# Integrated Care Implementation

*Grant Application*

COMCARE of
Sedgwick County

# Project Narrative

*Why Us, Why Now*

COMCARE and GraceMed have invested considerable time and effort into forging a relationship that will serve us well now and also into the distant future. It is this long term commitment of collaboration to improving the overall health of persons in our community through new models of care delivery that we believe makes our partnership unique. Rather than looking at integrated care implementation as a singular focus, we opted to establish a solid foundation by getting to know each other's values, strengths, weaknesses and problem solving styles over the past couple of years. This has allowed us to engage in tough conversations around our model of integration, financing and sustainability and has provided the avenue for collective decision making and mutual respect that will be needed to embark on this integrated care partnership. And while it could be argued that doing this as a single organization may be easier, we believe that by harnessing the assets of both organizations, it will provide a better outcome for the patients we both serve and our community. Additionally, we have begun discussions on how to grow the partnership once we settle into our current integrated care location at COMCARE to provide for increased behavioral health specialist presence in GraceMed clinics.

## Our Integration Model

COMCARE and GraceMed will be implementing a reverse co-location integrated care model by expanding GraceMed' s scope of work as a Federally Qualified Health Clinic by placing a new GraceMed clinic within our Outpatient Service location at 1919 N. Amidon. This location is ideal in that it is COMCARE's largest service location by patient volume and even more specifically as it is where a large number of our medical service providers reside and will therefore naturally increase collaboration between medical teams. Our initial staffing will be comprised of:

- 1 physical health Advanced Practice Registered Nurse (APRN)
- 1 behavioral health specialist
- 1 patient service representative
- 1 nurse or medical assistant to support the APRN

The goal is to add a second medical APRN within the first year. In addition, COMCARE and GraceMed will utilize existing Health Home staff to provide necessary care management/coordination and health promotion activities for chronic conditions as warranted. GraceMed will also utilize their existing referral specialists to access specialty and other care in the community.

Given decisions we have made in planning for our implementation, our integrated care clinic will be more than co-location and closer to system level integration. This is due to the fact that we have determined that we will:

- Interview potential integration staff together to assure a good fit and to communicate the vision of collaboration and team based care we desire
- Utilize a single health record – we have chosen to document all patient care activities into GraceMed' s eClinical Works electronic health record
- Do collaborative treatment planning on all shared patients
- Bill all encounters via GraceMed
- Operate from one set of care protocols
- Build in flexible scheduling to assure timely access and minimize no shows and cancellations
- Have transparency in that patients and providers will experience the operation as a single system treating the whole person
- One approach to gathering patient experience data

Given that both COMCARE and GraceMed are SMI Health Homes and GraceMed has achieved certification as a Patient Centered Medical Home, we firmly believe we are well prepared to implement a robust model of care that is closer to full integration than co-location – a model we would not have been able to achieve had we not spent the past two years developing our solid foundation of alignment.

Care in this clinic will look different in that warm handoffs will not only be the norm, but will be built into our philosophy of care. Providers will work cohesively and share ownership of patient outcomes. Curbside consultations and huddles will be routine practice and we will have consistent screening of both behavioral and physical health needs. This will include utilization of the PHQ-2 and PHQ-9 for depression screening and the GAD – 7 for screening for anxiety with all patients. SBIRT will also be utilized by the behavioral health consultant to screen for substance use as indicated within the clinic. Preventive health screenings to determine presence of chronic conditions such as diabetes, hypertension, hyperlipidemia, etc. will also be routine, as prevention and management of chronic conditions will improve quality of life and reduce avoidable inpatient admissions and emergency room visits. Accordingly, wellness activities will be core components of our integrated clinic, as another one of our goals is to increase motivation and self-management practices.

COMCARE and GraceMed currently have a letter of agreement in place for this collaboration, but will complete a Memorandum of Understanding (MOU) prior to our "go live" date. In addition we will have a Business Associate Agreement (BAA) in place to assure ease of communication. We will do geographic marketing with post cards and advertisement once our "go live" date is established to recruit patients to our integrated care clinic. We will also be increasing our communication efforts within both organizations to assure there is understanding of the project and to encourage referrals.

## Overall Approach

We described the population that both organizations serve in our response to the Sunflower Foundation planning grant in in our final summary of those activities so we will not repeat that information here. The Sunflower Foundation is aware that both GraceMed and COMCARE are the safety net clinics for the underinsured and uninsured individuals in our community. We often share a population whose health status is frequently shaped by the social determinants affecting them.

We envision serving individuals who approach either organization for care thought the development of a community clinic model. GraceMed and COMCARE will become part of the same fabric of care. The physical location of the GraceMed clinic in COMCARE's Outpatient program building will be closely comingled with COMCARE's program. We want people seeking care to see at first glance that we are in a partnership. Individuals utilizing the GraceMed clinic may be open to one or both organization or neither. The nature of the medical visit will not be apparent to others in the waiting room; ultimately resulting in a reduction of stigma for individuals entering this shared space. We seek to normalize behavioral health presenting problems as a part of everyday life and deserving of intervention.

Our integrated care philosophy embraces the collaborative impact model. In a recent newsletter from Open Minds on this model we agree that, "The premise of the model is that we need to replace performance measurements of individual organizations (Called "isolated impact") with the "collective impact" ability of a coordinated group of organizations working to solve a specific social problem. And this is done by harnessing five central elements – a separate centralized infrastructure uniting the group of organizations, a common agenda, shared performance measurements, continuous communication and mutually reinforcing activities among all participants." This model clearly describes the underlying principles and goals of integration activities.

During one of the leadership consultation sessions with HealthTeamWorks last year, we dialogued as a joint management team to articulate what we were striving for in this effort to integrate care. We were able to identify these goals:

- An increase in provider satisfaction in both organizations
- Reaching for the triple aim of access, cost containment/efficiency, and increased patient satisfaction.

- Systematically removing barriers to care for this shared population by a process of continuous course correction
- Functioning as a community clinic, not a two separate medical clinics
- Better ensuring solid coordination that reduces the number of individuals who fall through the cracks that are inherent in many health care systems
- Embracing the concept of shared care that not only makes us more effective and efficient but together ultimately more competitive and sustainable
- And with better individual health outcomes, the goal and focus of an improved population health status in our community

Both organizations have a shared investment in these goals and both are excited and proud to be continuing on this implementation journey together.

## Barriers

The barriers we will need to overcome are significant.

- CUTLURE: One of the most challenging potential barriers will be to implement the shared clinic vision to both organizations. Leaders of this integration will need to have a presence in both organizations to model the partnership in a meaningful way. Having experienced some early successes with the recent implementation of health homes in both organizations for those with a serious mental illness will help our staff see more clearly the opportunities for improved health that integration can produce. S.M.A.R.T. goals on page 6 and 7 address strategies for overcoming culture concerns. We also have the advantage of starting this program from the ground up where we will be creating culture rather than trying to change culture.
- FINANCIAL: One of the largest barriers continues to be the limited number of billable codes for this collaborative service delivery. Our systems have disparate approaches to payment. We are looking forward to the shift from the fee-for-service payment to a case rate system in behavioral health that will soon unfold. We know we will be more focused on outcomes and have the ability to be more creative in a health system that recognizes and rewards improved health outcomes as the goal. Until that time, we need to carefully track the coverage of the individuals we serve in this collaboration to ensure that sufficient revenue is produced. It should be noted that once trained to use the tool, the ability to bill for SBIRT will help in generating revenue for behavioral health services.
- HEALTHCARE ENVIRONMENT: The changing healthcare environment both locally and nationally is not only a challenge and opportunity but may prove to be a barrier as both organizations are implementing a number of new initiatives along with this integration collaborative.

Despite these barriers and challenges the leadership in both GraceMed and COMCARE believe this change is not only inevitable but critical to our patients, our organizations and our community. We believe in each other's ability to course correct in a manner that will enable us to succeed. We share a vision, a purpose and a commitment to this evolution in our system. Both COMCARE and GraceMed have been challenged with similar issues in the implementation of our SMI health homes and GraceMeds' certification and a patient centered medical home. We have several successful strategies in place to address the changing health care environment challenge including incorporating performance measures into our Quality Improvement Plans.

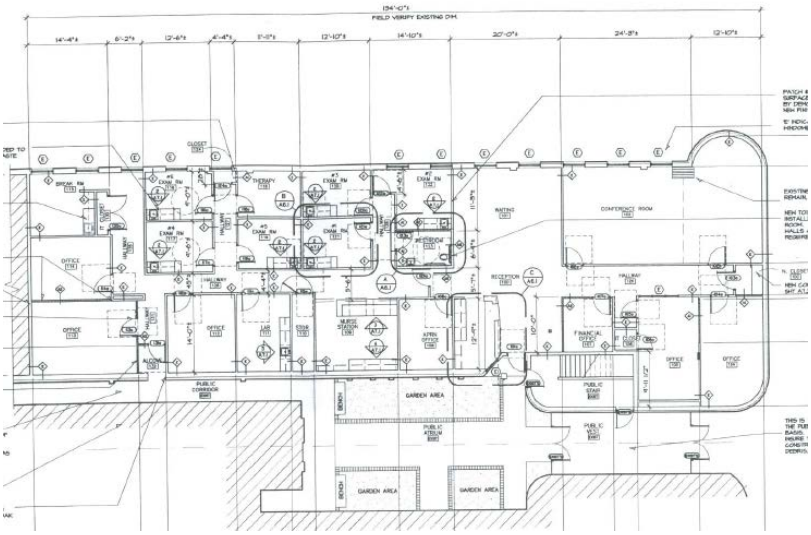
## Space Planning

As aforementioned, the **GraceMed at COMCARE** primary care integrated clinic will be located within our largest service location based on patient volume. We spent considerable time developing a space design that would meet opening day needs and beyond. We have been working with the Sedgwick County Facility staff as well as GraceMeds' facility planner. We have an initial schematic that shows the design needs of both organizations. The most significant modification to the existing space is to route water to the rooms designated as exam rooms. We have designed six exam rooms, a rest room, lab, nurse's station, financial office, reception, a space for the behavioral health consultant and shared space that encourages team consultations. In order to integrate even further, COMCARE intends to place two psychiatric prescribers in that location where they will also utilize a multiple exam room model of care. This proximity will naturally increase curbside collaboration on shared patients and will eventually allow for a smoother transition of patients who are stabilized on their medications to the primary care clinic, allowing our psychiatric prescribers to focus on the more complex patients.

Money for the space renovations has already been approved by the Sedgwick County Board of County Commission.

While not as timely as we had hoped, the renovation design has gone through several iterations, we have collectively agreed on demolition plans, space design, cost sharing, signage, plumbing, electrical and color scheme. The final design will be ready for review by the city within a couple of weeks and then it will go out for bid. We anticipate completion by the end of July 2015/beginning of August 2015 if all stays on schedule.

While not the best visual, below is the architectural rendering of our space.



## Timeline and S.M.A.R.T Goals

While we had originally anticipated a "go live" date of late June 2015, our capital improvement project is now projected to be complete at the end of July/beginning of August 2015. Between now and then we will:

Pre-Implementation S.M.A.R.T Goals

1. Develop job descriptions for the behavioral health consultant and primary care APRN and post openings for potential applicants by April 15, 2015. These vacancies will be posted both internal and external to the organizations and use common online job posting sites as well such Career Builder.com and college career development sites.

2. Develop our internal and external communication plan by April 30, 2015 to increase internal and community understanding of the integrated care collaboration.

3. Define marketing material needs and strategies for promoting the program close to our go live date in late July 2015.

4. COMCARE and GraceMed will identify what enhancements are needed for inclusion in GraceMeds electronic health record (eClinicalWorks) to capture all integration efforts (such as the GAD-7, a behavioral health encounter note, etc.) by July 1, 2015 to allow time for these modifications.

5. Develop a protocol for capturing patient satisfaction/experience data to commence on September 1, 2015.

6. Establish bi-weekly meetings with Project Services/Facilities staff by March 3, 2015 to assure that our renovation project stays on track.
7. Define membership and frequency of Leadership Team meetings for ongoing project development and course correction no later than April 1, 2015.
8. Define role and expectations of a Patient Advisory Committee by June 15, 2015.
9. Develop necessary policies and procedures by mid July 2015 to assure relevant protocols and documentation are in place in advance of staff training.
10. Create training plan for integrated care team by July 1, 2015.

Post-Implementation S.M.A.R.T. Goals

1. Develop an introductory script for the behavioral health consultant and medical provider(s) to use at initial visits by August 1, 2015. This will help ensure that the nature of team based care and role of the behavioral health consultant services is clear to all potential patients.
2. COMCARE will deliver Mental Health First Aid Training for GraceMed employees; employees to participate will be identified by September 15, 2015.
3. Identify screening tools to be used by the behavioral health consultant by July 31, 2015.
4. Training on how to utilize eClinicalWorks (the electronic medical record) will be delivered to the Integrated Care team by August 1, 2015.
5. Evaluation of additional outcome measures for determining success outcomes of the integrated care implementation by December 2015. Please see page 10 for initial implementation proposed outcome measures.
6. Establish routine means of evaluating if additional performance measures/outcomes are needed to determine the success of our integrated care implementation by October 1, 2015.
7. Implement a patient satisfaction/experience protocol by September 15, 2015.
8. Implement a provider satisfaction/experience protocol by November 1, 2015.
9. Incorporate course correction for a continuous improvement process for our integrated care program based on patient, provider, leadership and other feedback that is relevant and meaningful from date of implementation forward – goal is to be flexible and responsive to changing needs of the project with the ultimate goal of improving services and access to care for patients.

## Behaviorist on the Primary Care Team

With our implementation we will be embedding a full-time behavioral health consultant (BHC) within the primary care team. The BHC will be a licensed mental health service provider. The BHC will provide:

- Brief screening and targeted, real-time interventions to address the psychosocial aspects of primary care.
- Short-term psychosocial groups as warranted
- Consultation and communication with the primary care provider

Based on information from other successful integrated care clinics, we anticipate that the BHC will most often be requested to deliver screening and short term interventions that address health behavior, behavioral issues (both depression and anxiety, but other mental health issues as well), disease management, sleep hygiene, behavioral change and chronic disease management. This is not an exclusive list but serves to demonstrate the wide array of issues the BHC will address as a member of the primary care team.

During the brief intervention with the patient (10-15 minutes), the behavioral health consultant will clarify the problem, complete a brief screening/assessment (PHQ-2 , GAD-7 and PHQ-9 and SBIRT as warranted), engage the patient with a framework of change, establish goals or recommendations and provide feedback to the PCP. The BHC will schedule follow-up if needed.

- Follow up activities will include:
- Re-assessment of the presenting problem
- Review response to interventions and review of progress or obstacles to change
- Development of ongoing plan and/or referral to specialty mental health services

It should be noted that what distinguishes the role of BHC from traditional behavioral health services is that the BHC will **not** provide:

- Medical social work services other than routine community resource referrals
- Specialized case management services
- Long term psychotherapy
- Psychological testing – though as noted above, brief screening will occur
- Long term group therapy
- Specialty services such as occupational health and disability management

Our intent is that scheduling for the behavioral health consultant will parallel scheduling patterns of primary care providers which are typically set up in 15 minute increments. However there are times when two appointment slots totaling 30 minutes may be scheduled. This would be more likely for initial contacts versus routine follow-ups.

It will be critical to have open time in the schedule of the behavioral health consultant during high volume clinic times to assure the PCP has access to same-day appointments for patients that need to be seen. Bottom line: our goal is for the BHC to have enough flexibility in his/her schedule to absorb on-demand consults from the primary care provider(s).

The behavioral health consultant will use allowable CPT codes included within the service options of GraceMed – the federally qualified health center.

## Referral Protocol

We envision multiple ways that a patient will have access to the behavioral health consultant services. While not and exclusive list, these can include:

- Verbal request or on-demand referral from the PCP – usually for same day and urgent services
- Written referral from the PCP, when the patient is not available for a warm handoff
- Phone triage by either the primary care provider or nurse if the person is an established primary care patient
- When suggested by the behavioral health consultant as a result of appointment pre-screening or established patient contact

We also envision multiple ways that a patient will have access to the physical health APRN for initial visits:

- Open access appointments for COMCARE referrals needing an initial appointment. While most appointments will be scheduled we aim to build in flexibility to assure timely access for new patients.
- Referral from COMCARE providers via routine scheduling.

## Data Sharing

Data sharing will be addressed via a business associate agreement between COMCARE and GraceMed. As noted earlier, it is our intent to document all integrated care clinic activities within GraceMeds electronic health record eClinicalWorks. Thus, there will be no separate mental health record at our integrated care clinic. Documentation by the behavioral health provider will be visible to the GraceMed

medical provider(s). Any documentation needed by COMCARE employees working outside of the integrated care clinic will be managed as a routine record request.

## Performance Measures

At this time we have determined that at minimum we will be capturing the following on all patients:

- Patient Health Questionnaire 2 (PHQ-2) for depression screening. If yes to either question,
- Patient Health Questionnaire 9 (PHQ-9) for depression screening if positive response to PHQ-2
- Generalized Anxiety Disorder 7 (GAD-7) for anxiety screening
- SBIRT for substance use screening

The above are to be gathered within each 12 month period and are linked to quality indicators required for Federally Qualified Health Centers.

In addition, we will be capturing health metrics to include:

- Height
- Weight
- Blood Pressure
- Body Mass Index
- A1C readings for persons with diabetes
- Smoking status
- Other HRSA reported outcomes

## Funding Request

COMCARE is requesting funding for $200,000 to cover the salary expenses of the behavioral health consultant and part of one primary care provider. It is our intent to bill for all primary care services and we will utilize the two codes available for billing the behavioral health services. It is our hope that the state opens up additional codes for integrated services so that salary expenses can be covered in full over time. We know that at this time these costs will not be covered by the limited service codes available. Please see budget form and budget narrative for more specific information.

# Budget Form - Integrated Care Implemenation Grant Proposa

Sunflower Foundation
HEALTH CARE FOR KANSANS

**Time period covered by this budget:** From: August 1, 2015 To: July 31, 2017

**Applicant Organization:** COMCARE of Sedgwick County **Project Title:** GraceMed at COMCARE Primary Care Integration Clinic

| Budget prepared by: | |
|---|---|
| *Name* | Jeannette Livingston |
| *Title* | Contract Administrator |
| *Telephone* | (316) 660-7612 |
| *Email* | jlivings@sedgwick.gov |

| **Note: Round to nearest dollar** | **Sunflower Foundation*** | **Cash Match Contributions (From All Sources)** | **Other / In-Kind Contributions** | **Total (Revenue/Expenses)** |
|---|---|---|---|---|
| **Revenue** | | | | |
| Sunflower Foundation | $200,000 | | | $200,000 |
| Other Grant Funding (if applicable) | | $ | | |
| Applicant Organization | | | $ | |
| Projected Revenue (if applicable) | | $43,979 | $ | $43,979 |
| Other | | $ | $ | |
| | | $ | $ | |
| **Total Revenue** | $200,000 | $43,979 | | $243,979 |
| **Expenses** | | | | |
| Personnel (salaries) - Existing | | $ | $ | |
| Personnel (COMCARE salary) - New | $ 104,998 | $ | $ | $104,998 |
| Benefits | $ - | $33,726 | $ | $33,726 |
| Payroll Taxess | $ 9,759 | $10,253 | | $20,012 |
| Consultation Fees | | | | |
| Training | | | | |
| Milage Reimbursement | $ 1,550 | | | $1,550 |
| Materials/Supplies | | $ | $ | |
| Technology (hardware and/or software) | | $ | $ | |
| Space design/Planning | | | | |
| Other Grace Med APRN Salary | $ 68,753 | | | $68,753 |
| | | $ | $ | |
| | | $ | $ | |
| Up to 10% Indirect/Administrative Expenses | $ 14,940 | $ | $ | $14,940 |
| **Total Expenses** | $200,000 | $43,979 | | $243,979 |

NOTES:

*January 2013*

1) Budget amounts entered in the online application must match this budget.
2) Be sure your Budget Narrative clearly explains ALL budget entries included on this form; include the required match.
3) This form is in Microsoft Excel format; the columns are formulated to calculate totals.
4) For more budget guidelines, see the "RFP Definitions & Tips" document under "Downloads & Forms" on the foundation's Web site.

# Budget Narrative Form

## Integrated Care Initiative (Implementation Grant)

Instructions:

- Describe all entries on your Budget Form in detail, **including basis for calculations**.
- This form includes the key budget categories for which Sunflower Foundation grant funds are allowed. Add other line items as necessary for project expenses that are the responsibility of the applicant. Be sure to specify items funded by the required match.
- If a category does not apply and is blank on your Budget Form, write "N/A" in the space provided on this form.
- Elongate this form as necessary to adequately describe *all* entries.

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***Revenue***

Sunflower Foundation

- Total of $200,000 in grant revenue from Integrated Care Implementation Grant to cover costs related to salary and benefits of integrated care behavioral health consultant and APRN.

Other Grant Funding (if applicable): N/A

Applicant Organization:

- COMCARE will allocate $43,979 (a little over 21%) as a cash match to cover the cost of remaining employee benefits.

Projected Revenue (if applicable)

- As the grant recipient, COMCARE does not anticipate making revenue in year one for the behavioral health consultant position unless we are successful in recruiting and Ph.D. and/or Licensed Clinical Specialist Social Worker. This is due to the restrictions on billing code credentials. In the likely scenario that we are successful and recruit an LMSW, we will require the employee in the position to seek clinical specialist licensure within a timeframe specific to his/her training. This should provide us opportunity to generate limited revenue hopefully in year two, though we will not know until we see what our potential candidate pool looks like after posting the position.
- We do anticipate the medical APRN will generate revenue and be sustainable in year two. However, we are not yet clear on clinic volume or payer mix to make an informed, educated guess at this time. We do believe we can project this within six months of implementation and our goal is to have a sustainable clinic. It should be noted this will be revenue for our partner agency GraceMed and could not be included in COMCARE revenue given we our governmental budget practices.

***Expenses***

Personnel (salaries) –

- Behavioral Health Consultant: Salary for 2 year
  - Salary per year: $52,499
  - **Salary total over two years: $104,998**
- Medical APRN: Salary for 1 year
  - **Salary for one year: 68,753**

Benefits & Payroll Taxes

- Behavioral Health Consultant:
  - Benefits per year: $16,863
  - Benefits total over two years: $33,726
  - Payroll Taxes per one year: $10,006
  - Payroll Taxes total over two years: $20,012
- **Total cost over two years totals: $53,738**

Indirect/Administrative Expenses – (rate 7.47%):

- **Rate for two years totals $14,940**

Other:

Mileage Reimbursement

- Behavioral Health Consultant:
  - Current mileage rate is $0.58
  - **Mileage Reimbursement total: $1,550**

  (Note: It's not expected that this position will require extended amounts of driving time.)