AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Premera Rural Mental Health Integration Initiative (RMHII)

Frequently Asked Questions for Applicants

Updated 2/8/21 (see yellow highlights for revisions, additions indicated with date added)

APPLYING	
If an organization has more than one clinic, does it need to submit individual applications for each eligible clinic?	Yes. Clinical sites within one healthcare system can be quite different, and it would be difficult to capture clinic-level details (e.g., current behavioral health services offered, staffing) in one application. Because of this, organizations applying for multiple clinical sites should submit separate applications. Applicants can re-use certain application sections when they apply to all clinics (e.g., organization overview). If you have two clinics with a majority of the same staff members covering both, one grant would cover the training and coaching costs for both clinics.
Does the five-page application limit include the cover page, behavioral health integration assessment, and Clinic Implementation Team (CIT) appendix?	No. The five-page limit applies to the narrative section of the application and excludes the cover page, integration assessment, and CIT appendix.
If we have questions when filling out the application, who do we send them to?	Send any questions to ruralmh@uw.edu. One of our project staff members will answer your questions or connect you with someone who can.

ELIGIBILITY	
Do any of our clinic's patients need to be served by Premera?	No.
Can our clinic participate if we have worked with the AIMS Center before?	Yes.
Can our clinic participate if we already offer behavioral health care services?	Yes.
How do we use the RUCA codes to determine our location eligibility?	RMHII staff cross-referenced RUCA codes with zip codes internally, and there is no need for applicants to determine their own eligibility using RUCA codes. Appendix A in the RFA includes **ineligible** AK and WA zip codes. If your clinic location's zip code is not included in that appendix, your clinic is eligible for this initiative. In addition, all federally designated Rural Health Centers (RHCs) are eligible regardless of zip code.
My organization has clinics located in both eligible and ineligible zip codes. Can my organization apply?	Yes. Organizations can apply on behalf of clinics located in eligible zip codes but not those in ineligible zip codes.
Does the minimum patient population (1,500 unique patients ages 18+) apply only to a clinic's primary care services?	Yes. When determining your patient population, count patients who are part of your primary care services (these patients may also access specialty services your clinic offers, including specialty behavioral health). Do not include patients who **only** utilize specialty services without also being primary care patients.
What does "unique patient" mean?	"Unique" refers to an individual patient receiving treatment in your primary care clinic. Multiple visits (i.e., encounters) from the same individual do **not** count toward the 1,500 patient minimum. When determining your patient population, count individuals rather than encounters.
When determining our patient population, what is the expected time frame for the last reporting period?	Whatever mechanism and time frame you used most recently for generating a report on your clinic's services (e.g., to your board, to the federal government) is acceptable. We expect this will vary across clinics/health care organizations.
If an organization has more than one clinic, does each clinic need to have 1,500 unique adult primary care patients to participate?	Yes. This minimum unique adult patient number applies to each individual clinic that would be participating in this initiative. Organizations pooling patient populations across clinics to meet the 1,500 patient minimum are **not** eligible.
Do the 1,500 unique adult patients need to have a behavioral health diagnosis? Is it required that these patients are already receiving behavioral health services?	No. The minimum patient count refers to the number of patients who were treated in your primary care clinic in the last reporting year, regardless of if they were/are being treated for behavioral health issues or have a behavioral health diagnosis.

Would a mobile clinic be eligible for this initiative?	Mobile clinics may be eligible based on their ability to document having served 1,500 unique adult patients in a primary care capacity and based on the locations they serve.
Would a school-based health center be eligible for this initiative?	A school-based health center may be eligible if it can document having served 1,500 unique patients 18 years of age or older in a primary care capacity in the last reporting year.
Would a pediatric practice be eligible for this initiative?	No. This initiative focuses on adult mental health; clinics eligible to participate must have a primary care patient population of 1,500 unique patients ages 18+.
If we meet the other eligibility criteria, can we participate in this initiative to expand behavioral health care services to adolescents?	Yes. So long as you meet the location and adult primary care patient population criteria, there is no reason you could not use participation in this initiative to expand services to an adolescent population. However, the primary population of focus should be adults.

How many clinics does the AIMS Center expect to receive awards from Premera?	We will make awards to approximately ten clinics per cohort. Across three cohorts, we anticipate roughly 30 clinics total will receive awards.
What will the impact evaluation process look like?	Members of the Clinic Implementation Team (CIT) and clinical providers involved in each clinic's integrated behavioral health care program will participate in surveys prior to the planning phase or launch of clinical care and after implementation about their experiences and practice changes resulting from participation in the initiative. Clinics will also provide RMHII staff with a one-time report of diagnosis code data extracted from their electronic health records. This data will help illustrate the prevalence of different behavioral health conditions at each clinic; no identifying information about individual patients will be requested. RMHII staff do not expect or intend for the evaluation process to be a significant burden on participating clinics. However, time spent on these activities is part of the award and funds can be used to cover the time staff spend on the impact evaluation.
How much flexibility is there in the grant deliverables?	The grant deliverables consist of each Clinic Implementation Team (CIT) participating in remote (twice monthly) and in-person (if possible; if not, also remote) skills training and coaching activities. In addition, the psychiatric consultant and behavioral health care manager(s) will participate in regularly scheduled training activities following program launch. The psychiatric consultants will meet together as a group (virtually) every two months with an expert psychiatric consultant trainer. Two to three times during the initiative, the psychiatric consultant will participate in a call with their behavioral health care manager and the expert psychiatric consultant trainer to practice systematic caseload reviews. Behavioral health care managers will meet monthly with a clinical trainer. These meetings will occur once before CoCM program launch and for

	12 months following program launch; program launch occurs about 3 months following the start of the grant. We also ask that the CIT Leader and any other primary, behavioral health, and psychiatric providers who are part of your integrated BH program participate in several surveys as part of our evaluation. These occur roughly quarterly. Completing these activities is a required component of satisfactory participation in the initiative; each clinic's participation level determines whether they will receive their second installment of funds, roughly nine months into participation.

REGISTRY	
Do we need to purchase the AIMS Caseload Tracker to participate in this initiative?	No. You will be provided access to the AIMS Caseload Tracker (ACT) free of charge for two years as part of participation in this initiative. Following the two years, you would need to purchase the ACT to continue using it.
Is it possible to make changes to the AIMS Caseload Tracker (ACT) licensing agreement?	No. You would need to sign the ACT license agreement as it currently exists.
Is the ACT integrated into a clinic's electronic health record (EHR)?	No. The ACT is web-based and will need to be accessed separately from the EHR.

TEAM COMPOSITION	
Can the CIT Leader also fulfill another role, such as the BH Care Manager or PCP Champion?	Yes.
Do all required team roles need to be filled before applying?	No, you do not need all positions filled before you apply, but you need to be able to provide a credible plan for filling these positions.
What happens if we can't hire the required clinical staff over the course of the initiative?	The grant funding comes in two installments, and the second payment is contingent upon satisfactory participation in the initiative. If you are unable to fill any of these key roles, you would be ineligible to receive the second payment. Every effort should be made to fill the positions and RMHII staff will assist you with troubleshooting this implementation hurdle if it arises.
Is it acceptable for a clinic to use a psychiatric consultant via telemedicine?	Yes. The key component of the psychiatric consultant role is that it's not an ad-hoc service. This person needs to provide psychiatric consultation to your organization in an ongoing and routine way. The psychiatric consultant spends one hour per week per 1.0 FTE behavioral health care manager providing caseload-focused consultation. The BH care manager and psychiatric consultant review the caseload and select 5-6 patients per hour for consultation. Performing the functions of the psychiatric consultant typically requires 2-3 hours per week of time per 1.0 FTE behavioral health care manager, including the psychiatric consultant preparing for the consultation hour by reviewing the caseload in the web-based registry and documenting their recommendations in the clinic's EHR.
Will UW provide psychiatric consultation services as part of this initiative?	No, UW will not provide psychiatric consultation services for participating clinics. However, RMHII staff can provide resources and guidance for clinics to help them identify and hire a psychiatric consultant. The AIMS Center cannot guarantee this assistance will result in a successful hire.
Are participating clinics able to use UW consultative services as a psychiatric consultant?	Ad-hoc consultation services will not suffice. Psychiatric consultation associated with evidence-based integrated care is not ad-hoc. It is caseload consultation that occurs weekly for an hour per 1.0 FTE behavioral health care manage during which time the psychiatric consultant gives advice regarding patients who are not improving or for whom the primary care team needs diagnostic or treatment planning support. Performing this function typically requires 2-3 hours per week of time per 1.0 FTE behavioral health care manager, including the psychiatric consultant preparing for the consultation hour by reviewing the caseload in the web-based registry and documenting their recommendations in the clinic's EHR.
Would a psychiatric ARNP have acceptable qualifications to be a psychiatric consultant team member?	Yes. Especially in rural areas, psychiatric nurse practitioners often function as the psychiatric consultant.

	The provider filling the psychiatric consultant role should have experience with psychiatric medication prescribing.
How is the PCP (primary care provider) defined? Does this person have to be an MD, or can they be a mid-level provider?	Anybody who is licensed to provide primary care can serve in this role. Many clinics have nurse practitioners (NPs) or physician assistants (PAs) who serve as primary care providers.
What does sharing the BH care manager role typically look like?	In the package of activities that must be completed to fulfill the BH care manager role, not all require a license; see section 1B of the RFA for more information about this role. A licensed provider (e.g., LICSW, LMHC, LPC, LMFT) can share the set of BH care manager duties with someone who is an unlicensed provider (e.g., community health worker, medical assistant). Especially in rural areas where workforce challenges are particularly acute, we've seen some clinics focus the limited resource of licensed providers on those BH care management tasks that require a license (e.g., assisting with diagnosis, treatment planning, providing evidence-based psychotherapy when that is part of the treatment plan).
Can the required clinical roles be filled through partnerships with other organizations?	The clinic's PCPs and BH care manager(s) need to be staff employees of the clinic. The psychiatric consultant can be someone the clinic contracts with.
Do clinics need to use a psychiatric consultant if they already have an in-house psychiatrist?	If you already have a psychiatrist on staff, this person would be more than welcome to fulfill the psychiatric consultant role. However, the role of psychiatric consultant differs from the role of many co-located psychiatrists. For example, prescribing of all psychotropic medications for patients participating in the integrated care initiative will be done by the PCP, rather than the psychiatrist. The psychiatric consultant will meet weekly with the behavioral health care manager to conduct a caseload consultation. The psychiatrist does not see these patients directly but instead provides consultation to the primary care team regarding treatment. If a patient needs a level of care that exceeds what is reasonable for the primary care team to deliver (e.g., for bipolar disorder) the patient is referred to specialty care, which can be delivered in the primary care setting when that is available. These patients are then discharged from the behavioral health care manager's active caseload.
Can we use someone other than an LICSW for case management and data entry?	Yes. The behavioral health care manager is a role that can be filled by many different types of providers. This role is most commonly filled by a Master's level behavioral health provider like an LMHC, LPC, LMFT, or LCSW. However, some clinics – especially in rural areas where workforce shortages are most acute – share the full set of care manager duties between a licensed behavioral health provider and a paraprofessional like a medical assistant, community health worker, or similar. This arrangement allows your licensed providers to work to the top of their credentials while non-licensed providers complete tasks that do not require a license.

How much time would a licensed BH care manager need to devote to performing psychotherapy as part of the integrated BH program in a typical work week?	This depends on the proportion of patients in your clinic who have psychotherapy as part of their treatment plan.
Can our integrated BH care team include a substance use disorder specialist?	Yes, though this initiative will not include specific training about how to incorporate this role into the care team.
Could a psychiatric consultant be shared by clinics across cohorts?	Yes, given the psychiatric consultant has additional time available and could be on contract with another organization. We would expect this provider to participate in the in-person (or virtual) live training for both cohorts, as this training emphasizes skill-building within each clinic's unique care team.

TRAINING AND COACHING	
Given COVID-19, will clinic teams be expected to travel to Seattle for the one-day, in-person training?	Cohort 3's in-person training will be held in a virtual format if conditions necessitate this. The AIMS Center does not intend to put clinic teams or their communities at risk and will abide by all current public health guidance regarding travel and gatherings.
Which team roles need to attend the in-person (or live virtual) skills training?	Each clinic's CIT leader, PCP champion, BH care manager(s), and psychiatric consultants must attend the in-person (or live virtual) skills training. This includes psychiatric consultants working remotely and/or on contract with clinics.
Will there be any other in-person training beyond the full-day, in-person training in Seattle (if held in person)?	No. The only additional in-person training that may occur is if RMHII staff determine a clinic may benefit from additional onsite training. Again, this will depend on current public health guidance.
What does the ongoing virtual training and coaching look like before and after the in-person (or live virtual) skills training? Who should attend, and what are the time commitments?	The virtual training components consist of two types of training/coaching: 1) organization level, and 2) clinician level. **Clinic – level implementation training and coaching:** There is a monthly call that occurs individually with each clinic and an implementation expert from the AIMS Center. These is also a monthly call that occurs with all of the clinics in a cohort participating as a group. The required attendees at these calls are the Clinic Implementation Team (CIT) Leader and the PCP Champion, though some clinics elect to have other roles (e.g., BH care managers, psych consultants, clinic managers) participate as part of their CIT and have them participate in these activities. These calls occur monthly (except for the month during which the in-person training occurs) and last for 60 minutes each. In total: two, 60-minute monthly implementation calls for the CIT Leader and the PCP Champion (who must **both** be present). **Clinician-level training and coaching:** Prior to the in-person training all clinicians (PCPs, BH care managers, psychiatric consultants) participate in online training that prepares them for the in-person training. The amount of training varies by provider role. See Section 3 of the RFA for a detailed description of training requirements and anticipated time by role. Following launch, BH care managers will attend a monthly group call with the BH care managers at other clinics in their cohort group for the 12 months after program launch. These calls will alternate between 60 minutes (didactic content) and 90 minutes (presenting and discussing cases that apply the didactic content from the prior month).

	Following launch, psychiatric consultants will have a 60-minute group call every two months with all the psychiatric consultant in their cohort group. This call will be facilitated by an expert in this different type of consultation role. Psychiatric consultants will also participate in three sessions of individual caseload consultation where an AIMS Center psychiatric consultant expert will attend a regularly scheduled caseload consultation meeting with the BH care manager. These calls may be 60 or 90 minutes, depending on how long the psychiatric consultant and BH care manager(s) typically meet for caseload review. Providers may have individual calls with AIMS Center clinical trainers for additional support, when needed, but these are not required.
Are all PCPs at the clinic site required to participate in the pre-launch training, virtual learning communities, and other relevant activities of the grant?	The PCP Champion, as a member of the Clinic Implementation Team, will participate in all planning and training activities except those designed exclusively for BH care managers or psychiatric consultants. Other PCPs at the clinic will participate in limited training and evaluation activities. See Section 3 of the RFA for a detailed description of training requirements and anticipated time by role.
Will training include guidance for clinics on how to bill for services?	Yes, the training and coaching will include concrete guidance focused on developing workflows and systems around coding and billing that will support clinics in sustaining integrated care.
Will providers receive continuing education (CE) credit for the training?	Yes, there are CME, CE, and CNE credits available for providers who complete the online modules and attend the live virtual skills training sessions.

USE OF FUNDS	
Will funds come directly from Premera (private funding) or the UW (public funding)?	Award funds will come directly from Premera.
What kind of budgeting and/or financial reporting are clinics required to provide prior to and throughout participation in the initiative?	Neither the AIMS Center nor Premera will be requiring any budgets or financial reporting from participating clinics over the course of the initiative. However, clinics should keep records that will support their correct use of the funding in the event of an audit from Premera.
Can clinics use award funds to make up for lost productivity and revenue resulting from staff participating in training and similar activities?	Yes. The primary purpose of the award is to provide funds for release time of all clinic personnel, both clinical and non-clinical, who will participate in initiative activities. This includes covering all costs associated with attending the one-day, in-person training in Seattle for those clinic members who are required to participate in that activity.
Can clinics use award funds to backfill staff while staff participating in the initiative are out of the clinic for training?	Yes, so long as patients served by the covering clinician are treated exactly as they would be by the provider who is participating in training activities. This means the clinic will bill the patient and their payer in exactly the same manner as they would if the provider who is participating in training was seeing the patient. For example, if the PCP champion is out of the clinic for training, clinics may use award funds to pay a "locum" provider to cover for them. It is allowable for a different provider to see the patient and bill for the service. Only the cost associated with the time a locum provider spends covering for the staff provider who is participating in initiative activities can be covered by these funds.
Can clinics use award funds to deliver clinical services to patients?	No. Funds cannot be used for direct clinical service delivery (i.e., clinics must bill patients and payers for services rendered as they normally would). Staff salaries must be paid as they normally would. Only the time staff spend on activities directly related to participation in training, coaching, and evaluation activities can be covered by award funds.
Can clinics use award funds to hire or pay for the roles necessary to participate in this initiative?	No. Clinics cannot use funds to pay the salary of someone for delivering patient care or for administrative responsibilities not associated with participation in this initiative. Clinics **can** use funds to cover salary expenses for staff time spent on training, organization-level implementation coaching, and other non-patient-care tasks associated with participation in this initiative.
How are clinics expected to track/account for participation in the activities required to receive funds?	Clinics do not need to routinely report their fiscal activities associated with participation in this initiative to Premera, but clinics should keep records that will support their correct use of the funding in the event of an audit from Premera. Award payments are made in two installments. The second payment is contingent upon adequate participation in training, coaching, and evaluation activities. Participation in these activities

	will be monitored by RMHII staff and reported to Premera prior to award of the second payment.
Are clinics reimbursed at the cost of the providers' salaries, or at the cost of the visits they are not seeing?	Neither. Clinics accepted into the initiative receive an initial payment of $160,000 during Month 1 of participation. The second payment of $85,000 is contingent upon satisfactory participation. The payment to all selected clinics is the same, regardless of actual cost of participation.