



Social Determinants of Health

*Meeting the holistic needs
of individuals with serious
mental illness*

Presenters

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Session Objectives

Objective 1: Participants will be able to describe how social determinants of health affect the way that individuals view and access health care services.

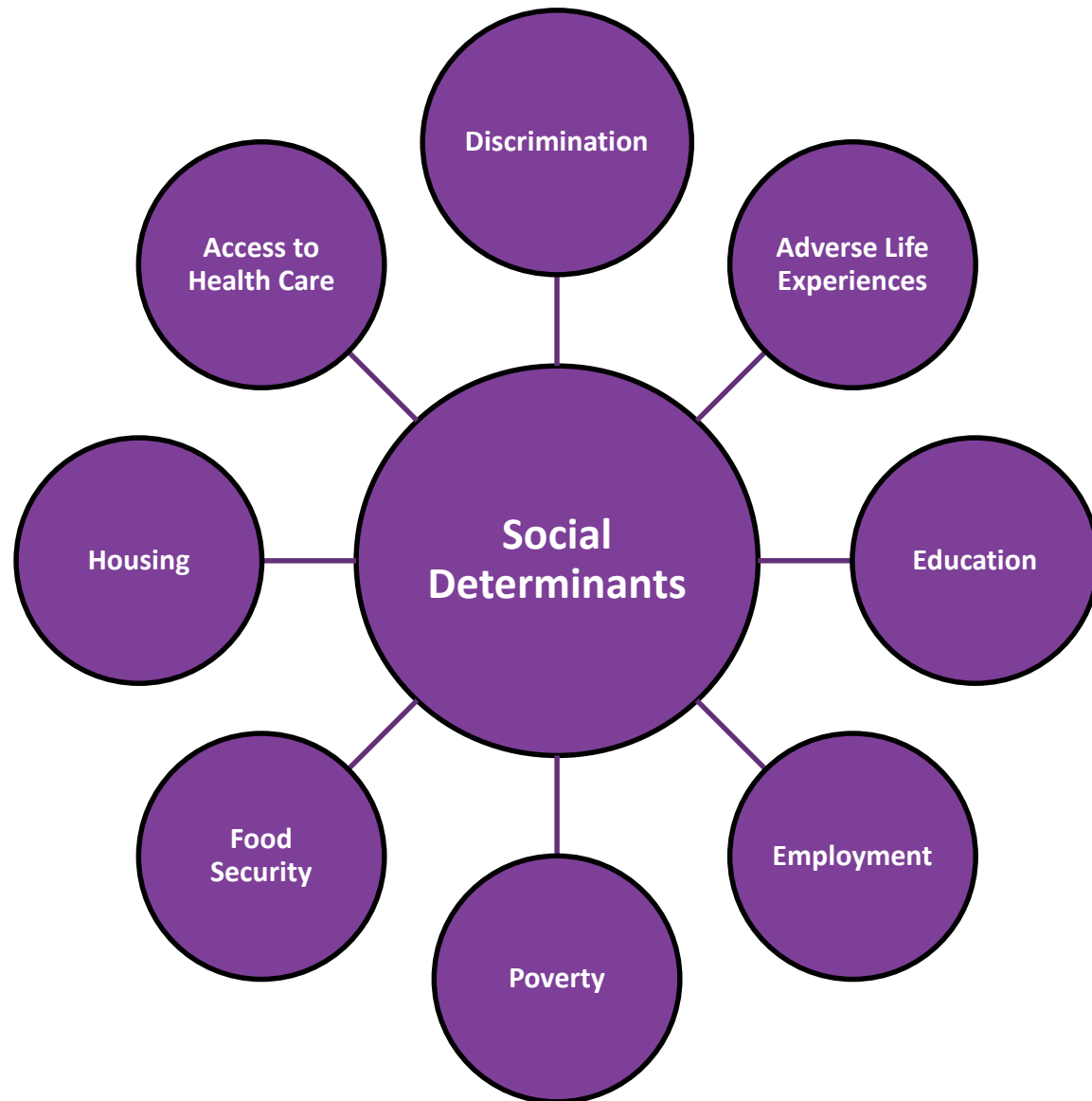
Objective 2: Participants will contribute to system level interventions to improve care delivery to meet the whole health needs of individuals with a Serious Mental Illness and their families.

Lesson 3: Participants will be able to implement person-centered interventions that result in improved health and wellness outcomes.

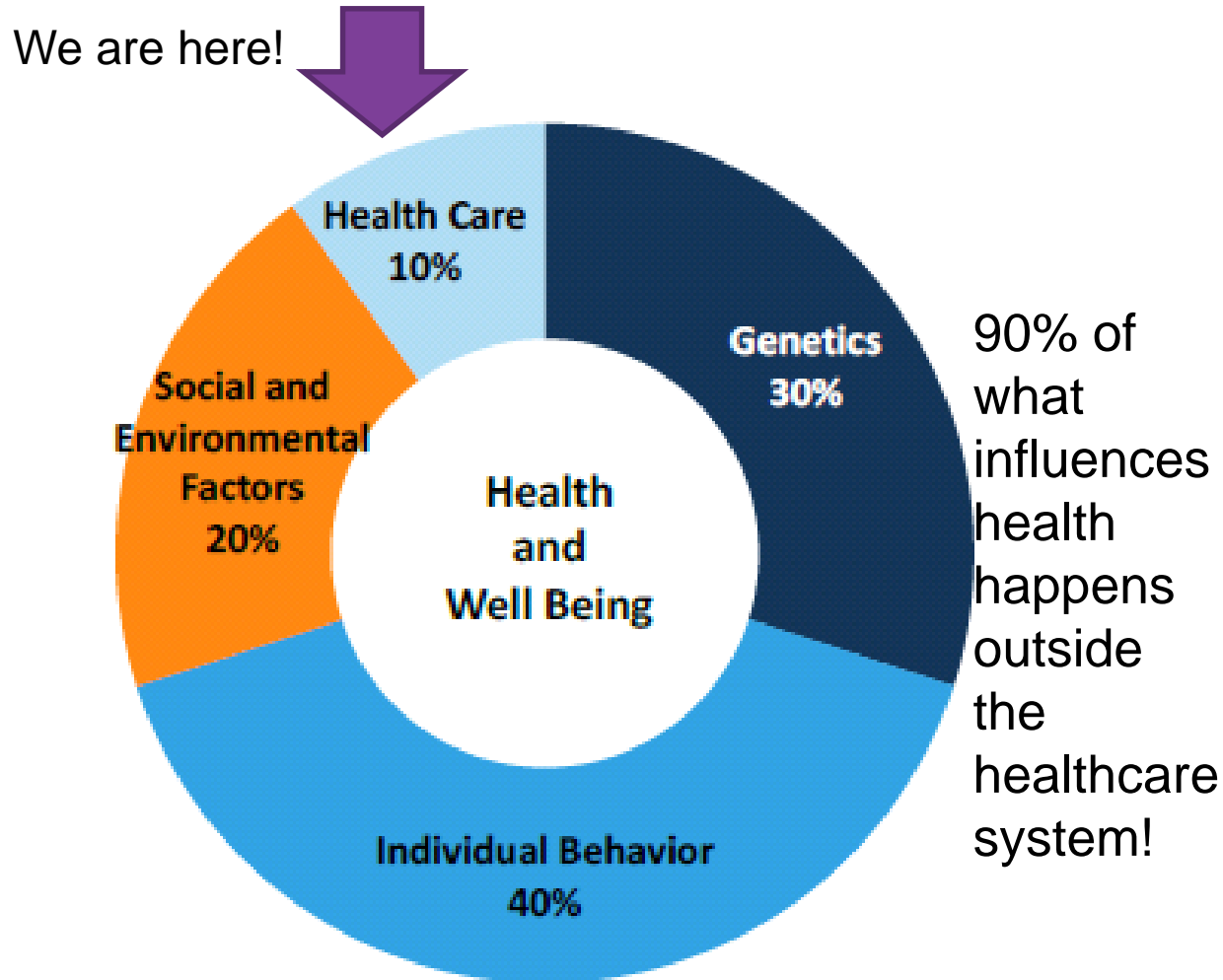
Social Determinants of Health Defined:

“The social determinants of health (SDH) 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. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.”¹

Social Determinants²



The sobering truth For healthcare providers³



Getting Upstream on Health

Figure 2

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
 Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

System-level Interventions



System-level Interventions

Mercy Maricopa's approach is member-centric and focuses on evidence-based drivers of holistic health, including:

- ✓ Housing first
- ✓ Employment
- ✓ Building natural supports through peers and families
- ✓ Transportation
- ✓ Food security
- ✓ Increased convenience through whole-health clinics & extended hours
- ✓ Supporting health literacy through health promotion and education
- ✓ Community-based care
- ✓ Accessibility and availability of services
- ✓ Self-determination through putting the member in the driver's seat

System-level Interventions

Medical

- PCP partnerships with ACT teams
- Integrated Health homes – use of Health Risk Assessment to facilitate clinic selection
- Health and Wellness programs

Behavioral Health

- Hospital and jail peer transition programs
- Comprehensive treatment team
- Care management

Outcomes

- Reduced readmission and increased follow up appointments upon discharge
- Reduced inpatient admissions (psychiatric and medical) and ED utilization
- Increase in the number of members with a PCP visit
- Reduction in homelessness (ACT)
- Increased employment (ACT)

System-level Interventions

Housing Assistance

- Assistance in securing and maintaining housing of choice
 - Partnership with housing authorities to establish bridge programs – connection for 100 members with incentives
 - Financial assistance to secure housing in community of choice - expanded Permanent Supportive Housing model by 809 members
 - Connection with supported employment providers to address ongoing financial stability and community connection – developed rapid rehousing model to serve up to 300 members that pairs Supported Employment with PSH and temporary financial assistance
 - Partnerships with Coordinated Entry and CASS to assist in direct connection of homeless members

Outcomes

- Reduced psychiatric and medical inpatient admissions
- Reduced crisis utilization
- Increased days housed and contribution to rent
- Access to housing within 30 days

System-level Interventions

Employment opportunities

- Implementation of Supported Employment to serve an additional 750 members
 - Implemented outcome/incentive contracts
- On site SE providers to work as part of clinical teams to provide services when a person states they are interested in working – no ready to work assessment completed
- Collaboration and agreement with RSA

Employment Status	SMI Members	Percentage of total members in category
Competitively employed full time	1093	5.8%
Competitively employed full time	1586	8.4%
Student	616	3.25%
Volunteer	394	2%
Unpaid Rehabilitation Activities	6,978	36%

System-level Interventions

Medical: health literacy, education and disease prevention

- Cancer screenings : cervical, breast, colorectal
- Diabetes care
- Pre and postpartum care
- EPSDT
- Flu shots
- Tobacco use reduction/cessation
- Antipsychotic prescribing to children
- Opioid prescribing to adults

Team based models of care increases everyone's health literacy – shifts focus to whole health and wellness

Person-Centered Interventions



Why it matters

PIR Prevalence of Chronic Conditions 2016

Condition	2010 AZ General Pop. (n= 6,392,017)*	PIR Arrowhead (n=685)	PIR Gateway (n=702)
Hypertension	30.7%	34%	43%
Respiratory/Asthma	8.9%	54.3%	35.8%
Diabetes	10.7%	14%	20.8%
Heart Disease	3%	32.6%	35.8%
Obesity/BMI	26.8%	58.7%	56.8%
Tobacco Use	16.3%	55.3%**	

Questions for Provider to Consider in a Social Determinants Healthcare World

Are we managing conditions, or consequences?

Do we as, a provider, add value?

Should we partner for success or go it alone?

How much will it cost?

Technology & data management

Changing workforce roles

Integrated healthcare facilities

How do we continue to engage the voice of service participants and providers as architects and designers of the system of care?



A Bit About Us

Transforming Lives Through Passion, Innovation and Action

- Partners In Recovery was formed in 2009 as a partnership of three long-standing behavioral health agencies serving children, DD, adults with mental illness and transitional youth.
- The founders shared a vision for a new way of offering services for persons with SMI in Arizona emphasizing:
 - Choice
 - Voice & involvement
 - Integration of best clinical practices with caring professionals and the wisdom of individuals receiving services and their family members
- Today PIR serves nearly 6,000 adults with SMI at seven outpatient locations in Maricopa County

Targeting access to healthcare

In 2011, PIR began experimenting with different models of delivering primary care and physician extender services

Co-location by a local FQHC (Mesa, Phoenix)

Physician group practice contracted for co-located primary care (Peoria)

First SMI clinic dually-licensed as a health home added in 2013 (Glendale)

Under the Integrated RBHA, the pace of change has accelerated!

Medical ACT Team - 2015

High contact ACT Team offers perfect platform for chronic disease management by embedding PCP within the teams

Multi-disciplinary positions (Employment, Housing, Living Skills) target multiple social determinants and needs

Targets SMI adults with most intractable MH symptoms and multiple chronic health conditions – 100 total members on team

Single care team with full responsibility for all aspects of care

24-7-365 response

Goal of the team

Not to re-direct all attention to health, but to help people make more informed decisions about their healthcare

Systematic management of the simple co-morbid conditions where progress can be made

Whole person focus with single plan of care

Equip team with enhanced tools (in-house PCP, increased knowledge, strong data) to lower barriers to healthcare access

Structure and operations

Traditional ACT staffing plus PCP services

Team is located in a behavioral health OTC next door to the primary care practice

ACT team is “closed” to 100 members

PCP practice is “open”

Coordination of Care

Morning meetings – 4x per week

New referral screening – 1 hour per week

Integrated care staffings – 2x per month

Brief “huddles” throughout the day

Using data to drive care

Actionable data focus

Using health metrics to drive care delivered by the Medical ACT team

Using satisfaction and voice to drive the team culture (art groups, walking groups, social hour)

Patient	PHQ-9	Cigs/Day	A1c	SBP	LDL	Housing Status	Recovery Scale
Mary	<u>20</u>	<u>20</u>	6.3	131	105	<u>55</u>	13
Lynn (new)	5	0	5.5	140	<u>138</u>	25	4
Greg	10	10	<u>10.0</u>	100	100	10	10

Arrowhead health home

Opened in 2013 as the first outpatient clinic for SMI adults dually-licensed for primary care under new state licensing rules

Mercy Maricopa Integrated Clinic VB Contract starting Aug 1

Auto-assignment to PCP and Arrowhead

Enhanced primary care rates

Shared incentives

Targeting consequences of social determinants

Center for Excellence in Chronic Disease Management for the common metabolic risk factors seen among our members:

A large waistline (abdominal obesity).

High triglyceride levels

Low HDL cholesterol levels, which raises the risk for heart disease.

High blood pressure, a common precipitator of stroke

High fasting blood sugar, an early warning sign of diabetes

Smoking, which increases the risks for heart disease and stroke

Structure and operations

Single, shared EMR and service plan

PCP clinic within the behavioral health facility

Care management for high-cost/high-risk

Stepped-care and treat to target (focus on non-responders)

**Comprehensive wellness & disease management program
using peer health coaches**

Physical rehabilitation services

Nutritionist

Peer health coaching

Defined a new role for peers focused on wellness

Goal of enhancing & augmenting Clinical Team with a recovery resource

Desire to preserve the special contribution of peers in the CM role

Peers received advanced training in Wellness Action Planning

Supplemental training/certification in:

Motivational Interviewing

Mindfulness

Emotional Wellness, Stress, Menu Planning

Stanford Chronic Disease Self Management

Role combines

Education & wellness groups

Activities (fitness, walking, stretching)

1:1 health coaching by assignment

Structure and operations

Caseloads of approx 1:50

Referred by PCP to work with people with more severe health conditions

HRA

CO2 monitoring

BP, weight monitoring

Self-management focus

Diet, nutrition education w/ nutritionist

Teaching people to use BP machines

Support in smoking cessation

Follow-up with PCP

Health coach outcomes

SF-36 Self-Report Outcomes

The SF-36 was administered with a sample of 100 PIR participants:

Mental Health Scores— showed improvement between .12 and 26.2 with 20 people demonstrating a +5 point increase or greater

Physical Health Scores— showed improvement between 0.33 and 23.3 with 42 people demonstrating a +5 point increase or greater

Weight Loss

Fifty-three program participants participated in a 6 month fitness tract:

Participants lost an average of 12 lbs

Total weight loss for the program was 640 lbs with a range of 2-43 lbs

Five participants lost more than 25 lbs each

Blood Pressure

100 program participants were checked for blood pressure at intervals throughout the program:

7.5% of participants with normal BP showed pre/post improvement.

37.5% of participants who were pre-hypertensive showed pre/post improvement.

Enhancing access & quality through health partnerships

Worked with Mercy Maricopa to enhance the service array focused on health, wellness & impacting social determinants

Co-located Supported Employment providers on site at 5 PIR locations

Family WRAP groups on site

Housing specialist at 6 locations

Final thoughts on aligning services with social determinants of health

What gets paid attention to, gets paid attention to

Power of data and investment in health IT

Know your strengths

PIR created many service opportunities, but we also turned many down

Think holistically about what our service populations need to be *well* and design around that

What can behavioral health add that is unique?

Ask the people we serve what they think – how do we implement so that it is person-directed and taps strengths?

Final thoughts

Behavioral health is uniquely poised to lead the charge in addressing social determinants

Experts in behavior and lifestyle change

Investments in staff who “walk the walk”

Understanding that recovery is a journey, not an event

References

1. **World Health Organization; Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. WHO website. [http://www.who.int/social_determinants/thecommission/fianlreport/en/](http://www.who.int/social_determinants/thecommission/finalreport/en/). Published 2008. Accessed June 2, 2016.**
2. **Bryant, Toba; Raphael, Dennis; Schrecker, Ted; Labonte, Ronald (2011). "Canada: A land of missed opportunity for addressing the social determinants of health". *Health Policy* 101 (1): 44–58.**
3. **Schroeder, SA (2007). We Can Do Better – Improving Health of the American People. NEIM. 357-1221-8**

Thank you

