CCBHC-E National Training and Technical Assistance Center

CCBHC Optimizing Data Learning Series

July 18, 2023

CCBHC-E National Training and Technical Assistance Center

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

Acknowledgements and Disclaimer

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Logistics

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    - Blaire Thomas, National Council
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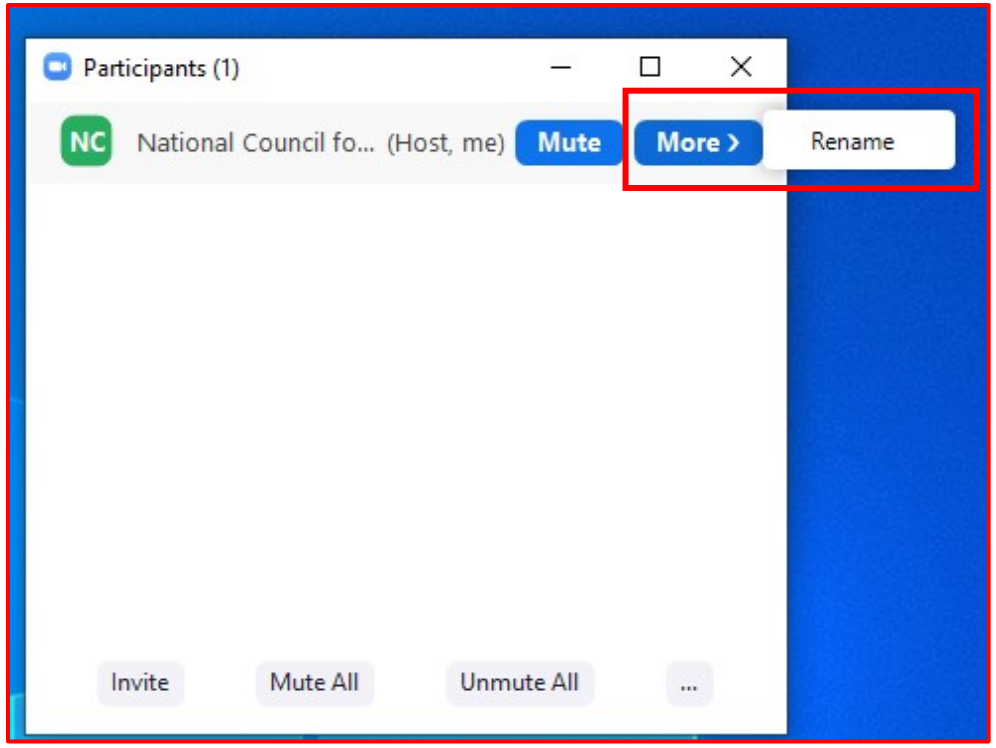

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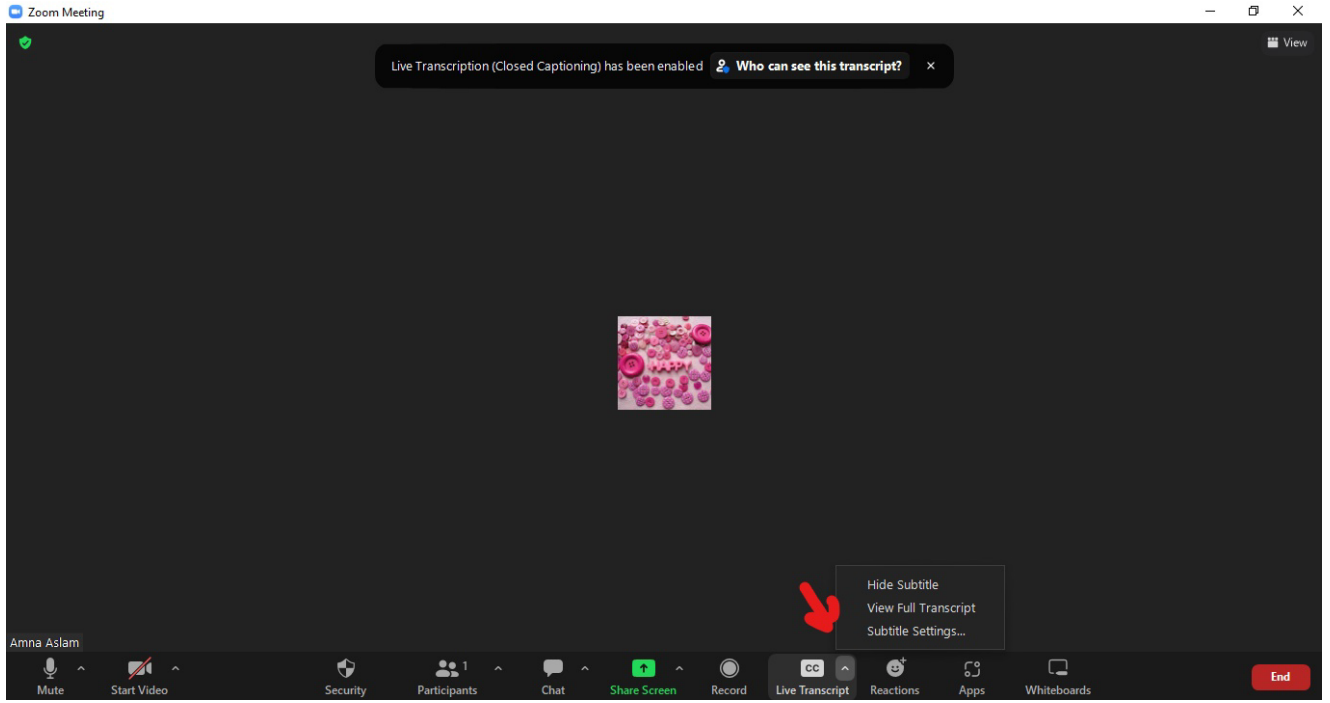

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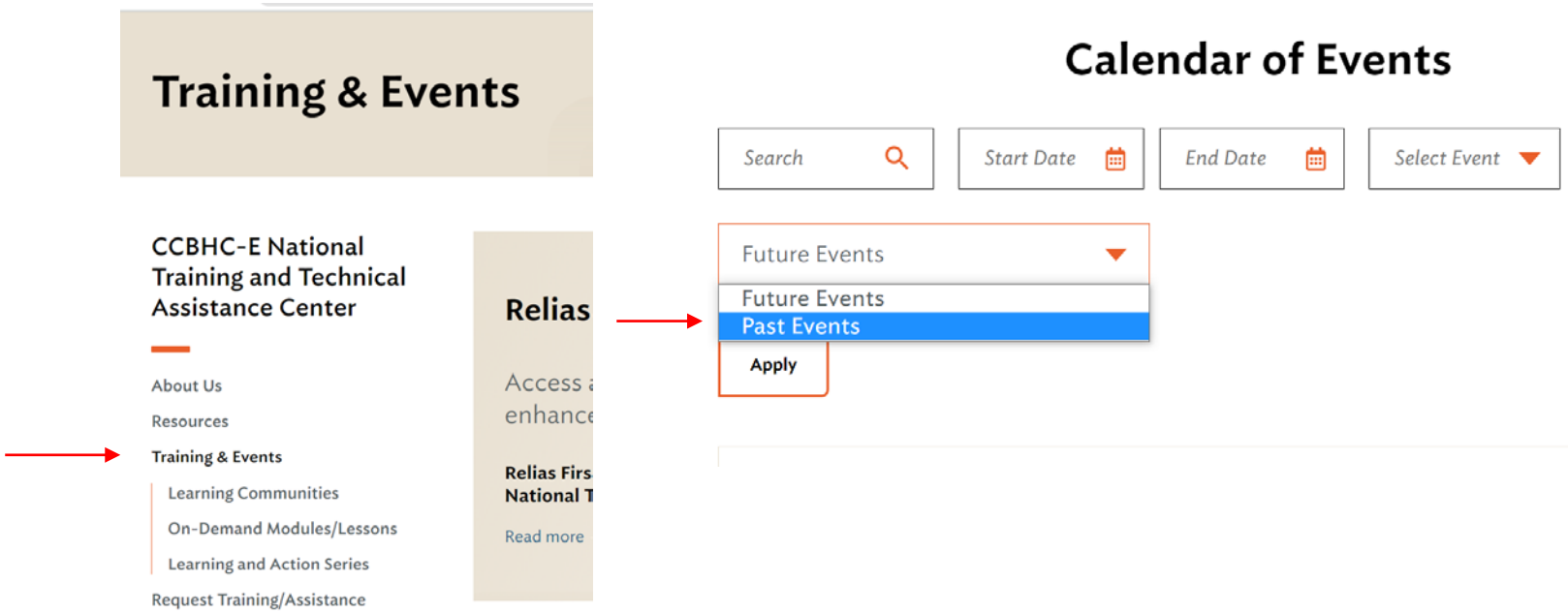
Today's Session: Slides and Recording

Slides and the session recording link will be available on the CCBHC-E NTTAC website under "Training and Events" > "Past Events" within 2 business days.



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Today's Agenda

- Review Purpose of Optimizing Data Learning Series
- Discuss How to Identify and Address Social Determinants of Health
- Provide Case Example
- Group Discussion

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CCBHC Advanced Optimizing Data Learning Series

Purpose

Designed for CCBHC grantees interested in learning about the advanced principles of leveraging data to advance consumer health outcomes, the four-session CCBHC Advanced Optimizing Data Learning Series will explore applying data to identify disparities, operationalizing data to expand screening, and integrating data to improve practice activities.

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Learning Series Topics

Date	Topic	Summary
May 16	Application of Data	Provide overview of National Standards for Culturally and Linguistically Appropriate Services (CLAS) and discuss how to use data to identify and address disparities.
June 20	Integrating Data Systems	Increase knowledge of data to support chronic disease management and identify opportunities for improved health outcomes.
July 18	**Operationalizing Data**	**Increase understanding of screening tools and opportunities to address social determinants of health.**
August 15	The Role of Data in Practice Improvement	Provide overview of measurement-based care (MBC) and discuss how to build organizational readiness to implement MBC.

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Your Learning Series Team

Jeff Capobianco, PhD,
Consultant and Subject Matter Expert

Clement Nsiah, PhD, MS
Director

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Project Manager

Kathryn Catamura, MHS
Project Coordinator

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Today's Presenters

Leigh Fischer, MPH
Principal, TriWest Group

Cassie Morgan, MSW, LCSW
Principal, TriWest Group

Elizabeth Cook, MBA, MAC, LPC
Quality Improvement Director
Egyptian Health Department

TriWest Health + Human Service Evaluation + Consulting

Egyptian Health Department

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What are Social Determinants of Health?

CDC defines social determinants of health (SDOH) as the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Social Determinants of Health & Health Equity

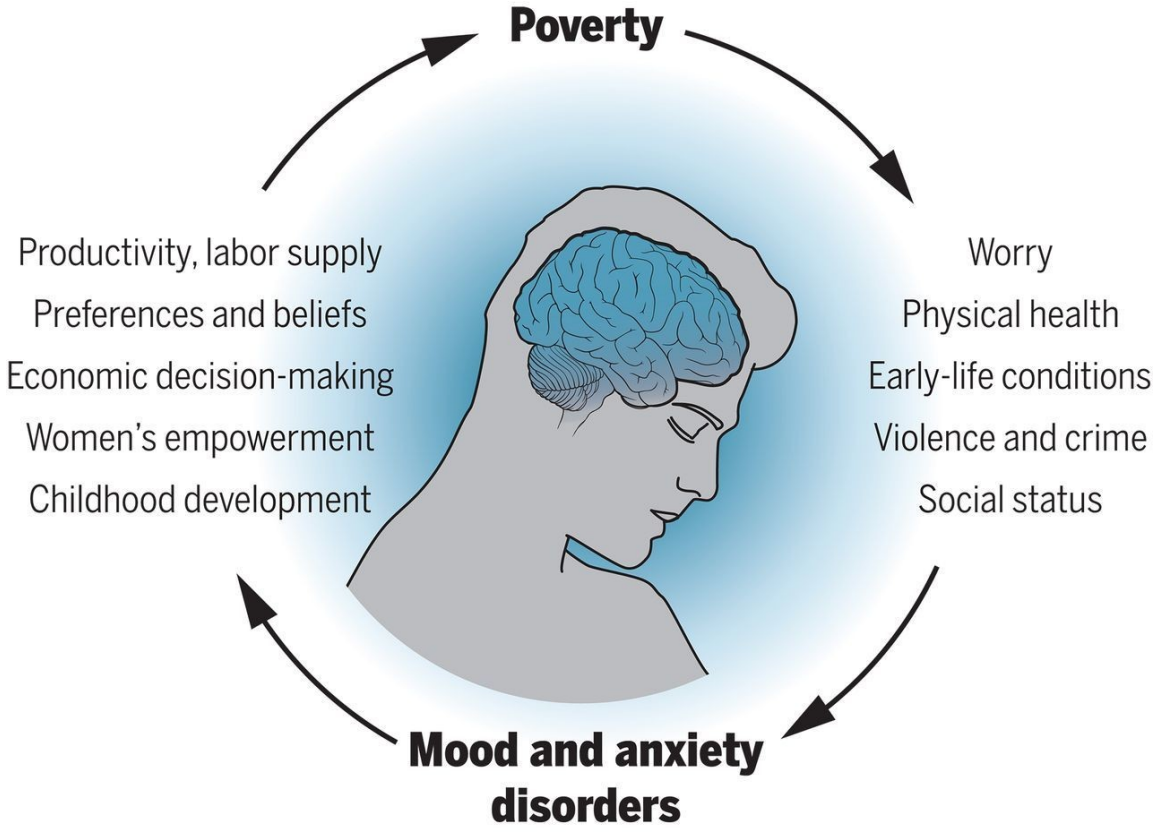
“Advancing behavioral health equity means working to ensure that every individual has the opportunity to be as healthy as possible. In conjunction with access to quality services, this involves addressing social determinants of health—such as employment and housing stability, insurance status, proximity to services, and culturally responsive care—all of which have an impact on behavioral health outcomes.” - SAMHSA

Role of CCBHCs in Addressing Social Needs

- Identifying and addressing SDOH is an integral part of fulfilling the CCBHC goals of increasing behavioral health access and reducing health inequities.
- The Disparity Impact Statement and Community Needs Assessment are guides to addressing area-specific social needs.
- The CCBHC certification criteria highlight the need to identify and address SDOH:
  - Include social determinants of health in the evaluation of all people receiving services (Screening, Assessment, and Diagnosis)
  - Help individuals develop skills that are important to addressing SDOH (Psychiatric Rehabilitation Services)

Social Determinants & Behavioral Health

Behavioral health issues and social determinants of health are interconnected and can easily build off each other, creating a cycle that many cannot escape on their own. For example, the cycle of mental health and poverty; mental disorders can lead to reduced income and employment, which entrenches poverty and in turn, increases the risk of mental disorders.



Science Magazine

Impacts on Behavioral Health

- Socioeconomic factors account for 47% of health outcomes, followed by health behaviors (34%), clinical care (16%), and the physical environment (3%).[1]
- Among mothers with food insecurity, rates of major depression and anxiety are higher, and children with food insecurity have higher rates of behavioral problems.[2]
- Communities living with poverty, urban crowding, poor access to healthcare or low education are associated with higher rates of trauma exposure, which in turn increases the risk of mental illness, substance use disorders, and criminal and juvenile justice involvement.[3]
- Low household income, low educational attainment, material disadvantage, unemployment, and social isolation are among the biggest factors associated with poor mental health. E.g., youth from homes with low SES are twice as likely to experience depression or anxiety.[3]

Addressing Social Determinants of Health

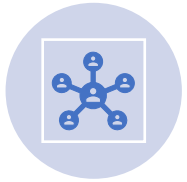
Screen for and track social needs

Approach clients with a Trauma-Informed Approach, sensitivity, and cultural awareness

Utilize peers and care coordinators to provide social support

Create food access plans and partnerships with healthy food providers (e.g., food pantries)

Refer clients to and partner with housing assistance programs



Improve coordination across social services

Provide financial support for rideshares and non-emergency medical transportation

Create a space for social interaction where people can develop relationships and community

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Screening Tools

- **The Accountable Health Communities Health-Related Social Needs Screening Tool** (AHC HRSN Screening Tool) from the Centers for Medicare & Medicaid Services
- **Social Needs Screening Tool** from the American Academy of Family Physicians (includes guides on how to build action plans for patients)
- **HealthBegins Upstream Risks Screening Tool**
- **PRAPARE - Protocol for Responding to and Assessment Patients' Assets, Risks, and Experiences** (available in 33 languages)
- **Structural Vulnerability Assessment Tool** (includes questions on discrimination)
- **WellRx Toolkit**
- **Your Current Life Situation** from Kaiser Permanente

Using Data to Address Social Needs

To make a positive impact on health equity, CCBHCs must work toward improving SDOH data collection, standardization, and integration into EHRs. This will also aid in improving an individual's health outcomes, and support research and policy decisions.

For example:

- Routinely collect all key SDOH **using one validated instrument** that is integrated into your EHR and other workflows
- Supplement the instrument with **behavioral health-specific questions** (e.g., life satisfaction, barriers to treatment)
- Utilize natural language processing and advanced machine learning algorithms to **mine EHR notes** to extract existing client SDOH data

Incorporating & Integrating Outside Data

Surveillance & Service Provision Data

- Community information systems
- Medicaid claims

Economic and Housing Data

- Home Mortgage Disclosure Act
- Unemployment data (Bureau of Labor Statistics)
- Poverty data (Census) Bureau

Local, State, and Federal Policy Data

Education Data

Lifespan Approach

This approach takes into account the differential experience and impact of social determinants throughout life.

Reduce Health Inequity Through Partnerships

- Creating healthier environments is a group effort, involving partnerships with community groups, schools, public health, and local providers.
- Examples of partnerships at the federal level:
  - **Housing Services Resource Center** (launched by Administration for Community Living, in partnership with CMS, SAMHSA, ASPE, and HUD) fosters cross-sector partnerships to streamline services, leverage resources, and make community living possible for more people.
  - **Advancing State Policy Integration for Recovery and Employment** (launched by the Office of Disability Employment Policy at DoL in partnership with ACL, ASPE, SAMHSA, ONDCP, Dept of Ed., VA, SSA, CMS) supports state efforts on employment of people with SMI.

Case Example: Operationalizing Data to Address Social Determinants of Health

Agency Overview

Egyptian Health Department is dedicated to providing human services that support and enhance the lives of individuals, families, and groups in Southern Illinois.

Services include:

- Whole Life Behavioral Health (Including Substance Use Prevention and Recovery) (CCBHC and CMHC)
- Environmental Health/Health Education/Public Health
- School Based Health Clinic
- Integrated Care for Kids (InCK) and Integrated Care for Adults (InCA)

Who we serve

Saline, Gallatin, White

- Public Health
- CCBHC
- CMHC
- School Based Health Clinic (Gallatin)

Wayne, Hamilton

- Additional Behavioral Health Services
- InCA/InCK SDOH services

Due to high poverty rates, food deserts, poor air quality, and lack of access to safe exercise, county health rankings have consistently placed Saline, Gallatin, and White counties in the bottom 12% of the state ranks for healthiest communities.

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Screening for Social Needs – How We Started

- In 2020, 7 sites nationally were selected for a 7-year CMS initiative called Integrated Care for Kids (InCK), including Egyptian.
- This model utilizes a social determinants of health screening for all Medicaid beneficiaries birth to 21 in order to provide early intervention and care coordination services that bridge the disconnect between schools, healthcare providers, child welfare, and community resources and organizations.
- A combination of claims data and the screening results determine the level of care each patient is tiered into.
- Early successes and predicted successes led to Egyptian and partners receiving Healthcare Transformation Collaborative funding for an adult version of the program called Integrated Care for Adults (InCA).

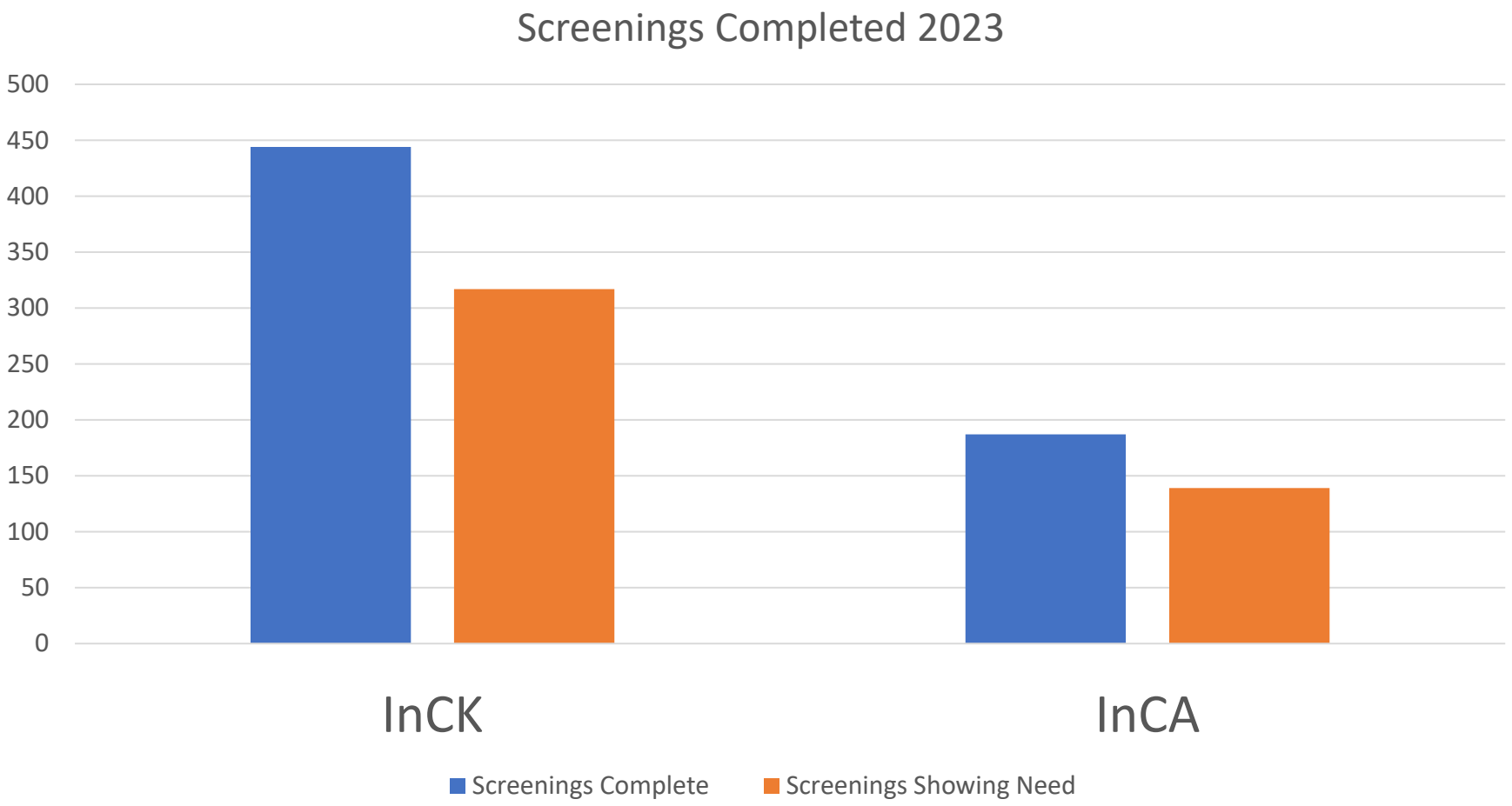
Screening for Social Needs

- Village InCK screening - food, housing, juvenile justice involvement, recent behavioral health and substance use concerns, child development, etc.
  - Tool was developed internally to suit the community and grant requirements and piloted with some families.
- InCA screening - Accountable Health Communities Health Related Social Needs (HSRN) Screening Tool.
- Both programs have a list of beneficiaries for cold calls and receive referrals.
- InCA embeds staff in Emergency Departments at partner hospitals, where they have the opportunity to screen patients prior to discharge.

Screening Pilot

- Pilot group – Families at a group and Family Resource Developers
- After the screening, took a survey, which included the question *"Are there other resources that your family or a family like yours could use that we did not ask about?"*
    - More access to fresh groceries
    - Transportation concerns
    - Lack of jobs
    - Laundry services missing from a county
- The Recovery Oriented System of Care program developed free laundry events in response.

Outcomes



Average number of needs identified per screened client with needs:

InCK - 2.93

InCA - 4.12

Current Top Needs, At a Glance

10 Most Common Service Types, based on Total Referrals Sent/Shared

← InCK

	Total Referrals Sent/Shared	Average Distance to Service (mi)
Food pantry	682	6.23
Youth counseling	376	24.68
Individual counseling	309	20.97
Clothing and shoes	280	10.75
SNAP application assistance	279	22.50
Primary care	208	5.72
WIC application assistance	192	16.17
Outpatient mental health program	147	32.36
Dental care	129	59.32
Developmental screening or assessment	128	30.85

10 Most Common Service Types, based on Total Referrals Sent/Shared

InCA →

	Total Referrals Sent/Shared	Average Distance to Service (mi)
Food pantry	503	6.74
Individual counseling	228	10.70
SNAP application assistance	164	21.57
Free or low-cost transportation	129	11.19
In-home personal care	109	33.56
Outpatient mental health program	103	21.11
Transportation to medical appointments	92	17.66
Paratransit or Dial-A-Ride service	80	26.14
Job search assistance	80	32.61
WIC application assistance	79	15.72

*Report from NowPow

Community Partnerships – We Depend On…

FQHCs

Hospitals

Libraries

Schools

Public Transportation

Laundromats

Grocery Stores

Homeless Shelters

Veterans Services

Senior Programs

Behavioral Health Centers

Food Pantries

Churches

Clothing Pantries

Housing Authority

Rental Assistance Programs

Community Action Agencies

Realtors

Specialty Medical Providers

WIC

Doctors' Offices

Department of Rehab Employment

MCOs

Village and Town Mayors

Employers

Family and Friends

….And even Clients themselves

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Success Story 1 – Anna, Age 19

- Referral came from local hospital – grandmother was going to nursing home, house condemned, grandchild would be homeless, as she was living in the hospital room.
- Mother had passed away in 2020, Anna did not know her social security number, which prevented her from getting a new copy of her birth certificate, which prevented her from getting an ID, which prevented her from working and from applying for housing and any kind of social services.
- Community Health Worker assigned to the case arranged placement in a children's homeless shelter, obtained releases from Anna for a previous mental health provider and requested her social security number.
- Once she had her SSN, the CHW helped her to get a copy of her birth certificate, which allowed her to get an ID, which helped her qualify for medical card and food stamps and start job hunting.
- Once she got all of these things, Anna was able to move to independent living, get health insurance, start behavioral health services, and is working part time.

Success Story 2 - Bob, Age 53

- Hospital referral after his third stroke in a year. Bob was homeless after a falling out with friends.
- He was a “frequent flyer” at the ER both due to complex medical needs and chronic homelessness.
- Bob has a felony conviction, which bars him from eligibility at local homeless shelters and public housing. Bob had been denied nursing home admission in the past though he did not have the ability to provide appropriate self-care.
- After Bob’s strokes he needed to be seen by a neurologist but did not have access to transportation.
- The InCA Community Health Worker engaged with a homeless shelter, which was willing to extend Bob’s stay to 6 weeks as long as he was actively working with the CHW and MCO.
- She engaged the MCO and together they got Bob into a neurologist, found transportation, helped Bob get replacement glasses, clothing, and hygiene items, and, the day before his weeks were up, found a placement in a nursing home.
- Bob’s CHW reports “He is living his best life.”

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Lessons Learned

- The best way to find out what your community needs is to ASK.
- The best partners are ANYONE willing to be a partner.
- Sometimes the data tells you exactly what you expect (a community with no grocery stores has a lot of need for groceries), but sometimes it surprises you (the need for assistance with job hunts is higher than anticipated).
- The best time to start figuring out how you will manage the data is yesterday, but the second best time is now.
- With a little bit of help from a strong community, even the worst situations have solutions and there is ALWAYS hope for a better tomorrow.

Discussion: Sharing with Your Peers

- What lessons have you learned in addressing social determinants of health?
- How are you currently monitoring social determinants of health? What are ways you could improve either data collection or data integration to understand SDOH?
- What is the next step you want to take to address social determinants in your organization?
- What remaining questions do you have?

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Closing

Next Session: *August 15, 2023 - The Role of Data in Practice Improvement (3pm – 4:30pm ET)*: Provide overview of measurement-based care (MBC) and discuss how to build organizational readiness to implement MBC.

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Thank You!

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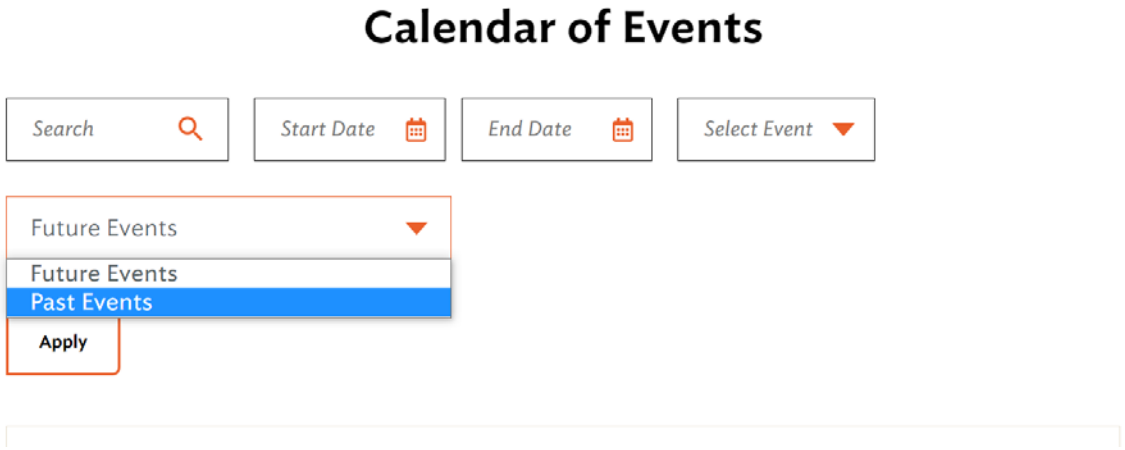

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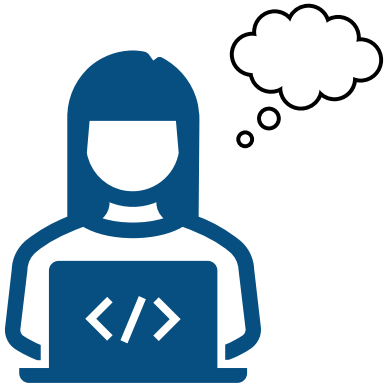

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