Better Health Together ACH
Cohort 1 Baseline Report
Washington Integrated Care Assessment (WA-ICA) for Primary Care 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 9 domains and 13 subdomains, the assessment framework lays out the key elements of behavioral health integration into the primary care setting. **Foundational domains** are those considered core to advancing integrations 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.

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Summary

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Executive Summary

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

1. **Primary care sites are at more advanced stages of integration than behavioral health sites.**
Eighteen (18) Better Health Together Primary Care sites responded in Cohort 1, representing a 75% site response rate.

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

Screening (1.1), Self-management Support (5.1), and Care Team (6.1)

3. **Opportunities for Improvement**:

Referral facilitation and feedback (1.2): Sites are split between Preliminary and Intermediate II/Advanced.

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

Foundational readiness for integration is quite strong, with opportunity to improve referral facilitation and feedback (1.2).

Opportunities for Improvement

Primary Care

Subdomains with 3 highest percentages of sites in Preliminary integration stage

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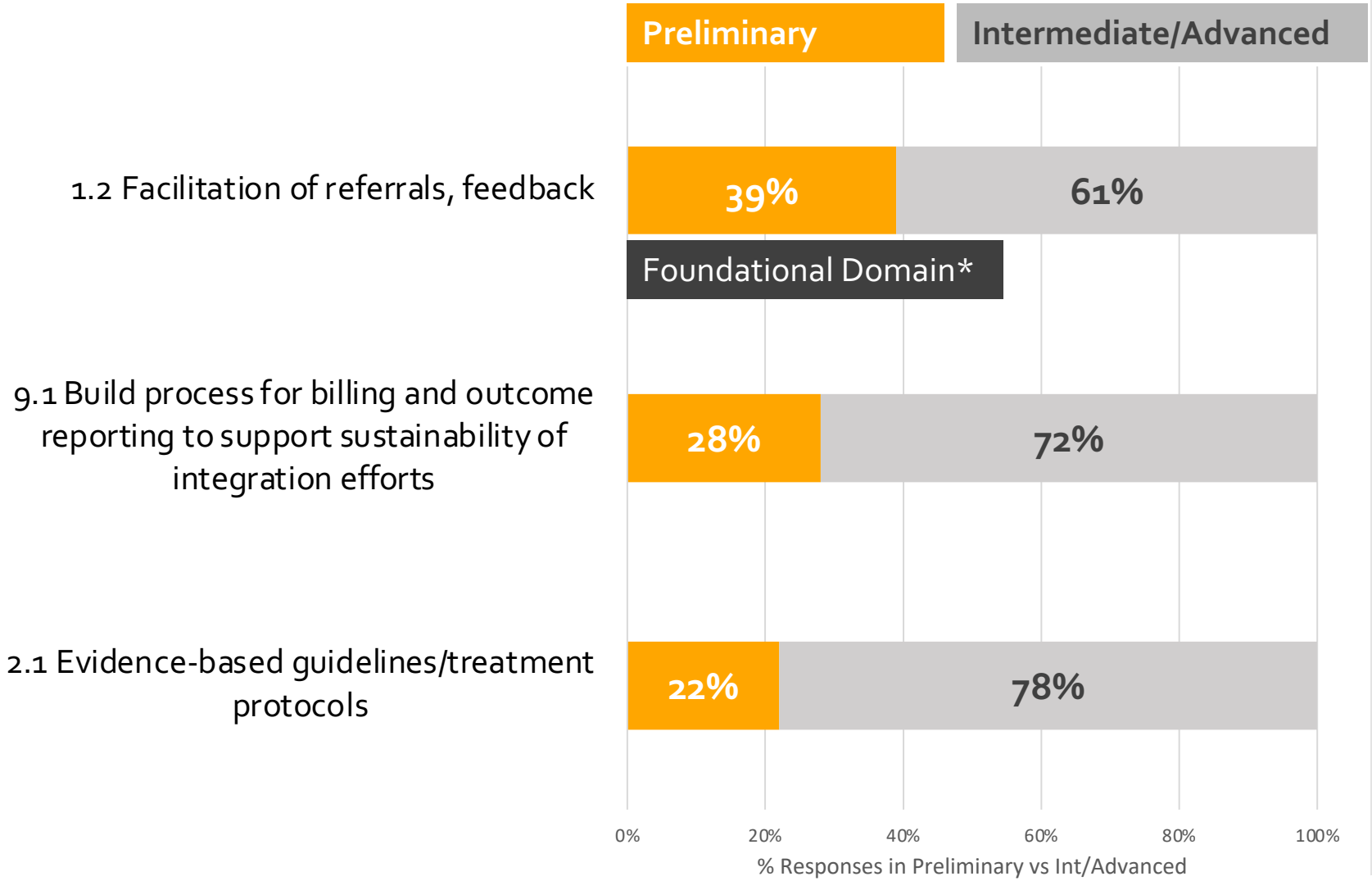
N = 18

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

Subdomains with Highest % Sites in **Preliminary**



Foundational Domains

Subdomains with % Sites in **Preliminary**

Primary Care

Foundational Domains* – Sites in Preliminary integration stage

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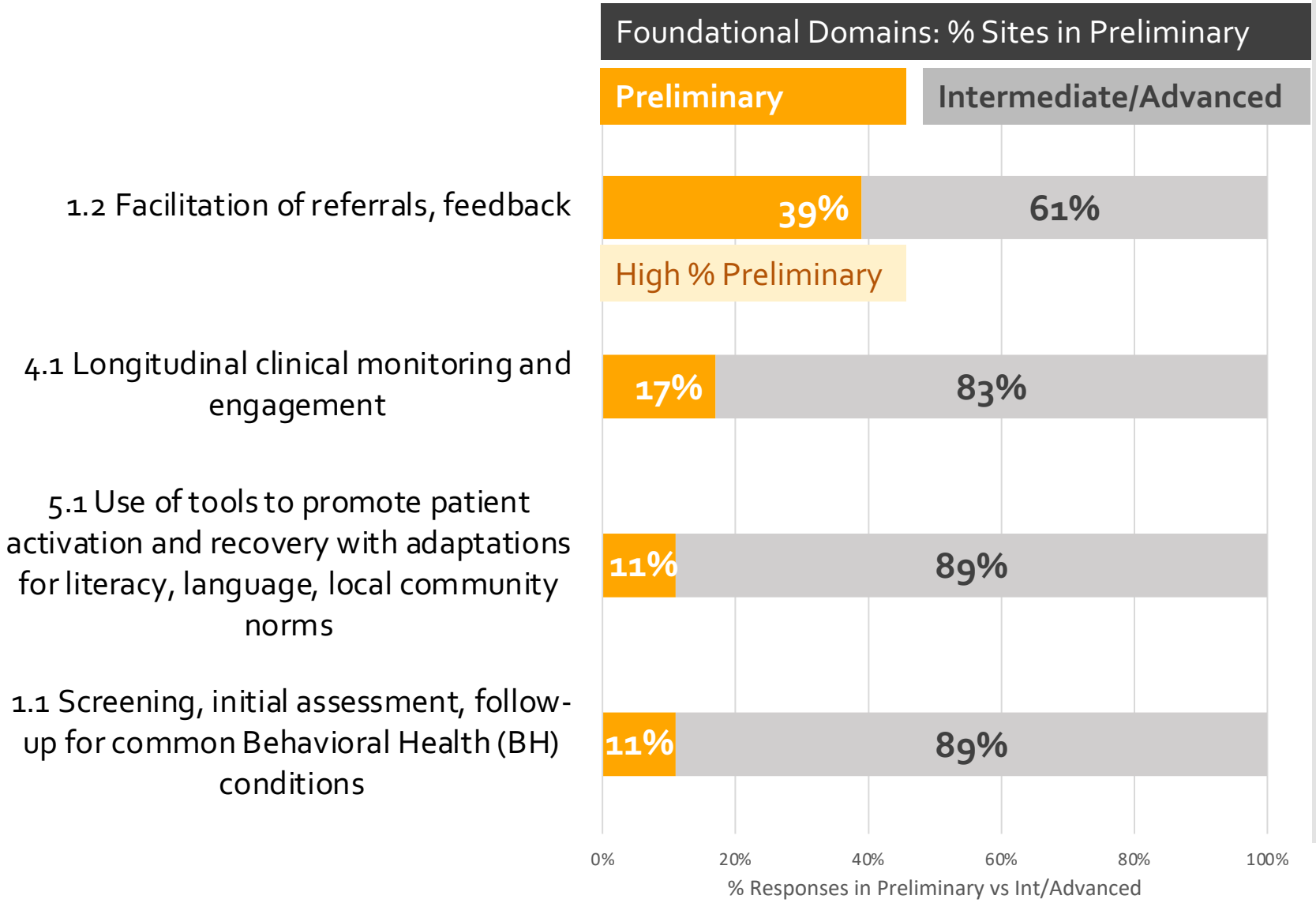
N = 18

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



Response Rate & Characteristics

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Primary Care

Response Rate

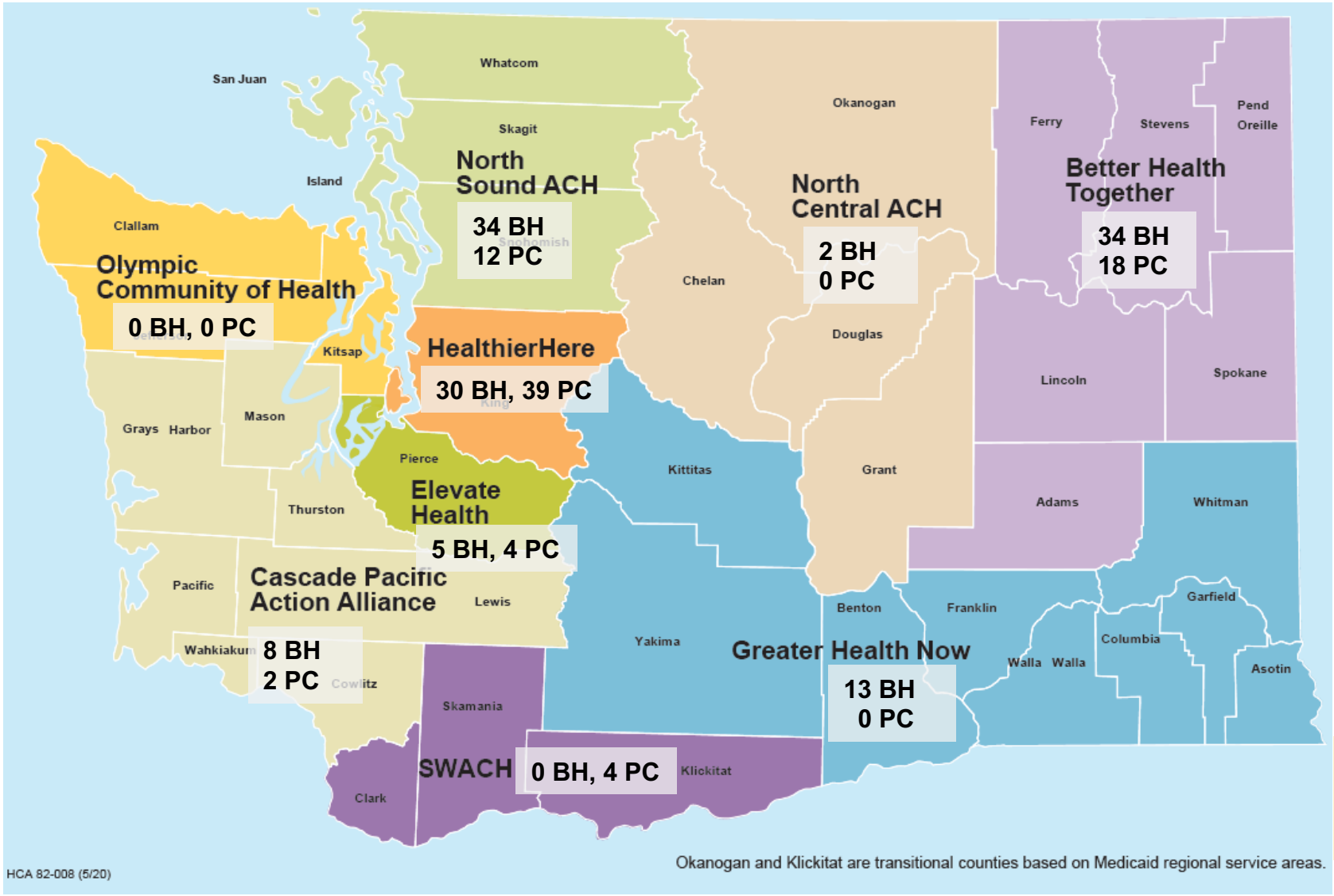
- **Cohort 1:**
- Responses Received July 11 - August 22, 2022

- 6 orgs responded out of 10 invited = **60%** Org Response Rate
- 18 sites responded out of 24 invited = **75%** Site Response Rate

	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)

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

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.

Primary Care

Characteristics of Cohort 1 Responses -

N = 18

Supplemental Questions

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

	# Sites	% Sites
Both	14	78%
Adults	4	22%
Pediatrics	0	0%
Total	18	100%

Primary Care

Characteristics of Cohort 1 Responses

-

N = 18

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

Clinic Type	Count	% Sites (count / N)
Co-located Behavioral Health and Primary Care	13	72%
Primary Care	5	28%
Rural Health Clinic	2	11%
Behavioral Health (mental health AND SUD)	1	6%
Other	1	6%
Opioid Treatment Program (OTP)	0	0%
Behavioral Health (SUD only)	0	0%
Behavioral Health (mental health only)	0	0%

Other categories:

- Obstetrics (OB)

Primary Care

Characteristics of Cohort 1 Responses

-

N = 18*

*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	50	725	1,531	2,423	15,000

Primary Care sites see about **10 times more patients than Behavioral Health sites** in this ACH for Cohort 1.

- Behavioral Health Median: **150** patients (versus **1,531**)
- Behavioral Health Max: **1,090** patients (vs **15,000**)

Primary Care

Characteristics of Cohort 1 Responses

-

N = 18*

*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	4%	12%	21%	58%	80%
Medicare	0%	18%	27%	49%	75%
Commercial Insurance	0%	19%	30%	37%	50%
Uninsured	0%	2%	3%	8%	18%
Fee for Service	0%	0%	0%	4%	100%
Other	0%	0%	0%	1%	9%

Payor mix differs between Behavioral Health and Primary Care sites in this region.

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.

Primary Care

Characteristics of Cohort 1 Responses

-

N = 18

- **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)
None of the above – our site does not currently use a screening tool	9	50%
Accountable Health Communities (AHC) tool (also known as the Health-Related Social Needs (HRSN) tool)	4	22%
PRAPARE	4	22%
Daily Living Activities—20 (DLA-20)	1	6%
WellRx	1	6%
Health Leads Social Needs Screening	0	0%
Other	0	0%

Half of Primary Care sites do not use any SDoH screening tool, similar to Behavioral Health sites in this region.

Primary Care

Characteristics of Cohort 1 Responses

-

N = 18

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

(select all that apply):

Type	Count	% Sites (count / N)
Fee for service billing	13	72%
Collaborative Care codes	9	50%
Grants	9	50%
Value based payment arrangements	8	44%
Capitated PMPM rate	1	6%
None	1	6%
Other	1	6%

Other sources:

- Foundations

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.

Primary Care

Characteristics of Cohort 1 Responses -

N = 18

- **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	18	100%
Electronic referrals to outside services	15	83%
Registries	12	67%
Health information exchanges (HIE)	11	61%
Shared care plans	8	44%
Closed loop referral systems with outside services	6	33%
Community information exchanges (CIE)	4	22%

Primary Care

Characteristics of Cohort 1 Responses

-

N = 18*

*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%	2%	5%	7%	90%
% Virtual (telephone only)	0%	0%	0%	3%	15%
% In-Person	10%	88%	94%	95%	100%

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

Primary Care

Characteristics of Cohort 1 Responses -

N = 18

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

Type	Count	% Sites (count / N)
Workforce	16	89%
Financial Support	13	72%
Partnerships with other clinical providers	10	56%
Technology	3	17%
Other	2	11%
Leadership Support	0	0%

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)

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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.
3. Information exchange among providers.
4. Ongoing care management.*
5. Self-management support that is adapted to culture, socioeconomic and life experiences of patients.*
6. Multi-disciplinary team (including patients) to provide care.
7. Systematic quality improvement.
8. Linkages with community/social services that improve general health and mitigate environmental risk factors.
9. Sustainability.

Screening

Foundational Domain

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

Subdomain
1.1 Screening, initial assessment, follow-up for common Behavioral Health (BH) conditions

Primary Care

N = 39

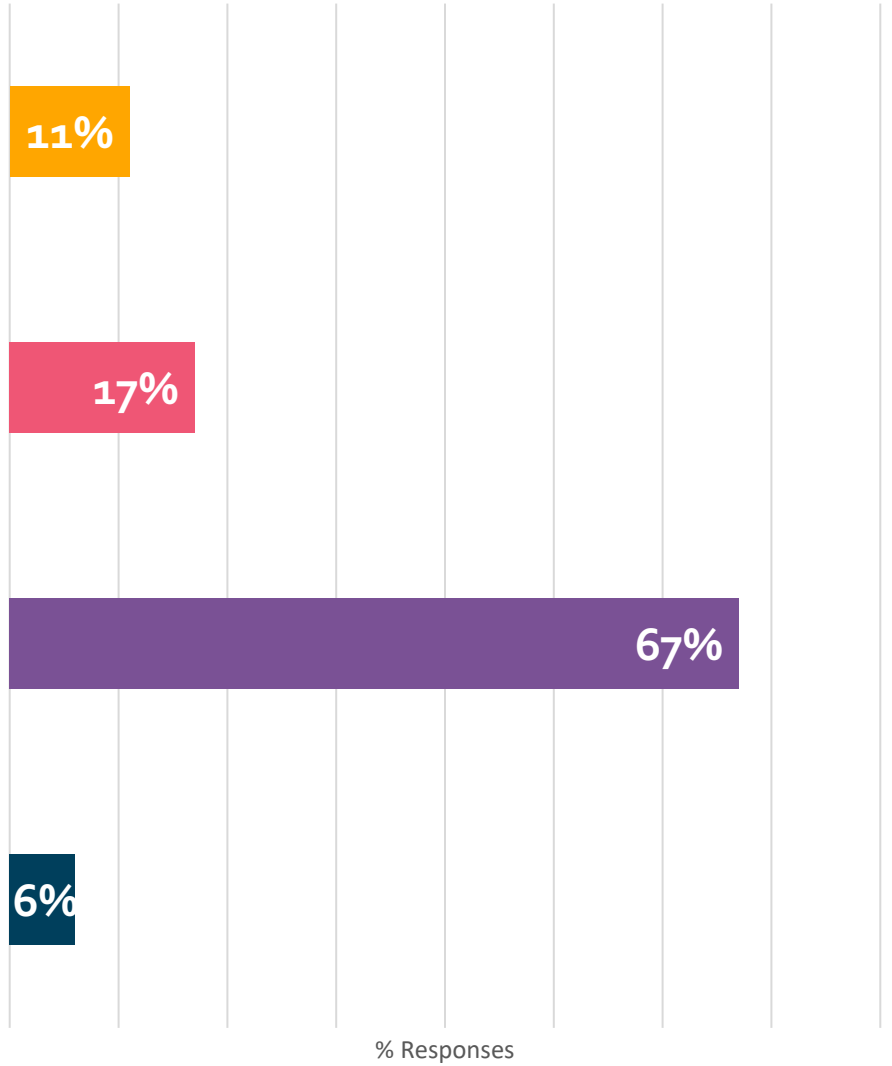
Question 11

Preliminary: Patient/clinician identification of those with BH symptoms—not systematic

Intermediate I: Systematic BH screening of targeted patient groups (e.g., those with diabetes, CAD), with follow-up for assessment

Intermediate II: Systematic BH screening of all patients, with follow-up for assessment and engagement

Advanced: Analysis of patient population to stratify patients with high-risk BH conditions for proactive assessment and engagement



Referrals

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

Subdomain
1.2 Facilitation of referrals, feedback

Primary Care

N = 39

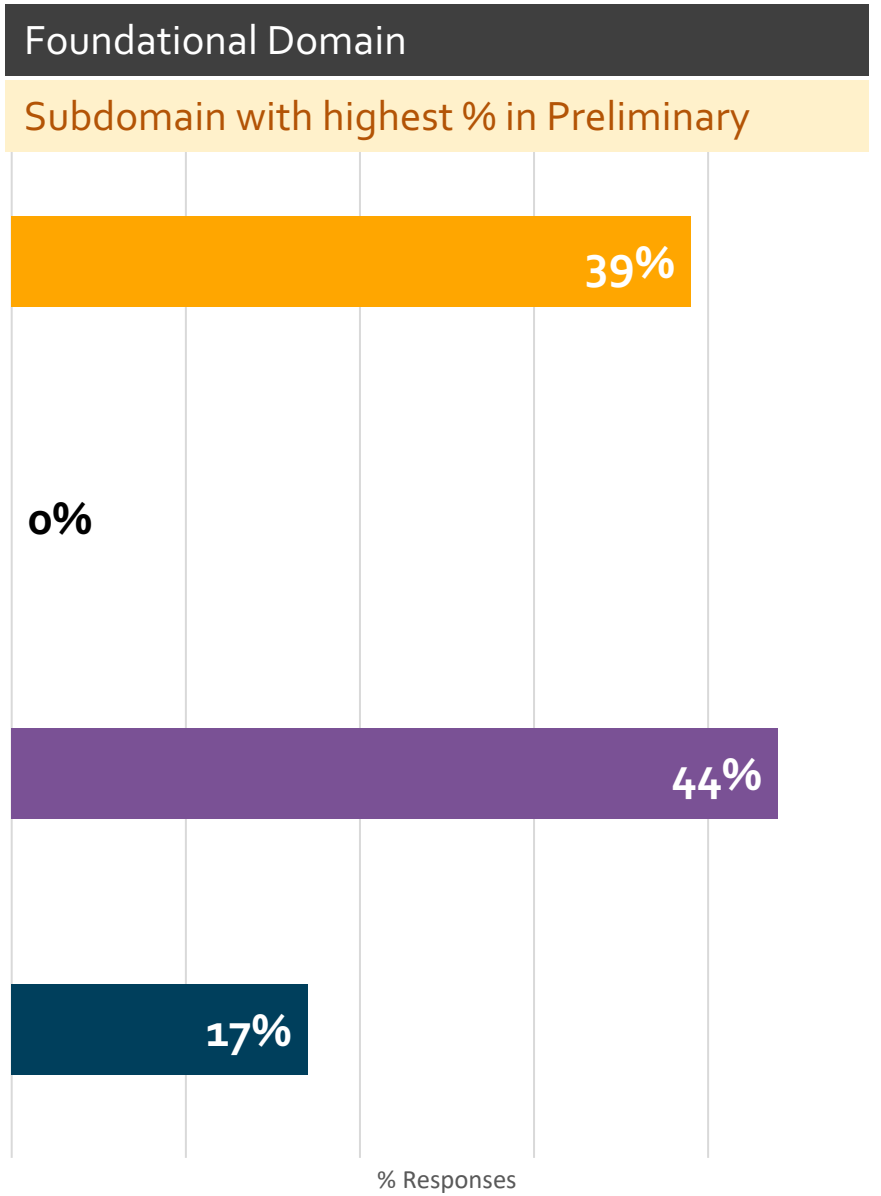
Question 12

Preliminary: Referral only, to external BH provider(s)/ psychiatrist

Intermediate I: Referral to external BH provider(s)/psychiatrist through a written agreement detailing engagement, with feedback strategies

Intermediate II: Enhanced referral to internal/co-located BH clinician(s)/psychiatrist, with assurance of "warm handoffs" when needed

Advanced: Enhanced referral facilitation with feedback via EHR or alternate data-sharing mechanism, and accountability for engagement



Evidence-based Care

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

Subdomain
2.1 Evidence-based guidelines/treatment protocols

Primary Care

N = 39

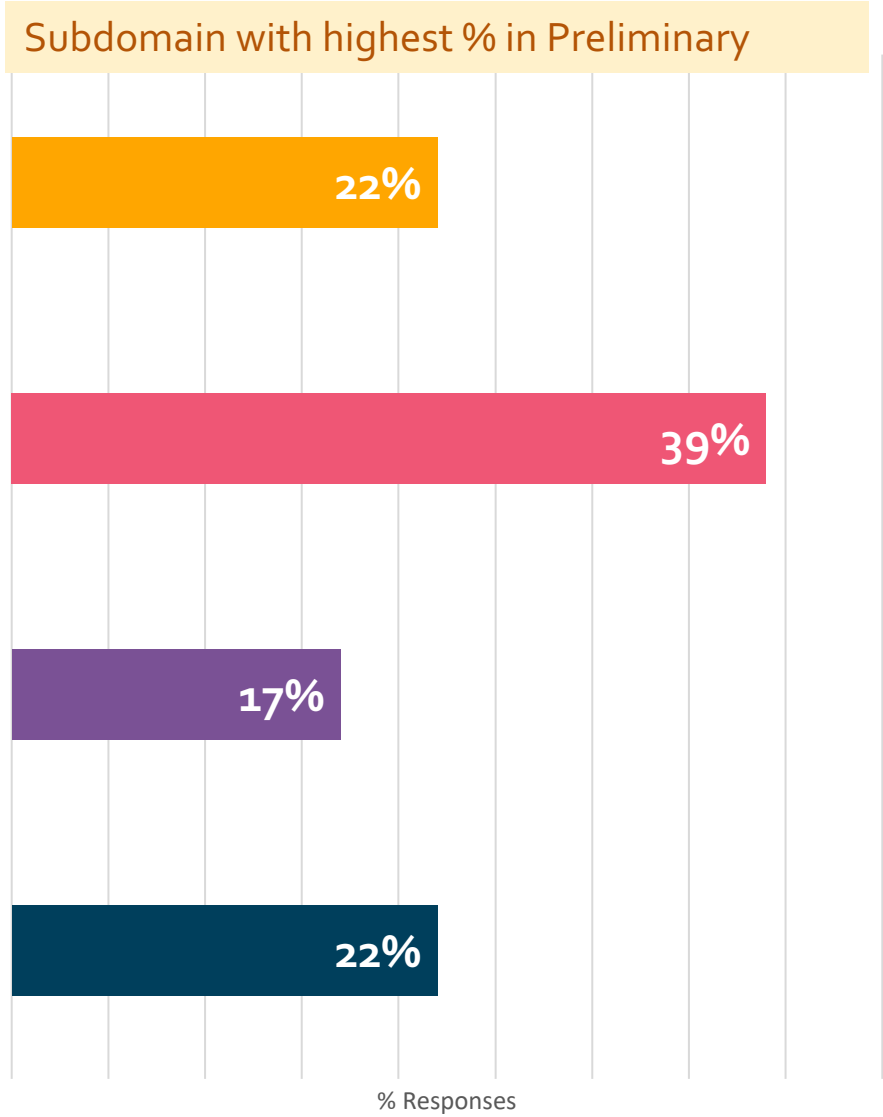
Question 13

Preliminary: None, with limited training on BH disorders and treatment

Intermediate I: PCP training on evidence-based guidelines for common behavioral health diagnoses and treatment

Intermediate II: Systematic use of evidence-based guidelines for all patients; tools for regular monitoring of symptoms

Advanced: Systematic tracking of symptom severity; protocols for intensification of treatment when appropriate



Medication Management

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

Subdomain
2.2 Use of psychiatric medications

Primary Care

N = 39

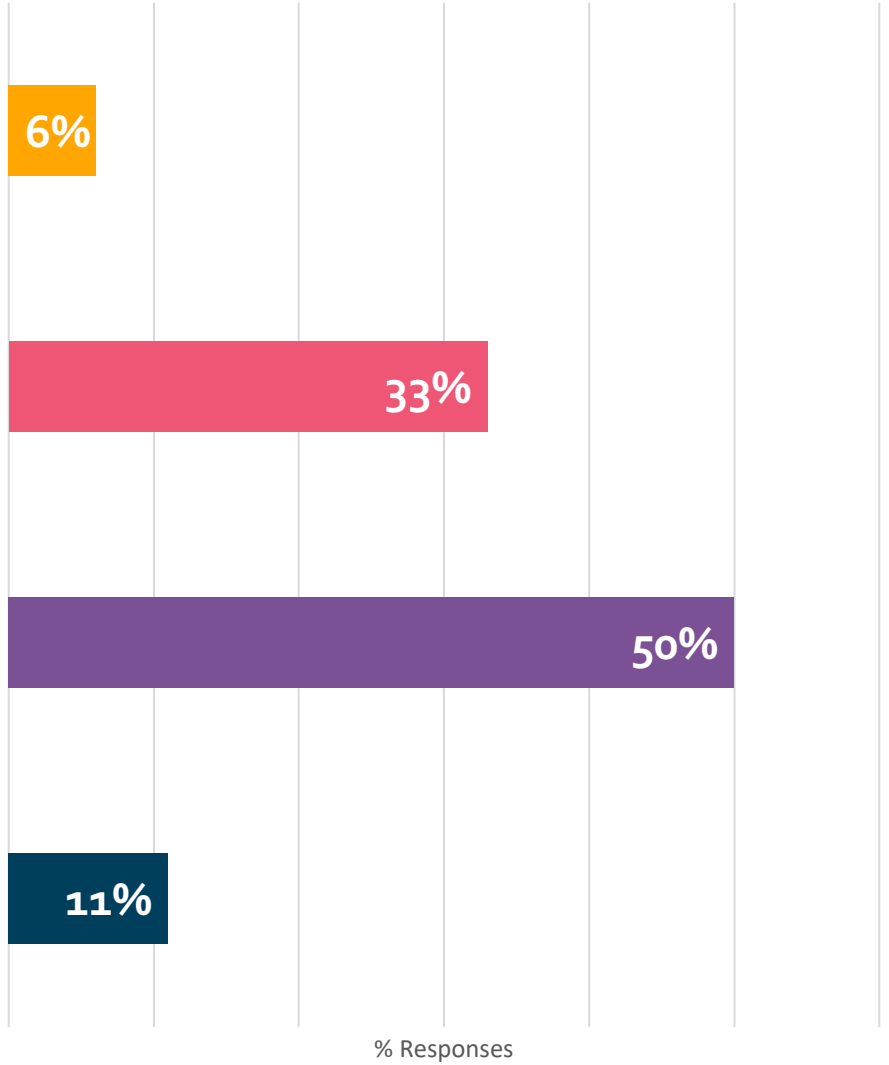
Question 14

Preliminary: PCP-initiated, limited ability to refer or receive guidance

Intermediate I: PCP-initiated, with referral when necessary to a prescribing BH prescriber /psychiatrist for medication follow-up

Intermediate II: PCP-managed, with support of BH prescriber/ psychiatrist as necessary

Advanced: PCP-managed, with care management supporting adherence between visits and BH prescriber(s)/ psychiatrist support



Therapy Access

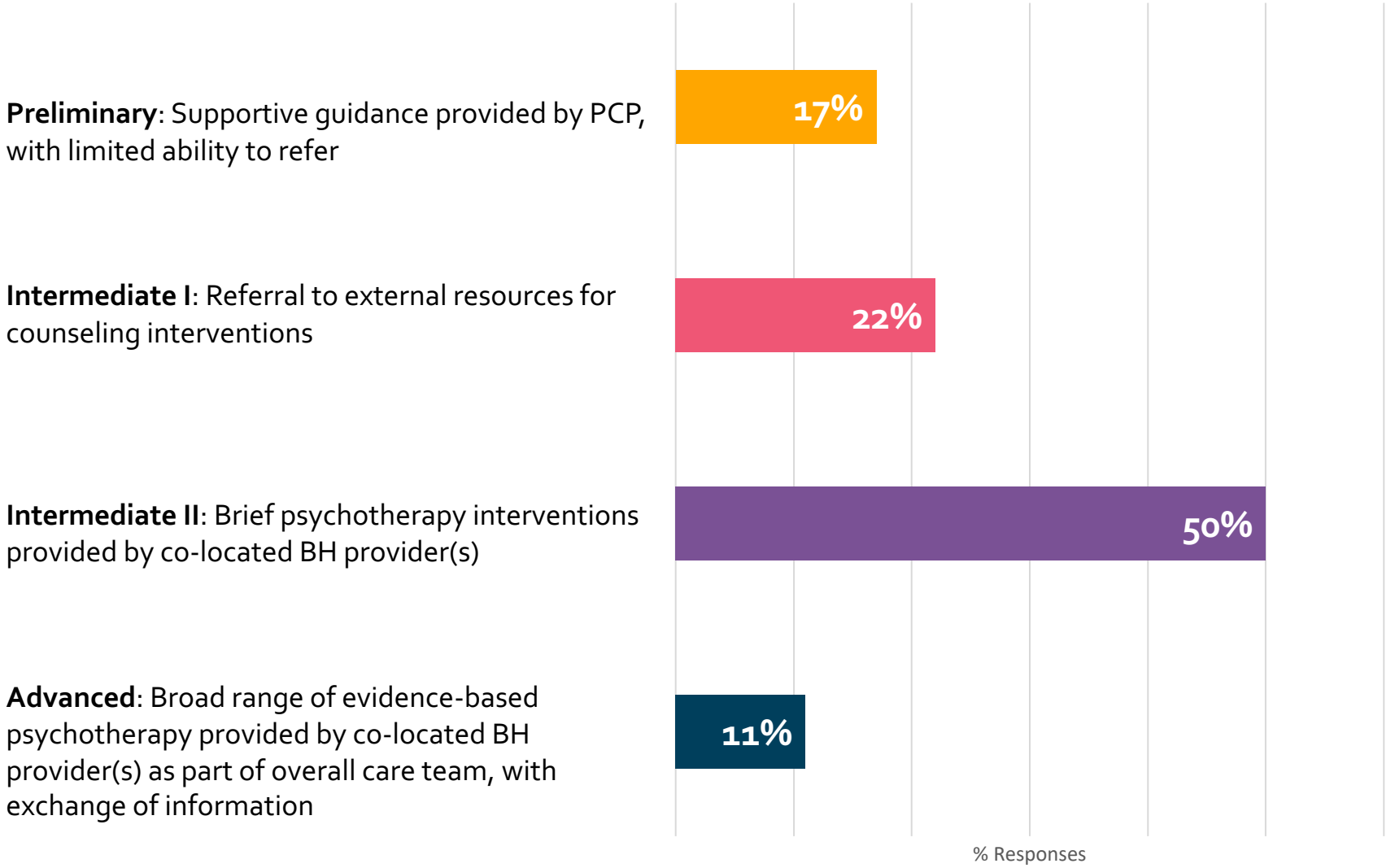
Domain
2. Evidence- based care for preventive interventions and common behavioral health conditions

Subdomain
2.3 Access to evidence-based psychotherapy with BH provider(s)

Primary Care

N = 39

Question 15



Information Sharing

Domain
3. Information exchange among providers

Subdomain
3.1 Sharing of treatment information

Primary Care

N = 39

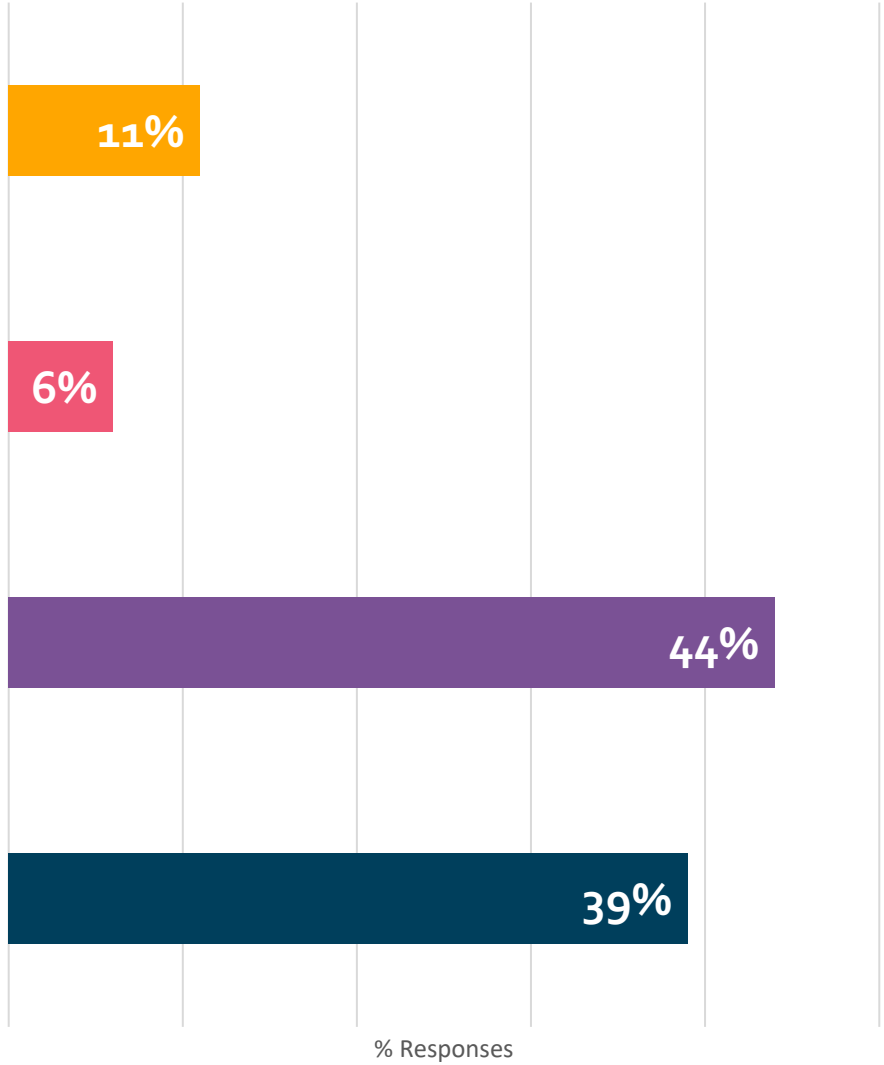
Question 16

Preliminary: Minimal sharing of treatment information within care team

Intermediate I: Informal phone or hallway exchange of treatment information, without regular chart documentation

Intermediate II: Exchange of treatment information through in-person or telephonic contact, with chart documentation

Advanced: Routine sharing of information through electronic means (registry, shared EHR, shared care plans)



Patient Tracking

Foundational Domain

Domain
4. Ongoing care management

Subdomain
4.1 Longitudinal clinical monitoring and engagement

Primary Care

N = 39

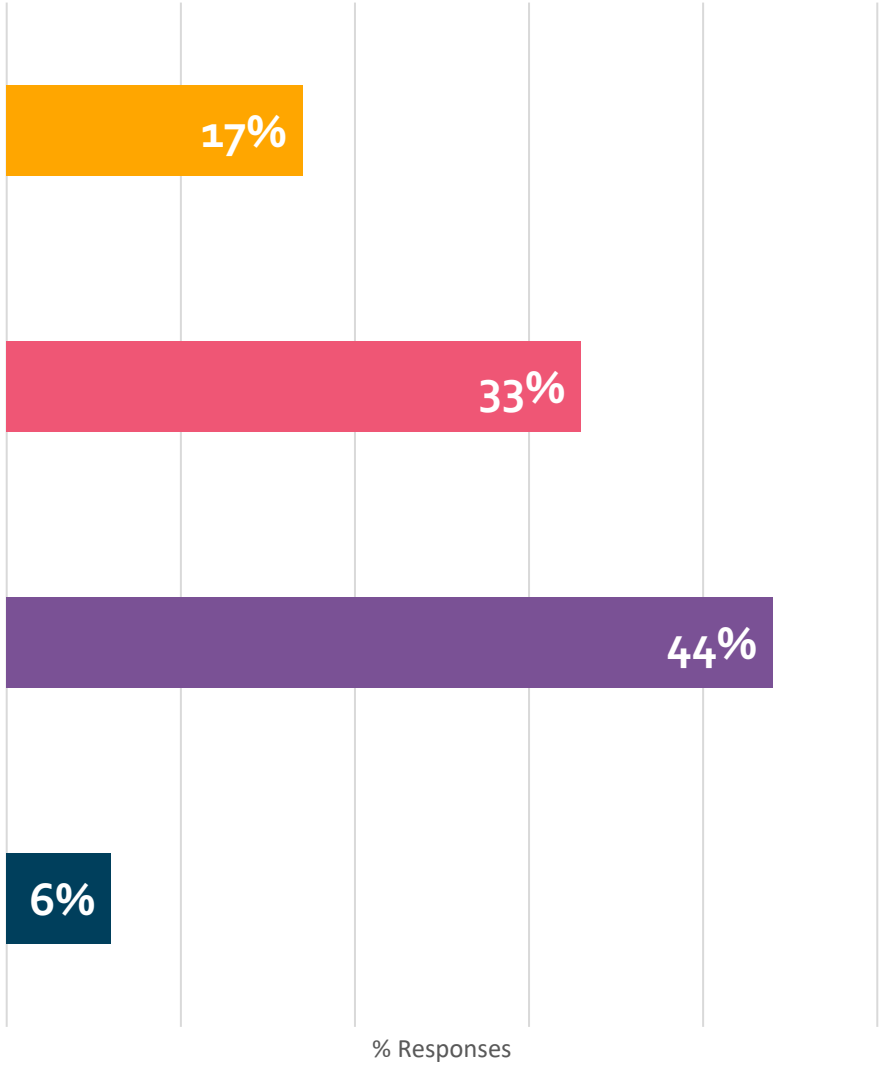
Question 17

Preliminary: Limited follow-up of patients by office staff

Intermediate I: Proactive follow-up (no less than monthly) to ensure engagement or early response to care

Intermediate II: Use of tracking tool to monitor symptoms over time and proactive follow-up with reminders for outreach

Advanced: Tracking integrated into EHR, including severity measurement, visits, care management interventions (e.g., relapse prevention techniques, behavioral activation), proactive follow-up; selected medical measures (e.g., blood pressure, A1C) tracked when appropriate



Self-Management Support

Foundational Domain

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

Subdomain
5.1 Use of tools to promote patient activation and recovery with adaptations for literacy, language, local community norms

Primary Care

N = 39

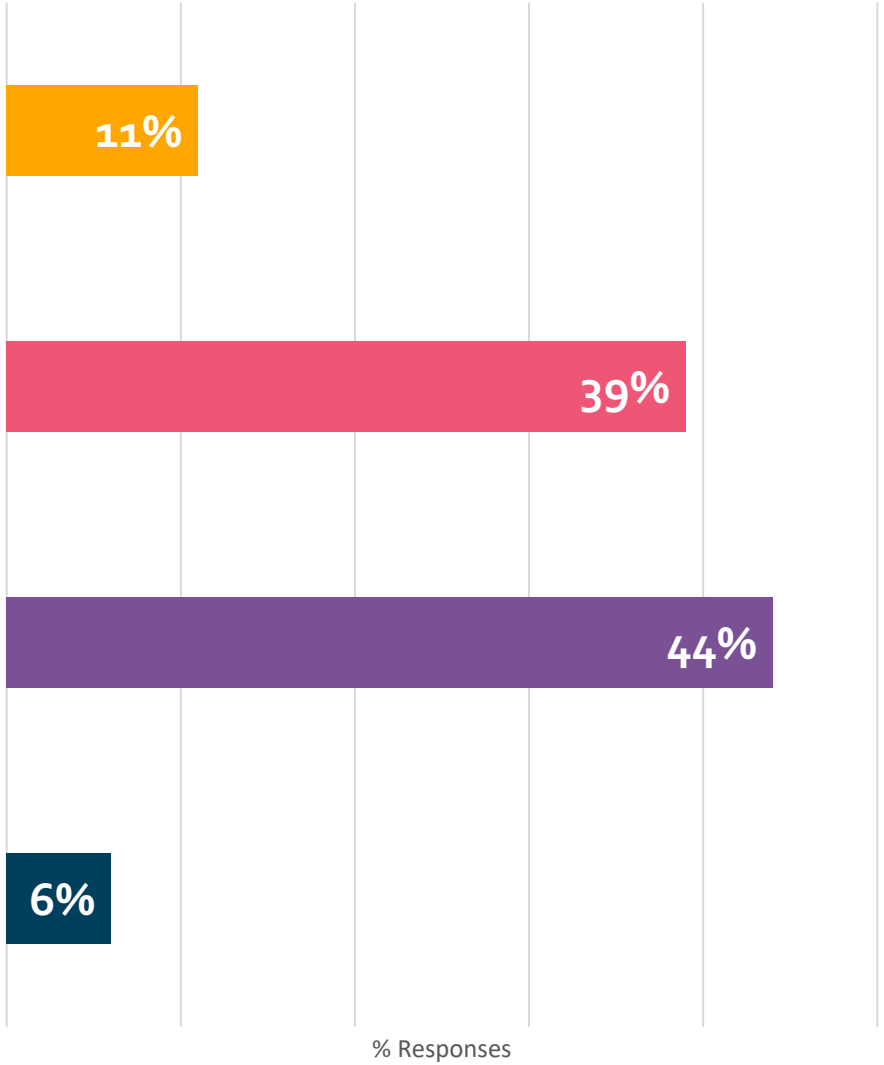
Question 18

Preliminary: Brief patient education on BH condition provided by PCP

Intermediate I: Brief patient education on BH condition, including materials/handouts and symptom score reviews, but limited focus on self-management goal-setting

Intermediate II: Patient education and participation in self-management goal setting (e.g., sleep hygiene, medication adherence, exercise)

Advanced: Systematic education and self-management goal-setting, with relapse prevention and care management support between visits



Care Team

Domain
6. Multidisciplinary team (including patients) to provide care

Subdomain
6.1 Care Team

Primary Care

N = 39

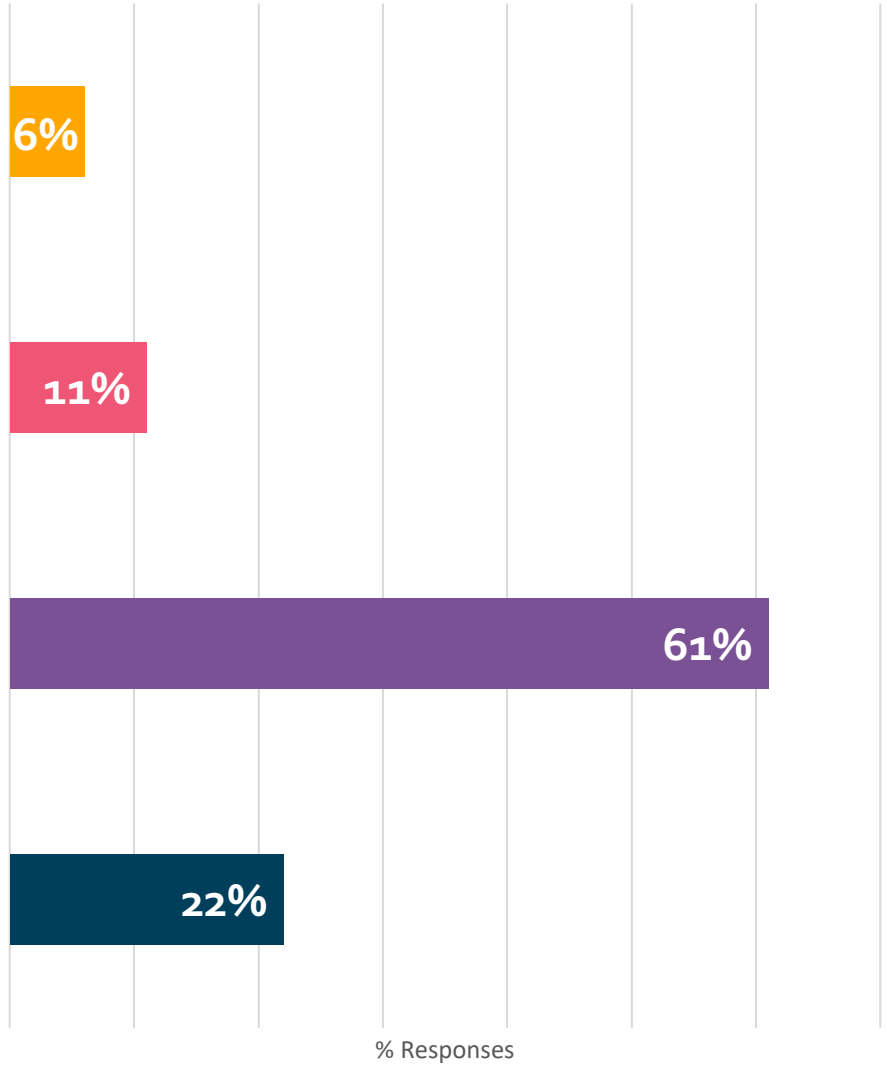
Question 19

Preliminary: PCP, patient

Intermediate I: PCP, patient, ancillary staff member

Intermediate II: PCP, patient, ancillary staff member, care manager, BH provider(s)

Advanced: PCP, patient, ancillary staff member, care manager, BH provider(s), psychiatrist (contributing to shared care plans)



Sharing Treatment Info

Domain
6. Multidisciplinary team (including patients) to provide care

Subdomain
6.2 Systematic multidisciplinary team-based patient care review processes

Primary Care

N = 39

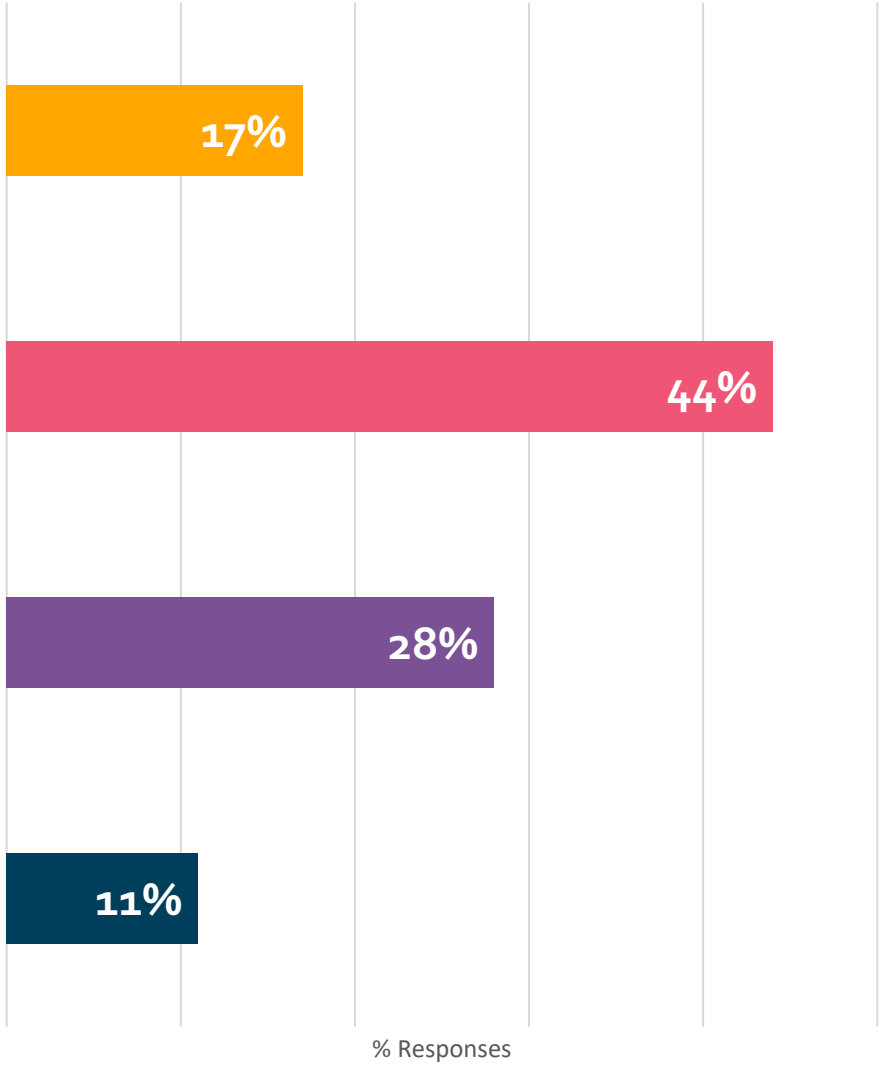
Question 20

Preliminary: Limited written communication and interpersonal interaction between PC-BH provider(s), driven by necessity or urgency, or using patient as conduit

Intermediate I: Regular written communication (notes/consult reports) between PCP and BH provider(s), occasional information exchange via ancillary staff, on complex patients

Intermediate II: Regular in-person, phone, or e-mail communications between PCP and BH provider(s) to discuss complex cases

Advanced: Weekly team-based case reviews to inform care planning and focus on patients not improving behaviorally or medically, with capability of informal interaction between PCP and BH provider(s)



Quality Improvement

Domain
7. Systematic Quality Improvement (QI)

Subdomain
7.1 Use of quality metrics for program improvement

Primary Care

N = 39

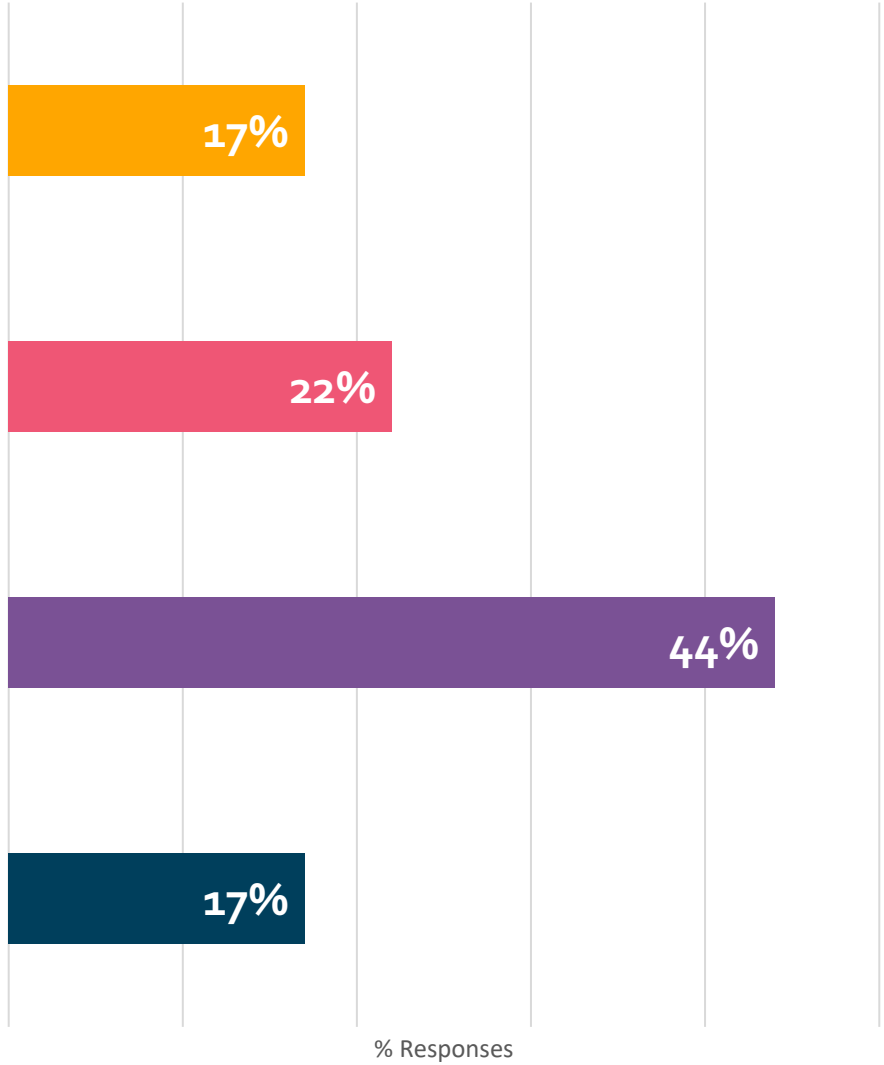
Question 21

Preliminary: Informal or limited use of BH quality metrics (limited use of data, anecdotes, case series)

Intermediate I: Use of identified metrics (e.g., depression screening rates, depression response rates) and some ability to regularly review performance

Intermediate II: Use of identified metrics, some ability to respond to findings using formal improvement strategies

Advanced: Ongoing systematic quality improvement (QI) with monitoring of population-level performance metrics, and implementation of improvement projects by QI team/champion



Social Service Links

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

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

Primary Care

N = 39

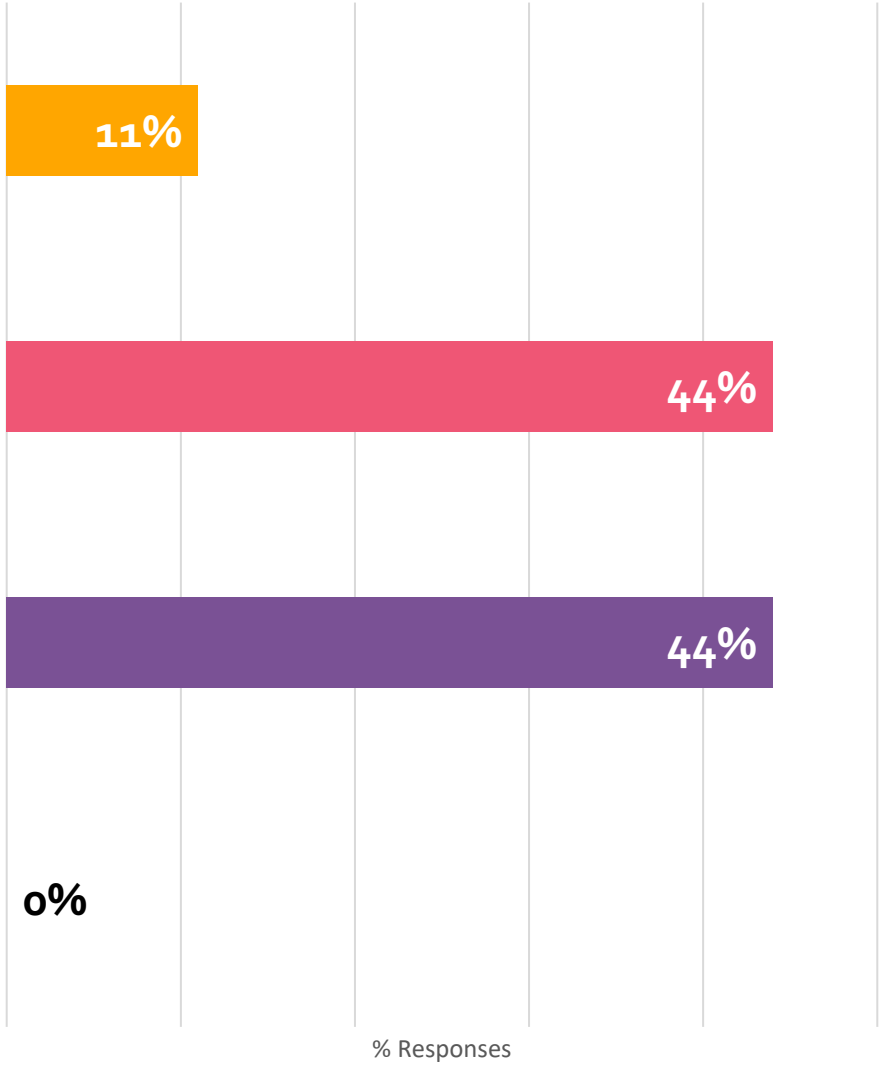
Question 22

Preliminary: Few linkages to social services, no formal arrangements

Intermediate I: Referrals made to agencies, some formal arrangements, but little capacity for follow-up

Intermediate II: Screening for social determinants of health (SDOH), patients linked to community organizations/resources, with follow-up

Advanced: Developing, sharing, implementing unified care plan between agencies, with SDOH referrals tracked



Billing Sustainability

Domain
9. Sustainability

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

Primary Care

N = 39

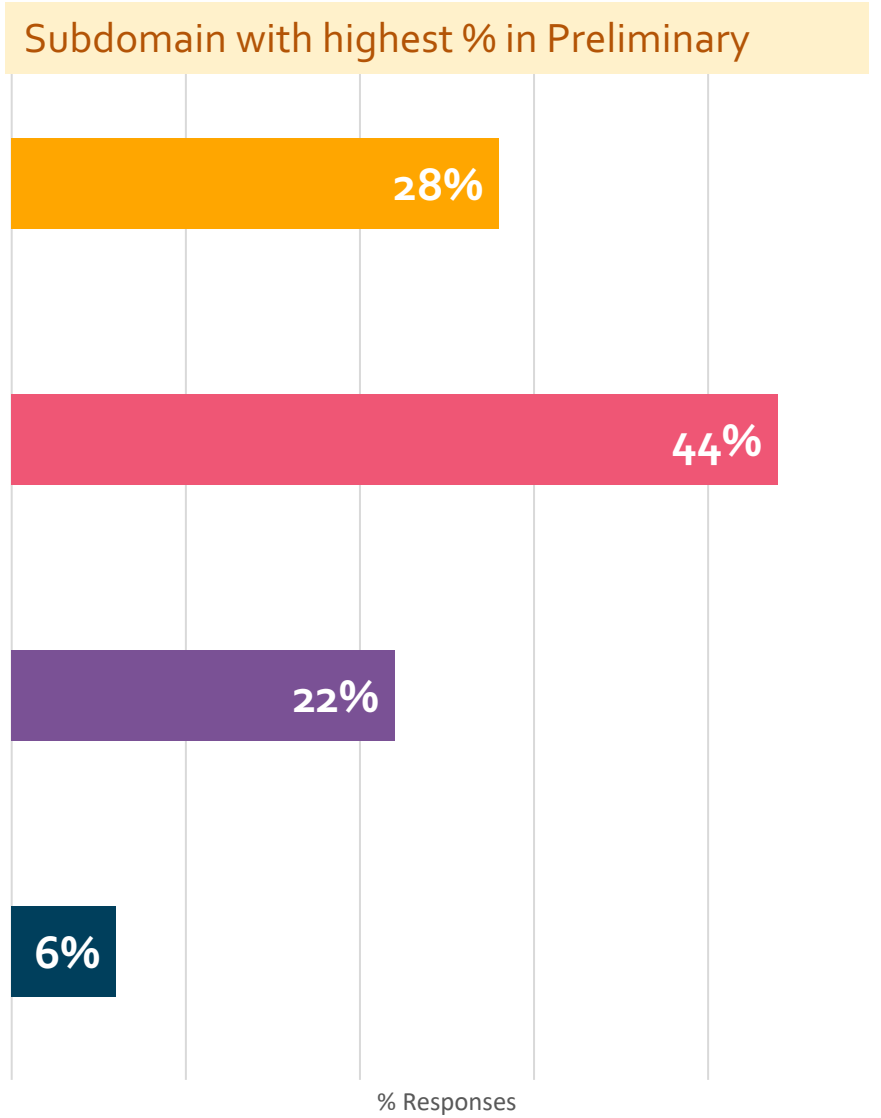
Question 23

Preliminary: Limited ability to bill for screening and treatment, or services supported primarily by grants

Intermediate I: Billing for screening and treatment services (e.g., SBIRT, PHQ screening, BH treatment, care coordination) under fee for service, with process in place for tracking reimbursements

Intermediate II: Fee for service billing, and additional revenue from quality incentives related to BH integration

Advanced: Receipt of global payments that account for achievement of behavioral health and physical health outcomes



- 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
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