Patient Centered Care Integration Initiative: Rounds I, II and III

A Summary of Findings

Final Report

March, 2014

Prepared for:
Maine Health Access Foundation
150 Capitol Street, Suite 4
Augusta, ME 04330
Phone: 207.620.8266
Website: www.mehaf.org

Prepared by:
Brenda M. Joly, PhD, MPH
Email: brendajoly@msn.com
Phone: 207.233.7647

Table of Contents

Overview

Over the last several years, the Maine Health Access Foundation (MeHAF) has invested $10 milliobn in the area of patient and family centered care. Since 2007, MeHAF has provided three rounds of funding to a variety of organizations throughout the state to improve the integration and delivery of mental/behavioral health and primary health care services. As part of the comprehensive evaluation of MeHAF's Integration Initiative, a post-grant survey was administered and a series of key informant interviews were conducted with grantees from each of the three cycles of funding.

Grantees

In all, 42 Integrated Care grants were awarded by MeHAF during 2007-2012. As a result, grantees implemented integrated care in 88 sites by the end of the grant period.

Round I — There were 17 grantees funded to implement integrated care during the first cycle of funding beginning in 2007. All of the sites were funded for a period of three years and all but two included a clinical setting.

Round II — The second round of funding began in 2008 and included 17 new recipients focusing on systems transformation (n=3), clinical implementation (n=6) or planning (n=8). Funding was provided for three years with the exception of the one-year planning grants.

Round III — The third round of grantees included four clinical sites and two agencies funded to address systems transformation. This grant cycle began in 2009 and ended in 2012.

Purpose and Focus of Report

This report is part of a larger effort by MeHAF to evaluate the impact of its funding, including the sustainability of integrated care. The results provide a snapshot of grantees' integrated care efforts at the time of the grant and since its completion. The report also details the models, type and level of integration across sites. The findings reflect the perceptions of grantees regarding the sustainability of integrated care.

Methods

This evaluation report is based on a retrospective approach. All grantees had concluded their grant one year prior to being contacted to participate in this final phase of the evaluation.

Data Collection

There were two sources of data: a grantee survey and key informant interviews. Data were collected in 2012 (round I), 2013 (round II) and 2014 (round III).

Grantee Survey. The survey was developed and administered by MeHAF staff to all clinical grantees via Survey Monkey. The questionnaire was designed to capture specific elements of integrated care that were part of a grantee's practice. The tool originally consisted of six items and was modified prior to round two (see Appendices A and B).

Key Informant Interviews. The key informant telephone interviews were based on a protocol that was developed by MeHAF staff. The round one protocol (see Appendix C) included a consent statement and 16 questions that focused primarily on: 1) the current level and type of integrated care, and 2) grantee experiences and perceptions about integrated care, MeHAF's role, and factors impacting the sustainability of integrated medical and behavioral health services.

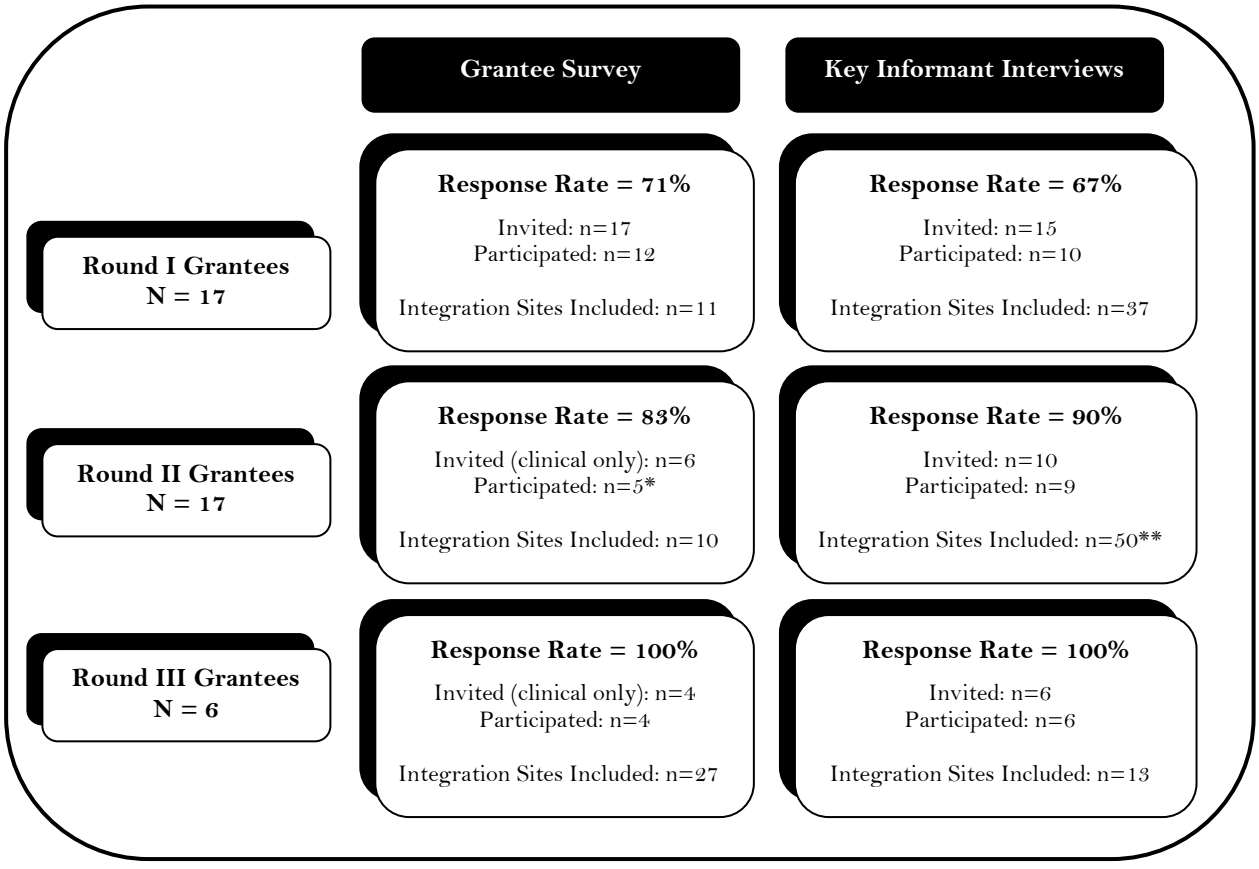
The round two protocols (see Appendix D) included the same focus areas. However, three different versions were created to accommodate the different types of grantees (e.g., system transformation, clinical implementation, planning). Interviews from the third funding cycle used the clinical implementation and systems transformation protocols from round two.

On average, the interviews lasted approximately 45 minutes. Most interviews were conducted with the project director. However, a few interviews included multiple members of the grant team or existing staff still employed by the agency.

Grantee Participation

As seen in Figure 1, the majority of grantees in each phase of funding agreed to participate in the data collection efforts. In all, a total of 48 sites were captured as part of the survey and 102 sites were identified and included as part of the interviews.

Figure 1. Survey and Interview Participants by Funding Cycle



* The survey was not relevant to one clinical site

** Only 17 sites were identified among clinical integration grantees and 7 of these sites included a phone consultation service only

Data Analysis

Survey data and closed-ended responses from the interviews were analyzed using descriptive statistics. While the samples from each round are small, efforts were made to be transparent with the response rates for each survey item. Therefore, the results section includes both the number of respondents as well as the overall percent.

Qualitative data analysis was based on standard coding techniques. The data were analyzed by systematically organizing, sorting and interpreting the information using categories and themes to identify patterns and relationships. The qualitative data were first analyzed by round of funding and then aggregated to determine themes across all three groups of grantees. Direct quotes were used, when appropriate, to illustrate the findings.

Limitations

There are several limitations that impact the generalizability and interpretation of the data. They include the following:

- Some interviews were conducted with individuals who were not involved in the initiative throughout the MeHAF grant. Although their perspective was often informed, their lack of participation throughout the project's entirety may have altered their responses.
- Given turnover and job changes, a few interviewees were not in a position to comment on the integration efforts *throughout* the entire organization. Also, some respondents were based in a site that was part of a larger health system and were unable to report on the integration efforts of the entire system.
- As noted by the responses rates seen in Figure 1, some grantees did not participate in the survey and/or interview. Among those that did, several sites did not address all items and missing data exist.
- To provide a more complete picture of grant efforts, a few sites requested and were granted a group interview with multiple grant staff. Although the standard protocol was used, the team approach was not consistent across sites.
- The findings are based on experiences from a grant that concluded several years ago. Recall bias is likely to have existed.
- Due to differences in integration models, some interview questions were not relevant for particular grantees.
- When appropriate, attempts were made to compare findings from each of the three rounds. However, due to differences in protocols, grantees and response rates – any comparisons should be made with caution.
- A small and selected number of grantees received more than one MeHAF integration grant during the five years of funding. Although there were attempts to separate the distinct grant activities, some of the survey and interview questions focused on the "organization's" efforts versus the "organization's grant-related efforts."

Despite these limitations, attempts were made to enhance the quality and credibility of the interview and analysis process based on strategies reported in the literature.[1] This includes standard protocols, technical rigor and the triangulation of survey and interview data.

[1] Patton MQ. (1999). Enhancing the quality and credibility of qualitative analysis. Health Services Research, 34(5); 1189-1208.

Results

This section summarizes the major findings among grantees from rounds one through three.

Application of Integrated Care Components

Grantees were asked to measure the extent to which their sites implemented 17 specific components of integrated care during the grant (Table 1). Among all grantees, the most frequently reported components of integrated care that were implemented to a "major extent" by at least half of respondents during each round of surveys were: using screening tools systematically, establishing systematic communication strategies, monitoring and providing referrals and using shared records (including electronic health records).

Table 1. Application of Integrated Care among Sites During the Grant

Components of Integrated Care	Not at All			Small Extent			Major Extent		
	Round 1 n = 10	Round 2 n = 4	Round 3 n = 4*	Round 1 n = 10	Round 2 n = 4	Round 3 n = 4*	Round 1 n = 10	Round 2 n = 4	Round 3 n = 4*
Included team with all providers and family	n=2 (20%)	n=0 (0%)	n=0 (0%)	n=5 (50%)	n=1 (25%)	n=1 (33%)	n=3 (30%)	n=3 (75%)	n=2 (67%)
Used screening tools systematically	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=4 (40%)	n=0 (0%)	n=1 (33%)	n=5 (50%)	n=4 (100%)	n=2 (67%)
Provided care/case management	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=2 (20%)	n=3 (75%)	n=3 (100%)	n=7 (70%)	n=1 (25%)	n=0 (0%)
Integrated and available treatment plans for team	n=3 (30%)	n=1 (25%)	n=0 (0%)	n=3 (30%)	n=0 (0%)	n=0 (0%)	n=4 (40%)	n=3 (75%)	n=3 (100%)
Established systematic communication for team	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=3 (30%)	n=0 (0%)	n=1 (33%)	n=6 (60%)	n=4 (100%)	n=2 (67%)
Used warm hand offs regularly	n=2 (20%)	n=0 (0%)	n=0 (0%)	n=6 (60%)	n=2 (50%)	n=2 (67%)	n=2 (20%)	n=2 (50%)	n=1 (33%)
Patients involved in decisions on care	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=5 (50%)	n=2 (50%)	n=0 (0%)	n=4 (40%)	n=2 (50%)	n=3 (100%)
Patients informed about integrated care approach	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=5 (50%)	n=1 (25%)	n=1 (33%)	n=4 (40%)	n=3 (75%)	n=2 (67%)
Practices had Patient Advisory Councils	n=1 (10%)	n=2 (50%)	n=0 (0%)	n=6 (60%)	n=0 (0%)	n=2 (67%)	n=3 (30%)	n=2 (50%)	n=1 (33%)
Monitored referrals for primary care	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=8 (80%)	n=4 (100%)	n=3 (100%)
Monitored referrals for behavioral health care	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=3 (30%)	n=1 (25%)	n=0 (0%)	n=6 (60%)	n=3 (75%)	n=3 (100%)
Provided seamless referrals to services	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=2 (20%)	n=2 (50%)	n=1 (33%)	n=7 (70%)	n=2 (50%)	n=2 (67%)
Used a shared record for behavioral and medical	n=3 (30%)	n=1 (25%)	n=0 (0%)	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=6 (60%)	n=3 (75%)	n=3 (100%)
Practices used shared electronic health records	n=4 (40%)	n=1 (25%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=6 (60%)	n=3 (75%)	n=3 (100%)
Routinely used data for quality improvement	n=1 (10%)	n=2 (50%)	n=0 (0%)	n=7 (70%)	n=1 (25%)	n=0 (0%)	n=2 (20%)	n=1 (25%)	n=3 (100%)
Routinely used data to monitor patient care	n=1 (10%)	n=1 (25%)	n=0 (0%)	n=5 (50%)	n=2 (50%)	n=2 (67%)	n=3 (30%)*	n=1 (25%)	n=1 (33%)
Routinely used data to monitor patient	n=1 (10%)	n=2 (50%)	n=0 (0%)	n=5 (50%)	n=2 (50%)	n=2 (67%)	n=3 (30%)*	n=0 (0%)	n=1 (33%)

* Missing data for one site

After the grant period, there were notable increases in the percent of grantees implementing the components of integrated care to a "major extent" among round one and two grantees. However, grantees in round three reported consistent findings suggesting that their current application of integrated care is consistent with their approach during the grant. Table 2 provides a summary of the respondents' current integrated care efforts.

Table 2. Current Application of Integrated Care Among All Grantee Sites

Components of Integrated Care	Not at All			Small Extent			Major Extent		
	Round 1 n = 11	Round 2 n = 4	Round 3 n = 4	Round 1 n = 11	Round 2 n = 4	Round 3 n = 4	Round 1 n = 11	Round 2 n = 4	Round 3 n = 4
Included team with all providers and family	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=5 (46%)	n=2 (50%)	n=1 (33%)	n=6 (55%)	n=2 (50%)	n=2 (67%)
Used screening tools systematically	n=2 (18%)	n=1 (25%)	n=0 (0%)	n=2 (18%)	n=0 (0%)	n=1 (33%)	n=7 (64%)	n=3 (75%)	n=2 (67%)
Provided care/case management	n=2 (20%)	n=0 (0%)	n=0 (0%)	n=3 (30%)	n=3 (75%)	n=3 (100%)	n=5 (50%)*	n=1 (25%)	n=0 (0%)
Integrated and available treatment plans for team	n=3 (30%)	n=0 (0%)	n=0 (0%)	n=1 (10%)	n=2 (50%)	n=0 (0%)	n=6 (60%)*	n=2 (50%)	n=3 (100%)
Established systematic communication for team	n=2 (20%)	n=0 (0%)	n=0 (0%)	n=3 (30%)	n=2 (50%)	n=1 (33%)	n=5 (50%)*	n=2 (50%)	n=2 (67%)
Used warm hand offs regularly	n=2 (20%)	n=0 (0%)	n=0 (0%)	n=4 (40%)	n=3 (75%)	n=2 (67%)	n=4 (40%)*	n=1 (25%)	n=1 (33%)
Patients involved in decisions on care	n=0 (10%)	n=0 (0%)	n=0 (0%)	n=2 (20%)	n=1 (25%)	n=0 (0%)	n=8 (80%)*	n=3 (75%)	n=3 (100%)
Patients informed about integrated care approach	n=1 (10%)	n=1 (25%)	n=0 (0%)	n=3 (30%)	n=0 (0%)	n=1 (33%)	n=6 (60%)*	n=3 (75%)	n=2 (67%)
Practices had Patient Advisory Councils	n=1 (10%)	n=2 (50%)	n=0 (0%)	n=6 (60%)	n=2 (50%)	n=2 (67%)	n=3 (30%)*	n=0 (0%)	n=1 (33%)
Monitored referrals for primary care	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=2 (20%)	n=0 (0%)	n=0 (0%)	n=7 (70%)*	n=4 (100%)	n=3 (100%)
Monitored referrals for behavioral health care	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=4 (40%)	n=0 (0%)	n=0 (0%)	n=5 (50%)*	n=4 (100%)	n=3 (100%)
Provided seamless referrals to services	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=5 (50%)	n=2 (50%)	n=1 (33%)	n=5 (50%)*	n=2 (50%)	n=2 (67%)
Used a shared record for behavioral and medical	n=2 (20%)	n=1 (25%)	n=0 (0%)	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=7 (70%)*	n=3 (75%)	n=3 (100%)
Practices used shared electronic health records	n=2 (20%)	n=1 (25%)	n=0 (0%)	n=1 (10%)	n=0 (0%)	n=0 (0%)	n=7 (70%)*	n=3 (75%)	n=3 (100%)
Routinely used data for quality improvement	n=0 (0%)	n=2 (50%)	n=0 (0%)	n=5 (50%)	n=0 (0%)	n=0 (0%)	n=5 (50%)*	n=2 (50%)	n=3 (100%)
Routinely used data to monitor patient care	n=2 (22%)	n=2 (50%)	n=0 (0%)	n=3 (33%)	n=2 (50%)	n=2 (67%)	n=4 (44%)*	n=0 (0%)	n=1 (33%)
Routinely used data to monitor patient	n=2 (22%)	n=2 (50%)	n=0 (0%)	n=2 (22%)	n=2 (50%)	n=2 (67%)	n=5 (56%)*	n=0 (0%)	n=1 (33%)

* Missing data from one or two respondents

In addition to the components above, several sites indicated implementing other components of integrated care. Peer navigation was mentioned by a couple of sites and a few respondents indicated that their model used psychiatric back-up services or psychiatric consultation. One site also mentioned outreach and psychoeducation while another identified the role of support specialists. Finally, one grantee indicated implementing a computerized assessment screening with built in scoring and cueing capabilities to assist providers with motivational interviewing.

Integrated Care Approach

Grantees were asked to describe their *current* integrated care approach and any changes since the end of the grant. Most round one interviewees described their approach by focusing on staff involved in delivering integrated services versus addressing the components identified above. The findings suggest that many of these initial sites were able to maintain or grow their staff to provide a team approach, while a few were not able to sustain all of their positions, particularly behavioral health personnel and case managers. Additionally, several round one respondents indicated that their approach is now more integrated and they have a better understanding of what integration entails, including the need to share records, have open access scheduling, and on-site practitioners. During the grant, one interviewee indicated that their organization was "willing to pilot any model or connection." However, now the organization has adopted an approach that works and aligns with their goal of being fully integrated. Similarly, round two sites also expressed a deeper appreciation of what it takes to make integration work, particularly given their experience with the MeHAF grant.

> *"It's been an evolution. We didn't know what we didn't know."*
>
> - Round One Grantee
>
> *"We're wiser now and would take more time to get the sites ready…"*
>
> - Round Two Grantee

While round two grantees were equally likely to focus on their model for staffing, the clinical sites represented somewhat unique approaches for conceptualizing and implementing integrated care given their focus (e.g., nursing home residents, infants and young families) or setting (inpatient or outpatient behavioral health). Their approaches to integrated care included providing phone psychiatric consultation services, using a standardized screening tool systematically across sites, and embedding their behavioral health staff in primary care practices providing full access to the team, ongoing reporting on progress, and sharing one plan of care through electronic records.

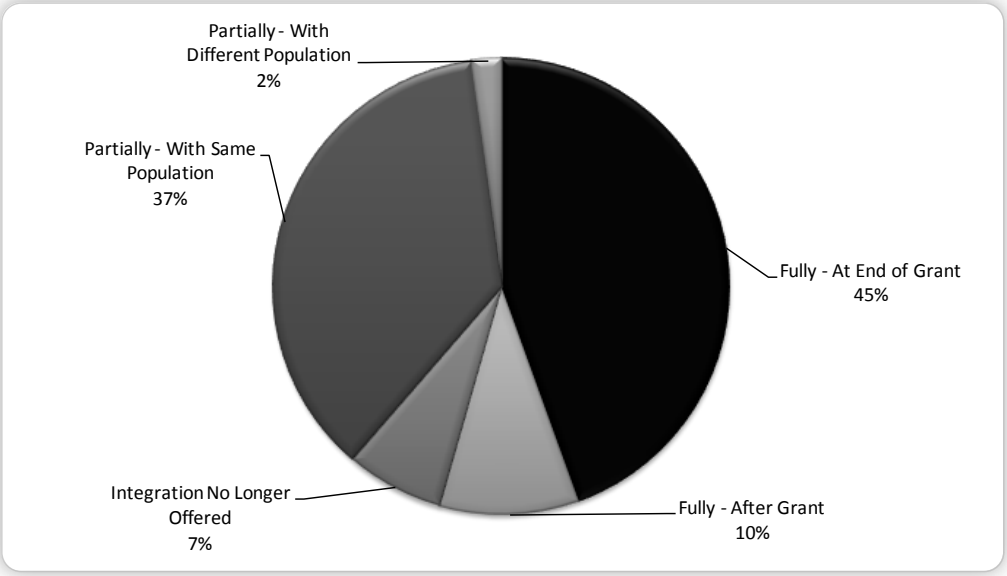
By comparison, round three grantees also described their approach in terms of staffing. However, unlike grantees from the previous two rounds, this group appeared more confident with the chosen integration model they had selected at the onset, and as indicated in the tables above, their reported integrated care components remained in place post-grant. One interviewee indicated that they sought out previous grantees to learn from their efforts. The round three interviews also revealed a more deliberate process and strategy for engaging sites and implementing integrated care.

> *"We get a sense before we meet with them [practices] what the culture is like."*
>
> - Round Three Grantee

Level of Integration

The level of integration among select MeHAF funded sites (n=60)[2] was assessed based on the following scale: 1) fully integrated by the end of the grant, 2) fully integrated after the grant, 3) partially integrated with the same population served during the grant, 4) partially integrated with a different population than served during the grant, and 5) integrated care no longer offered. As seen in Figure 2, the findings suggest that 45% (n=27) of the sites were fully integrated by the end of the grant, and an additional 10% (n=6) were fully integrated after the grant expired. Over one-third of the sites (37%) were classified as partially integrated with the same population served during the grant. Only four clinical sites (in rounds one and two) no longer offered integrated care due in large part to staff turnover, leadership support or changes in organizational partnerships.

Figure 2. Perceived Level of Current Integrated Care (n=60 sites)



Type of Integrated Care and Likelihood of Continuation

Respondents were asked to categorize their level of integration based on the following descriptions:[3]

- Coordinated: "Basic collaboration at a distance. Referral triggered periodic exchange of information between/among clinicians in separate medical and behavioral setting, with minimally-shared care plan or clinic culture."
- Co-located: "Basic collaboration on-site. Behavioral and medical clinicians in same space, with regular communication, usually separate systems, but some shared care plans and clinic culture."
- Integrated: "In partially or fully integrated system. Shared space and systems with regular communication, mostly unified rather than separate care plans, and largely shared culture and collaborative routines."

[2] Some sites were not able to categorize their level of integration given their approach

[3] AHRQ Publication No. 11-0067 (July 2011). A national agenda for research in collaborative care.

Most round one grantees indicated that their sites were "co-located" and several classified their sites as "integrated." However, only one clinical integration grantee from round two indicated their site was "co-located." This second round of grantees was more likely to report "coordinated" or "integrated," and this varied by setting. For example, the mental health facilities indicated their approach was consistent with the integrated definition. By comparison, round three grantees all indicated that their approach was "integrated" and one mentioned that this approach began "right from the start."

Across all three rounds of grantees, respondents overwhelmingly planned to continue providing integrated care. According to one grantee, "it's what patients want and what people deserve." A second grantee indicated that "it's the right thing to do."

When asked how likely they were to continue providing integrated care services, all respondents indicated "very likely" with the exception of three grantees. Among this minority group, one grantee represented a client-based model rather than a site-based approach. A second interviewee represented a telephonic consultation service that would only continue with financial resources. Finally, one respondent no longer worked for the grant site and was not in a position to report on *how likely* the agency was to continue providing integrated care.

Factors Associated with Providing Integrated Care. There was similar feedback across all grantees regarding the factors associated with the decision to continue providing integrated care. The findings reflect five major themes that emerged among all three rounds of grantees. First, several respondents indicated that the model works well and providers want to adopt it because they believe in the concept. The interviewees suggested that "provider and staff satisfaction" were key drivers influencing the decision to continue integration efforts.

Second, health systems are increasingly focusing on integrated care as a priority which has been reflected in organizational missions, strategic initiatives and greater investments in the Patient Centered Medical Home. According to one respondent, integration enhances primary care and is a core part of system transformation. Several grantees indicated that integrated care was an organizational priority.

Third, the patient feedback has been positive and the approach is more responsive to the needs of patients, which results in greater client satisfaction. One interviewee suggested that integrated care helps to reduce stigma, particularly in rural areas. Another interviewee indicated that this approach is reflective of community needs and aligned with "other movements to improve patient care."

Fourth, respondents believe that integrated care leads to better outcomes, quality of care and overall service delivery. One grantee indicated that "patient outcomes are better, it works and the quality of care is better." A second respondent suggested that patient outcomes are "astonishing."

Finally, grantees have become savvy in understanding how to bill for these services and the foundational work that needs to be done in advance. The lessons learned during the MeHAF grant have proved to be instrumental in shaping their decisions to continue. For example one site indicated that it was able to re-design its "business model" to bill for integrated services. A second site indicated that the Board of the organization approved integrated care as an "ongoing services because the billing was working out."

Integrated Care Efforts – Post Grant

Expansion of integrated care services occurred among all three rounds of grantees. Among the first round, nearly half of the organizations with "other sites" reported that they were able to expand their integrated care services to one or more of these sites and a few reported fairly substantial expansion activities. Round two and round three sites (clinical integration and system transformation grantees) reported fairly robust expansion efforts. The interview findings suggest that these grantees expanded their model to an additional 75 sites; the vast majority were sites outside their organization (see Appendix E).

Most round one and round three sites indicated an increase in the number of patients and providers (both primary care and behavioral health) engaged in or receiving integrated care at their organization *after* their MeHAF funding. However, only one of the six clinical sites interviewed in the second round indicated an increase in patients receiving, or providers engaged in, integrated care at their organization. This suggests that most expansion efforts led by this cohort occurred with outside organizations.

All three rounds of interviews revealed that providers typically held one of the following credentials: MD, NP, PNP, LCSW, LCPC, PA, and Psychologist. However, clinical integration grantees in rounds two and three also reported working with those credentialed as MSW, LABC, FNP, and RN. Additionally, one site reported working with MSW students. The most commonly-reported credential across all grantees was LCSW.

Partnerships: While several grantees had existing partnerships before the grant, the MeHAF integration funding often helped to strengthen their relationships by providing an opportunity to work together on a common goal.

> *"The partnerships were in place when we started the grant but it [grant] affirmed the partnerships."*
>
> - Round Three Grantee

In many instances, the partnerships were based on mutual interests and included information exchange and shared learning. In some instances, the partnerships were harder to sustain post grant, particularly for those that had developed a non-traditional model in a unique setting (e.g., mobile unit or school-based) or for those with trouble staffing their model.

Networking Opportunities: Grantees were asked to indicate whether or not they had engaged in a series of networking activities related to integrated care. The findings are depicted below in Table 3. All but three respondents indicated having contact with other MeHAF Integration Initiative grantees post-grant and most participated in several networking opportunities. The findings suggest that technical assistance and information sharing (e.g., exchange of ideas) were common within the grantee network and beyond this network – even after the grant ended.

In addition to the local and state-level connections, two grantees reported networking at the national level and one interviewee discussed connecting MeHAF with interested parties outside of Maine.

Table 3. Post Grant Networking Activities

Networking Activities	Participated in Activity		
	Round One n=10	Round Two n=9	Round Three n=6
Contact(s) with other MeHAF Integration Initiative grantees	n=10 (100%)	n=7 (78%)	n=5 (83%)
Receiving assistance or ideas from another MeHAF Integrated Initiative grantee	n=8 (80%)	n=6 (67%)	n=4 (67%)
Receiving assistance from the Integrated Care Training Academy awardees	n=4 (40%)	n=3 (33%)	n=2 (33%)
Providing assistance or ideas to other healthcare organizations	n=9 (90%)	n=7 (78%)	n=6 (100%)
Providing formal training about integrated care to other healthcare organizations	n=5 (50%)	n=7 (78%)	n=3 (50%)
Partnering with another organization for joint activities about integrated care	n=6 (60%)	n=6 (67%)	n=3 (50%)
Other contact with another organization or agency (not a MeHAF grantee) that you learned about from MeHAF	n=3 (30%)	n=2 (22%)	n=3 (50%)
Communicating with other funding sources in Maine about potential or actual new funding for this project	n=6 (60%)	n=8 (89%)	n=3 (50%)

Dissemination Activities: Grantees reported using a number of different methods to disseminate information about their MeHAF integrated care efforts (see Table 4). Most of the grant organizations gave a presentation to a local or state audience and wrote an article for a newspaper or brochure. Additionally, most provided technical assistance to other agencies trying to implement integrated care.

Table 4. Post Grant Dissemination Activities

Dissemination Activities	Participated in Activity		
	Round One n=10	Round Two n=9	Round Two n=6
Presented to a local or state-level professional audience	n=8 (80%)	n=8 (89%)	n=4 (67%)
Presented to a national or international professional audience	n=3 (30%)	n=6 (67%)	n=4 (67%)
Wrote article(s) that was (were) published, accepted, or being revised for publication in a peer-reviewed journal	n=0 (0%)	n=1 (11%)	n=0 (0%)
Wrote article(s) for a newsletter or brochure	n=7 (70%)	n=6 (67%)	n=3 (50%)
Had article(s) published in a local or state newspaper	n=2 (20%)	n=5 (56%)	n=1 (17%)
Received local or regional media coverage—including print, television or radio broadcast	n=3 (30%)	n=3 (33%)	n=1 (17%)
Received national media coverage—including print (NY Times, etc.), television or radio	n=0 (0%)	n=1 (11%)	n=1 (17%)
Used information or materials from the project in teaching a college-level course	n=1 (10%)	n=2 (22%)	n=1 (17%)
Developed a "how-to" manual or training package	n=3 (30%)	n=4 (44%)	n=1 (17%)
Provided technical assistance to other agencies trying to implement integrated care	n=5 (50%)	n=6 (67%)	n=5 (83%)

Sustaining Integrated Care Efforts

Interviewees were asked to identify the factors most likely to help their organization sustain integrated care and five overarching themes emerged across all three rounds of grantees. They include:

- Financial models
- Leadership commitment and support
- Staff buy-in and engagement
- Return on investment and perceived value
- Clear expectations

First, most sites indicated the need for a financial model that supports an integrated care approach, offsets the costs associated with delivering this type of care and one that decreases financial barriers that currently emphasize productivity. This includes a model with: 1) "thoughtful regulations" that match practice and provide consistency across settings (e.g., private practice versus a federally qualified health center), 2) clear guidelines on how to code visits including the ability to bill for behavioral health through existing codes, and 3) mechanisms for providing integrated care without "penalties" or the requirement of a specific "diagnoses" that is now required for reimbursement, and 4) value-based purchasing based on "whole-person" care. One respondent also indicated that this model needs to provide reimbursement for behavioral health phone consultation with primary care providers, not just face-to-face consultation with patients.

A second theme focused on organizational leadership, support and commitment. Interviewees believe that integrated care is more likely to be sustained if the leadership of an organization views this approach as a direction it wants to take. Grantees indicated that integrated care was not sustainable without the administration's support and its recognition as an organizational priority. In one site where integrated services were no longer offered, the interviewee stressed the role of leadership.

> *"At [organization name] everything is there to make it work except for administration commitment and priority. They can get paid for it and break even. Patients believed in it and providers liked it."*
>
> - Round Two Grantee

The third theme focused on direct care staff including their level of knowledge, buy-in and engagement with the approach. According to one respondent, buy-in from practitioners "makes the difference." For example, one site in the second round of funding expressed concerns experienced by their providers early in the process. Several staff members were worried about the perceived "cultural" shift this would create within their organization. They were primarily concerned about being viewed as a behavioral health facility, but this did not happened. One grantee also indicated the importance of matching the right clinicians with the right practice. Finally, two sites in round three indicated the need for a "champion" among the medical providers to help with provider education and engagement.

The forth theme focused on documenting the benefits of integration and articulating its value. Several grantees acknowledged that "clear outcome data" or "cost data" would help to make a persuasive argument that might lead to the sustainability of this approach. For example, one respondent suggested that "providing good clinical services that are valuable and valued by primary care practitioners and make a difference with their patients" would result in enhanced sustainability. Another respondent indicated that communicating the value of integration is critical.

> *"Make sure those in Administration know the expenses [related to integration of behavioral health and primary care] are worth it"*
>
> - Round Three Grantee

Finally, the last theme which emerged from the data revealed the need for clear expectations for integrated care. Several round two and round three grantees identified opportunities for sustaining integrated care based on the expectations of Accountable Care Organizations, Behavioral Health Homes, and strategies in the "SIM (State Innovations Model) grant." They believe that having a clear set of expectations regarding integrated care will help accelerate efforts to deliver behavioral health and primary health care services in an integrated and enhanced way.

Payment Strategies

Grantees were asked how their organization pays for personnel and other costs directly associated with integrated care services by site. The findings from the survey revealed that most sites were able to pay for behavioral health personnel costs through billing reimbursement; and all but three sites (round two and three) were able to pay for medical providers by billing public or private payors. Yet, few were able to use this payment strategy to cover case managers, support staff or others needed to deliver integrated care. As seen in Table 5, billing reimbursement, grant funding and absorbing the salaries and costs by the organization were the three most common strategies reported across sites. Contractual arrangements were also noted among all three rounds of grantees.

Bundling payments and performance incentives were the two mechanisms that were least likely to be reported. Two sites indicated bundling payments for medical personnel. Additionally, four sites reported providing performance incentives for medical providers. No global payments or performance incentives were reported for any other personnel involved in delivering integrated care.

In addition to the survey data on payment strategies, the second round of interviews also revealed that one grantee established a "transformation support fee." This fee was imposed on new practices.

Table 5. Use of Various Payment Mechanisms Among All Grantee Sites

Payment Mechanisms	Grantee	Medical Providers and Staff	Behavioral Health Providers and Staff	Case/Care Managers	Support Staff Specific to Integrated Care	Other (Example: Peer Navigators)
Billing reimbursement (Public and/ or private payors)	Round One	n=11 (100%)	n=11 (100%)	n=3 (27%)	n=1 (9%)	n=1 (9%)
	Round Two*	n=2 (67%)	n=3 (100%)	n=0 (0%)	n=0 (0%)	n=0 (0%)
	Round Three*	n=2 (50%)	n=2 (50%)	n=0 (0%)	n=0 (0%)	n=0 (0%)
Grant funding (specify source)	Round One	n=2 (18%)	n=2 (18%)	n=5 (45%)	n=5 (45%)	n=4 (36%)
	Round Two*	n=0 (0%)	n=1 (33%)	n=0 (0%)	n=2 (67%)	n=0 (0%)
	Round Three*	n=1 (25%)	n=1 (25%)	n=1 (25%)	n=1 (25%)	n=1 (25%)
Federal funding, except for reimbursements	Round One	n=1 (9%)	n=1 (9%)	n=2 (18%)	n=2 (18%)	n=1 (9%)
	Round Two*	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)
	Round Three*	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)
Patient Centered Medical Home per member per month enhanced payments	Round One	n=3 (27%)	n=1 (9%)	n=1 (9%)	n=1 (9%)	n=0 (0%)
	Round Two*	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)
	Round Three*	n=2 (50%)	n=1 (25%)	n=1 (25%)	n=0 (0%)	n=0 (0%)
Other bundled or global payments	Round One	n=2 (18%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)
	Round Two*	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)
	Round Three*	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)
Performance incentives	Round One	n=3 (27%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)
	Round Two*	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)
	Round Three*	n=1 (25%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)
Contractual agreements	Round One	n=0 (0%)	n=2 (18%)	n=1 (9%)	n=2 (18%)	n=0 (0%)
	Round Two*	n=0 (0%)	n=1 (50%)	n=1 (50%)	n=1 (50%)	n=1 (50%)
	Round Three*	n=0 (0%)	n=1 (25%)	n=0 (0%)	n=1 (25%)	n=1 (25%)
Salaries/benefits absorbed by organization	Round One	n=2 (18%)	n=2 (18%)	n=3 (27%)	n=3 (27%)	n=0 (0%)
	Round Two*	n=1 (50%)	n=1 (50%)	n=2 (100%)	n=2 (100%)	n=1 (50%)
	Round Three*	n=2 (50%)	n=2 (50%)	n=2 (50%)	n=1 (25%)	n=1 (25%)
Offset by prevented losses through improved patient flow, etc.	Round One	n=1 (9%)	n=1 (9%)	n=1 (9%)	n=1 (9%)	n=0 (0%)
	Round Two*	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)
	Round Three*	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)	n=0 (0%)

* Missing data from one or two respondents

Barriers to Integrated Care

Financial and Regulatory: As noted above, several sites indicated a mix of strategies for covering costs associated with integrated care, yet the financial and regulatory barriers were the most common challenges identified by grant recipients across all three rounds of funding. Several specific concerns were identified including: paying for the "warm-hand-off," reimbursing for care management, and covering LCPC services among Medicare recipients.

As one interviewee indicated, "It is easy for this to limp along at less than an ideal level. It needs operational and financial support." Another interviewee suggested that the current system pays for "widgets to increase volume and revenue." Yet, there is a need to pay for "quality outcomes, teamwork and clinical outcomes." As one round three respondent suggested, the current emphasis of some organizations remains on productivity.

> *"We continue to work on setting productivity standards"*
>
> - Round Three Grantee

Supportive Leadership and Staff: Several grantees indicated the lack of top level champions or leaders, the competing demands on clinical staff, and the lack of training some practitioners may have on this approach hinders integration efforts. Some interviewees also discussed the barriers of recruiting and hiring staff, particularly LCSWs given reimbursement issues with LCPCs.

Physical Space and Other Barriers: Two sites mentioned the challenges associated with having the space needed for this approach including having the right layout to support the "warm handoff." Additional barriers included the current climate, the "change demands" currently required of clinicians, people being "overwhelmed," the "crushing burden of documentation," the amount of time it takes to achieve transformational change, the perceived concerns about privacy and data sharing, the limited time available to connect and "talk about a case" and the need to change scheduling practices from 15 minute blocks to visits that accommodate integrated service delivery. Finally, one site noted technology challenges related to electronic medical records, including the flexibility of some existing systems to adapt to approaches that support integrated care.

MeHAF's Role in Sustainability of Integrated Care

Interviewees expressed gratitude for the opportunity to "play around with the model." By all accounts, MeHAF's financial support allowed grantees to implement a variety of approaches for integrating behavioral health and primary health care services. A few grantees acknowledged the Foundation's role in providing their organization with the "opportunity to put something into action" or the resources that "just got us up and going and now we're sustainable."

Although one interviewee cautioned MeHAF about expecting systems change in three years, many grantees identified specific efforts MeHAF could be engaged in, or continue to support, in an effort to sustain integrated care in Maine. The most common suggestion included the

continued use of learning collaboratives and forums as well as ongoing training and technical support. Additional suggestions included the following:

- "Advocacy at the state level for policy change"
- "Working with insurance companies"
- "Providing examples of what works"
- "Providing education at the state level on 'what is integration' and the need to create our own rules"
- Serving as the "bully pulpit" and translating information for those in the "trenches"
- Continuing to support multiple integrated care models
- Taking advantage of grantee expertise, particularly those with experience in unique approaches to providing integrated care
- Developing a common set of "metrics" to "measure success"
- Bringing clarity and structure to "ACAs, Behavioral Health Homes, Community Care Teams, Healthy Homes, and Patient Centered Medical Homes"
- Continuing to "work on reimbursement through all payor sources"
- Ongoing "support and training for Behavioral Health Specialists in a practice"
- Raising "awareness about the issue"
- Advocating for better "regulation, policy and funding"

Conclusions

The findings suggest that grantees played an important role in helping to shape the understanding, evolution, adoption, acceleration and spread of integrated care in Maine. The grant recipients served as important vehicles for exploring or testing various integrated care models, particularly early in MeHAF's funding cycle. This network of MeHAF grantees exchanged ideas, learned from the experiences of their peers and disseminated the findings of their efforts both within the network and beyond the grant-funded sites.

While nearly all interview participants reported favorable views towards integrated care and a commitment to continue providing integrated services, several barriers influencing sustainability continue to exist.

Appendix A. Survey Round One Grantees

Round 1 Integration Initiative Grantees (2007)
Clinical Implementation

Directions: Please respond to these questions about what has happened since the end of your Maine Health Access Foundation Integration Initiative (Integrated Care) grant which ended in December 2010. This survey is part of MeHAF's assessment of the sustainability of integrated care. An independently contracted evaluator will access the responses instead of MeHAF staff. We appreciate your time and willingness to participate in this survey.

1. Grantee Organization: *(Please select from drop down menu.)*

2. Number of current integrated behavioral health and primary care sites/practices in your organization. *(Please select from drop down menu.)*

3. Total number of current sites/practices in your organization. *(Please select from drop down menu.)*

4. The MeHAF-funded integrated behavioral health and primary care grants included many components of integrated care, which were assessed using the Site Self Assessment (SSA) tool. For each potential integration component below, please indicate the extent to which your project implemented this component *during the period* it was funded by MeHAF, and then the extent to which you are still implementing each component *at the current time at the majority of your integrated sites*:

Component	Did you implement during MeHAF-funded Period?			Are you still implementing this component now?		
	Not at All	Small Extent	Major Extent	Not at All	Small Extent	Major Extent
a) Was/Is there a team including primary care and mental/behavioral health care providers and the patient/family?						
b) Did you use screening tools systematically?						
c) Was/Is Care/Case Management provided?						
d) Were/Are treatment plans for BH, MH and PC integrated and available to all providers on the team?						
e) Was/Is a systematic communication strategy established among team members (e.g., EHR, regular communications, team huddles, and/or meetings)?						
f) Were/Are warm hand offs used regularly?						
g) Were/Are patients/families fully informed and involved in decisions about their care (shared decision making?)						

Continued…

h) Were/Are patients/families informed about integrated care as the approach being used for their care at the site?						
i) Did/Do the practices/sites have Patient Advisory Councils or groups or other ways to actively engage patients in decisions related to the implementation of integrated care?						
j) Did/Does the practice/site monitor follow-up referrals, clinical tests, etc. and provide follow up for medical care?						
k) Did/Does the practice/site monitor follow-up referrals, clinical tests, etc. and provide follow up for behavioral health services?						
l) Did/Do the practices/sites provide seamless referrals and links to community social services and supports (support groups, peer networks, transportation, housing supports, etc.) for patients?						
m) Did/Do the sites/practices use a shared record for behavioral and medical documentation and treatment planning?						
n) Did/Do the practices/sites routinely collect and use data for quality improvement?						
o) Did/Do the practices/sites routinely collect and use patient-level data to monitor and follow up on patient care for patients receiving integrated care?						
p) Did/Do the practices/sites routinely collect and use patient-level data to monitor and follow up on patient outcomes for patients receiving integrated care?						

Note: BH = Behavioral Health MH = Mental Health PC = Primary Care

5. Did your project have any components of integrated care that are *not* listed above? If so, please describe them briefly, and indicate whether you are still implementing those additional components (such as peer navigation, outreach and education, psychiatric services, medical consultations, other consultations, etc.): [Open-ended response.]

6. How do you pay for personnel and other costs directly related to integrated care services? Check all that apply. Complete the form for each currently-participating site, if you have variations in payment strategies among the sites.

Payment method	Medical Providers and Staff	Behavioral Health Providers and Staff	Case/Care Managers	Administrative, Infrastructure Support Staff specific to Integrated Care	Other (i.e., Peer Navigators, supervisors, trainers, etc.)
Billing reimbursement (Public and/or private payers)					
Grant funding (specify source)					
Federal funding, expect for reimbursements					
Patient Centered Medical Home pmpm enhanced payments					
Other bundled or global payments					
Performance incentives					
Contractual agreements					
Salaries/benefits absorbed by organization					
Offset by prevented losses through improved patient flow, reduced No Shows, etc.					
Other (Please describe.)					

Thank you very much for participating. Your answers will help us plan strategies to help sustain integrated care.

Appendix B. Interview Protocol Round One

Questions for One-Year Sustainability Interviews
Round 1 Integration Initiative Grantees (2007)
Clinical Implementation

Background Information:

Grantee Organization:_____

Partner Organizations:_____

Project Title:_____

Number of Sites: _____

Number of Sites (Expected/Planned) Involved During Grant Period: _____

Project Director: _____

Name of Interview Respondent: _____

Was Respondent Involved in Project Prior to December 2010: _____ Yes _____ No

Date of Interview: _____

[Note for interviewer: In case the person interviewed asks for clarification on the definition of integrated care, the definition we are using is "Integrated Care brings behavioral (including substance use), mental, and physical health to people in a coordinated way. It creates a relationship between a patient and a team of health professionals to achieve improved health and cost effectiveness."]

Introduction and Consent Statement

Thank you for agreeing to participate in this survey about your Integration Initiative grant funded by the Maine Health Access Foundation. As you (may) know, in 2007, your organization was awarded a three-year grant from MeHAF to implement integrated behavioral health and primary care.

I would like to ask you a few questions about what has happened since the end of your grant which wrapped up in December, 2010. This interview is part of the Foundation's assessment of the sustainability for integrated care. I hope you will provide honest answers about what is currently happening in your project. We all recognize that it is sometimes difficult to sustain projects funded from an external granting source like MeHAF so it is perfectly appropriate if you answer "no" to any of the questions on this survey.

While this interview is not anonymous, I'd like to assure you that the information you provide will be kept confidential and will not be shared outside of MeHAF and its contracted consultants/evaluators related to integrated care. Additionally, any information you share

today will not impact your future opportunities to partner with MeHAF, positively nor negatively.

I anticipate that the interview will take no longer than one hour. I want to be sure that I capture all of the information you provide and sometimes I can't write fast enough. Is it okay with you if I record our conversation?

Do you have any questions?....Okay, let's begin.

Interview Questions

1. The first set of questions focuses on the sites, practices or settings within your organization where you have provided integrated behavioral health and primary care services *through the MeHAF grant.* Can you list each of these sites for me?

2. Now, I'd like to learn about your ongoing integration efforts with these sites since December, 2010. For each site, I want to know if it was fully integrated (by the end of the grant or after), partially integrated, or no longer integrated. So, let's focus on your first site (refer to list above). Since December 2010, have you continued to provide integrated behavioral health and primary care services at the practices or in other settings involved in the MeHAF grant project: (Select all that apply. Answer separately for EACH site involved during grant period.)

Site	Fully – by the end of grant	Fully – but completed after grant ended	Partially – with same pop. Served during grant	Partially – different pop. served	Integrated care no longer offered. Why?

A. If 'integrated care no longer offered…" what would most help you to continue offering integrated care? [Omit for others.] – then skip to Q11
    a. Bundled or global payments;
    b. More opportunities for billing;
    c. Higher rates of reimbursement;
    d. ACO structure;
    e. Ability to recruit and retain high quality staff (what credentials?)
    f. More key leadership support in the organization;
    g. Key leadership support in state agencies;
    h. Other (Please specify.)

B. Have you expanded integrated care services to new sites since the end of your MeHAF grant in 2010? If so, how many new sites?

3. Please describe your *current* integrated care approach/program- overall. How is this different from the grant-period approach/program? (Interviewer has copy of JSI and Laura's summaries of the grant-period project.)

4. During the time that you were implementing the Integration Initiative grant, how would you categorize the level of integrated care at your sites/practices based on the following definitions? [Definitions come from the AHRQ Publication NO. 11-0067 (July 2011) *A national agenda for research in collaborative care.* Charlotte Mullican, editor.]
    a. Coordinated—"Basic collaboration at a distance. Referral-triggered periodic exchange of information between/among clinicians in separate medical and behavioral settings, with minimally-shared care plan or clinic culture.
    b. Co-located—"Basic collaboration on-site. Behavioral and medical clinicians in same space, with regular communication, usually separate systems, but some shared care plans and clinic culture."
    c. Integrated—In partially or fully integrated system. Shared space and systems with regular communication, mostly unified rather than separate care plans, and largely shared culture and collaborative routines."

5. How likely are you to continue your integrated care services?
    a. Very likely;
    b. Somewhat likely;
    c. Neither likely nor unlikely;
    d. Somewhat unlikely; or
    e. Very unlikely.

    A. What are the leading factors that have contributed to your choice?

The next set of questions focus on any changes your organization experienced in the proportion of patients and providers engaged in integrated care.

6. In your opinion, the *current* number of patients receiving integrated care in your organization is:

    a. More than at the end of the MeHAF-funded project;
    b. About the same number as at the end of the MeHAF-funded project;
    c. Fewer than at the end of the MeHAF-funded project;
    d. None; or
    e. Unknown.

7. The current number of Primary Care Providers engaged in integrated care at your organization is:
    a. More than at the end of the MeHAF-funded project;
    b. About the same number as at the end of the MeHAF-funded project;
    c. Fewer than at the end of the MeHAF-funded project;
    d. None; or
    e. Unknown.

8. The current number of Behavioral Health Providers engaged in integrated care at your organization is:
    a. More than at the end of the MeHAF-funded project;
    b. About the same number as at the end of the MeHAF-funded project;
    c. Fewer than at the end of the MeHAF-funded project;
    d. None; or
    e. Unknown.

9. Currently, what professional licensure do the people providing integrated care in your practices/sites hold (MD, NP, PNP, LCSW, LCPC, Psychiatrist, Psychologist, etc.)?

10. What partnerships (if any) were established as a result of the grant? Who were the partners and what were their roles? Have the partnerships established as part of the grant continued? Have they changed? If so, how?

11. What factors are most likely to help you sustain integrated care?

    [Interviewer: when possible, code responses based on the following.]
    a. Active support from your organization's/agency's executives or administrators;
    b. Actions by your organization's/agency's Board members;
    c. Program is essential to carrying out the mission of your agency;
    d. Actions of an internal "champion" or key leader;
    e. Agency has existing "capacity" (e.g., enough staff member, skills, resources) to continue the program;
    f. Reimbursements/third-party payments offset costs;
    g. Cost is low enough so you did not need substantial resources to continue;
    h. New grant funding is available;
    i. Outcome/evaluation data convinces potential funders of the value of program;
    j. Current or previous clients serve as advocates for the program;
    k. Staff members believe in the program so much they will not let it discontinue;
    l. Partnerships with other organizations help find new funding sources;
    m. Collaborative partners from the MeHAF grant period provide in-kind or other resources for continuation;
    n. Technical assistance or guidance from an external agency;
    o. Patients' acceptance of integrated care;
    p. Providers' acceptance of integrated care;
    q. Changes in state / federal policies and resources to support integrated care;
    r. Other helpful influences. (Please specify);

12. What are your greatest continuing barriers to providing integrated care?

[Interviewer: when possible, code responses based on the following.]

a. Obtaining funding from third-party reimbursement and other external sources;
b. Obtaining funding from organization's budget, or other internal sources;
c. Obtaining resources from partner organizations;
d. Obtaining other outside resources such as grants;
e. Obtaining support from organization's administrators for continuing project activities;
f. Project leader or other key project "champion" left the organization;
g. Turnover among staff members delivering project services;
h. Organization's priorities changed and the integrated care focus is no longer a priority;
i. Maintaining agreement among partners essential for continuing project activities;
j. Lack of the physical space (such as lease terminated, or project offices used for a different purpose, etc.);
k. Equipment or facilities needed (such as computers) no longer available;
l. Policy changes that were agreed on temporarily during project were not made permanent;
m. Partner organizations did not do what they promised;
n. Investment in resources was not worth the effort;
o. Lack of case management/care management;
p. Lack of sufficient patient volume to support the work;
q. Lack of patients' acceptance;
r. Lack of providers' buy in; and/or
s. Other barriers (please specify)

13. Since the end of your integrated care MeHAF grant in December 2010, have you or any of your grant partners participated in any of the following types of networking opportunities related to integrated care,? (Circle all that apply.) [Might want to make a chart for this in report.]

a. Contact(s) with other MeHAF Integration Initiative grantees;
b. Receiving assistance or ideas from another MeHAF Integrated Initiative grantee;
c. Receiving assistance from the Integrated Care Training Academy awardees;
d. Providing assistance or ideas to other healthcare organizations;
e. Providing formal training about integrated care to other healthcare organizations;
f. Partnering with another organization for joint activities about integrated care (Was it with a formal agreement, such as a memorandum of understanding?);
g. Other contact with another organization or agency (not a MeHAF grantee) that you learned about from MeHAF;
h. Communicating with other funding sources in Maine about potential or actual new funding for this project;
i. None of the above;
j. Other (please specify):

14. Since the end of your grant in December 2010, have you used any of the following methods to disseminate information about your MeHAF integrated care? (Circle all that apply.)
    a. Presented to a local or state-level professional audience;
    b. Presented to a national or international professional audience;
    c. Wrote article(s) that was (were) published, accepted, or being revised for publication in a peer-reviewed journal;
    d. Wrote article(s) for a newsletter or brochure;
    e. Had article(s) published in a local or state newspaper;
    f. Received local or regional media coverage—including print, television or radio broadcast;
    g. Received national media coverage—including print (NY Times, USA Today, Time, Newsweek, etc.), television or radio;
    h. Used information or materials from the project in teaching a college-level course;
    i. Developed a "how-to" manual or training package;
    j. Provided technical assistance to other agencies trying to implement integrated care;
    k. None of the above.
    l. Other (please specify):

15. How could MeHAF assist with sustaining your integrated care initiative (other than additional grant funds)?

16. Is there anything not addressed in this survey that you would like to share about your project since the MeHAF funding ended?

Thank you for taking time for today's interview. If you have any questions or have more detailed information to share, you may contact me at (Interviewer name, contact #). If you have questions or information you would like to share with MeHAF, you may contact Becky Hayes Boober at bhboober@mehaf.org or at 207-620-8266, ext. 114.

Again, thank you for participating in this survey to assist MeHAF with its efforts to support integrated behavioral health and primary care.

Maine Definition of Integrated Behavioral Health and Primary Care

External, Public Messages:

Integrated Care brings behavioral, mental, and physical health to people in a coordinated way. It creates a relationship between a patient and a team of health professionals to achieve improved health and cost effectiveness.

Desired Outcome

People's health, daily lives, and functioning improve as a result of engaging with a health care system that treats them as whole persons. The system integrates behavioral health and primary care and is cost effective.

Values and Guiding Principles

- Integrated behavioral health and primary care means that people get complete care for all their health needs in the right time and place.
- Care is patient and family-centered, so persons being served can be engaged, active, and knowledgeable.
- Individuals have a sustained and trusting relationship with healthcare professional(s) who serve as their primary care team guiding and coordinating their health care. This healing relationship relies on two-way communication and shared decision-making.
- Treatment incorporates the resources of communities where people live.
- No matter where or how people come into the health care system, they will receive the behavioral health and primary care services they need.
- Prevention, early intervention, and recovery are as important as disease/condition treatment and interventions.

Internal, Health Care System Messages:

Operational Elements (The Ideal)

1. In integrated care, people connect with a welcoming health home where they participate in their healthcare with one team of behavioral health and primary care professionals.
2. Physical and behavioral health providers and specialists as needed provide fully collaborative, patient-centered care across the continuum of care. The team, including the patient, develops and implements a coordinated health improvement and care plan. The integrated team shares a full spectrum of information to make informed decisions, most often using common health records. Formal relationships between behavioral health provider systems, primary care systems, and specialty care ensure access to a full range of coordinated treatment options.
3. People receiving services have an on-going relationship with and work closely with a primary health professional who provides care/case management onsite. Services appropriately address both physical and behavioral needs and link to necessary community resources.
4. People receiving services and their families are informed, active and competent partners with the health care system in their own health care assessments and plans as well as in the design of the system.
5. People receiving services can easily access their choice of setting(s) for their care.
6. Care is flexible and responsive, safe, timely, effective, of high quality, and grounded in evidence-based and promising-practice protocols. Care is efficient and does not waste resources, including the time of people being served.
7. Appropriately credentialed professionals who deliver integrated care are supported with ongoing high quality training and supervision.

8. An integrated services system of care incorporates elements of ongoing quality improvement, such as measured outcomes using standardized assessments and strategies.
9. To accomplish these elements, a state-level and organizational system of care must support integrated services through:
    a. Supportive financial, human resource development, and organizational systems;
    b. HIT which integrates behavioral health and primary care records and includes patients' access to their own health information; and
    c. Regulatory and licensing policies.

Appendix C. Survey Round Two Grantees

Round 2 Integration Initiative Grantees (2008)
Clinical Implementation

Directions: Please respond to these questions about what has happened since the end of your Maine Health Access Foundation Integration Initiative (Integrated Care) grant which ended in December 2010. This survey is part of MeHAF's assessment of the sustainability of integrated care. An independently contracted evaluator will access the responses instead of MeHAF staff. We appreciate your time and willingness to participate in this survey.

1. Grantee Organization: *(Please select from drop down menu.)*

2. Number of current integrated behavioral health and primary care sites/practices in your organization. *(Please select from drop down menu.)*

3. Please list all of the practices/sites in your organization that are currently providing integrated care. Include site/clinic along with the town.

4. How much did you implement during the MeHAF funded period?

Component	Extent of Implement.		
	Not at All	Small Extent	Major Extent
a) Was/Is there a team including primary care and mental/behavioral health care providers and the patient/family?			
b) Did you use screening tools systematically?			
c) Was/Is Care/Case Management provided?			
d) Were/Are treatment plans for BH, MH and PC integrated and available to all providers on the team?			
e) Was/Is a systematic communication strategy established among team members (e.g., EHR, regular communications, team huddles, meetings)?			
f) Were/Are warm hand offs used regularly?			
g) Were/Are patients/families fully informed and involved in decisions about their care (shared decision making?)			
h) Were/Are patients/families informed about integrated care as the approach being used for their care at the site?			
i) Did/Do the practices/sites have Patient Advisory Councils or groups or other ways to actively engage patients in decisions related to the implementation of integrated care?			
j) Did/Does the practice/site monitor follow-up referrals, clinical tests, etc. and provide follow up for medical care?			
k) Did/Does the practice/site monitor follow-up referrals, clinical tests, etc. and provide follow up for behavioral health services?			
l) Did/Do the practices/sites provide seamless referrals and links to community social services and supports (support groups, peer networks, transportation, housing supports, etc.) for patients?			
m) Did/Do the sites/practices use a shared record for behavioral and medical documentation and treatment planning?			
n) Did/Do the practices/sites routinely collect and use data for quality improvement?			
o) Did/Do the practices/sites routinely collect and use patient-level data to monitor and follow up on patient care for patients receiving integrated care?			
p) Did/Do the practices/sites routinely collect and use patient-level data to monitor and follow up on patient outcomes for patients receiving integrated care?			

Note: BH = Behavioral Health MH = Mental Health PC = Primary Care

5. Are you still implementing this component now?

Component	Extent of Implement.		
	Not at All	Small Extent	Major Extent
a) Was/Is there a team including primary care and mental/behavioral health care providers and the patient/family?			
b) Did you use screening tools systematically?			
c) Was/Is Care/Case Management provided?			
d) Were/Are treatment plans for BH, MH and PC integrated and available to all providers on the team?			
e) Was/Is a systematic communication strategy established among team members (e.g., EHR, regular communications, team huddles, meetings)?			
f) Were/Are warm hand offs used regularly?			
g) Were/Are patients/families fully informed and involved in decisions about their care (shared decision making?)			
h) Were/Are patients/families informed about integrated care as the approach being used for their care at the site?			
i) Did/Do the practices/sites have Patient Advisory Councils or groups or other ways to actively engage patients in decisions related to the implementation of integrated care?			
j) Did/Does the practice/site monitor follow-up referrals, clinical tests, etc. and provide follow up for medical care?			
k) Did/Does the practice/site monitor follow-up referrals, clinical tests, etc. and provide follow up for behavioral health services?			
l) Did/Do the practices/sites provide seamless referrals and links to community social services and supports (support groups, peer networks, transportation, housing supports, etc.) for patients?			
m) Did/Do the sites/practices use a shared record for behavioral and medical documentation and treatment planning?			
n) Did/Do the practices/sites routinely collect and use data for quality improvement?			
o) Did/Do the practices/sites routinely collect and use patient-level data to monitor and follow up on patient care for patients receiving integrated care?			
p) Did/Do the practices/sites routinely collect and use patient-level data to monitor and follow up on patient outcomes for patients receiving integrated care?			

Note: BH = Behavioral Health MH = Mental Health PC = Primary Care

6. Did your project have any components of integrated care that are *not* listed above? If so, please describe them briefly, and indicate whether you are still implementing those additional components (such as peer navigation, outreach and education, psychiatric services, medical consultations, other consultations, etc.): [Open-ended response.]

7. How do you pay for personnel and other costs directly related to integrated care services? Check all that apply. Complete the form for each currently-participating site, if you have variations in payment strategies among the sites.

Payment method	Medical Providers and Staff	Behavioral Health Providers and Staff	Case/Care Managers	Administrative, Infrastructure Support Staff specific to Integrated Care	Other (i.e., Peer Navigators, supervisors, trainers, etc.)
Billing reimbursement (Public and/or private payers)					
Grant funding (specify source)					
Federal funding, expect for reimbursements					
Patient Centered Medical Home pmpm enhanced payments					
Other bundled or global payments					
Performance incentives					
Contractual agreements					
Salaries/benefits absorbed by organization					
Offset by prevented losses through improved patient flow, reduced No Shows, etc.					
Other (Please describe.)					

Thank you very much for participating. Your answers will help us plan strategies to help sustain integrated care.

Appendix D. Interview Protocols Round Two

Sustainability Interviews
Round II Integration Initiative Grantees (2008)
Protocol for Clinical Implementation Grantees

Background Information:

Grantee Organization:_____

Number of Sites (see Survey Monkey results, if available): _____

Number of Sites Involved During Grant Period: _____

Project Director: _____

Name of Interviewee: _____

Was Respondent Involved in Project Prior to December 2009: _____ Yes _____ No

Date of Interview: _____

[Note for interviewer: In case the person interviewed asks for clarification on the definition of integrated care, the definition we are using is "Integrated Care brings behavioral (including substance use), mental, and physical health to people in a coordinated way. It creates a relationship between a patient and a team of health professionals to achieve improved health and cost effectiveness."]

Introduction and Consent Statement

Thank you for agreeing to participate in this survey about your Integration Initiative grant funded by the Maine Health Access Foundation. As you (may) know, in 2008, your organization was awarded a three-year grant from MeHAF to implement integrated behavioral health and primary care.

I would like to ask you a few questions about what has happened since the end of your grant which wrapped up in December, 2011. This interview is part of the Foundation's assessment of the sustainability for integrated care. I hope you will provide honest answers about what is currently happening. We all recognize that it is sometimes difficult to sustain projects funded from an external granting source like MeHAF so it is perfectly appropriate if you answer "no" to any of the questions on this survey.

While this interview is not anonymous, I'd like to assure you that the information you provide will be kept confidential and will not be shared outside of MeHAF and its contracted consultants/evaluators related to integrated care. Additionally, any information you share today will not impact your future opportunities to partner with MeHAF, positively nor negatively.

I anticipate that the interview will take no longer than one hour. I want to be sure that I capture all of the information you provide and sometimes I can't write fast enough. Is it okay with you if I record our conversation?

Do you have any questions?....Okay, let's begin.

Interview Questions

1. The first set of questions focuses on the sites, practices or settings within your organization where you currently provide integrated behavioral health and primary care services. Can you list each of these sites for me and the town they are located in? (Note: Verify list if available through Survey Monkey)

2. Now, I'd like to learn about your ongoing integration efforts with these sites since the end of the grant.

   A. Let's start with your grant funded sites first. How would you classify the level of integration at your first site [name] by the end of the grant…[read categories below].

Site	Fully – by the end of grant	Fully – but completed after grant ended	Partially – with same pop. Served during grant	Partially – different pop. served	Integrated care no longer offered. Why?

   A.1 If "integrated care no longer offered…" what would most help you to continue offering integrated care? [Omit for others.] – then skip to Q11
   a. Bundled or global payments;
   b. More opportunities for billing;
   c. Higher rates of reimbursement;
   d. ACO structure;
   e. Ability to recruit and retain high quality staff (what credentials?)
   f. More key leadership support in the organization;
   g. Key leadership support in state agencies;
   h. Other (Please specify.)

C. Now let's discuss your expansion sites (those that now include some level of integration). How would you classify the level of integration at [expansion site] now…fully integrated or partially integrated and who is being served?

Site	Fully	Partially	Population Served?

3. Please describe your *current* integrated care approach/practice- overall.

4. During the time that you were implementing the Integration Initiative grant, how would you categorize the level of integrated care at your sites/practices based on the following definitions? [Definitions come from the AHRQ Publication NO. 11-0067 (July 2011) *A national agenda for research in collaborative care.* Charlotte Mullican, editor.]
   a. C oordinated—"Basic collaboration at a distance. Referral-triggered periodic exchange of information between/among clinicians in separate medical and behavioral settings, with minimally-shared care plan or clinic culture.
   b. Co-located—"Basic collaboration on-site. Behavioral and medical clinicians in same space, with regular communication, usually separate systems, but some shared care plans and clinic culture."
   c. Integrated—"In partially or fully integrated system. Shared space and systems with regular communication, mostly unified rather than separate care plans, and largely shared culture and collaborative routines."

5. How likely are you to continue your integrated care services?
   a. Very likely;
   b. Somewhat likely;
   c. Neither likely nor unlikely;
   d. Somewhat unlikely; or
   e. Very unlikely.

B. What are the leading factors that have contributed to your choice?

The next set of questions focus on any changes your organization experienced in the proportion of patients and providers engaged in integrated care.

6. In your opinion, the *current* number of patients receiving integrated care in your organization is:

    a. More than at the end of the MeHAF-funded project;
    b. About the same number as at the end of the MeHAF-funded project;
    c. Fewer than at the end of the MeHAF-funded project;
    d. None; or
    e. Unknown.

7. The current number of Primary Care Providers engaged in integrated care at your organization is:
    a. More than at the end of the MeHAF-funded project;
    b. About the same number as at the end of the MeHAF-funded project;
    c. Fewer than at the end of the MeHAF-funded project;
    d. None; or
    e. Unknown.

8. The current number of Behavioral Health Providers engaged in integrated care at your organization is:
    a. More than at the end of the MeHAF-funded project;
    b. About the same number as at the end of the MeHAF-funded project;
    c. Fewer than at the end of the MeHAF-funded project;
    d. None; or
    e. Unknown.

9. Currently, what professional licensure do the people providing integrated care in your practices/sites hold (MD, NP, PNP, LCSW, LCPC, Psychiatrist, Psychologist, etc.)?

Probes:

Does your organization tend to use one type of provider (e.g., LCSW or LCPC versus Psychologists) more than others?

Are there others engaged in this work?

10. What partnerships (if any) were established as a result of the grant? Who were the partners and what were their roles? Have the partnerships established as part of the grant continued? Have they changed? If so, how?

11. What factors are most likely to help you sustain integrated care?

[Interviewer: when possible, code responses based on the following.]

a. Active support from your organization's/agency's executives or administrators;
b. Actions by your organization's/agency's Board members;
c. Program is essential to carrying out the mission of your agency;
d. Actions of an internal "champion" or key leader;
e. Agency has existing "capacity" (e.g., enough staff member, skills, resources) to continue the program;
f. Reimbursements/third-party payments offset costs;
g. Cost is low enough so you did not need substantial resources to continue;
h. New grant funding is available;
i. Outcome/evaluation data convinces potential funders of the value of this program;
j. Current or previous clients serve as advocates for the program;
k. Staff members believe in the program so much they will not let it discontinue;
l. Partnerships with other organizations help find new funding sources;
m. Collaborative partners from the MeHAF grant period provide in-kind or other resources for continuation;
n. Technical assistance or guidance from an external agency;
o. Patients' acceptance of integrated care;
p. Providers' acceptance of integrated care;
q. Changes in state and/or federal policies and resources to support integrated care;
r. Other helpful influences. (Please specify);

12. What are your greatest continuing barriers to providing integrated care?

[Interviewer: when possible, code responses based on the following.]

a. Obtaining funding from third-party reimbursement and other external sources;
b. Obtaining funding from organization's budget, or other internal sources;
c. Obtaining resources from partner organizations;
d. Obtaining other outside resources such as grants;
e. Obtaining support from organization's administrators for continuing project activities;
f. Project leader or other key project "champion" left the organization;
g. Turnover among staff members delivering project services;
h. Organization's priorities changed and the integrated care focus is no longer a priority;
i. Maintaining agreement among partners essential for continuing project activities;
j. Lack of the physical space (such as lease terminated, or project offices used for a different purpose, etc.);
k. Equipment or facilities needed (such as computers) no longer available;
l. Policy changes that were agreed on temporarily during project were not made permanent;
m. Partner organizations did not do what they promised;
n. Investment in resources was not worth the effort;
o. Lack of case management/care management;
p. Lack of sufficient patient volume to support the work;
q. Lack of patients' acceptance;
r. Lack of providers' buy in; and/or
s. Other barriers (please specify)

13. Since the end of your integrated care MeHAF grant in December 2010, have you or any of your grant partners participated in any of the following types of networking opportunities related to integrated care,? (Circle all that apply.) [Might want to make a chart for this in report.]

a. Contact(s) with other MeHAF Integration Initiative grantees;
b. Receiving assistance or ideas from another MeHAF Integrated Initiative grantee;
c. Receiving assistance from the Integrated Care Training Academy awardees;
d. Providing assistance or ideas to other healthcare organizations;
e. Providing formal training about integrated care to other healthcare organizations;
f. Partnering with another organization for joint activities about integrated care (Was it with a formal agreement, such as a memorandum of understanding?);
g. Other contact with another organization or agency (not a MeHAF grantee) that you learned about from MeHAF;
h. Communicating with other funding sources in Maine about potential or actual new funding for this project;
i. None of the above;
j. Other (please specify):

14. Since the end of your grant in December 2010, have you used any of the following methods to disseminate information about your MeHAF integrated care? (Circle all that apply.)

    a. Presented to a local or state-level professional audience;
    b. Presented to a national or international professional audience;
    c. Wrote article(s) that was (were) published, accepted, or being revised for publication in a peer-reviewed journal;
    d. Wrote article(s) for a newsletter or brochure;
    e. Had article(s) published in a local or state newspaper;
    f. Received local or regional media coverage—including print, television or radio broadcast;
    g. Received national media coverage—including print (NY Times, USA Today, Time, Newsweek, etc.), television or radio;
    h. Used information or materials from the project in teaching a college-level course;
    i. Developed a "how-to" manual or training package;
    j. Provided technical assistance to other agencies trying to implement integrated care;
    k. None of the above.
    l. Other (please specify):

15. How could MeHAF assist with sustaining your integrated care initiative (other than additional grant funds)?

16. Is there anything not addressed in this survey that you would like to share about your project since the MeHAF funding ended?

Thank you for taking time for today's interview. If you have any questions or have more detailed information to share, you may contact me at (Interviewer name, contact #). If you have questions or information you would like to share with MeHAF, you may contact Becky Hayes Boober at bhboober@mehaf.org or at 207-620-8266, ext. 114.

Again, thank you for participating in this survey to assist MeHAF with its efforts to support integrated behavioral health and primary care.

Maine Definition of Integrated Behavioral Health and Primary Care

External, Public Messages:

Integrated Care brings behavioral, mental, and physical health to people in a coordinated way. It creates a relationship between a patient and a team of health professionals to achieve improved health and cost effectiveness.

Desired Outcome

People's health, daily lives, and functioning improve as a result of engaging with a health care system that treats them as whole persons. The system integrates behavioral health and primary care and is cost effective.

Values and Guiding Principles

- Integrated behavioral health and primary care means that people get complete care for all their health needs in the right time and place.
- Care is patient and family-centered, so persons being served can be engaged, active, and knowledgeable.
- Individuals have a sustained and trusting relationship with healthcare professional(s) who serve as their primary care team guiding and coordinating their health care. This healing relationship relies on two-way communication and shared decision-making.
- Treatment incorporates the resources of communities where people live.
- No matter where or how people come into the health care system, they will receive the behavioral health and primary care services they need.
- Prevention, early intervention, and recovery are as important as disease/condition treatment and interventions.

Internal, Health Care System Messages:

Operational Elements (The Ideal)

1. In integrated care, people connect with a welcoming health home where they participate in their healthcare with one team of behavioral health and primary care professionals.
2. Physical and behavioral health providers and specialists as needed provide fully collaborative, patient-centered care across the continuum of care. The team, including the patient, develops and implements a coordinated health improvement and care plan. The integrated team shares a full spectrum of information to make informed decisions, most often using common health records. Formal relationships between behavioral health provider systems, primary care systems, and specialty care ensure access to a full range of coordinated treatment options.
3. People receiving services have an on-going relationship with and work closely with a primary health professional who provides care/case management onsite. Services appropriately address both physical and behavioral needs and link to necessary community resources.
4. People receiving services and their families are informed, active and competent partners with the health care system in their own health care assessments and plans as well as in the design of the system.
5. People receiving services can easily access their choice of setting(s) for their care.
6. Care is flexible and responsive, safe, timely, effective, of high quality, and grounded in evidence-based and promising-practice protocols. Care is efficient and does not waste resources, including the time of people being served.

7. Appropriately credentialed professionals who deliver integrated care are supported with ongoing high quality training and supervision.
8. An integrated services system of care incorporates elements of ongoing quality improvement, such as measured outcomes using standardized assessments and strategies.
9. To accomplish these elements, a state-level and organizational system of care must support integrated services through:
    a. Supportive financial, human resource development, and organizational systems;
    b. HIT which integrates behavioral health and primary care records and includes patients' access to their own health information; and
    c. Regulatory and licensing policies.

Sustainability Interviews
Round II Integration Initiative Grantees (2008)
Protocol for Systems Transformation Grantees

Background Information:

Grantee Organization:_____

Number of Sites (see Survey Monkey results, if available): _____

Number of Sites Involved During Grant Period: _____NA_____

Project Director: _____

Name of Interviewee: _____

Was Respondent Involved in Project Prior to December 2009: _____ Yes _____ No

Date of Interview: _____

[Note for interviewer: In case the person interviewed asks for clarification on the definition of integrated care, the definition we are using is "Integrated Care brings behavioral (including substance use), mental, and physical health to people in a coordinated way. It creates a relationship between a patient and a team of health professionals to achieve improved health and cost effectiveness."]

Introduction and Consent Statement

Thank you for agreeing to participate in this survey about your Integration Initiative grant funded by the Maine Health Access Foundation. As you (may) know, in 2008, your organization was awarded a three-year "systems transformation" grant from MeHAF regarding integrated behavioral health and primary care.

I would like to ask you a few questions about what has happened since the end of your grant which wrapped up in December, 2011. This interview is part of the Foundation's assessment of the sustainability for integrated care. I hope you will provide honest answers about what is currently happening. We all recognize that it is sometimes difficult to sustain projects funded from an external granting source like MeHAF so it is perfectly appropriate if you answer "no" to any of the questions on this survey.

While this interview is not anonymous, I'd like to assure you that the information you provide will be kept confidential and will not be shared outside of MeHAF and its contracted consultants/evaluators related to integrated care. Additionally, any information you share today will not impact your future opportunities to partner with MeHAF, positively nor negatively.

I anticipate that the interview will take no longer than one hour. I want to be sure that I capture all of the information you provide and sometimes I can't write fast enough. Is it okay with you if I record our conversation?

Do you have any questions?....Okay, let's begin.

Interview Questions

1. I'd like to start by having you describe the major components of your project/grant.

2. Which components of the grant have continued?

3. How are you funding these efforts now?

   Probes: Internal committees/groups
   Patient Centered Medical Home
   QI Efforts
   Expanded data collection efforts (e.g., BRFSS)

4. How likely are you to continue your integrated care program components?
   a. Very likely;
   b. Somewhat likely;
   c. Neither likely nor unlikely;
   d. Somewhat unlikely; or
   e. Very unlikely.

5. What are the leading factors that have contributed to your choice?

6. How did you measure your success on the grant in terms of achieving integrated care?

7. During your grant, did you work directly with clinical practices? If so, which practices (verify list, if data already available)?

   A. Which of these practices are you still working with to support integrated care?

   B. After the grant ended, did you expand your integration efforts with new practices? If so, how many?

8. What partnerships (if any) were established as a result of the grant? Who were the partners and what were their roles? Have the partnerships established as part of the grant continued? Have they changed? If so, how?

9. During your grant, did you work directly with other community groups? If so, who did you work with?

10. What factors are most likely to help you sustain integrated care?

    [Interviewer: when possible, code responses based on the following.]
    a. Active support from your organization's/agency's executives or administrators;
    b. Actions by your organization's/agency's Board members;
    c. Program is essential to carrying out the mission of your agency;
    d. Actions of an internal "champion" or key leader;
    e. Agency has existing "capacity" (e.g., enough staff member, skills, resources) to continue the program;
    f. Reimbursements/third-party payments offset costs;
    g. Cost is low enough so you did not need substantial resources to continue;
    h. New grant funding is available;
    i. Outcome/evaluation data convinces potential funders of the value of this program;
    j. Current or previous clients serve as advocates for the program;
    k. Staff members believe in the program so much they will not let it discontinue;
    l. Partnerships with other organizations help find new funding sources;
    m. Collaborative partners from the MeHAF grant period provide in-kind or other resources for continuation;
    n. Technical assistance or guidance from an external agency;
    o. Patients' acceptance of integrated care;
    p. Providers' acceptance of integrated care;
    q. Changes in state and/or federal policies and resources to support integrated care;
    r. Other helpful influences. (Please specify);

11. What are your greatest continuing barriers to providing integrated care?

[Interviewer: when possible, code responses based on the following.]

a. Obtaining funding from third-party reimbursement and other external sources;
b. Obtaining funding from organization's budget, or other internal sources;
c. Obtaining resources from partner organizations;
d. Obtaining other outside resources such as grants;
e. Obtaining support from organization's administrators for continuing project activities;
f. Project leader or other key project "champion" left the organization;
g. Turnover among staff members delivering project services;
h. Organization's priorities changed and the integrated care focus is no longer a priority;
i. Maintaining agreement among partners essential for continuing project activities;
j. Lack of the physical space (such as lease terminated, or project offices used for a different purpose, etc.);
k. Equipment or facilities needed (such as computers) no longer available;
l. Policy changes that were agreed on temporarily during project were not made permanent;
m. Partner organizations did not do what they promised;
n. Investment in resources was not worth the effort;
o. Lack of case management/care management;
p. Lack of sufficient patient volume to support the work;
q. Lack of patients' acceptance;
r. Lack of providers' buy in; and/or
s. Other barriers (please specify)

12. Since the end of your integrated care MeHAF grant in December 2010, have you or any of your grant partners participated in any of the following types of networking opportunities related to integrated care,? (Circle all that apply.) [Might want to make a chart for this in report.]

k. Contact(s) with other MeHAF Integration Initiative grantees;
l. Receiving assistance or ideas from another MeHAF Integrated Initiative grantee;
m. Receiving assistance from the Integrated Care Training Academy awardees;
n. Providing assistance or ideas to other healthcare organizations;
o. Providing formal training about integrated care to other healthcare organizations;
p. Partnering with another organization for joint activities about integrated care (Was it with a formal agreement, such as a memorandum of understanding?);
q. Other contact with another organization or agency (not a MeHAF grantee) that you learned about from MeHAF;
r. Communicating with other funding sources in Maine about potential or actual new funding for this project;
s. None of the above;
t. Other (please specify):

13. Since the end of your grant in December 2010, have you used any of the following methods to disseminate information about your MeHAF integrated care? (Circle all that apply.)
    m. Presented to a local or state-level professional audience;
    n. Presented to a national or international professional audience;
    o. Wrote article(s) that was (were) published, accepted, or being revised for publication in a peer-reviewed journal;
    p. Wrote article(s) for a newsletter or brochure;
    q. Had article(s) published in a local or state newspaper;
    r. Received local or regional media coverage—including print, television or radio broadcast;
    s. Received national media coverage—including print (NY Times, USA Today, Time, Newsweek, etc.), television or radio;
    t. Used information or materials from the project in teaching a college-level course;
    u. Developed a "how-to" manual or training package;
    v. Provided technical assistance to other agencies trying to implement integrated care;
    w. None of the above.
    x. Other (please specify):

14. How could MeHAF assist with sustaining your integrated care initiative (other than additional grant funds)?

15. Is there anything not addressed in this survey that you would like to share about your project since the MeHAF funding ended?

Thank you for taking time for today's interview. If you have any questions or have more detailed information to share, you may contact me at (Interviewer name, contact #). If you have questions or information you would like to share with MeHAF, you may contact Becky Hayes Boober at bhboober@mehaf.org or at 207-620-8266, ext. 114.

Again, thank you for participating in this survey to assist MeHAF with its efforts to support integrated behavioral health and primary care.

Maine Definition of Integrated Behavioral Health and Primary Care

External, Public Messages:

Integrated Care brings behavioral, mental, and physical health to people in a coordinated way. It creates a relationship between a patient and a team of health professionals to achieve improved health and cost effectiveness.

Desired Outcome

People's health, daily lives, and functioning improve as a result of engaging with a health care system that treats them as whole persons. The system integrates behavioral health and primary care and is cost effective.

Values and Guiding Principles

- Integrated behavioral health and primary care means that people get complete care for all their health needs in the right time and place.
- Care is patient and family-centered, so persons being served can be engaged, active, and knowledgeable.
- Individuals have a sustained and trusting relationship with healthcare professional(s) who serve as their primary care team guiding and coordinating their health care. This healing relationship relies on two-way communication and shared decision-making.
- Treatment incorporates the resources of communities where people live.
- No matter where or how people come into the health care system, they will receive the behavioral health and primary care services they need.
- Prevention, early intervention, and recovery are as important as disease/condition treatment and interventions.

Internal, Health Care System Messages:

Operational Elements (The Ideal)

1. In integrated care, people connect with a welcoming health home where they participate in their healthcare with one team of behavioral health and primary care professionals.
2. Physical and behavioral health providers and specialists as needed provide fully collaborative, patient-centered care across the continuum of care. The team, including the patient, develops and implements a coordinated health improvement and care plan. The integrated team shares a full spectrum of information to make informed decisions, most often using common health records. Formal relationships between behavioral health provider systems, primary care systems, and specialty care ensure access to a full range of coordinated treatment options.
3. People receiving services have an on-going relationship with and work closely with a primary health professional who provides care/case management onsite. Services appropriately address both physical and behavioral needs and link to necessary community resources.
4. People receiving services and their families are informed, active and competent partners with the health care system in their own health care assessments and plans as well as in the design of the system.
5. People receiving services can easily access their choice of setting(s) for their care.
6. Care is flexible and responsive, safe, timely, effective, of high quality, and grounded in evidence-based and promising-practice protocols. Care is efficient and does not waste resources, including the time of people being served.

7. Appropriately credentialed professionals who deliver integrated care are supported with ongoing high quality training and supervision.
8. An integrated services system of care incorporates elements of ongoing quality improvement, such as measured outcomes using standardized assessments and strategies.
9. To accomplish these elements, a state-level and organizational system of care must support integrated services through:
    a. Supportive financial, human resource development, and organizational systems;
    b. HIT which integrates behavioral health and primary care records and includes patients' access to their own health information; and
    c. Regulatory and licensing policies.

Sustainability Interviews
Round II Integration Initiative Grantees (2008)
Protocol for Planning Grantees

Background Information:

Grantee Organization:_____

Number of Sites (see Survey Monkey results, if available): _____

Number of Sites Involved During Grant Period: _____NA_____

Project Director: _____

Name of Interviewee: _____

Was Respondent Involved in Project Prior to December 2009: _____ Yes _____ No

Date of Interview: _____

[Note for interviewer: In case the person interviewed asks for clarification on the definition of integrated care, the definition we are using is "Integrated Care brings behavioral (including substance use), mental, and physical health to people in a coordinated way. It creates a relationship between a patient and a team of health professionals to achieve improved health and cost effectiveness."]

Introduction and Consent Statement

Thank you for agreeing to participate in this survey about your Integration Initiative grant funded by the Maine Health Access Foundation. As you (may) know, in 2008, your organization was awarded a one-year planning grant from MeHAF regarding integrated behavioral health and primary care.

I would like to ask you a few questions about what has happened since the end of your grant which wrapped up in December, 2009. This interview is part of the Foundation's assessment of the sustainability for integrated care. I hope you will provide honest answers about what is currently happening. We all recognize that it is sometimes difficult to sustain projects funded from an external granting source like MeHAF so it is perfectly appropriate if you answer "no" to any of the questions on this survey.

While this interview is not anonymous, I'd like to assure you that the information you provide will be kept confidential and will not be shared outside of MeHAF and its contracted consultants/evaluators related to integrated care. Additionally, any information you share today will not impact your future opportunities to partner with MeHAF, positively nor negatively.

I anticipate that the interview will take no longer than one hour. I want to be sure that I capture all of the information you provide and sometimes I can't write fast enough. Is it okay with you if I record our conversation?

Do you have any questions?....Okay, let's begin.

Interview Questions

1. The first set of questions focuses on the sites, practices or settings within your organization where you *currently* provide integrated behavioral health and primary care services. Can you list each of these sites for me and the town they are located in? (Note: Verify list if available through Survey Monkey)

2. Now, I'd like to learn about your ongoing integration efforts with these sites since the end of the MeHAF grant. How would you *currently* classify the level of integration at your [name] site [read categories below].

Site	Town	Fully	Partially	Population Served

3. Please describe your *current* integrated care approach/practice- overall.

4. Currently, how would you categorize the level of integrated care at your sites/practices based on the following definitions? [Definitions come from the AHRQ Publication NO. 11-0067 (July 2011) *A national agenda for research in collaborative care.* Charlotte Mullican, editor.]
    a. Coordinated—"Basic collaboration at a distance. Referral-triggered periodic exchange of information between/among clinicians in separate medical and behavioral settings, with minimally-shared care plan or clinic culture.
    b. Co-located—"Basic collaboration on-site. Behavioral and medical clinicians in same space, with regular communication, usually separate systems, but some shared care plans and clinic culture."
    c. Integrated—"In partially or fully integrated system. Shared space and systems with regular communication, mostly unified rather than separate care plans, and largely shared culture and collaborative routines."

5. How likely are you to continue your integrated care services?
    a. Very likely;
    b. Somewhat likely;
    c. Neither likely nor unlikely;
    d. Somewhat unlikely; or
    e. Very unlikely.

    C. What are the leading factors that have contributed to your choice?

The next set of questions focus on any changes your organization experienced in the proportion of patients and providers engaged in integrated care.

6. In your opinion, the *current* number of patients receiving integrated care in your organization is:

    a. More than at the end of the MeHAF-funded project;
    b. About the same number as at the end of the MeHAF-funded project;
    c. Fewer than at the end of the MeHAF-funded project;
    d. None; or
    e. Unknown.

7. The current number of Primary Care Providers engaged in integrated care at your organization is:
    a. More than at the end of the MeHAF-funded project;
    b. About the same number as at the end of the MeHAF-funded project;
    c. Fewer than at the end of the MeHAF-funded project;
    d. None; or
    e. Unknown.

8. The current number of Behavioral Health Providers engaged in integrated care at your organization is:
    a. More than at the end of the MeHAF-funded project;
    b. About the same number as at the end of the MeHAF-funded project;
    c. Fewer than at the end of the MeHAF-funded project;
    d. None; or
    e. Unknown.

9. Currently, what professional licensure do the people providing integrated care in your practices/sites hold (MD, NP, PNP, LCSW, LCPC, Psychiatrist, Psychologist, etc.)?

    Probes: Does your organization tend to use one type of provider (e.g., LCSW or LCPC versus Psychologists) more than others?

    Are there others engaged in this work?

10. What partnerships (if any) were established as a result of the grant? Who were the partners and what were their roles? Have the partnerships established as part of the grant continued? Have they changed? If so, how?

11. What factors are most likely to help you sustain integrated care?

    [Interviewer: when possible, code responses based on the following.]
    a. Active support from your organization's/agency's executives or administrators;
    b. Actions by your organization's/agency's Board members;
    c. Program is essential to carrying out the mission of your agency;
    d. Actions of an internal "champion" or key leader;
    e. Agency has existing "capacity" (e.g., enough staff member, skills, resources) to continue the program;
    f. Reimbursements/third-party payments offset costs;
    g. Cost is low enough so you did not need substantial resources to continue;
    h. New grant funding is available;
    i. Outcome/evaluation data convinces potential funders of the value of this program;
    j. Current or previous clients serve as advocates for the program;
    k. Staff members believe in the program so much they will not let it discontinue;
    l. Partnerships with other organizations help find new funding sources;
    m. Collaborative partners from the MeHAF grant period provide in-kind or other resources for continuation;
    n. Technical assistance or guidance from an external agency;
    o. Patients' acceptance of integrated care;
    p. Providers' acceptance of integrated care;
    q. Changes in state and/or federal policies and resources to support integrated care;
    r. Other helpful influences. (Please specify);

12. What are your greatest continuing barriers to providing integrated care?

[Interviewer: when possible, code responses based on the following.]

a. Obtaining funding from third-party reimbursement and other external sources;
b. Obtaining funding from organization's budget, or other internal sources;
c. Obtaining resources from partner organizations;
d. Obtaining other outside resources such as grants;
e. Obtaining support from organization's administrators for continuing project activities;
f. Project leader or other key project "champion" left the organization;
g. Turnover among staff members delivering project services;
h. Organization's priorities changed and the integrated care focus is no longer a priority;
i. Maintaining agreement among partners essential for continuing project activities;
j. Lack of the physical space (such as lease terminated, or project offices used for a different purpose, etc.);
k. Equipment or facilities needed (such as computers) no longer available;
l. Policy changes that were agreed on temporarily during project were not made permanent;
m. Partner organizations did not do what they promised;
n. Investment in resources was not worth the effort;
o. Lack of case management/care management;
p. Lack of sufficient patient volume to support the work;
q. Lack of patients' acceptance;
r. Lack of providers' buy in; and/or
s. Other barriers (please specify)

13. Since the end of your integrated care MeHAF grant in December 2010, have you or any of your grant partners participated in any of the following types of networking opportunities related to integrated care,? (Circle all that apply.) [Might want to make a chart for this in report.]

a. Contact(s) with other MeHAF Integration Initiative grantees;
b. Receiving assistance or ideas from another MeHAF Integrated Initiative grantee;
c. Receiving assistance from the Integrated Care Training Academy awardees;
d. Providing assistance or ideas to other healthcare organizations;
e. Providing formal training about integrated care to other healthcare organizations;
f. Partnering with another organization for joint activities about integrated care (Was it with a formal agreement, such as a memorandum of understanding?);
g. Other contact with another organization or agency (not a MeHAF grantee) that you learned about from MeHAF;
h. Communicating with other funding sources in Maine about potential or actual new funding for this project;
i. None of the above;
j. Other (please specify):

14. Since the end of your grant in December 2010, have you used any of the following methods to disseminate information about your MeHAF integrated care? (Circle all that apply.)
    a. Presented to a local or state-level professional audience;
    b. Presented to a national or international professional audience;
    c. Wrote article(s) that was (were) published, accepted, or being revised for publication in a peer-reviewed journal;
    d. Wrote article(s) for a newsletter or brochure;
    e. Had article(s) published in a local or state newspaper;
    f. Received local or regional media coverage—including print, television or radio broadcast;
    g. Received national media coverage—including print (NY Times, USA Today, Time, Newsweek, etc.), television or radio;
    h. Used information or materials from the project in teaching a college-level course;
    i. Developed a "how-to" manual or training package;
    j. Provided technical assistance to other agencies trying to implement integrated care;
    k. None of the above.
    l. Other (please specify):

15. How could MeHAF assist with sustaining your integrated care initiative (other than additional grant funds)?

16. Is there anything not addressed in this survey that you would like to share about your project since the MeHAF funding ended?

Thank you for taking time for today's interview. If you have any questions or have more detailed information to share, you may contact me at (Interviewer name, contact #). If you have questions or information you would like to share with MeHAF, you may contact Becky Hayes Boober at bhboober@mehaf.org or at 207-620-8266, ext. 114.

Again, thank you for participating in this survey to assist MeHAF with its efforts to support integrated behavioral health and primary care.

Maine Definition of Integrated Behavioral Health and Primary Care

External, Public Messages:

Integrated Care brings behavioral, mental, and physical health to people in a coordinated way. It creates a relationship between a patient and a team of health professionals to achieve improved health and cost effectiveness.

Desired Outcome

People's health, daily lives, and functioning improve as a result of engaging with a health care system that treats them as whole persons. The system integrates behavioral health and primary care and is cost effective.

Values and Guiding Principles

- Integrated behavioral health and primary care means that people get complete care for all their health needs in the right time and place.
- Care is patient and family-centered, so persons being served can be engaged, active, and knowledgeable.
- Individuals have a sustained and trusting relationship with healthcare professional(s) who serve as their primary care team guiding and coordinating their health care. This healing relationship relies on two-way communication and shared decision-making.
- Treatment incorporates the resources of communities where people live.
- No matter where or how people come into the health care system, they will receive the behavioral health and primary care services they need.
- Prevention, early intervention, and recovery are as important as disease/condition treatment and interventions.

Internal, Health Care System Messages:

Operational Elements (The Ideal)

1. In integrated care, people connect with a welcoming health home where they participate in their healthcare with one team of behavioral health and primary care professionals.
2. Physical and behavioral health providers and specialists as needed provide fully collaborative, patient-centered care across the continuum of care. The team, including the patient, develops and implements a coordinated health improvement and care plan. The integrated team shares a full spectrum of information to make informed decisions, most often using common health records. Formal relationships between behavioral health provider systems, primary care systems, and specialty care ensure access to a full range of coordinated treatment options.
3. People receiving services have an on-going relationship with and work closely with a primary health professional who provides care/case management onsite. Services appropriately address both physical and behavioral needs and link to necessary community resources.
4. People receiving services and their families are informed, active and competent partners with the health care system in their own health care assessments and plans as well as in the design of the system.
5. People receiving services can easily access their choice of setting(s) for their care.
6. Care is flexible and responsive, safe, timely, effective, of high quality, and grounded in evidence-based and promising-practice protocols. Care is efficient and does not waste resources, including the time of people being served.
7. Appropriately credentialed professionals who deliver integrated care are supported with ongoing high quality training and supervision.

8. An integrated services system of care incorporates elements of ongoing quality improvement, such as measured outcomes using standardized assessments and strategies.
9. To accomplish these elements, a state-level and organizational system of care must support integrated services through:
    a. Supportive financial, human resource development, and organizational systems;
    b. HIT which integrates behavioral health and primary care records and includes patients' access to their own health information; and
    c. Regulatory and licensing policies.

Appendix E. Expansion Sites: Round II and III Grantees

Practice or Site	Town/City
B Street Health Center	Lewiston
Brewer Health Center PA	Brewer
Brewer Medical Center	Brewer
Bridgton Internal Medicine	Bridgton
Bridgton Pediatrics	Bridgton
Bucksport Family Medicine	Bucksport
Cadillac Family Practice	Bar Harbor
Calias Women's Health Center	Calais
Castine Community Health Services	Castine
Central Maine Family Practice	Lewiston
Central Maine Family Residency	Lewiston
Central Maine Internal Medicine	Lewiston
Central Maine OB/GYN	Lewiston
Central Maine Residency	Lewiston
Central Maine Pediatrics	Lewiston
Eastport Health Care, Inc.- Eastport	Eastport
Eastport Health Care, Inc.- Machias	Machias
Eleanor Widener Dixon Memorial Clinic	Gouldsboro
Elsemore Dixfield Center	Dixfield
Elmwood Primary Care	Waterville
EMMC- Family Medicine of Brewer	Brewer
EMMC- Husson Family Medicine	Bangor
EMMC- Orono Family Medicine	Orono
Family Health Associates	Auburn
Family Medicine Institute	Augusta
Family Practice and Internal Medicine	Presque Isle
Farmington Family Practice	Farmington
Fore River Family Practice, MHSM	Portland
Fort Fairfield Health Center	Fort Fairfield
Franklin Internal Medicine	Farmington
Franklin Health Pediatrics	Franklin
Fryeburg Family Medicine	Fryeburg
Gorham Crossing Primary Care	Gorham
Inland Family Care- Fairfield	Fairfield
Inland Family Care- Oakland	Oakland
Inland Family Care- Unity	Unity
Inland Family Care- Washington St.	Waterville
Inland Family Care- Concourse St.	Waterville
Island Family Medicine	Stonington

Practice or Site	Town/City
Katahdin Nursing Home (now part of Rosscare)	Millinocket
Katahdin Valley Health Center- Houlton	Houlton
Katahdin Valley Health Center- Millinocket	Millinocket
Livermore Falls Family Practice	Livermore Falls
Lovejoy Health Center	Albion
Maine Dartmouth Family Practice	Fairfield
MMP Falmouth Family Medicine	Falmouth
Martin's Point Health Care- Brunswick Farley Road	Brunswick
Martin's Point Health Care- Portland Health Care Center	Portland
Martin's Point Healthcare- Bangor	Bangor
Mid Coast Medical Group Bath	Bath
Mid Coast Medical Group Brunswick	Brunswick
MMP Lakes Region Primary Care	Windham
Naples Family Practice	Naples
North Bridgton Family Practice	Bridgton
Northwoods Healthcare	Greenville
Oxford Hills Family Practice	Norway
Pediatric Continuity Clinic	Portland
Portland Internal Medicine	Portland
Rangeley Family Medicine	Rangeley
Richmond Area Health Center	Richmond
River Valley Internal Medicine	Rumford
Sacopee Valley Health Center	Porter
St. Mary's Poland Family Practice	Poland
St. Mary's Center for Family Medicine at Mollison Way	Lewiston
Strong Area Health Center	Strong
Swift River Healthcare	Rumford
SVH Family Care- Pittsfield	Pittsfield
SVH Family Care- Clinton	Clinton
SVH Family Care- Newport	Newport
Trenton Health Center	Trenton
Waterville Family Practice	Waterville
Wilton Family Practice	Wilton
Wiscasset Family Medicine	Wiscasset
Yarmouth Primary Care	Yarmouth
York County Community Health Care	Sanford