# So You've Screened Your Patients – Now What?

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# About Integral Care

- Integral Care is the Local Mental Health Authority for Travis County as designated by state law
- We are **1 of 39** Community Mental Health Centers in Texas
- Integral Care supports adults and children living with:
  - **mental illness**
  - **substance use disorder**
  - **intellectual and developmental disabilities**

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# Our System of Care

- During Fiscal Year 2023, Integral Care served over **29,000** individuals and provided over **470,000** services across the Travis County community
- Currently, Integral Care employs over **1,000** staff across **45** locations in Travis County

# What We Do - Provider

- Care Coordination
- 24/7 Crisis Response
- Integrated Behavioral Health
- Residential Services
- Homelessness and Housing Services
- Jail Diversion
- Substance Use Treatment
- Prevention and Wellness

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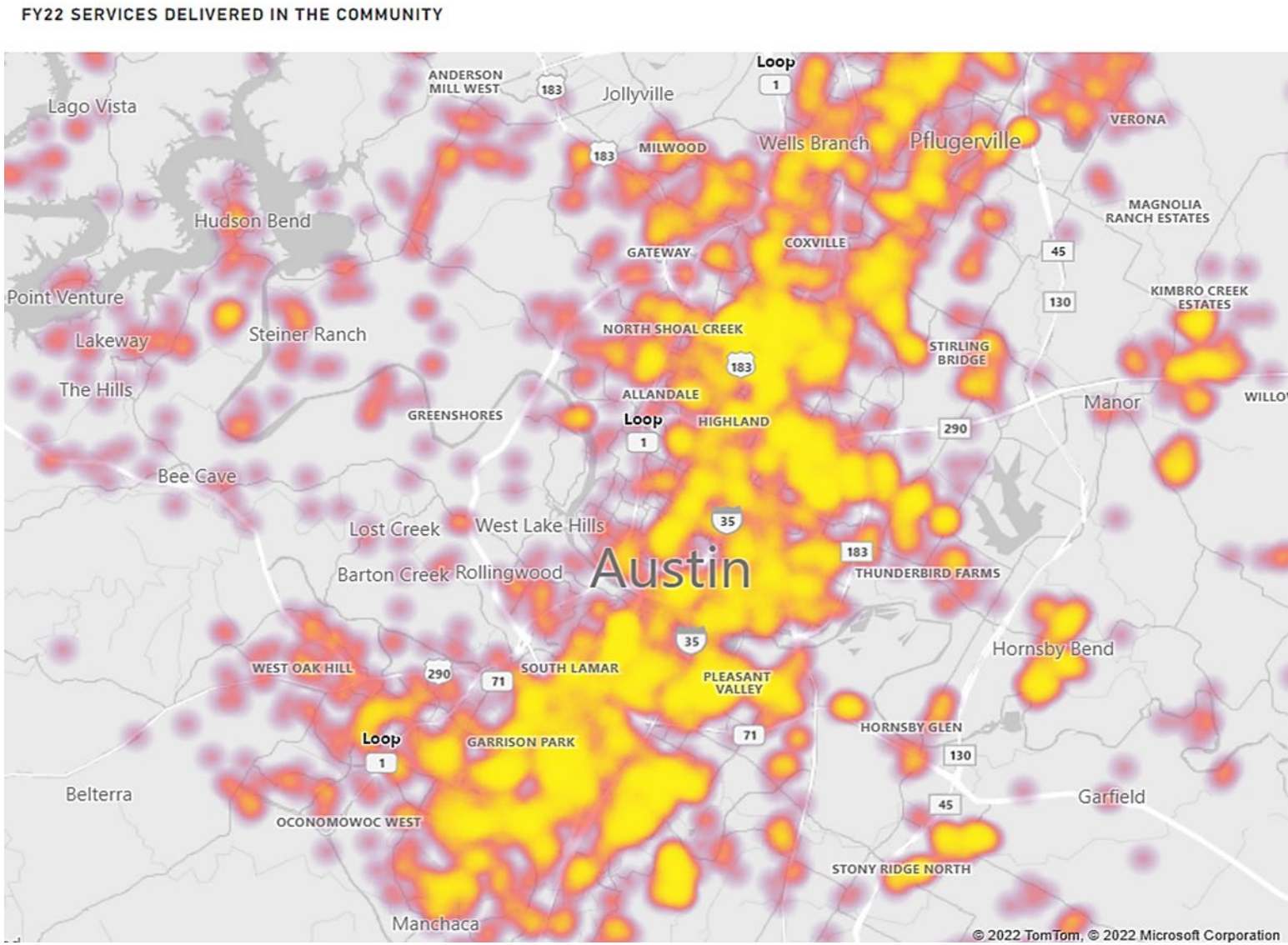
# Our Travis County Footprint

Where we provide services:

- ✓ Over the phone
- ✓ Via telehealth
- ✓ On a street corner
- ✓ At home
- ✓ In jails
- ✓ In clinics and residential facilities
- ✓ In emergency rooms
- ✓ In schools



# How We Collect Data

Through our role as a **Local Mental Health Authority (LMHA)** and **Certified Community Behavioral Health Clinic (CCBHC)**, we are required to complete a variety of screenings and assessments.

Even our assessments have assessments. Then we assess the assessments of our assessments.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# Integral Care Screenings and Assessments

- Adult Needs and Strengths Assessment (ANSA)
- Child and Adolescent Needs and Strengths (CANS)
- Nutritional Screening
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Patient Health Questionnaire (PHQ)
- National Outcome Measures (NOMS)
- Tobacco Use Assessment
- Quick Inventory of Depressive Symptomatology (QIDS)
- AIMS Scale
- Brief Addiction Monitor
- Psychiatric Evaluation
- Narrative Assessment
- Goal Attainment Scaling (GAS)
- AAFP Social Needs Screening Tool
- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Medical Screening
- CAGE-AID
- CRAFFT
- Screening and Risk Assessment
- Diagnostic Rating Scale
- WHODAS 2.0
- Prodromal Questionnaire — Brief Version (PQ-B)
- Bipolar Rating Scale
- Edinburg Form
- Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR)
- Women’s Health History Form
- Positive/Negative Rating Scale
- HCBS Uniform Assessment

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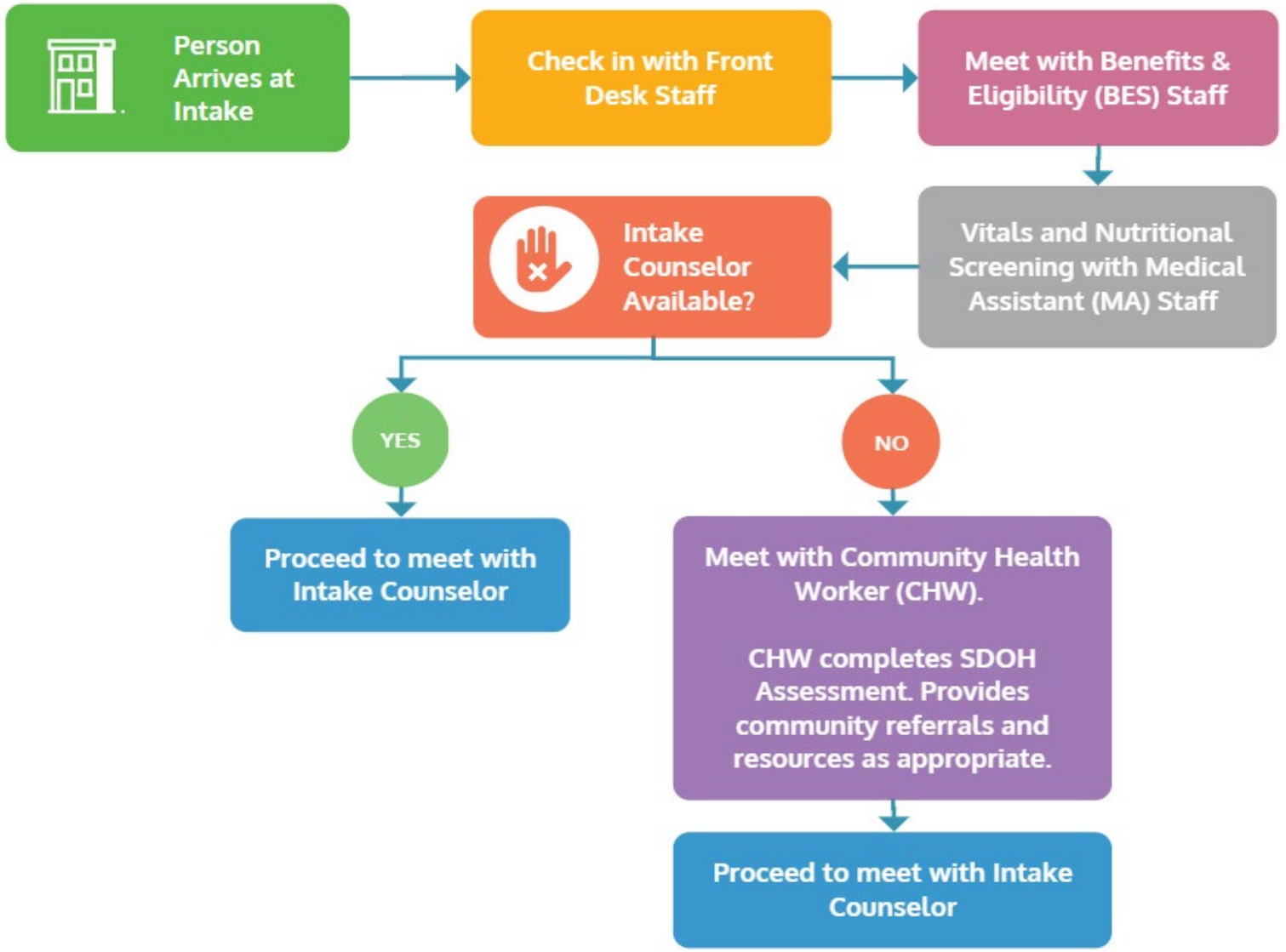
# The SDOH Assessment

Integral Care utilizes **Community Health Workers (CHWs)** to provide support to individuals who present to our clinics for intake.

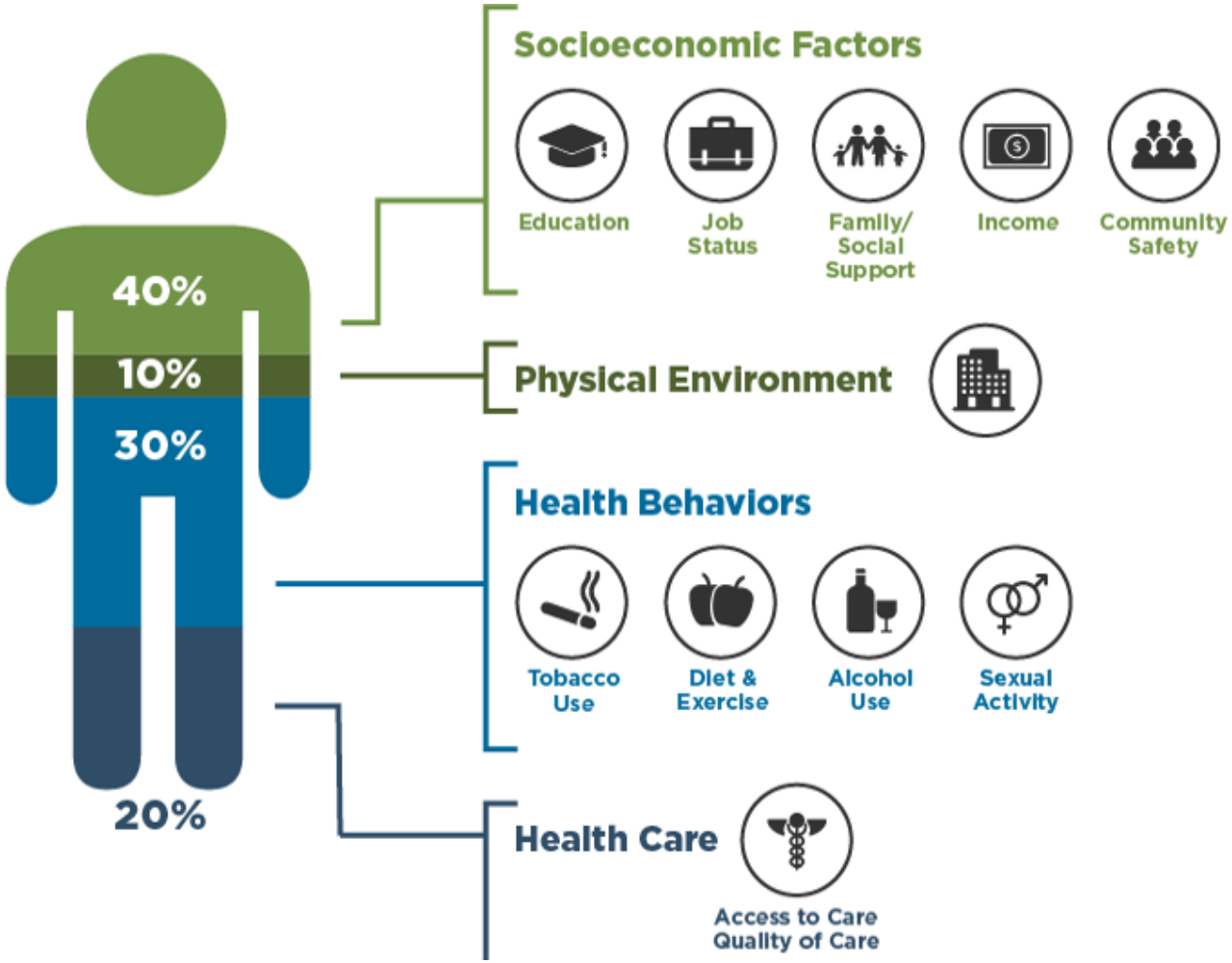
CHWs complete the **AAFP Social Needs Screening Tool,** then provide resources and referrals while the person waits for an intake clinician.

CHWs play a vital role in improving access to healthcare in their communities. They act as a bridge between providers and their communities, working to improve health outcomes, particularly in underserved or historically marginalized populations.



# Why We Screen for Non-Medical Drivers of Health

- Decades of research has established, and continues to reestablish, that **80% of health outcomes are based on non-medical factors** such as income, food access, race, and geography, with only 20% dependent on clinical care.



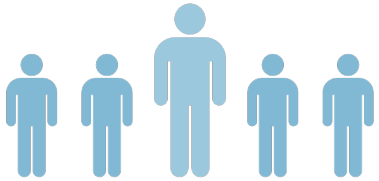
# Integral Care Health Data

**LIFE EXPECTANCY**

On average, between 2016 and 2021, Integral Care clients died 23 years earlier than the general United States population, with users of tobacco dying 25 years earlier

2 out of 3 Integral Care clients do not have access to health insurance

97% of Integral Care clients have an income of less than 200% of the federal poverty level



1 in 5 individuals served by Integral Care are experiencing homelessness

40% of individuals served by Integral Care have an active substance use diagnosis

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# From Collecting Data to Using Data

- **2019:** Integral Care receives SAMHSA grant to expand system of care
    - Launches “Amplify Care through CCBHC”, creating population management methodology to assist with data management and monitoring
- Coincided with the Texas shift away from **Delivery System Reform Incentive Payment (DSRIP) program**, which had helped to incentivize use of standardized data collection practices and screening tools

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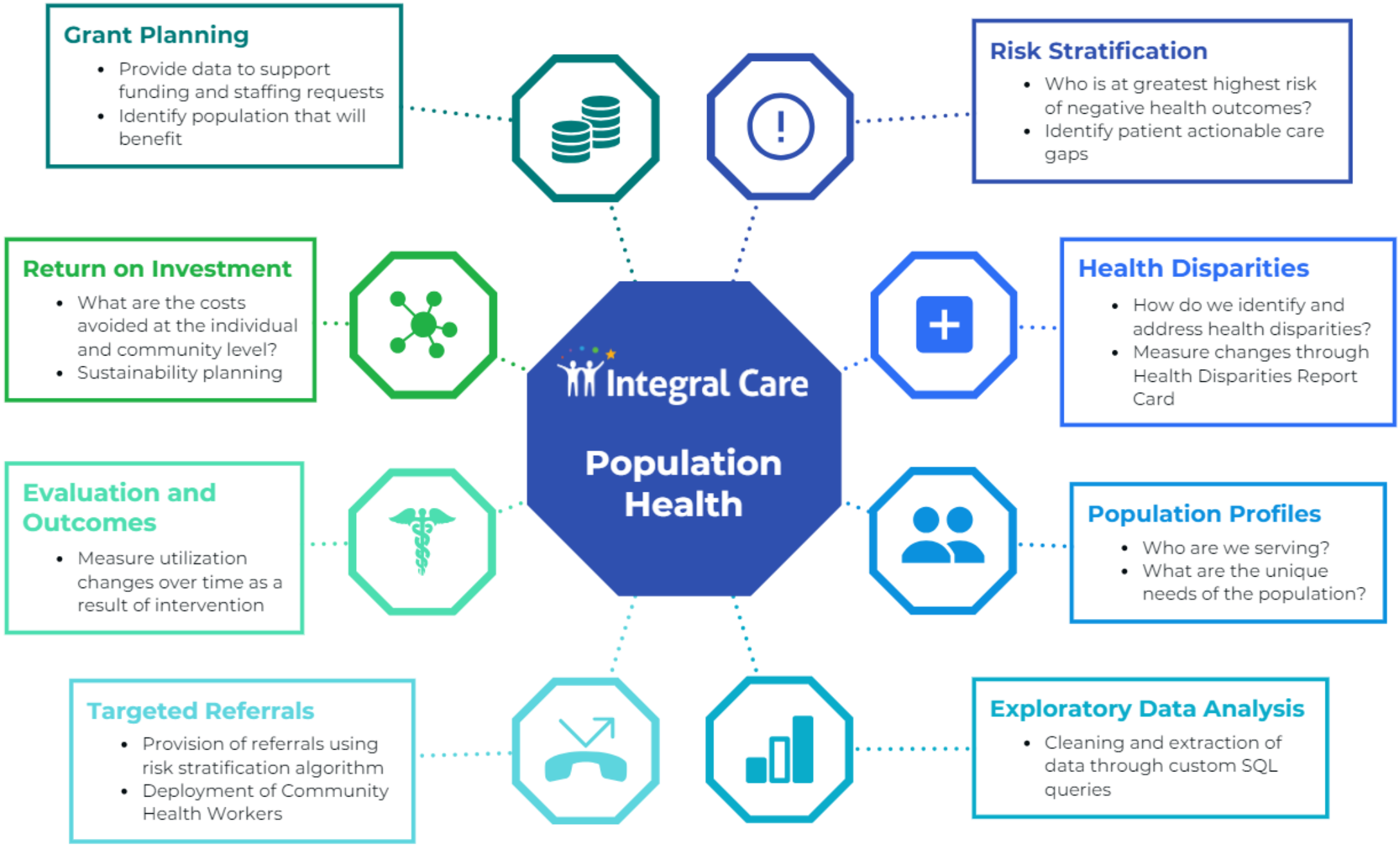
Grant Planning
Provide data to support funding and staffing requests
Identify population that will benefit
Risk Stratification
Who is at greatest highest risk of negative health outcomes?
Identify patient actionable care gaps
Return on Investment
What are the costs avoided at the individual and community level?
Sustainability planning
Health Disparities
How do we identify and address health disparities?
Measure changes through Health Disparities Report Card
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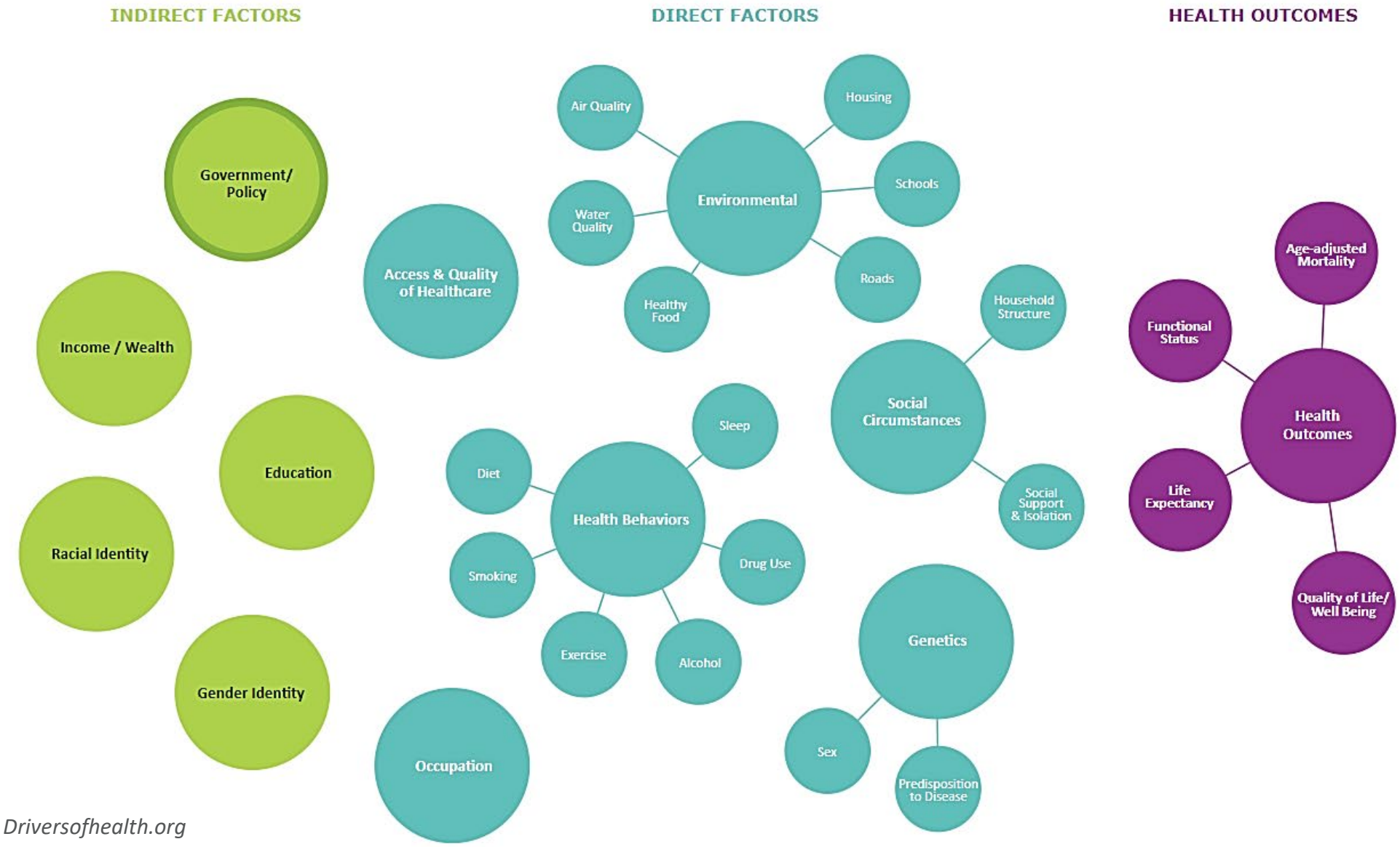
Population Health
Evaluation and Outcomes
Measure utilization changes over time as a result of intervention
Population Profiles
Who are we serving?
What are the unique needs of the population?
Targeted Referrals
Provision of referrals using risk stratification algorithm
Deployment of Community Health Workers
Exploratory Data Analysis
Cleaning and extraction of data through custom SQL queries

# Drivers of Health




*Harvard Global Health – Driversofhealth.org*

# Development of Data Profiles: Housing as a Driver of Health

Integral Care conducted an analysis to identify elevated risks among individuals experiencing homelessness. Among the findings included that those experiencing homelessness comprised 50% of all total emergency department visits, inpatient admissions, and EMS encounters among Integral Care clients, despite only comprising 19% of the total Integral Care client population.

| Encounter Type | Total Visits: Clients Experiencing Homelessness | Total Visits: Integral Care Total Population | % of Total |
|---|---|---|---|
| Medical Inpatient Admission | 741 | 2,004 | 37% |
| Emergency Room | 8,157 | 16,125 | 51% |
| EMS | 5,657 | 10,655 | 53% |
| Psychiatric Inpatient Admission | 767 | 2,151 | 36% |
| **Total** | **15,322** | **30,935** | **50%** |

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*ICC data for date range 9/1/2020-8/31/2021 was used for medical/EMS/ER data and may be underrepresented due to the opt-in nature of the ICC*

# Health Disparities Report Card

Integral Care utilizes data from our EHR to produce an annual Health Disparities Report Card. It is used to proactively identify disparities across our system and address identified needs and gaps. The report card currently reviews 24 different health indicators:

- ❑ Schizophrenia
- ❑ Oppositional Defiant Disorder
- ❑ Conduct Disorder
- ❑ Post-Traumatic Stress Disorder
- ❑ Clozapine Access
- ❑ Homelessness
- ❑ Tobacco Use
- ❑ Food Deserts
- ❑ Psychiatric Inpatient Hospitalization
- ❑ Justice Involvement - Parole/Probation
- ❑ Justice Involvement – Arrests
- ❑ Death Rate (All Cause)
- ❑ Suicide death rate
- ❑ Overdose Death Rate
- ❑ Heart Disease Death Rate
- ❑ Diabetes
- ❑ Hypertension
- ❑ Asthma
- ❑ Obesity
- ❑ HIV
- ❑ Cannabis-related disorders
- ❑ Alcohol-related disorders
- ❑ Opioid-related disorders
- ❑ Stimulant-related disorders

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# Health Findings

Looking at different health indicators allows us to identify strategies to promote health equity. It also provides a data driven approach to grant applications, programming, advocacy, and policy changes. Findings from past reports have included the following:

- Black and Hispanic clients served by Integral Care were more likely to reside in a food desert than any other race/ethnic group.
- Heart disease has been the leading cause of death among Integral Care clients for the past 8 years.
- Rates of death among those with an Essential Hypertension diagnoses were highest within designated food deserts
- Death by suicide was 8.3x higher among Transgender clients compared to the group with the lowest rates (cisgender females).
- Black/African-American clients had the overall highest rates in each major chronic disease category, with Hypertension being the most prevalent medical diagnosis.
- Clients whose primary language was Arabic had the highest rates of PTSD, at a rate 7.3x higher than the reference group.
- Integral Care clients living unsheltered accounted for 1 out of every 3 client deaths
- Rates of stimulant related disorders were 2.6x higher among Alaskan Native/American Indian clients compared to any other race/ethnicity group.

# How are These Findings Tied to NMDOH?

- Prior research has demonstrated that racial and ethnic minority groups often have fewer options to access healthy foods. Of Texas' 258 counties, 58 are considered Food Deserts according to USDA criteria. (Sansom & Hannibal, 2021; CDC, 2017).
- Hypertension, a leading cause of heart disease, is more common and poorly controlled among individuals living in poverty. (CDC, 2022).
- In Travis County and in the U.S., Black Americans have the highest rates of obesity of any race/ethnicity group. Contributing factors include inequities in stable and affordable housing, income, access to affordable and healthy food, and safe places to be physically active (Office of Minority Health, 2020; Austin Public Health, 2019).
- Lesbian, gay, bisexual, transgender, queer, or questioning youth living in the South U.S. are more likely to consider or attempt suicide than LGBTQ+ young people in other regions of the United States (Trevor Project, 2021).
- Traditionally underserved populations in the U.S., particularly rural and American Indian/Alaska Native (AI/AN) communities, are disproportionately impacted by the opioid and amphetamine epidemics and have a higher risk for substance use disorders. (Mitton, Jackson, Ho, & Tobey, 2020).

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# Return on Investment: Housing Intervention

Housed Cohort (N= 41 individuals housed for one year at Integral Care Terrace at Oak Springs)

| Total | Baseline | Intervention | % Reduction | Costs Avoided |
|---|---|---|---|---|
| Arrests | 25 | 10 | -60% | $ 3,255.00 |
| Private Psychiatric Inpatient Admissions | 2 | 0 | -100% | --- |
| Private Inpatient Psychiatric Bed Days | 12 | 0 | -100% | $ 25,791.00 |
| EMS Encounters | 101 | 142 | 41% | $ (35,916.00) |
| Emergency Room Visits | 101 | 49 | -51% | $ 72,800.00 |
| Medical Inpatient Admissions | 20 | 8 | -60% | --- |
| Medical Inpatient Bed Days | 139 | 29 | -79% | $ 528,000.00 |
| Total Costs Avoided (12 Months) | | | | $ 593,930.00 |
| Average Costs Avoided per Housed Individual (41 Clients) | | | | $ 14,486.10 |

*N= 41 formerly homeless individuals moved into Terrace at Oak Springs between 11/14/19 and 3/9/2020. Encounters in the 12 months prior to and following move in date.*

# Return on Investment: Value Based Care Team Intervention

6-Month Cohort (N= 90 participants served by Value Based Care Team between 6/1/21 and 12/31/21)

| Total | Baseline | Intervention | % Reduction | Costs Avoided |
|---|---|---|---|---|
| Arrests | 28 | 18 | -36% | $ 2,200.00 |
| EMS Encounters | 170 | 56 | -67% | $ 107,274.00 |
| Emergency Room Visits | 249 | 66 | -73% | $ 256,200.00 |
| Medical Inpatient Admissions | 29 | 6 | -79% | --- |
| Medical Inpatient Bed Days | 211 | 71 | -66% | $ 672,000.00 |
| Total Costs Avoided (6 Months) | | | | $ 1,037,674.00 |
| Average Costs Avoided Per Person (90 Clients) | | | | $ 11,529.71 |

*N= 90 clients served by Value Based Care Team between 6/1/21 and 12/31/21. Encounters in the 6 months prior to and following first service date.*

# Conclusion

1 Collect Accurate Demographic Information

2 Administer Validated Screenings and Assessments

3 Stratify Data to Identify Disparities and Risk Indicators

4 Develop and Assess Interventions to Close Care Gaps

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