

Success in Service Implementation: An Administrative Program Evaluation of an Integrated Health Home

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EXECUTIVE SUMMARY

Individuals with a severe mental illness diagnosis die an average of 25 years earlier than those without such a diagnosis. Iowa's Integrated Health Home (IHH) is an innovative, person-centered program designed to impact the issue of poor health and early deaths through care coordination, peer support services and population health management. The initiative began with pilot projects in 2011 and was fully disseminated across the state in 2014. Heartland Family Service is one of nearly forty providers of this service throughout Iowa and one of three in the Council Bluffs, Iowa, area.

Social service programs like IHH face implementation challenges such as infrastructure, financial stability, capacity and leadership engagement. Research literature is examined in the areas of program implementation, implementation challenges, implementation strategies, program sustainability and quality improvement, and healthcare and behavioral health homes. This review provides a framework for the research and study of an individual IHH implementation process.

The IHH program at Heartland Family Service was reviewed as a case study example for an administrative program evaluation. The intention of the research was to answer the question, "What key factors contribute to the successful implementation of a social service program?" Two research hypotheses are tested and results are shared.

- H1: A lack of clear and stable expectations leads to challenging implementation processes.
- H2: The availability of necessary training resources impacts the success of implementation.

In this study, data was collected through agency records and interviews. Since the IHH initiative was driven by the Iowa Department of Human Services and Magellan of Iowa, documents were secured from these entities for review as well. Interviewees included direct care staff within the IHH program, a vice president within the agency, and two IHH directors from other agencies.

The research findings supported both of the identified hypotheses. Statewide expectations were unclear to the direct care staff, while IHH leaders were able to ascertain these expectations more clearly. The expectations of the agency were slightly clearer to all interviewees. Results suggest that the expectations that impact implementation success are related to the role one plays in the process. Those leading an implementation project have a greater critical need to know and understand expectations at the larger level, while those in direct care must know and understand the expectations of the agency.

Information about training resources was collected through interviews and the examination of formal documents. Interviewees unanimously shared that training and technical assistance throughout the implementation process was inadequate, even various trainings were offered in many ways throughout the period.

Overall, the study supports that the Heartland Family Service IHH has been a successful implementation effort. However, there are recommendations for the agency and others who might benefit. These include: outline program expectations, create a program manual, build a strong foundation to support implementation, engage leadership at all levels, and consider fidelity measures and evidence-based practices.

INTRODUCTION

In studies from 2001-2003, 26% of U.S. adults were affected by behavioral health conditions (Boa, Casalino & Pincus, 2012). Individuals with severe mental illness die an average of 25 years earlier than those without such a diagnosis. Health disparities for this population are directly related to this issue. Preventable co-occurring chronic diseases such as diabetes, heart disease, asthma and other cardiopulmonary conditions are the cause of death for three out of every five individuals with a severe mental illness (Mantel, 2013; Rosenberg, 2009). Fifty percent of high-utilizers of health centers have a behavioral health diagnosis. Medicaid costs for individuals with both a chronic physical disease and a mental illness are 75% higher than those for beneficiaries without a mental illness (Montanaro & Pennington, 2013).

The Integrated Health Home (IHH) has been designed as an innovative, person-centered program that addresses the issue of poor health and early deaths through care coordination, peer support services and population health management. Iowa Department of Human Services (2013) offers that an IHH is “a team of professionals working together to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).” As healthcare costs rise and health conditions worsen, the IHH intends to impact individual and population health to reduce overall costs through increasing positive health interactions. Goals for IHH include improving population health, improving individual health, reducing healthcare costs due to reduced emergency room visits and inpatient hospitalizations, and providing whole-health care coordination.

The Integrated Health Home was born from the Affordable Care Act (ACA) of 2010. Section 2703 of the Affordable Care Act allows states to amend their Medicaid state plans to provide health homes for enrollees with chronic conditions (Schuffman, 2012). Medical homes are now common in communities, but there are many differences between the Affordable Care Act’s “health home” and the “medical home.” The health home (or Integrated Health Home as it is known in Iowa) is available to those who have a severe mental illness diagnosis. Health homes are run by agencies and organizations with expertise in behavioral healthcare, while medical homes are run by those with primary care expertise. These services are completely voluntary on the part of the individual, though strongly encouraged in order to manage health conditions. An individual cannot be enrolled in both, but rather must choose between the two if they choose to participate at all.

The Integrated Health Home effort in Iowa began in 2011 with pilot projects across the state. The first phase of implementation kicked off in July 2013 with a few sites, another 8-10 sites started serving individuals in April 2014 and the final sites opened in July 2014. As of July 1, 2014, every county in Iowa has access to an IHH provider. Heartland Family Service is one of three providers in the Council Bluffs, Iowa, area. The agency serves adults in a three-county area of Pottawattamie, Mills and Harrison counties. The purpose of IHH is clear but is ever changing. Over the first eight months of the program, service provisions and expectations have changed considerably. However, the staff structure and reimbursement rates have not.

As new innovative social service programs are designed and implemented, some are successful and some fall short of the expected outcomes. This paper addresses how programs are implemented and what is necessary to predict and ensure program success. The Integrated Health Home will be used as a case study, but results may be applicable to other programs in the social service field. An administrative program evaluation of the IHH will help to answer the research question, “What key factors contribute to the successful implementation of a social service

program?” Recommendations regarding the program’s administrative structure and processes, next steps to ensure ongoing success, and suggestions for future program planning and implementation to strengthen the potential for sustainability will be offered.

In the literature review, we will first review what program implementation is and some challenges that are faced when introducing new programming. A review of five strategies will be introduced and a discussion about program sustainability will follow. A specific analysis of the health home initiative will lead us into the methodology and findings of an administrative evaluation of an integrated health home in Iowa that is its infancy related to implementation. Through the research, I hope to find that the internal and external supports for this program implementation are critical to its success, including the argument that state, organizational and program-level resources (i.e. training, funding and leadership) are the key to effective implementation of this program.

LITERATURE ANALYSIS

Program Implementation

Community needs change and nonprofits are challenged to respond through new and innovative programs. New funding sources, new clients and even increased public legitimacy can develop within an organization by way of implementing new programming. However, there is potential for a social service agency to misread community and market needs and inadvertently shift into program areas that are unsustainable due to funding or demand (Auer, Twombly & DeVita, 2011).

“Implementation” can be described as a process in which an idea, program or set of activities is put into practice that is new to the people attempting to bring about change (Durlak & DuPre, 2008; Fullan, 1973; Ogden & Fixsen, 2014). Durlak and DuPre (2008) outline eight aspects of implementation, including: fidelity (extent to which the innovation corresponds to the original program), dosage (how much of the original program is delivered), quality (how well the various components of the program have been conducted), participant responsiveness (how well the program holds the attention of the participant), program differentiation (how well the program is individualized as compared to other programs), monitoring of control/comparison conditions (nature and amount of services received by each of these groups), program reach (rate of involvement and representation of program participants), and adaptation (changes made during implementation).

Implementation research continues to grow and permeate academic journals in an attempt to bridge together merely starting a new endeavor and finding success and sustainability in this effort. Irwin and Suplee (2012) write:

The goals of implementation research include understanding the factors that impede or promote effective implementation, testing new approaches, and determining causal relationships between implementation characteristics and impact. Implementation research can help us to understand the “how” and “why” a program works by unpacking the relationship between implementation and program outcomes. As funding becomes more closely aligned with evidence-based policy and policy makers are looking for more evidence of impact for investments, answering implementation questions has become critical. (p. 340)

Implementation is an ongoing process that begins with investigation and design and proceeds to full program operation. Successful implementation requires information about the program's intended operation needs, conditions of the environment and continuous support by the organization and stakeholders (Wang et al., 1984). Variables associated with communities, providers and innovations, prevention support systems such as technical assistance and training, and organizational functioning and other prevention delivery systems all affect the implementation process. Assessment is important early in the implementation process to identify problems in the program application that can be addressed quickly to improve success potential (Durlak & DuPre, 2008).

Successful implementation can be predicted by way of community readiness and evidence-based practice (EBP) adherence throughout the process (Durlak & DuPre, 2008; Woodbridge et al., 2014). Documentation of readiness during the investigation stage and adherence throughout the implementation process keeps fidelity at the forefront of the project (Woodbridge et al., 2014). Continuous communication regarding the results of the examination of these key areas will inform progress of the project implementation.

Implementation Challenges

The process of implementation is riddled with challenges. Organizations, individual leaders and practitioners face these challenges independently and as a group. Capacity and infrastructure, financial resources, practitioner engagement, adoption of changes, leadership attributes, and mission orientation and clarity are all potential challenges (Auer et al., 2011; Kliche, Plaumann, Nocker, Dubben and Walter, 2011; Krist et al., 2014; Ogden & Fixsen, 2014). Organizations must address personnel issues that may affect implementation such as adequate training, capacity within current workforce, inherent skills and abilities, and resistance to change (Auer et al., 2011; Kliche et al., 2011). Interestingly, change can lead to deeply rooted resistance in both individuals and the organization. Strong resistance, particularly that which is aimed toward social technologies and potential mission drift, can seriously impact the implementation process either by stifling progress or stopping it all together (Auer et al., 2011; Cummings & Worley, 2008).

Some organizations approach program implementation autocratically. This can create resistance and animosity. Through their own research, Krist et al. (2014) found that merely mandating a change to an already complicated and meticulous process only increased the likelihood that the change would occur poorly, if even at all. When considering the world of healthcare, and particularly mental health, it can sometimes take more than 20 years from the initial development of an EBP to collective adoption of the practice in the mental health field (Woodbridge et al., 2014). As the EBP is employed over time, the potential for diffusion-related drift is probable. This efficacy concern can be addressed through ongoing fidelity monitoring and reporting results of evaluation to those involved in the implementation process.

During implementation, decisions made based on market criteria rather than effectiveness can also suppress forward progress. When funding drives these choices and the organization is not aware of the direction or doesn't correct course when misguided, there is high potential for implementation failure. Effectiveness is a key factor in implementation success, as is consistency in frameworks used throughout the process, strong supportive interventions and high program fidelity (Kliche et al., 2011).

Political changes can greatly affect the implementation of programs. Organizations that are flexible and respond to such changes may inappropriately and naively change the purpose of

a program to meet changing political priorities or pressures. Program objectives must be clear and steady, while organizations should be aware of the impact excessive flexibility, ambiguity, and transparency can have on the implementation of new programs (Auer, Twombly & De Vita, 2011; Kliche et al., 2011).

Implementation Strategies

Implementation science is “the scientific study of methods to promote the integration of research findings and evidence-based interventions into health care policy and practice” (Cabassa and Baumann, 2013, p.3). Researchers have identified multiple implementation strategies or theories. Five such strategies (classic models, participatory framework, Community Development Teams, adaptive theory, and active implementation framework) are described and reviewed below for analysis purposes.

The *classic models* are best known for their top-down and bottom-up linear approaches. The top-down style brings new interventions to life from a central source to the local level rather than initiated by individuals or stakeholders within the local community (Ogden & Fixsen, 2014; Tataw, 2012). The “top-down” approach may be used when more accessible, cost-effective services are needed. However, there is potential that the local needs are overlooked. In contrast, the “bottom up” approach is driven by a decentralized, local action introduction of interventions, increasing ownership and commitment by practitioners. The downfall to this approach is in its potential to misguide the use of the intervention. Ogden & Fixsen (2014) offer a solution to use these two approaches in harmony, marrying “evidence-based-practice” and “practice-based evidence” for a successful implementation.

Tataw (2012) suggests an alternative to the classic model in his research using a *participatory framework*. In this framework model, participation and partnership synergy are critical to successful implementation. Tataw (2012) defines participation and participatory implementation as those efforts involving consumers and communities throughout the development process, including the planning, formulation, implementation, and evaluation phases. Participation is voluntary, so all levels of engagement are included and valued. The participatory framework embraces three conceptual elements: stakeholder participation in the program, cultural and structural relationships, and partnership synergy. This framework provides a horizontal construction of the process rather than the vertical construction of the classic models.

The *Community Development Team* (CDT) implementation strategy uses trained consultants with local expertise to lead a homogenous team toward problem-solving and implementation. CDT involves peers addressing challenges in delivering an evidence-based intervention rather than relying solely on external technical supports. This strategy was used by Brown et al. (2014) in a comparison study to determine if collaborative efforts and the use of cohort networking in county-based programming impacted the implementation process. Although not significant, this type of learning collaborative did produce positive results, outperforming those counties who were not involved in CDT strategies (Brown et al., 2014).

The *adaptive theory* provides factors as probable catalysts for change (Auer et al., 2011). Nonprofit organizations must have the fiscal capital and flexibility to accomplish changes. This theory suggests that fiscally healthier organizations are more likely to make programmatic changes than those who are financially vulnerable. The extent to which an organization is structured to operate in multiple service areas or to offer multiple programs is another factor impacting change readiness. Organizations that have a broad program reach have a greater

likelihood of starting a new program. Social service agencies tend to be structured in this way, creating a greater willingness to take a risk at implementation. The size and age of an organization, available resources, mission orientation and market competition are also factors affecting change (Auer et al., 2011). Overall, the adaptive theory suggests that an organization with these characteristics can be flexible and acclimate to the programming needs of the community based on these factors. Some organizations have greater adaptability and flexibility than others.

A variety of implementation frameworks have been reviewed by researchers to be combined into a comparative narrative (Meyers, Durlak & Wandersman, 2012). One of these is the *active implementation framework*. This particular framework integrates a multilevel approach to change. First, a focus on the purpose and rigor of the intervention prior to using it in practice is necessary. Next, emphasis is placed on the support mechanisms that are created to ensure effective application. This includes developing staff competencies, making organization changes to support the intervention, and engaging organization and program leadership. During this phase the multistage approach to change is integrated (exploration and adoption, program installation, initial and then full implementation), interacting and impacting the stages in an ongoing fashion rather than in a linear order. Finally, a focus on determining who does the work to implement the program is integral to this framework's success (Ogden & Fixsen, 2014).

Though not a formalized theory or strategy, Kliche et al. (2011) provide additional relevant insight into the implementation process. They present a collection of methods to address implementation quality and effectiveness including having a robust intervention plan, creating clear and comprehensive manuals, defining the intervention core and its periphery, securing organizational and leadership support, ensuring the qualification of intervention users and a systematic adaptation to local conditions. Kliche et al. (2011) outline three requirements related to program development: clear and comprehensive manuals (clear objectives, measurable indicators, elements necessary for effectiveness, adaptation step and costs/resources needed), quality assurance measures (available during program launch and implementation), and aggregated and published data on user experiences.

Program Sustainability and Continuous Quality Improvement

By definition, "sustainability" is the ability to last or continue for a long time (Merriam-Webster.com, 2015). In the realm of program implementation, sustainability can be defined as the capacity of programs to continuously respond to community issues (Mancini & Marek, 2004). Building sustainability within a program or organization requires strategic planning, resource development and community awareness, and understanding the needs of the target population (Wu & Shek, 2012). It may be more important to sustain the benefits of services to families and community rather than the activities of a specific program in order to avoid significant program drift or dilution (Mancini & Marek, 2004; Ogden & Fixsen, 2014).

As the community environment impacts the potential for developing sufficient implementation capacity by providers (Durlak & DuPre, 2008), organizations also experience internal environmental and cultural shifts that create challenges (Ogden & Fixsen, 2014). Internal factors such as leadership changes, staff retention concerns, and organizational support, as well as external impacts such as shifting funding requirements or political priority changes are significant factors in sustainability efforts. Training, technical assistance and other supports must be present to ensure success (Durlak & DuPre, 2008; Ogden & Fixsen, 2014).

Supports also include ongoing evaluation. Organizations may provide critical feedback through continuous quality improvement or continuous systematic monitoring, though some researchers suggest that programs should be fully operational before true evaluation and testing should take place (Ogden & Fixsen, 2014). “Evaluating programs before they mature may lead to poor results, the underestimation of the effectiveness, and doing disservice to the program. Also, programs should be fully implemented with fidelity before modifications are made” (Ogden & Fixsen, 2014, p.7).

Implementation teams can serve to maintain momentum and create capacity that may otherwise be absent. These teams can help to overcome the concern that implementation can deteriorate over time (Ogden & Fixsen, 2014). Mancini and Marek (2004) offer a sustainability framework that includes leadership competence, effective collaboration, understanding the community, demonstrating program results, strategic funding, staff involvement and integration, and program responsiveness. Combining these two suggestions to focus on results at every level may lead to effective program implementation.

Healthcare and Behavioral Health Homes

Healthcare programs are usually implemented at a point where feasibility studies and program development have been completed and the efficacy has been proven. However, its large-scale effectiveness has not been tested because the program has only been generally introduced once and may need modifications and adaptations (Kliche et al., 2011). Medical health homes are one such program. These programs were born through the Affordable Care Act and continue to grow and evolve.

Although the quality of care in the United States is impressive, people do not access necessary health care because the cost is too high (Davis, Schoen & Stremikis, 2010). According to the 2010 Mirror, Mirror on the Wall report, the U.S. ranks last overall in healthcare outcomes when compared to Australia, Canada, Germany, Netherlands, New Zealand, and the United Kingdom (Davis et al., 2010). Coordination of integrated patient care throughout the course of treatment positively impacts the cost of medical treatment and greatly impacts the individual patient’s overall health (Davis et al., 2010; Nielsen, 2014).

The medical health home aims to provide coordinated care for their patients. However, persons with severe mental illnesses (SMI) have unique needs and require expert care coordination from those with experience in behavioral health. Those individuals with SMI have a shorter life expectancy than the general population, mostly due to the co-occurring major physical health needs of this population (Viron et al., 2014). By integrating mental health into primary care, patients and the community will experience increased access for mental health services, reduced stigma and discrimination, interconnected mental and physical health needs and positive outcomes and cost-effectiveness in an expensive healthcare environment (Nielsen, 2014).

The collective challenge is to focus on the patient’s needs first and foremost and to support the individual person through integrated treatment and care. Integrated care is the strategic combination and coordination of behavioral health and primary care services to achieve positive outcomes with closely defined target groups (Davis et al., 2010; Viron et al., 2014). Several states lead the nation in integrated primary care and realizing impressive improvements in cost and health outcomes (Nielsen, 2014). States with approved Health Home State Plan Amendments include Alabama, Idaho, Iowa, Kansas, Maryland, Maine Missouri, New York,

North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Washington, and Wisconsin (Centers for Medicare and Medicaid Services, 2015).

The framework for integrated care and optimizing health system performance is the “Triple Aim.” The Institute for Healthcare Improvement created this approach in hopes of overall improvement of healthcare at all levels. The Triple Aim includes improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care (Institute for Healthcare Improvement, 2015). This framework is a guiding element of the integrated care model in many states, often referred to as the Behavioral Health Home.

Currently, patients with SMI frequently use the emergency room for primary care. Primary care that integrates mental health care is critical to avoiding wasteful spending and use of medical emergency room resources (Sacco & Twemlow, 2014). The impact primary care can have on an individual with SMI is significant. Approximately 70% of individuals with SMI have at least one chronic physical illness. Most of the mortality differential (25 or more years) can be attributed to early death due to preventable and treatable illnesses and disease. Cardiovascular disease is the most common cause of death, while cancer and respiratory illness are also contributing conditions. While these physical illnesses and chronic conditions and their risk factors are preventable and treatable, they often go unrecognized and unaddressed in this population (Viron et al., 2014).

The Affordable Care Act requires increased access to primary care and a focus on overall wellness. The ACA principles of wellness, cost containment and family engagement drive the Behavioral Health Home initiative (Sacco & Twemlow, 2014). Coordination of physical and mental health care driven by behavioral health experts has the potential to create a patient-centered system of care to improve the health and healthcare of people with SMI. The integration models incorporate the concepts of a health care team (involving the patient and a team of professionals to best care for the individual), stepped care (includes individualized treatment planning that is increased or decreased incrementally based on one’s improvement or decline), four-quadrant clinical integration (see Fig. 1; determines the ideal healthcare setting for integration depending on the combined physical and behavioral health complexity), and the medical home (Viron et al., 2014).

Challenges do exist within the integrated care approach. Medicaid patients with mild to moderate behavioral health conditions may be best served by their primary care providers in a traditional medical health home. However, those with SMI are likely best served through a Behavioral Health Home provider who has proficiency in the mental health field (Bao et al., 2013). There may still be significant challenges with care coordination between a Behavioral Health Home and primary care. Access to specialty medical care outside of emergency room settings may be impenetrable to those with SMI due to the challenges their mental health conditions present and their ability to navigate a complicated healthcare system (Bao et al., 2013). Sacco & Twemlow (2014) offers that adding medical support to behavioral health care is more efficient and less disruptive than increasing the strain of these patients to already overstressed primary care centers. The Behavioral Health Home is designed to serve these patients whose problems would otherwise interfere with the expected compliance most primary care centers require. A focus on engaging, patient-centered care will be critical to the success of the Behavioral Health Home.

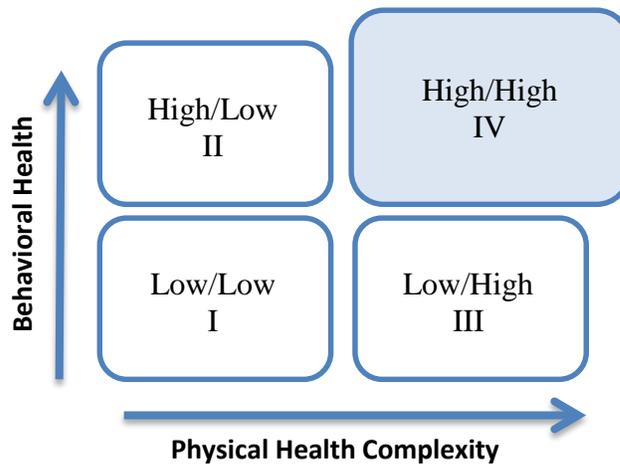


Figure 1. *Four quadrant model of physical and behavioral healthcare integration (Viron et al., 2014). Quadrant IV patients are best served in specialty behavioral health settings with integrated primary care services while quadrant I patients are likely better served in the primary care-style health home.*

METHODOLOGY

The literature and research surrounding program implementation methods provides a basis for the research question, “*What key factors contribute to the successful implementation of a social service program?*” Both formal interviews and a review of agency records provide research data and information to test the hypotheses. Data collection includes the review of agency records and formal interviews. Through gathering information about expectations, perceptions and resources, I will test the two hypotheses below. Threats to internal validity and dependability within this research are outlined with strategies to minimize them.

Two hypotheses are presented and studied in this research:

H1: *A lack of clear and stable expectations leads to challenging implementation processes.*

H2: *The availability of necessary training resources impacts the success of implementation.*

Data Collection

Agency Records

Heartland Family Service agency records such as organizational charts, agency and program policies and procedures, training documents and program forms were reviewed to inform the administrative program evaluation and implementation research. Additional documents including timelines, trainings and guides from Magellan of Iowa, the State of Iowa, and Iowa Department of Human Services were reviewed to establish statewide regulations, expectations and training opportunities. A review of these records is critical to understanding the program’s implementation process and assists in highlighting expectations, training resources and overall implementation activities. The records were readily available via the internet and agency provision.

Records reviewed:

- IHH Guidebook (Magellan of Iowa)
- Training documents and offerings (Magellan of Iowa, Heartland Family Service)
- Technical Assistance documents and offerings (Magellan of Iowa)

- Agency and program training protocols (Heartland Family Service)
- IHH program manual (Heartland Family Service)
- IHH organizational charts (Heartland Family Service)
- IHH contract (Heartland Family Service)
- IHH program logic model (Heartland Family Service)

Interviews

Formal interviews provided insight into the implementation process and program evaluation of the Heartland Family Service Integrated Health Home program. Interviews were held with agency leadership, program staff and cohort IHH agencies (Children’s Square USA and CHI Alegent Creighton Health). The Heartland Family Service Vice President of Counseling and Prevention, Mary O’Neill, was involved in a pilot version of IHH in 2011 and the full program implementation in 2014 and was interviewed for a longitudinal perspective. Four Heartland Family Service IHH program direct care employees who have been working in the program since 2014 provide their perspectives (Julie Michalski, Trish Nixon, Emily Kosmicki and Sheila McMinn). Finally, interviews were conducted with directors of the other two local IHH programs implemented in 2014 through similar state oversight (Kimberly Kolakowski and Kelly Houser). In total, seven interviews were conducted.

Interviews took place with each individual separately in order to gather specific input from each person. Notes were taken by the interviewer throughout the discussions and the following script was used to start the dialogue.

“Thank you for sharing your time with me today. I am doing my capstone research project on the implementation process and using the Heartland Family Service Integrated Health Home as a case study example to gather data and test my hypotheses. In addition to this interview, I will be talking with other staff and local cohorts for their input.

I am not going to be recording our conversation, but will be taking notes throughout our discussion. As I write my findings for this research, I will include your input. Are you willing to be named in this report, or would you rather be referred to as “anonymous” or listed by your position title?”

Interview questions were designed to gather data and perceptions regarding program implementation at the local and state level. Questions 1-3 provide a baseline of information about the interviewee’s background. Information about training and technical assistance is gathered in question 4. Questions 5-7 will provide insight into the purpose and expectations of the program at the local and state levels, including perceptions by staff. Questions 8-10 are designed to identify program-level implementation activities. Participatory activities are investigated in question 11 and overall perception of implementation is collected in question 12. Finally, question 13 provides insight into the program leadership needs and associated perspectives of each interviewee.

Formal interview questions:

1. What is your role with the Integrated Health Home?
2. How long have you been involved in this program?

3. Have you had any other experience with Integrated Health Homes?
4. What training have you received on Integrated Health?
 - a. Who provided the training and how was it delivered?
 - b. How often is training provided?
5. What is the purpose of the Integrated Health Home?
6. What are the expectations of Magellan of Iowa and the Iowa Department of Human Services regarding IHH?
7. What are the expectations of Heartland Family Service (or your agency) regarding IHH?
8. Does your program have a program manual that is available to staff? Where is it located?
9. Do you have quality improvement measures that are shared with all program staff? Can you tell me what they are and when they are measured?
10. How does your program apply ongoing evaluation practices? Please explain.
11. What role do you plan in ongoing quality improvement and program evaluation practices?
12. Do you feel that the IHH program implementation has been successful at the state level? Program/agency level? Why or why not?
13. What do you consider the critical characteristics of leadership during program implementation? Have these been present during the implementation of IHH?

Internal Validity and Dependability

Maturation Threat. Understanding that one's experiences and tenure with the program can impact responses, questions defining tenure and experience was gathered during the interview. A review of the IHH contract, guidebooks and other static documents assisted in defining the statewide and local expectations at points in time.

Instrumentation Threat. Adjusting questions with each interview can be an issue. However, a scripted greeting and defined questions will help to minimize this validity threat.

Mortality Threat. The staff retention rate for Heartland Family Service IHH is 78%, with the only turnover resting in temporary positions. This allows me to interview tenured staff and minimize a mortality threat.

Experimenter Bias. The researcher and author of this study is the director for the Heartland Family Service IHH program. In an effort to minimize validity concerns and threats due to this connection to the research subject, interviewees will be reassured of their employment safety regardless of their responses. Results of this study will be shared with the IHH program staff.

Participant Reactivity. Because the interviewer and researcher is the program's director, interviewees may anticipate expected answers or attempt to impress the interviewer. Likewise, the interviewee may withhold honest responses for fear of retaliation. Heartland Family Service agency policies regarding confidentiality and retaliation or behavior modification were shared to assure respondents. The study results will also be shared with the IHH program staff and the Heartland Family Service leadership team in order to minimize this validity threat.

THREAT	EXAMPLE	STRATEGIES TO ADDRESS THREATS
Maturation	Staff tenure in program; Previous experience with program area; New training offerings over time; Changed expectations and/or program activities over time	Gather experience information in interview; Review contract and other static document to define expectations at given point in time
Instrument	Questions altered with each interview	Create and use scripted greeting and questions
Mortality	Staff turnover since implementation; new staff since beginning of implementation	Interview those staff most tenured to the program and who have knowledge from design of program
Experimenter Bias	Researcher is directly associated with studied program	Assure interviewee of agency confidentiality and retaliation policies; Share results of study with IHH program staff and agency leadership
Participant Reactivity	Desire to answer questions to impress interviewer or to avoid conflict with interviewer	Assure interviewee of agency confidentiality and retaliation policies; Share results of study with IHH program staff and agency leadership

Table 1. Validity Threats and Strategies

FINDINGS

Interviewees were willing to share their experiences with program implementation. One interviewee was involved in a pilot version of the IHH so had more experience with the program, though the implementation process during the pilot was different from the current process. Of the directors, one was hired early in the implementation process and one was hired late in the process, a difference of approximately three months spanning the “go live” date of the program, April 1, 2014. Three of the direct care interviewees were hired within three weeks of the “go live” date and one was hired three months after this date. None of the interviewees had previous experience with integrated or medical health homes.

Training and Technical Assistance

Interviewees report a myriad of training opportunities, though most also reported that the trainings were inadequate for the support needed. Some interviewees reported that the amount of training was adequate while others thought the time spent in training during the early months of the implementation process was extensive as other significant activities were expected. Poor quality and frequency of training at the state level was a concern voiced by most interviewees. Information needed to perform quality care was not provided to the extent needed according to those interviewed.

One direct care staff stated that the agency “learned on the fly” as expectations changed throughout the implementation period. New trainings were offered, but being able to attend trainings was difficult given the short notice. “We tried to train to what we thought it [IHH] would be,” offered direct care employee Michalski (Julie Michalski, personal communication, April 6, 2015). Statewide collaboration meetings among IHH providers were noted as beneficial.

Some direct care staff recalled more training than others. Based on the responses, training opportunities varied depending upon the staff role. Specific trainings were available to each role, though interviewees did not find them to be adequate to learn their job function. At the state level, training opportunities were made available through webinars, telephone conference calls,

statewide conferences and personal coaching visits. Most webinars were recorded and made available through an online portal. Materials and tools from conferences were also made available via this portal for review at a later date if needed. The agency also provided educational opportunities through staff meetings, classroom trainings, informal shadowing and local IHH focus groups. Other opportunities were made available through meetings and focused gatherings within special interest groups such as the Iowa Association of Community Providers and the Iowa Behavioral Health Association.

TRAINING FACILITATOR	TRAINING TOPICS	TRAINING STYLES
Magellan of Iowa (including contracted Technical Assistance providers)	<ul style="list-style-type: none"> • Definition of Integrated Health Home • Habilitation Services • Child Mental Health Waiver Services • Nursing Education • Adult Medicaid Waivers • Intensive Case Management • Quality Improvement Practices • Peer Support Specialists in IHH • Supervising Peer Support Specialists • Risk Stratification • <i>Using the online IHH Portal</i> • <i>Coordination of the Medical Health Home and the IHH</i> • <i>Marketing the IHH in your community</i> • <i>Storytelling – Telling the IHH Story</i> • <i>Billing processes</i> • <i>Person-Centered Planning</i> 	Webinars Phone conference calls Conferences Personal Coaching visits
Heartland Family Service or other IHH Agency	<ul style="list-style-type: none"> • IHH staff roles • Mandatory Reporting • Orientation to Agency • Team building • Program population and how to work with them • <i>Home Visits</i> • <i>CPR and First Aid</i> • <i>Defensive Driving</i> 	Classroom Informal shadowing Focus Groups
Interest groups (i.e. Iowa Association for Community Providers (IACP) and Iowa Behavioral Health Association (IBHA)	<ul style="list-style-type: none"> • Working together with Habilitation Service providers 	Meetings Focus Groups

Table 2. Training Opportunities. Trainings identified by interviewees. Italics indicate a sampling of training topics provided throughout the implementation period but not identified by interviewees.

Purpose and Expectations

According to the *Iowa Integrated Health Home Guidebook* (Magellan Health Services, 2014), the goals of the IHH are (1) to improve the consistency and quality of health care delivery for Iowans through team-based care coordination of behavioral health, physical health, and other social support services, (2) to improve the total health of members served, and (3) decrease the

unnecessary costs of health care delivery. These are modeled after the Institute for Healthcare Improvement's "Triple Aim" as shown in Figure 2.

Magellan of Iowa has outlined two years of quarterly outcome measures that IHH programs must meet in order to access incentive funding. These measures include thirty-two specific outcomes including some focused on physical health goals, medication management, quality improvement efforts and client satisfaction survey responses. In addition to these outcome measures, IHH programs are expected to create sustainable business practices, partner with local healthcare providers and commit to quality services for those enrolled in the program.

Those interviewees in leadership positions (vice president and directors) were able to identify statewide expectations as specific measures related to financial impact and client utilization of services. Direct care staff more often identified statewide expectations as "unrealistic" and referenced an expectation to enroll a specified number of members as well as the expectation to be "two steps ahead of change" (Emily Kosmicki, personal communication, April 10, 2015).

A program logic model was available to define the Heartland Family Service IHH program purpose. Though not explicitly a purpose statement, the logic model does state that the IHH "has been designed as an innovative, person-centered program that addresses this issue through care coordination, peer support services and population health management." The vice president identified program expectations as fulfilling the contractual obligations and to access as much of the funding available to sustain the program as possible (Mary O'Neill, personal communication, April 15, 2015). The two directors noted that their program expectations are to fulfill the mission of their agency and to meet the expectations of Magellan of Iowa and, ultimately, the state of Iowa (Kelly Houser, personal communication, April 13, 2015, and Kimberly Kolakowski, personal communication, April 3, 2015).

Program-Level Implementation Activities

Quality improvement measures and ongoing evaluation processes are critical elements of the IHH implementation plan set out by Magellan of Iowa. Quality improvement coaches were assigned to each IHH program and meetings were held twice a month when the coach visited the site. The role of the coach is to provide technical assistance in the area of quality improvement to the IHH team, identifying opportunities and teaching quality improvement techniques to use throughout the program's activities. As previously mentioned, quality outcome measures were defined by Magellan of Iowa to drive compliance and impact. Heartland Family Service monitors program evaluation through weekly staff meetings, monthly financial and program budget reviews, and regular program reviews by the board of directors.

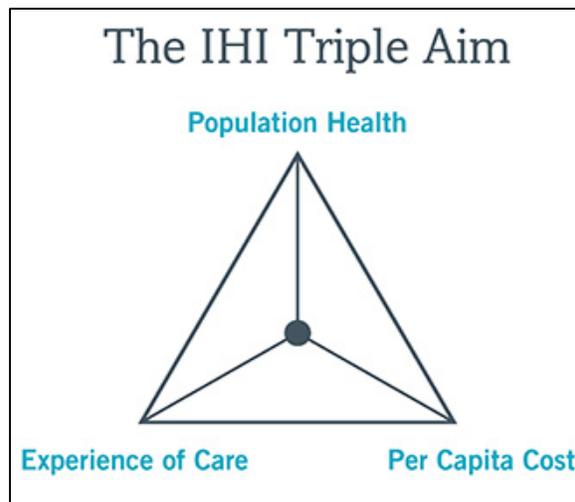


Figure 2. The Institute for Healthcare Improvement's Triple Aim

Perception of Implementation

Interviewee responses were mixed regarding the success of the implementation of the IHH program at both the statewide and local levels. At the statewide level, most responses were positive, noting that success has been documented by Magellan of Iowa. Emergency room visits and mental health hospital admissions have decreased by 16% and 18%, respectively (Magellan of Iowa, 2015). Aside from quantitative data findings, however, responses were riddled with concern for poor provider satisfaction, limited planning for geographical differences, lack of local sustainability planning, inadequate training and planning for the acquisition of habilitation service responsibilities, and the amount of resources committed to helping build strong program foundations. Kolakowski, IHH director, noted that the statewide implementation has been successful, but “not on account of Magellan.” Rather, she believes that the commitment of the IHH agency to collaborate across the state with other providers has been the key to statewide and local success. “Magellan did not provide guidance, oversight or support – they simply demanded [enrollment] numbers” (Kimberly Kolakowski, personal communication, April 3, 2015).

Implementation at the program level was unanimously identified as successful. No interviewees indicated that successful local implementation was easy, but that constant adaptation of the program’s practices has allowed for a greater success rate. The program was designed to focus on population health management rather than case management. However, interviewees across levels noted that the addition of expectations such as habilitation service management greatly impacted the implementation process. Policies and processes were regularly modified to meet new needs and learned expectations. A commitment to local IHH program success is shared among the three local organizations. Directors and staff across the three programs cross-train, share information and meet regularly to collaborate on various projects.

Leadership Needs

Transformational leadership qualities were recognized as critical to the implementation process. Experience in the field, a willingness to engage in the direct care role, commitment to success, supportive personality, strong communication skills, accountability to the team and program, high work quality, evaluation skills and strategic thinking skills were all necessary key elements identified by the interviewees.

Direct care staff and the vice president all noted that many of these skills were present at the local level. In contrast, responses were mixed regarding the leadership quality at the statewide level although the same skills were noted as necessary. These skills were not recognized as existing in the same fashion as they were at the local level. Leadership at the statewide level was seen as prescriptive and reactive rather than proactive and collaborative. Interviewees did not identify a single leader at the statewide level, but rather multiple individuals who may be considered potential leaders.

CONCLUSIONS

The goal of this administrative program evaluation was to identify factors that lead to successful program implementation. The study supports Hypothesis 1, “A lack of clear and stable expectations leads to challenging implementation processes.” Although statewide goals and intended outcomes were documented in guidebooks and contracts, these did not translate into specific expectations to those interviewed. Expectations changed over the course of the implementation period, leading to confusion, continuous adaptation, and apprehension regarding

what might be unveiled as the next unanticipated expectation. Statewide expectations were unclear to the direct care staff, while IHH leaders were able to ascertain these expectations more clearly. The expectations of the agency were slightly clearer to all interviewees. Results suggest that the expectations that impact implementation success are related to the role one plays in the process. Those leading an implementation project have a greater critical need to know and understand expectations at the larger level, while those in direct care must know and understand the expectations of the agency.

The second hypothesis, “the availability of necessary training resources impacts the success of implementation,” was also supported through this study. Training opportunities were available throughout the process, but rarely was a topic revisited at a statewide level when new employees were hired or new expectations were outlined. This was left to be done by the agency and often was not done proactively as changes were not communicated in enough time to do so. Research shows that training, technical assistance and other supports are necessary for successful program implementation. In the case of Heartland Family Service and the Integrated Health Home, the program implementation process has been successful, even with challenges in this area.

The top-down classic model and the participatory framework of implementation both are present in this case study example of the IHH. Iowa Department of Human Services and Magellan of Iowa created the integrated health home model as it is in Iowa. These agencies pursued partners throughout the state to operate the IHHs in their own communities. All the while, the ultimate program design was driven by the statewide agencies and their funding structures. The local agency was given the authority to adapt the program within the given model to meet the needs of the local community. Opportunities were available early in the implementation process to participate in designing the IHH model. Ongoing implementation and evaluation continue to be participatory efforts throughout the process. Statewide agencies have invited IHH directors to participate in modification of processes at the statewide level, seek feedback regarding current policies and encourage the involvement of consumers in the implementation and evaluation process.

Implications and Recommendations

Local social service programs are critical to the health of a community. If not implemented correctly, these programs can be lost due to lack of proper planning, staff burnout, financial instability and other preventable issues. A few recommendations have been identified for future implementation processes specifically for Heartland Family Service and potentially other agencies in similar situations.

- *Outline Program Expectations.* Clearly outline the expectations of the agency regarding a new program, including specific clarity around the expectations of funders or contractual entities. Share these details with the staff involved in achieving results within the program in order to engage them in the program’s success by understanding pertinent implementation details.
- *Create a Program Manual.* Even with frequently changing expectations and internal processes, a program manual can provide a tangible resource for reference. The manual should include program-specific policies and procedures created to meet the program goals and expectations.
- *Build a strong foundation to support implementation.* Program structure, financial resources and resilient staff create a foundation that can lead to successful

implementation efforts. Consider program sustainability during the planning stage and prepare for changes to the cost of implementation. Training and technical assistance should be considered as critical elements of this foundation and should be given great attention.

- *Engage leadership at all levels.* The CEO and other key leaders in the agency should be informed and engaged in the program implementation. The program director is naturally best informed of the activities involved in a program's implementation. However, without the support and engagement of the agency's leadership at all levels, efforts can be stunted if there is no response or support to program needs due simply to a lack of information and understanding.
- *Consider fidelity measures and evidence-based practices.* The Iowa IHH model is not an evidence-based practice. However, there are opportunities within the program to utilize practices that have been tested and determined successful. Even without use of such practices, fidelity measures should be considered so as to ensure appropriate and consistent delivery of services. The use of fidelity measures offers clear expectations that can support successful implementation.

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