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

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BACKGROUND

Pediatric Integrated Behavioral Healthcare (P-IBH) provides systematic screening and clinical services, as well as care management. Notably, P-IBH follows up a positive screen with a warm handoff to a clinician who is hired by or contracts with the practice. Then, depending on need, the clinician will initiate one or several sessions of brief treatment. These sessions can serve as a bridge to more traditional therapy, or the sessions can provide the patient with the skill building needed to address life stressors.

To test the P-IBH model in Rhode Island, CTC-RI, with funding from the Rhode Island Foundation, created the P-IBH pilot program. Eight pediatric practices enrolled in the P-IBH pilot—two hospital clinics, two FQHCs, and four traditional pediatric practices. Divided into two cohorts, the pilots ran from 2019 – 2021 and from 2020-2022. CTC-RI also contracted with consultants to conduct a qualitative evaluation to determine how sites implemented their programs, how the CTC-RI grant process supported sites and the impact of the pandemic of sites. The evaluation team reviewed the relevant literature related to program implementation overall, IBH program implementation, and pediatric depression screening guidelines. The evaluators conducted 30 interviews across the eight sites. Respondents included at least the pilot manager, the behavioral health clinician, and a physician/champion.

The evaluation results showed that even with the challenges of the pandemic—the temporary halting of non-emergent in-person visits; clinicians working from home; open clinician positions; warm handoff challenges; limitations of telemedicine; staff turnover; staff shortages—all eight sites were able to implement their P-IBH program. Each site conducted systematic screening, increased patient access to behavioral healthcare, and provided care management.

Overwhelmingly, staff, clinicians and providers appreciated that screening could find behavioral health issues before they developed into full blown problems, or find those adolescents who said they felt fine, but whose PHQ scores indicated suicidal thoughts or intent. Respondents reported screening and handoffs to clinicians helped patients and families normalize mental health as part of overall healthcare. P-IBH helped patients deal with depression, anxiety, bullying, suicidal ideation, and school anxiety among many other issues.

All sites planned on continuing their P-IBH program, with one site uncertain about sustainability.

KEY FINDINGS

Key findings and major points are organized using an IBH framework developed by Kwan et al. (2015) and also includes grant processes and impact of the pandemic.

Grant processes

CTC-RI's grant timeline, deliverables and facilitation provided a structure that helped grantees implement their pilot programs. Grant requirements, such as developing workflows and creating and using a registry, supported practices in implementing their programs.

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

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

The PDSA quality improvement projects PDSAs were a helpful tool. The first PDSA focused on screening rates. Interviewees at the sites enjoyed seeing their screening rates improve. However, issues around defining the first PDSA's denominator was a source of frustration.

Implementing P-IBH during a pandemic

The pandemic created barriers for effective P-IBH implementation, but determined practices found ways to make it work. This required staff to step up to take on additional roles and responsibilities. Sites used telemedicine when patients could not come to the practice, or the clinician worked from home.

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

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

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

P-IBH gave patients timely access to assessment and brief treatment, and helped mental health become destigmatized for patients and parents. Pediatric patients (and/or their parents) were more likely to accept therapy when P-IBH was explained and offered. Warm handoffs also were reported to increase acceptance of therapy.

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

Parents generally accepted the P-IBH screening, assessment, and treatment processes and came to see these processes as part of their child's ongoing medical care.

Provider experience

Providers recognized the importance of and need for P-IBH, but provider engagement varied. Even provider champions acknowledged P-IBH can add time to the encounter and can mean extra time is needed for follow-up. However, all felt that it was time well spent. Some providers demonstrated program drift, e.g., did not always review screening results within the encounter, or engage the clinician in a warm handoff.

P-IBH clinicians

P-IBH clinicians reported they love their job. However, it is essential to hire a clinician who can implement the IBH model. Not every clinician can or wants to do brief interventions or multitask in the way P-IBH clinicians must function. The clinician needs to have the skills to work with the full range of practice patients. Clinicians benefit from care management support and clinical supervision. Clinicians who are solely responsible for care management have less time to do brief interventions or other therapy, less time to provide consultation to providers, and are at risk for burnout.

Education, training, and practice preparation

Sites would have benefited from a more structured rollout that more explicitly engaged providers, staff, and clinicians around P-IBH as model of care, mental health training, and P-IBH workflows and responsibilities. Staff who administer the screening tools, e.g., medical assistants and front desk staff, would benefit from training and support. Program drift can occur when there is limited training or feedback offered to providers, clinicians, and staff.

Registry

Sites saw the value in creating and using a registry to track screening rates and patient follow-up. Sites that had good technology support and/or had a population health manager were better equipped to create or manage a registry and to track a range of outcomes. When an EHR-based registry was not feasible, paper-based registries worked, but all registries require additional staff time to manage.

Tracking outcomes for quality improvement/determining program outcomes

Sites used their data to track screening rates and patient follow-up. Very few sites used their data reliably for quality improvement.

Setting

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

Targeted populations and conditions

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

Clinical processes

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

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

It is possible to implement P-IBH without any clinician or with only a part-time clinician but achieving a high level of integration will be unlikely. When there is no clinician, the responsibility of follow-up falls to the provider or their designated staff.

Program oversight

For most of the sites, managing the P-IBH pilot was an added responsibility for staff already overseeing other projects or pilots. It was unclear how some sites would manage their programs or identify and address P-IBH issues systematically once CTC-RI facilitation ended.

Cost and Sustainability

All sites are committed to continuing their P-IBH programs. Most sites needed clinician billing revenue to fund their clinicians' salaries, but these sites were not concerned with covering overhead costs. FQHCs did not rely on clinician-generated revenue. There are many additional costs associated with P-IBH that billing does not cover.

RECOMMENDATIONS

Recommendations for CTC-RI

Rationale: P-IBH pilot managers oversaw multiple grants and programs. All pilot sites benefited from the facilitation provided by the grant. There are opportunities for CTC to continue supporting sites so existing P-IBH programs stay on track, and to support practices that start new P-IBH programs.

1. Consider whether it is possible for CTC-RI to create a P-IBH resource center, staffed with a facilitator who could manage and implement the following recommendations.
2. Support existing P-IBH sites through technical assistance and resource materials
    - Continue quarterly clinician meetings and provide periodic booster trainings for P-IBH clinicians to discuss issues they encounter in their work. Explore whether payers will fund participation in training sessions.
    - Create a P-IBH Resource Website that provides tip sheets and brief video trainings about the universal basics of the P-IBH model.
    - Explore with sites how the Learning Collaborative meetings could be modified to make them more relevant to sites. Explore whether pilot sites are interested in continuing to gather periodically to share best practices and to problem solve.
    - Continue to provide technical assistance in other areas, such as for the P-IBH registry, tracking systems, and workflows.

- Explore with practices their interest in using Master's level social workers who are in the process of getting licensed. If there is sufficient interest, determine how CTC-RI can develop a system of shared LICSW supervision for unlicensed staff at multiple practices.

3. Support practices that are newly interested in adopting P-IBH.
   - Modify the grant or implementation process to more closely match the Evidence Roadmap for Implementing IBH (Kwan, et al., 2015), e.g., include funding and technical assistance for roll-out activities to providers, clinicians, staff, patients and their families. Provide a more robust pilot management structure and ongoing quality improvement process.
   - Provide each practice with the same support grantees received, e.g., a facilitator and monthly facilitation meetings, timeline, and deliverables.
   - For any practice deciding to implement P-IBH, include in the P-IBH Resource Website materials related to the Evidence Roadmap for Implementing IBH (Kwan et al., 2015), sample implementation timelines, associated deliverables, and tips for achieving success.
   - Work with payers to create a funding stream that will support implementation and population health/outcomes tracking activities.

Grant structure and processes

Rationale: CTC-RI's grant structure and processes are both well known to, and appreciated by, Rhode Island pediatric practices. A gap in the grant structure is a lack of an emphasis on preparation, training and other rollout activities as well as creating a program oversight structure (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Siu & Force, 2016; Zuckerbrot, Cheung, Jensen, Stein, & Laraque, 2018).

1. When creating grants for pilots that are likely to progress into established programs, consistent with the implementation literature, consider ensuring grant activities include at least the following:
   - Rollout and continuing education activities to engage and educate staff and providers across the site's organization, patients, parents, and other stakeholders.
   - Development of an ongoing management structure that will continue beyond the duration of the grant.
   - Development of a systematic quality improvement process.
2. When providing facilitation for new programs, recognize that grantees will be in different stages of organizational readiness and will have varying levels of program expertise. Consider how some aspects of facilitation or facilitation meetings could be tailored to the specific circumstances of each practice.

Workforce development

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

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

Policy support

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

1. Continue to work with state policy makers to raise their awareness that addressing mental/behavioral health is a critical part of pediatric care and should be addressed through fully funded P-IBH programs. P-IBH should be included in PCMH-Kids payment or capitation rates and payment should include, at a minimum, a P-IBH clinician and a P-IBH care manager, program management and data monitoring activities, and EHR and technology needs.
2. Work with payers to develop a systems-wide approach to payment for screening, so that screenings after a positive screen are reimbursed.

Future studies

Rationale: As P-IBH services expand in Rhode Island, a quantitative evaluation can provide data about patient outcomes.

1. CTC-RI could contract with Brown University (or other) epidemiologists to study how the P-IBH services in RI have impacted rates of youth hospitalization rates for mental health issues, rates of youth suicide attempts and deaths, and rates of drug overdose and drug-related deaths in adolescents.

Recommendations for Payers

Rationale: P-IBH is a preventive service that should be offered in pediatric practices. P-IBH involves more than screening and hiring a clinician. Capitation rates are not sufficient to cover the range of staffing and technology support needed to make P-IBH function as intended. Current reimbursement rates do not reflect clinician salary expectations nor do rates reflect the increased time medical providers spend implementing P-IBH.

1. Many pilots prove to be successful and worthy of permanent adoption. When this seems likely to be the case, proactively plan how to fund these programs permanently.
2. Consider increasing capitation rates so that a P-IBH clinician and a P-IBH care manager are salaried positions within each pediatric practice. Capitation rates also should cover the full range of staff and technology needed to implement a successful P-IBH program. Salary ranges should reflect current market rates.

3. If the capitation rate cannot be increased to cover P-IBH managers, payers should create payment codes that allow P-IBH clinicians to bill for some or all care management activities.
4. Recognize that providing P-IBH services require physicians to spend additional time within the encounter to review screening results, discuss strategies with patients and parents, and engage the clinician in a warm handoff. Increase payment for pediatric encounters so that the standard pediatric encounter time is 30 minutes instead of 15.
5. Payers should recognize that patients who screen positive for behavioral health disorders will need to be screened on an ongoing basis to track patient progress. Reimburse practices for these follow-up screenings.

Recommendations for P-IBH Program Practices

Targeted populations and conditions

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

1. Practices should consider whether they have adequate internal resources, e.g., clinicians, care managers, program managers, technology support and program monitoring, before expanding screening to include younger ages or additional screening tools.

Rollout and practice preparation, education, training

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

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

1. Practices should plan to deliver ongoing presentations to staff and providers about the P-IBH program as part of rollout activities and then to keep providers and staff engaged. At a minimum, these presentations should include data regarding screening rates, warm handoff rates, patients engaged in brief treatment or OBH, patient no-show rates with and without a warm handoff, and stories of successful patient outcomes.
2. Practices should ensure that staff involved in administering the screening tools receive training about the importance of screening and how to respond to patient or parent inquiries. Practices could collaborate on creating these materials, or CTC-RI could develop these materials for distribution throughout the state.

3. With or without start-up or capitation funds, sites or organizations planning to implement P-IBH should develop introductory P-IBH materials for parents and patients, e.g., introductory letters, posters in exam rooms, post information on websites.
4. Practices should encourage staff and providers to take advantage of pediatric mental health trainings and certifications available at the Reach Institute.

Staffing and clinician retention

Rationale: In general, P-IBH clinicians expressed high job satisfaction and commitment to the P-IBH model of care. However, clinicians described experiencing work overload when care management support was not available.

1. Practices with onsite P-IBH clinicians need to ensure clinicians have sufficient care management support.
2. When additional care management support is not available, work with the clinician to determine how to make the workload manageable, e.g., reduce expectations regarding the number of patients a clinician will engage in warm handoffs or brief therapy.
3. Practices could explore hiring unlicensed clinicians to implement P-IBH. Currently, it is likely this only will be feasible for multi-site practices where clinical supervision is available.

Clinical processes

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

1. All sites should continue to review and revise their workflows, treatment protocols, and monitoring processes to ensure their program continues to function at a high level.

Setting

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

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

Information Technology

Rationale: All sites appeared to have access to the information technology needed to support a high functioning P-IBH program. While most sites could access their registry data for tracking screening and follow-up, most did not have the time to use their registry data for quality improvement.

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

Cost and sustainability

Rationale: For small practices, it did not appear that billing alone could support a robust P-IBH program. FQHCs and group practices were better able to absorb the cost of P-IBH. Small practices likely will be able to cover the cost of a clinician with billing, but billing will not cover other P-IBH costs.

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

References Cited in the Executive Summary

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