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The Readiness for Integrated Care Questionnaire (RICQ): An Instrument to Assess Readiness to Integrate Behavioral Health and Primary Care

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Integration of behavioral health and primary care services is a promising approach for reducing health disparities. The growing national emphasis on care coordination has mobilized efforts to integrate behavioral health and primary care services across the United States. These efforts align with broader health care system goals of improving health care quality, health equity, utilization efficiency, and patient outcomes. Drawing from our work on a multiyear integrated care initiative (Integrated Care Leadership Program; ICLP) and an implementation science heuristic for organizational readiness (**R**eadiness = **M**otivation x General **C**apacity and Innovation-Specific **C**apacity; R = MC^2), this article describes the development and implementation of a tool to assess organizational readiness for integrated care, referred to as the *Readiness for Integrated Care Questionnaire (RICQ).* The tool was piloted with 11 health care practices that serve vulnerable, underprivileged populations. Initial results from the RICQ revealed that participating practices were generally high in motivation, innovation-specific capacities, and general capacities at the start of ICLP. Additionally, analyses indicated that practices particularly needed support with increasing staff capacities (general knowledge and skills), improving access to and use of resources, and simplifying the steps in integrating care so the effort appears less daunting and difficult to health care team members. We discuss insights from the initial use of RICQ and practical implications of the new tool for driving integrated care efforts that can contribute to health equity.

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Public Policy Relevance Statement
This study piloted the Readiness for Integrated Care Questionnaire (RICQ) measurement tool and found that the RICQ is an effective tool for assessing and understanding practice readiness for integrated care among clinics serving vulnerable, minority patient populations. Integrated care is a promising approach for addressing disparities in health (particularly mental health) and advancing health equity.

Primary care settings play a critical role in meeting our nation's health care needs, with the majority of people with mental health problems, substance abuse disorders, and general illnesses receiving care in these settings (Kessler et al., 2005; Kessler, 2012). About two-thirds of primary care patients have comorbid psychosocial symptoms or problems that interfere with their daily functioning (Abed Faghri, Boisvert, & Faghri, 2010). Expanded treatment for mental illnesses and improved mental health outcomes is a key priority area under Healthy People 2020, a national health promotion initiative launched by the Department of Health and Human Services to achieve a set of national health goals and objectives (U.S. Department of Health and Human Services [DHHS], Office of Disease Prevention and Health Promotion [ODPHP], http://www.healthypeople.gov). Additionally, one of the four overarching goals of Healthy People 2020 is to "achieve health equity, eliminating disparities, and improve the health of all groups." Health equity refers to the opportunity for all people to experience optimal health.

Integrated Care as a Promising Approach for Reducing Health Disparities

Mental health is inextricably linked to physical health. Thus, primary care practices that effectively integrate behavioral health services are better positioned to improve clinical outcomes and quality of life for their patients (Satcher & Rachel, 2016; World Health Organization, 2001). Integrated care is a patient-centered approach to addressing the mental and physical health needs of a patient population involving collaboration among mental health and primary care services and providers within a health care delivery system (Peek & The National Integration Academy Council, 2013). Legislative changes in health care (e.g., Patient Protection and Affordable Care Act) and growing emphasis on care coordination have catalyzed efforts to integrate behavioral health and primary care services across the United States (Peikes, Zutshi, Genevro, Parchman, & Meyers, 2012).

Research has documented improvement in patient outcomes when practices use integrated care models that take their specific practice and patient population into account. For example, Ell and colleagues (2010) demonstrated improvement in depressive symptoms for a predominantly Hispanic diabetic patient population using a socioculturally adapted collaborative care model. Other studies have shown improvement in symptoms and rates of treatment among elderly minority patients and patients with limited English proficiency, respectively (Areán et al., 2005; Yeung et al., 2010). Integrated care is a promising approach for addressing health disparities among racial/ethnic minorities (Areán et al., 2005; Bridges et al., 2014; Katon et al., 2010; Sanchez, Chapa,

Ybarra, & Martinez, 2014). Because racial/ethnic minorities and low-income populations frequently experience reduced access to health care, an integrated primary care practice that services these populations can reach people with mental disorders who may otherwise fall through the cracks (Satcher & Rachel, 2016). Essentially, integrated practices can become a "one-stop shop" where patients—especially those with limited resources—can access providers who attend to a host of health concerns.

Although there are many barriers to implementing integrated care, organizations are increasingly interested in adopting evidence-based integrated care models due to the extensive data showing that integrated practice results in better access to care, health system cost savings, and improved clinical outcomes (Fortney et al., 2016). In the context of a larger integrated care capacity-building initiative, this article focuses on how readiness for integrated care is being assessed in health care organizations. Specifically, it discusses the development and initial use of the *Readiness for Integrated Care Questionnaire (RICQ)* as a vehicle for practice change and improvement.

Organizational Readiness and Integrated Care

Readiness refers to the extent to which an organization is both willing and able to implement a particular innovation (Drzensky, Egold, & Van Dick, 2012). Organizational readiness is widely recognized as a critical success factor for the implementation of new innovations (defined as a policy, program, or practice that is new to a setting; Drzensky et al., 2012; Holt & Vardaman, 2013; Scaccia et al., 2015). Scaccia and colleagues (2015) conducted a literature review of organizational readiness measures (e.g., Shea, Jacobs, Esserman, Bruce, & Weiner, 2014; Weiner, Amick, & Lee, 2008) and found that existing instruments capture motivational and general aspects of organizational functioning; however, these instruments only modestly assess variables associated with an organization's readiness for a specific innovation. Each innovation requires capacities that are specific to implementation of that innovation (Klein, Conn, & Sorra, 2001). Thus, capturing the extent to which there is organizational capacity for a given innovation (i.e., innovation-specific capacities), in addition to motivational and general capacities of an organization, provides a more comprehensive picture of organizational readiness for implementing a new innovation.

Scaccia and colleagues (2015) proposed a heuristic for organizational readiness involving a multiplicative relationship of the three components (a) the *motivation* to implement an innovation (the perceived incentives and disincentives of putting an innovation into practice), (b) the *general capacities* of an or-

ganization (structural, functional, and cultural aspects of an organization that impact its capabilities), and (c) the *innovation-specific capacities* needed for a particular innovation (the knowledge, skills, and conditions that are needed to implement the innovation); or R = MC^2 (*R*eadiness = *M*otivation x General *C*apacity x Innovation-Specific *C*apacity). Drawing upon the R = MC^2 heuristic, a team of researchers developed an organizational readiness tool (Scaccia & Wandersman, 2016). This tool was applied to a national community health improvement initiative (Spreading Community Accelerators through Learning and Evaluation [SCALE]; Scaccia & Wandersman, 2016) and then adapted to the integration of behavioral health and primary care, resulting in the *Readiness for Integrated Care Questionnaire (RICQ)* discussed in this article.

The Integrated Care Leadership Program

With support from Kaiser Permanente National Community Benefit and the Robert Wood Johnson Foundation, a multisite partnership was established among the University of South Carolina, the University of North Carolina Charlotte, and the Satcher Health Leadership Institute at the Morehouse School of Medicine (SHLI/MSM) to pilot the RICQ via the Integrated Care Leadership Program (ICLP). Led by SHLI/MSM, ICLP is a multiyear initiative aimed at promoting integrated care in the United States, with a primary focus on Georgia. The program was developed through a health equity lens. It emphasizes creation and advancement of opportunities for underserved, predominantly minority and low-income, patient populations and underresourced clinical settings to experience optimal health outcomes. These populations face disparities in mental health due to barriers to access, including lack of insurance, limited availability of mental health care providers and services, and various manifestations of stigma, or negative attitudes toward mental illness. (Cook, Doksum, Chen, Carle, & Alegria, 2013; Satcher & Rachel, 2016). The ICLP specifically promotes health equity among vulnerable populations by developing health leaders equipped to further integrate behavioral health and primary care services. By developing capacity among safety net practices to advance integrated care within their clinical setting, the program ensures that these effective models are accessible to patients most in need of facilitated access to high-quality behavioral health care. The ICLP involves a hybrid model of capacity-building for primary care sites consisting of (a) online training focused on transformative leadership, improving care quality, and sustaining integrated practices, (b) technical assistance via structured monthly leadership development coaching calls, mentoring via communities of practice members, monthly continuing education webinars, and site visits, and (c) the opportunity to apply for an innovation award to pilot a site-specific quality improvement project intended to advance integrated practice. A distinct aspect of the ICLP is examining and leveraging organizational readiness for integrated care. Through this process, sites' strengths and weaknesses are identified, thus enabling them to target specific focus areas for transforming their practices. In this article, we discuss how the RICQ was used as an assessment tool to measure and monitor organizational readiness for integrated care in a diverse set of health care organizations serving predominantly minority and low-income populations.

Method

Participants

The 2016 cohort of the ICLP consisted of 11 health care organizations that were at various stages of developing or enhancing their integrated health care practices. Participating sites were diverse in geographical location (Georgia, California, New York, Michigan, and Missouri), type of agency (see Table 1), and target patient populations (e.g., persons experiencing homelessness, geriatric, children and families). Ten sites were primary care centers and one site was a behavioral health agency seeking to better address the physical health needs of its patient population. Additional features of this sample included the participation of a school-based health center and a clinical practice affiliated with a medical school, which also served as a training facility for medical students and residents.

Measure: Readiness for Integrated Care Questionnaire (RICQ)

The RICQ assesses the components and subcomponents of readiness. There are three components (motivation, innovation-specific capacity, and general capacity) and 16 subcomponents (e.g., relative advantage, priority, leadership, resource utilization). See Table 2 for a list of the components and subcomponents, and their associated definitions.

The RICQ is an 82-item quantitative survey. Response choices are on a 7-point Likert scale: *Strongly Disagree* (1), *Disagree* (2), *Slightly Disagree* (3), *Neither Agree or Disagree* (4), *Slightly Agree* (5), *Agree* (6), or *Strongly Agree* (7). Sample items include, "Integrated care is a top priority in our practice," "We have enough resources in our practice to accomplish integrated care," and "An influential person in our practice strongly promotes integrated care." The reliability statistics (Cronbach alphas) for the subcomponents of the readiness questionnaire used in the SCALE initiative ranged from .73 to .95.

Questionnaire Development

The RICQ was adapted from a survey initially developed for the SCALE initiative. The original SCALE measure was developed after reviewing organizational readiness instruments and finding that no measure adequately captured our constructs of interest. A combination of steps was used to develop the original readiness measure for SCALE. First, the subcomponents were identified by synthesizing work on capacity (e.g., Flaspohler, Duffy, Wandersman, Stillman, & Maras, 2008; Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004) and motivation (Damschroder et al., 2009; Rogers, 2003; Weiner, 2009; Weiner et al., 2008), relating these constructs to quality of implementation. Then, a pool of items that assessed the components and subcomponents were inductively generated using methods outlined by DeVellis (2003). Several other readiness measurers were reviewed for items that addressed the constructs of interest (e.g., Lehman, Greener, &

Table 1. *Selected Characteristics of the 2016–2017 ICLP Cohort*

Variable	Participating sites (N = 11)
Geographic Location	
Rural	1 (9%)
Urban	10 (91%)
State	
Georgia	7 (64%)
Other states	4 (36%)
Type of Practice	
FQHC	5 (45%) *One of these is a school-based health agency
Public nonprofit	2 (18%)
Private nonprofit	2 (18%) *Medical school affiliation/training of residents
For-profit	1 (9%) *Primarily a behavioral health agency
Other	1 (9%)
Type of Population Served (Proportion of patient population)	
Pediatric (age < 18)	0–74%
Adult (age 18–65)	14–90%
Older Adult (age > 65)	1–86%
Number of patient encounters in 2014: Average = 24,230; Range = 2,676 to 84,817	
Number of unduplicated patients seen in 2014: Average = 6,888; Range = 440 to 20,035	

Note. ICLP = Integrated Care Leadership Program; FQHC = Federally Qualified Health Center.

Simpson, 2002; Shea et al., 2014; Weiner, Belden, Bergmire, & Johnston, 2011). Next, content experts (individuals with expertise and field experience on the subject of organizational readiness) were consulted to revise and reduce the total item pool. Feedback from the content experts helped improve the language of the items. This measure was piloted with two community respondents in SCALE for clarity, which led to additional refinement. The RICQ was then developed by adapting the items in the SCALE version for a new innovation: integrated care. This process involved working iteratively with integrated care subject matter experts and developers of the SCALE measure to review and adapt the items within each $R = MC^2$ subcomponent to the integrated care context.

Procedure

The RICQ was made available on the ICLP website as part of the application to participate in the ICLP. The instructions noted that the purpose of the questionnaire was to assess organizational readiness and capability for engaging in integrated care activities. It included the following description of integrated care to ensure a shared understanding of the term across respondents: "Integrated Care is the integration of behavioral health in primary care. This includes things the primary care provider does to improve recognition and/or management of behavioral health (e.g., screening), as well as use of a behavioral health specialist (peer, trained nurse or care manager, clinical social worker, psychologist, and/or psychiatrist to work collaboratively in the management of primary care patients to address co-occurring mental health and substance use disorders)." The instructions also included the following response criteria: (a) a minimum of three respondents per health care practice, (b) respondents represent different roles within their practice (e.g., member of the administrative team, primary care physician, behavioral health practitioner, nurse, front desk staff, or quality

improvement person), and (c) the set of respondents include the lead administrator and lead physician. Health care practices were encouraged to solicit more than three responses to provide a fuller picture of the practice.

For practices in which at least three individuals completed the RICQ, site-specific summaries were created. These summaries provided mean scores for each of the 82 items, along with component and subcomponent mean scores. A heat table coding system was applied to mean scores to visually highlight variations in readiness. In the actual site-specific summaries, the heat tables were produced in a color-coded continuum of red to yellow to green, with red indicating lower readiness scores, yellow indicating scores in the middle, and green indicating higher readiness scores. This color-coded scheme made it easier to identify specific areas of strengths, weaknesses, and trends. For the purposes of this article, we use gray-scale to illustrate the color-coded continuum, with darker shades representing lower scores and lighter shades representing higher scores. An aggregate summary was prepared to reflect average readiness scores across practices, in addition to the site-specific summaries for each practice. This research protocol was approved by the Morehouse School of Medicine Institutional Review Board (IRB).

Data Analyses

For the site-specific summaries, scores on the RICQ were first calculated at the item level by obtaining mean participant responses. Next, the mean of items comprising each subcomponent was calculated. Finally, a mean for each readiness component (motivation, general capacity, and innovation-specific capacity) was calculated via a mean of its subcomponents. The aggregate summary also included results at the item, subcomponent, and component level. Aggregate readiness scores were calculated by taking a mean of the individual mean scores. Lower mean scores

Table 2. *Readiness Component and Subcomponent Definitions*

Motivation[a]	
Subcomponent	Definition
Relative Advantage	Degree to which a particular innovation is perceived as being better than the current practices being used by the organization
Compatibility/Alignment	Degree to which an innovation is subjectively perceived as being consistent with the existing values, cultural norms, and needs of the organization.
Complexity	Degree to which an innovation is perceived as relatively difficult to understand and use; number of different components
Priority	Degree to which an innovation is expected, rewarded, and supported; if the innovation is mandated or required
Innovation-Specific Capacity[b]	
Innovation Specific Knowledge & Skills	Set of knowledge, skills, and abilities that are needed in order to implement with quality and reach intended outcomes
Program Champion	Individual(s) who put organizational weight behind an innovation
Implementation Climate Support	Extent that the innovation is tangibly supported by the organization (e.g., policies and resources that support the innovation)
Inter-organizational Relationships	Relationships between organizations that specifically facilitate use of an innovation
General Capacity[c]	
Culture	Set of expectations about how things are done in an organization; how an organization or a system functions
Climate	How employees collectively perceive, appraise and feel about their current working environment
Organizational Innovativeness	Receptiveness of an organization to change
Resource Utilization	How resources are acquired and used
Leadership	How effectively management sets tone and expectations for an organization
Structure	Organizational architecture, size, specialization, power structures, staff autonomy, staff cohesiveness, communication pathways, and internal decision-making processes that can impact how well an organization functions on a day-to-day basis.
Staff Capacity	General skills, education, and expertise that the staff possess
Process Capacities	General knowledge and skills needed to implement an innovation

[a] Perceived incentives and disincentives that contribute to the desirability to use an innovation. This includes beliefs about a) an innovation and b) support for the innovation that contributes to innovation use (Scaccia et al., 2015). [b] The knowledge, skills, and conditions that are needed to implement a *particular* innovation (Scaccia et al., 2015). [c] The knowledge, skills, and conditions that are necessary to implement *any* innovation (Flaspohler et al., 2008).

indicated lower levels of readiness, or areas for improvement; higher mean scores indicated higher levels of readiness, or areas of strength within the practice.

Results

Data were collected between December 2015 and February 2016. Ten of 11 health care practices had at least three members complete the RICQ for a total of 43 individual responses. Respondents were from clinical and/or administrative roles (see Table 3). The number of respondents per practice ranged from three to 10.

The mean scores and trends reported below reflect practice readiness for integrated care at the beginning of the ICLP, providing baseline readiness scores across participating practices.

Mean Scores and Trends

At the R = MC^2 component level, practices self-rated highest in motivation ($M = 5.69$, $SD = 1.38$), followed by general capacity ($M = 5.37$, $SD = 2.32$), and innovation-specific capacity ($M = 5.15$; $SD = 2.22$). The results indicate that, at the beginning of their engagement in the ICLP, practice members were motivated to move toward

Table 3. *Practice Respondent Roles Per Clinical and Administrative Responsibilities (N = 43)*

Clinical role*	% (n)
Nurse	35.56 (16)
Physician	22.22 (10)
Social Work	15.56 (7)
None Selected/NA	11.11 (5)
Psychologist	6.67 (3)
Medical Assistant	4.44 (2)
Licensed/Certified Counselor	4.44 (2)
Administrative Role**	
Director (e.g., Medical/Dental Director, Director of Behavioral Health, Director of Quality, Compliance and Education)	30.95 (13)
Not Applicable (indicating the respondent did not have an administrative role)	23.81 (10)
Manager (e.g., Nurse Manager, Practice Manager)	19.05 (8)
Executive Officer	9.52 (4)
Administrative Support (e.g., Administrative Assistant, Executive Assistant, Medical Assistant in Behavioral Health)	7.14 (3)
Other (e.g., sole clinic provider, behavioral health services)	4.76 (2)
Coordinator (e.g., Behavioral Health Coordinator, Care Coordinator)	4.76 (2)

* Three individuals selected two roles in their organization and are counted twice in this table: Nurse & Social Work, Nurse & Licensed/Certified Counselor, Psychologist & Licensed/Certified Counselor. One response is missing. ** One response is missing.

integrated care; however, as expected, they lacked some capacities needed for the specific effort to integrate their practice. General organizational functioning within the cohort of participating practices was positive. Overall, mean component scores indicated a moderate to high level of organizational readiness for integrated care among the participating practices (see Figure 1).

Mean scores at the subcomponent level varied more widely than at the component level, ranging from 4.58–6.29 (see Table 4). The top five subcomponent means were compatibility/alignment ($M = 6.29$, $SD = 0.98$), relative advantage ($M = 5.92$, $SD = 1.10$), culture ($M = 5.86$, $SD = 1.22$), leadership ($M = 5.83$, $SD = 1.25$), and priority ($M = 5.77$, $SD = 1.23$). These results indicated that, at the beginning of the ICLP, members of the participating practices viewed integrated care as compatible with their practice environment and that they perceived this model of care to be better than alternatives. It also revealed a positive general organizational culture, with engaged and supportive leadership. Staff capacity had the lowest subcomponent score ($M = 4.58$, $SD = 1.52$), indicating the need for additional training and skill development and/or additional experienced staff. The results also revealed concerns about how well resources were used (resource utilization: $M = 4.74$, $SD = 1.65$), and the complexity of integrated care ($M = 4.78$, $SD = 1.55$).

Discussion

Although there are many potential benefits of integrating behavioral health and primary care services, health care organiza-

tions are highly complex systems with varying stages of readiness for a collaborative approach to care. Variations in readiness are influenced by perceived incentives and disincentives of the collaborative approach, which impacts behavioral tendencies for engaging in integrated care efforts (Scaccia et al., 2015; Weiner, 2009). Assessing organizational readiness for integrated care can help practices more effectively provide collaborative care services for difficult-to-reach populations in resource-limited settings. Practical tools such as the RICQ can help practice leadership pinpoint specific areas for change and enable leadership to make timely, data-informed decisions about how to allocate limited resources most effectively. This organizational capability for strategic decision making is particularly critical in resource-limited settings and when serving vulnerable populations who often encounter greater difficulties with access to care. Motivation, general capacities of the organization, and availability of specific capacities required for integrated care provide a framework to assess factors that influence readiness.

At the start of the ICLP, results from the RICQ revealed that participating practices were generally high in motivation, innovation-specific capacities, and general capacities. This is not surprising, as the program's application requirement was expected, at some level, to screen out practices low in readiness for change. Higher initial scores may be partially explained by respondents' desire to be perceived as ready for the ICLP. It could also be an artifact of gaps in participant awareness of the complexity and intricacy of working toward integrated care. In other words, without fully understanding what it means to be "ready" for integrated care, participants may inaccurately perceive their practice as high in readiness. In addition, the baseline readiness assessment was primarily completed by clinic "champions" who were selected from their organization to participate in the ICLP and may be particularly inclined to rate their practice positively. Data analyses of the RICQ also revealed areas in which practices needed additional support in order to implement integrated care successfully. Specifically, these included the need for increased staff capacities (general knowledge and skills), improved access to and use of resources, and simplifying the steps to integrated care so the effort appears less difficult to health care team members.

Defining Features of the RICQ

Expanding on R = MC², there are three defining features of the RICQ. First, organizational readiness changes over time. For instance, a health care organization may initiate integrated care efforts with minimal staff capacities and resources; however, with external funding and technical support, the practice may find that it is better positioned for integrated care at a later time (e.g., 1 year later). Conversely, a practice with high leadership engagement and support for collaborative care may be high in readiness for integrated care at one time point, however, readiness levels could diminish with a change in leadership. In short, organizational readiness fluctuates and should be monitored continuously.

Second, readiness for integrated care is viewed on a continuum rather than as a dichotomous construct ("ready/not ready"). The RICQ is intended to measure the extent to which a practice is ready. The instrument is designed to facilitate capacity-building and quality improvement activities.
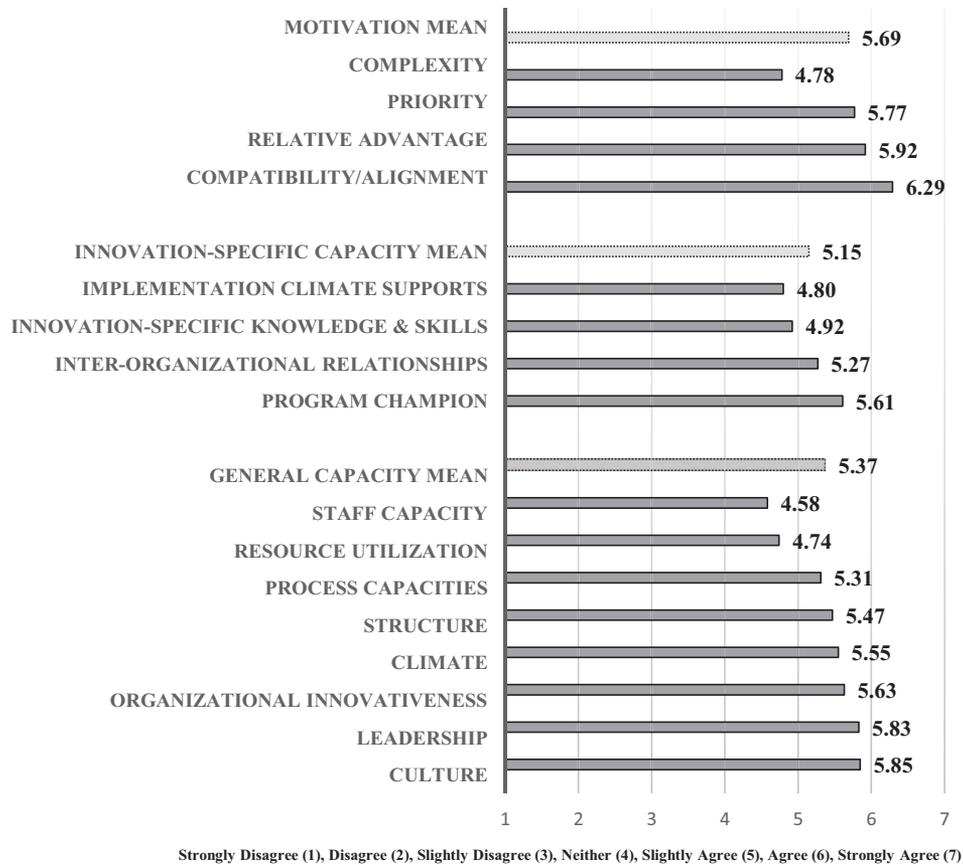
Strongly Disagree (1), Disagree (2), Slightly Disagree (3), Neither (4), Slightly Agree (5), Agree (6), Strongly Agree (7)

Figure 1. RICQ Component and Subcomponent Aggregate Mean Scores.

Third, we view the RICQ as part of a comprehensive planning, implementation, and evaluation process. In the ICLP, the RICQ data were used in conjunction with a variety of other programmatic data sources (e.g., clinical outcomes, practice-specific quality improvement plans, participant feedback and insights per routine coaching calls and site visits, webinar and training evaluations) to understand the progress and continuous needs of each practice. Readiness is not just a precursor to integrated care efforts, but also a construct that impacts the life span of the innovation (integrated care) within its host organization. Therefore, in the process of piloting the RICQ, we were deliberate about translating the RICQ results into a practitioner-friendly format to increase practitioner appreciation for and comfort with the tool. For example, each practice was provided with a site-specific summary of their readiness results. The summary included a brief description of organizational readiness, the key attributes of organizational readiness, why readiness matters, and trends in the readiness results. The descriptive text was accompanied with color-coded bar charts and a heat table. We also included an appendix defining key terms. Being fully aware of the busy schedule of health care practitioners, the summaries were intentionally short (total of four pages, including tables, figures, and list of terms and definitions). One hour video conference calls were scheduled with each practice to review and discuss their readiness scores. These calls included conversations about how practice members could use the data as a source

of encouragement for ongoing integrated care efforts as well as to facilitate suggestions for future improvements within their practice. During these discussions, we were mindful to have practice members (rather than ICLP-readiness team members) drive specific improvement decisions. We facilitated conversations and highlighted trends, but did not make specific recommendations for change. This helped practice members maintain ownership of their own change efforts.

Implications for Practice

Along with the ICLP participants, we have found that the RICQ is an effective tool for assessing and understanding practice readiness for integrated care among clinics serving underserved, minority and low-income patient populations. The tool identifies strengths and weaknesses of an organization along key dimensions of readiness. This helped us tailor programmatic supports and conversations with each health care organization, and provided participating practices with clarity on how to focus their energy and resources.

Through the ICLP, sites utilized their initial RICQ results to address challenges in the areas of capacity and resource utilization to improve the quality of mental health services provided to patients. For instance, RICQ results for one practice revealed low levels of innovation-specific knowledge and skills. In other words,

Table 4. *Color-Coded Subcomponent Mean Scores*

Color Coding Key:

Weak	Strong

Action recommended: identify strategies for improvement	Consider using as leverage for increasing readiness

Subcomponent	M (SD)
Compatibility/Alignment	6.29 (.98)
Relative Advantage	5.92 (1.10)
Culture	5.86 (1.22)
Leadership	5.83 (1.25)
Priority	5.77 (1.23)
Organizational Innovativeness	5.63 (1.58)
Program Champion	5.61 (1.57)
Climate	5.55 (1.76)
Structure	5.47 (1.31)
Process Capacities	5.31 (1.38)
Inter-organizational Relationships	5.27(1.56)
Innovation-Specific Knowledge & Skills	4.92 (1.58)
Implementation Climate Supports	4.80 (1.44)
Complexity*	4.78 (1.55)
Resource Utilization	4.74 (1.65)
Staff Capacity	4.58 (1.52)

Note. This table ranks subcomponent means across all 10 sites on a color-coded continuum, demonstrating each mean score relative to all subcomponent mean scores. Darker grey coloring identifies subcomponents with lower readiness scores; lighter grey coloring highlights subcomponents with higher mean scores. *M* = mean; *SD* = standard deviation. These results presented in grey-scale for print; in actual reports, they appear in multi-color.

* Complexity items were reverse-coded.

the practice's greatest need was for more information about integrated care and training on how to take concrete steps to becoming an integrated care practice. During conversations with the practice's leadership about their readiness scores, we learned that the practice was specifically interested in receiving mentoring and technical assistance from a successfully integrated practice. Given the practice's limited resources, the ICLP leadership team encouraged them to apply for an innovation award. The award monies were used by the practice for an in-person site visit with integrated care consultants and to send select practice members to a nationally recognized integrated care training program to help ensure the practice would be better-equipped to attend to the physical and mental health needs of the vulnerable, inner-city, mostly child and adolescent population it serves. Attendees of both the in-service training and site visit gained a better understanding of what it entails to blend behavioral health and primary care services. They used their learnings to help further integrate behavioral health and primary care services in order to improve clinical outcomes, access to health care, and overall quality of life for their clients and their families. Collectively, these improvements represent significant steps toward the ultimate advancement of health equity.

At another practice, the readiness assessment results were shared with senior leadership, which led to a conversation about staff concerns with the complexity of integrated care. Knowing concerns existed about the complexity of working toward integrated care, leadership decided to focus initial efforts on impactful

but readily feasible improvements. Specifically, the practice focused on implementing key patient mental health screening questionnaires (Patient Health Questionnaire [PHQ-9] and General Anxiety Disorder [GAD-7]), a critical step in the direction of integrated care. Medical assistants and nurses were trained in the administration of the questionnaires and, over time, the site screened 92% of their patient population, and 37% were referred to behavioral health services. Given that this particular practice serves low-income, predominantly minority senior citizens, the innovation implemented at the practice not only enabled access to behavioral health care that the patients previously did not have, but follow-up screenings showed a sharp decline in average PHQ-9 scores, indicating improvement or remission of depression symptoms. Moreover, the behavioral health department of the practice was allocated additional, more appropriate space at the site for psychotherapy, which improved the site's compliance with certain policies (e.g., HIPAA) as well as reduced stigma associated with receiving behavioral health services. By meeting these practice change and improvement goals, the site was able to begin to address certain disparities in access to quality mental health care in a substantive way.

Follow-up phone interviews with practice members revealed that the readiness assessment tool was useful for "identifying barriers to implementation and facilitat[ing] buy-in to address specific concerns." They also reported that "positive feedback reinforced current practices." Again, readiness enabled these underresourced health care practices to strategically allocate their already-limited capacities for increased efficiency.

In addition to illuminating within-practice trends, the RICQ is also useful for shedding light on trends across practices. We used aggregate-level data to guide ICLP programmatic decisions. For example, after sharing RICQ results with practice members, the ICLP team learned that participants desired a framework to address the practice-based challenges surfaced via the questionnaire. In response, an all-practice inclusive online training was provided. The training focused on how to move identified needs into action using an evidence-based implementation science approach (Getting to Outcomes; Chinman, Imm, & Wandersman, 2004). Attendees were mostly practice members in administrative roles and behavioral health providers, and they indicated that the training content and learning materials addressed needs or gaps in their knowledge or skills. Attendees also reported they learned a fair amount to a great deal of new knowledge about the topic, and they felt confident in working toward applying that knowledge gained in their practices. Additionally, the training facilitated conversations between leadership and frontline staff.

We also found that the RICQ is a useful tool for elevating and expanding ICLP participant engagement. After participants received their site-specific summaries, several participating organizations requested an extension on the initial readiness assessment timeframe to solicit additional responses from their practice. To our pleasant surprise, two practices with low completion rates on the readiness questionnaire began proactively allocating resources for an additional readiness assessment, plus consultation.

Lastly, results from the RICQ have been useful as a vertical and lateral communication tool within health care organizations. Practice leaders shared the results with their health care teams as an additional opportunity to discuss ongoing integrated care change efforts. After discovering the utility of the RICQ, they requested

that more mid- and front line staff complete the survey to enhance understanding of readiness for integrated care in their practice. Other practice members used the results to increase awareness about the state of their practice and to promote engagement by sharing site summaries with their peers and with leadership. In several of the practices, discussion of the items themselves, rather than just the subcomponent scores, was helpful in facilitating changes to support integrated care. For example, the item "we have the ability to access sources of revenue and resources" (under the resource utilization subcomponent) sparked conversations about additional sources of funding for integrated care efforts. These conversations encouraged practice members to submit applications for ICLP innovation awards, providing additional integrated care resources to practices.

Limitations and Future Directions

This article presents an emerging body of scholarly work on an organizational readiness tool that draws from the R = MC^2 heuristic. Our use of the RICQ revealed practical applications for the instrument. However, readiness scores reflected the responses of only a small sample of members in each participating practice. Responses from a larger number of members at each practice would provide a more comprehensive report of organizational readiness. As understanding of and appreciation for the utility of the RICQ increases among participating practices, we expect increases in participant use of the RICQ. Additional waves of data on the RICQ will be useful for understanding changes in readiness over time, both within and across practices. It can also illuminate variations in readiness per health care role (e.g., nurse practitioner, physician, administrator, social worker), variations in readiness per size of health care organization, and other salient issues (e.g., average response rates and response times).

The RICQ is still in development. Although it has been perceived as useful by stakeholders, we recognize that more rigorous psychometric and comparative analyses with similar tools will need to be conducted in order to have a greater degree of confidence in the results. Toward that end, we are planning to run additional reliability analyses with an independent sample and both exploratory and confirmatory factor analyses with a larger sample to see whether the constructs hold and assess the overall value of specific items. Additionally, we plan to conduct cross-validation with instruments that measure similar constructs (e.g., ORIC; Patterson et al., 2005). As the ICLP work expands, we anticipate having additional practices and responses, enabling us to run these analyses. Once these analyses are completed, we can be data-informed in how we adjust the measure for future administration (e.g., changing the wording of items, reducing redundant items, etc.) in a way that still preserves its practical utility.

In the process of refining the instrument, we will reconsider the length of the assessment tool. The RICQ is currently 82 items. A recent review of integrated care measurement tools indicated that the majority of existing tools contained between 20 and 40 items; however, these instruments largely measured a single construct (e.g., organizational culture) associated with integrated care, rather than a broad range of constructs as in the RICQ (Evans, Grudniewicz, Baker, & Wodchis, 2016). A benefit of using an integrated care instrument that measures a broad array of constructs is that it can serve as a diagnostic tool for identifying strengths and weak-

nesses across multiple organizational capabilities (Evans et al., 2016). During the pilot use of the RICQ, the length of the instrument did not appear to be an issue for participants. On the contrary, participants indicated that they appreciated the depth and breadth of the assessment. We did not track the average assessment completion time in this project, but data from the SCALE initiative, for which the readiness instrument included a similar number of items, revealed an approximate response time of 15–20 min. It may be useful to develop a short version of the survey in addition to the full, longer version.

In future research, we will continue to explore the potential of the RICQ as an intervention tool for increasing practice readiness for integrated care. More specifically, we can determine the ways the tool can be used to guide specific integrated care efforts and what supports, processes, or other resources are needed to maximize the utility of the RICQ as an intervention tool. Additionally, we will examine the predictive validity of the RICQ, in which prediction is not confounded by attempts to use the RICQ to build readiness. Finally, triangulated analyses of RICQ scores vis-à-vis changes in behavioral health status (e.g., reductions in PHQ-9 and GAD-7 scores) and clinical outcomes (e.g., HbA1c, blood pressure, BMI, tobacco/nicotine use) can be used to determine the full impact of readiness on integrated care, ultimately moving toward health equity. This effort would examine the effectiveness of the RICQ as a tool for predicting the likelihood of successful integration based on a practice's organizational readiness scores.

Lastly, the RICQ was piloted for the ICLP, which specifically and intentionally engages safety-net clinics that serve vulnerable and underserved patient populations. As such, we only know what the results look like from our sample. Future use of the RICQ in higher-resource settings may or may not yield similar results and/or lead us to employ alternative methods for survey administration and analysis.

Conclusion

American civil rights leader Dr. Martin Luther King Jr. famously said, "Of all the forms of inequality, injustice in health care is the most shocking and inhuman." Disparities in access to and quality of health care remain significant social justice issues in the United States today. Disparities in health among socially disadvantaged individuals and groups pose a direct obstacle to upward social mobility (Braveman et al., 2011). Thus, health inequities—both mental and physical—not only impact the lives of individuals and communities, but threaten economic productivity, national security, and competition in the global market, and trivialize our nation's character and commitment to justice and fairness of opportunity (National Academies of Sciences, Engineering, & Medicine, 2017).

The integration of behavioral and primary health care represents a promising mechanism for addressing disparities in health—particularly mental health—and advancing health equity (Holden et al., 2014). Integrated behavioral and primary care system designs increase patient access to behavioral health services and reduce the stigma associated with seeing a behavioral health provider. Additionally, integration improves provider-to-provider communication, service coordination, and continuity of care (Bartels et al., 2004; Gallo et al., 2004; Katon et al., 2010; Unützer et al., 2012). However, research and practical experience have dem-

onstrated the difficulty of making system-level changes. Challenges include disciplinary cultural changes, lack of leadership, change in workflow, and lack of sustainable reimbursement models (Kathol, Butler, McAlpine, & Kane, 2010; Grazier, Smith, Song, & Smiley, 2014).

The readiness of an organization to engage in change and build capacity in these areas influences the extent to which change efforts are successful. As an increasing number of health care organizations seek to redesign their practices to provide integrated care, we propose that a readiness tool like the RICQ can help guide transformation efforts. Our study of the RICQ suggests that the tool holds promise for measuring readiness, advancing integrated care, and furthering health equity.

Keywords: Organizational readiness; readiness for integrated care; integrated care; behavioral health; primary care

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