

Testing Models of Integrated Care

Process Evaluation of Year 1 (2020/2021)

by Nicole Turcheti (March/2022)

Background

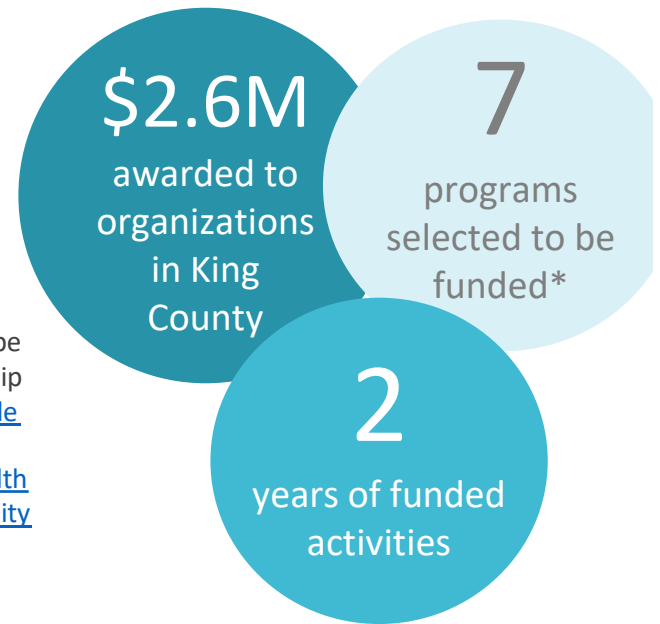
In 2019, HealthierHere issued Requests for Applications for “Testing Models of Integrated Care” – one of the Innovation Fund areas sponsored that year. The goal was to fund partnerships between behavioral health providers and primary care providers to design and test an integrated care delivery model that supports the whole health of shared Medicaid clients with co-occurring physical and behavioral health needs.

The programs proposed by the following organizations were selected to be funded: [HealthPoint](#) (in partnership with [Valley Cities](#)), [ICHHS](#) (in partnership with [ACRS](#)), [DESC](#) (in partnership with [Harborview Medical Center](#)), [Seattle Children's Care Network](#) (in partnership with [Seattle Children's Hospital](#)), [MultiCare](#) (in partnership with [Sea Mar](#)), [Virginian Mason Franciscan Health](#) (in partnership with [Valley Cities](#)) and [DESC](#) (in partnership with [Community Health Plan of Washington](#), [DCHS](#) and [PHSKC](#)).*

Partnership

For grantees, **benefits of being in partnership** include: (i) being able to promote and improve care coordination in primary care settings, (ii) improving patient care and seeing positive impacts for patients, (iii) learning from partner's expertise, (iv) strengthening the relationship with partner organization, and (v) helping to stay on track and to be accountable to moving integrated care work forward.

On the other hand, the **drawbacks** include (i) the fact that data sharing and management is challenging, particularly when dealing with different EHRs; and (ii) how challenging and/or time consuming it is to deal with logistics (e.g., IT issues) and to coordinate all the people involved.



*Only the first 6 programs listed are part of this evaluation, as they share similarities that allowed for a cross-program examination.



The pace with which the team could work collaboratively together towards building a system, workflows and shared patient focus was remarkable. ...we were able to impact the care of individuals with dual mental health and chronic physical conditions much more effectively than either organization could have done alone...

(Innovation Fund grantee)

What factors supported implementation?

- Engaging and/or **communicating** with partners and other stakeholders.
- Having skilled **project management**.
- Having support from an external **consultant** (UW AIMS and others).
- Having a talented and/or engaged **team**.
- Having organization **buy in** and/or **leadership support**.
- Stakeholders being transparent, flexible, patient and/or committed to the work.
- Having additional **staff** or **support** for staff.
- Partner organizations having **shared goals** and/or collaborating to achieve shared goals
- Having **training**.

What were the main challenges?

- COVID-19** created competing priorities for organizations, imposed logistical challenges to implement planned activities, and exacerbated existing inequities experienced by clients.
- Staff:** hiring, onboarding, and staff capacity were challenges that were aggravated by COVID-19.
- Data sharing & management:** sharing data amongst partners in order to identify shared patients, share patient information and track outcomes.
- Patient recruitment and engagement
- Project design or management:** issues around coordination, prioritization, and learning that the way the program was designed did not work well for clients.
- Organizational challenges**, such as having delays in the legal department impact the timeline for finalizing contracts.

What made grantees feel like celebrating?

- Hiring staff for the program.
- Collaborating, doing work together, or building trust with partners.
- Improving the services provided to clients.
- Client success stories and/or improved client outcomes.
- Learning about how to improve processes.
- Having support and engagement from providers.
- Making progress in managing and sharing data with partner.
- The fact that program teams started this work during the pandemic.



...we learned from a practice who had just started registering and seeing MH [mental health] patients, that they had an experience where a child came to their clinic for GI [gastrointestinal] issues. ...the GI issues were from a suicide attempt via overdose of ibuprofen. ...The practice activated their new suicide pathway and [they] were able to get the child to an ED where she was later hospitalized. Their new IBH [Integrated Behavioral Health] program, processes, and workflows helped save a pediatric life!

(Innovation Fund grantee)

What were some of the lessons learned?

- **Medication reconciliation** is critical to this work, as it ensures that everyone involved in a person's care is aware of treatment plans and avoids duplication of therapy or dangerous side effects. It is especially important if a patient utilizes more than one pharmacy.
- **High-risk patients** need communication with Care Coordinators more than once per month, especially if the contact is virtual (given that connection and rapport is more challenging to build virtually).
- **Documenting** processes and decisions is important to ensure continuation of project in case a key-person leaves the organization.
- **Data sharing & management:** (i) It could have been helpful to use more database skills at the onset of the project to figure out how to best share data. (ii) Having a dedicated data person who is present at every project meeting is critical. There is value to invest upfront in having both database skills and user experience skills. (iii) Excel is not ideal for sharing data due to limitations in automation and other data management needs.
- It would be helpful to have guidance on how to address **legal barriers** (e.g., implementing BAAs) to collaborating with other organizations at an early stage of the project.

Some of the key takeaways from the evaluation



COVID-19 had a significant impact on implementation. It created competing priorities for organizations, imposed logistical challenges to implement activities, and worsened existing inequities experienced by clients. It also exacerbated challenges related to workforce, and patient recruitment and engagement.



An ideal **care management platform** would: (i) be accessible to multiple users and organizations simultaneously; (ii) pull in a customized set of clinical and non-clinical data; (iii) allow data to be pulled from multiple organizations; (iv) update data automatically; (v) allow for user notations and messaging; (vi) allow for customizable summary views to cater to different tasks e.g., outreach, patient review, metric review.



Having a structure in place for partners to **meet regularly and frequently** is very important for a successful implementation. It helps navigate challenges, increase accountability, and foster the cultivation of relationships amongst partners.



Being able to share data amongst partners is only part of the **infrastructure** needed to replicate or scale up Integrated Care programs. Programs need to have tools, processes, and training in place to allow for efficient care coordination.



Having **support from senior leadership** "as far up as possible" in organizations was identified as an important factor for a successful implementation.



All programs pointed out **conditions** for scaling up or replicating their body of work. They include leadership support, a sustainable financial model, infrastructure to share data amongst partners, and the right staff to serve the program's client base.



Programs strived for health **equity** through the activities implemented, the communities served, having staff that reflect the client base, as well as collecting client input and demographic data.



Lack of **sustainable funding** is reported as a barrier to both scalability and sustainability of programs. There is a need for "a commitment at a high level" to make consistent care coordination possible.



Data sharing and management was a major challenge across the portfolio. Although grantees tried different workarounds, some programs continued having challenges at the end of year 1. This issue was pointed out as a drawback to working in partnership.