Integrated Care: Key Informant Interviews with Non-Grantees

A Brief Review of the Findings

August 2014

Overview

Over the last several years, the Maine Health Access Foundation (MeHAF) has invested heavily in projects to improve the integration of mental/behavioral health and primary health care services. To learn whether integrated care is disseminating to non-grantee organizations, two rounds of interviews with non-funded sites were conducted during the summer and fall of 2010 (round 1) and during the summer of 2014 (round 2). Organizations representing various sectors within the health system environment were identified, and representatives were invited to participate.

The interviews were designed to address the following evaluation questions:

1. Are non-MeHAF grantees aware of efforts to integrate primary and mental health care in Maine?
2. Have non-grantee organizations adopted or supported the adoption of integrated care efforts?
3. What could be done to accelerate the spread of integrated care in Maine and sustain efforts?

Brief Summary of Results

Non-Grantee Awareness of Integration

By all accounts, *most* of the respondents (both providers and non-providers) in both rounds of interviews were familiar with efforts to integrate primary and mental health care, and several gave examples specific to Maine. Many respondents had been aware of this concept for five or more years, and a few had previous experience working for an agency delivering integrated care or considering this approach. In recent years, the concept appears to have become more commonplace and its implementation less novel.

In addition to a relatively high level of awareness about the *concept* of integrated care, the interview findings also revealed positive views about the value and benefits of integration, particularly as they relate to patients. Several of the participants indicated their strong support for this approach despite the challenges. Interestingly, many of the respondents indicated a more thorough understanding and appreciation for the challenges and barriers to providing integrated care as their knowledge and experience with this approach increased.

While participants in round one had a *general understanding* of the notion of integrated care, it was difficult to determine the extent to which many of these interviewees fully understood the various aspect of integration, beyond the concept of co-location. However, respondents in round two appeared more sophisticated in their description of integrated care to include some of the key features. In some instances, interviewees from this second round also expanded their definition to include the integration of services beyond primary care and mental health.

Non-Grantee Adoption or Support of Integration

Among the providers, all were aware of efforts within their organization to integrate care and several provided specific examples of practice sites where primary and mental health care practitioners were co-located, engaging in a "warm hand-off" or coordinating care plans. Some sites were clearly more advanced in their efforts and the models of integration varied widely. However, there was general support for the adoption of integrated care in the provider agencies we interviewed.

In several sites, a strong interest among leaders and staff as well as the desire to more efficiently deliver care served as the impetus for integration efforts. Providing patient- centered care was also cited as an important factor. Interviewees from round two indicated increased attention being placed on integrated services among the State agencies and among funders.

Despite a *general level* of knowledge about existing integration efforts in the provider organizations, it was somewhat difficult to ascertain with certainty the *extent* to which integrated care was being implemented, including its reach and organization-wide diffusion. Several providers indicated implementing new screening or assessment tools, hiring new staff, changing the work roles of existing staff, forming teamwork structures, collecting data, providing training, and adopting or moving to implement electronic health records. However, it was hard to determine whether these activities were primarily driven by a desire to integrate efforts or if there was a different driving force. Moreover, it was also difficult for the providers to *quantify* the extent of integrated care within their organization due to lack of data and vast differences across practice sites.

Yet, despite the challenges with assessing the reach of integrated care, we did learn that providers in round two appeared to be enthusiastic about this approach. The providers said, "We are doing it everywhere we can" and "The potential is there to use it extensively." Although some organizations were in the early stages, expansion of integrated care was described as part of the strategy for providing more patient centered care.

Among the non-providers, most were able to share specific examples of their efforts in "promoting or supporting the use of integrated care." These included convening and engaging stakeholders and providing education, among others. Again, this group was overwhelmingly supportive of efforts to expand models of integrated care throughout the state.

Non-Grantee Opinions about Accelerating Integration

The issue of funding surfaced as a major theme related to the spread and sustainability of integrated care efforts in Maine. Several interviewees spoke of the need for creating a sustainable system focused on payment reform efforts, providing financing for "start-up," avoiding reimbursement structures that "limit access" in terms of who pays and where you can go to receive services, and identifying "pathways to implementation."

Interviewees in round two also discussed the need to address integration in more rural areas or among smaller practices with limited resources. Pooling resources, identifying models that work and training emerging providers were all strategies that were identified to expand and accelerate integrated care in Maine.

Other specific strategies discussed by interviewees included:

- Disseminating data on best practices and the effectiveness of various models
- Sharing outcomes that support integrated care delivery models
- Engaging key constituents to help advocate and disseminate information
- Promoting greater awareness among the public
- Providing technical assistance to teams and organizations on "how to" integrate care by translating research to practice
- Educating about, and advocating for, integrated care with stakeholders and policy makers

Conclusions

Overall, the findings revealed a relatively high level of awareness among interviewees regarding the concept, value and challenges of integrated care. While some participants, particularly in round one, were less familiar with all of the components that make up an integrated care model, there was clear consistency in the perceived benefits among most interviewees.

The results suggest that efforts are indeed underway among non-grantees to implement and support integrated care. However, in order to enhance existing efforts and achieve the vision of an integrated system of care available to everyone in Maine, financial and regulatory reform is needed to support a variety of models that adequately reflect and address the demographic and provider needs of a community. In addition, greater public awareness and support could help accelerate the demand for integrated care.