Improving Quality and Access to Integrated Care for Racially Diverse and Limited English Proficiency Communities

July 16, 2013
Slides for today’s webinar are available on the CIHS website at:

www.Integration.samhsa.gov

under About Us/Webinars
Welcome!

• **Moderator:**
  - Jenny Crawford, SAMHSA-HRSA Center for Integrated Health Care Services

• **Today’s Presenters:**
  - Katherine Sanchez, LCSW, PhD
  - Teresa Chapa, PhD, MPA, US HHS Office of Minority Health
  - Henry Chung, MD, Vice President and Chief Medical Officer of Care Management Company (CMO) of Montefiore Medical Center
Learning Objectives

• Identify persistent challenges faced by racially diverse and ethnic minority populations in accessing and receiving behavioral health services (both mental health and substance abuse) and how medical professionals can more effectively engage the community in services and health promotion efforts utilizing culturally and linguistically appropriate service delivery.

• Describe the role of cultural and linguistic competency in integrated care and how the recently released U.S. Department of Health and Human Services enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care standards provides a needed framework for practitioners and agencies.

• Discuss the recommendations related to the delivery of integrated health care services to racially diverse and ethnic minority communities as outlined in the Hogg Foundation/Office of Minority Health Consensus Report on Integrated health Care for Racial and Ethnic Minorities, including Limited English Proficiency Populations.
How to ask a question during the webinar

If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. (left)

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. (right)
The Health Challenge: Health Disparities & Health Equity

Katherine Sanchez, LCSW, PhD
Assistant Professor
School of Social Work
The University of Texas at Arlington
The Health Challenge: Health Disparities & Health Equity

• Current health and behavioral health care system is fraught with barriers.
• Behavioral health issues usually occur with other chronic health conditions.
• Consumers with SMI die prematurely due to preventable, physical conditions.
• Behavioral health issues are among the most expensive to treat.
Useful Definitions

• **Health Disparities** - differences in the incidence and prevalence of health conditions and health status between groups.

• **Health Equity** - when everyone has the opportunity to “attain their full health potential” and no one is “disadvantaged from achieving this potential because of their social position or other socially determined circumstance.”

• **Cultural and Linguistic Competence** - Services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and employed by all members of an organization at every point of contact.
Health Disparities

• Racial and ethnic minority populations are less likely to receive a variety of medical services, from routine procedures to appropriate cardiac medications and bypass surgery.

• MORE likely to have limb amputations as a result of diabetes and experience a lower quality of health services overall.

• Findings held even when controlling for insurance status, income, age and education level.
Behavioral Health Disparities

• Lack of access to in-language and culturally appropriate services.
• Little to no knowledge about mental health services.
• Poor doctor patient communication (DPC).
• Persistent stigma around issues of mental illness.
• LESS likely to receive evidence-based psychiatric interventions, such as state of the art psychototropic medications.
As a result, Racial and Ethnic Minorities:

- Receive delayed treatments.
- Receive low rate of evidence based interventions.
- Experience poor treatment engagement leading to:
  - Less follow through with referral to BH specialists.
  - Low use of anti-depressant medication.
  - Discontinuation of treatment without consulting their physician.
Factors that Contribute to Racial and Ethnic Minority Health Disparities

• Socioeconomic status
• Residential segregation and environmental living conditions
• Occupational risks/exposures
• Health risk and health seeking behavior
• Differences in access to care
• Differences in health care quality

Smedley, 7/21/09
Relationship between Social Determinants and Mortality (2000)

- Low education level
- Racial segregation
- Low social support
- Individual poverty
- Income inequality
- Area level poverty


Percent

Educational Level

High School Graduate or More
Bachelor's Degree or More
Advanced Degree


US Census Bureau, Educational Attainment
National High School Graduation Rates
2007 - 2008

Averaged Freshman Graduation Rate, 2007-2008 School Year

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Graduation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>61.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>63.5</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>64.2</td>
</tr>
<tr>
<td>White</td>
<td>81.0</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>91.4</td>
</tr>
</tbody>
</table>

Robert Stillwell
National Center for Education Statistics
Education: The Greatest Predictor of Longevity

- Lower education = unhealthy behaviors
- Lower education = higher death rate

< 12 years of education: 615.6 deaths per 100,000 for adults 18-65
> 13 years of education: 207.9 deaths per 100,000 for adults 18-65

CDC National Center for Health Statistics, Vital Statistics Vol. 53, #5, Deaths, 2002
Health literacy

“The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make ‘informed’ health choices.”

Adapted from Healthy People 2010
Definition: Levels of Health Literacy

- **Adequate** – understands most reading tasks; misreads only complex information.
- **Marginal** – sometimes misreads instructions and dosages and has difficulty with complex information.
- **Inadequate** – often misreads Rx instructions and appointment slips.

Higher health literacy is correlated with lower mortality rates.

Is Quality of Life Correlated with Health Literacy?

- **39.4%**
- **28.7%**
- **18.9%**

Note: Based on 3,260 Medicare managed-care who were interviewed in 1997 to determine their demographic characteristics, chronic conditions, self-reported physical and mental health, and health behaviors. Participants also completed the shortened version of the Test of Functional Health Literacy in Adults (S-TOFHLA) that included two reading passages and four numeracy items to assess comprehension of hospital forms and labeled prescription vials that contained numerical information. Main outcome measures included all-cause and cause specific (cardiovascular, cancer and other) mortality using data from the National Death Index through 2003.


Copyright © 2007 American Medical Association. All rights reserved.
Populations at Risk for Low Health Literacy

- Elderly (age 65+) - Two thirds of U.S. adults age 60 and over have inadequate or marginal literacy skills, and cannot read or understand basic materials such as prescription labels.

- “Minority” populations

- Immigrant, non-English speaking populations

- Low income - Approximately half of Medicare/Medicaid recipients read below the fifth-grade.

- People with chronic mental and/or physical health conditions

- Low educational attainment
Lack of English Fluency is an **Independent Predictor of**

- Poor control of chronic disease
- Reduced health care use
- Poor quality of primary care
- Absence of a regular source of care
- Lack of continuity of care
- Lack of patient satisfaction
- Poor quality patient education and understanding of their disorder
Factors that Affect Access for Immigrants and Minority Populations

- Limited health literacy
- Geographic inaccessibility
- Lack of medical insurance
- Citizenship status
- Level of acculturation
- Duration of residence in the U.S.
Depression Increases Risk for Chronic Disease

Chronic Disease

Depression

Early onset of diabetes, heart disease and other physical illnesses
Primary Care as the De Facto Mental Health Care System

- Lack of access to mental health specialists
- Income and insurance issues
- Stigma surrounding mental illness
- Trust of the relationship with the family physician
Why integrate?

Silos of Care

Primary Care
Psychiatry
Clinical Social Work & Psychology
Social Services
Community Based Services

Unutzer, 2009
Integrated Health Care

Patient:
- Understands the diagnosis
- Chooses treatment in consultation with provider(s):
  » e.g., medications and / or brief psychotherapy

Primary Care Provider (PCP):
- Initiates treatment
- Prescribes medications
- Works collaboratively with team
  + Care Manager
  + Consulting Psychiatrist

Strategies for Eliminating Behavioral Health Disparities through Integrated Care and Cultural and Linguistic Competence

Teresa Chapa, Ph.D., MPA
Senior Policy Advisor, Mental Health
U.S. Department of Health and Human Services
Office of Minority Health
Office of Minority Health Mission

To improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities.
OMH Strategies for Eliminating BH Disparities

Improvements in meaningful access and quality of behavioral healthcare alone could potentially eliminate behavioral health disparities

- Promote best, promising and evidence based practices that are culturally and linguistically appropriate.
- Encourage implementation of Integrated primary and behavioral healthcare models (collaborative care, patient centered health home).
- Support efforts to build a multidisciplinary diverse, knowledgeable, bilingual and culturally competent workforce.
- The Affordable Care Act.
- Improve rapid information and science dissemination strategies.

OMH Examines Integrated Care in 2004

- Responding to New Freedom Commission, National Minority Mental Health and Substance Use Leadership calls upon OMH to Address Behavioral Health Gaps.
- Provided Briefing to Office of the Secretary.
- Established workgroup on Integrated Care focused on Racial/Ethnic Minority and LEP Populations.
- Developed special focus on behavioral health and Integrated Care for diverse communities.
What is Role of OMH in BH & Integrated Care?

- Ensures that Racial and Ethnic Minority Populations are included at all levels.
- Promotes diversity and cultural competence.
- Leads, develops and supports Minority targeted initiatives & reports and disseminates findings.
- Convenes Minority-driven consensus meetings & leadership.
- Works with public and private partners.
- Works with federal partners and their contractors:
  - National Council for Community Behavioral Healthcare for Technical Assistance (SAMHSA/HRSA)
  - Integrated Care Portal (AHRQ)
Integrated Care Strategies to Potentially Eliminate Behavioral Health Disparities

- Increase knowledge and implementation of integrated primary and behavioral healthcare models that serve racial & ethnic minority communities and those with limited English proficiency.
- Promote best, promising and evidence based practices that are culturally and linguistically appropriate.
- Support efforts to build a multidisciplinary, diverse, knowledgeable, bilingual and culturally competent workforce and leadership for integrated care.
- Improve health & behavioral healthcare by addressing role of social determinants of health.
- Improve information and best practices dissemination strategies through efforts such as Learning Collaboratives.
Integrated Care: A Key Strategy of the ACA

- Promote Integrated Behavioral Health & Healthcare through the Patient-Centered Medical Home (PCMH).
- Coordination of care for patients' total healthcare needs in a timely, personal manner that achieves measurable high-quality outcomes.
- Improvement the quality of care.
- Address the social determinants of health.
- Establish functioning financial arrangements.
- Recruitment and training of culturally and linguistically competent workforce.
- Utilization of information technology for optimal communication among health professionals and patients.
Culturally and Linguistically Appropriate Services are...

Services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and employed by all members of an organization at every point of contact.
Culturally and Linguistically Appropriate Services

- Recognized for improving the quality of services.
- Increases patient safety (facilitating assessment & diagnosis & avoiding miscommunication).
- Enhancing effectiveness.
- Underscoring patient-centeredness.
- Increasingly included in local, state and national legislative, regulator and accreditation mandates, as seen in the Affordable Care Act.
Reasons to Incorporate Cultural and Linguistic Appropriate Services in Health, Behavioral Health and Integrated Care

• Respond to current and projected demographic needs.
• Eliminate long standing disparities in health status for people from diverse racial, ethnic and cultural backgrounds.
• Improve quality of services and outcomes.
• To meet legislative, regulatory and accreditation mandates.
• To decrease likelihood of liability/malpractice claims.

Providing Language Assistance to Persons with LEP

Language assistance will be provided through use of:

- Competent bilingual staff
- Staff interpreters
- Contracts or formal arrangements with local organizations providing interpretation or translation services, or
- Technology and telephonic interpretation services.

Source: US HHS Office of Civil Rights
http://www.hhs.gov/ocr/civilrights/clearance/exampleofapolicyandprocedureforlep.html
Agencies Serving Persons with Limited English Proficiency

(Insert name of your facility) will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of (Insert name of your facility) is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment.
What are the Enhanced National CLAS Standards?

The enhanced National CLAS Standards (2012) are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to implement and provide culturally and linguistically appropriate services.
The Enhanced National CLAS Standards

• Provides a blueprint for health and health care organizations to implement culturally and linguistically appropriate services.

• Composed of 15 standards and 3 intersecting themes—to advance health equity, improve quality, and help eliminate health care disparities.

• Recommends implementing all standards for a successful and robust outcome.
Reasons for Enhanced CLAS Standards

- Growth in the Field
- Changing Demographics
- Policies and Legislation (ACA)

Enhanced National CLAS Standards for Health and Health Care

- Improve Quality of Services
- Advance Health Equity
- Help Eliminate Disparities
CLAS and Eliminating Disparities

CLAS helps to **eliminate disparities** by offering a framework for treating individuals with respect and in accordance with their culture and language, which helps to:

- Build rapport and develop a trusting relationship
- Personalize care
- Improve engagement and treatment adherence
- Increase patient satisfaction
Poll Question 1:
I know where to obtain more information about the enhanced CLAS standards
Poll Question 2:

I think adopting the enhanced CLAS standards will help me/my agency to effectively address health disparities:
Poll Question 3:

Cultural and linguistic competence is an essential ingredient for quality care
Evolving Models of Integrated Behavioral Health Care: The Case for Decreasing Disparities in Treatment and Outcomes

Henry Chung, M.D.
Vice President and Chief Medical Officer

Montefiore Care Management Organization
and
Associate Professor of Clinical Psychiatry
Albert Einstein College of Medicine
Agenda

- BEHAVIORAL HEALTH DISPARITIES IN ACCESS AND QUALITY IN RACIAL ETHNIC GROUPS
- EVOLUTION OF INTEGRATED CARE MODEL IN PRIMARY CARE: CASE STUDY IN COMMUNITY HEALTH CENTERS SERVING LOW INCOME ASIAN AMERICANS
- INTEGRATED DEPRESSION CARE MODELS IN COLLEGE HEALTH: IMPLICATIONS FOR RACIAL ETHNIC GROUPS
- PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION IN A SAFETY NET ACO
- TAKEAWAYS THAT ILLUSTRATE CLAS STANDARDS IN ACTION
# Prevalence and Recognition of Depression in Low Income Asians & Latinos in Primary Care

<table>
<thead>
<tr>
<th></th>
<th>Asian (n=91)</th>
<th>Latino (n=133)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Mean</td>
</tr>
<tr>
<td>Sig Depressive Sx</td>
<td>41.6</td>
<td>47.3</td>
</tr>
<tr>
<td>Physician ID of a problem**</td>
<td>23.6</td>
<td>43.8</td>
</tr>
<tr>
<td>Accurate Diagnosis</td>
<td>17.2</td>
<td>30.3</td>
</tr>
<tr>
<td>Female **</td>
<td>53.8</td>
<td>72.9</td>
</tr>
<tr>
<td>Language Congruence**</td>
<td>90.1</td>
<td>64.7</td>
</tr>
<tr>
<td>CES-D Score</td>
<td>16.16</td>
<td>17.90</td>
</tr>
<tr>
<td>Age (yrs)</td>
<td>52.34</td>
<td>49.82</td>
</tr>
</tbody>
</table>

**p<.01.

*Chung et al., Community Mental Health Journal, 2002*
Perceived Causes of Depressive Symptoms Among Chinese American Patients in Primary Care

Takeaways

- Behavioral Disorders may not be easily understood as biopsychosocial illnesses.
- It is critically important to ask patients and their families about their explanatory models.
- All healthcare providers need to examine their own views about stigma and behavioral health disorders and assess their own intracultural and intercultural views.
- Universal or targeted condition screening can help mitigate patient stigma.
- BUT screening without systematic care supports is largely ineffective for improved outcomes.
Suicide and Death Ideation in Depressed Primary Care Elderly (PRISM-E Study, Bartels et al)
Takeaways

- Patients who complete suicide often visit a PCP 1-3 months prior.

- Inquiring about thoughts of death and self harm behavior/thoughts are critically important, even though it may be uncomfortable for clinicians.

- Using appropriate culturally syntonic metaphors may be helpful in reducing both provider and patient discomfort.
# Medicare Managed Care: Adherence to Guideline Based Treatment

## Percentage of Patients Taking Antidepressants Receiving Care

<table>
<thead>
<tr>
<th>Patients receiving care (%*)</th>
<th>White</th>
<th>African Amer.</th>
<th>Asian</th>
<th>Hispanic</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Optimal practitioner contacts</strong></td>
<td>12.5</td>
<td>12.0</td>
<td>11.1</td>
<td>10.6</td>
<td>11.7</td>
</tr>
<tr>
<td><strong>Effective acute-phase treatment</strong></td>
<td>60.1</td>
<td>48.5*</td>
<td>40.7*</td>
<td>57.6</td>
<td>58.6</td>
</tr>
<tr>
<td><strong>Effective continuation-phase treatment</strong></td>
<td>46.7</td>
<td>32.7*</td>
<td>31.9*</td>
<td>39.6*</td>
<td>43.1</td>
</tr>
</tbody>
</table>

*Rates are age and sex adjusted
+ P<0.05 vs. white

Depression Outcomes for Older Patients by Race-Ethnicity in Collaborative Care

Source: Arean, P., et al. (2005). Improving Depression Care for Older, Minority Patients in Primary Care. Medical Care, Vol.43, No. 4, 389.
The Asian American Bridge Program at CBWCHC (Phase I, 1998)

- Co-location in primary care using local partnering CMHC shared resource (LCSW) and psychiatrist.
- Training of PCPs and LCSW in the model.
- BH documentation in the Medical Record.
- Referral to CMHC for SMI patients.
- Results: Improved access and engagement rates compared to baseline.
The Asian American Bridge Program at CBWCHC and SCCHC (Phase 2, 2003)

- Co-location in primary care using internal resources (LCSW), psychiatrist, care manager in 2 separate sites.
- Care manager role in both face to face and telephonic follow-up.
- Increase responsibility of PCPs to screen, diagnose and treat using PHQ9.
- Results: Improved access and engagement rates maintained with measurable positive outcomes.

Chen T et al, 2006
Yeung A et al, 2004
The Asian American Bridge Program at CBWCHC and SCCHC (Phase 3, 2010)

- Integration with NCQA PCMH Level 3 recognition in multiple sites
- Full integration with EMR
- Sustainability issues continually addressed
- Locus of treatment responsibility is shared between PCP and BH team in the FQHC

Chen T et al, 2006
Yeung A et al, 2004
2011 CBWCHC
Distribution of MH Patients by Diagnosis

Number of patients
end of 2011 = 725

- Depression
- Anxiety
- Bipolar D/O
- Psychotic D/O
- ADHD
- Adjustment D/O
- Dementia
- Other
- Other Childhood D/O
Takeaways

- Integration models need to evolve as new evidence emerges.

- Sustainability issues must be considered at outset (access, productivity in FFS models; outcomes and more virtual approaches in value based arrangements).

- Providers in safety net settings need to be prepared for managing SMI patients in primary care, especially when compounded by few bilingual BH clinicians.

- Standard Measurement can reduce stigma and helps LEP populations to understand and monitor symptoms.
National College Depression Partnership
Collaborative Action Network

Overcoming Depression and Supporting Student Success
College Counseling Utilization by Racial/Ethnic Minority College Students


- Majority of counselors female (64%) and White (79%).

- Overall; 57% were judged clinical cases (OQ-45 >63); 65% Asian American; 60% Latinos; 55% African American; and 51% White.

Source: Kearney L et al, 2005
## PHQ-9 Change by Race/Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Baseline (n)</th>
<th>Baseline Mean</th>
<th>Follow up** (n)</th>
<th>Follow up Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1773</td>
<td>16.7</td>
<td>1177</td>
<td>9.3</td>
</tr>
<tr>
<td>Male</td>
<td>544</td>
<td>16.7</td>
<td>359</td>
<td>9.3</td>
</tr>
<tr>
<td>Female</td>
<td>1229</td>
<td>16.7</td>
<td>818</td>
<td>9.3</td>
</tr>
<tr>
<td>A.A./Black</td>
<td>112</td>
<td>17.3</td>
<td>91</td>
<td>9.4</td>
</tr>
<tr>
<td>Asian / Pacific Islander</td>
<td>167</td>
<td>17.6</td>
<td>111</td>
<td>10.7</td>
</tr>
<tr>
<td>Hispanic / Latino</td>
<td>103</td>
<td>17.6</td>
<td>80</td>
<td>9.1</td>
</tr>
<tr>
<td>Multiracial</td>
<td>33</td>
<td>17.5</td>
<td>25</td>
<td>10.1</td>
</tr>
<tr>
<td>Native American / AK Native</td>
<td>11</td>
<td>14.9</td>
<td>10</td>
<td>7.5</td>
</tr>
<tr>
<td>Other</td>
<td>51</td>
<td>16.5</td>
<td>35</td>
<td>8.1</td>
</tr>
<tr>
<td>White</td>
<td>1133</td>
<td>16.5</td>
<td>776</td>
<td>9.1</td>
</tr>
<tr>
<td>Unknown</td>
<td>159</td>
<td>16.3</td>
<td>123</td>
<td>11.0</td>
</tr>
</tbody>
</table>

* Data from 15/20 schools; ** At least 1 follow-up
### NCDP Clinical Outcome Measures by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>% 5 pt reduction at 8 weeks</th>
<th>% PHQ9 &lt;10 by 12 weeks</th>
<th>% Functional Score &lt;=1 by 12 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>All (n=1773)</td>
<td>38%</td>
<td>33%</td>
<td>41%</td>
</tr>
<tr>
<td>Male (n=544)</td>
<td>38%</td>
<td>34%</td>
<td>41%</td>
</tr>
<tr>
<td>Female (n=1229)</td>
<td>37%</td>
<td>34%</td>
<td>41%</td>
</tr>
<tr>
<td>A.A./Black (n=112)</td>
<td>45%</td>
<td>37%</td>
<td>43%</td>
</tr>
<tr>
<td>Asian/Pacific Islander (n=167)</td>
<td>31%</td>
<td>28%</td>
<td>41%</td>
</tr>
<tr>
<td>Hispanic/Latino (n=103)</td>
<td>41%</td>
<td>40%</td>
<td>47%</td>
</tr>
<tr>
<td>Multiracial total (n=33)</td>
<td>49%</td>
<td>37%</td>
<td>42%</td>
</tr>
<tr>
<td>Native American/AK Native (n=11)</td>
<td>55%</td>
<td>64%</td>
<td>73%</td>
</tr>
<tr>
<td>Other total (n=51)</td>
<td>45%</td>
<td>35%</td>
<td>47%</td>
</tr>
<tr>
<td>White total (n=1133)</td>
<td>39%</td>
<td>35%</td>
<td>43%</td>
</tr>
<tr>
<td>Unknown total (n=159)</td>
<td>28.3%</td>
<td>24.5%</td>
<td>33.3%</td>
</tr>
</tbody>
</table>
Takeaways

- College Health Centers and Counseling Centers can benefit from integration strategies using the collaborative care model.

- Outcomes among depressed students, especially for racial-ethnic minority students treated in these models are extremely positive, despite having more symptoms at baseline.

- Treating highly educated students DOES NOT mitigate the need to approach treatment alliance issues with a sense of cultural humility.
Montefiore ACO BH Integration Initiative Activities
Summary of Project Impact at Montefiore FQHC

- Enrolled 297 total patients into Project Impact
- 218 (73.4%) of those enrolled have completed program, kept all appointments
- 48 (16%) ended program by choice. Did not keep appointments
- 221 (74%) patients reduced their PHQ 9 scores by 50%

Graph of Measures

Project Impact by the Numbers

- Enrolled - 297
- Completed - 218
- Ended - 48
- Active - 31
- Reduced PHQ9 by 50%+ - 221
OUTCOMES OF HYPERTENSIVE PATIENTS WITH DEPRESSION

<table>
<thead>
<tr>
<th></th>
<th>% Became controlled</th>
<th>% Became or Stayed controlled</th>
<th>With Two+ Reads</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful PIC (79)</td>
<td>23%</td>
<td>59%</td>
<td>91%</td>
</tr>
<tr>
<td>Not enrolled (1486)</td>
<td>19%</td>
<td>47%</td>
<td>77%</td>
</tr>
</tbody>
</table>
Chronic Illness and Depression Care Management Model: TEAMcare Variant

PCMH Primary Care Team
12 PCP, Nursing Staff
- Educate about benefits of treatment
- Initiate appropriate medication treatment based on depression severity (PHQ-9 score) and patient choice
- Screen for depression, confirm clinical diagnosis
- Receive active feedback from Synergy Team via EMR and/or telephone

Behavioral Health Manager (LCSW)
1 FTE
- Initiates screening, eligibility, assessment
- Conducts face-to-face behavioral health treatment assessment and reviews treatment plan with consulting psychiatrist
- Provides onsite and telephonic brief psychotherapy tailored to patient’s needs
- Collaborates with nurse care manager, monitors PHQ-9, and medication effects, including side effects

Nurse Care Managers
3 experienced RNs, totaling 1 FTE effort
- Conducts comprehensive biopsychosocial assessment
- Monitors PHQ-9 and medical indicators
- Chronic disease education
- Assists with appointments and concrete services
- Uses patient-centered motivational strategies to promote self management and wellness

Consulting Psychiatrist
0.4 FTE
- Reviews cases with Synergy Team with focus on patients not at target goals
- Reviews EMR and confirms/recommends psychotropic medication adjustments or additional workup to PCP
- Limited face-to-face treatment for complex patients
- Available for telephone or email collaboration
## Synergy Program Assessment: Patient Experience (August 2012)

<table>
<thead>
<tr>
<th>Q2. I know more about how my mental health affects my physical health because of the program (n=23).</th>
<th>Mean (SD)</th>
<th>Percent Agree/Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3 (0.71)</td>
<td>87%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q3. I know more about how I can be more responsible for my health because of the program (n=23)</th>
<th>Mean (SD)</th>
<th>Percent Agree/Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 (0.92)</td>
<td>87%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q4. Overall, I feel my health has improved because of the program (n=22).</th>
<th>Mean (SD)</th>
<th>Percent Agree/Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0 (0.95)</td>
<td>64%</td>
<td></td>
</tr>
</tbody>
</table>
### Synergy Program Assessment: Patient Experience (August 2012)

<table>
<thead>
<tr>
<th>1 – Strongly Disagree, 2 – Disagree, 3- Neutral, 4 – Agree, 5 – Strongly Agree</th>
<th>Mean (SD)</th>
<th>Percent Agree/Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. My care team gave me choices when we talked about how to treat my depression (n=23).</td>
<td>4.0 (0.93)</td>
<td>83%</td>
</tr>
<tr>
<td>Q6. My care team valued my opinion when we talked about how to treat my depression (n=21).</td>
<td>4.0 (0.97)</td>
<td>81%</td>
</tr>
</tbody>
</table>
Takeaways

- Integrated delivery systems may need to employ flexible models especially when settings differ in population and resources.

- Providing choices in treatment especially for Racial ethnic groups is key; many initially refuse antidepressant medications.

- Full global capitation models may allow for more virtual and creative treatment approaches that may be more patient centric.
Integrated Care Resources


• Enhanced National CLAS Standards:
Additional Integrated Care Resources


Contact Information

Laura Galbreath, Director, SAMHSA-HRSA Center for Integrated Health Solutions
laurg@thenationalcouncil.org

Jenny Crawford, JD, LSCW-C, Deputy Director, Director, SAMHSA-HRSA Center for Integrated Health Solutions
jennyc@thenationalcouncil.org

Katherine Sanchez, LCSW, PhD, Assistant Professor, School of Social Work, The University of Texas at Arlington
ksanchez@uta.edu

Teresa Chapa, Ph.D., MPA, Senior Policy Advisor, Mental Health, U.S. Department of Health and Human Services, Office of Minority Health
Teresa.Chapa@hhs.gov

Henry Chung, M.D., Vice President and Chief Medical Officer, Montefiore Care Management Organization and Associate Professor of Clinical Psychiatry, Albert Einstein College of Medicine
HCHUNG@montefiore.org

Questions? SAMHSA-HRSA Center for Integrated Health Solutions
integration@thenationalcouncil.org
Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today’s webinar.