August 31, 2011

FORMATIVE EVALUATION REPORT

New Orleans Primary-Behavioral Health Integration Project

ID# 63540

February 15, 2008 – February 14, 2011

Total grant amount: $838,544

Goal: Mental health care capacity building and implementing effective models of treatment in primary care in New Orleans

Contact: Maria Ludwick, MPH E-mail: mludwick@lphi.org

Acknowledgements

This formative evaluation report is a product of the CIBHA Evaluation Team. The CIBHA Evaluation Team was comprised of the following individuals:

Chatrian Kanger *(Lead)*

Shelina Foderingham *(Co-Lead)*

Karen Mason

Deborah Daigle

Brittany Bickford

Jayne Nussbaum

Maria Ludwick

Kira Wortmann

The CIBHA Evaluation Team would like to thank Dr. Harold Pincus, M.D. and Jeanie Knox-Houtsinger for their dedication and guidance on the evaluation design, data collection instruments, and analysis of results without which this evaluation would not have been feasible.

Table of Contents

Acronyms

ACIC	Assessment of Chronic Illness Care
BRFSS	Behavioral Risk Factor Surveillance Systems
CCM	Chronic Care Model
CHCs	Community Health Centers
CIBHA	Collaborative to Improve Behavioral Healthcare Access
CMHCs	Community Mental Health Centers
CMWF	Commonwealth Fund
DHHS	Department of Health and Human Services
DRA	Deficit Reduction Act of 2005
HRSA	Health Resources and Services Administration
LCSW / LMSW	Licensed Clinical Social Worker / Licensed Masters of Social Work
LPHI	Louisiana Public Health Institute
MHIT	Mental Health Infrastructure and Training
NCQA	National Committee for Quality Assurance
PCASG	Primary Care Access and Stabilization Grant
PCMH	Patient-Centered Medical Home
RWJF	Robert Wood Johnson Foundation
UDS	Uniform Data System (HRSA)

Executive Summary

Nationwide, there is a growing interest to integrate general medical and behavioral health services in order to treat patients with co-morbid physical and behavioral health conditions, which typically account for higher medical costs. In order for any institution to integrate services effectively, coordination and collaboration among providers is key. In addition, there must exist a service delivery system and financial / payment model to support integrated care delivery. In 2006 the Institute of Medicine recently produced a report," Improving the Quality of Health Care for Mental and Substance-Use Conditions"[1], that recommends that providers of primary care services should establish "clinically effective linkages within their own organizations and between providers of mental health and substance use treatment."

Post Hurricane Katrina New Orleans provided a unique opportunity to support a fragile, compromised network of community-based primary and behavioral health care organizations to preserve and increase access to primary and behavioral health care services in the Greater New Orleans Region. Building on the Primary Care Access & Stabilization Program (PCASG), which was a one-time only $100 million award from the Centers for Medicare & Medicaid Services to the Louisiana Department of Health & Hospitals, administered by the Louisiana Public Health Institute (LPHI), a private non-profit, the Robert Wood Johnson Foundation (RWJF) was able to offer support to develop and deliver a quality improvement learning collaborative, the Collaborative to Improve Behavioral Healthcare Access (CIBHA). PCASG was awarded in September 2007 and CIBHA officially kicked off in July 2008.

CIBHA was a quality improvement learning collaborative to support the integration of behavioral and primary health care, thereby improving access to higher quality, more integrated services. CIBHA objectives were to build capacity for best practice treatment of depression and other common behavioral health conditions while also identifying strategies that would produce sustainable systemic change in the Greater New Orleans region. CIBHA has worked to assist local health care professionals and organizations to: integrate primary care, mental health and addictive disorder services; use evidence-based practices to manage depression and common behavioral health conditions; undertake quality improvement activities that advance patient treatment outcomes and increase access to services, and to identify and implement financial and non-financial incentives that support integration and sustainability. Specifically, CIBHA augmented the structural and financial components of the PCASG by offering:

- Annual conferences that provided grantee organizations technical assistance on a variety of behavioral health integration related issues.
- Interactive roundtables that facilitated networking between the grantee organizations.
- One on one technical assistance with national experts via conference calls and in person visits.

CIBHA participating practices included 23 organizations (Federally Qualified Health Centers, Community Health Centers, and Mental Health centers), awarded under the PCASG federal grant program, and represented more than 300 providers at its launch.

Given that the CIBHA program was interwoven into the PCASG program, much of the evaluation and data collection activities were also intertwined. The CIBHA evaluation relied upon both internal programmatic evaluation and monitoring activities at the practice and

[1] (Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, 2006)

systems level conducted by LPHI, as well as evaluation and research activities being administered by the University of California, San Francisco and The Commonwealth Fund – external evaluators for the PCASG at the patient-, practice- and systems-levels. This report synthesizes findings from both the local level evaluation and monitoring activities as well as the external data sources where possible. Some findings from the external evaluation have not yet been made available and are not included in this report. Lessons learned from the perspectives of the project team and participating organizations are provided for future integration efforts.

This report illustrates how a funder and a community through a local partner in collaboration with State and federal entities, successfully utilized a public private partnership to leverage federal resources to enhance the capacity, access and quality of behavioral health services in a community impacted by a disaster. Findings suggest that aligning the CIBHA learning collaborative with the PCASG program allowed the projects' team to most efficiently utilize their existing assets and relationships with the provider organizations and to deliver more effective technical assistance.

This report also shares the various approaches to integration by the CIBHA participant organizations, and highlights given the variation between CIBHA participating organization in terms of resources, goals, and levels of understanding about integration though the life of the initiative. Overall successes were achieved in areas such as: increased knowledge and understanding of the vision of integrated behavioral and primary health care, increased utilization of a standard screening tool for depression, and increased networks/linkages for behavioral health and primary care. Common facilitators identified included: presence of a champion, use of a standard screening tool, and data for performance feedback to providers. Barriers included: staff turnover, inadequate amounts of hands-on technical assistance, minimal funding for behavioral health staff, and challenges with the development of registries for data collection, reporting, and tracking of behavioral health patients in the primary care settings.

In terms of lessons learned, project team members most commonly found that for a project of this undertaking to be successful, clear and consistent goals, objectives, and deliverables need to be laid out from the onset. Team members observed that financial incentives are a necessary component of a behavioral health integration project such as CIBHA. Additionally, team members stated that time needs to be taken from the onset of the project to meet with grantee organizations and adequately assess what level of behavioral health integration is appropriate for their practice. Overwhelmingly, team members thought that the evaluation component of a project is integral and should be laid out at the beginning of the project. Lastly, there was consensus that CIBHA should have been incorporated into PCASG from the beginning of the project.

Advice for other communities attempting large-scale integration projects include: leveraging other assets and resources present in the community, such as other complementary programs to increase participation and technical assistance delivery; always tie data and evaluation reporting requirements to financial incentives in order to motivate as well as compensate busy practices for their additional efforts and time. Programmatically, team members advise that it is important to have consistent leadership throughout the project when possible, clearly lay out

goals, objectives, and deliverables and keep them consistent throughout the project, and know the data collection abilities and limitations of the grantee organizations when considering participation in the project.

Introduction/Background

The aftermath of hurricane Katrina caused a significant loss of life and massive loss of property and led to sharply heightened prevalence of common mental disorders. A 2006 survey coordinated by Harvard Medical School reported that 31% of those who lived in the hurricane-affected areas have a mental illness[2] . Eleven percent had a severe mental illness[2]. These were twice the levels recorded before the hurricane. As need had escalated, mental health services capacity had diminished. Of the 196 psychiatrists practicing in Orleans Parish prior to the storm only 22 were in practice immediately following the hurricane[3]. The number of psychiatric hospital beds in southeast Louisiana had shrunk from 462 to 190[4]. In the absence of an adequate psychiatric presence, the difficult role of handling the severely mentally ill had often fallen on the police department[5](Program Proposal LPHI).

Leaders realized that in crafting a response to this health crisis, it was important to recall that before the storm, Louisiana's health statistics were already among the worst in the nation (US DHHS, 2004). The post-Katrina New Orleans area, therefore, was at once plagued with increased mental health and substance abuse burden, and suffering from a perennial lack of capacity and coordination of behavioral health services. Behavioral health services in the New Orleans metro region were fractured between different organizations governing scant in-patient care, outpatient care, and preventive campaigns. They were sure that if all of the components of the health system were rebuilt as they were before the storm, the same disappointing health outcomes would result. (Program Proposal LPHI).

CIBHA was a 3-year grant supported by Robert Wood Johnson Foundation that began in 2008. The Collaborative was an adjunct program to the quality improvement incentive efforts the Primary Care Access and Stabilization Grant (PCASG). LPHI and its partners locally and nationally chose to focus the quality improvement collaborative on increasing access to behavioral health and primary care behavioral health integration, to help organizations meet criteria for quality improvement financial incentives provided under the PCASG, such as achievement of the National Committee for Quality Assurance (NCQA)Physician Practice Connections® Patient-Centered Medical Home™ (PPC-PCMH) program recognition.

Responding to the loss of healthcare delivery capacity resulting from the devastating aftermath of Hurricane Katrina, in May of 2007, the U.S. Department of Health and Human Services (DHHS) awarded the three-year $100 million PCASG to assist in the restoration and expansion of outpatient primary medical and behavioral healthcare services available through eligible public and private not-for-profit clinics in four Louisiana parishes – Orleans, Jefferson, St. Bernard, and Plaquemines. Funding under the PCASG was authorized in Section 6201 of the Deficit Reduction Act of 2005 (DRA) and awarded to the Louisiana Department of Health and Hospitals (DHH). Outlined in the federal notice of award, the state had to select a local partner

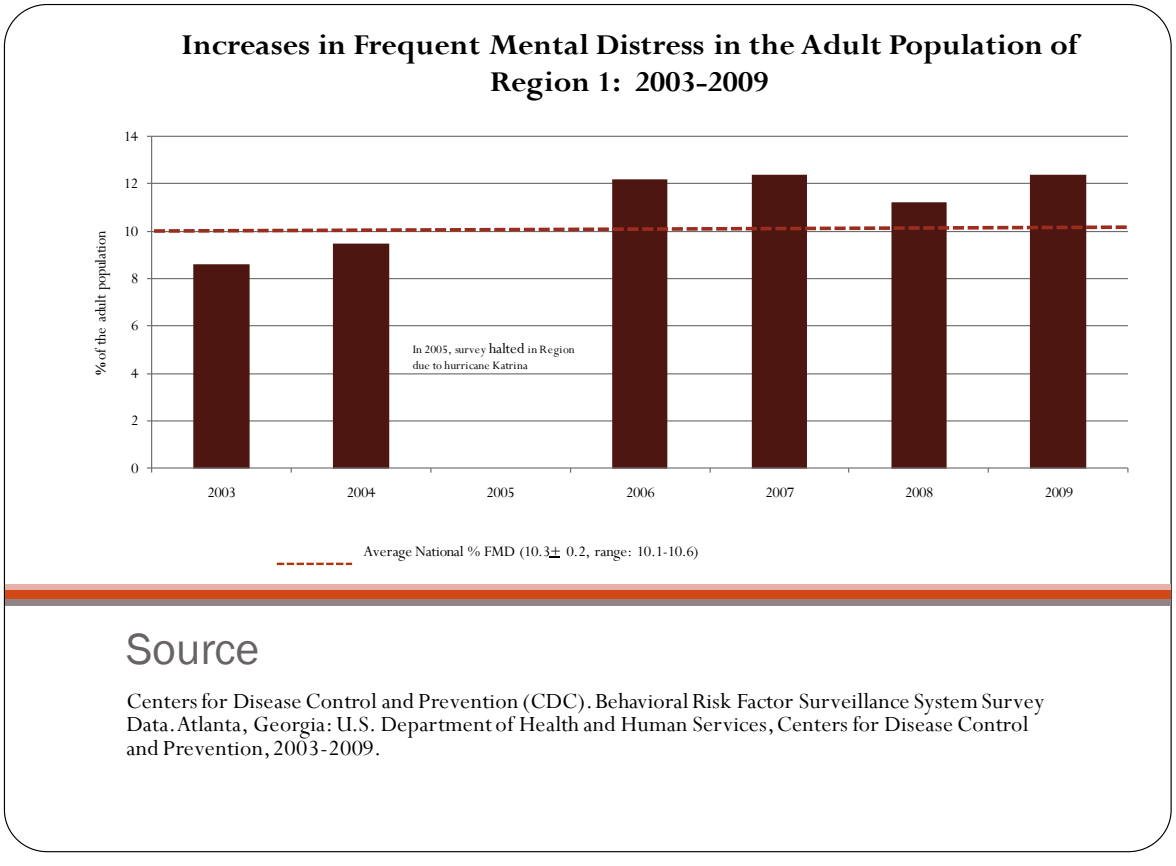
[2] (Galea, et al., 2007)
[3] (Weisler, Barbee IV, & Townsend, 2006)
[4] (Administration, 2006)
[5] (Spiegel, 2005)

with experience in planning for the region's safety-net, and the Louisiana Public Health Institute (LPHI) was selected as the State's local partner.

The goals of the three-year initiative were to:

- Increase access to care on a population basis;
- Develop sustainable business entities;
- Provide evidence-based, high quality healthcare; and
- Develop an organized system of care.

The Louisiana Public Health Institute (LPHI) along with local, state and national partners recognized the need to transform the healthcare delivery system, including the need to increase access to behavioral healthcare due to rising population need to address the emotional impact on the area's residents as a result of the devastation caused by hurricane Katrina in August of 2005, and occurring simultaneously with a loss of behavioral health professionals, in the region. As illustrated in Figure 1 below there was an increase in the increase in the estimated proportion of the adult population in the greater New Orleans region who reported experiencing frequent mental distress in the years following hurricane Katrina, as captured via the annual Behavioral Risk Factor Surveillance Survey[6] from 2003 to 2009.



Overview of Primary Care Access and Stabilization Grant (PCASG) and Collaborative to Improve Behavioral Healthcare Access (CIBHA) Initiatives

PCASG. PCASG was a one-time only $100 million federal grant awarded in September 2007 to aid in the region's recovery. The grant was designed to meet the increasing demand for healthcare services, provide high quality primary and behavioral health care at the community level, and decrease reliance on emergency rooms for conditions more appropriately treated in outpatient settings[7]. While the primary focus of PCASG was to increase access to primary and behavioral healthcare services, additional emphasis was placed on improving quality of care, coordination of care, and transforming the participating safety net providers into more sustainable business entities. PCASG provided much-needed support to community-based, non-profit, faith-based and philanthropic primary and behavioral health care organizations delivering services in Region 1 consisting of Jefferson, Orleans, Plaquemines, and St. Bernard parishes.

Both PCASG and CIBHA were administered by the Louisiana Public Health Institute (LPHI). LPHI partnered with **Harold Pincus, MD**, Director of the RWJF National Program for Depression in Primary Care, to facilitate CIBHA and provide expert consultation. Twenty-five organizations received PCASG funds over the duration of the grant period (September 2007 through September 2011) and were eligible for voluntary participation in the CIBHA collaborative.

PCASG Program Description. Eligible entities were public and private not-for-profit health care organizations, serving the Katrina impacted four parish area (Orleans Jefferson St Bernard, Plaquemines) as of June 18, 2007, Organizations had to agree to serve all, regardless of ability to pay; have long term sustainability plans, and agree to additional terms and conditions established and/or approved by CMS. This non-competitive that included Community Health Centers (CHCs), Federally Qualified Health Centers (FQHCs), Ryan White Program clinics serving residents with HIV/AIDS; publicly owned or non-profit outpatient community mental health clinics and outpatient clinics of hospitals and universities established specifically for the purpose of providing primary care; primary care clinics operated by charitable organizations, including faith-based organizations; and grass roots organizations that responded to the lack of health care services post Katrina.

Funds were primarily utilized to support personnel, expand service delivery site locations, services, and/or hours. Over the course of PCASG, the number of clinic service delivery sites somewhat fluctuated as organizations attempted to meet perceived needs in the region through site expansions and/or streamline services through site closures; Overall, the number of clinic sites steadily grew from 67 to reach a high of 95 sites, and as of June 2011, there were 71 sites operating in the Region under PCASG. The sites ranged in size from 1 FTE to 40 FTEs serving from approximately 150 patients annually to 16,000 patients annually. PCASG organizations in total employed more than 733 health care providers, not including clinical and operational support staff. Appendix A provides detail about the PCASG recipient organizations, including

[7] www.pcasg.org

their primary service category under the PCASG (primary care, behavioral health, etc), FQHC status, NCQA status, number of providers, and number of patients served annually.

By the end of the grant, the PCASG clinics had become an important source of care for a largely disadvantaged population that has historically relied on the public hospital and emergency rooms for primary care. Approximately one third of the PCASG-funded organizations were newly formed in the aftermath of hurricane Katrina. As a result of PCASG funding, tremendous progress has been made in developing a more integrated, higher quality community-based health system in the Greater New Orleans area. The success of the program goes beyond the rebuilding and redesign of the healthcare sector.

The federal government has made significant efforts to incorporate integration of behavioral health and primary care into legislation. Funding has been increased to SAMHSA, HRSA, and HIS to improve coordination between primary care and specialty care (including behavioral health), enhance the workforce and to ensure that coordination is occurring bi-directionally across settings (i.e. MH/SUD in primary care, PC in Mental Health settings, services and technical assistance, pharmacy opportunities through partnering).

Beyond responding to the critical needs of the community following Katrina, PCASG and CIBHA incorporated key themes, strategies and elements embodied in the healthcare reform movement and ultimately included in the Affordable Care Act. In particular, concepts associated with patient-centered medical homes, health homes, quality measurement, health information technology, mental health parity, primary care/behavioral health integration, pay for performance and value-based purchasing were all touched on in the training and technical assistance activities of CIBHA.

CIBHA Program Goal: The Collaborative to Improve Behavioral Healthcare Access (CIBHA) was a quality improvement learning collaborative to support the integration of behavioral and primary healthcare and thereby improve access to services. The primary objectives were to build local capacity for best practice treatment of depression and other common behavioral health conditions and to identify strategies that would produce sustainable systemic change in the Greater New Orleans region. CIBHA provided ongoing technical assistance and training targeted at organizations and clinics which serve low-income and uninsured patients and were funded through the federal Primary Care Access and Stabilization Grant (PCASG).

Depression still goes largely unrecognized and untreated by primary care providers[8]; the fast pace of health care practices often means that providers devote less attention to symptoms of depression. Additionally, health plans very often do not pay primary care physicians to treat depression or other behavioral health conditions. CIBHA was based on extensive behavioral health research that has demonstrated that depression in adult patients can be effectively treated in primary care settings[9]

CIBHA Program Components: Louisiana Public Health Institute staff (LPHI) staff in collaboration with Harold Pincus, MD at Columbia University and other CIBHA consultants worked to assist primary care and behavioral health care professionals and organizations to practice quality collaborative care and improve patient outcomes through:

[8] (Robert Wood Johnson Foundation, 2010)

[9] (Kilbourne, Schulberg, Post, Rollman, Belnap, & Pincus, 2004)

- Integrating primary care, mental health and addictive disorder services;
- Using evidence-based practices to manage depression and other common behavioral health conditions;
- Undertaking quality improvement activities that advance patient treatment outcomes and increase access to services; and
- Identifying and implementing financial and non-financial incentives that support integration and sustainability.

Dr. Harold Pincus of the Research Foundation for Mental Hygiene and Columbia University and Jeanie Knox Houtsinger of the University of Pittsburgh Department of Psychiatry provided ongoing consultation regarding project implementation, technical assistance to provider organizations, and the CIBHA evaluation. The consultation with the LPHI project team was conducted bi-weekly via phone and initially focused on structuring of the collaborative and the reporting framework for the participating CIBHA sites. Moving forward, Dr. Pincus and Ms. Knox-Houtsinger assisted in linking the CIBHA Team to experts that have successfully implemented system changes to monitor and support behavioral health integration; and assisted with the formative evaluation that assessed the degree of implementation of the clinical and economic strategies related to the primary care behavioral health integration model.

Twenty-three of the twenty-five PCASG organizations were engaged in CIBHA training and quality improvement activities consisting of workshops, phone and e-mail consultations, one-on-one site visits. Appendix B depicts the varying levels of engagement of the CIBHA participants.

The CIBHA Program focused on a bi-directional approach to integration of behavioral health and primary care. CIBHA supported Community Health Centers and Community Mental Health Centers in integrating primary care and behavioral health by implementing the Primary Care Behavioral Health (PCBH) Model (Robinson & Reiter, 2007) into primary care practices, and supported CMHCs in the development of contractual relationships with primary care providers.

Additionally, four of the CIBHA participants (Tulane Community Health Center @ Covenant House, Catholic Charities of New Orleans, Common Ground Health Clinic, St. Anna Medical Mission) were involved in the REACH NOLA Mental Health Infrastructure and Training Program from May 2008 – June 2009 (REACH NOLA, 2008)). REACH NOLA (www.reachnola.org), a collaboration of non-profit organizations addressing public health issues, joined forces with faculty from the RAND Health, University of Washington and UCLA to form the REACH NOLA Mental Health Infrastructure and Training (MHIT) program. MHIT aimed to address the urgent need for enhanced community outreach, greater access to services, and higher quality of care for stress and depression in the New Orleans community. From May 2008 to June 2009, MHIT supported New Orleans-based partners with expert-led training, consultation and technical support, to improve care provided to people with depression and post-traumatic stress disorder. Participating organizations and staff had the opportunity to learn and to implement an evidence-based, “team care” approach for treating depression and post-traumatic stress disorder (REACH NOLA, 2008)

CIBHA Technical Assistance and Training Activities

CIBHA has provided support for a number of technical assistance and training opportunities. Trainings and technical assistance were made available to any type of Provider (primary care, mental health and addictive disorder professionals) interested in practicing quality collaborative care and improving outcomes through treating behavioral health and other chronic disease conditions.

A complete list of workshops and training sessions can be found in Appendix B. During the life of the CIBHA program, LPHI hosted three conferences, two of which provided training on primary care behavioral health integration, the third provided an opportunity for CIBHA participating organizations to share experiences with integration, as well as, providing the organizations with information on how health reform will impact primary care behavioral health integration. As a part of the activities in Year Three, LPHI hosted a series of didactic and interactive workshops aimed to train clinicians, managers, and administrative staff on how to implement various components of the chronic care model and best practices for team-based care within the primary care setting. Additionally, in response to the CIBHA participants desiring more educational networking opportunities, LPHI began hosting roundtables to support networking and exchanging of information among CIBHA participants.

The CIBHA technical assistance and training opportunities gained tremendous popularity and added value over the course of the RWJF grant among the PCASG providers as well as expanded training and networking opportunities for non-PCASG community providers as well. In addition, evaluations were collected and reviewed to inform future training opportunities on an ongoing basis.

<u>Policy Component:</u>

A critical, complementary program component of CIBHA was policy-oriented to address systems issues aimed at increasing access to and financial sustainability of integrated primary care behavioral health services. To provide input on these issues, at the April 2009 CIBHA conference the CIBHA project team convened a small policy stakeholder group consisting of key local and state stakeholders, which resulted in a policy brief outlining issues and potential policy recommendations that addressed barriers to financial sustainability such as Medicaid reimbursement and provider eligibility (reference 2p. issue brief – see attached). This policy brief was presented to and well received by legislators, community organizations, non-profits and advocates at the 1st Annual Legislative Behavioral Health Summit held in Baton Rouge on May 15, 2009. Subsequently in the summer of 2009, LPHI formed a financial sustainability workgroup consisting of representatives of PCASG community clinics and local behavioral health stakeholders to provide further feedback and input. This workgroup reaffirmed the policy brief recommendations and also concluded that under Louisiana's Medicaid policies and reimbursement at that time FQHCs appeared to be the most viable model to provide financially sustainable integrated PCBH services.

In December 2009, the Public Affairs Research Council of Louisiana published a lengthy report *Public Mental Health Care in Louisiana: An Analysis of Louisiana's Fragmented System of Care*

and Options for Reform, recommending Medicaid policy changes and legislative appropriations for payment of integrated PCBH services (reference PAR report http://www.la-par.org/article.cfm?id=283&cateid=1).

Currently, LA DHH is implementing a new initiative, *The Louisiana Behavioral Health Partnership*, which will procure behavioral health services through a Statewide Management Organization with goals of better access and integrated/coordinated care for children and adults with severe mental illness and/or addictive disorders http://new.dhh.louisiana.gov/index.cfm/page/453/n/213. However, this initiative does not include policy changes or financial supports for integrated PCBH services for Medicaid patients with mild/moderate behavioral health conditions.

The Louisiana Department of Health and Hospitals (DHH) applied for a Medicaid Section 1115 demonstration waiver to continue the work of PCSAG, and prepare for health care reforms mandated by the Patient Protection and Affordable Care Act. The demonstration waiver, called the Greater New Orleans Community Health Connection (GNOCHC), was awarded to the state in September 2010, and is in effect from 10/1/10 through 12/31/13. It is a bridge to 2014—the year the state's Medicaid expansion and health insurance exchanges will begin.

The waiver allows the majority of uninsured patients served by PCASG to continue accessing services from their current medical homes, as well as provides health care services to additional uninsured adults. Enrollment in GNOCHC is available Greater New Orleans residents aged 19-64 years of age with family incomes up to 200% of the federal poverty level. In addition, participants must have not been insured for at least 6 months, and must not be otherwise eligible for Medicaid, LaCHIP or LaMOMS. ___ PCASG network clinics have been qualified as participating providers for the GNOCHC program. These clinics are able to bill Medicaid for services provided to GNOCHC-enrolled patients.

Based on the PCASG and CIBHA experience, one of the key features of the waiver is the preservation and increase in access to both primary care and behavioral health services, which allows PCASG clinic patients to continue receiving behavioral health services through their medical homes. Covered services include primary care, preventive health, care coordination, mental health, substance abuse, and specialty care.

GNOCHC is designed to help transitioning the PCASG clinics to a financially sustainable model. The clinics all are Medicaid application sites, and assist patients with enrollment in the waiver program, Medicaid, LaCHIP, and LaMOMS, and later will assist patients with coverage options of the new state health insurance exchange. With patients enrolled in health care coverage, clinics will be able to bill patients' plans for services that would have previously been covered under PCASG or the GNOCHC waiver. This change will allow patients to continue care, including behavior health care, in their medical homes, and clinics to develop a long-term business model.

DHH also has launched a Coordinated Care Network (CCN) initiative that includes care coordination of primary care and behavioral health for Medicaid participants. The CCNs will

provide coordination of care for patients, and have to meet administrative, cost, and quality of care performance measures. The CCN program will use two models, both of which use financial incentives to provide high quality care while minimizing unnecessary care. However, behavioral health providers (psychiatrists, psychologists, social workers, etc.) will not be included in the initial CCN provider networks. Medicaid providers treating enrollees with non-severe behavioral health conditions will continue under the current Medicaid limited fee-for-service reimbursement schedule.

CIBHA Evaluation Approach

As part of the proposal to the Robert Wood Johnson Foundation, the CIBHA project team engaged in a formative evaluation. The overall intent of the CIBHA collaborative evaluation strategy was to answer the following questions regarding the large-scale integration effort:

1. To what degree were the demonstration sites able to implement and sustain specific elements of the clinical model for behavioral health management in primary care settings?
2. What implementation barriers were encountered?
3. What strategies were used to overcome those barriers?
4. What are the overall lessons learned from the program and the implications for programs and policy?

In addition, the CIBHA evaluation strategy sought to provide lessons learned that would be applicable for other communities attempting to integrate behavioral and primary care service delivery. It is envisioned that the data collected, analyzed and reported will provide information for a variety of audiences:

- State policy makers (LA Medicaid, Office of Behavioral Health, and Office of Primary Care and Rural Health)
- Payors
- Partners in service delivery (e.g. FQHCs, School-based health centers, and Human Service Districts)
- Providers and Care Teams
- Private Foundations / Professional Organizations
- Healthcare reform

Data Sources:

Data Source	Description	Frequency	Use (how used in analysis)
Grantee Operational and Technical Assistance Planning Tool	Paper questionnaire that collected current status towards clinical integration and reports barriers in narrative format as well as technical assistance needs. *BH integration questions were adapted from ACIC*.	Annually	Characterizing accomplishments and changes in planned activities

Data Source	Description	Frequency	Use (how used in analysis)
CIBHA Participant Organization Interviews	General Interview Guide Approach to provide context and understanding for the quantitative data collected regarding the CIBHA participant organizations and their key team members involved in the integration efforts;	One-time only (post)	Characterize reflections on barriers and strategies and successes
Project Team Interviews	Interviews were conducted with CIBHA Administrative Team Members and External Consultants regarding Project Design, Implementation and Delivery, and Evaluation in order to capture lessons learned	One-time only (post)	Characterize CIBHA team members' reflections on barriers, strategies, and successes
Session evaluations from CIBHA workshops and TA activities	Evaluation forms collected after each CIBHA TA workshop, conference, activity inform staff on types of providers in attendance, level of understanding of content topics, suggestions for future TA topics	Ongoing	Determine level of engagement with CIBHA; identify future TA activities
Administrative Data	Programmatic administrative data including PCASG and CIBHA participant records and core reference documents, such as award amounts, Quality Improvement reports, site visit forms, participation in technical assistance activities, etc	Ongoing	Determine level of engagement with CIBHA / NCQA / Chronic Care Model
Programmatic Observations	As a natural part of program implementation, team members observed factors that facilitated and supported program goals and those that hindered engagement and/or reporting.	Ongoing	Characterize programmatic successes and challenges

Methods:

Analysis for the data collected for CIBHA consisted of the following components:

- *Literature Review*. Reviewed state and national models for integration to identify characteristics and components of other integration models that could have been applied to the CIBHA participant organizations, such as staffing patterns, reimbursement/finance strategies, and patient volumes/caseload.
- *Survey data (Planning Tool).* Responses by CIBHA participant organization were tracked over time and analyzed for common themes.
- *Participant interviews*. Structured interviews were conducted with a sample of CIBHA participant organizations based upon level of engagement. Thirteen interviews were conducted with 10 participant organizations (1 organization received 3 separate interviews due to differences in its structure and populations served) between August and November 2010, which represented those organizations most engaged with CIBHA. Each participant interview included a review of that organization's PCASG administrative records, planning tool survey responses, staffing patterns, and patient utilization data. Structured interviews were conducted with key members of the leadership or clinical team involved in the integration efforts. Interviews lasted about two hours. The purpose of the participant interviews was to provide:
  - Understanding about the quantitative data collected as part of the PCASG internal evaluation
  - In-depth information around the central themes of the RWJF CIBHA collaborative
  - Qualitative data around the CIBHA participants' successes and challenges regarding implementing the components of the clinical model to generate lessons learned

  Data were segmented into categories/topics of interest and coded according to indicators supporting or refuting each category. Codes were compared to identify consistencies and differences between reviewers and modified accordingly to reveal central themes.

- *Project Team Interviews. In July of 2011, LPHI CIBHA Team Members brought on an Evaluation Intern to conduct interviews with CIBHA Team Members. Interviews were conducted in an effort to collect qualitative data that would adequately depict the successes and lessons learned over the course of the CIBHA Project. The interviews took place from July 19, 2011 to August 11, 2011. Interviews were recorded and lasted approximately one hour; three were conducted over the phone and five in-person. Interviews were conducted with current LPHI staff members who were involved with CIBHA including: Chatrian Kanger, Shelina Foderingham, Jayne Nussbaum, and Maria Ludwick. External consultants, Jeanine Knox-Houtsinger and Dr. Harold Pincus, were interviewed as well as previous CIBHA Team Members, Clayton Williams and Sarah Hoffpauir. Topics discussed included:*
  - *Project Team,*
  - *Project Design,*
  - *Project Implementation and Delivery, and*

- *Evaluation.*

Individuals interviewed have been de-identified and referred to as "team members". The salient themes that emerged from the interviews are presented in aggregate in the following section.

Results

1. To what degree were the demonstration sites able to implement and sustain specific elements of the clinical model for behavioral health management in primary care settings?

Data sources presented below come from the Grantee Operational and Planning Tool (conducted annually) and the CIBHA Participant Interviews conducted in Fall 2010.

CIBHA participants were surveyed annually via the Grantee Operational and Planning Tool to gauge their degree of implementation of components of the chronic care model: Leadership, Decision Support, Delivery System Design, Clinical Information Systems, Self Management Support, and Community Resources. In Year 2, grantees were asked to indicate the level to which their organizations had implemented the components according to a scale of 0 to 3, where 0="Not At All", 1="Partially", 2="Mostly", and 3="Fully Implemented". *(The Year 1 Planning Tool was an open-ended questionnaire unlike Year 2 which used a Likert scale to assess degree of implementation. Both Planning Tools were self-reported data.)*

Prior to participating in CIBHA, PCASG practices possessed some elements, such as some care team structures, and a few practices had been using siloed registries for entering their patients identified with depression. At the start of CIBHA, all agencies who completed the Planning Tool identified areas for improvement in all of the components of the chronic care model; and, the most commonly cited areas of need for technical assistance included: developing protocols for appropriate referrals for behavioral health, incorporating screening tools for identification of patients with behavioral health conditions, identifying appropriate measures, building registries, and incorporating patient self-management tools into their practices. By Year 2, the component areas of the Planning Tool where primary care CIBHA participants indicated that they had made the most progress included: Decision Support and Leadership.

Decision Support. (category mean score=2.13) The category of decision support included implementing evidence-based guidelines, as well as having a systematic screening process is in place to identify patients with the condition of interest, such as depression. CIBHA participant interviews conducted in Fall 2010 revealed that organizations attributed some of their success in this area to the requirement of PCASG's Quality Improvement Program which required adopting an evidence-based guideline and implementing a PDSA cycle [plan-do-study-act] to monitor and make changes for care delivery, combined with the access to expert technical assistance that was made available via CIBHA.

Another aspect of Decision Support was having a systematic screening process in place to identify patients with depression. CIBHA participant interviews revealed that eleven of the fourteen practices interviewed indicated that they were utilizing the PHQ2 and/or PHQ9 as a screening tool for depression in their patient populations; one organization also cited using it as an outcome measure. Ten out of the twelve primary care practices were using the PHQ. Those practices indicating that they were *not* utilizing the PHQ2/9 were using "Other" screening tools, such as a SAMHSA tool or other modified versions of the PHQ9. In most cases, practices indicated that it was the care manager who administered the PHQ9. In fact, one practice explained that they had conducted a PDSA cycle to test the successfulness of the wellness coordinator in administering the PHQ9; however, their findings revealed several challenges with this format of administration, which required patients to stay for this additional "appointment" with a wellness coordinator that the patients did not wish to do, etc. This resulted in the practice re-assigning the function of PHQ9 administration to their care manager which has worked well thus far.

Leadership (category mean score =1.78) The category of Leadership included presence of a care team consisting of primary care, mental health, and senior administrative personnel that reviews guidelines for treatment and continuous quality improvement, and sets goals. A common theme noted throughout the CIBHA participant interviews was that many organizations realized the importance of having strong leaders with a vision to support their integration efforts.

The component areas where all CIBHA participants indicated the most challenge in implementing were: Clinical Information Systems, specifically establishing and maintaining patient disease registries for the management of depression, Delivery System Design, regarding role clarity between the Behavioral Health providers and primary care providers in primary care settings, as well as monitoring adherence to evidence-based guidelines and protocols for the treatment of depression, and Self-Management support for special populations. Further details are described under Question 2 "implementation barriers".

Financing and Sustaining the Integrated Care Model. Many of the CIBHA organizations remained mission-driven and had become accustomed to operating on shoe string budgets, focused on the immediate provision of client care with little attention to the thought of creating an organizational and financial model for a sustainable future. Yet, the unsustainable model they did run on in the past --volunteers, donations, grants, unreliable state and local governmental funds—had succeeded in providing uninterrupted services for many but was no longer an option on the brink of health care reform. Organizational change was challenging and had been driving many of these organizations to re-think business measures. One community health center followed the mantra: "No Margin, No Mission!"

Financing the implementation of and sustainability of the integrated care approach was the most common concern cited by PCASG/CIBHA participants. Issues included:

- Embargo on Mental Health Rehabilitation Sites,
- Enrolling newly licensed clinical social workers into Medicaid and other 3rd party payors,
- Reimbursement for same-day behavioral health and primary care encounters
- Coding for behavioral health encounters

For example, 4 out of 10 primary care clinics interviewed were not currently billing for behavioral health services provided. In some instances, organizations were not billing for behavioral health services because they had alternative funding to sustain their efforts. However, in most other cases, reasons for not billing were lack of an insured patient population and difficulty enrolling providers into Medicaid/insurance programs and/or capturing/coding behavioral health encounters and diagnoses within their electronic systems. Even in cases where clinics were billing, limitations existed, such as billing for behavioral health visits on the same day as a primary care visit were not billable visits; furthermore, most interviewees explained that the majority of their patient populations were uninsured leaving only a small pool of patients from which to submit a claim (lack of incentive to do so).

2. What implementation barriers were encountered?

CIBHA participant interviews conducted in Fall 2010 provided insight into the implementation barriers that were encountered over the course of CIBHA and supported findings from the Year 2 Planning Tool data.

Role Clarity of Behavioral Health Providers. Whereas the Medical Home concept assumes a team-based and collaborative care approach to improving population health, such as for those living with chronic conditions, and supports patients in their own self-management of their goals throughout their lifetime, the role of the behavioral health clinician had not been clearly defined [10]. This lack of clarity of the desired level of PCBH integration and corresponding role of behavioral health providers was experienced amongst the PCASG/CIBHA clinics. For example, behavioral healthcare providers at several FQHCs expressed that they see themselves not as behavior change consultants but rather as co-located therapists and/or 'heads' of their care teams.

Provider Education. Provider education was commonly expressed as a challenge from CIBHA providers on both the primary care side and the behavioral health side. One of the mental health agencies observed that their agency had long wait times for appointments. In examining their issues and incoming referrals, the agency found that they were being inundated with inappropriate referrals from the primary care clinics, which was contributing to their long delays in wait times.

How to best utilize behavioral health providers in the primary care setting presented a major culture shift for both the primary and behavioral health providers. Behavioral health providers had to adjust to operating within a primary care practice and, as one practice stated "utilize their assessment skills" to quickly identify the issue, and primary care providers stated long learning curves to understand and feel comfortable with what services their behavioral health consultant was able to provide for their patients. Building the trust between the primary care provider and the behavioral health consultant can be a challenge, as several practices pointed out, if the social worker / behavioral health consultant is inexperienced. Echoing these sentiments,

[10] National Council, 2009

behavioral health providers interviewed reported that their education/ training received in their academic institutions did not prepare them well for operating within primary care setting contexts. Due to time and financial constraints of primary care clinics, behavioral health consultants must shift their practice paradigm from lengthier individual psychotherapy sessions to shorter brief interventions or support groups focused on behavior change.

Leadership /staff turnover. An obstacle commonly experienced by the CIBHA participant organizations in their integration experiences was staff turnover. In regards to leadership, some agencies reported experiencing challenges with their champion or leader having to change roles and there not being anyone skilled enough to "take the reigns" to execute the vision that the champion had initiated. In other practices, staff reported challenges with finding a behavioral health consultant (social worker) – with the right personality and competencies – to be capable of succeeding in the primary care setting. As one practice explained: "To what extent do you fill the vacant [behavioral health consultant] position with someone that you know isn't the right fit just to have someone there, versus, waiting … possibly for several months on end, to find a social worker that will have the right skills set to operate and be successful here?" This practice had suffered from several social worker staff turnovers and decided that it was more important to get "the right fit" than to just fill the position. Yet, either way practices reported frustration with feeling as if each time a new person came on, their integration efforts had to nearly start all over again.

Poorly structured MOUs. A challenge that was identified early on yet persisted throughout the course of CIBHA centered around poorly structured memorandums of understanding (MOUs), contractual agreements, or the lack thereof. The most commonly reported issues associated with the MOUs included:

- Roles and responsibilities / expectations for behavioral health staff (both housed in the primary care setting and/or at a mental health agency, as a referral), especially around caseload
    - *Ex. – In one primary care clinic setting, there was a behavioral health consultant that was provided by another outside institution. The primary care providers had an expectation that the behavioral health consultant would be proactive in seeking out patients, but rather, sat in their office and barely saw any patients at all unless the primary care providers referred patients to him/her. Their MOU was not clear about supervision of that behavioral health consultant, nor did it outline any reporting expectations. CIBHA team members worked to address some of these key issues with the staff of the primary care clinic to present to their mental health supplier agency.*
    - *Ex. – In one behavioral health clinic that was co-located with a primary care clinic, the behavioral health entity stated that they were "not sure" if an MOU existed between their agencies, and they felt that they were never able to formalize their referral relationship because their organizations placed constraints on the number of behavioral health patients that their medical students would see. In addition, the behavioral health entity viewed each entity as having its own separate patient populations. And, where the behavioral health entity was*

reliant upon the primary care entity to see some of their patients even without a formalized agreement because they did not have a primary care provider on staff, the primary care clinic was not referring patients to the behavioral health agency because they had their own behavioral health clinician.

- Information sharing between the behavioral health providers and primary care entities, as concerns around HIPPAA were great
    - *Ex. – One primary care practice noted that there were concerns with where their behavioral health clinicians could put their psychotherapy notes within their EMR system. CIBHA conducted a 1-on-1 educational session with this entity to conduct provider education around expectations for information sharing under HIPPAA, and as a result, the practice reached a solution to keep a concise behavioral health note in the EMR and the lengthy psychotherapy note in a separate system.*

Workflow (screening tools, handoffs). The majority of the practices interviewed cited some type of integration implementation issue related to workflow. The most commonly cited challenges included:

- Incorporation of behavioral health screening tools into the clinic workflow – this was a commonly noted "trial and error" process to determine the most appropriate way to incorporate behavioral health screens into clinic workflows as well as the frequency with which those screens should be administered, scored, entered, and acted upon for follow-up.
- Screening tools being viewed as inappropriate for some patient populations – this was particularly noted for the substance abuse population
- Screening tools "boxing in" the provider mentality – to not look for other behavioral health conditions besides depression
- Being able to see a behavioral health consultant on the same day as a primary care visit – this was cited as a challenge by a few of the practices interviewed as they described some scenarios where patients needed to see the behavioral health consultant and he/she was unavailable, etc.

Clinical Information Systems. Many of the CIBHA practices were on some form of an electronic information system. However, most were still somewhat new to electronic information system usage. One organization noted, "It (electronic information system) is not as user-friendly as we thought it would've been." As a result, a commonly cited challenge is provider adoption and utilization of the EMR, particularly for behavioral health staff that tend to be concerned about HIPPAA privacy rules. In addition, the capacity of the clinical information systems themselves was often cited as a challenge in that the EMR systems required extensive customization in order to accommodate data capturing and reporting of clinical measures of interest, such as PHQ9 scores.

Some organizations were pleased with the implementation of the EMR: "The EMR is essential because this is the primary mode of communication—don't know how they would do integrated care without this."

Others cited that the nature of their target population made tracking problematic: “Our patients are transient so tracking is not always realistic.”

Another concern among providers was the issue of privacy in tracking psychotherapy notes on an electronic system. “There is a feature in the EMR to hide notes but (providers are) not using (it) because there is still some access to the notes by others.”

3. What strategies were used to overcome those barriers?

Interviews with the CIBHA participants conducted in the Fall of 2010 highlighted strategies that the key team members at participant organizations used to overcome their barriers**.**

Leadership. Presence of a leader/champion for integration at both the practice-level and executive/administrator level were cited by CIBHA organizations as critical to implementing and sustaining any integration efforts.

Practices that appeared to be more advanced in their integration efforts tended to have strong champions at each of these levels. In at least two of the participant interviews, project staff reported achieving milestones once a champion took leadership over the integration project. For example, in one clinic a case management program coordinator streamlined the referral process between primary care providers and the behavioral health staff which allowed them to see more patients. In practices where there did not appear to be a clear champion but rather several people each trying their own approach, integration efforts did not appear as advanced. For example, at one clinic there were three different social workers each of whom had their own approach and understanding of “integration”. As a result, they reported mixed results from providers – likely due to the fact that the providers were not clear about the standard protocols/processes since it varied according to each individual social worker at their clinic.

Presence of psychiatrist on-site. Many of the primary care practices interviewed stated that having a psychiatrist on-site for assistance with patients having more severe mental health needs was critical for integrating. While this seems to be a costly resource for a primary care setting, practices stated that they preferred having the psychiatrist on-site because they feared losing the patient if they referred out.

Training / Provider Education. At the start of CIBHA, most practices stated that did not understand the differences between care managers and case managers, and requested job descriptions and/or educational workshops about this topic. CIBHA did dedicate several sessions to the topic of care management and the role of the care manager, circulating job descriptions as requested by participant organizations. During the participant interview interviews, one practice credited CIBHA with “normalizing the Care Manager role”, which was seen as a big step for improving quality of care in the community. Practices that appeared to be further along in their integration efforts tended to have a care team (including a care manager) in place with dedicated time, personnel and resources to care for patients.

Additionally, one strategy that was commonly noted during interviews was expanding the scope of work for support staff to accomplish integration efforts, such as conducting or entering data for behavioral health screens and/or to remind providers of information about their patient or to complete needed documentation for their encounters.

Finally, educating providers on appropriateness of referrals was cited as a key strategy for achieving integration. Provider education for this purpose was described in numerous ways, including: team consults, performance feedback, exchange of a behavioral health provider to educate primary care doctors, and participation in CIBHA trainings.

Data monitoring. A legacy of PCASG was building the capacity of the grantee organizations to collect and report patient encounter data. At the start of PCASG, many practices were not formally tracking encounters and/or diagnosis codes, nor were they completing superbills for their encounters. Yet, as the reporting requirements for PCASG increased, and practices were required to engage in Quality Improvement activities, many practices interviewed credited PCASG and CIBHA with helping their practices to become comfortable with monitoring and using their data. For instance, one practice interviewed stated that as a result of the minimum quality improvement requirements for PCASG, their practice realized that their most common condition was different from what they had previously thought it was which allowed them to shift priorities and clinical focus. It was also noted among two of the behavioral health practices interviewed that the data collected by them for PCASG and fed back to them via data dashboards through CIBHA allowed them to realize that their behavioral health patients were not coming back for as many visits as their evidence-based guideline model therapies were designed for. For instance, one practice stated that upon reviewing their data, they realized that they could not depend on a model of care that was designed for 10-12 visits for a patient, when on average, their patients were only coming for a total of 5 or 6 visits.

Again, practices that appeared to be more advanced/successful in terms of their integration efforts tended to have engaged in some form of performance feedback. In most cases, it was the behavioral health consultant or a medical director-type of individual that provided feedback to primary care providers on the appropriateness of their referrals and the status/improvement of their patients' outcomes. These providers stated that while it took some time to begin to see results, the data was the most useful tool to help get their primary care providers "on board" with the idea of using the behavioral health consultant in their practice. In other practices, while actual data may not have been fed back to providers (e.g. if data was unavailable), a successful strategy cited was to have team consults and/or meetings to discuss what was working or not working with integration efforts.

Use of standardized screening tools, such as the PHQ9. Despite experiencing some challenges with incorporating use of standardized screening tools such as the PHQ2 or PHQ9 into practice settings, all of the practices interviewed believed that implementation of the screening tool was a key strategy for achieving their integration goals. As one provider explained, "it will help to keep people from falling through the cracks". Another CIBHA participant organization had started an innovative technique in that their medical director

instituted a clinical rule that in the event a chronic illness patient is in poor control of his/her condition for more than 2 visits, a PHQ9 would be administered on that patient.

Use of clinical information systems. In nearly all of the practices interviewed, successful implementation of integration efforts was related to use of the practice's clinical information systems, or EMR: whether to generate a clinical event rule to alert a provider to administer the PHQ9, or as a means to text / consult the behavioral health provider (as was noted in one setting), or for patient tracking through development of registries. One practice was advised by CIBHA project leadership to implement their integration efforts with the timing of their EMR deployment which was successful since the practice was going through change at that time. In another instance, practices cited utilizing their electronic scheduling systems to attempt to schedule patients for same day behavioral health and primary care appointments.

Networking. All of the practices interviewed believed that CIBHA provided much-needed opportunities to interact with community partners that allowed for learning about each partner's services available as well as identify opportunities to develop new referral relationships. For instance, CIBHA hosted a roundtable that allowed the Human Service Authority for Orleans parish, Metropolitan Human Services District, to present information about their new referral process and procedures with community partners to increase understanding and answer frequently asked questions.

- **Avoiding BH terminology with Patients.** Several of the practices interviewed stated that an important strategy for engaging their primary care patients to see a behavioral health consultant was to avoid use of behavioral health terminology. Examples provided were reported as a result of having gone through PDSA cycles/ testing of incorporating behavioral health components into their settings. Examples included: removing or changing the title of the behavioral/depression screening tool that patients may be handed to read; renaming behavioral health programs to less aversive or less stigmatized titles, such as "Stress Reduction" or "Wellness" programs and referring to social workers as 'behavioral health consultants'; and having shared waiting rooms and/or scheduling components for behavioral health and primary care appointments.

4. <u>What are the overall lessons learned from the program and the implications for programs and policy?</u>

Lessons Learned – Grantee Perspective:

During the CIBHA participant interviews conducted in Fall 2010, grantees were asked to share what they considered to be their lessons learned about implementing an integrated care model and suggestions for other communities that might be undertaking similar efforts. The following themes were most commonly noted among the most engaged CIBHA participant organizations:

- **Integration should occur in step-wise approach (PDSAs)** – In other words, start small and work up to organization-wide changes. For instance, one practice learned that universal screening of every patient was not reasonable given the capacity of the

behavioral health staff in that clinic. As a result, they re-focused their screening efforts to their patients with chronic illnesses.

- **Performance Feedback** – All of the practices interviewed stated that performance feedback (whether data was available or not) was an important component to facilitating integration efforts. "*Providing feedback to providers that can allow them to see that their patients are doing better as a result of seeing the behavioral health consultant is the greatest aid in generating buy-in to the model."*
- **Strong consistent leadership** – Having leaders with a vision and having strong consistent champions at the front-line level to execute the vision for integration were frequently cited as lessons learned by CIBHA participants. One organization cited the necessity of demonstrating to the staff the validity of the model as one of their major lessons learned: *"getting the staff on board with behavioral health integration required ensuring that they all understood exactly why integration was beneficial and why it could work".* There must exist a leader to hold staff accountable for achieving the target goals and outcomes for the integration efforts.
- **Strong MOUs** – For the CIBHA participant organizations there clearly existed a need for strong MOUs that outlined roles, expectations, information sharing, supervision/reporting, anticipated outcomes, and a performance feedback mechanism.
- **Integration should occur in the context of the Chronic Care Model –** Many of the practices interviewed stated that behavioral health could not be addressed in a silo, but rather needed to be couched in the context of the management of all chronic illnesses. Additionally, integration could not be fully achieved without addressing each component area of the Chronic Care Model. And the model itself provided a useful and meaningful framework for addressing key drivers for integration.

Participant interview findings revealed that the PCASG QI incentive payments were a primary motivator for practices to adopt components of Wagner's Chronic Care Model.

Motivators: Participant interview findings revealed that one of the primary motivators for PCASG grantees/CIBHA participants to adopt components of Wagner's Chronic Care Model for the treatment of depression was funding in the form of financial incentives via PCASG's payment methodology , and moreover, the NCQA Quality Incentive payments. PCASG incentivized practices to apply for NCQA recognition by funding their applications, and structured payment tiers for achieving recognition according to level of NCQA certification achieved. Once clinician explained:

NCQA recognition wouldn't have happened without the grant, the incentive payment, plus the opportunity to do it, and assistance in navigating the whole process. The [NCQA] requirements made us take a careful look at how we do business, especially EHR, and to identify what conditions we treated the most, and where to focus. The very specific 24/7 documenting, responding to calls, forced us in a good way to document what we were doing.

Respondents added that the CIBHA program introduced their organizations and providers to the idea of integration:

"When CIBHA began, we attended the training and thought it would be a good model to adopt." – *NOAIDS Task Force*

"When I went to the April [CIBHA] conference, I left there saying no matter what, LPHI will support me. LPHI put the data and literature in front of me and inspired me. On some level integration would have occurred but without the push – I had a fulfilling sense of responsibility after going to the Collaborative." – *St. Bernard Community Health Center*

Finally, since all of the CIBHA organizations are Safety Net providers, such as FQHCs or HIV/AIDS, homeless patients and the like, it was a fundamental part of their core to provide comprehensive services to their patients. Therefore, these types of organizations were pre-disposed to have had co-located behavioral health and primary care services prior to CIBHA; however, services were not integrated. The integrated model introduced by CIBHA was a logical fit with their "holistic approach" to patient care. Somewhat related to this aspect, another motivator for integration described by these same providers was often fear of losing patients to off-site referrals for behavioral health services.

Programmatic Successes and Challenges:

Over the course of the program, CIBHA Project Team members observed the following factors that facilitated and supported programmatic goals and those that hindered full participant engagement and participation in reporting.

Programmatic Structure – When CIBHA first began, CIBHA had its own program director and operated somewhat separately from the PCASG program upon which it was overlaid. This structure created duplicate efforts to communicate with grantees who were participating in both CIBHA and PCASG, as well as lacked full access to the broad resources available under PCASG. LPHI recognized that the program could operate more efficiently by moving it under the PCASG umbrella and under the LPHI Health Systems Director, accordingly. This shift allowed CIBHA to fully draw upon the staffing, structures and relationships that were already in place under PCASG and to more seamlessly interact with grantees.

PCASG Payment Methodology- *Successes*:

PCASG grantees were required under the grant to develop and implement quality improvement plans within their organizations, but PCASG and CIBHA leadership believed that rather than imposing change by requiring participation in CIBHA and its technical assistance activities, organizations and their providers should be allowed to access their desired level of technical assistance according to their own stage of interest and growth. The original design of CIBHA

was to offer a kickoff event to introduce the concept of integrated care and inform interested organizations of the technical assistance offerings and access to expert consultations that would be made available to them through CIBHA. Access to expert follow-up consultations would be made available through monthly group conference calls, with additional tailored or customized one-on-one consultation for those most engaged. At the start of the second year, a booster educational workshop would be offered to reinforce techniques learned in Year 1 and to address obstacles and challenges through peer-to-peer learning.

As part of its payment methodology, PCASG leadership worked with Dr. Pincus and other expert consultants, including The Commonwealth Fund, to design incentives for practices to become NCQA certified patient-centered medical homes. As this process unfolded, it became clear that the CIBHA Collaborative could serve as the lead technical assistance arm around quality improvement under PCASG to assist practices in meeting the NCQA requirements of a patient-centered medical home by applying techniques learned about depression care management to other clinically important conditions and care processes, guided by the framework and elements of Wager's Chronic Care Model. The combination of the quality incentive payment coupled with access to expert technical assistance made available through the CIBHA initiative proved to be a successful strategy that resulted in 40 practices achieving NCQA recognition over the course of PCASG.

PAYMENT METHODOLOGY – *Challenges:*

PCASG and CIBHA leadership attempted to incentivize same-day behavioral health and primary care encounters under the PCASG payment methodology. PCASG grantees were allowed to submit behavioral health encounters to be eligible for payment under PCASG that occurred on the same day as primary care encounters. However, interviews revealed that despite the PCASG effort to incentivize same day encounters, this message was lost in the complexity of the payment methodology and calculations. As a result, few organizations actually reported and accrued payments for same day encounters since most organizations were extracting encounter data from their billing systems – and same day behavioral health encounters were not billable services under the current LA Medicaid policies.

In addition, the PCASG payment methodology instituted a floor and a cap to amount of funding any grantee organization could receive as a means to control for equitable distribution of funds; an unintended consequence of this payment stratification became such that for larger primary care entities already at the cap, there became no incentive to go through the trouble of modifying their EMRs and/or building reports to start capturing and reporting their behavioral health encounters.

Quality Improvement:

As a part of their continued eligibility and participation in the PCASG, grantees were required to submit Quality Improvement Plans and report progress and changes implemented as a result every six months. Organizations chose the top three most prevalent conditions in their practice and identified an evidence-based guideline for at least one of these conditions to report to LPHI. Evaluation team members reviewed conditions chosen by grantees in order to determine

whether or not any primary care organizations chose to focus on depression as a result of participation in CIBHA. While Table 7 highlights the conditions for which an evidence-based guideline was selected to adopt and implement, none of the primary care organizations chose to focus on depression as one of their conditions despite the high prevalence of depression that was noted in the table below.

Top 3 Conditions Chosen by PC and BH Organizations

Top 3 Conditions Chosen by PC Organizations:	**Top 3 Conditions Chosen by BH Organizations:**
1. Hypertension	1. Depression
2. Diabetes	2. Substance Abuse
3. Sexually Transmitted Infections (HIV/AIDS, Chlaymydia, Ghonnorhea)	3. ADHD

However, over the course of the CIBHA collaborative, **40 clinic delivery sites (38 primary care and 2 behavioral health only) achieved NCQA recognition, 39 were CIBHA participants**. Recognizing that their primary care patient populations need differing types of collaborative/integrated treatment depending upon their assessed needs, CIBHA participants have determined that integrated care is an essential part of the medical home model in order to be effective in improving patient health outcomes.

Technical Assistance Approach:

"Become proactive instead of reactionary to a technical assistance approach"

Initial engagement of PCASG organizations in CIBHA was around 50%, with 13 of the 25 organizations participating at some level of CIBHA. Initial feedback was that monthly conference calls were less helpful due to barriers related to the mode of technical assistance and time of the call, recognizing that asking busy clinicians to dial into conference calls could be burdensome due to competing priorities, and that educational workshops that could offer an incentive, such as continuing education credits, were desired. As a result, CIBHA leadership expanded its mode of delivery of technical assistance to offer a series of didactic and interactive workshops which included the Certificate Program in Primary Care Behavioral Health and Managing Common Behavioral Health Problems in the Primary Care Setting which offered Continuing Education Units to social workers, nurses, and physicians. Additionally, an outside consultant, Dr. Patti Robinson of Mountainview Consulting Group was contracted to provide on-site walk-thru assessments via shadowing of the behavioral health providers in their primary care settings and to provide specific tailored recommendations and feedback to those sites. She began by outlining the integration model with staff members and addressing any questions or concerns. By shadowing behavioral health specialists, she was able to explicitly outline how the model could feasibly fit within their everyday practices, including lessons on how to shorten

appointments and how to cope with common problems. This form of technical assistance was extremely well-received and practices planned to continue follow-up progress monitoring with Dr. Robinson moving forward. As one participant remarked following Dr. Robinson's TA Visit that was conducted on-site,

I think this TA visit was invaluable to our clinic, especially the time she spent shadowing and modeling the program at each clinic. Having that one-on-one time with each of the social workers helped her to address any concerns we may have had, as well as allowed her to see how our own therapy styles could work within this model.

CIBHA Project Team Member Interview Findings

Shortly following the CIBHA Wrap-Up conference, the CIBHA Project Team members felt that the lessons that they had learned from a program management perspective needed to be further explored and reflected upon since other communities could most benefit from the CIBHA Team experiences. The Team Members were able to expand upon many of these themes highlighted throughout the report. These additional findings from those interviews are presented in aggregate in Appendix E. Lessons Learned and Conclusions are presented below.

Team members were asked: What were your major lessons learned from working on the CIBHA Project? If another institution were to take on a similar project, what advice would you give?

1. **Provide clear and consistent Project Goals and Objectives with an Overall Project Plan.**

The most salient theme that arose from the lessons learned by team members was the necessity of clearly laying out goals, objectives, deliverables, and project team members' roles and responsibilities. This theme came up in the responses in every area of the interview and was cited as the most common hindrance to team members in fulfilling aspects of their work on the Project.

When it comes to a program it's important to have a clear goal, clear objectives, actual deliverables that you must meet in order for the project to be effective.

Team members furthered that the project should be based on a framework that is clear and well communicated to everyone on board. Also, Project Team Members reiterated that the Evaluation Team should be an integral part of the team from the onset of the program.

2. **Provide adequate financial incentives.**

Team members also articulated that the grantees needed to be appropriately financially incentivized in a program like CIBHA, in which-- for some--required a major restructuring of how the organization operates. As one team member explained:

Though financial incentives were offered, it was poorly communicated and did not accommodate organizations with a high number of patients. In addition, the grantees need to be involved from the beginning and a plan needs to be geared towards each organization's feasible level of integration.

Team members concluded that one of the most important lessons learned was: primary care organizations will not generally focus on mental health issues on their own or without an incentive. They furthered that funders must build in specific, clear and sufficient incentives.

3. **Combine and leverage efforts with any relevant on-going projects.**

The team members found that rolling CIBHA into PCASG should have been a preliminary step, which also ties in with the necessity of financial incentives:

When you have a project that is very closely related to another very large, well-funded project that has QI goals, that you would try to leverage the larger funding's resources and integrate the two projects. They could have been more seamless and we could have leveraged funding (and had) money to dedicate to CIBHA participation and incentivize that.

4. **Offer tangible products.**

Team members articulated that CIBHA should have created and offered more tangible tools for the participating organizations--a toolkit that could be used in lieu of an in-house consultant:

This toolkit should be based on the need from the grantee and should be adaptable. A toolkit would be especially useful in instances of high turnover rates within the organization.

5. **Have clearly mandated requirements of partner agencies.**

One issue that arose in relation to the Evaluation was that a partner agency that was sub-contracted to deliver trainings on behalf of CIBHA was unable to provide LPHI with the follow-up data from their training. A way to avoid this in the future is to specify the delivery of evaluation data as a requirement in the partner agency's contract.

In the future, I think that ought to be a lesson learned that when you pay some entity for a training or to put on a workshop, that they be able to provide the data back to us.

6. **Have consistent leadership.**

Changes in leadership led to confusion among Project Team Members and a shift in the direction of CIBHA. Though this was in part due to unavoidable staff turnover, it nevertheless was a problem; the team members have suggested that program leadership needs to remain consistent for a project like CIBHA to be successful. Team members credited CIBHA with introducing and promoting the idea of integration to the grantees. The trainings and roundtables were well received by the grantees and the team members, and team members feel that the Evaluation Team was able to collect rich qualitative data that will be beneficial to further similar behavioral health initiatives.

The overwhelming consensus reported by the Project Team Members was that, in the future, all of the nuances of the project need to be clearly and explicitly laid out to avoid confusion and to better reach the project goals.

7. **Know the data collection abilities and limitations of grantee organizations.**

One team member explained that it would be helpful to have resource poor institutions who may not have the means to fully participate only be involved on a limited level—maybe by simply receiving technical assistance. This would require of the grantee organizations that they realize

…their limitations in terms of their own ability to provide quality data for purposes of evaluation

8. **Develop a clear sense of funding stream's capabilities.**

The team member interviews revealed that financial sustainability is difficult to attain without a comprehensive knowledge of where the funding would be to support the changes. They explained that to do so would require finding out if organizations are able to bill for care management services--or just the capacity to bill correctly--and also to ensure that whatever insurers the organizations are working with are paying them appropriately. They furthered that this problem was really a national one in that insurers have caveats regarding which behavioral health services they will pay for, and those they will not.

9. **Ensure commitment within the Project Team.**

One team member had also cited that ensuring commitment within the Project Team was one of the facilitators within the CIBHA Project and why it was able to have the success that it did. It referred to both the CIBHA Project Team in addition to the grantee organizations. They furthered that commitment implied working towards a common goal and being willing to be invested in the project for its duration. The team member explained that this should be assessed at the beginning so that those who are not committed can be excluded from participating in the project.

10. **Have a centralized administrative person responsible for scheduling, meetings, and timelines.**

The team members found that having a centralized administrative person responsible for scheduling meetings, and monitoring timelines is an important piece in moving a project such as CIBHA along, and keeping team members on the same page. They furthered that this person should also have skills in

getting people to be invested and willing to give their time and be flexible to maintain the time table for the project

The team members noted that CIBHA did this successfully and that it should be replicated in any further similar projects.

11. **Build in data collection systems from the beginning.**

Some team members recommended that building in data collection systems from the beginning of the project would allow the team members to provide grantee organizations routine feedback.

As new processes were being implemented, they explained, often there was not the capacity to see how it was working. The team member explained that there was a lack of "real time data", and that if they had been able to access that, it would've aided in adjusting strategies when necessary and maintaining the motivation of the organizations to be involved in the project.

CIBHA Workshops and Training Sessions Evaluation Summaries

Annual Conferences

Many of the attendees of the CIBHA Kickoff Event reported an increase in knowledge, for example: at the beginning of Day One, 31% reported that they were at an advanced knowledge level of the content of the conference whereas by the end of Day Two 50% of participants reported being at an advanced knowledge level. Sessions were evaluated as being "very helpful" at minimum 40% of the time with the majority of sessions scoring between "somewhat helpful" and "very helpful". Participants felt the small group and interactive discussions, the practical tools and handouts, and the PHQ-9 training were some of the most effective areas and least effective elements included too heavy of a focus on depression in primary care and a too heavy focus on the adult population. Requests for further technical assistance were made for the following areas: care management, disease registry, financial sustainability, and the inclusion of child and adolescent populations. Many of the technical assistance requests were future topics of the interactive Roundtables.

Sessions that were most commonly rated as "very useful" during the CIBHA Integrative Care in Action Conference were "Strengthening Relationships Between Primary Care and Behavioral Health" at 92.3% and "Clinical Cases: Treatment Non-Response, Medication Side Effects and Office Counseling" at 91.7%. Some of the areas cited as most effective were the panel discussion, the NCQA standards/tools, and the break-out sessions. Areas cited as least effective were: items that participants felt were too specific to the state, and the care management portion.

Sessions that were particularly well received in the CIBHA Wrap Up Conference were: "Successes and Challenges in Linking Behavioral and Primary Health Care in Louisiana Clinics", with 77% indicating it was "very useful", and "Primary Care Behavioral Health: A Global View" with 81% indicating it as being "very useful". Many participants reported an increase in knowledge after the conference: 28% labeled themselves as having an advanced level of knowledge at the beginning of the conference and by the end of the conference that number had increased to 56%. Overall, 88% of respondents rated the conference as "very good" or "excellent".

Roundtables

"De-escalating Aggressive Behavior" was well received: 20% of respondents felt they had an advanced level of knowledge before the roundtable and 68% felt they had an advanced level of knowledge after. Specifically, respondents felt the role-playing and real life demonstrations were especially effective. Requests for further technical assistance were made in the areas of referrals and services available.

The most effective elements of the "Implementing Brief Action Planning into Practice" Roundtable, as reported by participants, were the interpersonal delivery, the client empowered approach, the handouts, and the step-by-step Brief Action Planning procedure. All respondents labeled the Roundtable as "very good". Respondents requested further training in motivational interviewing and working with children and adolescents.

Areas of the "Adolescent Behavioral Health" Roundtable that were well received were: the discussion on suicide, the doctor's knowledge, and the sharing of cases and experiences. Almost all feedback was positive, though consistently respondents would have liked more time with the speaker, Mayling Walker.

The cited most effective elements of "Referrals to Metropolitan Human Services District" were that it is a useful community resource and the fact that there were people from each section of the agency present to give information on the services available.

Continuing Professional Education Series

Dr. Steve Cole's "Psychopharmacology of Depression: Core Concepts, New Data, and Participant interviews" and "Brief Action Planning: An Adaptation of Motivational Interviewing" were well received: 100% of attendees would have recommended the courses to their colleagues. Ninety-six percent of the participants said they felt the learning objectives were met. Some of the feedback from the participants, regarding changes they would make as a result of the conference, was "I will empower my patients more so that they can use their problem-solving skills to a greater degree" and (a participant said they) "will explain the treatment plan in more detail to patients." Specific areas that were cited as effective were: the presentation of medication and its effectiveness, the crowd participation, and the lessons on motivational interviewing. Some participants felt that the conference was a little too general and lacked specific skill use and content.

Dr. Patricia Robinson's "What Are You Doing; How Does It Work; and What Else Could You Do?" workshop was also well received: 96% of respondents said they would recommend the course to their colleagues. Eighty-five percent of attendees believed the learning objectives were met; 86% of attendees said that their daily practices would change as a result of the workshop. Cited changes attendees said they would be making included: (participant said they would) "address patient as a whole" and "try to get a behavioral health worker". Some areas in which further technical assistance was requested was in sustainability, barriers of integration between behavioral health practices and primary care practices, domestic violence, and sexual addiction.

UMASS Medical School Certificate Program in Primary Care Behavioral Health

The three components of the UMASS workshop--"Culture and Language", "Behavioral Heath Needs in Primary Care", and "Consulting With MDs" received positive remarks: "Consulting with

MDs" being the highest, with about 91% of respondents saying it was "very useful". Ninety percent of respondents rating the workshop as "very good" or "excellent", with 63.4% reporting improvements in their knowledge and skills in the presented areas. Cited effective areas of the workshop included: the group discussion and presentations on different cases samples, the presenter's expertise, and the learned new techniques to utilize with clients and patients. Future technical assistance requests were made in the following areas: electronic health system usage and disease registry database, motivational interviewing, financial sustainability, and case management vs. care manager behavioral health consultant.

PCASG Data Relevant to CIBHA:

The PCASG program collected data on the PCASG grantee organizations and their respective service delivery sites. The CIBHA Project Team studied the PCASG dataset to see if there were any findings or lessons to be learned that could inform the CIBHA effort. The PCASG dataset was examined for the following:

Quantitative:

1. What was the distribution of behavioral health diagnoses among patients in primary care and behavioral health settings?

2. What is the pattern of diagnoses in primary care and behavioral health settings across behavioral health categories?

3. Did the intensity (visits per patient) of services change among patients with a behavioral health diagnosis?

4. Did the number of behavioral health providers in primary care settings change?

Definitions, Data Sources and Data Collection Activities

Definitions

Patient Encounter Data – includes patient encounter dates, first and second diagnosis ICD-9 codes, examining provider type, and encounter location. Data reported includes all encounters in which services were delivered by the PCASG clinic/subawardee organizations, not just those encounters that were made possible as a direct result of PCASG funds.

Clinic Staffing -- refers to data collected about each PCASG service delivery site's staffing profile. This includes total number of providers at each clinic delivery site and their full time equivalency (FTE).

Information analyzed for evaluation purposes was collected via the following data sources:

Data Source	Description	Frequency	Use (how used in analysis)
PCASG Supplemental Payment Package	Excel workbook including patient encounter (visit) data, and detailed clinic staffing, such as provider types and full time equivalency (FTEs).	Quarterly	Characterizing changes in participant org capacity and populations

Data Source	Description	Frequency	Use (how used in analysis)
Administrative Data	Programmatic administrative data including PCASG and CIBHA participant records and core reference documents, such as award amounts, Quality Improvement reports, site visit forms, participation in technical assistance activities, etc	Ongoing	Determine level of engagement with CIBHA / NCQA / Chronic Care Model

The CIBHA evaluation also draws upon findings from some external data sources as well. External Data Sources include:

External Data Sources

Data Source	Description	Frequency	Use (how used in analysis)
The Commonwealth Fund, Survey of New Orleans Clinic Patients	Face-to-face survey of PCASG primary care clinic patients in Orleans parish only; surveys were conducted in waiting rooms of PCASG clinics with patients prior to and immediately following their visit.	One Time Only (March 2009)	Understand the experiences of patients in the PCASG clinics, and learn whether the clinics have become medical homes for patients, to understand the effect of medical homes on the quality of care.
Behavioral Risk Factor Surveillance Survey System (BRFSS)	Centers for Disease Control conducted telephone survey to track health conditions and risk behaviors in the US yearly.	Annually	Provide context regarding mental health status of population prior to and during the course of CIBHA

Methods

The PCASG data relevant for CIBHA includes: patient visits, provider FTE, and site (clinic) information were analyzed. Findings reported here examine changes over the two year period in these data. Diagnosis data was not reported in the first year of the grant.

Specific changes examined in the three year periods were examined to determine whether the access to and use of behavioral health care had improved, including: the number and intensity (# visits per patient) of patients receiving care for a behavioral health diagnosis; the numbers of sites which offered integrated care; the FTE (full time equivalent) for all behavioral health care providers; and the diagnosis of a mental health condition using the HRSA's Bureau of Primary health Care's Uniform Data Reporting System. For purposes of this analysis, patients and visits have been categorized into the following groupings according to their diagnosis code(s):

The following reference was used to categorize diagnosis codes used for the analysis:

- Patients with a Behavioral Health (BH) Diagnosis – patient was diagnosed with a behavioral health condition, specific ICD-9 CM codes specified by Harold Pincus via 'Personal Communication – Mark Olfson, MD' .
- Patients with a General Medical (GM) Diagnosis – patient was diagnosed with any specified condition with an ICD-9 CM code other than those identified as behavioral health specific ICD-9 CM codes specified by Harold Pincus via 'Personal Communication – Mark Olfson, MD' .
- codes or that were documented as "Other unknown/unspecified cause".
- Patients Missing a Diagnosis - patients are those with NO diagnosis reported during the two years reported here.
- **NOTE: Patient is categorized as a Behavioral Health patient if diagnosed with a behavioral health condition EVER during the year under PCASG. Patient is categorized as a General Medical patient if patient was NEVER diagnosed with a behavioral health condition under PCASG.**
- Visits with a Behavioral Health (BH) Diagnosis – visit documented a behavioral health condition specific ICD-9 CM codes specified by Harold Pincus via 'Personal Communication – Mark Olfson, MD' .
- Visits with a General Medical (GM) Diagnosis – visit documented a general medical condition other than behavioral health or other unknown/unspecified cause.
- Visits Missing a Diagnosis – visit was missing a documented diagnosis or one that fit under the behavioral health / general medical category, such as "Other unknown/unspecified cause" or V codes.

Limitations Associated with the Quantitative (PCASG Supplemental Payment Package Data):

In an effort to reduce reporting burden on the PCASG/CIBHA participants, CIBHA relied heavily upon data reported for PCASG. However, data collected for PCASG was primarily to ensure

compliance with grant requirements and to supply a dataset upon which the PCASG payments could be based, as opposed to a clinical dataset for research and/or evaluation purposes.

Additionally, the Greater New Orleans metropolitan region currently does not have a Master Patient Index or means of calculating unduplicated patient counts across organizations. While PCASG did collect unique medical record numbers for patients served, individual patient counts were only unduplicated within each of the 23 organizations. Overlap of any shared patients between organizations cannot be determined.

Thus, only the following data elements were audited for compliance with "eligible encounter "criteria (e.g. eligible for payment):

Table 5: Limitations Associated with the Quantitative Dataset:

PCASG SPP Data Element	Limitations Associated with Data Element:
• Encounter date (to ensure encounter dates fell within eligible reporting periods)	• None
• Encounter location (to ensure that encounters took place at an eligible PCASG site)	• None
• Patient Date of Birth, Gender, Race and Ethnicity (to capture demographics of population served; Patient Date of Birth was also used for weighting purposes)	• Patient Race and Ethnicity were often not reported/missing from patients
• Patient Zip Code (to ensure that the patient resided in the catchment area)	• None
• Patient Insurance Type (to assign payment weight factors)	• None, although it is important to note that some patients with insurance choose to self-pay for behavioral health visits
• Provider Type (to assure that the encounter was conducted with a licensed Louisiana provider)	• Provider type was audited to determine if the encounter was performed with an eligible (e.g. LA licensed) provider type
• Diagnosis Code (ICD-9; DSM-IV) (to ensure that the reported encounter diagnosis matched the diagnosis in the patient record)	• Only primary and secondary diagnosis codes were requested for PCASG reporting, thus additional diagnosis codes were not collected that may have contained behavioral health diagnoses resulting in a potential under-reporting of prevalence of BH conditions among PCASG patients. Additionally, there was no audit process for determining whether or not the codes reported were in fact the primary and secondary diagnoses. PCASG chart audits commonly revealed that Primary Care Practices were <u>not</u> routinely coding or

	reporting behavioral health diagnoses and/or treatments in their information systems.
• Provider FTEs	• Provider FTEs were self-reported. Some agencies may not have updated their FTEs each period; additionally, some practices only reported PCASG-funded providers and did not capture additional behavioral health staff funded by other entities; there also existed some challenges in the early rounds regarding definitions of provider types and whether or not to report non-licensed BH staff

Finally, a major limitation associated with the quantitative data reported under the PCASG is that most organizations were extracting patient encounter data from their billing systems – and behavioral health encounters in a primary care setting were not billable encounters under the State's Medicaid policies. Thus, many of the primary care practices were not well trained or experienced with coding and reporting for behavioral health services. As a result, many primary care practices did not report their behavioral health encounters.

As this multitude of challenges unfolded regarding use of the PCASG dataset for CIBHA evaluation purposes combined with the inexperience and inability of the CIBHA participants to capture and report behavioral health encounters that were happening within the context of primary care visits with primary care providers, the CIBHA Project Team Members realized that the evaluation for the CIBHA project would have to rely more heavily on the rich qualitative data captured and less on the quantitative data findings.

Results

Quantitative (from PCASG Supplemental Payment Package):

1. What was the distribution of behavioral health diagnoses among patients in primary care and behavioral health settings?

Overall, approximately 30% of the total patients seen within the PCASG program had a behavioral health diagnosis in Years 2 and 3 (Table 1a). About 78% of all patients were seen in a primary care setting, and 22% in a behavioral health setting, as reported by each PCASG grantee.

Whereas there was a decrease from Year2 to Year3 in the total number of patients seen under PCASG, and in the percentage of patients with a behavioral health diagnosis, this trend differed by the type of health care setting. Table 1b shows that the percentage of patients seen in a primary care setting who had a behavioral health diagnosis increased very slightly, while those with a general medical diagnosis showed a decrease. Similarly, a slight increase occurred in the percentage of patients with a general medical diagnosis in a behavioral care setting, with a concomitant decrease in behavioral health diagnosis (Table 1c). This may have been due to several initiatives spearheaded by CIBHA, such as increased screening for behavioral health conditions among primary care settings, and/or increased confidence of primary care providers to diagnose and manage patients with behavioral health conditions as a result of CIBHA educational workshops.

An increase in the percentage of patients with no diagnosis reported should be addressed. Many of the organizations were not recording diagnosis codes, particularly for behavioral health conditions. Interviews with clinicians during site visits revealed a hesitation to record diagnoses for behavioral health conditions for fear of stigmatizing patients. This may suggest that the increased percentage of patients with no reported diagnosis may be related to an increased number of patients being seen for a behavioral health condition.

Table 1a: Distribution of Total Patient Volume by Setting[a] and by Diagnosis[b] Type Period: September 2008 to September 2010

	Year2		Year3	
	#patients	% of all patients	#patients	% of all patients
Total patients seen	**116015**	**100%**	**113676**	**100%**
Patients seen in a PC setting[a]	88904	76.6%	88798	78.1%
Patients seen in a BH setting	27111	23.4%	24878	21.9%
Patients with a BH Diagnosis[b]	34851	30.0%	32018	28.2%
Patients with a GM Diagnosis	72441	62.5%	71185	62.6%
Patients Missing Diagnosis	8723	7.5%	10473	9.2%

[a] :PC=patient received care in a primary general medical care setting defined by the clinic/site type, as reported by the CIBHA grantee. BH= behavioral care setting. Dental & Ophthalmology clinics are omitted. School-Based Health Centers are included as Primary Care settings.

- [b]BH=Patient diagnosed with behavioral health condition specific ICD-9 CM codes specified by Harold Pincus via 'Personal Communication – Mark Olfson, MD' .
- . GM is a general medical condition which includes all other reported diagnoses. Patients missing diagnosis are those with none reported at any time during the period.

Patients are unduplicated within each clinic and each year

Table1b : Type of Diagnosis for Patients seen in a Primary Care Setting Period: September 2008 to September 2010

	Year2		Year3	
	#patients	% of all patients	#patients	% of all patients
Total patients seen in PC Setting	**88904**	**100%**	**88798**	**100%**
Patients with a BH Diagnosis	9786	11.0%	9850	11.1%
Patients with a GM Diagnosis	71450	80.4%	69962	78.8%
Patients Missing Diagnosis	7668	8.6%	8986	10.1%

Table1c : Type of Diagnosis for Patients seen in a Behavioral Care Setting Period: September 2008 to September 2010

	Year2		Year3	
	#patients	% of all patients	#patients	% of all patients
Total patients seen in BH Setting	**27111**	**100%**	**24878**	**100%**
Patients with a BH Diagnosis	25065	92.5%	22168	89.1%
Patients with a GM Diagnosis	991	3.7%	1223	4.9%
Patients Missing Diagnosis	1055	3.8%	1487	6.0%

2. What is the pattern of diagnoses in primary care and mental health settings across mental health categories?

The most common single behavioral health diagnosis reported over the course of PCASG in both primary and behavioral health settings for **adults** was depression / mood disorders (Tables 2a & 2b). Anxiety disorders were also commonly reported in primary care settings, which includes post-traumatic stress disorder (PTSD) and post-traumatic stress syndrome (PTSS).
The other large category was "Other Mental Disorders", which were overwhelmingly related to substance abuse disorders.

Table 2a: Specific Behavioral Health Diagnoses[a] Reported for ADULTS in Primary Care Setting[b] (A patient can have >1 diagnosis listed)

	Year2		Year3	
Total patients seen	88904		88798	
Total ADULT patients seen	72287		72747	
Total ADULT patients with BH Diagnosis	8471		8472	
	#patients	**% of all ADULT patients**	**#patients**	**% of all ADULT patients**
Schizophrenia/other psychoses	301	0.4%	287	0.4%
Depression / mood disorders	2897	4.0%	3160	4.3%
Bipolar disorders	400	0.6%	441	0.6%
Anxiety disorders	2315	3.2%	2381	3.3%
Childhood disorders / mental retardation	486	0.7%	494	0.7%
Adjustment disorders	296	0.4%	201	0.3%
Other mental disorders	3527	4.9%	3034	4.2%

Discrepancies in number of patients from previous tables due to missing age; at most only 0.2% of all patients.Adults are 19 and older.

- [a] :Behavioral Health diagnostic specific ICD-9 CM codes specified by Harold Pincus via 'Personal Communication – Mark Olfson, MD' .

[b] :PC=patient received care in a primary general medical care setting defined by the clinic/site type, as reported by the CIBHA grantee. Dental & Ophthalmology clinics are omitted. School-Based Health Centers are Primary Care.

Table 2b: Specific Behavioral Health Diagnoses[a] Reported for ADULTS in Behavioral Care Setting[b] (A patient can have >1 diagnosis listed)

	Year2		Year3	
Total patients seen	27111		24878	
Total ADULT patients seen	21019		19089	
Total ADULT patients with BH Diagnosis	19486		17054	
	#patients	**% of all ADULT patients**	**#patients**	**% of all ADULT patients**
Schizophrenia/other psychoses	4314	20.5%	3940	20.6%
Depression / mood disorders	7668	36.5%	6773	35.5%
Bipolar disorders	3046	14.5%	2877	15.1%
Anxiety disorders	3608	17.2%	3377	17.7%
Childhood disorders / mental retardation	1325	6.3%	1279	6.7%
Adjustment disorders	534	2.5%	468	2.5%
Other mental disorders	7810	37.2%	6957	36.4%

Discrepancies in number of patients from previous tables due to missing age; at most only 0.2% of all patients. Adults are 19 and older.

- [a] :Behavioral Health diagnostic specific ICD-9 CM codes specified by Harold Pincus via 'Personal Communication – Mark Olfson, MD' .

[b] :BH=patient received care in a behavioral care setting defined by the clinic/site type, as reported by the CIBHA grantee. Dental & Ophthalmology clinics are omitted. School-Based Health Centers are Primary Care.

Among the pediatric / adolescent population, attention deficit / hyperactivity disorder (ADHD) was the single most commonly reported behavioral health diagnosis in both primary and behavioral health care settings (see Tables 2c & 2d).

Table 2c: Specific Behavioral Health Diagnoses[a] Reported for ADOLESCENTS in Primary Care Setting[b] (A patient can have >1 diagnosis listed)

	Year2		Year3	
Total patients seen	88904		88798	
Total ADOLESCENT patients seen	16460		15950	
Total ADOLESCENT patients with BH	1307		1377	
Diagnosis	**#patients**	**% of all ADOLESCENT patients**	**#patients**	**% of all ADOLESCENT patients**
Schizophrenia/other psychoses	6	0.0%	14	0.1%

Bipolar disorders	25	0.2%	60	0.4%
Pervasive developmental disorders & retardation	53	0.3%	36	0.2%
Disruptive behavioral disorders	162	1.0%	136	0.9%
Attention deficit/hyperactivity disorder (ADHD)	607	3.7%	710	4.5%
Depression / mood disorders NOS	161	1.0%	189	1.2%
Anxiety disorders	160	1.0%	160	1.0%
Adjustment disorders	135	0.8%	87	0.5%
Communication & learning disorders	89	0.5%	90	0.6%
Other mental disorders	176	1.1%	219	1.4%

Discrepancies in number of patients from previous tables due to missing age; at most only 0.2% of all patients.Adolescents are under 18 years.

- [a] :Behavioral Health diagnostic specific ICD-9 CM codes specified by Harold Pincus via 'Personal Communication – Mark Olfson, MD' .

[b] :PC=patient received care in a primary general medical care setting defined by the clinic/site type, as reported by the CIBHA grantee. Dental & Ophthalmology clinics are omitted. School-Based Health Centers are Primary Care.

Table 2d: Specific Behavioral Health Diagnoses[a] Reported for ADOLESCENTS in Behavioral Care Setting[b] (A patient can have >1 diagnosis listed)

	Year2		Year3	
Total patients seen	27111		24878	
Total ADOLESCENT patients seen	6070		5773	
Total ADOLESCENT patients with BH Diagnosis	5562		5101	
	#patients	**% of all ADOLESCENT patients**	**#patients**	**% of all ADOLESCENT patients**
Schizophrenia/other psychoses	65	1.1%	79	1.4%
Bipolar disorders	169	2.8%	156	2.7%
Pervasive developmental disorders & retardation	424	7.0%	401	6.9%
Disruptive behavioral disorders	1661	27.4%	1588	27.5%
Attention deficit/hyperactivity disorder (ADHD)	2924	48.2%	2827	49.0%
Depression / mood disorders NOS	1226	20.2%	1179	20.4%
Anxiety disorders	992	16.3%	859	14.9%
Adjustment disorders	426	7.0%	362	6.3%
Communication & learning disorders	378	6.2%	291	5.0%

Other mental disorders	783	12.9%	788	13.6%

Discrepancies in number of patients from previous tables due to missing age; at most only 0.2% of all patients. Adolescents are under 18 years.

- [a] :Behavioral Health diagnostic specific ICD-9 CM codes specified by Harold Pincus via 'Personal Communication – Mark Olfson, MD' .

[b] :BH=patient received care in a behavioral health care setting defined by the clinic/site type, as reported by the CIBHA grantee. Dental & Ophthalmology clinics are omitted. School-Based Health Centers are Primary Care.

3. Did the intensity (visits per patient) of services change among patients with a behavioral health diagnosis and what was the intensity of the visits?

Whereas the total visits per patient with a behavioral health diagnosis increased under PCASG from Year 2 to Year 3(see Table 3a), further cross-section of the data reveals that total visits per patient with a behavioral health diagnosis seen in primary care settings did not increase (see Table 3b). In the primary care setting, it appears that patients with a behavioral health diagnosis generally experienced about 1 visit less than patients without a behavioral health diagnosis. There was also little variation in total visits per patient in the primary care setting from year to year.

Contrastingly, greater variation in total visits per patient from year to year was seen in the behavioral health setting. On average, visits per patient tended to be higher in a behavioral health setting than in the primary care setting. However, whereas the number of visits per patient in the primary care setting was decreasing for a patient with a behavioral health diagnosis from Year 2 to Year 3, the number of visits for a patient with a behavioral health diagnosis in a behavioral health setting increased. Total visits for patients without a behavioral health diagnosis in a behavioral health setting slightly decreased from Year 2 to Year 3.

Table 3a: Changes in the Intensity of Services (Visits per Patient) by Diagnosis
Period: September 2008 to September 2010

	Year2	Year3
All patients	3.5	3.6
Total visits per patient w/ BH diagnosis[a]	5.1	5.8
Total visits per patient w/ GM diagnosis	2.9	3.2

[a]: BH=Patient diagnosed with behavioral health condition specific ICD-9 CM codes specified by Harold Pincus via 'Personal Communication – Mark Olfson, MD,'

Table 3b: Changes in the Intensity of Services (Visits per Patient) by Diagnosis and by Setting
Period: September 2008 to September 2010

	Year2	Year3
PC setting		

Total visits per patient w/ BH diagnosis[a]	2.2	2.0
Total visits per patient w/GM diagnosis	2.9	3.2
BH setting		
Total visits per patient w/ BH diagnosis[a]	6.2	7.4
Total visits per patient w/ GM diagnosis	5.3	5.2

[a]: BH=Patient diagnosed with behavioral health condition specific ICD-9 CM codes specified by Harold Pincus via 'Personal Communication—Mark Olfson, MD,'

4. Did the number of behavioral health providers in primary care settings change?

PCASG attempted to collect "types of services offered" by service delivery site over time; however, the diversity among the sites with regard to their sophistication in the level of data collection and reporting created unique challenges to obtaining quality data in this area. LPHI offered ongoing technical assistance based on each grantee's needs to address these issues, but were more successful with some grantees than others. As a proxy for the number of service delivery sites offering integrated or co-located behavioral health services onsite, LPHI examined the staffing profiles to identify behavioral health positions (e.g. psychologists, LCSWs) of sites in order to determine whether or not primary care sites were staffing behavioral health providers over time. **The number of primary care sites with behavioral health staff increased from 13 sites to 20 sites over the course of PCASG.**

Tables 4a depicts the change in staffing among primary care sites by year. In terms of behavioral health, table 4a shows that the greatest growth within the primary care setting was among psychiatrists.

Table 4a: Change in the Number of BH Providers (FTEs) by Year – PC Setting

	Year1		Year2			Year3			
Provider type	**#providers**	**FTE**	**#providers**	**FTE**	**% change in FTE**	**#providers**	**FTE**	**% change in FTE**	**% change Overall**
Physicians	140	63.1	163	71.8	14%	159	65.5	-9%	**4%**
Physician Extenders	43	34.8	44	32.6	-6%	44	29.8	-9%	**-14%**
Psychiatrists	9	2.8	12	3.2	14%	16	3.8	19%	**36%**
Psychologists, LCSWs & Equivalents	25	15.7	28	13.5	-14%	33	14.6	8%	**-7%**
Masters-level, non-licensed providers	10	8.7	12	10.8	24%	10	7	-35%	**-20%**
Total	227	125	259	131.9	5%	262	121	-8%	**-4%**
Total BH providers only	44	27.2	52	27.5	1%	59	25.4	-8%	**-7%**

Provider type descriptions: Primary Care Physicians (MD's): categories are physicians specializing in general practice, family practice, internal medicine, and pediatrics. Physician Extenders: categories are physician

assistants, nurse practitioners, and certified nurse midwives. LCSWs & Equivalents: categories are LCSW, psychologists (PhD), Licensed Addiction Counselors, Licensed Professional Counselors, Licensed Marriage and Family Therapists. Masters-level, non-licensed: refers to all individuals with a master's degree that provide counseling or other behavioral health service.

The number of providers are unduplicated within year only.

In the context of all sites, Table 4b shows the change in the number of providers and FTEs by type across all PCASG settings by year. Overall, there was no change in FTEs among physicians, but a 1% increase in FTEs of psychiatrists. The greatest decrease was seen amongst masters-level non-licensed behavioral health providers (such as MSWs and GSWs), resulting in an overall decrease by 15% among behavioral health providers from Year 1 to Year 3 of the PCASG. Year 2 reflects a peak amongst provider capacity.

Table 4b: Change in the Number of BH Providers (FTEs) by Year – All Settings

	Year1		Year2			Year3			
Provider type	**#providers**	**FTE**	**#providers**	**FTE**	**% change in FTE**	**#providers**	**FTE**	**% change in FTE**	**% change Overall**
Physicians	177	72.4	198	78.8	9%	192	72.5	-8%	**0%**
Physician Extenders	43	34.8	44	32.6	-6%	44	29.8	-9%	**-14%**
Psychiatrists	85	35.8	83	40.2	12%	80	36.2	-10%	**1%**
Psychologists, LCSWs & Equivalents	157	117.7	156	111.5	-5%	154	103.6	-7%	**-12%**
Masters-level, non-licensed providers	61	56.7	82	77.3	36%	78	38.6	-50%	**-32%**
Total	523	317	563	340	7%	548	281	-18%	**-12%**
Total BH providers only	303	210.2	321	229	9%	312	178.4	-22%	**-15%**

Provider type descriptions: Primary Care Physicians (MD's): categories are physicians specializing in general practice, family practice, internal medicine, and pediatrics. Physician Extenders: categories are physician assistants, nurse practitioners, and certified nurse midwives. LCSWs & Equivalents: categories are LCSW, psychologists (PhD), Licensed Addiction Counselors, Licensed Professional Counselors, Licensed Marriage and Family Therapists. Masters-level, non-licensed: refers to all individuals with a master's degree that provide counseling or other behavioral health service.

The number of providers are unduplicated within year only.

Findings from External Data Sources:

Findings from the results of the 2009 survey of New Orleans primary care clinic patients confirm that the implications of integrated services are felt by patients. The Commonwealth Fund patient survey indicated that 78% of patients who needed to see a behavioral health professional were able to see a provider at their primary care clinic. Details about the type of provider that patients saw for a behavioral health service in their primary care clinic are shown below. Thirty six percent of patients reported that they saw their general physician for their behavioral health condition. This percentage is clearly higher than the 11% reportedly seen in the primary care setting for a BH condition noted in the PCASG dataset, which further confirms

the challenges expressed by the CIBHA participants with documenting and reporting behavioral health conditions seen in the primary care setting and highlighted within the PCASG dataset. The survey findings also revealed that patients were nearly seven times more likely to have an "excellent patient experience" where the doctor or medical professional talked to them about emotional concerns that were affecting their health in the primary care clinic (45%) as opposed to somewhere else (e.g. referred to a behavioral health site) (7%). Fifty one percent of patients who received behavioral health care in their primary care clinic rated the behavioral health care they received as "Excellent".

Type of Provider Seen for Behavioral Health Needs in Primary Care Clinics as Reported on The Commonwealth Fund 2009 Survey of New Orleans Clinic Patients

Percent	Provider Type
43%	Mental Health Counselor/Worker
40%	Psychiatrist
36%	General Practitioner
9%	Psychologist

SUMMARY OF LESSONS LEARNED

Behavioral health integration presents challenges for primary care systems under 'normal' circumstances. The CIBHA initiative provided LPHI with a unique opportunity to test the Chronic Care Model following a major natural disaster when the dearth of behavioral health specialists was even greater. Ongoing data collection and interviews, as well as using telephone-based consultation, were critical to identifying the needs of participating organizations and meeting those needs. In addition, the disparity between sites with regard to data collection and management created significant challenges to evaluating the impact of implementation of the clinical and economic/system changes by the sites.

Organizations initiating similar behavioral health integration projects must devote significant effort at the beginning of such initiatives to assess the capacity of sites to meet the data management requirements for participation and identify a list of data elements that can be collected and assessed among all sites. We also found that it was particularly challenging to combine data from numerous sources in order to evaluate the total impact of changes made by each site. In retrospect, it is evident that the data needs of the CIBHA project should have been incorporated into PCASG from the beginning of the initiative. In addition, the level of investment – both in terms of time and resources – by the leadership at participating organizations was a factor in the extent to which the site was able to participate in the CIBHA program and implement changes within their organization. The financing of behavioral health services – particularly following Hurricane Katrina - also affected the ability of CIBHA participants to implement sustainable economic and system changes.

While sites have been able to sustain some of the *system* changes implemented during the CIBHA initiative (e.g. depression screening, development of memos of understanding to facilitate ongoing integration of care), the delay with regard to the waiver has made it particularly

difficult to sustain payment for integrated services moving forward. The long-term success of the changes implemented through the CIBHA program will depend on the extent to which these changes meet the needs of and is acceptable to key stakeholders (e.g. patients, clinicians, economic leaders, and government) and the availability of clear, convincing evidence that the value of integrated care is greater than and differentiated from other approaches in terms of cost-effectiveness, improved quality, good clinical

Appendix