Advancing Behavioral Health Equity in Primary Care

Program Kick-Off

NOVEMBER 3, 2021 | 12pm-1:30pm PDT

While you are waiting…

Please RENAME yourself by adding your organization’s name.

(How: Right-click on your name in the Participant list, and click, “Rename”)
Housekeeping

Mute
Minimize Interruptions
Please make sure to mute yourself when you aren’t speaking.

Chat
Go Ahead, Speak Up!
Use the Zoom chat to ask questions and participate in activities.

Naming
Where Are You From?
Please rename yourself and add your organization’s name.

Tech Issues
Here to Help
Chat Wes Gabrillo privately if are having issues and need tech assistance.
Changing your name in Zoom

Please rename yourself and add your organization’s name following the instructions below.

1. After launching the Zoom meeting, click on the "Participants" icon at the bottom of the window.

2. In the "Participants" list on the right side of the Zoom window, hover over your name and click on the "Rename" button.

3. Type in the display name you’d like to appear in the meeting and click on "OK".
I Agenda

1. Welcome & Introductions
2. Program Roadmap
3. Meet the Cohort
4. Review Program Components
5. Review CAT Results
6. Review Evaluation Plan
7. Next Steps
Today’s Objectives

By the end of our session today, you will have...

1. Met the cohort and fostered connection through breakout activities.
2. Reviewed the program journey map, components, and vision.
3. Gained clarity on the cohort’s current state from CAT results.
4. Learned about the evaluation plan including timeline & activities.
Getting to know each other!
Meet the CCI Team

Juan Carlos Piña, MPH
He/Him/His
Program Manager

Juliane Tomlin, MA
She/Her/Hers
Director

Lydia Zemmali
She/Her/Hers
Program Coordinator
Meet your coaches…

Danielle King, PsyD
Director of Clinic and Community Collaborations
Cherokee Health Systems

Denise Armstorff
QI/Leadership Consultant

Gilmore Chung, MD
Physician at Venice Family Clinic

Michael Mabanglo, MSW, PhD
Director of IB and Mental Health at Santa Rossa Community Health
Joining us today…

Kathryn Phillips, MPH
Senior Program Officer
CA Health Care Foundation

Parinda Khatri, MD
ABHE, Clinical Director
Cherokee Health Systems

Jerry Lassa, MS
Metrics and Analytics Consultant

Ann Middleton, MPH
Research Associate
American Institute for Research
Program Roadmap
Sponsor Welcome

Kathryn Phillips, MPH
Senior Program Officer
California Health Care Foundation
ADVANCING BEHAVIORAL HEALTH EQUITY IN PRIMARY CARE

SPONSOR WELCOME
NOVEMBER 3, 2021

CALIFORNIA HEALTH CARE FOUNDATION
CALIFORNIA HEALTH CARE FOUNDATION’S COMMITMENT TO INTEGRATED BEHAVIORAL HEALTH

- Behavioral health (BH) conditions are common and undertreated, both in the US and California:
  - In 2018, fewer than half of adult Medi-Cal enrollees with mental illness received a mental health service.
  - Primary care providers (and their teams) are the frontline:
    - Approximately half of all care for common psychiatric disorders is provided by a PCP.
  - Social needs (housing, food, etc.) are major sources of stress for low-income persons and are frequently comorbid with BH needs.
  - People with BH conditions often experience poor health overall, and those with a diagnosis of serious mental illness or substance use disorder (SUD) die on average 20 years earlier than others, often from preventable physical illnesses.

HIGHLIGHTS FROM THE 2020 NATIONAL SURVEY ON DRUG USE AND HEALTH, SAMHSA

- Among adults aged 18+, 21% experienced a mental illness and 5.6% experienced SMI. Only 46.2% of adults with mental illness received treatment in the past year; 30.5% perceived an unmet need for mental health services.
- 12% of adolescents 12-17 had serious thoughts of suicide and 2.5% attempted suicide in the past year. Suicide is now the second leading cause of death among adolescents.
- 14.9% of people aged 12+ needed substance use treatment in the past year, but only 1.4% received care.
- Impact of COVID-19: In the last quarter of 2020, most adolescents and adults perceived at least some negative effect of the COVID-19 pandemic on their mental health: 38.7% of adults who received mental health services experienced delays or cancellations in appointments, and 10.7% were unable to access medical care resulting in a perceived moderate or severe impact on health.
Adults with serious psychological distress by race/ethnicity, California, 2015 and 2019

Percentage of Adults

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>2015</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latinx</td>
<td>9.6%</td>
<td>15.3%</td>
</tr>
<tr>
<td>White</td>
<td>8.3%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Black</td>
<td>9.1%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>6.6%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>10.1%</td>
<td>20.3%</td>
</tr>
</tbody>
</table>

Notes: Serious psychological distress (SPD) is a categorization for adolescents and adults. See page 3 for full definitions. Results for American Indian/Alaska Native and for Native Hawaiian/Pacific Islander are not shown because they are statistically unstable. Source uses Latino, Black or African American and Two or More Races. SPD is assessed for the worst month in the past year. Adults are age 18 and older.

Rates of self-reported serious psychological distress (SPD) in California adults varied among racial and ethnic groups. Rates for all groups increased from 2015 to 2019, with rates doubling for those reporting two or more races. Asians had the lowest rates of SPD in both years.

### A BRIEF TIMELINE: ABHE-PC IN THE MAKING

**Since 2014,** CHCF has helped 50+ community health centers (CHCs) operating 500+ primary care sites, improve the delivery of primary care services for at least 1.5 million Medi-Cal members.

Project models and toolkits have been adopted by other funders and programs, expanding the reach.

**In 2020,** we reviewed the collective performance of these programs with the goal of identifying remaining needs. Top priorities identified:
- Behavioral health integration
- Social needs care, specifically aligning social and behavioral health resources
- Health equity

Beginning in 2015, CHCF devoted significantly more resources to behavioral health in primary care and in specialty settings. CHCF’s focus has been on integration of MH, SUD, and physical health care.

<table>
<thead>
<tr>
<th>Year</th>
<th>Project/Program</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Safety Net Analytics Program (SNAP)</td>
<td>Treating Addiction in Primary Care (TAP-C)</td>
</tr>
<tr>
<td>2016</td>
<td>Capitation Payment Preparedness Program (CP3)</td>
<td>Population Health Learning Network (PHLN)</td>
</tr>
<tr>
<td>2017</td>
<td>Behavioral Health Integration A Blueprint for Medi-Cal (PHASE)</td>
<td>CalHIVE California</td>
</tr>
<tr>
<td>2018</td>
<td></td>
<td>Launched Advancing Primary Care Portfolio:</td>
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<tr>
<td></td>
<td></td>
<td>- Increasing investments in primary care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Modernizing payment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Accelerating adoption of integrated behavioral health</td>
</tr>
</tbody>
</table>

**DMC-ODS Launch**

Research demonstrates that care for Medi-Cal MCO enrollees stayed the same or declined for over half of the quality measures monitored by state health care officials, 2009-2018.

**CHCF emphasizes its commitment to health equity and racial justice.**
WHAT’S NEW AND DIFFERENT
WHAT MIGHT BE UNCOMFORTABLE (AT THE START, ANYWAY)

- Focus on particular patient sub-populations
  - Key to equity lens: Programs designed for the total population have failed to reduce health disparities
- An outcomes-focused evaluation; universal measure set and longer look back period
  - Capabilities are important, but payers, policymakers, and patients want to understand *impact*
- Expectation that participants collect, use, and share patient impact stories
  - Elevate voice of the consumer

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**Equitable Behavioral Health Integration (EBHI)**

A vision, program, or model for the integration of primary care and behavioral health specifically designed to reduce disparities in access, utilization, and outcomes among identified priority populations.

EBHI programs combine medical, behavioral health, and social care in a way that ensures each need is addressed in a coordinated way, led in collaboration by the patient and care team, and with emphasis on equity, resilience, and well-being.
WHAT WE HOPE TO LEARN... TOGETHER

- Which practice-level changes are associated with improvements in access, utilization, outcomes, and perceptions of equity
- Promising strategies, approaches, tools for designing, implementing, and sustaining equitable BHI programs

WHAT WE WILL SHARE

- Our results and reflections, including our challenges and mis-steps
- Evaluation approach/plan, measure set, and tools
- Practice change strategies
- Toolkit
WHERE DOES THIS PROJECT FIT IN THE CALIFORNIA LANDSCAPE?

- **CalAIM**, 5-year plan to transform Medi-Cal
- DMHC Health Equity and Quality Committee ([equity as protection](#))
- DHCS “comprehensive quality strategy” (draft for public comment avail Nov 15, submission to CMS in Jan 2023): engage members as owners of their own care, keep families and communities healthy via prevention, provide early interventions for rising risk and patient-centered chronic disease management, provide whole person care for high-risk populations, and address social determinants of health.
- DHCS’ Alternative Payment Methodology 2.0 Program (Jan 2023)
- Kaiser Permanente Population Health Management Program (Jan 2023)
- NASEM Implementing High Quality Primary Care

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**DHCS guiding principles** include eliminating health disparities through anti-racism and community-based partnerships and data driven improvements that address the whole person.

Targets, by 2025:

- Ensure all health plans exceed the 50th percentile for all children’s preventive care measures
- Close racial/ethnic disparities in well-child visits and immunizations by 50% (state level)
- Close maternity care disparity for Black and Native American persons by 50% (state level)
- **Improve maternal and adolescent depression screening by 50% (state level)**
- **Improve follow up after emergency department visit for mental health or substance use disorder by 50% (state level)**
THANK YOU FOR YOUR COMMITMENT
Parinda Khatri, PhD

Chief Clinical Officer
Cherokee Health Systems

ABHE Clinical Director

Behavioral Health Equity
The Journey Starts Here
Parinda Khatri, PhD
Chief Clinical Officer
Cherokee Health Systems
November 3, 2021
Care and services available combine medical and behavioral health services...

in a way that ensures each need is addressed..

in a coordinated way, led by the patient and care team in collaboration

All people have the opportunity to attain their highest possible level of mental health, resilience, and wellbeing.
Is there a perfect solution?
Compass of core values

Belonging

Dignity

Justice
A map to guide you

Coaches
Learning Sessions
CAT
Toolkits
Webinars
Site Visits
Identify a plan for action

- Identify BH inequities
- Resources and facilitators
- Design and implement
Triumphs
Battle Scars
Plan vs. Reality
Complex Adaptive Theory: Applications for ABHE

**SIMPLE**
- Recipe essential
- Recipe tested to assure replicability
- No particular expertise, knowing how to cook increases results

**COMPLICATED**
- Formulas are necessary
- High level of expertise in many specialized fields
- Separate parts and then coordinate

**COMPLEX**
- Formulas have limited application
- Expertise can help, but not key, relationships
- Can’t separate parts from whole
- Every child is unique
- Outcome is uncertain
Noticeable change requires patience
Meet Your Cohort
15 California Community Health Centers

42 Individual Clinic Sites

283,901 Number of Patients Served Annually Across all Clinic Sites
Cohort at a Glance

1. Chinatown Service Center
2. Community Health Centers of the Central Coast
3. Eisner Health
4. Elica Health Centers
5. Korean Community Services
6. LA USC California Primary Care
7. Marin City Health and Wellness Center
8. Open Door Community Health Centers
9. Petaluma Health Center
10. Samahan Health Centers
11. Santa Barbara Neighborhood Clinics
12. The Achievable Foundation
13. UC Davis Health
14. Valley Springs Health and Wellness Center
15. Via Care Community Health Center
Priority Subpopulations

### Race/Ethnicity

- **Latinx**: 9
- **Asian**: 6
- **Black/African-American**: 5
- **Pacific Islander/ Native Hawaiian**: 3
- **Middle Eastern/ Central Asian**: 1

### Patient Characteristics

- **Adolescents/Transition-age youth**: 5
- **LGBTQ+**: 4
- **Seriously and Persistently Mentally Ill**: 3
- **Substance Use Disorders**: 3
- **Immigrants**: 2
- **Refugees**: 1
- **Elderly**: 1
- **Intellectual and Developmental Disabilities**: 1
Please introduce yourself, your role, where you work, and what about the ABHE program is exciting to you in this moment?
Advancing Behavioral Health Equity in Primary Care

Program Overview

Juliane Tomlin
Program Director
Center for Care Innovations (CCI)
The Goal
To support 15 California community health centers (42 sites) in expanding integrated behavioral health care and improving outcomes with a specific focus on advancing health equity and aligning behavioral health and social needs resources.

Program Objectives
Sept 2021 – May 2023

1. Identify, manage, and treat mental health conditions and substance use disorders.
2. Identify & address patients’ unmet social needs through consistent screening, tracking, and robust referral processes.
3. Stratify data to identify and understand where inequities are greatest.
4. Take effective action to reduce barriers to care – specifically, racism, discrimination, stigma, and trauma.
5. Sustain and spread successes.
Key Drivers

Advancing Behavioral Health Equity in Primary Care

- Health Equity
  - Patient & Family Engagement
  - Culture of Improvement
- Senior Leadership & Organizational Commitment
- Data Driven Systems
- Access to Care
- Integrated Care Team & Care Delivery
- Patient Activation & Self-Management
- Community Partnerships
Key Program Elements

CAPABILITIES ASSESSMENT TOOL (CAT)

• **Completed 4 Times:** Baseline, Midpoint, Endpoint, 1 Year Post Program.

  ✓ Baseline completed by all ABHE teams (Oct 21)

• **Supports you** in goal setting.

• **Supports us** in curriculum planning.

• **Assesses progress** on key drivers of ABHE program.
Key Program Elements
ROADMAP / CHARTER

Due Feb 1, 2022

• Teams to develop in order to guide direction over course of program:
  • What are you trying to accomplish?
  • What changes will result in an improvement?
  • How will you know if you’ve improved?

• Includes your team’s:
  • Aim Statement
  • Key Drivers / Changes of Focus
  • Measurement Strategy
Key Program Elements

**PROGRAM DASHBOARD (PROCESS MEASURES)**

**Goal to have drafted by mid-January 2022**

- Developed as you develop your Aim Statements and Roadmaps/Charters
  - Jerry Lassa will co-design these with you!
- Includes measures that you will track regularly to assess progress toward your Aim Statement
- More actionable than Outcome Measures – will Drive Improvement!
Key Program Elements

Universal Measure Set

- **Completed 3 Times:**
  - Baseline (3/30/22)
  - Endpoint (8/31/23)
  - Post Program (8/31/24)

- Outcome Measures, slower to move
- Progress driven by ABHE curriculum and teams making progress toward their goals
- **More details today!**
How Does it All Come Together?

The ABHE Curriculum will focus on our key drivers in service of improvement in each of these elements.

The Program Evaluation will assess how this program has succeeded (listening sessions, observation, patient survey, etc.) (More in a Moment…)
## Program Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Activities</th>
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</thead>
<tbody>
<tr>
<td>2021</td>
<td>Oct-Nov</td>
<td>Commit, Collect, Choose</td>
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<tr>
<td>2022</td>
<td>Dec-Jan</td>
<td>Collaborate &amp; Learn</td>
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<tr>
<td>2023</td>
<td>Feb-Mar</td>
<td>Harvest, Integrate &amp; Implement</td>
</tr>
<tr>
<td>2023</td>
<td>Apr-May</td>
<td>Re-Commit, Spread &amp; Sustain</td>
</tr>
</tbody>
</table>

### Learning Sessions (Virtual / In-Person)
- **Nov 3** Kickoff Meeting
- **Dec 2** Learning Session #1
- **Webinars**
- **Site Visits (select 1)**
- **Deliverable**
- **Activities**

### Deliverable
- Baseline CAT (Oct 21)
- Submit Roadmap / Charter [Feb 1]
- Data Submission #1 [Mar 30]
- Midpoint CAT [Aug 19]
- (1) Endpoint CAT (2) Final Storyboard [May 15, 2023]

### Activities
- Create Project Charter (Aims, Measures, Key Areas of Focus)
- Identify Project Measures & Dashboard
- Test / Refine / Implement
- Collect Improvement Data
- Quarterly Progress Reports
- Collect Stories / Communications Activities
- Develop Draft Storyboard

### Monthly Coaching
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<tr>
<th>Learning Sessions (Virtual / In-Person)</th>
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<th>2022</th>
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<tr>
<td>Nov 3 Kickoff Meeting</td>
<td>Nov 17</td>
<td>Topical Webinar #1 (Date TBD)</td>
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<tr>
<td>Dec 2 Learning Session #1</td>
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<td>Nov 17 Evaluation / Universal Measures Orientation</td>
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<th>Webinars</th>
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<tr>
<td>Orientation</td>
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<tr>
<th>Deliverable</th>
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<tbody>
<tr>
<td>Using CAT, identify opportunity areas, draft Aims</td>
<td></td>
<td>Finalize Roadmap / Charter (Aim, Measures, Workplan (Due Feb 1)</td>
</tr>
<tr>
<td>Provide CCI with additional details on current state (to assess SDOH screening, demographic data collection)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify Project Measures &amp; Dashboard</td>
<td></td>
<td></td>
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<tr>
<td>Plan for Universal Measures Data Submission #1</td>
<td></td>
<td>Start Testing / Improvement (PDSAs)</td>
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<table>
<thead>
<tr>
<th>Activities</th>
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<td>Start Testing / Improvement (PDSAs)</td>
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</table>

<table>
<thead>
<tr>
<th>Coaching</th>
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<tbody>
<tr>
<td>Monthly Coaching Call</td>
<td>Monthly Coaching Call</td>
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<tr>
<td>Jerry Lassa to join coaching calls / Develop dashboards</td>
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<td>Monthly Coaching Call</td>
<td>Monthly Coaching Call</td>
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<tr>
<td>Executive Leaders join coaching calls – Review Aims / Charter</td>
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<td>Monthly Coaching Call</td>
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Center for Care Innovations
# Post-Program Data Collection

## Capabilities Assessment

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2023</th>
<th>2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3</td>
<td></td>
<td>Post-Program CAT Submission (May 31, 2024)</td>
</tr>
<tr>
<td>Q4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td></td>
<td></td>
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<tr>
<td>Q2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Universal Measures

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2023</th>
<th>2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3</td>
<td>Endline Data Submission (Aug 31, 2023)</td>
<td>Follow-Up Data Submission (Aug 31, 2024)</td>
</tr>
<tr>
<td>Q4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A Word About Capturing Patient Stories…
Capturing Patient Stories

Meet Anne!

Anne Sunderland, MPH
California Health Care Foundation
Senior Communications Officer, Improving Access

• **Expectations**
  - Each team submits 1+ *patient anecdote* with each quarterly progress report.
  - Clearly describes how a specific patient has been helped by this program (can be short!)

• **How will we package stories?**
  - We will pick compelling examples for potential video or blog.
  - You may be asked to help:
    - Arrange interviews
    - Help coordinate logistics for onsite photo or video shoot

• **What’s in it for you?**
  - These will be collaborative efforts
  - Final products can be used for your own communications / marketing efforts
**Key Points to Remember**

### Develop Your Roadmap / Charter! (Nov–Jan)
- Review the CAT to identify focus areas.
- Draft Program Aim Statement (likely to include multiple “sub-aims”).
- Invite Jerry to coaching call to develop Measurement Strategy / Organizational Dashboard

### Engage!
- Be present, make ASKS and OFFERS.
- Invite your Leaders to join a coaching call to review your draft Roadmap / Charter. (Due 2/1)
- Leverage your coach and the CCI team to set your team up for success.
- Join the ABHE Club to connect with colleagues.

### Be Curious
- There is no Playbook.
- Engage your staff, test new things
- Deepen your engagement with your patients & communities to better understand “the problem” and develop new solutions.
CAT Results Overview

How did we score relative to the group?

How can we use the results?
ABHE Key Drivers

Advancing Behavioral Health Equity in Primary Care

Health Equity

Patient & Family Engagement

Culture of Improvement

Senior Leadership & Organizational Commitment

Data Driven Systems

Access to Care

Integrated Care Team & Care Delivery

Patient Activation & Self-Management

Community Partnerships
**ABHE-PC Capability Assessment Tool (CAT)**

### 1. Senior Leadership & Organizational Commitment
- Leading, planning and creating an organization culture that prioritizes BH Equity (BHE)
- Listening to the voice of all patients
- Hiring an EID workforce
- Developing a culturally intelligent workforce
- Adopting TIC best practices

### 2. Data Driven Systems
- Integrated care registries support BHE PHM
- Data analysis and quality measures support BHE

### 3. Access to Care
- Appointment scheduling respect patient and family needs and preferences
- Multi-modal visits reduce barriers and provide a range of options for patients and families to access BH care

### 4. Integrated Care Team & Care Delivery
- MH, SUD, and PC services are integrated
- Team-based care is embedded into BH practice
- Screening, assessment and management is culturally and linguistically competent
- Clinical workflows are established with EB
- Staff are appropriately trained

### 5. Patient Activation & Self-Management
- Care plans activate patients to “find their voice,” self-management support empowers, and digital tools are fully leveraged
- Patient and caregiver education is driven by patient preferences and advances health literacy

### 6. Community Partnerships
- Agreements are in place and community partners are actively engaged in planning BHE initiatives
- Data Sharing facilitates a closed-loop referral that advances BHE
If I could get out of here, I’d take a course in data analysis.
Baseline Scoring Complete!

Added comments to explain scores!
CAT Results: A few qualifiers

- The CAT is still in training (being validated). Please share any feedback.

- The pandemic has taken its toll on centers. Be understanding of scores (yours and others).

- If you’re seeing lots of opportunities to advance equity, trauma informed care, addressing social needs, etc., you’re in the right program!

“Would you like to come over for dinner?”
Average CAT domain scores (n=15 organizations)

- Senior Lead & Org Commitment: 2.8
- Data Driven Systems: 2.2
- Access to Care: 5.0
- Integ. Care Team & Delivery: 4.1
- PT Activ & Self Mgmt: 2.9
- Comm Partnerships: 4.4
- Total Score: 3.6

**Highest** – Access to Care and Community Partnerships (likely got a “pandemic push”)

**Lowest** – Data driven challenges

15 org average at low end of “Intermediate I”
Total Score (All Orgs) by Driver Domain - Spread

Box Plot Key
- High
- 75%-tile
- Median
- Average (Mean)
- 25%-tile
- Low

5-6 point spread across all domains

TMI: Outliers are beyond +/- 1.5 IQR

Center for Care Innovations
Total Score Spread by Org

Beginner
n=6 (40%)

Intermediate I
n=8 (53%)

Intermediate II
n=1 (7%)

1.8 1.9 2.1 2.1 2.7 2.9 3.2 3.4 3.7 3.7 3.8 4.2 4.6 4.8 4.9 7.0
CAT Results: Deeper Insights

- Top factor correlates with org size:
  - Listening to the voice of all patients \((r=0.69)\)
  - Integrated care registries support equitable PHM \((r=0.52)\)
  - Clinical workflows are established for common BH comorbid conditions; Evidence-based interventions used \((r=0.34)\)

- Top factors driving Total Score:
  - Developing a culturally intelligent workforce \((r=0.95)\)
  - Patient and caregiver education driven by patient preferences, advances health literacy \((r=0.87)\)
  - Data Sharing with community partners facilitates a closed-loop referral \((r=0.85)\)

Low n, interpret with caution.
### Average Factor Scores (All Orgs)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
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<tbody>
<tr>
<td>Listening to the voice of all patients</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Integrated care registries</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>MH screening and management: SDOH</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>MH screening and management: SUD</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Clinical workflows: fast, for BH</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
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<tr>
<td>Self-trained for integrated care team roles, respones</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Agreements with comm partners; closed loop referral</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>PT activ &amp; self mgmt</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Comm partners</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Care plans activate pt; self-nigt support empowered; digital tools</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>MH, SA, and PC services are integrated</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Team-based care embedded into integrated BIP practice</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Multi-modal visits reduce barriers</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Data analysis accelerate reductions in health inequity</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Adopting TIC best practices</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Integrated care registries support equitable P&amp;H</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Appt scheduling respect pt/family needs, pref</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>High: Multi-modal visits</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Low: Integrated care registries</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Low: Listening to the voice of all patients</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>High: MH Screening</td>
<td>2.1</td>
<td>3.6</td>
<td>4.5</td>
</tr>
</tbody>
</table>
Senior Leadership & Org Commitment – ABHE “North Star”

Topics to focus on:
Leading org culture;
Listening to the voice of patients

Tap into best practices at this org

Box Plot Key
- High
- 75%-tile
- Average (Mean)
- Median
- 25%-tile
- Low
Integrated Care Team & Care Delivery

MH screening is strong

Topics to focus on: SDOH screening; Staff trained for integrated care team

Box Plot Key
- High
- 75%-tile
- Median
- Average (Mean)
- 25%-tile
- Low
You’ll receive a “CAT Comparison Report” that compares your organization’s baseline results against the ABHE Group results shared today.

Use to identify strengths that can be leveraged and potential opportunities to address in your Roadmap & Charter.
We want to hear from you.

What jumped out to you in the CAT results?

Any initial ideas for program support?
Questions?

1. Are there any questions that you have?
2. Is there something you would like more clarity on?
Review Evaluation Plan
Evaluation Roadmap

Ann Middleton, MPH

Research Associate
American Institute for Research
ABHE-PC Program Evaluation Goals

• Mixed methods evaluation
  – Implementation
  – Outcomes
  – Impact

• Systems Change/Drivers Targeted
  – Leadership & Organizational Commitment
  – Data Driven Systems and Decisions
  – Access
  – Care Team/Care Delivery
  – Patient Activation/Self-Management
  – Community Partnerships
Advancing Equity

• How do changes at CHCs impact perceptions of equity among patients and providers and equitable experiences or outcomes?

**Collect:**  
- Capability Assessment, document abstraction (policies and procedures, workflows)
- Universal Measure Set (EHR Data), patient and clinician surveys and interviews

**Analyze/Synthesize:** Quantitative analysis for standardized measures; thematic analysis of qualitative measures

**Contextualize:** Triangulation will allow us to examine issues of equity from multiple perspectives
Program Evaluation Data Collection Activities
Universal Measure Set

- Selected standardized quality measures commonly used in CA
- Extracted from EHR at the site level, stratified by REAL/SOGI when possible
- Small-group technical assistance sessions provided prior to each submission
- Guidance on data extraction and saving reports provided, customized by EHR to support subsequent waves of data collection
- Three waves of data collection on patient panel:

<table>
<thead>
<tr>
<th>ABHE Collection Period</th>
<th>Extract Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>March 30, 2022</td>
</tr>
<tr>
<td>Endline</td>
<td>August 31, 2023</td>
</tr>
<tr>
<td>Follow-Up</td>
<td>August 31, 2024</td>
</tr>
<tr>
<td>Measure Category</td>
<td>Measure Name (ID Number)</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cultural Congruence</td>
<td>Clinical Providers, Staff, and Adult Patient Demographics</td>
</tr>
<tr>
<td>BH Diagnosis</td>
<td>Depression Utilization of the PHQ-9 Tool (NQF 0712e)</td>
</tr>
<tr>
<td></td>
<td>Mental Health and Substance Use Disorder Diagnoses</td>
</tr>
<tr>
<td>BH/SUD Referrals</td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
</tr>
<tr>
<td></td>
<td>Number and proportion of patients referred to treatment by health need/diagnosis</td>
</tr>
<tr>
<td>BH Utilization*</td>
<td>Behavioral Health Care Utilization</td>
</tr>
<tr>
<td>BH Access*</td>
<td>Access to Care:</td>
</tr>
<tr>
<td></td>
<td>• No-show counts for first behavioral health appointment</td>
</tr>
<tr>
<td></td>
<td>• Timeliness of Care</td>
</tr>
<tr>
<td></td>
<td>• Types of care offered vs. used</td>
</tr>
<tr>
<td>BH Outcome</td>
<td>Depression Remission at Twelve Months (NQF 0710e)</td>
</tr>
</tbody>
</table>

* Further discussion and refinement during Evaluation Orientation Webinar on November 17.
# Universal Measures, Part 2

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Measure Name (ID number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD/Tobacco Screening and Treatment</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF 0004)</td>
</tr>
<tr>
<td></td>
<td>Substance Use Screening and Intervention Composite (NQF 2597)</td>
</tr>
<tr>
<td>Physical Health Outcome</td>
<td>Controlling High Blood Pressure (NQF 018)</td>
</tr>
<tr>
<td></td>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%) (NQF 0059)</td>
</tr>
<tr>
<td></td>
<td>Optimal Asthma Control (Quality ID 398)</td>
</tr>
</tbody>
</table>
Patient Experiences

• **Web-based Patient Survey**
  – Provided in five languages (English, Spanish, Tagalog, Cantonese, Vietnamese)
  – Primarily CAHPS ECHO Measures
  – AIR to support with:
    » dissemination protocols and monetary incentive distribution
  – Two waves of data collection:

<table>
<thead>
<tr>
<th>ABHE Collection Period</th>
<th>Survey Fielding Window</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>January-March 2022</td>
</tr>
<tr>
<td>Endline</td>
<td>January-March 2023</td>
</tr>
</tbody>
</table>
Capturing Integration, Systems-change

• **Ongoing data collection**
  – Coaching and event observations
  – Document review (e.g., policies, workflows, job aides, training documents)

• **Endline**
  – Listening sessions with CHC staff and patients
    » In-person and virtual
    » Incentives provided for patient listening sessions
AIR ABHE-PC Program Evaluation Team

Ann Middleton, MPH  
*Project Director*  
Public health, social needs identification and referral

Sarah Pedersen, MPP  
*Qualitative Lead*  
Qualitative researcher in healthcare systems and social services

Clea Vannet, MPH  
*Project Manager*  
Qualitative researcher in health equity

Lauren Kestner, MA  
*Qualitative Analyst*  
Qualitative researcher in mental health and substance use disorders

Brandon Hesgrove, PhD  
*Quantitative Lead*  
Health economist managing complex healthcare data
Key Advisors

- **Brandy Farrar, PhD**
  - **Evaluation Advisor**
  - Mixed methodologist, healthcare systems, and health equity

- **Melissa Hafner, MPP**
  - **Measures Expert**
  - Mixed methodologist and measurement lead

- **Maliha Ali, DrPH**
  - **Health Equity Expert**
  - Healthcare outcomes researcher focusing on vulnerable populations
Evaluation Orientation, November 17

• **Activities:**
  – Detailed discussion on evaluation activities
  – Refine measures around utilization and access
  – Review options for disseminating patient survey

• **Attendance is open – please invite:**
  – Lead staff,
  – Staff involved in EHR data management, and
  – Staff involved in patient outreach protocols.
Next steps
1. Please select the number that best represents your experience with today’s session.  
   - **5** – Excellent  
   - **4** – Very Good  
   - **3** – Good  
   - **2** – Fair  
   - **1** – Poor

2. Please select the number that best represents your response to the statement: Today’s session was a valuable use of my time.  
   - **5** – Strongly Agree  
   - **4** – Agree  
   - **3** – Neutral  
   - **2** – Disagree  
   - **1** – Strongly Disagree

3. Please select the number that best represents your response to the statement: "Today’s session presented information in a way that was accessible to me"  
   - **5** – Strongly Agree  
   - **4** – Agree  
   - **3** – Neutral  
   - **2** – Disagree  
   - **1** – Strongly Disagree

4. Please select the number that best represents your response to the statement: "I know what is expected of my team over the next few months."  
   - **5** – Strongly Agree  
   - **4** – Agree  
   - **3** – Neutral  
   - **2** – Disagree  
   - **1** – Strongly Disagree
Meet with your coaches in November
- Review CAT
- Start to identify areas of focus

Register for AIRs Evaluation Orientation on 11/17
- Attendees: Data Lead and Project Lead
- Registration: [https://www.careinnovations.org/abhe-evaluation-meeting/](https://www.careinnovations.org/abhe-evaluation-meeting/)

Prepare for Learnings Session #1 on 12/2
- Attendees: Core Team and Extended Team (All)
- Pre work: More details to come next week
- Registration: [https://www.careinnovations.org/abhe-learning-session-1-reg/](https://www.careinnovations.org/abhe-learning-session-1-reg/)

Join the ABHE Club!
- Continue your breakout conversations in the Cohort Collaboration tab
Questions

Juan Carlos Piña
He/Him/His
Program Manager
juancarlos@careinnovations.org

Lydia Zemmali
She/Her/Hers
Program Coordinator
lydia@careinnovations.org
Thank you!
Appendix
<table>
<thead>
<tr>
<th>Organization</th>
<th>City</th>
<th>Subpopulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinatown Service Center</td>
<td>Los Angeles</td>
<td>Asian, Pacific Islander</td>
</tr>
<tr>
<td>Community Health Centers of the Central Coast</td>
<td>Santa Maria</td>
<td>Latinx, Indigenous migrant populations, Transition-aged youth, LGBTQ+, Limited English Proficiency</td>
</tr>
<tr>
<td>Eisner Health</td>
<td>Los Angeles</td>
<td>Latinx, Black, Elderly, Transition-aged youth</td>
</tr>
<tr>
<td>Elica Health Centers</td>
<td>Sacramento</td>
<td>Middle Eastern/Central Asian immigrants and refugees (particularly from Afghanistan), Latinx</td>
</tr>
<tr>
<td>Korean Community Services</td>
<td>Anaheim</td>
<td>Asian, Native Hawaiian, Pacific Islander, Undocumented immigrants, Severe and persistently mentally ill</td>
</tr>
<tr>
<td>Los Angeles County University of Southern California Primary Care</td>
<td>Los Angeles</td>
<td>Black, Latinx, Substance use disorders, Mild to moderate depression</td>
</tr>
<tr>
<td>Marin City Health and Wellness Center</td>
<td>San Rafael</td>
<td>African American, Latinx, Serious and persistently mentally ill</td>
</tr>
<tr>
<td>Open Door Community Health Centers</td>
<td>Arcata</td>
<td>BIPOC, Seriously and persistently mentally ill, Co-occurring disorders (mental health and substance abuse)</td>
</tr>
<tr>
<td>Petaluma Health Center</td>
<td>Petaluma</td>
<td>LGBTQ+, specific transgender focus</td>
</tr>
<tr>
<td>Samahan Health Centers</td>
<td>National City</td>
<td>Asian, Native Hawaiian, Pacific Islander, Filipino,</td>
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<tr>
<td>Santa Barbara Neighborhood Clinics</td>
<td>Santa Barbara</td>
<td>Latinx, Transition-aged youth</td>
</tr>
<tr>
<td>The Achievable Foundation</td>
<td>Culver City</td>
<td>Latinx, Transition-aged youth, Patients with intellectual and developmental disabilities</td>
</tr>
<tr>
<td>UC Davis Health</td>
<td>Sacramento</td>
<td>Latinx, Black, Asian</td>
</tr>
<tr>
<td>Valley Springs Health and Wellness Center</td>
<td>Valley Springs</td>
<td>Latinx</td>
</tr>
<tr>
<td>Via Care Community Health Center</td>
<td>Los Angeles</td>
<td>Latinx, Asian, LGBTQ+, Transition-aged youth</td>
</tr>
</tbody>
</table>