Enhancing Behavioral Health Outcomes through Integrated Care and Social Drivers of Health

As societal factors increasingly influence behavioral health outcomes, understanding the vital relationship between social drivers of health (SDoH) and behavioral health care is crucial. SDoH refers to the environmental conditions where people are born, live, learn, work, play, worship, and age, that influence a wide range of health, functioning, and quality-of-life outcomes and risks. Carelon Behavioral Health of Connecticut (Carelon BH CT), with the collaboration of behavioral health providers, continue to explore innovative strategies for integrating social factors into healthcare systems that not only address immediate treatment needs but also create sustainable, equitable paths to wellness for all individuals.

Inpatient Psychiatry and Social Drivers of Health (SDoH)

The intersection of SDoH with inpatient psychiatry is crucial for enhancing mental health outcomes. Economic instability and lack of insurance often delay access to mental health services, resulting in hospitalization only when conditions severely escalate. Addressing SDoH enables preventive care, reducing the need for intensive interventions.

Communities with higher health risk factors face systemic barriers that increase hospitalization rates, highlighting disparities in care access and quality. Environmental stressors—such as violence and poor housing—can exacerbate psychiatric conditions, necessitating integrated care approaches that consider these factors during treatment.

To tackle these challenges, inpatient units offer temporary support; but achieving long-term success in mental wellness necessitates community-based solutions that address social isolation and other social drivers. By integrating comprehensive social support and strategic discharge planning, healthcare facilities can ensure smooth transitions from institutional care to community reintegration. This approach includes staff education on social drivers and collaboration with community organizations to provide essential resources like housing, employment, and education. These efforts help mitigate barriers such as transportation and housing instability, preventing cycles of insecurity and promoting stable recovery. By addressing both medical and social factors, the healthcare system can empower individuals to thrive post-hospitalization.

Collaborative workgroups also play a pivotal role in these efforts. On June 26, 2024, the first statewide inpatient/residential levels of care workgroup, Substance Use Disorder (SUD) System Integration: Enhancing the Patient Journey Throughout the Continuum of Care, convened. The audience included providers from ASAM 4.0 withdrawal management (WM), adult inpatient psychiatry facilities (IPF), emergency departments (ED), and ASAM 3.1-3.7 inpatient/residential levels of care. The focus was creating ways to enhance patient journeys across the continuum of care, fostering collaborative discussions and sharing best practices to address systemic barriers and optimize outcomes.

SUD Services and System Integration

In SUD services, addressing SDoH is equally essential. Challenges like long waitlists and housing instability directly impact service delivery and recovery. The lack of supportive housing increases demand for inpatient care and raises readmission risks, making seamless referral pathways through Connect-to-Care meetings vital. These meetings have identified deficiencies in residential bed availability, complicating care transitions and prolonging stays.

Fast Facts

211 Call data from January 1, 2024-December 31, 2024[1]:

- 33.2% of all calls were for housing and shelter requests.
- 12.4% of all calls were related to Mental Health and Addiction services.
- 11.9% of calls were for food assistance, including help buying food, and food pantry requests.

[1] source: https://ct.211counts.org/

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The Provider Analysis and Reporting (PAR) program focuses on data-driven care enhancements by collecting metrics on length of stay and readmission rates. Statewide workgroups contribute insights on referral processes and treatment best practices, focusing on opioid and alcohol use disorders. Collaborative efforts incorporate harm reduction strategies and health equity training, improving community-based treatment outcomes.

Medications for Substance Use Disorder treatment (also known as Medication-Assisted Treatment) practices in emergency departments highlight the importance of continuity in care through expedited referral systems. Integrated referral workflows enable effective communication and follow-up, crucial for maintaining treatment continuity and reducing overdose risks.

Overcoming Barriers and Enhancing Care

Successful discharge planning requires incorporating SDoH into strategy development, addressing transportation and socioeconomic barriers hindering access to aftercare. Housing remains a significant stressor, with many "high utilizers" affected by community resource limitations, demanding improved housing and transportation solutions.

By integrating comprehensive social support, fostering collaborative provider efforts, and employing data-driven strategies, healthcare systems can deliver holistic care that empowers individuals. These initiatives pave the way for equitable and sustainable recovery paths, transforming the landscape of inpatient psychiatry and SUD services to support individuals to thrive, not just survive, post-hospitalization.

Training and Development for Health Equity

The PAR program continues as a platform for sharing data through a health equity lens. In 2024, SDoH was explored within PAR strategies across all care levels, a focus that continues with the 2025 inpatient/residential PAR Program.

To support Carelon BH CT's regional network management (RNM) team in engaging providers around health equity, a three-part training, building on previous research and recent data, was provided by an external consultant. This training aims to embed a health equity lens across activities that address disparities in utilization, treatment, and outcomes for HUSKY Health members with substance use, mental health, or co-occurring disorders.

The first two training installments, held on July 10 and August 7, 2024, covered:

- ✓ Concepts, principles, and terms related to health equity.
- ✓ Structural and social drivers of health.
- ✓ Health equity clinical studies.
- ✓ Disparities in behavioral health services regionally and nationally.
- ✓ Communication strategies for provider and community education.
- ✓ Strategies for mitigating/eliminating disparities.
- ✓ Resources for fostering productive health equity discussions with providers.

Integrating SDoH into behavioral health care services is essential for achieving sustainable and equitable outcomes. Through initiatives like comprehensive social support, collaborative provider networks, and PAR program, healthcare systems can tackle barriers such as economic instability and housing issues. Enhancing care continuity with seamless referral pathways reduces risks like readmission and overdose. By focusing on prevention, treatment, and community reintegration, we can transform inpatient psychiatry and SUD services to empower individuals to thrive long-term. These efforts help create a more inclusive and responsive healthcare landscape.

Additional Resources

The After Care Follow-Up (AFU) section on the Connecticut Behavioral Health Partnership's (CT BHP) website was launched in January 2024 to provide resources for behavioral healthcare providers. This initiative emerged from a clinical study and offers tools like the importance of AFU, measurement methods, available services, and provider resources. Effective post-treatment care reduces hospital readmission, enhances continuity, and improves patient outcomes.

The site includes best practices for discharge planning and offers resources categorized by region, focusing on mental health, LGBTQIA+ support, autism, and more. Key programs like First Episode Psychosis, Peer Support, and Intensive Care Management are featured.

For more information, visit the AFU webpage here, or by going to www.ctbhp.com, selecting 'For Providers', and navigating to 'After Care Follow Up (AFU) from the right-hand menu.

Questions? Contact the CT BHP for support.

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