# Health Choice Network of Florida

## Care Management Medical Home Center – Integrated Behavioral Health Program

### *PROJECT OVERVIEW*

Health Choice Network (HCN) is a not-for-profit organization located in Miami, Florida. HCN collaborates with community health centers to develop, coordinate, and implement strategic health initiatives. By providing technical support to local federally qualified health centers (FQHCs) across 11 states, HCN seeks to improve the quality and accessibility of health care for vulnerable populations. The Care Management Medical Home Center (CMMHC) program has addressed both diabetic and behavioral health issues for more than 10,000 patients in Miami-Dade County. In an effort to remove barriers to patient compliance, HCN-Florida (HCNFL), which serves the state of Florida, implemented the Integrated Behavioral Health Project (IBHP) over the course of three years to establish comprehensive care and education for high-risk patients with both diabetes and depression diagnoses. The Integrated Behavioral Health Project set goals to: 1) improve delivery of their existing diabetes intervention program; and 2) engage patients considered "lost-to-care" into an integrated primary and behavioral health care management system. Lost-to care patients are individuals who have not attended health care visits in the previous 12 months with HbA1c levels > 9, and PHQ > 10 or a depression diagnosis.

### *CONTEXT AND PARTNERS*

Approximately 181,425 residents of Miami-Dade County currently have diabetes, with African Americans having twice the mortality rate as compared to White and Hispanic residents. Over 60% of residents are Hispanic, 18.5% African American, and 50% are foreign-born. With increasing uninsured and poor residents, the target population was selected to enhance care within underserved areas in south Miami-Dade County. This county consists of a large percentage of patients living at or below 200% of the federal poverty level and many are lost-to-care.

In an effort to address gaps in care for underserved patients, the HCNFL coordinators used a daily call roster to contact patients and follow up with appointments. Health staff enrolled patients and coordinated medical visits and services. The goals of the IBHP initiative were: 1) to integrate behavioral health with primary care for diabetes using engagement strategies; and 2) to improve health outcomes for participants.

Partners in the Care Management Medical Home Center – Integrated Behavioral Health Program included Federally Qualified Health Centers (FQHCs) and an academic medical center.

- Community Health of South Florida (CHI)
- Citrus Health Network (Citrus)
- University of Miami, Miller School of Medicine

### *ASSESSMENT AND PLANNING*

The planning and assessment phase occurred during the first six months of the funding period. To begin the assessment phase, the Project Manager conducted telephone surveys with patients meeting the criteria as lost-to-care in an effort to determine reasons for noncompliance with self-management and

appointments. Lost-to care patients are individuals who have not attended health care visits in the previous 12 months with HbA1c levels > 9, and PHQ > 10 or a depression diagnosis. Patients identified transportation, childcare, finance, illnesses, insurance issues, work and family, language issues, and other issues as barriers to care. HCN met with FQHCs to review results and recruit leaders to address each barrier. The leadership team included representatives from the partners to develop data collection forms and discuss strategies for promoting and tracking increased primary and behavioral health visits. The team engaged in monthly planning meetings with the purpose of sharing information, planning, and developing activities for the IBHP.

## *INTERVENTION*

The 30-month implementation period followed the planning phase. The IBHP project participants were screened and enrolled. The intervention used two approaches: 1) bidirectional referrals for patients with diabetes to behavioral health services and primary care physicians and 2) screening for patients at high risk by administering the Patient Health Questionnaire -9 (PHQ-9). The components and elements for the project are summarized in the table below.

| INTERVENTION COMPONENTS | SPECIFIC ELEMENTS (what was done) | MODES OF DELIVERY (by whom and how) |
|---|---|---|
| Diabetes Self-Management Education | •Initiate patient referrals for transportation, behavioral health counselors, medication assistance programs, nutrition, education, primary care physician, and labs<br>•Identifying and listing IBHP participants as priority patients<br>•Motivational interviewing conducted by Care Coordinators | •HCN and IBHP staff – phone calls to patients and healthcare providers |
| Support for Managing Diabetes and Distress | •PHQ-9 Form completion with patients<br>•Behavioral health services | • FQHCs – health care appointments, survey administration |
| Enhanced Access/Linkage to Care | •Complete Patient Contact and PHQ-9 Forms for project participation<br>•Motivational interviewing conducted by Care Coordinators<br>•Scheduling patient behavioral health appointments<br>•Scheduling patient primary care appointments<br>•Establish and maintain up-to-date patient registries through monthly rosters | •FQHCs – phone calls to patients<br>•FQHCs – in-person visits to patients<br>•FQHCs – phone calls to behavioral healthcare providers<br>•FQHCs – phone calls to primary healthcare providers<br>•HCNFL Business Intelligence Team – Monthly enrollment reports |
| Improve Quality of Care | • Initiating referrals for services (e.g. transportation, PCP) to patients seeking health care | •FQHCs |

## *STORY OF TRANSFORMATION – Engaging patients who were lost-to-care*

FQHC Care Coordinators build rapport with patients to assist them in achieving personal health and healthcare goals. Because the Care Coordinators have been trained to provide motivational interviewing, navigate barriers to care, and build rapport with members of the community, and are familiar with the healthcare process, they are able to provide a unique set of services to patients who are deemed lost-to-care. The following success stories were shared by health center staff on this project:

> *A 45- year-old male was diagnosed with diabetes and depression when I first contacted him. He did not want to speak to me stating he was too depressed, and did not have time to discuss his personal information with a person he does not know, and asked that I call him at a later time. I called him back 2 days later, and this time he was more open and admitted to me he knows he needs help. He expressed that he was very depressed, was hearing voices, and did not have insulin. I offered him a next day family medicine appointment and he accepted. Patient came to his appointment with no insurance so I referred him to our patient financial services department in CHI, as well as the DCF department to apply for Medicaid. Additionally, he did not have any money for his medication so I referred him to the medication assistant. Patient was able to see the doctor and to speak with our crisis unit for a behavior health appointment. The patient was very thankful and appreciative because I did not give up on him.*

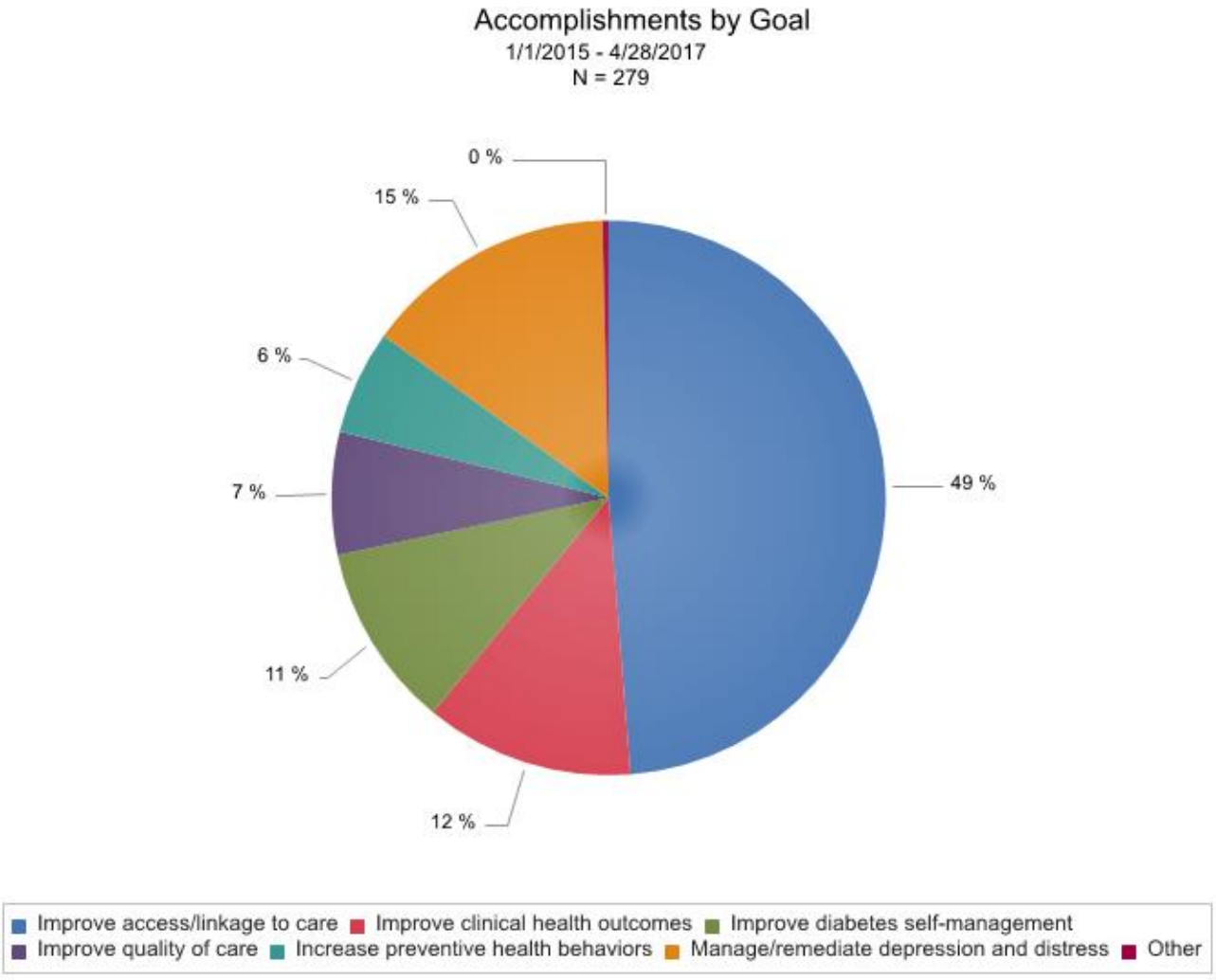
> *A staff member contacted patient Linda through IBHP enrollment list. She asked Linda the reason for not being under medical care for three years. Linda's initial response indicated lack of insurance and finances. Linda initially attempted to control her diabetic symptoms on her own. She used her family member's medication and home remedies but her efforts did not help. She was very upset as she could not control her diabetes on her own. The staff member navigated Linda into the CHI system by addressing numerous barriers. Linda connected with the primary care physician, behavior health department as well as the care coordinator. Linda was also referred to the medication assistance program where she could get her diabetes medication for $8.00 instead of $200. In addition, she was referred to smoking cessation program and DCF worker to apply for Medicaid benefits. Linda is now compliant with both her PCP appointments and her mental health appointments. Her sugar levels have reduced since then and her emotional health has improved. Linda is very pleased with IBHP's help and felt Community Health of South Florida staff as her second family.*

The care coordination and engagement aspect of IBHP demonstrates how communities can engage high-risk populations to address negative health outcomes. By training and engaging FQHC staff to access high-risk diabetes and depression patients, patients are more likely to seek services they need.

## *EVALUATION RESULTS AND FINDINGS*

Data on Project Implementation

This project documented 2 community changes, 22 development activities, 172 services provided, and 42 other activities as accomplishments supporting participants over the course of its 3-year funding cycle. Services provided included intervention components such as scheduling patient health appointments, initiating referrals, and completing assessments with patients. There were two community changes (new or modified programs, policies, and/or practices) throughout project implementation. This included development of monthly enrollment reports by the HCN Business Intelligence Team and engaging/training health center staff to contact patients, promote health care visits. Incentives were offered to health care providers for completing primary and behavioral health care visits. Development activities involved actions supporting planning, assessment, and capacity to implement project accomplishments in the community. Each of the documented accomplishments contributed to at least one *Together on Diabetes* goal area identified in the chart and legend below. The data below demonstrate findings over the lifetime of the funded project (January 2015 –April 2017). 238 activities were documents, and some of them targeted multiple goals increasing the number of goals targeted to 279.

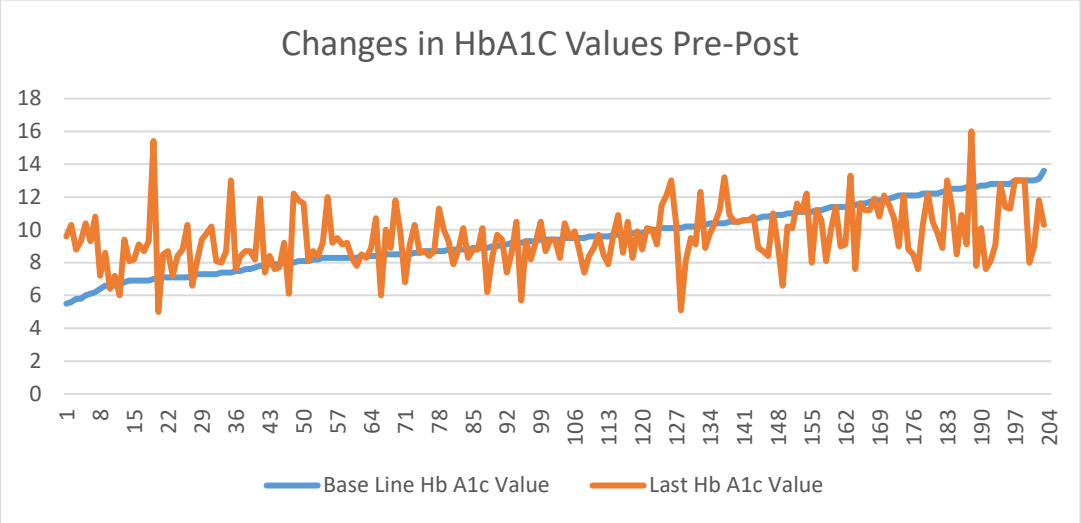


Results and Outcomes

Over 200 patients were enrolled in the program. Roughly 25% of the people recruited actually participated. There was an increase in behavioral health and primary care visits after enrollment in the program. 155 patients had between 0 and 5 behavioral health visits; 38 had between 5-10 visits; 6 had 10-15 visits and 4 had 20-25 visits. 172 patients had between 0 and 5 primary care visits; 26 patients had 5-10 PC visits; 4 had 10-15 PC visits; and 5 had more than 15 PC visits.

The following figure shows the level of A1C for participants at their pre and post screening. Most of the patients had their A1C between 8 and 10. The blue line indicates values at the beginning of the project – brown line indicates paired scores at the end of the project. The greatest improvement was among patients with elevated values at the beginning. They showed a marked reduction in HbA1C values

**A1C Distribution among Adults with Diagnosed Diabetes: Data Source-EHR (n=204)**




A paired sample t-test to determine whether the mean difference between two sets of observations is zero. Each patient was measured twice, before and after the completion of the program resulting in pairs of observations. Patients with A1C 7 and above were included in the analysis. The analysis found that those with A1C greater than 7 had a significant improvement in reducing A1C levels after completing the program ($p<.002$). This suggests the program successfully reduced A1C for high-risk patients with a co-morbid behavioral health condition. This is a particularly striking finding because the number of behavioral health visits was relatively few. Patients may have had psychosocial barriers to adherence, which responded readily to brief therapeutic intervention.

The results from 204 participating patients showed 40% improved their A1C level. 43% showed no decrease in A1C levels during the project, and 14% of the patient's last A1C level was between 7.5 and 8.7. Preliminary analysis revealed significant improvement in diabetes outcomes.

The PHQ9 data showed fewer patients with PHQ9 >9 after the program ended as compared to (70 pre, 56 post)at the beginning of the program, which suggests improvement in distress levels. Several patients were not included in the analysis as Pre/Post scores were not available. Most of the patients (24) have improved PHQ9 scores indicating lower levels of psychosocial distress. In contrast, distress increased for another

(15) patients. Several patients (30) were stable. Higher PHQ -9 scores indicate better behavioral health of the patients. This indicates that some patients benefited from the behavioral intervention.

## *WHAT WE ARE LEARNING*

The evaluation study found that there was little change in PHQ-9 scores, among program participants. In contrast, there was a significant improvement in HbA1c levels, indicating better glucose control, almost regardless of the number of sessions attended. One explanation is that brief therapeutic intervention is not of much use in resolving underlying levels of stress, but may be quite useful in addressing barriers and challenges to treatment adherence.

Health Choice Network of Florida identified key facilitating and restraining factors in implementing the project.

Facilitating factors contributing to project success:

- Patient outreach and engagement – FQHC Care Coordinators were trained in patient engagement and tasked with developing and maintaining relationships with participants throughout the project. Participants were receptive and comfortable sharing personal information with Project staff.
- Improved EHR tracking facilitated documentation of screenings, follow-up, and clinical information.
- Behavioral health care providers were able to distinguish between distress due to disease from co-occurring mental health conditions than other types of staff.

Restraining factors affecting project success:

- Challenges – The project model was re-designed in Year 2 to allow better EHR data reporting. The resulting 11 month intervention timeframe was too short to effectively engage patients in completing three primary care and four behavioral health visits. Staff training required allocation of sufficient time for ramp-up.

## *MOVING FORWARD AND PLANS FOR SUSTAINABILITY*

January 2015, an IBHP Lead Care Coordinator was hired at CHI. This permanent position oversees care coordination interventions and monitors the project goals and objectives to ensure sufficient performance.

Next steps included meeting with the FQHCs to review results and enlist leadership to address barriers for patients. The project investigators sought opportunities for incorporating new directions from the Bristol-Meyers Squibb Foundation and made revisions to their protocol based on community and foundation recommendations.

In an effort to sustain the community changes and programs for individuals with diabetes, the project investigators established a sustainable CMMHC business model with return on investment. Additional revenue offset the costs of operations and care to uninsured patients. Sustainability was demonstrated through (a) demonstration of improved health outcomes in the target populations; and (b) increased caseload/visits of patients with a payer source. Given FQHCs' growing role in serving low-income and uninsured individuals at higher risk for unmanaged chronic diseases, it is anticipated that public programs (e.g., Bureau of Primary Health Care, Centers for Medicare and Medicaid Services) will begin to offer a

mechanism to reimburse services proven to address triple aim objectives (i.e., better care, better outcomes, lower costs).

## *PROJECT PUBLICATIONS AND MATERIALS*

Abarca, C. (2010, Dec. & Jan.). Compass Points - Florida Department of Health. News from the Field.

Page, T. F., Amofah, S. A., McCann, S., Rivo, J., Varghese, A., James, T., ... & Williams, M. L. (2015). Care Management Medical Home Center model: preliminary results of a patient-centered approach to improving care quality for diabetic patients. *Health promotion practice*, 16(4), 609-616.

Rivo, J., Page, T. F., Arrieta, A., Amofah, S. A., McCann, S., Kassaye, H., ... & Williams, M. L. (2016). The impact of comprehensive pre-visit preparation on patient engagement and quality of care in a population of underserved patients with diabetes: evidence from the care management medical home center model. *Population health management*, 19(3), 171-177.

## *PROJECT CONTACT INFORMATION*

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## *EVALUATION CONTACT INFORMATION*

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