The Integrated Health Home Journey

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Executive Summary

In 2017, Access Community Health Network (ACCESS) embarked on a two-year journey to pilot an Integrated Health Home model within its system of 35 health centers. As one of the largest networks of federally-qualified health centers, ACCESS serves more than 175,000 patients each year, most of whom live in medically underserved and lower income neighborhoods in the Chicago metropolitan area.

While many of ACCESS' patients are in need of a multitude of services within the patient centered medical home, there is a portion of the population who are at very high risk due to the diagnosis of multiple and complex medical and behavioral health disorders. Many times these patients are limited in their ability to receive consistent care because their conditions (environmental or physical/mental health-related) prevent them from sustained wellness.

Addressing these patients through a comprehensive approach goes beyond the standard patient centered medical home model with the integration of behavioral health into medical care to what is now seen as an Integrated Health Home (IHH). The IHH is a model where there is full integration and sharing of information between medical provider, behavioral health provider and a suite of complex social services (housing, substance use treatment, employment, etc.) to fully support the patient. It seeks to overcome the challenges of a fragmented service delivery system that does not have the ability to reach the most vulnerable patients. There is a shared care plan, with a designated care team across multiple institutions, that confer regularly about the patient in order to support their needs. It goes beyond referral to services to true integration in support of the overall well-being of the patient.

With the support of multiple foundations, ACCESS and its partners embarked on creating this fully integrated model for patients with the highest level of care needs. Over the course of two years, the team refined workflows, redesigned the way the teams interacted across systems and were able to show success with patients who received care through this model.

This paper describes this Integrated Health Home model, discusses how the model functioned and elicits key learnings and recommendations for moving forward. Our goal is to share best practices and challenges for those who seek to implement a similar model.

Key Lessons Learned

- **The ACCESS IHH's communications infrastructure breaks down barriers in delivering aligned care by multiple sectors.** The fractured nature of the health care and social service systems are well- documented. The IHH infrastructure created a seamless system of care for patients. It included a shared medical record and care plan, weekly grand rounds, education about services and development of relationships between staff and organizations.
- **Engagement takes at least three to six months with multiple touches in order to bring the patient into care.** Patients who are at the highest level of risk due to multiple health and behavioral health conditions do not actively engage in care with just a few phone calls or visits. It took on average three to six months to engage these patients in dialogue with the team and develop trust over time.
- **Seasoned, highly experienced staff are critical for success.** Given the complexity of the patients in the IHH, experienced staff who understand and know how to address the various needs of patients and engage them in ongoing care – plus have the ability to support sustained outreach – are key. This is especially true when other caregivers are involved and when establishing trust with the patient and the larger family surrounding the patient is needed.
- **Patients are more likely to engage in health care if you can help them with basic needs first (i.e., housing, food, employment).** For the IHH patient population, addressing basic needs first was critical in providing them with the ability to engage in further conversations with their care team. For these patients, their priority was their basic needs – not their health care or behavioral health needs. Once these needs were resolved, we were able to better engage them into care.
- **It's important to leverage the power of your network to help find patients.** The power of the IHH model is in the strength of community partnerships, and the knowledge and trust created across the different portals of care. Since each partner typically sees patients in different settings all linked through a shared record, patients could be found in emergency departments or other settings by partners and directed to the IHH.

Critical to the success of this model are the people who provide care and their willingness to engage with each other and the patients who may be resistant due to their long-standing mistrust of the health care system. The dedication of these individuals coupled with their persistence and experience is what makes the IHH model work. This summary is dedicated to their efforts and those who do this work every day.

The Problem

For a significant portion of Chicago area residents, health care is irregular, unaffordable, or largely unattainable. This population faces a multitude of barriers to health care, including lack of health insurance or other financial resources to pay for care and the absence of a regular primary care provider. Behavioral health and mental health services in the region are highly limited and often siloed from primary care – an issue that is even more pronounced in underserved communities. Historical mistrust of the health care system and the stigma around mental health issues also present barriers to effective, comprehensive care that addresses both physical and mental well-being.

Federally qualified health centers (FQHCs) exist to serve medically underserved communities by promoting efficient, high quality, and comprehensive care that is accessible, culturally and linguistically competent, and patient-centered. Founded in 1991, Access Community Health Network (ACCESS), one of the largest FQHCs in the United States, provides community-based care in medically underserved regions of the Chicago metropolitan area to 175,000 patients annually.

Nearly sixty percent of ACCESS's patients are on Medicaid, and 20 percent have no health insurance at all. More than 80 percent of them live at or below 200 percent of the federal poverty level. The communities that ACCESS serves have some of the worst outcomes nationally with stark health inequities including disproportionately high rates of chronic conditions such as diabetes and heart failure, as well mental health issues such as depression, post-traumatic stress disorder, and substance use disorders.

These health inequities are often born out of multiple social factors including low educational attainment rates, high unemployment rates that result in food insecurity, unstable living situations or homelessness and extreme financial poverty. Many of these communities have suffered from decades of disinvestment and the impact of systemic, institutionalized racism.

In recent years, in line with national guidelines, ACCESS has developed an integrated model of primary and behavioral health care that addresses the intertwined impact of poor physical health on mental well-being, and vice versa. Patients receive routine screenings for depression and substance use disorders and our medical providers are trained to treat depression and in collaboration with our onsite clinical behavioral health consultants (BHCs) and community health specialists, receive treatment for substance use disorders, including opioid addiction. This integrated approach aims to treat the whole person and remove the barriers for people who are reluctant to seek behavioral health care.

However, there is a smaller population at ACCESS—approximately 10,000 patients—who suffer from serious mental illnesses, such as schizophrenia, major depression and bipolar disorders. This population, while smaller in number, frequently utilizes hospital emergency departments (ED), often have co-occurring substance use disorders, food and housing insecurity, while battling multiple chronic, uncontrolled physical diseases, such as hypertension and diabetes. People with serious mental illness typically die 15 to 30 years earlier than the general population, often due to the chronic lack of control of medical conditions that they have[1].

This highly vulnerable population needs primary care, behavioral health, and social services, often at the same time, to address their multifaceted challenges. However, care delivery is typically fragmented across agencies. This results in repeated screenings and multiple or even conflicting sets of instructions, all of which can be overwhelming to patients. ACCESS found that even with the support services of case management and care coordination added in, people who had more severe mental health conditions and the related social service needs were still falling through the cracks.

[1] *Colton, CW. & Manderscheid, RW. Prev Chronic Dis. 2006: 3(2): A42*

The Intervention

The Integrated Health Home Model

To address the need to improve upon our whole-person approach to care and treatment for people with serious mental illness, ACCESS embarked on a project in 2017 to implement an Integrated Health Home (IHH) model of care.

Since the introduction of the Affordable Care Act, a number of states have implemented various IHH models to better address the needs of high-risk populations and reduce avoidable costs, such as multiple hospitalizations. The State of Illinois has also proposed its own IHH model to address the needs of people with SMI, which it plans to launch in 2021. In designing the ACCESS model, we used a combination of approaches proposed by Illinois and already in place in New York and Arizona.

Our model uses a virtual network of partner agencies that provide a closed network of services coordinated by an ACCESS care coordinator. This model goes beyond the practice of coordinating services between agencies, by delivering integrated services through key elements including:

- **Formal Agreements:** Written agreements between ACCESS and each IHH agency requiring partners to commit to the IHH model and employ a patient-centered, trauma-informed approach to delivery of services.
- **Steering Committee:** The committee was convened by ACCESS from the inception of the program and includes all IHH partners. The committee has been responsible for determining services needed, selecting the appropriate technology for sharing information, and agreeing upon documentation, workflow design, best practices and areas for improvement, as well as monitoring the external environment and readiness for implementation with the state.
- **Integrated Workflows:** A subgroup of the steering committee met biweekly for four months prior to the launch of the ACCESS IHH launch to develop workflows that addressed different scenarios and possible patient profiles. These workflows factored in timeframes, documentation, and handoffs between agencies and were monitored and refined by the steering committee over time.
- **Single Shared Care Plan and Access to the Patient's Electronic Record:** The care plan is owned and edited by the ACCESS IHH care coordinator but is developed and kept updated through a multidisciplinary process involving all partners and the patient. Of critical importance, the plan documents the roles of each partner involved in the patient's care, and can be viewed, along with the rest of the patient's record through an online portal called Epic CareLink.
- **Interagency Communications Infrastructure for Frontline Staff:**
  - **Weekly rounds calls:** The ACCESS care coordinator convenes one-hour weekly calls between partners where cases are discussed to review new patients, transitions of care, best practices and areas for improvement.
  - **Messaging through Epic CareLink:** IHH partners can send secure messages through Epic CareLink to address patient care as well provide updates, such as completed assessments, that can be uploaded by the care coordinator into the patient's medical record.

Services

One of the first IHH planning activities completed by ACCESS was an assessment of the services that were needed to holistically serve IHH patients. ACCESS identified the services it would be responsible for and then reached

[2] *Information on the New York Health Home can be found at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes. Information on the Arizona model can be found at https://azdhs.gov/documents/az-state-hospital/magellan-integrated-health.pdf*

out to community partners with whom ACCESS has had longstanding relationships that could provide other needed IHH services that were outside of ACCESS' scope. The initial ACCESS IHH partners joined ACCESS' network due to a combination of service capability, capacity, and geographic reach for the chosen geographic area of the pilot. However, the view has always been to grow the network once we expand the geographic reach of the pilot to ensure patients across our Chicago-area network can access a service when needed. Below is a list of ACCESS' IHH partners as of July 2020 and their specific roles in providing integrated primary and behavioral health care as well as addressing basic social needs that determine good health:

- **ACCESS:** Care coordination; primary care; psychiatry; select behavioral health services, including assessment and diagnosis, clinical therapy; medication assisted treatment for opioid addiction; and data management, including management of patients' electronic health records
- **Catholic Charities:** Supportive housing, employment services and outpatient substance use disorder services
- **Trilogy, Inc.:** Community-based mental health services and employment services
- **Gateway Foundation:** All levels of treatment for substance use disorders including outpatient and residential services and medication-assisted substance withdrawal, such as detox programs
- **Mount Sinai Hospital and Holy Cross Hospital:** Crisis stabilization unit, inpatient and outpatient psychiatry, and inpatient specialty care for physical health care

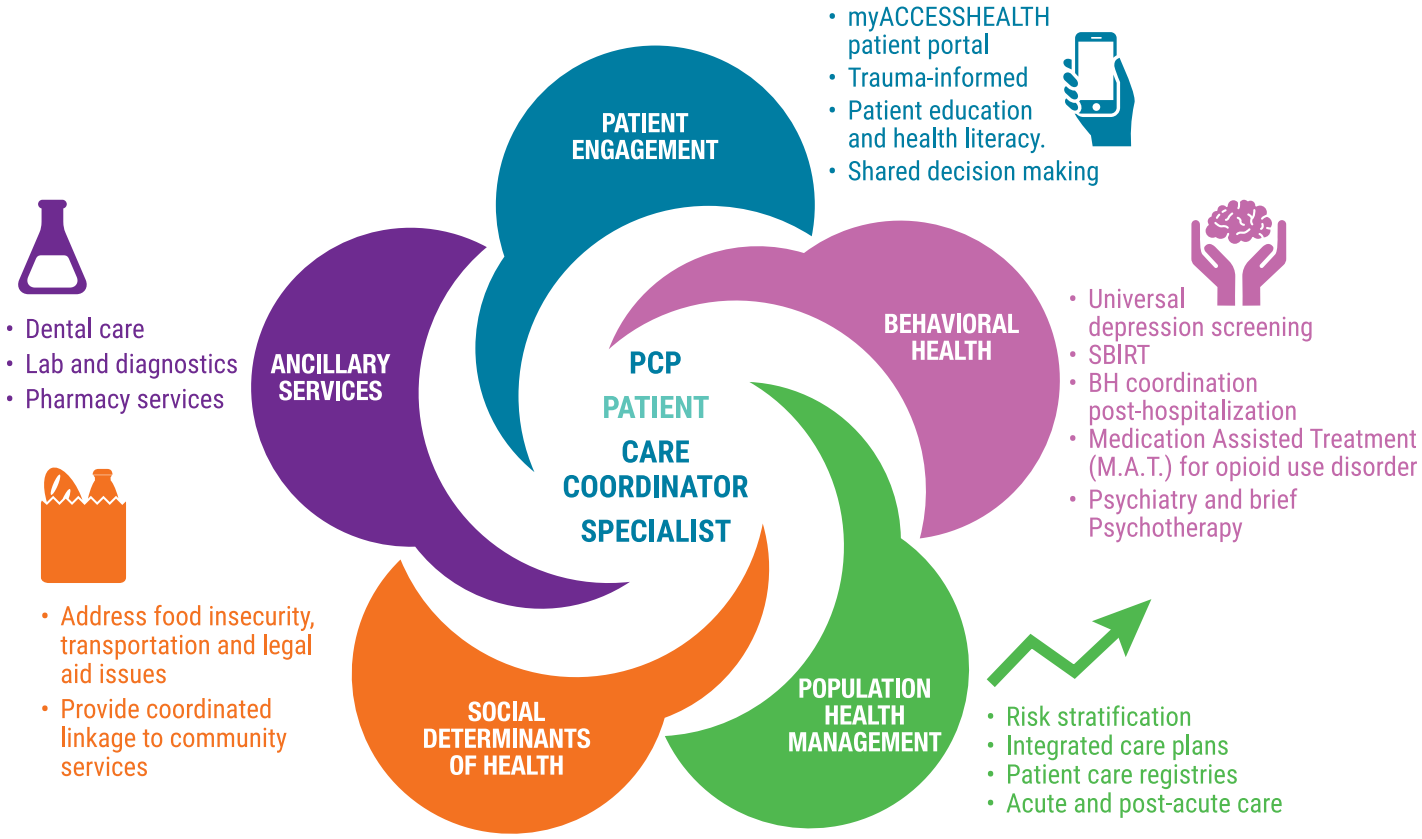

Figure 1: Integrated Health Home Model

How It Works

Figure 1 on the previous page shows the overall Integrated Health Home model. The patient and care team are at the center and the range of services are integrated around the needs of the patient.

The care coordinator is the anchor to the operation. Their role is to coordinate with the patient and IHH network's frontline staff and beyond, to ensure that the patient receives comprehensive care and does not get lost through follow-up.

1. ACCESS' care coordination team initiates contact with potential patients and, engages them into care over time. As further described below, this work often takes several months.
2. Once patients are engaged, an ACCESS Care Coordinator and behavioral health consultant assess each patient's physical and mental health.
3. The primary care team, which may also include a psychiatrist, then meets with the patient to establish goals and determine next steps, which are documented as an initial care plan.
4. The care coordinator then connects the patient to services at ACCESS and within the IHH network and tracks the patient's progress toward their care plan goals.
5. As goals are achieved, plans are updated with patients and next steps are identified and documented.

ACCESS' IHH Eligibility Criteria

- Adult (age 21 year and older)
- Diagnosis of serious mental illness (as defined by the state of Illinois' definition)
- Able to access care at nine ACCESS health centers located on the South, Southwest, and West sides of Chicago
- Acuity profile needed to have both high behavioral and physical needs

Patients eligible for enrollment have been identified through a number of ways including, generation of internal lists of patients that have the appropriate diagnosis codes for serious mental illness, internal referrals from ACCESS medical providers and behavioral health consultants, referrals from ACCESS' IHH partner agencies, and referrals from managed care organizations (MCOs).

Results

The results provided below reflect data collected on 86 patients between January 2018 and November 2019 (23 months).

Outreach and engagement

Table 1 describes the disposition of ACCESS' IHH patients. Achieving initial engagement was challenging. Although few patients declined the program, the timespan to engage each patient, which was defined as the time that the patient took to complete the initial assessments and had a care plan in place, took three to six months. Many patients were difficult to track down due to housing instability, had prior negative experiences with the health care system, or had multiple issues that needed to be addressed sequentially over time before true engagement could take occur. Of the six withdrawn patients, two patients reported stable health status, one transferred care to another provider, and the rest withdrew for unknown reasons.

Table 1. Disposition of Patients Assigned to IHH Care Coordinators (November 2019)

Patient Disposition	N	N
Enrolled: Active and engaged	40	47%
Enrolled: In process to re-engage	11	13%
First-time outreach in process	4	5%
Identified for outreach	12	14%
Lost to follow-up	3	3%
Declined	2	2%
Decreased	2	2%
Withdrawn	12	14%
Total	**86**	

Patient demographics

The demographics of the population are shown in Table 2. The race and ethnicity of the patient population reflects the demographics served by ACCESS. Nearly sixty percent of the patients identified as female. While the age range was broad, the mean and median age skewed older. We found that those who were developing chronic physical conditions as they aged were more willing and ready to engage and accept help, compared with younger individuals who were typically dealing with the onset of serious mental health illness such as schizophrenia and bipolar disorder.

Table 2. Patient Demographic

	N	%
Gender		
Female	51	59%
Male	35	41%
Ages (years)		
Mean	47	
Median	49	
Range	19 to 66	
Race and Ethnicity		
Non-Hispanic Black or African-American	52	60%
Hispanic or Latinx	16	19%
Non-Hispanic White	5	6%
Non-Hispanic Multiracial or Other	2	2%
Refused or Unknown	11	13%

Social determinants of health

A significant number of the individuals that enrolled in the pilot experienced challenging personal circumstances. As shown in Table 3, nearly twenty percent of patients were either food insecure or at-risk for food insecurity. Twenty-four percent were also either homeless, living on the streets, or living in some type of transient housing situation, as shown in Table 4. These factors made engagement with patients extremely challenging.

Hospitalizations

Hospitalizations varied among participants and because the sample of patients was so small, it was difficult to discern any change due to the IHH. Information on hospitalizations is also challenging to collect and future work should include this as a measure from the onset.

Outcomes

As enrollment into the IHH has taken so long, we do not have a sizeable cohort of patients yet with which to conduct a longitudinal analysis. Below and on the next page are some patient profiles and stories that illustrate the positive impact that we observed:

Patient Profile

One patient shared how grateful they are for the program because it "has saved their life" and helped them get into treatment and get sober. They have worked with almost all of the organizations participating in the program and others, obtaining clothing and housing support and are participating in both substance use disorder recovery and mental health services. The patient has gone from being homeless and suicidal on the street to living in their own apartment.

In several other challenging cases, we have experienced that with close coordination with hospital partners and MCOs, patients who have been extremely high utilizers of emergency departments have benefitted from residential placements that have helped to stabilize their circumstances and provide the holistic support that they need.

Table 3: Food insecurity status

Food Insecurity Status	n
Food insecure	11 (13%)
Assumed insecure	2 (2%)
At-risk	3 (3.5%)
Not food insecure	44 (51%)
Unknown	26 (30%)

Table 4: Housing status

Housing Status	n
Stable	**43 (50%)**
Stable, with family, spouse, partner, roommate	**15**
Rents apartment	12
Stable unspecified	9
SRO	2
Assumed stable	2
CHA	3
Homeless or in danger of homelessness	**9 (10%)**
Homeless	7
In danger of eviction, behind on rent	2
Transient	**12 (14%)**
Transient, e.g. "couch-surfing," staying with friends	8
Transient, in treatment facility	1
Transient, long-term shelter	3
Unknown	**22 (26%)**
Total	**86**

Lessons Learned and Critical Elements for Success

In the second year of the pilot, ACCESS conducted key informant interviews with our IHH partners and select staff providing direct service to discuss lessons learned, challenges and to identify critical elements and factors within each area, and next steps for further improvement.

Lesson 1: The ACCESS IHH's communications infrastructure breaks down the barriers to delivering aligned care by multiple sectors.

- **Weekly Rounds Call with All Partners:** Ensured smooth transitions of care among partners and flagged potential challenges with patients before they became barriers to care.
- **Shared Care Plan:** Ensured all providers were working toward a single set of goals for the patient and roles and responsibilities were clear, resulting in less duplication of efforts.
- **Access to the Electronic Health Record:** Ensured medication reconciliation could be completed more efficiently by partners and immediate access to demographic information in the chart increased the speed for housing patients by 20 days.

Patient Profile

Another patient shared that they are happy they are in this program because of the help that they have received, especially ACCESS' and Catholic Charities' help in getting them needed diabetes supplies. They had been trying to get diabetic supplies for ten months without success. This was a huge accomplishment for the patient to get these items as this occurred during this COVID-19 pandemic.

Lesson 2. Outreach and engagement is time consuming and intensive. Engagement takes at least three to six months with multiple touches in order to bring the patient into care.

- **Repeated and sustained outreach is needed:** Connecting with this vulnerable, at-risk population took at least three months of concentrated effort, and sometimes as much as six months. This involved multiple "touches"— repeated attempts to engage with patients before they stuck with the program.
- **Basic needs (housing and food) need to be addressed first:** Patients were more likely to engage and accept care if their basic needs (e.g., housing and food) were met first. One example is of a patient who told their care coordinator that it was impossible to think about mental health treatment when they didn't know where they would be living next.
- **Caseloads for IHH care coordinators need to be lower than traditional care coordination:** Caseloads for IHH care coordinators are low with a maximum of 35 patients at any one time. This is due to the time needed for outreach, plus the need to connect with the patient at least once a week. This is in stark contrast with traditional care coordination programs that typically average a caseload of 75 patients and engagement with the patient only once a month.

Lesson 3. Experience counts. Seasoned, highly experienced staff are critical for success.

- **Due to the complexity of patient needs, staff with deep expertise is critical.** Seasoned staff who have experience working with people with high behavioral health needs and their families, are persistent in follow-up and know how to collaborate in a team-based model are most successful. Due to the highly specialized needs of this patient population, without experienced staff, particularly care coordinators, it is unlikely that the IHH will be successful.

Lesson 4. Networks have an exponential impact. Leveraging the power of the network's partnerships helps find patients.

- **Understanding the breadth of services available through partners and taking time to get to know each other is key for the IHH model to work.** Each network partner has strength in reaching different parts of our communities. Therefore, the IHH can leverage the network to reach patients, because one partner may have reach where another does not. Incorporating time for each partner to visit sites and understand the breadth of services will enhance the ability of staff and leadership to deepen relationships with each other so that the delivery of care is more seamless.

Challenges and Recommendations

ACCESS and its partners encountered several barriers that hampered care for patients. The following describes these challenges and makes recommendations for how to overcome these in future iterations of IHH.

Challenge 1: Data integration. Despite our ability to expand access to the patient record to all IHH network providers, it is challenging to obtain a good picture of service utilization across our IHH network without a lot of manual follow-up. Additionally, the ability to access real-time information about patient hospitalizations that is not just dependent on patient self-reporting will be critical to successful follow-up of patients.

Recommendation:

- Develop technology or an interface that would enable documentation of service delivery across a network that relieves the burden on the provider
- Create real-time information via an ADT feed on patient hospitalizations

Challenge 2: Sustainability. To date, the IHH pilot has depended on grant funding to support non-reimbursable services.

Recommendation:

It is critical that future state funding streams address the following:

- Adequate reimbursement to support both outreach and intensive care coordination
- Sufficient reimbursement to support the delivery of services that are not reimbursed by Medicaid, but which are critical to outreach engagement, namely supportive housing, employment and food support
- Appropriate payment structures that incentivize networks to collaborate.

Challenge 3: Capacity is a barrier to expanding the IHH. There is a lack of capacity in the social service system (and in many cases the health care system as a whole) to provide adequate support – either tangibly through physical space such as affordable long-term supportive housing and access to beds in treatment programs, or with the intensive work of 1:1 care management.

Recommendation:

- Create pathways for the additional investment that will be needed to allow for patients to access what is needed in the long-term.

Next Steps

Regardless of the timing for the state's launch of an IHH model, ACCESS has determined that due to our experience with this pilot we will continue to provide this model of care for our patients living with a serious mental illness.

Key Focuses Moving Forward

1. **Build an outreach team to support the IHH care coordinators**. The IHH steering committee members are in agreement that in order to scale the program appropriately, it will be critical to build an outreach team, ideally of peer specialists who have lived experience to support outreach efforts. The goals of the team will be to reduce the time taken to engage with patients and provide the care coordinators with more capacity so that we can expand and serve more patients.
2. **Expand our geographic reach to serve more patients in ACCESS' network.** The ACCESS IHH model will continue to expand partnerships and determine appropriate staffing models to expand our reach.
3. **Conduct further analysis to:**
   - **Quantifiably determine the impact of ACCESS' IHH on patients.** Determining the appropriate metrics that indicate an impact is under discussion (e.g., change in risk status, medical loss ratio, etc.).
   - **Determine the appropriate level of IHH partner services to drive improvement.** A deeper analysis of service utilization by each partner type (e.g., supportive housing services, community mental health, number of touches by the IHH care coordinator) will be conducted for different patient profiles served by the IHH.

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