CTC-RI
Integrated Behavioral Health Pilot Program
Final Evaluation Full Report
including Executive Summary Report

Submitted:
August 29, 2018

Prepared by:

Mardia Coleman, MSc
May Street Consultants
mardcole@aol.com

Roberta E. Goldman, PhD
Alpert Medical School of Brown University
Roberta_Goldman@Brown.edu

Contents

About the Executive Summary Report and the Full Report

There are two IBH Pilot Program Evaluation reports—the Executive Summary Report and the Full Report. The Executive Summary Report (23 pages), is available separately from the Full Report. It provides a thorough but less detailed overview of the report findings. Both reports include the same set of recommendations. The Full Report is available upon request from CTC-RI.

The Full Report (87 pages), which is available upon request from CTC-RI, includes detailed information about how sites implemented their IBH programs. The Full Report includes the Executive Report as well as Attachment 1—Evaluation Research Questions; Attachment 2—Interview Guide; Attachment 3--Illustrative Stories about Practices' Experiences with IBH; and Attachment 4—AIMS Center Implementation Guide. The Executive Report does not include these attachments.

Executive Summary Report

Introduction

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

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

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

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

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

1. Increase the identification of patients with behavioral health and substance use disorders (SUD) through universal screening for depression, anxiety and SUD.
2. Increase ready access to brief behavioral health intervention for patients with moderate depression, anxiety, SUD and co-occurring chronic conditions.
3. Provide care coordination and intervention for patients with high emergency department (ED) utilization.
4. Improve interdisciplinary care coordination for patients with severe mental illness and SUD.
5. Test the proposed financial model for long-term sustainability with particular attention to ED and inpatient (IP) utilization/total cost of care as sustainable measures.

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

requirements included site participation in practice facilitation and in quarterly learning network meetings, and collecting data to support the Brown evaluation.

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

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

Methods

Methods for this evaluation were an IBH literature review; a review of CTC-RI and individual practice documents and websites related to the IBH pilot program requirements and processes; and qualitative interviews with open-ended questions. We interviewed state policy makers and state payers and CTC-RI to gain context and inform the development of the interview guide (n=9). A mix of individual and group interviews were conducted at each of the five Cohort 1 and five Cohort 2 IBH pilot sites (n=49).

Interviewees were selected based on a list of employees at each site who CTC-RI identified as associated with the IBH program (IBH managers, practice managers, IBH providers, physician champions, practice leadership, nurse care managers, site psychiatrist). Interviews were digitally audio recorded and were between 30 and 90 minutes long. A professional transcription service transcribed the interviews verbatim. The full evaluation report provides the research questions in Attachment 1 and the interview question in Attachment 2.

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

Findings

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

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

Provider and staff perceptions of IBH

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

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

Foundational activities

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

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

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

> "One of the things we identified was somebody was going [to the emergency department] almost every other day, and it was due to anxiety. So he was given tools to control that, and it actually empowered him. He felt like he had taken control of this issue. And his ER visits

> dropped right off. He was being seen here [at the primary care practice] more frequently, but that's okay. We'd rather he come here than go to the ER." *(Practice Coordinator)*

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

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

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

Implementation

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

Oversight. All sites had an individual tasked with managing the IBH program at the site level, although not all had a formally designated IBH manager or director. Some sites had an IBH manager or director who had dedicated time and authority to manage the problem, who directly supervised IBH providers, and who met regularly with other implementing staff. Those IBH managers also directly reported to or met with senior leadership regarding the IBH program. Some sites had regularly scheduled staff meetings to discuss the IBH program, other sites had larger practice staff meetings where IBH staff were included and IBH was an agenda item. It appeared sites with dedicated IBH managers were more agile in identifying and responding to program needs.

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

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

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

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

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

> *"I give you a pill to swallow, you feel better for a period of time. The pill stops, you're right back where you started from. You work with one of my [behavioral health] clinicians they're going to help you, and you're going to work together. You're going to learn how to manage these symptoms without medication, and it's something you can have for the rest of your days."*

Screening. Each site or organization implemented its screening and IBH treatment program in a different way. All sites screened patients with the PHQ-2/PHQ-9, GAD-7 and CAGE-AID at least annually, using a variety of techniques. Some sites screened at every visit because they felt a patient's status

could easily change, others because they did not have the capability to track who had already been screened. Sites conducted follow-up screenings at varying intervals for positive scores.

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

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

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

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

Care coordination. Practices have various idiosyncratic processes for accomplishing care coordination and management, depending on their staffing, size, and structure. No matter how coordination is achieved, the integration of behavioral health and medical health is seen as something that most practice staff value and patients appreciate. Naturally, practices in larger health care systems have access to care management staff and resources that are not available to independent practices. Some of the independent practices and health centers described the role of the Nurse Care Manager (NCM) as pivotal to care management for patients receiving IBH services. Where this occurs, NCMs are at risk for becoming overwhelmed with the quantity of patients they serve.

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

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

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

Sustainability

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

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

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

Policy issues

Copays. At all sites, interviewees described the difficulty that many patients have paying the elevated specialist copay for IBH. All sites felt that for IBH to be successful, payers needed to come together and implement a uniform copay scheme where the IBH copay is the same as the primary care copay, or the copay for IBH counseling provided in a primary care office is eliminated altogether. All sites wanted patients to have one primary care copay per visit to the office, even if the patient sees an IBH clinician and a medical provider at the same visit. Group medical visits for medical self-management also need to billed at one primary care rate, and not based on who is facilitating the group (e.g. not higher than primary care if an LICSW is facilitating, and no copay if the NCM is facilitating.)

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

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

Recommendations

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

Foundational Activities

IBH program start-up

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

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

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

Staffing

Rationale: "*Integrated care is a team-based model of care, based on the blending of numerous provider disciplines' expertise to treat a shared population through a collaborative treatment plan with clearly defined outcomes… The precise mix of providers in each setting is determined in part by the clinical*

setting, the population needs, funding, and pre-determined outcomes. Workforce development in integrated care has unique needs and challenges, including a focus on expansion and flexibility in provider function and roles; changes in traditional healthcare provider culture and provider training; and development of an effective and efficient team." [7]

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

Clinical services needs

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

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

Clinical services needs recommendations
1. It would be helpful if there were dedicated space for conducting IBH that providers can count on using to see patients, and that is located nearby the medical exam rooms.
2. Address barriers to uninsured or under-insured patients when counseling needs can't be met by IBH.

Clinical services needs recommendations
"We have an enormous amount of patients with trauma who don't have insurance who are coming in who I can't send anywhere."
3. Insurers can examine their authorization processes to make it easier for patients to receive behavioral health services

Implementation

Rollout and organizational culture of IBH

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

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

Creating a patient culture of IBH

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

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

Oversight and meetings

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

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

Policies and procedures

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

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

IBH training and cross training

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

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

Determining program success

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

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

Multi-site organizations and ACO engagement

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

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

Sustainability

Students as IBH providers

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

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

Licensed Independent clinical social workers and licensed social workers

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

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

Billing and coding

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

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

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

Policy Recommendations

Electronic Health Record (EHR)

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

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

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

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

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

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

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

Staffing—psychiatric consultant

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

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

Copays

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

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

Payment models

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

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

Credentialing

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

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

Social determinants of health—Social needs services

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

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

Full Evaluation Report

Introduction

As reported by the Agency for Healthcare Research and Quality (AHRQ), *"Integrated behavioral health care blends care in one setting for medical conditions and related behavioral health factors that affect health and well-being. Integrated behavioral health care, a part of 'whole-person care,' is a rapidly emerging shift in the practice of high-quality health care. It is a core function of the advanced patient-centered medical home."* [16]

The American Academy of Family Physicians developed the following Joint Principles for integrating behavioral health into the medical home.

1. **Personal physician.** Every patient in the PCMH has a personal physician who knows the patient's situation and biography and who is committed to the wellbeing of each patient, accepting responsibility for appropriate care.
2. **Physician directed medical practice.** The physician's practice will generally be the physical location of the PCMH, and this practice will rely on a team of health care professionals who will act together to integrate the physical, mental, emotional, and social aspects of the patient's health care needs.
3. **Whole person orientation.** Given that over one-half of primary care patients have a mental or behavioral diagnosis or symptoms that are significantly disabling, given that every medical problem has a psychosocial dimension, given that most personal care plans require substantial health behavior change—a PCMH would be incomplete without behavioral health care fully incorporated into its fabric.
4. **Care is coordinated or integrated** across all elements of the complex health care system.
5. **Quality and safety** are hallmarks of the medical home.
    - The partnership around the care planning process between the physician, the patient, and the patient's family must include behavioral health providers.
    - Information technology, particularly electronic health records, with appropriate security, privacy and confidentiality protections, must incorporate the behavioral health provider's notes, mental health screening and case finding tools, and the tracking of behavioral health outcomes.
    - The voluntary recognition process must include demonstration that attention to behavioral health care issues are incorporated into the medical home model.
6. **Enhanced access** includes access for patients, families, and physicians to behavioral health care resources through systems of collaboration, shared problem solving, flexible team leadership, and enhanced communication.
7. **Payment** appropriately recognizes the added value of behavioral health care as part of the PCMH, and of the behavioral health providers as members of the team. [17]

Implementing integrated behavioral healthcare (IBH) can be challenging. While healthcare organizations may be eager to bring IBH into their practices, few have direct experience or training in IBH or how to develop an IBH program. Medical and behavioral healthcare providers typically do not receive IBH training in their academic programs. Organizations need start-up funds to make the structural changes, for instance regarding physical location of services, and modifications to electronic health records. They also need to plan and lay the foundation for IBH within their organization.

SAMSHA, AHRQ, and The University of Washington's AIMS Center all provide tools for helping organizations implement IBH [5, 16, 18]. However, having IBH technical assistance and practice facilitation can help organizations proceed more smoothly [19]. There is increasing evidence that when physical healthcare and behavioral health services are coordinated and provided in integrated healthcare settings, health outcomes improve for patients, and the cost of care decreases. However, there are different levels of IBH, ranging from collocated to fully integrated. Within those levels, organizations have different resources, methods of oversight, and methods of determining patient and financial outcomes. There is a need for studies that examine how programs are implemented in order to have a better understanding of what factors influence successful practice implementation, patient outcomes and reduce cost of care.

Background

The Care Transformation Collaborative of RI (CTC-RI) is a multi-payer, advanced primary care (APC) initiative co-convened by the RI Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services (EOHHS). CTC-RI's focus is to transform primary care practices into high functioning Patient-Centered Medical Homes (PMCHs). One of CTC-RI's strategic priorities is to develop, implement and evaluate a sustainable integrated behavioral health (IBH) model serving adult patients within APC settings. In 2016, with funding from the Rhode Island Foundation's Fund for a Healthy Rhode Island and Tufts Health Plan Foundation, CTC-RI responded to this priority by implementing an Integrated Behavioral Health (IBH) pilot program initially comprised of two cohorts and ten pilot sites.

- Cohort 1 practices participated in the pilot program from January 1, 2016 to December 31, 2017, with the expectation of on-going participation in the learning network and evaluation data collection extending through 10/31/18.
- Cohort 2 practices participate from November 1, 2016 through October 31, 2018, with on-going participation in training and learning network opportunities from 1/1/16 through 10/31/18.

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

1. Increase the identification of patients with behavioral health and substance use disorders (SUD) through universal screening for depression, anxiety and SUD.
2. Increase ready access to brief behavioral health intervention for patients with moderate depression, anxiety, SUD and co-occurring chronic conditions.
3. Provide care coordination and intervention for patients with high emergency department (ED) utilization.
4. Improve interdisciplinary care coordination for patients with severe mental illness and SUD.
5. Test the proposed financial model for long-term sustainability with particular attention to ED and inpatient (IP) utilization/total cost of care as sustainable measures.

The CTC-RI Participation Agreement required sites to implement a clinical model over a two-year period that included universal screening for depression, anxiety and substance use disorders, and three projects using a quality improvement method calle Plan Do Study Act (PDSAs). PDSA 1 addressed screening rates, PDSA 2 addressed emergency department (ED) utilization, and PDSA 3 addressed identification and IBH interevention for population of patients with chronic disease. Sites had latitude as to how they met the pilot objectives, and implemented universal screening and rescreening. Notable

additional requirements included site participation in practice facilitation and in learning collaborative meetings, and collecting data to support the Brown evaluation.

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

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

CTC-RI contracted with Brown University to conduct a quantitative evaluation to determine whether pilot sites met these objectives. The quantitative evaluation specifically examines the IBH total cost of care of patients receiving IBH care versus a matched comparison group who are not receiving integrated care.

CTC-RI contracted with the authors of this report to conduct a qualitative evaluation to examine processes, barriers and facilitators related to IBH implementation. The qualitative evaluation also will inform the development of the next group of IBH practice sites. Additionally, the results of the qualitative evaluation will inform the financial and cost of care analysis by highlighting how sites implemented their programs and programmatic differences.

Methods

We used the evaluation's overall research questions; a review of the integrated behavioral health literature; a document review of IBH-related documents and key informant interviews to inform how we developed this evaluation. We used interviews with a range of IBH site staff and a review of CTC-RI documents, site documents, practice facilitation notes and PDSAs presentations, and site website reviews to gather data for the report findings. We used all sources to inform the report recommendations.

IBH literature review: We reviewed the peer-reviewed literature and relevant gray-literature (policy, advocacy, academic, state and federal sources) regarding IBH implementation and implementation best practices. We relied heavily on the University of Washington's AIMS Center, SAMSHA and AHRQ for best practice information.

IBH-related documents. We reviewed relevant documents including Facilitation Progress Reports, Financial Worksheets, Integrated Behavioral Health Meeting Minutes (10-13-16 through 7-13-17); Integrated Behavioral Health Milestones Summary (updated 9-12-17); SIM Evaluation Reports (February 2017-November 2017); Collaborative Agreement Scope of Service/Work; and Rhode Island Foundation Interim Report (11-30-17); and practice site patient information and advertising documents and websites. We used the monthly Practice Facilitation (PF) reports as a way to understand how sites conducted rollout activities and the PDSAs, attendance at the PF meetings, and issues sites experienced implementing the PDSAs. This review provided us with contextual background for each site, which allowed us to tailor some of the interview questions to the specific circumstances of the sites.

Key informant interviews (*n=9*). To understand the scope of the IBH pilot, we interviewed CTC-RI senior leadership and the IBH practice facilitator. To understand the views of external stakeholders, we interviewed a representative from the Rhode Island Office of the Health Insurance Commissioner, a representative from the State's SIM grant, and a representative from each of the health plans.

Interview guide. We created a comprehensive interview guide that corresponded to the research questions, the issues of interest to CTC-RI and external stakeholders as expressed to the evaluators during preliminary information-gathering interviews, and best practices for implementing IBH as identified in the literature. We incorporated questions about site-specific and all-site practice facilitation issues into the site interviews. Attachment 2 provides the interview guide.

Site interviews (*n=49*). We conducted a mix of individual and group interviews at each of the five Cohort 1 and five Cohort 2 IBH pilot sites, selecting interviewees based on a list of employees at each site who CTC-RI identified as associated with the IBH program (IBH managers, practice managers, IBH providers, physician champions, practice leadership, nurse care managers, site psychiatrist). At some of the sites, we interviewed additional individuals as requested by the site.

Interviews were digitally audio recorded and were between 30 and 90 minutes long. A professional transcription service transcribed the interviews verbatim.

Website review. As a measure of patient engagement, we reviewed each site's website for information related to Integrated Behavioral Healthcare. We examined whether the website included information about IBH, the prominence of the information, and the types of information, e.g., description of IBH, introduction to providers, description of services, and related other information.

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

Findings

We have organized the Findings into five areas: Provider and staff perceptions of IBH; Foundational activities; Implementation; Sustainability; and Policy.

Provider and staff perceptions of IBH

Sites were pleased they took part in the IBH pilot

Overall, sites were pleased to take part in the CTC-RI IBH pilot program. Interviewees reported IBH improved patient care in that the practices were able to provide services that treated the whole person, rather than just a medical condition. With IBH, patients gained access to a different model of therapy, one that was shorter, skills based and, for some patients, less stigmatizing than care at a freestanding mental health facility. Interviewees emphasized that they often presented IBH to patients as a way to help deal with the stressors of daily life and difficulties managing their medical conditions. As a result, patients gained skills in managing both their emotional and medical conditions. Many medical providers

expressed that now that they had experienced IBH in their practice, they could not imagine working in a setting without IBH services.

Foundational activities

Implementing the CTC model

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

CTC-RI support—Learning collaborative meetings

All sites appreciated having access to practice facilitation, defined by AHRQ as a *"…..supportive service provided to a primary care practice by a trained individual or team of individuals. These individuals use a range of organizational development, project management, quality improvement (QI), and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals."*[20] Facilitation was helpful in identifying and addressing implementation issues. (See detailed facilitation analysis in the next section.)

Many interviewees were very specific about who were designated to attend the on-site facilitation meetings and who were supposed to attend the off-site CTC-RI meetings. Those who did attend the CTC-RI meetings generally found them helpful. A number of interviewees told us they were designated to attend and would have liked to attend, but had to prioritize clinical work. In effect, interviewees who had more control over their schedule, or had administrative time.

Some attendees really liked hearing how other sites were addressing problems and issues, and on occasion, a site would adopt a practice that was discussed at a meeting. In addition, a number of interviewees said they liked hearing what was going on politically. However, others who attended the larger meetings found that since programs were so different at each of the sites, and sites had varying resources available to them, it was hard to know what was relevant to their own situations. Additionally, while the range of attendees brought varied views, some interviewees felt there were too many people for the meetings to be effective or useful. A specific gap that some noted was insufficient information and training about how to maximize billing and coding.

CTC-RI support—Practice facilitation

CTC-RI provided a PsyD psychologist IBH practice facilitator to the pilot sites for the entire 24 months of the pilot. The facilitator visited with each site for a regularly scheduled monthly meeting. The grant required that at a minimum, the following staff attend the practice facilitation meetings: IBH clinician(s), NCM, physician champion, and practice leadership. As stated in the participation agreement, the purpose of the meetings was "to provide coaching for leadership engagement, workflow development for implementation of screening tools and team based care, creation and utilization of behavioral health population registry, and use of rapid cycle quality improvement strategies."

Sites found practice facilitation helpful in a variety of ways:

- All sites appreciated having a practice facilitator provide technical support, especially with PDSA 1. They appreciated having someone who could help them with the nuts and bolts of designing the PDSA, carrying it out, making decisions about their own program processes, and implementation.
- Just as you need to have the right staff implementing IBH, you also need the right facilitator. Sites appreciated having a skilled facilitator who had direct and relevant IBH experience and provided sites with evidence-based or best practice options for addressing issues.

> "I thought (the facilitator) was fantastic…she always had a lot of insight. I think at first sometimes I'd be like why is she saying that. But it always came full circle, and she provided us with a lot of support. So I--personally I think we got a lot out of it."

- The facilitation meetings provided some project management to sites, and in many ways, the facilitator served as a de facto IBH implementation manager. Facilitation *"…helped us stay on track, solve problems. We would have gotten there, but would have taken much longer."*
- The facilitation meetings helped build cohesion among implementation staff and helped engage the NCM in the IBH program, particularly regarding PDSA 2 and 3.

> "I think [the facilitation meetings] were helpful to get everybody on the same page from a number of different perspective from, you know, what to do for reporting, how we're going to get things measured and into the program helping to articulate a vision and helping us figure out how we might execute on that vision."

- The facilitator supported IBH providers as they transitioned from providing long-term OBH to short-term IBH services. This was not easy for social workers or psychologists whose academic training was in traditional counseling. The facilitator provided individual training when needed. She also worked with IBH providers to understand workload, and techniques to prevent burnout.
- The facilitator helped the sites use their data.

> "Q. So what turned you around? A. The data, just the data in terms of…. what you should be reporting out for in terms of numbers of diagnosed patients with depression, anxiety and substance abuse. And pulling the UDS data that we submit based on pulling our diagnostic or pulling the data that we submit and seeing that we weren't reporting what the world historically reports."

Interviewees also reported ways that facilitation could have been more helpful. A number of these items reflect the focus required by the participation agreement.

- Facilitation did not take into account organizational readiness for change, and the site's readiness and ability to implement IBH.
- Facilitation was geared towards the PDSAs, and not ways to help the organization prepare for and adapt to IBH, or to get providers and staff on board.

- Facilitation did not provide information regarding how to maximize billing. There are differences between how public and commercial payers reimburse and codes they make live. ACOs payer contracts may differ. Interviewees felt site-specific training would have been helpful.

> "I honestly would love a hands-on-…This--with this plan you can bill for this. And break it down by Medicare Medicaid private, all of our different payers and work on how to help with the sustainability and how to best utilize the tools that we're probably not using."

- Some NCMs felt facilitation meetings were more focused on IBH, and not on the role of the NCM or other staff, for instance, how IBH would affect them regarding workload.
- There needed to be more flexibility regarding the scheduled day and time for facilitation. For at least one site, the meeting time did not coincide with when key staff were available.
- An offshoot of meeting schedules was that some key staff did not attend meetings on a regular basis, or dropped out because they had to (or chose to) focus on clinical productivity.
- While many interviewees reported they liked that the facilitator came with an agenda, others felt meetings did not always jive with where the site was at in its implementation.

> "It seemed out of--what can I say--chronologically out of order sometimes, how we were doing things. And I guess because they had benchmarks of what needed to be done at a certain time, we would just do it."

- It would have been helpful to some practices had facilitation taken into account the differences between practices that serve primarily commercially insured patients versus those that primarily serve publicly insured patients, and that practices have varying resources available to them. *"The facilitator also brought tips from her experience with community health centers but we don't have the same resources and so much of that was not applicable for our situation."*

Role of the ACOs and health plans

It did not appear either the ACOs or the health plans played a direct role in the implementation of the IBH pilot at the site level. Of course, ACOs had to approve EHR changes. ACOs and health plans sent representatives who participated in the quarterly CTC-RI IBH meetings and were engaged in that way. Some health plans contributed by providing billing and coding information on covered services. Two interviewees mentioned that both Care New England and Lifespan health systems have been convening meetings regarding making IBH a program across their practices.

The EHR and registries

EHR

Overall, sites are using their EHRs as designed. EHRs are an important tool for communication and managing patient care. All staff are able to view the EHR. Interviewees reported that their EHRs are HIPAA compliant.

However, consistent with previous studies, EHRs at these pilot sites need numerous modifications to support IBH. A 2015 publication confirms previous studies that EHRs do not have the capability to support the integration of primary care and behavioral health. For instance, most EHRs lack the

capability to document and track longitudinal data including behavioral health conditions, or to create shared care plans. EHRs lack or have poor registry capabilities; and, EHRs generally cannot be linked with external registries [6, 22]. Subsequently, other authors have reported health system leadership makes it possible to create an EHR that includes *"…transparent, retrievable, templated, bidirectional behavioral communication in EHRs".* Examples include Tennessee's Cherokee Health Systems and Alaska's Southeast Community Health Systems [23].

Many interviewees offered the same EHR challenges documented in the literature. Most notable was the problem sites had in adding and retrieving accurate GAD-7 and CAGE-AID screening data into their EHR. At many sites they created a data entry template, only to find the usability of the template (the need for one or two more, counter-intuitive clicks), led to data not being saved after data entry. After more EHR modifications, new workflows and diagrams, and staff retraining, data finally were entered correctly.

Many interviewees said they could not use the EHR to track changes in screening scores. Updated scores go in a notes field. This meant toggling back and forth to find past and current scores. Further, EHRs lacked the capability to create, share, and update the patient's care plan. What sites would like is:

> "…build it into your system in a way where you can report on and track it in your system. … don't have it be a free text field where you can't really look for it and track. Have it tie into whatever your health reminder system is, right, so that you--it will automatically--you do the screening. If it's negative, great. It's good for the year."

Interviewees stated that it is expensive to make EHR changes. Often, if the practice is part of a larger health system, such as Care New England or Lifespan, the practice is in the queue for IT and the wait for changes can be weeks or months. Smaller practices with more autonomy found it easier to make EHR modifications.

> "Well I can say--for month to month it was difficult because [the practice facilitator] would say, 'Okay, how did you progress with this issue you had with IT?' And then once a month later we're still sitting in the same place. You can put in your request. You get a ticket. But it's not getting worked on. We're in this giant corporation."

Further, when the site is part of a broader healthcare system, the EHR changes that the individual site's request then are in effect across all the practices for which they may not be relevant. The site must make the case the EHR change will be beneficial, or at least not burdensome, to other non-IBH practices. Other functional barriers to the EHR are the time it takes to load, usability issues, and the need to go back and forth to find information.

Registry

SAMSA and the AIMS Center both deem a patient registry as an essential feature of IBH. In IBH, a registry is a tool that *"tracks clinical outcomes for populations of patients and supports systematic changes in treatment for patients who are not improving as expected."* [21]

According to the AIMS Center, a registry:

- Tracks progress at the individual patient level and at caseload level

- Tracks population-based care
- Facilitates efficient systematic case review
- Prompts treatment to target

CTC-RI's Participant Agreement required pilot sites to create and implement a patient registry, effectively, a patient tracking system. The purpose of the tracking system was to collect data for the quantitative evaluation, to collect and report data required by the grant, help sites manage their programs, determine patient outcomes, and support quality improvement activities. The practice facilitator provided sites with AIMS Center resources to create their tracking system.

Due to limitations of time and resources, sites varied in their ability to create and use a tracking system. Additionally, EHRs are not designed to support patient tracking. Some sites noted being able to link their tracking system to the EHR would have simplified data entry and reporting.

> "When you're seeing the volume of patients we see every day, it was a job in and of itself just trying to figure out how to stay on top of it versus trying to figure out how to build tools into our EHR that would start doing that for the teams themselves. Right, things like health reminders for screenings and re-screenings and things like that in the system that made a lot more sense than trying to have this manual registry that was a bear to try to stay on top of."

However, if the registry and the EHR were linked, sites could be more receptive. *"….I do think if you can integrate it into the EHR there's a lot of value."*

Staff involved in providing IBH services

"Integrated care is a team-based model of care, based on the blending of numerous provider disciplines' expertise to treat a shared population through a collaborative treatment plan with clearly defined outcomes….The precise mix of providers in each setting is determined in part by the clinical setting, the population needs, funding, and pre-determined outcomes." [7]

We found each site staffed its IBH program based on available resources and funding, and ability to bill for services. In this section, we describe the staff that implement and administer the IBH pilot. Across sites, interviewees noted the importance of having the right staff to implement and oversee the IBH pilot. In this section, we provide a detailed inventory of the staff used to implement IBH.

IBH providers—Licensed staff

Sites used a variety of clinical staff to implement IBH, including LICSWs (7 sites); psychologists (4 sites); PhD psychology students (one site); and MSW students (5 sites.) Four sites had their IBH providers split their time between providing short-term IBH therapy and longer-term outpatient behavioral health (OBH) therapy. All sites except one limited their behavioral health services to patients of the practice. In order to "get the numbers up', and because behavioral health services are scarce in the area where the practice is located, one site recently opened up counseling appointments for people who are not patients of the practice.

The sites offering both IBH and OBH services reported that doing both allowed their behavioral health providers to bill enough to make their IBH program sustainable. Other sites reported their IBH clinician provided long-term counseling to a small percentage of patients if warranted by patient circumstances.

The facilitator advised sites to estimate approximately 10% of the patients seen by IBH providers could be long-term while still employing a robust IBH model of care and meeting patient needs.
The roles and responsibilities for IBH providers were consistent regarding the delivery of IBH clinical services. These include being available for warm handoffs, conducting brief psychiatric evaluations, providing short-term, evidence-based therapy, participating in huddles (only in some sites), participating in clinical team meetings, communicating formally and informally with medical providers, supporting the medical care plan and creating a behavioral health treatment plan.

Interviewees reported that it could be difficult to find the right clinical staff for IBH. Not every LICSW or psychologist has the proper training or flexibility in mindset regarding service delivery to be an IBH clinician. *"You could be very engaged in something that takes a lot of your emotional strength and power and then have five people knocking on the door for five other things that take a different portion of that."*

Another challenge is finding licensed staff who want to do short-term counseling. As an administrator said, *"… but then my next challenge was licensed clinicians, who are like, 'You know what, I didn't go to school for this. I want to do long-term therapy.'"* Some of the sites explicitly solved this problem by having their IBH providers split their time between short- and long-term counseling, some hired staff who were already familiar with the IBH model, and in other sites the IBH providers gradually became accustomed to working within the model. Some IBH providers, recognizing their lack of training in IBH, reached out to the pilot facilitator for help in gaining the skills needed to be effective conducting short-term therapy.

A number of sites reported it took time to find the right fit, and at some sites, the initial IBH clinician left due to difficulties in adapting to the IBH model. As an IBH manager explained, *"I do think we experienced some initial struggles with finding the right fit for this model. We kind of require some--a very specialized skillset I think, right?"*

Once sites found the even with the right IBH clinician, it could still take time for the new IBH providers to adapt to both the model, generally, the model as it is implemented in the particular practice, and then to meet productivity goals. *"It takes on average 6 months to find the right clinician. Another six months to feel comfortable. And you know, to get to productivity clinically…we thought would be six months, and most people took longer than that even."*

Variations in responsibilities arose in how much time clinical staff spent helping patients address social determinants of health and coordinating care. There were also variations in the availability of administrative time, e.g., time to participate in administrative meetings when IBH was an agenda item, and during the pilot, participation in facilitation meetings. Sites where providers provided both IBH and OBH therapy had an increased focus on billable hours and less available administrative time to attend IBH related meetings.

MSW, LCSW or PhD students as IBH providers
In some sites, students play an essential role in provision of IBH to ensure patients have access to IBH when they cannot afford the copay. In these sites, students provide IBH services to patients who are uninsured, have high copays, or have high deductibles and cannot afford to pay for IBH services. At one site, PhD students provide almost all IBH services. This site does not believe there should be variability in what patients pay for IBH services, even when patients have adequate health insurance coverage.

One site initially used licensed clinical social workers, but then found out LCSWs are not able to bill for services. The site had expected to be able to bill under the LICSW's license.

Psychiatry staff

Some sites reported having access to psychiatry consultation services through a staff psychiatrist available to the site part-time; one site has two full-time psychiatric nurse practitioners on staff. Psychiatrists primarily provide medication consultation, and consultation for difficult cases. At one multi-site practice, the psychiatrist also provided direct services. Sites that had their own psychiatric services found them to be invaluable. A medical provider stated, *"Let me tell you about our secret weapon. We have a psychiatrist eight hours a week."* Sites that do not have internal access to a psychiatrist for their IBH patients cited this service gap as extremely problematic.

Nurse care managers (NCMs)

The involvement of NCMs in IBH is, in theory, a natural fit. As one NCM stated, *"…even though we're nurses and we provide that clinical piece, we also provide that psychosocial--we provide a holistic approach. So actually it lends itself very well in my mind with IBH…"*

In the patient-centered medical home model, each practice has a nurse care manager who provides support and services to a panel of about 200 high-risk, high-cost patients. These patients often are high-risk, high-cost because of their use of the emergency department, and/or because of their medical or behavioral health comorbidities. NCMs may also provide health education around disease self-management.

In the CTC-RI IBH pilot program, with PDSA 2 (reduction of ED visits) and PDSA 3 (increasing chronic disease self-management and compliance with treatment as it relates to behavioral health), NCMs necessarily became involved with the IBH pilot. Their panel of high-risk, high-cost patients often overlapped with the PDSA target patients. As a result of the PDSAs, NCMs began to have more appreciation for how behavioral health interventions could help their patients. Similarly, IBH providers learned more about the impact of chronic disease on behavioral health and began working more collaboratively with NCMs.

In addition to the NCMs' panel of patients, medical providers at times asked NCMs to provide support to IBH patients who they were concerned about becoming high-risk, high-cost, patients who needed help with managing a chronic illness, or who needed care coordination. This happened primarily at practices that did not have access to health or behavioral health advocates or other similar support staff. One NCM explained,

> "Nine out of ten times if somebody is referred to (the IBH clinician)--I shouldn't say nine out of ten times. Probably seven out of ten times--I'm involved in one way, shape or form. In other words, there's something that I need to also do."

Pharmacist

One site has access to a pharmacist for medication review. This site felt the pharmacist was very helpful in providing services and consultation to the IBH team.

Health advocates or behavioral health advocates

Health or behavioral health advocates helped patients with issues related to care coordination, addressing patient social determinants of health issues and other issues related to the patients

managing their health or mental health. Within IBH, IBH providers and medical providers referred patients to these advocates based on screening scores and further formal or informal assessment. A number of sites in the pilot did not have access to these types of support staff. At these sites, the provider or clinician may try to address issues, may refer the patient to the NCM, or to some other staff. Two sites use social work students to fill the gap, one of which reported it did not regularly have a student.

One multi-site practice had support staff at each site, but also assigned a behavioral health advocate to the IBH clinician. The sites reported having assigned support staff helped increase the efficiency of the IBH clinician. For instance, if the IBH clinician was seeing another patient, the advocate could begin working with the patient to determine and address social needs. This helped the patient see the value of an IBH referral and kept the patient on-site until the clinician was free.

Medical assistants

Sites often felt that medical assistants were the backbone of their IBH program. At all sites, MAs are integral to IBH and in many ways are the lynchpin to keeping the program working smoothly. MAs have varying roles in screening, data entry and upload, serving as liaison between IBH and medical providers, alerting medical providers to a positive screening, warm handoffs, referring for IBH, and making IBH appointments. As one manager stated, *"At the same time we doubled down on the HCA's, the medical assistants, saying, 'This is the most crucial thing you might do. And if you find a grenade don't wait for me, the physician, to tell you it's a grenade'."*

Language Translators

A staffing innovation at one multi-site organization was to assign a translator to each of their IBH providers. The translator also served as an ad hoc behavioral health advocate.

Designated IBH director, manager, or point person

All sites had staff who provided some level of oversight and management to the IBH pilot, or who served as a point person. In most cases, responsibility for IBH was an additional responsibility. For example, in a 2-physician practice, both physicians provided oversight. At a multi-site practice, the Director of Behavioral Health managed the pilot with the IBH clinician responsible for operational oversight at the site. Two larger organizations had staff time allocated solely to IBH oversight. In one practice, there is a Director, Integrated Behavioral Health; at the other, there is a Behavioral Health Care Manager. At other sites, a clinical services manager or practice manager had oversight. What differed between sites was the amount of authority the IBH director, manager or point person had and to whom the person reported.

Physician champions

Physician champions in the pilot program defined their role as supporting other physicians, attending facilitation meetings, and being an overall "cheerleader" for IBH. Three sites did not have a physician champion—there was the perception that being a champion was too much work, or physician turnover meant there was not an experienced physician to take on the role. Champions sometimes varied in their understanding of the fine workings of the IBH program, and some champions reported interest in receiving additional IBH training or cross-training at staff meetings.

Other staff involved with IBH

Other staff directly involved with IBH implementation include those responsible for practice reporting, billing staff and the reception staff. We found staff throughout the organization of the practices often

contributed to the success of the IBH program. Importantly, when senior and executive leaders, including the medical directors, remained actively involved in the IBH program—through regular updates, making needed changes, or making resources available—it was clear to all staff that IBH was important. For example, one organization's medical director noted there was organizational commitment to IBH both horizontally and vertically, e.g., across implementing staff, and up and down the administrative chain of command. At another site, an IBH clinician commented that the system would work better if the front desk staff better understood the IBH program and how and when to schedule patients for IBH services.

Implementation

Pilot rollout and implementation issues

Pilot rollout

Sites varied as to how they rolled out the pilot to staff. Given the nature of the quick turnaround needed when receiving funds to implement a pilot program, most sites had little time for planning or preparation beyond meeting grant requirements and staff meeting presentations. However, at one organization and at one practice, both had already conducted IBH planning and preparation several months before their pilot. Both previously had made a commitment to implement IBH, and were doing so in a stepwise fashion. One practice followed the AIMS implementation model. [5]

Examples of how organizations rolled out the pilot are as follows.

- Most sites presented the IBH program at staff meetings and worked to address concerns. *"So, (the IBH program manager) would come and talk about the program and say, 'Here's what we're doing; how we're going to staff it. I have trainees. We're going to get social work students.' Providers loved it."*
- One organization with multiple sites did more extensive rollout activities, engaged staff, and addressed concerns. *"Messaging and communication at all levels--just answering: Why is it going to benefit me?"*

  "It's interesting because when we first looked to do this there was the initial 'I'm not going to do it because it's going to open a can of worms. And I don't have enough time'--right--was the initial response from providers…We responded, 'but we need to address this just like we would address if your patient had an elevated blood pressure.'"

- At a provider run practice, the medical providers were highly enthusiastic, as was the practice manager. However, it is unclear how they engaged the NCM and other support staff in developing a program that increased workloads.
- Another organization with multiple sites was an SBIRT grant recipient. The organization felt IBH was an extension of SBIRT and that SBIRT prepared their sites for IBH. This organization still did some outreach and education activities. However, the outreach and education did not address sufficiently how IBH would differ from SBIRT screening and referral.
- At a number of sites, the practice CEO and other senior management strongly endorsed the IBH program and then did not widely engage the clinical or medical staff when developing the program.
- At one site, rollout activities did not address the concerns of existing medical providers or make a sufficient case to them as to why they should change their existing workflow and patient practices. Staff turnover eventually allowed this site to train new staff from the start in their IBH procedures.

Implementation issues

Many interviewees felt that implementing IBH represented how they believed healthcare should be delivered. However, the details of implementation were not something many had considered. All sites reported issues with establishing workflows for identifying when patients needed to be screened, either annually or for rescreening based on previous results, and creating effective procedures for warm handoffs.

All sites reported issues with entering and retrieving accurate screening data in the EHR. Many sites reported they were unable to get needed EHR modifications completed in a timely manner. Since EHR modifications were central to conducting the PDSA1, this impacted sites' abilities to meet PDSA deadlines.

Examples of other rollout and implementations issues experienced by many or most sites include:

- Perception at some sites that management developed the program without adequate input throughout the practice, resulting in missed opportunities.
- Managing logistics of where IBH providers would sit – both to accommodate space needs of the program and to situate the IBH office conveniently near the medical providers' offices and/or the exam rooms.
- Projecting and achieving a reasonable workload for IBH providers and patient volume.
- Developing roles and responsibilities, procedures and policies.
- Understanding what sites could and could not bill for.
- Creating a registry, initially required by the CTC-RI grant. Because of the difficulty sites had in creating a registry and the time it took to manage a registry, CTC-RI discontinued the reporting around this requirement, but sites were expected to continue to maintain their registry.
- Some of the behavioral health providers had difficulties adapting to the IBH model of clinical intervention.
- Some medical providers had difficulty adapting to the new model and understanding how IBH could help their patients; these providers typically had low or no referral rates.
- Bridging the cultural differences between primary care and behavioral health, e.g., when are patients discharged for failure to attend appointments, the appointment length, how EHR notes are written.
- Managing expectations around patient volume; a few physician champions believed that the IBH providers were not yet meeting their maximum productivity. At those sites, the IBH providers themselves did not express that sentiment.
- Difficulties in managing patients' expectations around IBH services versus long-term counseling.

Many interviewees felt that these (and other) issues occurred in large part because while their senior administration was excited to bring IBH to their organization, administrators did not fully recognize what was involved in making IBH work.

> "It would have been helpful to establish policies and procedures before rollout, to have more understanding of how it would work at each site."

> "It would have been helpful to know about EHR issues ahead of time, before starting the pilot."

> "A lot of time primary care doctors struggle with finding patients care; provide behavioral health care, provide psycho-pharmacy. And at times we are not always super comfortable with that. So there was a sense of gratitude, but at the same time a sense of frustration. I didn't feel it so much, but other providers felt, why isn't this working better? Why is it that we have a wait list for counseling?"
>
> "…surprisingly off-base in a number of their calculations regarding [projecting patient volume.] In their defense, this hasn't been done a whole lot and there was a steep learning curve for them."
>
> "And I was having a really tough time because people do what they do, and they get used to what they do, and they don't want to change. Now that was on both sides. BH didn't want to change. Medical didn't want to change."

Program oversight and management

Policies and procedures

We did not ask every site about their IBH policies and procedures. However, for the sites we did ask, managers or others with oversight responsibilities stated there were written IBH policies and procedures. Two sites described spending a good deal of time creating, distributing and reviewing them with staff. At some sites, implementing staff, including physicians, did not always know there were written policies and procedures. One physician champion who apparently did not know the organization had policies and procedures said, *"It would be burdensome to have to write policies and procedures."* Another interviewee noted, *"…policies and procedures are more oral history."*

Staff primarily described learning about changes in policies and procedures at staff or administrative meetings. Some sites also described receiving emails about changes. Sites that had dedicated IBH meetings reviewed changes at those meetings. However, some interviewees said if the staff person missed the staff meeting or did not attend administrative meetings, learning about program changes tended to be word of mouth. For example, at one site where there were frequent changes to workflows. One staff who did attend administrative meetings described how burdensome it was to have multiple staff come and ask for the latest update.

Program oversight

All sites had someone who was considered to be the IBH program manager, director, or point person. What differentiated sites was whether or not:

- Practices designated a site manager or point person who reported to another administrator who had management authority; or, the practice had a dedicated Director of IBH, or IBH manager with management authority.
- Oversight responsibilities were added to existing responsibilities ("one more thing"); or, the IBH manager or director had dedicated time to perform oversight. The IBH program as one more responsibility, without a decrease in other tasks, was the case at many sites.
- The program manager or director had specific IBH training. Often, when the responsibilities were "one more thing", the site or overall manager typically did not have previous IBH training or experience.

- The IBH manager or director conducted direct supervision of the IBH clinician and conducted staff meetings with other implementing IBH staff. At some sites, a clinician managed the site but reported to another administrator. When the person with oversight responsibilities conducted supervision and staff meetings, that person appeared better able to understand program operations, issues and best practices.
- The IBH manager or director had authority to make decisions about the IBH program, e.g., programmatic changes, hiring decisions.
- The IBH manager or director participated in senior administration or other leadership team meetings, or had regularly scheduled meetings with senior leadership about the IBH program.

Examples of management and authority to make decisions are as follows:

- One practice has two physician champions jointly directing the program. The two physicians also manage the practice. Both have administrative authority. Both are dedicated to the IBH model and are committed to having a robust IBH program at their practice. They manage the IBH staff and run clinical team meetings. IBH is one of many programs and grants they manage at their practice. A good deal of IBH day-to-day management, however, fell to the practice manager.
- One multi-site FQHC has a full-time Director of IBH. The Director of IBH creates and oversees the implementation of IBH policies and procedures, conducts IBH orientation, supervises IBH staff, hires IBH staff, runs IBH staff meetings and has standing meetings with other implementing IBH staff, runs clinical team meetings, and reports to FQHC's leadership.
- One organization with two pilot sites has the Director of Behavioral Health manage the IBH program. The IBH providers at each site manage site-based operations. The IBH providers do not participate in leadership or administrative meetings where IBH decisions are made.
- One organization had the Director of Quality Improvement manage the IBH program. Then the organization made the decision to move oversight to the medical division. However, the physician given oversight responsibilities felt that he was not adequately involved from the start of the program and it took some adjusting to take on this supervision.

Types of meetings involving IBH staff and service issues

At oversight meetings, staff have an opportunity to share information about IBH program functioning, staff experiences and suggestions for program improvement. Types of oversight meetings where staff share information about the IBH pilot and get feedback include: IBH staff meetings; clinical supervision meetings; administrative meetings where IBH is an agenda item; practice staff meetings; pre-visit planning meetings; and case conferences. Practice facilitation meetings also provided opportunity for program staff to come together and problem solve, particularly about implementation issues, workflow, and PDSA efforts. In many cases, the facilitation meetings serve as additional IBH staff meetings.
The ongoing IBH staff meeting attendees typically involve the IBH provider(s) as well as student IBH providers, the IBH site or overall IBH manager, and the consulting or practice psychiatrist where there is one. NCMs usually attend, but at least at one site, the NCM does not. At some sites, the physician champion or a representative from the medical staff attends, but attendance could be sporadic.

> "So we meet weekly, and we talk about any updates, any barriers or concerns that are coming up. We also can do case consultation at that time which is really nice."

> "We meet every other week, we meet as an IBH team. Myself, the behavioral healthcare manager, the psychiatry consultant, the nurse care manager and all of the clinicians….We talk about patients who are improving. We talk about sort of grant stuff since there's been a lot of projects associated with the CTC grant, and it's a time where the nurse care manager and their team can sit down and talk about shared appointments that we want to have with medically complicated patients. So we sort of plan for the next few weeks."

What differentiates meetings is how issues are addressed. It is much easier and less frustrating to staff when the IBH manager or director has authority to make program decisions in conjunction with the senior management. At other sites, IBH changes are an agenda item, presented by a manager who is not regularly onsite.

How do sites know IBH is working?

Sites in the pilot developed tracking measures for their IBH program. Many measures were grant requirements, for example tracking warm handoff and screening and rescreening rates. Sites use their data for performance improvement and to help ensure that providers are meeting productivity standards. Examples of data that sites reported using include:

- Tracking the volume of people identified with depression, anxiety, or substance use disorder.
- Number of physician referrals.
- Using registry data to track patient scores, referrals, appointments and attendance.
- Number of warm handoffs by provider.
- Number of IBH clinical encounters (used to measure performance and income generation).
- Number of patients that move from short- to long-term treatment.
- PDSAs did some measurement regarding reduction in ED use and diabetes measures.
- One site tracks changes using the Diabetes Distress Scale with all diabetic patients.
- Three organizations (5 sites) have conducted cost of care analysis.

Sites reviewed data regularly and applied it in one or more of the following ways. (Sites with a dedicated IBH manager or Director used and presented data in most or all of the ways listed).

- To intervene or provide more training when provider referrals were low or not appropriate.
- To ensure IBH providers understand and meet productivity standards.
- To present data at IBH staff meetings.
- To present data at site staff meetings, and/or with their Board of Directors.
- To review at quarterly data review meetings.
- To present data to their Board of Directors.

In addition to data, the "feel" of the clinic could be an important means to understanding the program.

> "We track warm handoffs monthly. You can drill down and see by provider. We have a number of tools to see what's going on, but I don't--at this point I mean--at this point in the process, I think a lot of it is also sort of a feel for the clinic."

Yet there are considerable problems related to understanding the impact of one's program. A participant noted that it is hard to link changes in health outcomes to IBH because patients cycle in and out of IBH, have different numbers of visits, and may or may not receive services from support staff. A physician champion lamented that he cannot get access to data that will tell him how his program is doing, particularly in regard to ED usage. Another interviewee felt that their IBH program generates a lot of data, however, there is limited capacity to conduct data analysis.

> "So I think we're measuring enough, but what I do think would be great if we had more of--and I don't think any organization has this unless you're an academic one--is I wish we had someone that had a background in data analysis understanding the basic, basic research and could answer questions for me that we currently can't answer."

However, when data can be analyzed, perception is replaced by quantifiable outcomes.

> "There are always feel good stories and that--that is part of the selling to change the culture. The hardest, most objective data is just now starting to come to light…we've seen a decrease in total cost of care."

Sites in the pilot did not have a systematic process for measuring patient satisfaction with IBH services. At one site, for example, patient satisfaction surveys are distributed periodically regarding a patient's current visit so when the visit is for IBH, the site is able to collect patient satisfaction data for that IBH visit. However, it was unclear if the site had analyzed those data.

PDSAs

The grant's participation agreement required the pilot sites to conduct three PDSAs. Other CTC-RI documents and presentations report on the results of the PDSAs. This section provides reflections from the sites regarding the PDSAs. Throughout the sites, interviewees expressed appreciation for the help of the IBH facilitator in designing, tweaking, and implementing the PDSAs.

Interviewees at all sites felt the activities within PDSA 1 should be a requirement for any site implementing IBH. However many sites wanted to be able to conduct the work of getting screening tools into the EHR and developing workflows before they started implementation.

Sites had mixed reviews regarding PDSA 2, reducing emergency department use, and PDSA 3, population health focus within behavioral health. (At the time of interviews, sites in Cohort 2 had only just begun their PDSA 3.) Most interviewees agreed that PDSAs 2 and 3 helped to engage the NCM in the IBH pilot. That was important.

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

However, some interviewees felt the one-size-fits-all approach to PDSAs was not particularly helpful for their sites. In addition, some sites felt the PDSA designed to reduce ED use either was an abject failure or needed to be tweaked to make it more effective and less labor intensive. These sites appreciated the

experience of having tried the innovations, but felt the effort affected few patients who were already being monitored by the NCM.

Some sites that focused on diabetes for PDSA 3 had a similar experience. Running and recruiting group visits often was difficult, or was redundant with services the site already provided. Further, a notable disincentive to patients' participation in groups was that group visits have different copays, depending on who runs the group. There is no copay if the NCM runs the group, a specialty copay if the IBH clinician runs or co-facilitates the group, and a primary care copay if the medical provider runs the group.

Some interviewees felt they would have benefited more from implementing PDSAs that focused on addressing or refining other aspects of their IBH program.

IBH orientation and IBH training

IBH orientation and training help establish the importance each site placed on IBH. Both contribute to how well implementing staff understand the purpose of the program and how to implement it correctly.

We asked some, but not all interview participants about how site staff receive orientation to IBH. We found a range of approaches. At one end of the continuum, some managers or others with oversight responsibilities described an orientation process that included a lengthy introduction to IBH and how to implement the IBH program. At the other end was, *"They told me what to do, and I did it. This isn't rocket science."* However, it was clear across sites the MAs received detailed orientation and training regarding how to administer the screening tool, respond to a positive screen, and enter screening data into the EHR. Many sites described providing MAs with detailed workflows and written materials.

There were staff in some sites who previously or in conjunction with the start of the pilot program had formal training in IBH from the University of Massachusetts Medical School's Center for Integrated Behavioral Health, formal or self-taught training from the AIMS Center, or had done other reading and/or attended conferences. Some sites provided extensive IBH training as part of their staff orientation. One organization provides IBH training to all staff, regardless of their organizational role. In this way, the organization felt it builds an organizational culture of IBH. This also means any staff can respond to patients when asked about IBH or mental health services, or can suggest the program when working with a patient who could benefit from IBH.

Many sites made IBH presentations at staff meetings as part of the rollout. However, this was high-level information, rather than training. Some sites continued IBH presentations as part of all staff or clinical staff meetings. Cross training happened at some sites because of PDSA 3. At one site where the PDSA focused on diabetes, there were staff meeting trainings regarding how diabetes influences mental health, and the impact of depression and other behavioral health issues on diabetes. Providers and IBH providers felt these kinds of trainings were helpful, and should continue.

Staff who attended the facilitation meetings reported they received materials from the facilitator. The facilitation meetings also served as a way to educate staff about IBH. CTC-RI provided quarterly trainings at their learning collaborative meetings. As noted earlier, not all implementing staff had the schedule flexibility to attend those trainings.

Physician champions often said they provided behavioral health care throughout their career and did not need training. They welcomed having IBH in their practice. Some however thought that they would like to have more IBH training. This was particularly true if the provider came to the practice after the initial rollout of the IBH program.

Creating a culture of IBH among practice providers and other staff

The rollout of the IBH pilot was critical for setting the stage for IBH at each practice (see report section on Rollout). In particular, who was designated to be in charge of IBH, and how and at what point providers and other staff were engaged influenced perceptions of the program's benefits despite having to add new work processes such as pre-visit planning to include IBH and warm handoffs. However, the rollout alone was not enough at some practices to get everyone onboard with the program, depending on the idiosyncrasies of their own particular perspectives about the role of primary care in providing behavioral health services. *"We have cultural barriers. We have logistical barriers. We have financing barriers. Culture is the fun one to discuss because people didn't realize what they didn't know."*

In some practices, a gulf between the perceived culture of medicine and culture of behavioral health had to be spanned. As one IBH clinician stated, "We see less people more often, and they see more people less often. And that's why those two cultures and workflows are tough to put together." Even among proponents of IBH, in practices that were considered to be highly accepting of the program, protocols needed to be tested and modified (e.g. how to get the highest amount of patients screened; how to initiate warm handoffs in effective as well as efficient ways) before a process was created that suited the practice well and served its designated purpose. In addition, busy workdays could result in missing patients who needed to complete screening tools or not as many warm handoffs occurring as was expected/desired, and so on. The trial and error process could be wearing on practice employees. A medical provider explained that with staff turnover, the most disgruntled employees were no longer there and staff who newly joined the practice benefited from not having to have gone through the rough periods.

> "Like that growth process and the continuous quality improvement that comes with that-- the first time we tried how to do our routine behavioral health screenings, like the first time they didn't work great, and so we redid it. And we did it a little bit different. And then we did it a little bit different. Then we did it a little bit different. Like at some point I think [the providers and staff] fatigued of the change. They just wanted to go one way. And we kept changing it for the better in the end, and so now over the last two years--three years, however it's been--we've reached the point where it works really well."

A clinical director in another practice stated:

> "I think the nice thing is that the program has engrained [screening for depression, anxiety and substance abuse] as part of the culture and how [this practice] cares for their patients, and made that just the universal screening, and I think that's been tremendously valuable for the practice."

Given the initial challenges, practices therefore attempted to create and maintain a culture of IBH in various ways, including:

- Training in the concept of IBH as differentiated from outpatient behavioral health, particularly in practices that had collocated outpatient counseling prior to the new system for integrated behavioral health.
- Discussions at meetings to better understand the goals, policies and workflow at the particular practice.
- Discussions at meetings with both medical and behavioral providers to build medical providers' trust in the IBH staff.
- Changing protocols and workflow to improve efficiency and success in IBH.
- Changing program oversight to better align with work roles and workflow.
- Including IBH providers in the monthly peer review conducted among medical providers to demonstrate that they are one department and responsible to each other.
- Organizing the offices so that the medical providers and the IBH providers see each other throughout the day and can consult with each other informally.
- Giving it time: the work speaks for itself as medical providers see how having IBH in the same building helps them care for their patients in a typical week and helps them manage difficult patients individually and through clinical team meetings.
- Presenting data on reduced ED use, cost savings, etc. brought about by the IBH program.
- Leadership supporting IBH as an organizational value
- Sharing incentives across staff.
- Morning huddles: *"Huddles are the way to do it. So you really need to have that time together to be able to change culture."*

A medical provider explained:

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

Creating a culture of IBH among patients

None of the practices are collecting data about patient satisfaction with the IBH program, specifically. IBH is described at some practices during new patient orientation. Some websites specifically describe the IBH service, and others do not. Few interviewees spoke specifically about how their practices raised awareness about their IBH program among patients, or what they did to increase acceptance among patients of IBH services for themselves. This is in part because most of the practices did not feel that they had to make special efforts for patients to be onboard, especially if the medical provider spoke to the patient about IBH and they were able to do the warm handoff to IBH staff. Indeed, most felt that the patients were happy to have the service provided conveniently at the primary care setting. As one medical provider explained, there is no stigma involved for the patient: *"The idea is: Where are you going? I'm going to the psychiatrist. Oh, you know, where are you going? I'm going to my doctor's office. That piece has been pretty easy."*

Those interviewees who did talk about needing to convince patients to agree to IBH services said this is because for their patient population behavioral health interventions within the primary care setting is

unfamiliar, or feels inappropriate to them. One practice spins its presentation of IBH services as 'health coaching' in order to link IBH closely with medical health and eliminate any stigma associated with behavioral health. A coordinator at another practice explained that they posted flyers with the IBH provider's photograph around the practice, and ran a video in the waiting room explaining the program. In addition, the warm handoff alleviated most of the difficulty:

> "But [the medical provider] would explain--you know, [the IBH provider] can give you some really great techniques to help you with sleeping or whatever it may be, dealing with anxiety, dealing with depression, those type of things. So he would explain it to the patient, do the meet and greet, that warm handoff, and then [the IBH provider] would spend maybe five--less than five minutes with the patient just to do a quick introduction. And then they would move forward and schedule an appointment. . . . I think the way Dr. XX does things is in a very positive way so he's like, 'We have somebody great here that can help you with that. I'd like to introduce you to her. And most of Dr. XX's patients have been with him for so long that what he says, they're going to do. And I think that's the message I try to get out to everybody in the practice. We want to portray [the IBH service] as something positive. It's a good thing."

And a medical provider discussed the *"paradigm shift"* he underwent in how he addresses his patients' behavioral health issues. He tells patients:

> "'I give you a pill to swallow, you feel better for a period of time. The pill stops, you're right back where you started from. You work with one of my [behavioral health] clinicians they're going to help you, and you're going to work together. You're going to learn how to manage these symptoms without medication, and it's something you can have for the rest of your days.' I mean I say that over and over again. And I say over and over again to patients, 'Hear me. Why do you think I'm offering you time with my clinician before I offer you medication? Why do you think that? Because it works. Because it's better. That's why.' I don't know how many times I've said that over the past year, repeatedly, almost every day I say that. So that's a paradigm shift for me, not that I would always revert to medication, but if you don't have anything else that's all you have."

On the other hand, those patients who were already familiar with behavioral health counseling needed to be informed about how the IBH process differs from outpatient counseling.

> "It's not an hour. Most people assume that it's going to be an hour. So that was the other thing that we explained to patients. It's not an hour visit."

Screening and rescreening processes

Nation-wide, there are no firm guidelines about how often to screen, and virtually no evidence-base for rescreen frequency. It is generally accepted that at least annual screening is essential. The 2016 United States Preventive Task Force (USPTF) report states: *"The optimum interval for screening for depression is also unknown; more evidence for all populations is needed to identify ideal screening intervals. A pragmatic approach in the absence of data might include screening all adults who have not been screened previously and using clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted."*

The CTC-RI contract for meeting benchmarks of the IBH pilot calls for depression screening of adults at least once in previous 12 months using PHQ-2, and if positive, using PHQ-9 and rescreening of patients who score positive on the PHQ-9 within six months. Similarly, screening at least annually for anxiety using the GAD-7 and alcohol/substance abuse using the CAGE-AID is required. The program additionally provided practices with screening measurement specifications and gradually increasing thresholds for achieving incentive payments for meeting targets.

All practices met the standard of implementing universal screening for depression, anxiety and substance use disorders using PHQ-9, Cage-AID and GAD-7 and increased screening rates over the course of the pilot program.

One site screens with the PHQ-2, and if that is positive, then screens with the PHQ-9. The PHQ-9 was used in all sites prior to the pilot, and some had high rates of depression screening before the pilot, however some sites note that use of the PHQ-9 is more systematic now. Sites that had SBIRT grants were already using all three screening tools. It is not clear whether this was an advantage or not since those sites had not established a mechanism to track results through the EHR. Two of the sites use the Diabetes Distress Scale in addition to the other screening tools.

Sites differ in how often and when they screen and rescreen. Indeed, sites differ greatly in the capability they have to document and track screening ranging from inability of the front desk to identify patients who need to be screened, to effective manual mechanisms for tracking screening, to efficient digital means to track screening. The two sites that cannot track, screen every patient every visit; one includes acute visits and the other excludes acute visits. This is done in order to *"get the numbers up"* for screening. One interviewee felt that rescreening simply to meet screening benchmarks was like *"teaching to the test"* and did not make clinical sense.

Whether sites track which patients need to be annually screened or rescreened strongly impacts physicians' attitudes toward rescreening. Employees at those sites that require screening at every visit noted that many patients become frustrated with the repeated screening, and some start to refuse to complete the forms. A champion at one site noted that the practice can bill for the screening (though it is unclear whether they actually do so), and that this may impact the patient financially. No other practice spoke of billing for screening.

Sites that can track tend to screen annually unless the patient scores positive. If the PHQ-9 is positive, the patient is either: rescreened at the next visit; rescreened at the next visit unless it is a sick visit; rescreened every two weeks when they come in to the office, or rescreened by the BH advocate by phone; rescreened in six months and an appointment is made for this purpose. One site rescreens the patient on every visit for the time-period that they are receiving IBH services.

Among those practices that do not screen at every visit, the processes used to identify patients who need to be screened depend on the work of MAs. Examples:

a) Maintain a flow sheet that the MA consults while each patient is being 'worked up'.
b) MAs or behavioral health assistants or other support staff review charts for pre-visit planning to identify who needs to be screened based on a previous depression score, and place flags for the days panel of patients.

The processes sites use to obtain the completed screening forms, manage the data, and initiate action based on positive screens vary. Examples are:

a) In the exam room, while the MA does the vitals, the patient completes the screens on a white board, which takes about five minutes. The MA waits in the exam room for the patient to finish and uploads the results onto the computer. The medical provider sees the results on the computer screen right away, signs off on the results, talks with patient about the results if they are positive and initiates a warm handoff to the IBH provider.
b) Patient completes the screens on paper and the MA leaves the paper on a counter outside the exam room so that the medical provider sees it before going into the room. Results are later entered into the EHR; however, the medical provider does not usually look for the results there.
c) At one practice, a special magnet is placed on the outside of the exam room door to alert the medical provider to a positive screen.
d) Patient completes the screens on paper and the MA enters results into the record. The paper copies are put in a box for the BH assistant to review and ensure that the patients who score positive are referred to IBH.
e) Patient completes the screens and the MA reviews the results. MA contacts IBH for a warm handoff before patient sees the medical provider.
f) A new process that was about to be started at one site at the time of the interviews: patient completes the screens on a tablet that automatically populates to the medical record.

Practice employees noted that how they used the screening results took some time to develop.

> "In the beginning especially the doctors would use their judgment as we first started this process. Then as we got going into the screenings, what I would do is I would run the reports. I would look at patient scores for the PHQ9. And then I would put warnings in the chart for the providers …such as 'see [IBH provider]' or, you know, maybe 'do a repeat on the screen', just little reminders. Then we would talk about these in meetings so that everyone was on the same page.… eventually what would happen is, we got rolling where it was the medical assistant could also look at the screens to see 'hey doc, this is a little bit high; maybe we should recommend seeing [IBH provider]'. But that took months to get to that point where everybody was working together."

Warm handoffs

Warm handoffs to the IBH provider are the ideal and the goal of each practice. As a medical provider said, *"It's the norm. If she's with a patient she may still pop out for a few minutes to do the warm handoff."* Although warm handoffs do not happen for every patient, most medical providers believe that the handoff is extremely valuable and prevents no-shows.

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

How and how often this is accomplished varies depending on the number of IBH providers at the practice, whether they are part time or full time, and how busy the IBH providers' schedules are with either IBH or outpatient BH appointments. Under most circumstances, when a warm handoff is needed

and all IBH personnel are with patients, the MA or medical provider will interrupt the IBH visit to ask for a warm handoff. IBH staff say they let all their patients know that this may happen from time to time. If IBH providers are occupied and a student is at the practice, then the student does the warm handoff. When there are no IBH providers available onsite (since in some sites they are not full time positions), other mechanisms are used. For example, at one site, the patient is given a card that describes the IBH services, and the IBH clinician follows up with the patient within 24 hours.

Alerting the IBH staff about a need for a warm handoff is done through the dominant means of communication among staff at the practice. It may be through a mechanism on the computer such as instant messaging or another highly visible messaging technique, by phone, by the medical provider asking the MA to walk to the IBH office, or by the medical provider personally walking down the hall to the IBH office if the layout of the practice facilitates this. Varying means of initiating the warm handoff include: the medical provider contacts the IBH staff to come into the exam room to meet the patient; the MA contacts the IBH staff to come into the exam room to meet the patient; or less frequently, the patient is brought to the IBH office. In one practice, the MA typically does the warm handoff, and all staff are able to do the warm handoff, even without the patient seeing a medical provider. Another practice changed their protocol to have the MA initiate the warm handoff and have it occur prior to the physician seeing the patient. The IBH providers say this process has greatly increased the number of warm handoffs that occur, and there is no problem with the MA conducting the warm handoff instead of the medical provider because patients tend to have good relationships with the MAs at the practice. Their IBH providers explained what happened this way:

> IBH Clinician 1: We weren't getting as many warm handoffs before because I think what was happening was [the medical providers] were seeing their patient, and they were focused on wrapping that up, and they know they had another patient waiting for them. And the room needed to be free. So what was happening was they would send over an electronic referral, and we'd get them, and--
>
> IBH Clinician 2: It wasn't warm. We would then call the patient. Sometimes an hour after they just left here to schedule them. We're like, 'Oh, we could have gone in and seen them.' This actually has helped us to be able to get in front of the patients and for them to put a name to a face and to meet us, and we've scheduled a lot of appointments."

At a number of the sites, the medical providers and IBH providers praised the work of the MAs in their commitment to the IBH program and ensuring that warm handoffs occur.

> "Staff is invested. If problems come up I think they coordinate with the physicians well, or the nurse practitioner, in terms of me seeing a patient. If the medical assistants know somebody is coming in for a sick visit that's related to anxiety they'll come and knock on my door - which usually I'll read the note. But sometimes I'm so busy that I don't see that, so I feel like they're really invested in like making certain [I meet with the patient]. . . . I expect the physician and nurse practitioner to come knock on my door, but maybe not so much the MA, or even the front desk, and say, 'So and so is coming in. They need to see you.' They call up twice. I'm like, 'Okay, I'll be ready.' So it's even that. It flowed down to them where it's maybe not my expectation that they would." *(IBH Provider)*

Medical providers may sometimes step out of the exam room to orient the IBH clinician about the patient and then return to the room with the IBH clinician, although this is not usually practical. At one practice, the medical providers sometimes request that the IBH clinician come to the exam room, but does not wait for his/her arrival before leaving the room, which tends to surprise the patient. When no one is available for a warm handoff, or the medical provider feels there is no time to do a warm handoff, then the patient is told about IBH services and an appointment is made. In one practice a card for IBH services is given to the patient; in another a photograph and short bio of the IBH provider is posted in the exam rooms and a video about IBH is included in the video shorts loop in the waiting room. IBH providers feel that there is a higher chance of the patient not showing up for the IBH appointment if there was no in-person warm handoff. As an IBH provider explained:

> "So I had a patient--smoking cessation, right? We're not going to do that in 1 session, but [the physician] wants to refer them to me for smoking cessation. And it's still more likely they show up if I meet them, so [the physician] will say, 'This is xxxx She does smoking cessation. You know, I want you guys to meet. I'm going to refer you to her.' Shake hands. I say 'Great, let's meet'. And then I leave. And the physician stays in."

Referrals to IBH

Most of the medical providers throughout the sites are enthusiastic about referring to IBH, and believe that having IBH at the practice is beneficial to patients and enhances primary care. Not all providers, however, are equally enthusiastic about and engaged in the IBH program. At its best, one medical provider described the benefits:

> "Like the accessibility of it--if they don't have a copay--is incredible. You know? To be able to say 'Oh, you need therapy. Sure we can see you tomorrow.' It's crazy, right? That's like the dream of everybody doing primary care in the world: that there's no time barrier to behavioral health services when people need it."

And a medical provider at another site said:

> "I can bring [the IBH clinician] in the room and meet the person. She can have an appointment--the patient can have an appointment with her within a very short amount of time. And I know right away--I don't have to go through some big release of information. Sometimes mental health people are a little more reluctant than others to like share stuff. With [our IBH clinician] I can see the notes. She can make suggestions to me about things, or I think they could use a medication. Or I think you ought to get over to psychiatry, you know, or maybe the partial hospital, whatever, and it's just--the communication that goes on during the day--there's just zillions of messages that go back and forth."

Screening scores are the primary impetus for making a referral to IBH. All sites reviewed ED use as a PDSA to try to identify patients whose high ED use has a BH driver. Additionally, providers consider how self-management of medical illnesses may be improved with IBH services since addressing behavioral health issues is usually a precedent for improving disease self-management. Some sites discuss during morning huddles which patients have diagnoses or particular health care use patterns that warrant referral to IBH. The chronic illness PDSA was a motivator to raise awareness of the medical and BH interaction, and more practitioners are referring for reasons associated with medical condition

management and medication non-adherence. One practice has labeled the IBH services as 'health coaching', rather than using words associated with behavioral or mental health, in order to enhance acceptance of the program among both patients and providers.

> "And now that we've sort of framed it differently…I have this uncontrolled diabetic who just says yes all the time, and their blood sugar is still fourteen, and we can't get through to them. IBH is a great way to engage with them around behavior change and motivational interviewing and those sorts of things."

Either the MA makes the IBH appointment in the computer system for the patient, or requests the front desk to make the appointment, or the front desk staff make the appointments when the patient is checking out. Due to no-shows or protected slots for same day appointments, patients can at times see the IBH provider on the same day as the medical visit. More often, the patient is scheduled to come back to the practice for IBH within a few days of the medical visit.

Communication

Processes of communication are integrally related to processes of care coordination at the sites (see next section for details about care coordination). At all of the sites, IBH providers share EHR access for all patient documentation. Some medical and IBH providers claim to read each other's notes regularly to stay abreast of updates about patients seen in a day. Others say that they do not often read the long IBH EHR notes because it is too time-consuming, and instead they rely on in-person informal consultations and internal messaging systems to communicate about patient progress or problems (e.g. Tasking, skyping, instant messaging, texting). At one practice, the IBH providers said they have ceased sending the medical providers their notes because it was *"too cluttering."* At another practice, a medical provider said that he always puts the reason for the IBH referral in his EHR note, but he is not certain whether the IBH provider has a chance to read these notes.

In some practices, staff primarily use the computer for staying in communication throughout the day, and in in others, staff frequently walk over to the IBH and medical providers' offices if they are conveniently located near each other and the exam rooms. Most providers prefer to speak in person regarding patients for informal consultations, and in some practices it is also the norm for IBH staff to seek out medical providers in person. *"My most common form, just my preference, is I go and find the doc and say, 'Hey'." A physician explained: "Often I'll get a cup of coffee. I'll grab [the IBH provider] and say, 'So this guy is--you know, how's it going?'"* In one practice, the IBH and medical providers regularly place sticky notes on each other's doors to say that they would like to speak with them. In practices where the IBH clinician keeps a full schedule of patients and productivity for both behavioral health and medical personnel is a high concern, informal in-person communication with medical providers occurs less often because it is considered too time-consuming.

Care coordination and management

The coordination of care between medical and behavioral health providers is the crux of IBH. The CTC-RI pilot contract calls for "weekly review of high risk patients with BH conditions and monthly review of patients who have BH issues that interfere with management of chronic conditions with practice team." Practices have various idiosyncratic processes for accomplishing care coordination and management, depending on their staffing, size, and structure. Naturally, practices in larger health care systems have access to care management staff and resources that are not available to independent practices. One practice in such a system, for example, relies on the centralized risk management and care management

teams of the larger organization to identify high risk patients in their programs and coordinate across programs to ensure that the patients receive appropriate (and non-redundant) care. A leader at this site explained:

> "We try to match the right resource to the patient's needs at a particular time. And that's just part of our process and something that we actively work really hard at with our care team. . . . I think we've worked really hard with all of our care teams over the past few years to help them understand that sharing patients is not a negative reflection [on their own team's work]."

Some of the independent practices and health centers described the role of the Nurse Care Manager (NCM) as pivotal to care management for patients receiving IBH services, and all NCMs receive high risk/high cost lists from the health plans.
It had been anticipated that the NCM would be highly involved in the IBH programs of every practice in the pilot; however, in some practices it appeared that this was not the case. This may be due to turnover in NCM staff, unanticipated need for personal leaves, not having replaced a NCM as of yet, or trained the new NCM at the time of the interview, some practices did not describe the NCM as integrally involved in IBH.

Sites accomplished care coordination between the site's medical and behavioral health providers and other support staff primarily through the EHR (through notes and tasks), computer system messaging, hallway or sidebar conversations, telephone calls, emails and fax. The EHR, through notes and tasks, allows providers and IBH providers to document screening results, patient progress notes, and updates to the care plan. Another approach to care coordination is visibility and accessibility. Many sites noted that having the IBH accessible and where the IBH clinician is located are central to care coordination. Providers are more likely to seek out IBH providers when the offices are conveniently located. A medical provider stated, "Using the EHR can be too time consuming, especially when you can pop down the hall." Clinical team or care coordination meetings also helped coordinate care between providers.

Some practices convene daily morning huddles that include an IBH provider to discuss and plan for each day's patient panel. Staff participating in huddles varied by site. For example, at one site, medical and behavioral health providers, the NCM, health advocates and MAs participated in the morning huddles. At another site, the medical providers did not participate in the morning huddle due to an already full schedule of patient visits and other meetings. In contrast, some practices feel that they have no time for huddles, but discuss patient cases at designated case conferences. One practice has an MA do pre-visit planning review daily for all patients scheduled for the next day, and another practice has each MA with the doctor she works with do pre-visit planning several times a week at scheduled planning times. Monthly planning meetings with medical providers, IBH providers and the NCM are found to be useful along with the informal consultations these providers have with each other as the need arises.

> "And it's a lot of face time and a lot of shared exchange of information regarding patient needs and progress. . . . I'm pretty sure having regularly scheduled multidisciplinary team meetings that included behavioral health was a grant requirement somewhere along like the pathway, and so that's what led us to start the integrated nurse care management IBH provider care management meetings. I'm pretty sure that was like a mandate, some kind of push the envelope."

No matter how coordination is achieved, the integration of behavioral health and medical health is seen as something that practice staff wants to provide and that patients appreciate. As an IBH provider in one of the health centers stated, *"I feel like we're constantly communicating and constantly brainstorming. What can we do differently? Or what can we do for this patient from a medical standpoint and from a behavioral health standpoint and work together to best support the needs of the patients and really what they need."* And an IBH provider at another health center noted, *"I have heard patients really appreciate us having the whole coordinated care for our patients here."* A medical provider sums up the benefits of sharing an EHR among medical, IBH and an in-house psychiatrist: *"So the coordination of care with the totally open [EHR] system which we prescribe, our therapist, and primary care is like--everybody loves it--anecdotally, including the patient. They seem to love it."*

More formally, at least monthly clinical team meetings or case conferences for selected high-risk, high-cost patients provide an opportunity for staff to meet and review the patient's goals and treatment plan.

> "We're having a meeting next Tuesday…about a patient that we share between BH and medical and staff that. And so we'll have a half an hour staff care coordination meeting. Okay, how we going to help this person better? It may not focus on a specific disorder like diabetes or whatever, but it will focus on that person's overall care."

Across sites, clinical team meeting attendees included the IBH clinician, the medical provider, the psychiatrist (where there was one), and the IBH director or manager. At least one site did not have the NCM attend the clinical team meetings.

Care planning

AIMS and NCQA have care planning as an essential and specific function that engages the patient, family, medical provider and behavioral health provider. *"A care plan is a detailed approach to care customized to an individual patient's needs. Care plans are called for when a patient can benefit from personalized instruction and feedback to help manage a health condition or multiple conditions."* (https://integrationacademy.ahrq.gov/products/playbook/develop-shared-care-plan)

For all sites in the pilot, providers develop a care plan through the EHR. There is no formal process to develop a shared care plan, although providers refer to the EHR and provide updates through notes and tasks. An IBH provider explained, *"Sometimes I will add at the bottom of my note, 'conferred with PCP regarding treatment plan.'"* There is no section in the EHR that specifically addresses care planning. Updating the care plan means scrolling back and forth through the EHR to learn about the care plan status.

IBH providers also create a treatment plan, which is then shared with the medical providers.

> "In the initial evaluation, we ask the patient what their goals are. So we do some goal setting at the very beginning of the session, and we help to kind of tailor those goals to an integrated behavioral health setting; but it also tells us whether that's an appropriate person for integrated behavioral health. We communicate (to the MDs) what the patient's goals are and what we're going to work on and how we're going to work on it, and then how it goes and once they've been discharged we communicate that too."

Evidence-based treatment

Consistent with the AIMS and SAMHSA integrated care models, the pilot program sites typically provide 4-6 sessions of short-term interventions in which patients could see the IBH provider weekly, monthly, or cycle in and out of treatment as necessary, e.g., have one visit and come back later on when the patient was ready to engage further in treatment. The IBH clinician most often refers the patient to outpatient behavioral health if the patient needs more than six visits. For a minority of patients, IBH services may exceed the 6-visit norm, and in some of the practices since it is the same clinician who provides IBH and outpatient behavioral health, the line can be blurred. The sticking point for some of the IBH providers is the IBH model of a shorter patient visit, typically a maximum of 30 minutes. At some practices, the IBH providers have embraced the model more than at others where longer more traditional 45-minute visits still occur.

Also consistent with IBH best practice, sites reported their IBH providers provide a range of evidence-based, short-term interventions that included at least one or more of the following evidence-based treatments: motivational interviewing, behavioral activation, cognitive behavioral therapy, stress management interventions, or problem solving therapy.

Treatment innovations

We found many sites, had developed treatment innovations beyond the 4-6 IBH sessions. These innovations include the following.

- One site has developed YouTube videos regarding self-management techniques and a YouTube video that introduces patients to their IBH clinician and to IBH. These videos are available on the practice website. Additionally, the practice plays the videos in the waiting area. The site reports the YouTube videos help familiarize patients to the clinician and to IBH. Further, the self-management videos extend patients' access to treatment.
- This site also conducts group visits related to disease self-management, anxiety and stress management, and pain management for patients prescribed opioids. The site promotes these visits on the practice website. However, the copays for attending groups is an issue. We discuss this issue in the Billing section.
- Three sites recommend relaxation apps to their patients when appropriate.
- These three have developed posters and business cards about IBH and that introduce the IBH clinician at each sites. While this also falls under creating a patient culture of IBH, the sites report these materials help patients understand how IBH services can help address everyday stressors. This helps to destigmatize seeing a therapist or going to counseling.
- Another site has a resident sit in with the NCM one morning a week. The resident helps the NCM determine if there is a BH component the patient needs. This helps the NCM think "out of the box" about treatment options and about different ways to present treatment information to patients.
- Still another site has the IBH provider have telephone encounters with some patients so that they do not have to go to the office for the session every time.
- At a number of sites, the IBH clinician works with the NCM and medical providers to provide them with the skills to conduct motivational interviewing with patients.

Incorporating social work and psychology students into IBH services

Not all of the practices have students working within the IBH program, however those practices that do appear to appreciate the students' work, and rely heavily on the students to be able to provide IBH care at no cost to the patients. Particularly practices with patient populations that are largely non-Medicaid, the specialist co-pay for the IBH provider is a significant barrier to patient uptake of IBH services, as is being uninsured, under-insured, or having high deductibles. In these practices, students receive training and supervision by the site's licensed IBH clinician to conduct warm handoffs, provide the short-term brief IBH interventions for patients who would otherwise refuse services due to the copay, and to document the IBH interventions in the EHR. IBH providers train the students and meet with them regularly to discuss patient cases and progress, and review the students' notes. As two people from the same practice explained:

> "And so I think just making sure that the person precepting the student has a really good sense of the student's capabilities…that we don't just do the traditional see one- do one- teach one- practice that sometimes happens in medicine. But that we actively demonstrate skills and techniques and that we observe the student multiple times under multiple different settings before we allow them to see patients one on one…And then once we feel that they are ready and that we have faith in their clinical judgment then we let them fly on their own." *(Clinical Manager)*

> "[The student] shadowed me. She sat in on intakes. She sat in on follow-up sessions. She saw what I was doing. So she can see, okay, this I what I should be doing. . . . We have clinical supervision. And she'll talk about cases, and I'll say this is the direction you should take with the patient. This is what you should do." *(IBH Clinician)*

The practices do not bill for the student sessions, and the students' work frees up the salaried IBH staff to see patients for IBH who can afford the copay, and to see patients for billable, long-term outpatient behavioral health sessions. Nevertheless, supervision takes considerable time, although the students' IBH supervisors claimed that they have enough available time for supervision.

While the presence of students can be extremely helpful in an IBH program, and often the students come to the practices having had training at RIC, URI and Brown specifically in integrated behavioral health processes, there are concerns about such heavy reliance on students. Psychology doctoral students are on four-month rotations at a practice, and so it is conceivable that some patients' IBH counseling series can be interrupted with the student's departure. Social work students tend to remain at the practice for a year. Some IBH providers explained that IBH interventions are actually more complex and difficult than long-term BH, and they were concerned that the young students do not have enough experience to adequately address the needs of patients in an IBH program.

> "Short-term treatment perhaps is harder, all the more reason to use licensed staff vs. students… And diagnostics - because you need to be able to screen people quickly and know the scope of your abilities and assess those things in a way that you're not going to have forty-five minutes every week to sort of get this person's entire [situation]."

Furthermore, some practices have no input into which students will be placed with them; they may not always be able to interview students or otherwise choose or approve of the student they will have to

work with in their office. On the positive side, the time that the student is with the practice serves in essence as a trial phase, and practices can determine which students they might wan

Sustainability

Financial sustainability

It appeared many sites defined sustainability as the ability to cover the IBH clinician's salary, and did not consider all the costs involved with IBH, for example, space, oversight and supervision, administrative time for attending meetings, increased workloads of staff such as NCMs, medical assistants, and practice managers. Some sites did consider costs beyond clinician salary. The opinion about program sustainability sometimes differed within a site, with interviewees having contradictory perceptions.

Reflecting different definitions, interviewees at some sites felt that their program was more sustainable than did interviewees at other sites. There were also sites that were quite clear their IBH program was not sustainable. One site reported sustainability because it had additional grant funds. Most sites reported CTC-RI funds helped them with sustainability. Sites felt that IBH providers meeting billing targets, and coding and billing appropriately, were critical to cover costs. However, we also heard, *"[IIBH is] never going to support itself if you rely solely on billing."*

To foster sustainability, most sites used MSW students or, at one site, PhD psychology students, to provide IBH services to some or most of their patients, where patients could not afford copays or were under-or uninsured. Sites felt using students was a good value, particularly since most students come with IBH training and students receive regular supervision. However, some interviewees felt IBH required a higher set of skills than students were likely to have. Given sufficient funds, sites would use licensed independent social workers or psychologists to serve their patients and rely less on students.

At several sites, BH providers split their time between IBH and traditional outpatient counseling which resulted in enough billable sessions for their program to be financially sustainable (or to at least cover IBH providers' salaries.) One site recently began opening up its IBH services to the community residents who are not currently patients of the site.

At two sites it was stated that while IBH was highly valued, if it did not pay for itself, the medical providers would not be willing to pay the IBH providers' salaries from "their own pockets."
When sites meet their population health goals, the ACO gives some reward to the practice. Sites saw promise in IBH helping them with receiving a reward. However, it was unclear to what extent ACOs, commercial payers or public payers share cost savings with practices through their contractual arrangements. We do not know if the reward sites receive are enough to offset program costs.

> "The ACO means if you deliver the population to the goal and you save money you get some reward. That gives me all the incentive to double down on IBH absolutely, become self-funding at that point because it can save so much money because it's--the prevalence is so high." (Medical provider)

> "I mean tens of hundreds of thousands of dollars, you know, it is for--to save not going to the emergency rooms to address that--but what's the barrier for us? I'm not sure we're breaking even. We're saving the system a lot of money, but I'm not sure we're breaking even from it if it wasn't for the CTC." (Medical provider)

Invisible costs of IBH

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

Policy issues

Billing, coding and copays

The problem with patient copays was a recurring issue brought up throughout the practice interviews, in multiple contexts. One site resolved this issue in a unique way: they do not bill at all for IBH services because they do not want to discriminate among patients due to their ability to pay. This, of course, affects this site's ability to be sustainable.

Patients for whom there is a copay for IBH services (essentially all insured patients who do not have Medicaid coverage) are required to pay two copays if they receive IBH counseling on the same day as they see their primary care provider, and most commonly, the IBH copay is considered by their insurer to be a specialist copay which is higher than the primary care copay. The IBH copay is a problem for many patients even if they pay it on a different day than their primary care copay, largely due to the higher specialist category amount. According to interview participants, if the IBH provider is a psychologist rather than a social worker, the copay tends to be even higher. This problem is compounded when a patient attends a group visit; the amount of the copay differs depending on who is leading or co-leading the group. If the leader is a NCM, there is no copay; if the leader is a primary care physician it is the primary care level copay, which is higher if the leader is a social worker, and even higher if the group is facilitated by a psychologist. Patients may not be aware of these differences before attending a group visit session.

Success around billing and coding appeared to differ among the practices, particularly due to the prevalent types of insurance among patients in each practice. Some interviewees said they needed more guidance on billing and coding, and others believed there are only a few IBH codes to use and their practice has no problem with using them and billing. Responses from most interviewees reflected only a vague sense of how billing and coding is accomplished, with the discussion quickly diverted by the participant to the issue of whether the patient population at the site can afford the copays. For example, while a medical provider noted that behavioral health pays for itself, and "[the IBH clinician] doesn't have to be subsidized by the partners" the practice manager at that site asserted:

> "I can tell by looking at [the IBH provider's] schedule that she is billing for her visits. And patients are paying copays for them. Just judging by the sheer numbers I'm sure she's probably doing okay from a billing perspective. But I think if we really are going to effect change and really meet the needs of our patients that we serve here in Rhode Island, we have to find a way to--just in the same way that working with your nurse care

> manager is free to patients and there's no cost for that-- to do the same for behavioral health."

At another site where the IBH provider does her own coding while someone else does the billing, she has become comfortable using a small range of codes for successful billing, but she also immediately brought up the topic of patient barriers.

> "[The financial staff person] handles all that. She lets me know if I've coded something incorrectly. Usually there's only a few that I use. But I saw that there are several others you can use. I don't even touch those. So yeah, no I don't--and I've had patients say I can't come back to see you because I don't have enough visits left, or my copay is high."

An IBH provider explained how they use dummy codes in order to track visits even when they are not billing for them:

> "We are coding, but we're using dummy codes. We're using VHWH for warm handoffs. And BHCC for consultations that would be your IBH health coaching. So they can be calculated what we're doing--those BHCCs would normally be billable if we were in Providence where the majority of people are Medicaid funded insurance or Pawtucket, Blackstone Valley Community Health Center. Those places probably don't have the save issues we have. And so those normally would be billable, but they're not billable here. But they're trackable."

A number of sites struggled with understanding how to maximize billing. Interviewees at these practices said they would like to have additional training on coding and billing. One medical provider noted that the training should not be generic to IBH, but needs to be a specific consultation tailored to each site, as every site has different arrangements with each of the health insurers. However, confidentiality concerns may impede this.

> "I think the one big thing that's been hard to get good technical assistance on is the financial part. Largely because of this proprietary information versus not question. Each of us have different contracts with every insurer, and we don't want to share our contracts with other people, and we can't. And so even with [the CTC facilitator], well, how much can you tell her about how you get reimbursed by this person? Our contracts allow for certain codes to be billed and not others to be billed. And those are different for every health center. And so it's been very hard to know the best way to bill and thus the best way to build sustainability of the program. Even within the health center it's very complicated. And the answers are often vague from our insurers. So determining financial sustainability has been the hardest part. . . XX who is the biller will tell you that, 'Yes, we bill these codes. And they're reimbursed.' That's all she'll tell you.
>
> But the real question is well, can we bill better? Can we bill a different code? Can we bill that more frequently? Can we bill the same day as the PCP? Which ones are getting rejected? Are there other ways to format this financially that work better? Like that whole best practice financial part. We don't get that from CTC. . . . Just for example, for our integrated behavioral health psychiatrist or psych nurse practitioner, what do we do when she sees the patient the same day as the PCP? And [the CTC facilitator] can give some general guidance about what other people may do maybe, but the end question

is, 'What do our insurers--because same tax ID-- what will they and won't they pay for in the same day. And figuring that out is tricky."

Payment models

A few interviewees felt some sort of hybrid payment model was fine. However, interviewees typically did not articulate a clear payment model. Those without a clear model knew what they wanted. They want the IBH clinician and support staff to be considered a normal part of the PCMH, in the same way a NCM is part of the PCMH. They want removed all aspects of fee-for-service payment from IBH. They are willing to meet performance targets. They believe IBH will help them meet those performance targets; but, they want to focus on providing a valuable service for patients, not worry about billing codes. However this is accomplished, through a global rate or bundled rate or drastically increased PMPM, the rate should pay for support staff, IBH providers, IBH managers, and the additional time medical providers at all levels spend on IBH. This rate should eliminate IBH copays, including copays for group IBH visits, and those with a focus on disease management.

Credentialing

While not an issue at all sites, credentialing was a clear implementation barrier at some. IBH providers found that insurers had different timelines, and applications, and the credentialing process was unnecessarily bureaucratic, arbitrary, and time consuming. One clinician waited nine months to be credentialed by Cigna, because Cigna did not understand there is a difference between long-term therapy and IBH, and the need for IBH providers on the insurer's panel. When credentialing was drawn out, IBH providers saw patients for whom they could not bill. The providers felt, ethically, they could not stop treating the patient. IBH providers strongly advocated for the establishment of a universal credentialing process, at least within the State.

Addressing social determinants of health

Addressing social determinants of health is a key aspect of IBH. There was variation in the staff available to sites to address social determinants of health. Community health centers/ federally qualified health centers had staff whose function it is to help patients with their social needs, e.g., health advocates, behavioral health advocates, patient navigators. One practice had access to outreach care management teams as part of their ACO. Otherwise, helping patients address their social issues fell to the medical and IBH providers or to the NCM. IBH providers may try to solve simple problems by making a phone call, providing a resource list, or searching the internet for a specific resource location and phone number. Providers who cannot quickly solve problems often refer the patient to the NCM. In some cases, the patient is already on the NCM's panel of high-risk, high-cost patients. However, with additional patients referred from IBH, NCMs can find themselves with expanding patient panels.

Many interviewees noted that regardless of who helps patients address their social needs, there is a need for more resources. Areas of particular need are increased access to medical transportation offered that the state could provide a regularly updated, printable and sortable online resource list.

Limitations

This evaluation primarily used interviewee self-report to learn how each site's IBH program functioned. While many interviewees shared their experiences, warts and all, it is likely some interviewees did not fully disclose the workflow, personnel, financial and other challenges that they experienced and maybe continue to experience. The complete core question set was used across each site's interviewees, modifying as necessary according to the interviewee's role in the organization and the person's time constraints. It is possible by doing so the evaluators missed gathering some perspectives.
When comparing to best practices found in the published literature, evaluators found that some sites and organizations are high performing. However, it is not known if site activities led to improved patient outcomes, patient satisfaction with the IBH program, higher patient satisfaction with their healthcare overall, or provider and clinician satisfaction with the IBH program.

Some sites had conducted cost of care analysis and found their IBH program had reduced costs. Some sites reported their IBH program had achieved financial sustainability, as indicated either by self-report or by their financial worksheet. These findings are included in this report, however the evaluators had minimal information about costs, and do not know if the methods used by each site to come to their conclusions are sound.

The evaluators have provided key characteristics of each site that reported sustainability or lowered cost of care. It can only be surmised which characteristics played a role in site success.

Recommendations

Overall recommendation for practices and organizations that want to start an IBH program: Engage in planning, testing, team development, and addressing cultural issues of the practice environment prior to implementation of an IBH program.

Overall recommendation for potential IBH funders (ACOs, individual practices, granting agencies or organizations): Provide adequate funding for IBH planning and conducting foundational activities. Fund practice facilitation for the first 24 months of the program.

Overall recommendation for public and commercial payers and policy makers regarding payment: Fund IBH as a service truly integral to the primary care practice. Remove all aspects of fee-for-service payment from IBH and create a bundled or global rate, or a vastly increased PMPM rate. The rate should pay for support staff, IBH providers, IBH managers, and the additional time medical providers and staff at all levels spend on IBH services and administration. This bundled rate should eliminate IBH copays, including copays for group IBH visits. Support the development of universal EHR changes that will support IBH care planning, link to and support patient tracking and registry systems.

Overall recommendation for practices: Ensure that the IBH program has an IBH manager or director with dedicated program management time, who directly supervises clinical staff, who reports to senior leadership, and has the authority to develop and implement policies and procedures.

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

Foundational Activities

IBH program start-up

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

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

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

Staffing

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

Staffing recommendations
1. Sites developed their IBH staffing based on their patient volume, site and organizational needs, funding, and available resources. However, it could be helpful if individual sites and organizations had an IBH clinician (licensed or student) available during all practice hours. In this way, patients with high PHQ scores, suicidal ideation, or other serious issues could have immediate access to IBH assessment.
2. Sites and organizations should have a health or behavioral health advocate to address the social needs of IBH patients, psychiatry consultation, and an IBH manager with dedicated and sufficient time for IBH management and staff supervision.
3. Assess whether IBH will bring additional patients to the NCM's panel. Consider providing the NCM with a health advocate or patient navigator if the NCM's workload increases significantly because of IBH.
4. Determine if it is feasible to have long-term counseling services available on site, so that patients do not have to travel to another location.
5. Assess the language needs of patients, and as possible, hire bilingual IBH clinical staff and support staff.

Staffing recommendations
6. IBH generates a good deal of data, but sites and organizations often lack resources to conduct data analysis. Examine whether it is possible to hire a part-or full-time data analyst. Consider the possibility of sharing a data analyst with other practices.
7. All practices and organizations take on new projects and grants. However, IBH is supposed to be here to stay and is not "one more thing" that is temporary, in existence until the project is over. Determine if there are workload issues associated with IBH for medical providers, MAs, practice managers, care managers, and other staff that need to be addressed because of the time or responsibilities IBH programs require.

Clinical services needs

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

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

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

Implementation

Rollout and organizational culture of IBH

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

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

Creating a patient culture of IBH

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

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

Oversight and meetings

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

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

Oversight: Policies and procedures

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

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

IBH training and cross training

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

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

Determining program success

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

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

Multi-site organizations and ACO engagement

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

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

Sustainability

Students as IBH providers

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

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

Licensed Independent clinical social workers and licensed social workers

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

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

Billing and coding

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

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

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

Policy Recommendations

Electronic Health Record (EHR)

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

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

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

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

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

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

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

Staffing—psychiatric consultant

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

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

Copays

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

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

Payment models

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

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

Credentialing

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

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

Social determinants of health—Social needs services

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

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

Areas for future study

In the spirit of "If you've seen one program, you've seen one program" it is difficult to tell from the literature what exactly are the IBH program characteristics that lead to cost reductions, especially since each program implements IBH based on their organization needs and resources. Further, it is less clear how other variables affect patient outcomes and cost of care.

We feel it would be useful to conduct analysis to see if the following factors influenced patient outcomes and cost of care.

1. Staffing: Compare sites with dedicated IBH behavioral health advocates, access to health advocates or other care managers, no support staff.
2. Oversight and management: Compare strong, dedicated management vs. management as an added responsibility and more hands off approach.
3. IBH provider models: Compare high reliance on students, some reliance on students, no reliance on students.
4. No co-pays: One site is notable in that it did not charge patients copays and did not bill insurers for IBH services. Therefore, patients did not have to deal with meeting deductibles or paying copays.
    - It is likely Brown University is addressing this difference in its quantitative evaluation, e.g., but it would be important to determine how having free access to IBH affects cost of care, patient outcomes, medical treatment compliance, behavioral health treatment compliance.

The following are not related to cost of care, but would be important to know:

5. From a staffing perspective, it would be useful to see how IBH affects staff workloads. For example,
    - How does IBH affect the panel size of NCMs?
    - Has clinician, medical provider, NCM and medical assistant turnover decreased or increased since the implementation of IBH?
6. From a patient perspective, it would be useful to know how patients perceive the IBH program. For instance:
    - How knowledgeable are patients about the IBH program?
    - For patients who have used the IBH program, what is their level of program satisfaction? How would they improve the program?

References

1. Borkan, J., *Immersion/Crystallization*, in *Doing Qualitative Research*, B. Crabtree and W. Miller, Editors. 1999, Sage Publications: Thousand Oaks, CA. p. 179-194.
2. AHRQ, *Registries for Evaluating Patient Outcomes: A User's Guide [Internet].* 3rd ed. 2014, April 2, Rockville, MD: Agency for Healthcare Research and Quality.
3. University of Washington: AIMS Center. *Registry functions for population-based care and measurement-based treatment to target*. 2017 July 11, 2018]; Available from: https://aims.uw.edu/sites/default/files/CollaborativeCareRegistryRequirements.pdf.
4. AIMS Center; University of Washington. *Identify a population-based tracking system*. 2018; Available from: https://aims.uw.edu/collaborative-care/implementation-guide/plan-clinical-practice-change/identify-population-based.
5. University of Washington: AIMS Center. *Collaborative Care: A step-by-step guide to implementing the core model*. 2014 March 1, 2018]; Available from: https://aims.uw.edu/sites/default/files/CollaborativeCareImplementationGuide.pdf.
6. Cifuentes, M., et al., *Electronic Health Record Challenges, Workarounds, and Solutions Observed in Practices Integrating Behavioral Health and Primary Care.* The Journal of the American Board of Family Medicine, 2015. **28**(Supplement 1): p. S63-S72.
7. SAMHSA-HRSA Center for Integrated Health Solutions. *Team members*. n.d.; Available from: https://www.integration.samhsa.gov/workforce/team-members.
8. Center, A. *Psychiatric consultant*. 2018; Available from: https://aims.uw.edu/collaborative-care/team-structure/psychiatric-consultant.
9. Blount, F.A. and B.F. Miller, *Addressing the workforce crisis in integrated primary care.* Journal of Clinical Psychology in Medical Settings, 2009. **16**(1): p. 113.
10. Horevitz, E. and P. Manoleas, *Professional competencies and training needs of professional social workers in integrated behavioral health in primary care.* Social Work in Health Care, 2013. **52**(8): p. 752-787.
11. Heath, B., P. Wise Romero, and K. Reynolds, *A review and proposed standard framework for levels of integrated healthcare*. March 2013, SAMHSA-HRSA Center for Integrated Health Solutions: Washington, DC.
12. Maine Health Access Foundation, *Health and behavior codes--February 2016*. 2016.
13. Maine Mental Health Partners, *Maximizing reimbursement in today's fee for service world*. 2013, YouTube.
14. Solutions, S.-H.C.f.I.H. *SAMHSA-HRSA Center for Integrated Health Solutions*. n.d.; Available from: https://www.integration.samhsa.gov/.
15. university of Washington's AIMS Center. *AIMS Center--Advancing integrated mental health solutions*. 2018.
16. AHRQ. *What is integrated behavioral healthcare?* n.d.; Available from: https://integrationacademy.ahrq.gov/about/what-integrated-behavioral-health.
17. The Working Party Group on Integrated Behavioral Healthcare:, et al., *Joint principles: Integrating behavioral health care into the patient-centered medical home.* The Annals of Family Medicine, 2014. **12**(2): p. 183-185.
18. SAMHSA-HRSA Center for Integrated Health Solutions. *Making integrated care work. Informatics.* n.d.; Available from: https://www.integration.samhsa.gov/workforce/informatics.
19. Roderick, S., et al., *Integrated behavioral health practice facilitation in patient centered medical homes: A promising application.* Families, Systems, & Health, 2017. **35**(2): p. 227-237.

20. AHRQ. *Practice facilitation*. n.d.; Available from: https://pcmh.ahrq.gov/page/practice-facilitation.
21. University of Washington: AIMS Center. *REGISTRY*. 2018 July 11, 2018]; Available from: https://aims.uw.edu/keyword-tagging/registry.
22. Murphy, K. *Debating role of EHR use in behavioral health integration*. 2016; Available from: https://ehrintelligence.com/news/debating-role-of-ehr-use-in-behavioral-health-integration.
23. Kessler, R. and J.R. Hitt, *Re: Electronic Health Record challenges, workarounds, and solutions observed in practices integrating behavioral health and primary care.* The Journal of the American Board of Family Medicine, 2016. **29**(2): p. 289-290.

Attachment 1: Overall Research Questions

1. How is the IBH program being implemented at the practice sites (including, but not limited to: facilitator coaching meetings, PDSAs, behavioral health clinician service provision, service billing)?
    a. How and why does implementation vary across sites?
    b. What factors might be contributing to varied levels of achievement and success across sites?
2. How do practice IBH champions and other key practice staff experience the program at their sites?
    a. What do they see as facilitators and barriers to implementation, and why?
    b. How do they assess the program, overall, the individual components, and their ability to achieve stated goals?
3. How do practice IBH champions and other key practice staff perceive the appropriateness of the current payment models as incentives?
    a. How are the practices balancing billing for services, incentives and costs for the behavioral health clinician's time and other program expenses?

The interview guide was used to explore the following issues of particular interest to CTC-RI.

1. What structures are in place by practice to implement IBH, including types of and location of services, training mechanisms, quality improvement processes, screening tools, communication mechanisms, role and use of electronic health records for tracking IBH services and outcomes, practice staffing, support staff, hours of service, care coordination mechanisms?
    a. Brief description of each practice
2. What processes are in place to implement IBH? How do practice members work together and independently? How do practices interact and share their knowledge and skills? How are high-risk patient lists compiled? How are patients targeted for the intervention? How are patients initially approached for inclusion in the intervention? How do they generally respond to the idea?
3. What processes are in place to create and maintain provider, staff and patient buy-in? What are the evolving IBH roles and responsibilities?
4. What are the facilitators and barriers regarding engaging patients in behavioral health care and behavioral change?

Attachment 2: Interview Guide

Practice Administrators (PA): Practice administrator, Project manager, Medical Director
Medical Provider (MP): Physician, Nurse Care Manager
Behavioral Health Provider (BH): Licensed or Unlicensed BH provider

Respondents			Section
PA	**MP**	**BH**	**Questions**
			1. Project description and roll out ● **Primary Project Aims** ● **Location of Clinical Services** ● **Formal partnership with other organizations or entities, e.g., CMHCs, community organizations** ● **IBH program description (Please provide copy of program description ahead of interview.)** ● **Project rollout**
X	**X**	**X**	1. What are the **primary aims** of your IBH pilot?
X		**X**	2. **Where** are BH clinical services physically **located**? a. How does that work out for the practice site regarding space usage, patient privacy? b. For providers—do you feel office space is **adequate**? c. For patients? d. What were **barriers to locating** behavioral health providers at your practice? e. If you had to do it again, what would you **do differently**? The **same**?
X			3. What **formal partnerships or MOUs** did you enter into to support IBH? a. With **CMHCs**? b. With **other BH or substance use providers** or practices? c. With other **community organizations**? d. If you have **not formed** partnerships or MOUs, please tell us **why**.
X			4. Please describe briefly how you **rolled your project out,** including: a. How you **decided** to become a pilot b. **Identifying** project **staff**, including project champions i. Choose **practice champions**? ii. How did you **roll it out to staff and create buy-in**? iii. Processes to **maintain buy-in**? **c. Training** d. **Structural changes**, including your EHR, care planning, communication process e. How you worked with CTC, the practice facilitator, others
X	**X**	**X**	5. Please give us an **overview of your IBH program**: a. **Basic elements**: screening and other identification processes for behavioral health disorders; hand-offs; treatment; care management, referrals. b. What do we **need to know about your particular practice** to help us understand the environment or conditions affecting provision of IBH services?

Respondents			Section
PA	**MP**	**BH**	**Questions**
X	**X**	**X**	6. Please tell us how you **prioritize patients** for the IBH intervention. a. **Are all patients who screen positive referred**, or are patients triaged for the intervention? b. How are **high-risk** patient lists prioritized?
X	**X**	**X**	7. Looking at this SAMHSA integration chart, where do you think your practice is at?
PA	**MP**	**BH**	**Staffing: BH staffing <u>roles for providing services</u>** ● **Care Management, Nurse Care Managers, Patient navigators, Community health teams** ● **Types of BH interventions provided (specific therapies, such as Problem Solving Therapy-Primary Care, Cognitive Behavioral Therapy, Interpersonal Counseling, and Behavioral Activation.)** ● **Other treatment innovations**
X	**X**	**X**	1. How have IBH **roles** and responsibilities **changed**?
X	**X**	**X**	2. How have **other team or practice member roles** and responsibilities changed as you implemented the pilot, for example the reception staff, the medical assistant, the nurse care manager, others?
X	**X**	**X**	1. How has IBH changed team function? Can you give some examples?
X		**X**	3. Please describe the **type(s) of behavioral health/SUD interventions** your bh staff provide.
X		**X**	4. What **other methods** in addition to 1-1 counseling have you tried in order to meet patient **treatment** needs, such as apps, telehealth, or group counseling?
X			5. **How many** of your bh staff have received **specific IBH primary care training** outside of the IBH program facilitation provided by the practice facilitator (Nellie Burdette)? **What** did they receive?
X	**X**	**X**	6. How do **medical and behavioral** practice providers **work together and independently** to support **coordinated** patient care?
X	**X**	**X**	7. How do you continue to **coordinate** care **with external** bh/SUD providers?
X	**X**	**X**	8. **Are staffing levels adequate** to meet patient volume—both bh and other care management staff?
X	**X**	**X**	9. What have been **barriers, facilitators**, best practices regarding **hiring and retaining BH staff** (e.g., credentialing, language, salary, training.)
X	**X**	**X**	10. What has been your experience using **bachelor or master level students** to provide bh care?
X	**X**	**X**	11. Where are the **barriers** (stumbling blocks) to **regularly achieving coordinated care** for patients? a. What are barriers, facilitators, best practices regarding BH staff working with primary care staff, care management staff?
			12. How has **IBH changed patient care**? Examples?

Respondents			Section
PA	**MP**	**BH**	**Questions**
PA	**MP**	**BH**	**3. Organizational Components and <u>oversight roles</u>** ● Project Management and Project Implementation Team ● Project champions ● Role of practice managers and leadership ● Staff buy in ● Program monitoring
X	**X**	**X**	1. What is the **role of your IBH project management or implementation team**? a. What are the **responsibilities** of the **team**? b. **Who** is on your team? (Are senior administrators on the team?) c. How often does it **meet**?
X	**X**	**X**	2. **How** does the team **ensure IBH program fidelity**? Similarly, how does the team identify and address "program **drift**", other implementation problems?
X	**X**	**X**	3. How do practice **champions support** overall **implementation**?
PA	**MP**	**BH**	**4. Decision Support** ● Identification of Behavioral Health Disorders—screening, other processes ● Decision Support Protocols and Guidelines
X	**X**		1. What are your **decision support protocols** and guidelines regarding **f/up to screening**?
	X	**X**	2. How do you **determine** whether the patient's **BH or SUD needs will be met** within the practice or will be referred out?
X	**X**		3. Are there **other ways you identify patients** as needing BH services?
	X	**X**	4. How do you **determine treatment was effective**?
X	**X**	**X**	5. How will you **determine** if your decision support guidelines **target the right patients**?
PA	**MP**	**BH**	**5. Funding sources** ● One-time grants ● Other funding ● Incentives ● Billing/billing codes ● Payment models
X			1. What **grants, other funding sources** did you have to develop your program? Were they sufficient?
X	**X**	**X**	2. Is there **program infrastructure that still needs to be developed**?
X	**X**	**X**	3. What **incentives** are you **eligible for**? Did you meet criteria for meeting incentive thresholds?
X	**X**	**X**	4. What are **issues or facilitators around incentives**?
X	**X**	**X**	5. How do **payer's policies around particular covered and uncovered services** affect your ability to provide care?
X	**X**	**X**	6. What **billing codes** do you use for IBH? a. Do you **not use**? Why

Respondents			Section
PA	**MP**	**BH**	**Questions**
X	**X**	**X**	7. What **problems around billing** have you encountered? Please give me some examples. a. **What exactly were you billing for** when the problems arose? What happened?
X	**X**	**X**	8. What has **worked for you around coding and billing**? Please give me some examples.
X	**X**	**X**	9. What are **other payer-related (or payer-created) barriers** outside of coding and billing?
X	**X**	**X**	10. What are **government-created barriers** to IBH?
X	**X**	**X**	11. We know that **financial sustainability** is a barrier to IBH across the country. a. What can be **done immediately to address coding and billing issues**? What is needed to make that happen? b. What could **health plans do** to improve IBH sustainability? c. What could **OHIC do** improve sustainability? d. What **other recommendations** do you have to make IBH financially sustainable? e. What **other changes** should be made at the **state**, public/private **payer** level? f. At the **federal** level?
X	**X**	**X**	12. Overall, what would be the **most important thing to change** in order to have benefit **coverage that would best meet patient needs**?
X	**X**	**X**	13. Overall, what is the **payment model you feel will best support IBH**?
X	**X**	**X**	14. What are other **issues or facilitators around funding IBH overall**?
PA	**MP**	**BH**	**6. Training and technical assistance** ● Training and Consultation ● Practice Facilitation ● Role of CTC-RI/meetings ● Role of health plans ● Training in use of evidence-based treatment
X	**X**	**X**	1. What are the **types of training and consultation you received from CTC and elsewhere** to develop your program? What elements did you find to be **helpful**? What elements were **not so helpful**?
X			2. How do you view the **role of CTC-RI** in supporting IBH and the IBH pilots?
X	**X**	**X**	3. What **role** did the **learning network meetings** in helping you improve IBH?
X			4. How do you provide or **access ongoing IBH training and consultation**?
X	**X**	**X**	5. How do you view the **role of practice facilitation for supporting the IBH program** at your site?
X		**X**	6. How do **practices in the CTC IBH pilot interact with each other** and share their knowledge and skills?
X			7. What **role** have the **health plans** had in helping you **develop or manage the IBH pilot**?
X	**X**	**X**	8. What are **challenges, facilitators or best practice**s regarding **practice facilitation**, IBH **training** and **technical assistance** for your practice?

Respondents			Section
PA	**MP**	**BH**	**Questions**
PA	**MP**	**BH**	**Communication mechanisms** ● Information Technology/EHR ● HIPAA, Confidentiality and Release of Information Forms ● Internal Referral and Communication Processes and Tools ● External Referral and Communication Processes and Tools
X	**X**	**X**	1. What are the primary mechanisms for **communication between primary care providers and bh providers** NCMs, other care managers or CHT members regarding screening results and follow-up? (EHR, emails, calls, huddles, clinical team meetings) a. What are the most useful or effective mechanisms for communication? b. What are the **barriers**?
X	**X**	**X**	2. How does your **EHR**, other information technology **support or hinder communication**?
	X	**X**	3. How do you **manage HIPAA compliance and patient confidentiality** regarding the sharing of health and bh information between **internal** practice providers? Between **external** providers, such as a CMHC?
	X	**X**	4. What are **communication facilitators** or best practices?
X		**X**	5. What **compacts** do you have with BH specialists? a. Are they effective? b. What recommendations or best practices do you have regarding BH compacts?
PA	**MP**	**BH**	**7. Patient experience/engagement** ● Introduction to IBH model ● Treatment and/or referrals ● Care planning ● Patient experience
X	**X**		1. How do you let patients know about IBH at your practice? What it is? What to expect?
	X		2. Overall, how have your **patients responded to the IBH services** you provide here? How do patients generally react to the **"warm handoff"**?
	X	**X**	3. Please describe **how the patient care plan is developed**, including how the PCP, BH provider and the patient engage in care planning. a. To what extent do you **prospectively define desired medical and behavioral health outcomes and evaluate success towards these goals in real time**, as treatment is given?
	X	**X**	4. How do you assess or **measure patient experience** with IBH?
	X	**X**	5. Please tell us about any **issues patients have with IBH**, (probe about types of issues, frequency; how you document these issues; how you f/up with or address these issues).
	X	**X**	6. What are the **facilitators or best practices around engaging patients** in IBH? a. Where are the **barriers** (stumbling blocks) to regularly achieving coordinated care for patients?

Respondents			Section
PA	**MP**	**BH**	**Questions**
			b. What are barriers, facilitators, best practices regarding **BH staff working with primary care staff**, care management staff?
	X	**X**	7. One of the primary **aims** of the IBH pilot is to **reduce ED use and hospital readmission**s. How does **your IBH program work with patients** around these 2 issues? a. Are there specific **interventions** you are using? b. How are you **measuring** intervention **effectiveness**?
	X	**X**	8. What are the **facilitators and barriers** regarding **engaging patients in behavioral change?**
	X	**X**	9. Is there **anything else we should know about the patient engagement** or patient experience with IBH?
PA	**MP**	**BH**	**8. Physician/BH clinician experience** ● Roll-out ● Experience with internal, external referrals ● Experience coordinating patient care ● Facilitators and barriers
	X	**X**	1. Roll-out to IBH at your practice was over a year ago. Thinking back, what do you think are **best practices for making the transition from traditional primary care to IBH**?
	X	**X**	2. What are the **biggest barriers** you face in making IBH work **for your practice?** For your **patients**?
	X	**X**	3. How do you **provide feedback to CTC** about how the IBH pilot is working, what is working, what could be better?
	X	**X**	**4. ******Do you have any examples of where the IBH model made a difference for your patients?**
			9. PDSAs for change and Outcomes measurement ● Site-based measures or evaluation tools ● PDSA projects and other quality improvement practices ● Quality measures ● IBH measures
X	**X**	**X**	1. What did you think about the requirement of pilot participation to **conduct 3 PDSA projects?**
X	**X**	**X**	2. How **effective were the PDSA projects** in helping your practice improve care?
X	**X**	**X**	3. How do you **collect and analyze patient and practice data** to determine IBH progress, success? a. How do you use **electronic health records** for tracking IBH services and outcomes?
X	**X**	**X**	4. What are the **barriers or facilitators to collecting patient and practice data** for **quality improvement or evaluation purposes**?
PA	**MP**	**BH**	**Last thoughts and recommendations**
X	**X**	**X**	1. Overall, what is your **commitment to retaining the IBH model** at this practice? a. What would you **prioritize for change**?

Respondents			Section
PA	**MP**	**BH**	**Questions**
			b. What **resources or actions** are needed to make those changes?
X	**X**	**X**	2. How likely is it **you would recommend** that other practices transition to an IBH model?
X	**X**	**X**	3. How important is it to you to have a **systematic approach to IBH evaluation** at the practice level and at the state level? a. What is **needed** to provide systematic and ongoing measurement of patient outcomes, practice integration, patient experience, cost of care?
X	**X**	**X**	4. What **further recommendations** do you have **for funders, payers, state and federal policy makers**?
X	**X**	**X**	5. Are there any **other recommendations** you want to make, or anything else we need to know about the IBH program at your practice?

Attachment 3: Illustrative Stories about Practices' Experiences with IBH

Training and Preparation Necessary for Physician and Staff Buy-In to IBH Program, and Maintenance of Program Workflows
"They discussed [the IBH program] at their provider meetings and their staff meetings. So it is a part of the practice. The workflows are discussed. Their input is taken so that we figure out why would they not want to engage in this model, or how can we ease that transition for them too because it's also--and just from the provider perspective, not just the psychologist or psychiatrist, whoever is working this model. I think it's a twofold. So we definitely have done a lot of work around the workflow and the education piece." *(Practice Manager)* "There's been some intentional institutional level things in terms of health center retreats where we do team building things deliberately for a half a day that includes the IBH team and the behavioral health staff, so some of those things to put faces to names. . . . We have monthly health center meetings where we all get together with both behavioral health - mental and medical. And so we've done a fair number of behavioral health-related topics that talk about integrated behavioral health which has been important for building shared understanding about it." *(Medical Provider)* "I think it's a great program. And I think that the data speaks for itself. It shows that it definitely made an improvement for people. Right now the challenge is to keep it going and to sustain it. We're in a transition phase right now where I have a lot of new staff, so everything was working like a well-oiled machine. Everybody had their role in the project. Then they bring in new staff, and things start to slide off. . . . [Also] keeping it in the forefront of everybody's minds because we're always doing so many things that you'd notice like, 'Oh, we didn't have any meet and greets this week; Why?' So I'd send out a little message to the providers: Don't forget; don't forget. Things like that. So you have to stay on top of it anytime you introduce something new. You know, it could just fall to the wayside, so that's what we would do for that." *(Practice Manager)* "We were pretty consistent for a while, and now with the transition of new staff, it's kind of starting over again because you have to explain the program, explain what we're trying to do, why the screenings are so important. So I have more new staff than established staff." *(Practice Manager)*

Consistent BH Screening May Result in Surprising Information
"I'm surprised especially with the anxiety screener that there's more out there than I knew about. I was talking to somebody yesterday. You think this wouldn't be useful information. I know the patient pretty well, and the patients, if they had an issue, I'm sure they would tell me. But it comes up on this, on the screener." *(Medical Provider)*

Benefit of Warm Handoff and Quick Access to IBH Appointment
"So there's a young man--he kind of inherited this terrible anxiety, and he was doing pretty well, but I just saw him last week and he had a full blown panic attack. And so then [the IBH provider] came in. He's seeing [the IBH provider] this week. He said, 'Yes I want to talk to someone.' He just really wanted to talk to anyone about his situation." *(Medical Provider)*

"I find what I do a lot is when I do have somebody who has really serious depression that's out of control or anxiety that's out of control or a really big abuse history which I come across a frightful amount. And they have a lot of other health issues, I want to get them into counseling so that they're doing something to address these major issues that are interfering with their ability to manage their blood pressure or their diabetes. But they also feel overwhelmed by all of their mental and physical health issues.

So having the warm handoff where they can meet one of our IBH people and… put a personal face to… our counselors. 'They're wonderful. They're going to come in. You can meet them right now.' And sort of get that accountability. I don't have any data to support this, but I suspect that helps me get them in for follow-up with the counseling staff better because we remove that barrier from an abstract follow-up with counseling or engaging counseling, and it's become like a 'Here's your appointment. It will be with me.' What's so nice about it is when I do have someone who has serious chronic issues like really uncontrolled hypertension or they're recovering from stroke, and they can't focus on that stuff because their PTSD is out of control." *(Medical Provider)*

Integration and Teamwork Improves Care and Saves Medical Provider Time

After a patient's ED visit and appointment with medical provider at the primary care clinic: "I didn't book [another] appointment with him like I normally would - because I started some medicine with him, and I would always see someone in three or four weeks if I started them on an SSRI, which I did. But I said, 'You're going to be seeing [the IBH provider], and I'm going to be seeing from her how you're doing on this medication.' So it really - it frees me up too because I need all the freeing up I can do." *(Medical Provider)*

IBH Working with Medical Providers to Improve Chronic Illness Management

"To understand the impact of what they're doing on their health, so that allows them to see, 'Okay, just by getting more sleep I've . . . .' A lot of times, I'm one of the first mental health professionals people have seen. So just the idea that talking to somebody about doing these things is helpful." *(IBH Provider)*

"If [the medical providers] prescribe a certain medication the patients have to come to me [the IBH provider]. And we'll just meet, and then two weeks later look at side effects. And if there's adjustments that need to be made - I do not do any medication management, but I'll do consultation with the provider about they're not sleeping better, or they may be reporting that they still have increased anxiety. But compared to our first visit it's significantly decreased. And so for the patient, it's like it's horrible. I'm like, 'You're sleeping, right?' 'Oh yeah.' I'm like, 'It's been two weeks…you've been living with this for two years. Let's give it some time.' So I think that that's the kind of stuff that we'll do." *(IBH Provider)*

"I have this other guy who just had a stroke and has PTSD prior and so I can say, 'We have to take care of your blood pressure because I'm worried you're going to have another stroke. And then [the IBH provider] is going to come in, and we're going to make sure that we're taking care of your anxiety and your depression and those things, too. And that way we

IBH Working with Medical Providers to Improve Chronic Illness Management

aren't neglecting [your medical condition] and we're also not neglecting your anxiety and things like that." *(Medical Provider)*

IBH Rather Than Medication for Anxiety

"I've had a couple of young guys with autism spectrum disorder and/or developmental delay who screened positive on their anxiety questionnaire who had gotten in to see one of our behavioral health clinicians whose anxiety symptoms have improved. And we haven't needed to use medication for their anxiety symptoms." *(Medical Provider)*

IBH for Anxiety and Pain Management

"I had a male with anxiety who was--he had history of head trauma, and he was getting migraines, so he came to see [a medical provider]. And it was always migraine management, migraine management. And they had tried every medicine, every intervention, Botox and he was even on medical marijuana, I mean everything you could think of, and his headaches were still really bad and effecting everything in his life. He couldn't work. He had a good relationship with his wife, and his kids were iffy because he would yell at them because they were too loud. So he came in, and we focused on the behavioral piece of how to--what to do with those feelings when they come up, not so much the migraines. And it was only a half hour each time, maybe five or six times. He learned some anxiety management coping skills. And he's doing great. And the migraines are still there, but he knows how to cope with them a little better, and he's even smoking less now, smoking cigarettes." *(IBH Provider)*

IBH can Reduce ED Visits

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

IBH for Immediate Crisis Intervention

IBH Provider 1: I think a really big success is when we get called in for suicidal ideation, and in previous to IBH being here, they would just call the rescue. And so now when we get in we dig deeper. We dig deeper. We come up with maybe a safety plan. We sometimes reach out to a family member while a patient is still in there or if there's someone outside that they feel they can talk to about this. And I think we often divert suicidal patients from going to the emergency room.

IBH Provider 2: That's nice integration because we're here to help with the crisis piece.

IBH Provider 1: Yeah, I think that's probably our strongest point.

"I saw a young woman who was getting out of an abusive relationship… when she came to see me, just really having a breakdown. I didn't know what to do with her. That was one of my late days when I was the only [medical] provider there. But there's always an IBH person there. So I said let me go [and consult with someone]. I went and talked to [the IBH provider]. I said, 'I think she needs to go to the hospital for it, but I'm not sure what to do here.' And so we talked about what was going on. [The IBH provider] is like, 'Oh, well, here's this number for getting her directly into the

IBH for Immediate Crisis Intervention
hospital. They'll send someone to pick her up and make sure that we follow-up on what's going on with her psych stuff.' And she helped me in that acute setting, and then when that patient came back later after she was more stabilized, one of the integrated behavioral health came in and introduced themselves and we got her into counseling with us for follow-up from there."

IBH Group Visits for Depression and Chronic Illness
"With the group there were six participants, and I think out of the six, five of their A1Cs were lower by the end of the group. So we did the A1C at the beginning and the end. We did a PHQ at the beginning and the end. And so the A1C was a better indicator. The PHQ was up and down. I feel like out of the six PHQs, three stayed the same. One went up, and one went down. So I was like that didn't--but for the A1Cs the majority did go down." *(IBH Provider)*

IBH Can Be Beneficial when the Patient has External Psychiatric Care
"A younger woman I have with diabetes has done better, definitely, with behavioral health services. 'Oh, you see Dr. G. When did you last see Dr. G?' 'I see her every four months.' 'Did you tell her that you're suicidal?' 'No.' 'Do you want to come to therapy here?' So I think for many of those patients, they've pulled their care here coordinated between their PCP and their therapist and their prescriber. And they've gotten a lot better care, a lot, lot better care.' *(Medical Provider)*

IBH Enhances Care Coordination and Access to Multi-faceted Patient Services
"I just went in to do a warm handoff and that patient is set up with counseling, is set up with psych care. I'm setting her up with a community health worker. So we're able to go in and be a hub and get our patients connected to a few different people and types of services. And they're so grateful because they can just come to one spot and get all their care." *(IBH Provider)* "So this patient was referred based on a positive screen for integrated behavioral health, and our [student] intern went in and met with her and set her up with me. She suffered from extreme depression. I sent her over to the partial program. She was able to get the help--there was a cultural component. And her family didn't want her to go to the partial program. She still lived with them; she doesn't drive. They were her transportation. She saw me a good maybe four or five sessions, and I got her to the point where she said, 'No, I'm going to do this.' And she did the partial program--went in very much suicidal but came out in a very much different space and is doing better, is doing better. I mean, she's getting stronger and stronger every day. She has a lot of other things that she deals with. It is one of Dr. XX's patients, and we talk a lot about even things like her reproductive health and her having some control--she doesn't have a lot of control in her life over everything, but [the doctor] worked with her to help her get some reproductive health at least, and was able to set her up with some things that she needed. Things like that happen on a daily basis." *(IBH Provider)* "One is a very difficult family that I have with two grown sons that have autism, one who is almost nonverbal, and they need a lot of care coordination. I think they're homeless, and

IBH Enhances Care Coordination and Access to Multi-faceted Patient Services
either they needed a psychiatrist and--it's very complicated, and [the IBH provider] has been extremely helpful. Before I see them I meet with [the IBH provider], and I meet with XX sometimes who is the psychiatrist who is seeing them, and [the IBH provider] and I plan our approach to how we can best help this family." *(Medical Provider)*

IBH as the Entry Point for Outpatient BH Counseling
"It was a positive screening. Originally the MA said he doesn't want to talk about anything. I went in and I said, okay I'll just see if he feels safe today. Then he went on and on and on. I was in there for forty-five minutes. So he did a lot of talking, and we ended up scheduling him for counseling, for outpatient." *(IBH Provider)*

Medical Provider Enthusiasm for IBH
"I think one of the difficulties originally was that there was a dichotomy, right, a dichotomy between the behavioral health world and primary care world. But also within--it takes a lot of willingness to make change to allow change to happen. And I think from every few years the medical director creating a culture of team based care was a big priority. So it fed well into the IBH initiative." *(Medical Provider)* "I think that the doctors are really onboard with knowing that mental health issues need to be addressed and they're really using me correctly, and I think it's really helping the patients. And you know, it's a positive thing." *(IBH Provider)* "You know, talking to someone about an abnormal depression screen or an abnormal CAGE-AID, it's-- if you haven't been taught how to do that or you don't ever ask those questions and don't start asking those questions after never asking them for, you know, thirty years it's hard to do. It's change. I think the progress has been steady, so even the most resistant people have become increasingly willing to engage." *(Medical Provider)* "We have some great [medical] providers. They're in our office a lot, you know, and just brainstorming about patients and how can we work together. I have a joint visit next week with a medical provider, a patient, myself because the patient has some significant behavioral health concerns, and I know that [another IBH provider] has been called in when there's a difficult topic to talk about with the patient. They're pulling us in to just be a support for them too as they talk with patients. So we're pretty lucky. I think we have a nice team, and this has helped." *(IBH Provider)* About getting medical providers initially on board with IBH: "I feel like that was a really big barrier for us. Like we were sitting there saying, 'We have so much to offer. Just come and get us. Just get us for warm handoffs.' And that wasn't happening. And now I feel like we've finally turned the corner, so I think we're heading in the right direction. And I'd say 90% of our providers think very highly of IBH and find us to be extremely useful and beneficial and a very much big part of their care team. Another huge barrier—I think when I started there was a lot more separation between--we weren't fully integrated. There were the [medical] providers, and there was our team, and we weren't fully integrated. And I think we've made big strides in that." *(IBH Provider)* "I mean when I say how much I love having integrated behavioral health, the other half of that is that I can't imagine primary care without it. It just makes so much sense to me to have those resources all in

Medical Provider Enthusiasm for IBH
the same place because it's so important. So I love it. I can't speak highly enough of it." *(Medical Provider)* "IBH is really great. Most [medical] providers here I think would say--myself included--that we would never work in a place that didn't have IBH now. Which is the real vote of confidence. We have in particular our new providers who come in and experience it for what it is. Now they're like, 'Oh my gosh, I am never going to practice without this ever again because this is so much better.'" This provider noted it is easier to embrace the benefits of IBH if people have worked elsewhere without it. They can compare; having worked long-time in one practice, or having this as a first job for an NP does not provide the necessary perspective: "So having people with some concept of what good or great is in a health center makes them recognize and appreciate when things are actually really good." *(Medical Provider)* "I think one of the reasons why we've been successful is we didn't have anyone that was like, 'No, this isn't going to work. I don't want to do that.' We were all positive and thought that this was a great initiative and willing to put that work in which makes life so much easier. You know, if you have one person that's like, 'Yeah, I don't want to do that. . . .' We're usually excited, like, 'Okay this is best for our patients. It's best for the practice. Let's just get it done.'" *(Practice Manager)* <u>Reliance on MAs to make the program run</u>: "We have a really great team. We really do. We just said, you know, this is a new tool that we need to use for our patients for the behavioral health pilot that we're doing, and we really need to capture the information, and you know, they're really great. They just--as long as the training is there for them and you train them well, and they know the expectation, and they know what they need to do." *(Practice Manager)*

Attachment 4: AIMS Center Implementation Model