



SAMHSA-HRSA Center for Integrated Health Solutions

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

July 16, 2013



SAMHSA-HRSA Center for Integrated Health Solutions

**Slides for today's webinar are
available on the CIHS website at:**

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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

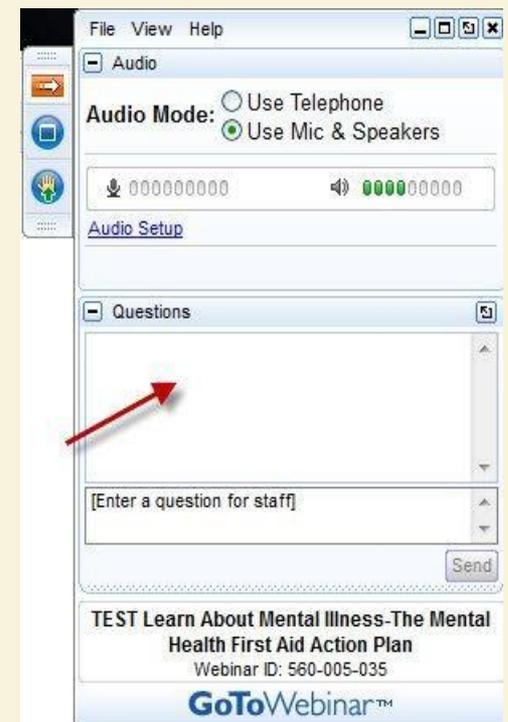
- Identify persistent challenges faced by racially diverse and ethnic minority populations in accessing and receiving behavioral health services (both mental health and substance abuse) and how medical professionals can more effectively engage the community in services and health promotion efforts utilizing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



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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.

Brennan Ramirez LK, Baker EA, Metzler M. Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008.

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 psychotropic medications.

As a result, Racial and Ethnic Minorities:

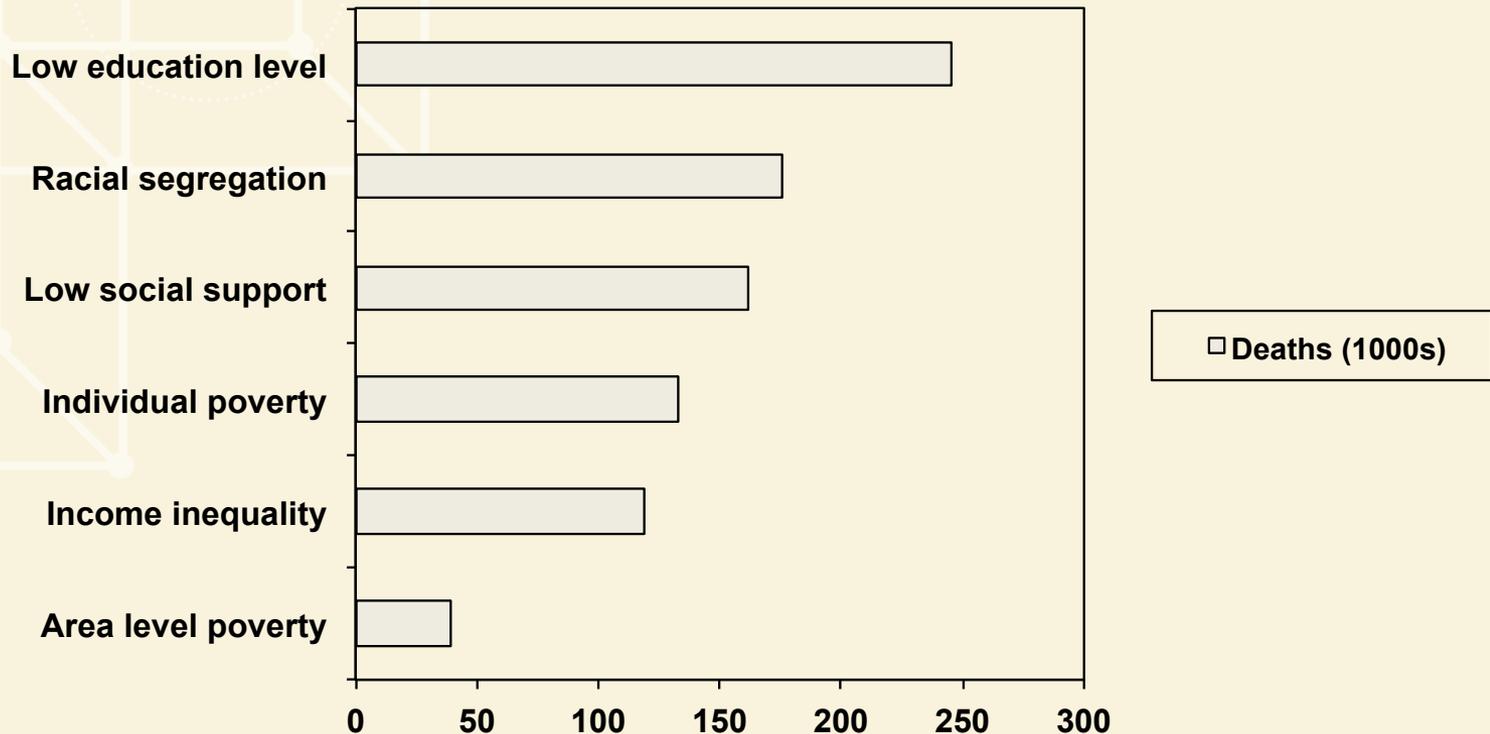
- Receive delayed treatments.
- Receive low rate of evidence based interventions.
- Experience poor treatment engagement leading to:
 - Less follow through with referral to BH specialists.
 - Low use of anti-depressant medication.
 - Discontinuation of treatment without consulting their physician.

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

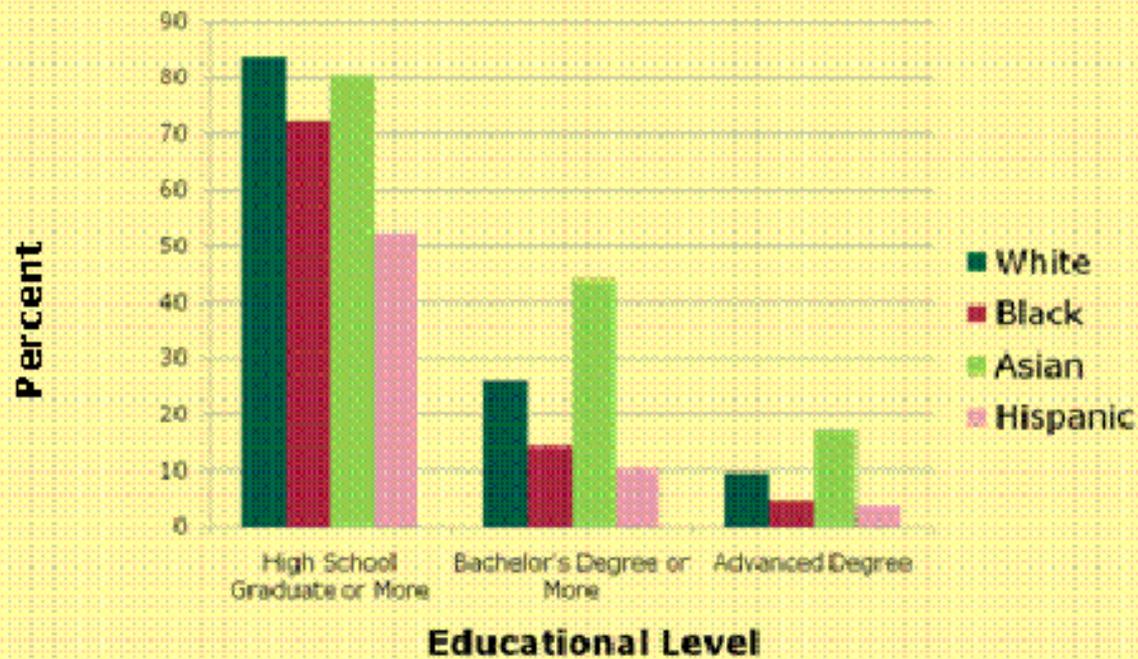
Smedley, 7/21/09

Relationship between Social Determinants and Mortality (2000)



Galea et al, Estimated Deaths Attributable to Social Factors in the United States ,
AJPH, August 2011, Vol 101, No. 8.

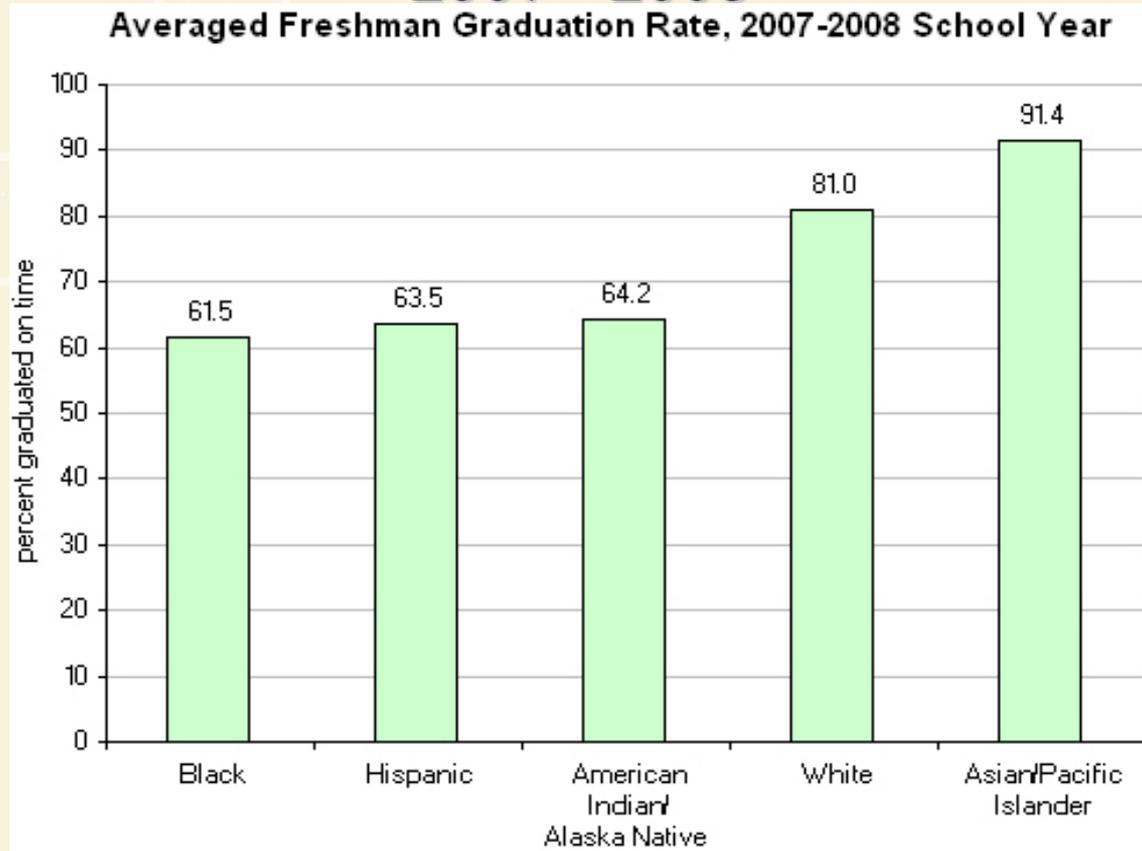
Educational Attainment of Population Over 25 by Race: 2000



Source: U.S. Bureau of the Census,
Educational Attainment: 2000

US Census Bureau, Educational Attainment

National High School Graduation Rates 2007 - 2008



Robert Stillwell
National Center for Education Statistics
<http://nces.ed.gov>.

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

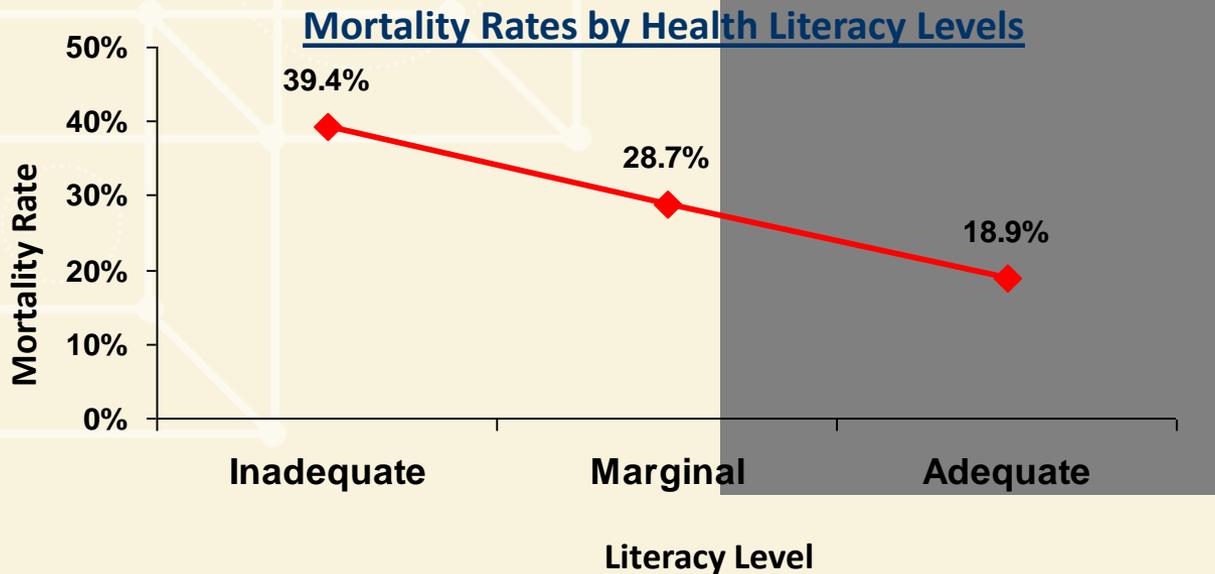
Health literacy

“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

Is Quality of Life Correlated with Health Literacy ?

Higher health literacy is correlated with lower mortality rates



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.

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.

Source: Baker, DW., et al. (2007) Health Literacy and Mortality Among Elderly Persons. Archives of Internal Medicine 167(14):1503-1509

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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



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

Unützer et al, *Med Care* 2001; 39(8):785-99

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 Functions



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.

Source: McGuire & Miranda, 2008

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.
- OMH produced Issue Brief: Mental Health Services in Primary Care Settings for Racial and Ethnic Minority Populations, 2004.
- 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.

Source: National Center for Cultural Competence, Goode& Dunne, 2003.

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.

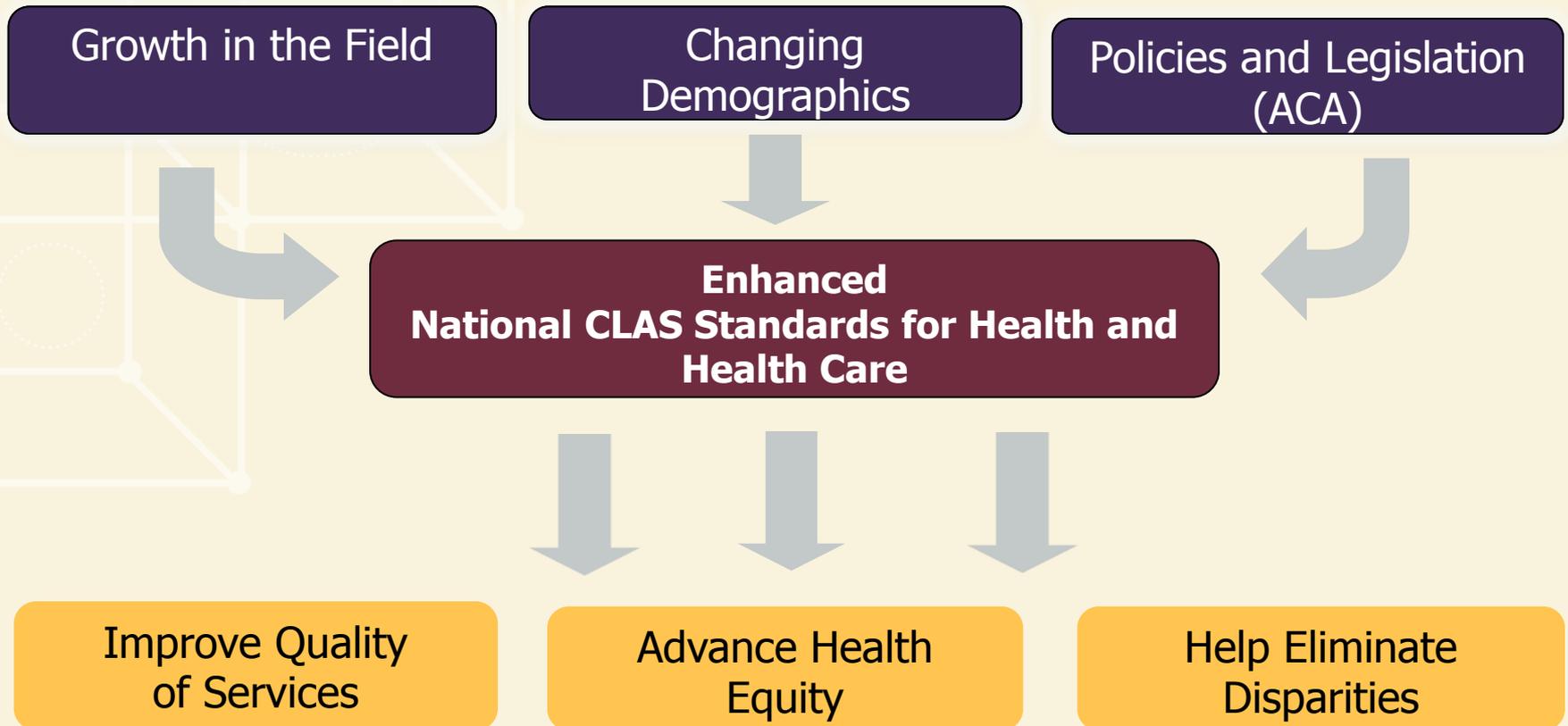
What are the Enhanced National CLAS Standards?

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



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

Think Cultural Health

www.thinkculturalhealth.hhs.gov

The screenshot shows the website's header with the U.S. Department of Health & Human Services logo and the Office of Minority Health. The main navigation bar includes links for Home, About TCH, CLAS & the CLAS Standards, Continuing Education, Communication Tools, and CLAS Clearinghouse. A central banner features the 'THINK CULTURAL HEALTH' logo and the tagline 'Advancing Health Equity at Every Point of Contact'. Below this is a large image of a diverse group of healthcare professionals. A sidebar on the right promotes joining the CLCCHC (Center for Linguistic and Cultural Competency in Health Care) with a search bar and a 'JOIN THE CLCCHC' button. A footer area contains quick links for Office of Minority Health, CLAS Standards, Ways to Connect, and Contact Us. A red button at the bottom right promotes online learning awards for Think Cultural Health.

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

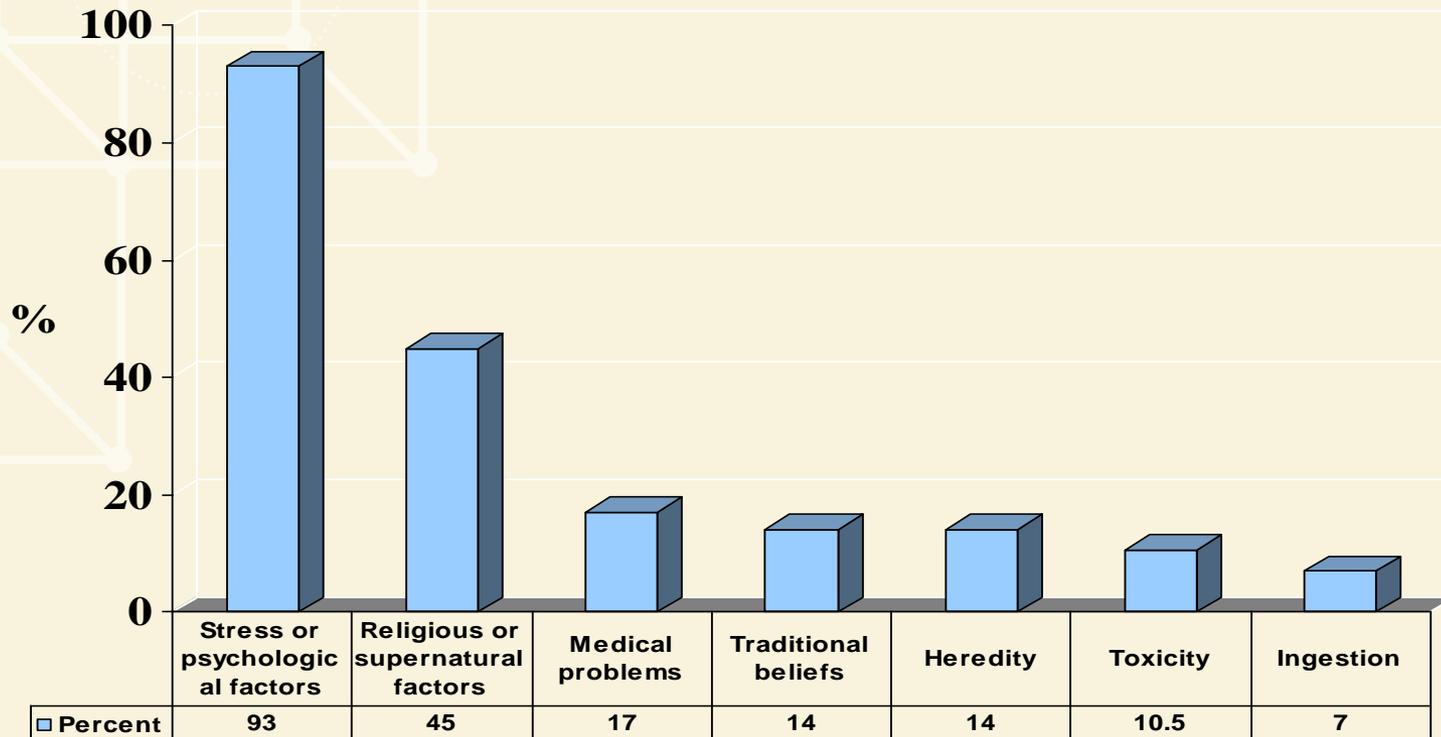
Prevalence and Recognition of Depression in Low Income Asians & Latinos in Primary Care

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

**p<.01.

Chung et al., Community Mental Health Journal , 2002

Perceived Causes of Depressive Symptoms Among Chinese American Patients in Primary Care

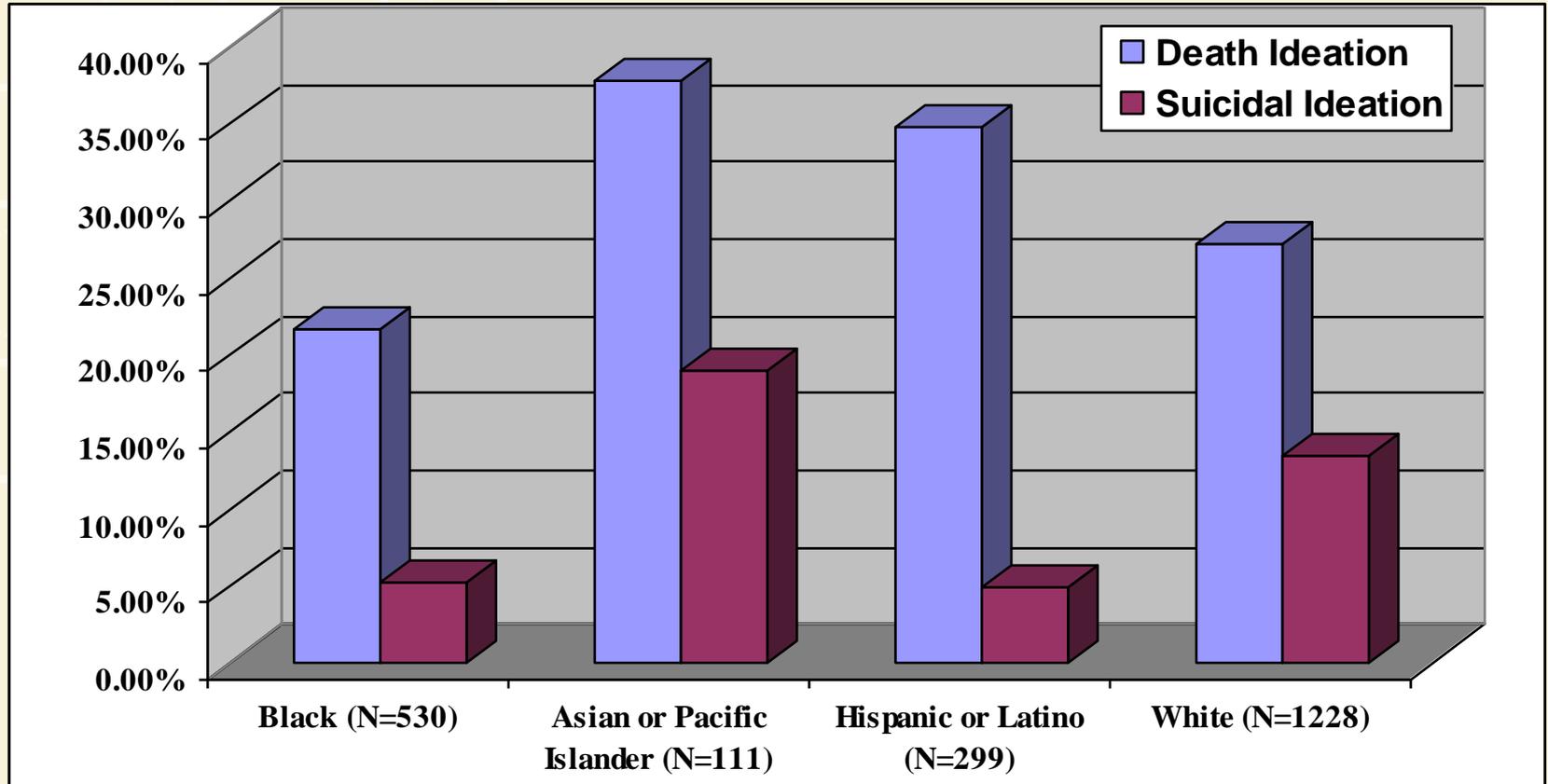


Source: Yeung et al. (2004). Illness Beliefs of Depressed Chinese American Patients in Primary Care. *Journal of Nervous and Mental Disease*, 192(4), 324-327.

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 syntonc 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

Patients receiving care (%*)	White	African Amer.	Asian	Hispanic	Overall
Optimal practitioner contacts	12.5	12.0	11.1	10.6	11.7
Effective acute-phase treatment	60.1	48.5 ⁺	40.7 ⁺	57.6	58.6
Effective continuation-phase treatment	46.7	32.7 ⁺	31.9 ⁺	39.6 ⁺	43.1

* Rates are age and sex adjusted

+ P<0.05 vs. white

Source: Virnig, B, et al. (2004). Does Medicare Managed Care Provide Equal Treatment for Mental Illness Across Races? Archives of General Psychiatry, 61, 201-205.

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

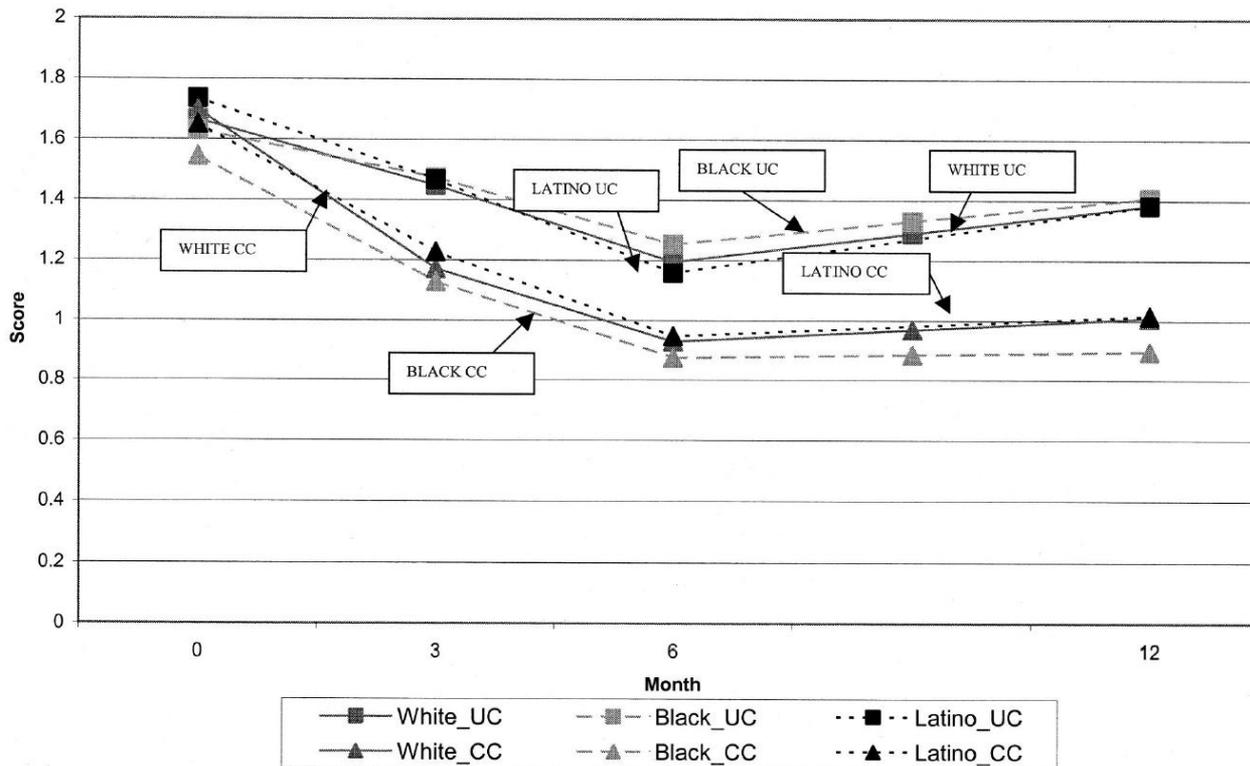


FIGURE 3. Mean SCL-20 Depression Score.

Source: Arian, 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

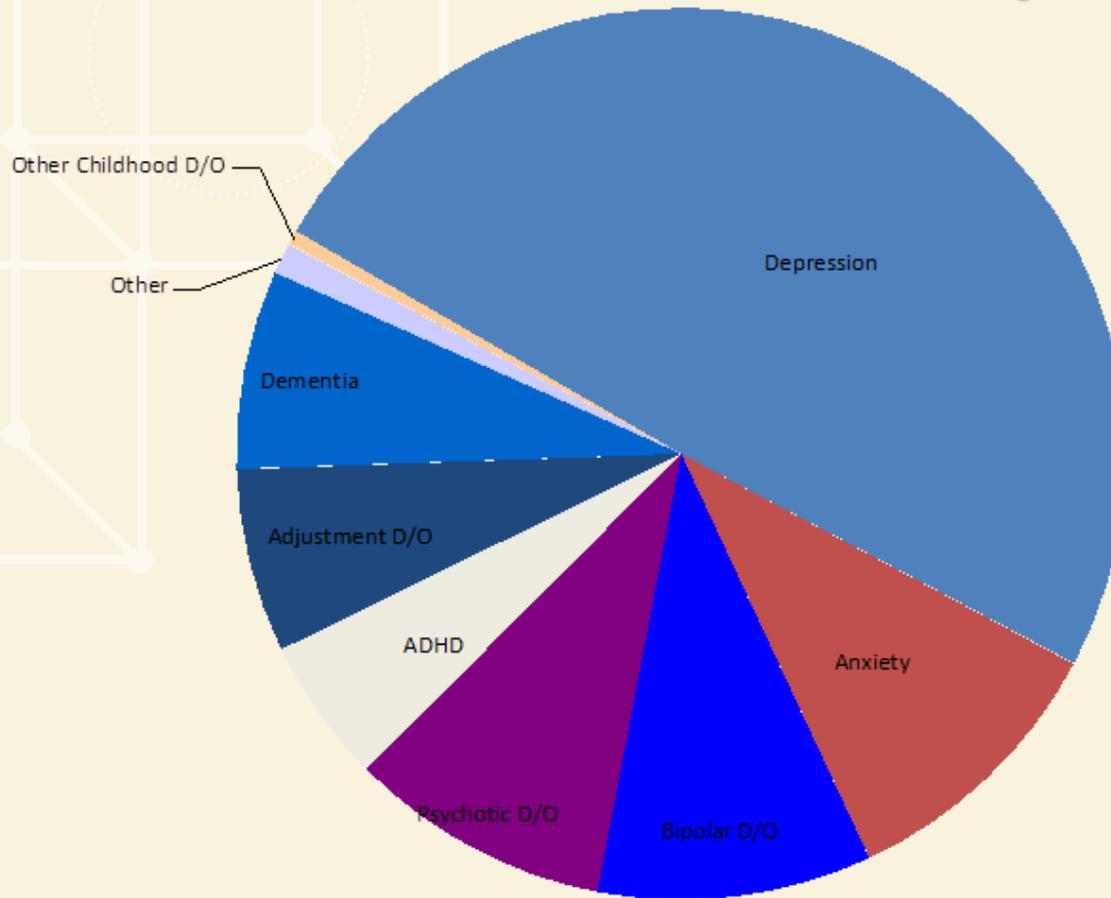
The Asian American Bridge Program at CBWCHC and SCCHC (Phase 3, 2010)

- 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**

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

- 1997-1998 Study Design and Sample: 1166 African American, Asian-American, Latino and White help-seeking students at 40 state supported universities counseling centers using OQ-45 at first and last therapy sessions.]
- 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

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

* Data from 15/20 schools; ** At least 1 follow-up

NCDP Clinical Outcome Measures by Race/Ethnicity

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

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

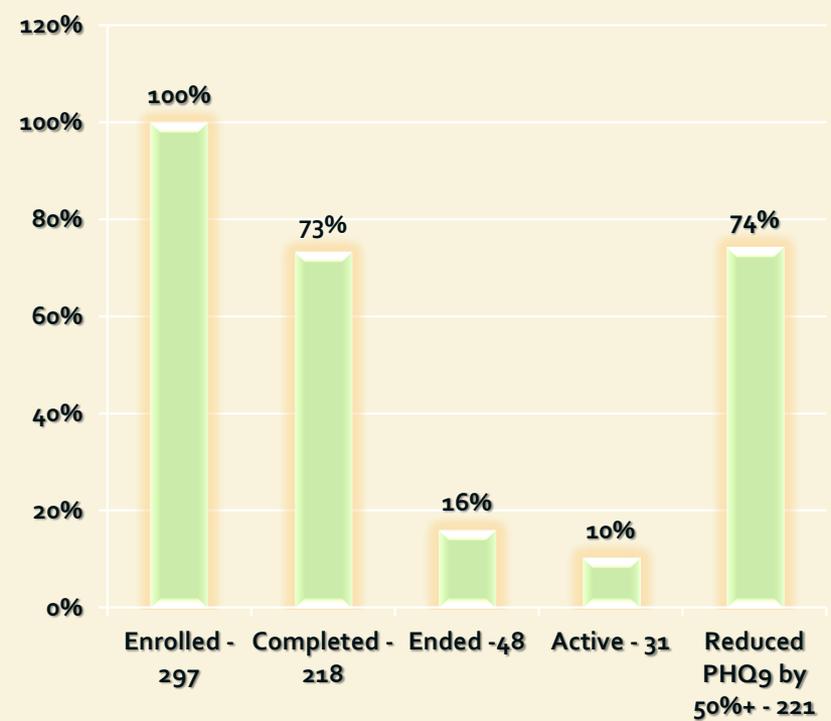
Summary of Project Impact at Montefiore FQHC

Measures

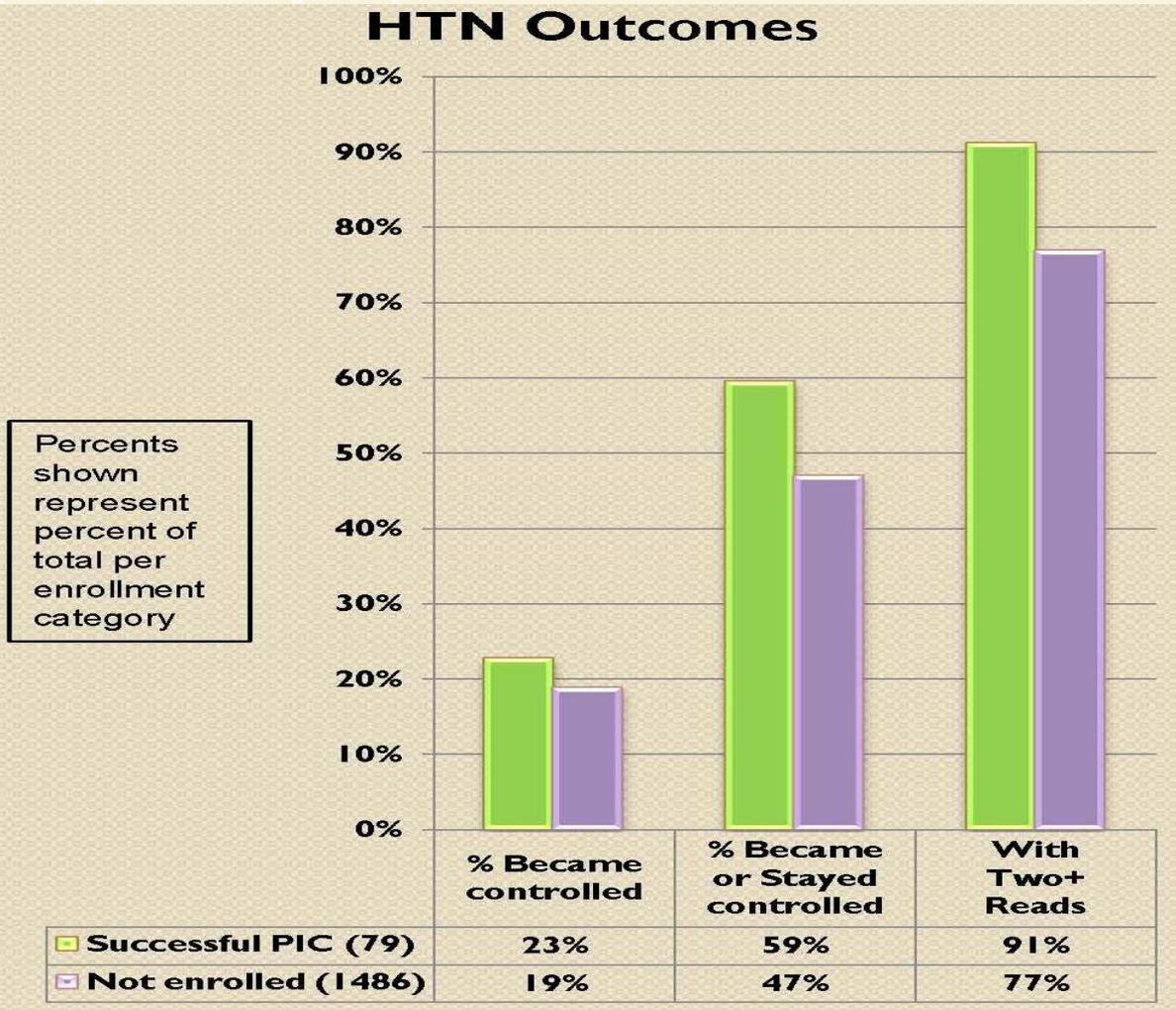
- Enrolled 297 total patients into Project Impact
- 218 (73.4%) of those enrolled have completed program, kept all appointments
- 48 (16%) ended program by choice. Did not keep appointments
- 221 (74%) patients reduced their PHQ 9 scores by 50%

Graph of Measures

Project Impact by the Numbers



OUTCOMES OF HYPERTENSIVE PATIENTS WITH DEPRESSION



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

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

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

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)

1 – Strongly Disagree, 2 – Disagree, 3- Neutral, 4 – Agree, 5 – Strongly Agree	Mean (SD)	Percent Agree/ Strongly Agree
Q2. I know more about how my mental health affects my physical health because of the program (n=23).	4.3 (0.71)	87%
Q3. I know more about how I can be more responsible for my health because of the program (n=23)	4.1 (0.92)	87%
Q4. Overall, I feel my health has improved because of the program (n=22).	4.0 (0.95)	64%

Synergy Program Assessment: Patient Experience (August 2012)

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

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

- Chapa, T and Acosta, H. (2010) Movilizandonos por Nuestro Futuro: Strategic Development of a Mental Health Workforce for Latinos, Consensus Statements and Recommendations.
- Davis, K. Pathways to Integrated Health Care, Strategies for African American Communities and Organizations. Consensus statements and recommendations. January 2011.
- Ida, DJ, SooHoo, J. & Chapa, T (2012), Integrated Care for Asian American, Native Hawaiian & Pacific Islander Communities: A Blueprint for Action, Consensus Statements and Recommendations.
- Enhanced National CLAS Standards:
<https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedNationalCLASStandards.pdf>

Additional Integrated Care Resources

- Sanchez, K, Chapa, T, Martinez, O, & Ybarra, R. (2012). Enhancing the Delivery of Health Care: Eliminating Health Disparities through a Culturally and Linguistically Centered Integrated Health Care Approach. U.S. Department of Health and Human Services, Office of Minority Health and the Hogg Foundation for Mental Health.
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