To: CTC-RI (CTC-ri@ctc-ri.org)

From: System of Care \_\_\_\_\_\_\_\_\_\_

RE: Practice participation in CTC-RI Integrated Behavioral Health (IBH) Primary Care Expansion

Date:

[Practice name and site] is a member of our System of Care. The practice is interested in participating in the CTC-RI integrated behavioral health primary care practice transformation program. We believe that this practice would benefit from participation in the IBH primary care expansion opportunity and as a system of care, are willing to provide the management support to assist the practice with making this transformation.

As a system of care, we will provide the practice with support for (check all that apply):

* Practice reporting for depression, anxiety and substance use disorder screening results; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Practice reporting for selected health related social needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* IT assistance for behavioral health templates within the practice electronic health record: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Assistance from billing department to code and bill for services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Assistance with hiring, on-boarding and obtaining health plan credentialing for behavioral health clinician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Meeting with the IBH trained practice facilitator during the startup phase: monthly for the first three months on a regular basis based on area of focus and thereafter as needed to provide system of care implementation status reports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Our system of care will collaborate and communicate with CTC-RI IBH practice facilitator to ensure that working together the Service Delivery Requirements are met within designated timeframes.

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Signature of SOC Representative Date Signature of Primary Care Practice Date

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