



The Missing Link: Integrating SDOH and Behavioral Health for Value- Based Success



Agenda

Introductions and Learning Objectives

Community Health Provider Alliance

Ardent Health

Discussion & Wrap-Up

Speakers



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Learning Objectives

- Identifying best practices such as leveraging technology to integrate SDOH and behavioral health data into EHRs, building sustainable partnerships with community-based organizations, and empowering care teams to assess and address these needs.
- How to align strategies, partnerships, and payment models, to enhance care delivery, improve population health outcomes, and reduce disparities.

Community Health Provider Alliance (CHPA)

DBA of Colorado Community Managed Care Network (CCMCN)

CCMCN-CHPA Merger

As of January 1, 2025 Community Health Provider Alliance (CHPA) and Colorado Community Managed Care Collaborative (CCMCN) have merged.

Stronger Together! The Impact of our Merger | Aligning CHPA as an accountable care organization—focused on supporting performance in value-based care contracts—with CCMCN’s expertise in community data integration and public health means:



Enhanced Data & Coordination – CHPA’s accountable care organization function is now powered by a stronger data infrastructure, dedicated data science teams, and advanced community care coordination systems.



Maximized Performance & Savings – Higher quality outcomes, greater cost savings, and increased member revenue.



Greater Impact – Improved population health, financial stability, and health equity across our communities.



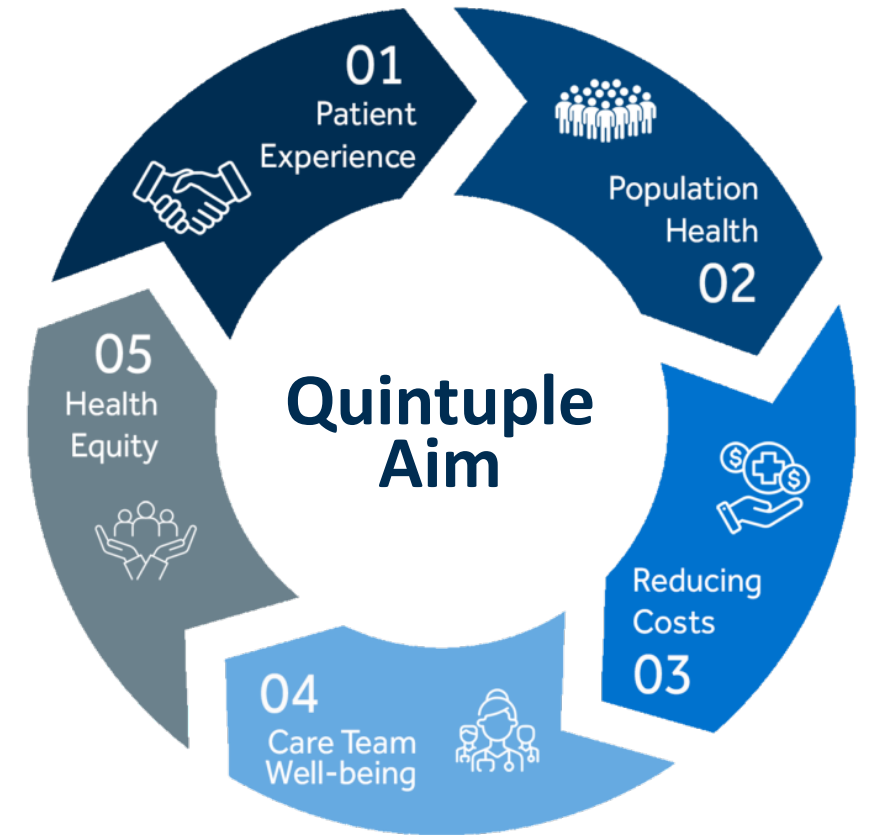
Streamlined Support – Increased efficiency for members by reducing the number of organizations from three to two, with CHPA-CCMCN working in close alignment with Colorado Community Health Network (CCHN).

Community Health Provider Alliance (CHPA)

CHPA was formed in 2014 as a 501(c)(3) organization and is focused on value-based contracts and the quintuple aim.

CHPA's network is comprised of 20 Colorado Federally Qualified Health Centers (FQHCs) and one urban Indian health program:

- 243 locations and 1,000+ medical and behavioral health providers
- Serving 832,000+ patients with a focus on those who are uninsured, underinsured, and under-resourced
- All participants are fully integrated with Medical, Dental and Behavioral Health services
- Over 75% of population with co-morbidities and are struggling with the social determinants of health (SDoH)



Behavioral Health Integration

100% of FQHCs in Colorado have integrated behavioral health (BH) employees.

In 2023, Colorado FQHCs had 272,825 mental health and substance use encounters (257,100 MH encounters and 15,725 SUD).

CHPAs BH and substance use disorder (SUD) utilization in 2023:

- 30% of CHPA members had a BH claim
- 87 psychiatric hospital stays vs. 34 ACO network median (2.5x as many stays)
- 427 substance abuse treatment services vs. 195 ACO network median (2x more services)
- 5.5% of total spend is on BH/SUD compared to <2% for the average ACO



Behavioral Health Integration

“Mental health and primary care are inseparable; any attempts to separate the two leads to inferior care.”

-Institute of Medicine, 1996

Behavioral Health Crisis

Demand for services is greater than capacity:

1 in 5 Adults have a mental health condition

- In 2019 less than ½ of adults received services
- The percent was lower in Black and Latinx communities
- Nearly 90% of people with a substance use disorder went untreated

As of 2023

- 55% of adults with a mental illness went untreated
- 60% of youth with major depression went untreated

Source: Bipartisan Policy Center

Standard Framework for Levels of Integration

COORDINATED		CO-LOCATED		INTEGRATED	
Key Element: Communication		Key Element: Physical Proximity		Key Element: Practice Change	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Minimal Collaboration	Basic Collaboration at a Distance	Basic Collaboration On-Site	Close Collaboration with some System Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in Integrated Setting
<p>BHP and PCP deliver care separately within their own practices.</p> <p>Information exchanged as needed.</p> <p>Limited collaboration outside of initial referral.</p>		<p>BHP and PCP deliver care within the same practice.</p> <p>Co-location = where services are provided.</p> <p>Patient care often siloed to each clinician's area of expertise</p>		<p>BHP and PCP work together to design and implement a patient care plan.</p> <p>Tightly integrated on-site teamwork with unified care plan</p>	

Source: http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

Elements of Integration

- Integrated: physically in the same space
- Shared Panel of Patients – Can Huddle as needed
- Shared Charting
- Universal Screenings
- Brief Interventions
- Population Health Approach Using Registries

Sample Integration Framework

Integrated Care Team

1 BHP : 3 PCP

- BHP Responsible for needs of Empaneled patients
- Screening
- Brief Intervention
- Assessment/DX
- Treatment Planning
- Brief Therapy
- Warm Hand-Off in Exam Room
- Scheduled Individual Therapy
- Group Visits
- Referrals for extended long-term treatment

Tools for Success

- Schedule Design
- Universal Depression/SUD Screenings
- Integrated Care Planner Tool
- Huddles
- Population Health Dashboard to Track Outcomes
- Chronic Disease Registries

Questions?