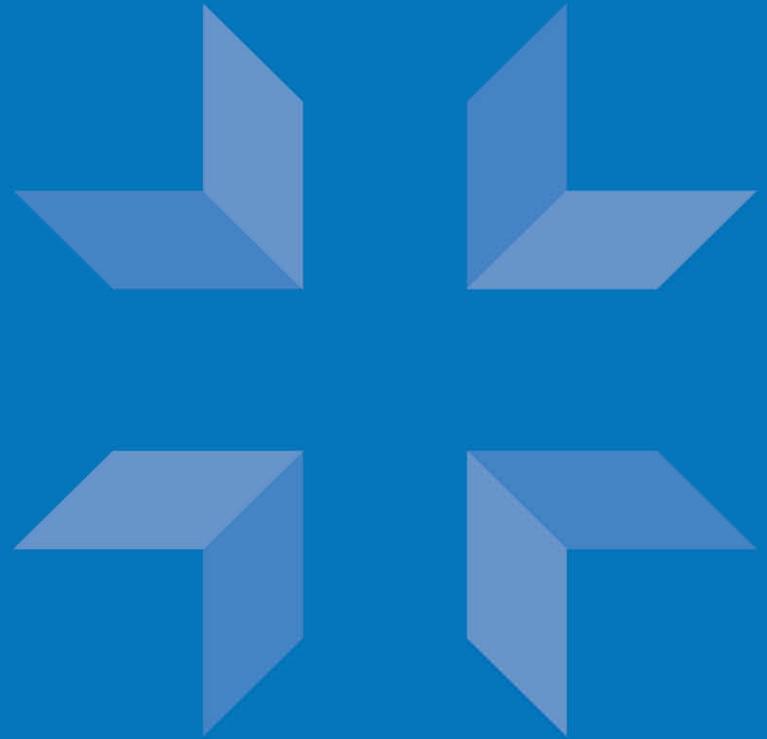
## Twin Cities Community Resource Finder

### The Solution:

A self-service digital tool that empowers patients to identify and gain access to social service resources in their neighborhoods.



# Project Rhizome



## Project Rhizome

### The Need:

Many OB patients could benefit from mental health support, but stigma against mental health combined with a resistance to feeling 'singled out' keeps many families from seeking or accessing support.





“There were several times during my pregnancies I wished that I had somebody there” - Lakisha

## Project Rhizome

### The Challenge:

How might we increase our ability to provide trauma-informed care and improve the way OB patients and families of color receive mental health support?



## Understanding Current State

- How do patients think about receiving mental health support?
- How do Care Team Members think about connecting patients with mental health support?
- What are the barriers to patients accessing mental health support?



## Identifying Barriers + Opportunities to Reduce Them

- **Normalize mental health**  
by framing it as a standard of care
- **Offer services proactively**  
but not prescriptively
- **Make emotional support easier to access**
- **Clarify Care Team roles**  
to build confidence in referrals

“There’s such a stigma, about therapy, about meds, as a black woman we are taught to just handle it all, be strong, eat those feelings up.” – Victoria B

“I never would have been in the mindset to get this support, but my provider framed it not as something you have to do – this is just extra support.” - Angela



## Creating A System-wide Solution

- **Create a continuum of care**  
from OB to Peds to support patients as they move from pregnancy to parenting
- **Make emotional support a standard of care** for all patients to reduce stigma
- **Offer tools for patients and providers** to introduce services and identify needs

## Project Rhizome

### The Solution:

**A system of trauma-informed care:** Make emotional support a standard of care that is available across the continuum as patients move from pregnancy to parenting.

#### Framing

*I understand what this service is and what I can expect to get out of it*

#### Invitation

*I feel cared for but not singled out - you're there at the right time*

#### Integration

*This doesn't feel like another thing I have to do - it fits into my busy life*

#### Expansion

*I feel like how I'm doing and my success really matters to people at HHS.*

#### Prototypes / Activities to Pursue

 FST handout

 Care team portrait

 OB - Peds continuum of care

 Drumbeat reminders

 FST patient intro

 Triggers tool

 Phone / SMS visits

 Standard of care visit

 Scheduling efficiencies at clinic

 Hitch Health partnership

 Group standard of care visit

 Alumna story share campaign

# Envision Community



## Envision Community

### The Need:

In cold climates, homelessness can cut a person's life expectancy in half. Affordable housing is too expensive and barriers to access housing are too high.



“Our interconnection is not only a natural and necessary part of our lives but also a force for good... social networks do things that no single person can do.”

Christakis, N.A. & Fowler, J.H. (2009). *Connected, the surprising power of our social networks and how they shape our lives*. New York, NY: Little, Brown and Company.



## Envision Community

### The Challenge:

How might we create a housing solution that helps all people have the opportunity to attain their highest possible level of health?



Envision Community

## Expert-driven from the Outset



Envision has been designed every step of the way with Street Voices of Change - an organization of individuals with current or past experiences with homelessness who come together to make positive changes in the systems that keep people homeless.



Envision Community

## We are a Growing Collaborative



Elim Church



Upstream  
Health  
Innovations



## Identifying Housing Needs

### Privacy

“At one point, you want your space. The only way to do that is if a person has their own key, and they can lock their door.”

- June, housing unstable

### Non-institutional

“It needs to have a homey feel. Little designs or a cut out in the wall where you can see from one room into another. Not just a cell. It needs colors.”

- Mateo, housing unstable

### Community

“Once I got housing, I thought about getting homeless again so I could be with my people. You wanna be in the mix.”

- Maya, housing unstable

### Low Barrier

“They need to make housing realistic for those of us who are ‘under-qualified.’”

- Diego, housing unstable



## Establishing Community as a Central Component



Providing shelter is not enough.

An accepting, flexible, and diverse community is essential to create stability and belonging.

This is what makes a house a home.

## Defining Shared Goals and Values

Residents of Envision live together with the common purpose of creating health equity by working cooperatively to build a lifestyle that reflects their shared values of:



**Autonomy**

**Trust**

**Letting go**

**Learning**

**Shared responsibility, and**

**Social change.**

## Addressing Key Tensions to Ensure Envision's Success

- **Making the Match:** Ensuring both new residents and the community have choice in who joins Envision while working within fair housing regulations
- **Caring for Envision:** Offering shared stewardship and interdependence while recognizing it will take time for some individuals to be ready for cooperative living
- **Addressing Addiction:** Being a low barrier housing option while creating a positive recovery environment



## Envision Community

### The Solution:

A dignified and diverse community of people intentionally living and learning together in inclusive, extremely affordable housing.





Thank you!

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