

Seeding & Scaling Health Care Innovation for Underserved Populations

a whole-person/whole-family approach to care
that promotes sustained wellness



clifford
beers

MOVING FORWARD

Seeding and Scaling Health Care Innovation for Underserved Populations

THE PROBLEM

Multiple interrelated factors contribute to health disparities among vulnerable populations. Vulnerability is the product of physical, psychological and social conditions that intersect and combine to increase health risk and create substantial barriers to accessing, and benefiting from, needed health services. Moreover, the disadvantage is cumulative; the likelihood of having unmet needs and poor outcomes increases as the number of risk factors increases (Shi & Stevens, 2005).

Vulnerable populations include racial and ethnic minorities, the socioeconomically disadvantaged, and those with developmental disabilities and chronic health conditions, including mental disorders (AJMC, 2006). The vulnerability of individuals in these groups can be exacerbated by co-occurring risk factors for poor access to care, such as low income, not having health insurance, and lacking a regular source of care or reliable transportation. Their health and healthcare problems overlap with structural factors, including housing instability and food insecurity.

Beyond affecting access, disadvantaged circumstances are also linked to other influences on health. Health-related behaviors, including risk-taking, treatment utilization and adherence, and adoption of healthy habits, are strongly shaped by social factors, including income, education, employment, and social support (Braveman & Gottlieb, 2014). Exposure to environmental health hazards and health-promoting environments correlates with socioeconomic status (CDC, 2013). For racial and ethnic minorities, discrimination in everyday life and health care professionals' bias play a role in health disparities (FitzGerald & Hurst, 2017; Braveman & Gottlieb, 2014).

Trauma is another interconnected determinant of health (Schnurr, P.P. & Green, B.L., 2004). Trauma can result from harmful or disturbing events, including abuse and neglect or witnessing violence, or from prolonged adversity such as the chronic stress associated with living with family members who have substance use disorders. The powerful Adverse Childhood Experiences (ACEs) Study established that childhood trauma exposure accounts for negative health outcomes across multiple diagnoses, from psychiatric (depression, anxiety, substance abuse) to physical (diabetes, heart disease, and cancer) (Anda et al., 2006; Felitti et al., 1998).

Differences in exposure and response to trauma have been linked to other risk factors, including poverty status and race and ethnicity.

Vulnerable populations are underserved by providers and systems that do not take into account these factors. The issue is not primarily lack of availability, but rather variable quality of care and fragmented, inconvenient, and difficult-to-navigate systems, which disproportionately affect those most at-risk. Health care's shortcomings have been well-documented:

A “focus on hospital-based, disease-based and self-contained “silo” curative care models undermines the ability of health systems to provide...equitable, high quality and financially sustainable care” (World Health Organization, 2015).

The organizational structure and function of our medical system emphasizes an acute care approach and marginalizes prevention and public health. U.S. health care uses “a piecemeal, task-based system...aimed at addressing acute conditions or acute exacerbations of chronic conditions.” The current model largely ignores social risk factors (Marvasti & Stafford, 2012).

“Mental health and substance abuse systems are often entirely separate, and both are segregated from the physical health system. This fragmentation of the health care system can lead to inappropriate care, disjointed care, gaps in care, and redundant care, and can result in increased health care costs” (Nardone, *et al.*, 2014).

Despite increased awareness of these limitations and many new initiatives to address them, only a little progress has been made in reducing the gaps in health care.

A FRAMEWORK FOR CHANGE

Clifford Beers (CB) is passionately pursuing care innovation based on a 360 degree view of health and wellness. Our updated mission, adopted in March 2017, *is to provide integrated services addressing mental, physical, and social determinants in order to improve the health, resiliency, and quality of life of children, families, and communities*. The following definition of integrated care captures the essence of our commitment:

Integrated care is the systematic coordination of behavioral and physical health care in order to improve an individual's



overall health. Integrated care programs are person- or family-centered, quality driven, trauma-informed, designed to treat the whole person, and promote recovery and wellness (Council on Accreditation, 2017).

To this end, CB's Board of Directors has set forth five strategic goals, which together represent the Board's blueprint for achieving CB's mission over the next five years.

1. Measurably improve the health of children, adults, and families by providing trauma-informed, integrated mental and physical health care and services that address the social determinants of health in multiple settings.
2. Disseminate CB's population health model throughout Connecticut and nationally.
3. Attract additional support and resources for CB and the populations we serve by enhancing our state and national visibility and reputation.
4. Strengthen CB's financial sustainability.
5. Influence public policy to support CB's mission and the populations we serve.

These statements articulate and formalize a direction that CB has been moving in for years. We have been designing and testing new models to promote the well-being of families with multiple and complex needs. Using a systems-oriented approach, CB's solutions address:

- facilitators and barriers to engagement in care;
- risk and protective factors;
- the whole person, not just an isolated set of symptom;
- the needs of the whole family, not just one person in it; and
- the underlying causes of a condition, disease, or disorder.

The new services focus on strengthening families for the long-term health of all members.

SOLUTIONS

Advanced Care CoORDination (ACCORD)

ACCORD began as a pilot in 2013 via a \$10 million federal innovation grant. Wraparound New Haven was successful because it deployed a team comprised of a care coordinator, clinician, and consulting physician with complementary roles addressing social determinants of health, family stressors, social-emotional functioning, understanding and managing medical conditions, and health care navigation. As a result of the pilot, CB served more than 1,800 children and family members; achieved significant medical cost savings; and, secured a contract with Anthem Blue Cross/Blue Shield to make similar services available to their Connecticut subscribers.

Based on lessons learned, the ACCORD program is multidimensional and adaptable to different populations. The essential elements include:

- Health care navigation (e.g., finding specialists, coordinating and keeping appointments, facilitating information exchange and coordination between providers);
- Treatment adherence monitoring, including medication management;

- Addressing mental and behavioral issues that may prevent improvement or exacerbate other conditions; and
- A reliable point of contact for linkages to community-based supports and services, support and encouragement, and facilitate understanding of medical information and instructions.

ACCORD teams include care coordinators, behavioral health clinicians, and consulting medical staff and other specialists to provide comprehensive care to families with complex needs involving behavioral health and medical conditions. Services are home-based, “whole-istic”, and family-centered; every member of the family can be enrolled and receive services. The ACCORD care team empowers the family to envision wellness goals and resolve underlying issues that could prevent achievement of those goals. A key piece of ACCORD is that core services are provided in the family’s home. This reduces access barriers, like transportation, and helps engage family members to actively participate in their care.

CB Marne Street Clinic

CB has provided behavioral health treatment for children with autism spectrum disorder (ASD) and other developmental disabilities for years. When the need for more and better services for this population was identified by state government and other payors, advocacy groups, and families, CB was motivated to use its strengths, resources, and capacities to respond (Autism Workgroup, 2013). After successfully piloting services within its existing facilities, CB is preparing to launch a dedicated center in neighboring Hamden, CT in fall 2017.

The Marne Street Clinic will initially provide comprehensive specialty care, including diagnostic evaluation, multiple therapies (e.g., occupational), social skills groups, parent and sibling support groups, care coordination, individual and family behavioral health treatment and medication management. Once operating, it will be able to accommodate over 400 people with disabilities and their families. Over time, the Clinic will expand to fully realize the one-stop shopping model and include the full complement of medical, dental, psychiatric, and general healthcare services. All family members including parents and siblings will have access to care and support.

Trauma-Informed Schools

Over the last five years, through the New Haven Trauma Coalition (NHTC), CB has developed and tested a multi-tiered, whole-school system of supports to assess and address a range of emotional and behavioral



health challenges that often serve as barriers to social and academic success. Tier 1 school-wide activities include professional development, screening, and school climate interventions. Tier 2 services include brief interventions and referrals as well as groups, like the evidence-based Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) program. For children who suffer from trauma exposure, Tier 3 interventions include individual treatment and family-centered care coordination. The entire school community – and not just those receiving direct care – is activated to create a climate conducive to recognizing the impact of trauma and responding appropriately.

CB has demonstrated and is building on the success of the NHTC. The model, currently in more than a dozen New Haven schools, has been effective at identifying students with mental health needs, engaging them in care, and improving their symptoms and school attendance. At the same time, their families' needs for supports and services are being met. Now, CB is spreading trauma-informed practices through contracts with districts across the state. Moreover, a book has been commissioned to document our model of care, our successes and challenges, and how such a program can be replicated in school communities across America.

BENEFITS OF CB'S APPROACH

Integrated care improves more than the health status of individuals with physical, mental, and developmental disorders. It reduces the social and economic burdens that can be associated with the family member's condition. Positive impacts can include:

- Better academic or occupational performance;
- Increased self-efficacy of family caregivers;
- Reduced parenting stress;
- Reduced caregiver lost work-days;
- Increased social support and connection; and
- Better family functioning, coping, and psychological adjustment.

This approach to care has the potential to improve the entire family's quality of life.

Addressing the needs of families with multiple and complex needs not only helps them, it drives overall improvements in quality of care and health for the broader population and results in reduction of unnecessary costs (Ubri & Artiga, 2016). Health disparities are costly in multiple ways. "One analysis estimates that approximately 30% of total direct medical expenditures for Blacks, Hispanics, and Asians are excess costs due to health inequities" (Williams, *et al.*, 2008). Other analyses have shown that if all adult Americans achieve the same level of health as the average college graduate, our country would experience sizable annual economic benefit.

Disparities not only affect the day-to-day experiences of individuals, but also threaten the prosperity and well-being of entire communities. As the country becomes more diverse, improving population health becomes imperative. The U.S. population is increasingly

heterogeneous; it is projected that people of color will account for over half of the population in 2045, with the largest growth occurring among Hispanics (Ubri & Artiga, 2016). Given that people of color make up a disproportionate share of the low-income and the uninsured relative to their size in the population, the growth of communities of color and widening of income gaps amplify the importance of addressing health and health care disparities.

“Moving upstream” or tackling the social determinants of health can lead to improvements in health and reductions in disparities (Williams, *et al.*, 2008). “The available evidence suggests that as important as medical care is, it is a relatively small contributor to the overall health status of the population” (*Ibid*, p. S9). The many benefits of high health care spending in the U.S. may be undermined by the nation’s very low investments in social services (McGovern, *et al.*, 2014). Most health problems occur long before people get to a doctor or hospital. Accordingly, efforts that include a multilevel focus on the conditions that promote health and the adoption of healthy behaviors stand to reap the most “bang” for our health care “buck” (*Ibid*, p. 6).

ABOUT CLIFFORD BEERS

Clifford Beers (CB) has been providing mental health services to the New Haven community since 1913, when it was founded as an outpatient clinic within the New Haven Dispensary, a medical care facility for the poor. Today, our mission is to provide integrated services addressing mental, physical, and social determinants in order to improve health, resiliency and quality of life for children, families and communities. Current programming includes prevention interventions, behavioral health treatment, comprehensive care coordination, and family strengthening services. CB operates with an annual budget of \$16 million and about 200 highly qualified and diverse employees.

Across Greater New Haven, our services reach approximately 5,500 children and 1,000 family members through clinic- and community-based care, as well as an additional 2,500 community members through professional development trainings, classroom screenings, and teacher supports. CB primarily serves those individuals who experience, or are most vulnerable to, poorer health and quality of life outcomes. These include children and families of color (43% Hispanic; 34% African-American), low-income and Medicaid eligible (83%) individuals, and people with complex health needs and disabilities.

CB is distinguished by its “**whole-istic**” approach, nationally-recognized expertise in trauma, and organizational culture of innovation. Our “whole family, whole health” programs produce outcomes that matter to funders and our families in terms of cost, quality and experience of care. We have demonstrated success in helping clients reduce symptoms of mental health disorders, like depression and posttraumatic stress, improve functioning in day-to-day life, and access supports for sustaining the changes.

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