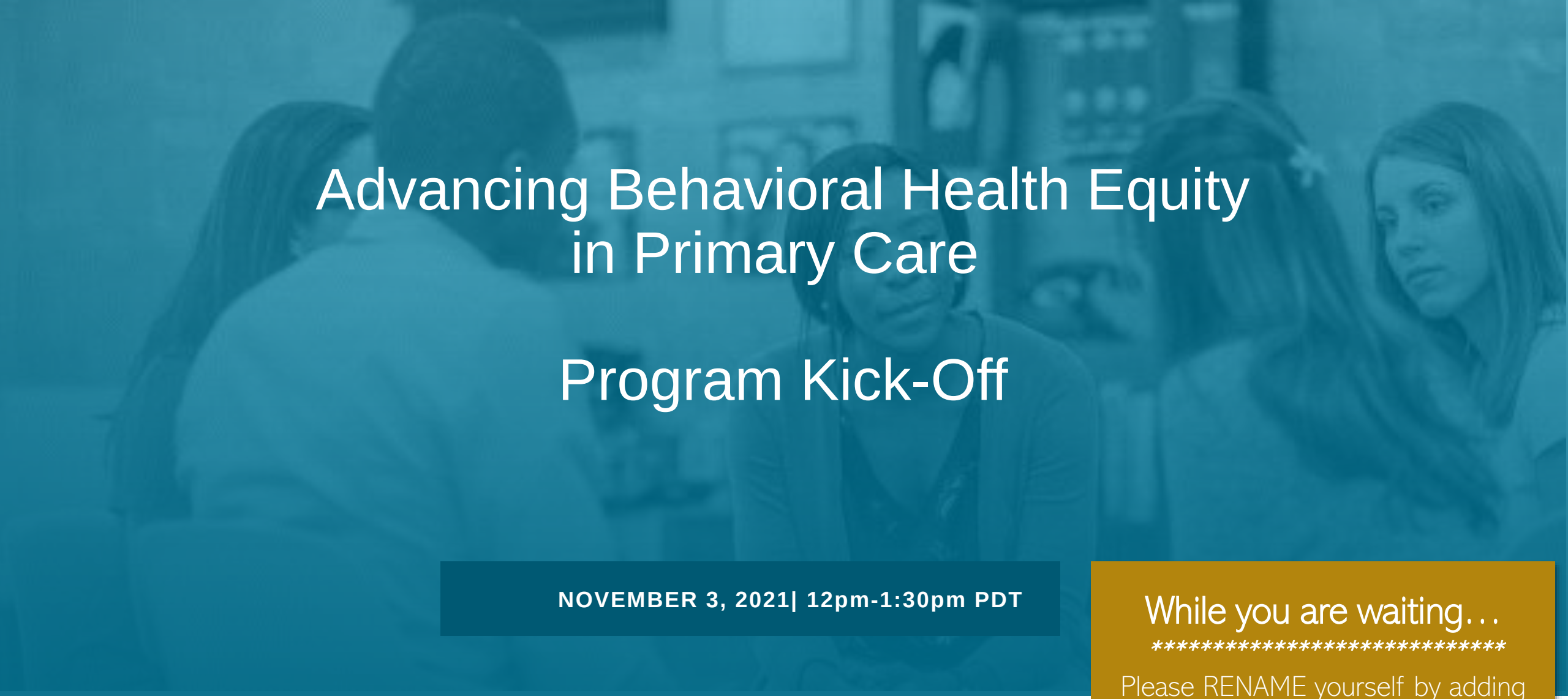


# Advancing Behavioral Health Equity in Primary Care

## Program Kick-Off

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

CCI CENTER FOR CARE INNOVATIONS + California Health Care Foundation

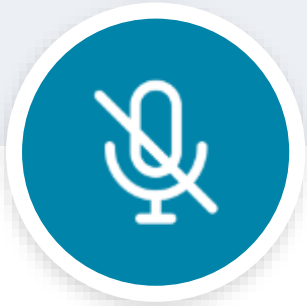
### While you are waiting…

**********

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.

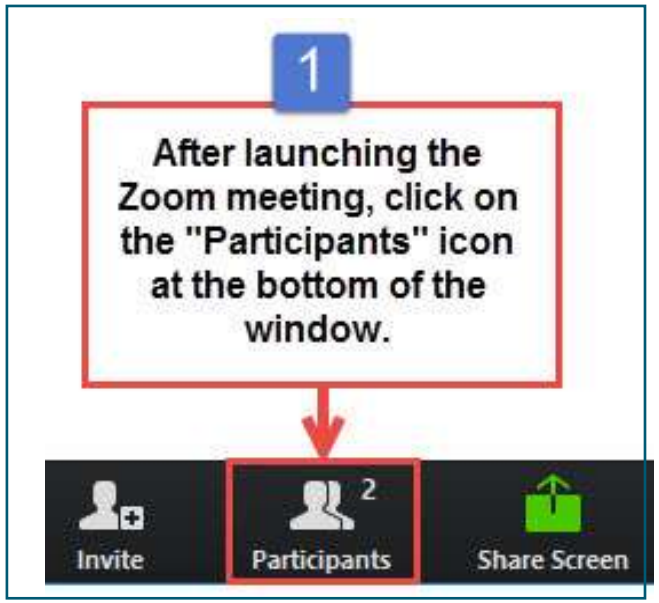
## Tech Issues

**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.





# 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 Analatics
Consultant

Ann Middleton, MPH
Research Associate
American Institute for Research

# Program Roadmap

# Sponsor Welcome

**Kathryn Phillips, MPH**

*Senior Program Officer*
California Health Care Foundation

CHCF

# ADVANCING BEHAVIORAL HEALTH EQUITY IN PRIMARY CARE

CHCF

SPONSOR WELCOME

NOVEMBER 3, 2021

# CALIFORNIA HEALTH CARE FOUNDATION'S COMMITMENT TO INTEGRATED BEHAVIORAL HEALTH

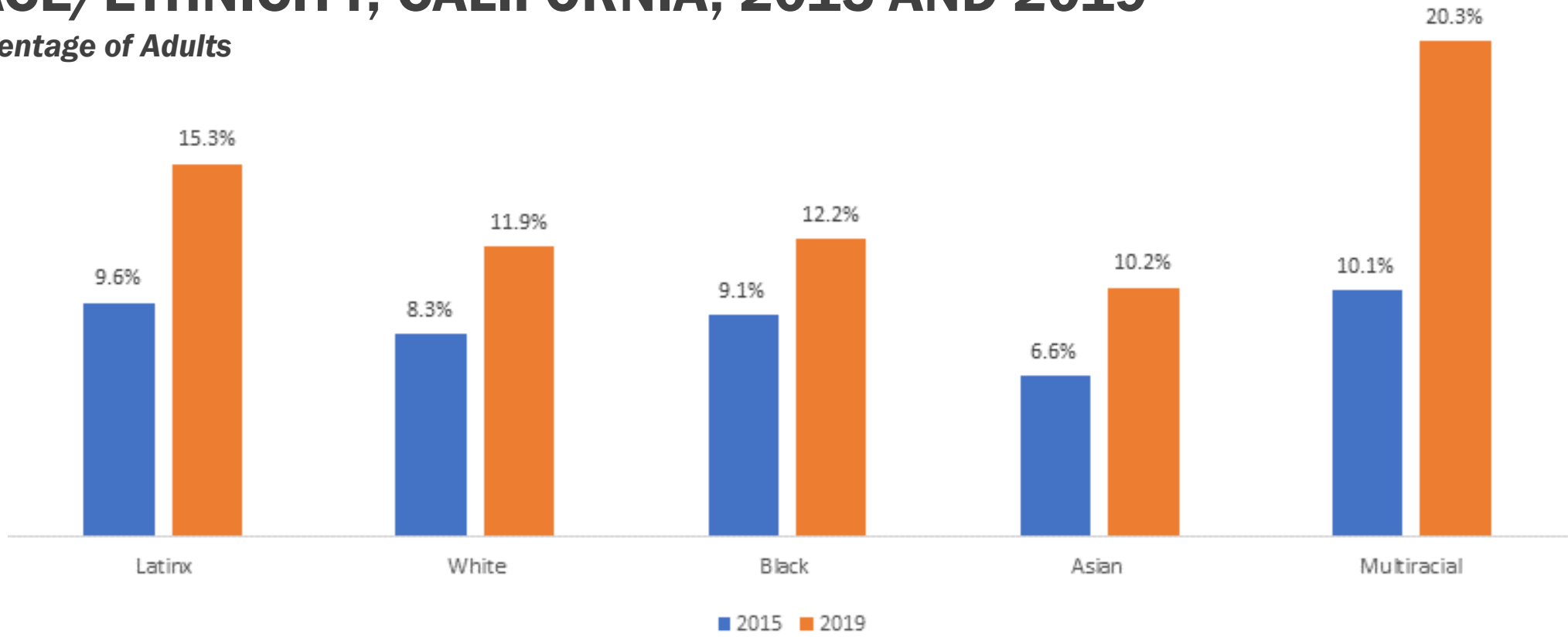
- Behavioral health (BH) conditions are common and undertreated, both in the US and California:
  - In 2018, fewer than half of adult Medi-Cal enrollees with mental illness received a mental health service.
- Primary care providers (and their teams) are the frontline:
  - Approximately half of all care 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 peopled age 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***




**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.

**Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2015 and 2019. http://ask.chis.ucla.edu

# A BRIEF TIMELINE: ABHE-PC IN THE MAKING

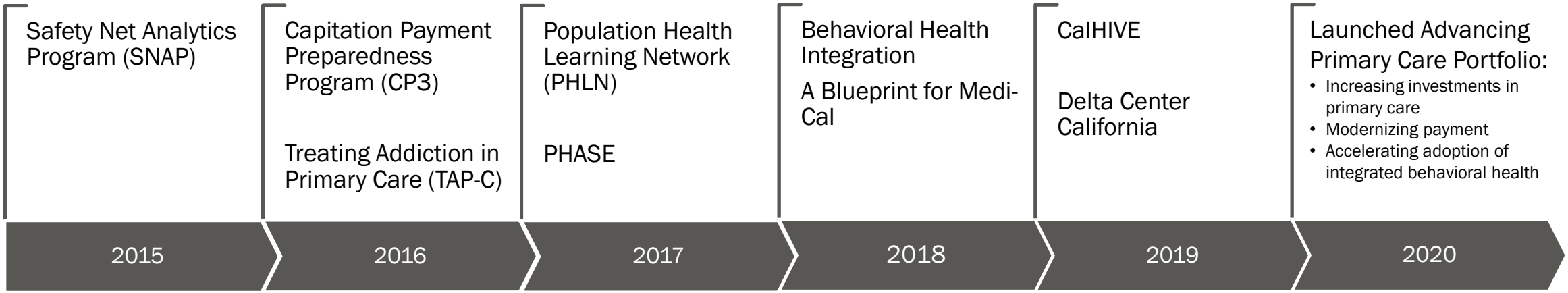
**Since 2014**, CHCF has helped 50+ community health centers (CHCs) operating 500+ primary care sites, improve the delivery of primary care services for at least 1.5 million Medi-Cal members.

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.




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

*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

**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

Feedback, questions, ideas, issues:

Kathryn E. Phillips, MPH
Senior Program Officer, Improving Access
California Health Care Foundation
Desk: 510.587.3122 | Direct: 206.851.4151 | Email:
kphillips@chcf.org
www.chcf.org

**Parinda Khatri, PhD**

*Chief Clinical Officer*
Cherokee Health Systems

*ABHE Clinical Director*

# Behavioral Health Equity
## The Journey Starts Here

Cherokee
HEALTH SYSTEMS

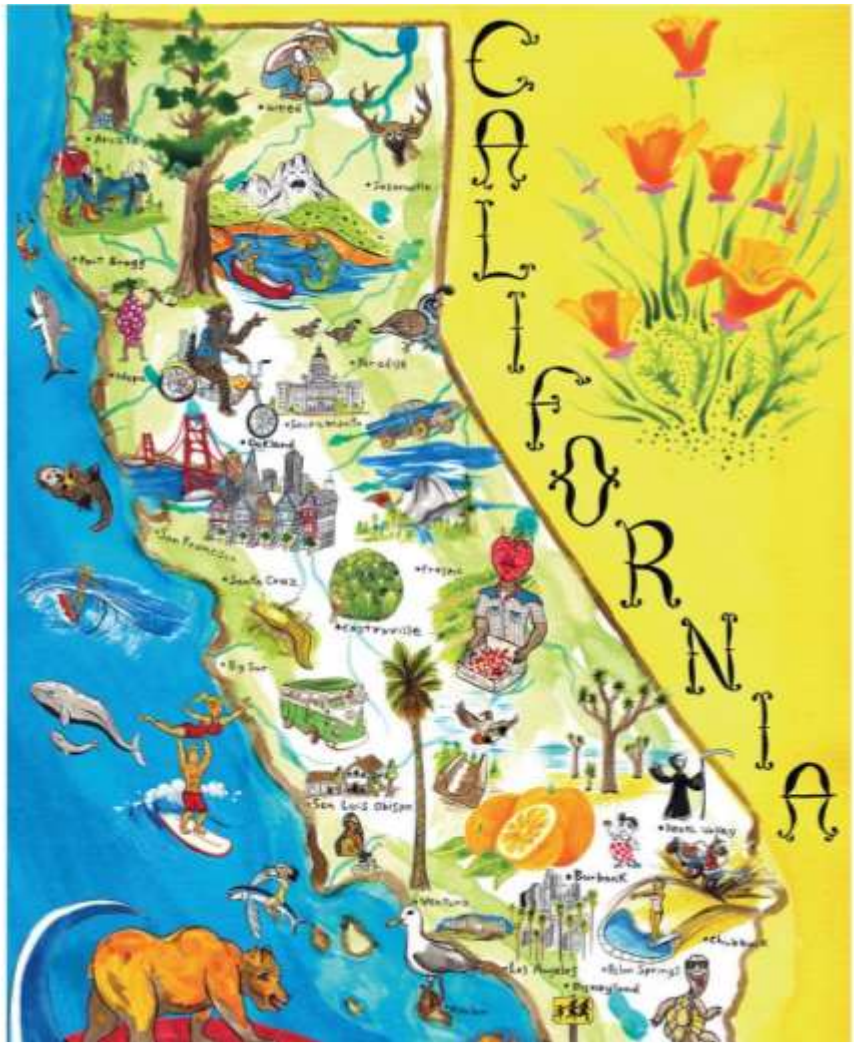
# Advancing Behavioral Health Equity in Primary Care

**Parinda Khatri, PhD**

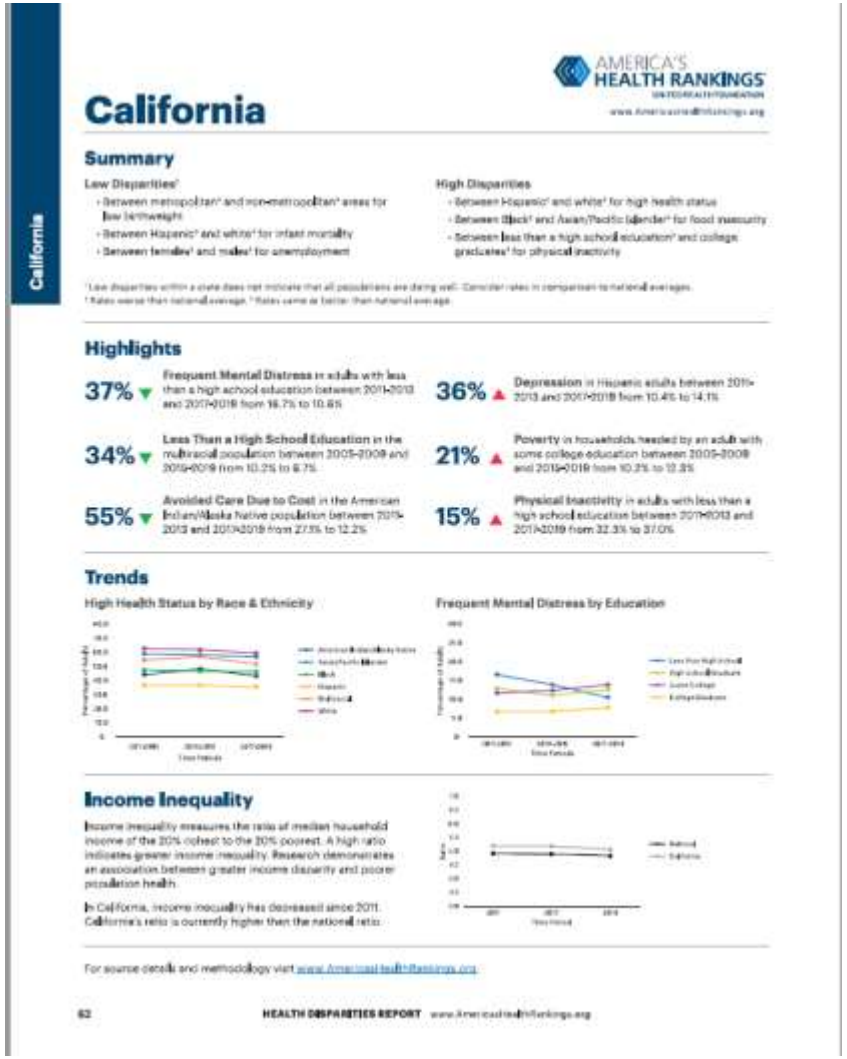
**Chief Clinical Officer**

**Cherokee Health Systems**

**November 3, 2021**



# What Now?

California

AMERICA'S HEALTH RANKINGS

## California

### Summary

Low Disparities[1]
- Between metropolitan[2] and non-metropolitan[3] areas for low birthweight
- Between Hispanic[2] and white[1] for infant mortality
- Between females[1] and males[2] for unemployment

High Disparities
- Between Hispanic[2] and white[1] for high health status
- Between Black[2] and Asian/Pacific Islander[1] for food insecurity
- Between less than a high school education[2] and college graduates[1] for physical inactivity

[1] Low disparities within a state does not indicate that all populations are doing well. Consider rates in comparison to national averages.
[2] Rates worse than national average. [3] Rates same or better than national average.

### Highlights

37% ▼ **Frequent Mental Distress** in adults with less than a high school education between 2011-2013 and 2017-2019 from 16.7% to 10.6%

36% ▲ **Depression** in Hispanic adults between 2011-2013 and 2017-2019 from 10.4% to 14.1%

34% ▼ **Less Than a High School Education** in the multiracial population between 2005-2009 and 2015-2019 from 10.2% to 6.7%

21% ▲ **Poverty** in households headed by an adult with some college education between 2005-2009 and 2015-2019 from 10.3% to 12.3%

55% ▼ **Avoided Care Due to Cost** in the American Indian/Alaska Native population between 2011-2013 and 2017-2019 from 27.5% to 12.2%

15% ▲ **Physical Inactivity** in adults with less than a high school education between 2011-2013 and 2017-2019 from 32.3% to 37.0%

### Trends

High Health Status by Race & Ethnicity

Frequent Mental Distress by Education

### Income Inequality

Income inequality measures the ratio of median household income of the 20% richest to the 20% poorest. A high ratio indicates greater income inequality. Research demonstrates an association between greater income disparity and poorer population health.

In California, income inequality has decreased since 2011. California's ratio is currently higher than the national ratio.

For source details and methodology visit www.AmericasHealthRankings.org

62 HEALTH DISPARITIES REPORT www.AmericasHealthRankings.org

# Our journey begins with the goal in mind…ABHE

*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

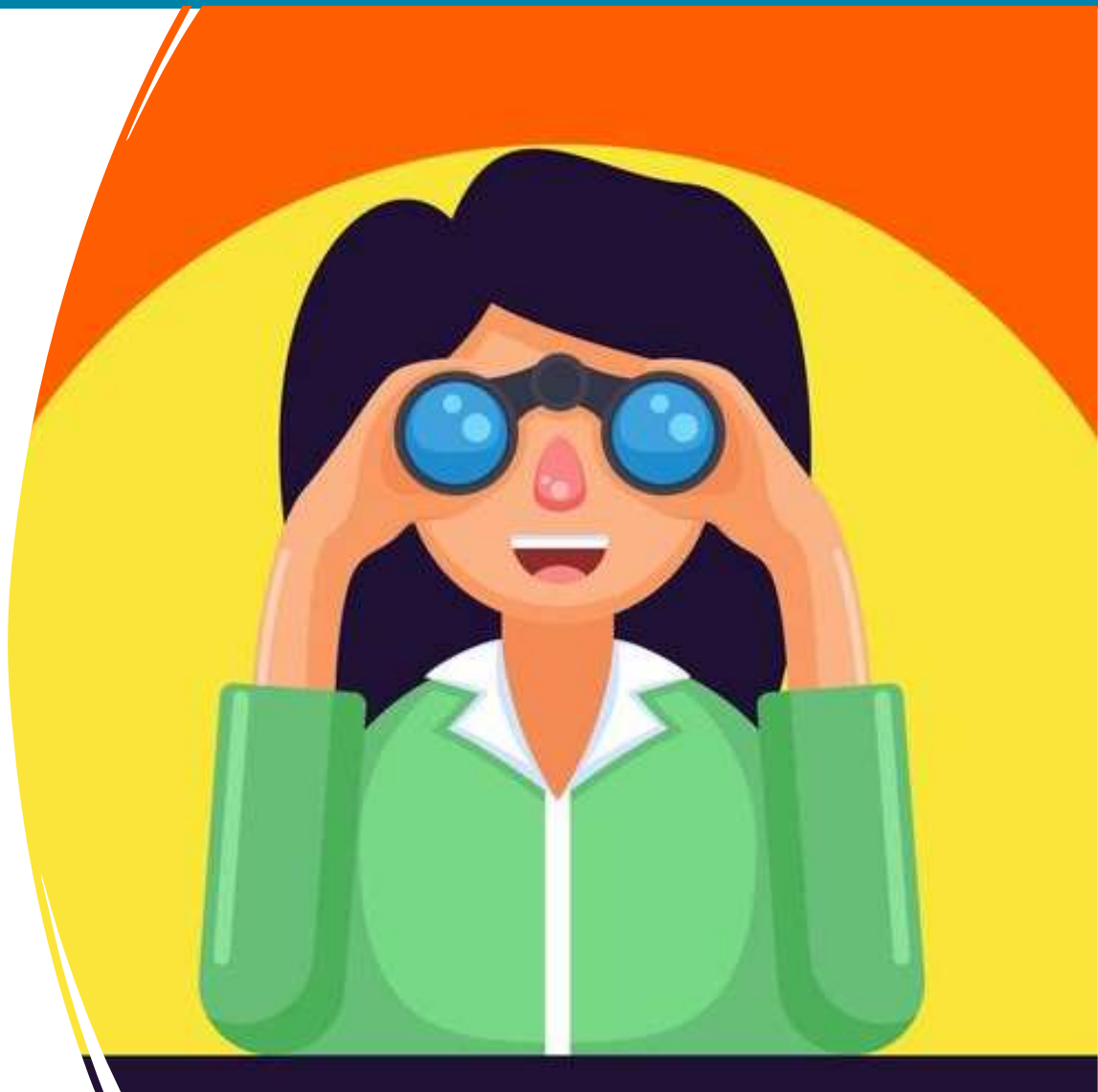
RESOURCES AND FACILITATORS

DESIGN AND IMPLEMENT

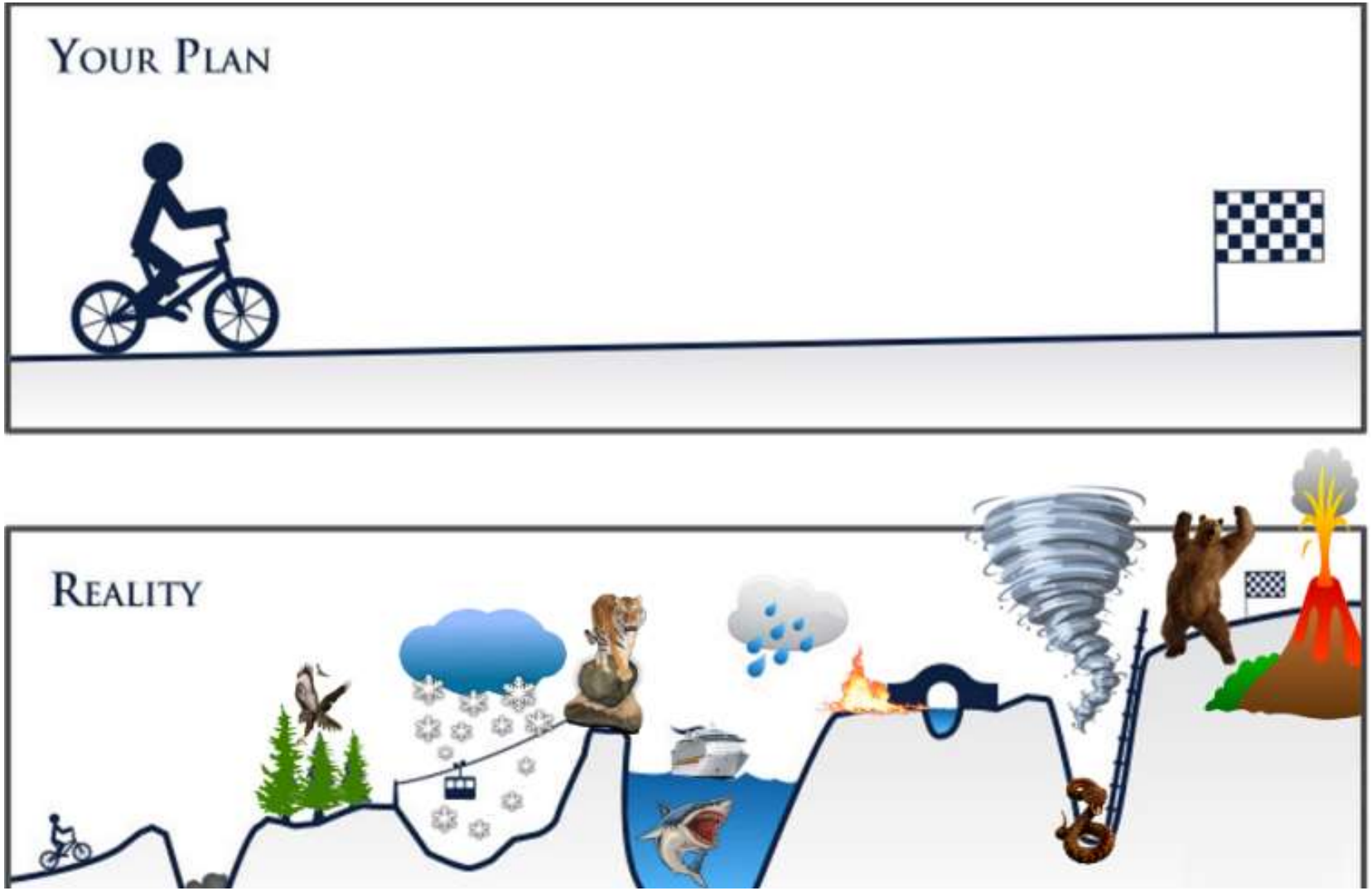
# The view

**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

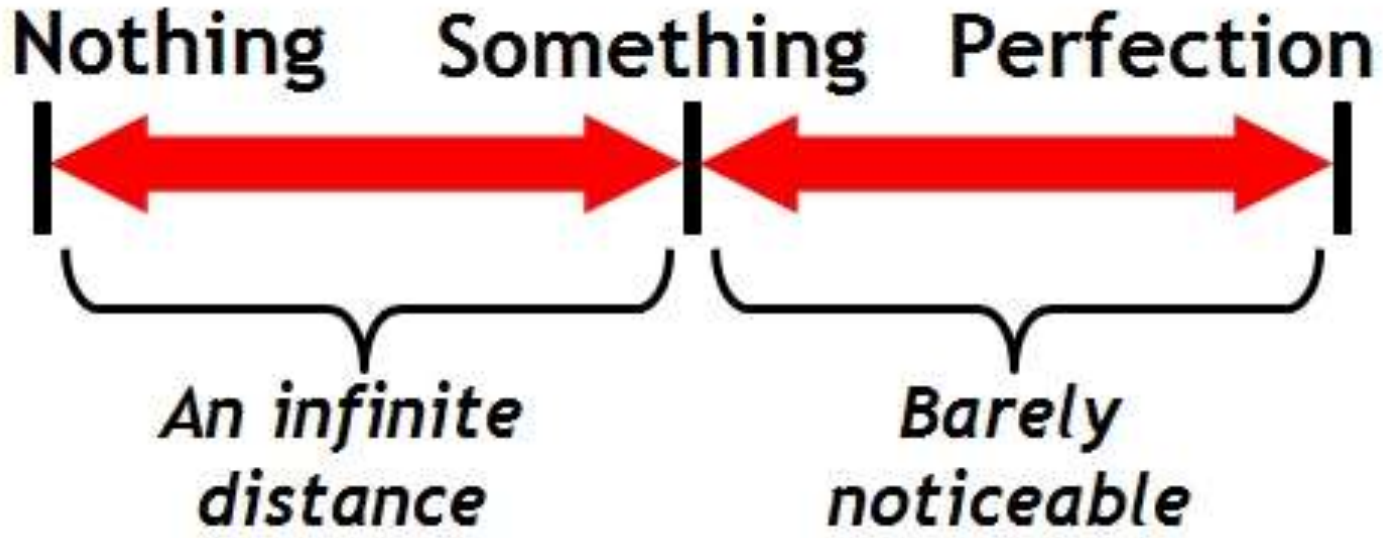
## COMPLICATED

- 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

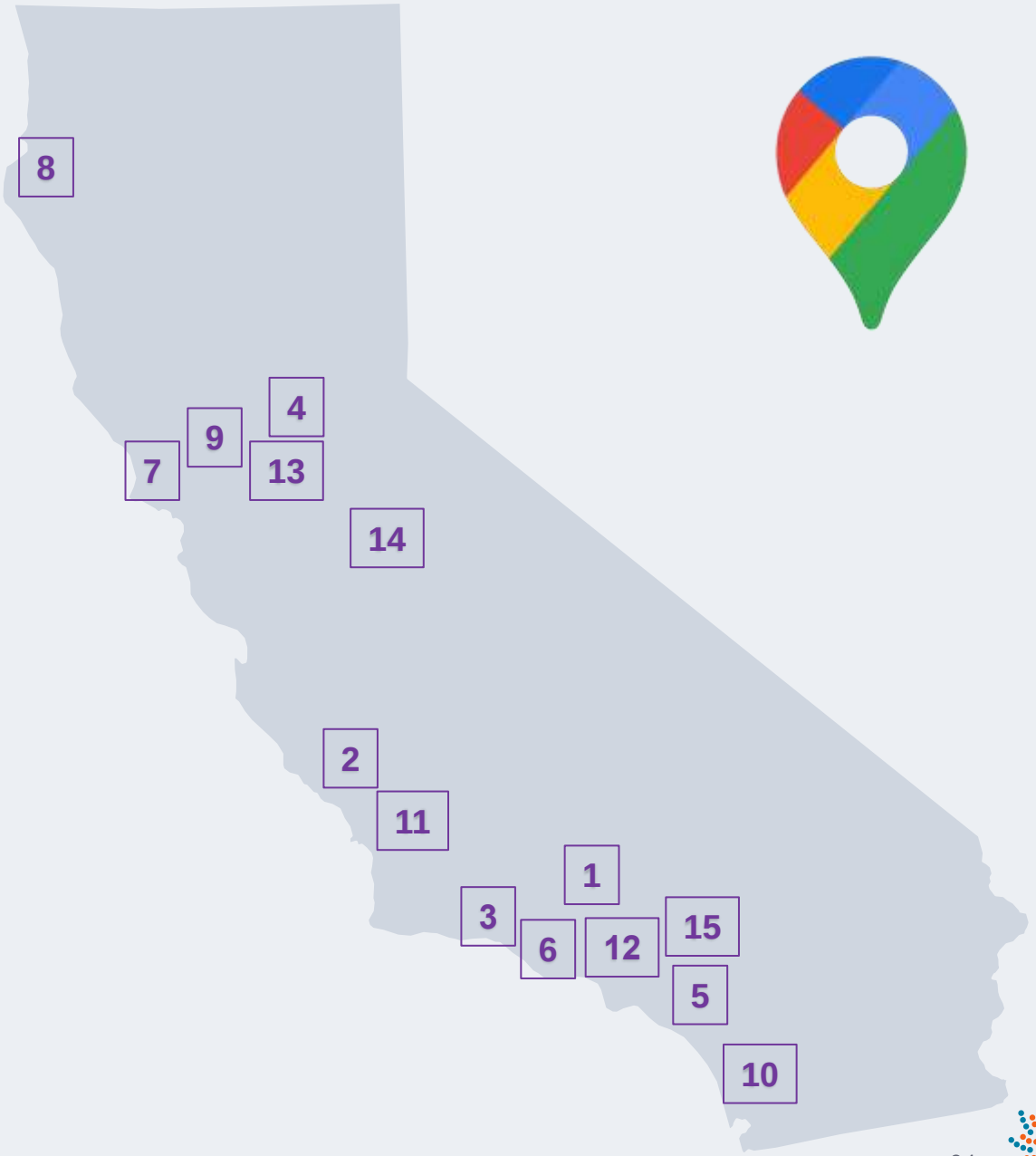
**283,901**

Number of Patients Served Annually Across all Clinic Sites



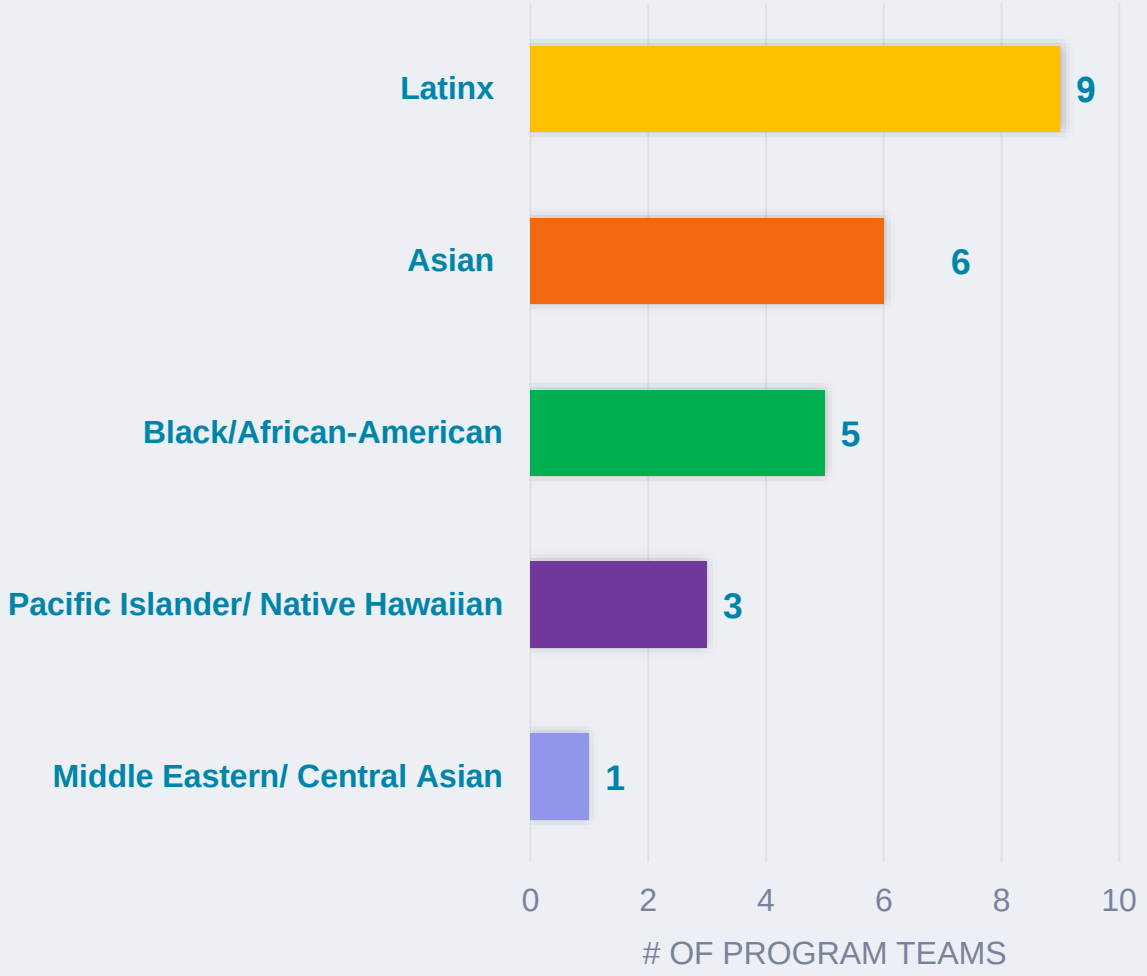
# Cohort at a Glance

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

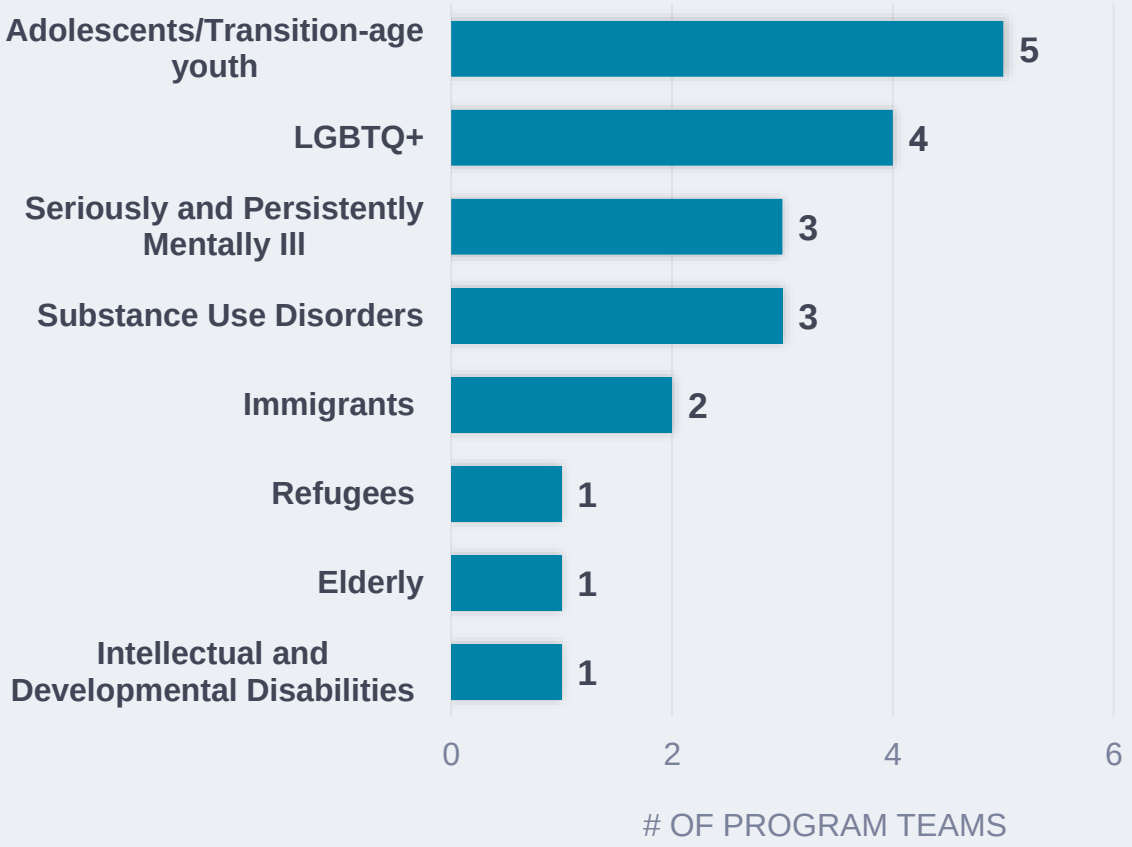


# Priority Subpopulations

## Race/Ethnicity




## Patient Characteristics



# Breakout [Mix of teams]

***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)

# Program Objectives

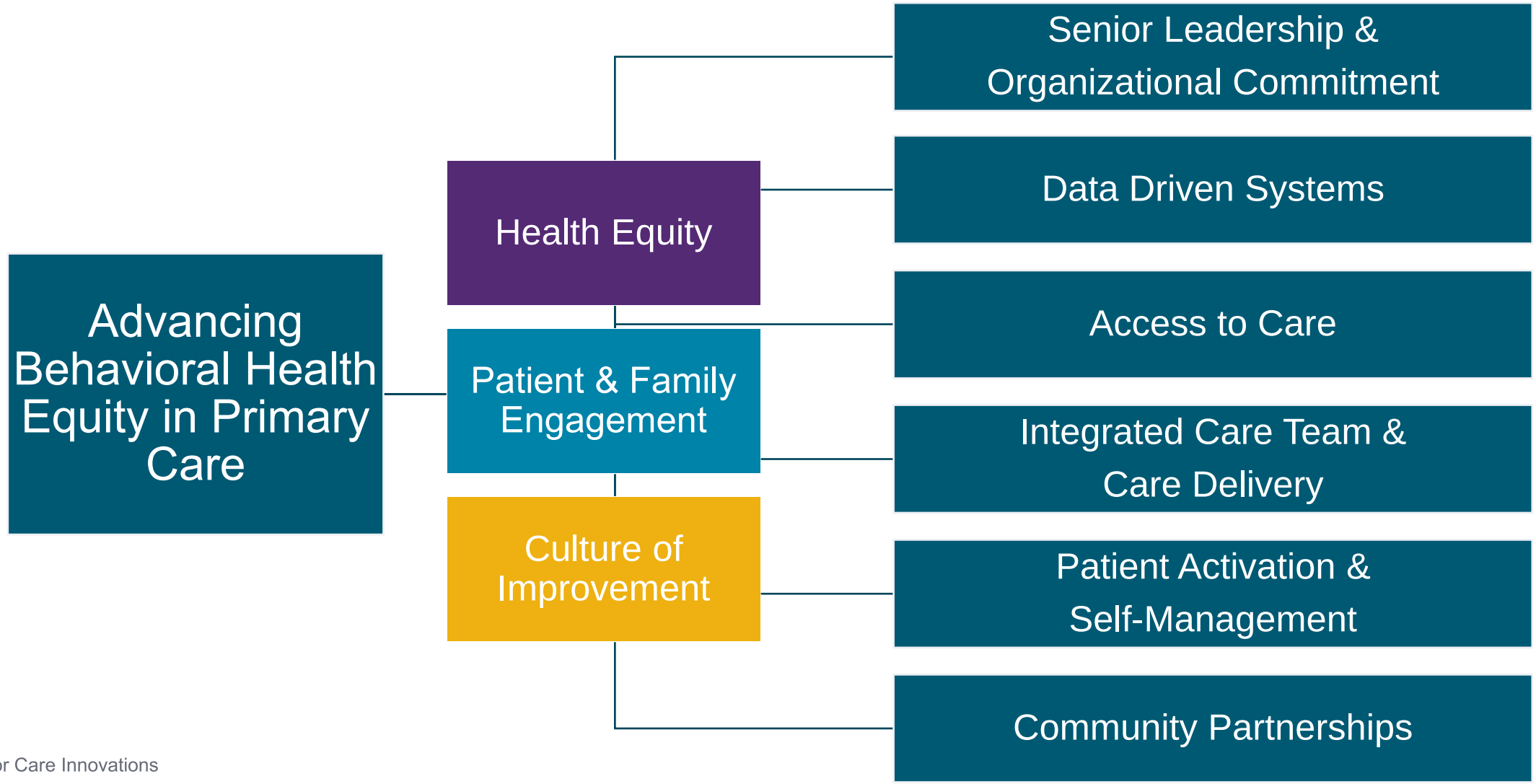
*Sept 2021 – May 2023*

## The Goal

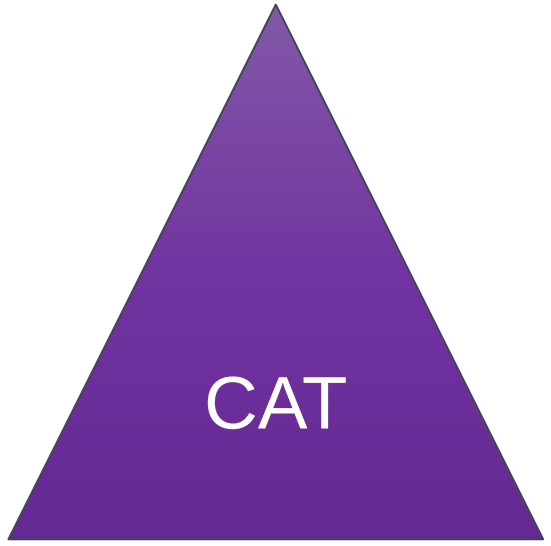
To support 15 California community health centers (42 sites) in expanding integrated behavioral health care and improving outcomes with a specific focus on advancing health equity and aligning behavioral health and social needs resources.

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)

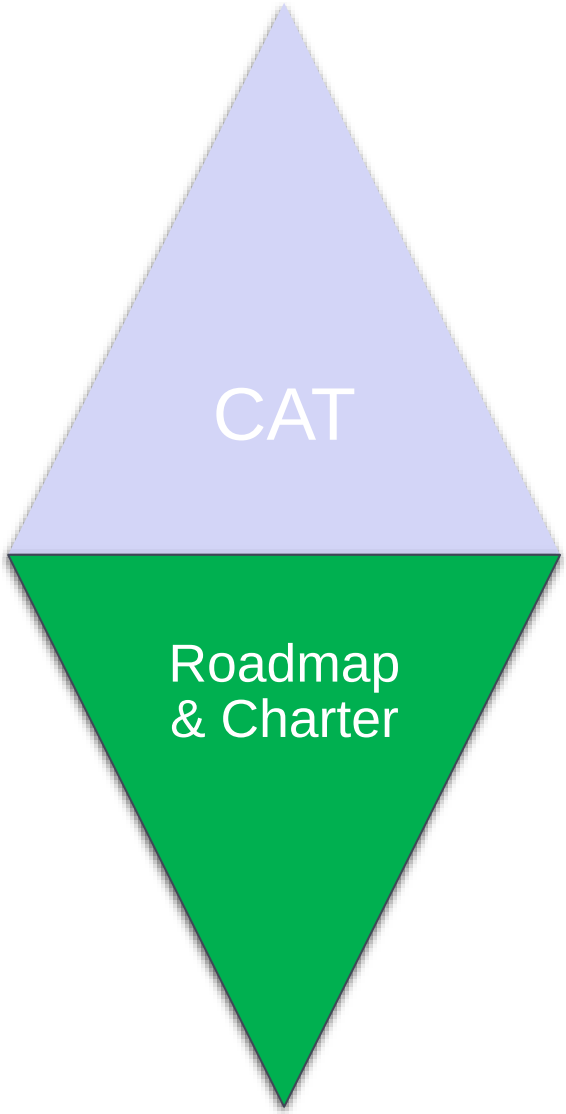



- **Completed 4 Times:** Baseline, Midpoint, Endpoint, 1 Year Post Program.

  ✓**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.

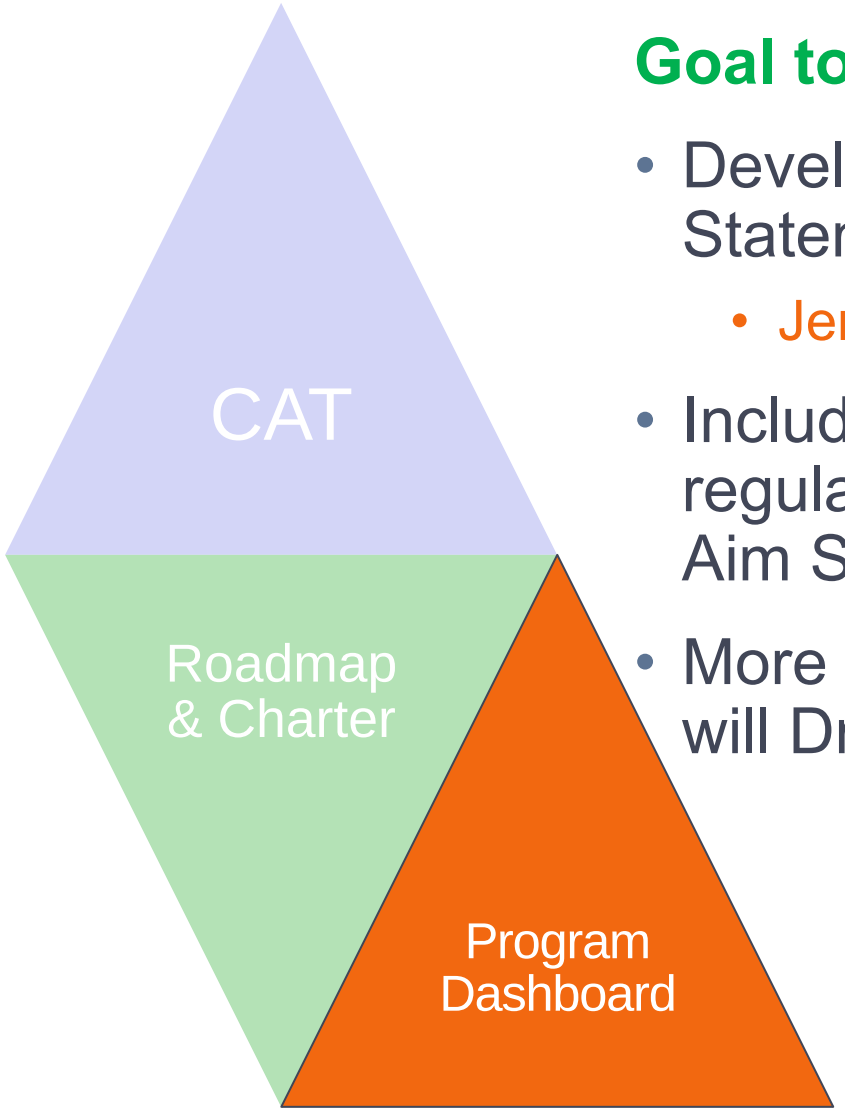
# Key Program Elements
## ROADMAP / CHARTER




**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

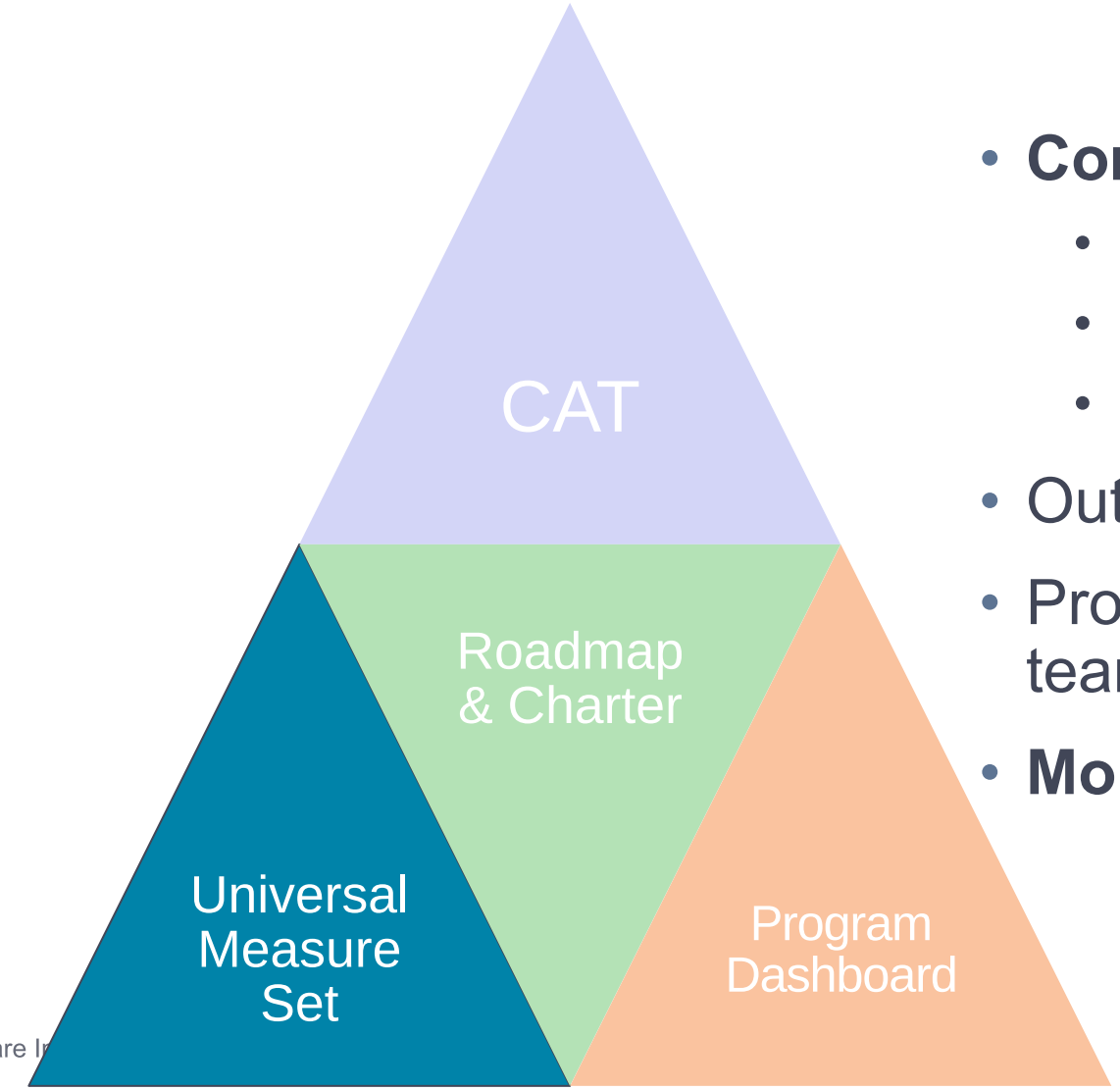
# Key Program Elements
## Program Dashboard (Process Measures)




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

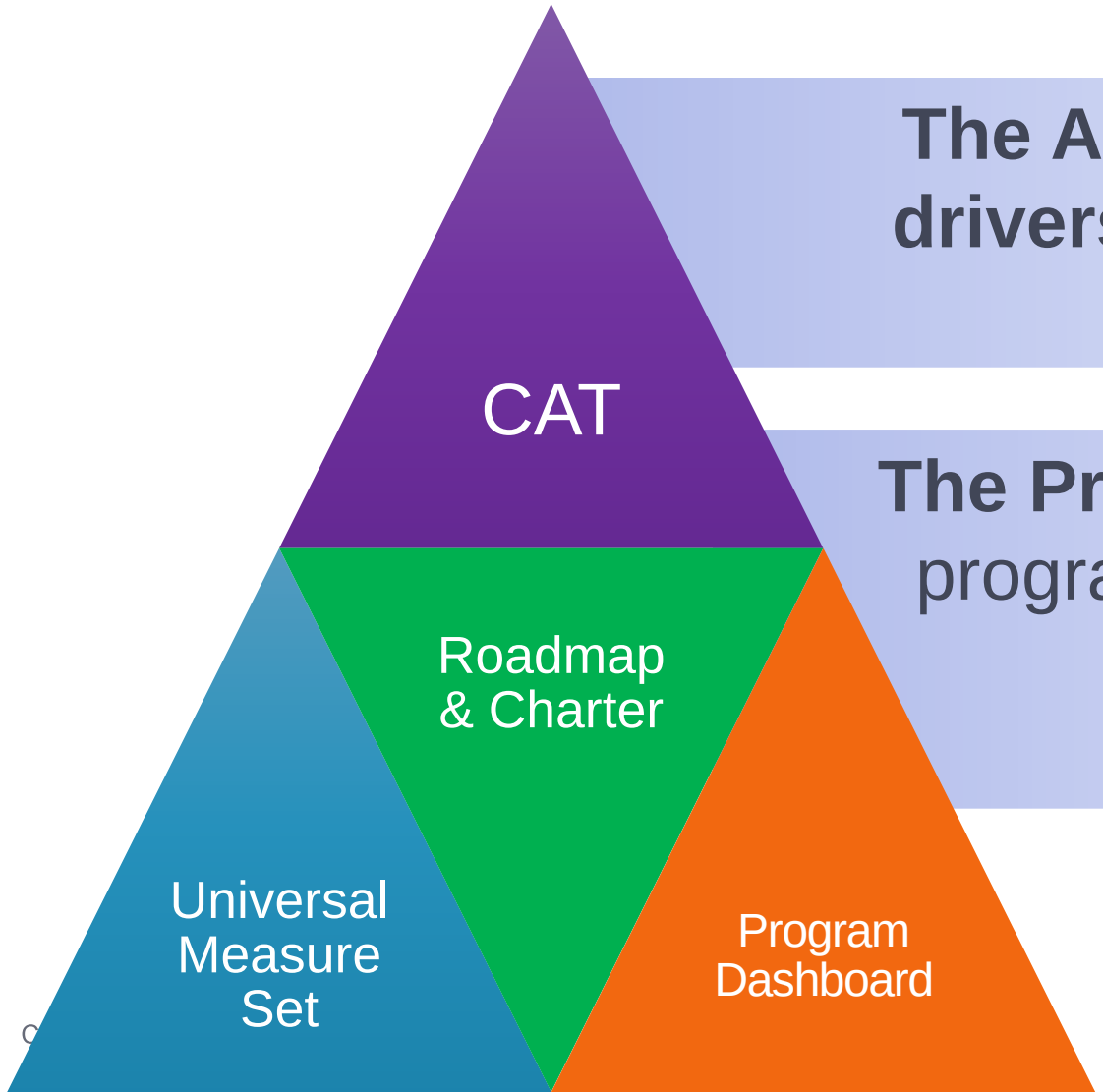
- Developed as you develop your Aim Statements and Roadmaps/Charters
  - Jerry Lassa will co-design these with you!
- Includes measures that you will track regularly to assess progress toward your Aim Statement
- More actionable than Outcome Measures – will Drive Improvement!

# 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!**

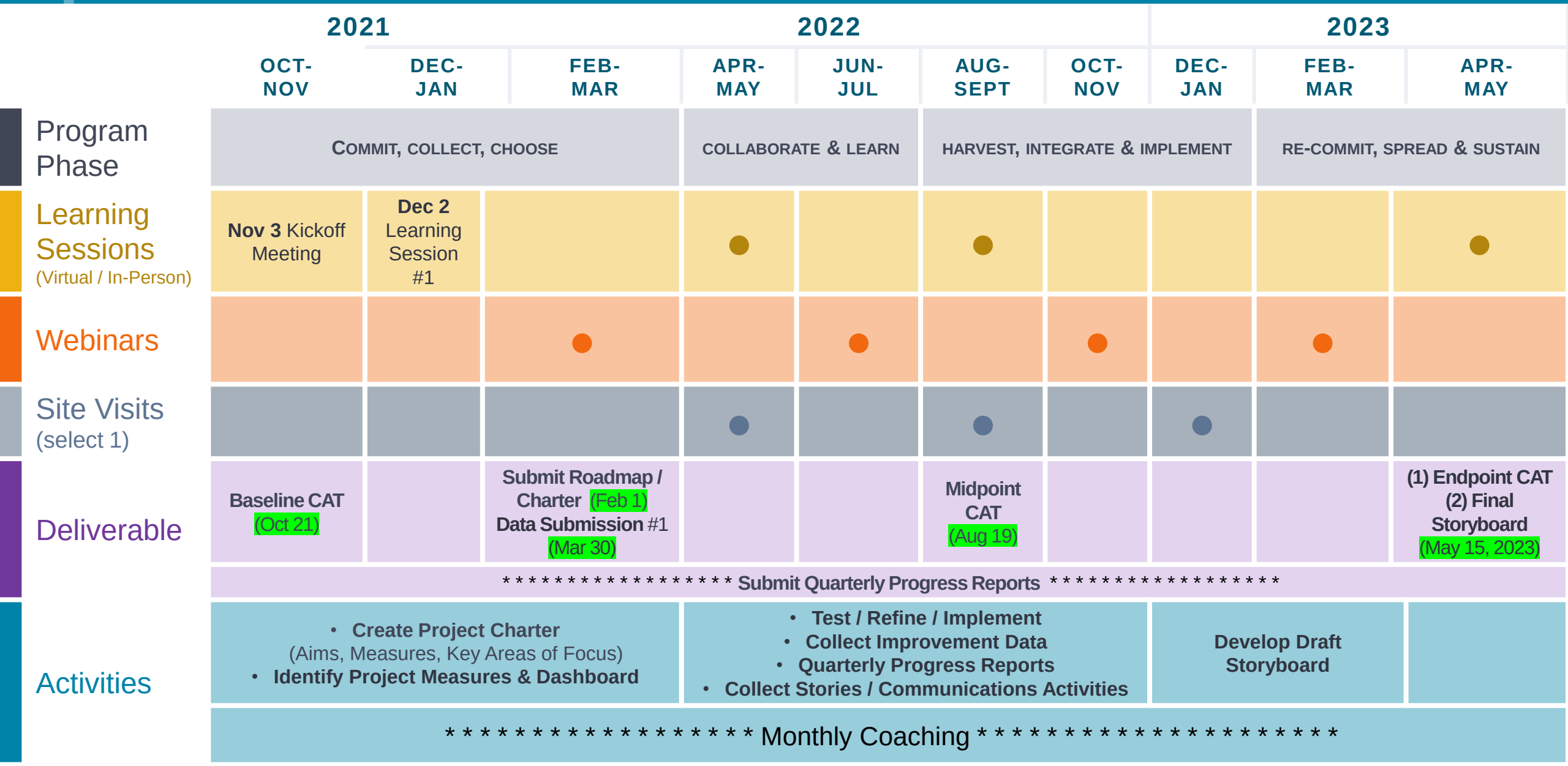
# How Does it All Come Together?




**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…)***

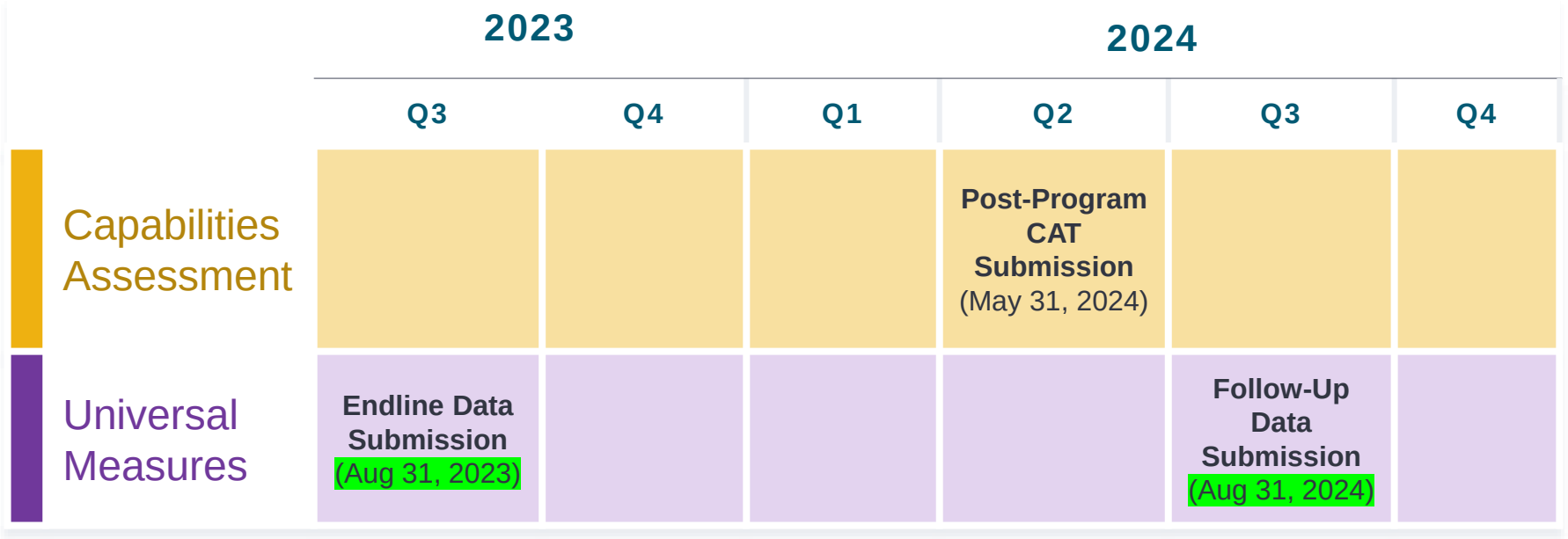
# Program Timeline



# Next 4 Months: Commit, Collect, Choose

| | 2021 | | 2022 | |
|---|---|---|---|---|
| | NOV | DEC | JAN | FEB |
| Program Phase | COMMIT, COLLECT, CHOOSE | | | |
| Learning Sessions (Virtual / In-Person) | **Nov 3** Kickoff Meeting | **Dec 2** Learning Session #1 | | |
| Webinars | **Nov 17** Evaluation / Universal Measures Orientation | | | **Topical Webinar #1** (Date TBD) |
| Deliverable | | | | **Submit Roadmap / Charter** (Feb 1) |
| Activities | **Using CAT, identify opportunity areas, draft Aims**<br><br>**Provide CCI with additional details on current state** (to assess SDOH screening, demographic data collection) | **Identify Project Measures & Dashboard**<br><br>**Plan for Universal Measures Data Submission #1** | **Finalize Roadmap / Charter (Aim, Measures, Workplan (Due Feb 1)**<br><br>**Start Testing / Improvement (PDSAs)**<br><br>**Plan for Universal Measures Data Submission #1 (cont.) (Due Mar 30)** | |
| Coaching | **Monthly Coaching Call** | **Monthly Coaching Call** Jerry Lassa to join coaching calls / Develop dashboards | **Monthly Coaching Call** Executive Leaders join coaching calls – Review Aims / Charter | **Monthly Coaching Call** |

# Post-Program Data Collection



# 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.

How did we score relative to the group?

# CAT Results Overview

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

Recap

# ABHE-PC Capability Assessment Tool (CAT)






6 Domains

18 Factors

### (1) Senior Leadership & Organizational Commitment

1. Leading, planning and creating an organization culture that prioritizes BH Equity (BHE)
2. Listening to the voice of all patients
3. Hiring an EID workforce
4. Developing a culturally intelligent workforce
5. Adopting TIC best practices

### (2) Data Driven Systems

1. Integrated care registries support BHE PHM
2. Data analysis and quality measures support BHE

### (3) Access to Care

1. Appointment scheduling respect patient and family needs and preferences
2. 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

1. MH, SUD, and PC services are integrated
2. Team-based care is embedded into BH practice
3. Screening, assessment and management is culturally and linguistically competent
4. Clinical workflows are established with EB
5. Staff are appropriately trained

### (5) Patient Activation & Self-Management

1. Care plans activate patients to "find their voice," self-management support empowers, and digital tools are fully leveraged
2. Patient and caregiver education is driven by patient preferences and advances health literacy

### (6) Community Partnerships

1. Agreements are in place and community partners are actively engaged in planning BHE initiatives
2. Data Sharing facilitates a closed-loop referral that advances BHE

# CAT Baseline Results

If I could get out of here, I'd take a course in data analysis.

# Baseline Scoring Complete!


Added comments to explain scores!

CHC
Community Health Centers

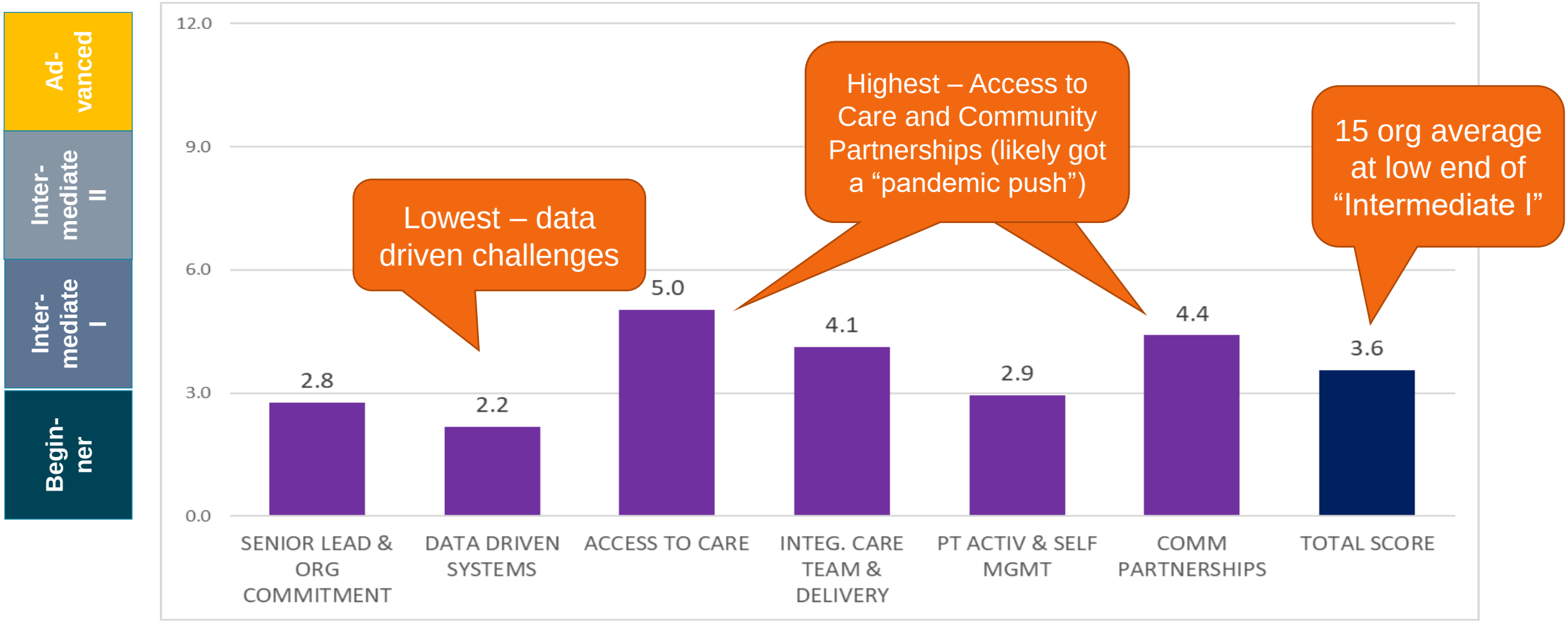
| Domains / Factors | Behavioral Health Equity in Primary Care Continuum | | | | | | | | | | | | ALL SITES SCORE | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Preliminary | | | Intermediate I | | | Intermediate II | | | Advanced | | | | |
| How many of the approaches described are deployed? | None | Many | Most | None | Many | Most | None | Many | Most | None | Many | Most | | |
| Score | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 11 | 12 | ALL SITES | Comments |
| **Senior Leadership & Organizational Commitment** | | | | | | | | | | | | | X | |
| **Leading, planning and creating an organizational culture that prioritizes health equity:** Senior leaders have established Behavioral Health Equity (BHE) as a clear strategic priority, are collecting data to measure behavioral health disparities and set goals for reducing them, have allocated resources to execute plans, and actively monitor and share progress towards achieving BHE. | Senior leaders have expressed a commitment to assessing and improving BHE but the focus on BH and efforts to improve health equity are disconnected. The strategic plan does not include a clear vision for measuring BHE disparities and outcomes and for achieving BHE. | Senior leaders have committed to assessing and addressing BHE integration by establishing it as an explicit strategic priority and dedicating resources. Strategic plans include a clear vision, objectives, measures and initiatives for advancing BHE. A BH clinician champion leads, advocates for, and provides clinical support to these efforts. | Senior leaders regularly monitor progress, measure improvements in BHE, and remove barriers to the execution of BHE strategic objectives. Leaders are held accountable for achieving goals. Leaders communicate within their respective departments to promote organization-wide support for BHE. | Senior leaders model an organization culture that views behavioral health as a key element of health care. They systematically plan for, monitor, and adjust strategy to continuously advance BHE. Measures and goals for patient experience, clinical, operational, and financial outcomes of health equity stretch the organization to be a leader in BHE. | X | |
| **Listening to the voice of all patients.** | The health center staff wants to improve BHE, but patient and client input to improve BHE care, address unmet social needs, and reduce barriers to care is obtained indirectly (e.g., through patient comments and surveys). A more focused and structured approach is being considered. | Patients and clients are authentically engaged in understanding of their life experiences, how to improve access to care and information, and how to improve communication and collaboration with the care team. Staff members meet regularly with patients and clients to better understand | Patients and clients that reflect the community makeup (language, race, ethnicity and SOGI) are engaged in regular meetings using mixed modes (in-person, mail, email, smartphone, etc.) to inform equitable care practices. Staff actively build relationships with the community and community partners to | Patient and clients representing the communities served systematically inform (e.g., via patient and family advisory councils or boards, focus groups, peer navigators) and drive strategic efforts to improve BHE in meeting their whole care needs. | X | |

# CAT Results:  A few qualifiers


*"Would you like to come over for dinner?"*

- 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!

# Total Score (All Orgs) by Driver Domain




Average CAT domain scores (n=15 organizations)

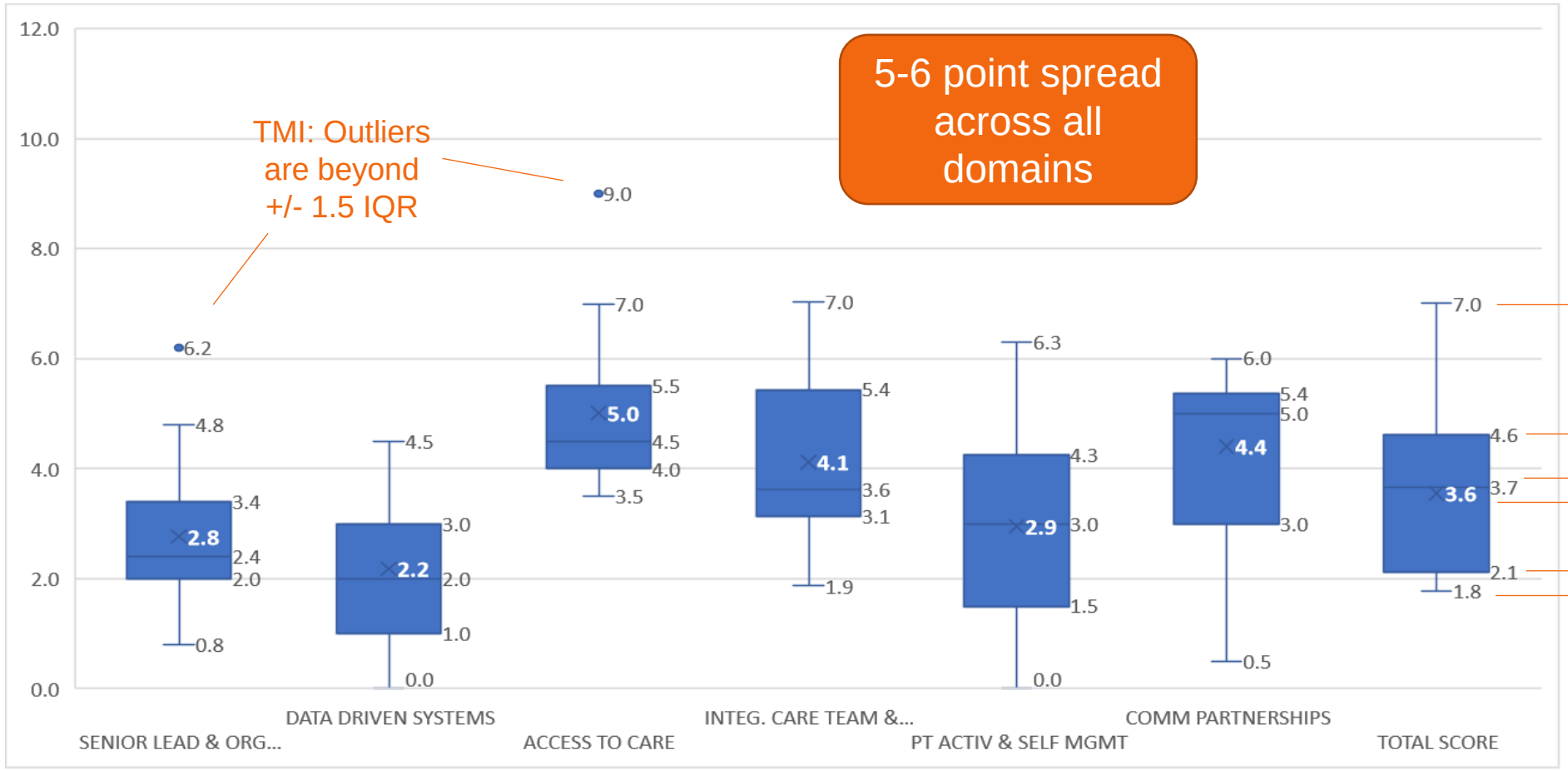
# Total Score (All Orgs) by Driver Domain - Spread

Ad-vanced

Inter-mediate II

Inter-mediate I

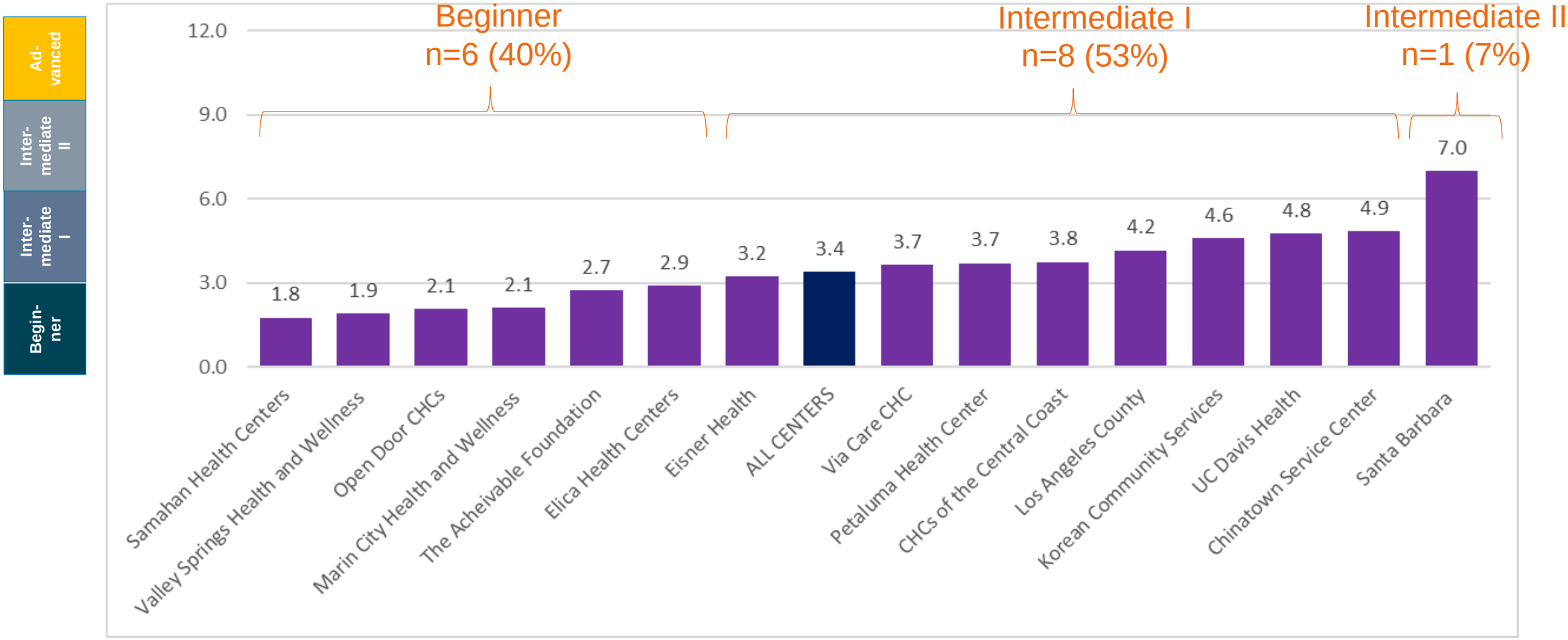
Begin-ner



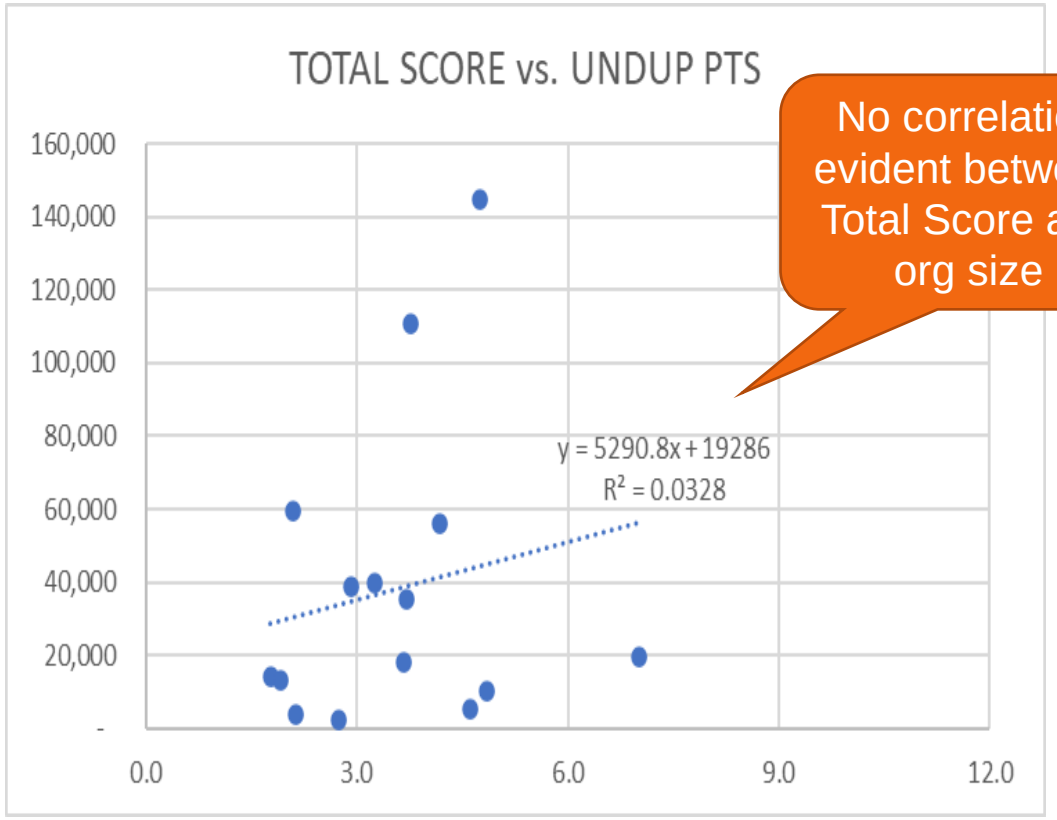

**Box Plot Key**

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

# Total Score Spread by Org



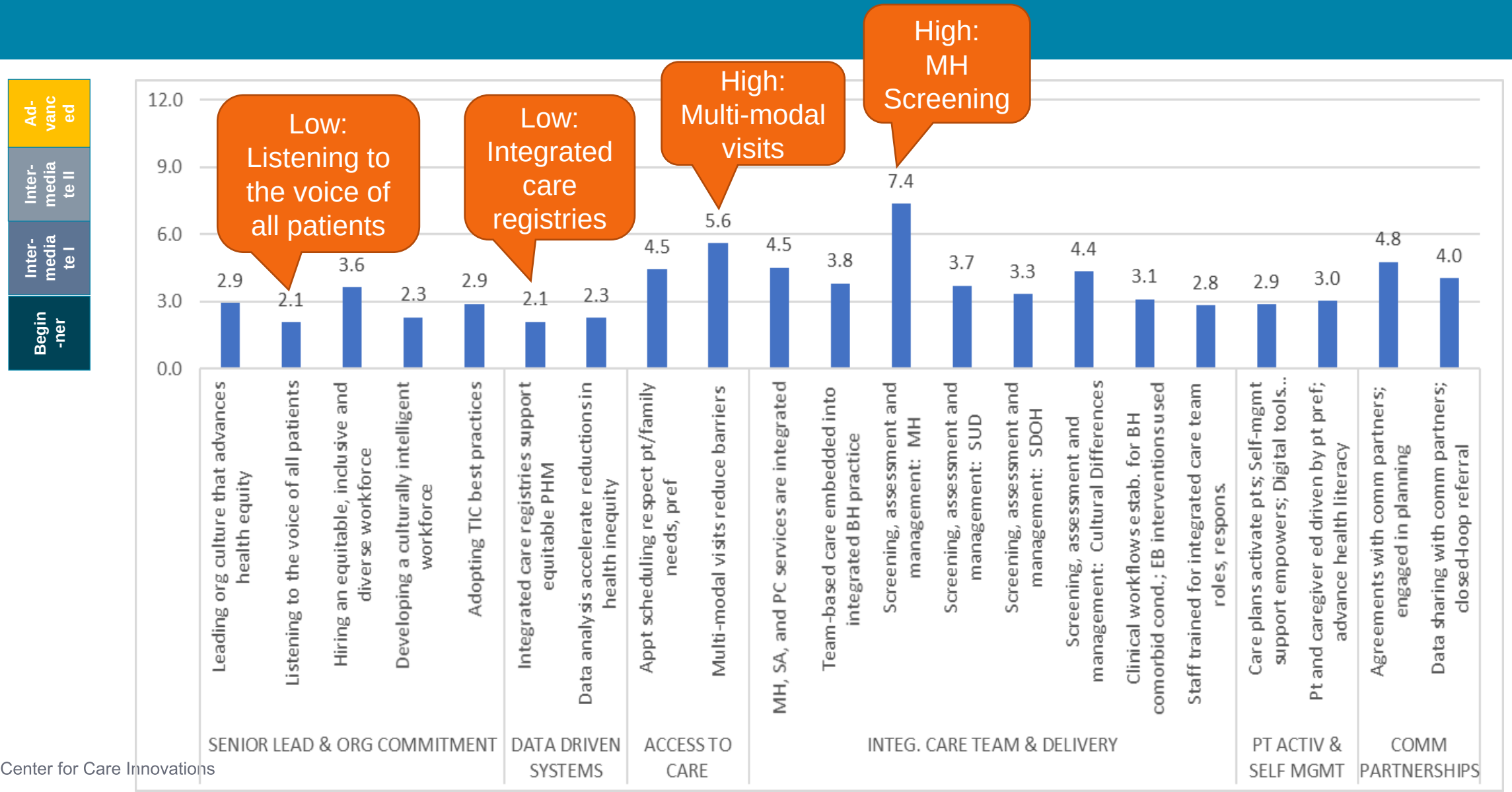
# CAT Results:  Deeper Insights




Low n, interpret with caution.

- 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)

# Average Factor Scores (All Orgs)



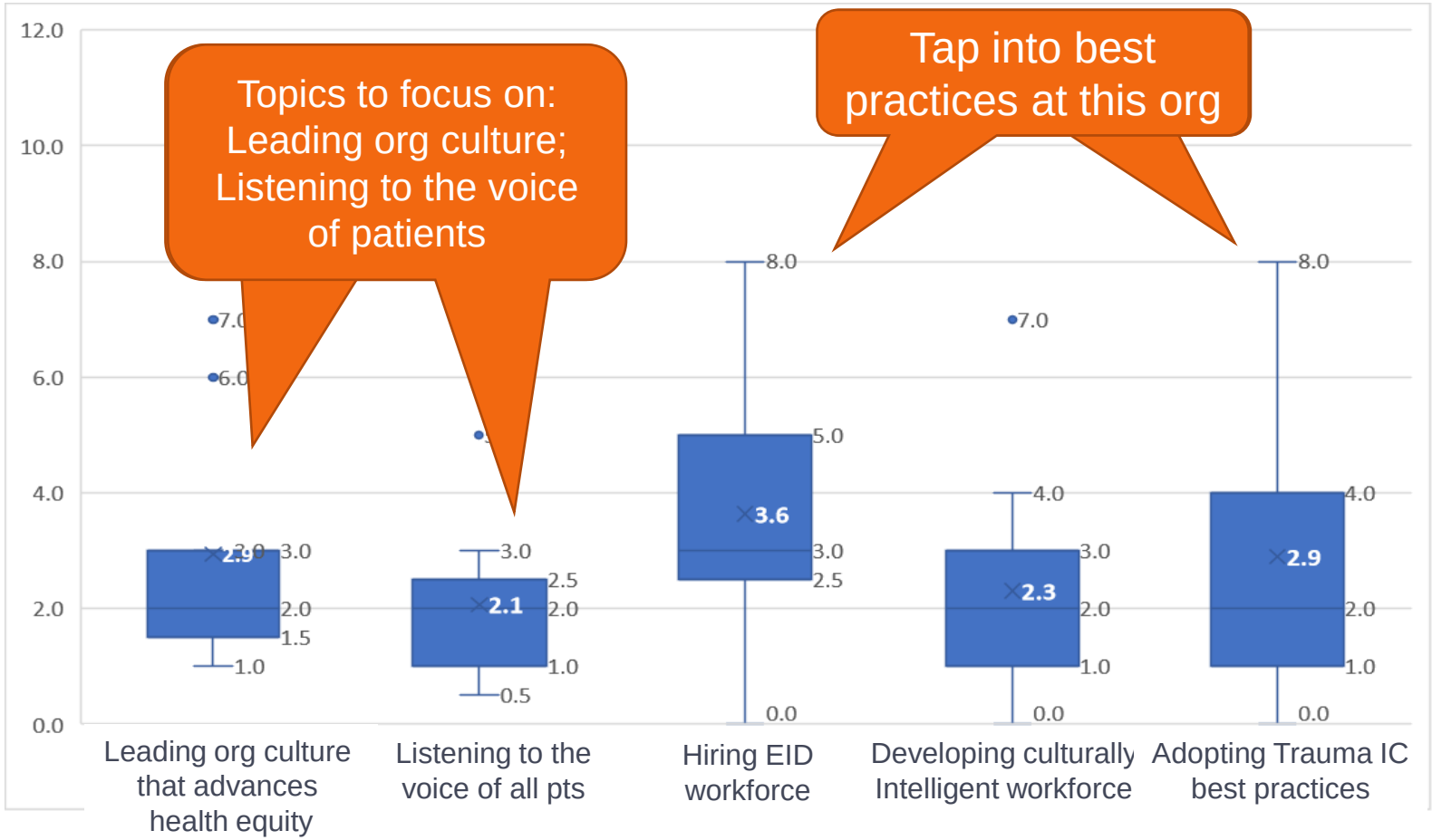
# Senior Leadership & Org Commitment – ABHE “North Star”

Ad-vanced

Inter-mediate II

Inter-mediate I

Begin-ner




**Box Plot Key**

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

# Integrated Care Team & Care Delivery

Ad-vanced

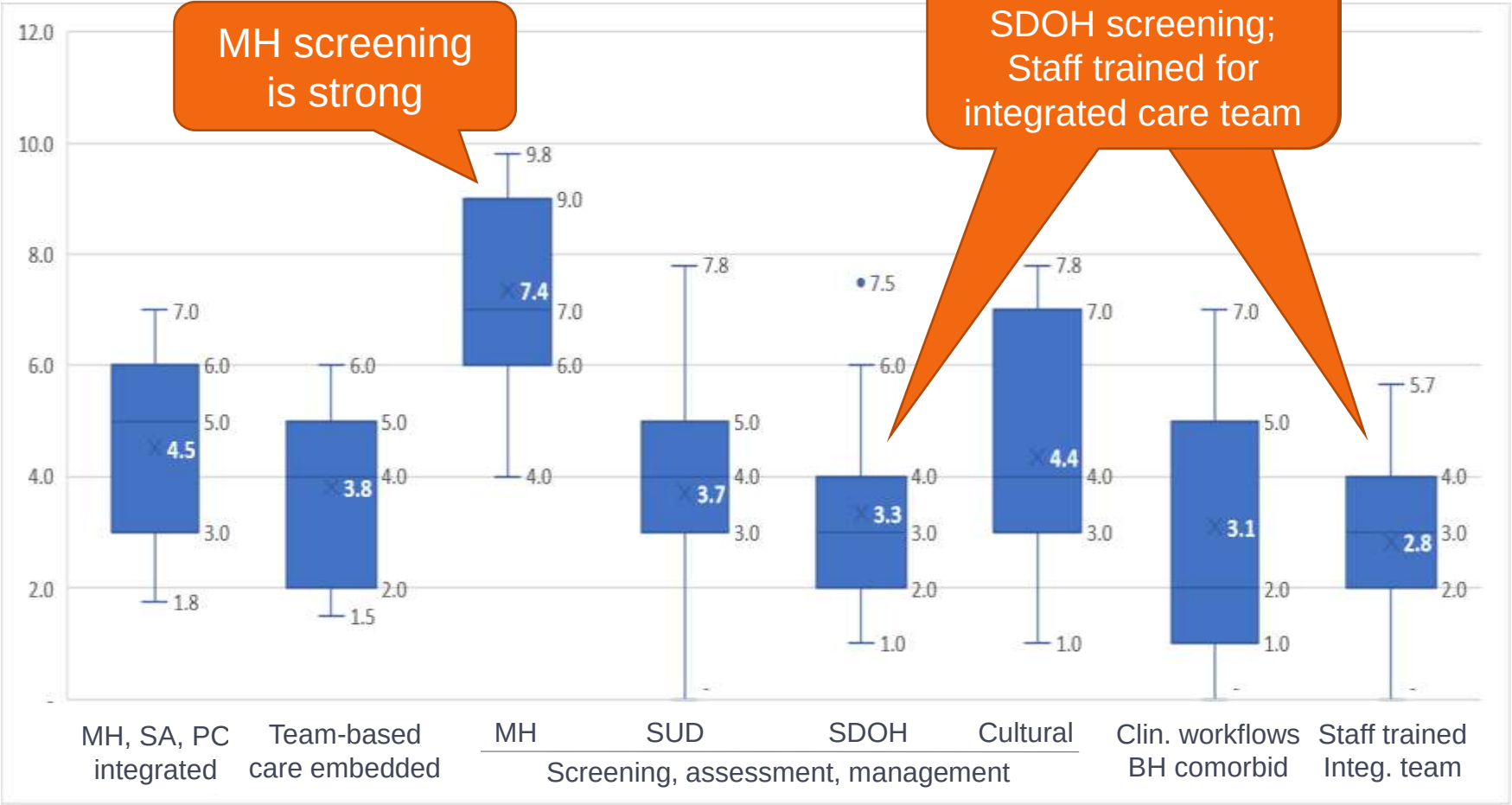
Inter-mediate II

Inter-mediate I

Begin-ner

MH screening is strong

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



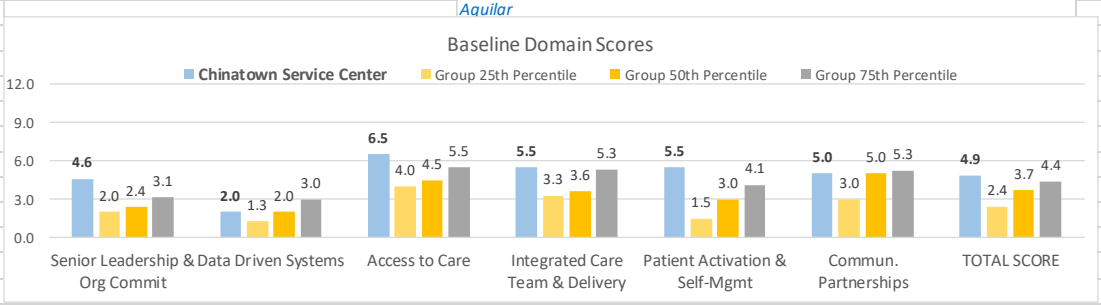

**Box Plot Key**

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

# Individual CAT Reports with Group Comparison

**Advancing Behavioral Health Equity in Primary Care**
**Capability Assessment Tool Comparison Report**
***October 2021 Baseline***
**Chinatown Service Center, Los Angeles**

| | |
|---|---|
| Sub-population: | *Asian, Pacific Islander* |
| # Partcipating Sites: | *2* |
| # Patients Served at Participating Sites: | *10,352* |
| # of Patients Served Annually: | *10,352* |
| Team completing CAT: | *Chun Mei Lam, Nina Loc, Matthew Wong, Janet Yu, Jack Cheng, Angela Ching, Felix Aguilar* |

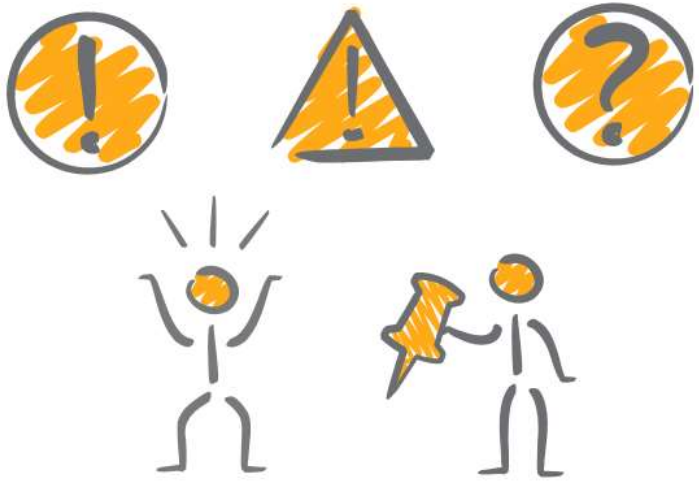



| Factor Detail | Chinatown Service Center | ABHE Group 25th Percentile | ABHE Group 50th Percentile | ABHE Group 75th Percentile |
|---|---|---|---|---|
| Senior Leadership & Organizational Commitment | 4.6 | 2.0 | 2.4 | 3.1 |
| Leading, planning and creating an organization culture that advances health equity | 7.0 | 1.8 | 2.0 | 3.0 |
| Listening to the voice of all patients | 2.0 | 1.5 | 2.0 | 2.3 |
| Hiring an equitable, inclusive and diverse workforce | 6.0 | 2.8 | 3.0 | 4.5 |
| Developing a culturally intelligent workforce | 4.0 | 1.0 | 2.0 | 3.0 |
| Adopting TIC best practices | 4.0 | 1.5 | 2.0 | 4.0 |
| Data Driven Systems | 2.0 | 1.3 | 2.0 | 3.0 |
| Integrated care registries support equitable PHM | 2.0 | 1.0 | 2.0 | 3.0 |
| Data analysis and measure reporting accelerate reductions in health inequity | 2.0 | 1.5 | 2.0 | 3.0 |
| Access to Care | 6.5 | 4.0 | 4.5 | 5.5 |
| Appointment scheduling respect patient and family needs and preferences | 8.0 | 3.0 | 4.0 | 5.5 |
| Multi-modal visits reduce barriers | 5.0 | 4.6 | 5.0 | 6.3 |

- 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:

| ABHE Collection Period | Extract Due Date |
|---|---|
| Baseline | March 30, 2022 |
| Endline | August 31, 2023 |
| Follow-Up | August 31, 2024 |

# Universal Measures, Part 1

| Measure Category | Measure Name (ID Number) |
|---|---|
| Cultural Congruence | Clinical Providers, Staff, and Adult Patient Demographics |
| BH Diagnosis | Depression Utilization of the PHQ-9 Tool (NQF 0712e) |
| | Mental Health and Substance Use Disorder Diagnoses |
| BH/SUD Referrals | Closing the Referral Loop: Receipt of Specialist Report |
| | Number and proportion of patients referred to treatment by health need/diagnosis |
| BH Utilization* | Behavioral Health Care Utilization |
| BH Access* | Access to Care:<br>• No-show counts for first behavioral health appointment<br>• Timeliness of Care<br>• Types of care offered vs. used |
| BH Outcome | Depression Remission at Twelve Months (NQF 0710e) |

* Further discussion and refinement during Evaluation Orientation Webinar on November 17.

# Universal Measures, Part 2

| Measure Category | Measure Name (ID number) |
|---|---|
| SUD/Tobacco Screening and Treatment | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF 0004) |
| | Substance Use Screening and Intervention Composite (NQF 2597) |
| Physical Health Outcome | Controlling High Blood Pressure (NQF 018) |
| | Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (NQF 0059) |
| | Optimal Asthma Control (Quality ID 398) |

# 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:

| ABHE Collection Period | Survey Fielding Window |
|---|---|
| Baseline | January-March 2022 |
| Endline | January-March 2023 |

# 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

# Poll

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

# Key Activities & Dates

**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/

**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/

**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!
CCI
CENTER FOR CARE
INNOVATIONS

# Appendix

# Population Focus

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