FINAL REPORT

NOCHF

NEW ORLEANS CHARITABLE HEALTH FUND

LPHI
Louisiana Public Health Institute

CONTENTS

Contents

Executive Summary

On October 26, 2011, the New Orleans Charitable Health Fund (NOCHF) was created with $8,299,191 resulting from a court settlement to support access to primary medical care for Greater New Orleans (GNO) area residents. Key community stakeholders and local and national experts assessed the health care needs of the GNO community and recognized the need for expanded access to behavioral health (mental health and substance abuse) services. The Louisiana Public Health Institute (LPHI) in coordination with Dr. Jane T. Bertrand (the court-appointed project consultant), the Plaintiffs' Steering Committee, and community stakeholders determined that a focus on behavioral health integration (BHI) would support the region's continuing transition to an accessible, high quality, coordinated, and sustainable health care delivery system. The NOCHF program was intended by the Steering Committee to focus on rigorous program implementation and technical assistance, not on behavioral health research and evaluation. Although improvements made during the program implementation will be sustained beyond the NOCHF program, the program's funding period ended December 31, 2015.

OVERALL NOCHF PROGRAMMATIC GOALS:

Increase access to care
Improve population health
Promote sustainable, systems-level change

Key Activities

To advance systems-level change and care delivery models for BHI, the NOCHF program included two primary components:

1. A competitive grant initiative for eligible GNO area community-based health care providers to implement innovative and evidence-based integrated models of primary health care, behavioral health care, and social services over a three-year period.

2. A regional learning community designed to improve access, quality, coordination, and sustainability of integrated models of care for all GNO health care providers.

Results

Advancing BHI across the Greater New Orleans area at both the systems and organization levels, the NOCHF program:

- Leveraged the expertise of community health leaders and content area experts to inform the program's design and implementation.
- Awarded funding through a competitive grant process to six community-based health care organizations to implement innovative and evidence-based models of integrated care.
- Developed strategic national and local partnerships with stakeholder organizations.
- Collaborated with local and regional programs to address challenges around behavioral health and HIV/AIDS-related stigma throughout Southeast Louisiana, as well as co-hosted the first Louisiana Statewide Stigma Summit.
- Continued regional efforts to expand and support the patient-centered medical home (PCMH) model, optimize health information technology (HIT), and increase participation in Partnership for Access to Healthcare (PATH), a regional health information exchange (HIE) with community-shared HIT infrastructure that supports electronic sharing of vital health information between care settings, including hospitals.
- Initiated the regional NOCHF Behavioral Health Integration Learning Community and hosted nine learning sessions for grantees over the program period to provide technical assistance, training, and resources for integration and system optimization.
- Worked with the Louisiana State Department of Health and Hospitals and the Louisiana Primary Care Association to coordinate state policy and community-based organizations' efforts to sustain BHI through recommendations for a Medicaid carve-in model for behavioral health and for primary care services to be managed by a single insurer for each individual.
- Expanded LPHI's knowledge of integrated care by participating in the SAMHSA-HRSA Center for Integrated Health Solutions Addressing Health Disparities Leadership Program.

Additionally, at the clinic level, the NOCHF program:

- Optimized and streamlined clinic processes for depression screening and referrals to care for six grantees.
- Increased patient volume and improved appointment attendance rates.
- Refined processes, standardized workflows, and created tools for grantees to self-monitor for quality improvement.
- Created an electronic health record (EHR) template for documenting and reporting behavioral health screening outcomes, including the Patient Health Questionnaire (PHQ)-2, PHQ-9, and the Columbia Suicide Severity Rating Scale (CSSR-S).

Acknowledgements

We would like to thank our key community stakeholders and local and national partners for their assistance and support during the program.

We would also like to extend a special thanks to Dr. Jane T. Bertrand, the court-appointed project consultant, and representatives from the Plaintiffs' Steering Committee for providing the oversight for the NOCHF program.

We would also like to extend special thanks to Joseph D. Kimbrell, MA, MSW; Jayne Nussbaum, MPAff; and Sarah Gillen, MPH for their leadership and direction.

This report was prepared by LPHI's NOCHF program team. We would like to acknowledge the following staff members for their contributions to this publication and program:

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Introduction and Overview

New Orleans Charitable Health Fund History

The *Joint Petition to Distribute the Charitable Health Fund* led to the creation of the New Orleans Charitable Health Fund (NOCHF), a fund to provide needed access to comprehensive care. Parties involved in the court settlement recognized a lack of access to primary care services in New Orleans East and provided $1 million to Daughters of Charity Services of New Orleans to rebuild the health care infrastructure in New Orleans East in partnership with the Orleans Parish Hospital Service District A. The remaining $7.3 million of the NOCHF funds were granted to the Louisiana Public Health Institute (LPHI) to develop and administer a grant and technical assistance program to expand access to behavioral health care services in the Greater New Orleans (GNO) area in coordination with Dr. Jane T. Bertrand, the court-appointed project consultant.

LPHI is a stand-alone, private, 501(c) (3) not-for-profit organization established in 1997 with a statewide mission of "health for all." LPHI works to promote and improve the health and quality of life of Louisianans through public-private partnerships at the community, parish, and state levels. LPHI was selected to administer the NOCHF program owing to prior experience coordinating and managing public health programs and initiatives in the areas of health systems development, health promotion, disease prevention and experience administering large federal, state, and local grants. LPHI was responsible for the development, implementation, and administration of the NOCHF program; provision of technical assistance to grantees; and development of collaborative partnerships with local, state, and national stakeholders to improve behavioral health integration (BHI) at the systems level through reconsideration of policy and reimbursement structures. NOCHF's core team consisted of LPHI staff, including a program director, program manager, program coordinator, and evaluation manager to manage the programmatic and financial aspects of the NOCHF program, in consultation with Dr. Bertrand and with oversight by the Plaintiff's Steering Committee. To support the core team, LPHI leveraged the capacity and expertise of LPHI's supporting staff: finance, administrative, communications, strategy, and evaluation. Additionally, LPHI brought in nationally recognized experts in integrated care, including the National Council for Behavioral Health, to share resources, tools, and best practices with NOCHF's team, grantees, and community partners.

The NOCHF program goals were to:

- ***Increase access to care.*** Provide easy and readily available access to integrated behavioral health, primary health care, and referrals to social services.
- ***Improve population health.*** Implement interventions and systems changes to improve health outcomes for the overall community.
- ***Promote sustainable systems-level change.*** Create lasting clinical and community interventions and systems change for the purpose of integrated behavioral health, primary health care, and referrals to social services.

The NOCHF program was intended to improve the community-based behavioral health landscape in New Orleans as a whole, however, the program placed particular focus on increasing access and quality for low-income, disadvantaged, and vulnerable populations.

Program Design

The NOCHF team created the following guiding principles to support the program's design:

- ***Community-based and whole person approach*** - Create holistic systems that support and strengthen the capacity of residents to take charge of their own health. Promote patient- and family-centered care that enables individuals to attain optimal levels of self-care, productivity, interpersonal relationships, and community engagement.
- ***Evidence-based and/or promising innovative practices*** - Use evidence-based or promising innovative practices to develop integrated primary care behavioral health systems.
- ***Capacity building*** - Create opportunities to promote workforce development and training, health information technology (HIT) optimization and utilization, and clinical- and community-level policy and procedure development.
- ***Quality improvement*** - Improve quality of care using process improvement techniques and tools to increase efficiency, accountability, performance, and other indicators of quality care which achieve equity and improve population health.

In addition to the guiding principles, the NOCHF program was designed with two primary components:

1. A competitive grant program for eligible GNO area community-based health care providers to implement innovative, evidence-based integrated models of primary health care, behavioral health care, and social services over three years.
2. A regional learning community designed to improve access, quality, coordination, and sustainability of integrated models of care for GNO health care providers.

Partnerships: National, State, and Local

The NOCHF team built and enhanced relationships with local, state, and national partners.

National Level

To ensure the nation's best practices for BHI were implemented in the program, the NOCHF team engaged the National Council for Behavioral Health in consultation throughout the program. The National Council for Behavioral Health is the unifying voice of America's community mental health and addictions treatment organizations. Together with 2,500 member organizations, it serves more than eight million adults and children living with mental illnesses and addiction disorders. The organization is committed to ensuring all Americans have access to comprehensive, high-quality care that affords every opportunity for recovery and full participation in community life.

Regional Level

The NOCHF team participated in a meeting with representatives from the five states within the U.S. Department of Health and Human Services (DHHS) Region VI. The group learned about the integrated care efforts in the region, identified common elements that demonstrated progress toward integrating behavioral health and primary care, learned about potential integrated program and policy options available, and developed action steps for states to accelerate efforts to integrate behavioral health and primary care.

As a result of the regional U.S. DHHS Region VI meeting mentioned above, the Louisiana State Team for Primary Care and Behavioral Health Care Integration was created. The team convened a quarterly statewide integration summit to improve integration through a comprehensive approach addressing care coordination, strategic communication, financing, and sustainability. This team continued to meet through the grant duration.

Local Level

Throughout the program, the NOCHF team maintained engagement and collaboration with the New Orleans Health Department. NOCHF representation was engaged with the City's Behavioral Health Interagency Council and its Municipal Court Behavioral Health Task Force, as well as the Jefferson Parish Mental Health Task Force and the New Orleans Care Collaborative to provide ongoing opportunities for coordination, communication, and integration.

Program Implementation

Competitive Grant Award Program

The first of the NOCHF's two primary programmatic components was the competitive grant award program designed to accelerate adoption of innovative, evidence-based integrated models of primary health care, behavioral health care, and social services during a three year period. The NOCHF team, stakeholders, and Dr. Bertrand established a formal competitive request for application process and timeline. NOCHF shared the request for application throughout the GNO area to identify organizations interested in advancing models for BHI. A review committee comprised of five national content experts, NOCHF staff, and Dr. Bertrand reviewed 31 applications based on set scoring criteria. Applications and scores were discussed at an in-person review panel meeting with a representative from the Plaintiffs' Steering Committee in attendance as an outside observer. Final scores were compiled and applications were ranked. The six applicants with the highest scores were selected to participate in a one-on-one meeting with the NOCHF team.

In July 2012, LPHI (on behalf of the NOCHF program) awarded $5.5 million to support implementation of nationally-recognized, innovative models for integrated care delivery to six local community-based health organizations.

The NOCHF Behavioral Health Integration Learning Community

Improving the system of behavioral health services in the Greater New Orleans area through innovative thinking, ongoing consultation, and peer information sharing among institutional leaders in integrated health

Access Health Louisiana, Administrators of the Tulane Educational Fund, Catholic Charities Archdiocese of New Orleans, EXCELth Incorporated, Jefferson Parish Human Services Authority, and New Orleans East Louisiana Community Health Center.

To strengthen access and delivery of integrated primary care, behavioral health services, and social services, the second component of the NOCHF program included a regional learning community hosted by LPHI's NOCHF team and facilitated by national integration experts, the National Council for Behavioral Health. Learning communities are a methodology used by LPHI to educate, inform, and support community partners through quality improvement and practice transformation initiatives. Additionally, the NOCHF team provided grantees with individual technical assistance, bi-monthly in-person meetings, a dedicated website with resources, webinars and two coaching calls per quarter to assess programmatic progress, and provide resources specific to barriers that might impede goal progress.

The regional learning community was designed to improve access, quality, coordination, and sustainability of integrated models of care for all GNO health care providers. The format for the learning community was based on growing evidence that shows collaborative learning approaches accelerate organizational and team work plan implementation.[1] The learning community was open to all organizations delivering or interested in delivering behavioral health care, primary health care, and/or social services to underserved populations in the GNO area, as well as to other LPHI partners along the Gulf Coast. LPHI also manages the Gulf Regional Health Outreach Program- Primary Care Capacity Project and leveraged the learning community to provide access to content, technical assistance and tools to Gulf Coast partners in Mississippi, Alabama, and the panhandle of Florida. Informed by the work of partners and NOCHF grantees, the NOCHF team worked in collaboration with the National Council for Behavioral Health to organize relevant and timely topics for the grantees in the field of integrated care. The learning community functioned as a forum to develop the network of grantees by a) integrating care to facilitate greater coordination and collaboration; b) introducing state-of-the-art approaches to the membership; c) strengthening behavioral health programming among grantees; and d) fostering peer learning. The learning community content included:

Year One

- May 2013: *Overview of Integrated Care and Financing and Sustaining Integrated Care* with Jeff Capobianco and Kathy Reynolds, the National Council for Behavioral Health

Year Two

- August 2013: *Sustained Integrated Care: Workflow Design* with Jeff Capobianco and Kathy Reynolds, the National Council for Behavioral Health
- December 2013: *Care Coordination* with Jeff Capobianco, National Council for Behavioral Health; and Benjamin Druss, MD, MPH, Professor and Rosalynn Carter Chair in Mental Health, School of Public Health: Health Policy & Management, Emory University
- March 2014: *Monitoring the Impact of Integrated Care* with Jeff Capobianco, the National Council for Behavioral Health; and Lori Raney, Axis Health Systems

Year Three

- August 2014: *Sustainability* with Jeff Capobianco, the National Council for Behavioral Health; and Virna Little, Psychosocial Services and Community Affairs at the Institute for Family Health
- January 2015: *Care Coordination Training for Providers* with Virna Little, Psychosocial Services and Community Affairs at the Institute for Family Health
- March 2015: *Motivational Interviewing* with Pamela Pietruszewski, the National Council for Behavioral Health
- May 2014: *Screening, Brief Intervention, and Referrals to Treatment Training* with Pamela Pietruszewski and Jacob Bowling, the National Council for Behavioral Health
- July 2015: *Health Communications: Telling Your Story* with Jeff Capobianco and Susan Partain, the National Council for Behavioral Health

Additional Program Activities

Integrated Care Policy Development

Throughout the program, the NOCHF team collaborated with the Louisiana Department of Health and Hospitals Medicaid Program, and the Louisiana Primary Care Association to develop recommendations to re-consider reimbursement and policies to support integrated care. Prior to and during the grant, behavioral health and substance use disorder services for Medicaid recipients were paid for through one single payer, Magellan, while physical health services including medications were generally paid for by one of five of Medicaid's managed care plans (Bayou Health Plans); known as a "carve-out" model. The carve-out model did not accomplish the coordinated care goal set out by the state. Patients and providers reported having disjointed care delivery and difficulty accessing appropriate care. The NOCHF team successfully worked with the National Council for Behavioral Health to support behavioral health policy change at the state level. Applying lessons learned through the NOCHF program about delivering integrated care, NOCHF staff and state policy-makers worked to plan a transition to an integrated model of behavioral health through an integrated payer system "carve-in." This initiative created the requirement for the five Bayou Health Plans to cover behavioral health services. With the state's adoption of the carve-in model, patients and providers will experience more coordinated care delivery. This policy change took place in December 2015.

Expansion of Psychiatric Services

NOCHF supported a pilot psychiatry consulting warm line administered by Tulane University School of Medicine Department of Psychiatry and Behavioral Sciences, Section of Child Psychiatry. The warm line provides consultation services to primary care providers (PCPs) for children ages 0-6. NOCHF also partnered with Tulane University, the HRSA Region VI Regional Public Health Training Center Partnership award recipient, to develop, adapt, and disseminate BHI training materials for online distance learning.

Quality Improvement (QI) Initiative

The NOCHF team created a quality improvement (QI) initiative during year three of the NOCHF program to address screening process inconsistencies and enhance grantee workflow for depression screening and follow up. The QI initiative lasted from November 2014- June 2015. During the QI initiative, each of the six NOCHF grantees worked with the NOCHF team to develop a "current state" process map of the grantee's patient flow at each clinic and recommendations to optimize sustainable integration based on evidence-based best practices. The recommendations informed a six-month action plan to be carried out following a site-visit. The action plan included identified target dates and organizational champions to lead each activity. The NOCHF team and expert consultants from the National Council for Behavioral Health held monthly coaching calls with each grantee where the teams provided action plan updates and requested and received advice regarding specific barriers to completing the tasks. Each of the grantees completed all of the recommended actions. The recommended actions included the following:

- Adjust the workflow to include the PHQ-2/-9, or PHQ-A depression screening.
- Adjust the workflow to include a warm hand-off (when the patient is introduced in-person by one provider to another care team member) from the provider to the social worker when the PHQ-9 is positive.
- Adjust billing procedures to include reconciliation of accounts receivable for social work staff billing.
- Review contracts for missing reimbursement codes.
- Negotiate with payers to include missing reimbursement codes to insure services sustainability.
- Develop system for staff credential applications, follow-up, and management.
- Ensure social work staff medical record documentation is appropriate for billing and compliance purposes.
- Develop standard operating procedures for counseling groups.
- Ensure counseling group sizes, duration, and content are appropriate for billing purposes.

Electronic Health Record Optimization

The NOCHF team found throughout the grant period that grantees experienced reporting difficulties stemming from non-standardized electronic health records (EHRs) that prevented reporting of key integration outcomes and process metrics. Separate primary care and behavioral health electronic record systems and high variation in internal integration processes provided opportunities for improvement in subsequent years. By the third year of the program, the five clinic-based grantees were using the same EHR system (i.e. SuccessEHS) which has assisted in the standardization of documentation, data collection, and billing.

From information gathered in the workflow site-visits with each grantee, a common theme emerged that the clinic's EHR systems did not optimally capture depression screening information. The grantees each used different parts of the EHR system to collect the information as a workaround to not having validated depression screening tools as functional templates. To address the issue, the NOCHF team hosted a series of meetings with representatives from each of the grantees to develop templates that were consistent and functional with their workflows within the clinic and collected the necessary data points for reporting. The evidence-based tools selected with the help of the National Council for Behavioral Health experts were the PHQ-2/-9 and Columbia Suicide Severity Rating Scale (C-SSRS). The group also developed the reports to appropriately pull the information from the new templates so that the clinics could more effectively and efficiently track screening rates, population health metrics, and individual patient improvement.

Annual Programmatic Activities Overview

YEAR ONE PROGRAM ACTIVITIES

Application Assessment and Refinement

The NOCHF team assessed the grantees' applications and conducted a site visit before final selection of the grantees. During the site visit the NOCHF team assessed the grantees utilizing: a) a baseline assessment tool, b) provider interviews, and c) a workflow assessment.

The NOCHF Learning Community

The NOCHF team engaged and developed relationships with grantees and partners through learning community meetings, quarterly reporting, site visits, phone calls, and webinars.

Individual Grantee Work Plans

The grantees worked individually with the NOCHF team to develop work plans, technical assistance plans, and revise project goals. By developing and refining goals, the grantees were able to further develop their core activities for the remainder of the grant.

Monitoring and Reporting

To capture and track grantee outcomes and processes throughout the grant, the NOCHF team created a reporting tool with the following process and outcomes indicators:

- Behavioral health and quality of life screening utilization
- Co-occurring physical health and behavioral health conditions
- Social services referrals
- Project successes
- Challenges/areas of improvement
- Progress toward grantee project goals

ANNUAL PROGRAMMATIC ACTIVITIES OVERVIEW

YEAR TWO PROGRAM ACTIVITIES

Data Standardization and Validation

The NOCHF team evaluated overall progress of year one through data collected in the quarterly and annual reports submitted by grantees. The NOCHF team initiated data quality checks through data validation and standardization practices, and prepared and distributed feedback reports to grantees to inform practice changes.

The NOCHF Learning Community

The learning community sessions continued in the form of full-day meetings, with follow-up webinars, small group coaching around quarterly data, and grantee check-in calls. Grantees used the information gained in the learning sessions to begin to implement changes based on feedback and evaluation.

Individual Grantee Work Plans

The NOCHF team continued to monitor progress on the grantees' individual work plans and adjusted the technical assistance plans according to the grantees' needs. Additionally, the NOCHF team saw the need for increased access to psychiatric services for children and partnered with Tulane University School of Medicine to develop a psychiatric warm line for pediatricians to consult a psychiatrist for children through six years of age.

YEAR THREE PROGRAM ACTIVITIES

Data Standardization and Validation

The NOCHF team continued to monitor progress on individual work plans and the quarterly data reported. The data in the quarterly reports and work plans indicated a need for data quality and process improvement. The team tailored the technical assistance plan to include an individualized QI initiative to focus on screening rates for depression.

The NOCHF Learning Community

Learning community trainings continued and were tailored to the collective needs of the grantees. Grantees and the NOCHF team recognized a need for a standardized mechanism to collect and monitor depression screening information. The program team, in partnership with the grantees and the common EHR system vendor, worked for several months to develop standardized EHR templates and reports for evidence-based depression screening tools to monitor screening processes and population health outcomes.

The NOCHF team continued to provide program partners opportunities to capture, share, and disseminate lessons learned to inform improvements in population health through the following technical assistance activities: convening the learning community full day in-person meetings, a follow-up group coaching call where providers could discuss their progress with each other, workflow meetings with each grantee, the EHR optimization workgroup, and monthly follow-up coaching calls. Throughout the grant period, the grantees developed relationships with over 120 community partners to support improvements in integration of primary care, behavioral health, and social services. Grantees also developed clinical structures and processes to foster sustainable and effective integration. Improvements in technical capabilities, workforce development, and leadership support contributed to major culture shifts within the grantee organizations. Evidence of BHI is demonstrated clearly in the Grantee Profiles section of this report (see below).

Workflow Standardization and Improvement

The NOCHF team helped the grantees standardize and improve clinical workflows, refine processes, and create better tools for self-monitoring for quality improvement (QI) while focusing on improved patient volume and organizational capacity to improve integrated care. Improvements in workflow processes allowed the grantees to improve three major components of sustainable systems change: flow-through capacity efficiency to serve patients, staff skills, and evidence-based care delivery.

Monitoring and Reporting

The NOCHF team developed a monitoring and reporting plan in year one to track the grantees and program progress toward access, quality, and sustainability of primary care, behavioral health and social service integration. The team updated the reporting tool and continued to monitor grantees' progress in years two and three.

Throughout the grant period, the team monitored the following:

- Depression screening rates and primary care needs screening rates to measure integrated care processes and protocols at each grantee site.
- Access to care and capacity to provide integrated services through employees hired with NOCHF funds.
- Workflow modifications including screening, warm hand-offs, and follow-up.
- Knowledge of integrated services based on interest and knowledge gained in integration topic areas.

Monitoring and Reporting Tools

Grantee baseline and follow-up assessment - Assessments were administered to each grantee. The assessment tool covered operational and financial profiles, staffing profiles and workforce capacity, HIT capacity and usage, patient population management, and transitions of care referral systems.

Quarterly reporting tools - Each grantee completed quarterly programmatic and financial reports using the reporting tool developed by the NOCHF team. The programmatic reporting tool included integrated care measures and narrative questions on progress and technical assistance needs in the following areas: workforce development, identification of target population, referrals and linkages, utilization of HIT, model implementation, and QI.

Site visits - The NOCHF team conducted site visits to clarify information submitted in the grantee reports and better understand the grantee's needs and challenges such as organizational capacity, project implementation, and project management. The site visits enhanced relationships among the clinical and administrative staff involved in project implementation and helped the NOCHF team identify topics for the learning community sessions and individual meetings with the grantees. Site visits were conducted on an ongoing basis throughout the NOCHF program with at least one per site per year.

Technical Assistance

Workflow assessments - The NOCHF team conducted workflow assessments of the current state of each grantee and provided guidance for implementing changes to maximize BHI. Each NOCHF site was provided an initial workflow analysis in year one. The NOCHF team then worked on-site with each grantee to develop a "current state" process map. In year three, the NOCHF team hosted on-site workflow analysis meetings with each grantee. The sessions lasted one and a half days each. On day one, the NOCHF team and a team of employees from multiple levels and departments (including front desk staff, medical assistants, billing staff, information technology staff, financial and administrative staff) mapped out the current state of the process. On day two, the teams developed an action plan toward a future-ideal state to inform the process improvement technical assistance work.

Process improvement - The NOCHF team developed work plans with each of the grantees to address gaps and opportunities for improving the depression screening processes at each site. Following work plan development, the NOCHF team coordinated and conducted monthly calls with each grantee for six months. On the calls, the NOCHF team received updates on progress toward goals and coached the grantees on best practices around specific issues for improving the depression screening processes.

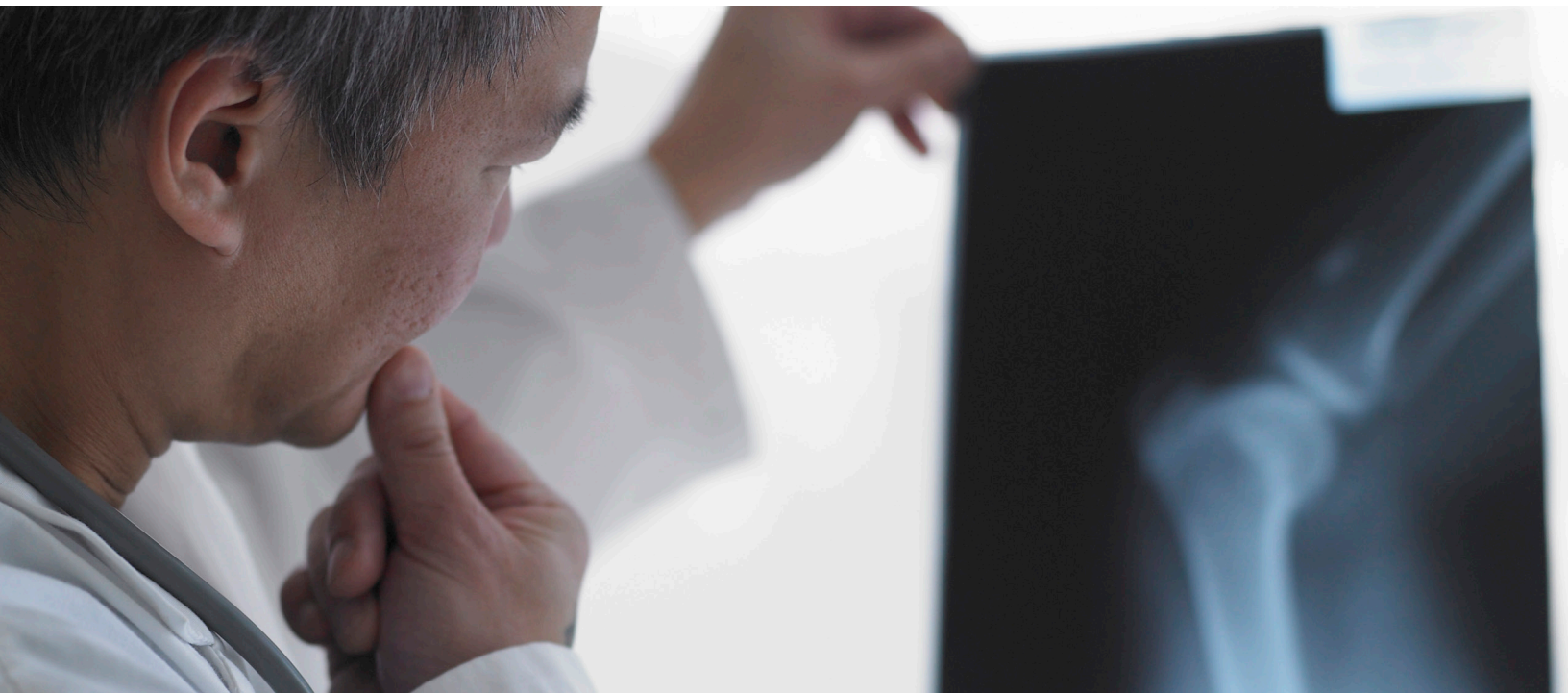
Best practices and models - The NOCHF team provided technical assistance and opportunities for grantees to capture, share, and disseminate lessons learned at learning community meetings.

Monitoring and reporting - The NOCHF team provided technical assistance around monitoring and reporting QI through learning communities, site visits, one-on-one training with data reporting staff, and specific guidance within the BHI reporting tool.

Sustainability – In order to assist program grantees in developing plans for sustaining integration, the NOCHF team provided technical assistance opportunities that addressed financing and sustainability co-facilitated by the National Council for Behavioral Health and SAMHSA-HRSA Center for Integrated Health Solutions. Activities included learning community sessions, a webinars series, coaching calls, and in-person meetings. All of the grantees are able to maintain integrated services beyond the NOCHF grant period.

EHR optimization - The program team convened a work group of champions within the NOCHF grantees to focus on changes to the EHR system to support their integration work processes. The changes included three new behavioral health templates for validated screening tools used for screening and monitoring patients for depression and suicide risk.

Reporting and self-monitoring optimization - The NOCHF team led an initiative to optimize the data reporting process by working with the EHR vendor to develop a reporting template for quality managers to monitor rates of depression screening. The report was standardized, with minor customization to tailor the report to each grantee's needs.



Administrators of the Tulane Educational Fund (Tulane)

Expanding Access to Integrated Primary Behavioral Health Care to Adults and Adolescents through Federally Qualified Health Centers (FQHCs) and School-Based Health Centers (SBHCs)

The Administrators of the Tulane Educational Fund (Tulane) operated two service delivery sites: Tulane Drop-in Clinic and Ruth Fertel Tulane Community Health Center.

The Tulane Drop-In Clinic is a health center serving high-risk and homeless youth up to age 24 and provides primary care and behavioral health, with additional immunization and HIV services. This clinic is located within Covenant House, a shelter that serves at-risk and homeless individuals. The Tulane Drop-in Clinic had a behavioral health provider prior to the inception of the NOCHF program.

The Ruth Fertel Community Health Center (CHC) is a Federally Qualified Health Center (FQHC) that was originally operated by Tulane. Ruth Fertel CHC had behavioral health services prior to the start of the NOCHF program through medical and psychiatry residents affiliated with Tulane University School of Medicine. Additional community and social services partners with the site included: Boys Town of Louisiana, Brotherhood, Inc., Connect to Protect, Covenant House New Orleans, Liberty House, Mind-Body Center of Louisiana, National Alliance for Mental Illness, NO/AIDS Task Force, NOPD Homeless Collaborative, NR Peace, Odyssey House, St. Anna's Medical Mission, UNITY of Greater New Orleans, and Women with a Vision.

The Ruth Fertel CHC and Tulane Drop-in Clinic underwent several systematic and operational changes during the NOCHF program period that impacted the program activities. In year one, Access Health Louisiana (AHL) assumed day-to-day operations of the Ruth Fertel CHC. However, Tulane maintained and provided physician services at the site. Simultaneously, the medical director and grant administrator departed from the Ruth Fertel CHC. As a result of the change in operator, the Ruth Fertel CHC changed its behavioral health service provision policies and procedures. At the start of the NOCHF grant, Tulane also operated two school-based health centers (SBHCs); in the second year, Cohen SBHC closed and Warren Easton SBHC transferred management to AHL. When the Cohen SBHC closed, the patients were referred to the Ruth Fertel CHC and the Drop-In Clinic for continuity of services. In September 2015, the NOCHF team worked with the Cohen High School and AHL to re-open the SBHC. AHL did not report numbers directly to the NOCHF team on this site as it was not linked to the NOCHF program. However, the site continues to remain open with integrated services available to Cohen High School and two additional school sites in the charter school operator's network of schools.

At both of its sites, Tulane's goal for the NOCHF program was to address two specific populations through implementation of the IMPACT model[1] of depression care: 1) medically underserved adult and pediatric patients, and 2) high-risk patients with serious mental illness or PHQ-9 greater than 20 (indicating severe depression). Tulane's goals also included expanding its care team and optimizing its EHR for care coordination and population health management.

Tulane, in order to meet the above stated goal of implementing the IMPACT model of depression care, had three programmatic aims:

- **Aim 1: Improve the quality of care and health outcomes for patients with depression.**
  - Enhance medical home care team support for integrating primary care with behavioral health and social services.
  - Enhance care coordination for high-risk patients.
  - Diversify scope of service for behavioral health care by licensed providers.
- **Aim 2: Establish behavioral health workforce and expand the use of HIT for the integration of primary care, behavioral health and social services in the medical home setting.**
  - Train staff on the IMPACT model.
- **Aim 3: Disseminate best practices for integrating primary care, behavioral health, and social services.**

[1] The IMPACT model, developed by Jürgen Unützer, Professor and Vice Chair, Psychiatry and Behavioral Sciences, University of Washington, is a flexible, evidence-based approach to treating depression in the primary care setting.

Year One Summary of Activities

- Added four behavioral health providers across the two NOCHF sites and included integrated care and the IMPACT model of depression care as standard curriculum for new medical residents.
- Formalized new referral partnerships for social services in the community for both sites, and enhanced partnerships with community stakeholders to support integrated care.
- Developed the integrated care workforce through training of clinicians, as well as providing mind-body training to 11 Tulane staff members through a project partner, the Mind Body Center of Louisiana.
- Developed and refined policies and protocols aimed at improving screening, identification, referral, and treatment of patients with co-occurring physical health and behavioral health needs.

In year one, Ruth Fertel CHC:

- Worked together with a new clinic operator, Access Health Louisiana (AHL), and new staff to share best practices and revise protocols while undergoing organizational changes.
- Improved its pre-existing PHQ-2/-9 depression screening by working to identify gaps in screening, documentation, referrals, and care plans within the depression care pathway.
- Assisted the Tulane Drop-in Clinic on standardizing practices across adolescent medicine sites (the Drop-In Clinic and SBHCs), a process that helped the Tulane Drop-In Clinic and SBHCs gain re-certification as a National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH).

In year one, Tulane Drop-In Clinic:

- Revised its depression care workflow for documenting PHQ-2/-9 results in the EHR in order to create an EHR registry to track patients with moderate to severe depression and to query reports for external reporting.
- Received assistance from Ruth Fertel CHC on standardizing practices across adolescent medicine sites, which helped in its re-certification process as an NCQA PCMH.

Year Two Summary of Activities

Tulane saw significant progress towards achieving two of its established aims: 1) improve the quality of care and health outcomes for patients with depression, and 2) establish formal workforce development on use of HIT, the integration of primary care, behavioral health and social services in the medical home setting.

In year two, Tulane achieved Aim 1 by accomplishing the following:

- Fully incorporated the PHQ-2 screening tool into the EHR at the Ruth Fertel CHC.
- Added the PHQ-2 screening tool for medical assistants to administer during patient triage.
- Increased the PHQ-2 screening rate by 42% over the previous year as a result of implementing the tool.
- Fully adopted standardized PHQ-2/-9 screening and reporting processes at the Tulane Drop-In Clinic.
- Standardized social service referral documentation at both the Tulane Drop-In Clinic and Ruth Fertel CHC.

In year two, Tulane accomplished Aim 2 by accomplishing the following:

- Established formal workforce development on the integration of primary care and behavioral health.
- Enabled Ruth Fertel CHC to focus on financial sustainability of behavioral health services as a member of a large FQHC network, while maintaining partnerships with Tulane providers.
- Preserved continuity of care by receiving patients referred to them with the closing of the Cohen SBHC.

In year two, Tulane Drop-In Clinic:

- Enhanced care coordination by implementing integrated team huddles, allowing providers to target interventions to the most urgent cases.
- Implemented regular huddles for behavioral health and PCPs to discuss cases.
- Hired a physician with dual licensure in internal medicine and psychiatry.

In year two, Ruth Fertel CHC:

- Launched a group psychotherapy intervention.
- Established an expanded role as a training site for Tulane School of Medicine's combined internal medicine and psychiatry residency program.

Year Three Summary of Activities

Ruth Fertel CHC and Tulane Drop-In Clinic participated in the NOCHF QI initiative, which propelled them towards further accomplishing the original goal and program aims. Both Ruth Fertel CHC and Tulane Drop-In Clinic standardized documentation of PHQ-2/-9 results in both sites EHR. Each also increased the number of warm handoffs performed through provider education.

In year three, the Ruth Fertel CHC:

- Through the NOCHF QI initiative, identified no-show patients as a barrier to improved efficiency, and thus implemented a shadow schedule to improve billing processes and clinical efficiency of providers.
- Implemented new care coordination techniques to reduce no-shows and improve visit attendance.
- Optimized capacity by using volunteers and interns to connect patients to social service programs while waiting in the waiting room.
- Enhanced its workforce development by training four internal medicine/psychiatry and 21 internal medicine resident physicians on the IMPACT model, care team roles, and the utilization of HIT for population health management and care coordination.
- Developed two new handoff protocols – a 15-minute, short, warm handoff and a 30-minute, behavioral health consult—which improved billing for time spent with patients.

In year three, the Tulane Drop-in Clinic:

- Began screening patients with the PHQ-9 at every visit and achieved successes in clinic efficiency in billing.
- Reduced behavioral health session times to 30 minutes, which follows evidence-based guidelines for appropriate care, and thus doubled the number of patients seen each day creating a basis of a more sustainable and accessible model for BHI.
- Involved patients and staff in the hiring process for a new licensed clinical social worker and community health worker to coordinate behavioral health and social services.

Overall Summary of Activities and Accomplishments

"I was in a pretty bad state- emotionally, physically, and mentally… But they pretty much saved me… I can't stress enough what it has done for me as a whole."
- Patient of Ruth Fertel Community Health Center

Over the three-year NOCHF grant period:

- **Ruth Fertel CHC saw over 17,000 patient visits, and Tulane Drop-in Clinic saw 6,800 patient visits.**
- **Based on the time frame with the most complete data (Y2Q2 to Y3Q4), Ruth Fertel CHC increased the proportion of patients screened by 66.3%.**
- **Based on the time frame with the most complete data (Y2Q2 to Y3Q4), Tulane Drop-in Clinic increased the proportion of patients screened by 19.7%.**
- **Over the 3-year grant period, Ruth Fertel CHC and Tulane Drop-in Clinic collectively made 2,126 social services referrals.**

With additional support of the NOCHF program, Tulane's sites also:

- Conducted 201 real-time training sessions during weekly resident continuity clinics throughout the duration of the NOCHF grant.
- Trained four internal medicine/psychiatry and 21 internal medicine residents.
- Improved its overall ability to track and monitor depression process outcomes, which can lead to an improvement in quality of care and health outcomes for patients with depression.

At the start of the NOCHF grant, Tulane Drop-in Clinic had 5.9 Full Time Equivalents (FTEs) in overall staff, 0.9 of which were behavioral health staff. The Ruth Fertel CHC had 18.7 FTEs in overall staff with 2 FTEs in behavioral health staff. By the end of the NOCHF grant period, both clinics were able to significantly increase provider availability due to the funding from the grant. At the end of year 3, Tulane Drop-in Clinic had 7.3 FTEs in overall staff with 2.2 FTEs in behavioral health staff; Ruth Fertel CHC had 37 FTEs in overall staff of which 7 FTEs were in behavioral health staff. During the grant period, the Tulane Drop-In Clinic also diversified its scope of service for behavioral healthcare through conducting individual and group psychotherapy to enhance self-management.

"… the ease at which our primary care providers know and understand that behavioral health providers are available to assist with those complicated patients that they need help with, and it has essentially resulted in better outcomes for our patients."
–provider at Ruth Fertel Community Health Center

Tulane's focus on improving sustainability of behavioral health services included behavioral health providers at Ruth Fertel CHC (who were formerly employed by Tulane) being formally hired by AHL, the new FQHC operator, to continue in its role past the completion of the NOCHF program. Ruth Fertel CHC and Tulane Drop-In Clinic improved billing for behavioral health services to be sustainable beyond the end of the grant.

AHL also began rolling out a standardized depression screening protocol across all 25 of its sites in Louisiana, modeled after the Ruth Fertel CHC process that was initiated under the NOCHF program. This protocol, developed under the NOCHF program, will be disseminated and implemented across the largest FQHC network in Louisiana spanning more than five parishes.

Access Health Louisiana (AHL)/Jefferson Parish Public School System School-Based Health Centers (SBHCs)

Expanding Access to Integrated Primary Behavioral Health Care in School-Based Health Centers in Jefferson Parish Public Schools

Access Health Louisiana (AHL) is an FQHC network that provides integrated behavioral health and primary care services to five school-based health centers (SBHCs). In total, these SBHCs serve 12 middle and high schools in Jefferson Parish and are housed within five schools. SBHCs are a valuable community resource as co-location within schools removes typical barriers of access to care for children and adolescents such as trust, follow-up, transportation, and scheduling. SBHCs were motivated to take part in the NOCHF program in order to leverage trusted health care delivery structures in schools to increase behavioral health services for at-risk youth. The SBHC staffing model includes a part-time physician, full-time nurse practitioner, nurse, medical assistant, and social worker. The services provided at the SBHCs are free to students and include prevention and treatment of conditions and ongoing assessments (e.g. required physicals). Prior to initiating the NOCHF program, the SBHCs were providing mental health services. The Jefferson Parish (JP) Public School System is a partner in the service delivery and management of the SBHCs. In addition to partnering with the JP Public School System, AHL partnered with the JP Juvenile Court and the Adolescent School Health Program, a program of the Louisiana Office of Public Health. AHL chose to work on two additional focus areas in addition to BHI including: 1) expanding services for students with delinquency issues, and 2) enrolling eligible students into the Louisiana Children's Health Insurance Program (LaCHIP). Total enrollment (students whose parents consented for their care at the SBHC) at the five SBHCs was 8,171 students at the start of the grant.

The SBHCs' overall goals for the NOCHF program included:

1. **Expand access through increased capacity at each SBHC.**
2. **Increase referrals to social services through risk assessments and case management.**
3. **Provide systematic physical exams for all students who receive prescribed medication for behavioral health issues.**
4. **Improve billing for behavioral health visits.**

The SBHCs, in order to meet the above stated goals, had four programmatic aims:

- **Aim 1: Provide the Guidelines for Adolescent Preventive Services (GAPS)[2] screening assessment to 1,800 students during the three-year program.**
- **Aim 2: Provide behavioral health services to 9,000 students during the three-year program.**
- **Aim 3: Provide a comprehensive physical exam to 100% of students who receive prescribed medication for behavioral health issues.**
- **Aim 4: Of students who receive behavioral health services, 75% report avoiding physical confrontation/fights, improved anger management, and improved decision-making.**

[2] Guidelines for Adolescent Preventive Services (GAPS) includes 24 recommendations developed by the American Medical Association's Department of Adolescent Health that encompass health care delivery, health guidance, screening and immunizations to improve health care delivery to adolescents to prevent and reduce adolescent morbidity and mortality.

Year One Summary of Activities

The SBHCs enhanced capacity to provide integrated care at all five sites through requiring BHI orientation for all new staff to improve the their understanding of BHI processes and service delivery.

- The SBHCs partnered with Tulane School of Medicine psychiatry residents to expand behavioral health staffing capacity.
- Four new behavioral health staff members were added, serving students across all five sites.
- All five SBHC sites developed new BHI policies and protocols, identified students needing behavioral health services, leveraged technology and software for integrating care, and developed continuous QI policies and protocols.
- The improved and streamlined referral process between primary care and behavioral health providers led all five sites to screen more students for behavioral health issues. This increased the number of cases reviewed by integrated teams allowing them to accomplish Aim 1. Outreach led to increased patient volume and improved student awareness about the available integrated services.
- The SBHCs performed over 1,400 screenings in year one, more than doubling the initial goal.

Year Two Summary of Activities

The SBHCs continued to train staff on the EHR system, including streamlining workflow and processes in both systems.

In year two:

- The SBHCs began marketing behavioral health services through targeted school initiatives.
- The SBHCs began accommodating same-day, walk-in patients.
- All five sites' referral systems were further adapted to assure appropriate referral processes and tracking systems. The sites continued to see progress on referring students needing additional behavioral health services following GAPS assessments and increased documentation and tracking of these visits and referrals.
- Leadership at the SBHCs and JP Public School System worked together to create long-lasting referral networks with a neighboring clinic (Jefferson Parish Human Services Authority) and a social service provider (Nurse Family Partnership) for behavioral health, primary care, and social service referrals.

Year Three Summary of Activities

In year three:

- All five sites developed processes for tracking and reporting students receiving medication. Procedures were developed, implemented, and evaluated at all five sites to refer students on behavioral health medications for comprehensive physical examinations.
- The SBHCs designed and implemented a student satisfaction survey and assessment process to inform ongoing patient-centered care.

Additionally, through the NOCHF QI initiative, the SBHCs:

- Adopted the standardized PHQ-2/-9 tools to screen for depression. The use of a standardized evidence-based tool improved the systematic monitoring and treating of patients with depression. School based health centers began EHR optimization and standardization with the PHQ-2/-9.
- All five sites improved billing for behavioral health visits and provider credentialing.
- The staff of all five sites attended trainings for Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
- The staff of all five sites attended trainings for behavioral health interventions motivational interviewing, a client-centered counseling style that focuses on engaging motivation within the client to facilitate behavior change.
- All five sites prioritized enrolling uninsured students or students with barriers to insurance coverage in LaCHIP, improving overall billing efficiency of the SBHCs for both primary care and behavioral health visits.
- The SBHCs evaluated and improved monitoring, reporting, and tracking of behavioral health services, and developed a performance improvement process.

Overall Summary of Activities and Accomplishments

"Teaching [individuals] those skills, they teach their family, and they teach their friends…"

- SBHC provider

Over the three-year NOCHF grant period:

- The SBHCs saw 5,950 patients for behavioral health visits.
- The SBHCs increased BHI organizational capacity through hiring behavioral health staff and developing partnerships with child psychiatric services. The funding from the NOCHF program allowed the SBHCs to increase clinical staff from 4 FTEs of behavioral health staff to 6.5 FTEs across all five sites during the three-year grant period.
- The SBHCs worked toward their third aim: to provide 100% of students who receive prescribed medications for behavioral health with comprehensive physical exams in years one, two, and three. During the grant period, SBHCs succeeded in increasing the proportion of students with prescribed behavioral health medications who received a physical exam from 47% in year one to 76% in year three.
- The SBHCs' fourth program aim was to increase the proportion of students receiving behavioral health services who reported better behavior outcomes such as avoiding fights, improved anger management, and improved decision making. Upon the conclusion of the program, 42% of students surveyed reported avoiding fights, 39% reported improved anger management, and 91% reported improved decision making.

Sustainability

Overall, the SBHCs were able to improve billing and coding for behavioral health services throughout the NOCHF program. This enabled them to sustain the providers that were hired during the program period who remain critical to maintaining the successful provision of behavioral health services at the five sites. Further, SBHC staff reported the NOCHF training allowed them to build professional capacity for providing integrated services.

Catholic Charities Archdiocese of New Orleans/Health Guardians (CCANO)

Patient Navigation Support to Individuals with Complex Health Needs who are High Utilizers of Area Emergency Services Model: Camden Coalition of Healthcare Providers Care Management and Care Transition Program Model ("The Hot Spotters")

Catholic Charities Archdiocese of New Orleans (CCANO) is a large, faith-based social service agency serving the GNO area. CCANO had one site affiliated with the NOCHF grant, and multiple additional sites offering other social services throughout the GNO area. CCANO serves patients through enrollment in a specialty program based on the Camden Model (Camden Coalition of Healthcare Providers, Camden, N.J.), which targets high utilizers of medical services with a high-intensity, holistic, social services and medical care integration program. CCANO's program, Health Guardians, specializes in serving patients with multiple chronic conditions. Program staff at CCANO work with participants referred from hospital partners to address health care, behavioral health, and social needs to improve outcomes and overall quality of life. Participants are approached to join the Health Guardians program based on hospital referral criteria, including lack of primary medical home or lack of appropriate use of their medical home. Participants may receive assistance with prescriptions, medical equipment and supplies, nutritious foods, group cooking classes, physical activity groups, financial education, health education, and application assistance for disability benefits and other social services. Participants in the Health Guardians program are considered to have 'graduated" following the client's fulfillment of the criteria for graduation. The criteria for graduation include: a) the patient has not been in the emergency room or hospital for the past 30 days; b) the patient understands his/her medical conditions and treatment plan; c) the patient knows how and when to take prescribed medications; and d) the patient has been to a PCP or has been enrolled in long-term care.

CCANO's overall goal in participating in the NOCHF grant was to develop a coordinated approach to medical, behavioral, and social services that improves health outcomes for high-need patients.

CCANO, in order to meet the above stated goal, had three programmatic aims:

- **Aim 1: Decrease emergency department and hospital use by the target population for healthcare needs that are best addressed by a community provider.**
- **Aim 2: 85% of patients will be able to understand their medical conditions and treatment plans by graduation from Health Guardians program.**
- **Aim 3: Improve self-reported quality of life for patients enrolled in the program, as measured by a 20% increase of their Healthy Days measure by the time of graduation.**

Year One Summary of Activities

In year one, CCANO:

- Adapted and refined policies and protocols for patient navigation.
- Expanded organizational BHI capacity by hiring new staff.
- Exceeded the original recruitment goal and trained emergency department staff on recruitment.
- Developed a use-case to participate in the Greater New Orleans Health Information Exchange (GNOHIE).
- Developed new partnerships with New Orleans Emergency Medical Services and other social services and health care providers.
- Developed and enhanced its electronic record system to support documentation, referrals tracking, and monitoring.

Year Two Summary of Activities

In year two, CCANO:

- Increased its annual goal of patients enrolled in the Patient Navigation program from 40 patients to 80 patients.
- Successfully recruited 77 patients, which amounted to 73% of those referred.
- Enhanced its electronic client management system to include evidence-based behavioral health screening and risk stratification tools, insurance information, and services delivered.
- Was accepted as a provider in the GNOHIE. This allows CCANO to use secure electronic messaging and the GNOHIE's record system to coordinate care across multiple providers.
- Received credentials from the State of Louisiana as a Medicaid rehabilitations service provider of psychosocial rehabilitation and community-based psychosocial treatment. CCANO is now able to bill for some services, thereby enhancing sustainability of the Health Guardians program.
- Received an additional grant from a local funder, Baptist Community Ministries, to build on its NOCHF program activities to develop diverse revenue streams for sustainable programming.

Year Three Summary of Activities

"We've been able to help people within the New Orleans community [by] getting them to a medical home, helping them navigate the health care system."
– CCANO staff member

CCANO increased its annual goal of patients enrolled in the Patient Navigation program from 80 to 120 patients enrolled. In year three, the program successfully recruited 68 patients, which amounted to 57% of those referred. In addition:

- 58% of patients who had been in the program for 90 days had no hospitalizations for at least 30 days upon graduating the program
- 89% of unduplicated patients had at least one recorded primary care visit
- 83% of patients who had been in the program for 90 days and had documented PHQ-4 greater than three (indicative of possible depression diagnosis) had at least one counseling session documented.

In year three, CCANO:

- Showed an improvement from 53% of patients reporting understanding their medical condition and treatment to 67%.
- Showed an increase in the number of patients with at least one health education session (from 86% at the start of year three to 100% at the end of year three), which may correspond to a higher number of patients being able to understand their medical condition and treatment plan.
- Improved perceived quality of life as measured by an increase in score on the Healthy Days measure. The proportion of patients reporting a 20% or greater improvement on the Healthy Days measure improved from 25% (n=9) in the first quarter of year three to 45% (n=13) in the final quarter of year three, for an overall year three average of 36%.
- Developed a management dashboard, which allowed administrators to better manage staff and monitor quality, and also allowed the patient navigators to better manage service delivery.
- Received a long-term grant managed by UNITY of Greater New Orleans to provide intensive case management and patient navigation to individuals who were homeless and now live in the Sacred Heart Apartments, by leveraging the program's capabilities with high-need populations.
- Enrolled 32 clients for case management services through Health Guardians at the Sacred Heart Apartments.
- Received a contract with LPHI's Greater New Orleans Community Health Connection - Primary Care Capacity Project Quality Improvement Initiative (GNOPQii)[3] to provide intensive patient navigation services to qualifying high-risk patients of ten FQHCs in the New Orleans area. Navigation services will include intensive case management services: appointment attendance, social service application assistance, medication assistance program application assistance, health education, behavioral health services, and primary care appointment attendance.
- Was awarded the Louisiana Quality Foundation's Level 1 Performance Excellence Award for 2014, exemplifying the program's level of quality of service provided.

CCANO's QI initiative with the NOCHF team focused on strategic thinking around the program and developing an updated logic model for Health Guardians that has been used in marketing, communications, and development of new activities.

Overall Summary of Activities and Accomplishments

"We're helping hospitals because we're allowing for more beds to be available for people who really have emergencies, not just going in to get a prescription, so it's helping the community as well on a larger scale, save money."
- CCANO staff member

Over the three-year NOCHF grant period:

- CCANO reported seeing 267 patients in the Health Guardians program.
- The Health Guardians Program saw an increase in patient volume from year two (n=63) to year three (n=149), an increase of 36%.
- CCANO increased its proportion of patients screened for depression from 90.7% in year one to 99.3% in year three.
- The Health Guardians made 1,160 social service referrals.
- CCANO increased the number of FTEs in total staff including an increase in behavioral health staff. At the start of the NOCHF grant, Health Guardians had 3.53 FTEs in total staff, of which 2.25 FTEs were behavioral health staff; at the end of year three, the program had 7 FTEs in total staff with 6 FTEs behavioral health staff.

Sustainability

"…Comparing before and after NOCHF, we're able to do more. The health education is more robust, helping people understand… more about their condition so that they're compliant with their medications. That's improved."
–CCANO staff member

CCANO will continue the work of the Health Guardians program through the Permanent Supportive Housing (PSH) program at Sacred Heart Apartments and through the GNOPQii program housed at LPHI. CCANO has been able to retain and hire patient navigators and other support staff for these programs. The GNOPQii program in particular will build upon the success of Health Guardians during the NOCHF grant by expanding the number of patients enrolled and providing systematic care coordination for the highest-risk patients in the low-income primary care setting in GNO. A refined data tracking and monitoring system, as well as updated measures, will help CCANO demonstrate the effectiveness of the program and more efficiently deliver services based on need and evidence of success.

[3] LPHI's Greater New Orleans Community Health Connection - Primary Care Capacity Project Quality Improvement Initiative (GNOPQii) is a initiative to reduce emergency room and inpatient hospital readmissions, and increase care coordination across agencies with a focus on improving access to primary health care, disease management and behavioral health integration.

EXCELth, Incorporated

Expanding Access to Integrated Primary Behavioral Health Care through FQHCs using Telemedicine and the Primary Care Behavioral Health (PCBH) Consultant Model

EXCELth, Incorporated (EXCELth) is an FQHC providing comprehensive services to populations throughout Orleans Parish at three separate sites: New Orleans East, Gentilly, and Algiers. In addition, EXCELth manages a freestanding behavioral health site in Baton Rouge that is not affiliated with the NOCHF grant. The New Orleans East clinic site opened during the course of the NOCHF grant to provide access to care for a medically underserved region of the GNO area. To enhance BHI efforts through the IMPACT, Chronic Care Model (CCM), and PCMH models, EXCELth implemented the Primary Care Behavioral Health Consultation (PCBH) model. The PCBH model assigns a licensed mental health professional or "consultant" to the primary care team. The consultant shadows the PCP and provides brief screenings and interventions to improve and promote overall health within the clinics' population. EXCELth had behavioral health providers before the start of the NOCHF grant, but did not provide integrated care. The implementation of the PCBH model was intended to move EXCELth from co-located care further along the continuum toward integration. EXCELth's project partners include Metropolitan Human Services District, JPHSA, and UNITY of Greater New Orleans.

EXCELth's overall goal in participating in the NOCHF grant was to enhance BHI efforts.

EXCELth, in order to meet the above stated goal, had three programmatic aims:

- **Aim 1: Increase access to care for the target population through service expansion by implementing the CCM and IMPACT model.**
- **Aim 2: Assure access to social services and other enabling services.**
- **Aim 3: Incorporate PCBH consultation services within the primary care delivery system.**

EXCELth proposed to implement the CCM and the IMPACT model of BHI. Its target populations were patients at-or-below the poverty level, patients with a clinical diagnosis of depression, and patients with chronic disease such as diabetes within its catchment areas of Algiers, Gentilly, and New Orleans East.

Year One Summary of Activities

EXCELth focused on the following three areas: 1) integrated care service expansion, 2) clinical systems interventions, and 3) community collaborations in order to establish a framework to improve access to care, coordinate disease management, and strengthen referral networks.

In year one, EXCELth:

- Expanded access to behavioral health services by implementing two evidence-based models: the IMPACT model for depression care and the CCM.
- Developed new integrated care and tele-behavioral health policies and protocols.
- Enhanced the use and documentation of the PHQ-2/-9 depression screening tools.
- Expanded its referral network through new partnerships.
- Hired four new behavioral health staff.
- Reported enhanced collaboration between primary care and behavioral health staff through the training and implementation of the CCM and IMPACT depression care model. This improved effectiveness of collaboration between primary care and behavioral health providers and cohesiveness as the team collectively strived to treat each person holistically.
- Increased the frequency of behavioral health referrals from primary care.
- Completed 2,545 internal and external social services referrals.

Year Two Summary of Activities

"We are bonded by mutual respect, dedication to our mission, and commitment to the well-being of our patients. Together, we are encouraging more innovation, partnering with more stakeholders, using evidence-based results to monitor progress and adapt accordingly, building more integrative approaches and harnessing technology to improve health." – EXCELth staff member

In year two, EXCELth celebrated the grand opening of the Family Health Center in New Orleans East. Throughout the year, the overall patient population of EXCELth grew by 32% with the addition of the new site. The patient population of the New Orleans East catchment area is slightly different from EXCELth's other catchment areas, with a larger Hispanic population contributing to the tripling of patients reporting Hispanic/Latino ethnicity. The New Orleans East site became the pilot site for the BHI project funded by the NOCHF program.

The clinic staff welcomed the implementation of the PCBH model, which:

- Prompted periodic reviews of clinical, HIT, social services, and referrals operating systems, and developed several new standardized policies based upon these reviews throughout its implementation.
- Improved disease prevention efforts through health education and improved access.
- Improved identification of physical and behavioral health conditions through screening.
- Improved follow-up and access to care for quick resolution and wellness.
- Provided focused feedback to PCPs through action-oriented recommendations.
- Expanded EXCELth's network of social service partnerships, allowing patients to access resources such as nutrition support, exercise classes, rental assistance, and other social needs.
- Contributed to a reduction in wait times for psychiatry services by increasing productivity and self-efficacy of PCPs.
- Established a collaborative system between the PCPs and PCBH consultant that supported the PCPs in prescribing an initial trial of psychotropic medication, thereby eliminating the need for an appointment with a psychiatrist.
- Led to the development of an agency-wide behavioral health brochure for patients, improving overall knowledge of behavioral health services provided by the agency.

Year Three Summary of Activities

EXCELth continued to improve its referral system resulting in patients receiving better access to services such as rental assistance, nutrition guidance, and access to a crisis hotline number.

In year three, EXCELth:

- Implemented a uniform screening protocol resulting in higher screening rates for patients aged 12 and older.

Through the QI initiative led by the NOCHF team, EXCELth:

- Focused on improving the sustainability of the behavioral health program and standardizing its PHQ-2/-9 clinical workflow.
- Improved billing and coding procedures for behavioral health.
- Applied aspects of its depression screening workflow from the New Orleans East site to two additional sites. The New Orleans East site began using the EHR template, developed through the NOCHF collective, to systematically track PHQ-2/-9 scores over time.

Overall Summary of Activities and Accomplishments

Over the three-year NOCHF grant period, EXCELth:

- Had over 34,000 patient visits with a 20% increase from 10,164 patient visits in year one to 12,226 visits in year three.
- Increased its depression screening rate from 29.4% in year one to 51.1% in year three.
- Increased patient access to providers by increasing its total staff from 18.5 FTEs, of which 3.7 FTEs were behavioral health staff, in year one to 31.5 FTEs in total staff, of which 8 FTEs of behavioral health staff, in year three.
- Made over 12,000 internal and external social services referrals.
- Successfully completed Aim 3, to incorporate PCBH consultation services within the primary care delivery system, after successfully deploying the model in the previous year with the hiring of a PCBH consultant.

Sustainability

EXCELth is well positioned to continue building its behavioral health program through the PCBH model. EXCELth will retain its BHI staff and continue to improve and expand the scope of its work in BHI. EXCELth now has improved billing and coding procedures that will allow the organization to bill for behavioral health services. EXCELth will use the standardized EHR template to continue to track and monitor behavioral health service provision and quality.

Jefferson Parish Human Services Authority (JPHSA)

Expanding Access to Integrated Primary Health Care in a Behavioral Health Organization

JPHSA is a local governing entity created by the Louisiana State Legislature to provide community-based behavioral health and developmental disability services to the citizens of Jefferson Parish. In July of 2012, JPHSA expanded access to integrated care by adding primary health care services in its behavioral health facilities, also known as a "reverse co-location" model of integrated care. The JPHSA health centers, known as JeffCare, utilize the Collaborative Care Model and serve as one-stop providers for individuals living with severe and persistent mental illness, substance use disorders, and/or a developmental disability.

JPHSA began the NOCHF grant as a community mental health agency with two sites interested in expanding primary care services. The implementation began at the location with a higher volume of patients, the West Jefferson Health Center. With support of the NOCHF grant, JPHSA began providing primary health care services at the West Jefferson location, with plans to expand to the East Jefferson Health Center. **In November of 2013, JPHSA and its co-applicant, JeffCare, were awarded a New Access Point grant and FQHC designation by HRSA.** As a result of adding primary care services during the program period, JPHSA is the only NOCHF grantee with a reverse co-location model of integrated care.

JPHSA's project partners include the Jefferson Parish Coroner's Office, the Jefferson Parish Sheriff's Office, the Office of Probation and Parole, West Jefferson Medical Center, Catholic Charities, EXCELth, Inc., and Jefferson Parish Homeless Outreach.

JPHSA's overall goal in participating in the NOCHF program was to reduce early mortality among seriously mentally ill (SMI) patients by integrating primary care services into its behavioral health service portfolio and increasing access to the social services within JPHSA and the community.

JPHSA, to meet the goal stated above, had three programmatic aims:

- **Aim 1: Reduce early mortality among SMI individuals by implementing primary care services that are fully integrated with JPHSA's behavioral health services and with social services within JPHSA and in the community.**
- **Aim 2: Develop support for integrated services.**
- **Aim 3: Obtain FQHC Look-Alike status and enhanced reimbursement rates to support services for uninsured people and sustain the comprehensive integrated services.**

Year One Summary of Activities

In year one, JPHSA:

- Launched primary care services for a population with social and financial barriers.
- Trained two family practice nurse practitioners to treat individuals with a serious mental illness and/or addiction issue.
- Repurposed and renovated two rooms into functional medical exam rooms.
- Applied for a New Access Point FQHC grant.
- Implemented an integrated EHR system.
- Developed new partnerships (for example, with the CCANO Health Guardians program).
- Provided initial training to organizational leadership responsible for integrated clinic based services for the FQHC.

Year Two Summary of Activities

"Without the funding and support provided by the NOCHF grant, JPHSA would not have been able to continue and expand its primary care services as we have in this second year." - JPHSA staff member

In year two, JPHSA:

- Addressed key workflow issues, improved teamwork and understanding of the integration model, developed a relationship with EXCELth to enhance its referral network, and increased the number of behavioral health patients who were linked to primary care.
- Formalized a discount fee policy for uninsured patients, and finalized the sliding fee scale for services.
- Completed a request for proposal process, selecting SuccessEHS as its single EHR system for all primary care, behavioral health, and integrated care services.
- Hired and trained three family practice nurse practitioners.
- Expanded services in the East Jefferson Health Center.

Additionally, JPHSA:

- Developed policies and procedures for integrated services and internal referrals, including social services.
- Received FQHC designation, a major accomplishment toward sustainability and integration.
- Formalized external relationships for comprehensive services with the implementation and maintenance of collaborative endeavor agreement or affiliation agreements with EXCELth, Inc., CrescentCare, West Jefferson Medical Center, and the Interim LSU Public Hospital to ensure a continuum of care for individuals needing services beyond primary care.

Year Three Summary of Activities

In year three, JPHSA:

- Expanded target clientele to include children, adolescents, and individuals seeking primary care only services.
- Overcame a knowledge management hurdle by ensuring that primary care and behavioral health providers use the same EHR for the same patients, which was a significant success towards accomplishing Aim 2.
- Improved front office workflow procedures and identified areas to improve customer service through patient satisfaction measures.
- Re-trained employees in integrated care processes, which led to improved patient tracking methods and a greater understanding of primary care workflow.
- Continued its progress in Aim 3 by implementing its business planning process with the new board in the third quarter of year three.

JPHSA participated in the year three QI initiative through the NOCHF grant. Through this initiative, JPHSA took several important steps to achieve its initial goals and move towards an evidence-based model of care. Specifically, JPHSA:

- Launched a performance and QI committee for monitoring and identifying initiatives for QI.
- Developed an integrated care plan in SuccessEHS and assigned PCPs to integrated teams.

Overall Summary of Activities and Accomplishments

"They're beginning to recognize that if a person takes care of themselves physically, they feel better and therefore some of their depressive symptoms reduce." - JPHSA staff member

Over the three-year NOCHF grant period:

- JPHSA saw a total of 27,461 patients, with an increase of 54.7% from 6,594 patients in year one to 10,206 patients in year three.
- JPHSA exceeded its goal of 450 patients screened for physical health care needs each year of the NOCHF grant.
- JPHSA performed 4,602 screenings for primary care, and more than doubled the percent of patients seen at the West Jefferson Health Center who were screened or treated for a physical health issue from year one to year three.
- JPHSA increased its overall staff from 13.8 FTEs to 34.1 FTEs and its behavior health staff from 8.9 FTEs to 9.9 FTEs between years one and three.
- JPHSA added 2.0 FTE primary care nurse practitioners, 2.0 FTE medical assistants, and 2.0 FTE care coordinators to provide integrated care services.

Sustainability

"[The care I received from the clinic] has been a life saver. I can't imagine what would have happened had I not been able to have such a smooth transition from losing my insurance into here- there really wasn't a loss in the services…On the physical and emotional side there are certain things that are always present, but when I first came, I was in a state to where I couldn't even have a conversation without crying and crying and crying. That's much improved."

-Patient of JPHSA

JPHSA's expansion into providing primary care at the affiliated JeffCare sites has allowed for further opportunities to achieve sustainability. During the NOCHF program, JPHSA obtained status as an FQHC, allowing for greater reimbursement and spurring volume growth. Through the QI initiative in year three, staff became more efficient at billing for behavioral health services and adopted a single EHR to integrate behavioral health and primary care services across sites, a critical step in reporting and documentation that is necessary to optimize billing, coding, and reimbursement. JPHSA and JeffCare have placed great emphasis on monitoring and reporting quality metrics, the addition of a quality and care coordinator, and a new clinical QI process.

New Orleans East Louisiana Community Health Center (NOELA)

Expanding Access to Culturally and Linguistically Appropriate Integrated Primary Behavioral Health Care Services

The New Orleans East Louisiana Community Health Center (NOELA) is a stand-alone FQHC that serves the New Orleans East community. NOELA serves a largely Asian population (40% of total patients, as opposed to an average of 6% at other NOCHF grantee sites), owing to the large number of Vietnamese residents in the New Orleans East community. NOELA served 81% of all Asian patients seen at NOCHF member sites in year three, quarter four. NOELA also has a large Hispanic/Latino patient population (13% of total patients, as compared to 7% of the NOCHF population). Prior to the start of the NOCHF grant, NOELA did not offer integrated behavioral health services. Upon completion of the NOCHF program, NOELA provides comprehensive integrated behavioral health with a focus on systematic depression screening and referrals to behavioral health and social services. NOELA's project partners include Metropolitan Human Services District, Odyssey House, and Heart Exercise Therapy, LLC.

NOELA's overall goal in participating in the NOCHF program was to achieve BHI by implementing the IMPACT model, hiring and supporting care managers and behavioral health consultants to work with PCPs, and partnering with Metropolitan Human Services District and external psychiatrists to provide care to patients with serious mental illness.

NOELA, in order to meet the above stated goal, had three programmatic aims:

- **Aim 1: Assemble a behavioral health care management team to provide integrated evidence-based behavioral and primary care.**
- **Aim 2: Leverage key features of EHR to assist the behavioral health care management team with providing proactive, population-based management.**
- **Aim 3: Collaborate with community partners to provide holistic, evidence-based, person-centered care.**

Year One Summary of Activities

In year one, NOELA:

- Assembled an integrated care team consisting of a care manager, behavioral health specialist, exercise physiologist, acupuncturist, yoga instructor, consulting Vietnamese psychiatrist, and PCPs.
- Built capacity within the health center's EHR to generate disease registries and reports on key performance measures for integrated care.
- Began offering cognitive behavioral and brief intervention therapy to patients with behavioral health conditions.
- Recognized a need to implement an appropriate depression screening tool for NOELA's culturally diverse population, enhanced community partnerships, and trained all providers in integrated care.

Year Two Summary of Activities

"Everyone in the team is more aware of behavioral health needs…"
–NOELA provider

In year two, NOELA:

- Enhanced workforce development through an intensive EHR training for all staff.
- Implemented monthly care team meetings to improve communication across the BHI care team.
- Improved monitoring and reporting for high-risk patients.
- Achieved Aim 2 through evaluation and improvement of its depression care management registry system, outcome measures, and comorbidity risk appraisal scoring system.
- Implemented the Vietnamese Depression Scale (VDS), an evidence-based depression screening tool that has been externally validated for use in depression screening for Vietnamese-American patients. It received positive feedback from predominantly older Vietnamese patients at the clinic. The integration of this new screening tool workflow was a highlight in NOELA's second year of the grant.
- Focused on integration of holistic patient care into the overall patient self-care plan through the integration of an acupuncture clinic.
- Continued to include acupuncture services and exercise therapy/cardiac rehabilitation as part of the ongoing self-care plan in year two to achieve Aim 3.
- Continued to monitor participant satisfaction, coordinate patient care, and meet with partners to review progress and lessons learned throughout the life of the grant.

Year Three Summary of Activities

"By participating in the NOCHF program, NOELA has been afforded the opportunity to learn from and work alongside other community organizations that share similar goals of increasing access to care, improving population health, and promoting sustainable systems change"
– NOELA staff member

In year three, NOELA:

- Improved its behavioral health care management teams by offering trainings to providers and staff on key BHI principles. The trainings included a consultation process with psychiatric specialists for difficult-to-manage behavioral health cases.
- Achieved Aim 1 upon completion of the hiring process for its behavioral health providers and care manager.
- Optimized the behavioral health consultant's time and instituted warm handoffs and internal referral mechanisms.
- Optimized billing for behavioral health services and integrated the PHQ-2/-9 into the clinic's workflow and EHR with the standard template, following the NOCHF QI initiative.
- Completed credentialing for several behavioral health providers through the initiative, which led them to be able to bill for behavioral health services already being provided.
- Started several targeted intervention groups for depression care.

Overall Summary of Activities and Accomplishments

"… as a result of the funding, we've been able to get staff in place and…. there's the great learning collaborative that has existed around the NOCHF… So definitely, I feel that the opportunity of working with NOCHF has really made a very big difference in us being able to do what we've been able to do."

- NOELA provider

Over the three-year NOCHF grant period, NOELA:

- Expanded from two separate adult and pediatric locations that totaled 2,500 sq. ft. into a new 8,900 sq. ft. building that houses both. The old facilities had a combined total of eight exam rooms; the new facility has 12 exam rooms in addition to a treatment room, two social services offices, and a community room.
- Recorded a 35.3% increase in patient visits from the start of the NOCHF program to the end owing to the physical expansion of facilities.
- Added a colposcopy clinic, allergy/immunology services, an eye clinic, and colorectal, breast, and cervical cancer screening services.
- Increased its number of FTEs. At the start of the NOCHF grant, NOELA had 2.8 FTEs in overall staff and no behavioral health staff. By the end of year three, they had 5.3 FTEs in overall staff with 1.4 FTEs in behavioral health staff.
- Achieved NCQA PCMH Level 3 recognition and gained status as an FQHC during the grant period.
- Implemented an evidence-based depression screening process into the primary care workflow. Prior to the NOCHF grant, NOELA was not systematically screening and referring for depression.
- Since implementing the PHQ-2/-9 into the workflow, NOELA has increased its screening rates from 10.6% to 35.2%.
- Worked with experts from the National Council for Behavioral Health to improve billing and coding related to the behavioral health consultant's patient visits.
- Optimized its EHR to capture mental/behavioral health data. NOELA aims to use these data to monitor behavioral health for QI.
- Focused on providing culturally appropriate screenings and depression care for the substantial Vietnamese population that they serve, particularly those of advanced age. During the life of the grant, NOELA implemented the validated VDS tool for screening Vietnamese populations for depression and has received positive feedback from Vietnamese clients. NOELA screened over 30 patients with the VDS tool during year three.
- Continued to monitor patient satisfaction, coordinate patient care, and meet with partners to review progress and lessons learned throughout the life of the grant.

Sustainability

NOELA took steps to ensure sustainability of behavioral health services operationally and financially. Throughout the NOCHF program, NOELA's behavioral health consultant was trained on how to effectively bill and schedule visits for optimal reimbursement. NOELA built capacity for sustainable behavioral health services through training and additional grant funding. In addition, NOELA optimized its use of an EHR template for documenting and tracking behavioral health visits, which will help them monitor and treat patients more effectively.

Throughout the NOCHF program, NOELA made many positive changes to its system, structure, and services. NOELA expanded to a new site that integrated adult and pediatric care into one location. They also increased staff volume, hiring administrative staff, behavioral health staff, and primary care staff such as MAs, psychiatrists, licensed clinical social workers, licensed professional counselors, and medical technicians. Additionally, NOELA achieved an increase in NCQA PCMH recognition level from Level 1 at the time of project initiation to Level 3 at the time of culmination.

During the life of the grant, NOELA increased its capacity to provide care coordination, noting that they developed systems, facilitated by the GNOHIE, to receive and send notifications and clinical summaries for their patients who visit the emergency room or were admitted for inpatient care.

Sustaining Impact

Leveraging Opportunities for Policy and Reimbursement Reform

The NOCHF team worked in collaboration with Louisiana Medicaid and the NOCHF grantees to develop recommendations for reconsidering reimbursement and policies to support the sustainability of integrated care. The reimbursement and policy reconsiderations were informed by the challenges NOCHF grantees and community partners were facing related to sustaining integration beyond grant funding as well as addressing primary care and behavioral health providers' comfort level practicing in an integrated care setting. For example, one major challenge reported by NOCHF grantees was that patients needed to have a primary care visit on a different day than the behavioral health provider because reimbursement policies only allowed the clinic to bill the services on different days. When scheduled for two appointments on separate days, the patients had more difficulty attending both appointments because of barriers such as transportation, child care, and work schedules. The NOCHF team developed strategic partnerships by ensuring program representation in the state-level integration work to carve-in behavioral health care into the Medicaid managed care plans.

Disseminating Best Practices and Program Implementation Information

Throughout the program, the NOCHF team shared best practices and lessons-learned as a result of the program to community, clinical, state, and national partners to further support the role of BHI in the GNO area and across Southwest Louisiana. Some dissemination efforts included the following activities:

- In 2011, the NOCHF team presented a poster presentation entitled "Using Data to Improve Access to Social and Behavioral Health for Vulnerable Populations" at the Xavier University Health Disparities Conference.
- In 2014, the NOCHF team presented "Behavioral Health Access in Louisiana" at the American Public Health Association Annual Meeting.
- In 2014, the NOCHF team presented a poster titled "Improving Access to Quality Behavioral Health Services" at the National Network of Public Health Institutes Annual Conference.
- In 2015, the NOCHF team presented a poster titled "Collaboration toward Technology Solutions in Integrated Care Settings" at the National Network of Public Health Institutes Annual Conference.
- In 2015, the NOCHF team presented "Sustainable Behavioral Health Systems Transformation," at the National Network of Public Health Institutes Annual Conference.
- In 2015, the NOCHF team presented, "Transforming Clinical Processes Creating Sustainable Systems for Behavioral Health Integration," at the Louisiana Primary Care Association Annual Continuing Education Conference.
- In 2015, the NOCHF team presented, "Despite the Odds: a Community's Journey to Leverage Change and Improve the Behavioral Health Services Continuum," at the National Council for Behavioral Health Annual Conference.


Reaching Special Populations: NOCHF & the New Orleans East Community

The New Orleans East Community is comprised of three primary ZIP codes: 70127, 70128, and 70129. According to 2013 U.S. Census data, the New Orleans East population totals 50,004 individuals with 53.9% classified as low-income and 29.9% classified as "in poverty."[4] Demographically, this population is 94.8% non-white (81.3% Black, 10.1% Asian, 3.9% Hispanic, and <1% American Indian/Alaska Native). Between 2007 and 2012, 15% of adults in this population had been diagnosed with diabetes at some point in their lives, and 33.7% of adults were obese. Given the known correlations between both race and depression with diabetes, obesity, and other chronic diseases, these indicators emphasize the importance of enhanced health care in this community.[2,3]

A total of eight federally qualified health centers (FQHCs) serve approximately 18% of all individuals in this geographic area.[4] Of those, four NOCHF affiliated centers serve this population: three are grantees of the NOCHF program (EXCELth, NOELA, and AHL) and another is supported through NOCHF's direct funding to Daughters of Charity. In total, these four NOCHF affiliates saw 85.2% of the total number of patients seen during 2014 at health centers in New Orleans East.[4] Of particular significance is the increased access to care provided to this underserved population through the NOCHF grant. Of the four NOCHF affiliated centers serving the New Orleans East community, three have locations in or adjacent to areas defined as medically underserved by Health Resources and Services Administration Uniform Data System data.[4]

NOELA Community Health Center

NOELA used funding and support from the NOCHF grant to expand its operation, located in the 70129 ZIP code of New Orleans East. The expansion of this facility is of particular importance as it caters to a unique population that is 41.0% Asian[4] and utilizes a culturally competent depression screening model with bilingual services. According to the Racial and Ethnic Approaches to Community Health (REACH) 2010 Risk Factor Annual Survey that assess minority communities in the U.S., a significantly lower than average proportion of Asians/Pacific Islanders reported having preventative services.[5] The expansion of a culturally competent clinic in a densely Asian population has the potential to significantly impact that population's medical access both to behavioral health providers and PCPs.

EXCELth Family Health Center

With funding and technical assistance from the NOCHF grant, EXCELth was able to open a new site in the 70127 ZIP code of New Orleans East. Approximately 59% of the population in this ZIP code was classified as low-income and 35% was classified as being below poverty according to 2013 U.S. Census data.[4] Given that EXCELth's target population for the NOCHF grant was "patients at or below poverty level," the addition of this site greatly increased its ability to reach this target population.

Daughters of Charity Health Center

At the start of the NOCHF grant, the Daughters of Charity Health Center was given a $1 million block grant to build a new site at the New Orleans East Hospital, located in the 70127 ZIP code. Daughters of Charity prides itself on its ability to provide "comprehensive, nationally recognized, high-quality care… to people to who are insured, underinsured, or uninsured."[6] Within the 70217 ZIP code, 30.9% of the population was uninsured in 2014. Between 2009-2013, 53.6% of the uninsured population was below 200% of the Federal Poverty Level.[4] The addition of this site has aided in bringing providers who are able to treat this particular population into the community thereby lessening many of the known barriers to care such as lack of transportation and lack of ability to pay.[7,8]

Lessons Learned & Recommendations

By understanding the successes, challenges, and lessons learned over the course of the three-year program period, the NOCHF team developed several recommendations for future projects' design and focus.

Data Quality and Reporting

Data and reporting presented a challenge to NOCHF grantees from the start of the grant. The grant was intended by the steering committee to focus on rigorous program implementation and technical assistance, not on research and evaluation activities. For grant monitoring purposes, grantees chose their own measures and methods for data collection and reporting. These measures and outcomes were not standardized across all grantees, given the variety of settings, grantee programs, and populations. Neither the NOCHF team nor grantees anticipated data monitoring and reporting to be such a significant challenge. The lack of available standardized EHR tools for monitoring depression screening and treatment meant that the methodology used to report on common outcomes varied among grantees, and thus the data were not able to be compared in all circumstances across grantees. In addition, some grantees experienced significant challenges in their EHR functionality across primary care and behavioral health that limited their ability to report on common measures. This limited the capacity of grantees and the NOCHF team to analyze and use data for QI. During year three, the NOCHF team revised the quarterly reporting tool and conducted a subsequent training on the new tool to collect more accurate and generalizable measures.

In the future, evidence-based tools should be identified and adopted at the onset of the program. Trainings on monitoring and collection tools, data quality, and internal validation should be conducted at the start of the project and on an as-needed basis throughout. The project team should work with the EHR vendors and clinic staff to develop a template if the tool is not already available. Having a simple but well-defined common reporting tool is essential in collecting and monitoring data from multiple grantees. To provide additional support, the NOCHF team created a QI checklist to guide grantees in monitoring internal processes like screening so that they could identify opportunities for improvement.

Targeting Audiences for Learning Opportunities

A key to the success of the NOCHF Learning Community was to target the trainings to specific audiences, and to teach skills and tools that staff were able to use the next day. For future programming, project teams should identify a clear strategy for training based on the system's gaps and then identify the target audiences for the trainings. The trainings should be tailored to the specific functional staff level and identify a specific goal that aligns with the overarching project's goal. The trainings should incorporate mechanisms for showing, telling, and practicing for each of the objectives of the training. Future projects incorporating learning community sessions should use feedback from evaluations from each learning session to help the team tailor the most applicable content to the target audiences and should consider a multifaceted approach to technical assistance and training. Webinars, in-person meetings, coaching calls, and site visits should be utilized to maximize opportunities for grantees to participate.

Leading Practice Transformation

Working with a diverse group of grantees can be challenging. In the beginning of the NOCHF program, grantees were apprehensive about sharing their challenges and divulging information to the other grantees. With increased interaction and rapport building among grantees at each of the learning community sessions, they became more open to sharing common challenges. Future projects working with multiple stakeholders should conduct a stakeholder analysis before the project begins and incorporate time for rapport building amongst partners.

When clinical partners go through periods of immense change, as with the NOCHF grantees, they need leaders with change management skills. Throughout the grant, grantee leadership responsible for leading the NOCHF program at each of the grantee sites was often tasked with many other projects. For future projects with significant structural and cultural change implications, the project team should assess the willingness of organizational leaders to prioritize the project and the skills required for change management. Furthermore, each grantee of the project should consider coordinating all parts of multiple projects through a single project manager at each-site. Future programs should take time at the beginning of the project to establish "buy-in" at all levels of the grantee organization. Consistent, transparent project schedules should outline communication expectations and establish mutual trust between the grant management organization and grantees.

Overall NOCHF Program Achievements

NOCHF funding allowed for both formal learning and coaching opportunities, as well as opportunities for grantees to pursue individual strategies toward BHI. Through participation in the NOCHF program and in utilizing NOCHF funding to work toward their organizational visions for BHI, the individual grantees improved the behavioral health landscape in the GNO area and the overall GNO health care system. Although grantees worked toward individual goals in a multitude of settings, as a whole they made significant, notable advances toward the overall NOCHF goals of increasing access to care, improving population health, and promoting sustainable systems-level change.

Goal 1. Access to Care

NOCHF funding allowed grantees to make concrete changes that had an immediate impact in increasing access to care in the GNO area. These changes included:

- Hiring behavioral health staff.
- Expanding and building new physical service access points.
- Making structural and process changes to decrease wait time to appointments.
- Standardizing the use of depression screening tools to achieve treat-to-target parameters.
- Increasing primary care and behavioral health staff team based approaches to care provision.

These changes led to improved quality of care and access to behavioral health services as well as a documented increase in patient volume. Patients who may not have been screened or may not have followed-up on their own now have easier access to behavioral health services when they are in the primary care setting. Overall, there were a total of 107,925 visits at NOCHF grantee sites over the course of the NOCHF program period.

Increased Staffing

NOCHF funding allowed for grantees to hire additional behavioral health staff to support BHI across the GNO. At the start of the NOCHF grant, there were 18.75 behavioral health FTEs across all grantees.

By the end of the NOCHF program, this had increased by 134% to 43.95 sustainable FTE position.

Expanded Facilities

Several NOCHF grantees made structural changes that allowed them to see more patients. NOELA built a new site that included an additional four exam rooms thereby increasing the number of patients seen. EXCELth opened a new clinic site in New Orleans East, a medically underserved area, which contributed to an increase in organization-wide patient volume by 32%.

Improved Appointment Availability

The NOCHF grantees prioritized increasing availability of appointments, particularly for behavioral health appointments. The workflow assessments, performed at each grantee site in partnership with the NOCHF team and the National Council for Behavioral Health, helped to identify areas for improvement in scheduling, no-show rates, and behavioral health appointment format. NOCHF grantees subsequently made improvements to their scheduling and clinical workflows and were able to reduce the typically long wait times for behavioral health appointments, including for psychiatry.

From the start of year three to the end of the grant period, clinics reporting "time to third next appointment"[4] had on average a 60% reduction in wait time for a behavioral health visit. One health center reported reducing their time to third next appointment from 19 days to less than one day.

Standardized depression screening tools

All NOCHF grantees examined their depression screening and treatment pathways during the NOCHF program and made improvements based on their findings. Standardized evidence-based depression screening processes and tools, including the PHQ-2/-9, are now an integrated part of the workflow at all NOCHF grantee sites. Standardizing the screening policy (e.g. administering the PHQ to all primary care patients regardless of the patient's chief complaint, per national guidelines) ensures adequate screening of all eligible patients and enables patients who may not have otherwise sought needed behavioral health services to access them. Furthermore, the warm handoff methodology that NOCHF grantees employ allows PCPs to easily transition a patient in need of behavioral health services directly to a behavioral health provider.

[4] Third to next appointment is the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

Increased Primary Care Provider Awareness

The NOCHF program helped raise awareness of the importance of behavioral health in the treatment of patients in the primary care setting, particularly for PCPs. PCPs have become more comfortable with discussing depression screening and treatment with patients, and providing referrals to behavioral health providers, including through warm handoffs. As one provider noted, ***"behavioral health people are confident in asking us for assistance as well, for instance we ended up seeing a person that I would never see very often…with the support of the behavioral health folks I was able to feel confident enough to do that because it needed to get done… [Behavioral health integration] enabled me to be more appropriately prepared."*** Shifts in PCP attitudes were also reflected throughout the integration process, particularly around the importance of addressing holistic wellbeing in the primary care setting. A PCP stated, ***"the culture has changed a lot…the ease at which [primary care providers] know and understand that behavioral health providers are available to assist with those complicated patients…has essentially resulted in better outcomes for our patients."***

Goal 2. Improve Population Health

The NOCHF program affected grantees and the populations they serve beyond increasing access to behavioral health services. Formal training and one-on-one technical assistance, workflow analysis, and deployment of evidence-based tools and models all aided NOCHF grantees in improving population health. These changes included:

- An expansion in services to populations that are deemed high-risk, including adolescents, SMI patients, high utilizers of emergency services, and other special populations.
- An expanded ability to care for these populations through optimization of HIT.
- The development of social service partnerships and referral mechanisms.
- Shift in provider attitudes towards BHI.

Health Information Technology

The expanded use of HIT to track and manage chronic disease and behavioral health patients has significant implications for population health. In year three of the NOCHF grant, grantees took part in the BHI template work group to design a new EHR template for documenting and reporting behavioral health screening outcomes, including the PHQ-2/-9. This template is now available to other health centers in the Greater New Orleans area, thereby allowing for more effective documentation and tracking of behavioral health screening, treatment, and progress. At least one grantee has taken advantage of its BHI template to start filtering high-risk depression patients into a depression care group.

Expanded Social Service Networks

Throughout the NOCHF program, there was a significant focus on improving care coordination and expanding networks of social service referrals. Learning sessions and trainings were offered that covered practical and patient-centered methodologies such as motivational interviewing, care coordination, and SBIRT. These skills are evidence-based techniques focusing on improvements in the quality of care delivery to promote improved population health outcomes. NOCHF grantees had opportunities to network with each other and social service referral agencies in the GNO area through the NOCHF Learning Community. The number of formal partnerships made by the NOCHF grantee grantees increased as well. Of the two grantees that began the NOCHF grant without a method for tracking referrals, both initiated and began utilizing a new system for referral tracking during the grant period. Another grantee developed a written protocol for referrals where there previously was none. Several NOCHF grantees began using depression care registries, and others improved processes and utilization of other chronic disease registries to track patient health outcomes.

Social service referrals more than doubled throughout the NOCHF grant period, from 3,281 referrals in year one to 9,197 referrals in year three.

Expanded Services to High-Risk and Vulnerable Populations

All NOCHF grantees primarily serve low-income populations, the majority of whom are uninsured, underinsured, or publicly insured. In addition to serving low-income patients, NOCHF grantees serve a number of other high-risk, difficult-to-reach, and special needs populations. Two grantees focused exclusively on providing integrated primary care and behavioral health to adolescents and young adults, a population that is difficult to reach in non-integrated settings.[9] One of these grantees, Tulane Drop-In Clinic, improved its scheduling and billing processes, allowing them to see more high-risk youth patients, reduce no-show rates, and be reimbursed more effectively. The Drop-In Clinic also streamlined its documentation and tracking of depression outcomes, leading to more responsive treatment and giving providers more effective tools to help patients reach their health and well-being goals. The Access Health/Jefferson Parish SBHCs increased patient volume at all five of its centers (serving over 8,000 students) and implemented validated depression screening and treatment processes. The SBHCs have reported positive outcomes from group behavioral health sessions, including self-reported reductions in participation in fights and improved anger management and decision-making.

Another grantee, JPHSA, focused on integrating primary care services for SMI patients. In a review that JPHSA performed prior to the NOCHF grant, they found that "individuals served by JPHSA died more than 23 years earlier" than the general population and that over half of these deaths were due to preventable medical conditions. In addition, JPHSA found that over half of their patients surveyed did not have or did not use a PCP. JPHSA has integrated primary care, gained FQHC status, and implemented same-day appointment scheduling for patients during the NOCHF grant to try to address the critical needs identified in the SMI population they serve. SMI patients have also benefitted from NOCHF's QI initiative at other grantee sites through reduced appointment wait times. Reducing wait times for front-line behavioral health providers by shifting screening and maintenance of stable patients to primary care led to a subsequent decrease in wait time for psychiatry appointments.

One NOCHF grantee, CCANO, developed a program that focused specifically on connecting patients with chronic conditions and multiple emergency room visits over a six-month period to primary care, behavioral health, and social services. By addressing patient needs through an integrated approach, they were able to increase the number of patients with no hospitalizations for at least 30 days and get 100% of patients into primary care by the end of the NOCHF grant. These programmatic gains have impacts beyond the patient level - they translate to cost savings and a reduction of the burden on strained hospital emergency rooms and emergency medical services.

Goal 3. Sustainable Systems Change

The NOCHF grant has had, and will continue to have, a lasting effect on the BHI landscape in the GNO area through expanding:

- High-quality, integrated behavioral health services provision across all NOCHF program-funded sites fostered by a three year learning community initiative.
- Ongoing dissemination of evidence-based tools developed and implemented throughout the NOCHF program that continue to be utilized and disseminated by the NOCHF team including a widely available BHI EHR template.
- Culture change around providing integrated care.
- Statewide policy advances around BHI.
- Enhanced QI capacity at the clinical level across multiple sites in the GNO area.

NOCHF Learning Community

Many of the learning community sessions throughout the NOCHF grant were open to community partners across the GNO region working on BHI. Opening the learning community to community partners beyond the grantees allowed for the incorporation of diverse perspectives and fostered collaboration of ideas and resources from across the region. For example, conversations and outcomes of the daylong learning community sessions informed policy change recommendations for the statewide integration task force to improve access and population health at the state level. At a local level, the grantees were able to network to build on one another's resources and services. One of the training opportunities featured a resource fair that connected grantees and other providers with social service agencies in the GNO area. Overall, the creation and implementation of the NOCHF Learning Community afforded grantees and additional community partners access to BHI educational opportunities that helped foster new ideas, provide critical feedback and assistance around ongoing integration efforts, and allow for an environment that fostered peer learning and lessons learned dissemination across the entire GNO community of providers.

Evidence-Based Tool Development

Throughout the first two years of the NOCHF grant, all of the NOCHF grantees experienced difficulty in tracking and reporting of key BHI outcomes and process metrics. The NOCHF team found that no standard EHR tool to track and report on behavioral health outcomes existed that was available to grantees. Thus, a template was developed in the third year by the BHI template user group, which consisted of grantee representatives with both administrative and clinical roles, the NOCHF team, and Greenway/SuccessEHS project managers and developers. The template and reporting tool was rolled out in the final quarter of the third year, and is available to any organization using SuccessEHS to download and use.

This tool has improved tracking and reporting at the clinic level and is a major highlight of NOCHF's lasting impact that GNO clinics can continue to incorporate into their clinical settings. Being able to track behavioral health outcomes over time enables clinicians to treat and manage behavioral health patients more effectively in primary care settings.

Ongoing Dissemination of Evidence-Based Tools Developed

The year three QI initiative also advanced grantees' understanding and application of evidence-based processes and policies for BHI. By ensuring that NOCHF grantees are implementing BHI programs that adhere to national guidelines and best practices, the NOCHF program has helped to improve the practice environment and collaborative primary care community of the GNO area. These applied best practices extend beyond just the NOCHF grantee sites. Access Health Louisiana (AHL), the operator of the Ruth Fertel CHC, has committed to implementing BHI at sites throughout its FQHC network, spanning six parishes and thousands of patients statewide. Provider collaboration and other statewide health center collaborative efforts, such as the Health Center Controlled Network (HCCN), offer opportunities for sharing lessons and opportunities with other health centers across the region and state.

Culture Change

Organizational culture change at NOCHF grantees will have a major lasting impact on the BHI landscape throughout GNO. Through participation in NOCHF activities, both primary care and behavioral health providers had the opportunity to learn from each other and collaborate to provide better patient-centered care. Buy-in around BHI has been greatly improved through the program. By valuing the importance of BHI in primary care, the NOCHF grantees will continue to raise awareness and advocate for integration throughout the health care system in the GNO area. As one provider noted, integration promoted positive changes "in terms of really appreciating the benefits of integration and…really being able to actually realize the benefits and seeing patients getting better and that has come about as a result of primary care working alongside with behavioral health and really finding solutions to problems that were maybe more challenging before."

Behavioral Health Policy Change

Throughout the grant, the NOCHF team, in partnership with the National Council for Behavioral Health, was successful in supporting behavioral health policy change at the state level. Applying lessons learned through the program about delivering integrated care, the NOCHF team and state policymakers worked to plan a transition to an integrated model of behavioral health through an integrated payer system "carve-in." This initiative created the requirement for the five Bayou Health Plans (contract administrators of Medicaid managed care plans) to cover behavioral health services. The policy change became effective December 1, 2015.

Enhanced Quality Improvement Capacity

The NOCHF program activities increased the capacity of grantees to conduct QI over the three-year grant period. Several of the activities required the grantees to conduct QI projects and apply QI principles. Improvements in data quality for tracking and reporting depression outcomes was a secondary achievement to the NOCHF monitoring and reporting requirements. At the start of the NOCHF grant, four of the six grantees were able to report on behavioral health measures. By the end of the grant period, all six grantees could report on behavioral health measures. In addition, the only clinic that started the NOCHF grant without a QI committee established one during the NOCHF grant period. By having a multifaceted approach to technical assistance and training, grantee staff of varying levels participated in QI work. Participation in activities like the workflow assessment gave staff the tools to lead QI and think differently about how the organization cares for patients.

CONCLUSION

The overall impact of the NOCHF program has been the successful promotion and support of sustainable systems-level change in the GNO area to provide holistic care that improves health outcomes for the overall community.

This support has strengthened the capacity of residents to take charge of their own health and has increased access to high-quality, integrated behavioral health, primary health care, and referrals to social services. Through the efforts of grant-making, technical assistance, and a regional learning community, as well as the commitment of the clinical grantees, integration of behavioral health, primary health care, and social services increased throughout the program period. Program grantees remain committed to providing long-term, sustainable, integrated services to continue to improve population health throughout the region.

Appendix 1. References

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Appendix 2:

Learning Community Organizations Membership

504 Health Net
Abbeville General Hospital
Aetna
Amerigroup
AmeriHealth Caritas
APEX Youth Center
APSB Ascension Parish School Board
Baptist Community Ministries
Baton Rouge Area Foundation
Bridge House
Broadmoor Community Clinic
Capital Area HSD (CAHSD)
Capital City Family Health Center
Cenpatico/Louisiana Healthcare Connection
Center for Hope
Children's Bureau of New Orleans
Children's Health Fund
Children's Hospital
Children's Special Health Services
Christus St. Patrick
Citizens for One Greater New Orleans
CLHSD
Cocaine Anonymous
Common Ground Health Clinic
Council on Alcohol and Drug Use
Covenant House
Daughters of Charity New Orleans
Delhi Hospital
DHH- Bayou Health Pharmacy
DHH: Children's Special Health Services
DHH: Medicaid Behavioral Health
DHH-OAAS
DRD New Orleans Medical Clinic
Favorr (favor and voices of recovery) Mississippi Recovery Advocacy Network
FPHSA Florida Parishes Human Services Authority
Franklin Primary Health Center
Global Health RC, Inc.
Grace House
Greater New Orleans Foundation
Gulf Coast Behavioral Health and Resiliency Center
Healing Hearts for Community Development
Healthcare for the Homeless
Healthy Heart Community Prevention Project
Institute of Mental Hygiene
Integrated Behavioral Health, LLC
Jefferson Legislative Delegation
Jen Care
JOB1
Kingsley House
Louisiana Department of Health and Hospitals
Lakeview Center, Inc.
LCMH Lake Charles Memorial Hospital
Leading Edge
LHA Louisiana Hospital Association
Liberty's Kitchen
Gulf Coast Behavioral Health and Resiliency Center
Healing Hearts for Community Development
Healthcare for the Homeless
Healthy Heart Community Prevention Project
Limitless Vistas
Louisiana DHH Birth Outcomes Initiative
Louisiana DHH Office of Behavioral Health
Louisiana Federation of Families
Louisiana Healthcare Connections
Louisiana Primary Care Association
Louisiana State University DePaul Inpatient Unit
Louisiana State University HSC SBHC's
Lower 9
LSU Health Sciences Center, Department of Psychiatry
LSU Psychiatry
Luke's House Clinic
Magellan Behavioral Health
Medicaid
Mental Health America Louisiana
Metropolitan Human Services District
Mobile County Health Dept.
Mobile Family Oriented Primary Health Care Clinic
Narcotics Anonymous
Natchitoches Regional Medical Center
Northeast Delta Human Services Authority
New Orleans EMS
New Orleans Faith Health Alliance
New Orleans Health Department
New Orleans Musicians' Clinic
No AIDS Task Force
NOHD- Office of Criminal Justice
Northshore Healthcare Alliance
Central Louisiana Human Services District
OBH-Region 5 (IMCAL HAS)
Ochsner, Dept. of Pediatrics
Odyssey House

Appendix 2 (Cont'd):

Learning Community Organizations Membership

Plaquemines Medical Center
Priority Health Care
Quad State Behavioral Health Consortium: UAB
Natchitoches Regional Medical Center
River Oaks, Inc.
SAMHSA
South Central Public Health Training Center
St. Anna's Episcopal Church
St. Tammany Parish-DHHS
St. Thomas CHC
Strength, Inc.
Tamber Health
Tulane Comprehensive Cancer Center
Tulane Department of Psychiatry
United Health Care/Optum
UNITY
University of South Alabama
University of West Florida
University of Southern Mississippi
University of Southern Mississippi
West Jefferson Medical Center
Winn Community Health Center
Woman's Hospital