Better Health Together ACH
Cohort 1 Baseline Report
Washington Integrated Care Assessment (WA-ICA) for Behavioral Health Settings

A Collaboration with the Health Care Authority, all 9 ACHs, and the 5 MCOs

Data Collection Period: July – Aug 2022

The Washington Integrated Care Assessment (WA-ICA) is a collaboration of the Health Care Authority, all 9 ACHs, and the 5 MCOs

About the Assessment Framework

- The **WA-ICA** has been adapted from the work of Dr. Henry Chung and the framework for Continuum-Based Behavioral Health Integration and General Health Integration in Behavioral Health Settings. This framework was developed using extensive literature review and stakeholder expertise.
- With 8 domains and 15 subdomains, the assessment framework lays out the key elements of general health integration into the behavioral health setting. **Foundational domains** are those considered core to advancing integration and can be an opportunity to focus improvement when a practice is in the preliminary stage.
- Practices assess their integrated care delivery along a continuum which identifies standards for a practice in the preliminary, intermediate I, intermediate II, and advanced categories of integration for each subdomain. This continuum-based model acknowledges that many practices range in their implementation of integration standards across domains, depending on population served, location, size, funding types/sources, workforce capacity, physical space, etc. This means that different practices may find that while they meet the advanced or intermediate category standards in some domains, they meet the preliminary standards in others.
- The framework allows practices to assess their readiness for advancement in any given domain or subdomain and to prioritize goals and resource allocation accordingly. Thus, in addition to assessing a practice's current level of integration, the assessment framework serves as a road map for progress.

Table of Contents

Summary

Return to Table of Contents

Executive Summary

* **Foundational Domain.** Sites in preliminary stages can focus on these areas to establish a foundation for advancing integrated care.

1. **Most behavioral sites are in earlier stages of integration compared to primary care.**
Thirty-four (34) Better Health Together Behavioral Health sites responded in Cohort 1, representing a 136% site response rate. The response rate exceeds 100% because additional sites (not originally invited) responded.

2. **Foundational Areas of Strength***:

Screening (subdomain 1.1)
Care Management – tracking and monitoring (3.1)

3. **Opportunities for Improvement:**

Financial Sustainability (8.1)
Medication Management (2.3)
Care Team (5.1)

4. **Opportunities for Foundational Improvement***:

Referral facilitation and engagement (1.2)

Opportunities for Improvement

Subdomains with Highest % Sites in **Preliminary**

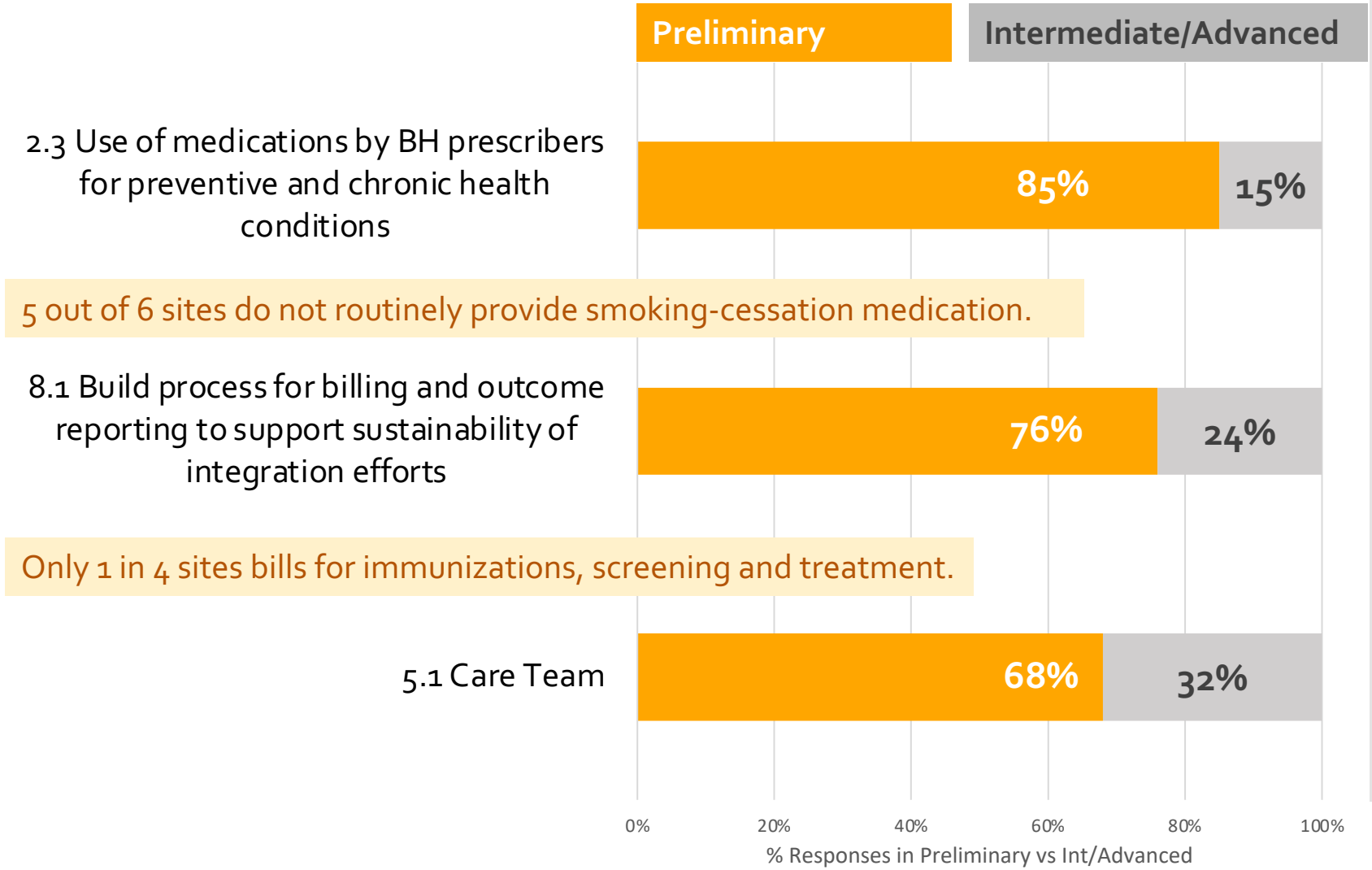
Behavioral Health

Subdomains with 3 highest percentages of sites in Preliminary integration stage

-

N = 34

* **Foundational Domain.** Sites in preliminary stages can focus on these areas to establish a foundation for advancing integrated care.



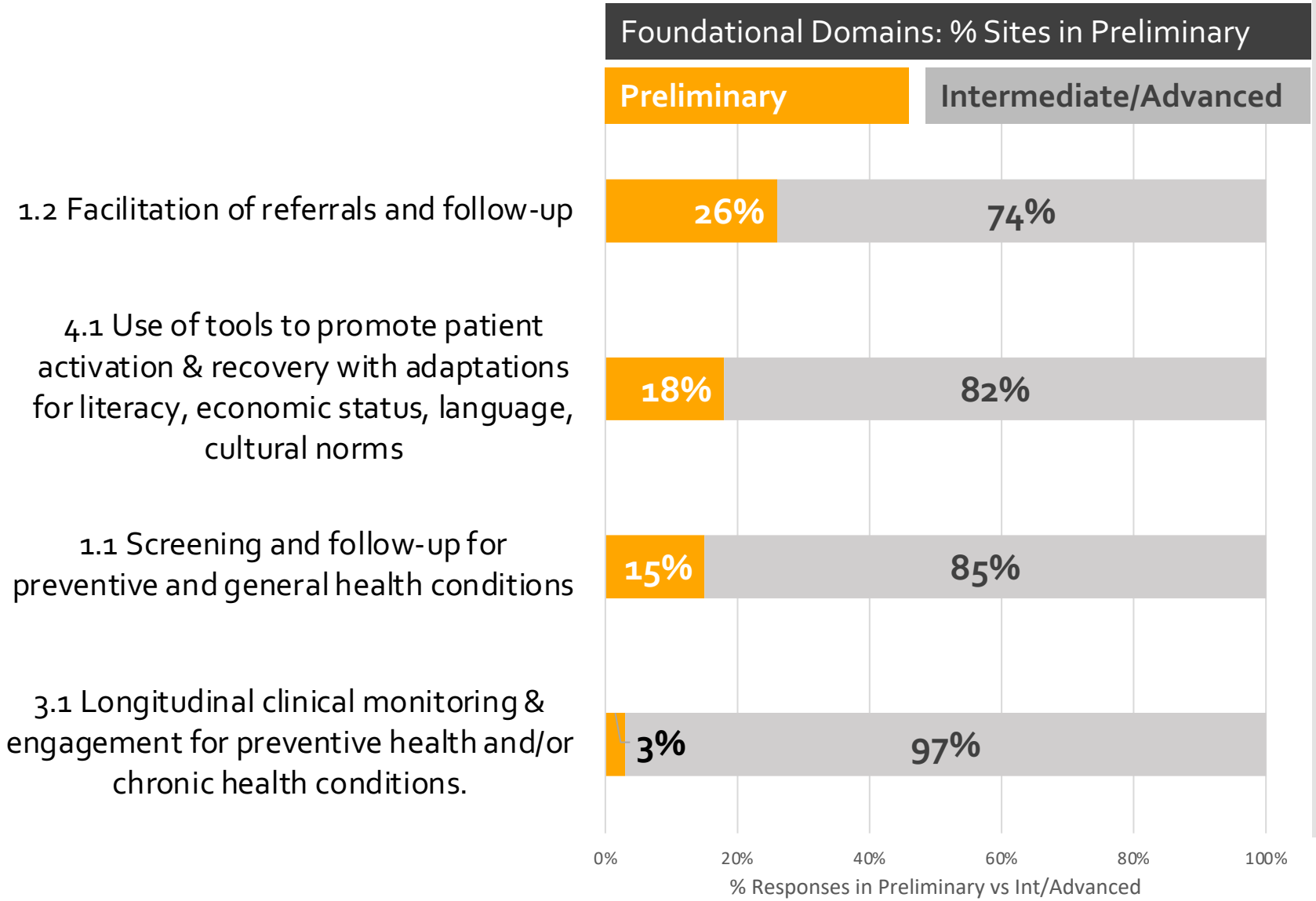
Foundational Domains

Subdomains with % Sites in **Preliminary**

Behavioral Health

Foundational Domains – Sites in Preliminary integration stage - N = 34

* **Foundational Domain.** Sites in preliminary stages can focus on these areas to establish a foundation for advancing integrated care.



Response Rate & Characteristics

Return to Table of Contents

Behavioral Health

Response Rate

Better Health Together ACH

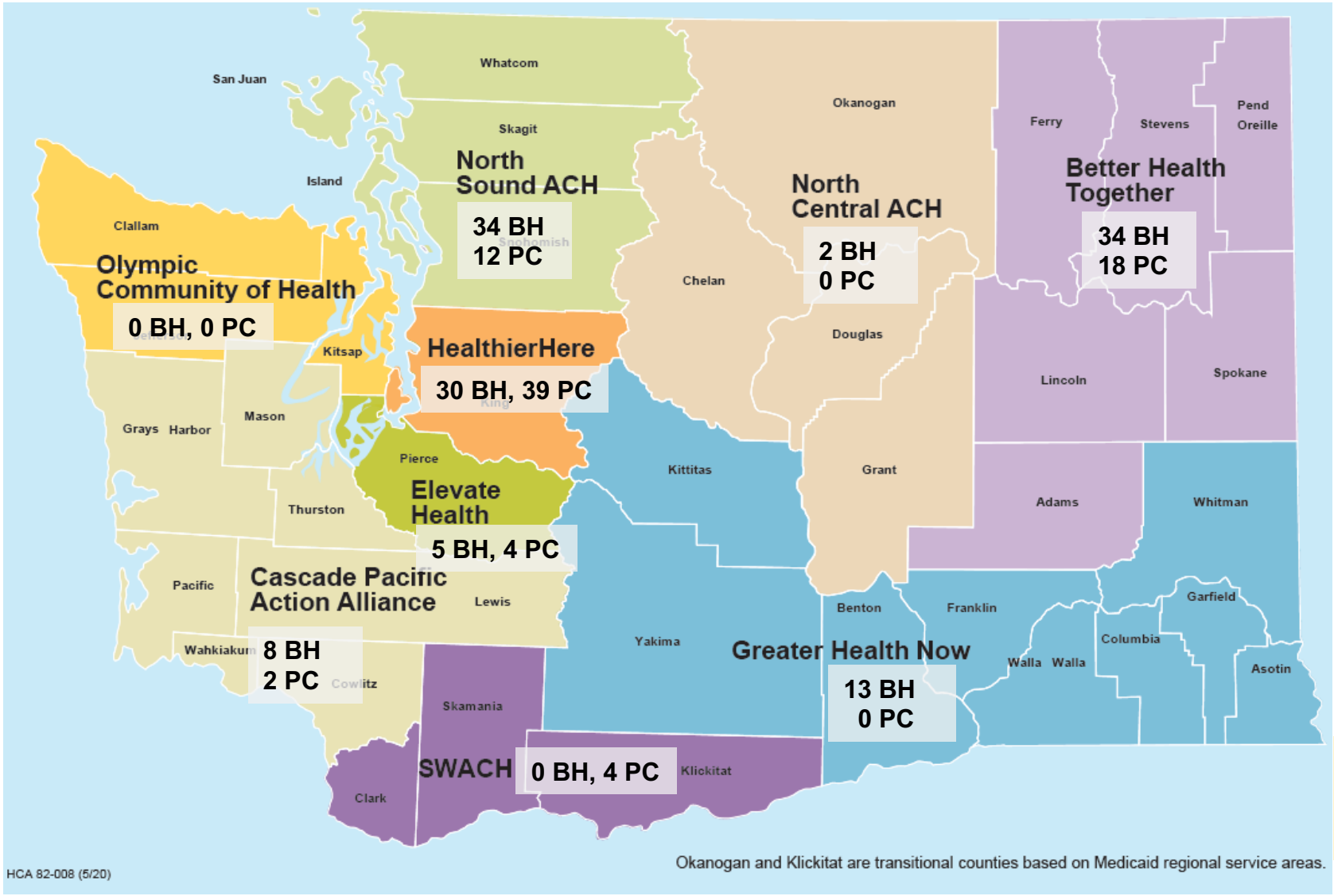
- **Cohort 1:**
- Responses Received July 11 - August 22, 2022

- 19 orgs responded / 21 orgs invited = **90%** Org Response Rate
- 34 sites responded / 25 sites invited = **136%*** Invited Site Response Rate (15 additional sites responded)

*Response rate exceeds 100% because additional (not originally invited) sites responded

	Org Response Rate (responded / invited)	**Site Response Rate** (responded / invited)
Behavioral Health	90% (19/21 orgs)	136%* (34/25 sites)
Primary Care	60% (6/10 orgs)	75% (18/24 sites)
All	74% (23/31 orgs)	106%* (52/49 sites)

ACH Region Response Count



Key

BH: Behavioral Health Site Responses

PC: Primary Care Site Responses

Region	BH	PC	% Total (BH+PC)
HealthierHere	30	39	34%
Better Health Together	34	18	25%
North Sound ACH	34	12	22%
Greater Columbia ACH	13	0	6%
Cascade Pacific Action Alliance	8	2	5%
Elevate Health	5	4	4%
Southwest ACH	0	4	2%
North Central ACH	2	0	1%
Olympic Community of Health	0	0	0%
Total	126	79	100%

Three regions account for 81% of site responses.

59% of Cohort 1 invitees were in these 3 regions.

Behavioral Health

Characteristics of Cohort 1 Responses -

N = 34

Supplemental Questions

- **1. Does your clinical site serve adults, pediatrics, or both?**

	# Sites	% Sites
Both	17	50%
Adults	16	47%
Pediatrics	1	3%
Total	34	100%

Behavioral Health

Characteristics of Cohort 1 Responses

-

N = 34

- **2. Please select <u>any/all</u> categories that apply to your clinical site:**

Clinic Type	Count	% Sites (count / N)
Behavioral Health (mental health only)	17	50%
Behavioral Health (mental health AND SUD)	12	35%
Behavioral Health (SUD only)	4	12%
Co-located Behavioral Health and Primary Care	3	9%
Rural Health Clinic	2	6%
Opioid Treatment Program (OTP)	1	3%
Other	1	3%
Primary Care	0	0%

Other categories:

- OTP and Mental Health

Behavioral Health

Characteristics of Cohort 1 Responses -

N = 34*

*Actual number of responses used in analysis may vary to account for data quality or missing data.

- **3. Approximately how many patients are seen at your clinical site each month?**

	Min	25% Percentile	Median	75% Percentile	Max
Monthly Patients	9	75	150	325	1,090

Behavioral Health

Characteristics of Cohort 1 Responses -

N = 34*

*Actual number of responses used in analysis may vary to account for data quality or missing data.

- **4. What is the approximate payor mix of patients seen at your clinical site in an average month?**

	Min	25% Percentile	Median	75% Percentile	Max
Medicaid	28%	86%	97%	97%	100%
Medicare	0%	0%	0%	0%	20%
Commercial Insurance	0%	0%	0%	4%	50%
Uninsured	0%	0%	0%	1%	9%
Fee for Service	0%	0%	2%	2%	100%
Other	0%	1%	1%	3%	30%

Other payor categories:

- Federal Bureau of Prisons
- Sliding Fee Scale
- BHASO
- City of Spokane Grants

Payor mix differs significantly between Behavioral Health and Primary Care sites.
Median Medicaid for Behavioral Health is more than 4x that of Primary Care (97% vs. 21%).

Medicare and commercial representation is lower at Behavioral Sites than Primary Care.
Medicare median is 0% for Behavioral vs 27% for Primary Care.
Commercial median is 0% for Behavioral vs 30% for Primary Care.

Behavioral Health

Characteristics of Cohort 1 Responses

-

N = 34

- **6. Does your clinical site currently use any of the following Social Determinants of Health (SDOH) screening tools?** (select all that apply):

Type	Count	% Sites (count / N)
Other	16	47%
None of the above – our site does not currently use a screening tool	15	44%
PRAPARE	2	6%
Daily Living Activities—20 (DLA-20)	1	3%
Health Leads Social Needs Screening	1	3%
Accountable Health Communities (AHC) tool (also known as the Health-Related Social Needs (HRSN) tool)	0	0%
WellRx	0	0%

Nearly half of sites do not use any SDoH screening tool, similar to Primary Care sites in this region.

Other screening tools:

- DSM 5 Mental Health Assessment
- STARS Health Care Screening Plan
- Social needs screening tool from American Academy of Family Physicians
- In house assessment

Behavioral Health

Characteristics of Cohort 1 Responses

-

N = 34

- **7. What funding sources support your integrated care efforts?**

(select all that apply):

Type	Count	% Sites (count / N)
Grants	25	74%
Fee for service billing	12	35%
Capitated PMPM rate	8	24%
Other	7	21%
Collaborative Care codes	2	6%
Value based payment arrangements	2	6%
None	0	0%

Other sources:

- MCO reimbursement schedules
- Sliding Fee Scale
- MHBG funding
- BHT contract/pay for performance
- Donations
- DSHS Home and Community

Collaborative Care Codes and **Value based payment arrangements (VBP)** support integrated care efforts at **half of Primary Care sites** versus **only 1 in 20 Behavioral Health sites** in this region.

Behavioral Health

Characteristics of Cohort 1 Responses

-

N = 34

- **9. Which of the following IT and/or population health tools are in use at your clinical site?** (select all that apply):

Type	Count	% Sites (count / N)
Electronic Health Records	34	100%
Health information exchanges (HIE)	18	53%
Electronic referrals to outside services	9	26%
Closed loop referral systems with outside services	7	21%
Registries	5	15%
Shared care plans	3	9%
Community information exchanges (CIE)	0	0%

Behavioral Health

Characteristics of Cohort 1 Responses - N = 34*

*Actual number of responses used in analysis may vary to account for data quality or missing data.

- **10. Approximately what percentage of patient visits at your clinical site are virtual vs. in-person in an average month?**

	Min	25% Percentile	Median	75% Percentile	Max
% Virtual (video)	0%	1%	0%	18%	52%
% Virtual (telephone only)	0%	0%	4%	9%	4%
% In-Person	5%	73%	79%	96%	100%

More Behavioral Health sites in this region reported In-Person visits and less virtual (video or telephone) compared to Statewide.

Behavioral Health

Characteristics of Cohort 1 Responses

-

N = 34

- **26. What are the top three challenges your site faces in advancing integration?** (select three)

Type	Count	% Sites (count / N)
Workforce	32	94%
Financial Support	28	82%
Technology	21	62%
Partnerships with other clinical providers	14	41%
Other	4	12%
Leadership Support	3	9%

Other challenges:

- "Financial sustainability in a low volume setting"
- Technology to communicate with external partners that is easy to use

Workforce and Financial Support are the top challenges to advancing integration. These were the top challenges for both Behavioral Health and Primary Care sites.

Behavioral Health providers reported challenges with technology at almost 4x the rate of Primary Care (62% vs 17%). This is reflective of historical underinvestment in Behavioral Health technology and EHR use.

Results by ICA Framework Subdomains (Distribution of Site Responses)

Return to Table of Contents

Index of ICA Framework Domains

* **Foundational Domain.** Sites in preliminary stages can focus on these areas to establish a foundation for advancing integrated care.

ICA Framework Domains

1. Screening, referral to care and follow-up.*
2. Evidence-based care for preventive interventions and common general medical conditions.
3. Ongoing care management.*
4. Self-management support adapted to culture, local environment, and life experiences of patients.*
5. Multi-disciplinary team-based care (including patients) with dedicated time to provide general health care.
6. Systematic quality improvement.
7. Linkages with community/social services that improve general health and mitigate environmental risk factors.
8. Sustainability.

Screening

Domain
1. Screening , Referral to Care and Follow-up

Subdomain
1.1 Screening and follow-up for preventive and general health conditions

Behavioral Health

N = 34

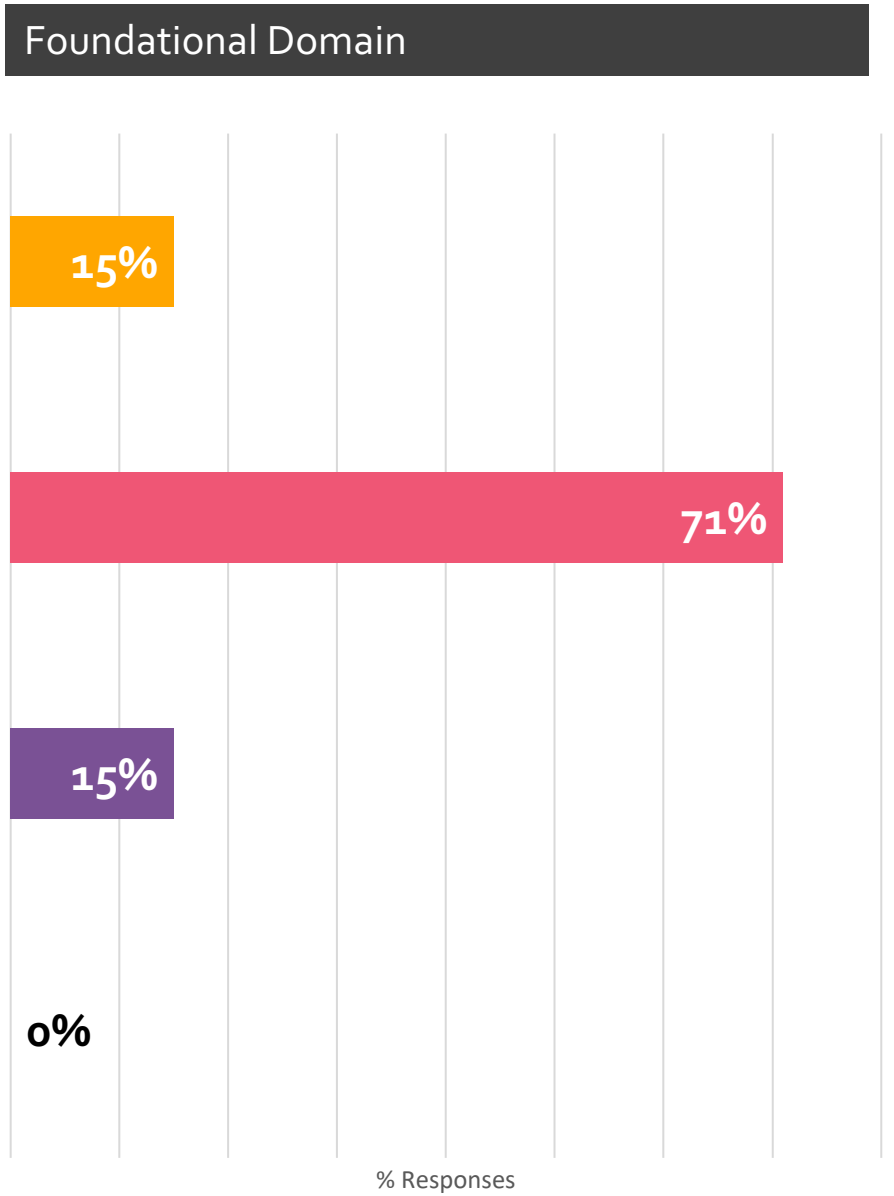
Question 11

Preliminary: Response to patient self-report of general health complaints and/or chronic illness with f/u only when prompted.

Intermediate I: Systematic screening for universal general health risk factors[iii] and proactive health education to support motivation to address risk factors.

Intermediate II: Systematic, screening and tracking of universal and relevant targeted health risk factors as well as routine f/u for general health conditions with the availability of in-person or telehealth primary care.

Advanced: Analysis of patient population to stratify by severity of medical complexity and/or high-cost utilization for proactive assessment tracking with in-person or telehealth primary care.



Referrals

Foundational Domain

Domain
1. Screening , Referral to Care and Follow-up

Subdomain
1.2 Facilitation of referrals and follow-up

Behavioral Health

N = 34

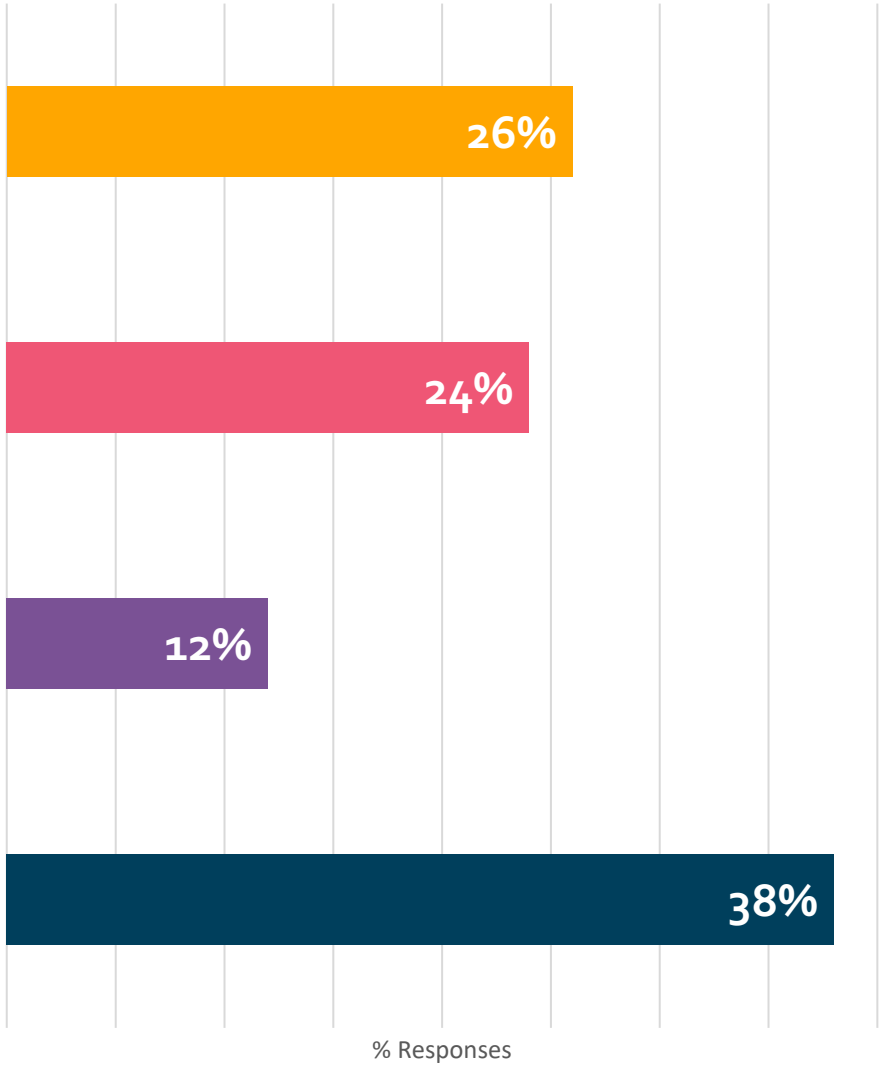
Question 12

Preliminary: Referral to external primary care provider(s) (PCP) and no/limited f/u.

Intermediate I: Written collaborative agreement with external primary care practice to facilitate referral that includes engagement and communication expectations between behavioral health and PCP.

Intermediate II: Referral to onsite, co-located PCP or availability of primary care telehealth appointments with assurance of "warm handoffs" when needed.

Advanced: Enhanced referral facilitation to onsite or closely integrated offsite PCPs, with electronic data sharing and accountability for engagement.



Evidence-based Guidelines for Prevention

Domain
2. Evidence based care for preventive interventions and common chronic health conditions

Subdomain
2.1 Evidence-based guidelines or treatment protocols for preventive interventions

Behavioral Health

N = 34

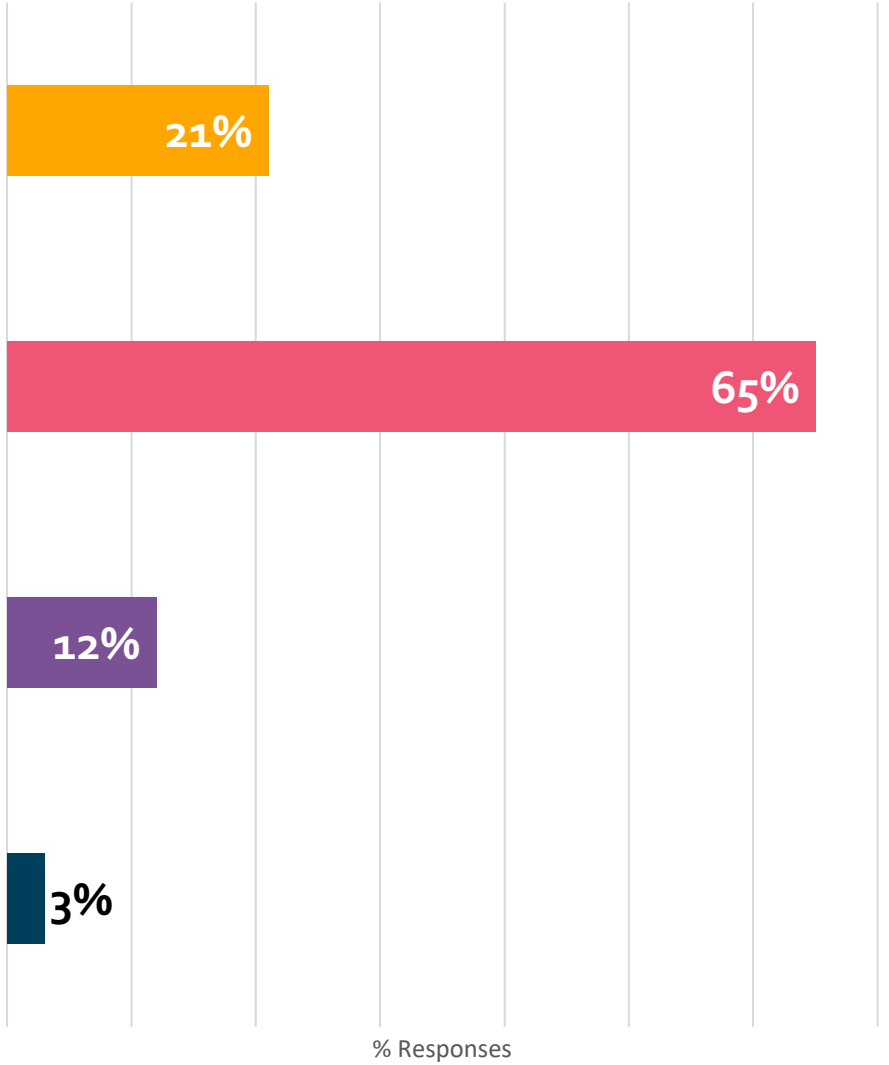
Question 13

Preliminary: Not used or minimal guidelines or protocols used for universal general health risk factor screenings care. No/minimal training for BH providers on preventive screening frequency and results.

Intermediate I: Routine use of evidence-based guidelines to engage patients on universal general health risk factor screenings with limited training for BH providers on screening frequency and result.

Intermediate II: Routine use of evidence-based guidelines for universal and targeted preventive screenings with use of standard workflows for f/u on positive results. BH staff routinely trained on screening frequency and result interpretation.

Advanced: Systematic tracking and reminder system (embedded in EHR) used to assess need for preventive screenings, workflows for f/u availability of EB and outcomes driven programs to reduce or mitigate general health risk factors (smoking, alcohol, overweight, etc.).



Evidence-based Guidelines for General Medical Conditions

Domain
2. Evidence based care for preventive interventions and common chronic health conditions

Subdomain
2.2 Evidence-based guidelines or treatment protocols for chronic health conditions

Behavioral Health

N = 34

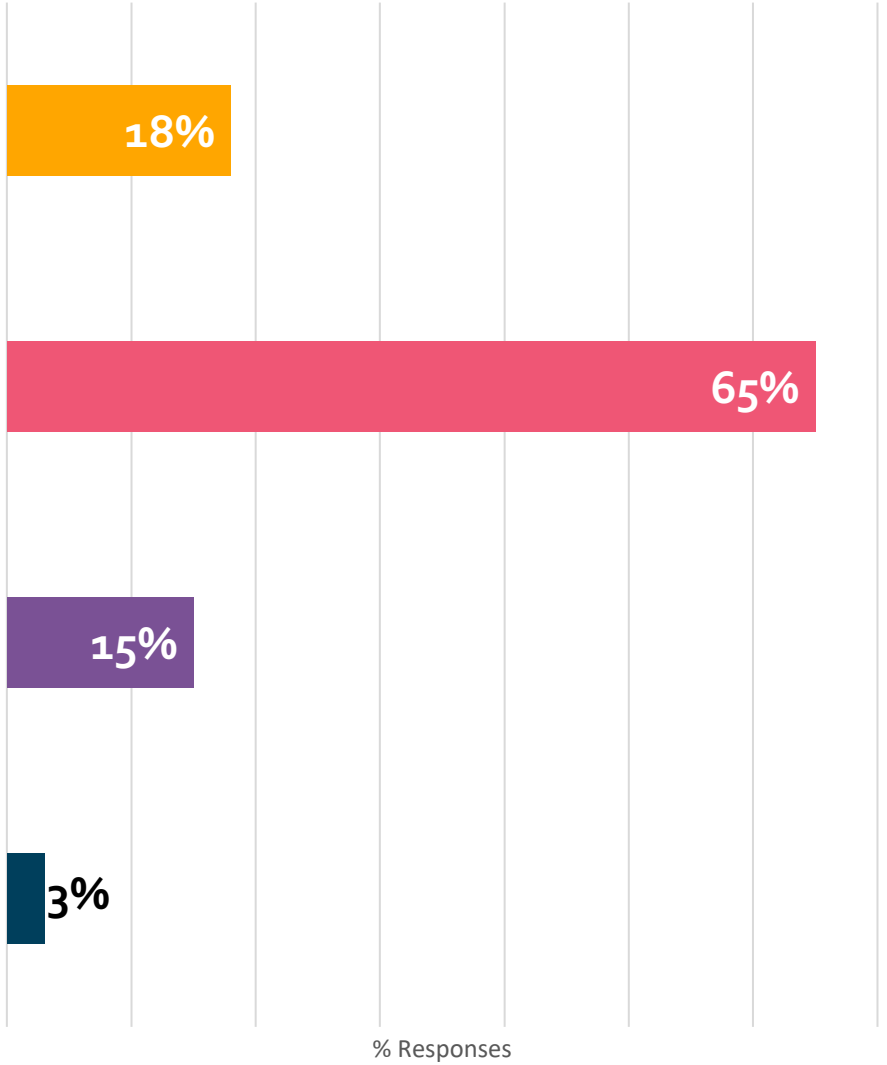
Question 14

Preliminary: Not used or with minimal guidelines or EB evidence-based workflows for improving access to care for chronic health conditions.

Intermediate I: Intermittent use of guidelines and/or evidence-based workflows of chronic health conditions with limited monitoring activities. BH staff and providers receive limited training on chronic health conditions.

Intermediate II: BH providers and/or embedded PCP routine use of evidence-based guidelines or workflows for patients with chronic health conditions, including monitoring treatment measures and linkage/navigation to medical services when appropriate. BH staff receives routine training in basics of common chronic health conditions.

Advanced: Use clinical decision-support tools (embedded in EHR) with point of service guidance on active clinical management for BH providers and/or embedded PCPs for patients with chronic health conditions.



Medication Management

Domain
2. Evidence based care for preventive interventions and common chronic health conditions

Subdomain
2.3 Use of medications by BH prescribers for preventive and chronic health conditions

Behavioral Health

N = 34

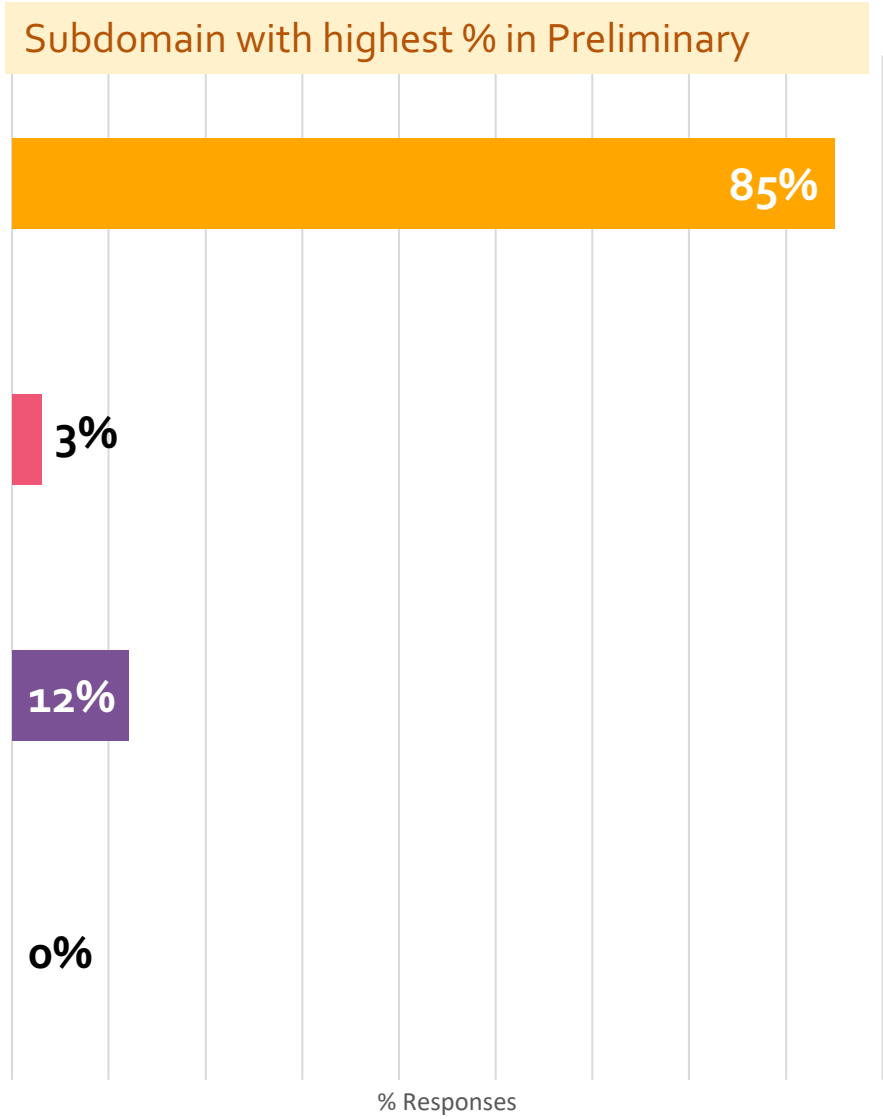
Question 15

Preliminary: None or very limited use of non-psychiatric medications by BH prescribers. Non-psychiatric medication concerns are primarily referred to primary care clinicians to manage.

Intermediate I: BH prescriber routinely prescribes nicotine replacement therapy (NRT) or other psychiatric medications for smoking reduction.

Intermediate II: BH prescriber routinely prescribes smoking cessation as previously. May occasionally make minor adjustments to medications for chronic health conditions when indicated, keeping PCP informed when doing so.

Advanced: BH prescriber can prescribe NRT as well as prescribe chronic health medications with assistance and consultation of PCP.



Trauma-informed Care

Domain
2. Evidence based care for preventive interventions and common chronic health conditions

Subdomain
2.4 Trauma-informed care

Behavioral Health

N = 34

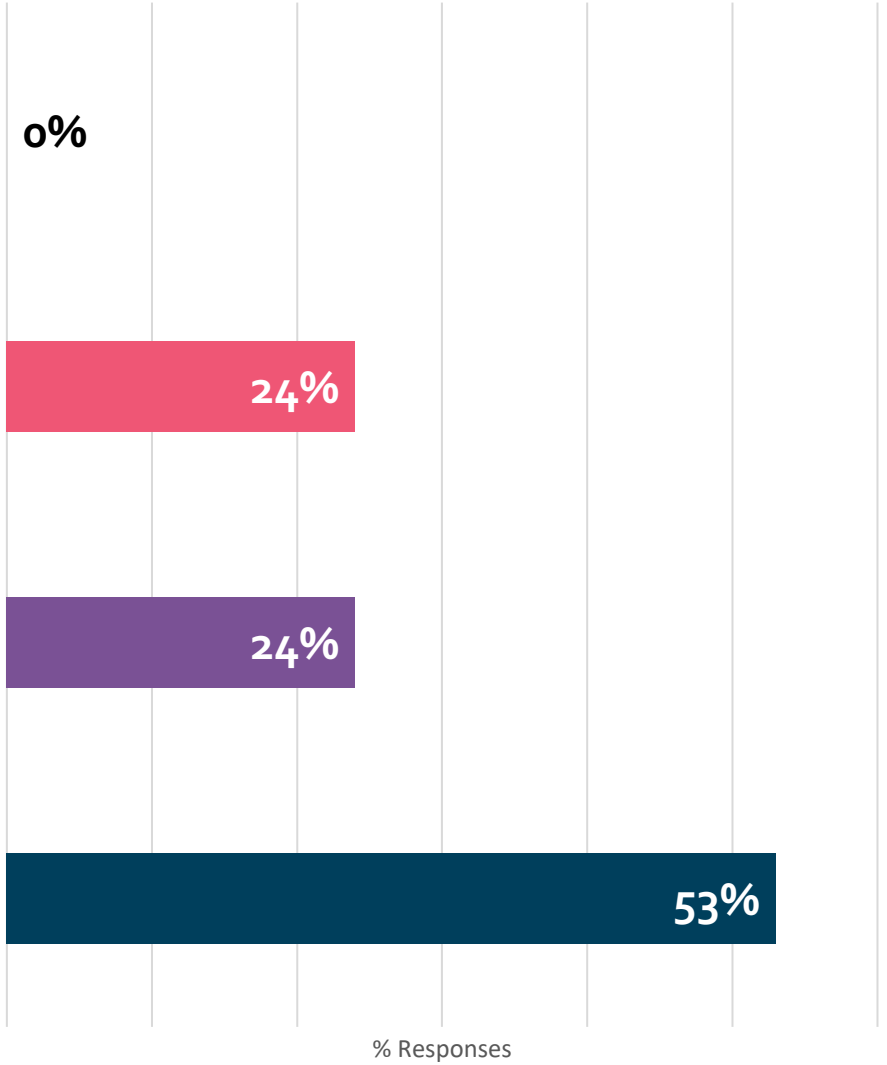
Question 16

Preliminary: BH staff have no or minimal awareness of effects of trauma on integrated health care.

Intermediate I: Limited staff education on trauma and impact on BH and general health care.

Intermediate II: Routine staff education on trauma-informed care model including strategies for managing risk of re-traumatizing. Limited use of validated screening measures for trauma when indicated.

Advanced: Adoption of trauma-informed care strategies, treatment and protocols by BH clinic for staff at all levels to promote resilience and address re-traumatizing and de-escalation procedures. Routine use of validated trauma assessment tools such as adverse childhood experiences (ACES) and PTSD checklist (PCL-C) when indicated.



Care Management

Foundational Domain

Domain
3. Ongoing care management

Subdomain
3.1 Longitudinal clinical monitoring & engagement for preventive health and/or chronic health conditions.

Behavioral Health

N = 34

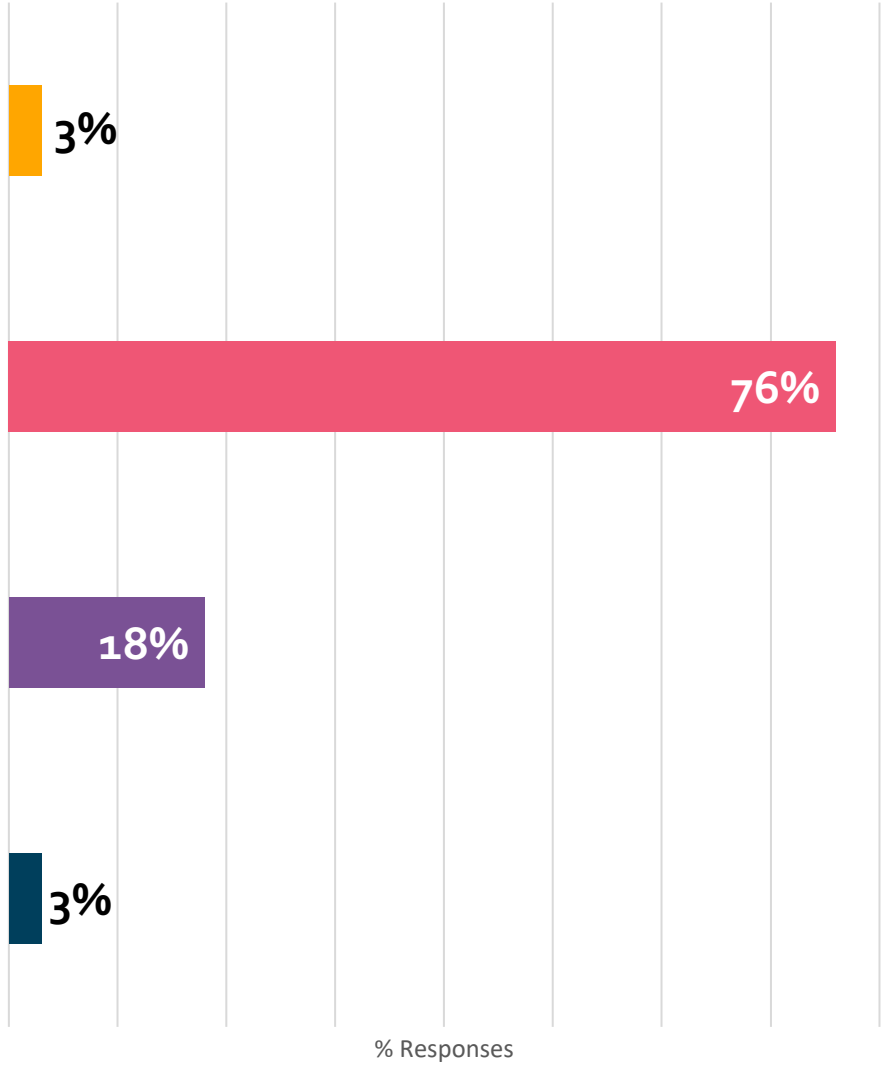
Question 17

Preliminary: None or minimal follow-up of patients referred to primary and medical specialty care.

Intermediate I: Some ability to perform follow-up of general health appointments, encourage medication adherence and navigation to appointments.

Intermediate II: Routine proactive follow-up and tracking of patient medical outcomes and availability of coaching (in person or using technology application) to ensure engagement and early response.

Advanced: Use of tracking tool (e.g., excel tracker or disease registry software) to monitor treatment response and outcomes over time at individual and group level, coaching and proactive f/u with appointment reminders.



Self-management Support

Foundational Domain

Domain
4. Self-management support that is adapted to culture, socioeconomic and life experiences of patients

Subdomain
4.1 Use of tools to promote patient activation & recovery with adaptations for literacy, economic status, language, cultural norms

Behavioral Health

N = 34

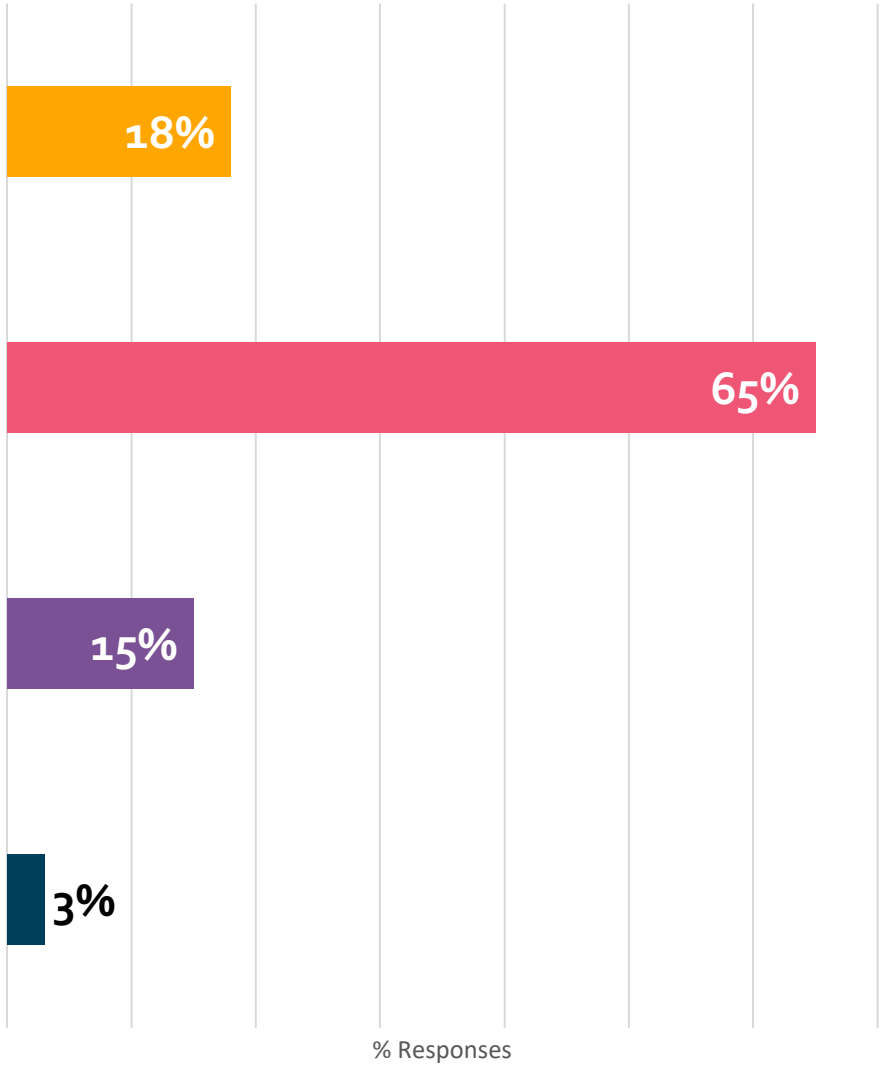
Question 18

Preliminary: None or minimal patient education on general medical conditions and universal general health risk factor screening recommendations.

Intermediate I: Some availability of patient education on universal general health risk factor screening recommendations, including materials/handouts/web-based resources, with limited focus on self-management goal-setting.

Intermediate II: Routine brief patient education delivered in person or technology application, on universal and targeted preventive screening recommendations and chronic health conditions. Treatment plans include diet and exercise, with routine use of self-management goal-setting.

Advanced: Routine patient education with practical strategies for patient activation and healthy lifestyle habits (exercise & healthy eating) delivered using group education, peer support, technology application and/or on-site or community-based exercise programs. Self-management goals outlined in treatment plans. Advanced directives discussed and documented when appropriate.



Care Team

Domain
5. Multidisciplinary team (including patients) with dedicated time to provide general health care

Subdomain
5.1 Care Team

Behavioral Health

N = 34

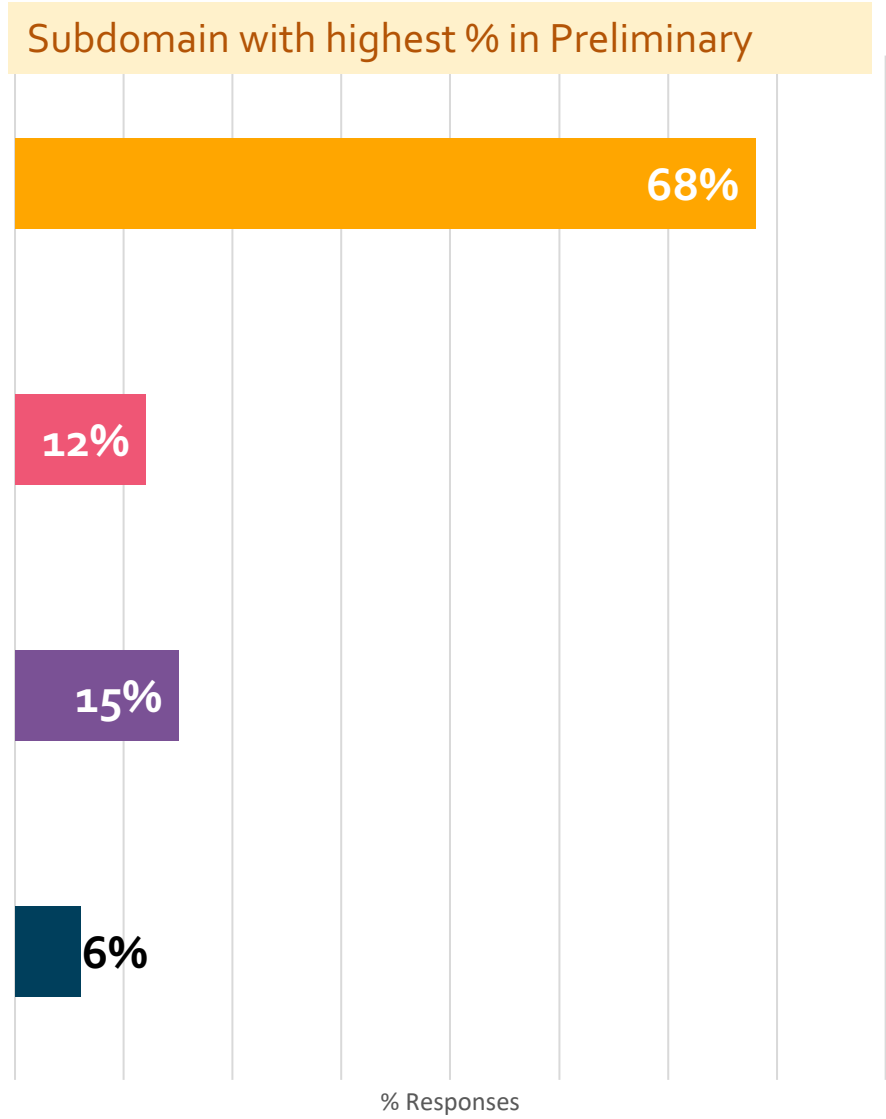
Question 19

Preliminary: BH provider(s), patient, family caregiver (if appropriate).

Intermediate I: BH provider(s), patient, nurse, family caregiver.

Intermediate II: BH provider(s), patient, nurse, peer, co-located PCP(s), (M.D., D.O., PA, NP), family caregiver.

Advanced: BH provider(s), patient, nurse, peer, PCP(s), care manager focused on general health integration, family caregiver.



Sharing Treatment Info

Domain
5. Multidisciplinary team (including patients) with dedicated time to provide general health care

Subdomain
5.2 Sharing of treatment information, case review, care plans and feedback

Behavioral Health

N = 34

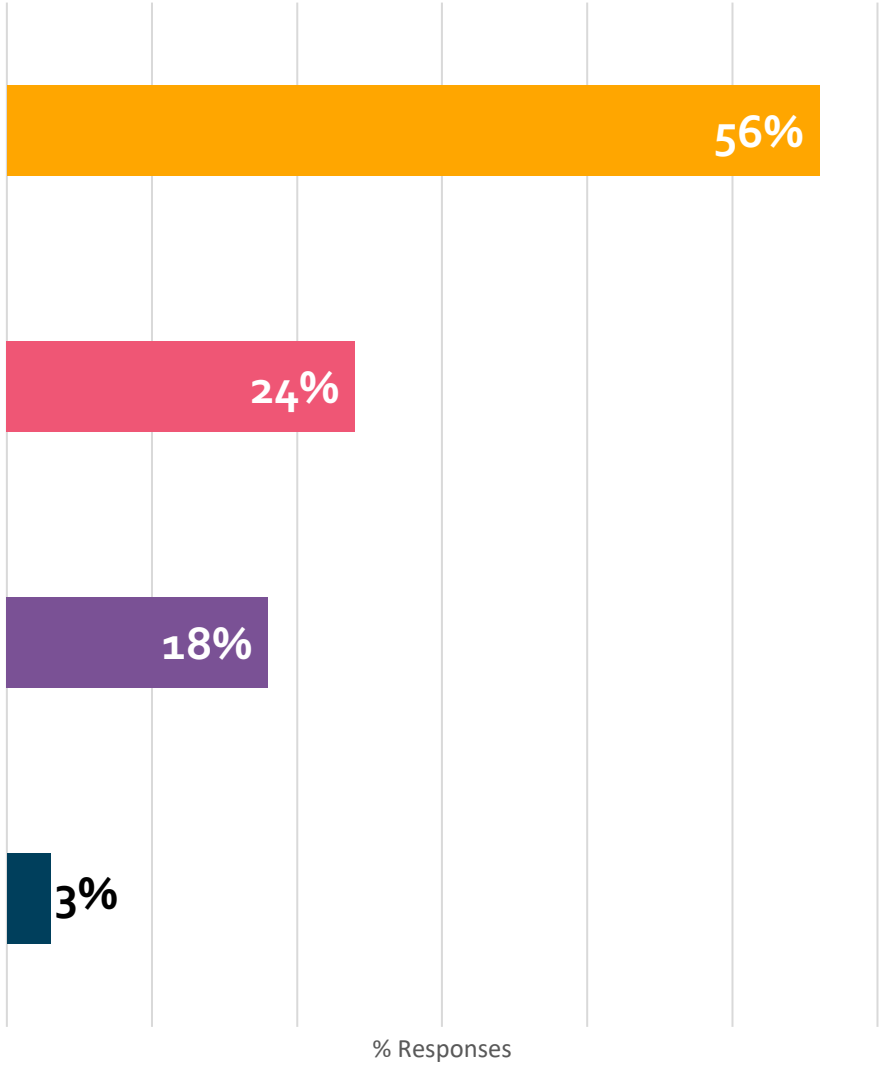
Question 20

Preliminary: No or minimal sharing of treatment information and feedback between BH and external PCP.

Intermediate I: Exchange of information (phone, fax) and routine consult retrieval from external PCP on changes of general health status, without regular chart documentation.

Intermediate II: Discussion of assessment and treatment plans in-person, virtual platform or by telephone when necessary and routine medical and BH notes visible for routine reviews.

Advanced: Regular in-person, phone, virtual or e-mail meetings to discuss complex cases and routine electronic sharing of information and care plans supported by an organizational culture of open communication channels.



Integrated Care Training

Domain
5. Multidisciplinary team (including patients) with dedicated time to provide general health care

Subdomain
5.3 Integrated care team training

Behavioral Health

N = 34

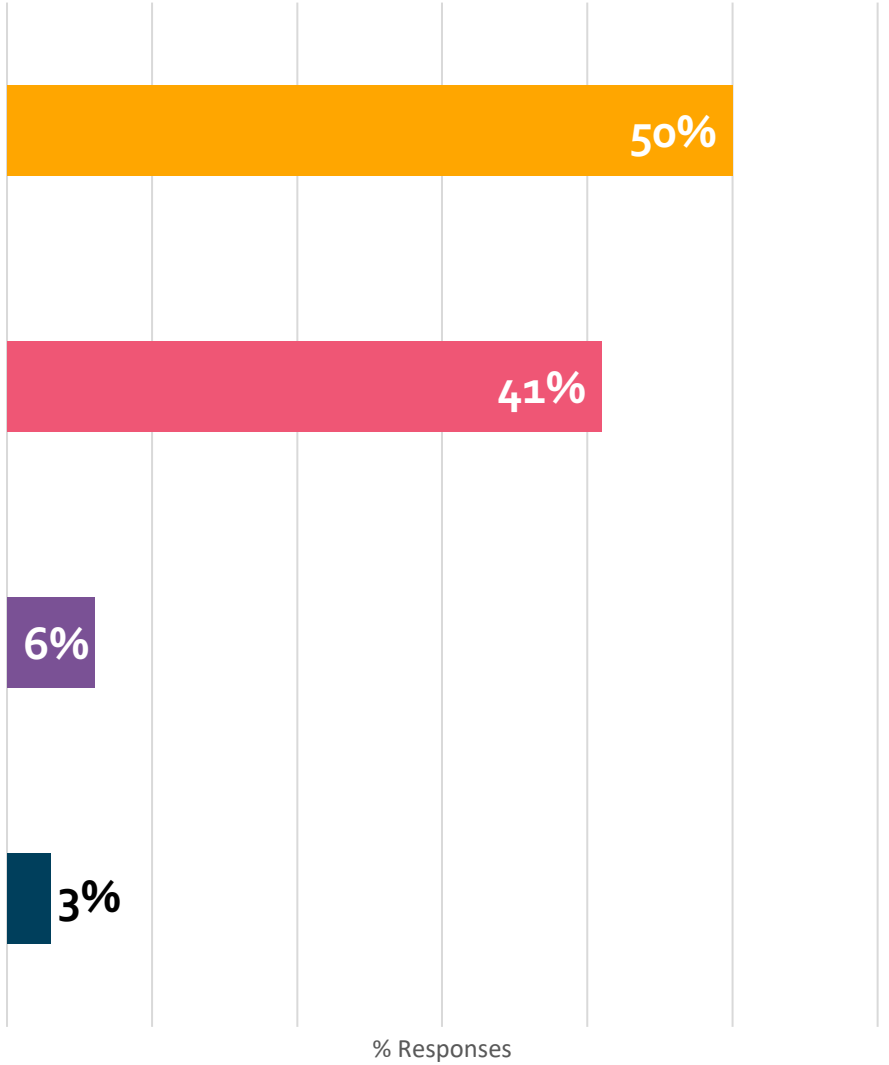
Question 21

Preliminary: None or minimal training of all staff levels on integrated care approach and incorporation of whole health concepts.

Intermediate I: Some training of all staff levels on integrated care approach and incorporation of whole health concepts.

Intermediate II: Routine training of all staff levels on integrated care approach and incorporation of whole health concepts with role accountabilities defined.

Advanced: Systematic annual training for all staff levels with learning materials that targets areas for improvement within the integrated clinic. Job descriptions that include defined responsibilities for integrated behavioral and physical health.



Quality Improvement

Domain
6. Systematic Quality Improvement (QI)

Subdomain
6.1 Use of quality metrics for general health program improvement and/or external reporting

Behavioral Health

N = 34

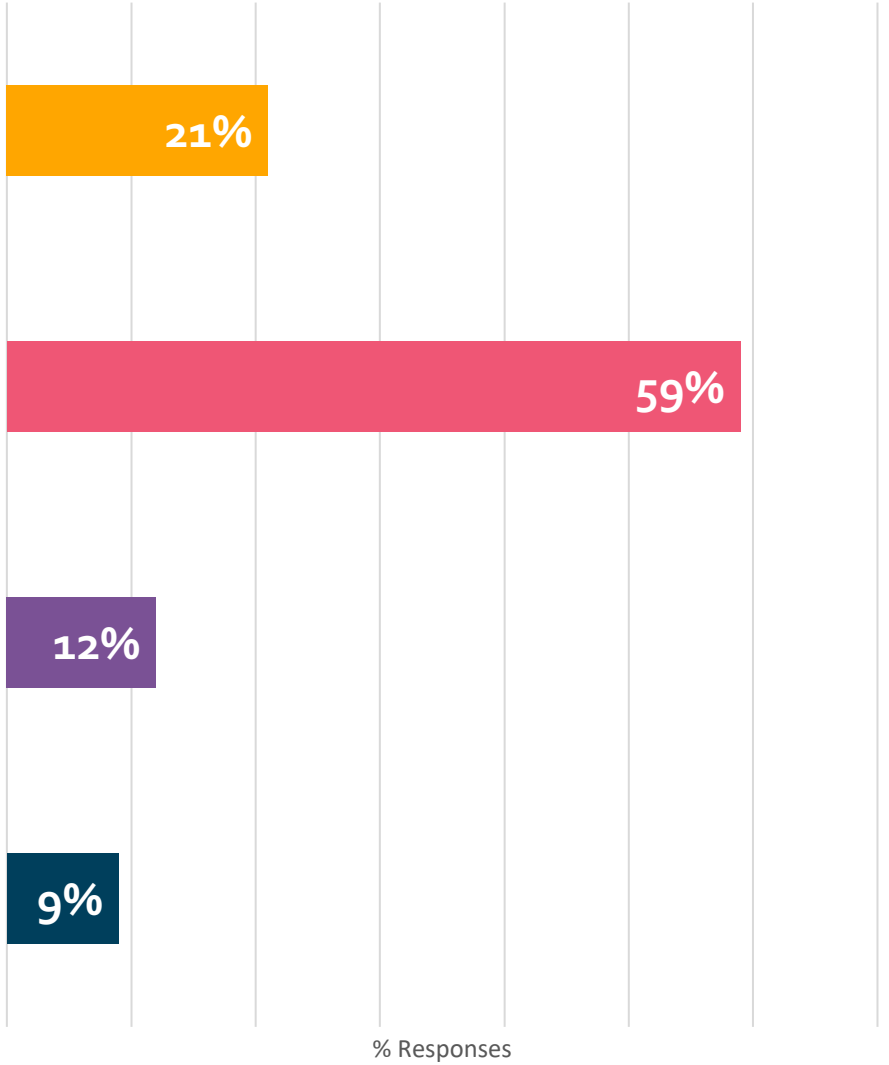
Question 22

Preliminary: None or minimal use of general health quality metrics (limited use of data, anecdotes, case series).

Intermediate I: Limited tracking of state or health plan quality metrics and some ability to track and report group level preventive care screening rates such as smoking, SUD, obesity, or HIV screening, etc.

Intermediate II: Periodic monitoring of identified outcome and general health quality metrics (e.g., BMI, smoking status, alcohol status, annual wellness visits, medications and common chronic disease metrics, primary care indicators) and ability to regularly review performance against benchmarks.

Advanced: Ongoing systematic monitoring of population level performance metrics (balanced mix of PC and BH indicators), ability to respond to findings using formal improvement strategies, and implementation of improvement projects by QI team/champion.



Social Service Links

Domain
7. Linkages with community/social services that improve general health and mitigate environmental risk factors

Subdomain
7.1 Linkages to housing, entitlement, other social support services

Behavioral Health

N = 34

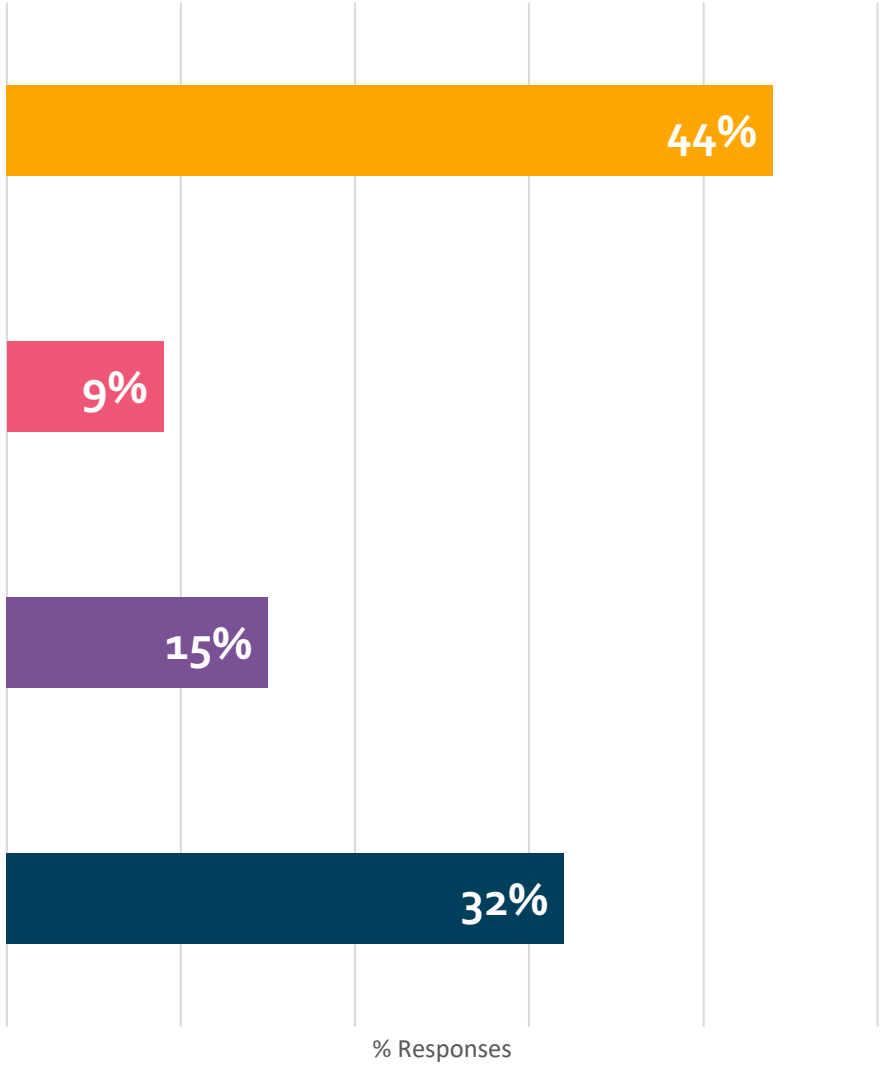
Question 23

Preliminary: No or limited/informal screening of social determinants of health (SDOH) and linkages to social service agencies, limited information exchange or follow-up.

Intermediate I: Routine SDOH screening and referrals made to social service agencies, with limited information exchange or follow-up.

Intermediate II: Routine SDOH screening, with information exchange with social service agencies, with limited capacity for follow-up.

Advanced: Detailed psychosocial assessment incorporating broad range of SDOH needs patients linked to social service organizations/resources to help improve appointment adherence (e.g., childcare, transportation tokens), healthy food sources (e.g., food pantry), with f/u to close the loop.



Billing Sustainability

Domain
8. Sustainability

Subdomain
8.1 Build process for billing and outcome reporting to support sustainability of integration efforts

Behavioral Health

N = 34

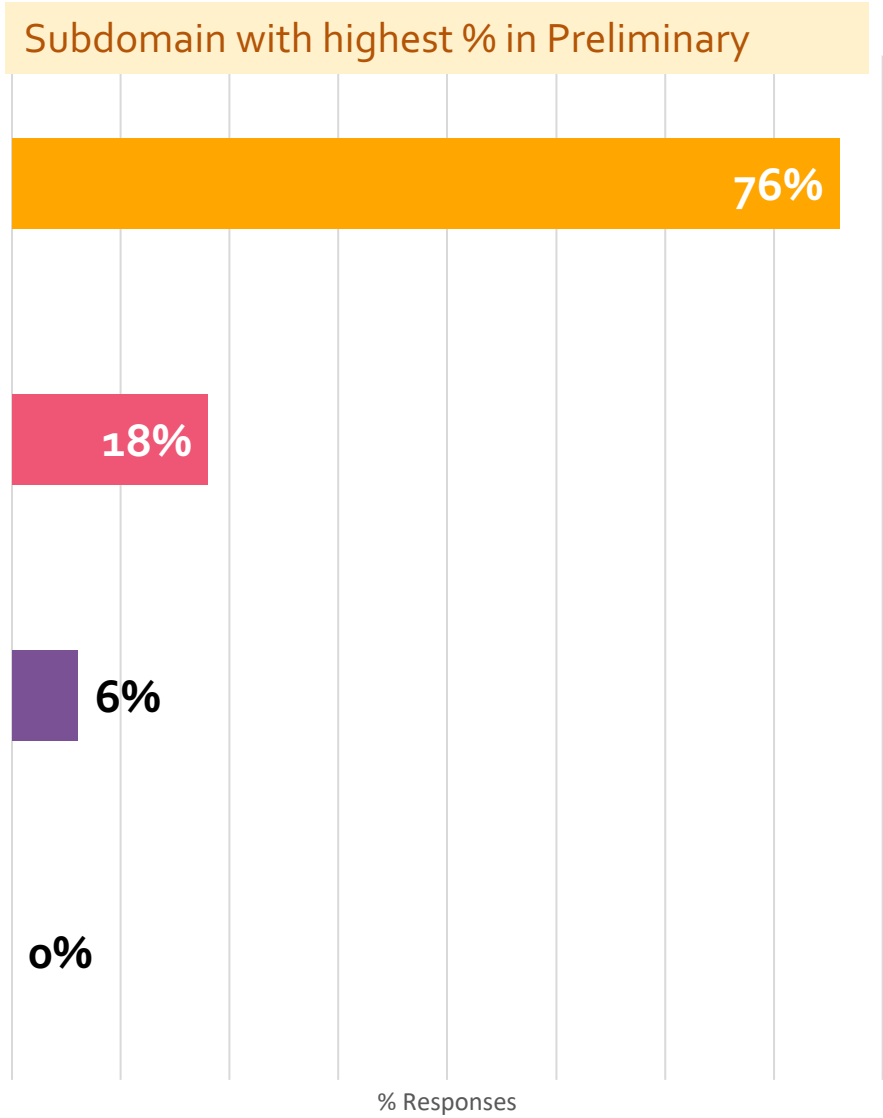
Question 24

Preliminary: No or minimal attempts to bill for immunizations, screening and treatment. Services supported primarily by grants or other non-reimbursable sources.

Intermediate I: Billing for screening and treatment services (e.g., HbA1c, preventive care, blood pressure monitoring) under fee-for-services with process in place for tracking reimbursements for general health care services.

Intermediate II: Fee-for-service billing as well as revenue from quality incentives related to physical health (e.g., diabetes and CV monitoring, tobacco screening). Able to bill for both primary care services and BH services.

Advanced: Receipt of value-based payments (shared savings) that reference achievement of BH and general health outcomes. Revenue helps support integrated physical health services and workforce.



Regulatory/Licensure

Domain
8. Sustainability

Subdomain
8.2 Build process for expanding regulatory and/or licensure opportunities

Behavioral Health

N = 34

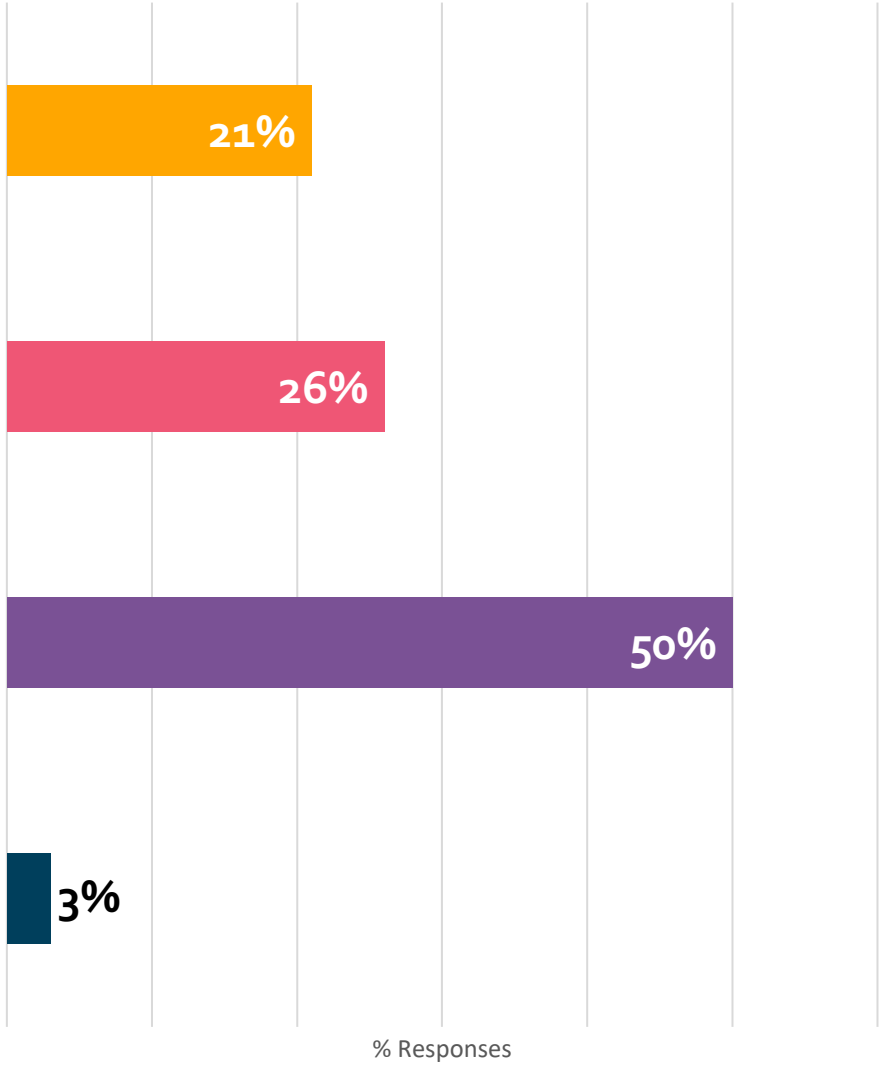
Question 25

Preliminary: No primary care arrangements that offer physical health services through linkage or partnership.

Intermediate I: Informal primary care arrangements that incorporate the basic array (e.g. appointment availability, feedback on engagement, report on required blood work) of desired physical health services.

Intermediate II: Consistent availability of primary care access, internal or external, with telehealth if appropriate that incorporate patient centered home services.

Advanced: Maintain appropriate dual licensure (WAC chapter 246-320 & RCW 70.41 and RCW 71.24 & WAC 246-341) for integrated physical and behavioral health services in a shared services setting and regularly assess the need for administrative or clinical updates as licensure requirements evolve.



- For more information on the WA – Integrated Care Assessment and for resources to advance integrated care:

https://waportal.org/partners/home/WA-ICA


Thank
You
Asante
Shukria
Dhanyavadagalu
شكرا
Vinaka
Kiitos
Maake
Manana
Dankon
Matondo
감사합니다
Kam Sah Hammida
Dankscheen
спасибо
köszönöm
Dank Je
Mauruuru
Biyan
Terima Kasih
Taiku
Tack
Blagodaram
Ngiyabonga
Dziekuje
Chokrane
Diolch i Chi
Grazie
Juspaxar
Arigato
Mochchakkeram
Gracias
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Tingki
நன்றி
धन्यवाद
cảm ơn bạn
Khap
Gratias
Tibi
Ua Tsaug
Rau Koj
Bedankt
Dakujem
Grazas
Di Ou Mèsi
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Kop Khun
Obrigado
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Nirringrazzjak
ありがとう
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Hvala
Djiere Dieuf
Rahmat
Nuwun
Matur
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Go Raibh Maith Agat
Eskerrik Asko
Misaotra
Danke
Merci
ขอขอบคุณคุณ
Salamat
Najis Tuke
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