Success in Service Implementation: An Administrative Program Evaluation of an Integrated Health Home

Jennifer Talarico

University of Nebraska Omaha

PA8990 Capstone

May 4, 2015

EXECUTIVE SUMMARY

Introduction

In studies from 2002-2003, 26% of U.S. adults were affected by behavioral health conditions (Boa, Casalino & Pincus, 2012). Individuals with severe mental illness die an average of 25 years earlier than those without such a diagnosis. Health disparities for this population are directly related to this issue. Preventable co-occurring chronic diseases such as diabetes, heart disease, asthma and other cardiopulmonary conditions are the cause of death for three out of every five individuals with a severe mental illness (Mental, 2013; Rosenberg, 2009). Fifty percent of high-utilizers of health centers have a behavioral health diagnosis. Medicaid costs for individuals with both a chronic physical disease and a mental illness are 75% higher than those for beneficiaries without a mental illness (Montanaro & Pennington, 2013).

The Integrated Health Home (IHH) has been designed as an innovative, person-centered program that addresses the issue of poor health and early deaths through care coordination, peer support services and population health management. Iowa Department of Human Services (2013) offers that an IHH is "a team of professionals working together to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED)." As healthcare costs rise and health conditions worsen, the IHH intends to impact individual and population health to reduce overall costs through increasing positive health interactions. Goals for IHH include improving population health, improving individual health, reducing healthcare costs due to reduced emergency room visits and inpatient hospitalizations, and providing whole-health care coordination.

The Integrated Health Home was born from the Affordable Care Act (ACA) of 2010. Section 2703 of the Affordable Care Act allows states to amend their Medicaid state plans to provide health homes for enrollees with chronic conditions (Schuffman, 2012). Medical homes are now common in communities, but there are many differences between the Affordable Care Act's "health home" and the "medical home." The health home (or Integrated Health Home as it is known in Iowa) is available to those who have a severe mental illness diagnosis. Health homes are run by agencies and organizations with expertise in behavioral health care, while medical homes are run by those with primary care expertise. These services are completely voluntary on the part of the individual, though strongly encouraged in order to manage health conditions. An individual cannot be enrolled in both, but rather must choose between the two if they choose to participate at all.

The Integrated Health Home effort in Iowa began in 2011 with pilot projects across the state. The first phase of implementation kicked off in July 2013 with a few sites, another 10 8-sites started serving individuals in April 2014 and the final sites opened in July 2014. As of July 1, 2014, every county in Iowa has access to an IHH provider. Heartland Family Service is one of three providers in the Council Bluffs, Iowa, area. The agency serves adults in a tri-county area of Pottawattamie, Mills and Harrison counties. The purpose of IHH is clear but is

likelihood of starting a new program. Social service agencies tend to be structured in this way, creating a greater willingness to take a risk at implementation. The size and age of an organization, available resources, mission orientation and market competition are also factor affecting change (Auer et al., 2011). Overall, the adaptive theory suggests that an organization with these characteristics can be flexible and acclimate to the programming needs of the community based on these factors. Some organizations have greater adaptability and flexibility than others.

A variety of implementation frameworks have been reviewed by researchers to be combined into a comparative narrative (Meyers, Durlak & Wandersman, 2012). One of these is the active implementation framework. This particular framework integrates a multilevel approach to change. First, a focus on the purpose and rigor of the intervention prior to using it in practice is necessary. Next, emphasis is placed on the support mechanisms that are created to ensure effective application. This includes developing staff competencies, making organization changes to support the intervention, and engaging organization and program leadership. During this phase the multistage approach to change is integrated (exploration and adoption, program installation, initial and then full implementation), interacting and impacting the stages in an ongoing fashion rather than in a linear order. Finally, a focus on determining who does the work to implement the program is integral to this framework's success (Ogden & Fixsen, 2014).

Though not a formalized theory or strategy, Kliche et al. (2011) provide additional relevant insight into the implementation process. They present a collection of methods to address implementation quality and effectiveness including having a robust intervention plan, creating clear and comprehensive manuals, defining the intervention core and its periphery, securing organizational and leadership support, ensuring the qualification of intervention users and a systematic adaptation to local conditions. Kliche et al. (2011) outline three requirements related to program development: clear and comprehensive manuals (clear objectives, measurable indicators, elements necessary for effectiveness, adaptation step and costs/resources needed), quality assurance measures (available during program launch and implementation), and aggregated and published data on user experiences.

Supports also include ongoing evaluation. Organizations may provide critical feedback through continuous quality improvement or continuous systematic monitoring, though some researchers suggest that programs should be fully operational before true evaluation and testing should take place (Ogden & Fixsen, 2014). Evaluating programs before they mature may lead to poor results, the underestimation of the effectiveness, and doing disservice to the program. Also, programs should be fully implemented with fidelity before modifications are made" (Ogden & Fixsen, 2014, p.7).

Implementation teams can serve to maintain momentum and create capacity that may otherwise be absent. These teams can help to overcome the concern that implementation can deteriorate over time (Ogden & Fixsen, 2014). Mancini and Marek (2004) offer a sustainability framework that includes leadership competence, effective collaboration, understanding the community, demonstrating program results, strategic funding, staff involvement and integration, and program responsivity. Combining these two suggestions to focus on results at every level may lead to effective program implementation.

Healthcare and Behavioral Health Homes

Healthcare programs are usually implemented at a point where feasibility studies and program development have been completed and the efficacy has been proven. However, its large-scale effectiveness has not been tested because the program has only been generally introduced once and may need modifications and adaptations (Kliche et al., 2011). Medical health homes are one such program. These programs were born through the Affordable Care Act and continue to grow and evolve.

Although the quality of care in the United States is impressive, people do not access necessary health care because the cost is too high (Davis, Schoen & Stremikis, 2010). According to the 2010 Mirror, Mirror on the Wall report, the U.S. ranks last overall in healthcare outcomes when compared to Australia, Canada, Germany, Netherlands, New Zealand, and the United Kingdom (Davis et al., 2010). Coordination of integrated patient care throughout the course of treatment positively impacts the cost of medical treatment and greatly impacts the individual patient's overall health (Davis et al., 2010

North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Washington, and Wisconsin (Centers for Medicare and Medicaid Services, 2015).

The framework for integrated care and optimizing health system performa

- Agency and program training protocols (Heartland Family Service)
- IHH program manual (Heartland Family Service)
- IHH organizational charts (Heartland Family Service)
- IHH contract (Heartland Family Service)
- IHH program logic model (Heartland Family Service)

d w-1(i-6( )3(othlc)4(-10(r)3(o)-10(g)10l0 Tc 0t6nc)4(d 04oi)-2sm)-6(hi-6(p, (s)Tj)-2(ni)2(oc)4(10(prs)

3. Have you had any other experience with Integrated Health Homes?
4. What training have you received on Integrated Health?
    a. Who provided the training and how was it delivered?
    b. How often is training provided?
5. What is the purpose of the Integrated Health Home?
6. What are the expectations of Magellan of Iowa and the Iowa Department of Human Services regarding IHH?
7. What are the expectations of Heartland Family Service (or your agency) regarding IHH?
8. Does your program have a program manua t0-1(p)-4er of4fffhu 4.9(at)-6(H)-2f ofWh-6(

- 1 4 (p) - 4 (e c

THREAT	EXAMPLE	STRATEGIES TO ADDRESS THREATS
Maturation	Staff tenure in program; Previous experience with program area; New training offerings over time; Changed expectations and/or program activities over time	Gather experience information in interview; Review contract and other static document to define expectations at given point in time
Instrument	Questions altered with each interview	Create and use scripted greeting and questions
Mortality	Staff turnover since implementation; new staff since beginning of implementation	Interview those staff most tenured to the program and who have knowledge from design of program
Experimenter Bias	Researcher is directly associated with studied program	Assure interviewee of agency confidentiality and retaliation policies; Share results of study with IHH program staff and agency leadership
Participant Reactivity	Desire to answer questions to impress interviewer or to avoid conflict with interviewer	Assure interviewee of agency confidentiality and retaliation policies; Share results of study with IHH program staff and agency leadership

Table 1. Validity Threats and Strategies

FINDINGS

Interviewees were willing to share their experiences with program implementation. One interviewee was involved in a pilot version of the IHH so had more experience with the program, though the implementation process during the pilot was different from the current process. Of the directors, one was hired early in the implementation process and one was hired late in the process, a difference of approximately three months spanning the "go live" date of the program, April 1, 2014. Three of the direct care interviewees were hired within three weeks of the "go live" date and one was hired three months after this date. None of the interviewees had previous experience with integrated or medical health homes.

Training and Technical Assistance

Interviewees report a myriad of training opportunities, though most also reported that the trainings were inadequate for the support needed. Some interviewees reported that the amount of training was adequate while others thought the time spent in training during the early months of the implementation process was extensive and other significant activities were expected. Poor quality and frequency of training at the state level was a concern voiced by most interviewees. Information needed to perform quality care was not provided to the extent needed according to those interviewed.

One direct care staff stated that the agency "learned on the fly" as expectations changed throughout the implementation period. New trainings were offered, but being able to attend trainings was difficult given the short notice. "We tried to train to what we thought it [IHH] would be," offered direct care employee Michalski (Julie Michalski, personal communication, April 6, 2015) Statewide collaboration meetings among IHH providers were noted as beneficial.

Some direct care staff recalled more training that others. Based on the responses, training opportunities varied depending upon the staff role. Specific trainings were available to each role, though interviewees did not find them to be adequate to learn their job function. At the state

statewide conferences and personal coaching visits. Most webinars were recorded and made available through an online portal. Materials and tools from conferences were also made available via this portal for review at a later date if needed. The agency also provided ed
ucati
opportunities through staff meetings, classroom trainings, informal shadowing and local IHH focus groups. Other opportunities
ere made avail

unnecessary costs of health care delivery. These are modeled after the Institute for Healthcare Improvement's "Triple Aim" as shown in Figure 2.

Magellan of Iowa has outlined two years of quarterly outcome measures that IHH programs must meet in order to access incentive funding. These measures include thirty specific outcomes including some focused on physical health goals, medication management, quality improvement efforts and client satisfaction survey responses. In addition to these outcome measures, IHH programs are expected to create sustainable business practices, partner with local healthcare providers and commit to quality services for those enrolled in the program.

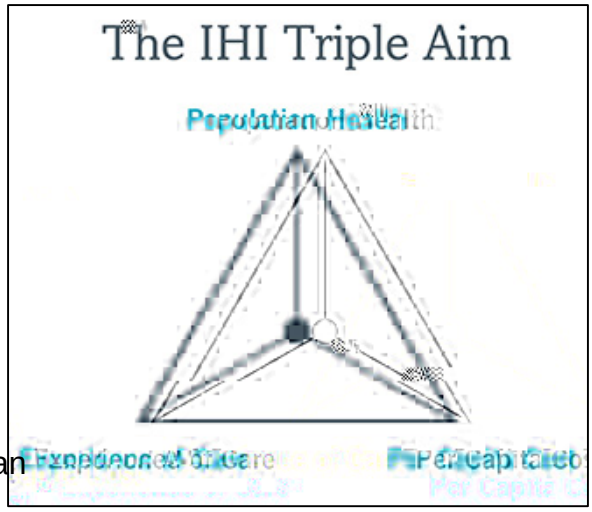

Figure 2. The Institute for Healthcare Improvement's Triple Aim

Those interviewees in leadership positions (vice president and directors) were able to identify statewide expectations as specific measures related to financial impact and client utilization of services. Direct care staff more often identified statewide expectations as "unrealistic" and referenced an expectation to enroll a specified number of members as well as the expectation to be "two steps ahead of change" (Emily Kosmicki, personal communication, April 10, 2015).

A program logic model was available to define the Heartland Family Service IHH program purpose. Though not explicitly a purpose statement, the logic model does state that the IHH "has been designed as an innovative, person-centered program that addresses this issue through care coordination, peer support services and population health management." The vice president identified program expectations as fulfilling the contractual obligations and to access as much of the funding available to sustain the program as possible (Mary O'Neil, personal communication, April 15, 2015). The two directors noted that their program expectations are to

Perception of Implementation

Interviewee responses were mixed regarding the success of the implementation of the IHH program at both the statewide and local levels. At the statewide level, most responses were positive, noting that success has been documented by Magellan of Iowa. Emergency room visits and mental health hospital admissions have decreased by 16% and 18%, respectively (Magellan of Iowa, 2015). Aside from quantitative data findings, however, responses were riddled with concern for poor provider satisfaction, limited planning for geographical differences, lack of local sustainability planning, inadequate training and planning for the acquisition of habilitation service responsibilities, and the amount of resources committed to helping build strong program foundations. Kolakowski, IHH director, noted that the statewide implementation has been successful, but "not on account of Magellan." Rather, she believes that the commitment of the IHH agency to collaborate across the state with other providers has been the key to statewide and local success. "Magellan did not provide guidance, oversight or support – they simply demanded [enrollment] numbers" (Kimberly Kolakowski, personal communication, April 3, 2015).

Implementation at the program level was unanimously identified as successful. No interviewees indicated that successful implementation was easy, but that constant adaptation of the program's practices has allowed for a greater success rate. The program was designed to focus on population health management rather than case management. However, interviewees across levels n

what might be unveiled as the next unanticipated expectation. Statewide expectations were unclear to the direct care staff, while IHH leaders were able to ascertain these expectations more clearly. The expectations of the agency were slightly clearer to all interviewees. Results suggest that the expectations that impact implementation success are related to the role one plays in the process. Those leading an implementation project have a greater critical need to know and understand expectations at the larger level, while those in direct care must know and understand the expectations of the agency.

The second hypothesis, "the availability of necessary training resources impact success of implementation," was also supported through this study. Training opportunities were available throughout the process, but rarely was a topic revisited at a statewide level when new employees were hired or new expectations were outlined. This was left to be done by the agency and often was not done proactively as changes were not communicated in enough time to do so. Research shows that training, technical assistance and other supports are necessary for successful program implementation. In the case of Heartland Family Service and Integrated Health Home, the program implementation process has been successful, even with challenges in this area.

The top-down classic model and the participatory framework of implementation both are present in this case study example of the IHH. Iowa Department of Human Services and Magellan of Iowa created the integrated health home model as it is in Iowa. These agencies pursued partners throughout the state to operate the IHHs in their own communities. All the while, the ultimate program design was driven by the statewide agencies and their funding structures. The local agency was given the authority to adapt the program within the given model to meet the needs of the local community. Opportunities were available early in the implementation process to participate in designing the IHH model. Ongoing implementation and evaluation continue to be participatory efforts throughout the process. Statewide agencies have invited IHH directors to participate in modification of processes at the statewide level, seek feedback regarding current policies and encourage the involvement of consumers in the implementation and evaluation process.

Implications and Recommendations

Local social service programs are critical to the health of a community. If not implemented correctly, these programs can be lost due to lack of proper planning, staff burnout, financial instability and other preventable issues. A few recommendations have been identified for future implementation processes specifically for Heartland Family Service and potentially other agencies in similar situations.

- Outline Program Expectations. Clearly outline the expectations of the agency regarding a new program, including specific clarity around the expectations of funders or contractual entities. Share these details with the staff involved in achieving results within the program in order to engage them in the program's success by understanding pertinent implementation details. Prunifions.

Sacco, F.C. and Twemlow, S.W. (2014). Behavioral health homes: A model for implementation of the Affordable Care Act. International Journal of Applied Psychoanalytic Studies, 11.2, 172-183. doi: 10.1002/aps.1407

Schuffman, D. (Director) (2012, June 7). Missouri's Primary Care and CMHC Health Homes. Open Minds: Planning and Innovation Institute. Lecture conducted from Open Minds.

Sustainability. 2015. In Merriam-Webster.com. Retrieved February 18, 2015, from http://www.merriam-webster.com/dictionary/sustainable.

Tataw, D.B. (2012). Toward a horizontal participatory implementation approach for community health programs serving vulnerable populations. Journal of Human Behavior in the Social Environment, 22, 421–435. doi: 10.1080/10911359.2012.664971

Viron, M., Zioto, K., Schweitzer, J., and Levine, G. (2014). Behavioral health homes: An opportunity to address healthcare inequities in people with serious mental illness. Asian Journal of Psychiatry, 10, 101-6. doi: 10.1016/j.ajp.2014.03.009

Wu, F.K.Y. and Shek, D.T.L. (2012). The role of program, people, process, policy and place (5Ps) in the implementation of a positive youth development program. International Journal of Medical Health, 24.3, 2012-06. doi: 10.1515/IJAMH.2012.030