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

Mardia Coleman, MS – May Street Consultants

mardcole@aol.com

Roberta E. Goldman, PhD – Brown University [Roberta\_Goldman@brown.edu](about:blank)

August 22, 2022

# BACKGROUND

Pediatric Integrated Behavioral Healthcare (P-IBH) provides systematic screening and clinical services for behavioral health and substance use issues, as well as care management within the primary care setting for minors and their family. Notably, P-IBH follows up a positive screen for behavioral health (BH) and substance use, e.g., a clinically significant screening result, with a warm handoff to a behavioral health clinician who is hired by or contracts with the practice. Then, depending on need, the integrated behavioral health 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 and/or family with the skill building needed to address the behavioral health and/or substance use needs within the context of the patient, family and/or school. P-IBH works to provide a model in which the medical provider, the family and/or the patients, and the clinician work collaboratively to ensure the patient’s physical health and mental health treatment are aligned.

To test the P-IBH model in Rhode Island, CTC-RI created the P-IBH pilot program, using funding provided by the Rhode Island Foundation, Tufts Health Plan and United Health Plan. Eight pediatric practices enrolled in the P-IBH pilot—two hospital clinics, two Federally Qualified Health Centers (FQHCs), and four traditional pediatric practices. Divided into two cohorts, the pilots ran from 2019 – 2021 and from 2020-2022. CTC-RI 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 on sites. The evaluation team reviewed the relevant literature related to overall IBH and P-IBH, P-IBH program implementation, as well as pediatric depression screening guidelines. The evaluators conducted 30 interviews across the eight sites. Participants included at minimum the primary care site manager, the behavioral health clinician, and a medical provider and/or physician champion from the primary care site.

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 behavioral health screening, increased patient access to behavioral healthcare, and provided care management.

Overwhelmingly, staff, clinicians and medical providers especially appreciated that behavioral health screening could identify BH concerns before a patient met diagnostic criteria for a BH disorder, or identify those adolescents who denied symptoms of depression, but whose PHQ9 scores indicated suicidal thoughts or intent. Respondents reported behavioral health screening and warm handoffs to integrated care 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 whether billing would be sufficient to make their program sustainable over time.

# 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.

**NOTE regarding report nomenclature**: In this document, we use **clinician** to indicate a **P-IBH clinician; provider** to indicate a **medical provider;** and **practice(s) or site(s)** to indicate primary care **P-IBH pilot sites**. **OBH** refers to **outpatient behavioral healthcare**.

## Grant processes

CTC-RI’s grant timeline, deliverables, training materials, and facilitation provided a structure that helped grantees successfully implement their pilot programs. Grant requirements, such as developing workflows and creating and using a registry also supported implementation.

Practice facilitation guided by a skilled CTC-RI facilitator was a key success factor for most sites. Monthly practice meetings provided a forum for identifying implementation barriers and problem-solving. All sites reported the CTC-RI facilitator was highly skilled and knowledgeable. The facilitator herself was a key success factor.

While an excellent learning forum, there are opportunities to assess how to make the Learning Collaborative and quarterly meetings more effective. Attendees represented a wide range of roles and responsibilities, with some attendees endorsing more benefits than others from meetings.

## Implementing P-IBH during a pandemic

The pandemic created barriers for effective P-IBH implementation, but practices found ways to overcome. The pandemic, with its many stressors, found staff willingly taking on additional roles and responsibilities to ensure their patients were screened and received IBH follow up as warranted. 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 warm handoffs.

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

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

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

Parents generally accepted the P-IBH behavioral health screening, and treatment processes and came to see these processes as part of their child’s ongoing medical care. Many parents were relieved their child could receive same day or near same day IBH services.

## Provider experience

Providers recognized the importance of and need for P-IBH. However, even provider champions acknowledged P-IBH can add time to the medical encounter and can mean additional 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 behavioral health screening results within the medical encounter, or did not engage the behavioral health clinician in a warm handoff.

## P-IBH clinicians

P-IBH clinicians reported they love their job. However, it is essential to hire a behavioral health 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 primary care practice needs. Clinicians benefit from care management support and clinical supervision focused on the P-IBH model as well as the clinical needs presented by such a broad array of patients. Clinicians who are solely responsible for care management have less time to do brief interventions or longer therapy sessions when needed and less time to do the ancillary tasks associated with P-IBH, e.g., provide consultation to medical providers, participate in huddles.

## 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 and P-IBH workflows and responsibilities. Staff who administer the behavioral health screening tools, e.g., medical assistants and front desk staff, would have benefited from additional training and support around mental health topics in general and responding to patient and parent questions and concerns. Participants told the evaluators program drift can occur when there is limited follow-up training or feedback offered to providers, clinicians, and staff regarding the IBH program, program outcomes, or patient experience.

## Registry

Sites saw the value in creating and using a registry to track behavioral health screening rates and patient follow-up. Sites with responsive 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. Some sites were not able to create a usable or useful EHR-based registry. In those cases, they created paper-based registries that met their needs. However, all registries require additional staff time to manage.

## Tracking outcomes for quality improvement/determining program outcomes

Sites used their data to track behavioral health screening rates and patient follow-up. At quarterly meetings, sites reported out on their efforts to improve screening rates. Very few sites used their data reliably to track patient outcomes at a population level or for organization improvement.

## Setting

Whether in a free-standing primary care 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, medical care teams, and patients.

## Targeted populations and conditions

All sites recognized the need for comprehensive behavioral health screening and will continue to screen using validated, age-appropriate screening tools. Some sites were considering expanding screening to additional age groups or adding validated 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 successful despite a pandemic and staffing shortages.

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

It is possible to implement components of P-IBH without a clinician or with only a part-time clinician but achieving a high level of integration will be unlikely. When there is no clinician or limited access to a clinician, either embedded or contracted, the responsibility for 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 andSustainability

All sites are committed to continuing their P-IBH programs. Most sites needed clinician billing revenue to fund their clinicians’ salaries. There are many additional costs associated with P-IBH that billing does not cover. FQHCs are less concerned with covering overhead, and one FQHC did not bill for P-IBH services.

# RECOMMENDATIONS

# Recommendations for CTC-RI

**Rationale:** All pilot sites benefited from the CTC’s grant structure and from practice facilitation. There are opportunities for CTC to continue supporting sites so existing P-IBH programs maintain sustainability, and for CTC 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, informed by the expertise of a practice 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 funding streams for 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. 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.
* Explore with primary care sites how the Learning Collaborative meetings could be modified to make them more relevant. Explore whether pilot sites are interested in continuing to gather periodically to share best practices and to problem solve barriers.
* Continue to provide technical assistance in other areas of common concern, such as for the P-IBH registry, tracking systems, and workflows.
* Explore with practices their interest in using Master’s degree social workers who are in the process of getting licensed. If there is sufficient interest, determine whether CTC-RI can develop a system of shared supervision for unlicensed staff at multiple practices.

1. Based on the success of the 8 pilot program sites, expect that additional Rhode Island pediatric practices will want to adopt P-IBH. As additional funding to CTC allows, newly interested sites will benefit from CTC’s support in the following areas:
   * As additional funding allows, support interested sites using the existing CTC grant structure but that also includes additional elements from the Evidence Roadmap for Implementing IBH (Kwan, et al., 2015), e.g., include technical assistance for roll-out and ongoing training or informational activities for providers, clinicians, staff, patients and their families. Help sites develop a program management structure, measurable program outcomes and fidelity checks.
   * Provide each practice with the same support grantees received, e.g., a facilitator and monthly facilitation meetings, timeline, and deliverables.
2. Many pilots prove to be successful and worthy of permanent adoption and statewide expansion. When this seems likely to be the case, work with payers to plan how existing programs can be sustained and new sites added.

## Grant structure and processes

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

1. The literature suggests that CTC’s current grant structure and processes could be enhanced by adding deliverables regarding site preparation, training and other rollout activities; creating a program oversight structure; and helping site grantees develop a clear process for determining and measuring program outcomes and program fidelity (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Siu & on behalf of the US Preventive Services Task Force, 2016; Zuckerbrot, Cheung, Jensen, Stein, & Laraque, 2018). Ensure grant activities include at least the following:
   * Rollout, training, and continuing education activities to engage and educate staff and providers across the site’s organization, patients, parents, and other stakeholders.
   * Development of an ongoing management structure and program outcome measures that will continue beyond the duration of the grant.
2. When providing facilitation for new programs, recognize that grantees will be in different stages of organizational readiness, program knowledge or expertise, and technology and staffing capacity. Consider how some aspects of facilitation or facilitation meetings and grant deliverables could be tailored to the specific circumstances of each practice.

## 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. When pilot grants support programs that are likely to be become statewide programs, work with payers proactively to ensure funding or payment mechanisms will be in place to allow existing programs to continue and that will support statewide adoption.
2. Continue to work with state policy makers to raise their awareness that addressing 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.
3. Work with payers to develop a systems-wide approach to payment for behavioral health and substance use screening, so that follow-up screenings after an initial 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 quantitative researchers to study how the P-IBH services in RI have impacted rates of youth hospitalization rates for mental health issues, rates of youth suicide attempts and deaths, and rates of drug overdose and drug-related deaths in adolescents.

# Recommendations for Payers

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

1. Consider increasing capitation rates so that a P-IBH clinician and a P-IBH care manager are salaried positions within each pediatric practice. Capitation rates also should cover the full range of staff and technology needed to implement a successful P-IBH program. Salary ranges should reflect current market rates.
2. If the capitation rate cannot be increased to cover P-IBH managers, payers should create payment codes that allow P-IBH clinicians to bill for some or all care management activities.
3. Recognize that providing P-IBH services require physicians to spend additional time within the encounter to review screening results, discuss strategies with patients and parents, and engage the clinician in a warm handoff. Increase payment for pediatric encounters so that the standard pediatric well child visit is 30 minutes instead of 15.
4. Recognize that patients and families may need care management services that can be delivered by staff other than IBH clinicians. These services could be delivered by staff other than IBH clinicians, for example, community health workers. However, this service needs to be financially covered.
5. With the rates of pediatric mental health distress rising rapidly, it is likely that patients will disclose behavioral health concerns to their providers at visits other than the annual well child visit. Consider increasing payment for all pediatric visits to reflect a 30-minute encounter when BH issues are raised.
6. Payers should recognize that patients who screen positive for behavioral health disorders will need to be screened on an ongoing basis to track patient progress. There is a need for multi-payer alignment around standardized payment for annual screening and follow-up for positive screens.
7. Consider adding a code for an annual wellness visit that includes a focus on mental health, or that occurs in concert with the annual wellness visit. This would allow primary care sites to have a yearly check-in with all patients around mental health and substance use. Other innovator states such as Massachusetts and Colorado have proposed and enacted legislation that would require payers to fund such visits (Second Regular Session, 73rd General Assembly, & Colorado General Assembly, 2020; US News and World Report, 2021).

# Recommendations for P-IBH Program Practices

## Targeted populations and conditions

**Rationale:** All pilot sites recognized the need for comprehensive behavioral health screening using age appropriate, validated screening tools. Some pilot sites were considering lowering the start age for behavioral health screenings or adding social determinants of health (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 behavioral health and substance use screening to include younger ages or additional screening tools.

## Rollout and practice preparation, education, training

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

Several providers reported they would have liked more initial training and more ongoing information about the program’s impact. Several clinicians noted medical assistants and front office staff would benefit from basic mental health training regarding mental health and how to respond to patient or parent questions about the behavioral health screeners.

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

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

## 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. Primary care 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, while recognizing the potential impact on financial sustainability.
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 primary care site worked to create P-IBH workflows that helped patients receive timely care and follow-up.

1. All sites should continue to review and revise their workflows, treatment protocols, and monitoring processes to ensure their program continues to function at a high level.
2. To support a high degree of P-IBH program functioning and to be to be recognized by OHIC as a IBH primary care practice sites that are Patient Centered Medical Homes can consider acquiring NCQA Behavioral Health Distinction

## Setting

**Rationale**: Some clinicians reported they did not have dedicated office space, or they lost it during the pandemic. Conversely, dedicated space far away from exam rooms, providers and other staff also presented challenges to implementing the P-IBH model.

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

## Information Technology

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

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

## Cost and sustainability

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

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

# Conclusion

It long has been recognized that primary care has become the de facto mental health system (Kessler & Stafford, 2008; Regier, Goldberg, & Taube, 1978). With the rates of pediatric mental health disorders rapidly rising, pediatrics offices are presented with a wide array of patients with a broad range of behavioral, mental health and behavioral health problems and disorders.

Medical providers can feel frustrated by the lack of behavioral health and/or substance use resources available in the community to their patients. P-IBH offers medical providers a pathway for their patients to receive systematic screening and same- or near same-day assessment and treatment within the primary care or pediatric practice.

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

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

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

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

Note: This Executive Summary is the companion piece to the evaluation full report. The full report, available upon request from CTC-RI, provides a more detailed discussion of the topics in this Executive Summary, along with the following supplemental materials. **Appendix 1**: research questions that guided this evaluation. **Appendix 2**: interview guide. **Appendix 3**: lessons learned with supporting quotes. **Appendix 4**: details about the warm handoff. **Appendix 5**: stories of the P-IBH pilot in participants’ own words. **Appendix 6**: P-IBH training and implementation resources. **Appendix 7**: P-IBH Pilot Program application and milestone document. **Appendix 8:** Table of Contents—P-IBH program orientation binder.

# References Cited in the Executive Summary

AIRN-Active Implementation Research Network. (2022). *Implementation stages*. Retrieved from [https://www.activeimplementation.org/frameworks/implementation-stages/](about:blank)

Fixsen, D., Naoom, S., Blase, K., Friedman, R., & Wallace, F. (2005). *Implementation research: A review of the literature*. Retrieved from Tampa, Florida: [https://nirn.fpg.unc.edu/resources/implementation-research-synthesis-literature](about:blank)

Jensen, P., Cheung, A., Zuckerbrot, R., & Levitt, A. (2018). *Guidelines for adolescent depression in primary care. GLAD PC. Toolkit*. Retrieved from New York, NY: [http://www.gladpc.org/](about:blank)

Kessler, R., & Stafford, D. (2008). Primary care is the de facto mental health system. In (pp. 9-21).

Regier, D. A., Goldberg, I. D., & Taube, C. A. (1978). The de facto US Mental Health Services System: A public health perspective. *Archives of General Psychiatry, 35*(6), 685-693. doi:10.1001/archpsyc.1978.01770300027002

Second Regular Session, 73rd General Assembly, & Colorado General Assembly. (2020). HB20-1086. Insurance Coverage Mental Health Wellness Exam. Retrieved from <https://leg.colorado.gov/bills/hb20-1086>

US News and World Report. (2021). Bill would guarantee annual mental health wellness exams. Retrieved from <https://www.usnews.com/news/best-states/massachusetts/articles/2021-11-12/bill-would-guarantee-annual-mental-health-wellness-exams>

Kwan, B. M., Valeras, A. B., Levey, S. B., Nease, D. E., & Talen, M. E. (2015). An Evidence Roadmap for Implementation of Integrated Behavioral Health under the Affordable Care Act. *AIMS public health, 2*(4), 691-717. doi:10.3934/publichealth.2015.4.691

Mass.gov. (2022). Building and training primary care and behavioral health workforce. Retrieved from [https://www.mass.gov/info-details/building-and-training-primary-care-and-behavioral-health-workforce#behavioral-health-workforce-development-program-(swi-1b)-](about:blank#behavioral-health-workforce-development-program-(swi-1b)-)

Second Regular Session, 73rd General Assembly, & Colorado General Assembly. (2020). HB20-1086. Insurance Coverage Mental Health Wellness Exam. Retrieved from [https://leg.colorado.gov/bills/hb20-1086](about:blank)

Siu, A. L., & on behalf of the US Preventive Services Task Force. (2016). Screening for Depression in Children and Adolescents: US Preventive Services Task Force Recommendation Statement. *Pediatrics, 137*(3). doi:10.1542/peds.2015-4467

US News and World Report. (2021). Bill would guarantee annual mental health wellness exams. Retrieved from [https://www.usnews.com/news/best-states/massachusetts/articles/2021-11-12/bill-would-guarantee-annual-mental-health-wellness-exams](about:blank)

Zuckerbrot, R., Cheung, A., Jensen, P., Stein, R., & Laraque, D. (2018). Depression in Adolescents: AAP updates guidelines on diagnosis and treatment. *Pediatrics, 141*(3), 1-20.