HC-SGV
Health Consortium of Greater San Gabriel Valley
Connecting • Planning • Collaborating

Health Integration Summits I and II
Summary Report of Participant Engagement & Recommendations
November 1, 2019

Introduction & Overview

Health Consortium of Greater San Gabriel Valley (Health Consortium-SGV) was invited by Community Clinic Association of Los Angeles County (CCALAC) to host two Health Integration Summits in the Spring of 2019, on March 5 and May 9. The overall goal of the Summits was *to forge new collaborations, partnerships and opportunities for networking to further enhance integration of physical health, mental health and substance use services in the Greater San Gabriel Valley*. Objectives across the two Summits included:

1. Promote networking and opportunities to meet other providers in the Greater SGV.
2. Learn about existing models for integrating services.
3. Identify needs related to health integration and actions to better integrate services.

The Health Integration Summits were planned with input from the Health Consortium-SGV's Integration Committee and a Summit Planning Work Group (see Appendix A). The Summits were attended by 86 and 83 people, respectively. The target audience was representatives from physical health, mental health and substance use disorder (SUD) service organizations who were familiar with their organization's program implementation, operations and/or clinical services, preferably with the ability to make organizational decisions and/or share ideas and suggestions with their organizational leadership.

Participant Engagement and Input

Considerable effort was made to gather input from Summit participants before, during and after both Summits in order to develop a better understanding of issues, challenges and participant recommendations related to health integration. This input was gathered during event registration, at the Summits via participant worksheets and facilitated small group discussions, and through evaluation surveys completed following each Summit. A full description of the methodology for obtaining engagement and input is in Attachment B. Below is a summary of key themes that were learned from these processes.

Summit Expectations & Reactions

Participants indicated they hoped for opportunities at the Summits to:

- Network with potential partners and engage in discussions regarding care coordination, linkages and access to care challenges.
- Partner and collaborate with others to fill gaps in their services.
- Learn about local services and resources for the underserved and how to access them.
- Learn about best practices and new ideas for integration, including:
    - Data and information sharing.
    - Strategies to overcome challenges.
    - Models of integration occurring in the SGV.

Evaluation results indicated that participants liked the following features of the Summits:

- The diversity/variety of participating providers and agencies who came together as a community with a shared focus on addressing common barriers/challenges and creating a "better, integrated healthcare system."
- Networking/relationship building, including both learning about and sharing information about services available in the community.
- Educational, informative and useful panel presentations and Summit content, particularly relative to:
    - Presentations on existing health integration efforts locally and countywide;
    - Discussions of challenges associated with integration; and
    - Provision of web links to information and resources.

Existing Efforts to Integrate Care

A number of strategies are currently in place to integrate care among partner agencies that attended the Summit, including:

- Care coordination and care planning.
- Linking with community resources.
- Patient/health navigation.
- Cross-training and staffing.
- MOUs/working collaborations between providers across agencies.
- Warm handoffs/referrals.
- Co-located programs and integrated services within agency (e.g., most FQHCs offer physical health, mental health and oral health services).
- Attend networking meetings/opportunities.

Gaps, Needs and Challenges re Integration

Participants were asked to share about the gaps, needs and challenges they experience relative to integrating services. Responses included:

1) Organizational Capacity Issues, such as lack of:
    - Communication/coordination/linkages within and across organizations and professions (i.e., thinking and working in silos).
    - Training and support.
    - Primary Care Provider (PCP) engagement.
    - Case managers/patient navigators to facilitate warm hand-offs, close referrals loops and serve as patient advocates.
    - Culturally competent providers.

2) System/System Capacity Issues, such as:
    - Lack of treatment/service options and/or capacity to meet need (e.g., substance use services for adolescents).
    - Funding availability and restrictions/sustainability.
    - Policy/legislative restrictions.
    - Data sharing challenges.
    - Lack of emergency housing/homeless services.

3) Social/Cultural Issues, including:
    - Stigma associated with mental health and SUD among health care providers as well as within different ethnic/cultural groups.
    - Language and cultural barriers.
    - Needs of specific population groups, including the homeless, immigrants and youth.

Recommended Priorities to Better Integrate Services and Improve Community Outcomes

Summit participants took part in small-group breakout discussions at both Summits I and II. Participants were pre-assigned to the breakout groups to ensure each group included providers from a variety of service types. Questions discussed in the breakout groups included:

- What opportunities do you see to improve services and outcomes through better integration with other agencies and organizations? (Summit I)
- What additional actions can your organization take to better integrate physical health, mental health, SUD and other services in the community? (Summit II)

The input from these discussion questions were reviewed and organized thematically.

The four priority recommendations that emerged from these discussions are:

1) Build relationships and networks for health integration across systems/service types.
2) Increase capacity, engagement and awareness of community resources among Primary Care Providers (PCPs) and other physical health, mental health and SUD providers through education & multi-disciplinary training.
3) Improve/streamline referral processes and care coordination through facilitation of shared information across providers.
4) Raise community awareness to reduce stigma and support health integration policy agendas.

Appendix C, below, provides suggested action steps associated with each of the four priority strategy recommendations.

A second tier of recommendations for future consideration were identified to include:

1) Expand organizational capacity relative to service delivery and administrative practices (e.g., become Medi-Cal approved, increase staff/workforce diversity to more fully meet integrated health needs, ensure knowledge of language-related resources and ensure proper training of bilingual interpreters, support agencies to expand service offerings).
2) Identify & address patient/client barriers to integrated care (e.g., transportation, motivation, language access, cultural barriers).
3) Increase service delivery system capacity to meet service needs.

Next Steps for the Health Consortium of Greater SGV & Other Community Partners

Health Consortium of Greater SGV partners will prioritize steps it can take to help support integration among physical health, mental health, SUD and other services in the Greater SGV area utilizing the strategies that align with its capacity and strategic plan; i.e.:

1. Compile/share information on resources & best practices.
2. Facilitate relationship/partnership/network building.
3. Trainings/workshops.

4. Program/technical support.
5. Facilitate access to information about local services and resources.
6. Support policy/advocacy.

Among other strategies to be identified, Health Consortium of Greater SGV will continue to host bi-monthly Full Group meetings that are open to community partners with presentations on topics that relate to health integration and that create opportunities for organizations to learn about each other and to build relationships. In addition, the Health Consortium will distribute this report to all Summit participants with the hopes that other partners in the community can also select strategies to take leadership on addressing.

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- Beacon Health Options
- California Community Foundation
- City of Hope
- Community Clinic Association of Los Angeles County
- Health Net, Inc.
- Kaiser Permanente Southern California
- L.A. Care Health Plan
- San Gabriel Valley Economic Partnership

Appendix A
Health Integration Summit Planning Team

Integration Committee Members

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Health Integration Summit - Planning Committee

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Appendix B
Participant Input & Engagement Strategies at Health Integration Summits I & II

In addition to hosting relevant and informative presentations to provide participants with current knowledge about data and best practices for integration in the San Gabriel Valley and Los Angeles County overall, active participant engagement was a high-level goal of the Summit Planning Team. Each Summit was designed to stimulate discussion among participants and gather input for future planning.

At Summit I, participants were pre-assigned to breakout groups to ensure a variety of provider types in each group and given one of three vignettes of a patient/client with multiple issues to review and discuss (each vignette was discussed by two groups). Each group was facilitated by a volunteer from Health Net or the Planning Committee and nursing students from Azusa Pacific University (APU) took notes on the discussions.

The discussion questions were designed for group members to learn more about the services available in the Greater SGV from the others in their group and to begin to think more broadly about opportunities for improving integration. Discussion questions included:

1. What are the main concerns and risk factors in this case?
2. What help or services could your agency provide to this client?
3. How do you identify other agencies to make referrals to?
4. How can other organizations make a referral to your organization/program?
5. How could your agency improve integration with other agencies to better provide services?

Follow-up discussion in the large group focused on these questions:

- What did you learn or find most interesting about the conversation in your breakout group?
- What are some suggestions that were made regarding opportunities for better collaboration relative to referral relationships and care management?

At Summit II, additional participant input and engagement strategies were put into place. During the registration process, people were asked to identify what they hope to get out of Summit II. At the Summit, participants completed worksheets as part of an icebreaker that asked them to share again what they hoped to get out of the Summit that day and also to share:

1. What is your organization already doing to integrate physical health, mental health, SUD and other services?
2. What are ongoing gaps or needs relative to integration faced by your organization?

The breakout discussion groups at Summit II were also pre-assigned to assure a mix of provider types. The discussion questions were designed to build on the worksheet responses and included:

1. What additional actions can your organization take to better integrate physical health, mental health, SUD and other services in the community?
2. What support does your organization need to move towards greater integration?
3. How can the Health Consortium-SGV continue to support health integration in the future?

Finally, participant evaluations from both Summits were a great opportunity to learn how participants responded to the Summit presentations as well as what they liked best about the events and to learn about suggestions for upcoming meeting topics.

Appendix C:
Health Integration Summit Report Recommendations

1) ***Build relationships and networks for health integration across systems/service types*.**

- Participate in coalitions/collaboratives, convenings, events and health fairs to improve knowledge of resources/services, share best practices, and to meet and partner with other providers to better address the full spectrum of client needs.
- Engage in discussions on care coordination, linkages and access to care challenges.
- Share ideas and best practices for integration.
- Build relationships with other important partners, such as hospitals and elected officials.
- Identify internal referral gaps.

2) ***Increase capacity, engagement and awareness of community resources among Primary Care Providers (PCPs) and other physical health, mental health and SUD providers through education & multi-disciplinary training*.**

- Provide or facilitate education and multi-disciplinary training for PCPs, behavioral health providers and other agencies in the broader continuum about the connection between physical and mental health; e.g., provide Mental Health First Aid training.
- Expand access to information about local services and resources for providers and clients.
    a. Provide education/training for agencies and clients about how to identify city and community services and also how to access them.
    b. Explore options for providing electronic access to information about services.
- Conduct case conferencing and share best practices & models of case conferencing across organizations and systems.
- Collaborate with psychiatrists.
- Identify and support agency "champions" related to different service types.

3) ***Improve/streamline referral processes and care coordination through facilitation of shared information across providers***. Reduce burden on agencies and clients and improve access to information about the status of referrals.
NOTE: Health Neighborhoods are working on this recommendation.

- Facilitate HIPAA and CFR 42 compliant data sharing through use of a shared Health Information Exchange system (HIE) or an accessible portal/website.
- Develop shared guidelines to support exchange of data/information.
- Network and build relationships to facilitate "warm hand-offs" across different services.
- Consider use of patient navigators/case managers to facilitate warm hand-offs.
- Formalize relationships (e.g., MOUs) to clarify expectations and create consistency.
- Reduce use of paper referrals and tracking systems and increase use of tablets, apps or an HIE.
- Accomplish referral tracking and closing the loop. Obtain "real time" updates on patient status.

4) ***Raise community awareness to reduce stigma and support health integration policy agendas.***

- Identify strategies to reduce stigma associated with mental illness and SUDs among specific ethnic/cultural groups, health care providers and general community; e.g., provide PSAs/community education and/or training to eliminate negative stereotypes.
- Use the collective power of Health Consortium and other community members to advocate with funders, organizations and elected officials to reduce barriers and restrictive policies to integrating across different professions and provider types.
- Raise awareness of policies and legislation that support or hinder health integration.