

Advancing Behavioral Health Equity in Primary Care

Program Kick-Off

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

While you are waiting...

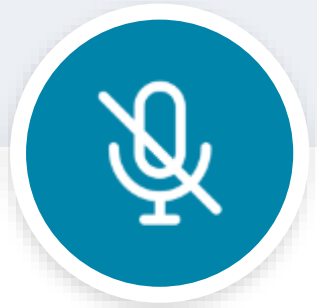
Please RENAME yourself by adding
your organization's name.

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



California
Health Care
Foundation

I 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.



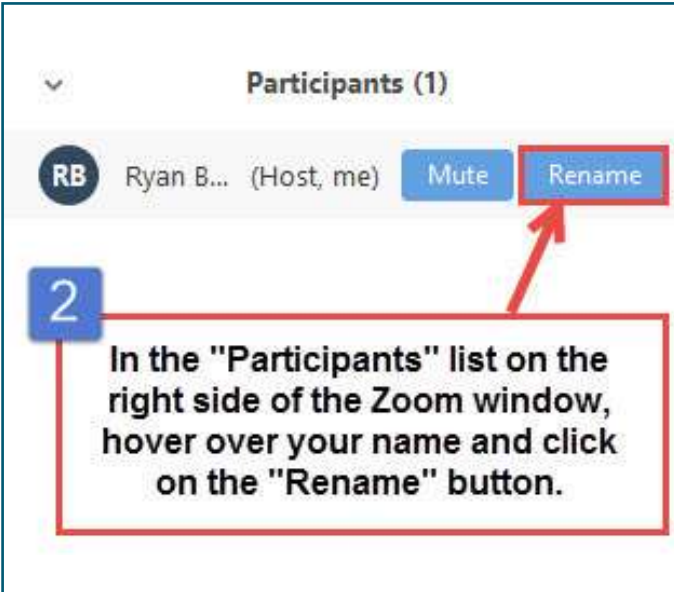
1

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

A screenshot of the Zoom bottom toolbar. It contains three icons: 'Invite' (a person with a plus sign), 'Participants' (two people icons), and 'Share Screen' (a green screen with an upward arrow). The 'Participants' icon is highlighted with a red box and a red arrow pointing to it from the text above.

2

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

A screenshot of the Zoom 'Participants' list. It shows a single participant: 'Ryan B...' (Host, me). To the right of the name are two buttons: 'Mute' and 'Rename'. The 'Rename' button is highlighted with a red box and a red arrow pointing to it from the text above.

3

Type in the display name you'd like to appear in the meeting and click on "OK".

A screenshot of the Zoom 'Rename' dialog box. It has a title bar that says 'Rename'. Inside, there is a text input field with the text 'Ryan B.' and a label 'Enter a new screen name:'. Below the input field are two buttons: 'OK' and 'Cancel'. The 'OK' button is highlighted with a red box and a red arrow pointing to it from the text above.

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



I 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 Rosa 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'S COMMITMENT TO INTEGRATED BEHAVIORAL HEALTH

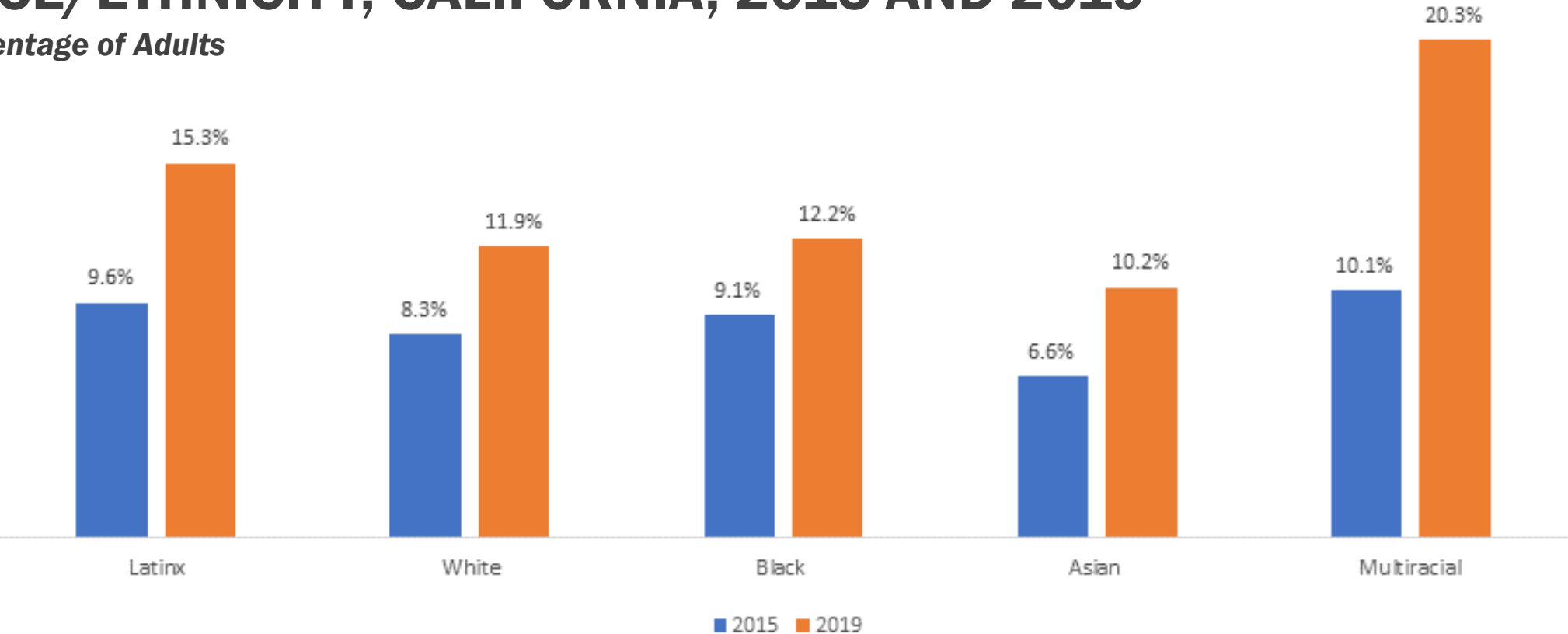
- Behavioral health (BH) conditions are common and undertreated, both in the US and California:
 - In 2018, fewer than half of adult Medi-Cal enrollees with mental illness received a mental health service.
- Primary care providers (and their teams) are the frontline:
 - Approximately half of all care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

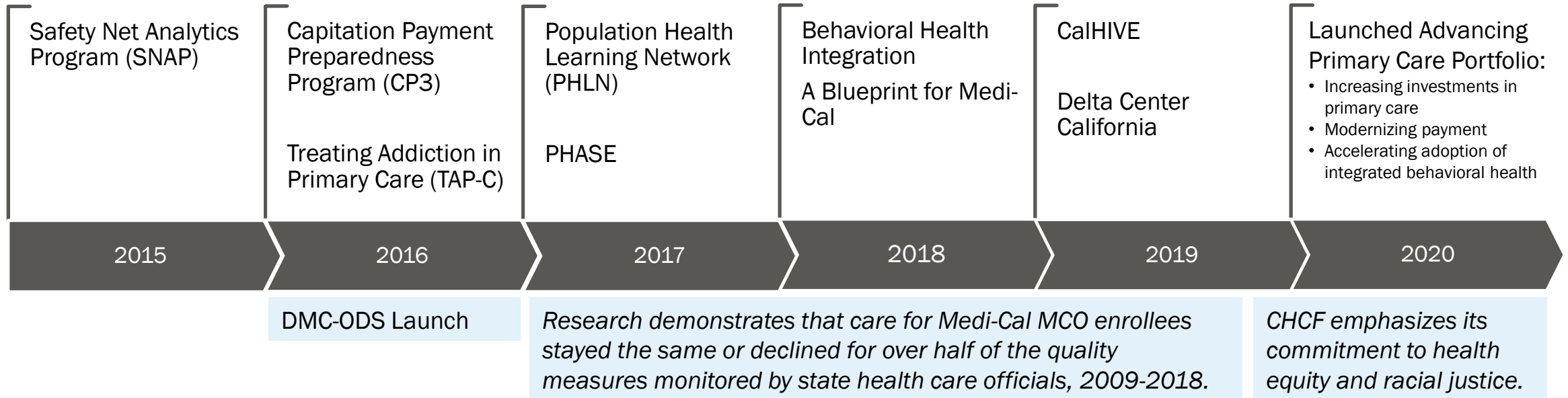
Since 2014, CHCF has helped 50+ community health centers (CHCs) operating 500+ primary care sites, improve the delivery of primary care services for at least 1.5 million Medi-Cal members.

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.



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
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kphillips@chcf.org
www.chcf.org



Parinda Khatri, PhD

Chief Clinical Officer
Cherokee Health Systems

ABHE Clinical Director

Behavioral Health Equity

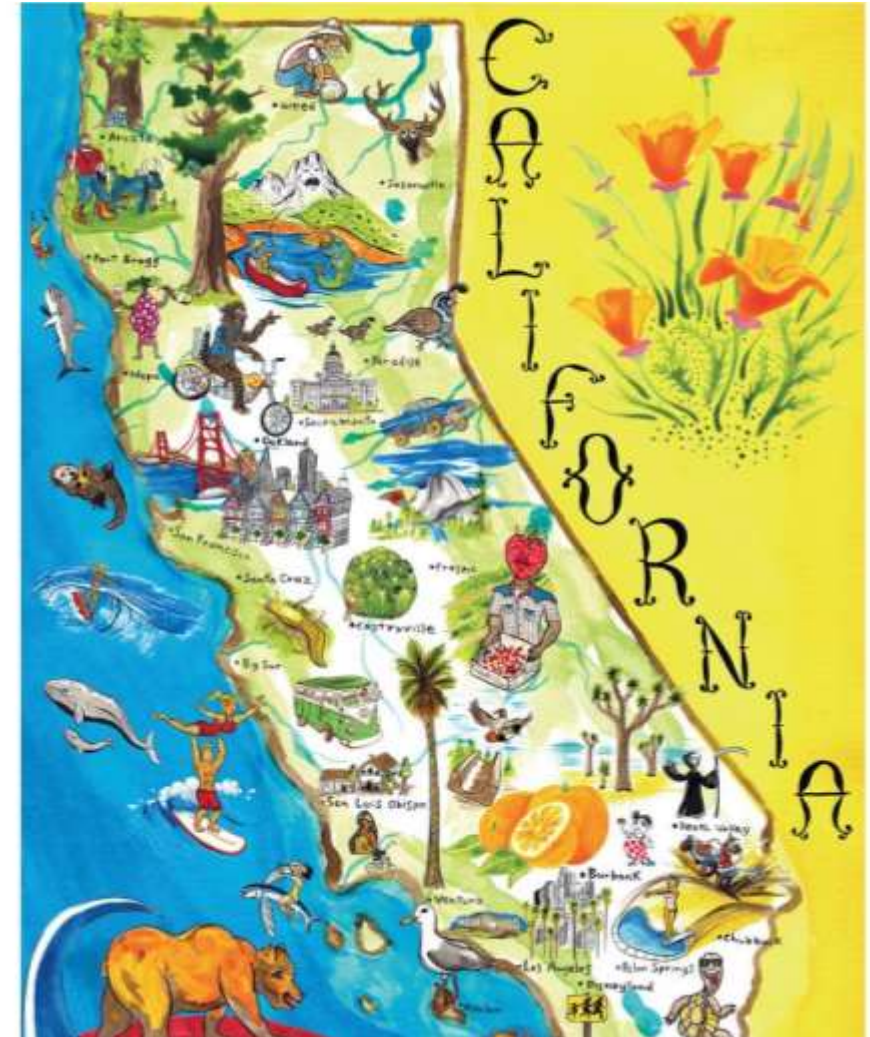
The Journey Starts Here



Advancing Behavioral Health Equity in Primary Care

Parinda Khatri, PhD

**Chief Clinical Officer
Cherokee Health Systems
November 3, 2021**



What Now?



California



Summary

Low Disparities¹

- Between metropolitan² and nonmetropolitan² areas for low birthweight
- Between Hispanic³ and white³ for infant mortality
- Between female⁴ and male⁴ for unemployment

High Disparities

- Between Hispanic³ and white³ for high health status
- Between Black³ and Asian/Pacific Islander³ for food insecurity
- Between less than a high school education⁵ and college graduates⁵ for physical inactivity

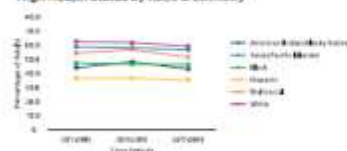
¹Low disparities within a state does not indicate that all populations are doing well. Consider rates in comparison to national averages.
²Rates worse than national average. ³Rates same as better than national average.

Highlights

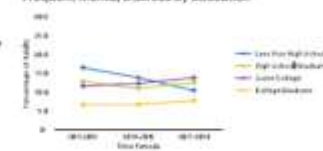
- 37%** Frequent Mental Distress in adults with less than a high school education between 2011-2013 and 2014-2016 from 16.7% to 10.6%
- 36%** Depression in Hispanic adults between 2011-2013 and 2014-2016 from 10.4% to 14.1%
- 34%** Less Than a High School Education in the multiracial population between 2005-2008 and 2014-2016 from 10.2% to 6.7%
- 21%** Poverty in households headed by an adult with some college education between 2005-2008 and 2014-2016 from 10.2% to 12.3%
- 55%** Avoided Care Due to Cost in the American Indian/Alaska Native population between 2011-2013 and 2014-2016 from 27.5% to 12.2%
- 15%** Physical inactivity in adults with less than a high school education between 2011-2013 and 2014-2016 from 32.3% to 37.0%

Trends

High Health Status by Race & Ethnicity



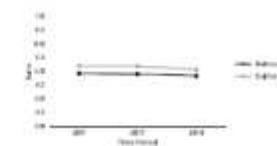
Frequent Mental Distress by Education



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.america'shealthrankings.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



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

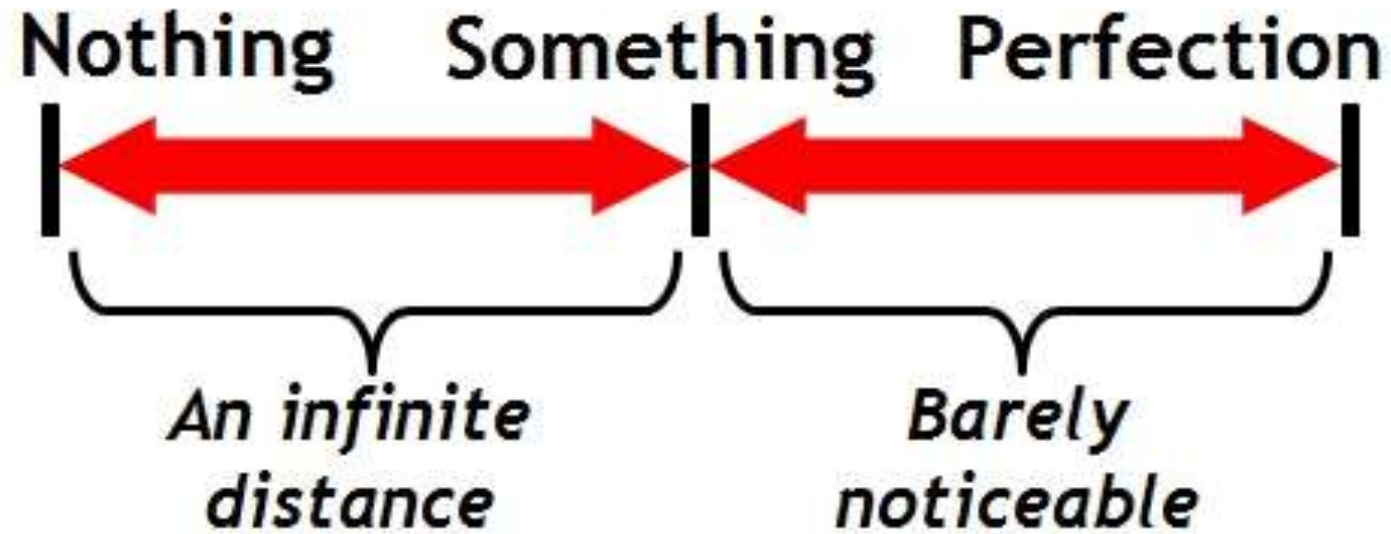
COMPLEX



- 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

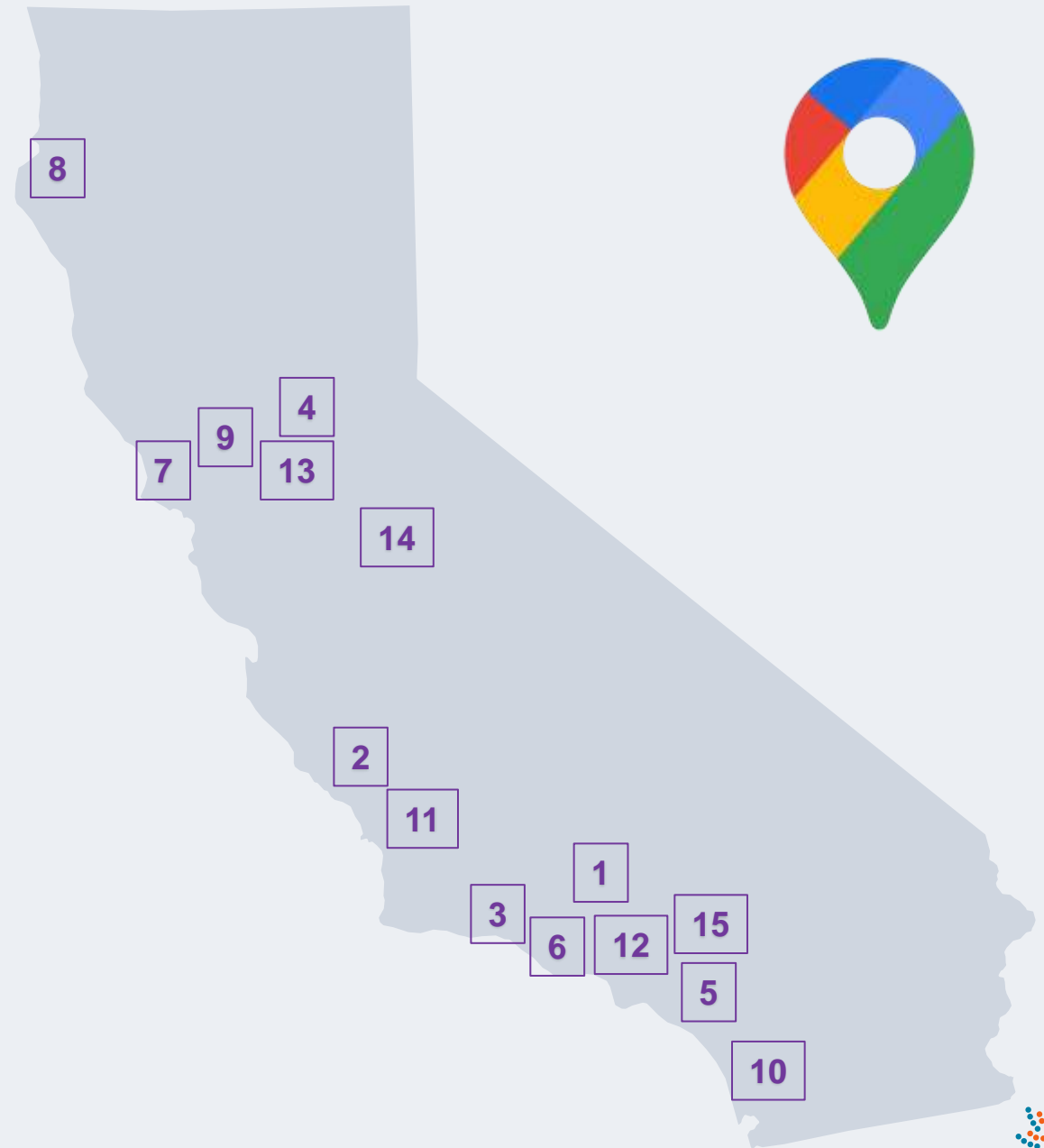
297,454

Number of Patients
Served Annually
Across all Clinic Sites



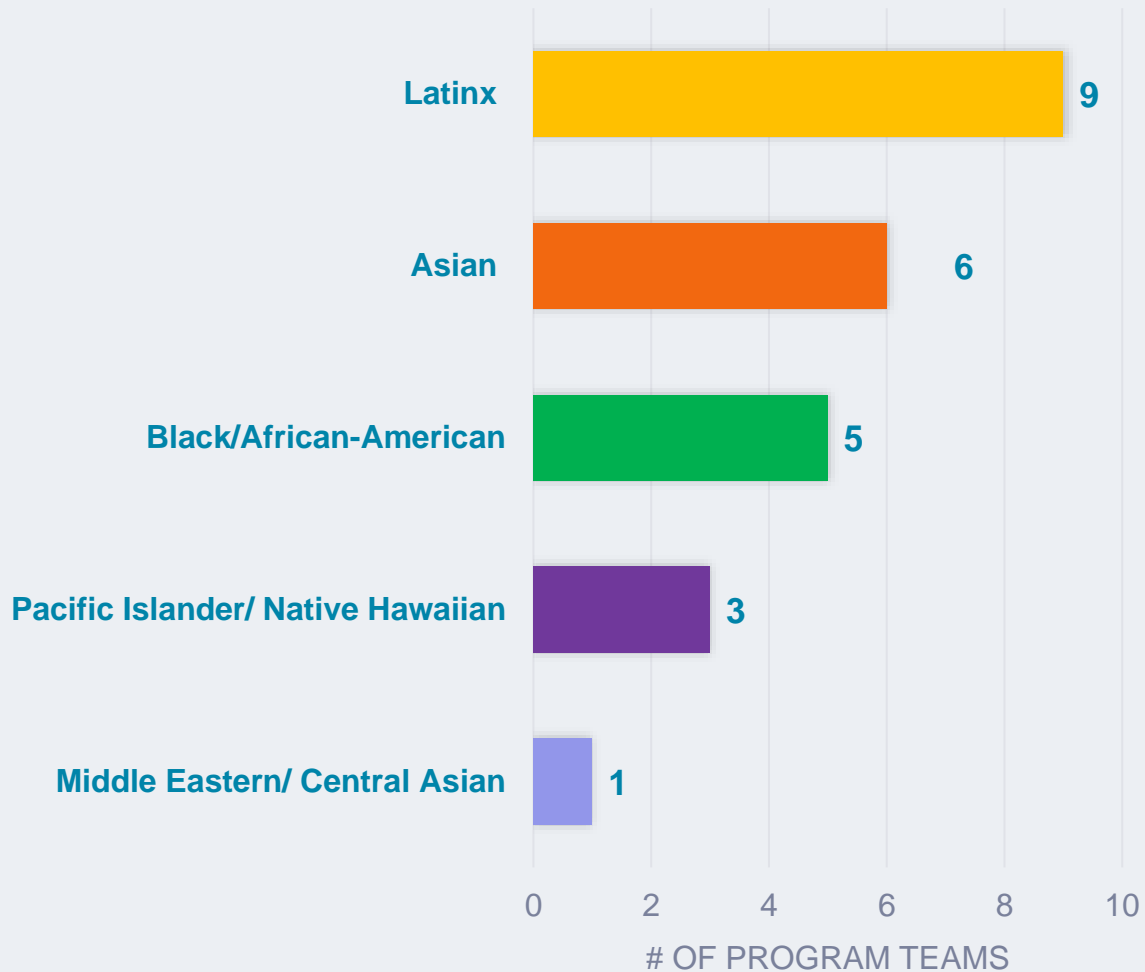
I Cohort at a Glance

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

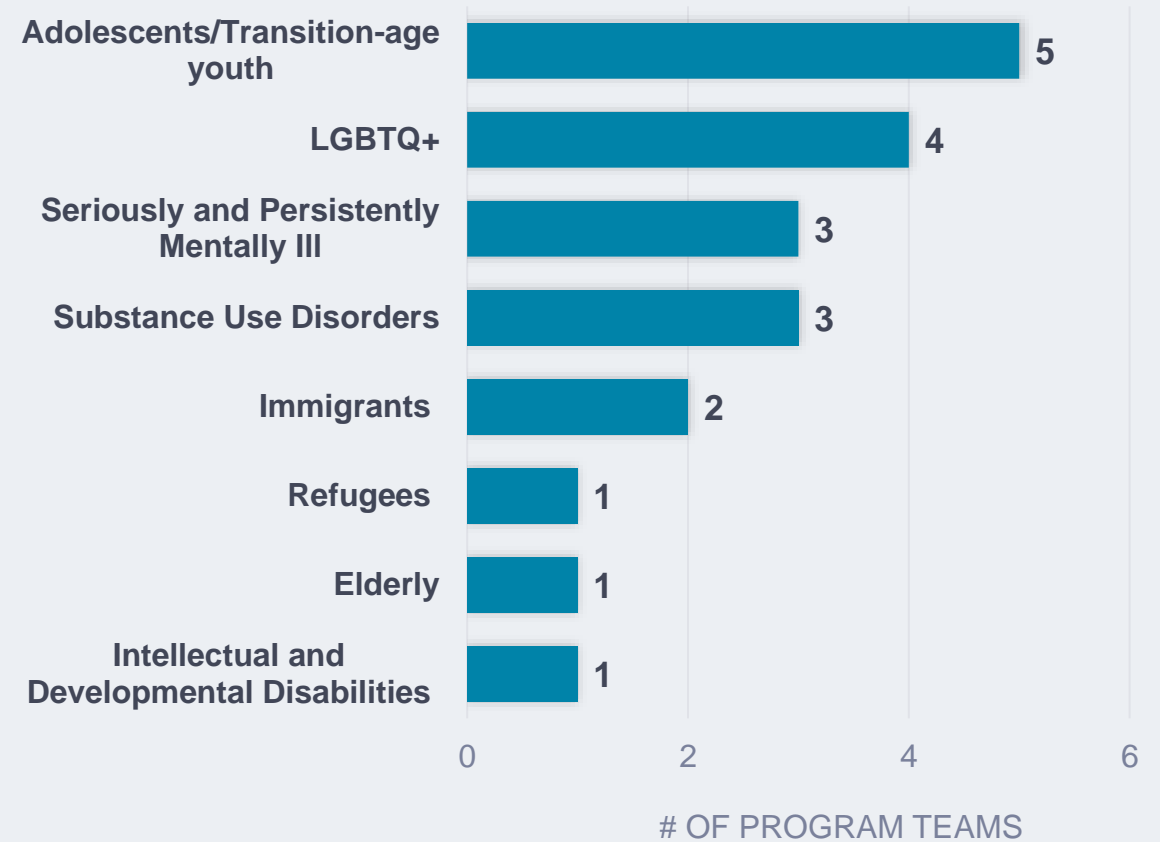


Priority Subpopulations

Race/Ethnicity



Patient Characteristics



I 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

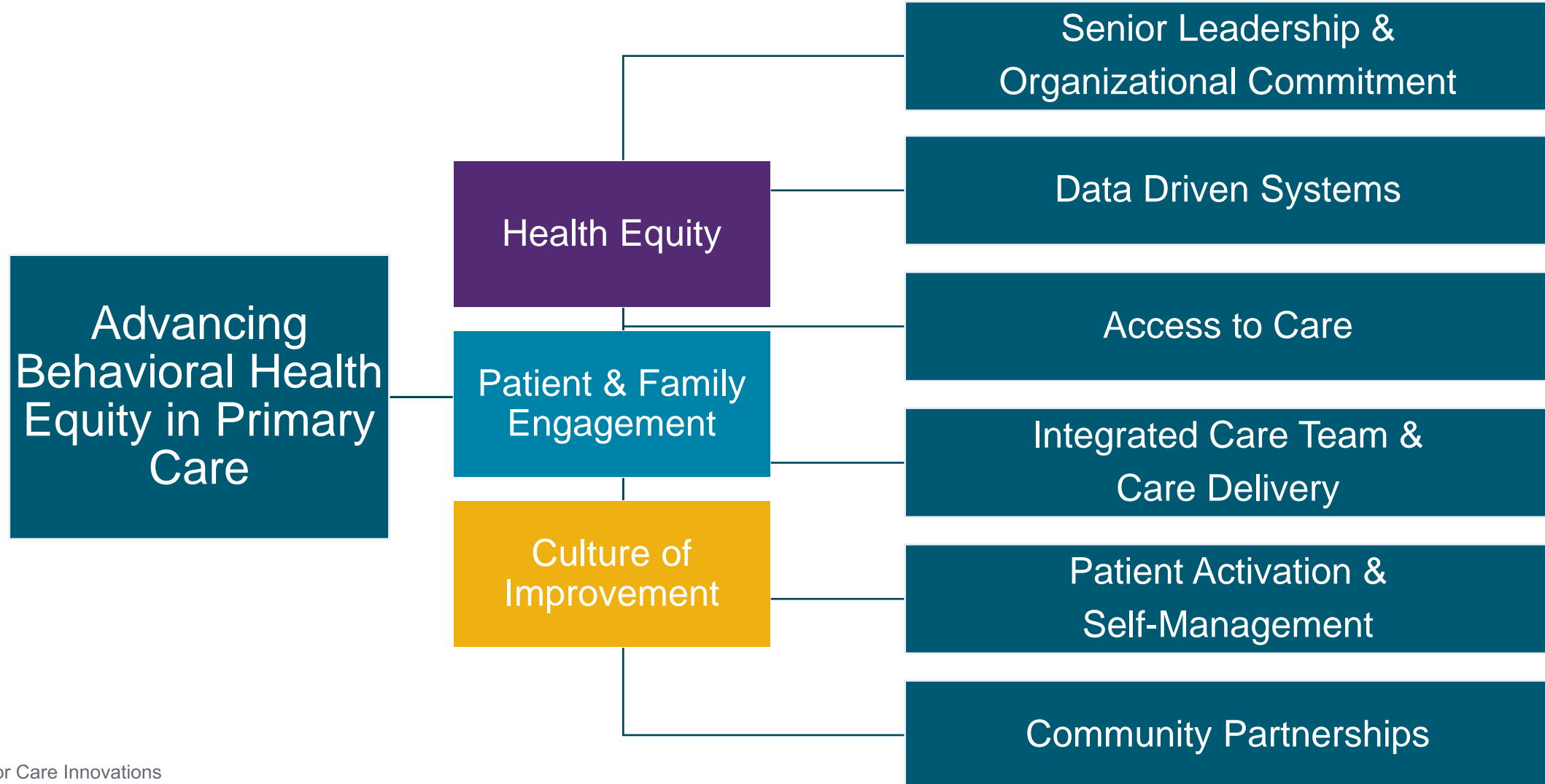
Take effective action to reduce barriers to care – specifically, *racism, discrimination, stigma, and trauma*.

5

Sustain and spread successes.

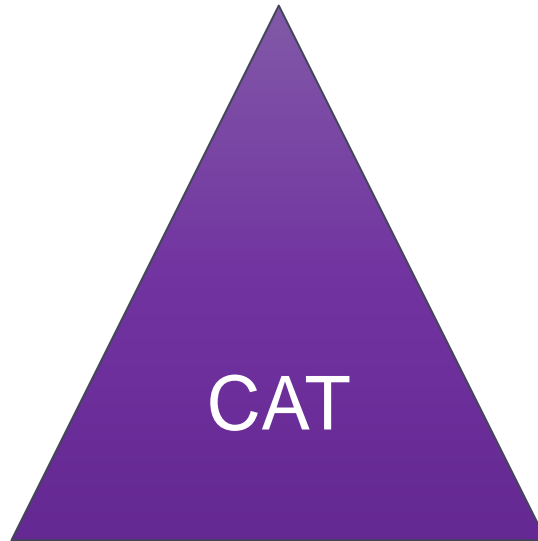


Key Drivers



Key Program Elements

CAPABILITIES ASSESSMENT TOOL (CAT)

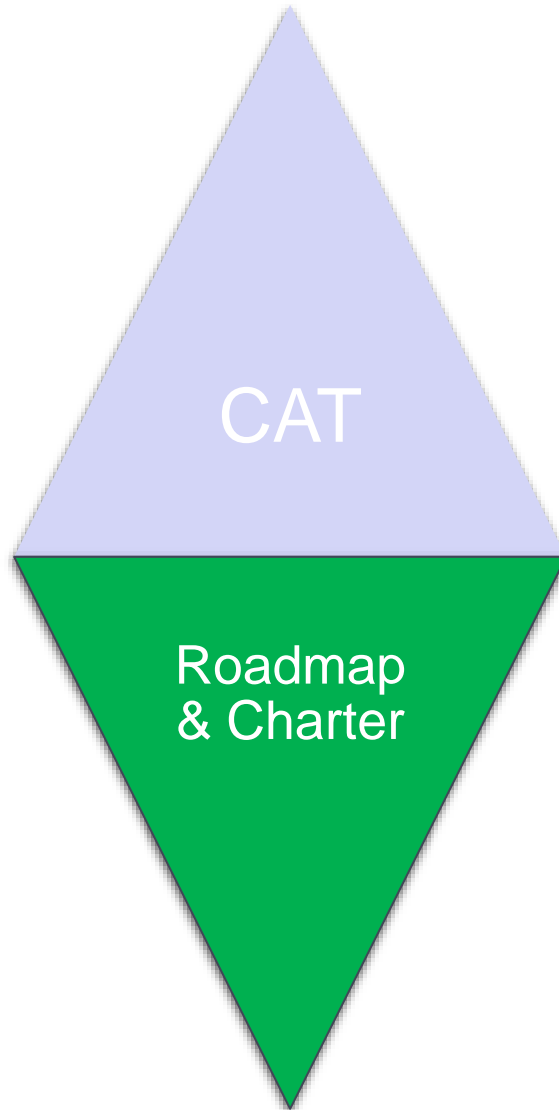


- **Completed 4 Times:** Baseline, Midpoint, Endpoint, 1 Year Post Program.
 - ✓ **Baseline completed by all ABHE teams (Oct 21)**
- **Supports you** in goal setting.
- **Supports us** in curriculum planning.
- **Assesses progress** on key drivers of ABHE program.



Key Program Elements

ROADMAP / CHARTER



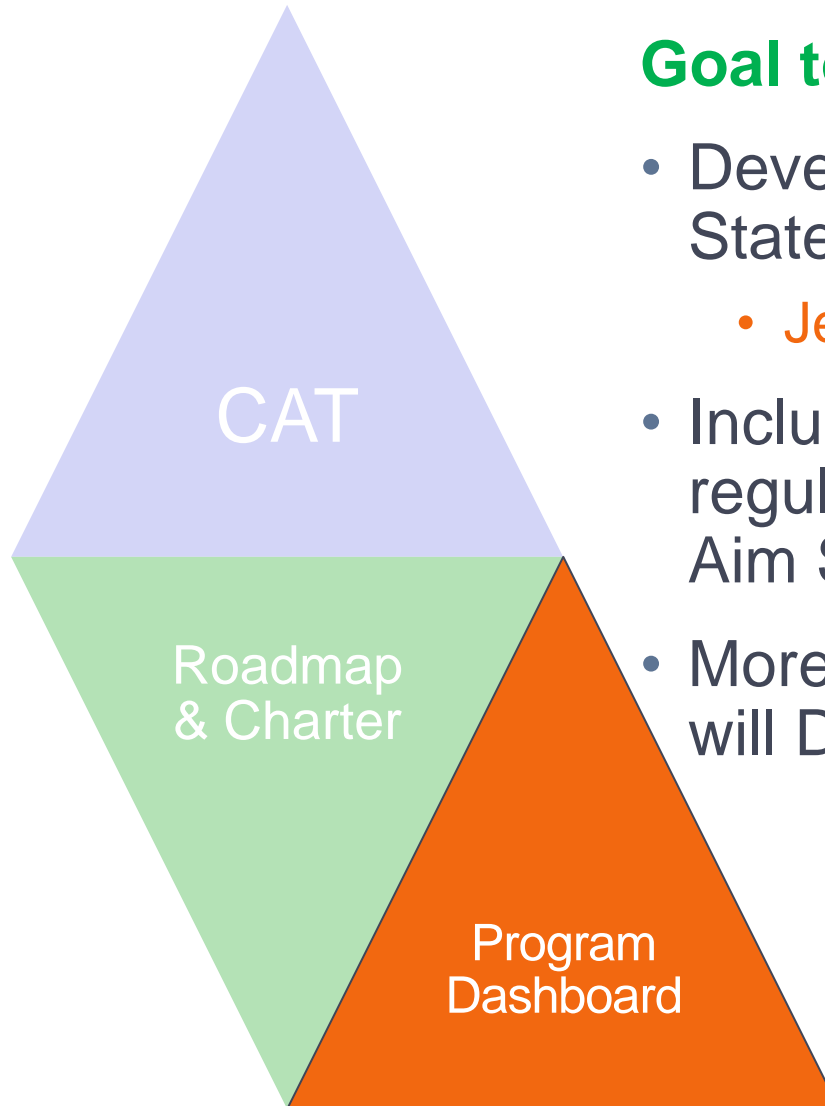
Due Feb 1, 2022

- 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)



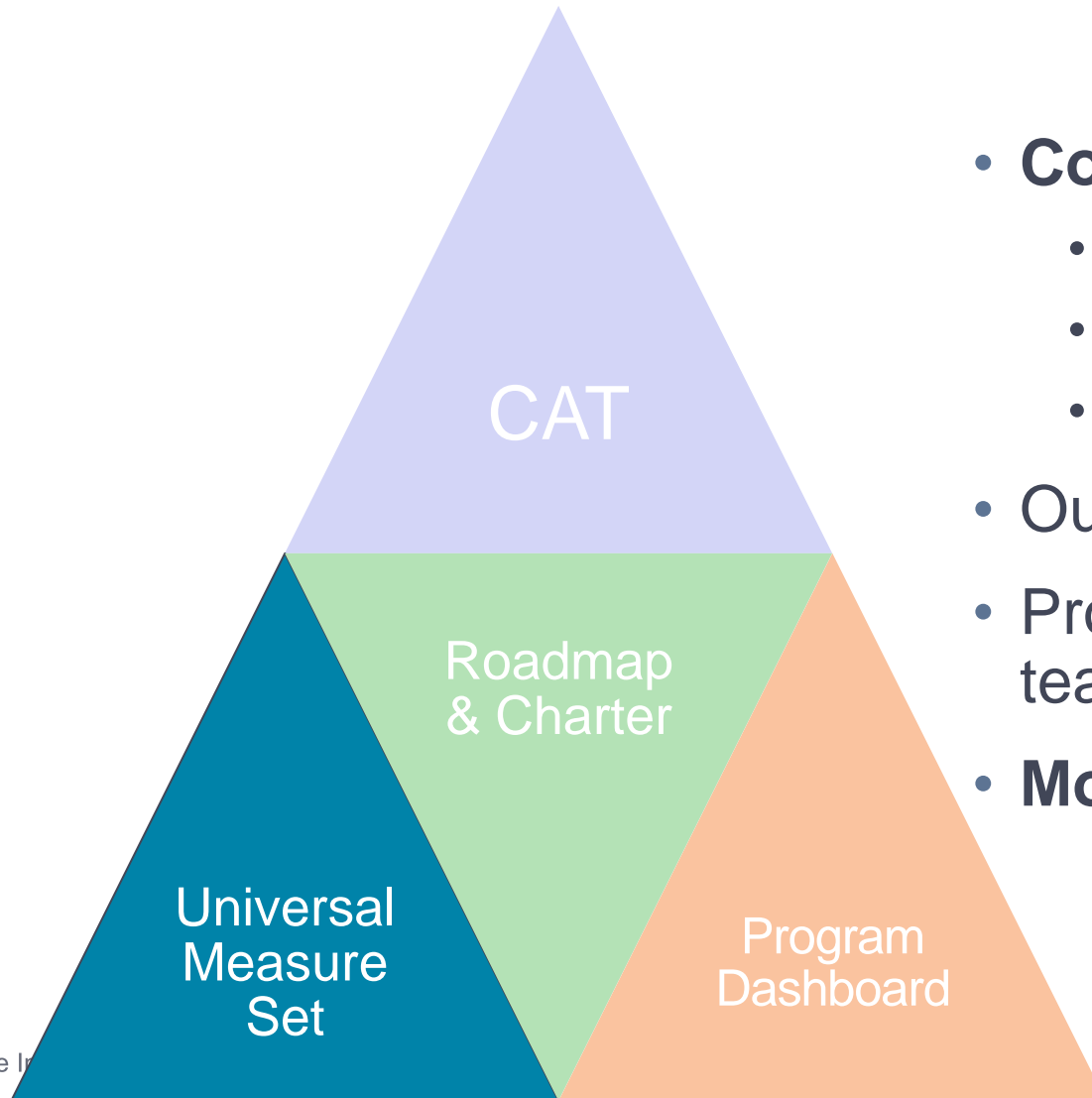
Goal to have drafted by mid-January 2022

- 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

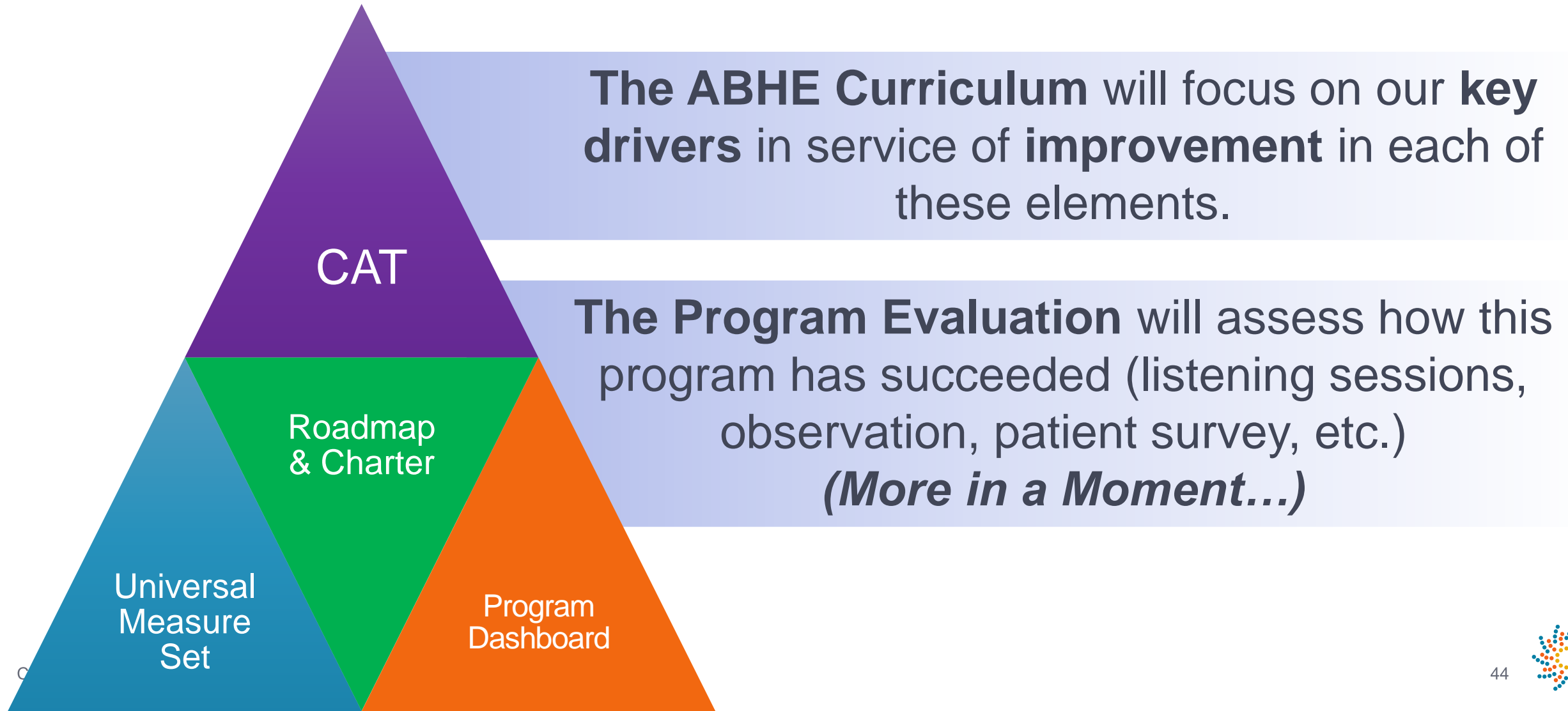
UNIVERSAL MEASURE SET



- **Completed 3 Times:**
 - Baseline (3/30/21)
 - 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?



Program Timeline

	2021			2022				2023		
	OCT-NOV	DEC-JAN	FEB-MAR	APR-MAY	JUN-JUL	AUG-SEPT	OCT-NOV	DEC-JAN	FEB-MAR	APR-MAY
Program Phase	COMMIT, COLLECT, CHOOSE			COLLABORATE & LEARN		HARVEST, INTEGRATE & IMPLEMENT		RE-COMMIT, SPREAD & SUSTAIN		
Learning Sessions (Virtual / In-Person)	Nov 3 Kickoff Meeting	Dec 2 Learning Session #1								
Webinars										
Site Visits (select 1)										
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)
	***** Submit Quarterly Progress Reports *****									
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 *****									

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 Provide CCI with additional details on current state (to assess SDOH screening, demographic data collection)	Identify Project Measures & Dashboard Plan for Universal Measures Data Submission #1	Finalize Roadmap / Charter (Aim, Measures, Workplan) (Due Feb 1) Start Testing / Improvement (PDSAs) 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

		2023			2024		
		Q3	Q4	Q1	Q2	Q3	Q4
Capabilities Assessment					Post-Program CAT Submission (May 31, 2024)		
Universal Measures		Endline Data Submission (Aug 31, 2023)				Follow-Up Data Submission (Aug 31, 2024)	





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.

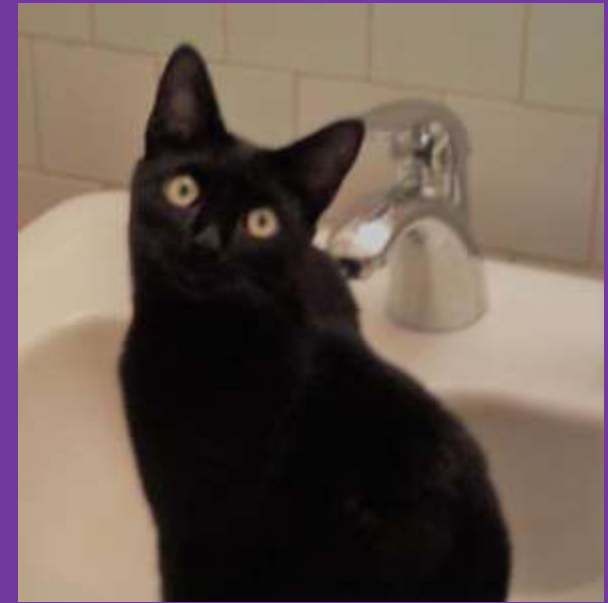
Be Curious

- 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?

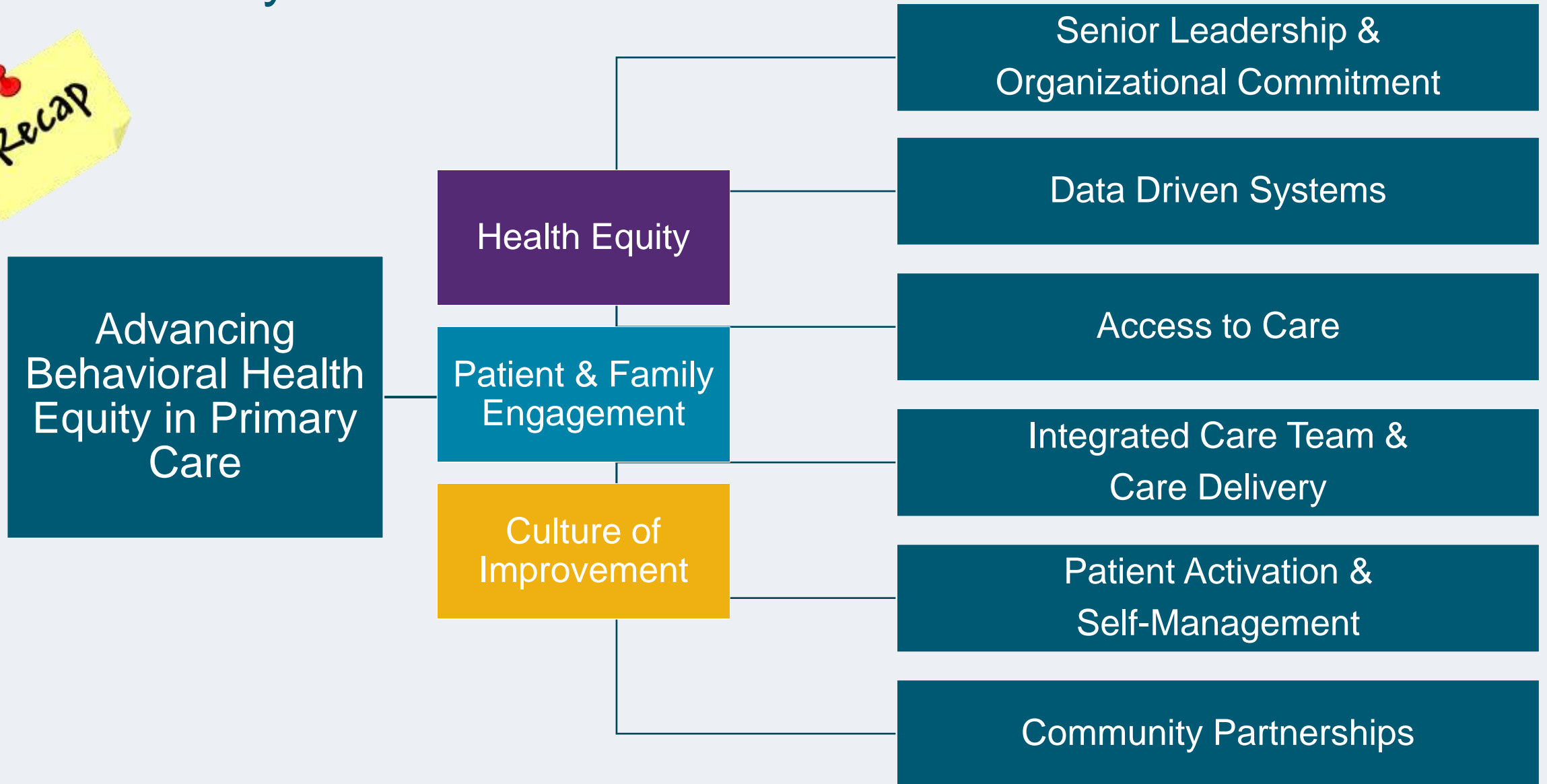


CAT Results Overview

How can
we use the
results?



ABHE Key Drivers



Recap

BHE-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

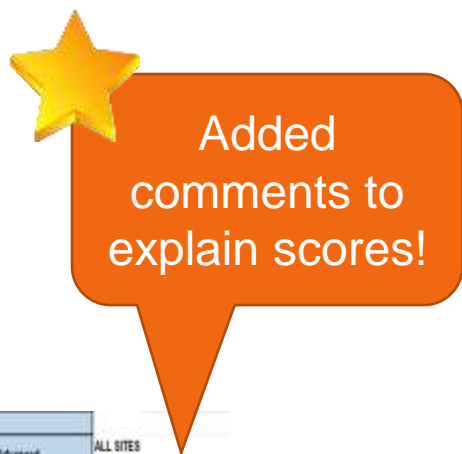


CAT Baseline Results



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

Baseline Scoring Complete!



Domains / Factors	Behavioral Health Equity in Primary Care Continuum												ALL SITES SCORE	Comments
	Preliminary			Intermediate I			Intermediate II			Advanced				
	June	May	Nov	June	May	Nov	June	May	Nov	June	Nov	Nov		
Time every 6th of the approach has described are approved													100% 1/11/2021	
Score	0	1	2	3	4	5	6	7	8	9	10	12	ALL 9750	
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 BHE 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 BHE clinical 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	Direct measure being tracked by PC. Need primary setting. Lack of primary response at Santa Maria Valley. At the Valley, need to bridge immediate care to PC. Community to determine community to determine care, not accounting preventative care.
Health Equity: Improving the conditions of social and people have the opportunity to meet the highest possible level of health.														
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 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 SOG) are engaged in regular meetings using varied 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	ACHC's BHE blog encouraging immediate needs that are being addressed but are not being met. Patients are not engaged substantially. Community based board. 100% patients on the board.



■ CAT Results: A few qualifiers

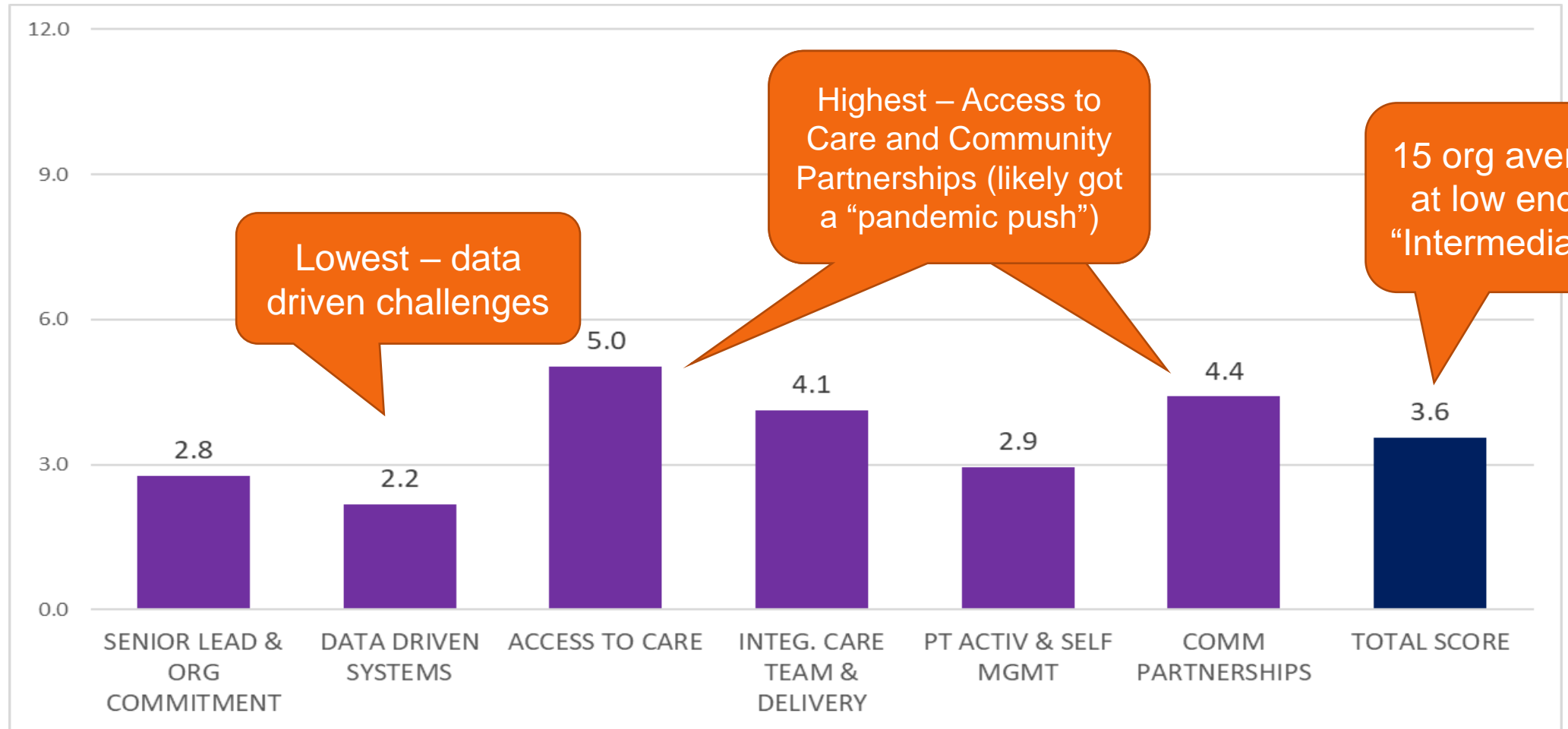


"Would you like to come over for dinner?"

- 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!



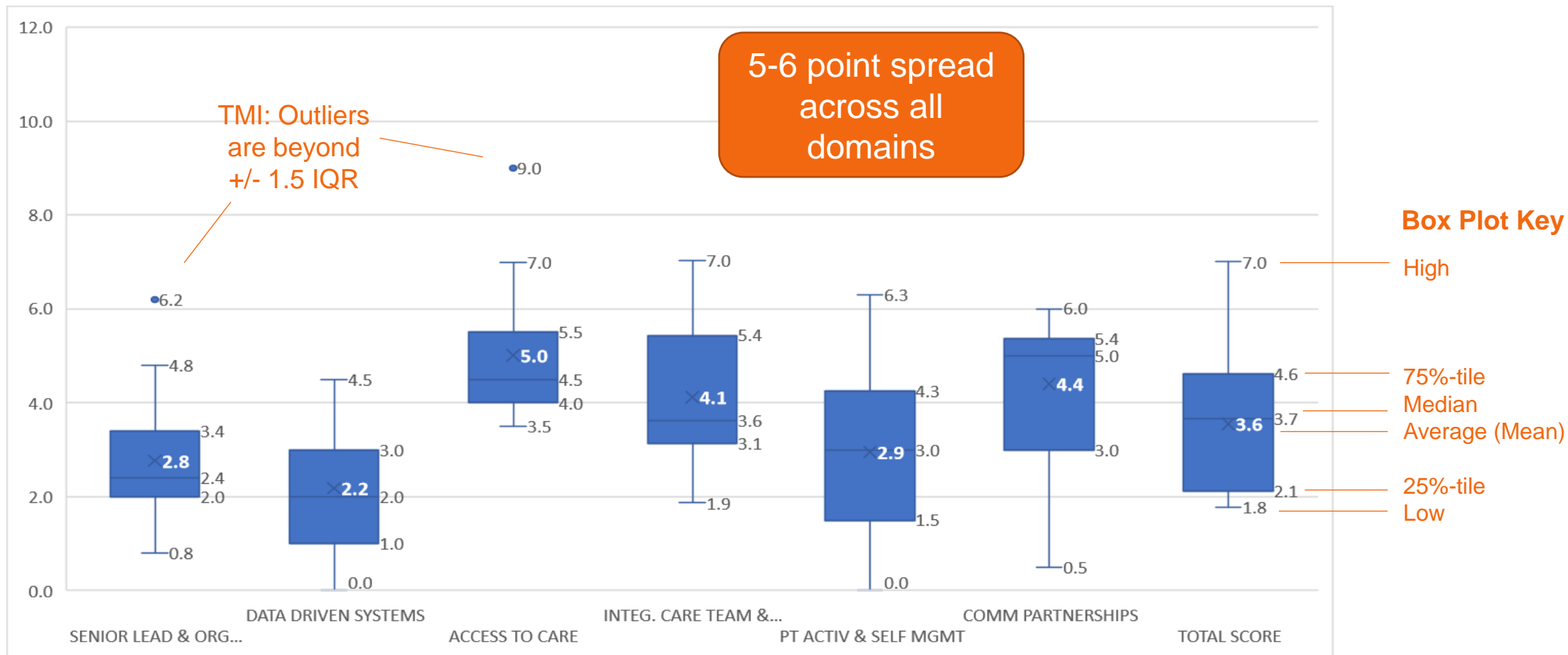
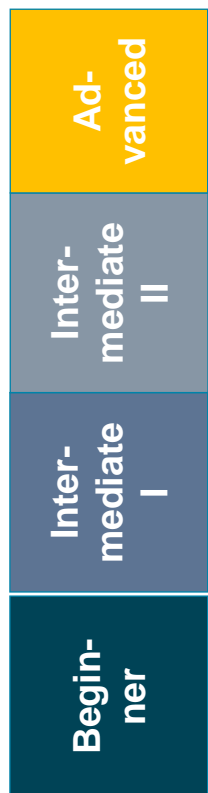
Total Score (All Orgs) by Driver Domain



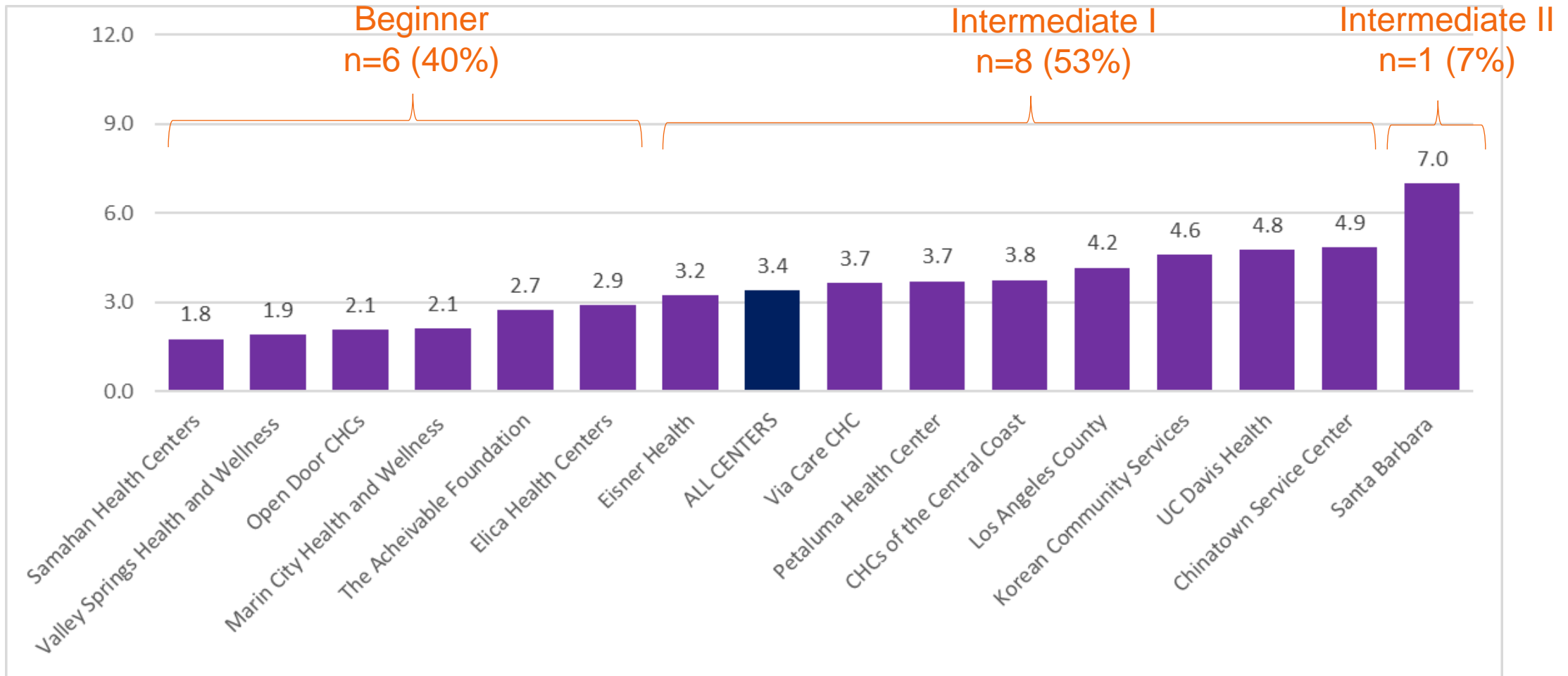
Average CAT domain scores (n=15 organizations)



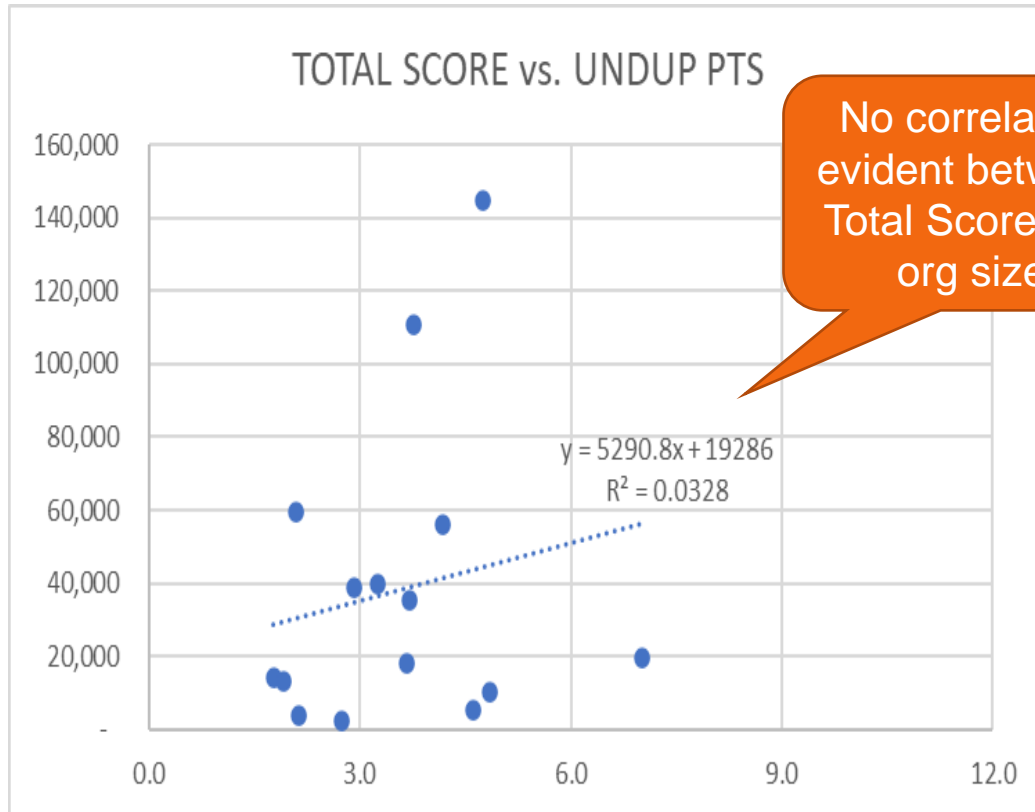
Total Score (All Orgs) by Driver Domain - Spread



Total Score Spread by Org



CAT Results: Deeper Insights

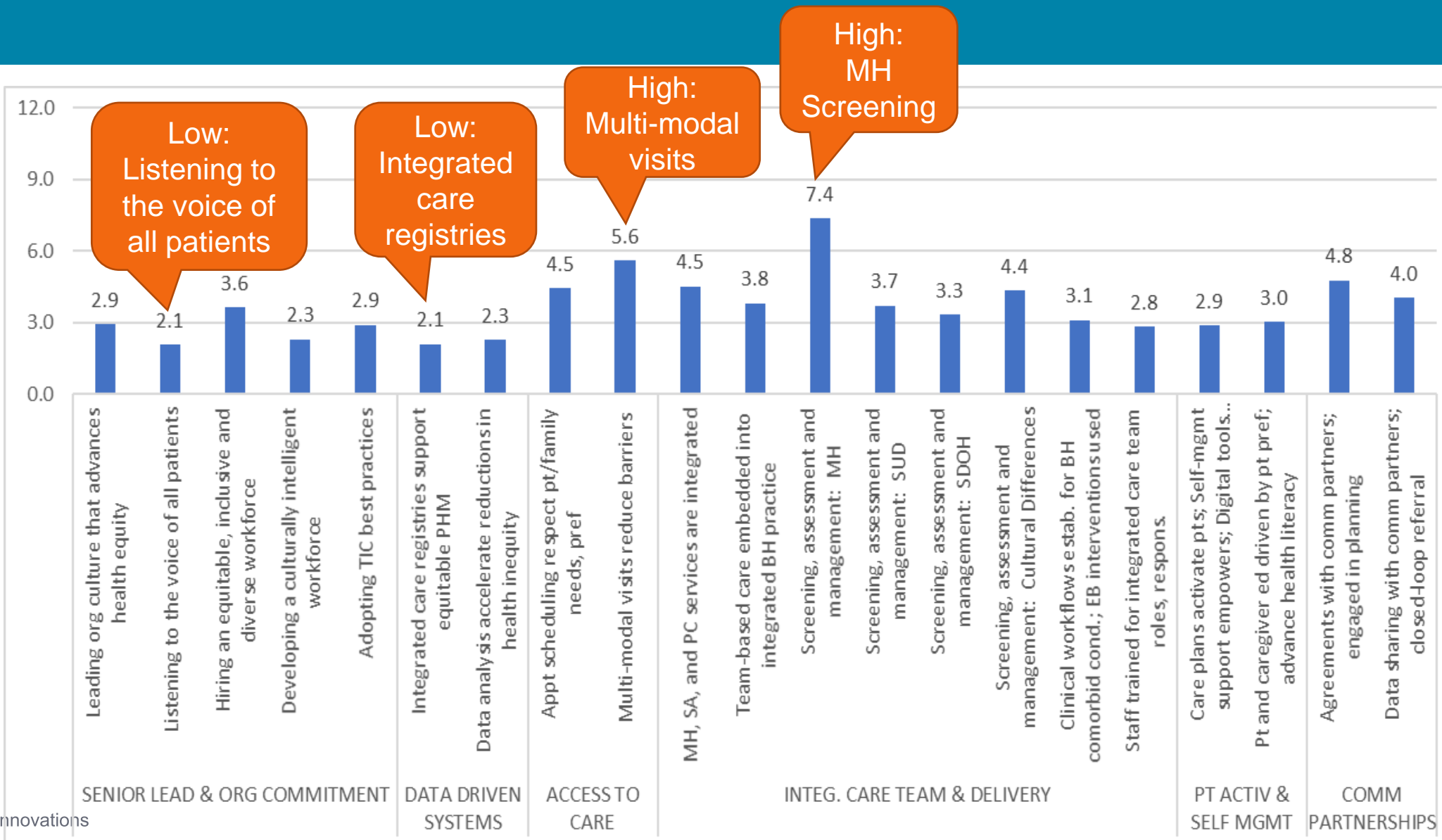


Low n, interpret with caution.

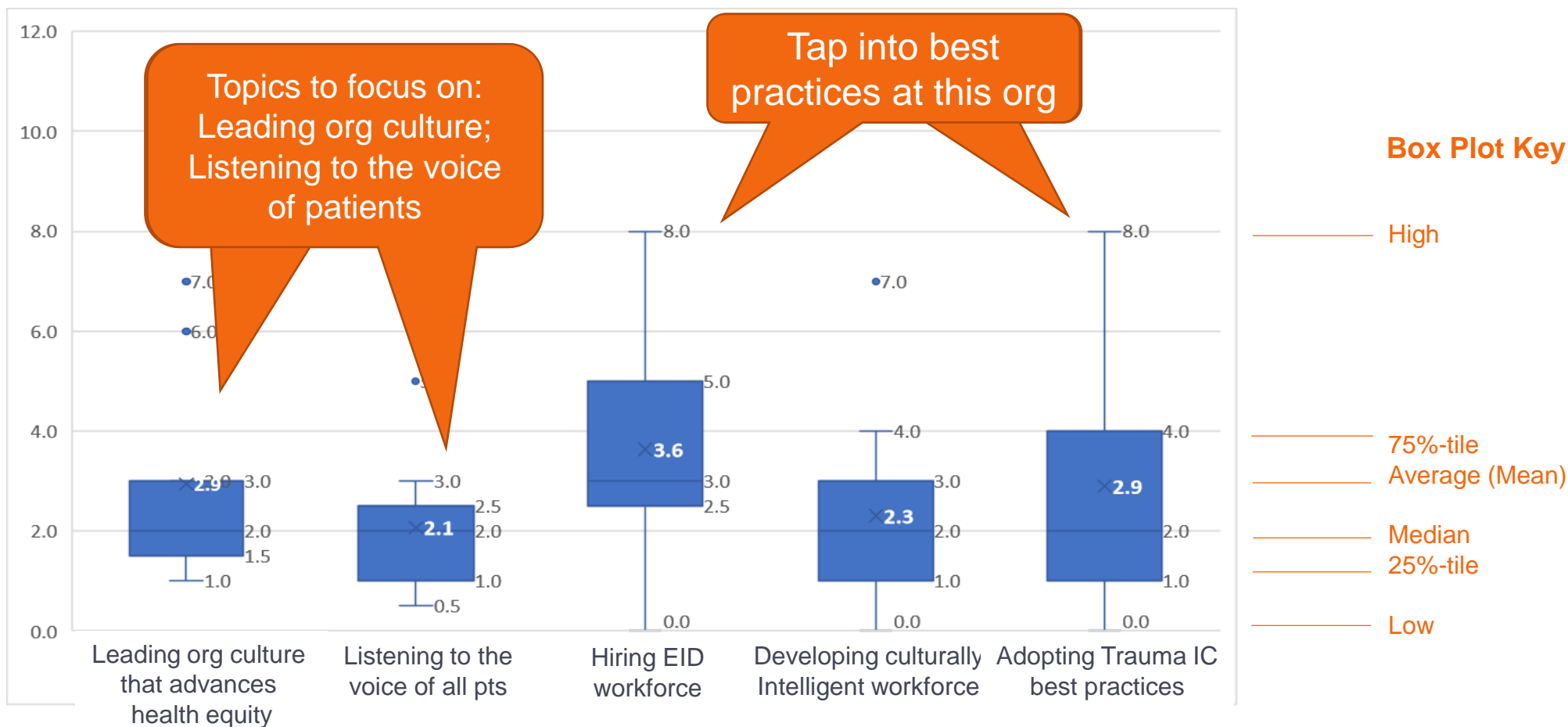
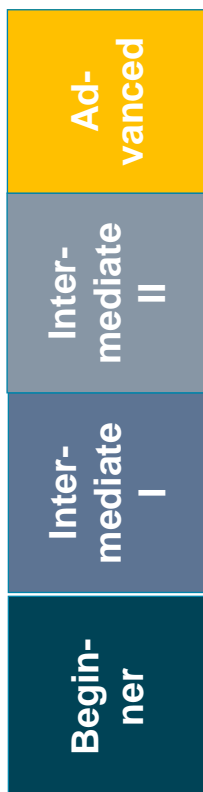
- Top factor correlates with org size:
 - Listening to the voice of all patients ($r=0.69$)
 - Integrated care registries support equitable PHM ($r=0.52$)
 - Clinical workflows are established for common BH comorbid conditions; Evidence-based interventions used ($r=0.34$)
- Top factors driving Total 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 ($r=0.85$)



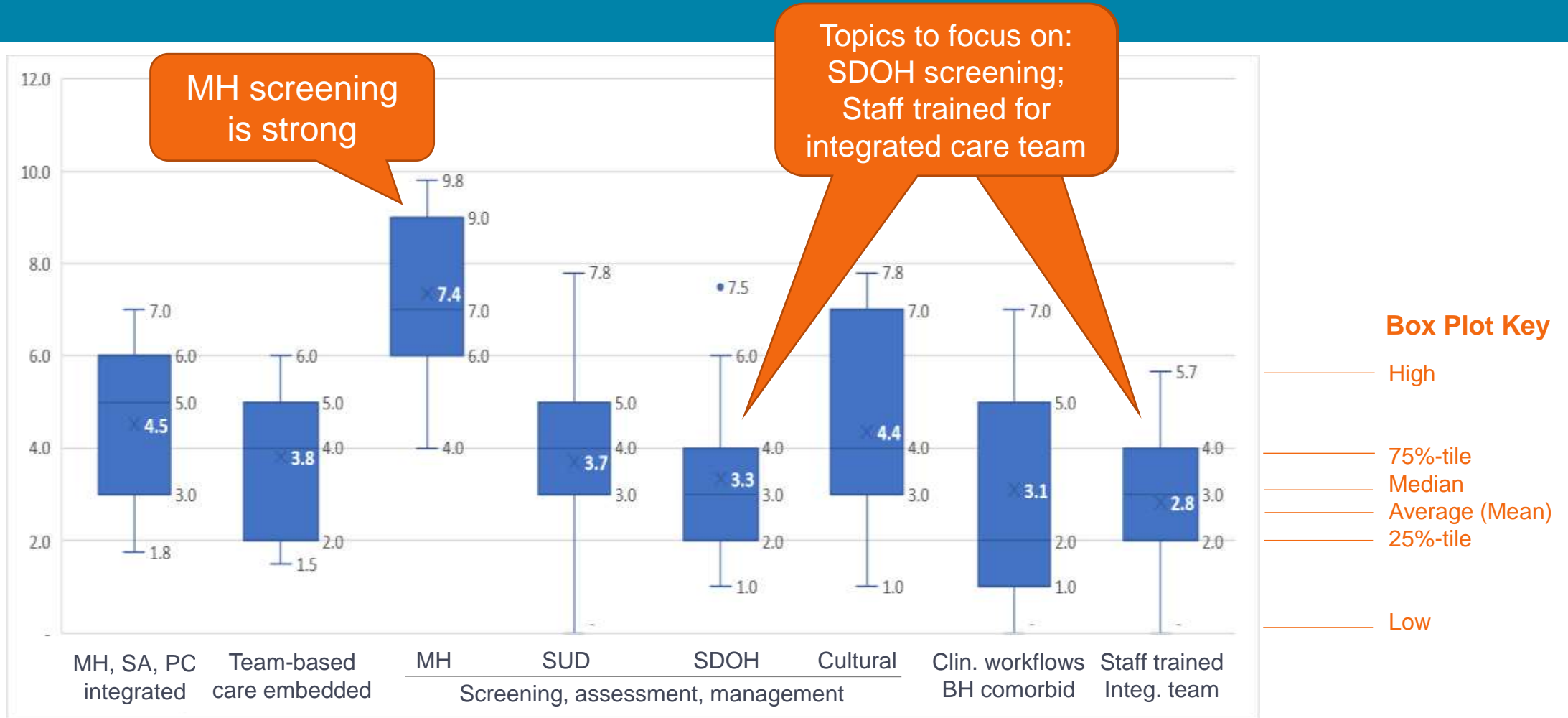
Average Factor Scores (All Orgs)



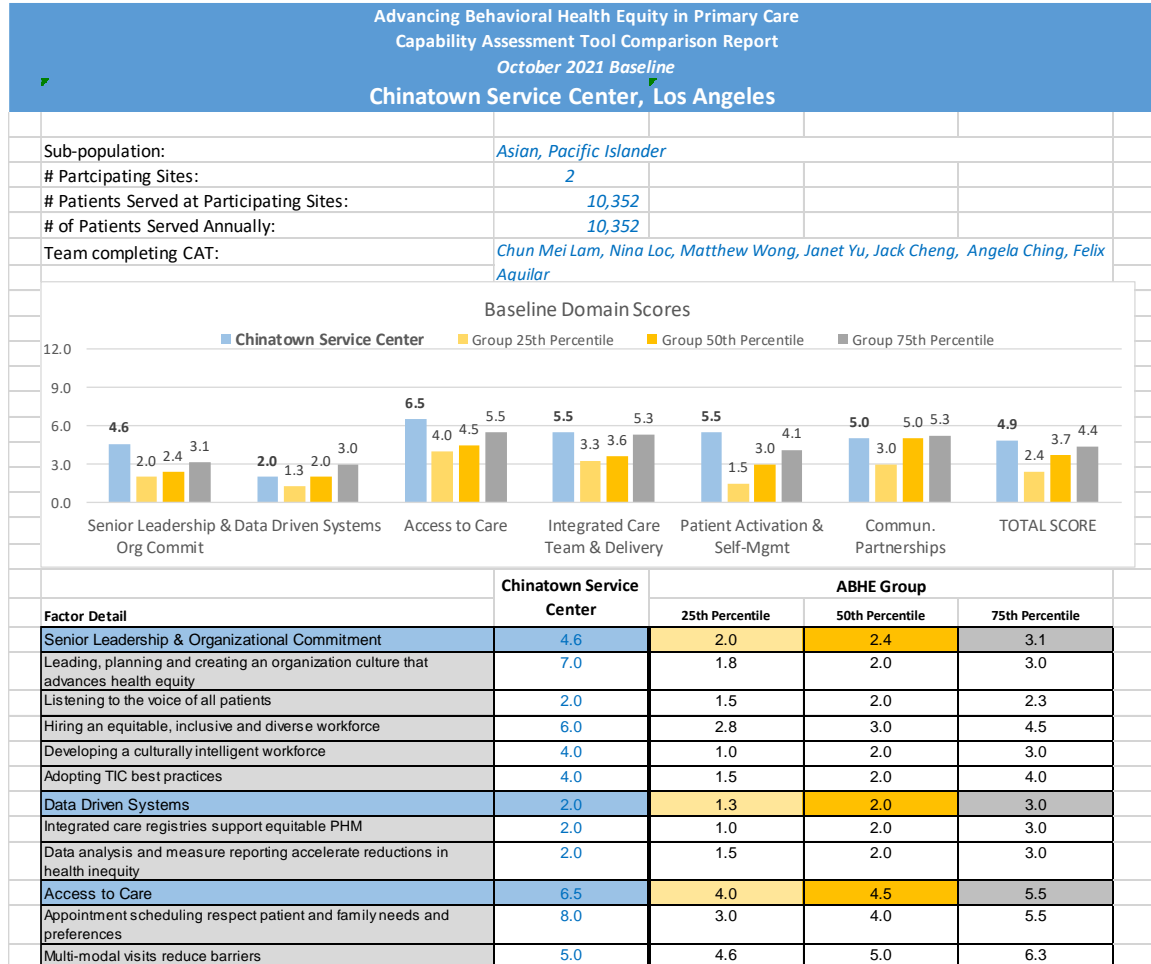
Senior Leadership & Org Commitment – ABHE “North Star”



Integrated Care Team & Care Delivery



Individual CAT Reports with Group Comparison



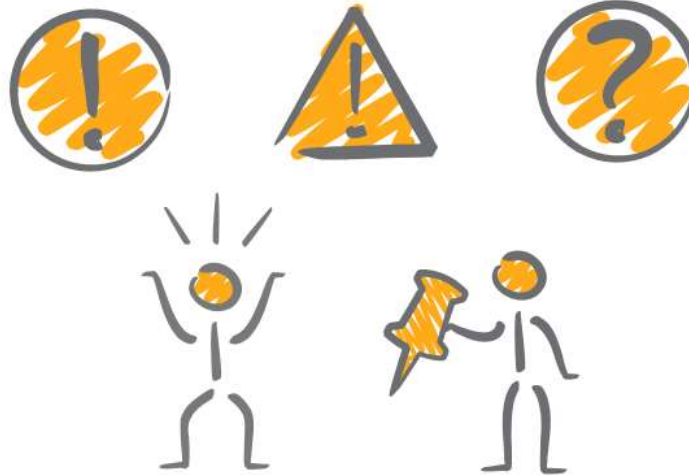
- You'll receive a "CAT Comparison Report" that compares your organization's baseline results against the ABHE Group results shared today.
- Use to identify strengths that can be leveraged and potential opportunities to address in your Roadmap & Charter.



I 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



Ann Middleton, MPH

Research Associate
American Institute for
Research

Evaluation Roadmap



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: <ul style="list-style-type: none"> • No-show counts for first behavioral health appointment • Timeliness of Care • 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

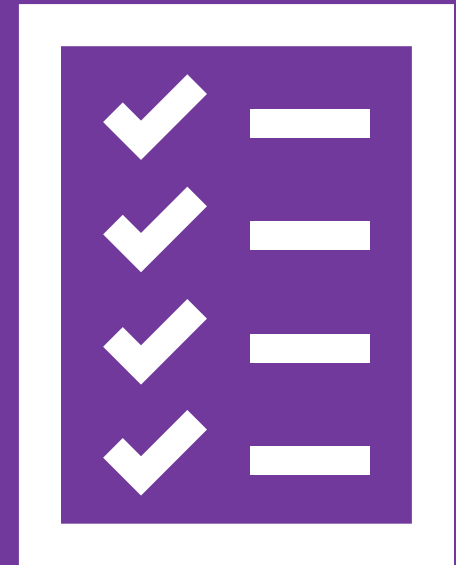
Health Equity Expert
Healthcare outcomes
researcher focusing
on vulnerable
populations

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



I 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/>



I Questions



Juan Carlos Piña

He/Him/His

Program Manager

juancarlos@careinnovations.org



Lydia Zemmali

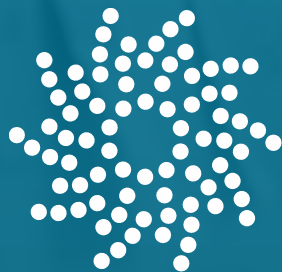
She/Her/Hers

Program Coordinator

lydia@careinnovations.org



Thank you!



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Appendix

I Population Focus

Organization	City	Sub-population
Open Door Community Health Centers	Arcata	African American, LGBTQ+
Samahan Health Centers	National City	Asian, Filipino, Native Hawaiian, Pacific Islander
Valley Springs Health and Wellness Center	Valley Springs	Latinx
Eisner Health	Los Angeles	African American, Elderly, Transition-aged youth, Latinx
Elica Health Centers	Sacramento	Central Asian, Immigrants, Latinx, Middle Eastern
LA USC California Primary Care	Los Angeles	African American, Latinx
Petaluma Health Center	Petaluma	LGBTQ+
Santa Barbara Neighborhood Clinics	Santa Barbara	Latinx, Adolescents, Transition-aged youth
Chinatown Service Center	Los Angeles	Asian, Pacific Islander
Korean Community Services	Anaheim	Asian, Immigrants, Native Hawaiian, Pacific Islander
Via Care Community Health Center	Los Angeles	Latinx, Asian, LGBTQ, and adolescents/transition-aged youth
Community Health Centers (Central Coast)	Santa Maria	Farmworkers, Latinx, LGBTQ+, Transition-age youth
Marin City Health and Wellness Center	San Rafael	African American, Latinx, Serious and Persistently Mentally Ill
The Achievable Foundation	Culver City	Latinx, Transition-aged youth, Developmental Disabilities
UC Davis Health	Sacramento	African American, Asian, Latinx

