Does It Really Work?: Evaluation and Policy Support for Integrated Care

12th Canadian Collaborative Mental Health Care Conference

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Program Officer

MEHAF

MAINE HEALTH ACCESS FOUNDATION

Disclosure of Financial Interest Statement

- The sole source of financial support for this presentation and for the integrated care initiative to be discussed is from the nonprofit foundation, Maine Health Access Foundation.

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Learning Objectives

- Explore options for evaluating state/province-wide collaborative care initiatives;
- Look at clinical and population outcomes for evaluating levels of collaborative/integrated care across settings and populations;
- Share tips on advocating with federal, state/provincial, and local policy makers, using data and experiences of sites; and
- Learn about leverages to improve reimbursement for integrated care with payers and policy-makers.

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Guiding Questions for Evaluation

- How much did we do?
  - # Served
- How well did we do it?
  - % Common measures, Activity-specific measures
- Is anyone better off?

» Friedman, M. (2005). *Trying hard is not enough: How to produce measurable improvements for customers and communities.* FPSI Publishing.

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Guiding Questions for Evaluation

- Is Anyone Better Off?
  - #/% Skills/Knowledge
  - #/% Attitude/Opinion
  - # Behavior
  - #Circumstance
  - #Improved Health Outcomes
  - Friedman, M. (2005). *Trying hard is not enough: How to produce measurable improvements for customers and communities.* FPSI Publishing.

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MeHAF Additions

- What did we learn?
- What should we share of what we learned to whom and for what reason?

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Background: MeHAF's Investment

- $10 million, 10 years
- Focus on Patient/Family-Centered Care
- Convening
- Grant Funding
- Research and Evaluation
- Policy Support for Sustainability

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MeHAF's Grant Making

- 3 rounds of funding (2007-2009)
- Planning and Implementation Grants
- Clinical Services and Systems Transformation
- 43 Grantees, over 90 Sites, over 150 partner organizations

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MeHAF Evaluation Stages: Phase I

- Stakeholders' work group and public engagement (focus groups)
- Barriers Study
- Development of Logic Model
- Development of Evaluation Plan Simultaneous to Grant-Making

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Barriers/Opportunities/Wishes

- What gets in the way of your providing the best possible integrated care? (What do you say are your barriers to providing integrated care? What would your patients say are barriers to receiving integrated care?)
- What helps you provide quality integrated care?
- What resources/policies/etc. do you wish were available to help you provide even better and more integrated care?

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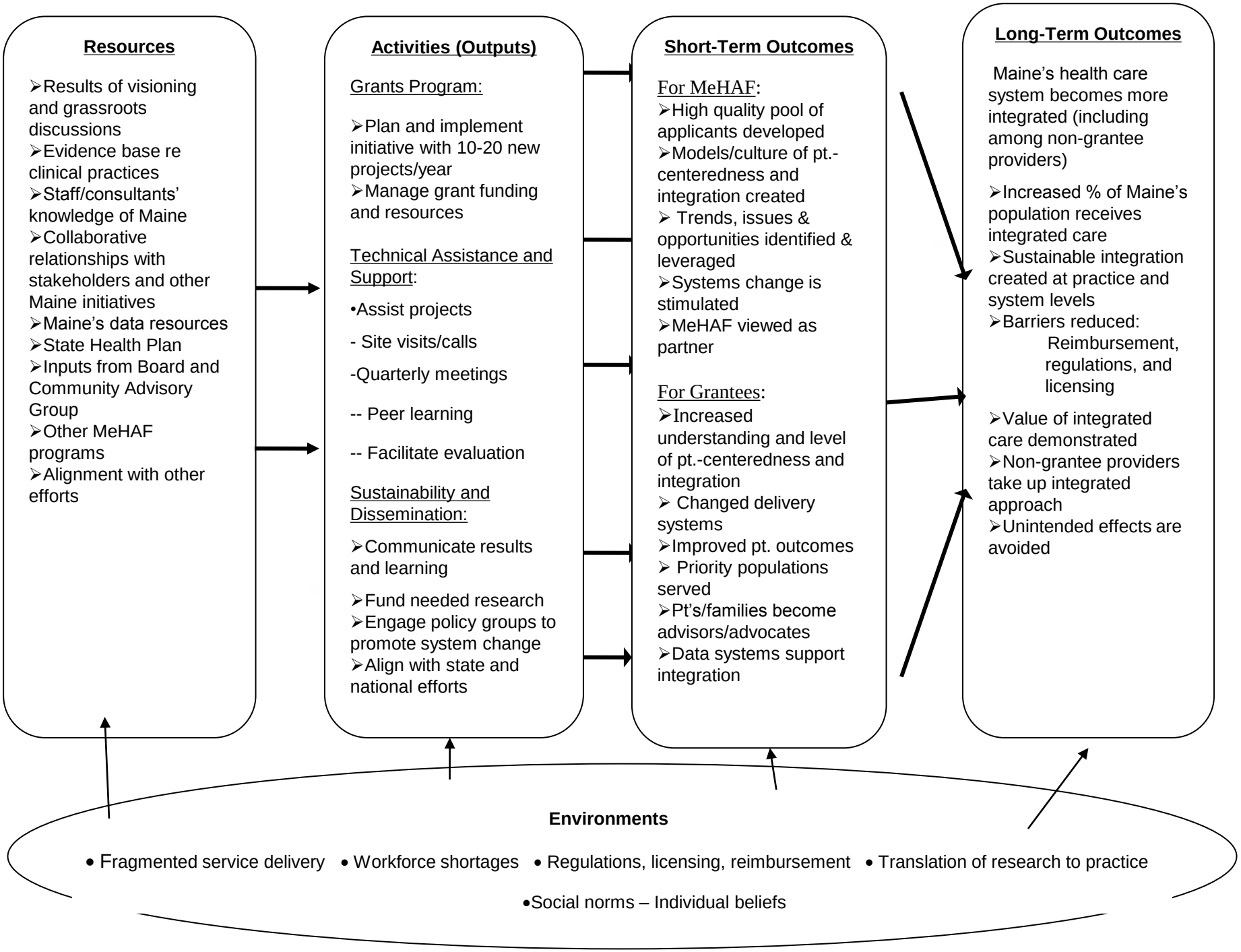
Resources
➢Results of visioning and grassroots discussions
➢Evidence base re clinical practices
➢Staff/consultants' knowledge of Maine
➢Collaborative relationships with stakeholders and other Maine initiatives
➢Maine's data resources
➢State Health Plan
➢Inputs from Board and Community Advisory Group
➢Other MeHAF programs
➢Alignment with other efforts
Activities (Outputs)
Grants Program:
➢Plan and implement initiative with 10-20 new projects/year
➢Manage grant funding and resources
Technical Assistance and Support:
•Assist projects
- Site visits/calls
-Quarterly meetings
-- Peer learning
-- Facilitate evaluation
Sustainability and Dissemination:
➢Communicate results and learning
➢Fund needed research
➢Engage policy groups to promote system change
➢Align with state and national efforts
Short-Term Outcomes
For MeHAF:
➢High quality pool of applicants developed
➢Models/culture of pt.-centeredness and integration created
➢ Trends, issues & opportunities identified & leveraged
➢Systems change is stimulated
➢MeHAF viewed as partner
For Grantees:
➢Increased understanding and level of pt.-centeredness and integration
➢ Changed delivery systems
➢Improved pt. outcomes
➢ Priority populations served
➢Pt's/families become advisors/advocates
➢Data systems support integration
Long-Term Outcomes
Maine's health care system becomes more integrated (including among non-grantee providers)
➢Increased % of Maine's population receives integrated care
➢Sustainable integration created at practice and system levels
➢Barriers reduced: Reimbursement, regulations, and licensing
➢Value of integrated care demonstrated
➢Non-grantee providers take up integrated approach
➢Unintended effects are avoided
Environments
• Fragmented service delivery • Workforce shortages • Regulations, licensing, reimbursement • Translation of research to practice
•Social norms – Individual beliefs

MeHAF Evaluation Stages: Phase II

- Implementation
  - **Clinical**
  - **State-level**
  - Grantees' Input
  - Patient/Family Engagement, Input
- Modifications, Updates

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Clinical/JSI Cross-site Evaluation

- Site Self Assessments
- Quarterly Client Data Elements reports (How much did we do?)
- Site-specific patient outcomes (How well did we do it?)
- Patient Engagement (Surveys, Focus Groups, Practice Steering Committees)

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SSA/Levels of Collaboration

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated/Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

Friedman's 12-word Customer Satisfaction Survey

- Did we treat you well?
- Did we help you with your problems?

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Clinical/JSI Cross-site Evaluation

- Site visits
- Interviews
- Analysis of 6-month, annual reports
- Analysis of supporting documents (models, etc.)

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Cross-site Evaluation Products

- Periodic CDE reports
- Annual Reports
- Case Studies

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State-level Evaluation

- Key informant interview report (2010, 2013)
- Population-based data analysis (BRFSS, MHDO)
- Logic Model indicators
- Mind Dump
- Case Studies
- Level of Patient/Family Engagement

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Patient, Family Engagement

- Clinical practice (surveys, focus groups, quality improvement groups)
- Organizational Quality Improvement
- Systemic planning (steering groups)

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Activity: Evaluation Planning Group A

- Imagine you have just been awarded a contract to conduct an evaluation of an Integrated Behavioral Health and Primary Care (Collaborative Care) initiative involving over 40 projects (grants) in over 100 sites and with over 150 partnering organizations. Your task is to determine whether the sites become more integrated and whether patient outcomes are improved as a result.
- You have unlimited resources, including data.
- What strategies and data would you use to accomplish this evaluation task?

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Activity: Evaluation Planning Group B

- Imagine you have just been awarded a contract to conduct an evaluation of an Integrated Behavioral Health and Primary Care (Collaborative Care) initiative involving over 40 projects (grants) in over 100 sites and with over 150 partnering organizations. Your task is to determine whether the integrated care becomes adopted broadly in your state/province and whether policies and systems are supportive of integrated care. Additionally, has the initiative created better patient outcomes as a result?
- You have unlimited resources, including data.
- What strategies and data would you use to accomplish this evaluation task?

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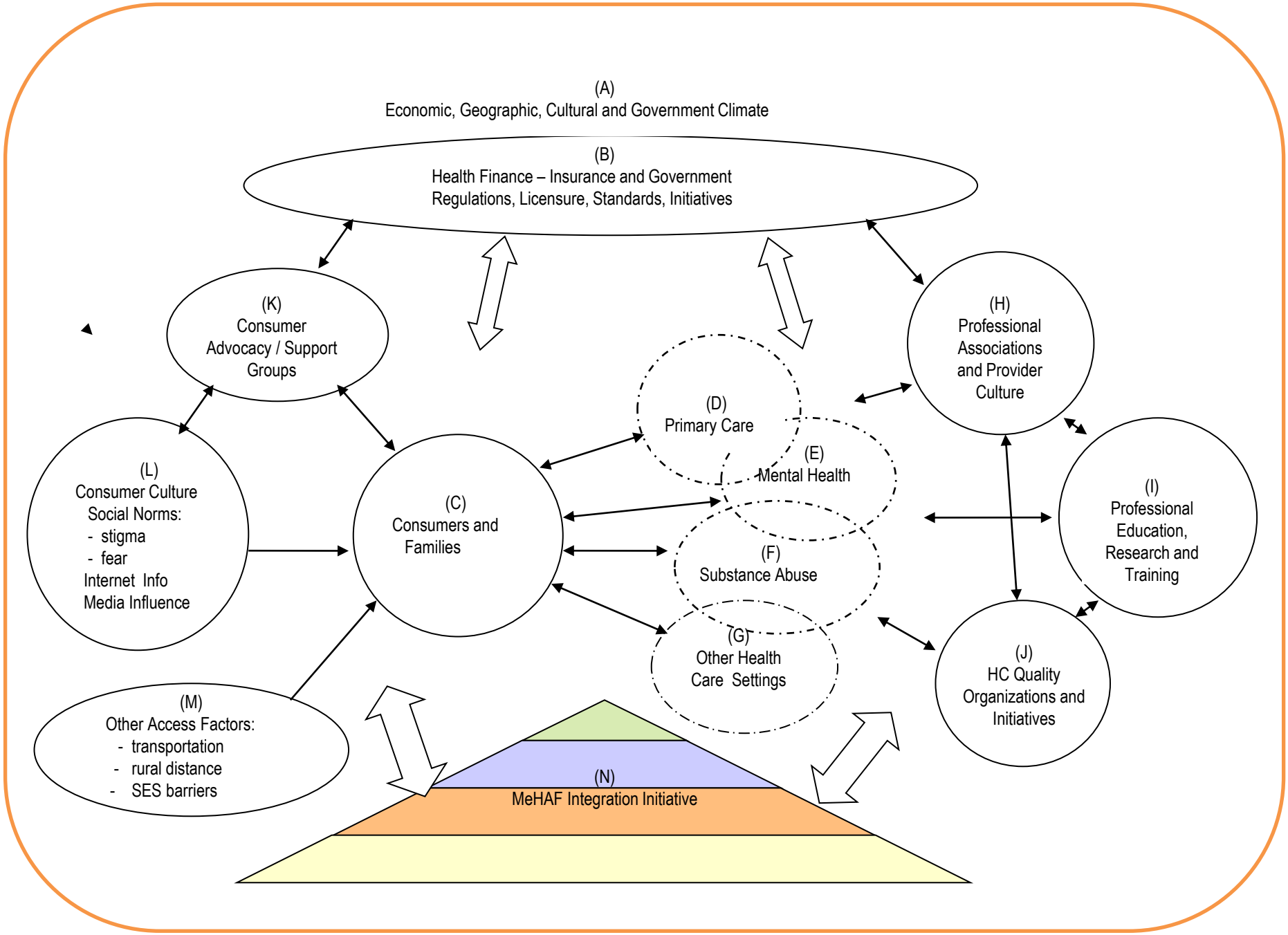
(A)
Economic, Geographic, Cultural and Government Climate
(B)
Health Finance – Insurance and Government
Regulations, Licensure, Standards, Initiatives
(K)
Consumer
Advocacy / Support
Groups
(H)
Professional
Associations
and Provider
Culture
(D)
Primary Care
(E)
Mental Health
(L)
Consumer Culture
Social Norms:
- stigma
- fear
Internet Info
Media Influence
(C)
Consumers and
Families
(F)
Substance Abuse
(I)
Professional
Education,
Research and
Training
(G)
Other Health
Care Settings
(J)
HC Quality
Organizations and
Initiatives
(M)
Other Access Factors:
- transportation
- rural distance
- SES barriers
(N)
MeHAF Integration Initiative

What Have We Learned?

- Adoption and Implementation Lessons
- Critical Elements
- Policy Needs

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Adoption: Critical Factors

- Model evolution
- PC provider buy-in
- Leadership commitment
- BHPs' willingness to adapt to PC settings and to market services
- Perception that integration provides value added
- Patient and Family involvement in Planning and Decision Making

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Implementation: Critical Factors

- Processes (screening, warm hand-offs, documentation)
- Changes in health conditions served
- Changes in practice patterns (PCP and BHPs)
- Figuring out communication/collaboration processes
- Case/care management
- Patient-centered care
- Helpful: HIT

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MeHAF Policy Support

- Integration Initiative Policy Committee
- Contracts
- Convening, Training
- Relationship building with policy makers
  - Policy Leaders Academy
  - Quarterly meetings with DHHS, Medicaid, payers

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Ice Cream

- List all the flavors of ice cream you can think of in 1 minute.

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MeHAF Policy Support Key Issues

- 5 Key areas in work plan (many specific to Maine project)
- Licensing, regulations, certification
- Work force development
- Patient-centered care
  - Same day co-pays

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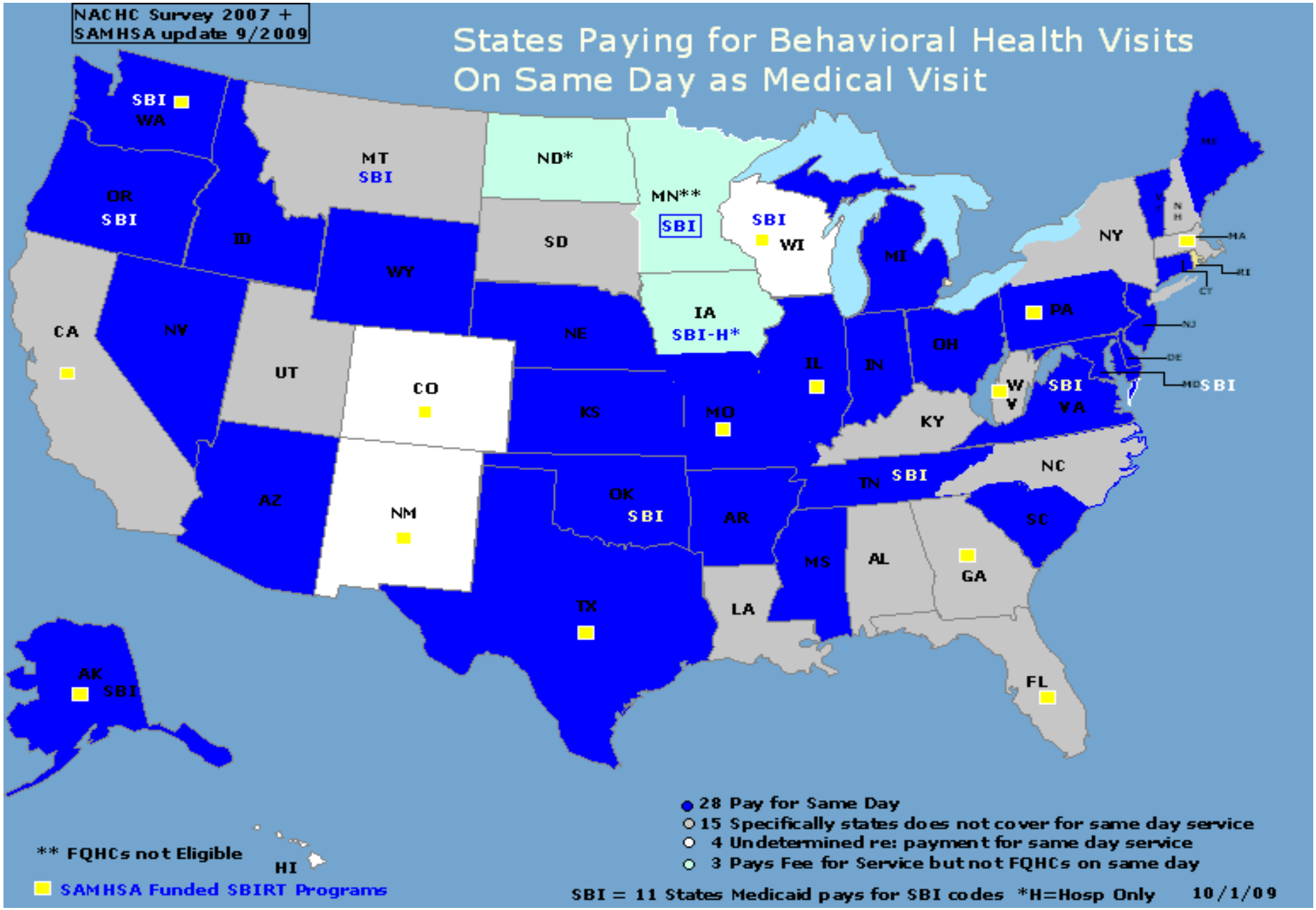
NACHC Survey 2007 +
SAMHSA update 9/2009
States Paying for Behavioral Health Visits
On Same Day as Medical Visit
SBI
WA
OR
SBI
CA
NV
ID
MT
SBI
WY
UT
AZ
CO
NM
ND*
SD
NE
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SBI
VA
PA
NY
ME
VT
NH
MA
RI
CT
NJ
DE
MD
SBI
AK
SBI
HI
** FQHCs not Eligible
SAMHSA Funded SBIRT Programs
28 Pay for Same Day
15 Specifically states does not cover for same day service
4 Undetermined re: payment for same day service
3 Pays Fee for Service but not FQHCs on same day
SBI = 11 States Medicaid pays for SBI codes *H=Hosp Only
10/1/09

MeHAF Policy Support Key Issues

- Sustainability
  - Building internal and external champions
  - Operational policies, procedures
  - HIT across PC and BH
  - Public and private payer commitment
  - Financial viability
    - Reimbursement, coding

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Funding, Licensing and Regulation Grid

Information for the state of Maine - Updated August 2009

MaineHealth

Commercial and State Funders			*MaineCare (Maine Medicaid)*			*Commercial*			*Commercial and State Funders*					
E&M			**Health & Behavior**			**Health & Behavior**			**Psychiatric Services Dependent on Mental Health License Section 90 or Section 65**					
									Section 65			**Section 90**		
99201-99205	New Pt	MD/NP/PA	96150	Assessment	Licensed provider-Episode of Care	96150	Assessment	Psych MD etc LCSW/PhD						
99211-99215	Established Pt	MD/NP/PA	96151	Re-assessment	Licensed provider-Episode of Care	96151	Re-assessment	Psych MD etc LCSW/PhD	90801	Assessment	Psych MD etc /LCSW/PhD	Comm, Medicare 99241-99245	Consult	Psych MD NP/PA
99401-99404	Prev Med Ind Couns	MD/NP/PA	96152	Ind Intervention	Licensed provider-Episode of Care	96152	Ind Intervention	Psych MD etc LCSW/PhD	90804 - 90808	Ind Tx	Psych MD etc /LCSW/PhD	90801	Psych Evals	Psych MD etc LCSW/PhD
99411-99412	Prev Med Grp Couns	MD/NP/PA	96153	Grp Intervention	Licensed provider-Episode of Care	96153	Grp Intervention	Psych MD etc LCSW/PhD	90862	Med Manage	Psych MD/NP/PA	90801	Assessment	Psych MD etc LCSW/PhD
99371-99373	Phone Consults	Minn - Physician, Medicaid only. Mass							90801	Psych Evals	Psych MD	90804 - 90808	Ind Tx	Psych MD etc LCSW/PhD
99242	Administration and Interpretation of Health Risk Assessment Instrument	Aetna - in Physician practice							96110	Dev Testing (MH Screening) Central Nervous System	Maine?	90862	Med Manag	Psych MD NP/PA
99443	Telephone eval and management service	Aetna - in Physician practice and for Psychiatry												
Hospital License			Hospital License			Hospital License						Hospital License		
									Mental Health License					
			Private MH Practice License			Private MH Practice License			Private MH Practice License					
Primary Care Office - Physician Practice			Primary Care Office - Physician Practice			Primary Care Office - Physician Practice								
Rural Health Clinic			Rural Health Clinic			Rural Health Clinic			Rural Health Clinic			Rural Health Clinic		
FQHC			FQHC			FQHC			FQHC			FQHC		
FQHC Look-alike			FQHC Look-alike			FQHC Look-alike			FQHC Look-alike			FQHC Look-alike		

Developed by Mary Jean Mork, Neil Korsen, Girard Robinson and MaineHealth Funding and Licensing workgroup - based on information available. Contact morkm@mmc.org

MeHAF Policy Committee

- Stakeholder group met monthly
- Refined Definition of Integrated Care for Maine
- Developed Policy Work Plan
- Contracted with Policy Consultant to help implement plan
- Contracted with Specialist to research and coach sites on reimbursement and licensing issues
- Develop relationship with policy-makers during administrative changes

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Lexicon Part I:

A Family Tree of Related Terms in use in the field of Collaborative Care

C.J. Peek with the CCRN Research Conference Program Committee

This page intended to be printed on 8.5 x 14 paper

Behavioral Health Care

Care that addresses a client's behavioral issues bearing on health (not only mental illnesses) via clinicians such as psychiatrists, psychologists, social workers, psychiatric nurse practitioners, marriage & family counselors, professional clinical counselors, licensed drug/alcohol abuse counselors & other MH professionals. (McGraw-Hill Concise Dictionary of Modern Medicine, 2002)

Mental Health Care

"Broad array of services & treatments to help people with mental illnesses & those at particular risk of developing them—to suffer less emotional pain and disability and live healthier, longer, more productive lives. A variety of caregivers in diverse, independent, loosely coordinated facilities & services—public and private—often referred to collectively as the de facto MH service system (Regier et al., 1978; Regier et al., 1993).

- *Specialty MH sector:* MH professionals trained specifically to treat people with mental disorders in public or private practices, psychiatric units, general hospitals or tx centers
- *General medical/PC sector*: Healthcare professionals such as physicians and NP's in clinics, hospitals, nursing homes.
- *Human services sector:* Social services, school-based counseling, residential rehab, vocational rehab, criminal justice/prison-based services, religious professional counselors.
- Voluntary support network sector: Self-help groups such as 12-step programs, peer counselors"

SAMHSA;mentalhealth.samhsa.gov/features/surgeongeneralreport/chapter6/sec1.asp

Co-located Care

BH and PC providers (i.e. physicians, NP's) delivering care in same practice; describes where services are provided rather than being a specific service. However, co-location employs a referral process, which may begin as medical cases are transferred to BH (Blount, 2003).

Primary Care Behavioral Health

". . Recent term for new relationships emerging between specialty MH services and PC. *Primary behavioral healthcare* refers to at least three related activities: 1) behavioral healthcare delivered by PC clinicians, 2) specialty behavioral healthcare delivered in the PC setting, and 3) innovative programs that integrate elements of PC and specialty behavioral healthcare into new formats. . ." (Sabin JE & Borus JF; 2009. Changing Roles in Primary Behavioral Healthcare. Chap in "Textbook of administrative psychiatry: New concepts for a changing behavioral health system"; JA Talbott & RE Hales, Eds)

Behavioral Medicine

"An interdisciplinary field of medicine concerned with the development and integration of psychosocial, behavioral and biomedical knowledge relevant to health and illness. (Wikipedia)

Care Management*

Specific type of service, often disease specific (e.g. depression, congestive heart failure) whereby a BH clinician, usually a nurse or other non-physician, provides assessment, intervention, care facilitation, and follow up (e.g., Belnap et al., 2006).

Shared Care

Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in a shared system, maintaining 1 treatment plan addressing all patients' health needs in a shared med record (e.g. Craven & Bland, 2006)

Collaborative Care*

An overarching term describing ongoing relationships between clinicians (e.g., BH and PC) over time (Doherty, McDaniel, & Baird, 1996). Not a fixed model, but a larger construct consisting of various components which when combined create models of collaborative care. (Craven & Bland, 2006; Peek, 2007).

Integrated Primary Care

Combines medical & BH services for the spectrum of problems that patients bring to primary medical care. Because most patients in PC have a physical ailment affected by stress, problems maintaining healthy lifestyles or a psychological disorder, it is clinically effective & cost-effective to make BH providers part of PC. Patients can feel that for any problem they bring, they have come to the right place. Teamwork of MH & medical providers is an embodiment of the biopsychosocial model. (Blount; www.integratedprimarycare.com)

Patient-Centered Medical Home

"An approach to comprehensive PC for children, youth and adults—a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family". (Joint Princ of PCMH, 2007)

Consultation / Liaison

Activities of psychiatry, psychology, or nursing that specialize in the interface between medicine & MH, usually in a hospital or medical setting. Role is to see patients in medical settings by request of medical clinicians as a "consult". (Adapted from Wikipedia)

Chemical Dependency / SA Care

Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks, and live healthier, longer, more productive lives.

Provided by 1) specialty addictions or substance abuse clinicians or counselors in SA tx clinics or settings, 2) clinicians or counselors in general medical or hospital settings, and 3) human services contexts such as schools, rehabilitation centers, criminal justice system or religious-based counseling and 4) the voluntary support networks such as 12-step programs and peer counselors.

(Adapted from SAMHSA def. for MH Care)

Coordinated Care*

BH providers and PCPs practice separately within their respective systems. Info regarding mutual patients exchanged as needed, and collaboration is limited outside of the initial referral (Blount, 2003).

Integrated Care*

Tightly integrated, on-site teamwork with unified care plan. Often connotes organizational integration as well, perhaps involving social & other services (Blount, 2003; Blount et al., 2007).

"Altitudes" of integration (SAMHSA):

- *Integrated treatment*: Interactions between clinicians to address pt. needs combining interventions for MH disorders in a primary treatment relationship or service setting.
- *Integrated program:* An organizational structure that ensures staff & linkages with other programs to address all patient needs.
- *Integrated system:* Organizational structure that supports array of programs for individuals with different needs through funding, credentialing, licensing, data collection/reporting, needs assessment, planning, and other operational functions.

Family-Centered Medical Home

Family-centered version of "medical home"; emphasize parents and families who play a large role in child health and mental health and who are also "the client" in child / pediatric settings.

Person-Centered Health Care Home

Variation emphasizing BH in PC and PC in specialty MH settings (Mauer-NCCBH)

Patient-Centered Care

"Care that is respectful of and responsive to individual patient preferences, needs, and guides all clinical decisions" (Institute of Medicine, 2001)

* A special case or subset of a much larger concept in use across the larger field of healthcare.

Maine's Refined Definition

- Integrated Care brings behavioral, mental, and physical health to people in a coordinated way. It creates a relationship between a patient and a team of health professionals to achieve improved health and cost effectiveness.
- Desired Outcome: People's health, daily lives, and functioning improve as a result of engaging with a health care system that treats them as whole persons. The system integrates behavioral health and primary care and is cost effective.

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Refined Definition: Values

- Integrated behavioral health and primary care means that people get complete care for all their health needs in the right time and place.
- Care is patient and family-centered, so persons being served can be engaged, active, and knowledgeable.
- Individuals have a sustained and trusting relationship with healthcare professional(s) who serve as their primary care team guiding and coordinating their health care. This healing relationship relies on two-way communication and shared decision-making.
- Treatment incorporates the resources of communities where people live.
- No matter where or how people come into the health care system, they will receive the behavioral health and primary care services they need.
- Prevention, early intervention, and recovery are as important as disease/condition treatment and interventions.

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Policy Committee

- Work Plan
- Implementation
  - Continued meetings, subgroups
  - Policy contract
  - Reimbursement, licensing contract
  - Engagement with national efforts
    - AIMS Summit; ARHQ Academy, SAMHSA

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Increasing Awareness

- Hosting events and site visits with federal and state officials (Build Relationships)
- Messaging to the public (still working on)
- Messaging to employers and payers
- Regularly-scheduled meetings to address issues
- Stories
- Compelling data

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Integrated Care Training Academy

- Coaching and supports for new and expanding integrated care sites
  - –Operational and clinical support
  - –Family engagement support
- Systems Support

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Promoting Policy

- Building the Business Case
  - Why is it important to promote/sustain integrated care?
  - AIMS Summit work group
  - Functionality (What speaks to employers, policy makers?)

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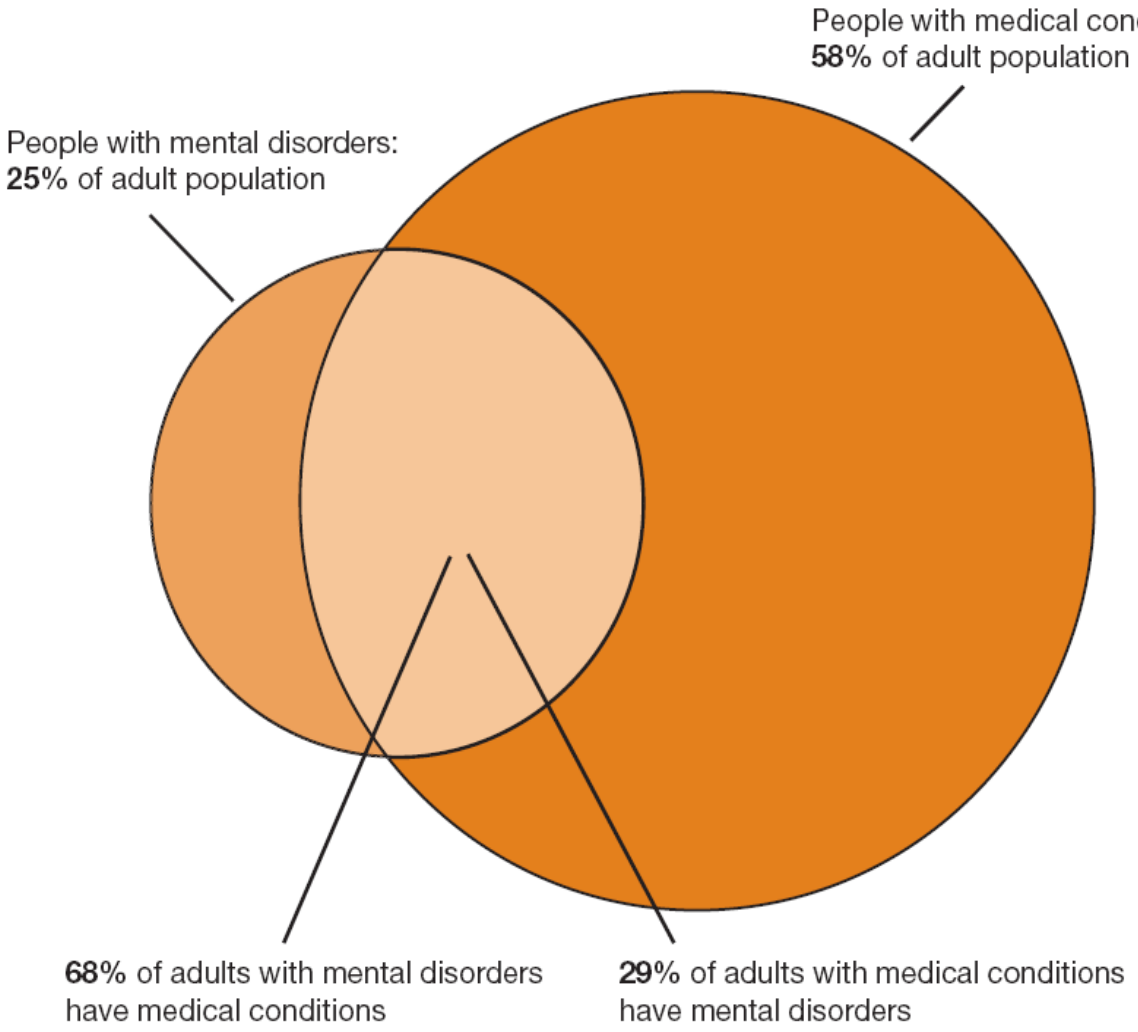
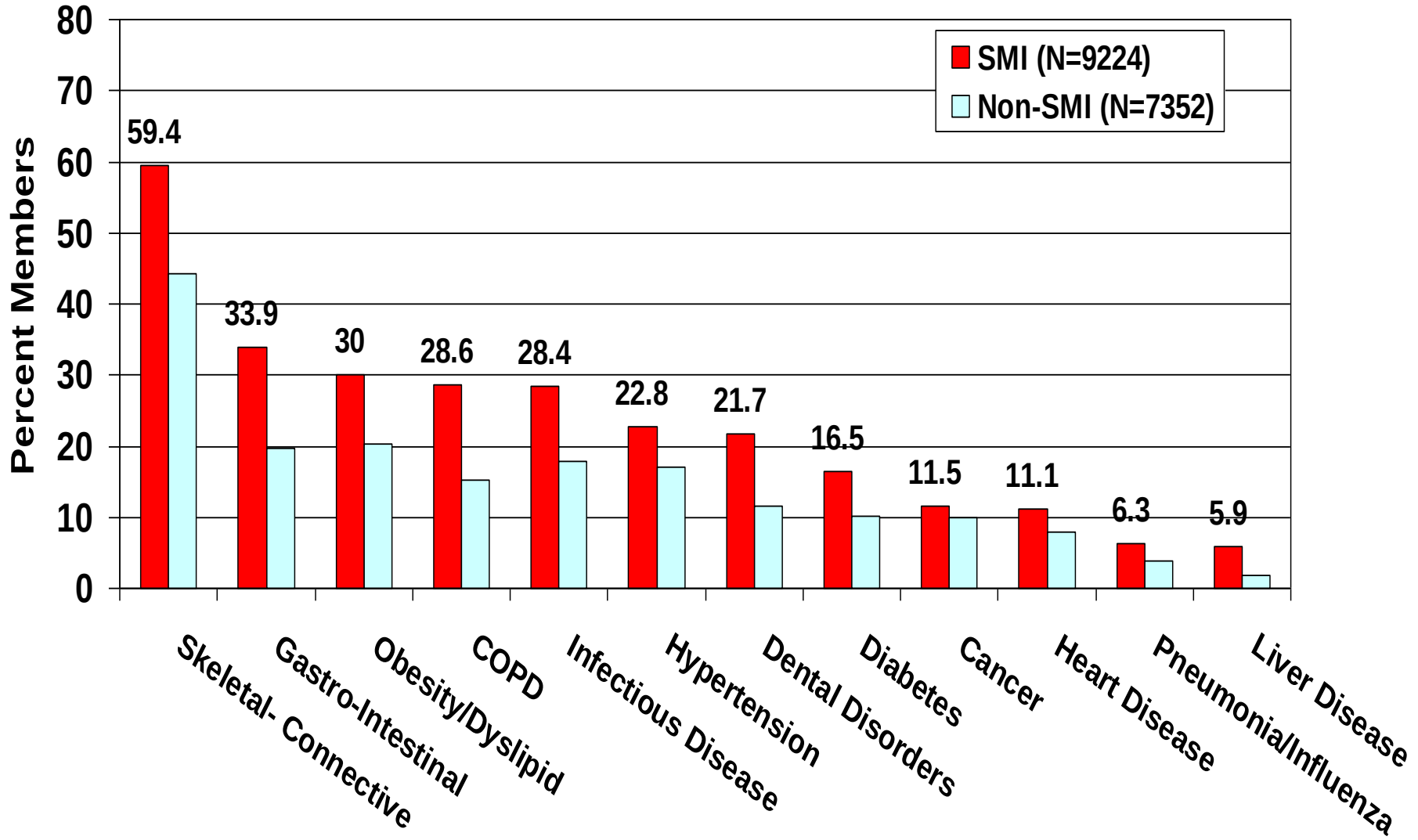
Figure 1: Percentage of adults with mental disorders and/or medical conditions, 2001–2003



Source: Adapted from the National Comorbidity Survey Replication, 2001–2003 (Reference 2)

Maine Study: Comparison of Health Disorders Between SMI & Non-SMI Groups



Making the Case Compelling: IBHP

- "if a 10% reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated medical-behavioral healthcare program, $5.4 million of healthcare savings could be achieved for each group of 100,000 insured members…the cost of doing nothing may exceed $300 billion per year in the United States." [Note: this analysis based on commercially-insured population]

Chronic conditions and comorbid psychological disorders
Milliman Research Report. July 2008

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Reduce (at least control) Per Capita Cost of Total Healthcare

- Depression care management for Medicaid enrollees can reduce overall healthcare costs by $2,040 per year with impressive reductions in emergency department visits and hospital days. (US)
- A Kaiser Northern California study showed that those who received SU treatment had a 35% reduction in inpatient cost, 39% reduction in ER cost, and a 26% reduction in total medical cost, compared to control group. (US)

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Full IBHP Business Case Report

- The full report from which this presentation was created, The Business Case for Bidirectional Integrated Care, contains information critical to both national and state level payment reform decisions.
- Research citations supporting the information in this presentation are documented in the full report.
- http://www.ibhp.org http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx

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Policy Enhancement

- Reimbursement and payment reform
- Licensure, credentialing, and scope of practice
- Confidentiality and other regulations
- Agreement on core elements
- Workplace development
- Relationships, relationships, relationships

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Key Steps for Policy Work

- Plan
- Create, clear message
- Collect stories
- Plan immediate and long-term successes
- Build and nurture relationships
- Publicize results

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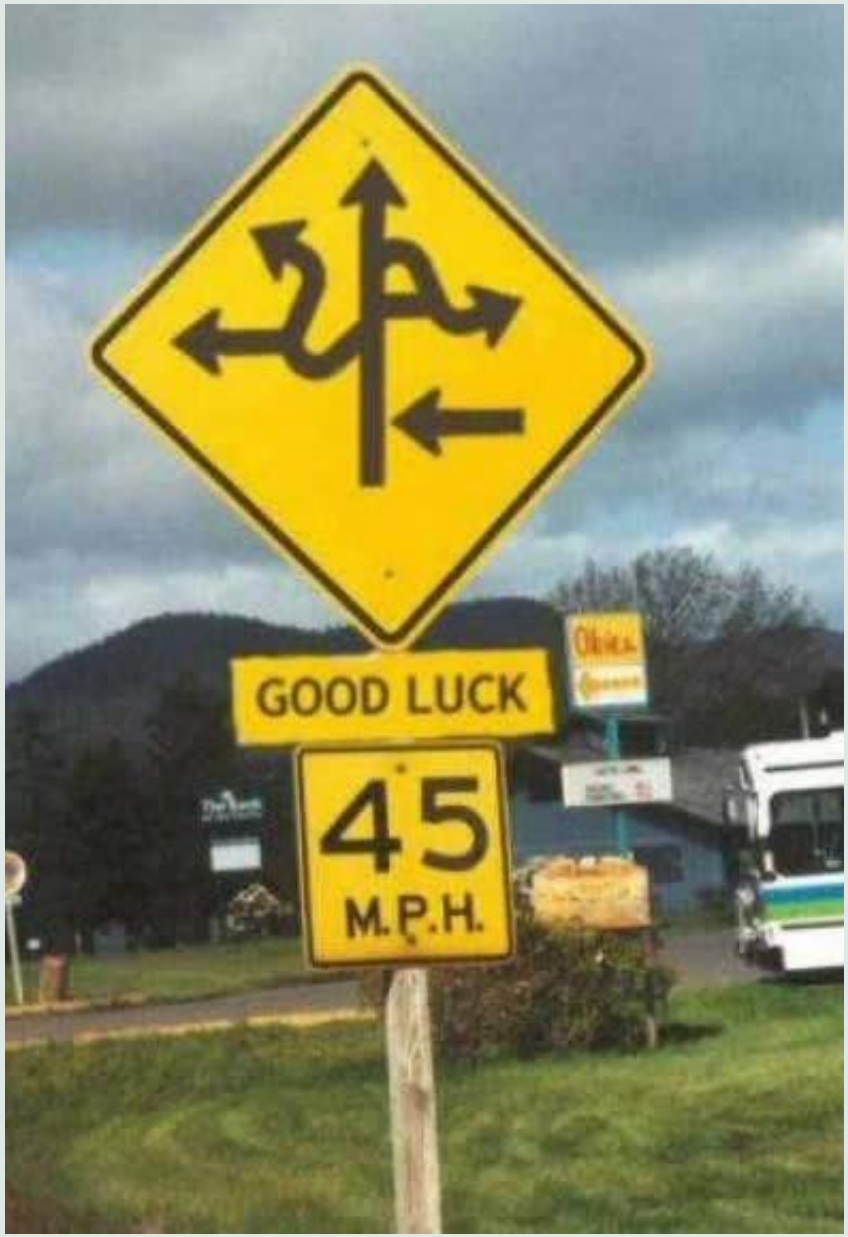

Complex Work: Worth The Effort!

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