Merging Parallel Tracks: Opportunities to Integrate Behavioral and Social Health to Provide Whole-Person Care

December 5, 2019

12:00pm – 1:00pm EST

Health Leads

Housekeeping slide

- Please call in using your Attendee ID#
- The Q&A function is located on the bottom right-hand side of the screen
  - If you experience technical issues, please private message the **Event Producer**
- Send all questions and feedback through the Q&A function
- We will share a poll at the end
- The webinar is being recorded and will be shared afterwards

OUR VISION:

Health, well-being and dignity for every person in every community.

OUR MISSION:

We partner with communities and health systems to address systemic causes of inequity and disease. We do this by removing barriers that keep people from identifying, accessing and choosing the resources everyone needs to be healthy.

Objectives for today

1) Discuss how aligned behavioral health and social health integration efforts can reduce fragmentation in primary care transformation and support the delivery of comprehensive, whole-person care
2) Share strategies and examples of how primary care leaders have transformed their care models to better meet the whole-person needs of the patients and communities they serve
3) Hear from you!

Panelists

Wendi Vierra, PhD

Director of Behavioral Health Operations

Neighborhood Healthcare and Interfaith Community Services

Michael Tang, MD MBA

Chief Behavioral Health Officer

The Dimock Center

Damon Francis, MD

Chief Clinical Officer

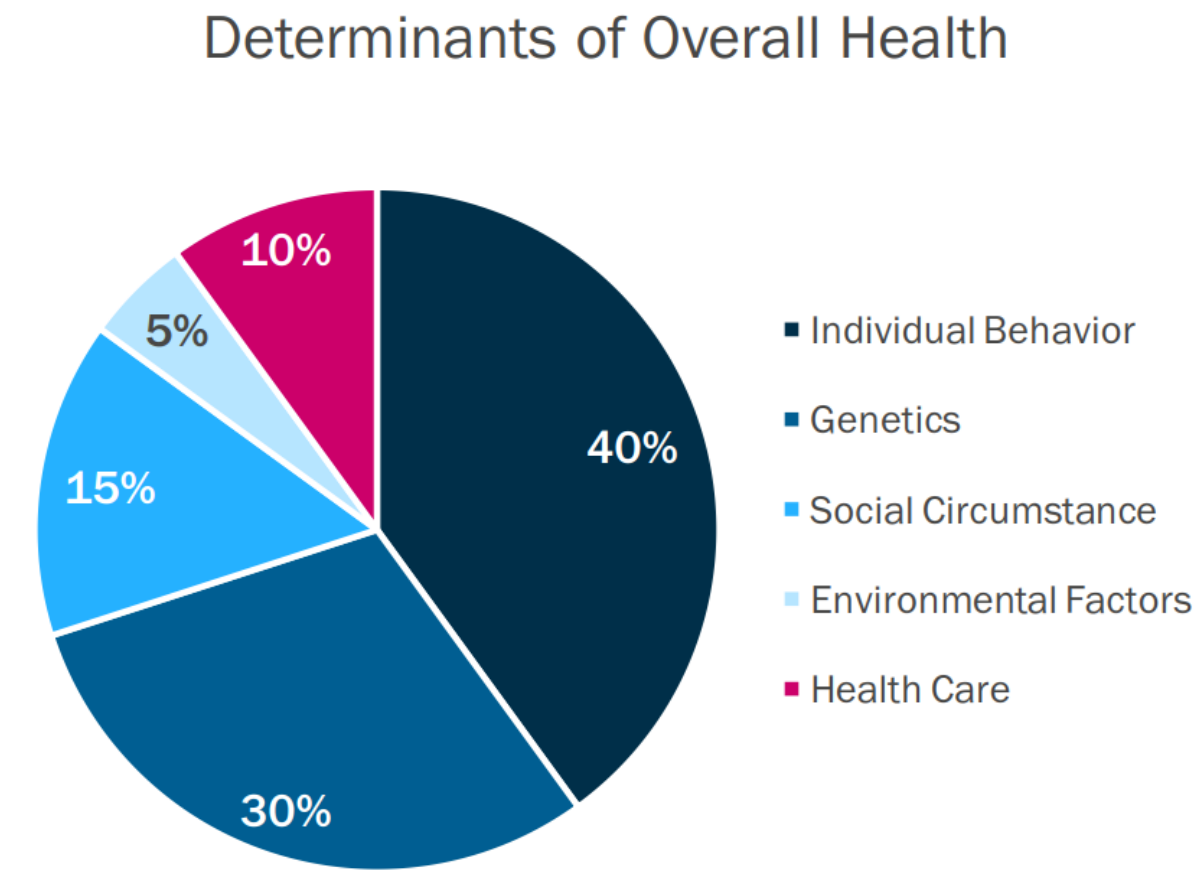
Health Leads

Therese Wetterman, MPH

Director, Program

Health Leads

As people, we are integrated, but systems we interact with are not



Source: *We Can Do Better — Improving the Health of the American People*, The New England Journal of Medicine, September 2007

70% of an individual's health is determined by factors that can be addressed through individual and system-level interventions

Yet, for most individuals the systems they interact with to address their essential needs are fragmented and siloed.

Lots of thinking, but not much progress

- 1,180 studies on Behavioral Health Integration Models conducted from 2010-2015 (Millbank, 2016)
- 39 SDoH-related policy statements published by 9 professional medical associations from 2002-2018 (Gussoff, 2018)

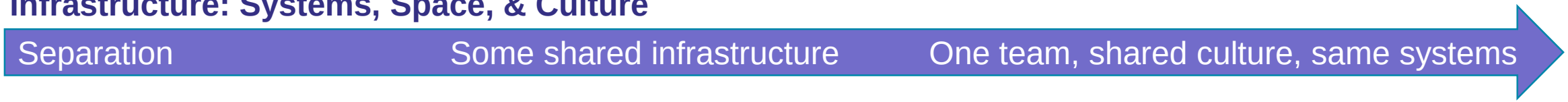
Yet, common barriers remain:

- Funding
- Separate systems
- Workforce & resource shortages
- Infrastructure
- Bias and stigma

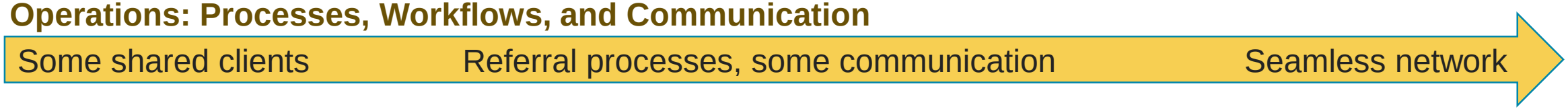
Aligned Integration Frameworks

Minimal Coordination	Basic Coordination at a Distance	Basic Collaboration	Some system integration	Approaching Integrated Practice	Fully Integrated
"Nobody knows my name. Who are you?"	*"I help your consumers."*	*"I am your consultant."*	*"We collaborate closely on the care of shared consumers."*	*"We are a team in the care of consumers."*	*"Together, we teach others how to be a team in care of consumers and design of a care system."*

Infrastructure: Systems, Space, & Culture



Operations: Processes, Workflows, and Communication



Populations Driving Collaboration

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.

THE DIMOCK CENTER

- Multi-service agency in Boston, MA
- Over 19,000 unique patients each year
- 90% minority, 75% Medicaid or uninsured

1. Health Center
   - Adult and Pediatric Primary Care
   - OB/GYN, Eye, Dental, HIV
   - Integrated Outpatient Adult & Pediatric Behavioral Health, Substance Use Care
   - Social Needs Services in Primary Care
2. Behavioral Health
   - Inpatient Detox, 4 Residential Recovery Homes, 2 Shelters, Homes for Disabled
3. Child and Family

Neighborhood Healthcare

Neighborhood Healthcare: 16 Clinics in San Diego & Riverside Counties

Population Served:

- Low-income, medically underserved, uninsured, and underinsured
- Behavioral Health integrated in all primary care clinics

Approximately 71k unique patients, 305k visits/year

Interfaith Community Services: 50 Programs

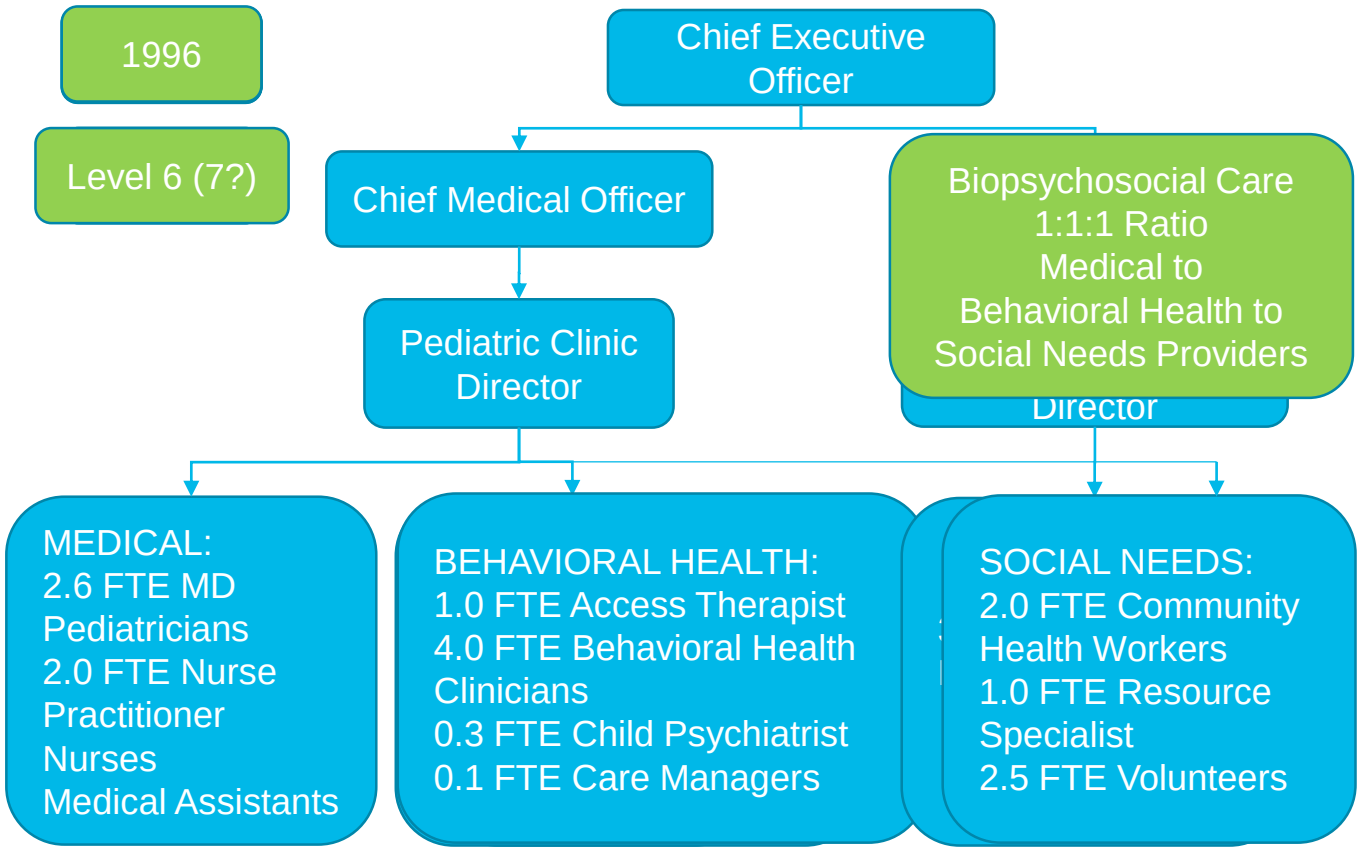
- Supportive Services
- Behavioral Health
- Employment & Economic Development
- Recovery & Wellness
- Housing Services

Panel discussion

1. We’re seeing two different models to address the social needs of patients emerge in primary care systems – ancillary social need programs and social need services that are integrated as part of the primary care model.

   What do you see as the main differences between the two models for patients, communities, and care teams?

Dimock – Care model evolution



- **2015:** Merging of Adult Primary Care and Behavioral Health Outpatient Clinics
- First CHWs in Adult, Pediatrics and OBGYN
- **2017:** Merging of Adult Outpatient Substance Use Disorder Clinic
- **2018:** Massachusetts Medicaid Accountable Care Organization Started
- **2019:** Now 10 CHWs

Integrated SDOH workflow for primary care

- Certified Enrollment Specialist qualifies patient
- Patient Service Representative provides intake packet
  - PHQ2/PHQ9; AUDIT; DAST; SDOH (social determinants of health)
- Primary Care reviews screening responses
  - Warm Hand Off's (WHO's) to Behavioral Health Consultant (LCSW)
    - Triage to PMHNP psychiatry and medication assisted treatment
    - Inter-agency WHO to coordinate care with Interfaith's programs

Neighborhood Healthcare lessons learned

- Ask what is the most important issue for you today that I can assist you with?
- Ask what is your time commitment/availability today to address these issues?
- Ask how best can we assist you today?
- Take a moment to explain options to establish a collaborative relationship from the beginning
- Use PDSA's (plan, do, study, act) to monitor your effectiveness: Are you doing what you say you are? Be flexible and adaptable with feedback!
  - Mock simulations – be willing to be vulnerable
  - Assess at different touch points to determine best fit for SDOH
- Assess staff level of comfort with asking these questions

Is deeper integration less effective, harder to implement, or just harder to study?

Model	Description	Research Evidence
Care management for depression (IMPACT)	Team-based approach to managing depression from within primary care. Nurse or psychologist provides education, care management, and medication support or brief psychotherapy.	• Improvement in access to depression treatment • ~50% reduction in depression symptoms • Lower healthcare costs
Three component model	Care management and enhanced mental health support within a "prepared practice;" providers educated on treatment protocols.	• Significant reduction in depression symptoms • Clinically significant improvements among service members with PTSD
Co-located collaborative care	**Mental health specialists onsite in a primary care clinic and provide services to patients of that clinic**	• **Increased access to mental health services** • ***No significant clinical improvements***
Primary care in specialty mental health	Primary care provided in mental health settings through co-location or care coordination	• Increases in receiving recommended preventive services • Improvements in mental health symptoms

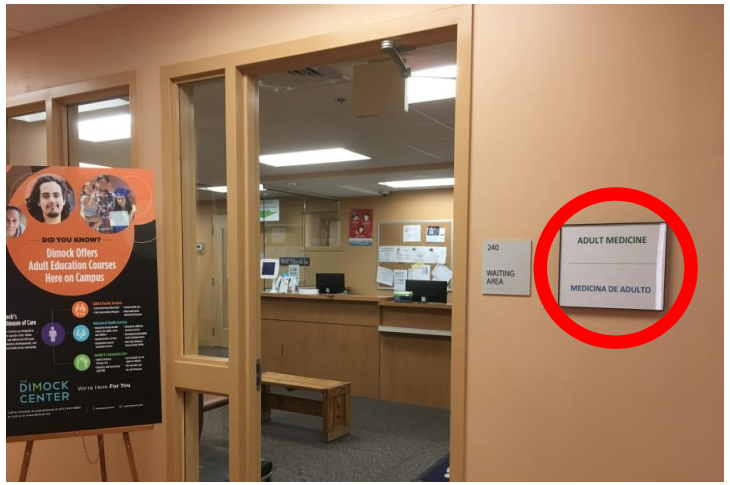
Adapted from *Kwan, et al, AIMS Public Health, 2015*

Panel discussion

2. What strategies have you used to address common integration barriers, including financing and the formation of high performing interdisciplinary care teams?

Dimock benefits of integrated management

Integrated team



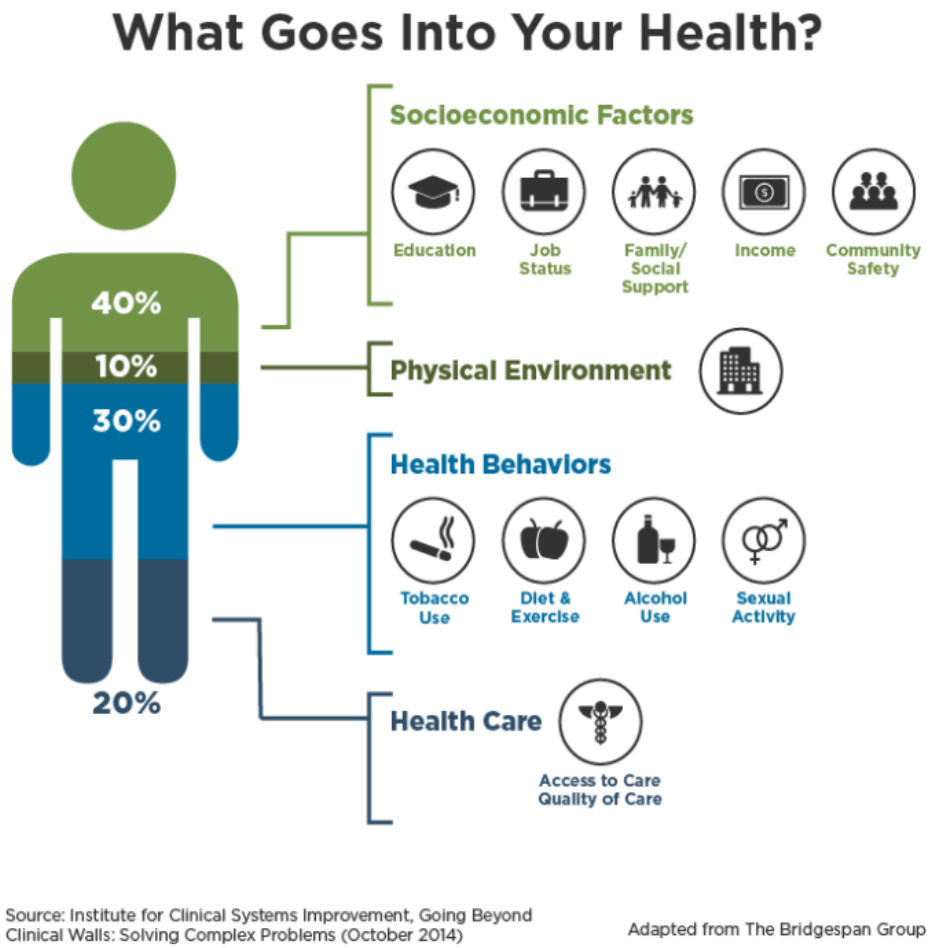
Reduced stigma

Average weekly therapy minutes and monthly payments received from insurance before and after resource support implementation

	Before intervention	After Intervention
Mean cumulative time per week conducting therapy (in minutes)	223.71 minutes [195.65-251.78]	267.76 minutes [240.40-295.12]
Mean monthly payments (in dollars) [95% confidence interval]	$804.10 [$680.99-$927.22]	$1,258.43 [$1,090.62-$1,426.24]

Financial gains

Neighborhood Healthcare's journey



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Adapted from The Bridgespan Group

- **Recognize & Understand** the Issue
- **Assess** patient needs
- **Resist** the "yes, buts" – they are quicksand!
- **Imagine** possibilities through coordinated collaborative partnerships – **We are Better Together!**
- **Jump in** – start small and build
- **Kaizen** – continuous improvement

“Best Life” – Gigantic vision – How do we get there?

Start by Integrating SDOH into Strategic Plan:

“Giving people the resources they need to live their best lives”

- What is that?
  - Income, Housing, Food/Clothing, Healthcare, Equity, Connection, Hope…
- We cannot do this alone!
- Leverage our strengths to build partnerships
- Enlist every voice and resource available
  - Internal taskforce to remove barriers and develop champions
  - PDSA’s with consumers, caretakers, providers

Panel discussion

3. How have your efforts to integrate services impacted the community and your ability to address community health and health equity?

neighborhood HEALTHCARE

For Advanced Partnerships

Partnership **A**ssessment **T**ool for **H**ealth "PATH" - tool to support working more effectively to maximize the impact of the partnership

Assess partnership strengths, gaps, challenges, and opportunities

- Internal & External Relationships
- Service Delivery & Workflow
- Funding & Finance
- Data & Outcomes

https://www.chcs.org/media/Partnership-Assessment-Tool-for-Health_-FINAL.pdf

neighborhood HEALTHCARE

INTERFAITH COMMUNITY SERVICES OPENS MEDICAL CENTER AT ITS ESCONDIDO HEADQUARTERS

Partnership with Neighborhood Healthcare Allows Full Integration of Healthcare and Social Services

One element of the integration of healthcare and social services is Corinne's Cottage Interfaith's short-term transitional shelter for women with a severe mental health diagnosis, located in Escondido. Resident Coordinator Saundra Davis and her certified therapy dog Jeana Boots brings joy, support and respite to the women at Corinne's Cottage on a daily basis.

Homelessness can make people sick — really sick. Among the 20,000 homeless people surveyed nationally through The 100,000 Homes Campaign, more than one in five suffer with a chronic health condition, accompanied by substance use and addiction and/or mental illness. These co-occurring conditions are then exacerbated by the harsh realities of life on the streets.

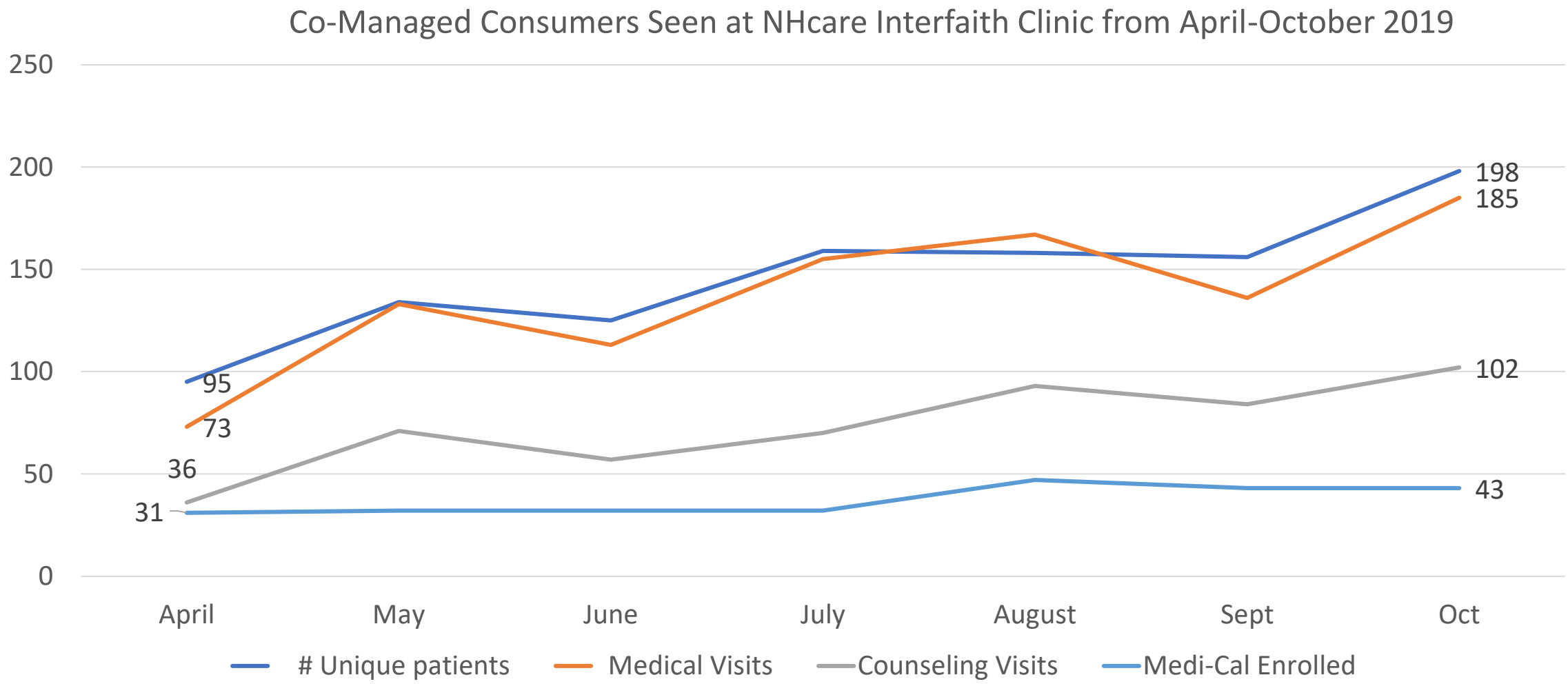
In an effort to address the health conditions of our most vulnerable community members, Interfaith Community Services, in collaboration with Neighborhood Healthcare, is moving closer to fulfilling their vision that all individuals, regardless of their ability to pay, should have the opportunity to pursue physical and mental wellness and recovery, and in turn, experience healing and an improved quality of life.

By focusing on person-centered care, Interfaith's new facility holistically addresses physical, behavioral, chronic health and substance use disorders. This whole-person approach may also include a multitude of other appropriate services, such as emergency food, basic hygiene needs, employment training, benefit assistance, tax preparation and legal assistance, transitional housing, eventual independent housing and aftercare.

LIVE WELL SAN DIEGO

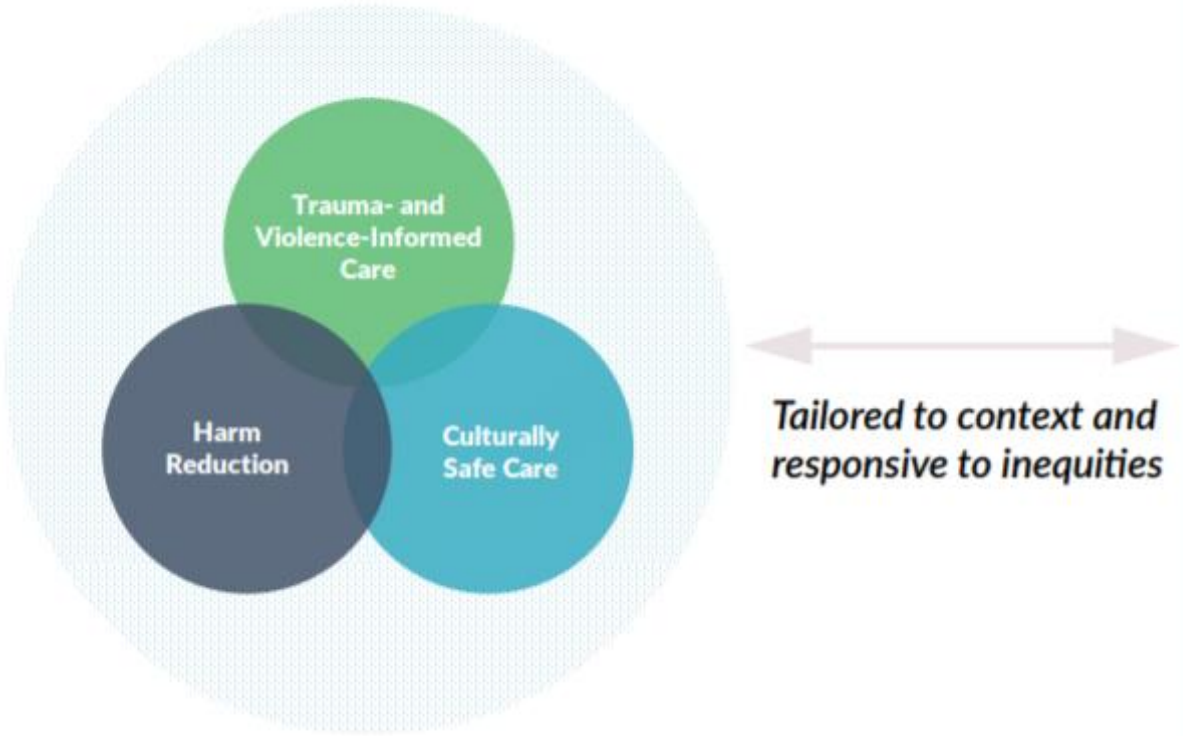
Interfaith Community Services in partnership with Neighborhood Healthcare is excited to offer a continuum of care that allows for flexibility through the levels of care based on the changing needs of the individual, alongside the wraparound social services that are vital to long-term success. As always, Interfaith's *Helping People Help Themselves* model ensures the commitment of each individual served to be part of the positive change in their own lives.

Stronger together: Integrated BH & PCP in Interfaith



Should we be focusing on equity rather than integration?

Key Dimensions of Equity-Oriented Care



Tailored to context and responsive to inequities

10 Strategies to Guide Organizations in Enhancing Capacity For Equity-Oriented Services

- Explicitly commit to equity
- Develop supportive organizational structures, policies, and processes
- Re-vision the use of time
- Attend to power differentials
- Tailor care, programs and services to local contexts
- Actively counter racism and discrimination
- Promote meaningful community + patient engagement
- Tailor care to address inter-related forms of violence
- Enhance access to the social determinants of health
- Optimize use of place and space

EQUIP Health Care. (2017). Key Dimensions of Equity-Oriented Care: 10 Strategies to Guide Organizations in Enhancing Capacity for Equity-Oriented Health Care. Retrieved from www.equiphealthcare.ca

Q&A

- Send questions through the Q&A function on the right side of the screen
- If you wish to come off mute to ask your question, simply click the **Hand Raise** icon on the right side of your screen so we can unmute you

Thank you!

Questions?

Send to:

Network@healthleadsusa.org

https://healthleadsusa.org/network/

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