ADDRESSING HEALTH DISPARITIES

Horizons Health Services
Primary and Behavioral Care Integration Team
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- Coastal Horizons Center, Inc. (CHC) Horizons Health Services Primary and Behavioral Health Care Integration Team (HHS–PBHCIT) proposes to deliver a system of integrated and coordinated care among adults with SMI and/or co-occurring SUD/MH in 1 urban (New Hanover) and 2 rural clinics (Pender and Brunswick) in 3 counties in southeastern North Carolina.
- Plan to serve 200 clients Year 1, 375 in Year 2, 475 in Year 3, and 600 in Year 4.
- Outstanding difference between demographic profiles of people with SMI served by CHC and general population is over-representation of females with SMI and under-representation of African-Americans and Hispanic/Latinos.

POPULATION OF FOCUS

	BRUNSWICK %(N)	NEW HANOVER %(N)	PENDER %(N)
White	92% (200)	81% (144)	80% (253)
Black	6% (14)	17% (30)	16% (50)
Hispanic/Latino origin	1% (3)	2% (3)	4% (12)
Asian			< 1% (1)
Females	68% (147)	45% (81)	67% (212)
Males	32% (70)	55% (96)	33% (104)
On Medicaid	19% (42)	10% (17)	36% (114)

Demographic Profile of the Population of Focus (Adults with SMI)

- CHC staff members reflect demographic diversities, participate in annual cultural competence training raising awareness to racial, ethnic, gender and socioeconomic differences, provide interpreters for the deaf, those unable to communicate orally, and Spanish speaking only.
- *Clinica Latina* CHC program is dedicated to providing physical and behavioral health care services in Spanish.
- Primary Care medical chart Patient Registration, Health History, Insurance Information, HIPAA and Patient Rights forms were translated to Spanish.

Implementation Practices

- Spanish translated NOMs questionnaire utilized when appropriate
- HHS Wellness program offers teaching activities with the assistance of Spanish interpreter and language and cultural appropriate educational materials.
- HHS Wellness recommendations consider age and agility for physical activity, dietary preferences, habits, restrictions due to ethnicity/religion.
- Clinical Masters level Social Work Intern assists with Prescription Assistance Program, health insurance enrollment, and case management

Implementation Practices

- Challenge drafting Health Disparities Statement: hired new Care Integration Coordinator assigned to develop statement 1 week prior to submission deadline. Based on GPO recommendations, statement revised/approved to include detailed Grant goals and objectives, expanded outcome measures
- Lengthy challenge with local FQHCs to hire NP for primary care clinics, resolved 5/13/2013 for 2 sites, 8/15/2013 for 3rd site
- Transportation limitations in rural counties served often present a barrier for access to care

Challenges and Barriers

Goal 1: Provide integrated care to adults with SMI and/or co-occurring MH/SUD disorders

- Objective 1: Screen and assess population of focus for risk factors/physical conditions (quarterly H indicator data)
- Objective 2: Establish Care Management teams with co-located PC and BH providers for each individual served and their families (Tele-health established at all 3 sites - enable consultation)
- Objective 3: Develop a person-centered plan that integrates identified physical and BH care needs (quarterly Individual Wellness Report)
- Objective 4: Coordinate services among multiple agencies typically involved with SMI adults (HHS Advisory Board, DELTA Behavioral Health)

Data & Collection Measures

Goal 2: Provide health promotion activities to modify lifestyle/behavior patterns associated with risk factors prevalent among SMI adults

- Objective 1: offer health education to enable people to understand/manage their health conditions to include immunizations/screening (HHS Monthly Report)
- Objective 2: Ensure self-management plan includes medication regimen, tobacco prevention/recovery, nutrition, obesity prevention/reduction, exercise, stress management (Individual Wellness Report and HHS Monthly Report)
- Objective 3: Support a media campaign to raise awareness and focus on prevention activities (pending)

Data Specialist for the project developed a tracking guide that allows for quarterly data input on the status of each goal and objective for monitoring purposes.

Data & Collection Measures

Looking Ahead
Sustainability & the next 6 months

- Become health homes for PBHCI clients
- Recruit for & Grow 3rd party revenue-based services
- Facilitate health insurance application and enrollment process for uninsured clients who may become eligible under the Affordable Care Act
- Continuous dialogue with Care Integration Advisory Board, sharing data collected, and adding more consumers
- Recruit/retain patients
- Explore community partnerships & related funding opportunities