

# The Social Determinants of Mental Health

## Assessment, Intervention, and Wholistic Health Equity: Part 2

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### ABSTRACT

**Purpose:** The social determinants of mental health (SDoMH) continue to exert their fierce presence around the globe. The factors known to influence health outcomes equally impact mental health. A global mental health chasm has widened courtesy of COVID-19's intersection with every psychosocial aspect of functioning, inclusive of how people are born, live, learn, work, socialize, worship, and die. Racial, ethnic, and cultural inequities across the diversity, equity, and inclusion space have led to rising morbidity and mortality across every population. Part 2 of this article series is dedicated to assessment and intervention tools for the workforce. A key fifth or Quintile Aim of wholistic health equity is also presented to advance the industry's seminal quality compass, the Triple Aim, for the future.

**Learning Outcomes:** After reading this article, learners will be able to:

- Explore recent population-based data;
- Apply dedicated assessment tools toward behavioral health management;
- Identify short-term counseling interventions; and
- Examine the fifth or Quintile Aim of wholistic health equity.

**Finding/Conclusion:** Access to quality wholistic health care encompasses pathophysiology, psychopathology, and psychosocial circumstances and remains a challenge across populations. Mental health, along with health disparities, has been fueled by systematic racism that has facilitated inadequate funding, poor reimbursement, decreased treatment options, and pervasive stigma across the cultural divide (e.g., race, ethnicity, gender, sexual orientation, familial status, disability, socioeconomic status). The SDoMH mandate a fresh lens by health and behavioral health professionals, and particularly case management, to ensure a more proactive and comprehensive approach to care. To achieve the successful outcomes mandated by this approach, the industry's quality compass, the Triple/Quadruple Aim, must be expanded to include a Quintile Aim of wholistic health equity.

**Implications for Case Management Practice:** Case management's unique transdisciplinary composition has the workforce well positioned to effect grand change in population health perspectives. Wider attention to clinical and fiscal outcomes for health and mental health inequities mandates innovative approaches to patient care, which encompasses a wholistic health triad of pathophysiology, psychopathology, and psychosocial circumstances.

**Key words:** behavioral health, concordant care, discordant care, mental health, mental illness, maternal mental health, Quintile Aim, social determinants of health (SDoH), social determinants of mental health (SDoMH), systematic racism, wholistic health equity, wholistic health triad

The social determinants of mental health (SDoMH) are now recognized as a priority for the health care industry. Society has been hit by a wave of disruptive influences triggering a ferocious escalation of behavioral health challenges for populations around the globe. Health and mental health are forever intertwined, influencing each aspect of how populations are born, grow, live, age, learn, work, worship, and ultimately die. In response, the entire workforce, especially case management professionals, must assess patients from a fresh perspective that encompasses a wholistic health triad (Fink-Samnick, 2021).

Preexisting social determinants of health (SDoH) continue to drive disproportionately high mortality rates among minority, marginalized, and other vulnerable populations, spurring a range of behavioral health issues. Fear of the unknown has translated to record numbers of persons seeking counseling

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intervention for various forms of anxiety and stress-related diagnoses (e.g., adjustment disorders, insomnia, generalized anxiety disorder, posttraumatic stress disorder). Social isolation has been both a blessing and a curse. There have been unintended consequences despite the intended goal, to keep persons safe from virus transmission. Domestic and family violence is on the rise, along with child and adult abuse. Populations already prone to isolation and more sedentary lives (e.g., persons with disabilities, chronic and life-limiting illnesses, older adults) have experienced depression, suicidal ideation, and psychotic and delusional disorders. Increased stress has fueled an uptick in at-risk health behaviors (e.g., poor nutrition, smoking, substance use and abuse) and associated mortality; the fiscal and clinical costs of co-occurring chronic and behavioral health conditions continue to soar.

Fierce societal narratives of racism, diversity, equity, and inclusion have frazzled patients, their communities, and practitioners tasked with their care. For persons of color and those residing in lower socioeconomic conditions, these realities have only amplified challenges with access to, affordability, and attainment of timely and appropriate mental health intervention. Seminal reports note alarming surges in behavioral health claims for emergency department (ED) admissions in the form of psychiatric emergencies: psychotic episodes, panic attacks, suicide gestures, and overdoses (Bernardini et al., 2021; Fair Health, 2021). Delays in care access for necessary follow-up intervention have created a vicious cycle of mental health onset, emergency “band aid” intervention, and then lengthy wait-lists for follow-up treatment; this cycle too often yields poor, if not fatal, patient outcomes. The reality of these circumstances dictates fresh workforce approaches to assessment and intervention, and especially quality metrics.

Part 1 of this article series (Fink-Samnack, 2021) provided a comprehensive foundation of the SDoMH, from key definitions and population health evidence to implications of systematic racism through provider shortages, reimbursement, and lack of mental health parity. Part 2 renders strategic recommendations to enhance professional practice encompassing assessment tools, interventions, and expansion of the Triple/Quadruple Aim. The Centers for Disease Control and Prevention’s (CDC, 2021a) declaration of racism as a public health crisis has legitimized the mandate for all health care organizations, providers, and professionals to reconcile health and behavioral health disparities. This action compels progression of the industry’s seminal quality compass to incorporate a fifth aim, one that fulfills society’s directive for holistic health equity.

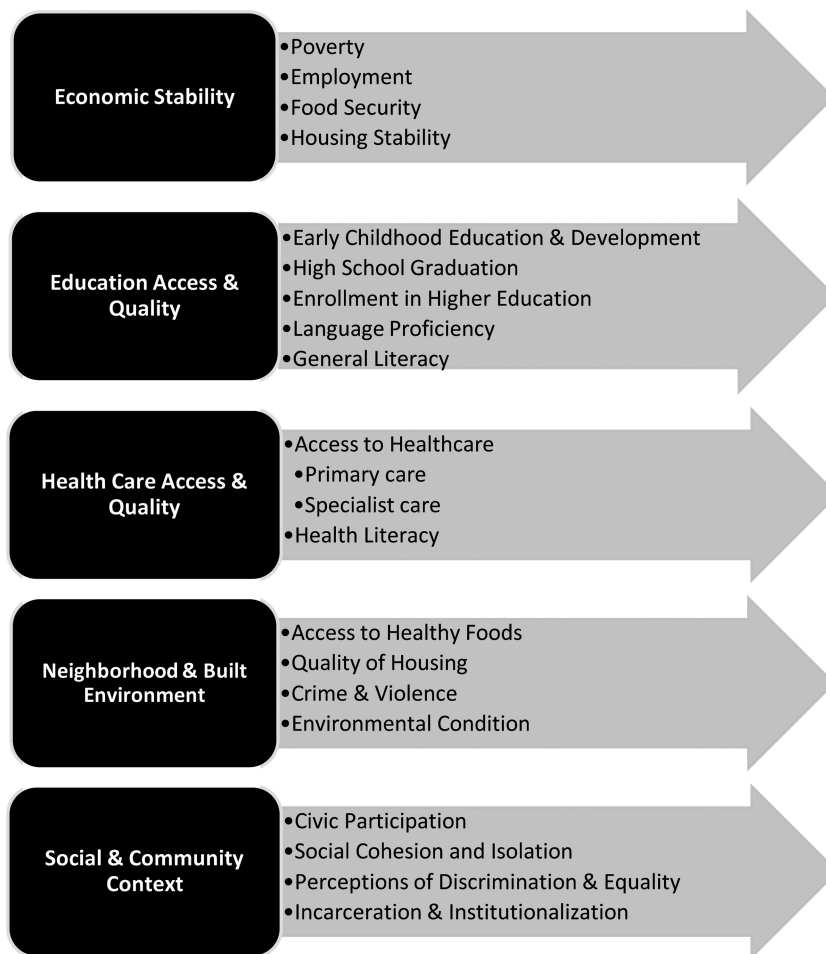
## THE EVOLVING DATA SCHEMA

### Rising Inequities and Incidence

Long-standing racial, cultural, and other embedded societal inequities advanced the five domains associated with the SDoH and mental health displayed in Figure 1. Abundant literature validates how surges in unemployment prompted loss of health insurance and subsequent delays in and obstacles to care. The interweave of employment and housing insecurity has impacted mental health exacerbation, with studies identifying increased incidence of diagnosable anxiety, depression, and other disorders (Bentley et al., 2019; Ettman et al., 2020).

Unemployment and shifting eviction moratoriums have contributed to an increasing incidence of housing insufficiency, particularly for persons leasing or renting their residences. Roughly 50% of the 20.8 million rental households in the United States faced eviction; 80% were persons of color, primarily Black, Latinx, and women-headed households (Prattah & Landen, 2021). The lesbian, gay, bisexual, transgender, intersex, and queer (LGBTQ+) community is also heavily impacted by housing challenges. The literature identifies the community as more likely to face homelessness, figures ranging from 20% to 40% of the homeless population (Fraser et al., 2019). Housing instability transects with other chronic challenges for the community of family rejection, abandonment, and discrimination; the intersection of these issues mean LGBTQ+ persons can be more prone to mental health and substance use issues (Fraser et al., 2019).

Nagata et al. (2021) completed a cross-sectional analysis of data from 63,674 participants of the *U.S. Census Household Pulse Survey*. Nutritional hardship was identified as a major hardship for many persons. Food insufficiency among vulnerable populations (e.g., Blacks, Latinx, those experiencing recent employment loss, those with income below the poverty line) rose 8.1%–10% during March to June 2020. The factor was also independently associated with all symptoms of poor mental health inclusive of anxiety, depression, insomnia, and worry; persons with the highest risk of food insecurity are at a greater risk of experiencing mental health symptoms (Nagata et al., 2021). The Families First Coronavirus Response Act passed by the U.S. Department of Agriculture (USDA; effective December 31, 2020) allowed states to temporarily modify procedures that would make it easier for families to continue participating in or apply for the Supplemental Nutrition Assistance Program (SNAP). In addition, the Act temporarily suspended the 3-month time limits on benefits for unemployed



**FIGURE 1**  
Social determinants of health and mental health. From “Health Disparities,” In *End of life Care for Case Management* (chapter 8), by E. Fink-Samnack, 2020a. HCPro.

adults younger than 50 years without children in their home (USDA, 2021). Although these actions greatly eased the stress and burden for millions of families, concerns for longer term nutritional stability and sustainability remain.

Overall, behavioral health claims have risen significantly during the pandemic and, mostly, in response to stressors associated with the SDoMH. Mental health disparities have acted as mediators and moderators of the pandemic’s immense impact (Bernardini et al., 2021). Emergency department overdose visits are up 45%, with mortality on the rise; more than 81,000 deaths were recorded during June 2019 to June 2021 (Ahmad et al., 2021). Fair Health (2021) reviewed more than 32 billion private health care claims from January to November 2020, identifying a significant rise in mental health claims: roughly 50% of adults and more than double the number of pediatric mental health claims for persons aged 13–19 and 19–22 years. Data yields more than a 90% rise in claims for youth that reflected intentional self-harm (Fair Health, 2021).

## TREATMENT INEQUITIES AND MENTAL HEALTH

### Discrimination, Diversity, and Inequities of Mental Health Treatment

Studies reveal how discrimination and implicit bias directly impact clinical treatment across persons of color, gender, and other marginalized groups. Providers and practices have been shown to treat patients differently, whether due to race, ethnicity, social class, gender identity, religion, primary language, or even insurer. Refusal by practitioners to accept Medicaid plans has long been cited as a major factor to impede the delivery of general and behavioral health care. Historically, studies have shown that as many as 31% of providers have refused to accept Medicaid patients, with rising rejection of both Medicare Advantage beneficiaries and members of the LGBTQ+ community (Decker, 2012; Mirza & Rooney, 2018; Pear, 2018).

Williams (2018) explored how people of color are less likely to be properly diagnosed and treated

for mental health conditions and more frequently experience discrimination when trying to access care. This process creates a concerning cycle for all patients across age groups. Discrimination has also been closely associated with escalating rates of mental and behavioral health challenges starting as early as childhood (Williams, 2018).

Black and Latinx patients are often prescribed fewer pain medications than White patients with the same complaints (Lee et al., 2019; Pagán, 2018). These populations, along with female patients more readily have their physical and mental health symptoms dismissed than White populations (Pagán, 2018). Research by Jones et al. (2018) reflected how when persons of color visit their primary care provider for a behavioral health concern (e.g., anxiety, depression, panic attacks), they are less likely to receive either a specialty mental referral or prescription compared to their White counterparts.

The theme of mental illness stigma between racial minorities and majorities was extensively researched by Eylem et al. (2020); the authors completed a systematic review and meta-analysis that summarized the evidence of 29 studies with 193,418 participants ( $N = 35,836$  in racial minorities). The impact of the assorted types of stigma on racial and ethnic groups, as discussed in the Part 1 article (e.g., experienced, anticipated, perceived), impacted how readily these populations accessed mental health care (Eylem et al., 2020; Fink-Samnack, 2021). The conclusions were emphatic: Mental health stigma is far higher among minority groups, with “anti-stigma” strategies a must to enhance successful linkage and engagement in outreach treatment (Eylem et al., 2020).

### **Maternal Mental Health**

Maternal mental health is an industry imperative, though data for immigrants and women of color yield alarming outcomes. Black women are twice as likely as Whites to suffer from perinatal mood and anxiety disorders (e.g., postpartum depression) and less likely to receive treatment, as high as 40% of the population compared with 20%–25% (Pao et al., 2019). Studies reflect that immigrants have an increased risk of postpartum depression, with low satisfaction of acknowledgment and support by providers (Almeida et al., 2016). Migrant women present at a greater risk for behavioral health manifestations during their pregnancies (e.g., depression, schizophrenia, posttraumatic stress) from the interaction of specific psychosocial determinants such as forced migration, generalized insecurity associated with refugees and asylum seekers, human trafficking, and their tendency to integrate low-income employment with scarce security conditions (Almeida et al., 2016). Other barriers to

health care access can equally obstruct any migrant woman's ability to access appropriate health and mental health, from language, mobility, and legal status to country of origin, health care provider's attitudes, and culture, besides occupational factors. These factors contribute to the increased vulnerability of immigrant women during pregnancy and emergence of psychopathological complications pre- and postbirth, as in postnatal depression and psychosis (Almeida et al., 2016). Research by Owais et al. (2020) identified how Indigenous women are at far greater risk of mental health problems (e.g., depression, anxiety, substance misuse) during the perinatal period, with the prevalence from 17% to 47% of the population.

### **Concordant Versus Discordant Care**

Unconscious, implicit, and explicit bias impacts patient engagement, treatment, and ultimately outcomes, as discussed in Part 1 (Fink-Samnack, 2021). Yet, a rapidly emerging body of research is focused on the disparity of treatment outcomes from culturally or racially discordant versus concordant care: having a shared identity between patient and practitioner versus differing (racial, ethnic, cultural) identities.

Takeshita et al. (2020) found that patients are more comfortable and have a higher quality patient experience and level of engagement with practitioners of the same race. A cross-sectional analysis of 117,589 Press Ganey patient satisfaction surveys were completed from adult outpatient practices of an urban, academic health system from 2014 to 2017. The study revealed physicians among racially and ethnically discordant patient–physician dyads had significantly lower odds of receiving the maximum patient experience score than concordant dyads (Takeshita et al., 2020). This research is consistent with work by Meyer and Zane (2013), which explored how the culture and race of providers impacted patient responsiveness to care. Minorities valued when their provider was knowledgeable about the ethnic and racial group's history of prejudice and discrimination and more readily engaged in treatment. For minority patients who engaged with care providers that did not acknowledge or process the reality of living in a racist society, a poorer quality of care was experienced (Meyer & Zane, 2013).

These factors are timely considerations amid the CDC (2021a) declaration of racism as a “fundamental driver of disparities.” Greater awareness of the disparities and social injustices that create chasms in all care is driving new models of professional education and fresh treatment interventions. Failure to properly address these chasms will further hinder care equity, as well as yield ongoing challenges in attaining true patient-centered care and successful wholistic health outcomes.



## Engagement of Patients Versus Patient Engagement

Increasing literature focuses on a variety of dimensions to contemplate when engaging patient populations in dialogues about behavioral health, especially populations impacted by the SDoH and mental health. The front end of any patient conversation sets a vital tone for the entire relationship, independent of the practice setting and mode by which connection with the target population occurs (e.g., in person, telephonic, virtual). The quality of engagement and establishing rapport with a patient (or family) can dictate the success (or failure) of an entire patient encounter (Fink-Samnack, 2020a).

Emphasis across practice settings is on how to attain successful patient engagement. This umbrella term merges patient activation with dedicated interventions (e.g., motivational interviewing [MI]) that increase the level of patient motivation, the intent to promote treatment adherence and attention to at-risk behaviors that impact overall health and wellness (e.g., activity and endurance, excessive substance use and abuse, nutrition, insomnia, smoking). This type of engagement is integral to successful and sustainable patient outcomes, though the clear onus for behavioral change is on the patient.

Yet, it has become a priority for the workforce to understand engagement from another lens: how practitioners and case managers can leverage their expertise to build rapport with patients and their support systems through development of positive relationships. The responsibility for this action is on the professional and takes definitive strategies, as well as patience. Engaging patients is among the most important skills taught to the interprofessional team. Social work and other behavioral health professionals are weaned on this concept in their academic training, though the concept is not equally emphasized or taught across other disciplines. The concept can be easily missed during onboarding processes, especially in the fast-paced practice world. Instead, the workforce can unintentionally talk at, versus talk to, a patient. Patient reluctance (or resistance) to accept psychopharmacological medication, psychiatrist referral, or follow-up counseling may be mistaken for treatment nonadherence as opposed to cultural perspectives-related mental health stigma. Behavioral

health is laden with stigma for certain patient populations, especially persons of color, and specific ethnic groups. The workforce can take a proactive stance and engage distinct strategies to ease this often difficult part of the relationship-building process.

A case manager's competency to build and develop rapport with another person is the heart of any patient-centered and inclusive treatment process. Imagine the scene: The patient and the professional are of different races or speak different languages. The busy case manager quickly contacts the patient, whether virtual or telephonic; if in person, the interaction is more of a fly-by. There may not be a need for introductions, as the patient must remember the case manager from that last quick visit or call. The case manager talks at the patient, rather than with them: "Mr. P., here's that list of mental health providers." The interaction occurs so quickly that the patient is provided no ability to express concerns about the need for a behavioral health referral, discuss the stigma of mental health for their particular family, culture, or race, or ask further questions. It is doubtful any case manager would expect this quality of case management engagement or the lack thereof, yet it remains the reality of far too many patient interactions.

Engaging patients is not easy, though especially in the context of mental health, there must be a high level of empathy and sensitivity to the topic. The health care experience is fraught with stressors, pressures, and unexpected emotion. A planned, or even sudden, health or behavioral health emergency triggers countless reactions for all involved. A positive engagement experience involves working through the muck and mire of these reactions and finding any opportunities to build trust among involved stakeholders, patient and practitioner alike. The opening may be no bigger than a pinhole, but successful outcomes depend on a professional's ability to find that space. Box 1 offers strategies to foster interprofessional patient engagement.

### Assessment and Intervention

#### Assessment tools

The workforce is increasingly tasked to assess patients quickly and comprehensively. Within so small a time frame, it can be difficult to obtain a solid sense of the patient's reality. Yet, practitioners must

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have a wide variety of easy tools and interventions at their disposal to assess patients and the severity of their behavioral health symptoms. The often brief interactions by practitioners mean a greater reliance on, and use of, these resources. Table 1 offers a list of common tools employed by the industry for mental health behaviors and conditions that may appear across practice settings and populations.

### **Interventions**

#### *The "5 A's" Model*

Prior articles across the literature and this journal have addressed the substantial value of motivational interviewing MI for populations with chronic illnesses, comorbid health and behavioral health conditions,

and substance use issues (DiClemente et al., 2017; Jensen & Mottern, 2016; Tahan & Sminkey, 2012). In comparison, the "5 A's" model is an established evidence-based behavioral and cognitive-focused intervention. Shown in Figure 2, the model has demonstrated considerable success for management of at-risk behaviors and conditions (e.g., depression, intense anxiety, panic disorder, physical activity, smoking, weight management) and in promoting patient treatment adherence (AHRQ, 2012; Glasgow et al., 2006; Hunter et al., 2017).

The model comprises five steps: Ask, Advise, Assess, Assist, and Arrange. These steps have been implemented across integrated care models, exclusively within primary care practices that embed behavioral health consultant roles. Use of the model allows for comprehensive assessment of a patient's motivation to change behaviors with development of a reflective individualized action plan. Professionals have found considerable success integrating other short-term psychotherapy interventions within the "5 A's" model, such as MI, cognitive behavioral therapy, or solution-focused brief therapy. A comprehensive therapy process can be completed within a time-limited session of 30 min or less, which is optimal for all involved in the treatment approach: practitioner, patient, and involved team members. Given the popularity of MI across the health and behavioral health landscape, application of the "5 A's" model with a twist appears through the case scenario in Box 2 and Table 2.

## **BOX 1**

### **Engagement of Patients**

1. Open with empathy and respect
2. Use empathic communication and (active) listening
3. Speak to, not at patients and their support systems
4. Be intentional, yet open and honest
5. Assure culturally inclusive practices
6. Engage patients (and involved support system) as partners to:
  - a. Understand diagnosis, prognosis, and options
  - b. Define a care, and
  - c. Ensure points for further clarification
7. Educate when necessary:
  - a. Explain why treatment recommendations are made
  - b. Include necessary team members, specialists, providers
  - c. Appropriate patient education tools (e.g., infographics, apps, reliable websites)
8. Encourage questions to clarify and inform
9. Keep jargon limited
10. Stay patient
11. Be dependable:
  - a. Timely follow-up when necessary
  - b. Consistent communications
12. Define accountability for:
  - a. Follow-up actions
  - b. Further meetings, conversations
13. Work toward consensus when possible:
  - a. Agree to disagree as needed
  - b. Accept differing perspectives of treatment
14. Ensure necessary information is shared via:
  - a. Patient portals
  - b. Electronic health records
  - c. Modes that allow for accommodation (e.g., TTY systems)
15. Don't Take Things Personally
  - a. Allow for patient and support system emotion, and
  - b. THINK:
    - i. How would I feel in this situation?
    - ii. What would I expect?
  - c. Set limits as appropriate

*Note.* From "Assessment and Engagement," In *End of Life Care for Case Management* (chapter 10), by E. Fink-Samnick, 2020b. HCPro.

#### *Ethno-racial Trauma*

The construct of ethno-racial trauma (ERT) is defined as the "individual and/or collective psychological distress and fear of danger that results from experiencing or witnessing discrimination, threats of harm, violence, and intimidation directed at ethno-racial minority groups" (Chavez-Dueñas et al., 2019). This legacy of oppression becomes embedded in the socio-cultural practices of a society through its laws, policies, and practices with fierce mental health repercussions. Ongoing institutional and systematic racism against marginalized populations across society further exacerbates mental health concerns.

The model of ERT takes its cues from liberation psychology (LP) and trauma-informed care (TIC). The two theoretical approaches empower the patient beyond the traumatic event(s) through identification of individual innate value and strengths. In LP, emphasis is on an enhanced understanding of the sociopolitical structures that all too often negatively impact the lives of oppressed and impoverished individuals and their communities, such as themes of racial and social intolerance and injustice. The approach fuels recovery of historical memories that aid in identifying the significance of each person's cultural heritage

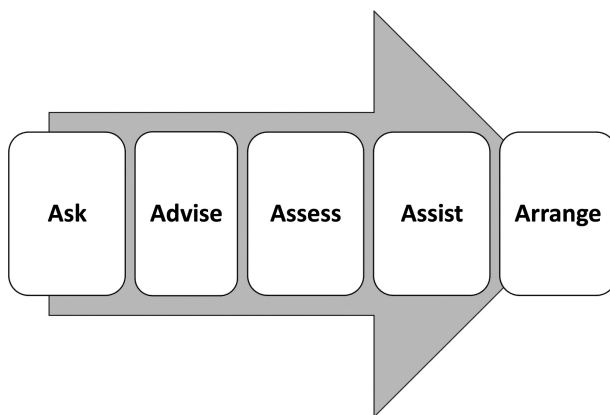
**TABLE 1**  
Behavioral Health Assessment Tools

Tool Name	Primary Function
Adverse Childhood Experiences Questionnaire (CDC, 2021b)	Ten questions tally exposure to adverse childhood experiences: <ul style="list-style-type: none"> <li>• Types of abuse, neglect, or exploitation (e.g., physical, emotional, sexual)</li> <li>• Other types of trauma (e.g., abandonment by a parent or caregiver, exposure to household member who experienced substance use, mental illness, was incarcerated).</li> </ul>
AUDIT-C (MD+CALC, 2021a)	Brief questionnaire to identify at-risk drinkers (e.g., binge drinking) who may not be alcohol dependent
CAGE-AID (MD+CALC, 2021b)	Screens for excessive drinking and alcoholism
Columbia Suicide Severity Rating Scale (C-SSRS) Short and Long Versions (MD+CALC, 2021c)	Screens for suicidal ideation and behavior
DASS-21 (The Calculator, 2021a)	Questionnaire evaluates severity of mental disorder symptoms associated with depression, anxiety, and stress, with a rating of mild, moderate, or severe for each disorder.
Generalized Anxiety Disorder (GAD) 7 Calculator (The Calculator, 2021b)	The test evaluates the several of anxiety based on the most common seven anxiety symptoms (e.g., feeling on edge, excessive worrying, trouble relaxing, restlessness, easily annoyed/irritable, fear of an impending bad event)
PHQ-2 PHQ-9 (Patient Info, 2021)	<ul style="list-style-type: none"> <li>• Preliminary two-question screening tool for depression</li> <li>• Nine-question screening tool developed to align and score the nine <i>DSM-IV</i> (no <i>DSM 5</i>) criteria associated with major depressive disorder from “0” (not at all) to “3” (nearly every day)</li> </ul>
Modified Mini Screen (MMS) (Behavioral health Evolution, 2016)	A self-report measure that rapidly assesses for present mood, anxiety, and psychotic-spectrum disorders
PTSD Checklist: PCL-5 (U.S. Department of Veterans Affairs, 2021)	20-item self-report measure that assesses the 20 <i>DSM-5</i> symptoms of PTSD; serving to <ul style="list-style-type: none"> <li>• Monitor symptom change during and after treatment</li> <li>• Screen individuals for PTSD</li> <li>• Make a provisional PTSD diagnosis</li> </ul>

Note. *DSM-IV* = *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.); *DSM 5* = *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.); PTSD = posttraumatic stress disorder.

and pride. From this stance, a patient can work with their therapist to rebuild and reinforce their sense of identity (Chavez-Duenas et al., 2019).

Trauma-informed care emphasizes five seminal principles developed by Harris and Fallot (2001), which are shown in Figure 3: safety, choice, collaboration, trustworthiness, and empowerment. Starting from, and heavily integrating, the basic therapy prin-



**FIGURE 2**  
The “Five A’s.” Data from *The 5 A’s of Intervention*, by Agency for Healthcare Research and Quality (AHRQ), 2012. Agency for Healthcare Research and Quality (<https://www.ahrq.gov/prevention/guidelines/tobacco/5steps.htm>).

ciple of engagement, TIC evolves a safe and nurturing space. The stage is then set for a firm foundation to foster a trusting treatment partnership. From here, the practitioner and patient can work to forge a collaboration that inspires patient choice toward developing an armory of coping skills. Trauma-informed care is being actively applied across practice settings and populations to ensure an empathic awareness of the presence and impact of trauma, whether experienced through advance childhood experiences (ACEs) or other life events (e.g., sudden illness onset, hospitalization, unexpected family death).

Models associated with addressing ERT, include the HEART framework (Chavez-Dueñas et al., 2019), which integrates four phases that transcend individuals, families, and communities, as depicted in Table 3. Each phase is aligned with a distinct goal that sets a framework for clinicians to guide the patient’s attainment of growth, wellness, and healing. A key objective of each phase is to promote the innate capacity of patients to understand and reconcile their experienced trauma.

Although ERT was originally written for Latinx populations, it has clear application to other marginalized and oppressed groups (e.g., immigrants, BIPOC, LGBTQ+, women, religious). The intersection of historical and structural systems within cultures can negatively influence patient trust in the health and

## BOX 2

### Case Scenario for Combined “5A’s” and Motivational Interviewing Approach

Mika is a 58-year-old single man admitted to the cardiac care unit for observation from the ED. This is the patient’s third ED admission and hospitalization in the last 3 months, with complaints of feeling light-headed, passing out, and experiencing chest tightness. Mika has been referred to this behavioral health consultant by his primary care physician for assessment and short-term recommendations to address the patient’s treatment nonadherence and increased irritability.

Mika has a 5-year history of atrial fibrillation and hypertension, for which he is followed by a cardiologist; prescribed medicines are diltiazem (Cardizem) 5 mg t.i.d. and one baby aspirin qPM, though does not recall when he took his cardiac medication last. Mika admits to not taking the prescription consistently.

Mika has had been transported to the hospital via ambulance three times in as many months. All visits warranted hospitalization for bouts of unstable cardiac rhythms, medication management, and necessary testing. Mika’s primary care physician at the community health center recommended exercise, nutrition, and stress management, though the patient canceled the appointments scheduled with the treatment team. He consistently minimizes the need for attention to his health behaviors.

Mika expresses frustration in how his hospitalizations and other issues (e.g., headaches, blackouts) interfere with his ability to work; he is a day laborer who picks up jobs by waiting at the local convenient store each morning. He verbalizes anger and depression for being unable to get up early enough in the mornings to be at the designated pickup point. “It’s not worth it,” says Mika.

Mika’s brother died of pancreatitis 4 years ago, and a mother recently died of COVID-19. He has no other family in the United States and a limited peer support system; “Everyone I know works, drinks, then sleeps.”

*Note.* ED = emergency department; qPM = every afternoon or evening; t.i.d. = three times daily.

mental health system and their willingness to seek care; the various stigmas, as well as perceived and experienced trauma, can impede access to appropriate care. Fears of deportation can interfere with patients feeling safe enough to leave their homes and obtain needed evaluation, assessment, as well as treatment.

Even amid expanded telehealth access, individuals may be concerned about their whereabouts being tracked through digital devices or computer platforms. These powerful dynamics underscore the impact of the psychosocial determinants, upstream and aggressive immigration policies, and power dynamics that

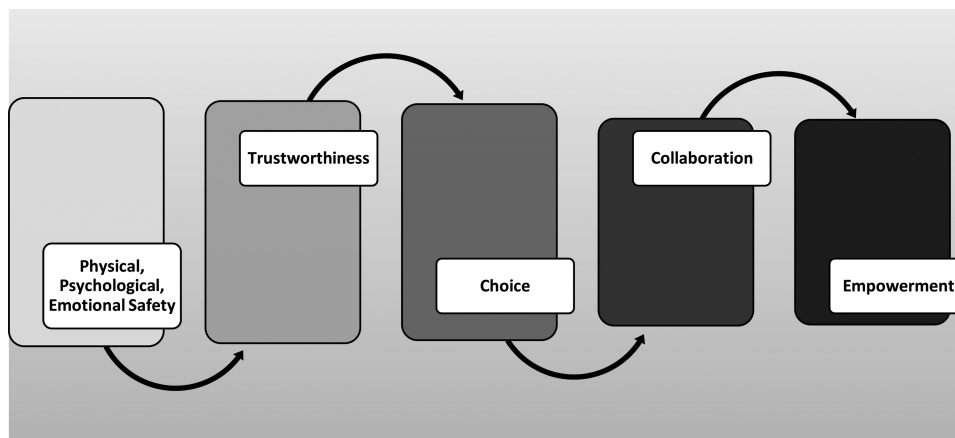
## TABLE 2

### Application of “5A’s” and Motivational Interviewing Combined

“5A’s”(AHRQ, 2012)	Description	Motivational Interviewing (Miller & Rollnick, 2013)
Ask	Practitioner asks Mika: <ul style="list-style-type: none"><li>• Assessment questions for patients with cardiovascular disease including:<ul style="list-style-type: none"><li>○ Health behaviors (e.g., tobacco use, weight, height, body mass index, typical meals per day, amount of sodium and fat in food, type(s) and amount and of alcohol consumed per day or week)</li><li>○ Emotional behaviors (e.g., using a Likert scale ask how stressed the person is; presence of recent life changes or stressors; changes in job, employment, or financial status; strategies to manage stress; presence of family, partner or peer support; frustration tolerance; exposure to intimate partner or family violence)</li></ul></li></ul>	Establish rapport
Advise	Practitioner provides Mika with tempered advice via primary psychoeducation <ul style="list-style-type: none"><li>• Specific to cardiovascular disease and substance use</li><li>• Medication management</li></ul>	Express empathy
Agree	Practitioner elicits from Mika what he would like to change and collaboratively sets goals. Examples include the following: <ul style="list-style-type: none"><li>• Improve sleep hygiene</li><li>• Increase ability to get up for day laborer crew assignments</li><li>• Reduce alcohol use</li><li>• Homework: Initiate mindfulness exercises three times daily to reduce stress, alcohol use log, track days. Mika is able to get up on time to be at designated day laborer crew assignment point.</li></ul>	Develop discrepancy
Assist	The practitioner uses brief counseling intervention (e.g., MI) for Mika to develop how identified behavior change(s) will take place: <ul style="list-style-type: none"><li>• Add homework: Mindfulness three times daily, sleep hygiene log (monitor for improvement in event attendance consistency; periods of irritability, further ED admissions/hospitalizations)</li><li>• Provide sleep hygiene list</li></ul>	Avoid argument/roll with resistance
Arrange	Practitioner arranges for Mika: <ul style="list-style-type: none"><li>• Follow-up visits at clinic and with other specialty providers</li><li>• Additional resources (e.g., nutrition, exercise, cardiac rehabilitation; individual therapy)</li><li>• Continue mindfulness, medication log, sleep hygiene, work attendance log</li></ul>	Support self-efficacy

*Note.* ED = emergency department; MI = Motivational Interviewing.





**FIGURE 3**

Trauma-informed care. From *Using Trauma Theory to Design Service Systems. New Directions for Mental Health Services*, by M. Harris and R. D. Fallot, 2001. Jossey-Bass.

are a reality for marginalized populations. Healing is addressed through interventions focused on the internal symptoms of trauma experienced by the patient and interlocking external systems of oppression that caused and maintained manifesting psychological distress (Chavez-Dueñas et al., 2019).

**Infographics**

Infographics are vital and effective tools to convey patient information about treatment, medications, and other clinical topics and interventions (McCrorie et al., 2016; Provvidenza et al., 2019; Scott et al., 2016). These innovative resources relate

**TABLE 3**

**Addressing Ethno-racial Trauma: HEART Framework**

Phase	Goal	Example
I. Establish sanctuary space for patients experiencing ERT	<ul style="list-style-type: none"> <li>Assist with immediate relief from the effects of ERT</li> </ul>	<ul style="list-style-type: none"> <li>Create mission statements that underscore nondiscrimination specific to immigration status</li> <li>Set a safe, nurturing space to meet</li> <li>Allow for crisis intervention through intakes, walk-in, and/or team consultations</li> <li>Ensure privacy and confidentiality</li> <li>Reflect acceptance through empathy</li> </ul>
II. Acknowledge, reprocess, and cope with symptoms of ERT	<ul style="list-style-type: none"> <li>Help clients develop awareness of how systems of oppression impact the self, family, and community</li> <li>Reprocess traumatic experiences and provide support to cope with emotional stress and symptoms associated with ERT</li> </ul>	<ul style="list-style-type: none"> <li>Use trauma-informed care interventions to affirm consistent acceptance</li> <li>Use psychoeducation to present trauma impact</li> <li>Reframe patient as survivor vs. victim</li> <li>Connect patient with social and professional support including appropriate referrals to behavioral health practitioners trained in trauma-informed practices</li> </ul>
III. Strengthen and connect individuals, families, and communities to survival strategies and cultural traditions that heal	<ul style="list-style-type: none"> <li>Assist individuals, families, and communities to connect to the Latinx (or other) culture, learn and utilize collective cultural strengths, and engage in traditions that are healing</li> </ul>	<ul style="list-style-type: none"> <li>Ensure awareness of patient stage/status of (racial, cultural, ethnic) identity</li> <li>Organize events and programs on dimensions of ERT</li> <li>Encourage development of coping strategies</li> <li>Role-play and model appreciation of connection to culture of origin</li> <li>Create treatment goals as clinically prepared to do so, including:               <ul style="list-style-type: none"> <li>Teach cultural knowledge</li> <li>Practice cultural traditions</li> <li>Learn about/celebrating cultural strengths to abate effects of ERT</li> <li>Encourage healthy cultural distrust</li> </ul> </li> </ul>
IV. Liberation and resistance	<ul style="list-style-type: none"> <li>Develop a social justice orientation through collective action and resistance to foster psychological liberation</li> </ul>	<ul style="list-style-type: none"> <li>Explore causes patients are passionate about and where they would like to create change</li> <li>Identify ways to engage and contribute to systemic change</li> <li>Find activities and roles to engage in social action such as volunteering, marches, rallies, social media groups, running for local leadership roles</li> </ul>

Note. From "Healing Ethno-Racial Trauma in Latinx Immigrant Communities: Cultivating Hope, Resistance, and Action," by N. Y. Chavez-Dueñas, H. Y. Adames, J. G. Perez-Chavez, and S. P. Salas, 2019, *American Psychologist*, 74(1), pp. 49–62 (<http://dx.doi.org/10.1037/amp0000289>). Copyright [year] by the [name of the copyright holder]. Adapted with permission. ERT = ethnoracial trauma.

key information to health and behavioral health consumers in a “logical manner” via use of pictures and other graphics with minimal verbiage; the effort relies on the power of images to inform individuals of specific topic messaging. Infographics are particularly useful to mitigate health literacy or language proficiency challenges that present across patient populations and practice settings (McCrorie et al., 2016). They can also be used to inform populations of key mental health issues as symptom manifestation, acute and chronic management, and treatment approaches.

Patients are more than 6.5 times more likely to recall information from an infographic opposed to simply reading text (Scott et al., 2016). Providenza et al. (2019) identified an enhanced understanding of health issues for patients and other health professionals when infographics were implemented. Study participants met knowledge needs 91% of the time and were more easily able to acquire new knowledge through infographic use for 87% of users (Providenza et al., 2019).

## WHOLISTIC HEALTH EQUITY

Since the Institute of Medicine’s (2001) seminal work, *Crossing the Quality Chasm*, attention has been targeted on patient-centered, quality-driven practices. The Institute for Health Improvement (IHI) then set a quality course driven by the Triple Aim. The goal of this quality compass was to set a framework that would guide health care organizations to improve the population experience through rendering the right care, at the right cost, and right time (McCarthy & Klein, 2010). Although the model emphasized the critical role of quality metrics and outcomes, it would soon face a rising challenge; the industry was forced to reconcile an increased incidence of poor outcomes as an unwelcome side effect of workforce burnout (Fink-Samnick, 2017). A new fourth, or Quadruple Aim, became integrated within the model—the explicit goal to find the joy and meaning of the work (Bodenheimer & Sinsky, 2014); a happier and more fulfilled workforce would be more inclined to provide higher quality care.

However, at this important precipice of health care history, experts argue the Quadruple Aim should be expanded. This recommendation is simple; the seminal model must better account for the industry’s prime directive to mitigate health equity and both SDoH and SDoMH.

### The Fifth or Quintile Aim: A New Direction for the Quality Compass

Health and behavioral health are in a synergistic relationship, with disparities a major disruptor of outcomes. Integration of a quality health and behavioral health experience is the preferred model of care to achieve the best outcomes (Health Research and

Educational Trust, 2016). Yet, despite the promise, this level of integration remains one of the most challenging issues facing health systems and the industry today. Robust amounts of data provided through both parts of this article series reveal concerns and gaps in patient health and mental health that enhance morbidity and mortality.

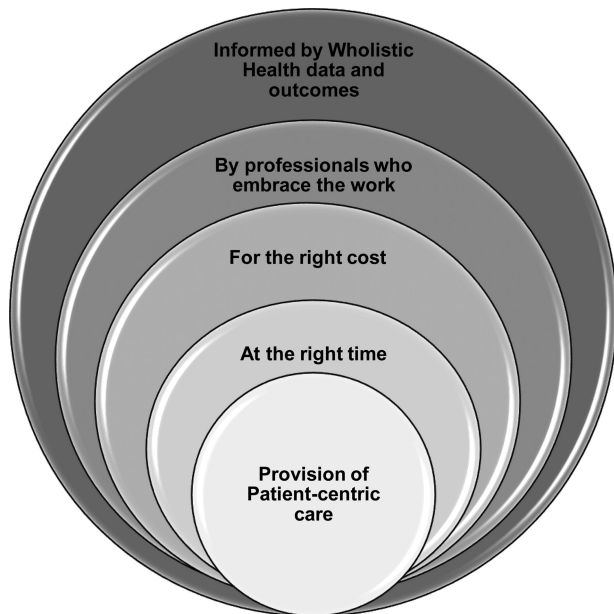
It has become an industry mandate for every organization and practice setting to embrace wholistic health equity as the fifth aim. The Quintile Aim encompasses the following four elements:

1. Population-focused care that incorporates the wholistic health triad (e.g., pathophysiology, psychopathology, psychosocial circumstances) (Fink-Samnick, 2020a);
2. Practices attentive to ethnic, racial, and cultural inclusion across populations;
3. Realistic reimbursement and funding that ensure mental health parity and value-based care accountability; and
4. Data and outcomes that accurately measure the wholistic health triad (Fink-Samnick, 2021).

The Fifth aim stands firmly positioned as the quality compass for the future that will promote patient-centric, safe, equitable care across populations, providers, and profit margins, as shown in Figure 4. Mate (2020) framed the industry mandate well; the health and behavioral health industry cannot improve equity without taking on institutional (and all forms of) racism.

Yes, improving safety, effectiveness, patient-centeredness, timeliness, and efficiency is difficult, but equity is the most challenging because we never intentionally designed systems to harm patients. We never legislated long waiting times. We never imposed rules, regulations, customs, and norms for ineffective care. We did, however, legislate inequity. It’s in the founding documents of our country. It’s how we built this nation. It’s in our language. It’s in the way that we read and write. It’s in the way that we build our cities. It’s in what we see online. (Mate, 2020)

The mandate for the Fifth aim of wholistic health equity is clear. Only through this effort can the industry address the embedded ethos of systematic racism that disrupts access to necessary and inclusive care for all persons. This expanded approach would also account for the impact of all iterations of trauma experienced by society: historical, oppression, child and adult abuse, neglect, exploitation, family violence, sexual assault, victims of criminal acts, motor vehicle accidents; man-made and natural disasters, mass violence events, health and mental health emergencies, plus other populations and circumstances.



**FIGURE 4**  
The Quintile Aim.

Attention to the first two elements of the Quintile Aim have been addressed in Part 1 and earlier in this article. However, knowledge will now be provided on how to mitigate gaps in SDoMH funding and reimbursement, as well as the need for accurate population health data and manifesting quality chasms.

### **Funding and Reimbursement**

Operationalizing a Quintile Aim will take far more than annual organizational training programs focused on cultural awareness and unconscious bias (Silvashanker & Mohta, 2020). Promoting wholistic health equity is dependent on a range of factors, especially reimbursement for mental health services that are equitable across private and public insurers. Grant funding should be leveraged to the fullest as a means to mitigate gaps in care and treatment. Funding to address the health and mental health disparities has increased exponentially through a variety of funding streams. A list of current grant funding resources appears in Box 3.

Health care organizations are more actively investing in community partnerships to mitigate the gaps in care of their target populations. Reports continue to reflect an industry dominated by increasing mergers and acquisitions, as insurers, health care organizations, providers, community-based agencies, clinics, and other entities navigate complex and costly populations in need. More than 30 behavioral health organizations across the country partnered during the first quarter of 2021 to bridge care gaps, primarily in the areas of addiction and autism treatment and more general mental health (Taggart, 2021). This level of

partnering takes strategic considerations, which are presented in Box 4.

### **Community Investment**

Health care organizations are positioning themselves for success through community investment and development. These efforts promote the ability of entities to address the profound costs associated with health and mental health disparities, especially for hospitals. Nonprofit hospitals in the United States have spent on average of \$67.9 billion on community benefits in 2020. More than 50% of these expenditures were dedicated toward patient care: 41.2% for unreimbursed care, and 20.9% for charity care.

Community investments are traditionally divided into nine subcategories that transverse hospital size, geographic region, and poverty rates. Each subgroup provides vast opportunities for health care organizations to partner on community-spending initiatives with community-based organizations and other programs. These initiatives can make a measurable difference in targeted programming for the SDoH and SDoMH. The funding subcategories appear in Box 5.

Nonprofit hospitals face increased obstacles to achieve their mission of promoting the health and well-being of their targeted populations. These obstacles include rising utilization rates and costs often associated with high rates of uncompensated care. This rate rose steadily from \$17.4 billion in 1995 to a high of \$41.3 billion in 2019 (American Hospital Association, 2021). The slight decrease reflected at the start of 2020 was quickly erased by COVID-19. A dramatic shift in the hospital payer mix has emerged during the pandemic; bad debt, uncompensated care, and self-pay areas have risen considerably for a majority of organizations, adding to other revenue and clinical challenges.

Facilities in communities with the highest admission and acuity rates continue to balance revenue losses from decreased insurance reimbursement due to pandemic-related unemployment. Studies reflect decreased percentages of privately insured patients across most organizations, particularly those relying on elective and other ambulatory surgeries (Kaufman Hall & Associates, 2020). More than 10 million persons are projected to lose employer-sponsored health coverage due to layoffs, furloughs, and other job shifts, adding to the uninsured population ranks by 10%; many adults choosing not to enroll in Medicaid or other Affordable Care Act market coverage plans (Haley & Wengle, 2021). These shifts will mean further impediments to mental health access.

### **Data, Outcomes, and Quality Metrics**

Every health care organization values successful outcomes and quality metrics. Yet, these constructs are only

## BOX 3

### Grant Funding Sources

#### General Portals

Association of Schools and Programs of Public Health: Funding opportunities. <https://www.aspph.org/teach-research/funding-opportunities/>

Commonwealth Fund: General portal list of funding options. <https://www.commonwealthfund.org/grants-fellowships/grants>

Partners in Information Access for the Public Health Workforce. [https://phpartners.org/ph\\_public/grants](https://phpartners.org/ph_public/grants)

Rural Health Hub: Grant opportunities for rural regions serving the SDoH and SDoMH. <https://www.ruralhealthinfo.org/funding/topics/social-determinants-of-health>

#### Individual Funding Entities

Aetna Foundation: Grants to improve access to and quality of care. <https://www.aetna-foundation.org/grants-partnerships.html>

Agency for Healthcare Research and Quality: Grant announcements from the Agency for Healthcare Research and Quality for supporting research to improve the quality, effectiveness, accessibility, and cost-effectiveness of health care. <https://www.ahrq.gov/funding/index.html>

Bill & Melinda Gates Foundation: Funding to enhance the human condition. <https://www.gatesfoundation.org/How-We-Work>

Centers for Disease Control and Prevention: Funding targeted for public health, health equity, and quality of care

- Main Portal: <https://www.cdc.gov/grants/index.html>
- Prevention and Public Health Fund Portal: <https://www.cdc.gov/funding/pphf/index.html>

First Nations: Strengthens American Indian economies to support healthy Native communities. <https://www.firstnations.org/grantmaking/>

Hogg Foundation for Mental Health: Invests in programs, policy analysis, research, and education through grants, scholarships, and fellowships to transform how communities promote mental health in everyday life. <https://hogg.utexas.edu/funding-opportunities>

Indian Health Service: Federal Health Program for American Indians and Alaska Natives. <https://www.ihs.gov/dgm/>

Kaiser Permanente: Addressing quality of and access to care in California. <https://share.kaiserpermanente.org/community-health/communities-we-serve/northern-california-community/grants/>

Medline Community Impact Grants: The Community Impact Grant Program addresses SDoH by investing crucial financial and human resources to help stimulate health equity and improve population health.

- General portal: <https://www.medline.com/pages/community-impact-grant/>

National Reentry Resource Center: The nation's primary source of information and guidance in reentry from incarceration

- The Second Chance Act Grant Program: <https://csgjusticecenter.org/nrc/projects/second-chance-act/>

National Institutes of Mental Health: Expansive funding options for the mental health. Funding and opportunities: <https://www.nimh.nih.gov/funding/opportunities-announcements/index.shtml>

National Institute on Minority Health and Health Disparities: Funding on health disparities. <https://www.nimhd.nih.gov/funding/nimhd-funding/>

Patient-Centered Outcomes Research Institute: Funding opportunities focused on patient-centered comparative clinical effectiveness research (CER) projects aligned with five priority areas for research.

- Assessment of prevention, diagnosis, and treatment options
- Improving health care systems
- Communication and dissemination research
- Addressing disparities
- Accelerating patient-centered outcomes research and methodological research

<https://www.pcori.org/funding-opportunities>

Pfizer: Health literacy and clear communication funding. <https://www.pfizer.com/health/literacy/healthcare-professionals/public-policy-researchers/opportunities>

Robert Wood Johnson Foundation: Fund program and policy initiatives in four areas that are each critical to health equity—enabling everyone in our nation to live a healthier life. <https://www.rwjf.org/en/how-we-work/grants-and-grant-programs.html>

Substance Abuse and Mental Health Services Administration: Funding focused on substance use, abuse, and mental health

- General Grant Portal: <https://www.samhsa.gov/grants>

*Note.* Grant opportunities and websites will change. SDoH = social determinants of health; SDoMH = social determinants of mental health.

valuable when the data being used is accurate. There have been significant issues with algorithm bias and other sources used to capture and analyze key health and behavioral health data. The rising incidence of these situations has resulted in flawed data used to define treatment across the racial, ethnic, and gender divide.

Even when predictive models account for racial and cultural factors, performance of the models can still be flawed. Coley et al. (2021) reviewed algorithms for two prediction models to assess suicide risk across racial and ethnic groups. More than 768

suicides that occurred 90 days post-clinician visit were studied. Although both models accurately predicted suicide risk for visits by White, Hispanic, and Asian patients, they fell short in predictions for Black and American Indian/Alaskan Native patients who did not report their race or ethnicity (Coley et al., 2021). The imperative to improve predictive performance for disadvantaged populations is a mandate. Otherwise, mental health disparities will continue to become more embedded within society, leading to greater mortality.



## BOX 4

### Ways to Advance Funding Collaborations

1. Compile a list of the SDoMH for the populations served by your organization:
  - a. Prioritize one or two areas to address (you can always expand later).
  - b. Keep a list for the future. (With each success you leverage potential for other projects.)
  - c. Develop a program idea or initiative to address the funding gap.
2. Consider if your idea(s) require fiscal investment vs. restructuring of organizational manpower (e.g., staffing).
3. Reach out to model programs and initiatives to inquire how they got their efforts moving. Ask about:
  - a. Obstacles
  - b. Who they involved in their organizations
  - c. Recommended community stakeholders
  - d. What they would do differently, or
  - e. Lessons learned
  - f. Anything else they would like to share
4. Consider who you can partner with (e.g., other organizations). Remember:
  - a. Nothing gets accomplished in silos.
  - b. Funding entities value common interests achieved through collaboration
5. Learn what has been done to address the issue(s):
  - a. By your organization, and
  - b. The surrounding community
  - c. By other organizations
6. Make a list of funding entities to monitor.
  - a. Set up email notifications for upcoming funding opportunities.
7. When you approach your own leadership to move a concept forward:
  - a. Be clear: What's the problem and what's your solution?
  - b. Bring numbers about the population (and current outcomes) from at least the past 2 years.
  - c. Define a realistic threshold; fixing 100% of the challenge is well intended but unrealistic (e.g., reduce clinic no-shows by 20%, decrease ED visits for clients by 25%).
  - d. Develop solutions for short- and long-term funding (e.g., potential seed grants, funding sources).
    - i. Work to have the program fund itself, as you can.
8. Follow-up to keep your idea moving forward!
9. Celebrate the win!
  - a. Use social media, and
  - b. Press releases
  - c. Write quarterly reports to keep all vested stakeholders engaged and updated!

Note. ED = emergency department; SDoMH = social determinants of mental health.

Accrediting, credentialing, and regulatory entities are advancing their quality models to incorporate metrics that more appropriately reflect the diversity of patient populations. At the time of this writing, public comment has just closed on new HEDIS measures for the National Committee for Quality Assurance (NCQA). The accrediting body plans to advance health equity by leveraging HEDIS

to hold health plans accountable for disparities in care among their patient populations; race and ethnicity stratification will be introduced, targeting five measures in MY 2022 and a minimum of 15 measures stratified by MY 2024. Mental health utilization is expected to be integrated across commercial, Medicaid, and Medicare product lines (NCQA, 2021).

## BOX 5

### Hospital Community Development and Investment Subcategories

- *Physical Improvements and Housing*: Enhancement of targeted programs for vulnerable populations involving neighborhood improvement and revitalization, housing upon inpatient discharge, housing for seniors, and parks and playgrounds;
- *Economic Development*: Assisting small business development and creating employment opportunities in areas with high unemployment;
- *Community Support*: Encompassing childcare, mentoring programs, neighborhood support groups, violence prevention, disaster readiness, public health emergency preparedness, and community disease surveillance;
- *Environmental Improvements*: Addressing environmental hazards impacting community health, such as alleviation of water or air pollution, removal or treatment of waste, or other activities;
- *Leadership Development and Training in Conflict Resolution*: Advancing of civic, cultural, or language skills; or medical interpreter skills for community residents;
- *Coalition Building*: Commitment to build initiatives that address health and safety issues;
- *Community Health Improvement Advocacy*: Supporting policies and programs to safeguard or improve public health, access to health care services, housing, the environment, and transportation; and finally
- *Workforce Development*: Recruitment of physicians and other health professionals to work in underserved areas and collaborate with educational institutions to train and recruit health professionals as needed.
- *"Other" subcategory*: Addresses activities not described in these categories.

Note. From Exploring Hospital Investments in Community Development, by H. Savage and E. Divringi, 2020. Federal Reserve Bank of Philadelphia (<https://www.philadelphiafed.org/-/media/frbp/assets/community-development/reports/hospital-investments-in-cd.pdf?la=en>). In the public domain.

*Every health care organization values successful outcomes and quality metrics. Yet, these constructs are only valuable when the data being used are accurate. There have been significant issues with algorithm bias and other sources used to capture and analyze key health and behavioral health data. This rising incidence of these situations has resulted in flawed data used to define treatment across the racial, ethnic, and gender divide.*

### **Interprofessional Teams With Embedded Behavioral Health Consultants**

The industry's ability to heed the original Triple Aim and then Quadruple Aim has had to keep pace with more wholistic approaches to care. These approaches incorporate the integration of fresh models, including the expansion of interprofessional and integrated care teams. Successful clinical and fiscal outcomes have been identified through use of these teams, which embed behavioral health consultants. Integration of these individuals and teams across the areas of highest treatment utilization (e.g., costs per day, length of stay, psychopharmacological prescription, and resource use) has contributed to reduced hospitalizations and length of stay, costs, and increased patient treatment adherence. It has also served to expand the bandwidth of organizations in rendering mental health care for patients most in need, the majority of whom seek care in primary care clinics and EDs (Laderman & Mate, 2016). The success of these models is driven by including new generations of practitioners who span health and human services disciplines, many holding a Doctoral degree in behavioral health. These professionals are specifically trained in population health, wholistic health equity, as well as short-term assessment and counseling interventions for comorbid chronic illness and behavioral health.

Sixty percent of annual visits for chronic illness were through the ED and totaled more than \$8.3 billion; Medicaid was the primary payer with the lowest average cost per visit, more than 50% lower than the average costs for Medicare and 30% lower than commercial payers (Moore & Liang, 2020; Premier, 2020). High percentages of patients with chronic obstructive pulmonary disease (COPD) wrestle co-

occurring behavioral health issues. Panagioti et al. (2014) identified 30% of COPD patients experiencing both depression and anxiety. The pandemic has inflated these rates to 40% of the population (Cutler & Summers, 2020). Health care utilization has been found to decrease by up to 2.3 days, with cost savings of \$630,000 for patients followed by an integrated care team (Dajczman et al., 2013). Patients with recurrent hospitalizations who received physical and behavioral health interventions through integrated teams were 70% less likely to seek care in the ED and 65% less likely to be hospitalized (Dajczman et al., 2013; Gaglioti et al., 2017).

Patients hospitalized with COPD who received psychopharmacological interventions combined with short-term psychotherapies (e.g., cognitive behavioral therapy, guided imagery, mindfulness, sleep hygiene) demonstrated decreased anxiety and depression, as well as improved treatment outcomes and overall quality of life. Co-treatment (e.g., relaxation techniques) by the behavioral health consultant and respiratory therapist contributes to decreased pulmonary treatments and psychopharmacological medications (e.g., nebulizers, oxygen, inhalers, ventilators, benzodiazepines) for patients (Cully et al., 2017; Panagioti et al., 2014; Tselebis et al., 2016). Consider the promise of a physical therapist and a behavioral health consultant co-treating a patient with asthma and severe anxiety. Use of relaxation techniques, pursed breathing, and guided imagery can enhance endurance, activity, and recovery, not to mention treatment adherence. These are outcomes that make case managers and their employers ecstatic.

These teams can be replicated across populations and programs that transcend chronic illnesses, including women's health. Case management professionals should also be integrated within the team and play a collaborative role in addressing psychosocial stressors, trauma, and insurance reimbursement and negotiation when needed. These new interprofessional models of care promote the juggling skills of health care organizations to keep the balls associated with wholistic health equity and the Quintile Aim in the air.

*Accrediting, credentialing, and regulatory entities are advancing their quality models to incorporate metrics that more appropriately reflect the diversity of patient populations.*

*These new interprofessional models of care promote the juggling skills of health care organizations to keep the balls associated with wholistic health equity and the Quintile Aim in the air.*

## CONCLUSION

Massive efforts are needed for the industry to best ensure consistent and enduring attention to SDoMH. Many of these actions are addressed through this article, though a full list of change is massive. Further considerations include, but are not limited to, the following:

- Attention to practitioner shortages by expanded provider networks, increased reimbursement, and attention to specialty care needs of BIPOC, LGBTQ+, and all marginalized populations.
- Treatment beds and space substantiated to ensure access to quality health and behavioral health. Access to appropriate, timely, and reflective mental health treatment without appointment delays is a must to maximize stabilization and prescription management.
- Interprofessional academic preparation and continuing education for providers and practitioners on all types of stigma and biases that disrupt patient care and treatment, with
- Attention to the impact of trauma and ACEs on illness morbidity and mortality across the developmental stages (e.g., infancy, children, adolescents, adults).

Society may not have intentionally designed systems to harm patients, but that reality has played out repeatedly over time. Wholistic health equity and a meaningful Quintile Aim can be achieved through strategic, committed, and measurable action plans by every organization, in the same way the industry initially implemented the Triple Aim and then the Quadruple Aim. Any less rigorous of an effort will yield unsustainable programming and care. Only then can the industry attain clinically, equitable, and fiscally appropriate care that meets the health, mental health, and psychosocial needs of each individual patient, family, community, and population.

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