Best Practices in Behavioral Health Integration

Eagle Ridge Golf Course, Gilroy, CA
October 27, 2017

All event resources will be available on the HIP website

www.hipscc.org

Check us out on Facebook, Twitter, and Youtube.

Wifi: WedgewoodGuest
Password: Wedgewood1
Health Improvement Partnership (HIP)

What do we do?

• The 4 T’s of HIP
• HIP is a Table where leaders convene
• HIP Tees up issues that are beyond any one organization’s capacity
• HIP builds Trust and Transparency
• HIP brings Transformative ideas to improve the health of Santa Cruz County residents
HIP BSCF IBH Efforts
January 2014-Present

“Catalyzing Innovative Models for Advancing Behavioral Health in the Safety Net”

TA to 4 safety net primary care organizations to expand BH services

IBHAC (IBH Action Coalition)
April 2015 - Present

“Advance Primary Care and Behavioral Health Integration through Community Collaboration”
Why we’re here today

IBHAC Charter Goals (approved July 2015)

• Improve system-level integration of behavioral health services into primary care to:
  • Improve the patient and family experience
  • Create a collaborative, integrative, and inclusive system of whole-person care
  • Strive toward optimal wellness and physical/emotional prosperity
• We want to work toward a system with the following characteristics:
  • A “no wrong door” approach
  • More seamless care transitions
  • Payer blind
  • Culturally and linguistically appropriate
BEHAVIORAL HEALTH DASHBOARDS: A community health perspective

Merced County, CA

Kathleen Grassi, R.D., M.P.H, Director
Kristyyn Sullivan, PhD, Epidemiologist
Merced County
Department of Public Health
October 2017
# Merced County Whole Health Partnership

## Current Active Partnership Members

<table>
<thead>
<tr>
<th>Organization</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central California Alliance for Health</td>
<td>MCO</td>
</tr>
<tr>
<td>Dignity Health Mercy Medical Centers</td>
<td>Hospital and RHC</td>
</tr>
<tr>
<td>Golden Valley Health Centers</td>
<td>FQHC</td>
</tr>
<tr>
<td>Livingston Community Health Health</td>
<td>FQHC</td>
</tr>
<tr>
<td>Merced County Department of Behavioral Health and Recovery Services</td>
<td>Mental Health/SUD</td>
</tr>
<tr>
<td>Merced County Department of Public Health</td>
<td>Convener/Grant Administrator</td>
</tr>
<tr>
<td>NAMI</td>
<td>Community Representation</td>
</tr>
</tbody>
</table>
Consumer Engagement Survey

• Identify perceptions and practices

• Managed through sub-contracts with clinic partners (FQHC staff) and with community partners (Building Healthy Communities volunteers)

• Developed English, Spanish, Hmong-language questionnaires

• Administered questionnaires as interviews

• Collected 488 interviews at 18 sites throughout the county over a three-month period
## Survey Results Highlights

### What health issues worry the people in your community?

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>260</td>
<td>Chronic Diseases</td>
</tr>
<tr>
<td>162</td>
<td>Mental Health</td>
</tr>
<tr>
<td>319</td>
<td>Drugs and Alcohol</td>
</tr>
<tr>
<td>66</td>
<td>Other*</td>
</tr>
</tbody>
</table>

**Other:**
- Obesity / Childhood Obesity
- Homelessness
- Depression
- Drugs / Alcohol

“Alcoholism not recognized as an issue because it is part of social situation”

### Please tell me who you think is the most trusted source of support that people in your community would talk to about stress/sadness/anxiety?

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>240</td>
<td>Family Member</td>
</tr>
<tr>
<td>202</td>
<td>Doctor</td>
</tr>
<tr>
<td>58</td>
<td>Nurse</td>
</tr>
<tr>
<td>99</td>
<td>Church Leader</td>
</tr>
<tr>
<td>32</td>
<td>Community Leader</td>
</tr>
<tr>
<td>90</td>
<td>Community Health Worker/Promotora</td>
</tr>
<tr>
<td>126</td>
<td>Other*</td>
</tr>
</tbody>
</table>

**Other:**
- Friends / Compadres
- Counselor (school)
- Cultural Broker / Navigator
- Shaman

“I don’t think the vast majority would be aware…as to who to refer people to”
Survey Results Highlights

Do the members of your community go to a doctor to talk about feelings of stress/sadness or anxiety?

Why Not:
- Embarrassed/Not Comfortable
- Doctor too busy / doesn’t listen / just give medicine
- No insurance
- Language barrier

```
<table>
<thead>
<tr>
<th>Respondents</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>231</td>
<td>Yes</td>
</tr>
<tr>
<td>243</td>
<td>No</td>
</tr>
<tr>
<td>177</td>
<td>If no, why not (response)*</td>
</tr>
</tbody>
</table>
```

“No, it is taboo...to talk about sadness and stress to a doctor. Patients only talk about physical ailments.”

Do the members of your community go to a doctor to talk about concerns with alcohol or drug use?

Why Not:
- Fear of being turned in
- Afraid to admit to a problem
- Feel they will be judged
- Not an issue a doctor addresses

```
<table>
<thead>
<tr>
<th>Respondents</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>193</td>
<td>Yes</td>
</tr>
<tr>
<td>278</td>
<td>No</td>
</tr>
<tr>
<td>191</td>
<td>If no, why not (response)*</td>
</tr>
</tbody>
</table>
```

“We don’t see drugs or alcohol as an issue or problem, just a choice.”
2015 Community Convening

**Top Priorities**

| Theme #1 (tie) | Increase community outreach, assuring cultural responsiveness  
Reduce stigma to mental / behavioral health services |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme #2</td>
<td>Use of technology for coordinating patient/client care (i.e., HIE, e-referral, Universal Release of Information)</td>
</tr>
<tr>
<td>Theme #3</td>
<td>Provide behavioral health services in non-institutional settings</td>
</tr>
<tr>
<td>Theme #4</td>
<td>Develop career paths (i.e., medical academies)</td>
</tr>
<tr>
<td>Theme #5</td>
<td>Train cultural brokers / patient navigators / community health workers to link residents to services</td>
</tr>
<tr>
<td>Theme #6</td>
<td>Address mobility needs – provide services where the people are already, increase outreach.</td>
</tr>
</tbody>
</table>
2016

**Use of technology for coordinating patient/client care**

- Pt data extraction to map referral patterns and provider communication loops
  
  *(Release of Information/e-Referral and HIE functionality)*

**Increase outreach and responsiveness and reduce stigma**

- Trainings for provider and community agency staff and community—
  
  *Wellbeing for the Mental Health Provider In Our Own Voice*
## 2015 Gap Assessment → 2017 Activities

<table>
<thead>
<tr>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use of technology for coordinating patient/client care</strong></td>
</tr>
<tr>
<td>• Data dashboard development to identify high-risk Pts and their utilization patterns - Clinic / Emergency Department</td>
</tr>
<tr>
<td>• Data dashboard development to identify patients with heart disease, diabetes and depression – pilot for CACHI*</td>
</tr>
</tbody>
</table>

**Trainings**

Primary care provider training / *Medication Assisted Treatment*

---

California Accountable Communities for Health
Data Analytics and Data Sharing
Current Project

• Population of Interest
  • Depression (broadly) AND Heart Disease OR Diabetes

• Why Mapping?
  • Visually appealing
  • Highlight neighborhoods for interventions
  • Geographical level is of interest to community
Getting the Data

• Directly from FQHCs
  • Would be much easier with HIE (analytics)
  • Barrier in data sharing – HIPAA
  • Signed data sharing agreements with both (modeled after OSHPD)
Data “How To”

- Basic Demographics
- Clean and Geocode Data
- ArcGIS
  - Plot XY data
  - Density Plot
  - Link to Block Groups
  - Create Rates
  - Choropleth Map
Disease Demographics

Disease - Percent*

<table>
<thead>
<tr>
<th>Disease</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both</td>
<td>9.16</td>
</tr>
<tr>
<td>Diabetes</td>
<td>74.87</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>15.98</td>
</tr>
</tbody>
</table>

*Only LCH
Planada (66.67)

- Inflated because of PO Boxes
- But, known vulnerable populations

Livingston (56.20)
Planada

- 75.1% Hispanic/Latino/a
- 39.2% household income less than 30k
- 68.1% less than high school education
- Food Desert

Livingston

- 82.7% Hispanic/Latino/a
- 51.3% household income less than 30k
- 81.4% less than high school education
Next Steps

- Neighborhood Scan
- Resource mapping
- Targeted intervention
Thank you

- Contact information:

  Kathleen Grassi
  kgrassi@co.merced.ca.us

  Kristynn Sullivan
  ksullivan@co.merced.ca.us
MONTEREY COUNTY
WHOLE PERSON CARE PILOT

Presentation to Health Improvement Partnership  Oct 27, 2017
Who

We Serve:
Medi-Cal Eligible, Homeless, Most Vulnerable:
  Multiple Medically Complex Conditions
  Mental Health Disorders
  Substance Use Disorders
  Highest Use/Highest Cost: ED & Hospital / Mental Health Unit Readmissions

The Team:
WPC Case Management Team = Public Health Nurse and an assistant, either Behavioral Health Aid (BHA) or LVN. There are four teams. Each team carries a case load of about 40 high acuity cases, each case is followed for a period of one year. At the end of five years we will have addressed the needs of 600 clients

Our Partners:
Are within the Health Department: Behavioral Health. And within the community: NGOs
WHOLE PERSON CARE PILOT

What

Intensive and Comprehensive Nurse Case Management for Monterey County’s most vulnerable Homeless, Medi-Cal recipients
Launch Date: Y1, 2016 was the Design year
Current Year: Y2 2017 Implementation begins
Time Frame: Five years
Funding: State of California: Title 1115

Why

Expand services for the most vulnerable Medi-Cal beneficiaries with complex needs to:
Improve health outcomes, functionality and quality of life
Improve the management of complex chronic disease, mental illness, and substance abuse through integrative care
Reduce the cost of care
WHOLE PERSON CARE PILOT

How

Assess enrolled clients for health, behavioral health, substance use disorder, housing and social service needs. Then use an integrative model of care to:

Assist clients with finding and scheduling behavioral health and medical provider appointments, mental health assessments, substance abuse program intake appointments and therapists. Accompanying them and helping them to navigate social services, DMV, housing placement, educational reentry and employment training. Providing transportation and food

Continually assess for welfare and compliance

Advocate for clients in any needed setting

Team lead in collaborating with partners to integrate all facets of the client’s holistic care to create an optimal environment for mental and physical health
WHOLE PERSON CARE PILOT

+/Δ (Successes and things we would like to change!)

All of our clients are homeless, 100% have complex medical needs, 63% have mental health disorders, 68% have substance abuse disorders, half have been housed at least once, we have been able to get patients exhibiting worsening mental and medical health symptoms prioritized into appropriate care avoiding an EMS ride and an ED visit.

Building real collaboration with partners to help clients and create systems change

We are in the process of change. WPC is a pilot intended to create a revolutionary change. The barriers we are encountering are long standing. Creative collaboration will give us a successful and workable prototype To serve the most vulnerable and lower the cost of care
WHOLE PERSON CARE PILOT

Future Plans and Possibilities

- Cross system data sharing between all Monterey County hospitals, clinics, mental health units, substance use disorder treatment facilities, providers and EMS in order to identify those in greatest need
- Continued and increased prioritization of WPC clients into care: PCPs, BH Clinics, treatment centers and housing
  - Sobering Center
  - Respite Center
  - Peer Navigators
  - On-site Housing Sustainability Services
- New possibilities on the horizon for housing resources and access opportunities
- New possibilities for reintegration of clients
- Sustainability - Making the possibilities laid out in the Pilot a part of a systems change that addresses the needs of the most vulnerable and contains the cost of care
- Link the systems: master person index, data warehousing and care collaboration in case management for effective use of resources and cost savings so that services are efficiently directed where needed
Patricia Zerounian, Program Manager for Whole Person Care
831-755-4583. ZerounianP@co.monterey.ca.us

Moira Lewis, PHN, MPH, Supervising Public Health Nurse for Whole Person Care
831-755-4642. lewism1@co.monterey.ca.us

The WEBPAGE! You can Google Monterey County Whole Person care
http://www.co.monterey.ca.us/government/departments-a-h/health/public-health/whole-person-care

CA Department of Health Care Services
http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx