About RCHN Community Health Foundation

RCHN CHF is a private, not-for-profit, New York City-based foundation with a nation-wide footprint, established in 2006 to support community health center research, policy and transformation.

Primary Goal: To help community health centers address key operational, clinical and program challenges, promote innovation, and drive positive sustainable change.

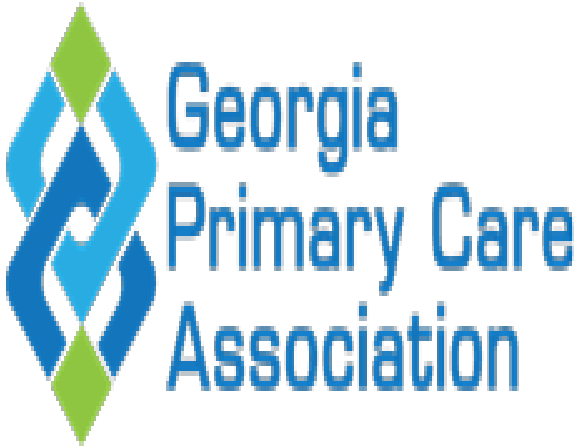
RCHN CHF Population Health Initiative Aims

- To support health center-level progress toward improving population health management capacity and outcomes
  - Strengthen capacity to identify, engage and manage health in a defined population, incorporating both patient- and community-level approaches.
  - Deepen features of patient- and community-centered health homes.
  - Influence social determinants of health and promote health equity.
- To encourage local and regional collaborations and broader opportunities for sharing best practices.

Supported population health projects

- Health outcomes in defined geographic areas:
  - African American Infant Mortality (Erie County, OH)
  - Smoking reduction in New York City's Chinatown (New York, NY)
- Patients identified with defined health center or system of care
  - High-risk, chronically ill homeless individuals (Santa Rosa, CA)
  - Patients with uncontrolled diabetes (Joplin, MO) and food-related interventions for high-risk populations (Nogales, AZ and ID)
  - Colorectal and breast cancer (Phoenix, AZ) cervical cancer screening (CO) and comprehensive women's health (CO)
  - Pediatric emergency room utilization and care management (Queensbury, NY)
  - Pediatric Asthma (Los Angeles, CA)
  - Integrated Health Neighborhood (Chicago, IL); and, primary care behavioral health care integration planning (New York and Pacific Northwest)
  - Adolescent care management for youth in juvenile justice system (Georgia)
  - Integrated, primary care-focused substance use treatment /MAT (Boston, MA)

Planning Community Coordination for Youth in the Juvenile Justice System- Savannah, Georgia



Project Summary

The Georgia Primary Care Association (GPCA) is a 34-member organization responsible for the operation of all 207 Federally Qualified Health Centers (FQHCs) covering 111 counties in the State of Georgia and serving over 400,000 patients. GPCA is designated as the state Primary Care Association.

In Cooperation with RCHN CHF, GPCA is working with Curtis V. Cooper Primary Health Care (CVC) to build upon an existing collaboration with the Chatham County Juvenile Court (CCJC) to coordinate referrals for vulnerable youth to CVC.

Identifying the Barriers

- Adolescents involved in the system had histories of inadequate health, lapsed or no health insurance
- Limited health questions on intake form
- No staff requirement to document health issues
- No standard instrument for documentation of health needs
- No required documentation of a referral to a health care provider
- Immediate needs for behavioral health took priority

Foundation Building

- Buy-in and support from the judges and key leadership staff
- Creation of formal partnerships
- Getting broad involvement and perspectives of the court, health center leadership and stakeholders with the planning and implementation of the project
- The capacity to be adaptable to organizational changes.

Implementation

The proposed activities were similar to the family planning project model, including

- A planning phase
- Creating and facilitating leadership quality improvement team meetings
- Identifying and delivering training for court staff
- Providing outreach/educational materials to court staff and families,
- Court to identify liaison(s) with project for administrative, data, and training needs
- Requiring court to collect and report referrals to family planning services
- Collecting ongoing stakeholder input from court staff, parents, and youth involved with juvenile justice system. Additional proposed activities for the RCHN project were
- Review/change in the intake form and process for health needs and services
- More emphasis on parent engagement/outreach
- Training content for primary care and other health topics.

Responding to a Changing Environment

The court has experienced high turnover in the past year; several champions including those most likely to make referrals left court employment; key administrators involved with the project also left as well as the person assigned to data collection.

Responding to a Changing Environment

Nearly all staff previously trained and oriented to the family planning project were no longer employed by the juvenile court. Court staff turnover and chronic understaffing led to a crisis management approach. Long-term experienced administrators and staff became overloaded with completing required tasks and training new employees.

Responding to a Changing Environment

The project worked with the court to develop activities that were feasible with their current structure and staffing, realizing flexibility is key.

Responding to a Changing Environment

Newly Proposed Activities

- Recognize that most court staff were new and required training
- Adapt training to a Lunch n Learn model when possible;
- Provide space/time for a RCHN project liaison to be present at the court site
- Facilitate parent/teen survey about health needs within court site
- Provide outreach to families with health fair, mobile unit and other activities delivered at court site to build family knowledge about primary health care services
- Provide process mapping and other technical assistance to improve referral process and data and
- Increase stakeholder data collection and engagement such as parent/teen/staff surveys, community education outreach events, training as well as the documentation of referrals for evaluation of the project.

Evaluation

Identifying measures of value across different systems (criminal justice and community health) requires significant motivation and problem-solving for both partners in the collaboration.

Evaluation

Opportunities for measurement include:

- Data from staff training e.g. frequency, attendance, topics
- Frequency and content of leadership meetings
- Number and types of referrals to health center
- Number and type of court contacts with project staff/liaison
- Survey/interview data from stakeholders, court staff, parents, and youth

Evaluation

The criminal justice system is attempting to address the health needs of persons involved with juvenile justice with new approaches that result in widespread organizational and staff changes.

Evaluation

Stakeholder involvement in planning and implementation increases with visible implementation of their suggestions.

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Focusing on low-threshold:

Integration of substance use and behavioral health programs at Fenway Health

Presentation by: Kellan McNally, LICSW & Dana Longobardi, MPH

RCHN Project Team

OBJECTIVE

To streamline access to BH care for Fenway patients enrolled in Medication Assisted Treatment (MAT)

WHAT IS MEDICATION ASSISTED TREATMENT?

- MAT is the use of addiction medicines to fight opioid and alcohol dependence
- Medications block the effects of opioids and alcohol, allowing individuals to control craving and withdrawal systems and lowering the risk of relapse
- In order to prescribe addiction medications, providers must be licensed and waivered
- MAT works best when paired with counseling and behavioral therapy- a requirement in some states

MAT PROGRAM OVERVIEW

- Housed within Primary Care
  - Roughly 15 DEA waivered primary care provide
    Suboxone
  - PCP Care Teams: MA, RN, case manager, behavioral health specialist
- ~120 MAT patients as of May, 2019
- Pts seeking Suboxone come in for an intake/induction, and then proceed with weekly or biweekly follow up appts
- SAMHSA defines MAT as combining behavioral therapy and medications to treat substance abuse, however Fenway Health did not offer a low threshold BH component at program inception

MAT PATIENT COMPLEXITY

White, male, average age is 38

History of incarceration, chronic homelessness and housing insecurity, unemployed

Comorbidities: Hepatitis C and IV Drug use

58% have a co-occurring stimulant use disorder (injection)

BEHAVIORAL HEALTH PROGRAMS & SERVICES

Traditional scheduled therapy, walk-in (unscheduled therapy), psychiatry, group psychotherapy, onsite crisis intervention

Addiction Recovery Wellness Program (ARWP): includes several BH programs offered at Fenway Health, including:

Drop-in recovery skills groups, acupuncture, addiction & recovery coaching, and high acuity substance use case management.

THE CHALLENGE:

BH service enrollment requires an extensive intake process which presents a barrier to MAT patients who want BH care

Relevant data:

- 24/124 (20%) of MAT patients have used the BH walk in clinic at least 1 time
- 12/24 (50%) MAT patients who have used BH walk in have only been seen once and have not had an intake
- Only 6/24 (25%) MAT patients are engaged with a BH service excluding the walk in clinic
- 8/24 (33%) are no longer active MAT patients. Could higher levels of BH engagement improve retention?

MAT: PHASE 1

- MAT program commenced in January, 2018 without a clear pathway to BH support for patients
  - Funded by Bureau of Substance Abuse Services- a Massachusetts state government office

- Wait time for a BH intake at Fenway Health was over 3 months, and the waitlist contained over 400 patients

PHASE 1 CHALLENGES

- Patients attempting to enroll in BH faced long wait times and were not getting BH support when they needed it most
- Extended wait for an intake meant that many patients no showed their intake appointment
- "Anxious attachment" phenomenon occurred due to scarce resources- in this case, access to a therapist.

MAT PHASE 2: BH WALK IN CLINIC INCEPTION

MAT patients came for scheduled follow up visits and were offered “expedited access” to BH intake through the BH walk-in service.

MAT provider informed patients of walk-in service location and hours. This did not resolve all the barriers.

PHASE 2 CHALLENGES

- MAT patients are often seeking help in states of high distress.
- Many are judged on their appearance, feel insecure, are distrusting of professionals.
- Although within the same building, MAT and BH services are located on different floors.
- Intake processes are redundant and tedious and often require that patients answer the same questions over and over again.

PHASE 3: DUAL ENROLLMENT

Current state: RCHN grant is funding a pilot that will test the merging of the MAT and BH intake.

MAT pts who express interest in BH services will be able to enroll in both MAT and BH by way of **one intake appointment** at their first point of contact with MAT. The BH intake is completed by the BH walk-in clinician.

Even though we lose billing opportunities, we hope to demonstrate that the increase in BH volume will make up for the financial loss

DATA

Baseline: % of MAT patients who expressed in interest in therapy and did not engage with BH walk-in services

Impact: % of patients who had a dual intake and who subsequently engaged in walk in BH therapy

ANTICIPATED CHALLENGES

- Financial
- Staffing
  - Increase in time demand for the BH walk in clinician who will be present during MAT intakes
  - Emerging "triage by acuity" model
- Data: how can we demonstrate that immediate access to ARWP improves retention in care and overall health outcomes related to substance use?