QUALITATIVE EVALUATION REPORT FOR THE CTC-RI PEDIATRIC INTEGRATED BEHAVIORAL HEALTH (P-IBH) PILOT PROGRAM

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# Background

Over recent years, rates of adolescents reporting thoughts of sadness, symptoms of depression, suicidal ideation and suicide attempts have been rising at alarming rates, with the pandemic exacerbating those trends (Miller-Matero et al., 2016; Racine et al., 2021). In 2021, the American Academy of Pediatrics issued a joint statement declaring a children’s mental health emergency (AAP-AACAP-CHA, 2021). A recent MedPage Today opinion piece cautioned pediatricians to assume every patient could have PTSD (Wu, May 28, 2022).

In 2016, the American Academy of Pediatricians recognized this growing problem and issued depression screening guidelines, as did the United States Preventive Services Task Force (Siu & on behalf of the US Preventive Services Task Force, 2016). While many pediatric practices have implemented screening, that screening may be sporadic, and some patients get missed or follow-up is inconsistent. Further, getting patients into the treatment they need can be challenging, with long wait times often the norm. (AAP-AACAP-CHA, 2021; Rhode Island Executive Office of Health and Human Services (EOHHS), October 5, 2021)

Pediatric Integrated Behavioral Healthcare (P-IBH) is a model that provides systematic screening *and* clinical services, along with care management. Ideally, P-IBH follows up a positive screen, e.g., a clinically significant screening result, with a warm handoff from the medical provider to an IBH clinician who is hired by or contracts with the primary care practice and is located within the practice. Then, depending on need, the clinician provides one or more sessions of assessment or brief treatment on site in the primary care practice, via telehealth, or in combination. These brief sessions may provide the patient with the support and skill building needed to address current life stressors. Alternatively, the IBH sessions may serve as a bridge to longer-term traditional therapy with referral to an outpatient behavioral health (OBH) department at the primary care practice, or to external OBH services. Even for patients who ultimately require longer term OBH care, often it is the warm handoff and the IBH sessions that encourage reluctant or ambivalent patients to accept behavioral health treatment (Beck et al., 2021; "PCC. Primary Care Collaborative," 2022; Society for Adolescent Health and Medicine, 2020).

To test implementation of the P-IBH model in Rhode Island, CTC-RI, with funding from the Rhode Island Foundation, Tufts Health Plan, and United Healthcare, created a P-IBH pilot program, “Universal Integrated Behavioral Health Screening and Treatment in Pediatric Primary Care for Children, Adolescents and Postpartum Mothers.” The pilot incorporated the following objectives.

**Pediatric Integrated Behavioral Health Pilot Objectives:**

1. To increase the identification, early intervention, and treatment of behavioral health challenges before children, adolescents and families reach crisis by implementing developmentally appropriate behavioral guidance, evidence-based screening guidelines, tools and treatment models for different populations of focus;
2. To increase access to brief behavioral health intervention for patients with behavioral health conditions by hiring and integrating an on-site behavioral health clinician (based on size of the practice but no less than 0.5 FTE licensed behavioral health clinician);
3. To provide care coordination for children, adolescents and families by developing a robust relationship with a community partner based on an identified population health behavioral health need;
4. To improve performance by implementing two performance improvement studies, participating in quarterly learning network meetings and having practice team members participate in monthly planning meetings that are facilitated by the pediatric IBH practice facilitator.

## Table 1: Pilot’s Intervention Populations and Related Screening Tools\*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Middle childhood** | **Adolescent** | **Caregiver up to 6 months postpartum** |
| Pediatric Symptom Checklist | X |  |  |
| GAD-7 |  | X |  |
| CRAFFT or CAGE-AID (substance use) |  | X |  |
| Edinburgh Postnatal Depression Scale (EPDS) |  |  | X |
| PHQ2/9 |  | X |  |

\*The grant required sites to choose three of these tools to administer.

Eight pediatric practices enrolled in the P-IBH pilot: two hospital-owned clinics, two FQHCs, and four community-based outpatient pediatric primary care sites. Separated into two cohort waves for the intervention, the pilot ran from 2019 to 2021, and from 2020 to 2022. Both cohorts have now completed their pilot programs and are continuing to provide P-IBH services. Of note, both cohorts implemented their pilots within the extraordinary context of the COVID-19 pandemic.

To understand facilitators, barriers, and best practices for continued and expanded provision of P-IBH in Rhode Island, CTC-RI received funding from the Rhode Island Foundation, Tufts Health Plan and United Health Plan to conduct an evaluation study of the pilot program. This report of study findings offers an overview of the CTC-RI pilot activities and processes, as well as lessons learned from the pilot, and recommendations for future P-IBH programming in the State.

# Methods

CTC-RI contracted with consultants, Mardia Coleman, MS, from May Street Consultants, and Roberta E. Goldman, PhD, from Brown University, to conduct a qualitative evaluation to determine how sites implemented their programs, success factors, and lessons learned. An additional evaluation aim was to determine how the CTC-RI grant structure supported grantees in developing their pilots and if there were opportunities to improve the grant process.

The evaluators reviewed the American Academy of Pediatrics (AAP) depression screening guidelines, the implementation literature, and adult IBH implementation framework developed by Kwan, et al (Kwan, Valeras, Levey, Nease, & Talen, 2015) to provide context for our analysis. The evaluators also reviewed relevant literature, CTC-RI and individual pilot site documents, and websites related to the P-IBH pilot program requirements. They conducted interviews with CTC-RI program staff, including the P-IBH practice facilitator. They worked with CTC-RI to create an individual interview guide that reflected the research questions and organization’s interests.

The evaluators conducted 30 interviews across the eight sites. Participants at each primary care site included the IBH pilot program manager, one or more IBH clinicians, and the physician champion. To ensure completeness of information, they conducted additional interviews which may have included an additional medical provider at the practice, the IBH clinician supervisor, staff psychiatrist, and the data or population health manager. Interviews occurred over Zoom, lasted 30 - 60 minutes, were digitally recorded and then professionally transcribed verbatim.

The evaluators used two processes to conduct the qualitative analysis. Review of transcripts resulted in a defined codebook for application with DELVE qualitative coding software for high level coding. Next, evaluators used ‘immersion/crystallization’ (Borkan, 2021) processes to read and analyze the reports of topically-coded data that were generated in DELVE, along with selected reading of complete transcripts. These analysis processes resulted in identification of content, patterns, and differences among practices, which are reported in this document.

## Table 2: Interview Participants’ Practice Type and Role

| **Cohort** | **Practice Type\*** | **Physician champion** | **Practice Manager** | **Nurse Care Manager** | **P-IBH Clinician** | **Physician/**  **PA** | **IBH Supervisor** | **Other** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **Hospital PPC practice** | X | X |  | X |  |  |  |
| **1** | **PPC practice** | X |  |  | X | X |  |  |
| **1** | **FQHC** | X | X |  | X |  | X | Organization’s social work supervisor |
| **2** | **Hospital PPC practice** | X |  | X | X |  |  | Organization’s psychologist |
| **2** | **PPC practice/ organization** |  | X | X | X | X |  | Organization’s psychiatrist + Organization’s Population Health manager |
| **2** | **PPC practice/ organization** | X | X |  |  |  |  |
| **2** | **PPC practice** | X |  | X | X |  |  |  |
| **2** | **FQHC** | X |  |  | X |  | X | Pilot Project manager |
| **\*PPC=Pediatric primary care practice; PPC practice/organization = PPC practice within a larger umbrella organization** | | | | | | | | |

The evaluators adapted the adult IBH implementation framework developed by Kwan, et al. (Kwan et al., 2015) to organize this report’s findings and recommendations, along with using additional categories tailored to the CTC-RI pilot program. The Kwan framework is consistent with implementation literature regarding best practices (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

## Table 3. Kwan, et al. (2015) Model Components for IBH Implementation Success

| **Category** | **Items included or addressed as per the Kwan, et al. 2015 model** |
| --- | --- |
| **Care delivery team (engaging the whole team)** | Patients & family, provider, nurse, care managers, pharmacists, and Behavioral Health Clinicians (social workers, psychologists, psychiatrists, therapists) |
| **Education, training and practice preparation** | Establishing buy-in and stakeholder engagement in planning,  workforce development, training programs, continuing education, in-services, conferences, informal consultation, team-building exercises |
| **Information Technology** | Access to shared computers, telephones, electronic medical records, email, registries, dashboards and portals for tracking outcomes, telemedicine and mobile health technology, access to data for Quality Improvement (QI) |
| **Setting** | Whether in a free-standing clinic, or part of hospital system, dedicated physical or virtual space for BHC to interact with providers, teams, and patients |
| **Targeted populations and conditions** | Universal services vs. prioritizing patients of a certain age (children, adults); level of risk, or with certain types of conditions (depression, anxiety, serious mental illness) or psychosocial concerns |
| **Clinical processes** | Screening and population identification protocols, risk stratification algorithms for appropriate level of care, access, treatment, monitoring and referral protocols |
| **Cost / Sustainability** | Securing funding (fund-raising, grants, advocacy, partnerships with payers), appropriate allocation of resources, receipt of payment for billable services |
| **Management policies and protocols** | Established leadership and development of practice mission and values, time and effort protocols, privacy policies, billing and coding protocols, incentives and support for collaboration, and QI policies |

# Findings

In this section, the report provides findings regarding the CTC-RI grant processes and other findings organized by the Kwan et al. (2015) categories. This section also addresses the implementation issues that arose due to the COVID-19 pandemic.

[Note on content: Included here are brief discussions of evaluation study findings. Note that **Appendices** provide more details on selected topics. **Appendix 1**: research questions that guided this evaluation. **Appendix 2**: interview guide. **Appendix 3**: lessons learned with supporting quotes. **Appendix 4**: details about the warm handoff. **Appendix 5**: stories of the P-IBH pilot in participants’ own words. **Appendix 6**: P-IBH training and implementation resources. **Appendix 7**: P-IBH Pilot Program application and milestone document. **Appendix 8:** Table of Contents—P-IBH program orientation binder.]

**Note on nomenclature**: In this report, ‘**pilot site’** or ‘**practice**’ always refers to the primary care practices included in the pilot program. ‘**Providers**’ refers to medical providers. ‘**Clinicians’** refers to behavioral health clinicians, particularly in this case, P-IBH clinicians. ‘**OBH**’ refers to outpatient behavioral healthcare.

## Grant processes

### Grant structure and requirements

**Key point:** **CTC-RI’s grant timeline, deliverables and facilitation provided a structure that helped grantees implement their pilot programs.**

All sites had been previous CTC-RI grantees and were somewhat familiar with CTC processes. Participants reported they greatly appreciate CTC’s grant format and grant support. The grant structure provided a program implementation plan with manageable timelines and deliverables, infrastructure and incentive payment, practice facilitation, a resource guide and quarterly peer learning sessions. These resources can be found at <https://www.ctc-ri.org/integrated-behavioral-health/pediatric-behavioral-health-programs>.

The requirement that most sites needed help with was the registry and retrieving and using data from their electronic medical records. While all sites acknowledged the importance of the registry, for many sites it was a time-consuming task. Those who could not create a registry using their EHR created tracking spreadsheets.

One interviewee suggested in future grants it might be worthwhile to have sites create a registry before starting implementation. Another noted the pandemic made creating and using the registry an especially difficult task. Of note, CTC extended the registry deadlines to ensure sites had adequate time to create a registry that would work for each site’s situation.

“There were some timing issues with what we had the bandwidth to do because as the pandemic was raging and people being pulled in multiple directions to manage things, bandwidth for us to focus on behavioral health just shrank tremendously. … When our data team is completely cluttered with needing to pull COVID data reports, we just did not have the time. …We didn't have the staffing. We didn't have the resources to be able to do some of those things.” *Site facilitation team member*

### Facilitation

**Key points: Facilitation guided by a skilled facilitator was a key success factor for most sites. Facilitation provided a forum for identifying implementation barriers and problem-solving.**

Interviewees at all sites said the facilitator and the facilitation process brought great value to their programs, helping to make their programs better and stronger. For most sites, the facilitator served as a de facto project manager who worked with each pilot site’s facilitation team to ensure sites met their grant requirements. For all sites, monthly facilitation meetings provided accountability for grant tasks and deliverables, which interviewees very much appreciated. Interviewees at all sites acknowledged tasks might not have been accomplished by the deadlines without those scheduled facilitation meetings.

Facilitation provided a forum for problem solving and skills development at the sites. Moreover, facilitation meetings provided new clinical or administrative staff an opportunity to learn about P-IBH. Some interview participants noted that having these meetings virtually because of the pandemic made the meetings slightly less effective than when they were in-person. And at some sites, participants expressed they would have preferred less focus in the meetings on the registry. A few interviewees said they would have liked the facilitation to be tailored more closely to their own organization’s level of sophistication or staffing patterns.

Overall, however, most interview participants explicitly expressed their appreciation of having a knowledgeable and skilled facilitator. The following quotes illustrate the sentiments of many:

“I think [the facilitator] was an invaluable wealth of knowledge and information. It was very helpful, and it was holding us accountable and bringing us together to talk. ... [The facilitator] had such a wealth of knowledge and information that it was just so easy to ask for her to weigh in on different topics and different challenges and bring that wealth of knowledge to us. So, I think it held us accountable, forced us to talk about changes and review the data together, which you need to do when you're building any new program. And then also to be able to ask questions and work with her has been invaluable. The one thing that was challenging for us … we lived through a pandemic while trying to work with her.” *Site facilitation team member*

“It's intense, and it's involved. And you need a lot more help than you thought you were going to need!” *Medical provider*

Several participants, particularly clinicians, thought facilitation was so beneficial that sites would value facilitation continuing beyond the pilot. They expressed misgivings about being able to continue effectively without a dedicated, scheduled forum to bring together the program manager and other staff to problem solve with a facilitator. The facilitator also led a monthly IBH clinician peer support group. The purpose of the group was to address the application of the IBH model clinically, to provide support and connection among the IBH clinicians, to discuss the role of the IBHC, and to help the IBHCs problem solve around implementation barriers.

### Learning Collaborative and quarterly meetings

**Key point: While an excellent learning forum, there are opportunities to assess how to make the Learning Collaborative and other meetings more effective.**

Interviewees reported the Learning Collaborative and the quarterly meetings provided training on relevant topics and the chance to meet with colleagues. Most said they benefited from hearing reports about the progress and processes of other pilot sites. Some, however, thought since each site’s structure and workflow are different, it did not benefit them to hear about how others implement P-IBH. These interviewees would have preferred information they could apply to their own sites and programs. And some felt their presence was not needed and that others in their organization would have benefited more from the meetings. It appeared that, generally, an individual’s roles and responsibilities within the IBH program and/or within the practice influenced to what extent they found the Learning Collaborative or quarterly meetings useful.

### PDSA quality improvement projects

**Key point: PDSAs are a helpful tool, especially when they have clear parameters.**

The PDSA quality improvement projects were a helpful tool. The first PDSA focused on behavioral health screening rates and quarterly reporting. Some sites identified defining the screening rate denominator (i.e., what constituted the most accurate total number of those who should be included in the screening) as an issue for the PDSA and data reporting. Settling on what should be the denominator was a source of frustration. Regardless of this issue, all sites created workflows that improved their screening rates, and all met their PDSA screening goal. Sites implemented a second PDSA of their choosing and were generally successful.

## Implementing P-IBH during a pandemic

**Key points: The pandemic created barriers for effective P-IBH implementation, but determined practices found ways to make it work. This required staff to step up to take on additional roles and responsibilities.**

The evaluation interviews revealed that even with the challenges of the pandemic (i.e., the temporary halting of non-emergent in-person visits; clinicians working from home; persisting unfilled clinician positions; warm handoff challenges; limitations of telemedicine; staff shortages; and staff turnover), all sites were able to implement a form of P-IBH services.

Each site conducted systematic screening, increased patient access to behavioral healthcare, and provided care management. Each site exhibited a commitment to P-IBH, with some staff assuming additional roles, for example, a practice manager taking on tracking and follow-up tasks or a nurse care manager taking on warm handoffs.

## Care Delivery Team: Patient, Parent, Provider, IBH Clinician

### Patient experience (according to provider, clinician and staff interviewees)

**Key points: P-IBH gave patients timely access to assessment and brief treatment and helped destigmatize mental health for patients and parents. Pediatric patients (and/or their parents/caretakers) were more likely to accept behavioral health interventions when P-IBH was explained and offered. Overall, patients trusted the medical practice staff to direct them to the services they need. Special consideration must be taken for both language needs and trust when working with non-English speaking families.**

Interview participants stated that having P-IBH services meant patients who screened positive had access to same-day (or near same-day) assessment and behavioral health treatment, which all participants recognized as important aspects of their primary care practice. Participants believed that when screening is part of a routine primary care visit, patients are more likely to accept behavioral health as part of their overall health care. Interviewees declared that screening can actually give patients permission to disclose their problems.

“It’s almost as if they are waiting to be asked.” *Medical provider*

Interviewees stated that patients benefited from a warm handoff, particularly when that handoff was made within the timing and context of the encounter. Clinicians said a warm handoff made a marked difference in whether a patient would accept P-IBH interventions and would keep future appointments.

“This kiddo started getting teased in the fifth grade for being fat. … She became suicidal, came into my office saying she really was thinking about hurting herself. It was lovely because [P-IBH clinician] came in and talked to them. They met with [P-IBH clinician] officially later--they had an appointment with [P-IBH clinician] later on the day. [P-IBH clinician] was able to diffuse the situation, follow her a little bit and reach out to her a little bit over the next week or two. And it actually went very, very well.” *Medical provider*

Participants asserted that behavioral health services provided within the primary care practice helped to destigmatize “therapy”. One provider reported having patients who did not realize they were in therapy: “They just know they are speaking with [Name].” Brief IBH interventions helped patients then accept referrals to longer-term outpatient therapy, if necessary. Given the convenience and normalization of IBH within the practice, participants believed they were reaching more patients in need.

“I think we kind of touched on all of the types of patients that I think this is particularly helpful for. You know, the reluctant patient, the misinformed patient. And I just think it's been very helpful.” *Medical provider*

A factor that may have impacted patient/parent/caretaker experience is whether the P-IBH program had a clinician who is fluent in languages that are prevalent among the patient population at the site. Some clinicians expressed concern about whether patients were willing to speak openly when a language line or interpreter was used during the behavioral health encounter, and whether the interpreters were conveying the patients’ meaning accurately.

### Parent/caretaker experience (according to provider, clinician and staff interviewees)

**Key points: Parents/caretakers generally accepted the P-IBH screening, , and treatment processes and came to see these processes as part of their child’s ongoing medical care.**

Interview participants asserted that, overall, parents/caretakers accepted the screening process. Some parents/caretakers had questions about the screeners or wanted to see their child’s responses. In those cases, the medical assistants explained that the screeners are confidential, or they asked the parent to discuss their questions with the medical provider.

Interviewees said that parents/caretakers have varying levels of acceptance regarding their child’s need for services, with some parents being initially skeptical of the recommendation for further P-IBH assessment or services. Most parents eventually came to see the need for services, especially after engaging in a warm handoff.

One site increased parent/caretaker and patient acceptance by sending out a letter describing the screening process to new patients and their parents. The letters also help support the idea that mental health is part of overall health.

Interviewees observed that many parents/caretakers were relieved and grateful their child could see the P-IBH clinician on the day of the medical visit, or soon after, especially if their child had already been placed on a waiting list for outpatient behavioral therapy.

“Sometimes I get phone calls, and it's a phone call from a mom, crying because her son just told them that he's depressed, and this came out of nowhere, and I don't know where to go from here. And she’s called therapy and they have a wait list, and the mom is so upset. And so when I say that we have [Clinician Name], and [Name] will give you a call; you can talk to her and we can set up an appointment. They're so relieved. … It's an immediate help as soon as somebody calls the office, there is someone there that they can talk to. … It's just, and we say this all the time, but how could we, how did we, do it without [name]?” *Site facilitation team member*

### Provider experience

**Key points: Providers recognized the importance of and need for P-IBH, but provider engagement varied. Even provider champions acknowledged P-IBH can add time to the encounter and can mean extra time is needed for follow-up.**

Overall, medical providers interviewed appreciated the pilot as a preventive, on-site service that could prevent potential crises as well as identify patients who were already in crisis. Many expressed that P-IBH is an essential service in their primary care practice.

“I wish every provider could have their own IBH [clinician] because every provider then can get feedback from the actual behavioral health clinician.” *Medical provider*

Providers often turned to the P-IBH clinician for support and consultation. They found it helpful to have someone on site with whom they could discuss the patient’s case and/or engage the patient with for P-IBH services.

“But definitely I loved the idea that we had a handoff, and we could all three be there at the same time, and I could say, ‘This is [P-IBH clinician].” *Medical provider*

Even those providers interviewed who were initially hesitant about engaging with P-IBH said now they can see the benefits and they would not want to go back to not having P-IBH at the practice.

However, some interviewees who are not medical providers noted that within some practices there were differences among the medical providers in how involved they became with the P-IBH program. Factors cited for lack of medical provider engagement included: 1) Rollout to medical providers was inconsistent, with some sites doing a better job of preparing providers than others; 2) With practices taking on multiple projects and pilots, interviewees suggested it would have been helpful to have more information ahead of the P-IBH pilot start, and periodic substantive updates and stories about the P-IBH pilot’s impacts; 3) The level of visibility and availability of the P-IBH clinician impacted provider acceptance and engagement with the program.

“You need to make sure that the provider itself also believes in the program, you know, for it to be successful. And I think it starts from--not only from the training, but from a provider perspective, from huddling.” *Site facilitation team member*

Some interviewees noted that P-IBH could lead to additional burden for medical providers. Screening results had to be reviewed and positive screens addressed with the patient/parent/caretaker. Waiting for the clinician to conduct a warm handoff extended the encounter time in the visit room. When there was no P-IBH clinician at the practice, follow-up could fall to the medical provider and/or the provider’s nurse.

“So primary care - I expected it would be like wide open, welcoming the program. Then I felt when I came in, I'll talk more about IBH. It's sometimes felt like you're almost pushing yourself [on the providers], and it's something like, ‘I have to do this huddle’. Or I have to do the warm handoff. So sometimes I felt it's looked at as an extra to be done by the PCPs, or I'm going to say, by staff in general. I mean the administrative, they want IBH. They're always advocating for it and talking about it. I don't know if it's just the workflow, the work quota, so many factors, but I felt like are we chasing the PCP to have the huddles.” *P-IBH clinician*

### P-IBH clinicians

**Key points: It is essential to hire a clinician who embraces the IBH model. Not every clinician can or wants to do brief interventions or multitask in the way P-IBH clinicians must function. The clinician needs to have the skills to work with the full range of practice patients and have an interest in pediatric medicine. Clinicians benefit from care management support and clinical supervision.**

Interviewees emphasized that having “the right” clinician for the P-IBH program was critical, and some still mourned the loss of excellent IBH clinicians who had left the practice.

“Sometimes you end up hiring the right person for the right job. And that really is what sometimes makes that pilot actually a success.” *Site facilitation team member*

Some sites were fortunate to have P-IBH clinicians who immediately understood P-IBH concepts and hit the ground running; others had to provide support and guidance while the clinician became familiar with the model. Some participants noted that not every clinician is a good fit for P-IBH, and a successful clinician must be willing to be visible and interact with providers throughout the day.

“You need a desire, yeah. And just part of your personality is who you are because it's fast paced at times, and you've got to challenge sometimes physicians on old thinking, and you just really have to be kind of sure of yourself I think as a professional, which is hard for social workers.” *P-IBH clinician*

“I'm a big believer of relationships. I think when you start any job you have to build a relationship with people. Sometimes when we were all here I'll make an effort, you know, every one hour, I'll get up for five minutes for just, you know, small talk. ... So I believe relationship comes first. If you don't know who I am, if you don't have any clue, I fear it's hard to follow because if I don't know you... I think human contact is a huge impact.” *P-IBH clinician*

Most P-IBH pilot sites targeted adolescents and post-partum mothers or caretakers for screening, with two sites screening younger children. However, all clinicians noted they work with children of all ages as well as parents and caretakers. They needed to be skilled working with a range of ages from 0-3, preschool, elementary age, adolescent, emerging adult, and adult patients.

Behavioral health clinicians and other interviewees asserted clinicians need care management support in order to have time to provide the brief interventions to patients and consultation to providers.

“I'll tell the kid, I'm laughing, I'm like, ‘Alright, we've got five minutes to give you a coping skill. Here's what I think is going to work.’ And these teenagers follow through.” *P-IBH clinician*

Clinicians reported they benefited from onsite supervision or regular meetings with a supervisor or colleague (when that supervisor/colleague had a strong commitment and understanding of P-IBH), and regional P-IBH clinician meetings convened by CTC-RI. Supervision and support helped move a more traditional or novice behavioral health clinician toward becoming a skilled P-IBH clinician.

Overall, the clinicians interviewed who fully believe in the P-IBH model assert they “love” their job. They assert they are providing an essential service to patients and to the practice and are proud to be part of the patient’s care team. Many did note that patient need for IBH is greater than they can fulfill in their weekly schedule. Some directly stated their site needed more than one clinician, especially when they lack care management support. One medical provider felt their practice needed to assign a clinician to each medical provider to meet patient needs.

### Hiring barriers and workforce development

**Key points: Some sites experienced challenges hiring a P-IBH clinician. Hiring barriers included finding applicants, salary requirements and a lack of familiarity with IBH or P-IBH. There is a need for P-IBH clinician workforce development that includes a pipeline to Rhode Island’s primary care practices.**

Two sites had difficulties hiring or replacing a P-IBH clinician during the pilot’s duration. One site was unable to hire a clinician who would be willing to implement P-IBH across the two-year grant period, and one site was unable to replace a clinician who had left the practice. It appeared salary requirements were a primary barrier to getting a candidate to even accept an interview. Interviewees reported candidates asking for salary starting at over $90,000.

Another hiring barrier mentioned by interviewees was that behavioral health clinicians unfamiliar with the P-IBH model applied for the P-IBH position and expected to conduct traditional outpatient therapy.

In terms of workforce development initiatives to produce IBH clinicians trained and ready to work in RI, Rhode Island College has an IBH social work program focused on services within primary care, the University of Rhode Island has a health psychology track, and there is a PsyD health psychology track at William James College in Newton, Massachusetts. The psychology programs, however, are not specifically focused on behavioral health for primary care. Therefore, the pilot practices’ difficulty in hiring a trained IBH clinician highlights the persisting workforce gap between supply and demand for IBH clinicians.

## Practice preparation, education, and training

**Key points: Sites would have benefited from a more structured rollout that more explicitly trained and engaged providers, staff, and clinicians regarding the P-IBH model and P-IBH workflows and responsibilities. CTC learning collaborative information and materials typically did not get shared within practices.**

**Staff who administer the screening tools, e.g., medical assistants and front desk staff, would benefit from training and support. Program drift can occur when there is limited training or feedback offered to providers, clinicians, and staff.**

The primary care pilot sites varied in how they rolled out their program to providers and staff and how they continued to provide training. At a minimum, there were presentations at staff meetings when the program was about to start. These presentations can be found at <https://www.ctc-ri.org/integrated-behavioral-health/pediatric-behavioral-health-programs>. However, those presentations were not accessed by a number of providers or staff, due to staff turnover and the hiring of new staff. Some medical providers interviewed stated they did not attend program rollout activities, never received an orientation to P-IBH, and had to gradually find out the details on their own.

Sites that made a concerted effort to engage their medical providers and/or provided opportunities for them to hear success stories, updates and become involved in problem-solving at staff meetings appeared to have providers who were more actively engaged in the P-IBH program. Sites that had highly visible clinicians who worked closely with the medical providers also had more engaged providers.

“Every Wednesday the providers have their own lunch and learn time. It’s become a great opportunity for IBH to kind of go in and not only provide training on what IBH is for the newer providers but also talk about things. You know, if there's specific patterns we're noticing or training needs, things like that. We're really trying to get in there and prevent [missing patients who screen high] from happening.” *IBH director*

CTC-RI provided all sites with a binder of P-IBH materials. CTC also made these materials available on their website. However, no interviewee knew about the digital materials. Most noted the binder of materials was in their office, and few said they had shared the materials with providers and staff at the practice especially once the pilot became operational.

Interviewees from just a few sites reported they provided training to the staff who gave the screening tools to patients, such as medical assistants or front desk staff. Some sites provided these staff with periodic training when their clinician saw the need, and the clinician created training materials or held specific training sessions with providers and MAs.

“This is actually an ongoing discussion we've actually had, and it's funny because when we talk about training - we do all these initial trainings, but really it's ongoing all the time training and just reorienting staff with all of the changes that we've had. And then new staff turnover when people leave, you know, just remembering is part of their onboarding that we need to do a training on these specific things and helping the staff understand why, so how important it is for the clinical screeners in a medical visit, you know, because I think sometimes people come in, they don't understand the integration. But yeah we actually just had this discussion again. We're going to do a training with the MA's specifically in a couple of weeks.” *IBH director*

This type of ongoing training is very clinician-specific, and if an activated clinician left, training often did not continue. Some interviewees stated that it was simply the responsibility of particular staff to administer the tools, and training about the IBH model therefore was not necessary.

Most P-IBH clinicians spoke about their efforts to keep the practice apprised of the program processes. Interviewees noted that even for medical providers who remained throughout the pilot, periodic reminders about the program were needed to ensure they remembered to review the screeners and appropriately decide whether the patient needed P-IBH follow-up, and to solicit warm handoffs to the P-IBH clinicians when warranted.

“I do think that having that guidance and structure and support [from CTC] would definitely be important especially if you're just starting out. And even just to have them to revisit it later on--just to make sure like, ‘Okay are we still on the right track? Just to kind of keep it going and flowing the pace that it needs to, and also that you're running it with fidelity too. And so I definitely think having that support because you can go through your day and do all the things that you're doing and continuing and continue, and then if you don't have that timeline or that meeting set up I would imagine it can go astray pretty quickly. And that would not be what you would want for the program. So I think having their guidance and support throughout would be really important.” *IBH clinician*

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## Information Technology

### Registry

**Key points: Sites saw the value in creating and using a registry to track screening rates and patient follow-up. Sites that had technology support and/or had a population health manager were better equipped to create or manage a registry and to track a range of outcomes. When an EHR-based registry was not feasible, paper-based registries worked, but all registries require additional staff time to manage. Sites that used tablets for screening often found completing screeners on paper was more efficient and easier to manage.**

Creating and using a registry located within the EHR was a grant requirement. Ease in creating and using the registry depended on the site’s EHR and the availability of tech support. For practices with an existing registry, creating a parallel registry was a duplicative task.

All participants saw value in tracking patient follow-up and outcomes, but most admitted they fell short in this regard. An electronic registry requires the ability to make EHR modifications, which requires having IT staff, time, organizational willingness, and knowledge of how to make those changes. Faced with these challenges, some sites moved to using a paper registry instead.

Despite the logistical difficulties with the registries, interviewees recognized the registry’s value. One interviewee found reviewing charts quarterly more efficient and more accurate than doing an EPIC report.

“A lot of the time we actually catch in our registry report that we've created where we're seeing all the kids that were screened for the prior month. And then if we see that there are kids on there that have high screeners and we don't see that there's an IBH appointment, or we don't see that there's like a behavioral health piece in the registry, we're going into those charts and looking and seeing, ‘Okay, what happened in that provider visit? How come we didn't get the referral?’ So the registry even though it's kind of a monster still, it's been helpful for that.” *Site facilitation team member*

### Tracking outcomes and determining program outcomes

**Key points: Sites used their registry data to track screening rates and follow-up. However, most site managers had limited time to use their data for program improvement or to track patient outcomes at a population level.**

At quarterly meetings, sites reported out on their efforts to improve screening rates. Most participants said they relied at their practice on provider report, their screening rates and a sense of whether more patients received treatment, and/or stories about patient experiences as measures of program success. Patient tracking occurred at the patient level versus the population level, making treatment outcomes or trends difficult to discern. Some interviewees noted they just did not have time to explore their data. Yet some did track outcomes and valued the effort. One site with dedicated data support, a population health data manager, was able to use their data to improve clinician practice and support population health.

“Start with good framing and expectations up front. Make multiple points for check-in to see how things are going and be ready to change when they're not. And build things early on that will help you capture the data to tell the story to your clinicians, to your executives, to everybody about the value and to help ensure the sustainability over time. So be ready to track outcomes from day one.” *Site facilitation team member*

### Use of telemedicine for P-IBH services

**Key point: Telemedicine has a role to play in P-IBH, but it has limitations.**

Interview participants reported limited use of telemedicine prior to the pandemic. With the onset of the pandemic, sites had to quickly adapt their technology and processes to maintain patient access to behavioral health and medical care.

Overall, participants thought telemedicine has a role in P-IBH, and even some advantages, but telemedicine also has limitations. Telemedicine during the worst of the pandemic allowed patients to receive behavioral health interventions when practices were closed or when P-IBH clinicians worked completely offsite. Telemedicine was convenient for patients who lacked transportation, preferred meeting with the clinician from their home, or did not want to leave home during the pandemic. Telemedicine also worked well for college students living away from home, and for some teens who preferred not to speak with a clinician in person.

Clinicians cited a benefit of telemedicine was that it provided them a view into the patient’s home environment and sibling or parent/child interactions. However, holding the session with patients at their home led to confidentiality and privacy issues for patients. Clinicians reported having patients conduct their sessions in a closet or going out to sit in the family car to have privacy.

Behavioral health clinician interviewees explained that telemedicine was not especially well-suited for brief encounters. Longer sessions on virtual devices with patients could also be challenging. Whether for brief or traditional-length sessions, clinicians noted younger children (i.e., toddlers, preschool or elementary age patients) could be difficult as clinicians had to spend a large portion of the allotted session time getting the children to settle down in front of the screen.

Achieving success with P-IBH delivered through telemedicine required creativity. One P-IBH clinician described how she adapted to doing telemedicine sessions with younger children, and felt she was successful.

“The little ones were maybe having a trickier time sitting in front of the screen. But when I got them up and moving and doing kind of little scavenger hunts or something or talking to the parent … even through a screen and [I could] help the parent through something or help the kiddo with something. Make a calming space with them in their room, doing all these breathing strategies…I actually think it worked really, really well… At first, I had no idea that I'd be able to pull this off…whether or not that was just sheer luck of flying by the seat, right?”

### Implementation of P-IBH and the (d)evolution of warm handoffs during the pandemic.

**Key points: Technology can support telehealth warm handoffs. However, there can be significant challenges in ensuring that all have the appropriate technology, getting that technology to work, and managing the warm handoff logistics. Having clinicians offsite was a barrier to real-time handoffs.**

Most, but not all, sites with P-IBH clinicians working from home tried to develop workarounds to maintain warm handoffs. However, when clinicians were off-site during the pandemic it was difficult to sustain warm handoff efforts. The use of telehealth was hampered by logistical and technological difficulties and lack of tech support.

“[The P-IBH clinician] would--we would face time … through some sort of technological app on the phone. But basically, I'd be in the exam room, and I'd say, ‘Are you available?’ and she'd say ‘Yes” or ‘In five minutes” or whatever. And then she'd give me the number for them [the patients/parents] to send a message to, and then she would get on their device. They would have their own devices … and we'd be there for a few minutes, and then she would be with them, and I would leave.” *Medical provider*

Many interviewees highlighted just how important the warm handoff is to the success of P-IBH in that when a warm handoff was not possible with telehealth, patients/parents/caretakers might change their minds about accepting P-IBH services before the clinician connected with them.

When practices reopened, medical providers’ schedules were overwhelmed. At least one site reported that when the P-IBH clinician returned to the practice, medical providers had reverted to old habits and were much less likely to seek out the clinician for a warm handoff.

*See* ***Appendix 3*** *for more details and quotes related to warm handoffs during the pilot.*

## Setting

**Key point: Whether in a free-standing clinic, or part of a hospital system, sites need dedicated physical space for P-IBH that both provides privacy and allows the IBH clinician regular interaction with providers, teams, and patients.**

Some P-IBH clinicians reported they did not have dedicated office space, or they lost their space during the pandemic. This led to clinicians experiencing time constraints around meeting with patients and having to provide the initial brief intervention in the exam room or available space outside the exam room, such as the hallway. Subsequent brief interventions took place in whatever space could be found. While conducting the brief IBH intervention in the exam room has been considered ideal (Gunn et al., 2015), providers reported that use of the exam room for IBH delays rooming of the next scheduled patient. All interviewed IBH clinicians declared that having a private, quiet room for the brief IBH intervention is essential.

“Got to have a room. Even right now we share a room, so the social worker and I will switch off who makes the calls so we're not speaking over one another. But you've got to have a space with a couch or family room.” *Clinician*

IBH clinicians who had office space separated from the medical visit rooms described limitations to this arrangement. While that separate space provides privacy and a less noisy environment, it also places the clinician out of the mainstream of provider interactions. Interviewees at one site asserted that without a designated office, their P-IBH clinicians were more available to providers and warm handoffs were easier to arrange.

## Targeted populations and conditions

**Key point: All sites recognized the need for comprehensive behavioral health screening and will continue to screen, with some sites looking to expand screening to additional age groups or adding additional screening tools.**

All sites will continue to do behavioral health screening with patients. Interviewees at sites already conducting screening prior to implementing the grant said the grant’s PDSA and, eventually, the grant-required registry, helped them be more systematic in administering their screening tools.

Some sites were considering lowering the age range for behavioral health screenings, adding social determinants of health (SDOH) screening or other screening tools. However, there was considerable site variation in staffing capabilities to follow up and provide brief IBH or OBH treatment for patients, or to provide the care management needed to follow up SDOH needs.

## Clinical processes

**Key points: The grant provided sites with a framework for developing or enhancing their clinical processes and workflows related to integrated behavioral health care. Committed practices made P-IBH work despite a pandemic and staffing shortages.**

Interviewees at each site had a keen interest in addressing behavioral health issues in their practice, with each recognizing the importance of identifying and addressing behavioral health concerns in their patients. The pilot offered grantees the opportunity to build upon their existing screening efforts or to start new screening initiatives. While sites differed in the specific means by which they implemented P-IBH, each site’s program development and associated workflows were guided by the grant requirements, grant timelines and associated deliverables.

Each site conducted screening at a minimum at the well child visit; for the EPDS, screenings were conducted at prescribed intervals. Each site had a workflow to follow up on a positive screening result that involved initial referral to clinical services either onsite with an IBH clinician, onsite to outpatient behavioral health services, or offsite to outpatient behavioral health services.

Sites varied in their ability to provide warm handoffs within the medical visit. If a warm handoff was not possible at the time of the visit (due to time conflicts, no available IBH clinician, screenings reviewed at day’s end, telehealth, or the IBH clinician working only virtually), a clinician (or practice personnel when there was no clinician) usually contacted the patient/parent/caretaker later the same day or within 24-48 hours, depending on clinician availability and the level of urgency.

Each site had processes in place to ensure patients with very high scores, or who reported high levels of distress, received real time or same day assessment. However, these processes often required a high degree of follow-up to ensure the patient was seen, especially for sites that had to rely on referrals to external sources such as Bradley Hospital. Regardless of the timing, patients who needed services received IBH treatment or were referred to outpatient behavioral health services, as available and appropriate to the situation.

The COVID pandemic required sites to modify their workflows to reflect a switch to telemedicine and then a subsequent return to in-person care. The inability to hire a P-IBH clinician also led to implementation barriers and workarounds.

At the time of the first screening, all sites relied first on physician assessment, followed by clinician judgement, as to the type of intervention needed and when and where to refer the patient to external resources. Subsequently, treatment judgments were made by the clinician or the clinician in consultation with the provider, consistent with a team approach to care.

Interviewees at all sites reported delays of varying lengths when referring patients to other agencies for treatment, with the pandemic exacerbating wait times.

“I mean I think across the board, I historically could occasionally pull in a favor that wasn't really owed to me, you know, ‘Hey, can you take this patient for me?’ And I've run out of favors. There's really not any--everybody is full.” *Site facilitation team member*

P-IBH clinicians were able to provide services for patients who were on wait lists for traditional outpatient therapy, however providing brief interventions or traditional therapy over many weeks or months tended to tie up the P-IBH clinician’s schedule.

“Yes, so I'm lucky in that (practice social worker) does the external referrals for the most part. She's very helpful … It's the adolescents who a lot of folks are not taking people for at least a month to six weeks, at least the 13-year-old-ish people. They're staying with me right now, and there's a huge demand, and they're coming in suicidal or whatever, and so I'm holding them over until they can get into partial. But often the backlog keeps coming. So it ends up keeping me kind of stuck with a lot of high acuity patients which is happening to the other … clinicians. So I know it's not just me, but it's definitely not allowing me to do trueIBH right now.” *P-IBH clinician*

Many sites reported communication between community providers and medical providers to be a challenge. Despite patients signing HIPAA releases for information-sharing between provider agencies, many community agencies do not regularly provide progress reports to medical providers or IBH clinicians.

### Implementing P-IBH without a clinician or with only a part-time clinician

**Key point: It is possible to implement components of P-IBH without any clinician or with only a part-time clinician but achieving a high level of integration will be unlikely.**

When sites do not have an IBH clinician, or the clinician works part-time, sites are unable to implement a fully integrated behavioral health program. Screening can be implemented according to the P-IBH model; however, the program will have to rely in part or in full on referring out for assessment and treatment rather than in-house warm handoffs and brief intervention.

“And so right now it's just the doctors taking on--most of my staff have taken on the nurse care manager's job splitting--each doctor has a team. They have a secretarial person. They have an MA, and then it's themselves, and so their secretarial person has been taking on helping them with setting up things and referrals. So that's the model that we're working with now, but it's not good because I think my staff are going to get stressed out because it's just too much they're taking on.” *Site facilitation team member*

One site contracted with an agency to provide a clinician two days a week. The warm handoff was to the nurse care manager who told the patient/parent/caretaker what to expect and who would be contacting them. Having a contracted clinician allowed for direct connection to a known clinician and for better information flow between the provider and the clinician. However, the clinician worked for an agency and provided traditional therapy rather than brief IBH model counseling.

When there are no P-IBH clinicians at the practice, in addition to or instead of referral, staff give their patients resources to help fill in treatment gaps.

“So we've tried to be creative … you know, what can we do to recommend specific websites or specific--what can we do to provide more self-directed--for kids that are earlier on in their anxiety or earlier on in their depressive illness. Or it's ADHD--okay, what books can we provide to the parents? What websites? What tools might we be able to provide that can be self-directed? For example I have a couple of older adolescents that I've said, ‘Look, cognitive behavioral therapy for insomnia--you're not sleeping. Here's an online program. It's $59.00. It is six sessions. And that is so much cheaper than paying six therapy sessions to just do this.’” *Site facilitation team member*

As another example, a practice employed a P-IBH psychologist just a half day per week. The program also employed a social worker who was there more often and had a triage function along with providing community resources. The social worker did not provide counseling. Instead, she met quickly with the patient, assessed the patient’s needs, including those stemming from SDOH issues, and connected the patient to resources. If the social worker deemed that further IBH intervention was required, she referred the patient to the psychologist. This practice recognized how well this team functioned, but acknowledged that getting additional psychologist time was critical.

### Perceived differences between pediatric and adult IBH

**Key point: Interviewees noted pediatric and adult IBH had similar principles, and some were able to list elements that differentiate care for the two populations.**

Most participants who addressed how pediatric IBH differs from adult IBH initially claimed they are “basically the same.” However, as the interview progressed, some did come to note differences, including that adult IBH has care management support while P-IBH does not. Some explained that pediatric and adult behavioral health are intertwined within the family context, so when one receives treatment, it is likely to impact the other. The major difference these participants identified lies in “this whole universe of social emotional challenges in families.”

“I recently engaged our IBH folks around a mother daughter pair who are really at loggerheads over, you know, her curfew or her cell phone use or something... I mean I have learned so much because when I have time I've sat in on those conversations and listened to how someone who was trained in counseling really sets the stage for a productive discussion. I don't know if that happens with adult IBH practices. I think it is something that has been really important in pediatric IBH.” *Medical provider*

### Program oversight and project champions

**Key points: Leadership that understood the P-IBH model was a critical success factor as were physician champions and staff champions. For most of the sites, managing the P-IBH pilot was an added responsibility. It was unclear how some sites would manage their programs or identify and address P-IBH issues systematically once CTC-RI facilitation ended.**

Leadership commitment to implementing the P-IBH model impacted the IBH program. At sites where leadership did not have a good understanding of P-IBH, clinicians were more likely to be asked to implement a more traditional social work model.

Having P-IBH champions at the practice from varying work roles facilitated pilot progress and program fidelity. Some physician champions were already champions of the IBH model even before implementation; others were given the role by administration and had to learn to value the program. Other staff across a variety of roles became champions as they saw how patients benefited from P-IBH.

With few exceptions, the grant requirements and facilitation served for most sites as the project management plan. It did not appear many sites had other processes to routinely identify and address problems with pilot implementation, or to build on the pilots’ successful outcomes. Sites typically used staff meetings to raise issues about the pilot, however, the pilot was not a regular item on the agenda.

### Case Story of an FQHC that initially combined IBH and OBH in the same department, and later separated the two services into different departments.

This is a case description of a health center that is fortunate to have an outpatient behavioral health (OBH) department located within the health center building. When IBH began at this health center, short-term IBH services were included in the OBH department, effectively making the department a merging of OBH and IBH. At that time, staff provided both OBH and IBH services, and were not designated as being responsible for one or the other. There was one department administrator who oversaw both types of services. At times, providing IBH had lower priority than providing OBH.

In the spring of 2021, the health center created a new department solely for IBH. Therefore, now IBH and OBH each has its own department, each with its own director, care coordinator, and counseling staff. The IBH director noted that having hired a clinician who was educated in the IBH model helped push the health center to create a separate IBH department. The IBH clinician explained that initially she worked for both OBH and IBH, and eventually was able to focus solely on IBH.

“And it was [in the beginning] multiple roles. I will do IBH, warm handoffs, but also I did a lot of admin with the outpatient. I did the intake for a year. And for the past year, that's when we started to actually have a separate department. IBH now, it's separate from outpatient. We get more into going back to the huddles with the PCPs. I think it's been going really well.  We have a student from RIC who did a project. And the data, it's showing a correlation between the huddles, and it creates warm handoffs, which we thought was great.”

The two departments coordinate with each other. When referrals to behavioral health from the health center’s physicians go to the IBH department, IBH clinicians triage the patient for the most appropriate services. The clinicians note that at times physicians incorrectly refer patients to IBH who would better benefit from direct referral to OBH. The IBH clinicians typically counsel patients for up to five or six sessions, and if longer term counseling is needed, the patient is transferred to the OBH department. The IBH clinicians can communicate with the OBH coordinator to check whether the patient actually gets into the OBH schedule. During periods when there is a long waiting list for OBH, IBH clinicians may provide additional sessions to the patient to bridge the gap while waiting for an OBH slot. The IBH clinician asserted, “We just need more sessions here.  Why have them wait for the outpatient?  Let's just finish with the treatment.”

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## Cost andSustainability

**Key points: All sites are committed to continuing their P-IBH programs. Most sites used clinician billing revenue to fund their clinicians’ salaries. There are many additional costs associated with P-IBH that billing does not cover.**

We analyzed interviewees’ responses about sustainability in four categories: financial, clinical, stakeholder burden, and program integrity.

### Financial

All sites planned on continuing their P-IBH program, with interviewees from one program concerned that the capitation rate and billing may not allow them to continue long-term. Sites that used MSWs (as opposed to independently licensed social workers) to provide clinical services did not bill for therapeutic services. Those who used licensed staff believed that so long as billing covered the IBH clinician’s salary, their program was sustainable.

However, the billing calculations described above did not necessarily include the increased need for care management and follow-up. Other nonbillable P-IBH clinician activities include consulting with medical providers, providing some BH training to staff, and conducting short “meet and greets” with patients.

Sites such as FQHCs had sufficient care management or care coordination staff to support the P-IBH clinician. There are many additional costs associated with P-IBH that billing does not cover. FQHCs are less concerned with covering overhead, and one FQHC did not bill for P-IBH services. Some sites had nurse care managers assist with follow-up activities in addition to their existing care management activities. Others had limited ability to support the P-IBH clinician. Additionally, billing did not cover EHR/IT related costs as sites worked to make modifications to accommodate improved communication. Billing also did not provide salary coverage for a program manager. Some interviewees asserted that moving the sites’ P-IBH efforts from pilot to established program may present some financial risk. Interviewees expressed the need for funding that would ensure the stability of P-IBH services.

“That would be ideal if they're willing to support the position regardless of how much money you bring in, which probably it might not be possible in smaller practices. But in group practices they're showing it's possible, at least for ours. So, I think it's worth it because you'll get quality clinicians who want to do the work and want to stay.” *P-IBH clinician*

“[It] would be great if the insurance companies paid for social workers in all the offices like they paid for nurse care managers in the beginning of time. Funding is an issue. And when this care is done right in the medical home where the trust is, it can save money down the line. So, it would be great to have a steady funding stream specifically for salary and fringe support as opposed to on a per-visit basis, because there's so much care coordination that can't be charged out on a fee for service world. So, whether that's value-based contracting that has a behavioral health component, or I don't know what. But funding is an issue for sure.” *Physician*

### Clinical

Two sites had difficulty hiring a new or replacement P-IBH clinician, with salary expectations that exceeded the budgeted salary being a key factor in applicants declining to be interviewed. Most sites were reluctant to use unlicensed Masters level clinicians because of the need to bill for services, concern about practitioners who have less developed clinical skills, or the site did not have access to a LICSW supervisor. Of note, the FQHC site that has the supervisory resources allowing them to use unlicensed staff did not experience hiring problems.

It may be a persisting problem that sites will have difficulty hiring clinicians who have the desire to implement P-IBH and who are willing to accept the salaries offered by practices.

### Stakeholder Burden

It was clear that dedicated staff and providers in each practice took on additional tasks to make the pilot work and to fulfill grant requirements. All stated that they recognized the importance of the work. However, with many sites experiencing staff turnover and position vacancies, interviewees were concerned how long staff and providers could sustain this.

Program integrity

Some interviewees expressed concern about program “drift” in terms of how easy it can be for screening protocols to become overlooked. Sites reported numerous examples:

* Medical providers lost sight of the need to seek warm handoffs with the clinician
* Screening results were not reviewed during the visit but only at the end of the day
* Clinicians did not spend time regularly checking in with providers and/or attending huddles
* New staff and providers did not receive orientation training regarding P-IBH components and processes
* Staffing shortages caused delays in follow-up.

Some sites had the internal resources to provide their P-IBH clinician with clinical supervision, but others did not. Supervision supported clinicians in implementing P-IBH. Pilot management was often an added responsibility for staff who were already near capacity with their other responsibilities. It is unclear to what extent sites will be able to closely monitor their P-IBH programs now that facilitation meetings have ended, and yet monitoring fidelity and providers’ continued attention to P-IBH components are critical for success into the future.

# Lessons learned – Pilot Site Interviewees’ Perspectives

*Interviewees offered insights about lessons learned from their experiences during their P-IBH pilot implementation. These points are to be distinguished from the evaluators’ recommendations which follow in a subsequent section.*

Below is a summary of key points as expressed by the participants in the interview evaluation. **Appendix 3** provides these key points *along with supporting quotes.*

## Pilot Program Components and Facilitation

* P-IBH needs ongoing monitoring to stay on track and help from CTC.
* CTC learning collaborative information and materials are made available to all practices at the start of the program. Practice facilitation mentoring and discussion of use of materials could occur during the monthly meetings. Awareness of and use of the materials by the full IBH team varied by site.

## Care Delivery Team: Patient, Parent, Provider, P-IBH Clinician, other Program Staff

* Teamwork is important for providing the best patient care.
* Special consideration must be taken for both language needs and trust when working with immigrant families.
* Provider buy-in to the P-IBH program is essential to success, but at times challenging to initially achieve or to maintain over time.
* Patients trust the medical practice staff to direct them to the services they need, so IBH embedded directly within the practice is an ideal model for patients’ comfort.

## Education, Training and Practice Preparation

* MAs are often the linchpin to ensuring providers are aware of patients’ screener scores, and with high MA turnover, they must be trained and reminded about this critical part of their job.
* Physicians need periodic reminders to look at and address the screening results at the time of the visit.
* Ongoing or periodic training of staff in all roles related to the P-IBH program is essential given staff/provider/clinician turnover and the need to maintain knowledge and engagement.

## Information Technology

* It is helpful to harness IT, as available, and create protocols to effectively track patient care and outcomes.
* At times, however, paper-based processes may work better than processes requiring digital devices. Completing screeners on paper can turn out to be simpler and quicker than doing the screeners electronically. Reviewing charts at the end of each day or week to ensure patients received needed follow-up may be easier than generating reports from the electronic record.

## Clinical Processes, Workflow, and Practice Philosophy

* Behavioral health screening is considered by providers, clinicians and staff to be essential for good patient care.
* Strategies are needed to ensure adolescent patients complete the screeners themselves instead of their parent doing it for them.
* Success is enhanced when staffing, workflow and the workspace are set up, to the greatest extent possible, to facilitate the best of the P-IBH model. This fosters close collaboration between medical providers and IBH clinicians, and provides private space for patient meetings when the visit room is not available. P-IBH clinicians who are situated to be highly visible in the practice appear to achieve better collaboration with medical providers.
* When understaffed for P-IBH such that clinicians must prioritize their time for huddles, it can be expedient to focus huddle time with medical providers who have had low rates of referrals to IBH. Another approach to huddles could be to focus on the most concerning patients on the day’s schedule.
* It is helpful to have workflow structures in place to ensure screens are reviewed by medical providers so that follow-up for patients who could benefit from P-IBH is accomplished in a timely manner. It can help to do pre-visit planning to identify patients who might need behavioral health interventions.
* Triage processes can enhance efficiency of care delivery. One practice benefited from hiring a social worker for immediate crisis intervention, to make phone calls for external referrals, and to address social determinants of health needs. This saved the psychologist’s time for patients who would benefit from an IBH counseling series.
* It is important to support P-IBH clinicians by having other staff review patients’ behavioral health screener results and inform medical providers at the time of the visit, structuring into the workflow time for huddles, providing support to the P-IBH program by care managers and coordinators, and hiring enough P-IBH clinicians to meet patient need. This can help avoid having clinicians succumb to feelings of burnout and may slow turnover. Ensure the behavioral health clinician who is hired is a good fit for the IBH position by not only understanding the specific set of interests and skills the clinician brings but also the competencies needed to succeed, such as those provided by SAMHSA or described in Horwetz, et al. (Hoge M.A., Morris J.A, Laraia M, Pomerantz A., & Farley, 2014; Horevitz & Manoleas, 2013).
* Interviewees found it critical to recognize the importance of understanding SDOH, and how to address them while preserving patient dignity.

## Cost and Sustainability

* Interviewees looked at the experience of their sites, and asserted that support of IBH clinicians, regardless of billing, would create more stability in P-IBH services.
* Interviewees fully believe that P-IBH is invaluable, though they recognized the concrete dilemma that not all components necessary for providing IBH services are revenue-generating (i.e., warm hand-offs, huddles, consults between medical provider and clinician without the patient present). Therefore creative thinking is called for to increase the capability of primary care practices to begin and/or continue P-IBH work, even when billing is not enough to sustain the model.

# Limitations

When this qualitative study was initially designed, the evaluators’ plan was to interview 3-4 key informants at each site—at a minimum, the program manager, a physician or physician champion, and the P-IBH clinician—using an interview guide covering topics of interest to CTC-RI that would yield an interview lasting about one and a half hours. Due to the overwhelming effect of the COVID-19 pandemic on primary care practices, interviews were shortened to reduce burden on interviewees. The complete interview guide was used with the first interviewees at each site, and subsequent interviews were tailored according to the interviewees’ role in the pilot, information gaps, and their time constraints.

The findings section on physician experience may not reflect the full range of provider experience because those interviewed included the physician champions and others who agreed to be interviewed. Their views of P-IBH may not necessarily match those of physicians not as involved in the program. Patients and parents were not interviewed for this evaluation study. The findings section on patient and parent experience is therefore based solely on analysis of medical providers’, IBH clinicians’, and other interviewees’ perceptions of how patients and their parents responded to P-IBH.

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# Recommendations

Recommendations are included in three categories: recommendations for CTC-RI, recommendations to payers and policy makers, and recommendations to pilot sites. Recommendations for P-IBH program sites are organized using Kwan et al. (2015) framework categories, and rationales for offering these recommendations are provided.

Many of the recommendations listed here rely on staff, providers and clinicians continuing to take on additional roles and responsibilities for P-IBH-related tasks, for instance, creating and conducting trainings, creating and implementing an ongoing process for program oversight, and using program data to identify and address program barriers and needed modifications. Without increased P-IBH funding, some recommendations will not be feasible.

## Recommendations for CTC-RI

Recommendations for CTC-RI are provided in four categories—program support for P-IBH programs; grant structure and processes; workforce development; policy support.

### **Program support for existing and emerging P-IBH programs**

**Rationale:** All pilot sites benefited from the grant structure and facilitation. There are opportunities for CTC to continue supporting sites so existing P-IBH programs stay on track, and to support practices that start new P-IBH programs. Based on the success of the eight program pilot sites, it is anticipated that additional Rhode Island pediatric practices will move to adopt P-IBH.

1. Consider whether it is possible for CTC-RI to create a P-IBH resource center, staffed with a facilitator who could manage and implement the following recommendations.
2. Support existing P-IBH sites through technical assistance and resource materials

* Continue quarterly clinician meetings and provide periodic booster trainings for P-IBH clinicians to discuss issues they encounter in their work. Explore whether payers will fund participation in training sessions.
* Create a P-IBH Resource Website that provides tip sheets and brief video trainings about the universal basics of the P-IBH model. Sites can use these materials for initial orientation of front office staff, MAs, medical providers, P-IBH clinicians and other practice staff, managers, coordinators and administrators, as well as orientation of new employees, and ongoing/periodic trainings to maintain program integrity. While each practice implements their P-IBH program somewhat differently, discussion of practice-specific protocols can build upon this basic foundation of understanding about the P-IBH model and its typical mission and components.
* Explore with sites how the Learning Collaborative meetings could be modified to make them more relevant to sites. Explore whether pilot sites are interested in continuing to gather periodically to share best practices and to problem solve.
* Continue to provide technical assistance in other areas, such as for the P-IBH registry, tracking systems, and workflows.
* Explore with practices their interest in using Master’s level social workers who are in the process of getting licensed. If there is sufficient interest, determine whether CTC-RI can develop a system of shared LICSW supervision for unlicensed staff at multiple practices.

1. Based on the success of the eight pilot program sites, expect that additional Rhode Island pediatric practices will want to adopt P-IBH. As additional funding allows, newly interested sites will benefit from CTC’s support in the following areas.
   * As additional funding allows, provide interested sites with an implementation process based on the current CTC-RI grant structure and processes, but include additional elements found in the Evidence Roadmap for Implementing IBH (Kwan, et al., 2015), e.g., include technical assistance for roll-out activities to providers, clinicians, staff, patients and their families. Help sites develop a program management structure and ongoing quality improvement process.
   * Provide each new practice with the same support grantees received, e.g., a facilitator and monthly facilitation meetings, timeline, and deliverables.
2. Many pilots prove to be successful and worthy of permanent adoption and statewide expansion. When this seems likely to be the case, work with payers to plan how existing programs can be sustained and new sites added.

### Grant structure and processes

**Rationale:** CTC-RI has developed a strong granting structure that provides clear timelines, deliverables, quality improvement projects, training opportunities, and monthly facilitation meetings. The grant structure is well known and appreciated by Rhode Island pediatric and adult practices.

1. The literature suggests that current CTC’s grant structure and processes could be enhanced by adding deliverables regarding site preparation, training and other rollout activities; creating a program oversight structure; and helping sites grantees develop a clear process for determining and measuring program outcomes and program fidelity (Fixsen et al., 2005; Siu & on behalf of the US Preventive Services Task Force, 2016; Zuckerbrot, Cheung, Jensen, Stein, & Laraque, 2018).
2. When creating IBH grants for pilots that are likely to progress into established programs, consider using the AIMS Center components (<https://aims.uw.edu/collaborative-care/implementation-guide/lay-foundation>) or the Evidence Roadmap for Implementing IBH (Kwan, et al., 2015) to ensure grant activities include at least the following:
   * Rollout, training, and continuing education activities to engage and educate staff and providers across the site’s organization, patients, parents, and other stakeholders;
   * Development of an ongoing program management structure that will continue beyond the duration of the grant.
3. When providing facilitation for new programs, recognize that grantees will be in different stages of organizational readiness, program knowledge or expertise, and technology and staffing capacity. Consider how some aspects of facilitation or facilitation meetings and grant deliverables could be tailored to the specific circumstances of each practice.

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### Workforce development

**Rationale:** The nation is experiencing a shortage of behavioral health clinicians. There are a limited number of clinicians trained to deliver IBH or P-IBH.

1. To support sites hiring unlicensed clinicians, CTC-RI, payers and practices can explore opportunities to create a centralized LICSW oversight resource for unlicensed social workers. This resource would provide oversight, clinical supervision and mentoring.
2. Clinicians specifically trained in the IBH model (as opposed to traditional long-term counseling) are preferable as providers of clinical IBH care. Payers should consider how they can support P-IBH or IBH clinician workforce development and training at local or regional MSW programs that provide specific training in IBH (Horevitz & Manoleas, 2013). For instance, Massachusetts has an IBH student loan forgiveness program for practicing IBH clinicians. (Mass.gov., 2022)

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### Policy support

**Rationale**: A core component of CTC-RI’s mission is to effect policy change.

1. When pilot grants support programs that are likely to be adopted statewide, work with payers proactively to ensure funding or payment mechanisms will be in place to allow existing programs to continue and that will support statewide adoption.
2. Continue to work with state policy makers to raise their awareness that addressing behavioral health is a critical part of pediatric care and should be addressed through fully funded P-IBH programs. P-IBH should be included in PCMH-Kids payment or capitation rates and payment should include, at a minimum, a P-IBH clinician and a P-IBH care manager, program management and data monitoring activities, and EHR and technology needs.
3. Work with payers to develop a systems-wide approach to payment for screening, so that screenings subsequent to a positive screen can be reimbursed.
4. Other innovating states such as Colorado and Massachusetts are proposing and enacting legislation that requires payers to fund an annual mental health wellness visit. An annual mental health visit allows more time to focus on the patient’s mental health or behavioral health needs. CTC should consider advocating for a new payment code for this annual visit (Colorado House Democrats, 2021; Second Regular Session, 73rd General Assembly, & Colorado General Assembly, 2020; US News and World Report, 2021).

### Provider and clinician training

**Rationale:** There are opportunities for sites to provide or receive additional IBH-related training to staff, clinicians and providers. Effective trainings can be provided in “small bites”, such as self-directed modules, tip sheets, brief presentations at staff meetings. Past CTC-RI experience indicates providing compensation may improve training attendance at didactic sessions.

1. To extend provider, care manager and clinician capabilities regarding the provision of mental health services within the clinical encounter, encourage sites and their staff to take advantage of training and certification opportunities. See **Appendix 6** for a resource list.
2. Determine if there are funding sources to provide compensation for training attendance.
3. If CTC-RI develops trainings for use by P-IBH practices, review best practices for provider, staff, and clinician trainings so that offerings match learning styles and time constraints (Horevitz & Manoleas, 2013).

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### Future studies

1. CTC-RI could contract with quantitative researchers to study how the P-IBH services in RI have impacted rates of youth hospitalization rates for mental health issues, rates of youth suicide attempts and deaths, and rates of drug overdose and drug-related deaths in adolescents.
2. Consider adding a set of behavioral health experience questions to annual patient satisfaction surveys.

## Recommendations for Payers

### Payment

**Rationale**: P-IBH is a preventive service that should be offered in pediatric practices. P-IBH involves more than behavioral health and substance use screening and hiring a clinician. P-IBH should have care managers or community health workers that support the P-IBH clinician. Screening reimbursement is inconsistent across payers. Capitation rates need to be sufficient to cover the range of staffing and technology support needed to make P-IBH function optimally. Current reimbursement rates do not reflect clinician salary expectations nor do rates reflect the increased time medical providers spend implementing P-IBH.

1. Consider increasing capitation rates so that a P-IBH clinician and a P-IBH care manager are salaried positions within each pediatric practice. Capitation rates also should cover the full range of staff and technology needed to implement a successful P-IBH program. Salary ranges should reflect current market rates.
2. If the capitation rate cannot be increased to cover P-IBH managers, payers should create payment codes that allow P-IBH clinicians to bill for some or all care management activities.
3. Recognize that providing P-IBH services require physicians to spend additional time within the encounter to review screening results, discuss strategies with patients and parents, and engage the clinician in a warm handoff. Increase payment for pediatric encounters so that the standard pediatric well child visit is 30 minutes instead of 15.
4. Recognize that patients and families may need care management services that can be delivered by staff other than IBH clinicians. These services could be delivered by non-clinicians, for example, community health workers. This could be an effective multi-payer strategy given the urgent concerns with behavioral health workforce shortages and the need to provide services to patients who need language support.
5. With the rates of pediatric mental health distress rising rapidly, it is likely that patients will disclose behavioral health concerns to their providers at visits other than the annual well child visit. Consider increasing payment for all pediatric visits to reflect a 30-minute encounter when BH issues are raised.
6. Payers should recognize that patients who screen positive for behavioral health disorders will need to be screened on an ongoing basis to track patient progress. There is a need for multi-payer alignment around standardized payment for annual screening and follow-up for positive screens.
7. Consider adding a code for an annual wellness visit that includes a focus on mental health, or that occurs in concert with the annual wellness visit. This would allow primary care sites to have a yearly check-in with all patients around mental health and substance use. Other innovator states such as Massachusetts and Colorado have proposed and/or enacted legislation that would require payers to fund such visits (Second Regular Session et al., 2020; US News and World Report, 2021).

## Recommendations for P-IBH Program Practices

### Targeted populations and conditions

**Rationale:** All pilot sites recognized the need for comprehensive behavioral health screening using age appropriate, validated screening tools. Some sites were considering lowering the start age for behavioral health screenings or adding SDOH or additional screening tools. However, there was considerable site variation in staffing capabilities to follow up and provide brief or OBH treatment for patients.

1. Practices should consider whether they have adequate internal resources, e.g., clinicians, care managers, program managers, technology support and program monitoring, before expanding screening to include younger ages or additional screening tools.
2. Practices could explore hiring unlicensed clinicians to implement P-IBH. Currently, this recommendation likely is only feasible for multi-site practices where clinical supervision is available.

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### Rollout and practice preparation, education, training

**Rationale:** Implementation is a dynamic, ongoing process. To be effective, ongoing rollout, practice preparation, education and ongoing training activities are needed that can respond to environmental, personnel, and population changes and that support program fidelity (AIRN-Active Implementation Research Network, 2022; Jensen, Cheung, Zuckerbrot, & Levitt, 2018; Kwan et al., 2015).

Primary care practices typically do not have the time to do pilot program rollout activities and the pilot grant did not require sites to do so. Several providers reported they would have liked more initial training and more ongoing information about the program’s impact. Several clinicians noted medical assistants and front office staff would benefit from basic mental health training regarding mental health and how to respond to patient or parent questions about the behavioral health screeners.

Parents and patients received little information about the P-IBH program. Only one site provided materials to patients and parents about P-IBH screening. Few practice websites included information about their P-IBH programs.

1. With or without start-up or capitation funds, sites or organizations planning to implement P-IBH should use an evidence-based framework to design their program such as Kwan, et al. (2015), the AIMS Center (<https://aims.uw.edu/collaborative-care/implementation-guide/lay-foundation>), or other frameworks. These should be used to develop and implement an overall approach for P-IBH roll-out activities, on-going trainings, and other P-IBH adoption activities. These activities should engage the full range of practice staff.
2. Practices should plan to deliver ongoing presentations or updates to staff and providers about the P-IBH program. Updates should include data regarding screening rates, warm handoff rates, patients engaged in brief treatment or OBH, patient no-show rates with and without a warm handoff, and stories of successful patient outcomes.
3. Practices should ensure that staff involved in administering the screening tools receive training about the importance of screening and how to respond to patient or parent inquiries. Practices could collaborate on creating these materials, or CTC-RI could develop these materials for distribution throughout the state.
4. With or without start-up or capitation funds, sites or organizations planning to implement P-IBH should develop introductory P-IBH materials for parents and patients, e.g., introductory letters, posters in exam rooms, post information on websites.
5. Sites can make available to providers, clinicians and staff training resources regarding IBH, collaborative care, and providing cognitive behavioral therapy. See **Appendix 6** for a listing of resources.

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### Staffing and clinician retention

**Rationale**: In general, P-IBH clinicians expressed high job satisfaction and commitment to the P-IBH model of care. However, clinicians described experiencing work overload when care management support is not available. When additional care management support is not available, there is a risk that the IBHC will become overwhelmed with practice and patient needs. There are opportunities for practices to create a clear process to identify patients to whom the P-IBH clinician will provide care management.

1. Practices with onsite P-IBH clinicians need to ensure clinicians have sufficient care management support.
2. When additional care management support is not available, work with the clinician to determine how to make the workload manageable, e.g., develop a prioritization scheme to address which patients the clinician will or will not provide care management, or reduce expectations regarding the number of patients a clinician will engage in warm handoffs or brief therapy, while recognizing the potential impact on financial sustainability.

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## Clinical processes

**Rationale**: Every primary care site worked to create P-IBH workflows that helped patients receive timely care and follow-up.

1. All sites should continue to review and revise their workflows, treatment protocols, and monitoring processes to ensure their program continues to function at a high level.
2. To support a high degree of P-IBH program functioning and to be eligible for advanced payment from the Office of the Health Insurance Commissioner (OHIC), sites that are Patient Centered Medical Homes can consider acquiring NCQA Behavioral Health Distinction.

### Setting

**Rationale**: Some clinicians reported they did not have dedicated office space, or they lost it during the pandemic. Conversely, dedicated space far away from exam rooms, providers and other staff also was not ideal.

1. Practices need to provide dedicated, private space for their P-IBH clinicians to meet with patients and parents, ideally on the same floor and within easy access to the medical providers (Jensen et al., 2018).
2. If practices need to locate their P-IBH clinician(s) on a separate floor, engage in a thoughtful and ongoing process to ensure the clinician has meaningful opportunities to interact with medical providers and other staff, e.g., participation in huddles, presentations at staff meetings, availability for consultation.

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### Information Technology

**Rationale**: All sites appeared to have access to the information technology needed to support a high functioning P-IBH program; however, some sites lack timely technology support to implement needed changes. While most sites could access their registry data for tracking screening and follow-up, most did not have the time to use their registry data for organizational quality improvement. Sites that had IBH departments or a population health manager were more likely to use data for quality improvement.

1. Primary care sites that have the staffing resources should continue to use their data for program and clinical improvement. Sites that do not could find ways to carve out time at least monthly to look at trends in their data.

### Cost and sustainability

**Rationale**: For some practices, it appeared billing could support a P-IBH clinician, but not other necessary P-IBH costs. FQHCs and group practices were better able to absorb the cost of P-IBH.

1. CTC-RI and all practice types should advocate for payers to increase the capitation rate to include the full cost of running a P-IBH program.

# Conclusion

It long has been recognized that primary care has become the de facto mental health system (Kessler & Stafford, 2008; Regier, Goldberg, & Taube, 1978). Especially now, with the rates of pediatric mental health disorders rapidly rising, pediatrician offices are presented with a wide array of patients with a broad range of behavioral, mental health and behavioral health problems and disorders. Medical providers can feel frustrated by the lack of behavioral health and/or substance use resources available in the community to patients. P-IBH offers medical providers a pathway for their patients to receive systematic screening and same- or near same-day assessment and treatment within the primary care or pediatric practice.

“…so I think every practice should have that (onsite clinician.) Every patient and family should have access to that kind of support in the moment when we’re courageous enough to say, ‘we need help’.…And the payoff may not be to you, insurance company, your foundations; but it’s going to be a payoff to society at large, and that’s really, really important.” *Medical provider*

The eight pilot sites successfully implemented their P-IBH programs despite the many challenges presented by the COVID pandemic. Providers reported high satisfaction with the program and offered many patient or parent success stories.

CTC-RI’s grant structure and processes provided sites with a clear implementation road map that also served as a project management plan. The CTC-RI facilitator provided valuable technical support to implement that plan. The CTC-RI grant structure and processes are very strong but could be more impactful. With or without adjustments, the overall grant structure of clear timelines, deliverables, and facilitation is established to provide effective support to other practices interested in adopting P-IBH.

The success of these eight sites likely will lead to adoption of P-IBH across Rhode Island pediatric practices. While this is to be celebrated, adoption will be hindered by the lack of meaningful P-IBH payment or funding. Current capitation rates and billing reimbursement do not support the full range of P-IBH staffing needs, infrastructure needs, program management and other related activities, particularly care management. State policy makers and public and commercial payers should come together and develop a standardized approach to P-IBH payment that will allow P-IBH to flourish within pediatric primary care.

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# Appendix 1. Evaluation Study Research Questions

1. How is the P-IBH program being implemented at the practice sites (including, but not limited to: training and culture change activities, practice facilitation meetings, PDSAs, behavioral health screening, behavioral health clinician service provision, service billing, implementing large scale telemedicine service delivery)?
2. How do practice IBH champions and other key practice staff experience the program at their sites?
   1. What do they see as facilitators and barriers to implementation, and why?
   2. What solutions did each site craft to address barriers?
   3. How do they assess the overall program, the individual components, and their ability to achieve stated goals?
   4. What are their thoughts about improvements or enhancements to the program?
   5. How do staff perceive the effectiveness of integrated behavioral health telemedicine services?
   6. Overall, how satisfied or dissatisfied are providers with the P-IBH model?
   7. What barriers or facilitators to patient or parent satisfaction with P-IBH did patients or parents report to providers?
3. How did the COVID-19 pandemic affect implementation, service delivery, and patient behavioral health needs and access to BH services?
4. How sustainable is the P-IBH program?
   1. How will each site choose to continue their P-IBH program, e.g., what components of the P-IBH program will sites continue or expand upon??
   2. What factors do or do not contribute to the program’s sustainability, including but not limited to: patient experience; financial viability; issues regarding staffing, workflow, technology, and space.

# Appendix 2. Evaluation Study Qualitative Interview Guide

| **Practice description** |
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| **Practice Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Practice type:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **How frequently do you screen for anxiety and depression in your pediatric patients?** |

| **Interview Guide** |
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| 1. **Project description:** Primary project aims, P-IBH program description, impact of P-IBH program |
| **Questions:**   1. What should we know about your particular practice to help us understand the environment or conditions affecting provision of P-IBH services? 2. We understand your program contains the following elements: [list them from their project description and confirm or update] Please let us know if anything I list is not accurate.    1. Basic elements: screening and other identification processes for behavioral health disorders; warm hand-offs; triage/referrals, treatment; care management. 3. Before the pilot, what was your previous experience with pediatric behavioral health? 4. Before going into this pilot, what were you thinking would be different about providing IBH for kids than what would be needed for adults? 5. How did your early vision for how the P-IBH services would be implemented match the reality of what you were able to implement? Let’s start with what you were able to do before the pandemic.    1. What changed once the pandemic was underway? 6. What impact has pediatric behavioral health integration had on your day-to-day work here at [clinic name]? 7. Would you say that participation in the P-IBH program with CTC has added to your day-to-day work burden, or relieved some stress in that regard? Why? |

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| 1. **Rollout and implementation** |
| 1. How did you decide to become a pilot site for P-IBH? Who was involved in that decision? What did you think when you first heard the practice would be participating in the pilot? What differences did you think participation would bring to your practice? (Concerns, anticipation, etc.) 2. Roll-out to IBH at your practice was two years ago. If you can recall, how did staff respond to adding P-IBH?    1. How did your clinic/practice get staff buy-in? (Probe for: role of project champions; role of practice managers/leadership; training; feedback mechanisms, etc.) 3. Where were/are P-IBH clinical services physically located before the pandemic, during the pandemic, currently?    1. How did/does that work out for the practice site regarding space usage, patient privacy?    2. For providers—do you feel office space is adequate?    3. For patients?    4. What were barriers to locating behavioral health providers at your practice?    5. If you had to do it again, what would you do differently? The same? 4. How have other elements of [clinic name]’s infrastructure (e.g., staffing, equipment, technology, financing) changed as a result of participation in the P-IBH pilot? pediatric behavioral health integration? The pandemic?    1. What infrastructural supports are still needed? 5. What has [clinic name] been doing right in your opinion, in implementing P-IBH? 6. What barriers remain for your practice in making P-IBH work well here? Why? How might these barriers be overcome? 7. What barriers do some of your patients still face? Why? How might these barriers be overcome? 8. What challenges do you think [clinic name] is/has been encountering in its efforts to fully integrate behavioral health into pediatric primary care? Why? How might these barriers be overcome? 9. You conducted a baseline of IBH assessment when you started the pilot using the Maine self-evaluation tool. Please tell us your baseline score—where you were at when you started the pilot. Where are you now? 10. Your project was implemented during the pandemic. What elements of how you thought your project would proceed were impacted by the pandemic?     1. What have you had to do differently than you anticipated?     2. What have you had to implement to accommodate P-IBH during the pandemic?     3. How have you dealt with warm handoffs during telehealth visits?     4. After the pandemic subsides, will you continue to offer telehealth for a hybrid approach? Why or why not? |

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| 1. **CTC-RI technical assistance:** Training and consultation; practice facilitation and learning collaboratives, role of CTC-RI/meetings |
| 1. What types of support did you receive from CTC as you planned for and began implementing P-IBH?    1. What elements did you find to be helpful?    2. What elements were not so helpful?    3. What else would you have liked to have had help with from CTC?    4. [If not already mentioned] What kind of support did CTC provide as you transitioned to telemedicine P-IBH visits? 2. [If not already discussed] Regarding CTC practice facilitation:    1. What elements of facilitation did you find to be helpful?    2. What elements of facilitation were not so helpful?    3. What else would you have liked the facilitator to have helped you and your practice with? 3. We know that maintaining adequate staffing is a problem throughout healthcare. What has your site’s experience been with turnover of staff involved in P-IBH?    1. How did you get new staff trained re P-IBH after the original staff in the pilot left?    2. What would be helpful to you in terms of durable training materials that CTC might provide?       1. E.g. short videos explaining P-IBH; tailored short videos made with your site specific to your site’s P-IBH processes; handouts; etc. 4. What did you think about doing the PDSA? How helpful was it as you implemented your pilot? 5. How has your practice’s participation in the Learning Collaborative affected your clinical practice?    1. What has been useful from the Learning Collaborative?    2. What aspects of the Learning Collaborative content have been challenging to incorporate into your clinical practice or seem irrelevant to your practice?    3. What do you think about your institution’s contributions to the Learning Collaborative sessions?    4. What do you feel is missing from the Learning Collaborative that will improve its applicability to your clinical practice? (e.g., maybe there are topics/content that you think should be added, etc. 6. What do you think about the level of support you’ve received from your practice leadership throughout implementation? During rollout? EHR modifications? During the transition to telemedicine?    1. How were telemedicine modifications paid for?    2. How did leadership help in sorting out billing issues? 7. What assistance would you have liked from CTC to help you make P-IBH at your site sustainable into the future? |

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| 1. **Provider roles and experience** 2. What impact has pediatric behavioral health integration had on your day-to-day work here at [clinic name]? 3. How has your day-to-day practice changed, if at all, as a result of [clinic name]’s implementation of pediatric behavioral health integration efforts?    1. *For primary care providers and behavioral health clinicians*: Where do you see assessing for and treating pediatric behavioral health problems belonging within the scope of the pediatric primary care providers’ job?       1. Ideally, where should the role of a primary care provider end and the behavioral health clinician begin? That is, what should be the parameters of the primary care provider’s role within the context of pediatric behavioral health integration? 4. *For primary care providers*:    1. How comfortable were you before the pilot P-IBH program in diagnosing and treating behavioral health problems (such as anxiety and depression)? Please rate your comfort level: *Not at all comfortable; somewhat comfortable; comfortable; very comfortable; completely comfortable.* Why?       1. How comfortable are you now, since the IBH program was implemented here? Please rate your comfort level: *Not at all comfortable; somewhat comfortable; comfortable; very comfortable; completely comfortable.* Why?    2. How comfortable were you before the IBH program prescribing psychiatric medication? Please rate your comfort level: *Not at all comfortable; somewhat comfortable; comfortable; very comfortable; completely comfortable. Why?*       1. How comfortable are you now, since the IBH program was implemented here? Please rate your comfort level: *Not at all comfortable; somewhat comfortable; comfortable; very comfortable; completely comfortable.* Why?    3. How comfortable were you before the IBH program talking about behavioral health topics with children and their families? Please rate your comfort level: *Not at all comfortable; somewhat comfortable; comfortable; very comfortable; completely comfortable.* Why?       1. How comfortable are you now, since the IBH program was implemented here? Please rate your comfort level: *Not at all comfortable; somewhat comfortable; comfortable; very comfortable; completely comfortable.* Why?    4. How did having an IBH provider in the practice affect your ability to treat patients?    5. What barriers to screening as often as you need to have occurred due to regulations from insurers’ payment for screening? 5. Ideally, what would your role be in an integrated model and how does that compare to the way you are practicing now? Why do you think that is? 6. How has pediatric behavioral health integration affected your sense of professional fulfillment?    1. How has it affected feelings of burnout?    2. What emotional supports (ways to enhance resilience, focus, and energy) are in place for providers involved in integration services? 7. Overall, how affected was your work life during the COVID pandemic?    1. How stressed or burned out have you felt?    2. Beyond IBH, overall, how did you feel about your ability to deliver the care you felt was needed?    3. What supportive resources were available to you and other staff during the pandemic? |
| 1. **Staffing P-IBH** |
| 1. In your opinion, how adequate are clinical staffing levels for P-IBH services to meet patient volume?    1. How adequate are staffing levels to meet patient needs? 2. How has workforce issues in RI impacted your program? What have been barriers, facilitators, best practices regarding hiring and retaining BH staff (e.g., credentialing, language, salary, training, finding appropriate applicants for IBH positions, maintaining MAs.) (PD, BH)    1. What has helped solve staffing issues? How helpful has your health system/institution/human resources department been in assisting with recruitment, hiring, onboarding needed staff? 3. Has your practice/clinic used bachelor’s or master’s level students to provide P-IBH? Yes/No    1. What has been your experience using bachelor’s or master’s level students to provide P-IBH care? |
| 1. **Decision Support:** Identification of behavioral health disorders—screening, other processes; decision support protocols and guidelines |
| 1. What are your decision support protocols and guidelines regarding f/up to screening?    1. Regarding discharge from treatment? 2. How do you determine whether the patient’s BH needs will be met within the practice or will be referred out? (Special populations, severity/dx, etc.) 3. Are sources adequately available for you to refer patients out to for all pediatric patients in all age groups? (Are there children/adolescents whose needs largely go unmet?) |
| 1. **Communication mechanisms** |
| 1. What are the primary mechanisms for communication between primary care providers and P-IBH providers regarding screening results and follow-up? (EHR, emails, calls, huddles, clinical team meetings)    1. How did the pandemic and a switch to telemedicine affect communication mechanisms?    2. Affect your satisfaction regarding communication and care coordination?    3. How do compacts or lack of compacts affect communication and coordination? |

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| 1. **Patient experience/engagement** |
| 1. Overall, how have your patients responded to the P-IBH services you provide here? 2. How did patient response change, if at all, when you transitioned to telemedicine? 3. I’d like to hear about some examples of where the P-IBH model made a difference for your patients. 4. How do you manage HIPAA compliance and patient confidentiality when providing P-IBH? What additional HIPAA challenges did telemedicine bring? 5. What have been challenges for patients/parents with P-IBH? (Equity, translation, technology, etc.)    1. When using telemedicine, how were you able to approximate the “warm handoff” experience to ease the patient/parent into P-IBH services?    2. What did find to be the positive impacts of having provided services via zoom during the pandemic, if any? 6. To what extent will you continue to use telemedicine now that in-person services have resumed? What factors will be in play? (Provider preference, patient preference?) 7. During the pandemic, there were periods when no co-pays were collected. How did this impact parents’ interest in P-IBH for their children? 8. How are you assessing or measuring patient experience with P-IBH?    1. With P-IBH and telemedicine? |
| 1. **Funding sources:** One-time grants, funding; billing/billing codes |
| 1. What grants, other funding sources did you have to develop your program? Were they sufficient? 2. What funding sources did you have to help transition to telemedicine visits? 3. Is there program infrastructure that still needs to be developed? 4. Has the P-IBH pilot been sustainable through billing? Why? 5. Have there been any problems around billing? Please give me some examples. |
| 1. **Measurement** |
| 1. How is your practice/clinic measuring P-IBH effectiveness?    1. How helpful is that to your practice?    2. How has your institution’s IT staff assisted you in producing data reports or impeded you in being able to produce the needed data reports? 2. What could make it easier for you to produce the data reports? |
| 1. **Sustainability** |
| 1. What are your plans for P-IBH now that the pilot is over (coming to an end)? (Probe—in what format, do you have adequate funding, staffing concerns.)    1. What components do you want to be certain can continue?    2. What would you prioritize for change?    3. What resources or actions are needed to ensure sustainability and/or make those changes?    4. What you need to expand your P-IBH reach to other populations, such as kids with chronic conditions? 2. How is your health system/institution involved in planning for financial sustainability of P-IBH? |
| 1. **Last thoughts and recommendations** |
| 1. Thinking back, what do you think are best practices for making the transition from traditional pediatric primary care to P-IBH? 2. How likely is it you would recommend that other pediatric practices transition to a P-IBH model? Please rate this likelihood: *Not at all likely; somewhat likely; likely; very likely.* Why do you say that? 3. Thinking about the grant and grant requirements, what recommendations would you make to CTC and funders as they look to expand the P-IBH program and/or develop other pilot programs? 4. Are there any other recommendations you want to make, or anything else you’d like to tell us? |

# Appendix 3. Lessons Learned by Pilot Practices in Interviewees’ Own Words

“Do it and measure it and then learn from it and grow from it.” *NCM*

## Pilot Program Components and Facilitation

**P-IBH needs ongoing monitoring to stay on track and help from CTC.**

“I do think that having that guidance and structure and support [from CTC] would definitely be important especially if you're just starting out. And even just to have them to revisit it later on--just to make sure like, ‘Okay are we still on the right track? Just to kind of keep it going and flowing the pace that it needs to, and also that you're running it with fidelity too. And so I definitely think having that support because you can go through your day and do all the things that you're doing and continuing and continue, and then if you don't have that timeline or that meeting set up I would imagine it can go astray pretty quickly. And that would not be what you would want for the program. So I think having their guidance and support throughout would be really important.” *IBH clinician*

“It's intense, and it's involved. And you think you need a lot more help than you thought you were going to need!” *Physician*

**CTC learning collaborative information and materials do not typically get shared within practices.**

Q. “So how does that information from the learning collaborative get generalized or promulgated across your sites? A. I don't think it does.” *Psychiatrist*

## Care Delivery Team: Patient, Parent, Provider, P-IBH Clinician, other Program Staff

**Teamwork amongst the practice staff is important for providing the best patient care.**

“I truly love my job. And I love being able to help families and like, you know, our future, right? Someday these kids are going to hopefully be like, ‘Oh I remember Nurse [name]. Like she helped my family. But it's so important to kind of give back and learn from it, and I love my practice. We're really--we're unique. Liz can vouch for that. She often will say, ‘You guys really work well together.’ So that makes it easier.” *NCM*

**Special consideration must be taken for both language needs and trust when working with immigrant families.**

“I don't know if I should call it trust, but it's question. You know, sometimes maybe you have to do a little bit extra. Maybe you'll meet with the parents together at the beginning to accommodate. And then next time when they feel comfortable with you they just say, ‘Okay I'm just here to’‑‑this is‑‑you know, like I guess you dance around it. You're not wrestling with the parents. And they just say, ‘I want my kids to work on‑‑they're not good in school’. Or ‘They are not performing well’. So you'll meet them in the middle. Okay, let's‑‑’I'll work with you on that’. Then you get a chance to meet with the patient alone. Then you do what the patients need. *P-IBH clinician*

**Provider buy-in to the P-IBH program is essential to success, but at times challenging.**

“So primary care - I expected it would be like wide open, welcoming the program. Then I felt when I came in, I'll talk more about IBH. It's sometimes felt like you're almost pushing yourself [on the providers], and it's something like, ‘I have to do this huddle’. Or I have to do the warm handoff. So sometimes I felt it's looked at as an extra to be done by the PCP's, or I'm going to say, by staff in general. I mean the administrative, they want IBH. They're always advocating for it and talking about it. I don't know if it's just the workflow, the work quota, so many factors, but I felt like are we chasing the PCP to have the huddles. I felt like it has to be [recognized as] a good thing. ‘Let's do this!’ You know, that excitement I have about IBH. But in reality, you almost have to be laidback, and you know, obviously when it comes to work nothing is personal. It's a business. But you always go and explain [about P-IBH], and again and again and talk about it, and come to it from different angles.” *P-IBH clinician*

“You need to make sure that the provider itself also believes in the program, you know, for it to be successful. And I think it starts from--not only from the training, but from a provider perspective, from huddling. I think the huddles are huge itself. We also have monthly meetings that [the IBH clinician] used to come as well with our teams to talk about things that are going well, things that are not going as well and how do we actually make it better. And then we also talk about those patients that will keep us awake at night. And some of them actually have comorbid behavioral health issues that, you know, she came into that meeting, and she also was like, ‘Okay. So I will follow-up with with John Doe about this and I haven't seen him.’ So that's also important as part of the team.” *Site facilitation team member*

**Patients trust the medical practice staff to direct them to the services they need, so IBH within the practice is an ideal model for patients’ comfort.**

“I think they may not always know that we have someone in-house, but if they bring it up to me I will, you know, do my best to find--even if it can't be [P-IBH clinician], you know, they know that just with their experience of our practice like we--we really, really try our best to get patients the services they need.” *Physician*

“I think having somebody available during their working hours, I mean the great aspect of mental health and insurance would be somebody on call, but I do refer them to Kids Length through the Bradley, the twenty-four hour access line, that, you know, if you feel your child is not safe because I'm not available 24/7, if you feel your child is not safe you can call this number, and the access line can tell you like what to do or maybe take your kid to Hasbro or Bradley. So I have done that. But it would be nice to have somebody there during the working hours. I think it's a benefit. I mean I do think this way you're already coming to a place you're familiar with. You're familiar with your pediatrician. You've been going there since you were a baby probably. And you know where it is. You know the hours. You know the people. You're comfortable there. And this person is there. So you don't have to go somewhere else after or go to another building, travel somewhere else, and you're already comfortable. You already know it's here. It's accessible from a comfortable place. It's like you can do this. You know? At the doctor's office where you go to all the time. And you can do it before your hockey practice.” *P-IBH clinician*

“I one hundred percent would recommend it. I think that it makes you a better practice because you'll be able to provide for your patient right then and there. So that loss of time in between A to B--it's almost obsolete. So it's worth it. Every practice is different. And whether you choose to hire within or contract or via independent, I think that whatever works for your practice--anything is better than nothing.” *NCM*

**Employ staff to fulfill all roles related to P-IBH is important and new strategies may be needed to accomplish this.**

“We tried having MSW level social work, and it was and honestly in our adult we don't do any billing because the logistics of billing are a barrier to just helping to problem solve for high risk patients, high acuity needs and things like that. But yes, could there be a benefit for somebody that's not quite licensed and just the bachelor's in social work? Yes. I think the bigger thing that pediatrics needs and something we're actually in the middle of is a big redesign within pediatric care management. I think we need somebody that's even a behavioral health coordinator, behavioral health navigator, somebody that can track all of the behavioral health referrals and make sure that they got their [services].” *Site facilitation team member*

“So that's been the experience in our adult practices is we have all three levels. We have the bachelor's level. We have the no degree or associates level. And then we have our licensed clinicians. And I think it's a marriage of all of those things, to be honest with you. I think you have to have all three. And in pediatrics we even have the fourth, because we have the psychiatrist. So we’ve really got four levels of care.” *Site facilitation team member*

“I need the billing. In order to support the salary when we started this project two years ago I already had 60 hours of care coordination in the office. We had a nurse care manager of 40 hours a week. We had a parent consultant at 20 hours a week. And so when we looked at what behavioral health niche we needed filled with a social work clinician, it really was the warm handoff quick treatment, stabilize, move forward, and so we were hoping to have booked our social worker 60%, 70% clinical, and then the rest would be care coordination because I already had the care coordination in those other two beautiful employees. They both left. Our parent consultant retired last week, and our nurse care manager left for another job last month. And so now I have no hours of care coordination. And so that also is another challenge and does change what we're looking for in a social worker. And it gives us ‘every closed door has a little window open’, right? So, the window here is, okay, let's look at what works with those 60 hours. Look at what didn't work. I think our job task distribution was not even, and we overworked our nurse care manager for things that should have been done by the parent consultant for a variety of reasons. And let's re-envision what we want in a social worker. I still think billing is going to have to be a part of it because the other piece of this, as you know, through the pandemic is the salary requests for social workers has gone up ten to fifteen thousand dollars. I could barely afford what the market rate was before the pandemic. I can't afford on my own without grants. I can't afford to have a social worker. Now I realize penny wise pound foolish. I hear my grandfather. You can't afford not to have, and I get that too, and that's the bubble I'm straddling right now is how to financially afford, emotionally afford what jobs do we have. And that's my work task for this weekend. I know [another practice leader] has done a ton of this work already. I want to catch up in my own thought processes before she and I cross pollinate what we each have been thinking. And let's figure out what we do especially as we have a candidate to possibly interview next week.” *Physician*

## Education, Training and Practice Preparation

**MAs are often the linchpin to ensuring providers are aware of patients’ screener scores, and with high MA turnover, they must be trained and reminded about this critical part of their job.**

“How the workflow goes is that for high screeners, the MA would alert the provider before they go into their rooms, saying like ‘Patient A has a high GAD, or has a positive CRAFFT’. Letting the provider know so that when they go into the room that's what they can speak on and recommend that the patient see IBH and if they can have [an IBH clinician] come into the room after their appointment. So it's kind of like the MAs speak to the provider. They do review all those clinical screeners beforehand. And at that point the MAs wouldn't have enough time to abstract all of them into the template. That's why that conversation piece to let the provider know what's a high screener and what's not [is essential].” *QI staffperson*

“Our MA's definitely focus on question number nine in the PHQ9 that talks about suicidal ideation attempt. That's a big red flag. Also for the SDOH screener when it asks about if you're feeling safe at home‑‑that's another question that we focus on. We really want to make sure that those questions never get missed. So that's like things that they're kind of like looking for and red flags so they can tell the provider before they come into the room. It's also like a training piece. And that's kind of why we're doing a retraining for all the providers and MAs of what's the best way for them to get that information and different access points. *QI staffperson*

**Physicians must be reminded to look at the screening results.**

“So it's not just the template [in the electronic medical record]. They can actually look at the pdf [that automatically loads into the record]. So they can review some of the questions. That's one thing that I want the providers to focus on just in case the MA forgets to mention that they have screeners. ‘You still have the responsibility to look at those pdf's to review the screeners before you get into the room or when you're in the room with the patient’.” *QI staffperson*

“Every Wednesday the providers have their own lunch and learn time. It’s become a great opportunity for IBH to kind of go in and not only provide training on what IBH is for the newer providers but also talk about things. You know, if there's specific patterns we're noticing or training needs, things like that. We're really trying to get in there and prevent [missing patients who screen high] from happening.” *IBH director*

**Ongoing or periodic training is essential.**

“This is actually an ongoing discussion we've actually had, and it's funny because when we talk about training like we try we do all these initial trainings, but really it's a lot of--it's ongoing all the time training and just reorienting staff with all of the changes that we've had, but--and then new staff turnover when people leave, you know, just remembering is part of their onboarding that we need to do a training on these specific things and helping the staff understand why, so how important it is for the clinical screeners in a medical visit, you know, because I think sometimes people come in they don't understand the integration. So but yeah we actually just had this discussion again. We're going to do a training with the MA's specifically in a couple of weeks.” *IBH director*

## Information Technology

**It is important to recognize when simpler may be better. Sometimes paper trumps digital devices. Completing screeners on paper can turn out to be simpler and quicker than doing the screeners electronically. Reviewing charts quarterly may be more efficient and more accurate than doing an EPIC report.** *[quotes not included – these points were explained by a physician champion]*

**Harness IT and create protocols to effectively track patient care.**

**“**Track people that have been hospitalized. Use the closing the loop report to help identify needs and make sure that people get scheduled for follow-up appointments. Even if they aren't the clinical person, we can create protocols and workflows for this person to do to ensure that the behavioral health needs of the patients are being met. And yeah, you could hire higher level, however, higher level is a much higher cost, and we've seen that even something of an advanced medical assistant can do some of this type of work very effectively. *Site facilitation team member*

“Start with good framing and expectations up front. Make multiple points for check-in to see how things are going, and be ready to change when they're not. And build things early on that will help you capture the data to tell the story to your clinicians, to your executives, to everybody about the value and to help ensure the sustainability over time. So be ready to track outcomes from day one.” *Site facilitation team member*

## Clinical Processes, Workflow, and Practice Philosophy

**Screening is essential for good patient care.**

“Do I think once a year is enough? Obviously not for some kids. I also think that we have plenty of kids unfortunately who come in, screen negative and end up in the ER in mental health crisis in the next month or two. I mean that's happened as well. So how good are the screens at preventing crisis in a very dynamic time of life when things happen and can throw you over the edge? I don't know the answer to that either. You know, I think to me screening once a year also has the important message that we care about your emotions and your feelings, and this is part of why you could come to the doctor if you have concerns. So, leaving that door open, you know, this is part of your health, and we can help you with it is sort of part of the message. And we talk about that when--you know, you'd screen even if it's negative. You know, it look like you're feeling well today. This is great. But we know this is a really tough time, and a lot of people are struggling. Give us a call if you need some help. So, I think in that respect for many kids once a year is okay. But I would love to really have time set aside for just a visit about feelings, just a visit about stress and feelings and emotions I think would be very helpful.” *Physician*

**Ways must be found to ensure that adolescent patients complete the screeners themselves instead of their parent doing it.**

“You don't know really if the kids complete the screeners. I had a few patients who would say ‘I've never seen this before’.” *P-IBH clinician*

**Set up staffing, workflow and workspace to facilitate the best of the P-IBH model to foster close collaboration between medical providers and IBH clinicians, and to provide private space for counseling. When the P-IBH clinician is very visible in the practice, collaboration with medical providers is enhanced.**

“And for the past year that's when we started to actually have a separate department [for IBH]. IBH now - it's separate from outpatient. We get more into working, going back to the huddles with the PCP's, which I think, it's been going really well. We have a student from RIC who did a project. And the data - it's showing actually there is a correlation between the huddles, and it creates warm handoffs, which we thought was great.” *P-IBH clinician*

“That common workspace has been very valuable for us in terms of good communication. … But the discussions and the decision-making process happen more with the flow of this clinic because everybody is in the same room. So I may come out of a session, and there's an issue around medication. And so I grab the attending, and we talk right then. You know, and I can do the other way. I can bring the attending then into my session, so it goes that way as well. But those happen in that common room where we are. I think sometimes at lunchtime if we have a little more time then. Certainly, you know, during the teaching time when attendings are teaching residents these conversations happen.” *P-IBH clinician*

“Got to have a room. Got to have a room. Even right now we share a room, so the social worker and I will switch off who makes the calls so we're not speaking over one another. But yeah, you've got to have a space with a couch or family room. We don't actually have a family room.” *P-IBH clinician*

“I'm a big believer of relationships. I think when you start any job you have to build a relationship with people. Sometimes when we were all here I'll make an effort, you know, every one hour, I'll get up for five minutes for just, you know, small talk. ... So I believe relationship comes first. If you don't know who I am, if you don't have any clue, I fear it's hard to follow because if I don't know you... I think human contact is a huge impact.” *P-IBH clinician*

**When understaffed for P-IBH such that clinicians have to prioritize their time for huddles, focus huddle time with medical providers who have had low rates of referrals to IBH, or the most concerning patients on the day’s schedule.**

“One of the clinicians will go to the huddles with the primary care. I mean we're not huddling with all due to we don't have enough. The ratio between IBH clinician and the primary‑‑it's a big difference. If we huddle with each one, we wouldn't be able to really see patients. … All the referrals for behavioral health come to us. So we triage it. And so we're looking into the number of the referrals, and we see if the PCPs usually have a history of asking for warm handoffs, doing the referrals. So we're doing the huddle with the new doctor [who] seemed new to the IBH. We did some training, but we felt like one training - it's not enough. You have so many things you're dealing with. So we started to huddle with her. … She likes the idea of ‘care coordination’ with multidisciplinaries, so she likes the fact and always appreciates us for the service we provide. I mean the reality sometimes is if she has 25 patients a day‑‑and to huddle for fifteen minutes‑‑we experience some issues with time let's just say. Not every day it's going smoothly. But we always are trying to make the best of it, and lately we talked about how about if when we huddle we're going to discuss just the one that they having concern for, or something is going on besides that if somebody scored a five or plus on the universal screeners either the PHQ A or the GAD or the CRAFFT. Then that will be automatic warm handoff unless if the parents‑‑or the child‑‑they don't want us to be seen. So that was what we started doing. If there’s time, we'll go through all the patients. If not, we'll discuss just the one they might be a potential warm handoff or we have some concern or they’ve been involved with behavioral health before. We're also looking for the screeners. Let's just say they score 10 last time, but for whatever reason the screeners were missed or were not seen…” *P-IBH clinician*

**Put workflow structures in place to ensure follow-through for patients who could benefit from P-IBH, starting with pre-visit planning.**

“Pre-visit planning. So we'll go into the PCP schedule. Ideally the day before, the night before we look in the patient who's coming in. We'll look into the record. Then if we end up not huddling we'll send the message‑‑you know, instant message through that (inaudible) so this is the patient that I've noticed‑‑like let's just say they're missing or they scored very high on the PHQ9 when they were here last time. They have a history or any communication that we can provide to the PCP for potential warm handoff. And that would be it. Sometimes we get the warm handoff, or we get the feedback from the PCP. Okay I've talked to the patient, not interested. Or seeing somebody outside. But sometimes you don't get any. They basically forgot about it. And it'll be that.” P-IBH clinician

“We generate reports on pre-visit planning. So we'll check through the patient panel of the next day for that provider, look for like behavioral health history. We'll look at diagnoses, look at anything clinically significant that we spot that might be helpful for the providers to know or that we want to be sure to be available for when that patient comes in for the visit. So we'll internally in our IBH team communicate that with each other.” *IBH director*

“A lot of the time we actually catch in our registry report that we've created where we're seeing all the kids that were screened for the prior month. And then if we see that there are kids on there that have high screeners and we don't see that there's an IBH appointment, or we don't see that there's like a behavioral health piece in the registry, we're going into those charts and looking and seeing, ‘Okay, what happened in that provider visit? How come we didn't get the referral?’ So the registry even though it's kind of a monster still, it's been helpful for that.” *IBH director*

“So if really if [the providers] don’t tell us [about positive screens] we wouldn't know. Sometimes we’ll audit, and for the project now we have monthly meetings. We'll just like, ‘Okay I have some time today to check in.’ Then I'll just send out a message reminder to the PCP ‘Oh I noticed so and so, the GAD still isn’t completed. So you get an answer usually. Patient refused, and we have a way how to document refuse. Then you'll just say ‘Well if you can please document it?’ ‘Well we forgot.’ ‘Patient was running late.’ You'll get some type of answer. Then our nurse care manager will put into the follow-up appointment, in the details, that extra layer like the patient needs a GAD, and you're hoping next time when they come in they complete that.” *P-IBH clinician*

“Just train again the MA about where to look, just becomes part of a workflow. Any time you checked in the patient you just have to go check here [for the screener results], and you provide this to the PCP. Then if the patients don't want to be seen, that's okay. But at least we want to discuss it because it's dangerous to screen patients and don't say anything about it. Liability. And it's also no good. Let’s just say the patient did [the screeners], took time and you’re defeating the purpose of screening. It is like a funny commercial about dental. The patient went and said do I have a cavity? Are you going to fix this? [The dentist said] ‘No my job is just to tell you have it.’” *P-IBH clinician*

**Use triage processes within staff to enhance efficiency of care delivery. One practice hired a social worker for immediate crisis intervention, to make phone calls for external referrals, and to address social determinants of health needs. This saves the P-IBH psychologist’s time for patients who would benefit from an IBH counseling series.**

“So I've always pretty much identified as a person who triages. I'm here three days a week. I have more availability. I don't really have a schedule. And so the clinic specifically had that need for the social worker to be available more openly versus to meet people in an IBH role which is why we have Janet [psychologist]. [Psychologist name] does therapy. I do brief assessments and crises intervention.” *Social worker*

“I personally talk to the doctors about things to look out for, you know, and just ways to engage with the kids and‑‑not engage with them but you know just talk about the answers and then figure out if this is really somebody who needs therapy, and sometimes they even bring up therapy. Do you want some resources? We have some here. Do you want me to give them to you? Oh no I don't want to talk to a therapist. And you know, it's like a tiered, right? Okay I'm going to ask this question. If you say yes I'm going to ask you this. If you say no then there's other questions. Okay you don't want a therapist. Would you still be open to our social worker calling you just to see if they might be able to offer some support. So yes that's usually how it breaks down.” *Social worker*

**Acknowledge the level of need in the practice for IBH services, hire sufficient clinicians and support them to avoid burnout and turnover. Encourage teamwork. Ensure the clinician that is hired is right for IBH.**

“Sometimes you end up hiring the right person for the right job. And that really is what sometimes makes that pilot actually a success.” *Site facilitation team member*

“You need a desire, yeah. And just part of your personality is who you are because it's fast paced at times, and you've got to challenge sometimes physicians on old thinking, and you just really have to be kind of sure of yourself I think as a professional, which is hard for social workers.” *P-IBH clinician*

“Be a team. And have an idea of what you would expect from a clinical social worker - not a caseworker who just does DHS applications, but you have someone who can assess for safety, and this is what safety planning looks like. And it does take an hour. So be willing to sacrifice that time and everything for the patient.” *P-IBH clinician*

“The people are going to matter. … I do think that there needs to be--the team maybe, like having a team of clinicians there might be nice for practices. I think one of the other things maybe making sure that prioritizing having time off or doing your in-service and things like that or taking time for you personally and professionally. My place did that. But I don't know if all practices are like that. So making sure that they're able to take care of themselves so that they can take care of others.” *P-IBH clinician*

“Have the funds, and respect the social worker the way everyone here has. They don't just look at me as non-medical. They value my input.” *P-IBH clinician*

“I think we quickly learned that we couldn't have too much of an IBH clinician. You know, we could certainly use more than one.” *Site facilitation team member*

**Recognize the importance of understanding social determinants of health, and how to address them while preserving patient dignity.**

First, it means not just focusing on the negative, the stuff that's going bad. It's also asking about what are you proud of. What are you good at? What's going on? Or ,who can you go to when you're feeling sad, or who knows when you're stressed? Or how do you tell people that you're stressed? And I think what you uncover is all sorts of pathways to supporting families other than just connecting them to a provider in the community. And I think it's also to me--far more respectful of families to recognize--I'm thinking about with our screening for social determinants of health, for years. I am very happy that for years [practice site] has been doing screening for social needs and connecting with families. But for many years all we used was a checklist of deficits. Do you have a problem with housing? Do you have problems with food? Do you have a problem with diapers? Instead of starting with what's the most exciting thing about being a new parent? Or what's the wonderful thing that your child did yesterday? Or what do you love about being a parent? To really couch our questioning of family needs in a way that acknowledges them as people with strengths and abilities and, you know, potential solutions rather than just making a checklist of what they don't have and saying here's a list of food pantries.” *Physician*

## Cost and Sustainability

**Support of IBH clinicians unattached to billing would create stability in services.**

“That would be ideal if they're willing to support the position regardless of how much money you bring in, which probably it might not be possible in smaller practices. But in group practices they're showing it's possible, at least for ours. So I think it's worth it because you'll get quality clinicians who want to do the work and want to stay.” *P-IBH clinician*

“[It] would be great if the insurance companies paid for social workers in all the offices like they paid for nurse care managers in the beginning of time. Funding is an issue. And when this care is done right in the medical home where the trust is, it can save money down the line. So, it would be great to have a steady funding stream specifically for salary and fringe support as opposed to on a per visit basis, because there's so much care coordination that can't be charged out on a fee for service world. So, whether that's value-based contracting that has a behavioral health component, or I don't know what. But funding is an issue for sure.” *Physician*

**P-IBH is invaluable.**

“I think the returns on investment in mental health are really clear. These are children. They're the ACE scorers, adverse childhood events, and we know very clearly that children that have higher ACE scores have more challenges and more expensive healthcare needs as adults. And so, as a layer of prevention, addressing those stressors in a child's life are very, very important. Like everything else in pediatrics, return on investment is not going to be in 90 days. Investing in a full healthcare team which includes nurse care management, school support and mental health support is key. And that money just needs to be invested. We know that the payoff may not be to you insurance company, you foundations, specifically, but it's going to be a payoff to the society at large, and that's really, really important.” *Physician*

# Appendix 4. Warm Handoff Processes

All participants asserted that warm handoffs between the medical provider and the IBH clinician, where the provider introduces the patient to the IBH clinician in person at the time of the medical visit, are a component that can have a strong influence on patients’ acceptance of mental health care, and therefore are an important contributing factor for successful P-IBH. As a practice manager explained, “And people like to see a face, and like to see, just you know, is she warm? Are the kids going to connect with her? Things like that that they want to see for themselves, which I think makes it more successful.”

Participants noted that at times adolescent patients can be reluctant to agree to mental health care due to stigma or misunderstanding of the benefits of counseling, so actually meeting the IBH clinician within the context of a medical visit is extremely helpful. A physician assistant asserted, “She speaks to them on their level. I think that just kind of breaks the ice with a reluctant patient. . . So with the patient who is not yet willing to admit that there is some sort of mind-body connection here going on with the anxiety and the stomach pain, the anxiety and the headaches, or the school avoidance and the depression. So the reluctant patient often has a lot of misconceptions about what therapy actually is. And the warm handoff can be really useful in terms of putting a person in the room with [the IBH clinician] and actually letting her explain what she does.”

A provider explained how the warm handoff is also helpful in alleviating parents’ misconceptions about mental health care. “I chat with the mom and patient and say, you know, we have a clinician right onboard here. If you give me a few minutes, I’ll go out and see who’s available. And they come in and they speak with them and make an appointment right away and get things rolling.”

Most, but not all, of the practices were able to conduct some form of warm handoff, at least some of the time, even if it is just for a minute and the P-IBH clinician “pops in” to meet the patient and say that they will call the family later.

Due to varying practice staffing and workflow processes between the sites as well as within each site over time, and also in part because of COVID pandemic interruptions to in-person care and the concomitant uptick in patients needing mental health care during the pandemic, sites were not always able to consistently implement their own warm handoff protocols, and the frequency and means of warm handoffs differed among the practices.

When patients were shifted to telehealth during the pandemic, some practices eliminated the warm handoff altogether, and others attempted to provide a semblance of warm handoff with telehealth though few were completely successful with telehealth warm handoffs. During telehealth, one provider explained how beneficial it was that the IBH clinician was actually able to join the patient on the virtual visit app at the end of the medical visit: “All three of us would be there at the same time and be like, ‘This is [P-IBH clinician]’ and then she would have her little spiel with them, and we would head out.’” Another site had this capacity, but found it to be too time consuming so they resorted to just having the IBH clinician call later. Participants did note that when their usual warm handoff was not possible because of the switch to telehealth, they were at risk of losing the patients’ and/or parents’ commitment to accepting IBH care because of the delay between the provider talking to them about it and their receiving a call from the IBH clinician. Another practice that does not have an IBH clinician on-site every day is considering starting to do virtual warm handoffs going into the future.

In some practices, periods of time occurred when there was no P-IBH clinician on-site or even employed at the practice, and so providers became unaccustomed to seeking a warm handoff. In these cases providers had to be reminded and retrained in IBH protocols when a clinician became available. One P-IBH clinician noted that in their practice, despite the availability of the IBH clinician, providers seem to prefer to simply send the screeners to the clinician at the end of each day:

“[We’re] having problems with warm handoffs, especially since the pandemic and return to offices. [The P-IBH clinician] is very visible, does her notes in the workroom, attends huddles, attends monthly provider meetings. We have to change the [MD] culture around warm handoffs. Liz was helpful in providing suggestions.”

And a social work supervisor at another site noted, “Any time we get a new IBH person it is really hard to get the providers to kind of do a warm handoff with somebody.”

# Appendix 5. Stories from Participants about the Impact of P-IBH on their Practices, their Work, and their Patients

**Skilled, collegial, engaged P-IBH clinicians are essential – hire them or develop them.**

*Physician:* “And then we also had an amazing IBH provider. So that definitely helped the situation as well.”

*Program Director:* “After [the new IBH clinicians] had adolescents that benefited from meeting with them, then they went, ‘Oh, I guess it is important to do this.’ I think that's what opened their eyes a little bit more.”

**Physicians felt supported by the IBH clinician.**

*Physician:* “I mean definitely a sigh of relief--I felt much more well supported when I knew I was going to a patient that I, you know, wasn't quite sure I was going to know how to handle or didn't know what I was going to do in terms of where I was going to send them or what kind of resources I was going to provide them for. I mean it was nice to know that you had someone in your office that could touch base with that person, that could help you take care of that person in the acuteness of it all. “

***It is easier for families to agree to IBH than to seek outpatient behavioral health.***

*Physician:* “We could start with her and have her kind of meet you guys and assess and kind of just give you some strategies and some feedback and then take it from there, and they almost always would say yes to that versus being like you need to go search someone out. Here's a contact list. You need to call. You need to make an appointment--that kind of stuff. This felt so much more easy for them to do and so much more doable for a lot of our families that sometimes struggled to do that other stuff that requires a lot more effort and time and work. ... But there was familiarity, familiarity about, you know, how the office runs, who's in the office. This is someone that we trusted in our office. So I think it was--honestly I think it's an essential service. I mean I hate that we don't have a provider right now. I think we lose a lot by not having one in the office.”

***P-IBH is important to have when the patient is in a behavioral health crisis; screening can identify a previously unknown crisis.***

*P-IBH clinician:* “Yeah, she was 14 years old, Hispanic family. PHQ9 was concerning. So we did some very general safety planning. I think I was able to connect with the kid because I've seen them like four times since then. They call me. They follow through on the safety plan. When she's feeling dysregulated, they'll come here in person, reassess. She'll use a statement from our previous meetings which is a reference of our conversations. So I'm like, ‘You thought about what we talked about, really cool.’ And then I was able to connect them with emergency psychiatry. And she already had a therapist, so I didn't have to do that. But yeah we built rapport. The mother knew she could call me, and she knew that I would share everything with the doctors. And I'll see them at their next visit.”

*Physician champion:* “A child--12 year old or so who I don't see very often because she's pretty healthy, who is adopted but was in foster care with her brother for about the first six or seven years and had multiple placements. And you know, very supportive family, things going well, she's a crowd pleaser this young person. She said once she had some therapy during some of these transitions, and she said that she didn't find it too helpful because as you know, ‘I just say what I know people want me to say.’ She's agreeing to make people happy. So she does that with me too, right? But on the screen [during a telehealth visit] she was able to tell us that she was not happy and was actually suicidal. So we were able to get her sort of an emergency. What we love to do is use the screen so we catch people before that, feeling that badly.”

*P-IBH clinician:* “I encountered this teenager who the diagnosis was dissociative identity disorder. And I've never worked with that population. We were just learning about this person and just trying to work with mom. Mom was very stressed. There was obviously a trauma in the person's past. And they were going to go to court. And the mom didn't want them getting dissociative all over again. And trying to integrate the personalities and [they had] at least five or six personalities: some female, some male, a child, an animal. And all the readings are telling me like this is dissociative identity disorder. I'm concerned. So I referred her for medication. They met with the nurse practitioner. I think mom got her own therapy. I just did a lot of research. I read a lot of books. I read the child appropriate books to this person. I got special dolls, and I think near the end it helped. And I'm sorry I don't see them anymore. I don't know how it ended up, but like I put in a lot of work, and I think it helped. And it made me feel good.”

*Physician champion:* “We had an 11 year old-another family that I've known forever-who's lived with her single mom who was a teenager when she was born. They've had really nice family support. They lived with mom's grandma. And they've done really well. And this kiddo started getting teased in fifth grade for being fat and became suicidal and came into my office saying that she really was thinking about hurting herself. And it was lovely because [the P-IBH clinician] came in and talked to them. They met with [the P-IBH clinician] officially later--they had an appointment with her later in the day. [The P-IBH clinician] was really able to diffuse the situation and follow her a little bit and reach out to her a little bit over the next week or two. And it really actually went very, very well. And I feel like we avoided the dreaded visit to the behavioral health folks and the Hasbro ER, and got her settled and doing well, and it really just went very well. I mean it could have been just such a disaster because she wasn't interested in contracting for safety, and we were going to end up sending her down to the emergency room. And it was going to be a nightmare. And we avoided all of that. Yeah, and she did really well.”

*Social work supervisor:* “We had one where a parent really didn't believe mental health issues were a real thing. But when the questions were asked for the PHQ, the teen indicated that they were highly suicidal. I mean like you couldn't have missed it. If you looked at the score, you'd be like, ‘Ah, we're going to send him out right now.’ And he had a previous suicide attempt also. So this was somebody that if we had missed that opportunity to be able to provide education to that parent in the moment, even knowing they had a previous suicide attempt, still didn't believe in mental health being an issue. Well that person allowing her child to come back and meet with the IBH clinicians I think is a success in itself. The person is still suicidal. They did end up in the hospital. And then back out, but the process I feel like worked enough to allow that child to get services because IBH kind of allows the kids to come in without needing both parents' consent in the same way that you would need for an outpatient traditional counseling. So I think it just allows for a different type of availability for the same kind of level of skills and education to both the parent and the kid.”

***P-IBH is helpful and convenient for non-crisis behavioral health issues.***

*P-IBH clinician:* The ones I really enjoy is general anxiety, maybe some school bullying, because those are really [actionable]. And I can get a release for school, coordinate with the school social worker, provide incident report forms to kids, provide some confidence, sort of therapeutic dialogue with kids as far as, you know, ‘You can trust adults in this situation. You're not a tattletale. You're not a rat. It's not going to make things worse. If it does, you continue reaching out to us.’ It's a great integrated team here because of the way I've been able to insert myself with the doctors, and they've developed that trust. They know that they can depend on my assessment.”

*P-IBH psychologist:* “Well, there's a little 7 year old that I'm working with who has had high level of separation anxiety, and she and mom were in for a well child visit, and the doc recognized the level of anxiety for this child and mom was talking about she's not sleeping; she's not going to bed. So I was able to take her on. This was pretty early when I was coming on--was able to take them on and then be able to continue to work with them, and support them, and doing the family therapy with some CBT work around her anxiety and around the separation anxiety as well as some behavioral reward work, behavioral chart reward work with them as they also transitioned to a new home. And this kiddo is actually doing quite well right now. And so being able to check in with the physician around the progress and what was happening to let them know when she was coming back in for another medical visit. I think for the family it would have been harder if they had been referred out rather than coming into this clinic which is where they were familiar and where this child with her level of anxiety was familiar coming in. So I think while that doesn't sound like any great dramatic difference than an outpatient therapy, having it within the medical clinic allowed this family to access care. But it's over a few months because we were able to space out the visits in a way that worked within the clinic and allowed her to keep both individual work and the family therapy--allowed her to really make the progress that she was able to make. And again so the major thing with that is that she was coming into a familiar space. It was easy to come into. She knew the docs. She was familiar with the offices. And it was easy for me to work with them, and they also made an easy transition when we had to do a couple of zoom sessions and could keep up the treatment.”

*Assistant medical director:* “Some of the remarkable stories I have is, kiddos who are being bullied. I think she recently had moved from Puerto Rico, was living with her mother and brother and also her father. And the long story short mom and dad were going through a divorce. And it's not that they weren't paying attention to her. It's just that they were more focused on addressing their marriage issues. And it started affecting her in school. And eventually she started hurting herself. And she started having some marks on her arms which we identified during one of our exams. We took mom out, and we went through a questionnaire with her. And at that point, you know, we identified that she was having some depression, and she was also hurting herself because of the consequences of mom and dad actually getting the divorce. And immediately we ended up having her behavioral health clinician come in, intervene and had a couple of sessions with her and eventually referred her out. So it took a couple of sessions to really break that ice, you know, and for them to be open to actually seeking further medical management and also therapy. But the remarkable thing was that when I did that warm handoff, our behavioral health clinician connected well with her. She opened up with the clinician, and then she coordinated, you know, several visits with her, and they actually did an outpatient--and then she did a referral to one of our therapists upstairs for therapy, and that process we continued to address those barriers with dad specifically that was open to it, and eventually he noticed that not only she was indeed depressed, this was an issue for her. And this now was affecting school, and now she was hurting herself to the point that one day she could actually kill herself. ... We did a warm handoff. Immediately one of the behavioral health clinicians came in and talked to her, immediately intervening, and she followed with that patient for about three sessions. And at the end of the three sessions they coordinated appropriate referral. And she did better. You know, during the summer she ended up passing [her classes], and she came back in the fall, and she was looking forward to going back to school. She said that she had gained that trust in herself to be successful in school.”

*Physician champion:* “And she ended up meeting with [the P-IBH clinician] multiple times after being resistant to going to counseling for years. Ended up deciding that maybe an SSRI would help. It seemed better on an SSRI and better with counseling, and she did really, really well.”

*Program director: “*This girl was going through a lot of trauma. And she was here the other day, and she looked totally different. I don't know the whole story about her. But I know she's been seen in behavioral health, and she saw the IBH clinician. She's being treated [in outpatient behavioral health]. And she looks totally different now. She looks like a happy kid. Before she looked like a miserable little brat.”

*P-IBH clinician:* “The ones I really enjoy is general anxiety, maybe some school bullying because those are really (inaudible). And I can get a release for school, coordinate with the school social worker, provide incident report forms to kids, provide some confidence sort of therapeutic dialogue with kids as far as, you know, you can trust adults in this situation. You're not a tattletale. You're not a rat. It's not going to make things worse. If it does you continue reaching out to us. It's a great integrated team here because of the way I've been able to insert myself with the doctors, and they've developed that trust. They know that they can depend on my assessment.”

***Primary care providers feel they know their patients well, even without screening.***

*NCM:* “So for the most part the people that were really depressed--we knew they were depressed. It was good they got the actual screen and they got the care that they needed, but I don't think I picked up on anyone that would have been a shock. Because even some of the ones you would get on phone, they still weren't interested in coming in. They didn't want to—‘No, no, I'll be fine now.’ We ended up having them back into doctor visits, but we didn't end up like--no I have no stories. I'm sorry.”

***Children’s mental health benefits when their parents receive treatment they need.***

*P-IBH social worker:* “Sometimes people need a little bit more handholding to make phone calls. I have one kiddo I've been working with for a while. But mom is so depressed. Her affect is so flat. She's a patient of ours too. She's an adult, but I had to turn all my attention to her because he [the woman’s son] could not get services until she was getting services.”

***P-IBH teamwork amongst behavioral health clinicians with different roles.***

“So sometimes [the P-IBH psychologist] is able to just refer out, and other times it's, ‘Hey, this is a special request.’ Like this person needs in-person in some language, or just something, and so she'll say, ‘Hey, could you help them?’ Or she had one patient who met with the former psychologist for a very long time. And when [the current psychologist] first started--I'm very familiar with this person for a lot of socioeconomic needs, and I talked to her. I said ‘[The IBH psychologist] is only, like, limited basis. You're only going to have a few sessions. She's willing to cover you until we can you another outpatient provider, but she's not a long-term therapist. She needs to keep her schedule open.’ So months and months and months go by, and [the IBH psychologist] is like, ‘Oh, you know, the patient is still with me. Do you know what's going on?’ And so it was like going back. And like, ‘Okay ma'am, let's make some phone calls together.’ And again, that's adult, but I'm trying to think--there was another kiddo who was seeing [the IBH psychologist] for a while, very depressed. I felt my assessment was like they had a lot of gender dysmorphia and so needing outpatient long-term therapy connection to pride groups and, you know, just a lot of social support, and so it was a lot of--I was contacting mom, and mom was ‘No, no, no they're all set. They're all set.’ And then ultimately just dropped out with [the IBH psychologist]. It's different each and every time. I can't say one thing one time because it's always a little bit different. But she and I work well together. So that's good.”

***P-IBH facilitates children and adolescents to open up about their problems.***

*Physician champion:* “A 17 year old former refugee, and she's been here for maybe eight years, seven years, doing really well, wants to go to college. And again, mental health means different things for different people and different cultures and different lives and experiences. I'm so convinced that with the pressure that she was under to be a support to her family in a way that doesn't create more difficulties, she would not have necessarily talked to me about that. Our social worker actually went in and talked to her and talked to the father at the end of that visit, which was useful.”

*P-IBH social worker:* “One time mom came in with her son, and he was like completely dysregulated. I sat down with them both, had like a little family therapy session with them. And we were really able to get him to open up and agree to therapy because he was a very mature 10 year old who was like, ‘I don't need therapy. I have. . .’ I can't remember exactly everything he said. But he just acted very mature for his age, and so eventually broke down, and was like, ‘Okay I agree.’ So I think just having the IBH role here, because there was so much conflict within the family. There was conflict at school with the child, conflict at the home, conflict, you know, between parent and child. And so just having somebody there who could run into the room and say, ‘Hey, what's going on? Let's talk about this. What are you seeing? What are you thinking? And really just to mediate between the family to find out the underlying issues and try to help get them to some treatment. And then last time I talked they were doing pretty well. So that was a pretty great thing.”

***Adolescents may not truthfully disclose how they feel on the screening forms, and actually meeting with a P-IBH clinician may reveal mental health issues.***

*Practice manager:* “I had a doctor meeting last week, and one of the doctors said, ‘You wouldn't believe what happened to my well visit. I go into the well visit, and mom and dad and the kid are all happy. And then I ask the parents to leave, and the kid said she's been trying to kill herself for the last few—I go, What?’ So there are things they're not going to disclose. And so when that digital form goes to--even if mom says, ‘Here fill this out’, they're wondering, ‘Well mom is going to look at it to send it back.’”

***P-IBH is helpful for many different kinds of patient situations.***

*PA:* “I think we kind of touched on all of the types of patients that I think this is particularly helpful for. The reluctant patient, the misinformed patient. I just think it's been very helpful. The program has been great, and I found so many children have connected with [the P-IBH clinician], and children that I know would not have connected with therapists or clinicians in another setting--they've made connections with her and trust her, and that's been really important. And then it kind of just goes full circle and validates that I wasn't shoving them off, you know, that we're all in this together and trying to really help them because their mental health is a part of their overall health. Given one patient I know--She's just been really excelling and just flourishing. She met with [the P-IBH clinician]--she had what we call extended stay with [the P-IBH clinician]. But she really flourished. She was a student--she wasn't even going to school. She wouldn't even get out of her bed. And she's in school. She's on the honor roll now. And she's moved on to another therapist, a long-term therapist, and she's just doing great. So I think [the P-IBH program] has been really important.”

***P-IBH is helpful when patients’ mental health and social issues are too complex for primary care physicians to address on their own.***

*Physician champion:* “I had a situation where dad brought in his two children. In the meantime, they were separated undergoing divorce. So, he brought in the two children. And the whole visit was very problematic. He was very uncomfortable. And then mom showed up at the front desk. And she wanted to be involved, and it got very, very complicated. And that's when I really appreciated somebody coming in and speaking with the mom in particular, because dad had already taken the children out into the waiting room, and mom was beside herself. And [the P-IBH clinician] sort of negotiated, you know, between the mom and dad. Then I had a child who was an adolescent who was out actually prostituting herself and started into substance abuse and stuff, and we had someone come in right away, and she is in the process of getting further services because this is getting way beyond I think everyone's level of comfort here. The mom said, ‘Look it, I don't know what to do. My daughter--she was cutting herself.’ She was cutting herself. She was out prostituting herself. She was getting fully involved in alcohol, and mom was beside herself. And I was comforted in knowing that I had to [involve the P-IBH clinician], because I wouldn't know where to begin with something like this. It's way beyond my level of comfort.”

*Physician champion:* “I can say, ‘We have a warm handoff program. I can get someone right in the exam room right away, set up an appointment.’ If it's above and beyond their level of expertise or their level of comfort, they have a better communication with some of the outside resources like Providence Center or Bradley or Butler or one of these places. I admit that. I can get somebody into cardiology within a couple of days, or ortho. But when it comes to behavioral health, some of our clinicians even trained at some of these institutions and clinics, and so, they can make that phone call and get them in and get them seen a lot quicker if the acuity and the complexity is that demanding. So that's amazing. I think the patients here are very fortunate to have that, and I think they realize that too.”

***The post-partum depression screener administered in pediatric practices is extremely important.***

*NCM:* “She had a baby. And she's really suffering right now. Because nobody is taking new patients. Even if you're established and you haven't seen them in a while, they're like, ‘Oh well you can go on a wait list.’ Like you can't go on a wait list when you have postpartum depression. So I think that that screener is very important in a pediatrician's office, and almost more important in pediatricians than in OBGYN. ... I mean postpartum is no joke, no joke at all. And then you add COVID, right? So that's one thing that causes depression is isolation, right? So we have all these moms. My numbers of positive screens - I used to get like one a week, or if it was a bad month I'd get five. I'm getting three to five a week.”

*Physician champion:* “So you figure something out. Most of them can go back to their obstetrical provider. And most of them, actually, sort of know how to do that. What some of them need is a little bit of validation that, ‘Yeah, you know, this is something that happens after you have a baby, and yes, you should be seeking care for it because there is care, and it will make you feel better.’ So we don't actually do any of the care for the moms.”

***Occasionally, doing P-IBH via telehealth can be illuminating about the child’s home life.***

*Office manager:* “[The P-IBH clinician] felt there was some benefits to [telehealth]. She got to see a lot of interactions that she wouldn't necessarily see because the child was at home, and they felt a little more comfortable opening up to her. Her funniest story - she was seeing one girl who was about 14 who she had known, and the girl said, ‘Oh, let me show you my room.’ And she took her camera and showed her the whole room. And then her sister came in who shared the room--and she started yelling, ‘Get out I'm talking to [P-IBH clinician]. It's my room too.’ And they actually started having a fist fight right on camera.”

# Appendix 6. P-IBH Training and Implementation Resources

| **Resource** | **Behavioral health training and support** | **Implementation** |
| --- | --- | --- |
| **AIMS Center: Collaborative care model** | <https://aims.uw.edu/training-support>  Offers comprehensive, CME-eligible online training programs for Behavioral Health Care Managers, Psychiatric Consultants, Primary Care Providers, and Suicide Prevention. | <https://aims.uw.edu/collaborative-care/implementation-guide>  HRSA recommended guide for implementing collaborative care |
| [Reach Institute](https://thereachinstitute.org/) | <https://thereachinstitute.org/> Provides mental health training for doctors, therapists, educators, and parents.  REACH increases the nation’s capacity to help children with mental health disorders. | [Guidelines for adolescent depression in primary care. GLAD PC. Toolkit](http://www.gladpc.org/) |
| [Beck Institute](https://beckinstitute.org/training/) | Beck Institute offers a full range of CBT and CT-R training opportunities for professionals across disciplines, experience, and skill levels. |  |
| **AAP** | [Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management](https://publications.aap.org/pediatrics/article/141/3/e20174081/37626/Guidelines-for-Adolescent-Depression-in-Primary?autologincheck=redirected) |  |
| [COPE](https://www.cope2thrive.com/)**2Thrive** | COPE2Thrive provides trainings for all-inclusive evidence and Cognitive Behavioral Therapy (CBT)-based programs designed to help children, teens and college students coping with anxiety, stress and depression. |  |
| [Implementation Research: A Synthesis of the Literature](https://nirn.fpg.unc.edu/resources/implementation-research-synthesis-literature) |  | Provides rationale, best practices for program implementation |
| [Project Teach](https://projectteachny.org/about/) |  | Provides maternal and pediatric primary care clinicians CME-certified training on how to assess, treat and manage mental health concerns |
| [US Preventive Services Task Force](https://www.uspreventiveservicestaskforce.org/uspstf/draft-recommendation/screening-depression-suicide-risk-children-adolescents) | Guidelines: Depression and Suicide Risk in Children and Adolescents: Screening |  |
| [An Evidence Roadmap for Implementation of Integrated Behavioral Health under the Affordable Care Act](https://pubmed.ncbi.nlm.nih.gov/29546130) |  | Provides a roadmap for IBH implementation that is applicable to P-IBH |

**Graphical user interface, application

Description automatically generated**

**Call for Applications:**

**Implementation and Evaluation of an Integrated Behavioral Health (IBH)**

**Model in Pediatric Primary Care**

**Care Transformation Collaborative of Rhode Island (CTC-RI) and PCMH Kids are pleased to offer primary care practices the opportunity to apply for funding for the Integrated Pediatric Behavioral Health Initiative: “Universal Integrated Behavioral Health Screening and Treatment in Pediatric Primary Care for Children, Adolescents and Postpartum Mothers”, funded by the Rhode Island Foundation Behavioral Health Fund and Tufts Health Plan. Outlined below is the Pediatric IBH “Call for Applications” for interested pediatric/family medicine primary care practices.**

**Introduction:**

PCMH Kids is a state-wide collaborative covering 110,000 children from 37 practice sites representing ½ the children in RI and 80% of the Medicaid population. This PCMH Kids IBH initiative would be offered at 8 pediatric practice sites throughout Rhode Island which is anticipated to serve approximately 30,000 children and represent both independent practice sites and practices that are part of systems of care. Priority will be given to practices that serve vulnerable populations. This initiative recognizes and capitalizes on the fact that primary care is the logical center piece for providing effective mental health promotion and prevention because the pediatrician is the most likely medical professional that children and adolescents come in contact with during their early and adolescent years.

From 2016 to 2019, CTC-RI led an Adult Integrated Behavioral Health (IBH) PCMH project with ten adult primary care practices. Practices implemented universal screening for depression, anxiety, and substance use disorders and through on-site behavioral health clinicians, improved access to brief behavioral health intervention. CTC’s adult IBH model has shown strong outcomes in promoting better care at reduced costs.

Through this pediatric IBH initiative, CTC-RI and PCMH Kids will build on its success in implementing integrated behavioral health in adult primary care practices as well as leverage the behavioral health work done in pediatrics through our PCMH-Kids program over the past 3 years.

**Vision of CTC-RI and PCMH-Kids**

Rhode Islanders enjoy excellent health and quality of life, and children and youth will grow up healthy to reach their optimal potential. All children and youth in RI will be cared for in high quality, family and patient centered, medical homes.

**Mission of CTC-RI** **and PCMH-Kids**

To lead the transformation of primary care in Rhode Island in the context of an integrated health care system.

To engage providers, payers, patients, parents, purchasers, and policy makers to develop high quality, family and patient-centered medical homes for adults, children and youth, and provide health care in an affordable, integrated healthcare system that promotes active participation, wellness, and delivers high quality comprehensive health care dedicated to data-driven system improvement. PCMH’s for children will be cost effective and sustainably resourced.

**Strategic Goals:**

CTC/PCMH Kids: To develop, implement and evaluate a sustainable IBH model serving children, adolescent and postpartum moms within primary care settings.

Rhode Island Behavioral Health Fund: To address behavioral health (mental health and substance use) needs *before* people are in crisis.

**Pediatric Integrated Behavioral Health Objectives:**

1. To increase the identification, early intervention, and treatment of behavioral health challenges before children, adolescents and families reach crisis by implementing developmentally appropriate behavioral guidance, evidence-based screening guidelines, tools and treatment models for different populations of focus;
2. To increase ready access to brief behavioral health intervention for patients with behavioral health conditions by hiring and integrating an on-site behavioral health clinician (based on size of the practice but no less than 0.5 FTE licensed behavioral health clinician);
3. To provide care coordination for children, adolescents and families by developing a robust relationship with a community partner based on an identified population health behavioral health need;
4. To improve performance by implementing two performance improvement studies, participating in quarterly learning network meetings and having practice team members participate in monthly planning meetings that are facilitated by the pediatric IBH practice facilitator.

**CTC-RI Support to practice**

CTC-RI will provide support to Practice as follows:

1. Minimum infrastructure payment of $18,000, in two installments, that practices can use to off-set costs associated with on boarding behavioral health clinician, developing coding and billing mechanisms needed for sustainability and costs associated with non-billable time; larger practices may be eligible for additional infrastructure payment.
2. Eligibility for up to $10,000 in incentive payments based on meeting service delivery requirements and screening rate thresholds;
3. Two years of monthly on-site consultation from a trained Pediatric Integrated Behavioral Health Practice Facilitator;
4. Quarterly learning collaborative with content experts and best practice sharing from other practices participating in IBH initiative;
5. Data management support in evaluating outcomes and utilization.

Practices would select, implement and report on three out of five standardized evidence-based screening measures based on the populations of focus most relevant to the practice site. CTC will provide practices with measurement specifications that practices will apply when reporting screening outcomes. Payment will be prorated based on percentage of targets met. CTC will make incentive payment to the practice at the end of Start-up Year (Year 1) and the end of Performance Year (Year 2). CTC reserves the right to delay/withhold payments if Practice fails to meet any of the practice requirements.

Populations of Focus:

1) Depression: PHQ-A(adolescent)

2) Anxiety: GAD-7 (adolescent)

3) Substance use: CRAFFT or CAGE-AID (adolescent)

4) Middle childhood: Pediatric Symptom Checklist

5) Postpartum depression: Edinburgh Postnatal Depression Scale.

Screening Rate Thresholds

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Depression | Anxiety | Substance use | Middle childhood | Postpartum screening |
| **End of Startup Year 1** | 60% | 40% | 40% | 40% | 40% |
| **End of Performance Year (Year 2)** | 75% | 60% | 60% | 60% | 60% |

**CTC /PMCH Kids IBH Funding Details:**

There will be two IBH cohorts, each with 4 practices, servicing an anticipated combined attributed patient population of approximately 30,000 children and adolescents. Each practice will be eligible for two years of funding to support IBH efforts.

Cohort 1: July 2019-June 2021 (with expectation that practice will participate in July 2019 Orientation Program, quarterly learning network meetings (through March 2022 and collect and submit data through March 2022)

Cohort 2: April 2020-March 31, 2022 (with expectation that practices will participate in July 2019 Orientation Program and quarterly learning network meetings (starting in September 2019 through March 2022 and submit data starting in May 2020 through March 2022.

Each Cohort will have a phased Start-up (Year 1) and a second Performance Year (Year 2) implementation schedule with each year having defined program expectations. Funding in Startup Year 1 is designed to support IBH infrastructure development with incentive payment based on meeting initial threshold screening targets and service delivery requirements, and funding in Performance Year (Year 2) is designed to provide incentive payment based on achieving a higher level of threshold performance, initiating a community based performance improvement initiative around a practice identified population health gap in care and meeting Year 2 service delivery requirements.

**Prerequisites:**

* Team completion and submission of [Maine Health Access Evaluation Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool) with application;
* EHR system that can support a shared BH documentation, care plan and billing with submission of sample screening report with application;
* [Executed Letter of Support from System of Care](https://www.ctc-ri.org/sites/default/files/uploads/SOC%20letter%20of%20support%20Pediatric%20IBH.docx) indicating anticipated support for initiative (i.e. IT support for practice reporting, behavioral health documentation templates, business management support for implementing billing codes;
* NCQA patient centered medical home recognition (or intent to obtain within 1 year)

**Practice Requirements:**

**IBH Start-Up (Year 1):**

* Participate in Orientation Program and quarterly participation in quarterly webinar/live learning events;
* Identity team membership (to include provider champion, nurse care manager/care coordinator, behavioral health clinician (if hired) and practice/office manager; host monthly on-site IBH practice facilitation-initial meeting within 30-45 days of start of program;
* Develop a staffing plan for patients to be able to access BH assessment/treatment with same day to 48-hour access and post behavioral health clinician position if not already in place within 2 months;
* Select three out of five populations of focus and identify mechanisms within the electronic health record for being able to capture and report screening rates and provide baseline within 2 months;
* Establish billing systems that will allow for the billing of BH services and/or establish supervision of BH interns (within three (3) months of start date of IBH clinician or award notification if IBH clinician already hired);
* Hire behavioral health (BH) staff if not already in place with a staffing ratio between 0.5-1.0 FTE’ s depending on practice size with staff ready to see patients within 4 (four) months of award notification;
* Establish IBH workflows including roles and responsibilities for screening protocols, implementing warm hand-offs and care coordination of referrals when external behavioral health resources are needed (within six (6) months of award notification);
* Implement program identified evidence-based screening tools for 3 out of 5 populations of focus within six (6) months of award notification and provide quarterly reports;
* Submit an AIM statement and performance improvement (PI) plan for improving screening rates within nine (9) months (or other relevant PI study if practice is meeting screening thresholds for three of the selected populations of focus);
* Complete [Maine Health Access Evaluation Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool) at completion of the one year.

**IBH Performance Year (Year 2):**

* Execute Memorandum of Agreement with PEDI PRN (if not already in place) and MOMS PRN (if available) within month 1;
* Submit an updated performance improvement outcome plan for increasing screening rates by month three (3) (or other relevant PI study if already meeting screening thresholds);
* Demonstrate use of registry report which provides information on initial screening results for selected behavioral health condition and follow up screening result post intervention by month four (4);
* Submit an AIM statement performance improvement (PI) plan for addressing a population health need that can be addressed through improved connections to community resources by month six (6);
* Submit an updated AIM statement and performance improvement (PI) outcome based on implementing the community resource intervention by month twelve (12);
* Complete [Maine Health Access Evaluation Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool) at completion of the year 2.
* Continue to meet monthly with on-site IBH practice facilitator, attend quarterly learning network meetings and submit quarterly screening results.
* Participate in interview process as part of the qualitative research study.

**Timeline for Selection Process:**

|  |  |  |
| --- | --- | --- |
| **Step** | **Activity** | **Date** |
| 1 | CTC releases “Call for Applications” for Pediatric IBH Initiative | May 24, 2019 |
| 1 | Conference call with interested parties to answer any questions.  Call-in number: 508-856-8222 code: 4614 (12 noon) | June 4, 2019 |
| 2 | Submit letter of intent to apply electronically to:  [ckarner@ctc-ri.org](mailto:ckarner@ctc-ri.org) (optional; not required) | June 7th, 5pm |
| **3** | **Practices submit completed application package- electronically to: ckarner@ctc-ri.org;**  **Please include application checklist.** | **June 19th, 5pm** |
| 4 | A Selection Committee will meet to review submitted applications. | June 20-26, 2019 |
| 5 | Final recommendations to CTC Board of Directors | June 28, 2019 |
| 6 | Notification will be sent to practices that have been chosen | June 28,2019 |
| 7 | Orientation for newly selected practices (both Cohort 1 and Cohort2)  7:30-9:00 am | July 11,2019 |

**For questions contact:**

Carolyn Karner, CTC PCMH Kids Project Coordinator

(ckarner@ctc-ri.org)

T: 978-852-2250 Fax: 401 871-9048

**Application Package Submission Checklist**

|  |  |
| --- | --- |
| **Check if complete** | Item |
|  | (optional) Submit letter of intent to apply electronically to Carolyn Karner, Project Coordinator(ckarner@ctc-ri.org)  Letter to include: practice name, practice address, physician champion, practice leadership person, application key contact name of person responsible for project implementation, email address, and phone. If a multi-site practice, indicate physician champion at each site. |
| Final Package for Submission | |
|  | Cover [letter indicating the practice’s commitment](https://www.ctc-ri.org/sites/default/files/uploads/Sample%202019%20Pediatric%20IBH%20practice%20letter%20of%20support.docx) and acceptance of the conditions stated in the application, **signed by all members of the IBH implementation team in the practice.** |
|  | *Prerequisite # 1:* Copy of current NCQA Recognition; |
|  | *Prerequisite # 2:* Copy of team completion of [Maine Health Access Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool) **(one per site needed).** |
|  | *Prerequisite #3:* Executed [Letter of Support from System of Care](https://www.ctc-ri.org/sites/default/files/uploads/SOC%20letter%20of%20support%20Pediatric%20IBH.docx) |
|  | *Prerequisite #4:* Sample standardized population health report |
|  | Application Form filled out completely |
|  | Written response to three essay questions |
|  | Completed Application Package Checklist |

**Completed application packages – including completed checklist - should be received by 5:00 PM on 6/19/19.**

**Email application package to: ckarner@ctc-ri.org**

**For questions, contact:**

Carolyn Karner, Project Coordinator

(ckarner@ctc-ri.org)

Telephone: 978-852-2250

# Appendix 7: P-IBH pilot program application and Milestone Document

**Application for IBH Pediatric Pilot Program**

**Practice Information**

Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Zip \_\_\_\_\_\_

Phone: \_\_\_-\_\_\_-\_\_\_\_

Practice Tax ID Number (TIN): \_\_\_\_\_\_\_\_\_

Type of Practice (e.g. Pediatric, Family, FQHC, Hospital-Based Clinic) \_\_\_\_\_\_\_\_\_\_

Multisite practice: Yes/No\_\_\_\_

(If yes) Identify other practice sites: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single site applying with other primary care practices: Yes/No\_\_\_\_

(If yes) Identify other practices: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Champion Contact

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Leader who will be responsible for project implementation:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_-\_\_\_\_-\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **List name and NPI number for all Practitioners (MDs, DOs, NPs and PAs):** | | | |
| Name | NPI# | Name | NPI# |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Practice Payer Mix:** | | | | | | |
| Payer | Number of Pts | % of Total Practice | Payer | Number of Pts | | % of Total Practice |
| Tufts Commercial |  |  | NHP-RI |  | |  |
| BCBSRI |  |  | Tufts Managed Medicaid |  | |  |
| United Commercial |  |  | United Managed Medicaid |  | |  |
| Insured Other |  |  | Uninsured |  | |  |
|  |  |  | Medicaid FFS |  |  | |
| Total |  |  | Total |  |  | |

**Application**

**Prerequisites:**

1. Does your practice currently have PCMH NCQA Recognition? Yes/no

Year \_\_\_\_\_\_\_\_ Expiration date: \_\_\_\_\_\_ please provide copy with application;

1a. If your practice does not have NCQA currently but plans to obtain, what is the anticipated date?

2. Has the practice team completed the [Maine Health Access Evaluation Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool) for your practice? Yes/No

Total Score: \_\_\_\_\_\_\_\_\_ please provide self-assessment with application;

3. Does the EHR system have the capacity to bill for BH services? Yes/No

If no, indicate plan for offsetting BH costs or billing for BH services.

Electronic Health Record: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;

Indicate plans if your practice is anticipating changing electronic health systems within the next two years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a copy of a sample standardized population health report (or screen shots demonstrating system capacity to generate practice reports).

4a. Does your practice have an attributed patient panel size of 5,000 or more patients? Yes/No

Total attributed patient panel size: \_\_\_\_\_\_\_\_\_; if less than 5,000 attributed patients, indicate practices that you will work with, together with practice attributed lives (or with a minimum of 2,500 attributed patients with 0.5FTE staffing plan:

|  |  |  |
| --- | --- | --- |
| **Practice** | **Location** | **Patient attributed lives** |
|  |  |  |
|  |  |  |

5a. Is your practice part of a system of care? If yes: indicate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide an executed System of Care Letter of Support indicating how the system of care will provide support ([see sample letter of support](https://www.ctc-ri.org/sites/default/files/uploads/SOC%20letter%20of%20support%20Pediatric%20IBH.docx)).

1. Which Cohort would you prefer to participate in?

Cohort 1: Begins July 2019\_\_\_

Cohort 2: Begins April 2020\_\_\_

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Application**

**Additional Application Information**

1. Does your practice currently employ a BH staff member(s)? Yes/No\_\_\_\_\_\_\_

If yes, please complete chart below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | # of people | Hours per week | Contract or employee | Co-located or integrated |
| Psychologist |  |  |  |  |
| LICSW |  |  |  |  |
| Licensed Social Worker |  |  |  |  |
| Nurse Practitioner (Psychiatric) |  |  |  |  |
| Psychiatrist |  |  |  |  |
| Other |  |  |  |  |

2. Does your practice presently have a compact for community BH? Yes/No\_\_\_\_\_

If yes, indicate organizations you have a compact with:

1. Name of organization/person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate behavioral health conditions that are covered in the compact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name of organization/person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate behavioral health conditions that are covered in the compact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Has your practice previously participated in an IBH training program? Yes/No\_\_\_\_\_

If yes, please describe the program and results:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **N/A** | **Comment** |
| If your practice does not have IBH clinician in place (0.5-1.0 FTE depending on practice size) can you hire and be ready to start working with IBH staff within 4 months of award notification? |  |  |  |  |
| Can you develop an IBH staffing plan within 2 months for patients to be able to access IBH services with same day to no later than 48-hour access from original referral? |  |  |  |  |
| Can you establish billing systems for billing of IBH services within 3 months? |  |  |  |  |
| If planning to hire non-independently licensed IBH providers, can you establish supervision of these individuals? |  |  |  |  |
| Can 3 evidence-based screening tools for selected populations of focus be in place for all patients annually within 6 months of award notification? |  |  |  |  |
| For the three evidence-based screening tools your practice selects, can the PHQA (depression), GAD7 (anxiety) and CRAFFT or CAGE-AID (alcohol and drugs), Pediatric Symptom Checklist (Middle Childhood) Postpartum depression (Edinburgh Postnatal Depression Scale) be primary tools used? *If no, please justify rationale for using other screening tools in the essay section.* |  |  |  |  |
| Can baseline reports be provided on 3 out of the 5 populations of focus selected within 2 month of award notification? |  |  |  |  |
| Can monthly practice registry reports on screening results (initial and follow-up as indicated by score on initial) occur by Year 2 month 4? |  |  |  |  |
| Can patients be re-screened within 6 months of initial screening if score on any screening is in moderate-severe range? |  |  |  |  |
| Can the practice agree to monthly on-site IBH consultation over 2 years with a minimum of physician/clinical IBH champion, nurse care manager, IBH provider, administrative/operational liaison, and IT professional present (as applicable)? |  |  |  |  |
| Can the practice commit to monthly team meetings separate from the IBH consultation meetings as a way to follow through with recommendations made by consultant and engage all team members? |  |  |  |  |
| Does site have a workflow in place for management of high-risk/high-utilizer patients with behavioral health conditions? |  |  |  |  |
| If the site does not have a workflow in place for management of high-risk/high-utilizers patients with behavioral health conditions is there a commitment to creating one? |  |  |  |  |
| If there is no agreement with PEDI PRN, is there a commitment to obtain by Year 2, month 1? |  |  |  |  |
| Can the practice track and coordinate care of referrals to specialty mental health to report whether first appointment occurred? If not, can practice assist in identifying barriers to specialty mental health referral and track? |  |  |  |  |
| Based on an identified BH services gap in care, you recognize in your practice, would you be able to work with a community resource to improve care coordination in Year 2? |  |  |  |  |

**Essay Questions:**

**Please provide a response to each question (limit responses to a maximum of 500 words per question)**

1. The goal of this CTC-RI and PCMH Kids opportunity is to help practices transform into PCMHs with a strong IBH infrastructure by either hiring IBH providers or training current IBH providers within evidence-based models of integrated care that align with primary care transformation. Please describe the behavioral health population goals you would most like to address in your practice, and how you anticipate using the funding and support to achieve those goals.
2. One of the qualities of successful IBH practices in the PCMH model is strong physician and/or organizational leadership with commitment to practice transformation and broad support from practice team.
   1. Please describe the physician, NCM and top organizational leadership commitment to IBH transformation in your practice.
   2. Please describe the qualifications and commitment of the person who will be designated as project manager for this project.
   3. Is there broad support from all providers (including NCM/Care Coordinator, behavioral health) in the practice? If not, what do you think are the factors contributing to this?
   4. Identify up to three potential barriers to achieving desired outcomes and how do you anticipate addressing these challenges?
3. Based on the results of the baseline Maine Health Assessment Tool, what are the top three areas you would like to target with the support of the IBH consultant

**CTC-RI Selection Committee Policy and Procedure (2019)**

We anticipate that we may have more applications than available slots, therefore it is critical that applications for participation in CTC-RI IBH Pilot Project be reviewed and scored in an objective, fair, and transparent manner. The following reflects CTC’s policy and procedure for application review:

**Conflict of interest:**

Reviewers must disclose any potential conflict of interest related to a specific applicant. A conflict of interest is defined as a real or potential monetary benefit or having an organizational affiliation with the applicant. The Selection Committee will discuss the potential conflicts of interest and make a determination of whether a conflict of interest exists. If so, the reviewer must recuse themselves from the review of that application.

**Selection Committee Group Process for Review of Total Scores:**   
The Selection Committee will convene in June 2019, when a primary and secondary reviewer will present and discuss the rationale for scoring. The group will then discuss the ratings to reach consensus on application scoring. Final scores will be entered into a spread sheet, totaled and divided by the number of scores to reach a mean score for each criterion and an overall total score for the application. Once this process has been completed for all applications, the applications will be rank ordered by anticipated developmental stage. *The Selection Committee reserves the right to interview applicants if further review is warranted.*

**Review Criteria:**   
All reviewers will read and score each application independently using the scoring form and criteria established by the CTC Selection Committee. Reviewers will submit their scores to CTC Management in June 2019. CTC Management will compile all scores into one table per application with a total number of points. The maximum number of points is 70. Applications will be rank ordered by anticipated developmental stage.

We anticipate that we will select up to 8 practice sites. These practices will enter CTC in Stage 1-Start-Up and be assigned to Cohort 1 or Cohort 2.

In the event of a tie, the following criteria will be used:

1. Completion of application; submitted on time and complete;
2. Number of Medicaid members-priority will be given to practices that serve vulnerable populations;
3. Diversity in patient demographics; and/or
4. Previous experience with IBH model-practice can serve as a mentor.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **NCQA (max 2)** | **Score** |  | **EHR Capacity (max 9)** | **Score** |  | **% Medicaid (max 2)** | **Score** |
|  |  |  |  |  |  |  |  |
| NCQA achieved | 2 |  | Ability to bill for BH services | Add 1 point |  | <10 | 0 |
| NCQA not achieved but anticipated within 12 months | 1 |  | Registries for depression | Add 1 point |  | >10 | 1 |
|  |  |  | Registry for anxiety | Add 1 point |  | >30% | 2 |
|  |  |  | Registry for SUD | Add 1 point |  |  |  |
|  |  |  | Registry for Pediatric Symptom Checklist | Add 1 point |  |  |  |
|  |  |  | Registry for Edinburgh | Add 1 point |  |  |  |
|  |  |  | Standard plus custom reporting capability | Add 1 point |  |  |  |
|  |  |  | Designated staff/support | Add 1 point |  |  |  |
|  |  |  | Tracking referrals to specialty mental health capacity | Add 1 point |  |  |  |
| **# Providers/ Patients (max 3)** | **Score** |  | **CurrentCare (max 1)** | **Score** |  | **BH (max 6)** | **Score** |
| <2500  attributed patients | 0 |  | No plans to use | 0 |  | No experience with BH | 0 |
| 2500-3000  attributed patients | 1 |  | Enrolling patients, using viewer or hospital alerts or has direct account | 1 |  | Some experience with embedded or co-located BH | 1 |
| 3001-4999  attributed patients | 2 |  |  |  |  | Extensive experience with embedded, co-located, or integrated BH in practice | 2 |
| >5 FTE and >5000 attributed patients | 3 |  |  |  |  | Compacts in place (inclusive of meeting needs of patients with serious BH/SUD needs) | Add 1 point |
|  |  |  |  |  |  | PEDI PRN agreement in place | Add 1 point |
|  |  |  |  |  |  | Psychiatry consultation in place | Add 1 point |
|  |  |  |  |  |  | BHC currently working in practice | Add 1 point |
|  |  |  |  |  |  |  |  |

**Reviewer Scoring Notes**

1. NCQA: A total of 2 points are available. Practice must complete [Maine Health Access Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool). Assign 2 points if NCQA achieved and 1 point if anticipated to be obtained within 12 months;
2. # of Patients: A total of 3 points are available. Assign 0 points for practices with less than 2500 patients; assign 1 point if 2500-3000attributed patients; 2 points if 3001-4999 attributed patients; and 3 points if greater than 5 FTEs, and greater than 5000 attributed patients.
3. EHR Capacity: A total of 9 points are available.
4. CurrentCare: A total of 1 point is available. Assign 0 points for practices without plans to use Current Care. Add 1 point if enrolling patients, using Hospital Alerts, using CurrentCare Viewer, or has Direct account.
5. % Medicaid: A total of 2 point is available. Combine percentage of Managed Medicaid and Medicaid FFS
6. BH: A total of 6 points are available. Assign 1 point if practice has some experience with embedded or co-located BH; Assign 2 points if practice has extensive experience with embedded, co-located, or integrated BH in practice; Add 1 point each for the following: compacts in place, PEDI PRN agreement in place, BHC in place.
7. Essay Questions: A total of 10 points is possible for each question. 2 points if question answered; an additional 2-3 points if response demonstrated organizational interest/commitment and moderate degree of readiness; additional 4-5 points for above average response suggesting that the practice has high degree of readiness, has begun transformation work and is making progress towards IBH transformation.

Graphical user interface, application

Description automatically generated

# Appendix 8: Table of Contents—P-IBH program orientation binder

**Pediatric IBH Program Orientation Binder**

**Table of Contents**

Tab 1: Orientation Kick Off Agenda & Presentation

Tab 2: Contact Information, Agreement & Milestone Documents

* Contact Information
* Integrated Behavioral Health Agreement
* Milestone Summary
* Measurement Specifications
* MeHAF
* PDSA Worksheet

Tab 3: Resources

* Sample Job Description for PEDI IBHC
* Sample Job Description and Interview Questions (from Starfish)
* Sample Pediatric IBH Schedules
* Sample EHR checklist
* Sample Compact
* Referral Form
* PEDIPRN letter & Enrollment Form
* Moms PRN
* Strategies to Support the Integration of Behavioral Health and Primary Care: What Have We Learned Thus Far?
* Providing Confidential Care to Adolescents in Healthcare Settings

Tab 4: Billing & Coding

* Integrated BH Coding Guidelines
* AAP Coding for Pediatric Preventative Care, 2019 – selected pages
* AAP Standardized Screening / Testing Coding Fact Sheet for Primary Care Pediatricians: Developmental/Behavioral/Emotional

Tab 5: Screeners

* Pediatric Symptom Checklist with Instructions
* Scoring the PSC
* PHQ & GAD Instruction Manual
* PHQ-A
* GAD-7
* Edinburgh Postnatal Depression Scale
* CRAFFT Screening Interview (updated version)

Tab 6: Behavioral Health Conditions

* Screening for Depression in Children and Adolescents: US Preventive Services Task Force Recommendation Statement
* Brief Behavioral Therapy for Pediatric Anxiety and Depression in Primary Care
* KIDS COUNT Children’s Mental Health Fact Sheet 2019
* KIDS COUNT Adolescent Alcohol & Drugs Fact Sheet 2019
* AAP Clinical Report – Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice
* KIDS COUNT Maternal Depression Issue Brief 2018

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| **Reviewers Score Sheet** | | | | | | | | | | | | | | |
|  | Prerequisites (check if met) | | | | Application Questions | | | | | | Essay Questions | | |  |
| App # | PR 1 | PR 2 | PR 3 | PR 4 | NCQA  *(max 2)* | # of Prov/ Pt (max 3) | EHR Cap  (max 9) | CurrCare  (max 1) | % Medicaid  (max 2) | BH  (max 6) | E #1 *(max 10)* | E #2 *(max 10)* | E #3  *(max 10)* | **Total**  ***(max 53)*** |
| **1** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **2** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **5** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **19** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **20** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |