Behavioral Health Integration in Primary Care Continuum Based Framework

Community & Social Services Linkages

April 14, 2021 | 12-1PM

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

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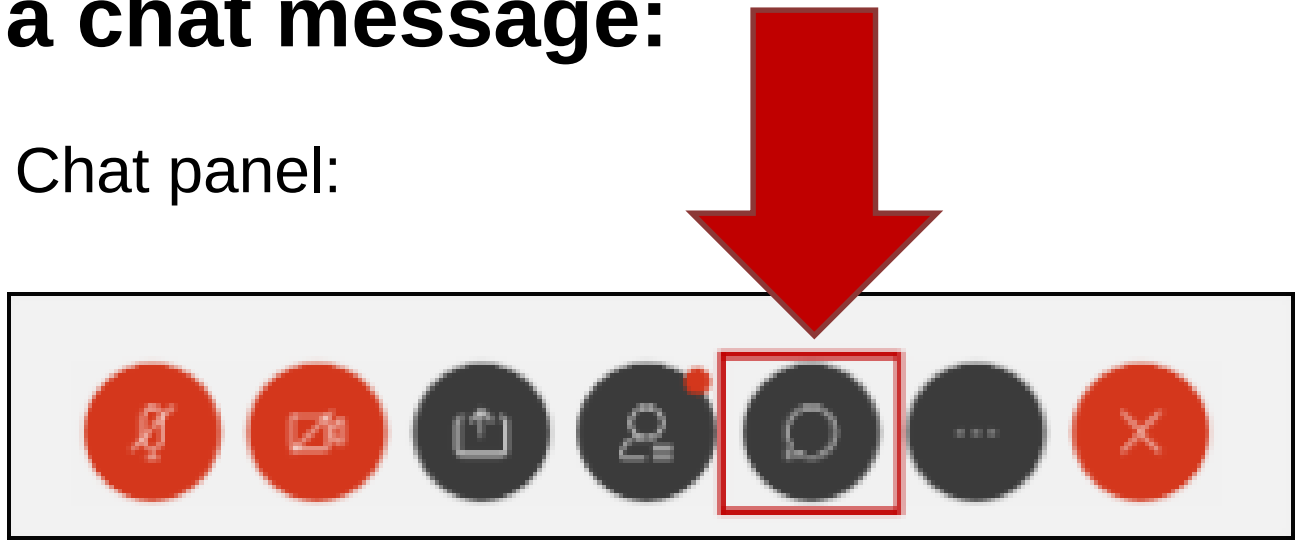

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Behavioral Health Integration Domains

1	Case finding, screening, and referral to care
2	Decision support for measurement-based stepped care
3	Information exchange among providers
4	Ongoing care management
5	Self-management support that is culturally adapted
6	Multi-disciplinary team (including patients) used to provide care
7	Systematic Quality Improvement
8	Linkages with community and social services
9	Sustainability

Our Presenters

Quality Improvement Organizations
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Biography

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Health Leads

Director, Programs and Learning

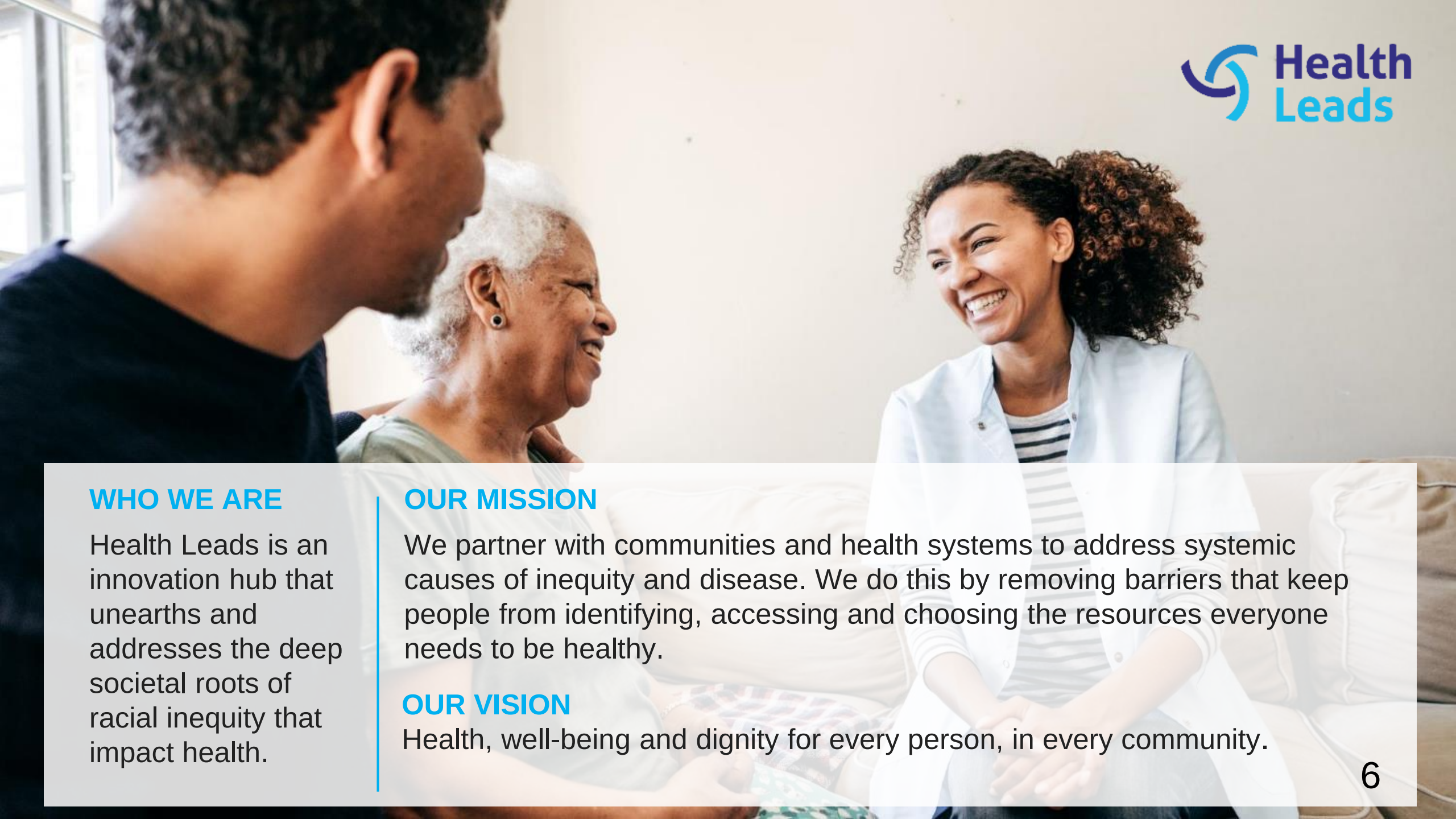
Biography

Improving Patient Care with SDOH Screening

Therese Wetterman, MPH

Director, Program and Learning

Health Leads



WHO WE ARE

Health Leads is an innovation hub that unearths and addresses the deep societal roots of racial inequity that impact health.

OUR MISSION

We partner with communities and health systems to address systemic causes of inequity and disease. We do this by removing barriers that keep people from identifying, accessing and choosing the resources everyone needs to be healthy.

OUR VISION

Health, well-being and dignity for every person, in every community.

Objectives for today

- Discuss the importance of screening for and addressing social risk factors
- Provide examples of ways that practices screen for social needs and refer patients to resources
- Describe how referrals are tracked and integrated into EHRs
- Share new learning on social health integration from the Collaborative to Advance Social Health Integration

Impact of SDOH inequities during the COVID-19 Era

Racism and discrimination exhibited towards Asian/Pacific Islander community

Higher % of deaths within African American and Latinx communities

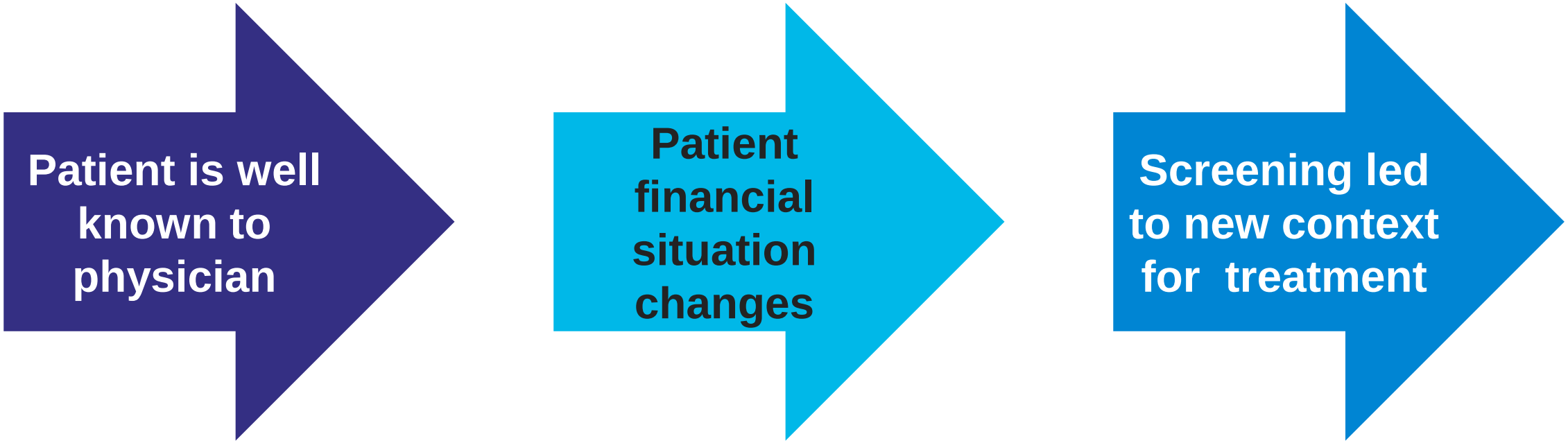
Patients currently within the safety net have even more difficulty obtaining the essential resources needed to be healthy

Impact following shelter in place has hit historically underinvested communities harder

Patient Story: John’s Pre-Surgery appointment

- New needs identified via screening
- Addressed with connection to resources
- Impacted patient’s ability to recover and improved health outcomes
- Provided better context for treatment

Removing Assumptions and Changing Narratives



Traditional Health Leads Social Need Intervention Model

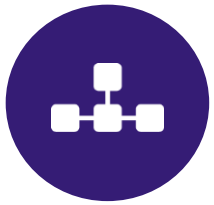
Crisis Response

Resource Maintenance

Primary Drivers of Social Health Integration

Leadership & Change Management

How will this work benefit your patients and staff? How will you engage them in the design process? What funding sources are available? Have you identified a social needs champion with the ability to allocate resources?



Social Needs Team & Workflow

Who will provide resource support for patients? How will this integrate with broader clinical/behavioral processes?

Navigation & Resource Connections

For which specific social needs will you offer support? What level and type of support?

Community Partnerships

What community-based organizations are critical to the health of your patients? How will you continually improve access to resources?

Patient Identification & Screening

Which patient population will you support and how will you surface their social needs and goals?

Data & Health Information Technology

How will you monitor and improve quality of your model? How will you maximize the impact of your investment? How will you maintain a resource database?

Inclusive creation of social health screening & referral interventions with key stakeholders

Identify Stakeholders

⑩ Include:

- Patients
- Healthcare providers
- Operations managers
- Medical Assistant / RNs / SW
- Health literacy expert
- IT Analyst
- Community resource partners (local CBOs)
- Community engagement specialist

Select SDOH Domains

⑩ Consider:

- Impact on health outcomes
- Clinical relevance to patients/community served
- Feasibility of addressing needs identified
- Financial impact

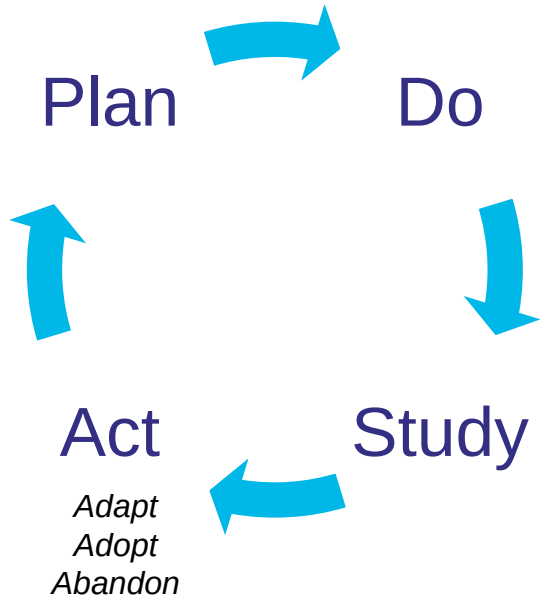
Co-Design

⑩ Ask:

- How can the screening questions be clearer and culturally relevant?
- How comfortable will people be answering the question(s)?
- Who should be asking them?
- What are the gaps in the resource landscape?
- What level of navigation support do people prefer?
- What capacity do community service partners have to take on new referrals?

The most important stakeholders in this process are the end users

Start Small and Use PDSA Cycles to Expand



Example:

Phase 1:
Paper pilot in 1 primary care clinic (new pts only)

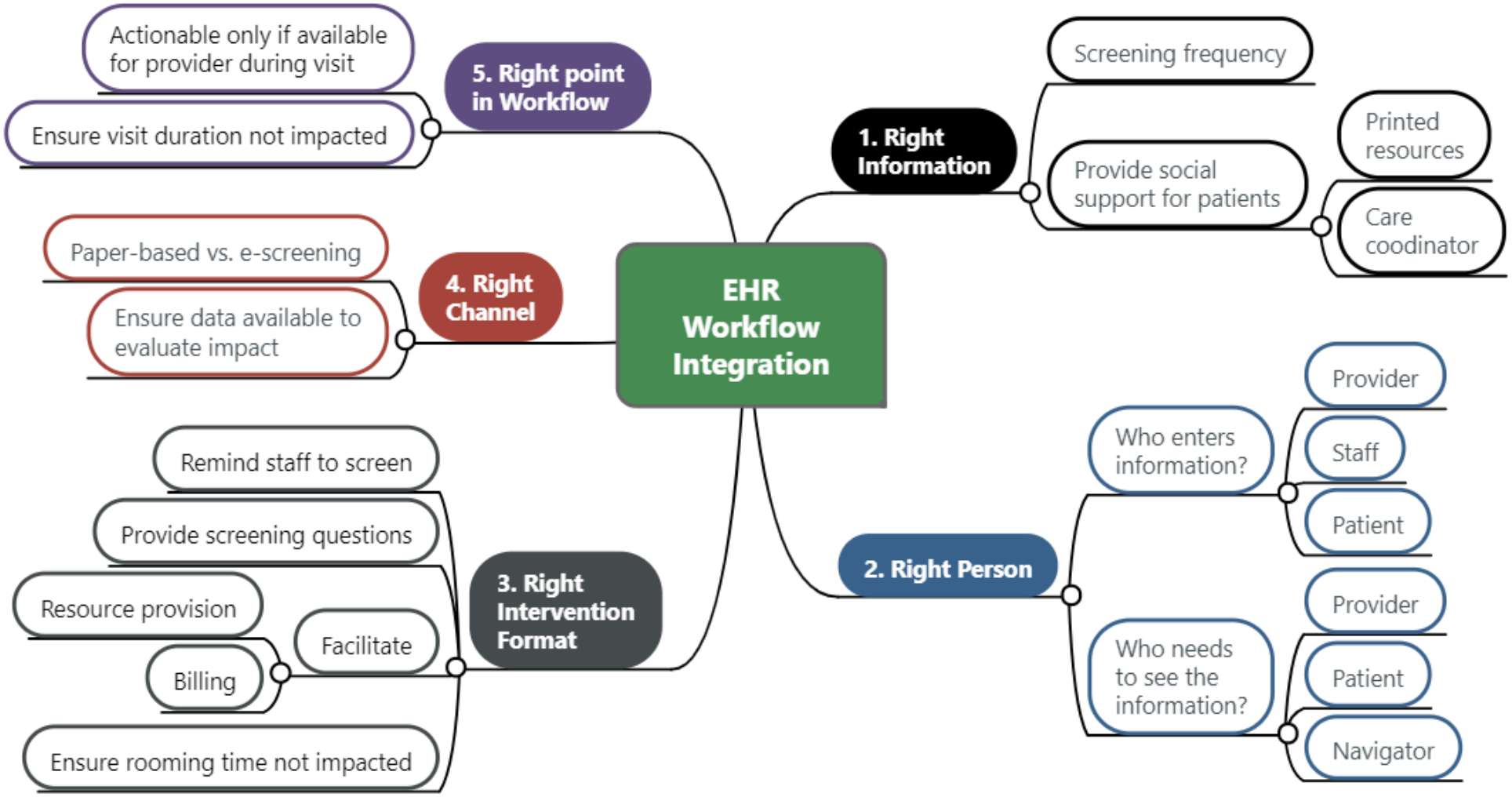
Phase 2:
EHR pilot in two primary care clinics (new pts only)

Phase 3:
EHR pilot in ALL primary care departments

Adopt and spread

Integrating Social Health Data into the EHR

Develop workflow *before* build ● Center patients' experience ● Engage staff responsible in workflow design



Source: Boston Medical Center

Collaborative to Advance Social Health Integration (CASHI)

2017-2019

Health Leads' Collaborative to Advance Social Health Integration (CASHI)

Increase the number of patients whose essential resource needs are met and spread successful changes to multiple sites

Successful intervention; ready to **improve & spread**

Sustainably funded social health integration

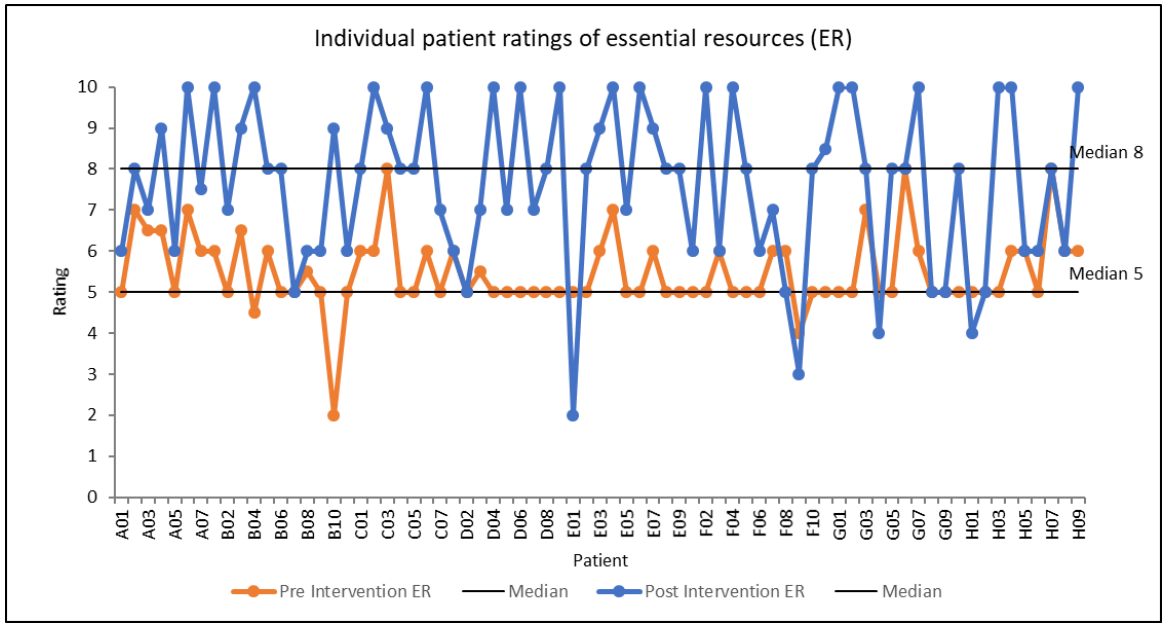
CASHI AIM:

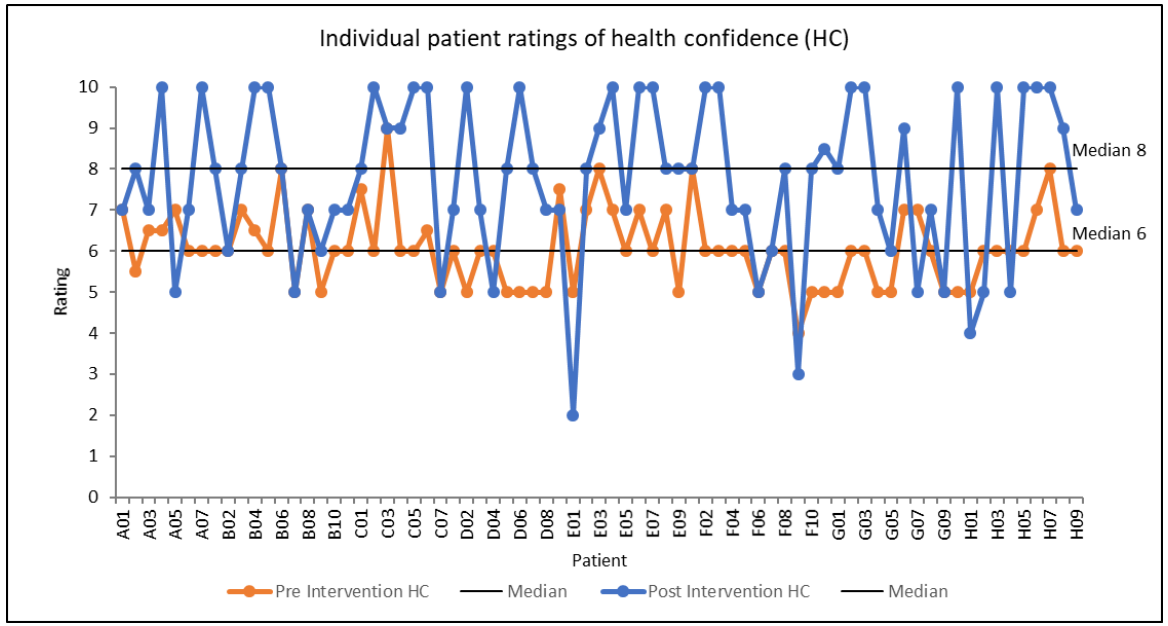
By October 2019, participating healthcare organizations will integrate social health into primary care such that

- There is an increase in the percentage of patients who report they have the essential resources to be healthy; and
- 75% or more patients report they are confident that they can control and manage most of their health problems.

The CASHI Cohort

What we learned: Measures





CHI Saint Joseph Health patient-reported outcome measures data, January-August 2019.

- Although challenging to implement, patient-reported outcome measures (PROMs) support better conversations between care teams and patients
- Different populations need different self-reported health outcome measures

What we learned: Business Case

CASHI Business Case Approach

There is value in the disciplined process required in work on the business case

Value Proposition
Hypothesis for the value you will demonstrate to whom (must include those who will pay)

Total Cost
Analysis of funds required. What drives cost? Potential efficiencies?

Funding & Revenue Sources
How you will cover your costs. Who will pay and what do they need to see?

Measures & Data Collection
How to demonstrate the value (measures, data collection & analysis)

Learnings

Financial sustainability is about more than ROI ….

- Sustainability will take many forms
- Financial sustainability is supported by developing a comprehensive view of value
- Detailed cost analyses help teams to focus intervention decisions on what drives value.
- Integration into current workflows with strong community partnership are essential ingredients.

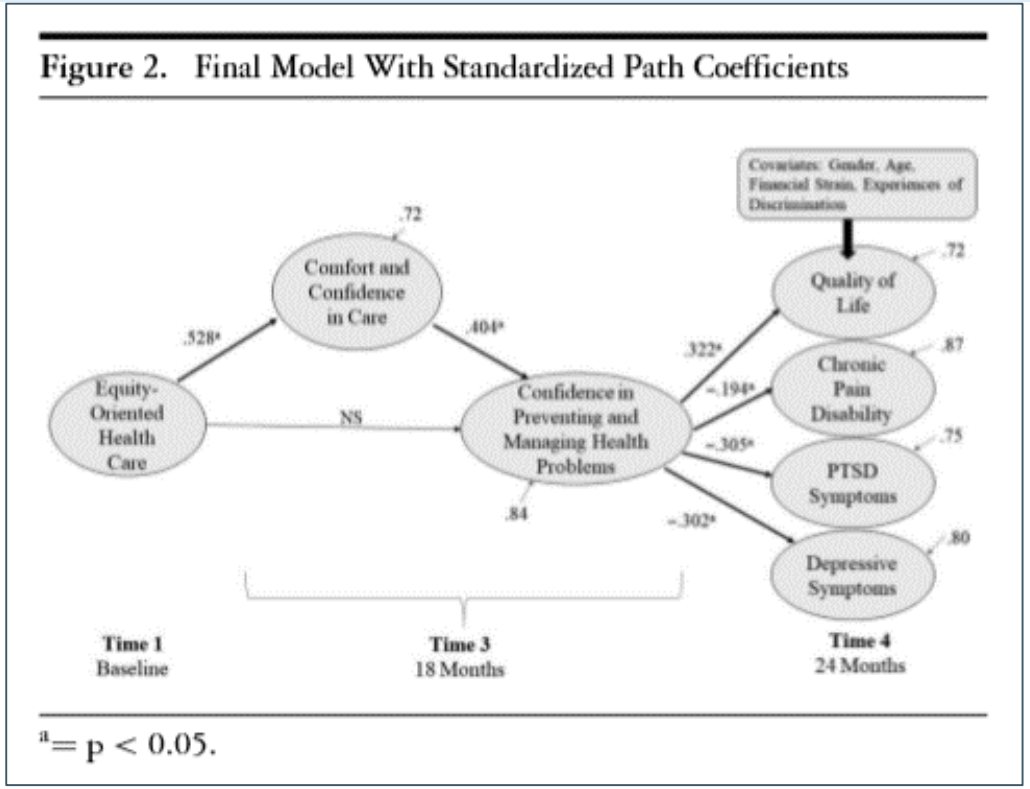
What learned: Health Equity

What is “equity-oriented health care” (EOHC)?

Dimensions of equity-oriented health care:

- **Trauma and violence-informed care:** Acknowledge and address effects of interpersonal and structural forms of violence on people’s lives and health
- **Culturally safe care:** Address inequitable power relations, racism, discrimination, and inequities in health care encounters
- **Contextually tailored care:** Offers services tailored to populations served and local and wider social contexts

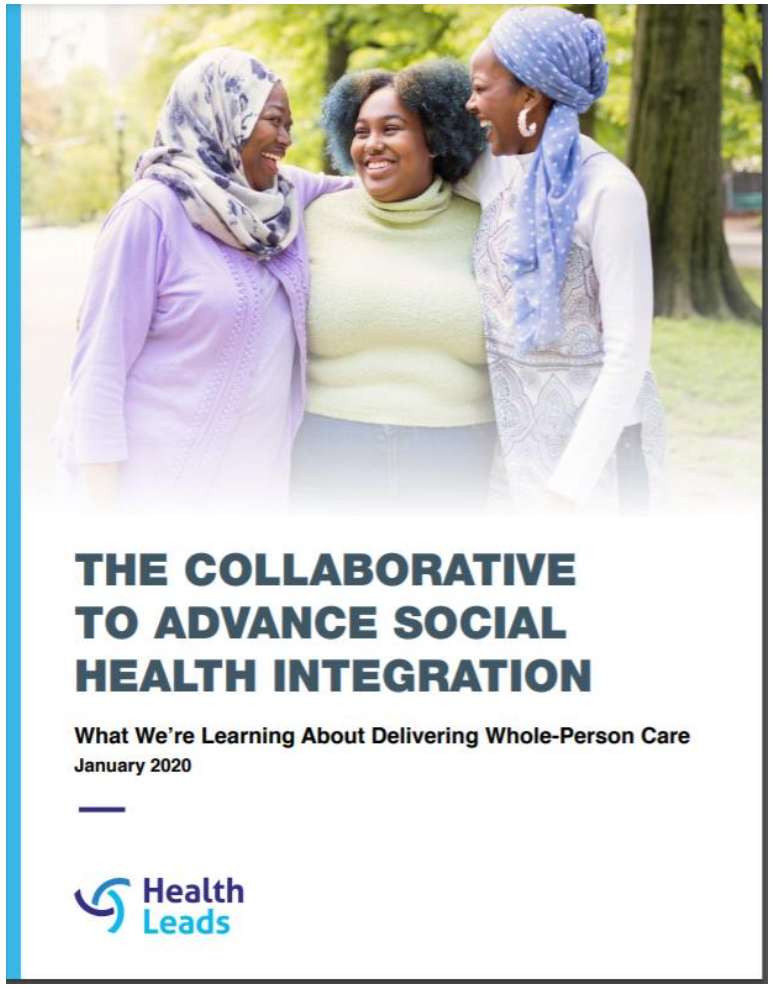
Pathway by which EOHC improves health

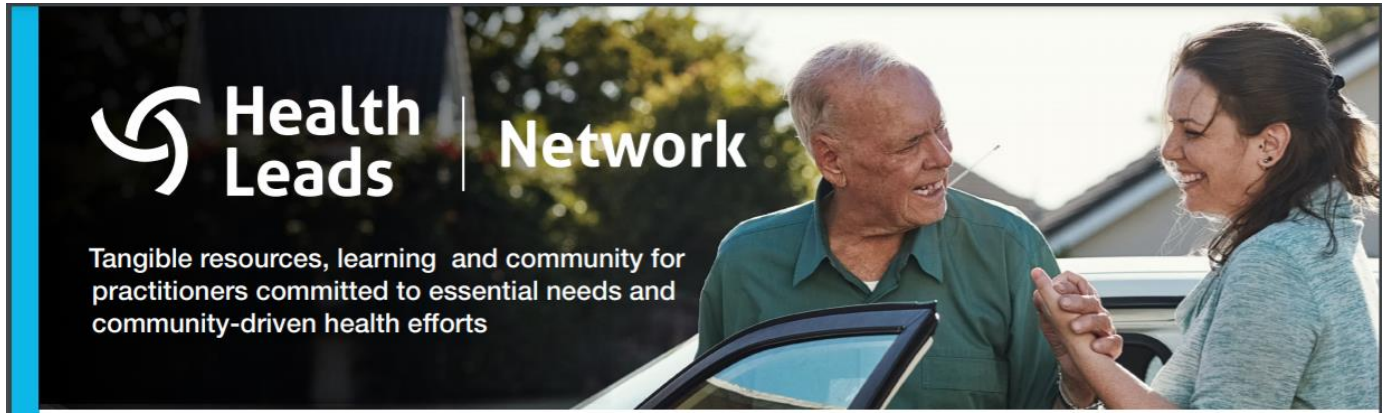


- CASHI Teams helped to identify some promising practices to support EOHC (e.g. trauma-informed racial equity training)
- CASHI Teams are generating evidence in support of the model (e.g. link between EOHC and health confidence)
- Now want to expand knowledge of practices, deepen evidence around them, and validate measures

Source: Ford-Gilboe et. al., Milbank Quarterly, 2019.

Connect with us to learn more!





https://healthleadsusa.org/network/

Thank you!

Questions?

twetterman@healthleadsusa.org

Join our network at:
https://healthleadsusa.org/network/

Health Leads

Community Linkage to Care Program

Past, Present & Future Directions

Qlarant Webinar, *Community and Social Services Linkages*
April 14, 2021

Kevin Fiori MD, MPH, MSc
Department of Family & Social Medicine, Division of Research
Department of Pediatrics, Division of Academic General Pediatrics
Office of Community & Population Health
Montefiore Health System / Albert Einstein College of Medicine

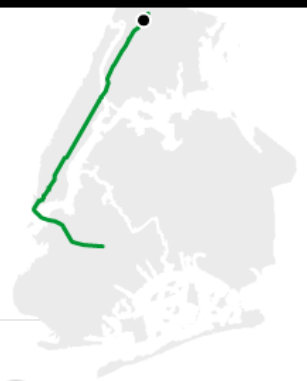
EINSTEIN Albert Einstein College of Medicine Montefiore

THE NEW YORKER

IDEA OF THE WEEK

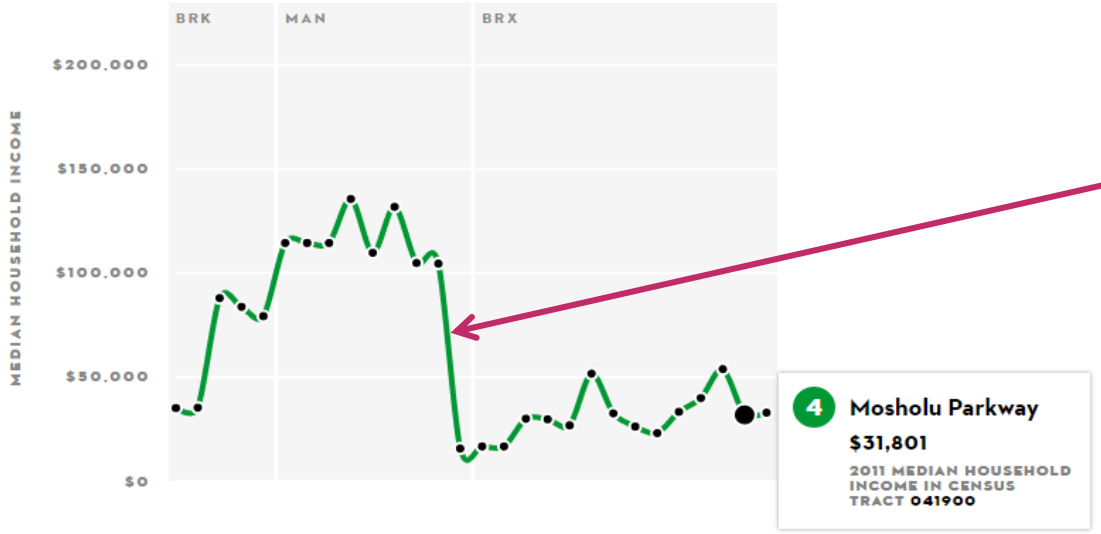
INEQUALITY AND NEW YORK'S SUBWAY

New York City has a problem with income inequality. And it's getting worse—the top of the spectrum is gaining and the bottom is losing. Along individual subway lines, earnings range from poverty to considerable wealth. The interactive infographic here charts these shifts, using data on median household income, from the U.S. Census Bureau, for census tracts with subway stations.



CHOOSE A LINE, TAKE A RIDE

1 2 3 **4** 5 6 7 A C E B D F M N Q R J Z G L



4 Mosholu Parkway

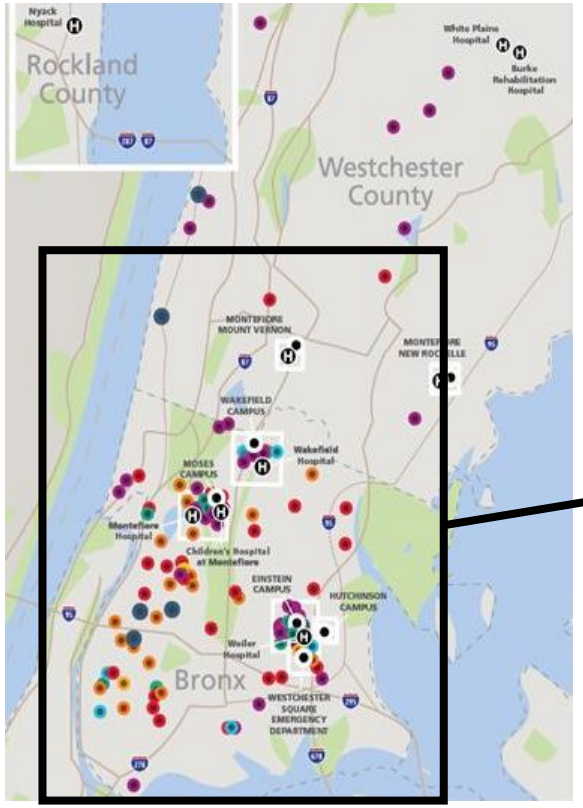
$31,801

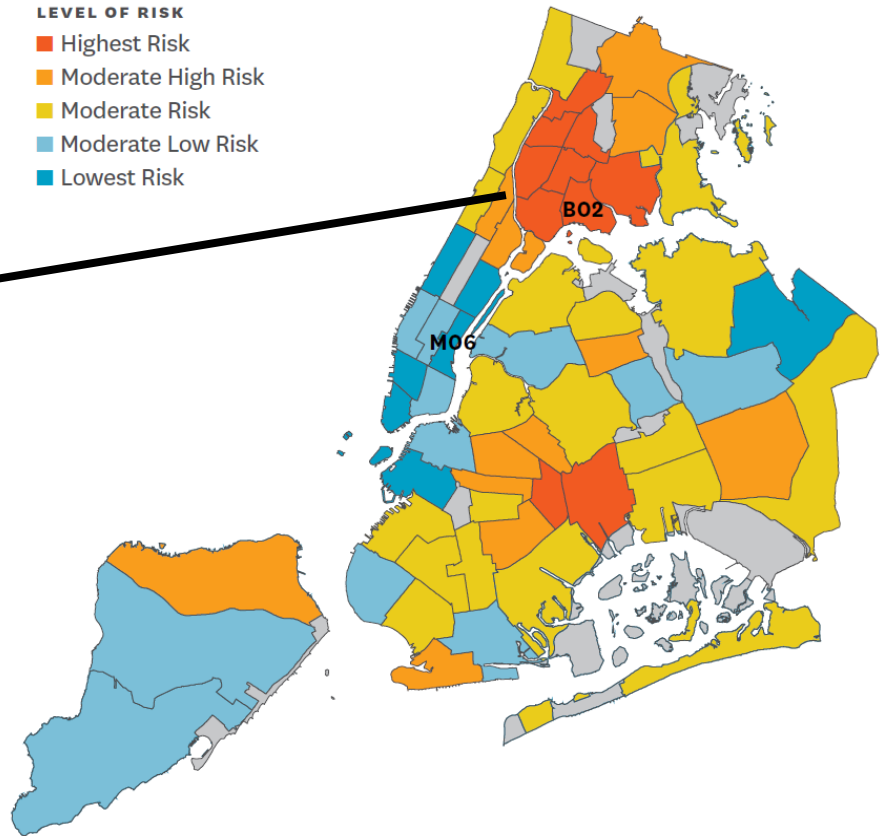
2011 MEDIAN HOUSEHOLD INCOME IN CENSUS TRACT 041900

By Larry Buchanan | Sources: NYC OpenData, U.S. Census Bureau

Neighborhood: Health & Income Bronx, County NY

CCC's Community Risk Ranking provides a composite picture of the concentration of risk to child well-being across New York City's 59 community districts (CDs). This measure combines all six domains of child well-being.

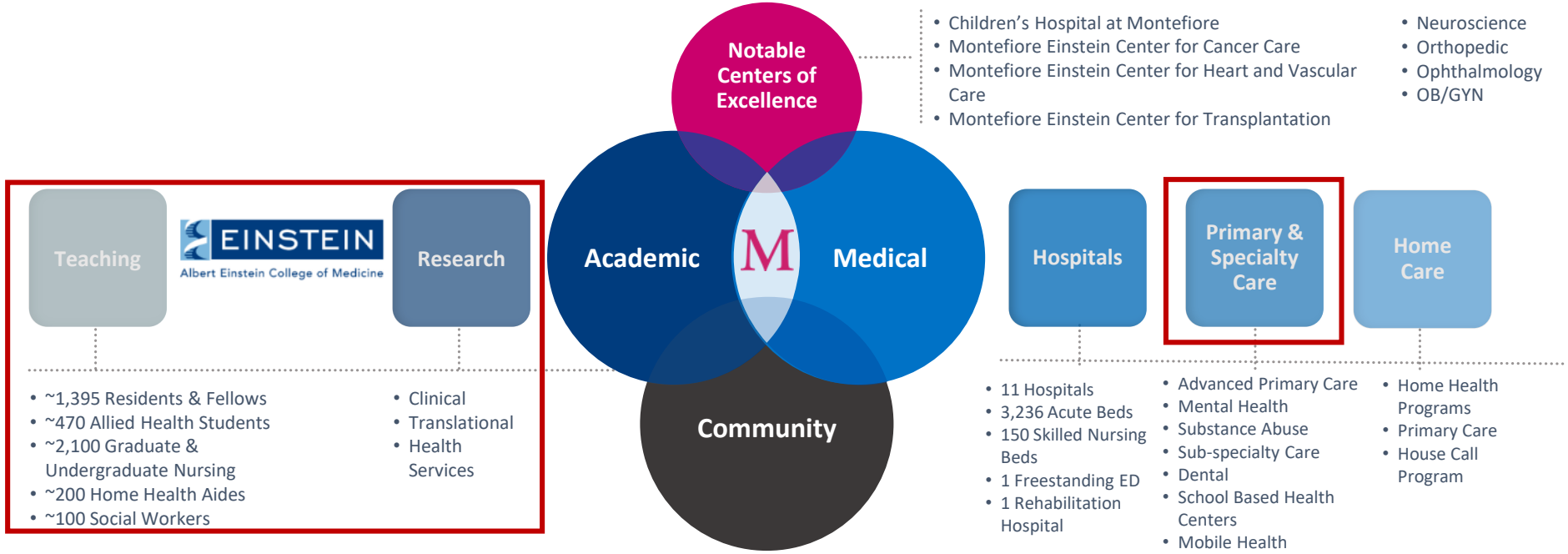




Ranking by CD

▼ HIGHEST RISK ▼		
1	Hunts Point	(B02)
2	East Tremont	(B06)
3	Mott Haven	(B01)
4	Brownsville	(K16)
5	Morrisania	(B03)
6	University Heights	(B05)
7	Concourse/Highbridge	(B04)
8	East New York	(K05)
9	Unionport/Soundview	(B09)
10	Bedford Park	(B07)
▼ MODERATE HIGH RISK ▼		
11	Williamsbridge	(B12)
12	Bushwick	(K04)
13	Bedford Stuyvesant	(K03)
14	East Flatbush	(K17)
15	East Harlem	(M11)
16	Central Harlem	(M10)
17	Jamaica/St. Albans	(Q12)
18	Crown Heights North	(K08)
19	Pelham Parkway	(B11)
20	Coney Island	(K13)
21	Elmhurst/Corona	(Q04)
22	St. George	(S01)
▼ MODERATE RISK ▼		
23	Washington Heights	(M12)
24	Howard Beach	(Q10)
25	The Rockaways	(Q14)
26	Flatbush/Midwood	(K14)
27	Jackson Heights	(Q03)
28	Riverdale	(B08)
29	Crown Heights South	(K09)
30	Sunset Park	(K07)
31	Throgs Neck	(B10)
32	Borough Park	(K12)
33	Woodhaven	(Q09)
34	Canarsie	(K18)

Montefiore Health System, Bronx, NY



- Children's Hospital at Montefiore
- Montefiore Einstein Center for Cancer Care
- Montefiore Einstein Center for Heart and Vascular Care
- Montefiore Einstein Center for Transplantation
- Neuroscience
- Orthopedic
- Ophthalmology
- OB/GYN

- ~1,395 Residents & Fellows
- ~470 Allied Health Students
- ~2,100 Graduate & Undergraduate Nursing
- ~200 Home Health Aides
- ~100 Social Workers

- Clinical
- Translational
- Health Services

- 11 Hospitals
- 3,236 Acute Beds
- 150 Skilled Nursing Beds
- 1 Freestanding ED
- 1 Rehabilitation Hospital

- Advanced Primary Care
- Mental Health
- Substance Abuse
- Sub-specialty Care
- Dental
- School Based Health Centers
- Mobile Health

- Home Health Programs
- Primary Care
- House Call Program

- Health Education
- Community Advocacy
- Wellness
- Disease Mgmt.
- Nutrition
- Obesity Prevention
- Physical Activity
- Reduce Teen Pregnancy
- Lead Poisoning Prevention

- Finance
- Legal
- Strategic Planning
- Purchasing
- Compliance
- Marketing
- Public Affairs
- Human Resources

- Clinical support
- Network applications

- Care Management (~ 400K Covered Lives)
- Disease Management
- Care Coordination
- Telemedicine
- Pharmacy Education

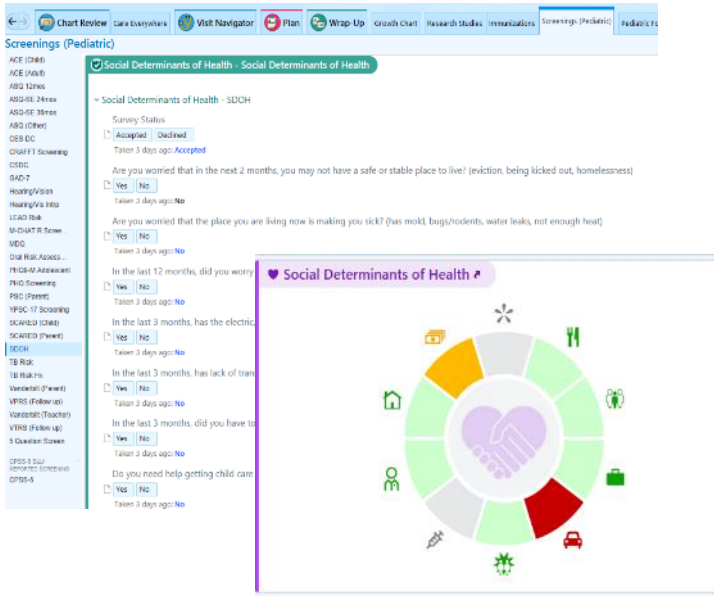
- ~30,000 Employees
- ~2,000 Physicians
- ~ 4,800 Medical & Allied Health Staff
- ~3,890 Integrated Provider Association Providers
  - ~3,150 Employed
- ~5,650 RN/LPN
  - ~3,600 NYSNA RNs
- ~10,900 SEIU/1199

Albert Einstein College of Medicine

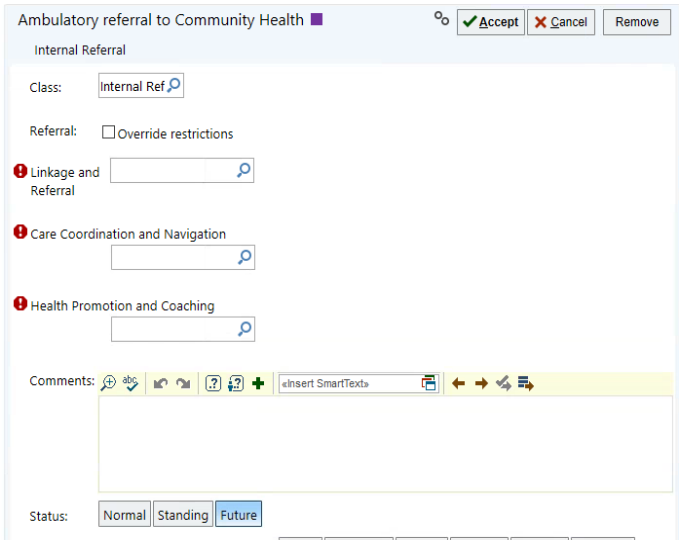
Montefiore

Past: Integrating Social Needs Screening & Referrals @ Montefiore Health System

Montefiore: Integrated Social Needs Screening & Outreach (2017-2021)



CHW REFERRAL



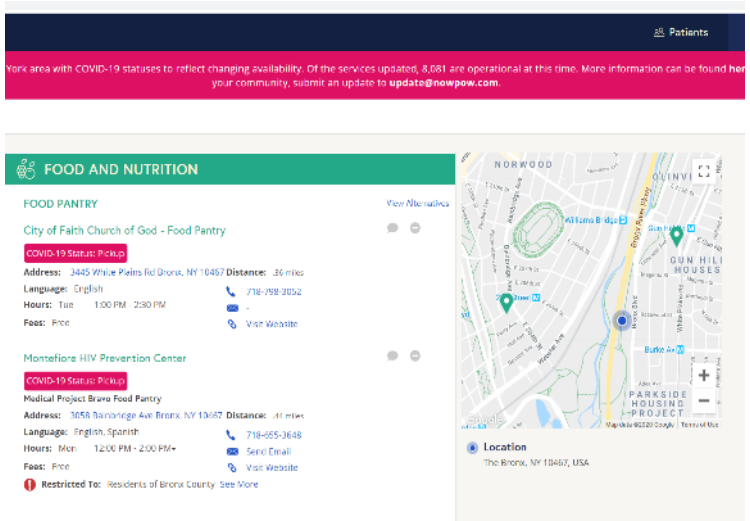
Standardized Social Needs Screen

Referrals

Referral Support

		YES / NO
	Are you worried that in the next 2 months, you may not have a safe or stable place to live? (eviction, being kicked out, homelessness)	Y N
	Are you worried that the place you are living now is making you sick? (has mold, bugs/rodents, water leaks, not enough heat)	Y N
	In the last 12 months, did you worry that your food could run out before you got money to buy more?	Y N
	In the last 3 months, has the electric, gas, oil or water company threatened to shut off services to your home?	Y N
	In the last 3 months, has lack of transportation kept you from medical appointments or getting your medications?	Y N
	In the last 3 months, did you have to skip buying medications or going to doctor's appointments to save money?	Y N
	Do you need help getting child care or care for an elderly or sick adult?	Y N
	Do you need legal help? (child/family services, immigration, housing discrimination, domestic issues, etc.)	Y N
	Are you finding it so hard to get along with a partner, spouse, or family members that it is causing you stress?	Y N
	Does anyone in your life hurt you, threaten you, frighten you or make you feel unsafe?	Y N

Do you want help? Y N



BCHN Bronx Community Health Network

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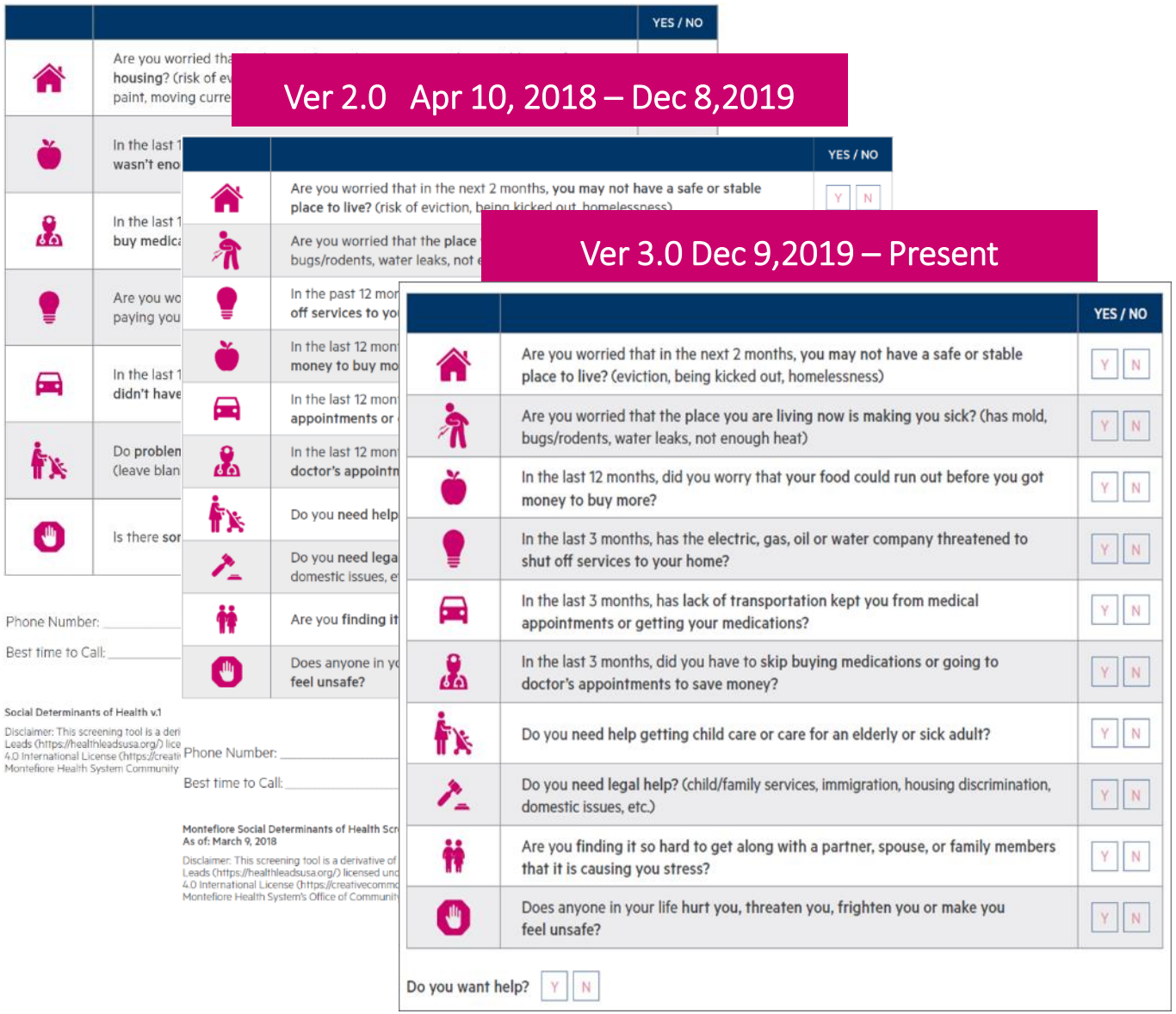
Screen Development: Versions of Screening Tool

Ver 1.0 May 2017 – Apr 9, 2018

Ver 2.0 Apr 10, 2018 – Dec 8,2019

Ver 3.0 Dec 9,2019 – Present



Screener Changes

Version 1

- Modified from Health Leads Survey
- Seven questions

Version 2

- Increased screener to 10 questions
- Added Legal Questions
- Added Household Quality

Version 3

- Reduced time period to 3 months from 12 months on Transportation, Medication and Utility Questions
- Added stress aspect to familial relationship question
- Added Do You Want Help Question

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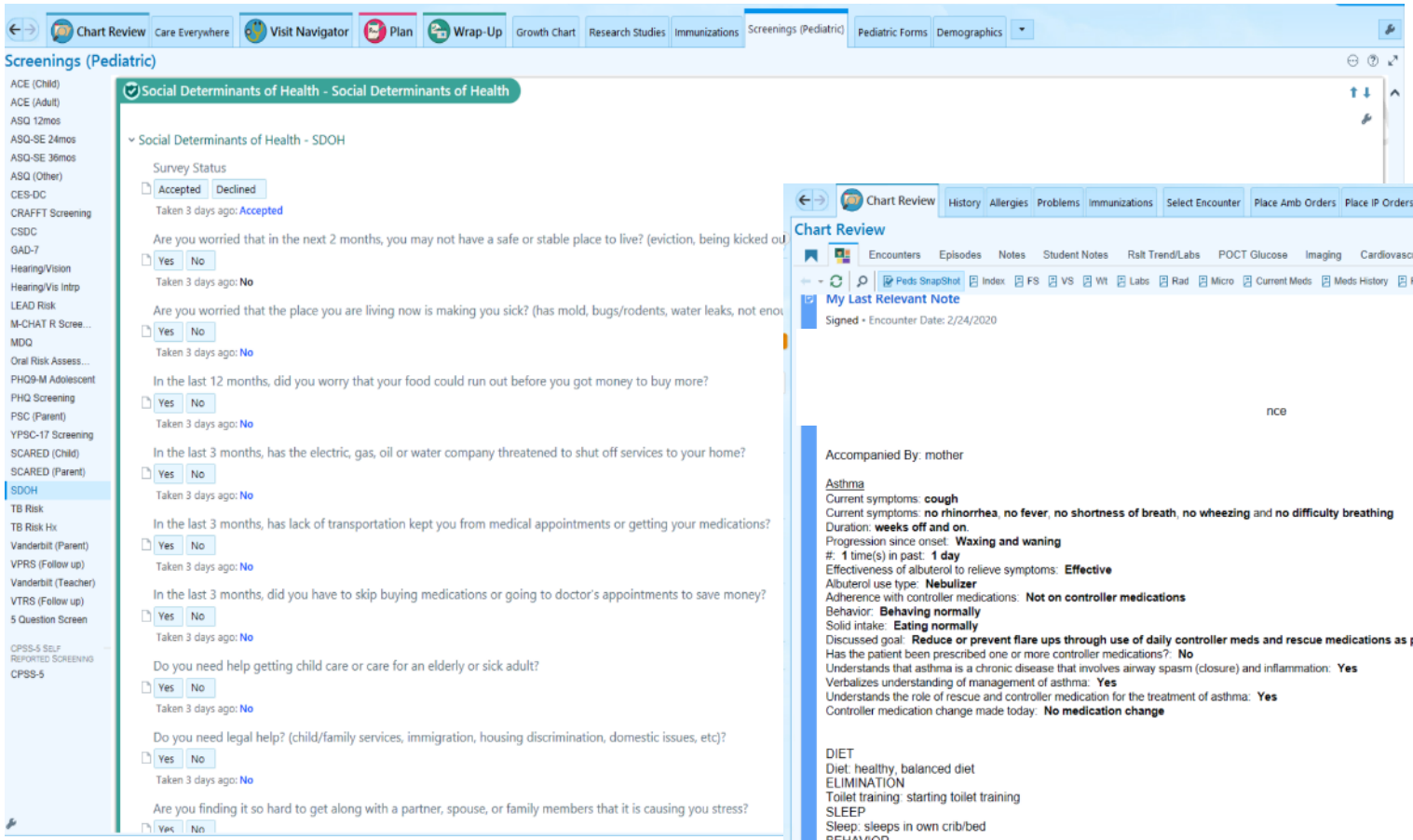
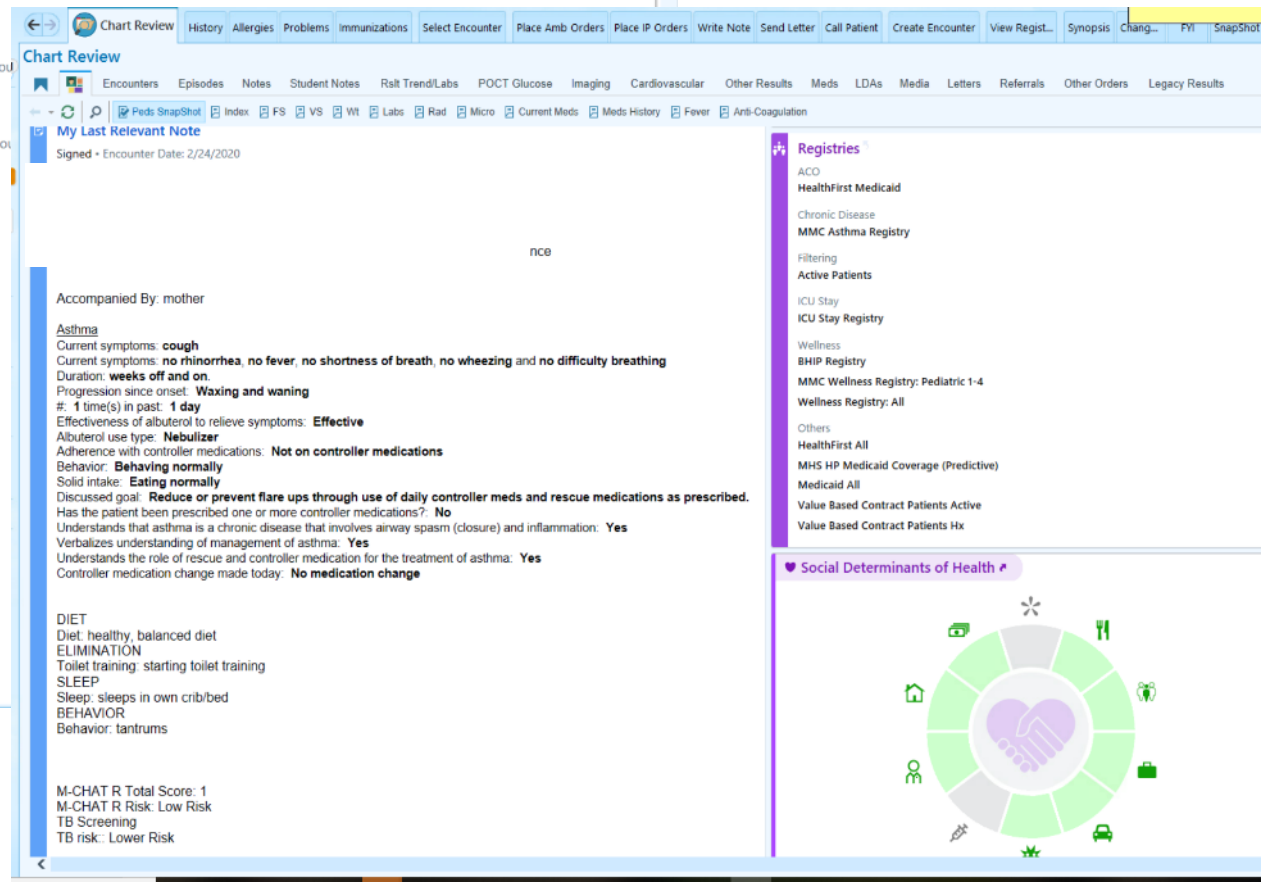
EHR Integration: Standardized Screen in Electronic Health Record





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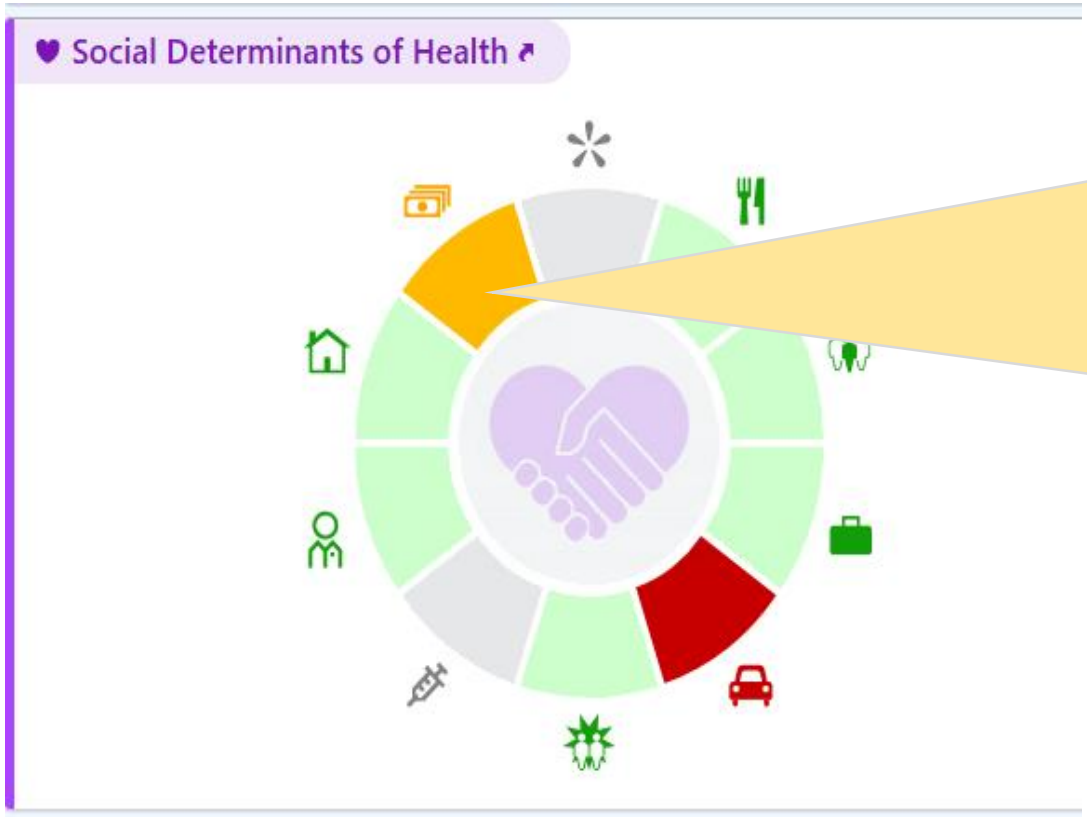
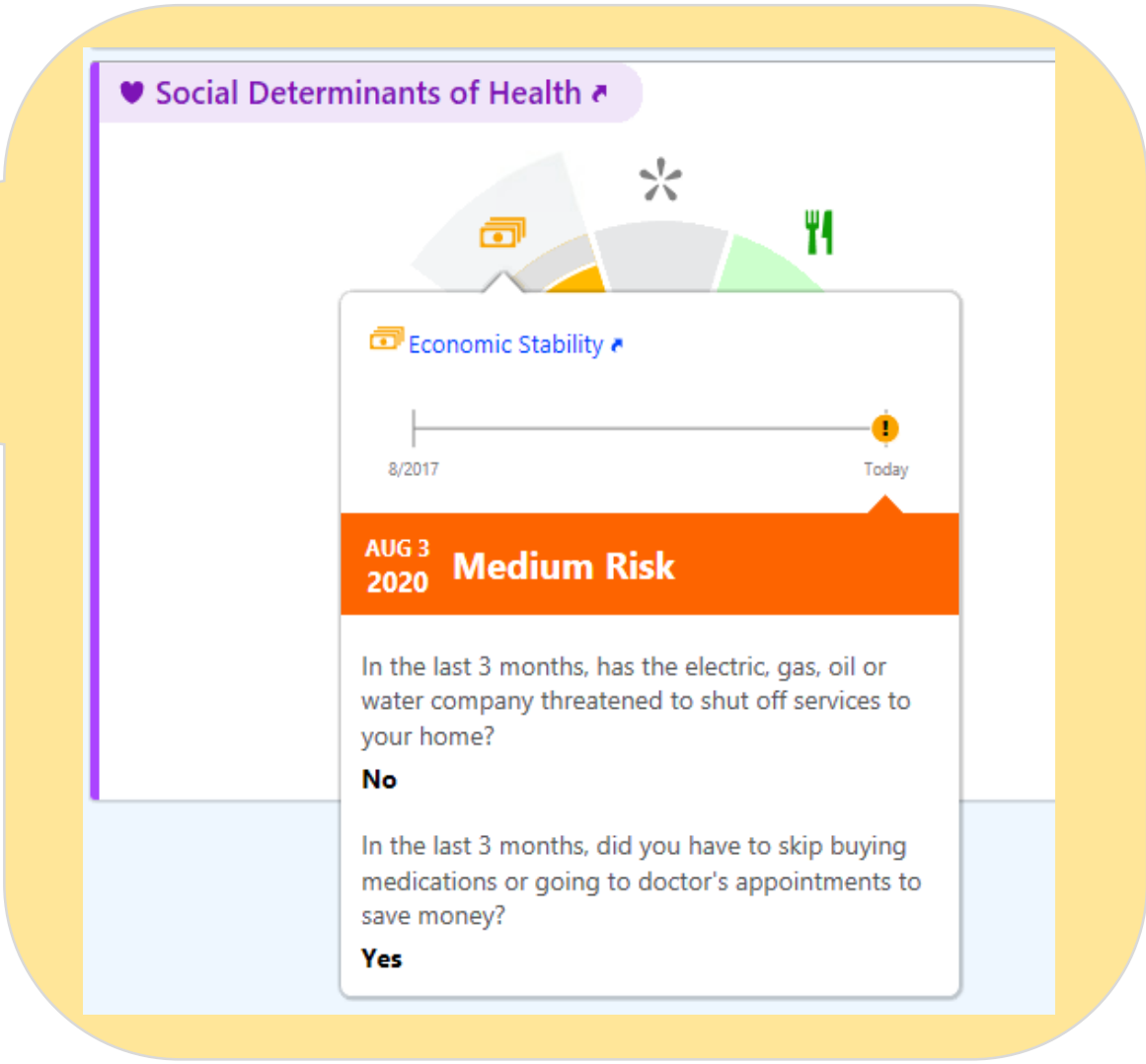
EHR Integration: Information On Social Need And Risk Level





EHR Referral Order ("Community Health"): Referral Support

CHW REFERRAL

Ambulatory referral to Community Health ■ ✔Accept ✖Cancel Remove

Internal Referral

Class: Internal Ref

Referral: ☐ Override restrictions

Linkage and Referral

Care Coordination and Navigation

Health Promotion and Coaching

Comments:

Status: Normal Standing Future

Search:

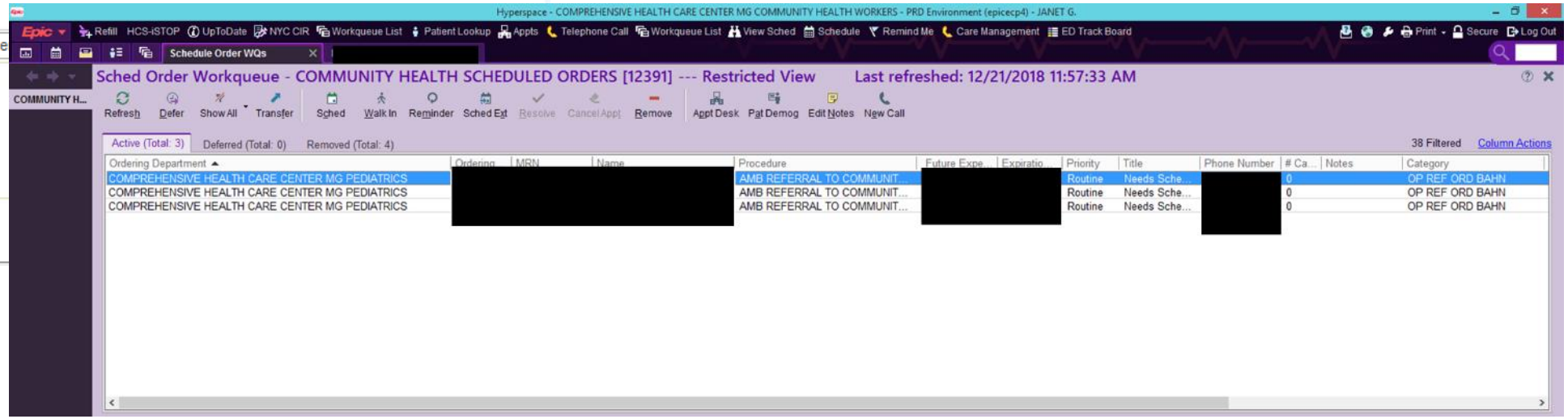
Title
Housing / uUtilities
Food Assistance
Trasportation
Childcare support
Employment / vocational/ career training
Benefits (SSD/SSI)
Legal Services

Search:

Title
Appointment adherence
Patient care navigation & accompaniment
Home visits

Search:

Title
Healthy lifestle activities (i.e. walking groups, nutrition, tobacco cessation)
Care plan support (i.e. increase health literacy, offer follow up, help navigate challenges)
Other



Documentation: CHW Note in Electronic Health Record

My Note

Tag | AutoRefres

«Insert SmartText»

History

No past medical history on file.
No past surgical history on file.

Social History

Socioeconomic History

• Marital status:	Single
Spouse name:	Not on file
• Number of children:	Not on file
• Years of education:	Not on file
• Highest education level:	Not on file

Tobacco Use

• Smoking status:	Current Some Day Smoker
• Smokeless tobacco:	Never Used

Family History

Problem	Relation	Age of Onset
• Asthma	Mother	
• CHF	Father	
• Congenital heart disease	Brother	

Patient Categories

{Patient Categories:23925}

Patient Needs

{Housing Needs:23926}

{Employment/Vocational/Career Needs:23927}

{Benefits/Entitlement Needs:23928}

{Care Coordination & Navigation Needs:23931}

Plan

{Housing Needs:23942}

{Employment/Vocational/Career Needs:23943}

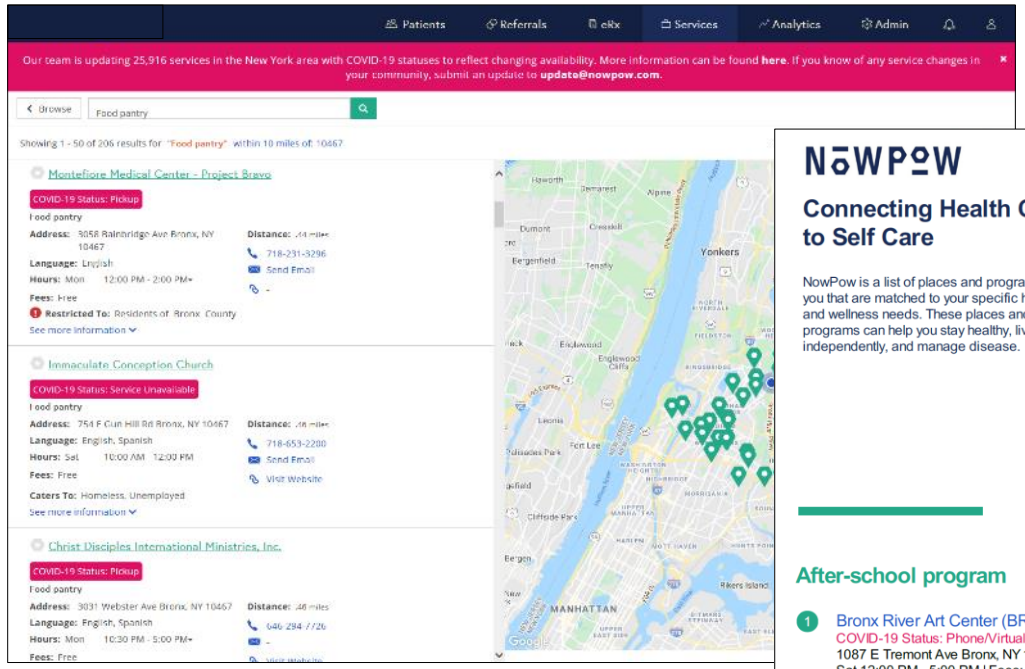
{Benefits/Entitlement Needs:23944}

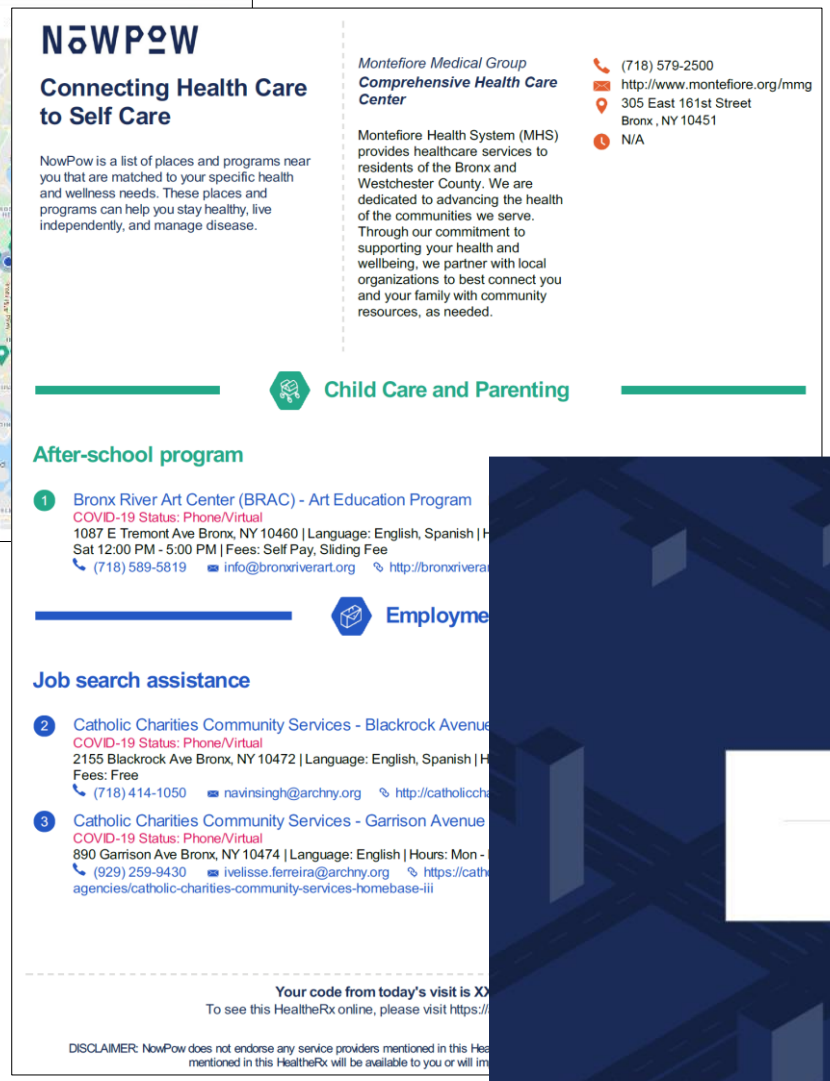
{Care Navigation Needs:23945}

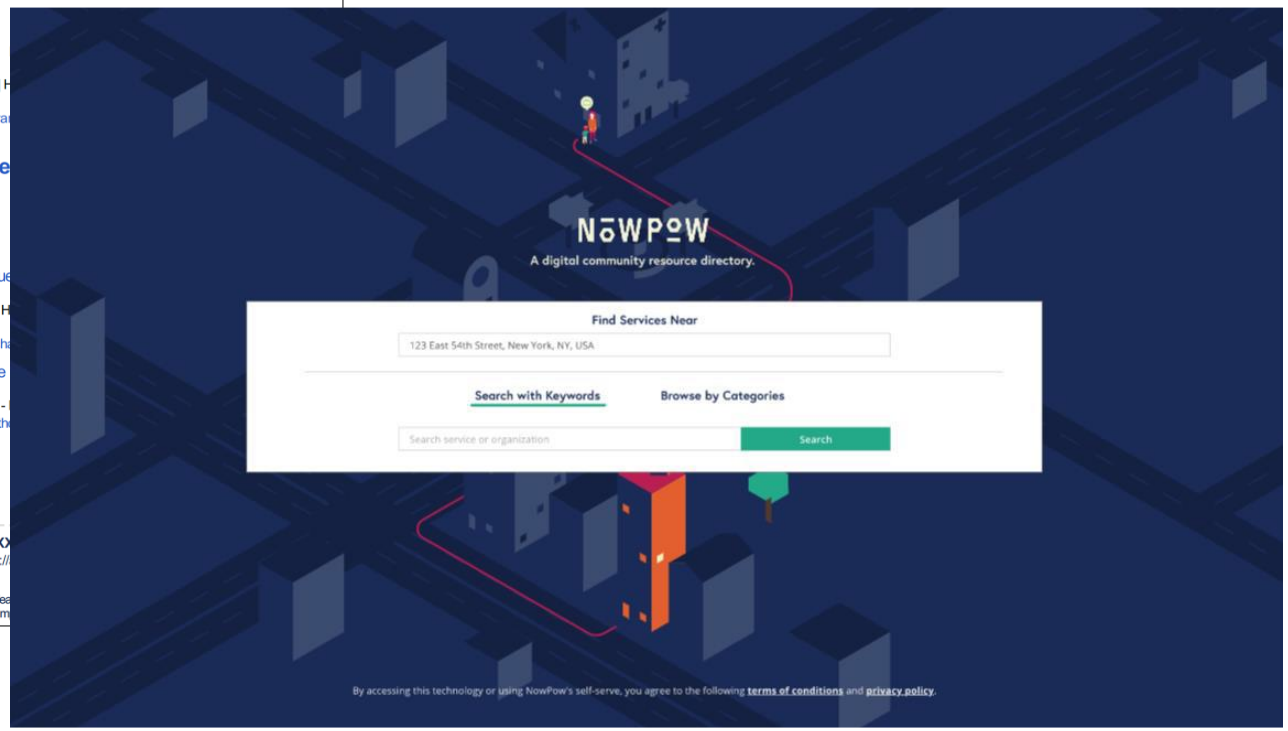
{Legal Needs:23946}

{Youth & Family Services:23948}

Social Service Resources: Toolkit (3 Tiers)

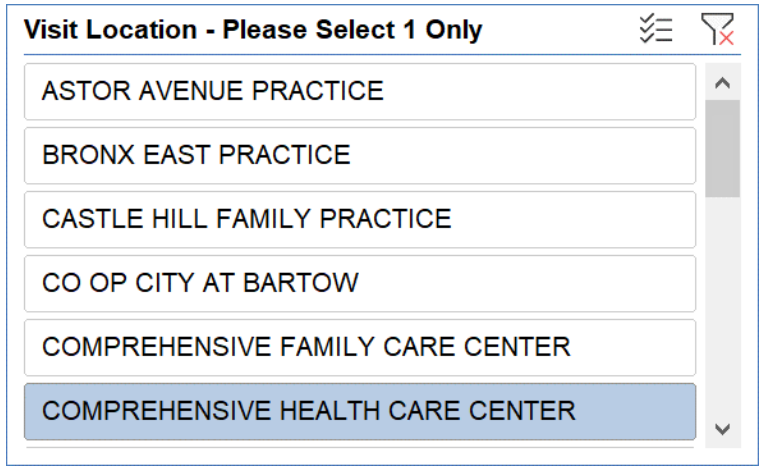


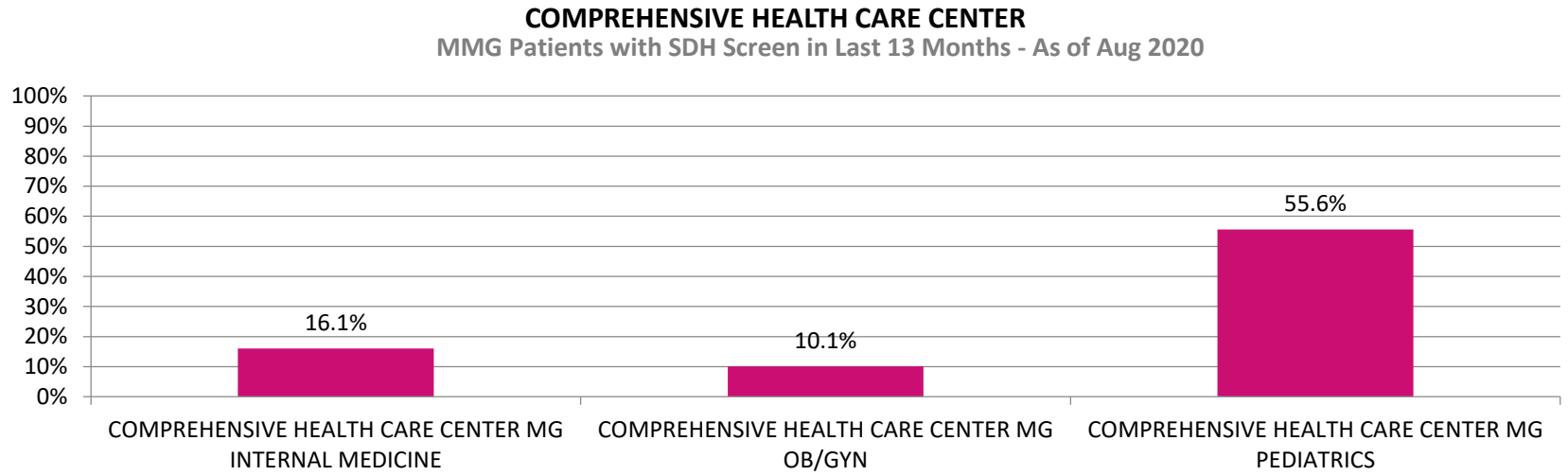


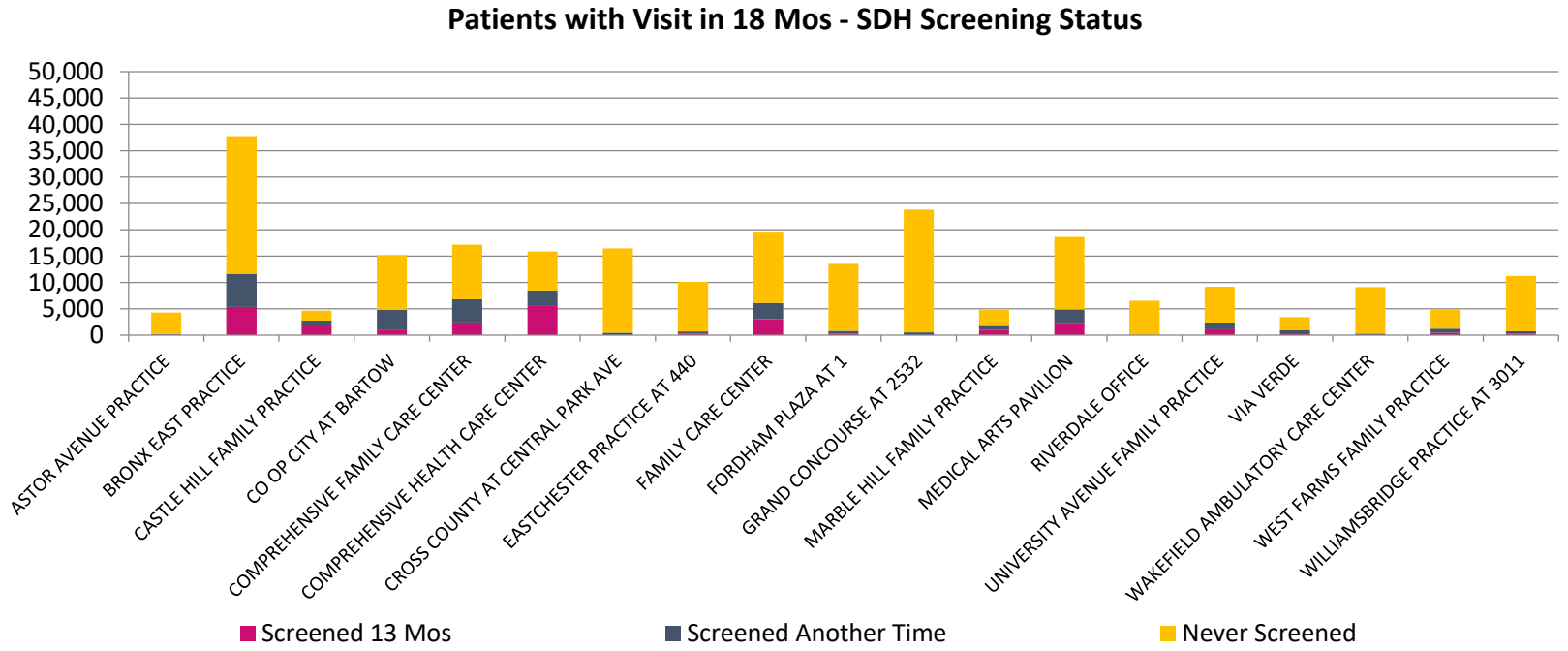


Data: Dashboards for Clinical Teams on Screening Outcomes

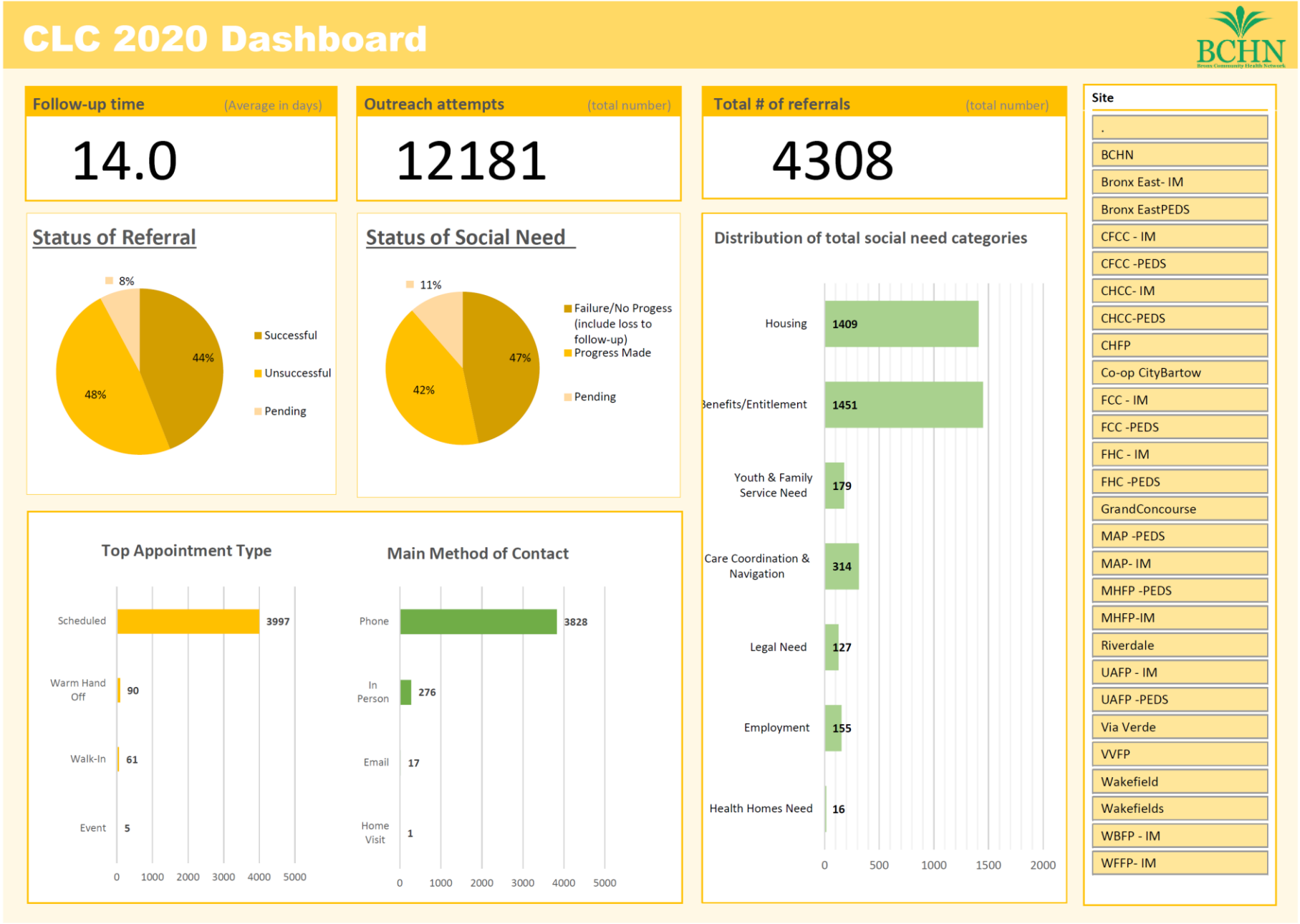
Metrics
1) % Active Population Screened
2) Positivity Rate
3) Number of screens





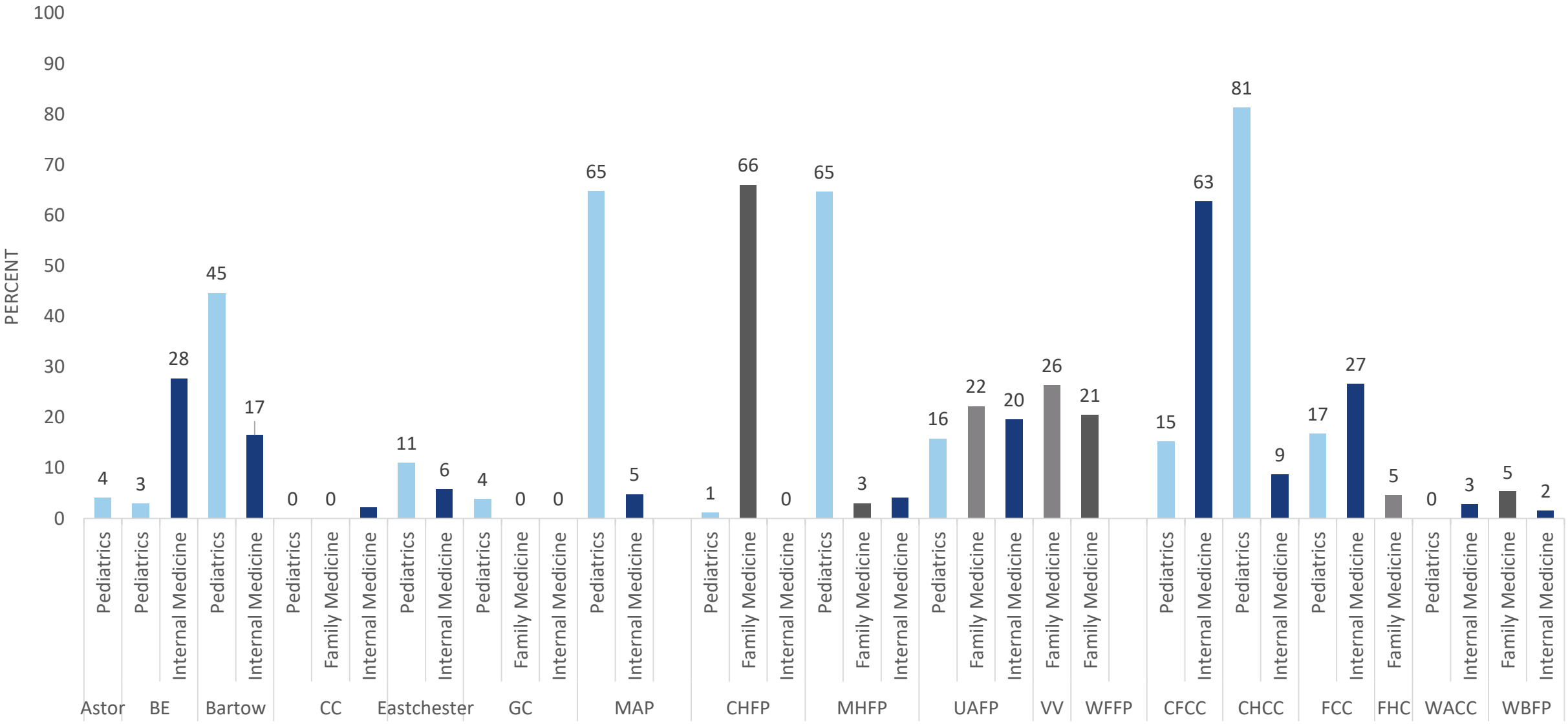


Data: Dashboards for Clinical Teams on Referral Outcomes



Current: Understanding & Leveraging Best Practices

Implementation: Active Patients Screened, 22% (n=53,096)



Denominator includes unique patients with visits to screening specialties between April 2018-December 2019
Median excludes specialties that are not screening

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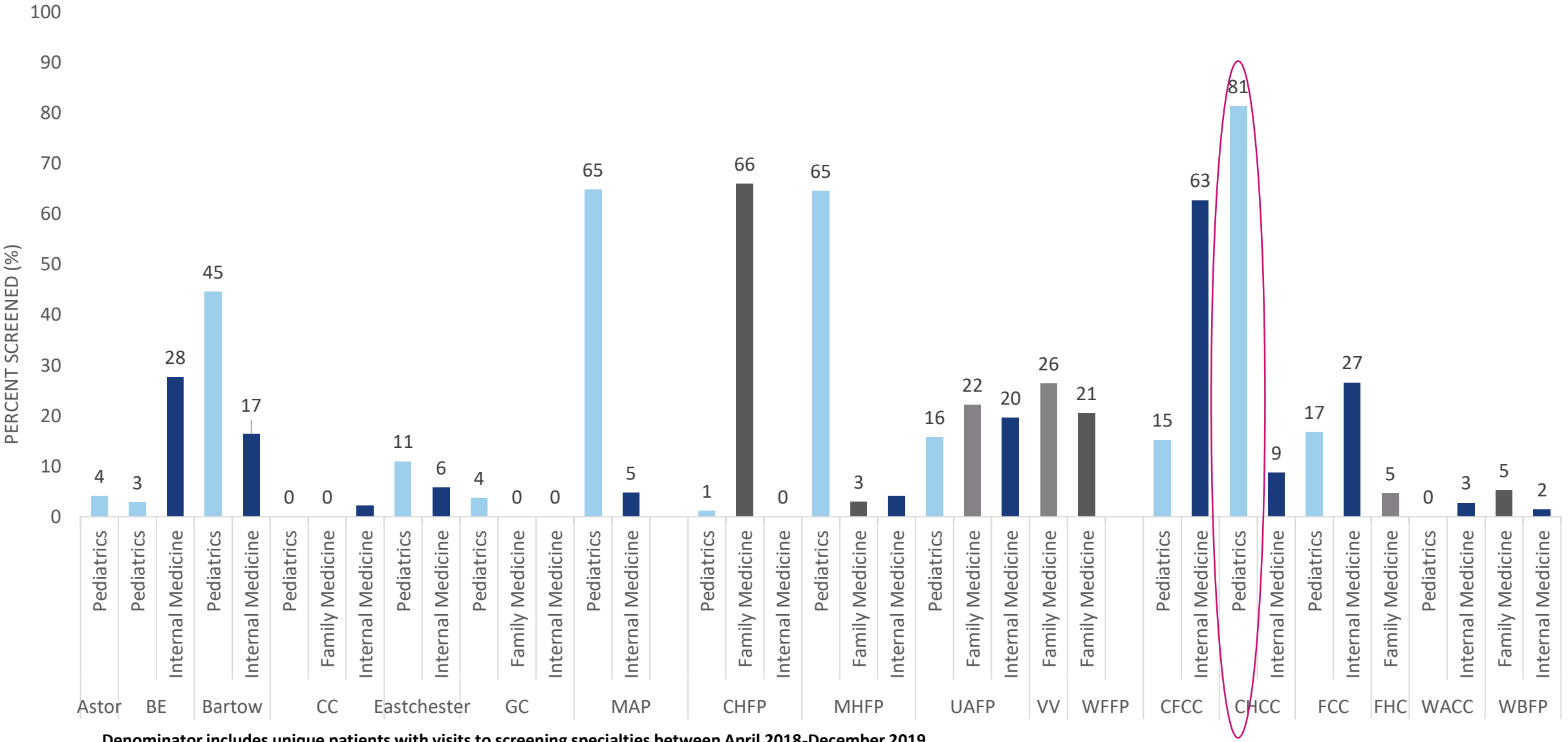
Best Practices: Community Linkage to Care Program



Denominator includes unique patients with visits to screening specialties between April 2018-December 2019
Median excludes specialties that are not screening

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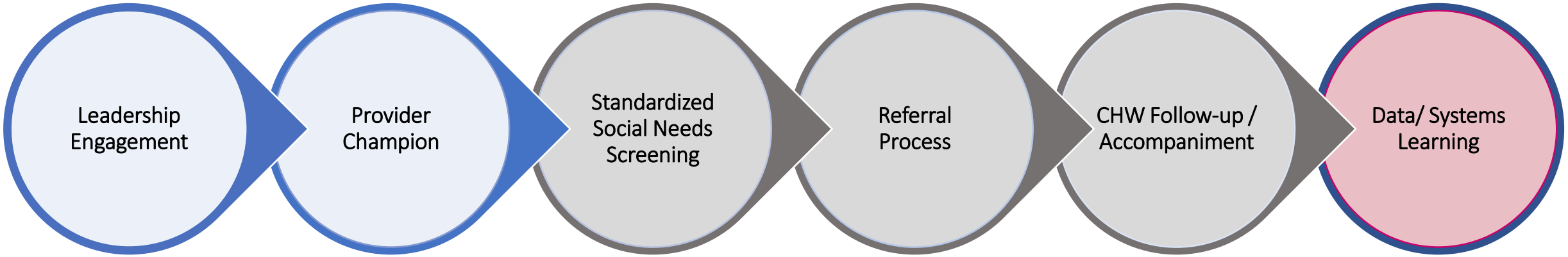
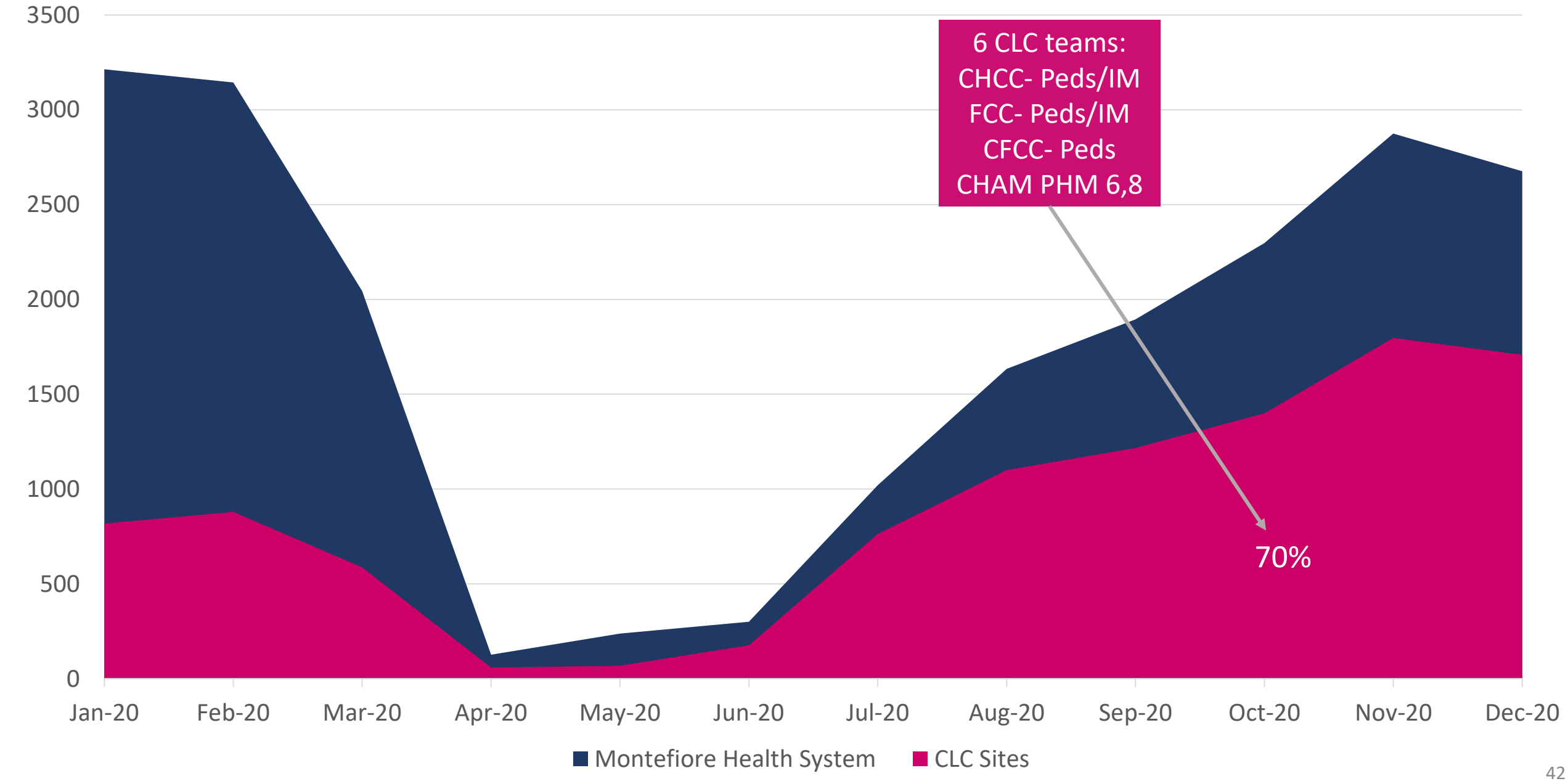
Best Practices: core program elements @ practice-level, *Community Linkage to Care (CLC) Program*



Leadership	Provider(s)	Screening	Referrals	Follow-up	Data
-Medical & administrative buy-in -Integration within ongoing improvement	-Coach/ mentor -Adaption lead -Performance improvement	-Target population (who, when, by whom, where)	-EMR based electronic order & note -Scope of work	-Multi-touch -Weekly status checks	-Dashboard -Monthly data calls
		Standardized Workflow			

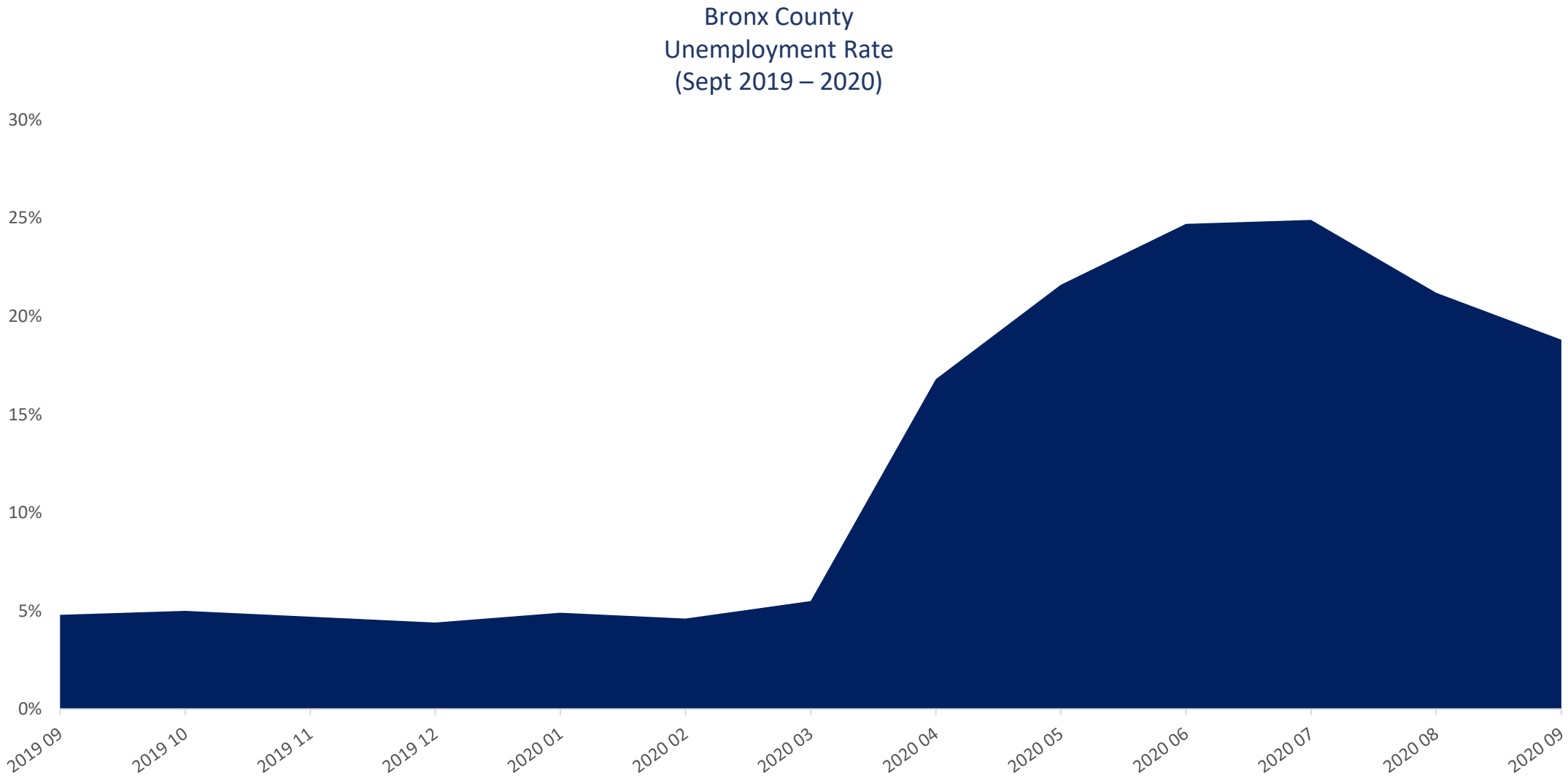
From: Fiori et al. Integrating social needs screening and community health workers in primary care: the Community Linkage to Care Program. *Clin Pediatr*. 2020

CLC Program Sites: 54% of screens in 2020, 70% in Q4 2020 9 (6 CLC sites)



Future: Harmonization, Scale & Augment

COVID-19 *Refractive Pileup*: Economic Wave(s)



Systems Harmonization: Social Needs Screening 2020-1

Project Charter

Montefiore Learning Network

Goal Statement

- By December 31, 2021, **develop universal social needs screening guidelines, workflows, and quality measure(s)** to support universal screening of every Montefiore patient annually

Problem Statement:

- Social needs screening varies by population and frequency across MMG/MMC sites
- Social need referral workflow implementation is inconsistent across MMG/MMC sites
- No social need quality measure currently exists to incentivize providers to screen

Patient/Client/Customer Value:

- Compile complete data on social risk prevalence within patient population
- Enhance access to clinical and community resources to address patient social needs
- Improve patient satisfaction with care
- Increase appropriate task shifting from providers
- Develop social risk profile for patients across the health system
- Identify associations with major clinical outcomes (ASC, hospital readmissions, missed appointments)
- Become a national leader in social needs population-based assessment and engagement

Objectives / Deliverables

- Complete implementation readiness needs assessment
- Design timeline for universal screening roll out across network
- Operationalize referral pathway for internal/external resources to address social needs
- Complete training plan for MMC staff related to screening/referral
- Finalize social need quality measure(s)

Timeline: 1/1/2021-12/31/2021

Champion:
Andrew Racine

Sponsor(s):
Matt McDonough, Allison McGuire & Allison Stark

Team Leader(s):
Kevin Fiori & Liz Spurrell Huss

Team Members:

Otis Lewis
Sybil Hodgson
Kevin Fiori
Diane Bloomfield
Caroline Heller
Oni Tongo
Alan Shapiro
Rosy Chhabra
Tashi Chodon
Anna Flattau
Michael Moore
Liz Spurrell-Huss
Michael Rinke
Suzette Oyeku
Vanessa Pratomo

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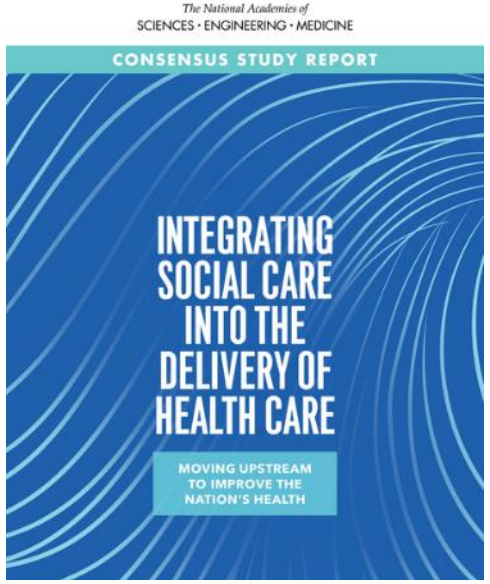
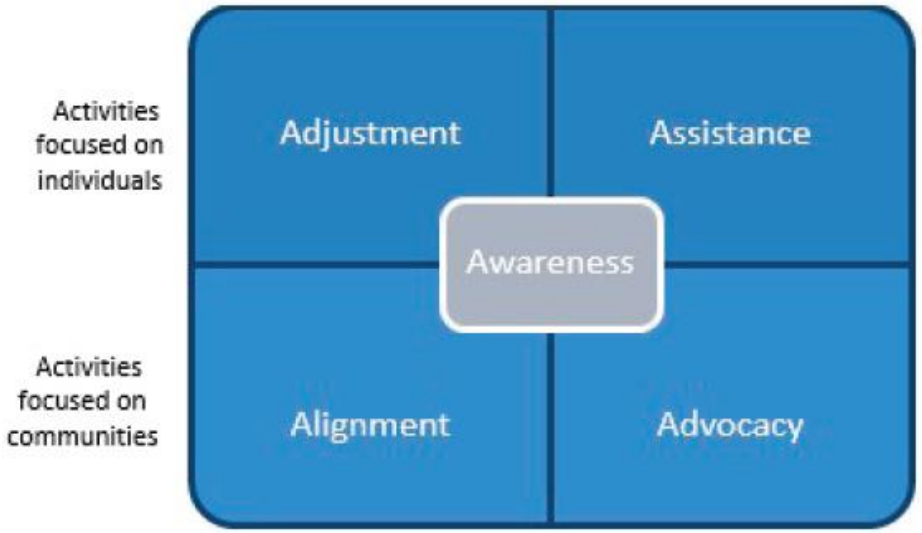
Roadmap: National Academy of Sciences Report (2019)

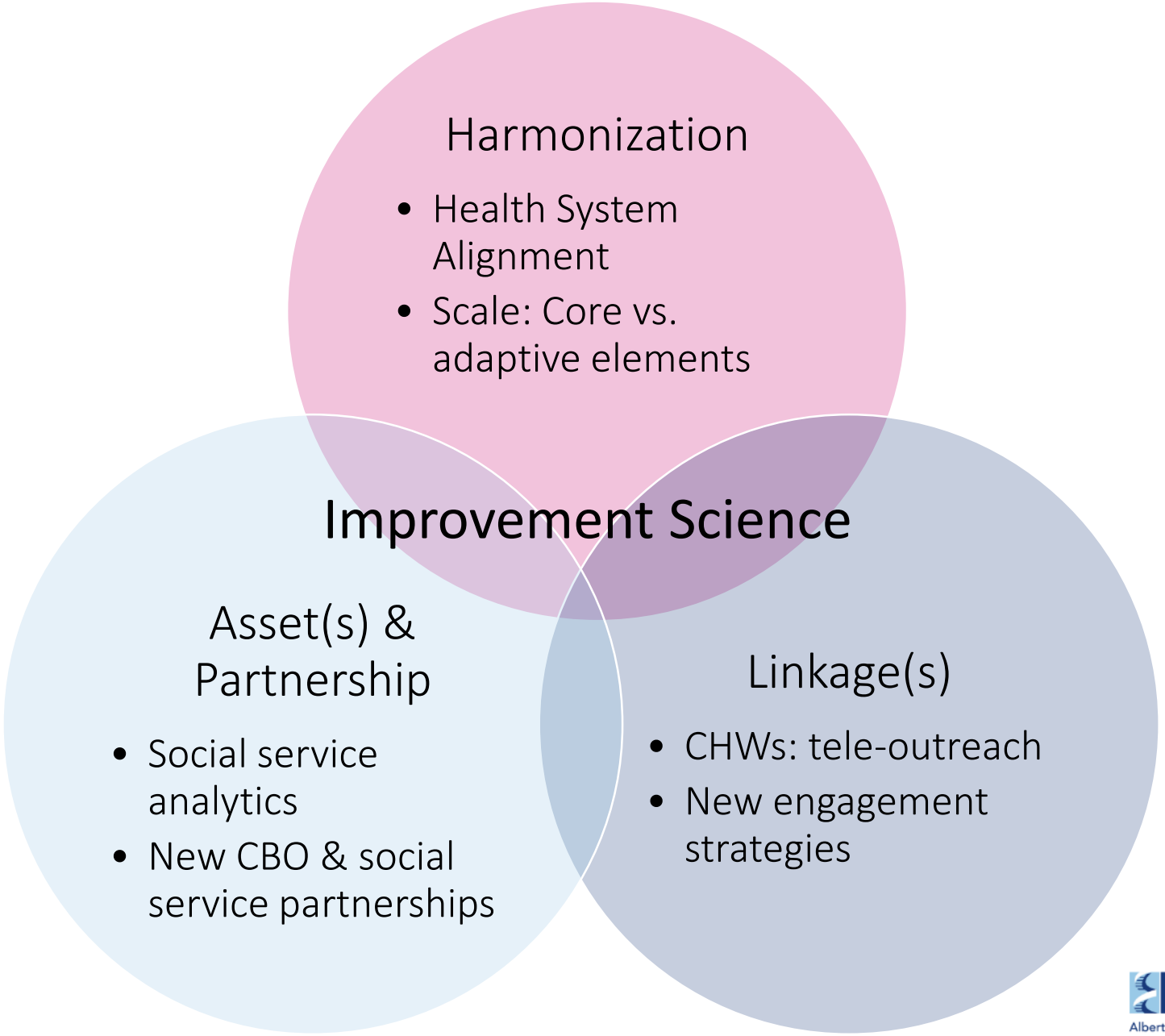




Activity	Definition	Transportation-Related Example
Awareness	Activities that identify the social risks and assets of defined patients and populations.	Ask people about their access to transportation.
Adjustment	Activities that focus on altering clinical care to accommodate identified social barriers.	Reduce the need for in-person health care appointments by using other options such as telehealth appointments.
Assistance	Activities that reduce social risk by providing assistance in connecting patients with relevant social care resources.	Provide transportation vouchers so that patients can travel to health care appointments. Vouchers can be used for ride-sharing services or public transit.
Alignment	Activities undertaken by health care systems to understand existing social care assets in the community, organize them to facilitate synergies, and invest in and deploy them to positively affect health outcomes.	Invest in community ride-sharing or time-bank programs.
Advocacy	Activities in which health care organizations work with partner social care organizations to promote policies that facilitate the creation and redeployment of assets or resources to address health and social needs.	Work to promote policies that fundamentally change the transportation infrastructure within the community.

National Academies of Sciences, Engineering, and Medicine. 2019. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health.* Washington, DC: The National Academies Press. https://doi.org/10.17226/25467.

Future Direction(s): leveraging progress & using science



Accompaniment (Linkage) in Practice

“ Ms. A met with me back when she was being displaced from her home. We have worked together from the moment she went in the shelter, until the moment she came back out.

Ms. A always returned to me in good faith to check in or obtain additional applications. It took much encouragement, always insisted that she does not lose hope because there is something waiting for her right around the corner.

It is with great satisfaction I share, Ms. A has successfully been placed in permanent housing, has obtained her CNA certification and has obtained her citizenship. ”

-Janet Gonzalez, Community Health Worker

Thank You

Kevin Fiori
kfiori@montefiore.org

Discussion

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We welcome your questions and comments!

Next Steps

Readiness Assessment

- Be on the look out for an email with a link to the assessment
- Complete by May 12, 2021

Bi-weekly Learning Circles from 12-1PM

- April 28 – Coding for Behavioral Health Services
- May 26 – Where to Go From Here

Publications

- Read the resources shared during the sessions

Next Session

Sustainability: Coding for Behavioral Health Services

April 28, 2021 • 12-1PM EDT

How to get paid for added behavioral health screenings and follow-up for primary care patients.

Register

Our Speaker

Earl Berman, MD, FACP, MALPS-L

Chief Medical Officer

CMD J-15 Part B

CGS Administrators, LLC

Your SWEEP Team

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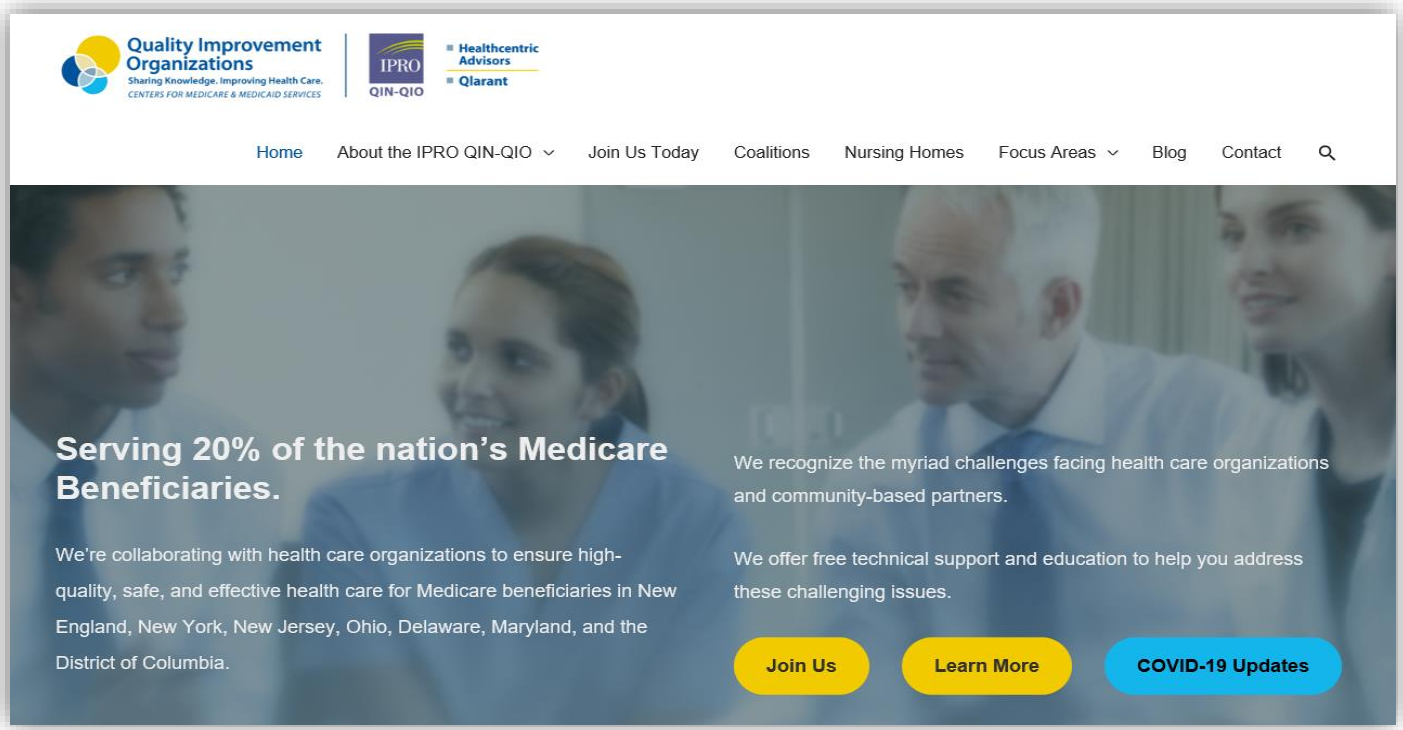
Have a question? Contact us!

Bonnie Horvath	Laura Benzel	Lynn Wilson	Gail Gresko
horvathb@qlarant.com	benzell@qlarant.com	lwilson@ipro.org	ggresko@ipro.org
Qlarant	Qlarant	IPRO	IPRO

Integrating Behavioral Health with Primary Care: Series Information & Materials

Learn More & Stay Connected

https://qi.ipro.org/



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This material was prepared by the IPRO QIN-QIO, a collaboration of Healthcentric Advisors, Qlarant and IPRO, serving as the Medicare Quality Innovation Network-Quality Improvement Organization for the New England states, NY, NJ, OH, DE, MD, and the District of Columbia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 12SOW-IPRO-QIN-T2-A1-21-316

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