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Evaluation of the Integrated Health Home (IHH) program in Iowa: Qualitative interviews with site administrators

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Evaluation of the Integrated Health Home (IHH) program in Iowa

Qualitative interviews with site administrators

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Executive Summary

The Iowa Integrated Health Home (IHH) initiative was launched in 2013 as a partnership between the Iowa Department of Human Services (DHS) and Magellan Behavioral Care of Iowa, a private health management company that has managed the Iowa Plan for Behavioral Health (Iowa Plan) since 1995. The purpose of an IHH is to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). IHH sites are responsible for comprehensive care management, care coordination, health promotion, comprehensive transitional care, facilitating access to individual and family support services, and referring clients to community and social support services.

Qualitative, in-depth telephone interviews were conducted with administrators (n=28) at Phase I and II sites across Iowa. Administrators were asked to comment on barriers and facilitators related to different aspects of IHH program implementation, including recruitment and enrollment of members, care coordination, performance measures, and communication with program administration. Interviews were transcribed and analyzed for common themes.

Interviews with administrators revealed several issues related to IHH program implementation. Many activities mandated by the program—namely, recruitment of new members, expectations for program performance measures, and administrative load—were perceived as unduly burdensome to agencies. Although communication from IHH program administration was mostly described as sufficient in quantity, respondents felt that guidelines issued by the administration were often inconsistent and lacked an understanding of circumstances at the agency level.

Practice Transformation Coaches (or ‘practice coaches’), who are contracted with the program to instruct and assist IHH sites with issues related to technical assistance, practice transformation, and quality improvement, were also interviewed (n=3). Using a brief qualitative instrument, practice coaches were asked about the purpose and scope of their role, the support needed by IHH sites, their perspective on lessons learned from Phases 1-3 of the program, and ways program administration can enhance support and communication with practice coaches and program sites. Practice coaches reported giving assistance to IHH agencies of a type and degree that varied widely by site. Practice coaches described concerns about the program similar to some raised during interviews with administrators—namely, issues associated with the enrollment period and communication with Magellan about program guidelines and best practices.
IHH Program Background

Under Section 2703 of the Patient Protection and Affordable Care Act (ACA) of 2010, states were given the option to submit a State Plan Amendment (SPA) for the establishment of ‘health homes’ targeting Medicaid enrollees with chronic health conditions. As defined by the Centers for Medicare and Medicaid (CMS), the health home model provides care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.\(^1\) The Iowa Integrated Health Home (IHH) initiative was launched on July 1, 2013 as a partnership between the Iowa Department of Human Services (DHS) Magellan Behavioral Care of Iowa, a private health management company that has managed the Iowa Plan for Behavioral Health (Iowa Plan) since 1995.\(^2\) The purpose of an IHH is to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).\(^3\) The IHH represents an adaptation of the evidence-based practices of the health home model to locate the health home in behavioral health practices and incorporate a focus on behavioral care for individuals with serious psychological conditions.

Enrollment in an IHH is intended to mitigate some barriers to care among this population—namely, the challenges involved with navigating fragmented systems of care which often lack adequate coordination between behavioral and physical health services. Many primary care providers may lack the specialized training needed to help patients manage a mental health diagnosis, while behavioral health providers are limited in their knowledge and experience with physical health conditions and the scope of primary care services they can provide. The IHH initiative attempts to create a singular point-of-access for individuals with a mental health diagnosis to obtain coordinated, comprehensive healthcare services across a spectrum of needs and conditions.

Through the IHH initiative, care is provided by community-based health homes across the state and overseen by Magellan, which is the lead administrative body for the program. Iowa DHS oversees the Iowa Plan for Medicaid-funded services, while IDPH manages the Iowa Plan for IDPH-funded substance abuse services. To be credentialed as an IHH, providers must meet criteria related to behavioral health accreditation and demonstrate the ability to establish the team of healthcare professionals needed to provide comprehensive care coordination.

Beginning July 1, 2013, five Iowa counties (Linn, Polk, Warren, Woodbury, and Dubuque) began offering services as part of Phase I, with the remaining sites phased in as part of Phase II (April 2014) or Phase III (July 2014) over the succeeding 18 months. Individuals with an SMI already receiving community-based care through the Medicaid case management service known as Targeted Case Management (TCM) were given a transition period of six months after assignment to an IHH for the complete transfer of care over to the IHH. As of January 2015, more than 21,000 individuals have been enrolled in the program.\(^4\)

Scope and services

The goal of an IHH is to provide whole-person, patient-centered, coordinated care for individuals with SMI or SED to improve overall health outcomes. Under the stipulations of the program, an IHH is responsible for the following.

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1. **Comprehensive Care Management**
   • Prevention and management of physical and behavioral health problems

2. **Care Coordination**
   • Establishment of a team of healthcare professionals who support an integrated system of care for the patient for all of their healthcare needs
   • Involvement of the individual and family in the creation of a goal-oriented and person-centered care coordination plan (CCP)
   • Collaboration as needed with community-based or other supportive services

3. **Health Promotion**
   • Empowerment of individuals and families to make healthier decisions and engage in self-management and monitoring of health status

4. **Comprehensive Transitional Care**
   • Establishment of a comprehensive discharge plan after emergency department admission or hospital stays, including but not limited to the development of a safety/crisis plan, review of medications, identification of linkages between long-term care and home and community-based services, and ongoing follow-up

5. **Individual and Family Support Services**
   • Facilitated access to a network of peer and family peer support specialists

6. **Referral to Community and Social Support Services**
   • Involvement of and coordination with community agencies and other partners to provide services and supports to individuals and their families.

7. **Provider eligibility**
   • To be credentialed as an IHH, providers must be accredited under the Iowa Code as
     o A community mental health center,
     o A mental health service provider,
     o A residential, licensed group care setting, or
     o A psychiatric medical institution for children (PMIC) facility.

   • Eligible providers can also be those that meet national accreditation standards that apply to mental health rehabilitative services as determined by the Council on Accreditation (COA), the Joint Commission, or the Commission on Accreditation of Rehabilitation Facilities (CARF).

   • Providers must also demonstrate the provision of community-based mental health services to the target population. The IHH is a team-based model for healthcare delivery and the core IHH teams include:
     o Nurse care managers,
     o Care coordinators,
     o Peer support specialists (for adults) & Family peer support specialists (for children),
     o IHH Director, and
     o Supervisor(s).

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Figure 1.1 Map of IHH provider service areas in Iowa by population (adult, child, or both) as of January 2015

Green = Providers serving both adults and children; Blue = Providers serving only adults; Red = Providers serving only children.

(Member courtesy of Magellan Healthcare)

**Member eligibility**

**Adults**

A Medicaid-enrolled adult (18 or older) in Iowa with a diagnosis meeting the criteria for a serious mental illness (SMI) is eligible for IHH services. SMI refers collectively to a subset of diagnosable mental disorders and may include major depressive disorder, schizophrenia and related schizoaffective disorders, bipolar disorder, obsessive-compulsive disorder (OCD), and psychotic disorders. SMI is characterized by extended impairment in functioning and reliance on psychiatric treatment, rehabilitation, and supports exceeding that required by less severe mental disorders.

**Children**

A Medicaid-enrolled child or youth up to age 18 in Iowa who meets the criteria for a serious emotional disturbance (SED) is eligible for IHH services. A SED is defined as a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet criteria as specified by the most current edition of the Diagnostic and Statistical Manual of mental disorders (DSM) that has resulted in “functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities.” A determination of SED may co-occur with substance abuse disorders, learning disorders, or intellectual disorders that may also be a focus of clinical attention.

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7 Substance Abuse and Mental Health Services Administration. (1993). Final notice establishing definitions for (1) Children with a serious emotional disturbance, and (2) adults with a serious mental illness. Federal Register, 58(96), 29422-29425.
Magellan Behavioral Healthcare identifies individuals (adults and children) as eligible for IHH services based on a review of behavioral and physical medical claims. Members who are Medicaid-eligible and who meet the diagnostic criteria are IHH-eligible. In this sense, potentially eligible Medicaid members are “passively” enrolled into the IHH program. Magellan then provides the eligible member information to the IHH providers who then meet with these individuals to determine whether IHH is appropriate for them and to confirm their enrollment into the IHH. Eligible members may also be identified by IHH providers, community providers, or may be self-referred.

**Methods**

**Interviews with site administrators**

In-depth, qualitative telephone interviews with IHH site administrators were conducted in order to better understand successes and challenges related to IHH implementation. A semi-structured qualitative interview protocol was developed by researchers at the University of Iowa Public Policy Center in consultation with representatives from the Iowa Medicaid Enterprise (IME). The interview protocol was pilot tested on two IHH administrators and refined based on their recommendations.

Interviews were conducted with Phase I and II sites only. Information about IHH site phase, counties served, population (adult, pediatric, or both), and contact information for administrators was provided by Magellan. Administrative contacts were mailed a letter explaining the purpose and methods of the study. The letter also contained a request (and instructions) to contact the University of Iowa Public Policy Center to schedule a 45-minute interview. Recruitment letters were mailed to each Phase I or II site (n=28). Administrators who did not contact the University of Iowa to schedule an interview within one week of the mailing were sent a follow-up email. A total of 28 administrators from 20 different agencies were interviewed for this study.

**Interviews with practice coaches**

Practice Transformation Coaches (or ‘practice coaches’), who are contracted with the program to instruct and assist IHH sites with issues related to technical assistance, practice transformation, and quality improvement, were interviewed (n=3). Using a brief qualitative instrument, practice coaches were asked about the purpose and scope of their role, the support needed by IHH sites, their perspective on lessons learned from Phases 1-3 of the program, and ways program administration can enhance support and communication with practice coaches and program sites.

Interviews were conducted over the phone after completion of the administrator interviews and were audio-recorded and transcribed. Themes uncovered from interviews with practice coaches are described below.

**Findings**

**Interviews with site administrators**

**Recruitment and retention of clients to IHH program**

**Internal referrals of clients**

Several agencies did not have to conduct many recruitment activities to get clients enrolled in the IHH program due to a high volume of referrals from existing case management services and other programs internal to the agency. In general, respondents from larger agencies that offer multiple programs serving Medicaid-eligible individuals with a behavioral health diagnosis reported the
greatest proportion of internal referrals to the IHH program.

The majority of our success for enrollment came from identifying those that were kind of already coming through our doors.

...since [other programs] are housed in the same building as the mental health center, a lot of [recruitment] was just kind of looked off of people’s schedules to see who was eligible and coming in.

Attribution list of potential clients from IME

Magellan provides IHH sites with an attribution list of contact information for individuals in a given county eligible for the IHH program based on Medicaid data. This attribution list across the board was found by respondents to be incomplete, outdated, and generally not useful on its own as a recruitment tool. A handful of clinics described the attribution list as helpful only insofar as it gave clinics a sense of the volume and geographic reach of their eligible member base.

And I said the attribution list was probably, as far as we’re concerned, maybe um, most effective in helping us estimate how many of these folks, you know, are within our geographical area.

A respondent from one agency described the attribution list as helpful in identifying ‘low-hanging fruit’—i.e., taking individuals from the list whose entries are complete and reaching out to those individuals and families first as a starting point for recruitment.

Community outreach and referrals

Interviewees noted that drawing on existing community partnerships to garner referrals from other agencies was a particularly successful means of recruitment. Many respondents noted that targeting providers who serve a similar population and educating them about the IHH program was generally more successful than direct community outreach with the public.

I would say that definitely the marketing component overall [has been most successful]. We just go and, I guess we call other providers or agencies and see if we can come to them and just speak about IHH… And again, that’s everybody from a school to food pantry to, um, a hospital. But I think that’s been our biggest success is that we do it not only initially but we go back, maybe a second or a third time, because we don’t expect people just to remember who we are and get a flood of referrals in. So I think for both phases that’s been a huge asset to our enrollment.

And that’s where our enrollment efforts have stayed ongoing, is that it’s all about relationships and partnerships. So, it’s all about the places that serve the clients that we are, you know, the members that we are looking for. So we have partnerships with pretty much all of the therapy and BHIS [Behavioral Health Intervention Services] agencies in the area. The school district, um, boys and girls club, um, psychiatrist office, things like that. And then, also some of, you know, some other places like the YMCA and the public library.

Some respondents recalled having a presence at community health fairs or related outreach events, but that these were generally less effective in bringing patients in the door than provider education.

And we’ve tried [resource fairs]. We’ll have AUDs [Authorizations to Use and Disclose Information] on hand in case they want to sign up right there. But, um, most of the time they, you know, they don’t want to. So then we started doing, just having a small slip of paper that they could put their contact information and it’s basically just, oh gosh, you know, it sounds like, you know, we might really be able to help support your family, um, it, you
know, why don’t you give us your contact information and we’ll follow up with you. And they do, but then oftentimes we can’t ever get ahold of them after that.

Cold calling and door-to-door outreach were generally not effective in engaging potential members, in part because of the inaccuracy of the attribution list and the difficulties of reaching this population. Some administrators were hesitant to send program staff out to client homes, and found that individuals and families were not receptive to this mode of communication about the program.

Other recruitment strategies

In terms of specific recruitment and engagement strategies that proved most successful, agencies identified personalized contact and consistent messaging as key components in directly engaging potential clients. Many families lacked an understanding of how the IHH model offers benefits different from that of a traditional mental health services provider, and were more responsive to outreach that involved warm, personal connections with staff members who took time to explain the program.

Yes I do. I think that it’s still hard for people to understand what Integrated Health is. They’re not sure, you know, they maybe think it’s still kind of the state, or things like that, you know what I mean?

And we found that the family peer support specialist was the best person to make those calls. Because they could quickly connect with the family just from their own experience of having (kids) themselves. I think once they introduced themselves as someone who has kids with mental health diagnoses themselves and then got help, so I’m very much in the same boat where you are, the family immediately, kind of, relaxes.

A few IHH sites with strong connections to local hospitals described effectively using the emergency department as a place to recruit new members.

Two team members go up two days a week and kind of present IHH and what it is and the benefits of it. To all of the people who are admitted for that time being, on that day. So they not only get the education. But they also, again, get to meet the team members and who they may be working with.

Impact of recruitment on agency

Respondents were asked to describe the impact of recruitment activities on the agency. Many agencies—particularly smaller agencies with fewer staff members—reported feeling overwhelmed by the demands of recruiting members to the IHH program.

...when you’re trying to take care of the cases you currently have, it’s hard to go out and build more cases. Because we’re kind of at our max.

For most agencies regardless of size, the focus on meeting enrollment goals in the first few months of the program meant insufficient staff time focused on actually developing the program and coordinating care for members. Many respondents reported feeling initially unprepared to provide services to the new influx of IHH clients after the burden of meeting enrollment quotas.

Now recruitment certainly is consuming a lot of my time, yes. Which, early on, definitely took away from, um, me being able to develop the program and enrich the program. It was all about enrollment, enrollment, enrollment. So, you know, that was the focus. And of course once you’re enrolling these goo-gobs of people all at once, you’ve also got to do something with them then. So there was, of course, that stress of, now we’re enrolling these people and now we’ve also got to engage them and care coordinate and all of that sort of thing.
Recruitment and outreach have continued to pose a strain on agency resources as the program has unfolded. Many agencies do not have the staff to support sustained outreach efforts in addition to providing program services.

*It was easier in the beginning, because we didn’t have as many clients. Now we’re full, we have, our staff have a full caseload, and we don’t have anybody to go do any more outreach or. Like right now, I had the homeless shelter call and the, the inpatient unit call, and want staff there. And I don’t have staff to give them.*

### Use of Intake Coordinators

Agencies implemented multiple different strategies to get eligible members enrolled efficiently in the program. Some sites—typically those who are larger or more well-established—have been able to hire and utilize a dedicated intake coordinator.

The most successful practices reported by administrators include heightening staff accountability for different points in the intake process, timely follow-up with enrollees, consistent communication with enrollees, and sending one or more members of the care team to meet the client quickly after enrollment is initiated.

*Um, I think the benefits of that is having the team member present. So, they may not be working directly with that client once the client is enrolled, they kind of get a feel of who, um, their team members might, like what they might be like.*

Although respondents from several agencies praised the utility of having a team member or multiple members present for initial intake visits, logistical challenges were a problem in connecting patients with the right team.

*Yeah. I think the challenge is that if we know, as our teams increase and, um, build and build and build, that they have caseloads of, you know, close to 200, 220, and so we think that a team specifically would be beneficial to this newly enrolled client, but we can’t give them that team because they’re at max capacity. Like, they’re already stretched thin. So then they kind of just have to go with somebody else.*

However, agencies were often met with disinterest from clients even after completion of the enrollment process and establishment of a care team. Many administrators described the frustration that resulted from using limited staff resources toward enrollment only to be met with a client who refuses follow-up.

*It is just so strange how you can sit there, face to face with somebody and tell them about the program, and enroll them, and then a week later, you know, you’re trying to reach out to them again and they won’t answer the phone or return your call and you don’t ever hear from them again… It might be kind of like, buyer’s remorse. You know, they got excited, they signed up, and then it just sort of cooled and then it was kind of like, I don’t really need this.*

### Dis-enrollment from the IHH

Most clinics conduct some level of tracking and follow-up with members who have dis-enrolled from the IHH. For members who have been administratively dis-enrolled from IHH due to lapses in Medicaid coverage, most agencies make attempts to reach out and help the individual retain coverage. Magellan makes this data available for providers. For pediatric sites, some members age out of the program, in which case the IHH tries to facilitate the transition to new providers.

Many sites have observed members dis-enroll purposefully. Administrators
most commonly describe the reasons for dis-enrollment as the individual not wanting yet another care provider interfering in their life.

_Some people have said they don’t like how much we have to contact them. So they don’t really want to be bothered._

Lower-utilizers are more likely to dis-enroll because they do not feel like they need IHH services.

… _there are the people who just are not active. Um, they kind of just fall off of our radar, or they’re hard to get a hold of or (straight up) to say that they don’t want it, they don’t think it’s doing anything for them. And that’s usually, um, more of the less severe clientele that we serve, that they’re more stable. So if we just, kind of, check in on them I think they’re thinking to themselves, well you guys don’t do anything except check in._

Other members who chose to dis-enroll reported a mismatch between their expectations for the program and the realities of care coordination. Some of these members were former intensive case management (ICM) clients who had been transitioned to IHH and were accustomed to a different intensity and model of care.

_Um, well, some of it in the beginning was just, um, kind of adversarial because they wanted their targeted case manager back._

**Patient care**

**Medical information**

All agencies interviewed reported that their agency tracks baseline medical information (e.g., vitals, weights) for IHH clients. However, this information is obtained in a variety of ways depending on the structure and staff composition of the site. Many IHH sites are not clinics and are only able to collect cursory clinical information on clients like height and weight. As one respondent pointed out, “We did not evolve out of a clinic. We are evolved out of the child welfare agency as a community-based service, so. It’s basically not a medical environment that we’re in.”

Some IHH sites that are not based in a clinical setting described some additions to the provision of medical or primary care services as part of the IHH program.

_You know, we have a twice a month, um, Ask The Nurse session, and that is just time that is identified on the event calendar that is mailed out to all the members of, you know, when the nurse is here in the office and available on a walk-in basis, no appointment needed, that you can come and talk to the health specialist about anything medical-related, nursing-related, um, you know, so if the kid, you know, if the parent had a medication question or the kid had a weird rash or whatever…_

Agencies without clinical staff or more sophisticated medical instrumentation available described how they often rely on the client’s medical record for much of the information about a client’s physical health status. This information may be incomplete or outdated depending on the provider(s) who manage the medical record. Some respondents described collecting this information from clients as an iterative process, contingent on building a relationship with the client.

_And then kind of just straggling to get more information as they get to know the person. But right now, um, especially since they have a team member present, especially if it’s, for example, when the person comes in to get enrolled they fill out that core paperwork. There’s more dialogue. We know what questions to kind of prompt, to get certain answers or certain informa-
tion out of the clients that they may not just think of off the top of their head to present. But then if it’s a care coordinator doing that, um, that time with the client, we make sure that if a nurse is available, we walk right down the hall and collect their BMI and their, um, other basic vitals. And so we have them on record so we don’t have to rely on, um, requesting that information from doctors’ offices. Or having the client come in again. So we’ve tried to, kind of, fine-tune and get more of that, one-stop-shop feeling where they can get everything done that first day, and then the initial visit from the team is just, hey, this is who I am, this is who you are, let’s get to know one another.

Care coordination

Many respondents described issues in trying to coordinate care for IHH members with primary care providers. Outside providers were responsive in varying degrees to requests for information or communication from the IHH. While some providers, especially in smaller communities or those with whom the IHH had previously established a strong relationship, were more than willing to engage with the IHH care team, most respondents described problems trying to work with other providers.

We have those clinics that, for whatever reason, are more receptive to the request [for information]. And then we have those clinics that won’t respond at all. And we’ve tried various things. Um, you know, calling, faxing, emailing, you know, and they just absolutely ignore.

For agencies that offer co-located primary care services, coordination around the care of IHH clients has not been seamless, either. In many cases, communication between behavioral and primary care providers prior to IHH implementation was described as minimal. Although these agencies have the benefit of immediate access to the medical record and other patient information, respondents described how truly coordinating care as a team has been a work in progress during IHH implementation.

I would say for now, it’s more just kind of that collateral contact via, um, records are classed, um, calls or emails, there hasn’t been much of, um, meetings specifically about clients or a certain caseload. Just because we’ve been working on those relationships getting formed, and it hasn’t been the easiest. Especially with the phase two office. Um. But I would definitely say that we’re working towards that, thankfully. But with that, we’re gonna have to, kind of, figure out. What’s the best way to go about it, because I know there will be some speed bumps because it’s kind of new to everybody.

Rural-urban differences in care coordination

One theme that emerged from interview responses was the difference in the ease of care coordination for IHH sites in rural areas versus those in more populous areas. In more urban parts of the state, IHH providers may face a barrier to coordinating care in terms of the greater volume of outside providers, hospitals, and services available when they are trying to communicate with multiple providers for an IHH client. More rural communities may only have one hospital and a small number of other medical providers, making it easier for the IHH care team to pinpoint where a client has been seen and coordinate care. In addition, IHH sites in smaller communities may benefit from a more personal relationship with providers outside of the agency, resulting in greater ease of communication among offices.

Performance measure collection by the IHHs

Several of the performance measures for the program emerged as particularly challenging for IHH sites to work toward and meet. These problematic measures include those on which the IHH staff can exert limited control, such as the flu shot, ADHD screening (for pediatric sites only), and the emergency department
7-day-follow-up requirement.

Where it’s 50 percent of the enrolled members have to have their flu shot. While again, best of intentions but what is our, um, what impact do we actually have? And we definitely educate people, we ask those probing questions of, you know, have you gone, where have you gone? Get the date so we can pull those records to prove it. Um, again, but I think, like, just educating, how much influence do we actually have? You can talk ’til you’re blue in the face. But it’s really up to that person (laughing) to actually follow through with it… I mean we, because we can’t take every single person to their PCP and have them get a flu shot.

Some pediatric sites mentioned that the performance measure around completion of the quality caregiver survey (QCS), administered quarterly, was challenging to meet.

I think it is difficult because, you know, parents don’t return calls, they, I mean. It’s just hard. We’re doing it quarterly. Now comparatively, um, to the adult measure which they do their health and wellness questionnaire? That’s done on an annual basis. So all of the adult programs, their percentages are really high, most of them, for completing that health and wellness questionnaire.

Risk stratification

Respondents from the majority of agencies described their IHH site as being in the early stages of fully implementing risk stratification. Many agencies currently rely on spreadsheets to track relevant client information but are unable to pull population data at a more sophisticated level. Other agencies have adapted the tool provided by Magellan to stratify their patient population.

Emergency department utilization and hospital admissions

Identifying ED visits

Respondents were asked to describe the process of identifying when an IHH member has visited the emergency department (ED). According to respondents, this process lacks a consistent means of getting accurate, timely information about ED utilization among IHH members.

So it’s really hit or miss, but there’s no consistent way, and I would not say that we have good tabs on when that is happening.

At the most basic level, agencies will look at information from the sweep reports given to them by Magellan. However, these sweep reports are unreliable in that agencies only receive them after the patient is already discharged.

Um, Magellan does provide (sweep) reports, but they’re pretty worthless because some of them have been, literally, a couple of weeks delayed.

The lack of timeliness impacts both patient care-- since the IHH care team is unable to establish follow-up while the member is still in the hospital and are excluded from discharge planning-- and performance measure outcomes, since the lag time between generation of a sweep report and the establishment of a follow-up appointment is often greater than the seven days permitted by the measure.

Respondents described factors that have been most successful in quickly identifying when IHH members have been admitted to the hospital. The single most effective strategy described by respondents was establishing a strong and mutually communicative relationship with the hospital(s) at which their IHH clients are typically seen.
But I think we’ve built the relationships with the hospitals so they at least make us aware as much as they can.

Other respondents described the benefit of building trust and communication with the clients themselves and/or their families. Respondents described how clients who have a strong relationship with their IHH care team are more likely to contact the IHH when they have been admitted to the hospital.

Um, a pocket of the population, like they’ve been more upfront because they’ve been comfortable with their team members.

Decreasing ED utilization

On the preventive side, agencies have tried a variety of tactics to encourage appropriate ED utilization among their IHH clients. Respondents from almost all agencies interviewed reported either that their agency has an in-house 24-hour crisis line or that a crisis line exists in the community to which they can refer clients. Many agencies have created promotional materials such as magnets or handouts with the number of the crisis line printed on it.

Um, thankfully [our agency] has a mobile crisis outreach. That’s kind of newly implemented because of the region. Um, so we give out that number, that phone number and resource like candy.

IHH care team members also engage in counseling and education of clients around appropriate ED utilization.

You know, we work on those coping skills and defining, you know, when is a legit time to go to the ER and seek to be committed or admitted? And when is it ok to maybe stay home and challenge yourself a little bit more. Or, you know, utilize your support system and whatnot. And I think we’ve had a lot of success stories with that. Um, where a lot of people who were really high utilizers have kind of calmed down, so to speak, and utilized it only when it’s absolutely needed, and they’ve actually, kind of, persevered during other times.

However, others described these preventive measures as ineffective in reducing ED utilization among the IHH patient population. We’ve tried to do education with our members, and also the teams and also community providers on, you know, alternatives that are available and crisis line and our 24-hour support line for our members. Um, but, um, I feel that that’s largely ineffective. Simply because, when a kid goes out of control, and they’re having a meltdown, most of our parents want nothing more but for somebody else to deal with it.

Follow-up care

Despite the lack of consistent and timely information about ED utilization among IHH members, many IHH sites described their work on the back-end of the visit trying to obtain follow-up care for the client.

So when or if I get a sweep report from Magellan, I automatically send the information to the county supervisor who then, um, communicates, um, with the administrative assistant for that county or phase. And then they get on our EHR and kind of see, does the client have an upcoming appointment with their therapist or, um, prescriber internally? And then if we know that, we’ll kind of take it upon IHH team members to call and make, and say that hey, we know you’re admitted or discharged recently, make sure you get to that appointment and follow it up, like, do you need a ride there? Do you want us to come and just be with you in the waiting room? That type of thing. Or, um, if it was externally, so we can’t see that they have appointments in our EHR system, obviously. We will reach out, um, to their therapist and do that collateral contact where we say like, hey heads up, this is the knowledge on our end, that they were recently discharged, we just
want you to know, and do they have an appointment with you, or, we can't
get ahold of them, have you seen them lately, that type of thing.

**Discharge planning**

The IHH team at many sites is typically excluded from discharge planning
following a hospitalization by one of their clients. The IHH agency is often not
notified about an ED visit until after the patient has already been discharged.

Um, out here [name of hospital] has been good about notifying us when
somebody is discharging. Now I guess I can’t say that they generally involve
us in the process, basically we get notified that they’re discharging and then
we get sent their discharge paperwork, so that’s not really involving us in
the process. Because it’s, like, all decided already. But I think it’s at least--
it’s better than nothing.

**Community resources**

Respondents described the availability of community services in their area for
the IHH population. IHH team members routinely work with a wide variety of
community-based organizations to connect their clients with relevant services.
Community resources commonly utilized include: other mental health service
providers or agencies, housing and food assistance, and transportation.

For agencies with sites in multiple locations, some sites were described as being
more resource rich than others. The program as a whole may be able to draw
upon the resources and expertise of the site within a larger city, but issues—
namely, transportation-- remain with connecting patients with these services.

Um, I would say there’s definitely a lot of outside referrals, like outside the
county I mean. Thankfully, because we have that connection with Dubuque
since we share, you know, team members and whatnot, that helps. But then
you get into more of those systemic problems of not having transportation
because there’s financial problems in the home, so they can’t just drive up to
Dubuque for something. Um, and then we can’t provide transportation all
the time either.

Administrators were asked about the process by which connections to
community organizations were made in their agency for IHH clients. In most
cases, IHH staff members come from the very community they serve and are
extensively familiar with the services available in the area. Some agencies use a
binder or informational board to keep staff up-to-date on available opportunities
and services.

**Administrative considerations**

**Habilitation funding and case management services**

Many IHH administrators reported difficulties with the integration of case
management services (for adult clients) and Children’s Mental Health Waiver
services (pediatric clients) into the IHH model.

Um, both the community, the direct care workers, as well as the clients were
very dissatisfied with the transition, um, because they felt. I know they got
letters in the mail but they just, they didn’t understand why the funding
had changed, as well as the DHS targeted case managers weren’t happy and
were letting that flow over into their clients and what they were telling their
clients.

Um, we put a lot of the HAB [habilitation services] population, the respon-
sible team members, the care coordinator, because they’re doing a lot of that
paperwork. And going to meetings and whatnot. Um, kind of that behind
the scenes action. But also they need that monthly contact. Which I think
drains us because, I think Magellan’s intention was to have, I forget what the exact percentage is, but to have, like, 25 percent of your population be that HAB. Um, but ours is very much (laughing) closer to like 50 percent. Um, so it kind of depletes us at times because we’re constantly running, just trying to make the contact, let alone set up and maintain those services.

Um, so that’s definitely been a learning curve. And I also think that even just the paperwork for that, it wasn’t, um, handed over by Magellan by any means. So we had to create our own forms, we had to talk to case management, um, and kind of get a lesson on HAB 101, what is that, what is the paperwork that you need. What are the regs [regulations] surrounding it, because I don’t feel like Magellan, um, I personally don’t feel like Magellan did that the best. Now we have our heads on straight, and it’s a lot more efficient, but our, I mean, there’s a bulk of our population that seeks those services. So, again it’s time-consuming.

Changes in provision of services by type of provider

Administrators were asked to speak to any changes in provider roles and responsibilities resultant from IHH implementation. Many reported that they had not noticed a shift in how different types of providers practiced as a result of the program. However, several respondents described initial difficulties for practitioners making the mental shift from direct care provision to care coordination—particularly among providers used to high amounts of patient contact, like social workers.

Yeah. I think in the beginning, it was really difficult to have, kind of, your three disciplines per team. Um, because we wanted to make it very black and white. Like, care coordinators do only this, and, you know, your nurses do only this and so forth. Because they do a lot of the same thing, they all make referrals. They all provide support, they all provide knowledge, but it’s just differing degrees. And especially, it depends on where that person comes from, um, educationally, professionally and all that stuff. So I think we’ve had to go through our growing pains with that. And now it’s just kind of accepted that we all do the same thing. Um. So like I just said, it’s just kind of different depending on what team you belong to.

Paradigm shift

Administrators reported varying degrees of frustration or challenges in the transition from a fee-for-service model of care provision to the care coordination model espoused by the IHH program. Several respondents described how their agency had already functioned in this manner before IHH implementation; therefore, the transition was relatively seamless.

I mean, we’ve always been care coordination here. So we’ve had a lot of experience with that. So I think that’s been our biggest, um, from the beginning that’s been our biggest positive.

We haven’t had to go from a medical model to a business model because we started out as a business model.

Other agencies less familiar with operating under a care coordination model reported frustrations with some aspects of the transition, on the administrative side and for practitioners.

The transition too, because what we’ve done is we’ve taken traditional social workers and case managers in the community and we’ve brought them in and said, this kind of looks like case management but it’s not.

So the paradigm shift really hasn’t, it’s, the paradigm shift and the thought of population health and population care is the philosophy, but the processes and the procedures have not followed the philosophy. Process and procedures are still fee for service.
Magellan

Administrators were asked to comment on the level of support and communication provided by Magellan throughout the process of IHH implementation. The overriding sentiment expressed among respondents was that Magellan had tried its best but had neglected in many ways to provide adequate support to IHH sites and take feedback into consideration.

And they’re very aware of, kind of, our concerns or opinions. Um, and I think that Magellan tries to do the best they can. Because it’s a massive initiative. But, um, I think there’s still, um, concerns on our end that may not be getting addressed, or maybe as timely as we’d want them or more of, like, a need. Because if we see that if they keep going this way, we’re gonna almost dig ourselves into this hole. But we can only do so much from our end. And I’m sure it’s the same for Magellan, they’re looking at us, saying hey, we can only move so quickly.

Administrative load

Most respondents described how involvement in the program had resulted in sharp increases in administrative work for IHH staff, particularly on the front end of the program. Administrators described the burden of additional paperwork, staff training time, quality assurance improvements, and changes to agency structure that arose from the program.

Many of the frustrations related to this increase in administrative load were compounded by the perceived lack of assistance from Magellan during the program’s roll out. Several respondents described feeling unsupported in tackling issues related to different aspects of the program.

Now, Magellan’s willingness, uh, to, I think hear the IHHs out and when we come and say, you know, this isn’t working well or whatever, I don’t feel like Magellan’s been very receptive to that, it’s pretty much, you know, I feel a lot like it’s been, you know, this is your problem to figure out. The attribution lists were crap. And that was, oh well, that’s your problem as an IHH to figure it out. Figure it out! Go find these members and get them enrolled.

Communication with Magellan

Communication between Magellan and IHH administrators at individual sites was described as a ‘mixed bag’ by one respondent—a sentiment echoed by many other administrators interviewed. Respondents named specific individual staff members at Magellan who they described as helpful and responsive, and in particular were complimentary of the billing department for their willingness to answer questions and troubleshoot issues with individual sites.

However, many administrators described frustration at what they perceived as inconsistent messaging as a whole about program expectations. Some respondents reported instances when Magellan would give different sites multiple answers to the same question.

Yes, um. I would say, in a very general sense, [quality of communication] really depends on who you’re talking to at Magellan.

There’ve been a lot of positives. I feel like, um, there are certain staff that we’ve worked with that have been really helpful in helping us get our arms around it and figured out, and supporting us in the process. Um, I think, from a larger system side when we get together as kind of a state-wide, um, directors group, and what we find is that we’re all getting lots of different messages about, asking the same question but each getting different answers.

Many respondents felt that the IHH program would benefit from more direct
oversight and guidance from Magellan. Although respondents described the occasional IHH webinars and trainings as helpful, they felt Magellan administration lacks regular contact with program staff on the ground at individual IHH sites and were often unreachable for feedback or questions.

And so sometimes there’s not as much guidance as I would like to see. Um, and I know that, for certain people that I’ve reached out to who aren’t the most timely.

Um, I personally think that it would be great to have more of a presence. Whether that is conference calls, like check-ins. Or, you know, coming onsite and just visiting. Not necessarily for an assessment to, um, kind of, be in that, um, chair of, like, judgment. But just kind of to see how things are going and hold meetings and ask what they can do for us or how, almost like this kind of phone call. I would love to provide that feedback instead of sending via email and then, oh that person’s out of the office, or never.

**Interviews with IHH Practice Coaches**

A total of 6 practice coaches were in practice at the time of interview sampling. Three practice coaches were selected to participate in interviews in order to purposefully represent a range of practice coach settings and roles. One respondent worked for the University of Iowa, another for a private healthcare consulting firm, and the third was an independent contractor overseeing other practice coaches.

*Purpose of practice coach role*

Practice coaches felt their role was in line with the formal title of ‘practice transformation coach’ in the sense that they instructed and supported IHH sites in the transition to becoming a patient-centered medical home.

[We help IHHs] to implement those fundamentals to transform their practice to be able to manage their patients in a different way than they ever have before, and to help them meet the Triple Aim.

… what practices really need to learn are things like team-based care, population management, health information technology at a very high capacity for patient care. Um, some other big components, of course, were care coordination, you know, looking at satisfaction, looking at cost containment.

Practice coaches each served multiple different IHH sites across Iowa. Since the launch of the IHH program, one respondent had transitioned from direct practice coaching to working as a consultant with Magellan program staff to guide development of coaching materials and resources.

*Support provided to IHH sites*

Practice coaches were asked about issues and questions commonly presented to them from the IHH sites in their service area. All three practice coaches interviewed had provided support to IHH sites in each of the program phases (Phase 1, Phase 2, and Phase 3). Respondents described how needs differed depending on where an individual site was in the process of program implementation. IHH sites initially needed support with recruitment, marketing, and enrollment of clients into the program. Once enrollment quotas were met, respondents described the need of sites for help with building internal processes related to implementing the program.

Um, whether it’s about how to market to build enrollment. How to, even at times, manage the staff that is unhappy or about something or they’re overwhelmed with all the change and the director may just need some support with helping to understand how to manage all of that. To, you know, strategic planning and planning for meeting measures and, and, you know, just a
lot of discussion around what’s the process, you know, constantly bringing it back to the process.

Respondents also described how baseline differences among the sites in readiness to implement the IHH program determined where practice coach support was most needed:

And [our support] kind of varies on, depending on where they’re at in the process but as I see it, there’s very site-specific support, um, because the sites are so different from each other and their capabilities of starting a new program, basic things about program project management.

Many IHH site administrators turned to practice coaches for assistance with roles clarification with regard to the different types of clinicians needed for the IHH program. One practice coach described how some behavioral health agencies had never employed a registered nurse before and were initially unsure about their purpose within the scope of the program.

You know, how do I use this nurse? And especially it gets, role clarification was difficult because at the beginning when they’re in that enrollment push, everybody’s doing the same thing. So then once everybody’s doing the same thing, there comes to be a certain volume where that doesn’t work anymore. So then you need to split out of, into your separate roles. So that whole, you know, it’s just, it’s muddy first of all because they’re not familiar with an RN particularly and, like I said, everybody’s doing the same thing at the beginning.

Communication with IHH sites

Respondents described open channels of communication with IHH sites in their service area. In addition to providing onsite instruction and technical assistance and assisting Magellan in the planning and hosting of Learning Collaborative events, practice coaches described frequent informal contact with program staff at sites:

…it they call me whenever they need to. Um. That exchange is always open for them.

Um, yeah there’s certainly best practices for, you know, processing type things. Um, and I think we could do a better job at identifying those and sharing those. You know and how are THEY doing compared to other people and, you know. Because we’re, we’re really their primary source of that information. They, they’re starting to develop their own networks at lot better now, informal networks. So I don’t think they’re quite as relying on us, they’re calling their, their own contacts which is good.

Lessons learned

Echoing the concerns raised in interviews with IHH administrators, the practice coaches interviewed touched on the difficulties associated with the initial enrollment push of the program.

You know, I think that some of the sites really struggled with the, um, push for enrollment and also at the same time providing the quality level of care that they want to provide.

I think if we could’ve streamlined that a little bit differently or assigned people an IHH based on what we already know about them and they were just automatically assigned rather than had to, you know, go out and get them enrolled. You know, something like that could’ve made it just be a little bit smoother.

I just sometimes feel like there was so much more that we learned and understood as we went along, that if we had really spent more time on training
for some of those techniques in the very beginning and have some of that in place for them, it could’ve saved them more work in the long run. However that said, I don’t know that they would have been able to comprehend all of that in the beginning when they’re so focused on just enrollment.

Practice coaches also noted issues inherent to the nature of the sites involved in the program. One practice coach pointed out that behavioral health agencies may have a relative lack of experience with primary care processes and care integration, making swift implementation of the IHH model a challenge.

I think one of the biggest themes, um, for coaches and for myself has really been the, the structural organization of community mental health centers themselves… what, what really became clear when IHH was implemented was the lack of internal communication and the lack of internal coordination that was going on within community mental health centers.

Practice coaches also described the challenges involved with navigating the implementation of a brand new program that had little precedent.

And it’s hard when it’s brand new because they’re not able to look at a process that’s been in place for a while and say ok, what’s really happening, where is the waste and where can we improve it. What we had to do was sort of just make it up and try something and then try to improve it. Um, because there wasn’t anything that existed before.

And I think the lack of standardization has been a gift. A blessing and a curse. So, you know, not defining roles, letting agencies do that. Not handing them, um, standardized risk stratification systems to all the sites and expecting them to build their own. You know, all those things, I think, are a blessing and a curse at the same time.

And I, I just sometimes feel like there was so much more that we learned and understood as we went along, that if we had really spent more time on training for some of those techniques in the very beginning and have some of that in place for them, it could’ve saved them more work in the long run. However that said, I don’t know that they would have been able to comprehend all of that in the beginning when they’re so focused on just enrollment.

Practice coaches were asked to describe any differences observed between high-performing sites and those that were adapting more slowly to the program. Respondents identified strong agency leadership, past experience with care coordination, and organizational willingness to engage with a new model of care as predictors of more successful IHH implementation.

…just like anything else, the key factor is a good leader.

I believe that the sites that have embraced quality improvement as a part of their culture and the sites that have executive-level leadership. Really on-board with their transformation and what this means to their organization have been more successful. Those sites that are still viewing the IHH as its own silo in and amongst all the other silos in their overall organization are still, and will continue to struggle.

Communication with Magellan

Again echoing the sentiments of IHH agency administrators, practice coaches characterized Magellan’s leadership throughout the program’s rollout as well-meaning but with some issues. Respondents described how lapses in communication between Magellan, the practice coaches, and the IHH sites fostered confusion about program rules and proceedings:

…[Magellan] could have used the folks that are onsite with the agencies bet-
ter. So for instance, providing us with more information about, um, things that they’re working on. I mean, a lot of times I’d show up at a site and they’d be working on something with Magellan, and I didn’t even know it.

So, for example, a real simple example is the performance measures. Um, when I started, you know, there’s a document and it lists all the performance measures and how they are calculated, what the rate is that they are expected to hit. So, it wasn’t really necessarily clear what they were looking for. So I would, when they sent it I’d get a lot of questions [from IHH administrators] about, well how do I interpret this? How am I going to interpret that? And I had wanted to work with Magellan to enhance that document as we dug into it deeper and learned more about it, put it in the document so everybody could benefit from that information. Um, but Magellan wanted, no, no, they should call us one-on-one. So I spent about three months at the beginning, really at most meetings, saying, you need to call Magellan about that, you need to call Magellan about that. Which is ok but once again it was one of those things where it seems like it would, because I was the one there, had I had more information or if we’d had a more standard, um, way to communicate the additional information that they were giving to the sites, it would have been much more effective.