Implementation of the Integrated Behavioral Health Plus (IBH+) Services Model: Mixed methods evaluation of baseline contextual factors

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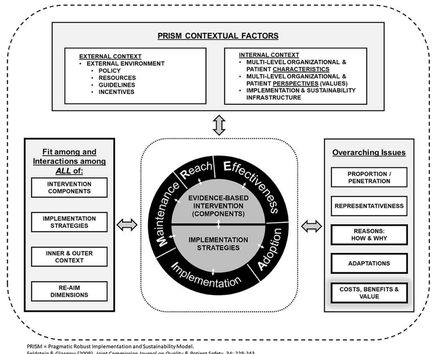
Background

- The University of Colorado Integrated Behavioral Health Plus (IBH+) services model provides behavioral health services in primary care from a team of primary care providers and psychologists, accompanied by telepsychiatry and psychiatry e-consults.
- The model was implemented in 7 family medicine practices in the summer and fall of 2020.
- A participatory evaluation led by embedded researchers informs program decision making about implementation and sustainability of the model.
- This presentation reports findings of a baseline context evaluation guided by the Practical Robust Implementation and Sustainability Model (PRISM).[1]



PRISM = Pragmatic Robust Implementation and Sustainability Model. Feldstein & Glasgow (2008). *Joint Commission Journal on Quality & Patient Safety*, 34: 228-243.

[1]Marina S McCreight, Borsika A Rabin, Russell E Glasgow, Roman A Ayele, Chelsea A Leonard, Heather M Gilmartin, Joseph W Frank, Paul L Hess, Robert E Burke, Catherine T Battaglia, Using the Practical, Robust Implementation and Sustainability Model (PRISM) to qualitatively assess multilevel contextual factors to help plan, implement, evaluate, and disseminate health services programs, *Translational Behavioral Medicine*, Volume 9, Issue 6, December 2019, Pages 1002–1011, https://doi.org/10.1093/tbm/ibz085

Methods

Semi-structured interviews (n = 32) and surveys (n = 178) with clinicians, staff, and leadership were used to assess PRISM contextual factors in 3 domains:

1. **Organizational perspectives** on perceived need for the intervention and barriers and facilitators.
2. **Organizational characteristics** such as goals, priorities, and definitions of success for behavioral health service delivery.
3. **Implementation and Sustainability Infrastructure** change culture and processes; implementation climate and readiness for change.

- **Measures**:
  - Organizational Readiness to Change Assessment (ORCA) (Figure 1) *(Helfrich et al., 2009)*
  - Patient Centered Medical Home Practice Monitor (PCMH Monitor) (Figure 2) *(Dickinson et al., 2014)*
  - Practice Culture Assessment (PCA) (Figure 3) *(Dickinson et al., 2014)*
- **Analysis**: descriptive statistics (surveys), qualitative content analysis (interviews), joint displays (mixed methods)

Results

Figure 1. Organizational Readiness to Change

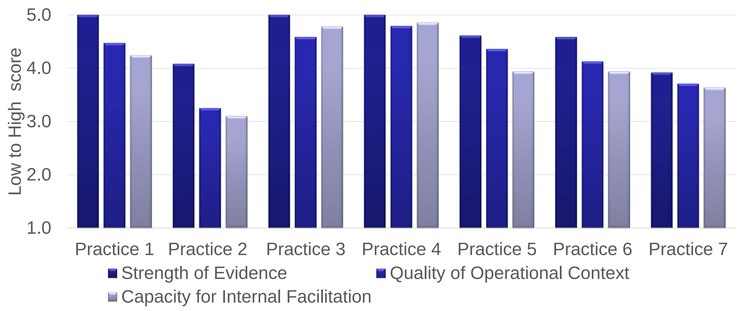
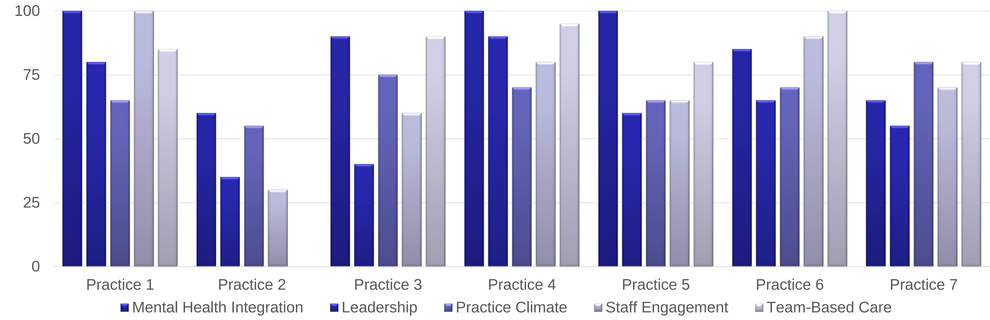


Figure 2. PCMH Practice Monitor - Select Domains



Key Qualitative Findings: Organizational Perspectives and Characteristics

Perceived Need and Expected Benefits:

- All seven family medicine practices were highly optimistic about the implementation of integrated care services and reported high need
- Both organizational leaders and practice representatives believe the integrated care model will be highly utilized among their patients.
- Primary care providers believe integrated care encourages caring for the whole patient and enables them to collaborate with behavioral health providers efficiently.

Anticipated Barriers and Facilitators:

- When the practices are fully staffed and operational, a key benefit is expected to be patient access.
- Many anticipated significant barriers around communication, logistics, and personnel
- Providers reported frustration when describing their patient's waiting for weeks to access behavioral health appointments.
- Time to develop communication and workflows are fundamental to success.

Figure 3. Practice Culture Assessment (PCA)

Characterizing Practice Context: Joint Displays of Mixed Methods Findings

Interview quotes and themes were used to help understand and explain survey findings for individual practices' strengths and weaknesses.
The evaluation team created a joint display of baseline context for each practice.
Excerpts from two examples shown here:

Practice 4: High Readiness for Change and Strong PCMH Foundation Practice

Survey findings*	Interview quotes	Summary
Strengths		
Strength of evidence (ORCA)+ Quality of organizational context (ORCA)+ Capacity for internal facilitation (ORCA)+ Leadership (PCMH)+ Team-based (PCMH)+ Coordination of care (PCMH)+ Mental and behavioral health integration (PCMH)+	*"I think that our integrative services that we offer are amazing and I think it's definitely a need…and the fact that we have mental health services available on-demand within our clinic every day of the week is something that is light years ahead of most private practices that are within our community and I think it's something that should be expanded." (0928)* *"[The organization] wants to and continues to push to be on the forefront of what's right for patients and what consumers want from just a business survival perspective, right? This [organization] works hard to not want to be the next Blockbuster, but we wanna be Netflix." (0821)* *"I'm really excited at the opportunity to expand our services here and reduce the time to appointments for these people. It's a win for our patients, a win for our community, and a win for our primary care doctors who didn't sign up to be psychologists, right?" (0821)* *"I think we had a lot [of support] from the department level on up 'cause we've talked about it. They were able to get us behavioral health, which is huge, and then we found out not too long ago that we were gonna be getting a second one, which was a very big deal because we've been asking for that for probably close to a year. We felt a need. So there's a lot of support from the department." (0826)*	[Practice 4] was the highest scoring clinic on a number of items in the ORCA and PCMH: strength of evidence, quality of organizational context, capacity for facilitation, leadership, coordination of care, mental and behavioral health integration. Interviews supported all of the strengths identified in the surveys. In particular, strong leadership and quality of organizational context facilitated [Practice 4]'s ability to provide integrated behavioral health services. By the time the interviews were conducted, the clinic had already been providing integrated behavioral health care for over a year. Interviewees described their clinic as being at the forefront of behavioral health, with one interviewee explaining that this was made possible by organizational funding and support. They welcomed IBH+ because they already had the infrastructure in place and were eager to expand services. The interviews also spoke to the high scores in coordination of care and team-based work, describing workflows that prioritized a warm handoff for patients and streamlined the workload across different providers.
Weaknesses		
Practice chaos (PCA)+	*"And that's the sort of world we live in. In all—the information with [COVID] is coming so fast that it just changes all the time. And I think the group has been, at times, tired…but it's what we signed up for. And so, I don't see this any different. I see this as…less about change and more about quality improvement. And quality improvement often includes change, right? But we're all about quality improvement, here. We have a Quality Improvement committee that is good and focused and we've made a lot of good changes recently and we'll continue to always seek them out." (0821)*	[Practice 4] scored in the middle of the pack on the PCA item for Practice Chaos. Interviewees accounted for this score by explaining that the clinic has been in a constant state of growth since it opened. At times this can cause patient demand for services to outpace their supply; while the clinic was already prepared to implement IBH+, all interviewees cited lack of sufficient space and staffing as a barrier to effectively meeting patients' needs. Additionally, interviewees explained that the clinic's emphasis on quality improvement means that there is also constant change, and that the usual pace of change has been accelerated due to COVID.

Practice 2: Low Readiness for Change and High Chaos Practice

Survey findings*	Interview quotes	Summary
Strengths		
Strength of Evidence for IBH+ (ORCA)+	*"…I think [the need for integrated care services is] essential. I think for too long, health care and mental health care were seen as two separate things. I don't believe they are." (0813)* *"Our providers are super excited, and I think our staff is, too. We—our particular clinic was acquired about a year and a half ago and our previous clinic had had a psychologist for many, many years, so our staff is really used to having those services available for the patients." (0727)*	The interview and survey results for [Practice 2] portray a clinic that is still finding its way following a fairly recent transition from private practice. The strength of evidence for IBH+ within [Practice 2] was strong, but still lower compared to other clinics. Interviewees did agree that there was a huge need for this level of care, and expressed excitement at the opportunity to serve their patient population.
Weaknesses		
Leadership (PCMH)~ Staff Engagement (PCMH)+ Patient and Family Engagement (PCMH)~ Coordination of Care (PCMH)+ Practice Chaos (PCA)+	*"…we basically just had a psychologist show up on our door and we were given no information." (0727)* *"…so the clinic used to be a private practice run on a really slim budget. And more for seeing lots of patients and I don't think there was a lot of integrated care or team-based care that was pushed until CU took over… I don't know that my manager necessarily has experience in that realm and knows how to create a team" (0729)* *"So it's hard for me to speak to the goals of the clinic as a whole because I'm only one person here and one unfortunate thing is that there isn't much in the way of staff meetings or team meetings." (0813)*	Survey responses indicated that both leadership and staff engagement were challenges for [Practice 2]. Some interviewees spoke to a dearth in communication and support from leadership, while others expressed feeling very supported by their supervisors. Interviewees described a lack of team meetings and situations in which the staff are told what to do, rather than engaged for their opinions and solutions. In addition to team huddles, the coordination of care item also assesses community collaborations, referrals, etc. Based on the interviews, the high level of practice chaos conveyed in the surveys were in alignment with the environment that participants described – a busy clinic with several concerns about communication gaps and coordination.

Conclusions

- Practices reported high demand for IBH+ services and varied in readiness to change, implementation climate, and need for internal facilitation and support during implementation.
- Understanding baseline context as defined by PRISM informed opportunities for improving implementation processes.

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