Evaluation and Program Planning 53 (2015) 57–64

Contents lists available at ScienceDirect

Evaluation and Program Planning

journal homepage: www.elsevier.com/locate/evalprogplan

Manual development: A strategy for identifying core components of integrated health programs

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ARTICLE INFO

Article history:
Received 9 March 2015
Received in revised form 29 July 2015
Accepted 6 August 2015
Available online 14 August 2015

Keywords:
Core components
Program evaluations
Program dissemination
Integrated care models

ABSTRACT

Integrated care models are gaining popularity as a clinical strategy to reduce costs and improve client outcomes; however, implementation of such complex models requires an understanding of programmatic core components essential to producing positive outcomes. To promote this understanding, evaluators can work collaboratively with organization staff and leaderships to gather information on program implementation, adaptations, organizational buy-in, and project outcomes. In 2011, SAMHSA funded two Miami health clinics to implement integrated care models in co-located settings. Changes in the federal healthcare landscape, non-Medicaid expansion for Florida, and the complexity of projects goals led evaluators to facilitate a core component review as part of evaluation. A manual was developed throughout the project and captured a description, adaptations, inputs needed, lessons learned, and sustainability for each integrated care component. To increase chances for program success, evaluators should institute a method to better define core components of new programs and implementation adaptations, while keeping program replication in mind. Breaking down the program structurally gave the evaluation utility for stakeholders, and ultimately served as a resource for organizations to better understand their program model. The manual also continues to serve as a dissemination and replication source for other providers looking to implement integrated care.

1. Introduction

A program's core components are the essential functions and associated activities of a program or intervention. Identifying and describing these principles can assist researchers and the provider team in a stronger conceptualization of the program theory and subsequent long-term outcomes and impacts (Blase & Fixsen, 2013). Components generally reflect program aspects related to context, structure, and specific program practices. Furthermore, in instances where programs do not produce successful or expected outcomes, a deep understanding of the core components may provide insight as to whether the intervention, the implementation, or a combination of both contributed to the lack of programmatic success (NIRN, 2015). Competing priorities and lack of funding often mean that even programs demonstrating effectiveness may not be sustained following the removal of program funding. Identification and description of structural core components can promote program sustainability and dissemination/replication. For example, an organization may wish to adopt a model of integrated care, but have limited resources; thus, understanding which programmatic components are feasible and the best fit can be helpful in determining how to allocate resources towards those components while also allowing freedom for cultural and context specific adaptations (Blase & Fixsen, 2013; Bauman, Stein, & Ireys, 1991). A meta-analysis on program modification and adaptation revealed that program changes addressing cultural context, language, and literacy were the most common adaptations made by sites, followed by modifications related to the program duration or pace (Stirman, Miller, Toder, & Calloway, 2013). Without documenting program adaptations and subsequent programmatic outcomes, implementation sites and evaluators will not be able to discern reasons for program success or failure.

Even with effective program models and programmatic components, effective implementation must occur for program success. Implementation aspects that contribute to active and successful program implementation include competency, organization, and leadership supports (Johnson, Jackson, Guillaume,

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http://dx.doi.org/10.1016/j.evalprogplan.2015.08.004
0149-7189/

Meier, & Goyder, 2010; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). To facilitate a change on staffing roles, responsibilities, and processes, clinical staff and administrators must develop new skills and competencies. These are often built through training and technical assistance focusing on specific programmatic components. Other implementation drivers, such as organization and leadership, often require buy-in. To promote program/intervention buy-in and community ownership, evaluation teams can work with providers to facilitate stakeholder input and community-driven implementation (National Research Council and Institute of Medicine, 2009). Research has also shown that program administrators need to have a strong understanding of what the program is doing through process and descriptive evaluations to strengthen the chances for success (Koskan, Friedman, Hilfinger-Messias, Brandt, & Walsemann, 2013).

Additionally, when designed from the onset of a new program implementation project, evaluation models that incorporate community feedback and organizational buy-in through participation fair better regarding the routinization and institutionalization of new, complex innovations (Johnson, Hays, Center, & Daley, 2004; Harvey & Hurworth, 2005). Facilitated implementation sessions and meetings can be used to monitor organization and systems barriers and challenges, to develop strategies to increase implementation effectiveness, and to better understand how core components contribute to client-level successes. Johnson et al. (2010) noted that invested organizational leadership could facilitate program implementation through removing barriers to logistical and technical challenges of operating program core components. Evaluators are in a unique position to assist organizations and their leaders in defining and monitoring core component implementation for many reasons. First, they document effectiveness, a precursor to sustaining a program. Evaluators also understand programmatic processes. Finally, they can use data-driven approaches to assess program adaptations, if made. For pilot programs and newer interventions, specific program component data may need to be captured to determine whether certain program elements facilitate or hinder program success (Blase & Fixsen, 2013). This may be particularly important when fidelity has not been developed around the program or practice,

Scheirer (2005) suggests programmatic component operationalization as a method evaluators can use to better define the program and measure success. If this level of program defining occurs at the project beginning and throughout implementation, it can also serve as the foundation for program sustainability planning. Specifically, for programmatic models that are flexible or that are new and lack particular fidelity thresholds or guidelines, collecting data regarding core components of an intervention can lend insight about how structural components relate to programmatic outcomes. Furthermore, evaluation data collected throughout project core component implementation and related outcomes and is also needed for successful dissemination (Blase & Fixsen, 2013). To facilitate this process of sustainability and dissemination, funders could emphasize that grantees specify the core components of programs as deliverables at the end of a demonstration or pilot phase to facilitate replication and scalability.

1.1. The current study

Estimates have shown that as many as 24–40% of persons with a chronic disease also have co-occurring depression, and Health Centers that have implemented universal screening among chronically ill patients are finding incidence of co-occurring behavioral health issues as high as 70% (CSI Solutions, 2013). Persons affected with chronic medical and behavioral health conditions experience significantly higher medical care costs and are more likely to experience earlier death (Department of Health and Human Services, 1999). Thus, integrated care models are gaining strength as a strategy clinical settings can employ to reduce costs and improve client outcomes (Milliman, 2014). Integrated care models aim to offer an all-inclusive healthcare experience in which a client or patient has multiple healthcare needs met via one door or through one group of coordinated providers. In spite of the positive evidence supporting these models, they remain complex and wrought with logistical challenges to implementation including issues related to space, consent forms and data sharing, and staff roles (Collins, Hewson, Munger, & Wade, 2010).

Integrated care model implementation requires a shift in current health clinic processes and provider roles and responsibilities. Furthermore, because integrated care models are broad and allow for specific practices to vary according to clinical context (i.e. setting, space, staffing, target population), adopted models must also remain flexible. Thus, an understanding of what structural components make up integrated care models, and what each component consists of is needed to monitor processes and allow for non-compromising level of adaptations (Blase & Fixsen, 2013). For example, randomized control trials have revealed specific components of co-located integrated care models, such as care coordination, are clinically and cost-effective (Blount et al., 2007). Both clinical and fiscal outcomes have been attributed to integrated care models, particularly for those with the poorest health (Craven & Bland, 2006). Still, there remains a dearth of research on specific program components' within integrated models across settings and relationships between components and positive outcomes.

In 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a call for proposals specific to the twelve cities most impacted by HIV/AIDS, to implement integrated care programs by offering HIV and behavioral health services in primary care settings (the MAI-TCE project). Miami received dollars to implement these services within two large health clinics overseen by a Behavioral Health Services Managing Entity (an arm of the state Department of Children and Families). The two health clinics that participated included a primary care-based clinic also offering behavioral health and ancillary services and catering to the African-American and Caribbean/Haitian community (Clinic A); and a behavioral health clinic also offering primary medical and ancillary services, with a mainly Hispanic/Latino clientele (Clinic B). An evaluation team was also funded. Integrated services provided included behavioral health screening and assessment, HIV testing, HIV prevention interventions, HIV clinical interventions for positives, and outpatient behavioral health services, and peer support. These specific services, known as the core components, were the program's structural elements written into the grant application prior to funding. The lead grant writer was no longer with the Managing Entity when notice of funding was issued. Therefore, the core components remained and were implemented based on interpretation from the ground level team.

To document the wide service array and to examine implementation differences across the two sites, the evaluation team began developing a core component manual including service definitions, implementation process and adaptations, lessons learned, case examples of the component in action, and sustainability plans. Manual development took place with feedback from the project team during year three of the project, with year one focused on clinics building buy-in, hiring staff, and receiving training in the selected evidence-based practices written into the funded proposal. Phase two (late year one–year two) focused on making adaptations to either core components, component implementation, and focusing on infrastructure