CTC-RI
Integrated Behavioral Health Pilot Program
Executive Report

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Contents

About the Executive Report and the Full Report

There are two IBH Pilot Program Evaluation reports—the Executive Report and the Full Report. The Full Report (86 pages) includes detailed information about how sites implemented their IBH programs. The Full Report includes the Executive Report as well as Attachment 1—Evaluation Research Questions; Attachment 2—Interview Guide; Attachment 3-- Illustrative Stories about Practices' Experiences with IBH; and Attachment 4—AIMS Center Implementation Guide. The Executive Report does not include these Attachments.

The Executive Report (22 pages) provides a thorough but less detailed overview of the report findings. Both reports include the same set of recommendations. The Full Report is available upon request from CTC-RI.

Introduction

There is increasing evidence that when physical healthcare and behavioral health services are coordinated and provided in integrated healthcare settings, health outcomes improve for patients, and the cost of care decreases. However, there are different levels of Integrated Behavioral Care (IBH), ranging from collocated to fully integrated. Within those levels, organizations have different resources, methods of oversight, and methods of determining patient and financial outcomes.

The Care Transformation Collaborative of RI (CTC-RI) is a multi-payer, advanced primary care (APC) initiative co-convened by the RI Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services (EOHHS). In 2016, with funding from the Rhode Island Foundation's Fund for a Healthy Rhode Island and Tufts Health Plan Foundation and State SIM grant, CTC-RI responded to this priority by implementing an Integrated Behavioral Health (IBH) pilot program. To determine the IBH program's ability to effect cost of care, CTC-RI contracted with Brown University to conduct a quantitative, cost-of-care analysis. To determine barriers and facilitators to implementing the IBH program and to provide context to the Brown evaluation, CTC-RI contracted with the authors to conduct a qualitative evaluation.

The overall purposes of this qualitative evaluation were to explore with each of the pilot practices how they designed and implemented their IBH programs; how practice providers, IBH providers and other staff experience and assess the workings of the program at their sites; identify the challenges and facilitators to implementation and sustainability; and provide recommendations for going forward with integrated behavioral health (IBH) expansion within primary care in Rhode Island.

The IBH program initially was comprised of two cohorts and twelve pilot sites (however, two elected to withdraw within the first three months due to organizational and workforce issues.)

CTC-RI's IBH pilot program objectives are to:

1. Increase the identification of patients with behavioral health and substance use disorders (SUD) through universal screening for depression, anxiety and SUD.
2. Increase ready access to brief behavioral health intervention for patients with moderate depression, anxiety, SUD and co-occurring chronic conditions.
3. Provide care coordination and intervention for patients with high emergency department (ED) utilization.
4. Improve interdisciplinary care coordination for patients with severe mental illness and SUD.

5. Test the proposed financial model for long-term sustainability with particular attention to ED and inpatient (IP) utilization/total cost of care as sustainable measures.

The CTC-RI Participation Agreement required sites to implement a clinical model over a two-year period that included universal screening for depression, anxiety and substance use disorders, and three projects using the Plan Do Study Act model (PDSAs). PDSA 1 addressed screening rates, PDSA 2 addressed emergency department (ED) utilization, and PDSA 3 addressed identification and IBH interevention for population of patients with chronic disease. Sites had latitude as to how they met the pilot objectives, and implemented universal screening and rescreening. Notable additional requirements included site participation in practice facilitation and in quarterly learning network meetings, and collecting data to support the Brown evaluation.

Additionally, sites received financial support through an infrastructure payment of $15,000 for each patient panel of 5,000 attributed lives (prorated based on health plan attributed lives assignment) in two installments. CTC provided primary care practice with prorated payment (based on 5,000 attributed lives) of $10,000.00 in Start-up (Year 1) and $10,000.00 for Performance Year (Year 2) based on meeting screening targets as outlined below:

	Depression	Anxiety	SUD
Start-Up (Year 1)	70%	50%	50%
Performance Year (Year 2)	90%	70%	70%

Methods

Methods for this evaluation were an IBH literature review; a review of CTC-RI and individual practice documents and websites related to the IBH pilot program requirements and processes; and qualitative interviews with open-ended questions. We interviewed state policy makers and state payers and CTC-RI to gain context and inform the development of the interview guide. A mix of individual and group interviews were conducted at each of the five Cohort 1 and five Cohort 2 IBH pilot sites. Interviewees were selected based on a list of employees at each site who CTC-RI identified as associated with the IBH program (IBH managers, practice managers, IBH providers, physician champions, practice leadership, nurse care managers, site psychiatrist). Interviews were digitally audio recorded and were between 30 and 90 minutes long. A professional transcription service transcribed the interviews verbatim. The full evaluation report provides the research questions in Attachment 1 and the interview question in Attachment 2.

Qualitative data were analyzed using traditional qualitative analysis processes that have, in recent years, been labeled “immersion/crystallization”. [1] This process entails individually reading the transcripts, and taking analytic notes throughout the process. Throughout the analysis process, we maintained notes on a template grid to facilitate comparison among the pilot sites. The data were discussed by the evaluators to explore divergent interpretations and to arrive at the final presentation of the findings.

Findings

There is a saying often heard regarding healthcare, “If you have seen one program, you have seen one program.” While each of the practices in the pilot followed CTC-RI guidelines, sites developed their programs to meet their organizational needs and to match their available resources. Thus, while the sites have many similarities, each program has its own unique features, means of achieving goals,

facilitators and barriers. The findings below illustrate both the common and unique features of IBH implementation.

We have organized the Findings into five areas: Provider and staff perceptions of IBH; Foundational activities; Implementation; Sustainability; and Policy. Included throughout the Executive Report and Full Report are representative quotes that illustrate key findings.

Positive provider and staff perceptions of IBH

Providers and staff value IBH. Overall, sites were pleased to take part in the CTC-RI IBH pilot program. Interviewees reported IBH improved patient care—practices were able to provide services that treated the whole person, rather than just a medical condition. With IBH, patients gained access to a different model of therapy, one that was shorter, skills based and, for some patients, less stigmatizing than care at a freestanding mental health facility. Interviewees emphasized that they often presented IBH to patients as a way to help deal with the stressors of daily life and difficulties managing their medical conditions. As a result, patients gained skills in managing both their emotional and medical conditions. Many medical providers expressed that now that they had experienced IBH in their practice, they could not imagine working in a setting without IBH services. Attachment 3-- Illustrative Stories about Practices' Experiences, found in the full report, provides additional insight into provider and staff experiences.

> *"….when I say how much I love having integrated behavioral health, is that I can't imagine primary care without it. It just makes so much sense to me to have those resources all in the same place because it's so important. So I love it. I can't speak highly enough of it." (Medical Provider)*

Foundational activities

Implementing the CTC model. While all sites implemented the CTC-RI IBH model, sites implemented an IBH program that met their organizational needs, matched their available resources and met the grant requirements. Core elements of all the programs included: screening at least annually and rescreening patients who screened positive; a warm handoff to the IBH provider; 1-6 sessions of short-term therapy with referrals to long-term therapy as indicated by assessment or progress made in short-term therapy; care planning; care coordination between medical providers and IBH providers; and clinical team meetings for high-risk, high-cost or problematic patients.

Support for IBH from CTC-RI. CTC-RI provided systematic and structured financial and programmatic support and oversight. CTC-RI provided orientation, training, and practice facilitation to support sites in developing their programs. CTC-RI used incentives to ensure sites developed robust screening, referral and treatment workflows. Sites benefited from grant funds and incentive payments.

IBH staff at all sites clearly appreciated having a skilled and experienced facilitator for the IBH program. Facilitation served an important role in providing sites oversight and serving in some respects as a project management tool, keeping sites on track in meeting their requirements. Facilitation corresponded to the grant requirements and necessarily had a focus on helping sites implement their three PDSA projects. The first PDSA, establishing a screening process including data entry and retrieval, may have been better as a preparatory activity, where EHR modifications, screening workflows and data entry could be tested and refined before actual implementation began. Sites also could have benefited from facilitation and PDSAs that addressed organizational readiness, provider and clinician training, and

training to maximize billing. However, sites appreciated and benefited from conducting each of the PDSAs.

> "One of the things we identified was somebody was going [to the emergency department] almost every other day, and it was due to anxiety. So he was given tools to control that, and it actually empowered him. He felt like he had taken control of this issue. And his ER visits dropped right off. He was being seen here [at the primary care practice] more frequently, but that's okay. We'd rather he come here than go to the ER." *(Practice Coordinator)*

EHR. All sites reported their EHR needed modifications to support IBH. Sites had difficulties making modifications that easily accommodated IBH data entry. EHR limitations that sites were not able to address were: linking a patient registry to the EHR, creating and updating a shared care plan, and being able to track screening scores over time. When a site is part of an ACO, EHR changes affect the entire organization, not just the site implementing IBH. All sites reported EHR modifications take time to make and are costly. Modification requests sometimes languish in the IT queue.

Registry or patient tracking system. CTC-RI required sites to create either a registry or patient tracking system. The purpose of the tracking system was to collect data for the quantitative evaluation, to collect and report data required by the grant, help sites manage their programs, determine patient outcomes, and support quality improvement activities. Due to limitations of time and resources, sites varied in their ability to create and use a tracking system. Additionally, EHRs are not designed to support patient tracking. Some sites noted being able to link their tracking system to the EHR would have simplified data entry and reporting. As with the EHR, developing and testing a patient registry could have been better addressed as a foundational activity.

Staffing. How organizations and sites in the pilot staffed their IBH program varied widely, with most employing licensed independent clinical social workers to provide IBH services, and some employing a psychologist. Many of the sites had students who also provided IBH counseling. MAs were central to the smooth functioning of the IBH system. Health centers, FQHCs and some of the other sites that are part of larger organizations had access to staff who could help patients address social determinants of health. Some, but not all, sites had a psychiatrist on staff at least part-time. Having a psychiatrist on staff or consulting to the practice was deemed essential to the IBH program, and an important gap in those practices without direct psychiatry access.

Implementation

Rollout and implementation barriers. Many of the individual sites and practice organizations had been considering implementing IBH prior to the pilot, and some had collocated behavioral health services. The CTC-RI grant served as an impetus to move forward. Grant timelines meant there was little time to engage staff; to create an organizational culture of IBH; to provide robust training to IBH providers, medical providers and other staff on their roles and responsibilities; to create and test workflows and EHR modifications; and to establish, test and refine policies and procedures. Each of the sites experienced implementation issues in some or all of these areas. Many sites felt they could have avoided some difficulties had they better understood at the outset what would be involved in implementation.

Oversight. All sites had an individual tasked with managing the IBH program at the site level, although not all had a formally designated IBH manager or director. Some sites had an IBH manager or director

who had dedicated time and authority to manage the problem, who directly supervised IBH providers, and who met regularly with other implementing staff. Those IBH managers also directly reported to or met with senior leadership regarding the IBH program. Some sites had regularly scheduled staff meetings to discuss the IBH program, other sites had larger practice staff meetings where IBH staff were included and IBH was an agenda item. It appeared sites with dedicated IBH managers were more agile in identifying and responding to program needs.

Creating an organizational culture of IBH. Sites with strong and sustained organizational commitment were more likely to view IBH as an organizational value, rather than a pilot program to be tested. They were more likely to invest in a dedicated IBH manager or director. Their senior leadership and boards were more likely to be engaged in reviewing IBH progress. The rollout of the IBH pilot and early involvement of relevant employees throughout the practice was critical for setting the stage for IBH at each practice. Where this did not adequately occur, medical providers were slower to appreciate how referring to IBH would benefit patient care. Having providers accessible and working together in the shared interest of improving patient outcomes was a clear success factor.

> *"To the extent that we have been successful at all, we have had the therapist, the psychiatrist with us in the medical building. Sharing space and accessible by walking down the hall was incredibly powerful. And that is the way you excite people about the change."*

In some practices, a gulf between the perceived culture of medicine and culture of behavioral health had to be spanned. Even among proponents of IBH, in practices that were considered to have an accepting culture for IBH, protocols needed to be tested and modified in sometimes frustrating iterative experiments, before a process was created that suited the practice well and served its designated purpose. This trial and error at times eroded enthusiasm among providers for IBH.

Given the initial challenges, practices therefore attempted to create and maintain a culture of IBH in various ways, including: training in the concept of IBH as differentiated from outpatient behavioral health; discussions at regularly scheduled meetings to build trust and understanding; morning huddle; changing workflow to improve efficiency and success in IBH; placing the IBH office near medical providers; recognize successes over time (e.g. better patient care, reduced ED use, cost savings); shared incentives across staff.

Creating a culture of IBH among patients. IBH is described and "advertised" more at some practices than others. This is in part because most practices did not feel they had to make special efforts for patients to be onboard, especially if the medical provider spoke to the patient about IBH and they were able to do the warm handoff to IBH staff. (A warm handoff is defined as a quick introduction between the medical provider, IBH provider and patient that is typically non-billable and less than 15 minutes.) Indeed, most felt that patients were happy to have the service provided conveniently at the primary care setting, which reduced the stigma of seeking behavioral health treatment. Where the population was more unfamiliar with counseling, effort varied in ways to inform patients about the services. Those patients who were already familiar with behavioral health counseling needed to be informed about how the IBH process differs from outpatient counseling in terms of shortened length and duration of visits.

> *"I give you a pill to swallow, you feel better for a period of time. The pill stops, you're right back where you started from. You work with one of my [behavioral health] clinicians they're going to*

help you, and you're going to work together. You're going to learn how to manage these symptoms without medication, and it's something you can have for the rest of your days."

Screening. Each site or organization implemented its screening and IBH treatment program in a different way. All sites screened patients with the PHQ-2/PHQ-9, GAD-7 and CAGE-AID at least annually, using a variety of techniques. Some sites screened at every visit because they felt a patient's status could easily change, others because they did not have the capability to track who had already been screened. Sites conducted follow-up screenings at varying intervals for positive scores.

Warm handoffs. All sites aimed for warm handoffs, and accomplished them by alerting the IBH staff about a need for a warm handoff through the dominant means of communication among staff at the practice: computer messaging systems, phone or the medical provider or MA walking to the IBH office. In most sites, the medical provider initiated the warm handoff; in a few sites, this was the responsibility of the MA. The work of MAs is integral in most practices for the smooth functioning of the screening and warm handoff systems.

"*Because [the BH] was right here in our office, and the patients trust the doctors, I think they felt more comfortable, and they're comfortable with the office. So they were willing to come in [for the IBH counseling].*"

Referrals to IBH. The majority of medical providers throughout the sites are enthusiastic about referring to IBH, and believe that having IBH at the practice is beneficial to patients and enhances primary care. Rates of referral to IBH differ, even among providers who are on board with the IBH program. Screening scores are the primary impetus for making a referral to IBH along with considerations about high ED use and whether self-management of medical illnesses may be improved with IBH services. Most often, the patient is scheduled to come back to the practice for IBH interventions within a few days of the medical visit. Due to no-shows or protected slots that are held for same day appointments, patients can at times see the IBH provider on the same day as the medical visit. Sites initially focused on IBH as a way to address their patients' traditional behavioral health needs. As the IBH program progressed, providers and Nurse Care Managers (NCMs) also came to see the value of IBH as a way to help patients manage their medical conditions.

Communication. Processes of communication are integrally related to care coordination at the sites. The sites have varying computer-based messaging systems that are heavily utilized, and at all of the sites, all provider types share EHR records for patient notes. However not all medical and IBH providers regularly read each other's notes, preferring in-person informal and formal meetings or computer messaging. In practices where the IBH clinician keeps a full schedule of patients and productivity for billable appointments is a high concern, there is less time available for informal in-person communication with medical providers. Busy medical providers similarly find it difficult to find time for informal communication with IBH providers. Yet, both behavioral and medical providers make sure communication happens.

Care coordination. Practices have various idiosyncratic processes for accomplishing care coordination and management, depending on their staffing, size, and structure. No matter how coordination is achieved, the integration of behavioral health and medical health is seen as something that most practice staff value and patients appreciate. Naturally, practices in larger health care systems have access to care management staff and resources that are not available to independent practices. Some of the independent practices and health centers described the role of the Nurse Care Manager (NCM) as

pivotal to care management for patients receiving IBH services. Where this occurs, NCMs are at risk for becoming overwhelmed with the quantity of patients they serve.

Daily morning huddles that include IBH staff occur in some practices, and pre-visit planning by MAs or periodic case conferences occur in others. Monthly planning meetings with medical providers, IBH providers and the NCM when available are found to be useful along with the informal consultations these IBH providers have with each other as the need arises.

Care planning. All sites have developed processes to create and share care plans and updates. A limitation is that EHRs do not support a unified care plan. Patients appreciated a coordinated approach to their overall care.

> *"I have heard patients really appreciate us having the whole coordinated care for our patients here."*

Sustainability

Sustainability varies. Interviewees at some sites felt that their program was more sustainable than did interviewees at other sites. To support sustainability, most sites used MSW students or, at one site, PhD psychology students, to provide IBH services to some or all of their patients who cannot afford the copay. Sites felt this was a good value, particularly since most students come with IBH training and students receive regular supervision. However, some interviewees felt IBH required a higher skillset than students were likely to have. Given sufficient funds, sites indicated they would be less reliant on students.

At several sites, BH providers split their time between IBH and outpatient counseling which resulted in enough billable sessions for their program to be financially sustainable. This model warrants further examination. An FQHC felt their payment structure supported IBH sustainability. At two sites it was stated that while IBH was highly valued, if it did not pay for itself, the medical providers would not be willing to support it from "their own pockets." A number of sites struggled with understanding how to maximize billing and wanted training in this area. To ensure all patients had equal access to IBH, one site did no billing and used PhD psychology students to provide IBH sessions.

Invisible costs of IBH. There are unintended consequences payers and organizations may not consider when determining how sustainability can be achieved. These include increased workloads and responsibilities. For instance, NCMs can experience increased caseloads when asked to help IBH patients who are not on their panel. Physicians and IBH providers need time to participate in meetings and supervise staff. The mechanics of IBH—to conduct warm handoffs, to have formal and informal consultations, to make and track referrals, to assist patients in addressing their social needs—extends the time needed for medical and behavioral health encounters. There may be a decrease in billable encounters when administrative responsibilities are increased, for example, when a behavioral health clinician takes time to develop materials, supervise students or administer the program. There is a loss in productivity when EHR changes are made.

Policy issues

Copays. At all sites, interviewees described the difficulty that many patients have paying the elevated specialist copay for IBH. All sites felt that for IBH to be successful, payers needed to come together and implement a uniform copay scheme where the IBH copay is the same as the primary care

copay, or the copay for IBH counseling provided in a primary care office is eliminated altogether. All sites wanted patients to have one primary care copay per visit to the office, even if the patient sees an IBH clinician and a medical provider at the same visit. Group medical visits for medical self-management also need to billed at one primary care rate, and not based on who is facilitating the group (e.g. not higher than primary care if an LICSW is facilitating, and no copay if the NCM is facilitating.)

Billing and coding. CTC-RI reported it discussed billing and coding and health plans provided their policies and guidelines for billing at several of the quarterly collaborative meetings. However, success around billing and coding appeared to differ among the practices. Some interviewees said they would like to have additional training on coding and billing, and this should be tailored to the types of contracts each site has with each insurance payer. Others believed that there are only a few IBH codes to use and their practice has no problem with using them and successfully billing. Responses from most interviewees reflected only a vague sense of how billing and coding are accomplished, with the discussion quickly diverted to the issue of whether the patient population at the site can afford their copays. At one site they do not bill at all for IBH services because they do not believe there should be a disparity in copays. At many sites, the patient is seen by a student so that the visit is not billable.

Credentialing. Some IBH providers reported the credentialing process is unnecessarily time consuming, frustrating, inefficient, and caused tremendous delay in their ability to start providing integrated BH services rather than fee-for-service, traditional therapy. They would like to see a universal application packet and process so that credentialing is a one-stop, one-time event.

Recommendations

We have organized the recommendations into four areas: Foundational Activities; Implementation; Sustainability; and Policy.

Foundational Activities

IBH program start-up

Rationale: Just as IBH addresses the needs of the whole person, it takes the whole organization to develop and implement a successful IBH program. It is important that organizations and/or implementing sites have the time and staff resources to engage in planning and getting their practice and staff ready to implement IBH in a way that engages the entire organization.

The AIMS Center recommends a stepped, iterative approach to implementation. This approach proactively addresses many of the issues sites encountered during implementation. Attachment 4, found in the Full Report, provides the implementation stages and activities. [5] Going forward, grant funds could focus equally on preparation and on implementation, using the AIMS Center implementation approach. With or without start-up funds, sites or organizations planning to implement IBH should use the AIMS Center materials to guide implementation.

IBH program start-up recommendations	
1.	Funders need to provide adequate financial resources and incorporate reasonable implementation timelines that support structured and systematic IBH program planning and implementation.
2.	There are many necessary steps to developing an IBH program and laying a foundation for IBH across an organization. To support program development, organizations should consider using the AIMS Center or SAMHSA-AHRQ resources and toolkits for their program development and implementation.

Staffing

Rationale: "*Integrated care is a team-based model of care, based on the blending of numerous provider disciplines' expertise to treat a shared population through a collaborative treatment plan with clearly defined outcomes… The precise mix of providers in each setting is determined in part by the clinical setting, the population needs, funding, and pre-determined outcomes. Workforce development in integrated care has unique needs and challenges, including a focus on expansion and flexibility in provider function and roles; changes in traditional healthcare provider culture and provider training; and development of an effective and efficient team." [7]*

Staffing recommendations
1. Sites developed their IBH staffing based on their patient volume, site and organizational needs, funding, and available resources. However, it could be helpful if individual sites and organizations had an IBH clinician (licensed or student) available during all practice hours. In this way, patients with high PHQ scores, suicidal ideation, or other serious issues could have immediate access to IBH assessment.
2. Sites and organizations should have a health or behavioral health advocate to address the social needs of IBH patients, psychiatry consultation, and an IBH manager with dedicated and sufficient time for IBH management and staff supervision.
3. Assess whether IBH will bring additional patients to the NCM's panel. Consider providing the NCM with a health advocate or patient navigator if the NCM's workload increases significantly because of IBH.
4. Determine if it is feasible to have long-term counseling services available on site, so that patients do not have to travel to another location.
5. Assess the language needs of patients, and as possible, hire bilingual IBH clinical staff and support staff.
6. IBH generates a good deal of data, but sites and organizations often lack resources to conduct data analysis. Examine whether it is possible to hire a part-or full-time data analyst. Consider the possibility of sharing a data analyst with other practices.
7. All practices and organizations take on new projects and grants. However, IBH is supposed to be here to stay and is not "one more thing" that is temporary, in existence until the project is over. Determine if there are workload issues associated with IBH for medical providers, MAs, practice managers, care managers, and other staff that need to be addressed because of the time or responsibilities IBH programs require.

Clinical services needs

Rationale: Sites created workarounds to engage the patient in IBH services for circumstances when the IBH provider was not available. Many interviewees felt it is important for sites to have a full-time IBH provider so that patients have immediate access to IBH assessment, especially when patients have high PHQ scores, suicidal ideation, or other serious issues. A number of interviewees felt their site needed additional IBH clinical staff. Further, some IBH providers reported there could be problems with referring patients for long-term counseling—the patient could not travel to another site, the patient did not receive authorization for services, there was a long wait for services, or the patient was reluctant to go to another site for services.

Many sites noted that being crowded for space helped support communication between medical and IBH providers. Staff (literally) kept bumping into one another. At some sites, IBH providers see patients in available exam rooms. Some noted this is not always ideal.

Clinical services needs recommendations
1. It would be helpful if there were dedicated space for conducting IBH that providers can count on using to see patients, and that is located nearby the medical exam rooms.
2. Address barriers to uninsured or under-insured patients when counseling needs can't be met by IBH. *"We have an enormous amount of patients with trauma who don't have insurance who are coming in who I can't send anywhere."*
3. Insurers can examine their authorization processes to make it easier for patients to receive behavioral health services

Implementation

Rollout and organizational culture of IBH

Rationale: How sites rolled out their IBH program influenced how quickly or readily staff across the organization understood their roles and responsibilities, and helped establish the organization's commitment to IBH.

Rollout and organizational culture of IBH recommendations
1. Providing adequate planning time is essential for smooth rollout and maintenance of the program. Plan early on, prior to implementation, how to roll out the program, who will take the leads, and how to engage staff in all roles throughout the practice in understanding and valuing IBH. These steps are addressed in the AIMS Center implementation model, noted earlier.
2. Engage all staff in discussions of potential cultural barriers between medical providers and IBH providers – prior to implementation and regularly to identify attitudinal problems before they become serious barriers to success.
3. For multi-site organizations, consider rolling out the program in stages. *"It was great it was at one site and was with one care team. And you work out those kinks, and then you expand to everyone else."*
4. Similarly, consider implementing new screening tools in stages, for example, start with the PHQ, then CAGE-AID, then GAD-7. This could apply to other state agency screening tool requirements, such as Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.
5. Emphasize in each practice that all of the practice's teams should be invested in IBH. The AIMS Center notes it takes staff cooperation to make IBH work.
6. Senior management and administrators should make clear their ongoing interest and support of the IBH program. They should ensure IBH results or program successes are included in their organization's newsletter or monthly updates, or are a standing staff meeting agenda item.

Creating a patient culture of IBH

Rationale: In a fully integrated system, consumers and providers have the same expectations of IBH system(s). Consumers understand what IBH is, and what to expect.[11] Sites varied in how they presented IBH to patients, with some making more explicit efforts than others to educate their patients about IBH.

Creating a patient culture of IBH recommendations
1. Describe the IBH services and the IBH providers in a prominent location on the website, and in flyers, posters, and videos displayed in the waiting room, patient exam rooms and other relevant locations.
2. Demonstrate to patients that IBH is integral to the normal services provided at the medical practice.
3. Educate patients about how IBH services differ from longer-term outpatient behavioral health counseling.
4. Ensure the site or organizational website includes information about IBH and IBH services. If possible, include pictures of the IBH providers.

Oversight and meetings

Rationale: We found variation in how sites managed their IBH programs. Additionally, IBH providers and others may not be able to attend important learning collaborative meetings or trainings, or attend practice facilitation meetings because limited administrative time or productivity concerns or demands.

Oversight and meetings recommendations
1. Designate a dedicated IBH manager, director or point person who oversees IBH providers and other staff, engages in quality improvement, *and has authority within the practice or the organization.* This person should have dedicated time to conduct program management. Ideally, the manager should have training and experience with implementing IBH.
2. Ensure staff who are actively engaged in IBH attend facilitation meetings. Consider opening up facilitation meetings to include medical assistants or practice staff who are actively engaged in screening and identifying patients who would benefit from IBH.
3. Create a strong relationship with care management; maximize rather than duplicate services.
4. Integrate IBH providers into the medical teams and meetings. Conversely, integrate medical providers and nurse care managers into IBH meetings.

Oversight: Policies and procedures

Rationale: Clear policies and procedures allow organizations to establish a clear roadway for program implementation, and help ensure programs are implemented as designed. We found wide variation in how sites developed and shared current and updated policies and procedures.

IBH policy and procedures recommendations
1. Create and update as needed clear IBH policies and procedures. Store policies and procedures in an accessible location. Provide training on IBH policies and procedures when staff are hired as part of orientation, and provide continued review of key policies and procedures at staff meetings.
2. Create an effective, easily usable process for ensuring all staff know when policies or procedures change. Provide training and support when policies or procedures change substantially.

IBH training and cross training

Rationale: There are opportunities to provide continued IBH training. IBH providers and medical providers felt they could benefit from continued IBH training, cross discipline training, or more training and information about the integrated care model. While providers said they would appreciate and benefit from continued training, it was unclear if providers or IBH managers had the time to develop or attend these trainings. It is likely sites would benefit from funding for training development. CTC-RI already conducts quarterly IBH trainings at its learning collaborative meetings. There are opportunities to expand the reach of the CTC-RI trainings so that more staff can access training.

IBH training and cross training recommendations
1. Sites should conduct an IBH-related training needs assessment to develop potential topics regarding IBH and the impact of behavioral health on medical conditions and the impact of medical conditions on behavioral health.
2. Ensure all staff receive initial IBH training and attend subsequent IBH trainings.
3. Provide training to all staff regarding how to be effective when interacting with a person with behavioral health needs.
4. CTC-RI or a RI state agency could develop and/or fund training.
5. CTC-RI provides quarterly IBH trainings at their learning collaborative meetings. Determine whether CTC can convert past trainings to and conduct future trainings in an archived webinar format that can be made available to all site staff. CTC-RI could then maintain an on-line library of IBH trainings.

Determining program success

Rationale: Sites collect data to meet CTC-RI requirements and to ensure they are meeting patient volume. For a number of reasons, sites varied in their ability to use their data for quality improvement. Further, it was unclear if sites collected a consistent set of IBH data. Having a core set of IBH data collected consistently across sites will support data evaluation.

Determining program success recommendations
1. Consider how to provide data analysis throughout the participating practices, possibly by sharing data analysts.
2. As noted in the EHR and registry/patient tracking sections, find ways to build data tracking, extraction and analysis into EHR functions.
3. Ensure sites are able to collect the data each needs to manage their programs, track IBH processes, and track patient outcomes.
4. The State of RI should establish and fund the data collection of a core set of IBH data.

Multi-site organizations and ACO engagement

Rationale: As ACOs and multi-site organizations continue to implement IBH across their organizations, practices and sites are developing their own best practices innovations. However, innovations may not be widely shared across an ACO's or organization's practice sites.

ACO and Accountable Entity recommendations
1. ACOs and large organizations should consider convening at least quarterly organization-wide IBH meetings attended by IBH providers, medical providers, IBH managers and others who help implement the organization's IBH program. These meetings could serve as on-going practice facilitation meetings and provide opportunities for sharing best practices.

Sustainability

Students as IBH providers

Rationale: It is clear that sites found using students cost-effective and supported the financial sustainability of their IBH program. Given sufficient funds, however, and if copays were not a problem for many patients, sites indicated they would be less reliant on students. Placements are needed for students to gain expertise in delivering IBH interventions and to contribute to building a qualified integrated behavioral health workforce. [9, 10]. It is unclear if students are as effective in providing treatment as are licensed independent social workers or psychologists. Further, it is unclear if there will be ethnic, language, or income disparities between patients who see students and those who see licensed, experienced professionals.

Students as IBH providers recommendations
1. It would be useful to determine if patients who see licensed independent social workers or psychologists have similar health and behavioral health outcomes as patients who see supervised students. CTC-RI or another entity could contract with an academic institution to conduct a comparative analysis of patient outcomes by provider type.
2. Administer patient surveys to determine patient satisfaction with IBH services and compare patient satisfaction by provider type.
3. Collect and track data to determine if there is a disparity between the types of counseling professional patients have access to, based on their insurance status, medical diagnosis, age, ethnicity/race, economic status, screening results, behavioral health diagnoses.

Licensed Independent clinical social workers and licensed social workers

Rationale: Licensed social workers have completed their academic training, and need to have supervised clinical hours to become licensed independent social workers. Only LICSWs can bill for services.

Licensed independent clinical social workers and licensed social worker recommendations
1. To support sustainability, allow licensed social workers to bill under the LICSW's license and supervision. However, the rate of reimbursement would be lower.
2. Conduct similar analyses as those recommended for students providing IBH to ensure patients are well-served by this payment innovation.

Billing and coding

Rationale: Despite the fact CTC-RI provided trainings around billing and coding, many of the sites wanted additional support and training around effective billing and coding for IBH services. Commercial insurers use different coding schemes for different populations, e.g., commercial, Medicaid, Medicare, and insurers and sites have individualized contracts. It is likely sites need more individualized trainings, making one-size-fits-all trainings ineffective.

When creating trainings, consider reviewing the trainings created by Maine Health Access Foundation and Maine Mental Health Partners. Each has created a number of online, YouTube and print resources that could serve as training examples. [12-15] The best way to solve the problem, however, is for public and commercial insurers to come together and streamline and synchronize their billing and coding processes.

Billing and coding recommendations
1. Consider creating general overview YouTube or other online presentations regarding how to maximize billing and coding so that training can be accessed at any time.
2. Convene site-specific work groups that include IBH providers and the practice staff involved in billing to ensure all know how to maximize billing.
3. Streamline billing and coding, so that there are few, if any, differences between the various commercial insurers and between the commercial and public insurers.

Policy Recommendations

Electronic Health Record (EHR)

Rationale: It was clear in the interviews the EHR was an obstacle for all sites in terms of managing the IBH program. EHRs were not designed to support behavioral health, IBH, or registries/patient tracking systems, or care planning. It is possible for health systems to address the EHR barriers systematically and make comprehensive system changes that support delivery of behavioral health and IBH, as evidenced by Cherokee Health Systems (Tennessee) and Community Health Systems (Alaska.) [6] Sites can make EHR changes to support IBH, but those changes will be site-specific and not systemic. Therefore, to the extent possible, there should be investment at the state, organizational or systems level to support the systematic development of comprehensive and system-wide EHR changes that support best practices in the delivery of IBH.

EHR recommendations
1. It would be advantageous if PCMH organizations, ACOs, and the impending Accountable Care Entities modified or created their EHRs so that EHRs collect roughly the same IBH data and IBH related data (warm handoffs, referrals to OBH) and link to a registry or patient tracking system that reports the IBH data consistently across organizations. It would be useful for the State to develop standards for IBH data capture within the EHR.
2. Similarly, while this is likely not possible to be implemented in the short run, one interviewee thought having one, universal EHR could be helpful, especially since RI is a small state. Changes in one EHR would be a change in all EHRs. State policy makers could explore if having one statewide EHR would make more sense than the amount of time and money that is spent making changes at a site or organizational level.

EHR recommendations
3. Until organizations or the State develop a more consistent approach to EHR modifications, funders and ACOs need to recognize that IBH will continue to require EHR changes and be willing to fund changes appropriately. For instance, with changing billing regulations will come additional documentation requirements that the EHR will need to accommodate.
4. At a state or organizational level, determine what is needed for the EHR to have the capacity to support a uniform and shared care plan so that all aspects of the plan are visible in one location, and updates can be entered easily by all involved providers and behavioral health staff. EHR users should be able to print the care plan from the EHR. Then, fund the development and implementation to make care planning possible.
5. Related to a patient tracking system linked to the EHR, the EHR should have the capacity to track and graphically display screening scores taken over time.
6. The EHR should have the capacity to track notes and comments, rather than users having to clumsily toggle back and forth between pages.

Registry or patient tracking system [2, 3]
Rationale: "*Effective management of common mental health conditions requires the ability to track clinical outcomes for populations of patients and to support systematic changes in treatment for patients who are not improving as expected. This measurement-based, treatment-to-target approach is one of the core principles of Collaborative Care and is essential in ensuring stated goals are being met. It requires a systematic method of tracking information on all patients being treated for behavioral health conditions, like anxiety or depression. How it is done is much less important than that it is done."* [4]

- Not all sites had developed a robust system for tracking patients and clinical outcomes.
- Creating a registry or patient tracking system takes time and planning. The AIMS Center planning and implementation process shows creating a registry as a step that sites take before implementation, rather than after implementation has begun. [5]
- Once a tracking system is in place, sites need financial resources to allocate staff time to registry activities, train staff and then to conduct timely and accurate data entry, and to use the registry effectively.
- A tracking system will be easier to use and more effective when linked to the EHR.
- Not all organizations and individual sites in the pilot felt creating and using a robust registry was worth the resources it would take to design it, get it up and running, and then to use it. Even if they did, it is unclear they had the staff resources to manage the registry, or to do the subsequent reporting.
- If the State of RI or ACOs want to use registry or patient tracking data for overall program improvement and across numerous practice sites, there is a benefit to having sites collect registry data in a consistent way, from the very start of their IBH programs.

Registry or patient tracking system recommendations
1. Practices and organizations with IBH programs should create and use a patient tracking system with the capability to track clinical outcomes and support systematic program changes.
2. If possible, the State should incentivize a core set of IBH patient tracking measures. This would allow external evaluators and policy makers to conduct statewide data analysis.

Registry or patient tracking system recommendations
3. The State should provide financial support for organizations to purchase or create a registry, train staff, test and refine data collection and data reporting capacity. This support should include funds to link the registry to the EHR.
4. Some interviewees felt the registry was too time consuming to develop and maintain. Conduct return-on-investment analysis to determine that creating a registry is worth the practice's time and money investments.

Staffing—psychiatric consultant

Rationale: Collaborative models stress the importance of having psychiatric consultation services. [8] Sites that had a psychiatrist either as a consultant or on staff found the psychiatrist to be an essential service provider. Sites without access to a psychiatrist declared this was a serious gap in their service provision.

Staffing—psychiatric consultant recommendations
1. Policy makers and funders should work to include funding for psychiatric services within the IBH or PCMH model.
2. Psychiatrists also need training in the IBH model. Organizations need to ensure staff or consulting psychiatrists have training in the IBH model and understand their changing IBH roles and responsibilities.
3. Policy makers should address the reimbursement issues that make practicing as a fee-for-service or salaried psychiatrist not as attractive as working as private practice psychiatrist.
4. Policy makers should work with regional medical schools to create specific psychiatry IBH training and residency tracks.
5. Sites could work to create contracts for sharing a psychiatrist between practices.
6. Determine if it is feasible to have the umbrella organization of the multi-site program (in this case, CTC-RI) provide practices with access to a consulting psychiatrist.

Copays

Rationale: All sites reported that behavioral health copays, whether for IBH or long-term counseling, served as a barrier to patients receiving behavioral health treatment, regardless of their insurance source (except for those with Medicaid.) For IBH to be effective, patients must be able to access treatment. The following recommendations are in order of site preference, and apply to individual counseling and group visits.

Copay recommendations
1. Eliminate copays for behavioral health services overall when delivered within the PCMH—IBH visits, OBH counseling, IBH group visits, and psychiatry or counseling appointments.
2. If the above is not feasible, eliminate copays for IBH treatment and any IBH related psychiatric consultation and IBH related disease management groups.
3. If the above is not feasible, IBH copays should be the same copay as a primary care visit. (NOTE: In July 2017, the State of RI implemented this policy.)
4. Patients should have only one copay per primary care visit, regardless of how many medical or IBH providers the patient sees at the primary care office that day.

Payment models

Rationale: Sites and organizations provided what they wanted to see in a payment model, rather than naming a particular payment model. They all agreed the current model does not work well for providing IBH services, and for fostering IBH sustainability. Sites are willing to continue with a hybrid funding mechanism. Ideally, what they would like to see funded in IBH (through bundled payments, global payments, increased PMPM or some hybrid model) is as follows.

Payment model recommendations
1. Similar to NCMs, IBH providers are salaried employees that are an integral component of the PCMH model. IBH providers would be expected to meet standards regarding patient volume, screening and assessment, treatment sessions, and to some extent, patient outcomes. There would be no billing.
2. Additionally, for sites that do not have access to care management staff or community health teams, a new payment model will fund behavioral health advocates, based on patient volume.
3. Payment model should eliminate behavioral health copays.
4. Payment model should adequately reimburse for related IBH activities, e.g., administrative time, informal consultations, EHR communications.

Credentialing

Rationale: IBH providers reported the credentialing application process is time consuming, requires completing multiple and similar application packets, and takes too long to obtain, thus delaying their ability to provide IBH services. Further, not all insurers recognize IBH as a separate form of therapy.

Credentialing recommendations
1. Streamline credentialing so that there is one credentialing process and one, universal application that applies to all insurers.
2. Add IBH as its own therapy category, separate and distinct from long-term therapy, with its own panel of providers.

Social determinants of health—Social needs services

Rationale: A hallmark of IBH is that it addresses the whole person, including the person's social needs. Recommendations for the state of RI include:

Social determinants of health—Social needs services recommendations
1. To help sites provide SDH services, the state could develop and maintain an up-to-date, online, printable, and sortable list of SDH resources.
2. Expand patient access to transportation, which could include functioning of the existing Logisticare services and establishing formal relationships with other on-demand transportation services.
3. Work to address resource gaps, for example, lack of affordable housing, lack of resources to address domestic violence, food insecurity.

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