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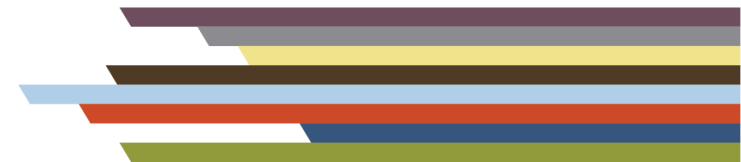
Substance Abuse and Mental Health
Services Administration

Considerations in Maintaining Equity on Our Path to Pediatric Primary Care

Kayzandra Bond, Ph.D.- Tidal Integrated Health

Anitra Warrior, Ph.D.- Morningstar Counseling and Consultation

Arthur "Trey" Andrews III, Ph.D.- Assistant Professor, University
of Nebraska-Lincoln



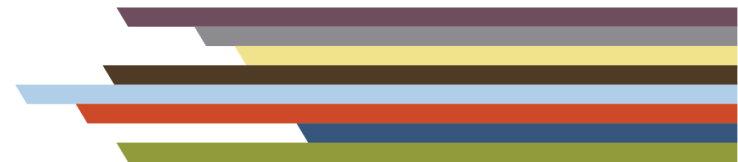
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Kay Bond, LP



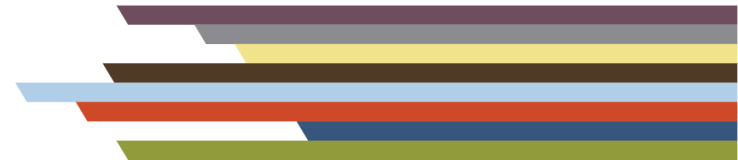
Kay Bond, LP, is the co-founder of Tidal Integrated Health, Inc., and co-director of Behavioral Pediatrics in Primary Care at NOVA Behavioral Healthcare Corporation in Goldsboro, NC. Dr. Bond is passionate about providing high-quality behavioral health services to young people and their families in rural, low-income, and underserved communities. She is also an experienced behavioral health supervisor. Most recently, Dr. Bond established two pediatric integrated behavioral health clinics designed to increase children's access to behavioral health treatment and reduce the stigma involved in participating in therapy. Dr. Bond's clinical and research interests include sleep, elimination disorders, and disruptive behavior and noncompliance. In addition, Dr. Bond is interested in integrating behavioral health into primary care practices and clinical supervision. She earned her Ph.D. in Pediatric School Psychology at East Carolina University in 2016, and she completed her internship and fellowship in Behavioral Pediatrics/Integrated Primary Care at the Munroe-Meyer Institute at the University of Nebraska Medical Center in 2018.



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Dr. Trey Andrews



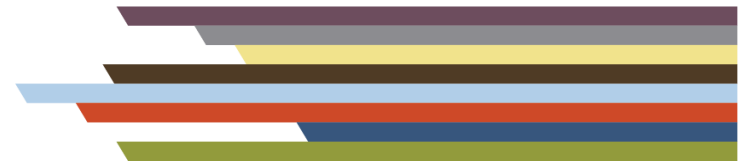
Dr. Trey Andrews is an assistant professor at the University of Nebraska-Lincoln in the Clinical Psychology Ph.D. program and is joint-appointed in Psychology and Ethnic Studies. He earned his Ph.D. in Clinical Psychology in 2014 from the University of Arkansas. As a graduate student, he helped solidify an integrated care practice that was in its second year and re-establish an additional site at an FQHC. He completed his internship (2014) and NIMH-funded postdoctoral fellowship (2016) at the Medical University of South Carolina with a focus on traumatic stress. While there, he laid the groundwork for integrated primary care practices in conjunction with family practice resident training and consulted with a local FQHC that was beginning its integrated care program. He now supervises students at an FQHC in Nebraska and has previously supervised students in another primary care clinic in Nebraska. Overall, the majority of the clinical services he provided and supervised have occurred in Spanish with Latinx populations. Beyond his practical experience, he has collaborated and led the publication of multiple research articles evaluating equity in primary care.



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What is the Mid-America MHTTC?



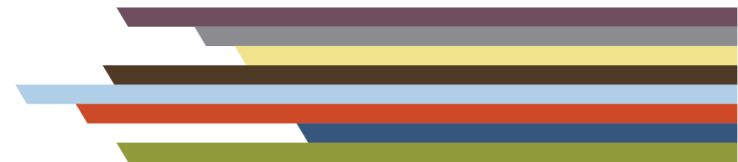
- Funded by the Substance Abuse and Mental Health Services Administration
- 5-year grant awarded to Dr. Joseph Evans at the University of Nebraska Medical Center
- Aligns mental health systems and professional competencies with evidence-based practices
- Primary target states: Missouri, Iowa, Nebraska, and Kansas - but available to any provider(s).
- Provides free/low cost training and technical assistance on topics leading to effective behavioral health practice

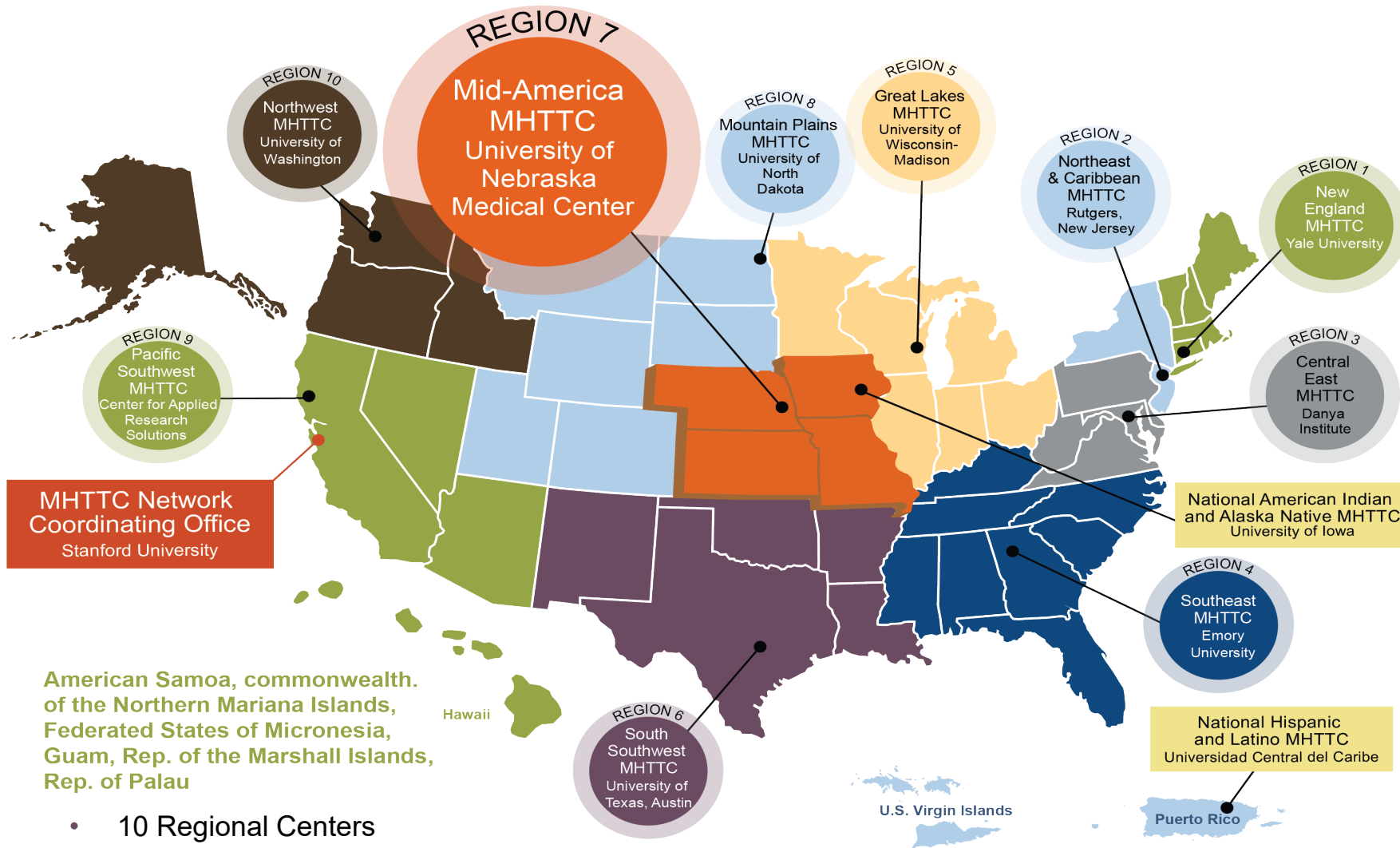


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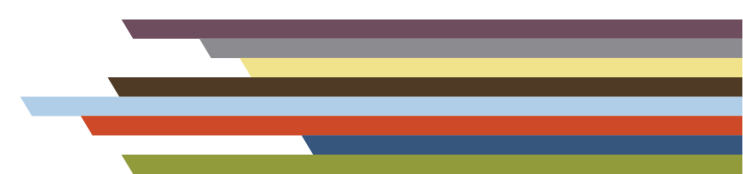
- 10 Regional Centers
- National Hispanic & Latino Center
- National American Indian and Alaska Native Center
- Network Coordinating Office



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Specialized Training Topics



Integrated behavioral health in primary care



School mental health ***



Serious mental illness



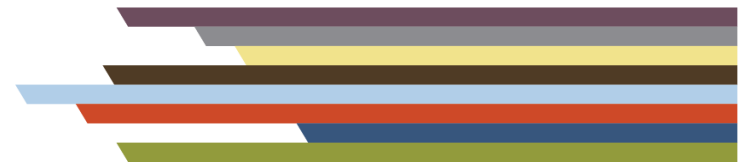
Behavioral health workforce development



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Integrated Behavioral Health in Primary Care



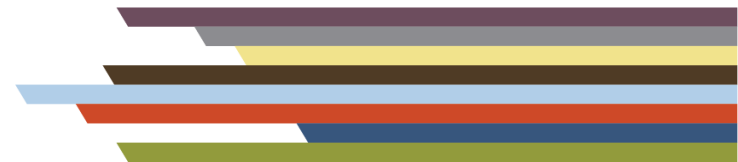
Our MHTTC staff have 20+ years of experience integrating behavioral health into primary care in 40+ rural, suburban, and urban sites



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MHTTC: Providing Training and TA in Integrated Care



QUALITY INDICATORS OF
INTEGRATED BEHAVIORAL
HEALTH IN PRIMARY CARE



EVIDENCE-BASED
BEHAVIORAL HEALTH
INTERVENTIONS FOR
CHILDREN AND ADULTS
APPLIED IN INTEGRATED
CARE SETTINGS



TECHNICAL ASSISTANCE ON
IMPLEMENTATION OF
INTEGRATED CARE



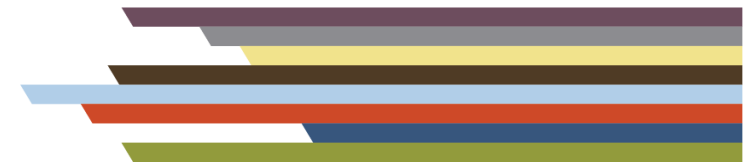
ONLINE AND IN-PERSON
COURSES FOCUSED ON
INTEGRATED CARE AND
SPECIAL TOPICS IN
PEDIATRIC AND ADULT
SERVICES (IN
DEVELOPMENT)



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Racial and Ethnic Equity Considerations in Integrated Care

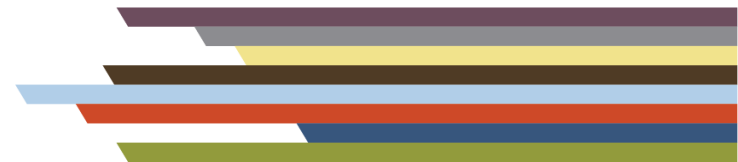
Dr. Kay Bond



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Behavioral Health Equity



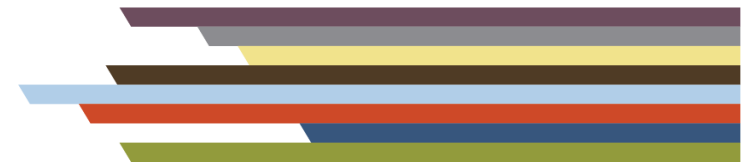
- SAMHSA - The right to access quality health care for all populations regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location.
- Race is one among many social determinates of health.
- Racial Equity-
 - CAPD- “The condition that would be achieved if one's racial identity no longer predicted...how one fares,” by addressing “policies, practices, attitudes and cultural messages that reinforce differential outcomes by race...”



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Use Of Behavioral Health Services



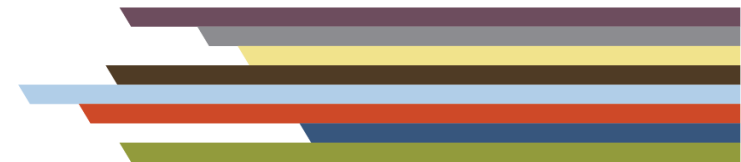
- African Americans, American Indians, and Asian Americans use Behavioral Health services at lower rates than White counterparts.
- Disparities in behavioral health care access increased in African Americans and Hispanics between 2004 to 2012 and remained consistent in Asian Americans.
- Barriers to access include - Financial (uninsured, under insured), Language and Communication Barriers, Lack of providers from diverse racial/ethnic background, Mistrust of Providers/System, Mental Illness Stigma, Unawareness of Services, and Lack of appropriate intervention services.



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Lessons Learned from Our Experts



In what ways does Integrated Care, as a method of service delivery, address barriers to racial equity?

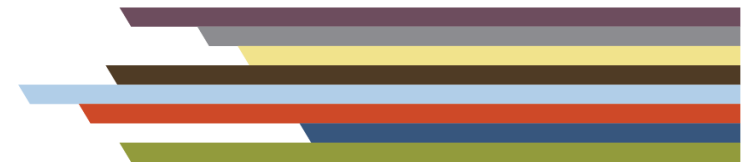
- Lack of appropriate intervention
- Unawareness of Services
- Mistrust of Providers/System
- Mental Illness Stigma



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Tidal Integrated Health – Dr. Kay Bond



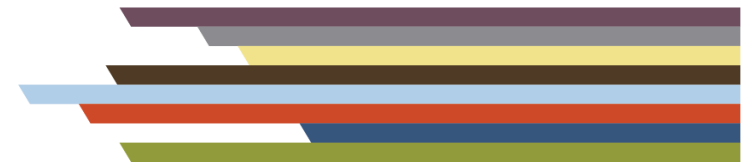
- Tidal is a division of NOVA Behavioral Health Care Corporation in Eastern North Carolina.
- Eastern NC is a primarily rural, low income 1/3rd of the state. Health outcomes in this section of the state are poor, and access to healthcare is limited. Every county in the area is a Health Professional Shortage Area.
- NOVA has offered Tier III level behavioral health services for more than 30 years.



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Tidal Integrated Health – Dr. Kay Bond



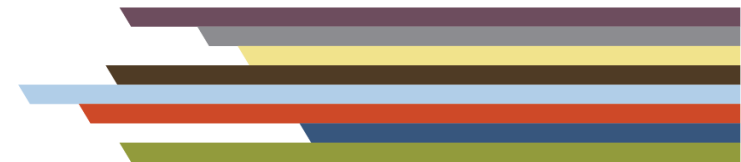
- The Tidal service was founded 2 years ago to provide integrated care services to private pediatric practices in Eastern NC through a co-located model.
- The goal of the service was to reach children and their families earlier, and to prevent the need for higher levels of care.
- Tidal currently has 2 clinics in pediatric offices providing assessment and treatment and offers psychological testing in traditional outpatient clinic.
- More than 30% of patients have Medicaid.
- Tidal also offers various educational resources for behavioral health trainees, medical providers, and parents in Eastern NC
 - Goal is to reduce the health professional shortage and improve the behavioral health outcomes of children by educating caregivers and professionals.



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Considerations to Improve Racial and Ethnic Equity Integrated Behavioral Health



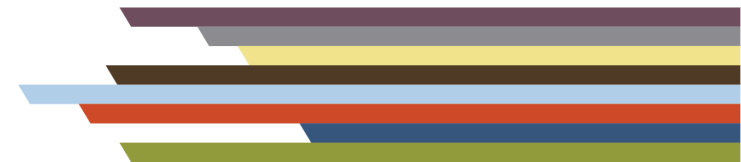
- Linguistic
- Socioeconomic
- Cultural differences



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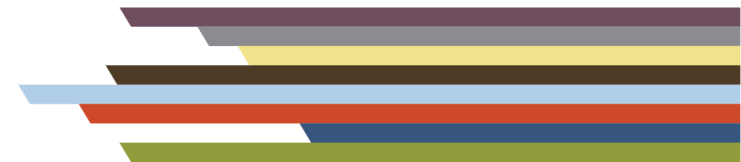
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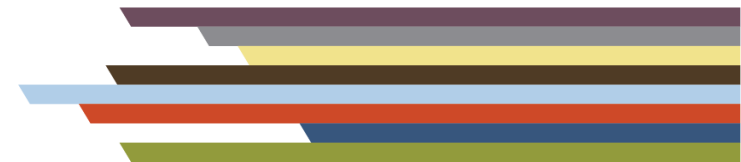
Linguistic Considerations

- How is care impacted when English is not the primary language of the patient?
 - Patient not knowing services available to them
 - Inability to be understood by and understand the provider
 - Reluctance to seek or maintain care
 - Providers misunderstanding the needs of the patient
 - Lower quality care
 - Timing (delays in service, more time required to receive service)



Linguistic Considerations

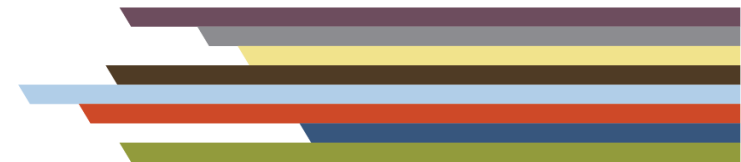
- What can a practice do to mitigate linguistic barriers?
 - Bilingual Providers
 - Interpreters
 - Translated documents
 - Planned time



Socioeconomic Considerations

How is care impacted by the economic constraints and educational attainment of the patient?

- Uninsured
- Under insured
- Mental Illness Stigma
- Unaware of Services
- Reduced availability for appointments
 - Work schedule
 - Transportation
 - Ability to pay
- Increased Adverse Experiences and Crises



Socioeconomic Considerations

What can a practice do to address socioeconomic barriers?

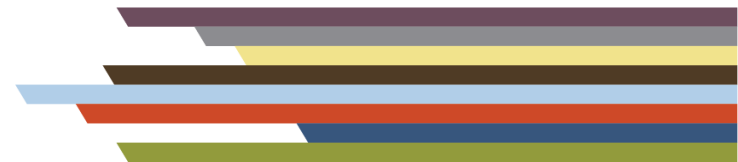
- Accept Medicaid and Children's Health Insurance Program
- Provide Sliding Scale payment option
- Make your self visible, and available in the office
- Try to make behavioral health service appear like primary care
- Flexibility in Scheduling
- Flexibility in Treatment



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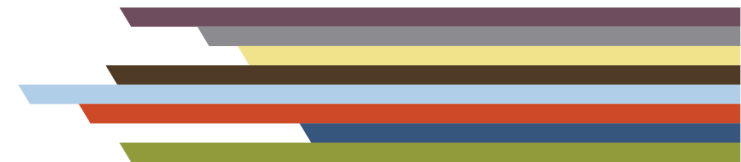
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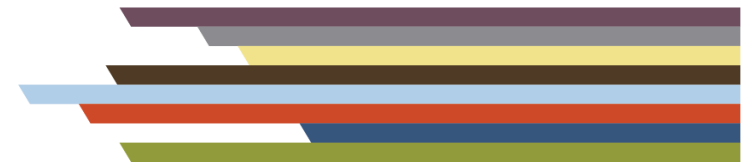
Flexibility

- What can flexibility in scheduling look like?
 - Offering early morning, evening, and/or weekend appointments helps people with inflexible work schedules.
 - Leaving space in the day for same-day appointments helps address crises
 - Providing multiple reminders of scheduled meetings helps people who need to arrange transportation, and people who have inconsistent, late notice work schedules.



Flexibility

- What can flexibility in treatment look like?
 - Communication with providers and community
 - Plan on brevity
 - Focus on the patient's goal for treatment specifically
 - Use the most efficient tools
 - Prepare to address crisis situations in session
 - Prepare to connect patient with resources to meet immediate needs



Cultural Difference Considerations

How is care impacted by the culture of the patient?

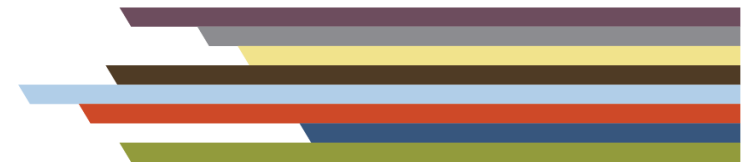
- Attitude and Stigma to behavioral health and services
- Comfort in communicating with a provider
- Differences between provider and patient



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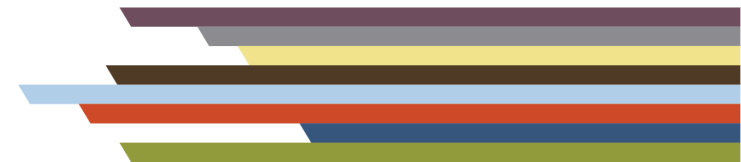
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Stigma and attitudes toward seeking behavioral health services

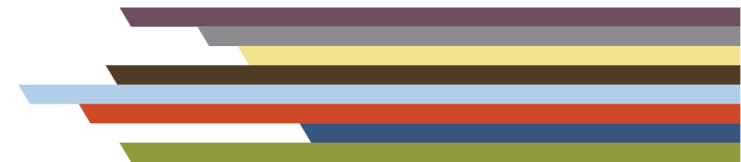
- African Americans had more willingness and less embarrassment than Non- Hispanic Whites. They reported less comfort in communicating with providers, however.
- Hispanic or Latino ethnic identity was not predictive of attitudes towards behavioral health services when accounting for SES. This emphasizes the importance of considering SES in addition to race.
- Education, Income and Employment predicted comfort level with talking to a behavioral health professional, more than race in African Americans and Hispanics/Latinos.



Cultural Difference Considerations

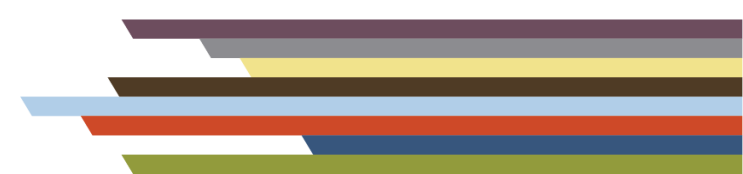
What can a practice do to address barriers related to cultural difference?

- Systemically
 - Communicate with community members and PCPs
 - Ensure procedures of practice address and embrace various cultures
 - Allow for a feedback system to address concerns as they arise
- Individually
 - Respect for patients' cultures
 - Openness to self-evaluation



Evidence-Based Strategies Efforts for Enhancing Equity

Dr. Trey Andrews, Assistant Professor



Evidence for Enhancing Equity

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Lincoln



 **Latinx Mental Health**
+ Treatment Outcomes Lab

MHDDI

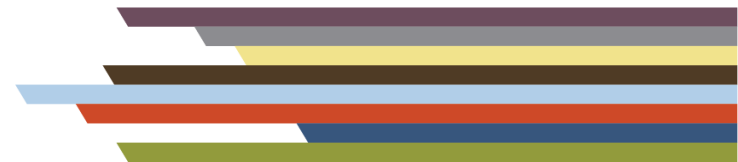
- At least two models have shown improvements in care access and outcomes
 - Collaborative care (e.g., Lee-Tauler et al., 2018)
 - Primary care behavioral health consultation (e.g., Bridges et al., 2014)



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Components of Care

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 **Latinx Mental Health
+ Treatment Outcomes Lab**

MHDD

- “Active ingredients” may look fairly similar, but format will vary across models
- In PC-BHC model, behavioral activation and modified exposure were associated with better outcomes (Bridges et al., 2015)
- Still have to rethink *how* we deliver them



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Public Health Impact



Thinking about health evidence-based components of health equity:

$$\text{Impact} = \text{reach} \times \text{efficacy} \times \text{fidelity}$$

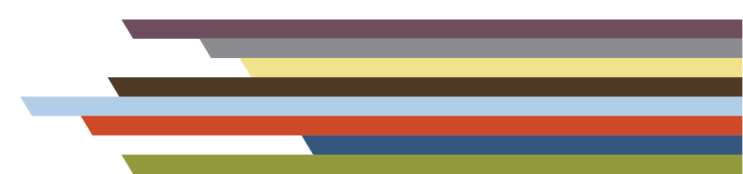
What variable likely influences equity most in mental health services?



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Public Health Impact



Thinking about health evidence-based components of health equity:

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What variable likely influences equity most in mental health services?

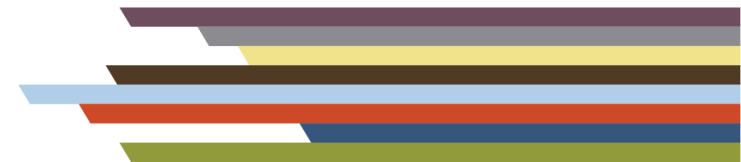
Reach: African Americans, Asian Americans, Latinx populations, and Native Americans all receive services at ~60% the rate of Whites or less (NSDUH, 2019)



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Rethinking the Service Model

Starts with
rethinking structure
of services

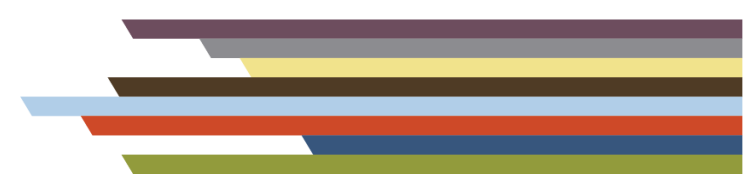
- Traditional 1 hour per week, during the workday for 3-4 months, likely will not work

Rethink focus of
care

- Population/Community health

Rethink point of
entry

- Where are people already going? What is culturally acceptable? What are sources of resilience/strength?



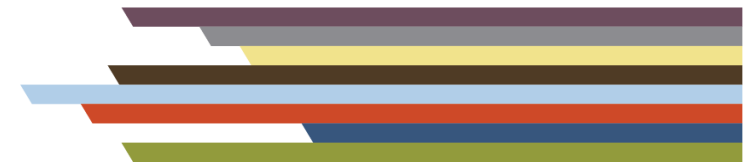
Rethinking the Service Model

Rethink the client and clinician relationship

- In PC-BHC, relationship is more like primary care: open-ended, longstanding, incorporates prevention and health promotion, flexible (Robinson & Strosahl, 2009)
- May operate as “hub” provider
- Personal opinion: needs to explicitly and frequently consider systems-level issues in care

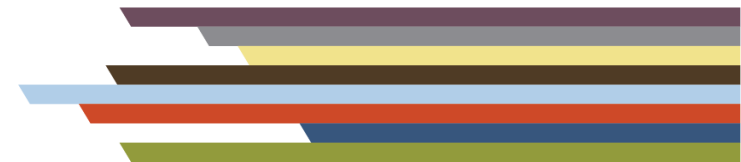
Can look a variety of different ways

- Match the community and match the culture - even down to terminology



Examples from FQHCs Implementing PC-BHC

- Structure of services (Robinson & Reiter, 2007)
 - Prioritize same-day “warm handoffs”
 - Match cultures centered on personal relationships
 - Reduce burdens and stigma from keeping/attending additional appointment for MH only
 - Efficiency in scheduled and follow-up appointments
 - Greatest source of variability in these models
 - Interpretation services available*
 - Regular check-ins with any physician visits, even if just for “maintenance” and re-evaluation



Examples (cont.)

Adapt to primary care hours

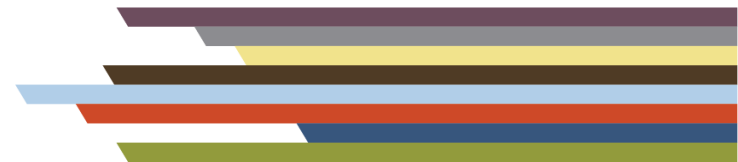
- For most FQHCs, includes nights and weekends

Cultural adaptations in short visits

- Emphasize how the patient/client views the problem
- Match intervention details and explanations to patient/client worldview

Treatment of MH/BHC providers by other staff/providers is key

- Most effective when viewed as part of collective team



Getting Started



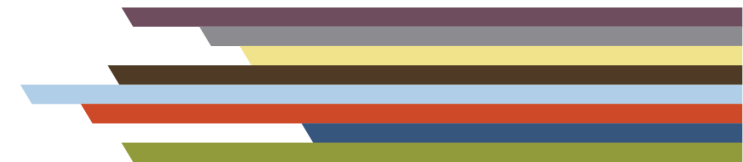
- Questions to ask (assuming you already have a partner clinic):
 - What is my community and who am I trying to serve?
 - What kinds of models best fit the community at large and the people already at the PC clinic?
 - What gets in the way of my target community from receiving MH care?
 - What mental health beliefs already exist?
- Ask around, find data, do brief surveys in the PC clinic if you can



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Lessons Learned from Our Experts



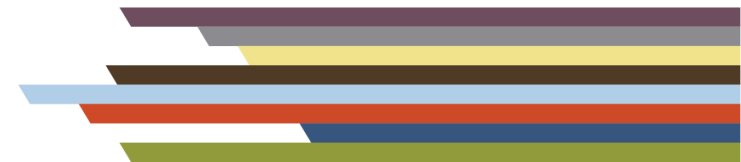
- How have you adapted your model to fit your community to improve health equity?
 - Culturally
 - Systems-level



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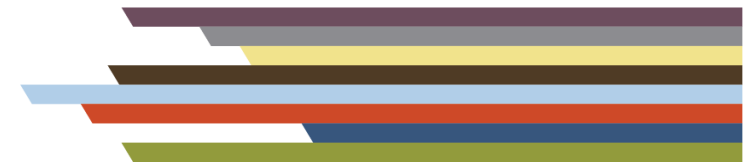
- What has been most critical to your success in primary care?
 - As a clinic
 - As an individual provider/director



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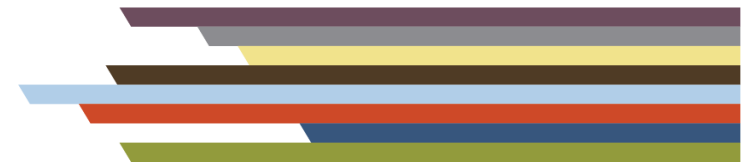
- What has been most helpful in trying to achieve racial/ethnic equity in your clinics?
- What is left to do?



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Coming Home to Primary Care Pediatric Integrated Health Series

Last Friday of each month, 12-1pm Central Time

- January 29: Addressing Linguistic Diversity in Pediatric Integrated Care
- February 26: Building an Equitable Workforce in Pediatric Integrated Care
- March 26: Equity Considerations in Underserved Communities in Pediatric Integrated Care: Low Income, Rural, and Reservations

- Recordings will be made available

<https://mhttcnetwork.org/centers/mid-america-mhttc/coming-home-primary-care-pediatric-integrated-behavioral-health>



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