Integrated Behavioral Health in Rhode Island: A Decade of Practice and Promise

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INTRODUCTION

Over the past decade in Rhode Island, Integrated Behavioral Health (IBH) has shifted from a proof of concept to an operational necessity as primary care faces rising behavioral health needs, workforce instability, and increasing clinical complexity. This commentary advances the premise that IBH is most effective and sustainable when embedded within stable, advanced primary care (APC) systems. Drawing on Rhode Island's experience as an early adopter of IBH through the Care Transformation Collaborative of Rhode Island (CTC-RI) and PCMH-Kids, there is a fundamental connection between IBH and primary care. As IBH strengthens primary care's capacity to manage complexity, so does primary care's stability provide the clinical, operational, and financial conditions required for IBH to flourish. Rhode Island's experience offers a practical perspective on both the promise of integration and the risks of scaling IBH without a strong primary care foundation.

IBH AS A FUNCTION OF ADVANCED PRIMARY CARE

The purpose of IBH is to integrate behavioral health clinicians into primary care teams to deliver brief, evidence-based interventions, support shared decision-making, and address psychosocial drivers of health at the point of care.[1] Evidence from IBH models documents improvements in care processes and clinical outcomes for adults receiving mental health services in primary care settings[2]; similar benefits have been demonstrated for pediatric populations through collaborative-care approaches that improve behavioral health symptoms and engagement.[3] Recent primary care research further indicates that practices with higher degrees of behavioral health integration report better patient outcomes, reinforcing the relationship between the level of integration and clinical quality across adult and family medicine settings.[4] However, these outcomes are contingent on primary care practices having the infrastructure to support team-based workflows, population management, and measurement-based care as a routine skill, rather than a reporting and funding requirement.[5]

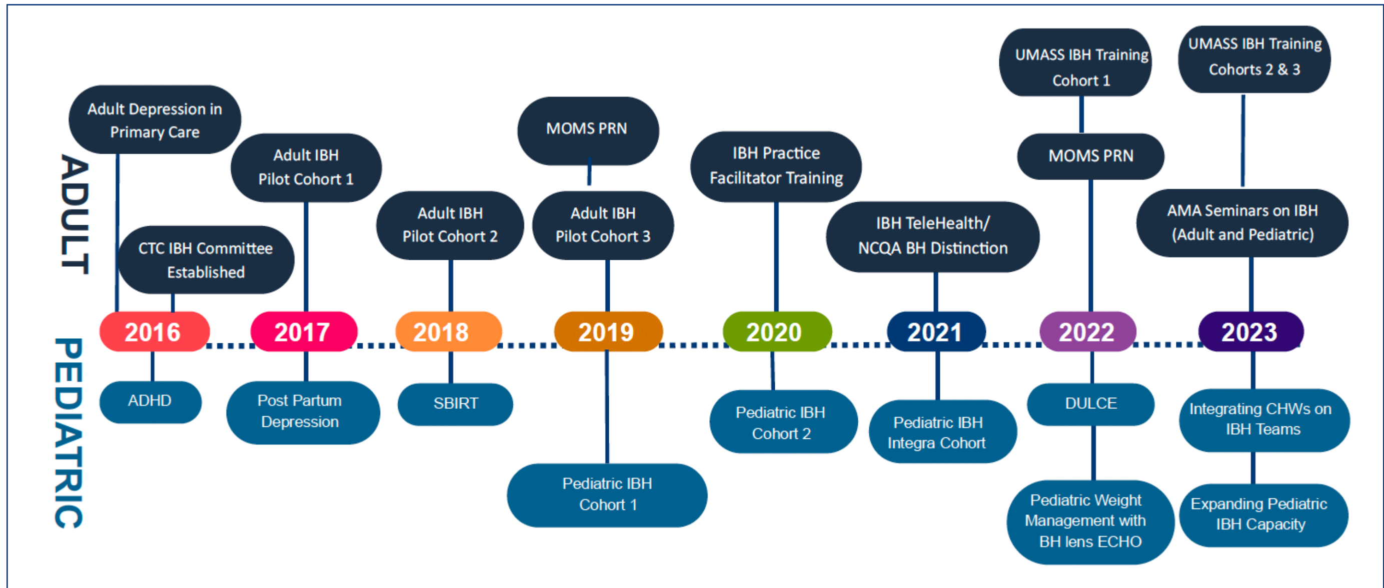
Recent evidence highlights that the most immediate and measurable effects of IBH occur at the level of care delivery. Practices receiving structured IBH support demonstrated significantly higher levels of integration compared with practices providing behavioral health services as usual,[6] which suggests that IBH functions as a catalyst for strengthening team-based care within primary care. Advanced primary care (APC) models, distinct from, but inclusive of the key features of patient-centered medical homes (PCMH), including a common contract with payers for supplemental payments to support care management/care coordination resources, quality reporting, and primary care transformation, represent a more mature stage of primary care transformation.[7,8] APC centers around team-based care that incorporates proactive, population health management; systematic care coordination across settings; routine use of data for measurement-based improvement; and payment models that support traditionally non-billable work, such as care navigation, consultation, and team collaboration. While PCMH recognition established important structural and process standards, APC reflects sustained operational and financial alignment required in managing complex, longitudinal patient needs. Furthermore, APC provides the operational backbone required for IBH to function as an integrated, team-based service, rather than as an ancillary program.[7,8] Rhode Island's experience underscores that integration is not an add-on service, but a core function of transformation in primary care.

CTC-RI AND THE EVOLUTION OF IBH IN RHODE ISLAND

Founded in 2008, the Care Transformation Collaborative of Rhode Island (CTC-RI) is a statewide, multi-payer, public–private partnership designed to advance comprehensive primary care transformation. The 2015 merger with PCMH-Kids established a unified infrastructure supporting pediatric and adult primary care, with an explicit emphasis on IBH across the lifespan.[7] Through aligned payment models, learning collaboratives and practice facilitation, IBH is positioned as a foundational component of advanced primary care [**Figure 1**].

A defining feature of CTC-RI's approach to IBH has been practice facilitators with subject-matter expertise focused on both clinical integration and operational redesign. Evaluation of IBH practice facilitation within Rhode Island medical homes demonstrated significant increases in levels of behavioral health integration over time, with practices

Figure 1. Timeline of CTC-RI Integrated Behavioral Health (IBH) Initiatives, 2016–2023, depicting evolution of IBH initiatives supported by CTC-RI and PCMH-Kids.



achieving practice-led integration goals rather than uniform benchmarks.[9]

To strengthen consistency and address training gaps, CTC-RI developed a structured, IBH practice facilitator training model, emphasizing shared competencies, role clarity, and supervision within primary care. These efforts addressed a well-documented gap in professional training, as both medical and behavioral health education programs often underprepare clinicians for generalist, team-based practice in integrated settings.[10]

CLINICAL, OPERATIONAL, WORKFORCE IBH LESSONS

Consistent with national patterns, Rhode Island's IBH initiatives expanded access to behavioral health support within primary care, and increased use of brief, targeted interventions, particularly in pediatric settings, where early identification can alter long-term trajectories.[3] These gains, however, are closely tied to primary care stability. Primary care in Rhode Island has experienced significant disruption related to provider shortages, comparatively low-payment rates relative to neighboring states, and rising cost pressures affecting practice sustainability and access.[11]

Evidence consistently shows that successful implementation of integrated mental health models depends on stable staffing, reliable workflows, training capacity, and functional health information system exchange within primary care.[2] When practices experience high turnover, productivity pressure, or unstable financing, IBH clinicians are less able to function effectively. In particular, Federally Qualified Health Centers (FQHCs) across Rhode Island served as IBH early adopters and, while initially setting the standard, struggled to sustain efforts in spite of loan repayment options, training within various IBH models, and peer support groups offered across the state through CTC-RI.

Workforce challenges further complicated scalability. Beyond discipline-specific skill gaps, research shows the importance of teamwork and collaboration between team members with different professional roles, and the importance of training to teach teamwork skills essential to integrated care delivery.[12] Rhode Island's experience suggests that investing in shared training across disciplines, supervision for those new to their roles, and facilitation from content experts and quality improvement leads is as critical as funding clinical positions, and not sufficient to ensure sustainability. Training specifically focused on interdisciplinary team-based care in a medical setting has been shown to have the most utility across CTC-RI initiatives, and is often the missing link between implementation and sustainability.

FINANCIAL AND POLICY IMPLICATIONS

Rhode Island's multi-payer environment, anchored by the Office of the Health Insurance Commission (OHIC) and Medicaid, positioned Rhode Island as an early national leader in primary care transformation. Affordability standards were created and aimed at requiring commercial health plans to participate in primary care innovation designed to improve healthcare affordability. These standards directed the adoption of the PCMH, advancing use of CurrentCare, (Rhode Island's health information exchange), and comprehensive payment reform across the delivery system. This alignment of policy and payer participation created the conditions for

early experimentation with IBH through aligned incentives and shared pilot funding.[11] Recent outcome data indicates that practices achieving higher levels of behavioral health integration report better patient outcomes,[4] suggesting the role that financing may play to enable deeper integration and further enhance clinical quality. Yet long-term sustainability remains constrained by payment models that inadequately support team-based care. Both IBH and primary care rely on care coordination and population management, which are inadequately reimbursed under current fee-for-service payment structures.[8] Even within the health center model of stable, prospective payment system (PPS) rates, in which IBH services were included, costs related to the non-billable members of the team that are critical could not make up for the costs needed to continue providing high-functioning, team-based care services. If primary care provides the foundation for increased and predictable revenue streams sufficient to support team-based, non-visit-based care, IBH can be positioned to sustain.

CONCLUSION

Rhode Island's decade of experience demonstrates that IBH is most effective when treated as a core function of APC, rather than as an add-on. National trends increasingly frame integrated care as a response to rising clinical complexity, whole-person care expectations, and system strain, with emphasis on outcomes rather than on discipline-specific models of delivery.[1] Multiple behavioral health roles, including psychologists, social workers, psychiatrists and community health workers, represent one component of this transformation, contributing essential team-based care designed to address medical and behavioral needs together. The evidence from Rhode Island aligns with this national trajectory: IBH improves access, normalizes behavioral health within routine care, and enhances system efficiency, but only when primary care infrastructure is stable and adequately financed.[7]

Looking forward, the central question is not whether IBH should be pursued, but whether primary care systems are designed to enable it. Moving from pilot-driven experimentation to sustainable system design will require alignment in training pathways, outcome measurements, and payment reform that recognizes integrated care as foundational. Rhode Island's experience suggests that when primary care stability is prioritized, integrated behavioral health can move from promise to permanence. Absent renewed and increased investment in primary care infrastructure, Rhode Island risks losing the integration gains achieved over the past decade, and transforming IBH from a core function back into a series of fragile pilots.

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Disclosures

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