Learning Lab Objectives

1. Identify opportunities for integrated care within your organization

2. Identify challenges to achieving integrated care and strategies for overcoming them
Roadmap

Introduction (20 min)
Framing the Issue (10 min)
Integration Engagement Activity (30 min)
Experts Ignite - Practice Applications (30 min)
Learning to SOAR - Consultation with Experts to Overcome Your Stuck Points (30 min)
Break (30 min)
Is the Change an Improvement? - Evaluation (20 min)
Wrap-up and Taking the Next Step (10 min)
Presentation Team

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SHLI Training Team

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Participant Introductions

- What is your name?
- What is your role at your organization?
- If you knew me well…
- What do you hope to get out of this learning lab?
Mental Health Disparities and Integrated Care: Framing the Issue

Ruth Shim, MD, MPH
Health Disparities and Inequities

**Health Disparities:** differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities

**Health Inequities:** disparities in health that are a result of systemic, avoidable, and unjust social and economic policies and practices that create barriers to opportunity

Racial/Ethnic Minorities:
• Have *less access* to and availability of care
• Receive generally *poorer quality* mental health services
• Experience a *greater disability* burden from unmet mental health needs
Percentage of People with No Access to Alcoholism, Drug Abuse, or Mental Health Care among those with Perceived Need

Rates of Follow-Up after Hospitalization for Mental Illness among Patients with Medicare Managed Care Plans

Chronicity of Major Depressive Disorder by Race/Ethnicity

Percentage

African Americans | Caribbean blacks | whites

Individuals with serious mental illnesses die, on average, **25 years earlier** than the general population.
General Assistance-Unemployable (GA-U) Program in Washington State

Co-occurring Diagnoses and the GA-U Population

52 percent had substance abuse or mental illness identified.
31 percent had a chronic physical condition only.

Disease Conditions

- Chronic Physical: 69%
- Mental Illness: 36%
- Substance Abuse: 32%

SOURCES: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2003-04. Chronic physical and mental illness diagnosis groups derived from CDPS grouper.
Comorbid Physical and Mental Health Conditions

2006 Milliman, Inc US Health Care Study
Other Population Group Disparities

- Rural/Urban Populations
- Geographic Location
- LGBTQ Populations
- Military Populations
- Incarcerated Populations
- The Social Gradient – Class Structure
Why Do Disparities Exist?  
Treatment Barriers

<table>
<thead>
<tr>
<th>System-Level</th>
<th>Provider-Level</th>
<th>Patient-Level</th>
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<tbody>
<tr>
<td>• Cost of Care</td>
<td>• Lack of Awareness of Cultural Issues</td>
<td>• Fear and Mistrust of Treatment</td>
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<td>• Societal Stigma</td>
<td>• Bias and Stereotyping</td>
<td>• Treatment - Seeking Behaviors</td>
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<tr>
<td>• Fragmentation of Services</td>
<td>• Language Barriers</td>
<td>• Self Stigma</td>
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<td>• Racism and Discrimination</td>
<td>• Geographic Differences</td>
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<td>• Insurance Differences</td>
<td>• Lack of Diverse Workforce</td>
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<td>• Social Determinants of Mental Health</td>
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Disparities in Percentage of Uninsured by Race/Ethnicity

- Non-Hispanic Whites
- Asian Americans
- African Americans
- Hispanics/Latinos
Reasons for Not Receiving Mental Health Services in the Past Year among Adults Aged 18 or Older with an Unmet Need for Mental Health Care Who Did Not Receive Mental Health Services: 2010

- Could Not Afford Cost: 43.7%
- Could Handle Problem without Treatment: 32.2%
- Did Not Know Where to Go for Services: 20.5%
- Did Not Have Time: 14.6%
- Did Not Want Others to Find Out: 10.0%
- Might Cause Neighbors/Community to Have Negative Opinion: 9.9%
- Treatment Would Not Help: 9.8%
- Concerned about Confidentiality: 9.4%
- Health Insurance Did Not Cover Enough Treatment: 9.4%
- Did Not Feel Need for Treatment: 9.4%
- Might Have Negative Effect on Job: 8.3%
- Health Insurance Did Not Cover Any Treatment: 7.8%
- Fear of Being Committed/Having to Take Medicine: 7.6%

Percent among Adults Who Did Not Receive Mental Health Care
Outpatient Mental Health Visits By Provider Type

- PCP Visits
- Psychiatrist Visits
- Other Provider Visits

Percentage

African American

White
“Today’s mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities…The time has long passed for yet another piecemeal approach to mental health reform.”

New Freedom Commission on Mental Health, 2003
INTEGRATED CARE AS A POTENTIAL SOLUTION
What Is Integrated Care?

“In this team-based model, medical and behavioral health providers partner to address both the physical and mental health needs of their patients.”
No Wrong Door
Integration
Engagement
Activity

Glenda Wrenn, MD, MSHP

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Benefits and Barriers to Integrated Care Engagement

• This activity was developed as an initial engagement activity for clinical sites developing integrated care change efforts
• It has also been used as a system “temperature check” on engagement and as a quick feedback tool
• We developed a handout to facilitate clinic leadership replication of this activity
What is Integrated Care? A Clinical Model

Joel Hornberger, MHS
What is integrated care?

“The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress related physical symptoms, and ineffective patterns of health care utilization.”

Cherokee Behaviorally Enhanced Healthcare Home

- Behaviorist on Primary Care (PC) team
- Consulting Psychiatrist on PC Team
- Shared patient panel and population health goals
- Shared support staff, physical space, and clinical flow
- BH Access and collaboration at point of PC
- PC Team based co-management and care coordination
- Shared clinical documentation, communication, and treatment planning

http://integrationacademy.ahrq.gov
Behavioral Health Consultant (BHC) Scope of Practice

- Management of psychosocial aspects of chronic and acute diseases
- Application of behavioral principles to address lifestyle and health risk issues
- Consultation and co-management in the treatment of mental disorders and psychosocial issues
Patient Check-In...
Vitals – BP...
Vitals – BH...
Shared Space...
PCP with Patient...
PCP Consults BHC...
BHC Chart Review...
BHC Transition...
BHC Consultation with Patient...
BHC Feedback to PCP...
Patient and BHC Coordinate a Follow-Up Plan…
Make it Your Own

- Think about what workflow challenges you are currently facing
- Identify (3) areas of potential workflow improvement to better engage BHCs.
Crafting the Message

Ana Isabel Gallego, MPH
Engaging stakeholders

1. What matters to **them**? (who is **them**?)
2. Who is a “peer” or an “influencer” to **them**?
3. Complete your message puzzle
Method:
• We took all people who visited the hospital (ED, Inpatient, Observation) due to an Ambulatory Care Sensitive Condition (ACSC) in 2013.
• We stratified the data based on behavioral health co-morbidity and county of residence.

Results:
• **Behavioral Health status stratification:** Patients with behavioral health co-morbidity spend on average 77% more time at a hospital for ACSC than those without BH co-morbidity.

• **Further stratification – geographic:** The behavioral health disparity in two rural counties with strong and widespread behavioral health integration models was only 40%

Hypothesis
• Behavioral Health/Primary Care Integration reduces primary care preventable utilization of the hospital for patients with a behavioral health co-morbidity
One example – Crafting your message

1. What matters to **them**?
   - Funding
   - Good outcomes
   - Fairness

2. Who is a “peer” or an “influencer” to them?
   - Non-traditional partner
   - **Your new best friend!**

3. Crafting a message that matters to them
   - Resources ARE NOT unlimited
   - …but they could be used in a better way…

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1. **Data:** Our behaviorally ill patients are spending 77% more time in a hospital due to conditions suitable to be managed by primary care.

2. **Opportunity:** Our neighbors in Healthy County have been able to reduce that disparity to 40%...plus they are reimbursed for physical AND behavioral health services.

3. **Human story:** Mark’s story of improved outcomes with behavioral health integration.

4. **Call to Action:** Let’s pilot behavioral health integration in our practice.

5. **Messenger:** Peer / Influencer
   - Physician?
   - CFO?
   - Board member?
Make it Your Own

Refer to the Message Crafting Worksheet
Reasons for Homeless Care Integration

Incidence of Chronic Physical Disorders, Mental Disorders, and Addictive Disorders Within the US Homeless Population

- Substance Abuse: 60%
- Mental Health: 45%
- Chronic Health Condition: 46%
- Tri-morbidity: 25%

Burt, et al. “2013 100,000 Homes Campaign Vulnerability Index Survey.” Found online at: http://100khomes.org
Reasons for Homeless Care Integration

- Severe psychiatric and physical health disorders
- Poor access to resources
  - Personal
  - Clinics serving the homeless
- Few providers with training in homeless health care
- Incentives – HRSA, Patient-Centered Medical Home
Integrated Clinic Flow

Mr. Smith

Screening

PHQ-9

Primary Care Provider

Referral

Consulting Psychiatrist

Referral

Behavioral Health Specialist

Treatment
On the Ground Perspective

- Think about unique populations within your organization.
- What do you need to ensure they benefit from integrated care efforts?
Learning to Soar

Instructions:

• Break up into groups with the trainer you would like to consult with
• Bring your SOAR strategic planning worksheet
• Share your challenge and leverage group expertise to problem solve ways to overcome a stuck point you are facing
Is the Change an Improvement?

Gilberte “Gigi” Bastien, PhD
Carizma Amila Chapman, DMFT, PhD, LMFT
Program Evaluation

- Why evaluate?
  - Organizational capacity building
  - Are we meeting our objectives?
  - Accountability
  - Process improvement

- Common Barriers
  - “Perfect is the enemy of the good”
  - “We don’t have the resources”
  - “It’s too late”
  - “We already know what we’re doing works”

- You can do it!
How do we do this?

“Failing to plan is planning to Fail”

- Buy in & Commitment
- Engage partners
- Establish resources
Walking through the process

- Program description
  - Logic Model
- Framing the work
  - Questions & Objectives
- Making it happen
  - Levels of evaluation
  - Deciding on Methods
- Making sense of data
  - Analyze, interpret, & summarize
  - Presentation/reporting of findings

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Building a Logic Model

Components of a logic model
- Inputs/resources
- Activities
- Outputs
- Outcomes (short-term, intermediate, long-term)
- Assumptions

Sample logic model

Let’s practice!
Wrap Up and Taking the Next Step

Instructions:
Identify something you plan to do as a result of participating in today’s session.
Complete the accountability promise postcard for us to mail to you in a month.
Partner with Us

Integrated Care Leadership Program

• Now accepting applications
• 12-month fully funded online learning collaborative
• http://integratedcare.satcherinstitute.org

Follow us on Twitter @SHLI_Integrated

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