# Meeting Summary for Committee on Diversity, Equity & Inclusion in Behavioral Health Zoom Meeting

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Quick recap
The meeting covered various topics, including the success of the recent iCAN Conference, the meeting covered the Carelon (ASO) Health Equity Project addressing healthcare disparities, and strategies to improve follow-up care after hospitalization. Discussions focused on cultural competency, provider collaboration, and developing interventions to support high-risk patients in connecting to care post-discharge. The team also explored the creation of a predictive model, coordinated meetings between providers, and emphasized the importance of addressing social drivers of health and implicit biases in healthcare.

Next steps
The Carelon team to continue updating the website section dedicated to aftercare follow-up. https://providers.ctbhp.com/quality-improvement/after-care-follow-up-afu/

The Carelon team to facilitate one-on-one meetings between providers to assist in the aftercare follow-up process.
Felicia (Director of Peer Services) to review and improve the process of matching peers to members based on demographics and experiences.
The Carelon team to further investigate and understand the reasons why certain groups (people of color, unhoused, DCF-involved) are less likely to connect to aftercare.
The Carelon team to explore ways to incorporate faith-based entities and ministerial aspects into the ICM support system.
The Carelon team to develop interventions addressing implicit biases and lack of cultural competencies among providers.
The Carelon team to share the presentation slides on the ICARE conference topics with the committee members.

Summary
Discussing iCAN Conference Attendance and Upcoming 10th Anniversary

The meeting began with Bernetta discussing the positive reception of the iCan Conference. Attendance of the iCan Conference, was confirmed around 300 with 286 attendees. Co-Chair (of both the committee and conference) Bernetta Henry also mentioned that some attendees had emergencies preventing them from attending. Yvonne Jones and Lynne Ringer (both from Carelon) joined the conversation, with Yvonne expressing her enjoyment of the conference and the positive feedback received. The team also discussed the upcoming 10th anniversary of their organization, with Bernetta mentioning that plans are already in motion. The conversation ended with the team expressing their excitement for the upcoming anniversary.

Conference Success and Aftercare Discussion

The meeting discussed the success of the recent conference, which had the largest attendance of over 286 participants. The theme of the conference was aftercare and continuum of care, with a focus on equitable services for all communities, including rural ones. The conference also offered CEUs for the first time, which drew attention. The Consumer and Family Advisory Council was praised for their hard work. The team expressed their appreciation for the work of the committee members, particularly Neva Caldwell, Carmen,

Teresa Rosario, and Bernetta. The conversation ended with a presentation on aftercare by Lynne and Lynne.

## Addressing Healthcare Disparities and Project Overview

Lynne and Lynn discussed the background and context of their project, which aimed to address disparities in healthcare, particularly in follow-up care after hospitalization. They highlighted the involvement of various departments and the importance of member and provider voices in the process. The project, titled The All ASO Health Equity Project, focused on subgroups with behavioral health diagnoses and aimed to identify access to care issues. They also discussed the use of the follow-up after hospitalization HEDIS measure to identify disparities. The next steps included developing a predictive model and a member intervention. The conversation ended with a call for questions and discussions.

## Addressing Health Disparities and Follow-Up Rates

Lynn discussed the 4 Eyes for Equity, a roadmap to reduce health disparities. She highlighted the need to identify and prioritize reducing disparities, implement evidence-based interventions, invest in health equity performance measures, and incentivize the reduction of disparities. Lynn also addressed the issue of lower follow-up rates after hospitalization among black individuals compared to white individuals, noting that this could lead to negative outcomes. She explained that follow-up visits were associated with lower readmission rates and reduced risk of subsequent acute care use. Alice asked for a definition of 'follow-up', which Lynn clarified as a visit with a behavioral health professional within 7 days of hospitalization. iPhone asked about barriers to follow-up, to which Lynn promised to provide more information later in the presentation.

## Addressing Barriers and Improving Care Coordination

Lynn and her team discussed the outcomes of their focus groups and interviews, highlighting the need for cultural competency among providers, stronger collaboration, and care planning. They noted the importance of provider education, direct communication between providers, and hard handoffs for effective connections after hospitalization. The team also identified barriers such as social drivers of health, implicit bias, lack of cultural competence, staffing issues, and language barriers. They proposed solutions like increasing staffing, care coordination, health literacy, member involvement, and realistic treatment planning. The team also discussed the importance of utilizing peer supports and addressing passion fatigue among clinicians. The quotes used in the discussion were from the interviewees, including both providers and members.

## Improving Husky Health Program Follow-Up Plans

Lynn discussed the focus groups conducted with members of the Husky Health program, highlighting their experiences and suggestions for improvement. The members expressed dissatisfaction with the follow-up plans offered, citing poor communication and engagement issues. They also noted a lack of cultural awareness and the expectation that patients are solely responsible for their follow-up. The members suggested that better communication, equitable access to services, and the involvement of family members could improve the situation. Lynn also mentioned the importance of partnerships with doctors and patient or er services, as well as the need for assigned case managers before discharge. She concluded by discussing best practices for discharge planning, emphasizing comprehensive planning, timely communication, patient and caregiver education, and open communication between providers.

## Creating Predictive Model for High-Risk Patients

Lynne discussed the creation of a predictive model to identify patients at highest risk of not connecting to care after discharge from inpatient services. The model, based on a year and a half to two years of data, showed that females, individuals under 18, whites, and those with certain diagnoses or backgrounds were more likely to follow up. The model was used to create an intervention, starting in May, where the team reached out to hospitals to aid high-risk patients. The intervention involved offering intensive care managers to provide support to patients and working with hospitals to identify potential barriers in discharge planning.

## Hospital Post-Discharge Follow-Up Process

Lynne discussed the post-discharge follow-up process for hospital members, emphasizing the importance of addressing any barriers to accessing aftercare appointments. She mentioned that they work towards connecting members with transportation or new providers if needed. Lynne also highlighted the role of family or friends in supporting members and the use of home visits for those actively involved with the Intensive Care Manager (ICM). She detailed the member intervention process, which includes rapport building, assessing treatment history, addressing social drivers of health, and ensuring appointment awareness. Lynne also mentioned the importance of obtaining updated contact information and connecting with providers to schedule visits. Neva expressed her appreciation for the work being done, emphasizing the need for this connection.

## Outpatient and Inpatient Provider Coordination Meeting

Lynne discussed the coordination of meetings between outpatient and inpatient providers at the member's request. She also mentioned the team's work with the regional network management team and the medical affairs team to develop provider interventions. Lynn highlighted the team's efforts to update the website with an aftercare follow-up section and their collaboration with various providers, including MTM for transportation, CHN for community supports, and C car for peer support services. The team also engaged community care teams to strengthen their work with high-risk members.

## Statewide CCT Collaborative Meetings and ICM Roles

Lynn and Lynne discussed the progress of their statewide CCT collaborative meetings and the upcoming one-on-one meetings with local mental health authorities. They talked about the role of the ICM intervention in connecting members with peers. Yohanna asked about the reasons behind certain risk factors identified through data analysis, such as being a person of color, unhoused, or having DCF involvement. Lynn mentioned that they plan to better understand the reasons through further connection with members. Alice inquired about the funding and roles of peer counselors and community health workers. Lynne clarified that ICM staff are licensed clinicians, while peers are certified, and the ICM services are funded by Medicaid. Lynne also mentioned that the team is working on addressing implicit biases and lack of cultural competencies in healthcare providers, as well as incorporating spirituality and faith-based organizations when beneficial for patients.