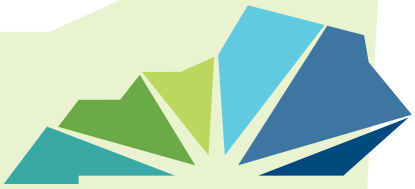
One Foundation's Experience with Primary and Integrated Care Grantmaking

Lessons on Leverage and Policy Change



FOUNDATION FOR A HEALTHY KENTUCKY

Acknowledgements

The Foundation for a Healthy Kentucky is an endowed health legacy foundation. Our mission is to address the unmet health care needs of Kentuckians. Our approach centers on informing health policy, to promote lasting change in the systems by which health care is provided, for the purposes of:

- Improving access to care
- Reducing health risks and disparities
- Promoting health equity

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The authors wish to acknowledge the work of the Foundation's grantees and the members of the Integrated Care Action Team (ICAT) and the Rural Health Oversight Committee (RHOC) for helping, through the Initiatives described here, to shape the vision of a Kentucky in which all residents have access, when needed, affordable quality healthcare.

Introduction

When the Foundation for a Healthy Kentucky first began making grants, they were typically a year in duration and could be filed under one of two responsive grantmaking programs: Community Grants of up to $5,000 (later raised to $10,000) and Access to Health Care Grants, which could be as large as $125,000. Most of the latter grants typically went into unfunded extension periods, as th ey sought to implement the proposed project activities and measure their impact. Learning from these earliest grants, the Foundation moved to a more strategic approach in 2007 – 2011, during which we:

- More clearly identified areas of interest for investment
- Intended multi-year commitments to selected grantees – contingent on satisfactory progress and availability of funds
- Funded a lower-cost planning period in advance of funding a project at a higher level (this approach permitted grantees to plan more fully for implementation of the effort they proposed), conduct a feasibility assessment and develop a more specific plan for implementation
- Combined funding and technical assistance to grantees
- Provided an external evaluation consultant, paid for by the Foundation, both to evaluate the impact of Foundation initiatives and to provide technical assistance to grantees to better assess the implementation and impact of their own efforts.

Two of these more focused initiatives address dimensions of access to primary care services, identified in our earliest series of town hall meetings held across the Commonwealth, to help shape the Foundation's funding priorities:

The Primary Care Initiative sought to bring primary care services to underserved geographic areas of the state, with an aim to make such care more accessible to low-income families.

The Integrating Mental Health and Medical Services (IMHMS) Initiative responded to a specific need identified through the meetings, to help assure that patients with both behavioral health and medical conditions could obtain the help they needed regardless of where they first sought care. Although these efforts both involved health care safety net providers, they are described separately here, as the arc of implementation and the lessons learned have been quite different for each.

Primary Care

Why Did We Fund It?

At the time our work began in this area, most counties in Kentucky were designated as medically underserved areas; 37 were health professional shortage areas for primary care for the total population, another 42 were primary care professional shortage areas for low-income populations. Among Kentucky's 120 counties were 43 of the nation's 386 persistent -poverty counties (defined by the Economic Research Service as counties experiencing poverty rates of 20% or higher in each Census from 1970-2000). Aging solo practitioners were not finding younger physicians to assume their practices. The Foundation believed these challenges could be addressed by innovative approaches to care delivery that would make quality primary care more accessible in remote rural areas, and sought to be part of that solution process.

How Did We Do It?

We engaged the services of the Kentucky Primary Care Association as a technical assistance provider and issued a Request for Proposals, to identify communities ready to undertake the planning needed to assess the feasibility of bringing needed primary care services to their community.

Funding for an initial planning phase was provided to:

- Big Sandy Health Care, Inc. (Eastern KY)
- Cumberland Family Medical Center (South Central KY)
- Fairview Community Health Center (South Central KY)
- Four Rivers Behavioral Health, Inc. (Western KY)
- Lexington-Fayette County Health Department (Central KY)

Three of the successful applicants already operated federally qualified health centers in Kentucky; one operated a community mental health center; one was a county health department.

The end product of a first funded planning period was to be a Health Plan, assessing the health needs of their population and the resources available to address them, and a Business Plan, laying out an approach to addressing the identified health needs that could be sustained beyond the Foundation-funded start-up phase through a mix of contributions and third-party payments.

The Kentucky Primary Care Association, working in conjunction with Crown Medical Management, offered both group training workshops and individualized technical assistance, to help communities assess their needs and resources and design a primary care program to meet anticipated demand for local services.

What Did We Learn?

Funding was provided to five sites, geographically distributed across the Commonwealth, to develop their Health Plan and Business Plan to submit to the Foundation for implementation funding. At the end of the planning phase, one of the sites – the community mental health center – decided not to pursue operation of a primary care clinic, as their board was reluctant to make the governance changes needed to pursue federally qualified health clinic status. A second site – Lexington Fayette County Health Department – asked to repurpose their implementation funding for future planning after a member of their planning coalition successfully obtained federal approval to open a federally-qualified health clinic to serve the population that was the identified service target of the planning grant. This request was declined, as the Foundation viewed establishment of the intended clinical services, although not created in the intended manner, as a successful accomplishment of the project's aims.

The great strength of the Foundation's Primary Care Initiative was the assistance it offered to medically-underserved communities to access federal funding, creating and sustaining new service sites.

The "big story" of the Foundation's Primary Care Initiative was the confluence of our interest in creating new access points for primary care in the Commonwealth with the federal government's infusion of funding into the federally-qualified health center (FQHC) system, to create new access points in medically-underserved areas of the nation. The planning period which the Foundation and the Kentucky Primary Care Association (KPCA) supported, with funding and technical assistance respectively, permitted funded sites to compete successfully for FQHC funding. When funded sites are added to those receiving only technical assistance, the Foundation's investment attracted over $17 million in federal resources for needed primary care service expansion.

Grantee/TA Recipient	Model	Status - 2011
Grantees: Planning and Implementation Grants		
Cumberland Family Medical Center	Converted private practices into FQHCs	Established clinics in Cumberland, Adair, Clinton, Russell, and McCreary counties by converting private practices into CHCs. Exploring needs and potential expansion into Green and Hart counties.
Fairview Community Health Center	Satellite clinic of existing FQHC	Satellite clinic opened in Butler County on April 16, 2008. Exploring needs and potential expansion into Edmonson county.

Grantees: Planning Grants		
Big Sandy Health Care, Inc.	Satellite clinic of existing FQHC	Martin County satellite clinic opened on June 29, 2009 and is fully operational. Exploring needs and potential expansion into Johnson and Lawrence counties.
Four Rivers Behavioral Health, Inc.	FQHC tied to a Community Mental Health Coordinator	Determined it was not feasible to pursue because of governance issues between the FQHC and CMHC models.
Lexington-Fayette County Health Department	Improved coordination of safety net providers to meet cmomunity needs	Bluegrass Community Health Center (a key partner) received federal funds to establish a clinic serving the targeted population; additional funding was not sought.

What Did We Do Next?

The great strength of the Foundation's Primary Care Initiative was the assistance it offered to medically-underserved communities to access federal funding, creating and sustaining new service sites. However, this opportunity trumped efforts to help communities create innovative new approaches to care delivery. To counter this limitation of the Initiative, the Foundation convened a group of experienced health service delivery experts – dubbed the Rural Health Oversight Committee (RHOC) - to look closely at delivery of services in rural Kentucky and suggest strategies for delivering care in more cost-effective ways. The result was an issue brief, Rural Healthcare that Works: Access, Quality & Innovation, available on the Foundation's website here. A KET special also lifted up innovative strategies identified through this work: Remaking Rural Health is available here. Rural Health advances and opportunities also became the theme of our 2011 Howard L. Bost Health Policy Forum.

As we began a new strategic planning period, 2012-2017, policy priorities identified through this work carried over into the Foundation's new Initiative, Promoting Responsive Health Policy. The Foundation's Board has called out the following areas as dimensions of access policy on which to focus in the years ahead, to support improved access to integrated primary care services (encompassing physical, behavioral and oral health services):

- Licensing changes
- Scope of practice changes
- Incentives for work in underserved areas
- Increasing provider slots
- Tracking rates of insurance coverage for previously uninsured populations

First priorities have been to propose changes to licensing and service reimbursement that encourage (a) provision of behavioral health services on-site at primary care facilities and the provision of primary care services on-site at behavioral health facilities, and (b) create and permit reimbursement for community health workers.

While not initially an identified priority, actions taken in Kentucky under the Affordable Care Act – to create a state-run health insurance exchange or State-Based Marketplace (SBM), kynect, and to authorize Medicaid expansion – increased interest in the impacts of these actions on previously uninsured populations.
Going forward, we have taken to heart the suggestions offered by CCHE, the Foundation's external evaluator:

- Continue to work to influence state policy change related to primary care access.
- The Foundation has modified our staffing for 2012-2017, with the addition of a Health Policy Officer and a Communications Director. We have

also contracted with the Urban Institute, for a multiyear study of the impacts of Kentucky's move to Medicaid managed care statewide on access to care, costs of care and care outcomes. A successor study is budgeted to evaluate the impacts of Kentucky's expansion of Medicaid and establishment of a SBM as allowed under the Affordable Care Act on care access, cost and outcomes.

- Improve the use of media to reach the grassroots/ consumers of health care.
- While sustaining the Foundation's relationship with KET public television, we have added relationships with the Institute for Rural Journalism and – most recently – public radio. With the assistance of our Communications Director, we are working to be more strategic in our use of media.
- Provide episodic and responsive technical assistance (TA) to local communities and organizations serving those communities.
- The Foundation has developed and continues to offer a series of workshops and webinars each year, Health for a Change, targeted to community-based nonprofit organizations and local health coalitions.
- In addition, the Board has created a designated budget to support workshops and symposia offered by other organizations.
- Advocate for the proposed solutions identified by RHOC.

The Foundation continues to work to advance solutions and leverage opportunities identified by the RHOC. We secured a competitive multi-year grant from the federal Social Innovation Fund, which we have used in part to fund demonstration projects advancing telemedicine, use of lay community health workers, and operation of nurse-managed clinics. In addition, we have encouraged local health departments working on a community needs assessment process (Mobilizing for Action through Planning and partnership – or MAPP) and hospitals developing more robust community benefit plans to work collaboratively – together, they can be an important force for changes in the way care is delivered.

- Continue to promote health equity in funding initiatives and policy work.

The Foundation has elevated the importance of health equity in our work through training and inviting input from our 31-member Community Advisory Committee and being more explicit about this priority in Requests for Proposals and workshops for prospective and current grantees. By regularly convening leaders working on health equity in Kentucky, and participating actively in the Southeastern Health Equity Council, we intend to continue to inform our work with effective strategies for addressing health equity.

- Explicitly link learnings from this initiative to the Foundation's new strategic focus areas

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Access to care remains an important dimension of the Foundation's new Promoting Responsive Health Policy Initiative.

- Disseminate lessons learned from the Primary Care Initiative.

Through this document, the Health Policy Forum, the KET special, and the evaluation reports developed by CCHE, we continue to share what we have learned about Primary Care service delivery. Moving forward, we remain a clear voice for the need to "do care differently" if all Kentuckians are to have access to affordable, safe and effective care.

Lessons for the Field?

Our work in the Primary Care area has been a lesson in humility and flexibility. On the humility side, we've learned the importance of making sure the size of our philanthropic investment is commensurate with

intended impacts. On the flexibility side, we've learned that being able to use our modest resources to attract much more substantial funding from federal or larger philanthropic sources can help local nonprofits to greatly increase their scale and impact. We've also learned the importance of making sure that our technical assistance providers' vision and skill sets are aligned with the intent of an Initiative. While KPCA was very good at helping local communities secure funding for federally-qualified health centers, their skill set was less-suited for the task of assisting those communities seeking other ways to deliver low-cost, accessible care (for example, variants of a free or volunteer-staffed clinic).

Of the new clinic sites created under this initiative, most were established with federal funding, after a design phase funded by the Foundation. Few were open evening or weekend hours, although "hours of operation" had been identified at the start as a potential barrier to care access. Most did not place a priority on cultural and linguistic access. Due to a then-present carve-out for Medicaid funding of behavioral health services, few offered on site behavioral health care. Had we more explicitly named these as requirements of the Initiative, rather than aims, they might have been more frequent – although, once the Foundation ceased to be the funder of these new FQHC sites, we had far less leverage to modify their approach to care.

A last dimension of our learning – even more apparent in our efforts to care integration – is that demonstration projects are most likely to have staying power if they can be sustained through payment mechanisms currently available and conform to current licensure and reimbursement regulations. When that is not the case, funders and grantees together may need to use the evidence from their funded experiment to advocate for the changes needed in law and regulation to deliver care in demonstrably more cost-effective ways. Even with stronger evidence than we were able to amass, this can be a difficult road. Private and governmental payers may see any additions to reimbursable services or types of professionals as a cost expansion in the near term, even if cost savings can be demonstrated further out.

Integrating Mental Health and Medical Services (IMHMS)

Why Did We Fund It?

In addition to the challenges of poverty and primary care shortages in Kentucky, the community mental health center (CMHC) system had received level funding for several years, while the population's need for mental health services continued to grow. CMHC's were struggling to deal with the needs of the most acutely and severely mentally ill. As in other parts of the nation, patients dealing with anxiety, depression and less severe behavioral health issues were most often being treated with prescription medications by their primary care providers with little if any access to accompanying cognitive and behavior change therapies. For patients with Medicaid, the historic payment carve-out required that mental health services be provided by these overburdened CMHCs. In the Foundation's earliest years of responsive grantmaking, four Access to Health Care projects had been funded that sought to make behavioral health services more accessible, for example by bringing them on-site at a trusted community center in a predominately African-American community or a busy federally-qualified health center or by incorporating group counseling into the regimen of patients undergoing cancer treatment. As the Foundation moved into the 2007-2011 strategic plan period, we sought to build on this early work in a more intentional way.

How Did We Do It?

As with our work in Primary Care, our earliest grant-making taught us that a year was not long enough to design and launch a successful program. Accordingly, with the 2007-2011 strategic planning period, we offered grantees the opportunity to plan a proposed delivery strategy before implementation funding was awarded. Grant applicants were offered the opportunity to design an approach to care integration they believed would best address the needs of the populations they already served – either newly integrating services or removing barriers to integration in an existing program. The Foundation intentionally selected a mix of projects providing services to different populations and in different settings. As with the Primary Care Initiative, the first funding period underwrote community planning efforts. The aim was to bring key stakeholders together, to develop a business plan for provision of better-integrated primary care and behavioral health

services in these varied settings.

After the one-year planning period, four of six original IMHMS grantees applied for and were awarded one year of implementation funding. Two of the six grantees determined that their organizations were not ready to move forward with implementing integrated services at that time. In 2009, the Foundation awarded a second year of implementation funding to two grantees that had demonstrated satisfactory progress in the first year of implementation. Grant funding supported planning and/or implementation of demonstration projects to integrate mental health and primary care services in or across the following delivery settings:

- Community-based primary care center
- Health department primary care clinic
- Hospital satellite clinics
- School-based health centers
- Community mental health centers
- Community social service center

Some sought to co-locate services at the same site; others to develop more effective referral practices. It became clear early in the implementation process that there were barriers in state law and regulation that made the work of integration more challenging. When the Foundation first gathered grantees to meet with state officials from Behavioral Health, Public Health and Medicaid and share the work that was underway ("No Wrong Door" conference), conversation quickly turned to these barriers. In addition to regulatory obstacles, there were challenges identified that had more to do with the way medical and behavioral health professionals were trained: while physicians were accustomed to brief encounters, behavioral health professionals were used to nearly hour-long sessions. Could the latter learn to have an effective, more-rapid intervention in the primary care setting?

The Foundation retained the services of Benjamin Miller, Ph.D., then a post-doctoral fellow at the University of Massachusetts School of Medicine, Department of Family Medicine and Community Health, to work with grantees and help the Foundation better understand barriers to care integration. Dr. Miller, in turn, introduced us to the work of the Collaborative Family Health Care Association and helped the Foundation to offer a distance learning program to grantees, presenting approaches to integration taught by Dr. Sandy Blount at the University of Massachusetts. As a result of the grantees' challenges with implementing integrated care delivery models, the Foundation created an "integrated care action team" (ICAT) to create a forum for problem-solving around identified regulatory and reimbursement barriers to integration.

Formed in early 2009, the ICAT consisted of former and active integrated care grantees, as well as other Kentucky stakeholders in integrated care efforts. Our aim, in creating and hosting the ICAT, was to encourage those working on care integration to: (1) share experiences, protocols, and data on their integrated care models; (2) discuss the policy and regulatory barriers hindering the advancement of integrated care in Kentucky; and (3) devise an action plan for addressing these barriers. It met three times during the grant Initiative period. One unanticipated result of the ICAT process was that the Executive Directors of the Kentucky Primary Care Association and the Kentucky Association of Regional Programs (KARP, the membership association for the state's Community Mental Helath Centers) met for the first time, with Foundation staff, and agreed to support and work toward ICAT recommended actions. The Foundation crafted the ICAT recommendations into an Issue Brief, No Wrong Door: Bridging Mental Health and Primary Care Silos in Kentucky. ICAT recommendations were:

1. Medicaid reimbursement for physician care at community mental health centers
2. Offsite provision of primary care services (specifically, provision of physical health services at community mental health services through partnerships with licensed primary care centers)
3. Medicaid reimbursement for mental health consultation in primary care settings
4. Medicaid reimbursement for telemedicine collaboration (allowing both the provider of services where the patient is located and the consulting provider to be reimbursed)
5. Medicaid reimbursement for peer support specialists (training and licensing peer support specialists as part of a mental health team)

As the Initiative came to a close, two of the grantee

teams had developed sustainable strategies for care integration. While staffing changes impacted continuation of one effort (the Lexington-based partnership of the Lexington-Fayette County Health Department and the Bluegrass Community Mental Health Center), the partnership of Primary Plus (FQHC) and Comprehend, Inc. (CMHC) has endured beyond the departure of key staff.

What Did We Learn?

An external evaluation, completed for the Foundation by the Center for Community Health and Evaluation, is available here. The conclusions of that study were:

Overwhelmingly, the Foundation is seen as a key player in the attempt to integrate services in Kentucky.

While the success of the Foundation's investments in demonstration projects has been varied, significant—project specific—accomplishments were achieved; these include: illustrating that mental health services can successfully be integrated into a FQHC primary care setting; adding legitimacy to the concept of integrated services; and gaining national recognition for integrated efforts. The Foundation's investment has been credited with creating two examples of integrated care models. However, overall, there is not agreement among key stakeholders as to whether the level of integrated care has increased since the beginning of the initiative.

Policy and regulatory barriers, particularly around reimbursement and training of health care professionals, are considered the primary challenges to implementing and sustaining integrated services.

Additionally, there is a long history of competition and tension between the primary care and mental health communities. The Foundation is seen as an effective, neutral convener of key stakeholders as illustrated in their facilitation of the ICAT to develop the "No Wrong Door: Bridging Mental Health and Primary Care Silos in Kentucky" issue brief and the coordination of the health policy summit in conjunction with the CFHA conference.

Overwhelmingly, the Foundation is seen as a key player in the attempt to integrate services in Kentucky and stakeholders often made comments like "if they aren't doing it, nobody will." There is support for the Foundation to be more involved at the state policy level to advocate for integrated services, particularly in the context of national health care reform and the state's move to Medicaid managed care.

What Did We Do Next?

Recognizing that we are nowhere near the goalposts of fully-integrated care, we keep carrying the ball. To be specific, the Foundation remains connected, both nationally and within the state, to groups and organizations working to advance care integration.

We were pleased when the State's Request for Proposals (2011) for statewide provision of Medicaid Managed Care included behavioral health and medical services in the request, although the selected providers generally managed the behavioral health claims through a separate subsidiary. More recently (2013-14), Kentucky's Cabinet for Health and Family Services has addressed other care integration barriers identified through the ICAT process by:

- Authorizing changes to reimbursement for telemedicine, including the elimination of a 4 visits per beneficiary per year limit; expansion of clinical services that can be reimbursed; and expansion of providers who can be reimbursed, including primary care providers (the amendment did not provide for payment of a facility fee on the patient's end, but work is in progress for this issue as well)
- Authorizing Medicaid reimbursement for psychologists and social workers providing behavioral health services in primary care settings
- Authorizing Medicaid reimbursement for peer support as a covered benefit (though not all Medicaid Managed Care Organizations provide this)

- Expanding the network of Medicaid reimbursable behavioral health providers beyond CMHCs

In addition, legislation pending (HB527) in the 2014 Kentucky legislative session would provide for reimbursement of primary care services delivered at a Community Mental Health Center.

The Foundation's 2012 Howard L. Bost Health Policy Forum focused on the topic of care integration. An updated issue brief, available here on our website was developed in support of that meeting, and speakers were drawn from across the nation and within the state to share best practices. In 2013, the Foundation's Health Policy Officer was invited to join a task force of staff of the Cabinet for Health and Family Services to develop recommendations for the better care integration in the State's Medicaid program, with funding from the National Council for Behavioral Health At this writing, the task force recommendations are still under review. Further, care integration has been identified as a top priority for the Office on Health Policy within the Cabinet for Health and Family Services.

Lessons for the Field?

Significant changes in health care practice usually require changes in compensation practice – and may also require changes in licensing (of facilities and/or professions), certification and professional training. This is important work that requires a long-term commitment. And it may give rise to push-back from various sources invested in the current state of affairs:

- Professionals, not wanting others to be licensed to perform similar services at lower reimbursement rates
- Payers, not wanting to open a door to new categories of reimbursable services
- Training institutions reluctant to alter curriculum, until it is clear that a new approach has staying power

Foundations are in a powerful position to speak out for change, as we "don't have a dog in the fight." That neutrality can be our strength, particularly as we become known for speaking clearly and from a basis in factual information and evidence-based approaches.

Yet another learning from our foray into care integration is that facts and figures can only go so far. Because systems change is not undertaken lightly, such moves are best made from a position of trust. Among our grantees, those who moved the furthest, fastest were those with long established mutual respect and shared commitment to improved patient outcomes.

When a foundation enters this playing field, where alliances may have been formed many years before our arrival and teams long squared off for battle, our neutrality is a strength but our newness is a challenge to overcome. We must build relationships with those already engaged, so that they can grow to trust the sincerity and transparency of our purpose and our actions. The Affordable Care Act and the growing scrutiny of costs and impacts of health care investments may increase the readiness of payers, providers and academicians to do care differently. We must be ready to act on change opportunities when they arise.