

Statewide Baseline Report Cohort 1

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

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.

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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. **Most behavioral sites are in earlier stages of integration compared to primary care.**

(126) Behavioral Health sites across Washington state responded in Cohort 1, representing a 65% site response rate.



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

Screening (subdomain 1.1)
Care Management – tracking and monitoring (3.1)
Patient Self-management (4.1)



3. **Opportunities for Improvement:**

Financial Sustainability (8.1) & Medication Management (2.3)
Subdomains with most improvement potential are consistent across ACH and MCO regions. Both behavioral and primary orgs use EHRs, but the use of other population health tools like external referrals and shared care plans is significantly less at behavioral orgs.

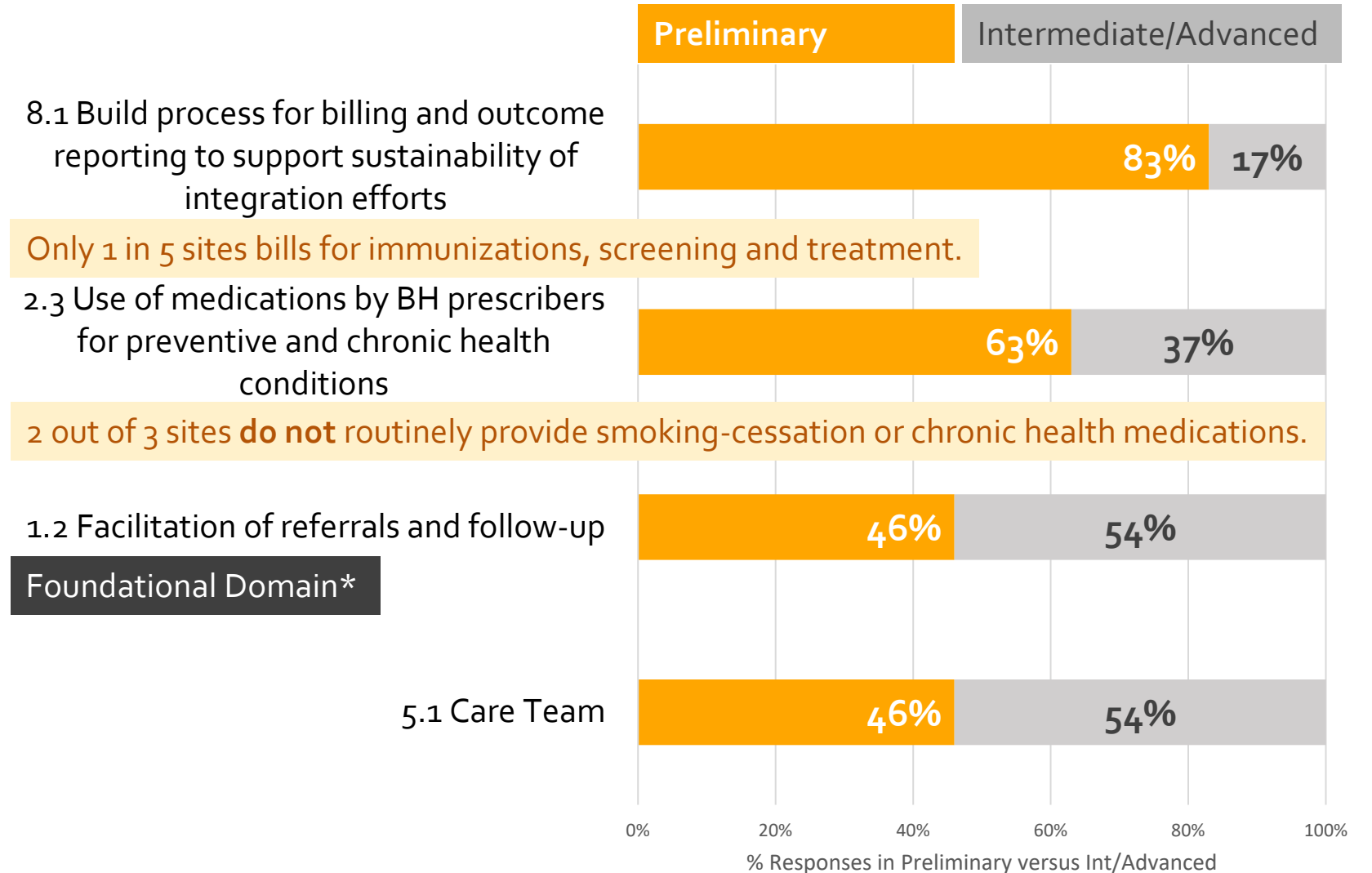


4. **Opportunities for Foundational Improvement*:**

Referral facilitation and engagement (1.2)
Patient Self-management (4.1) is mostly passive at Intermediate I stage. Progress further by moving to active goal-setting and goal incorporation into care plan.

Opportunities for Improvement

Subdomains with Highest % Sites in Preliminary



Behavioral Health

Subdomains with 3 highest percentages of sites in Preliminary integration stage

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N = 126

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

Behavioral Health

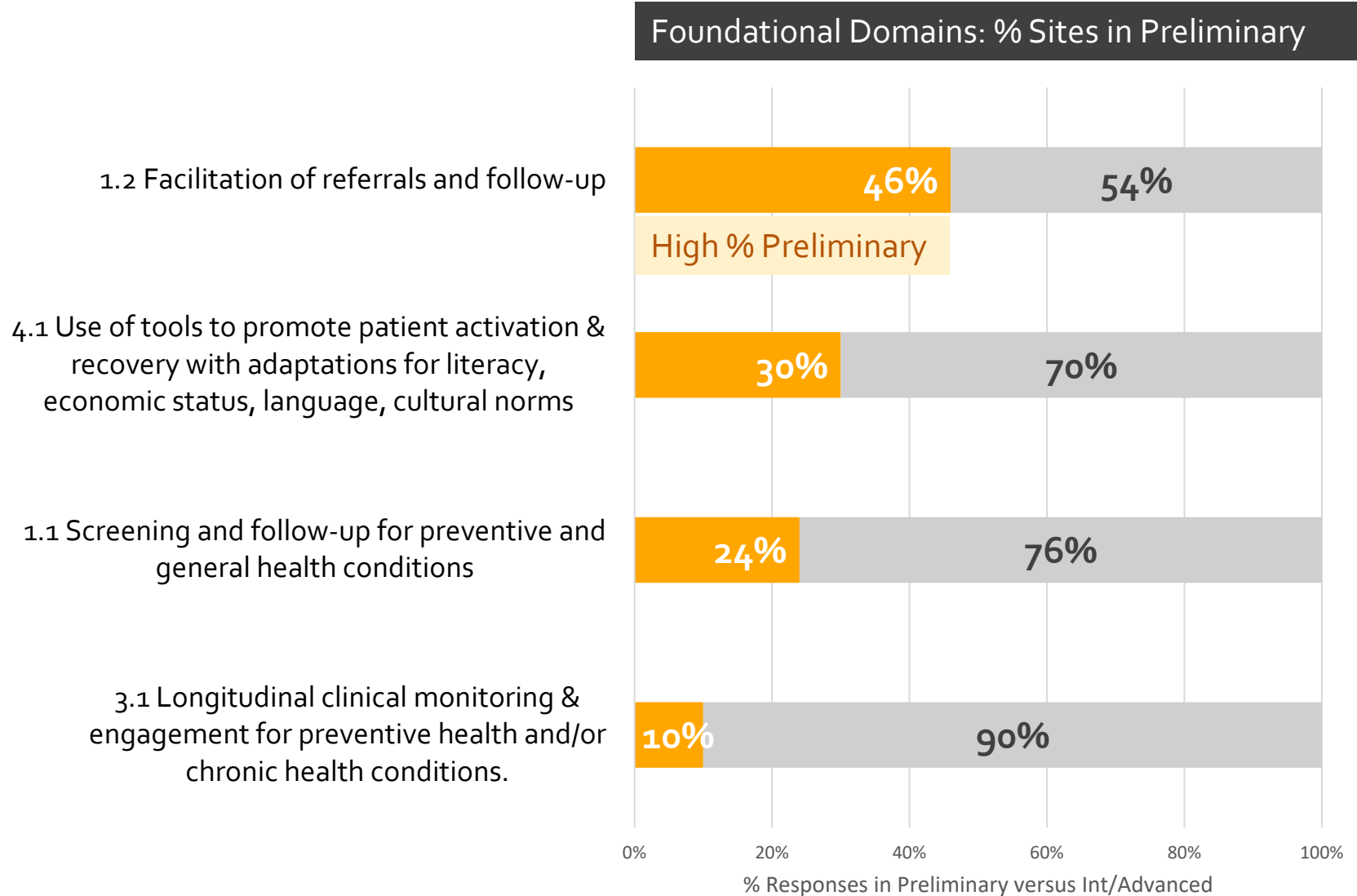
Foundational Domains* – Sites in Preliminary integration stage

N = 126

* **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



Response Rate & Characteristics

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Behavioral Health

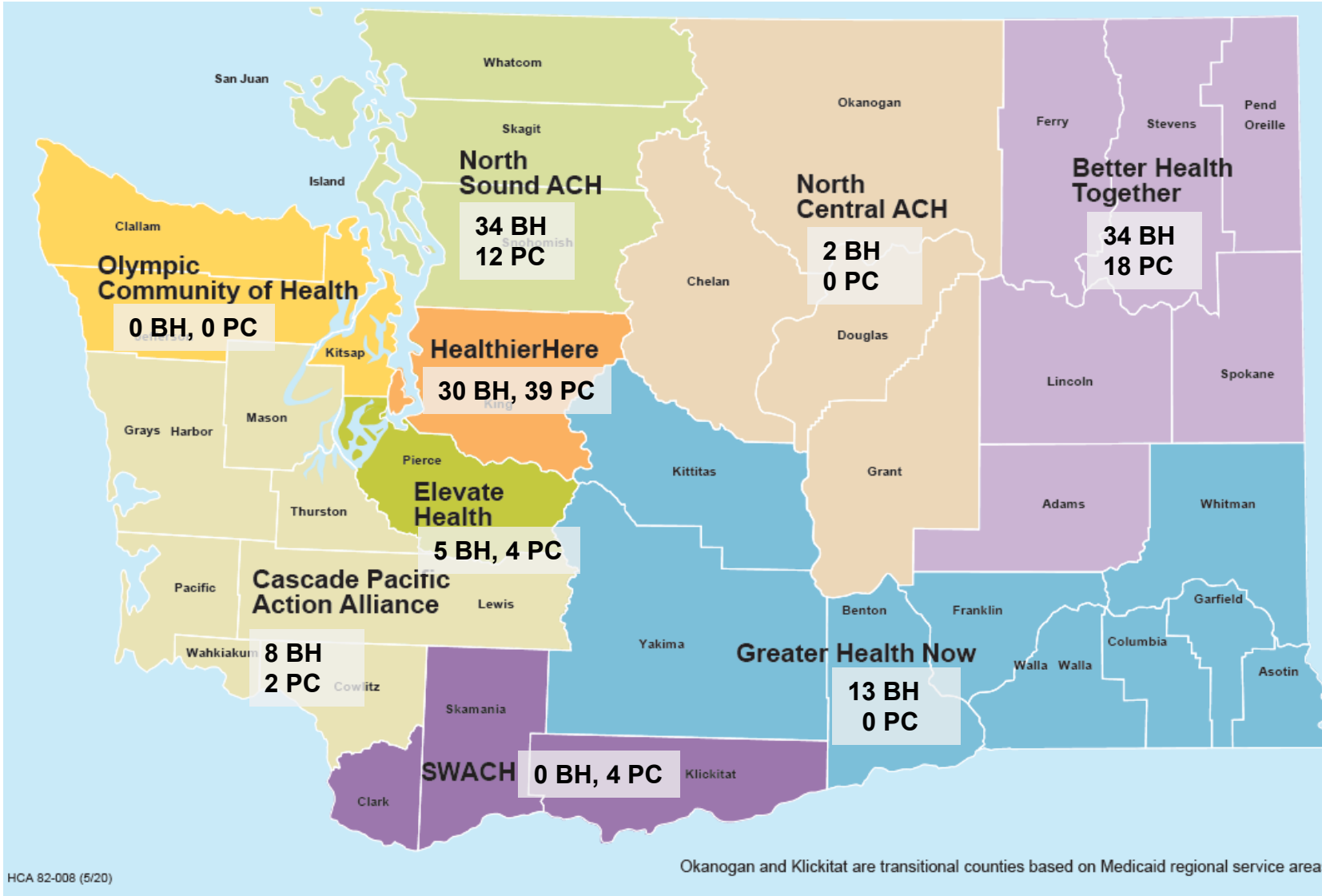
Statewide Response Rate

Cohort 1 - Responses received July 11 - August 22, 2022

- 195 behavioral health sites representing 102 behavioral health organizations were invited to complete the assessment
- 58 orgs responded / 102 orgs invited = **57%** Org Response Rate
- 126 sites responded / 195 sites invited = **65%** Site Response Rate

	Org Response Rate (responded / invited)	Site Response Rate (responded / invited)
Behavioral Health	57% (58/102 orgs)	65% (126/195 sites)
Primary Care	51% (28/55 orgs)	45% (79/174 sites)
All	55% (86/157 orgs)	56% (205/369 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

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N = 126

Supplemental Questions

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

	# Sites	% of Sites
Both	65	52%
Adults	47	37%
Pediatrics	14	11%
Total	126	100%

Behavioral Health

Characteristics of Cohort 1 Responses

N = 126

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

Clinic Type	Count	% of Sites (count / N)
Behavioral Health (mental health only)	52	41%
Behavioral Health (mental health AND SUD)	46	37%
Co-located Behavioral Health and Primary Care	25	20%
Opioid Treatment Program (OTP)	15	12%
Behavioral Health (SUD only)	12	10%
Other	4	3%
Primary Care	3	2%
Rural Health Clinic	2	2%

Behavioral Health

Characteristics of Cohort 1 Responses

BH Sites N = 126*
PC Sites N = 79*

*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
BH Sites - Monthly Patients	9	83	228	587	4,030
Primary Care Sites - Monthly Patients	50	781	1,461	2,000	15,000

Behavioral Health

Characteristics of Cohort 1 Responses

N = 126*

*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	20%	75%	89%	96%	100%
Medicare	0%	0%	1%	3%	22%
Commercial Insurance	0%	0%	4%	11%	55%
Uninsured	0%	0%	1%	3%	63%
Fee for Service	0%	0%	0%	1%	100%
Other	0%	0%	0%	1%	56%

Payor mix differs significantly between Behavioral Health and Primary Care sites. Median Medicaid for Behavioral Health is double that of Primary Care (89% vs. 44%).

Medicare and commercial representation is lower at Behavioral Sites than Primary Care. Medicare median is 1% for Behavioral vs 17% for Primary Care. Commercial median is 4% for Behavioral vs 21% for Primary Care.

Behavioral Health

Characteristics of Cohort 1 Responses

N = 126

- 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	79	63%
None of the above – our site does not currently use a screening tool	34	27%
Daily Living Activities—20 (DLA-20)	14	11%
PRAPARE	2	2%
Health Leads Social Needs Screening	1	1%
Accountable Health Communities (AHC) tool (also known as the Health-Related Social Needs (HRSN) tool)	0	0%
WellRx	0	0%

'Other' is the top screening tool cited by sites.

A quarter of sites do not use any SDOH screening tool.

Behavioral Health

Characteristics of Cohort 1 Responses

N = 126

- 7. What funding sources support your integrated care efforts? (select all that apply):

Type	Count	% Sites (count / N)
Grants	92	73%
Fee for service billing	72	57%
Capitated PMPM rate	49	39%
Other	24	19%
Value based payment arrangements	14	11%
None	7	6%
Collaborative Care codes	3	2%

Grants support integrated care efforts for three-quarters of Behavioral Health sites.

Only 11% of BH sites reported value-based payments for their efforts vs. 44% of PC sites. VBP supports 1 in 10 Behavioral Health sites, compared to half of all Primary Care sites.

Collaborative Care codes support only 2% of BH sites for integration versus 28% for PC sites. CoCM codes support only 1 in 50 Behavioral Health sites, compared to 1 in 3 Primary Care sites.

Behavioral Health

Characteristics of Cohort 1 Responses

N = 126

- 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	125	99%
Health information exchanges (HIE)	52	41%
Registries	39	31%
Shared care plans	35	28%
Electronic referrals to outside services	29	23%
Closed loop referral systems with outside services	19	15%
Community information exchanges (CIE)	7	6%

Nearly all sites use an EHR system.

1 in 4 sites uses shared care plans and external electronic referrals.

Both behavioral and primary care orgs use EHRs, but the relative use of other population health tools is significantly less at behavioral orgs.

Behavioral Health

Characteristics of Cohort 1 Responses

N = 126*

*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%	5%	15%	30%	92%
% Virtual (telephone only)	0%	1%	7%	20%	71%
% In-Person	5%	49%	73%	91%	100%

Most sites reported significantly more in-person visits than virtual. Among virtual visits, video is used more than telephone-only. Behavioral Health sites use more virtual video patient visits than Primary Care sites.

Behavioral Health

Characteristics of Cohort 1 Responses

N = 126

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

Type	Count	% Sites (count / N)
Workforce	115	91%
Financial Support	97	77%
Technology	74	59%
Partnerships with other clinical providers	60	48%
Other	20	16%
Leadership Support	12	10%

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 triple the rate of Primary Care (59% vs 22%). This is reflective of historical underinvestment in Behavioral Health technology and EHR use.

Narratives: Equity, Licensing and Reimbursement, Support

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Behavioral Health

Cohort 1 Narrative Response Summary

N = 79

Summary of Narrative Themes

- 5. How will advancing integration help you address health equity?

1. Address Whole-Person Care
2. Improved Cultural Responsiveness and Trust in Healthcare
3. Effective Advocacy and Referrals

- 8a. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts?

1. SUD/MH Integration
2. Capitated Contract Funding
3. Provider Relationships with ACHs and MCOs
4. Support from ACHs

- 8b. Where is there room for improvement?

1. Licensure Requirements and Timing
2. Payment Structures and Reimbursement

- 25. What resources/support does your clinical site need to advance integration?

1. Support with EHR Technology
2. Payment Reform
3. Workforce Support
4. Shared Vision and Executive Buy-in
5. Clinical Partnerships
6. Technical Assistance for Integration

Behavioral Health

Cohort 1 Narrative Responses and Themes

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N = 126

• 5. How will advancing integration help you address health equity?

Health equity means that everyone has a fair and just opportunity to be as healthy as possible and clinical sites have a responsibility to create a welcoming and accountable environment meant for people of color, all gender identities and sexual orientations, and people with disabilities.

1. Address Whole-person Care

“Integration, ultimately will help [us] ensure better care outcomes for those left behind by the mainstream health systems.”

“Equitable access to high quality healthcare is negatively impacted by transportation, family/childcare, timeliness of appointments for working parents, multiple appointments over many days and different locations. Integrated care delivery - physical, behavioral and oral health - in a single location or co-location would address many of these identified equity issues. Integrated or co-located healthcare sites could be designed to be more culturally welcoming, multiple language friendly, and create friendly community-based care (as opposed to institutionally designed settings)”

“The individuals in the community that we work with are primarily the underserved, Medicaid, low SES, have significant impacts of mental health symptoms, poor physical health and hygiene. With the capacity to offer integrated healthcare for primary care and behavioral health in the same location, we are able to make a bigger impact on helping individuals address not only their mental health but also their physical health and help them learn how the two are intertwined.”

Behavioral Health

Cohort 1 Narrative Responses and Themes

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N = 126

• 5. How will advancing integration help you address health equity?

2. Improved Cultural Responsiveness and Trust in Healthcare

“Integration will allow us to strengthen our ability to...ensure that clients can start working on whichever health issues that are most relevant to them with the providers they most trust. Integration will close the loop when physical health is not being effectively addressed, will reduce the burden on the individual seeking services, and will allow positive transfer of reputation when a trusted agency refers to another partner with confidence. Taken together, these efforts should increase trust in the healthcare system, which is particularly important for system-weary clients. Integration may help reduce discrimination, bias, and stigma experienced within the healthcare system.”

“Our clients often mistrust traditional medical institutions and if we are able to assess the type of support they need and can refer directly to an office that we have a relationship with it would be a huge benefit. Training us to help clients navigate the medical system improves their long-term health by providing them a trusted resource to rely on throughout their journey.”

3. Effective Advocacy and Referrals

“Advancing integration will help our agency staff understand and recognize obstacles to equitable access to services...and will create a basis for effective advocacy and referral within and between systems.”

Behavioral Health

Cohort 1 Narrative Responses and Themes

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N = 126

• 8a. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts?

1. SUD/MH Integration

“SUD/MH integration and reimbursement for coordination efforts”

“The expansion of approved education and experience for credentialing of mental health professionals (MHPs) under WAC 246-341-0515 has allowed the agency to address shortages in qualified mental health professionals.”

2. Capitated Contract Funding

“Without capitated payments, we would not be able to remain in business.”

“Capitation funding model is excellent for integrated care efforts.”

“Capitated contract is good for stability during transition to value-based care.”

3. Provider Relationships with ACHs and MCOs

“Relationships with GCACH (Greater Health Now) and MCOs in the region make it easier to communicate and problem solve. The quarterly GCACH reporting helps give staff as a whole a better visual of the great work that they are doing at our weekly staff meetings.”

4. Support from ACHs

“BHT (Better Health Together ACH) provides licensing reimbursement which is very helpful and works well.”

“Our ACH BHT is the sole supporter of integration efforts for a BHA in this region.”

Cohort 1 Narrative Responses and Themes

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N = 126

- **8b. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts?**

Where is there room for improvement?

1. Licensure Requirements and Timing

“Recognition and allowance to practice for providers with non-USA certifications and licensure for healthcare providers from other countries.”

“HCA department of licensing has been slow in licensing new providers. For example for the WISe (Wraparound with Intensive Services) program, some providers have been waiting for their license for the last 3 months.”

“Most insurances (especially commercial) do not backdate paneling. We would like to see a standard for backdating paneling to capture reimbursement for services provided while (sometimes lengthy) paneling decisions are made.”

“Increase reimbursement for licensure renewals would improve provider retention. 3 training days per year per clinician and 5 training days per med provider, and funds available towards training. Consortium trainings available to staff would be helpful.”

Cohort 1 Narrative Responses and Themes

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N = 126

- **8b. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts?**

Where is there room for improvement?

2. Payment Structures and Reimbursement

“Medicaid payment models do not reimburse for engagement efforts and travel time related to outreach activities. Additionally, current behavioral health Medicaid payment models do not allot funding specifically for medical staff positions or preventative health interventions such as vaccinations, wound care, or health screenings.”

“The Collaborative Care codes were developed for delivery of mental health in a primary care setting and there is not a parallel set of codes or process for behavioral health care providers. Few payers have developed value based payment arrangements for behavioral health and those that have been tried are not sustainable (e.g., Pathways Community HUB through ACH), fee for service billing does not adequately account for the amount of care coordination needed for behavioral health clients.”

“The current payment structure in King County is not conducive to integrated care delivery. Payment in KC is siloed without clear incentive, or opportunity to explore alternative payment models.”

“There is no funding model for or license/credential for care navigator (like community health worker) positions for mental health providers.”

Behavioral Health

Cohort 1 Narrative Responses and Themes

N = 126

- **8b. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts?**

Where is there room for improvement?

2. Payment Structures and Reimbursement (continued)

“Direct funding for our self-identified integrated care implementation goals has been most helpful as it provides incentives for us to choose goals that are relevant to the clients we serve and feasible with our service delivery models. We might benefit from being able to make bespoke integrated targets, where the amount of reimbursement is proportional to the significance of the effort as well as the efforts required to implement it.”

“Collaborative care codes...has proven very difficult to implement through our EHR system (Epic), and we haven't been able to bill yet due to the complications building it in our EHR.”

“Expanding SERI for SUD providers to [be] able to bill for integrated services. Currently we can only bill for a certain number of codes.”

“We have asked to include primary care in our MCO contracts, but there never seems to be an opportunity to negotiate the contracts to open it up. We receive very poor reimbursement for our medical care and get paid less than it takes to maintain a provider.”

Cohort 1 Narrative Responses and Themes

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N = 126

- 27. **What resources/support does your clinical site need to advance integration?**
[See page 18](#) for a breakdown of top challenges faced by behavioral health practices.

1. Support with EHR Technology

“An HLN7 interoperability framework that would bridge multiple EHR systems, allowing for sharing or integration of client information across the spectrum of integrated healthcare systems.”

“Funding for data analysis and software development positions to build EHR interoperability with other community healthcare organizations, electronic drug prescription and medication management, integration of additional health metric tracking, and workflow improvement and automation (our ... Innovation projects are still using spreadsheets to manage the workflow and track metrics for much of their work).”

“We are not able...to utilize our school nurses in a way that aligns with integration. If we were able to implement an HIE with local hospitals, that would be a way to connect our agency to physical health providers in a meaningful way.”

“We would also like to update our system to include a more prescriber friendly interface.”

2. Payment Reform

“Advocacy for billable codes for behavioral health integrated into primary care and billing options for multiple types of licenses.”

“Reimbursement for integrated training that would include underwriting the salary of the staff attending AND underwriting the revenue generation lost by attending training rather than providing client care.”

3. Workforce Support

“Workforce shortage continues to be a challenge, so information or support around recruiting, hiring, and retaining employees.”

Behavioral Health

Cohort 1 Narrative Responses and Themes

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N = 126

- 27. **What resources/support does your clinical site need to advance integration?**
[See page 18](#) for a breakdown of top challenges faced by behavioral health practices.

4. Shared Vision and Executive Buy-in

“It could be helpful for staff to hear leaderships plan/vision for what integrated healthcare will look like as an agency and what it could look like for each program. Additional trainings available to staff which highlight the importance of how physical and behavioral health are interconnected could get buy in from clinicians who might be cautious with offering general healthcare information to clients.”

“Internal prioritization from our executive leadership.”

5. Clinical Partnerships

“In a rural community, it would be really helpful to have a partnership or linkage with a medical clinic (most clients utilize the same local clinic), in order to increase communication and collaboration.”

“Start having meetings with local PCP [Primary Care] agencies on establishing mutual understanding for each other's protocol and expectations on coordination of care process”

“More formal partnerships re: integration, workforce available, technology”

6. Technical Assistance for Integration

“Staff training and time for evidence-based practices including systematic screening tool for universal general health risk factors, guidelines to engage patients universal general health risk factor screening, guideline and treatment protocols for chronic health conditions, culturally competent tools to promote patient activation and recovery, general health quality metrics, etc.”

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 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

Foundational Domain

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 = 126

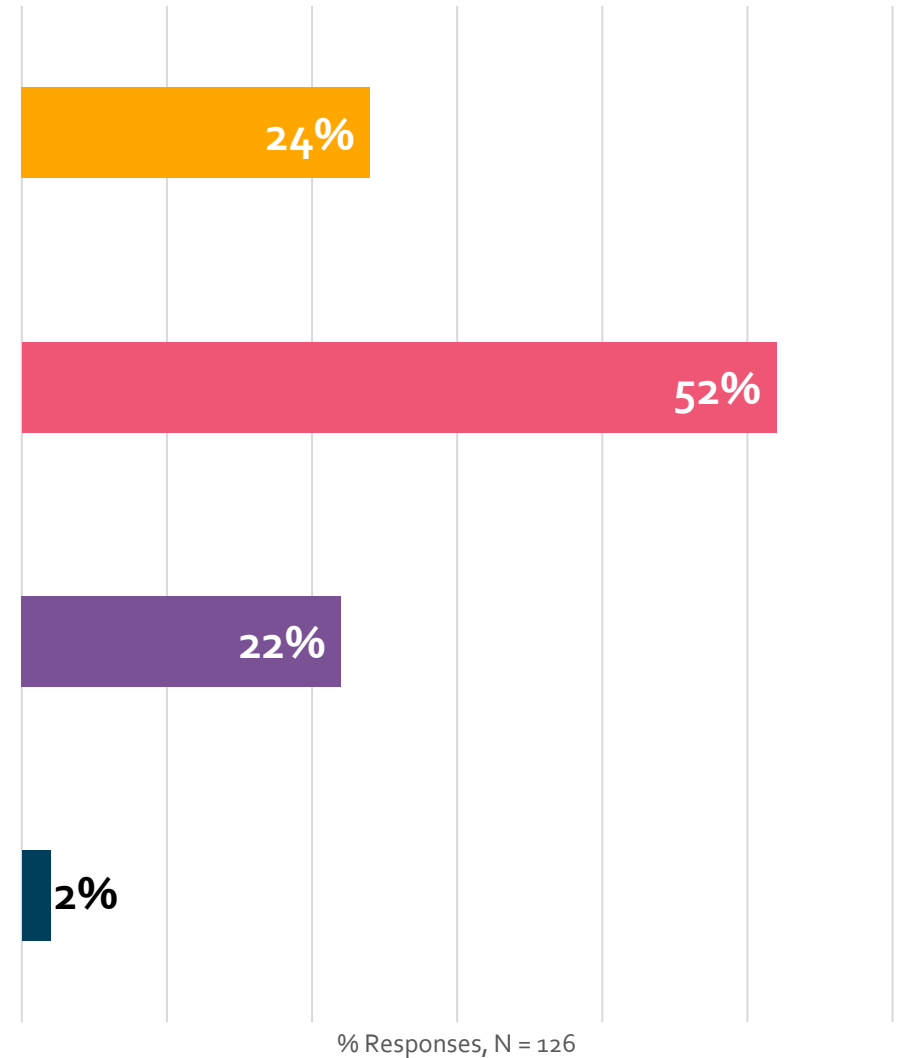
Question 11

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.



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

Subdomain
1.2 Facilitation of referrals and follow-up

Behavioral Health

N = 126

Question 12

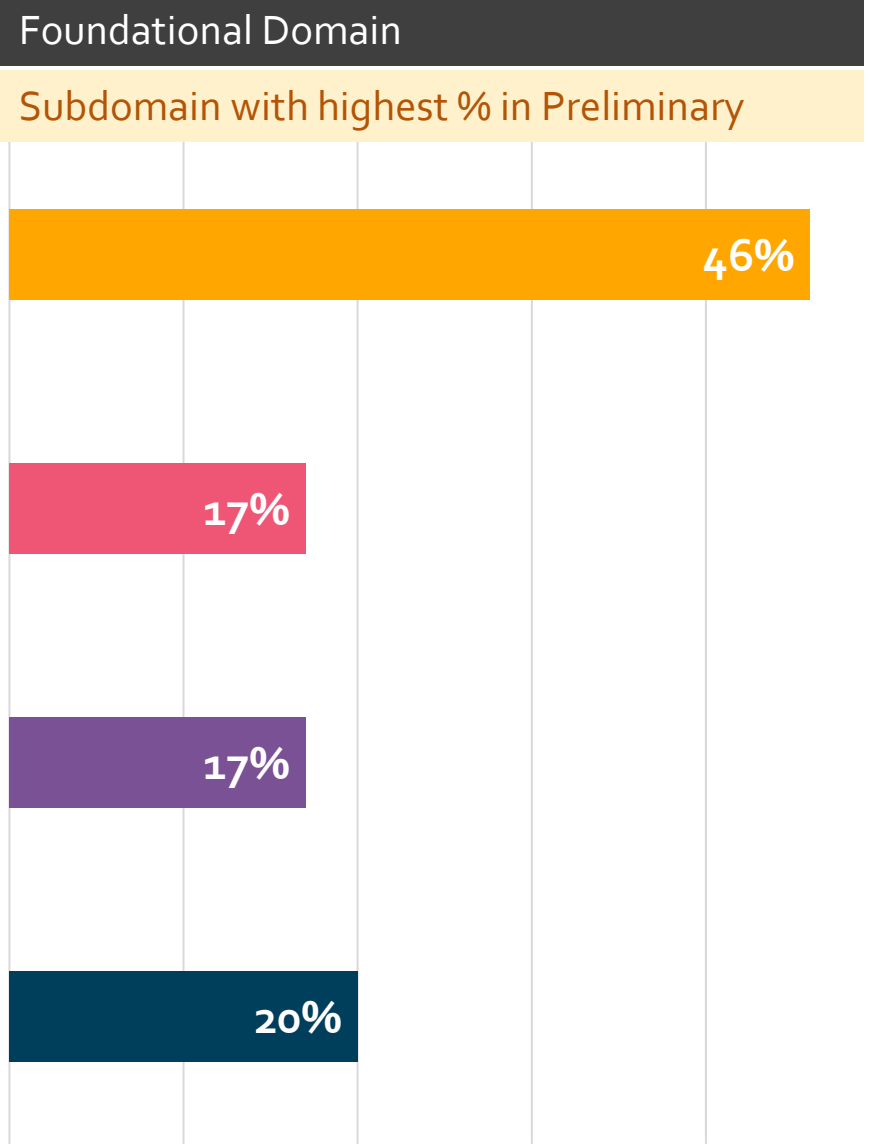
Referrals

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.



% Responses, N = 126

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 = 126

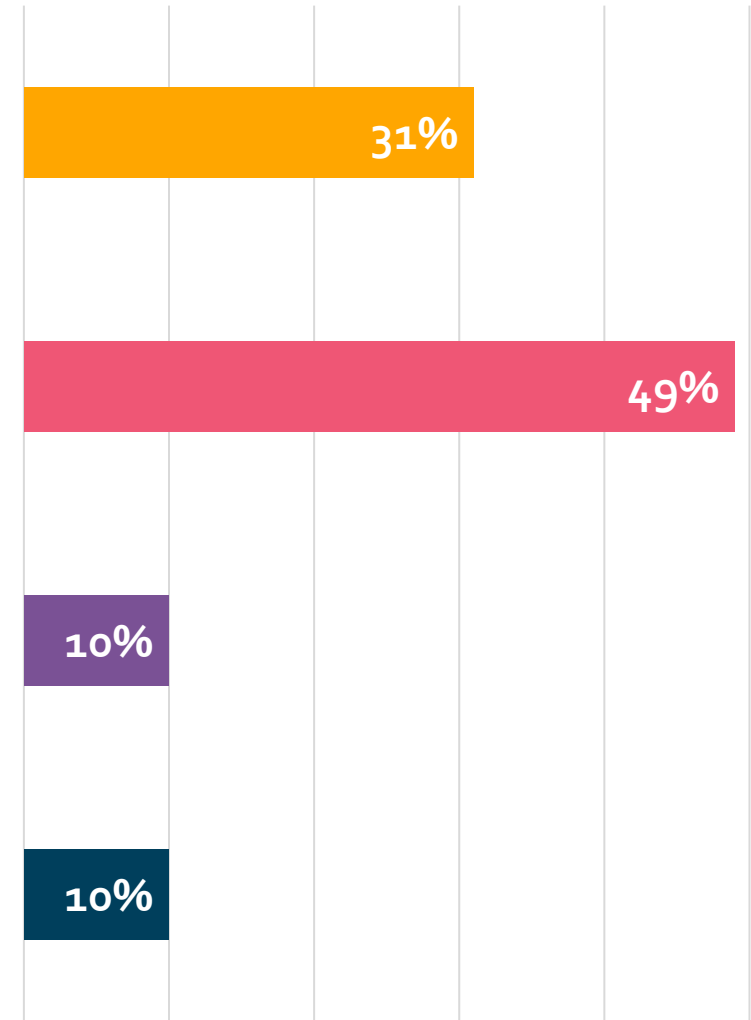
Question 13

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.).



% Responses, N = 126

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 = 126

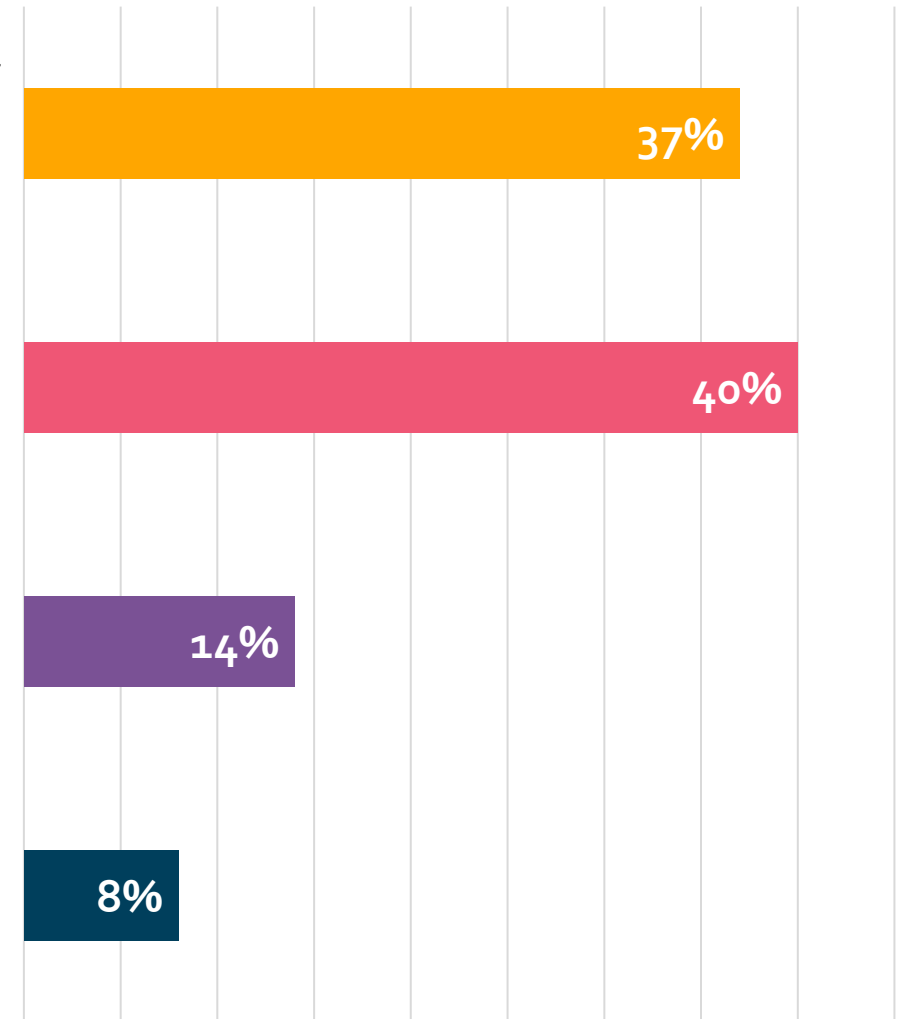
Question 14

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.



% Responses, N = 126

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 = 126

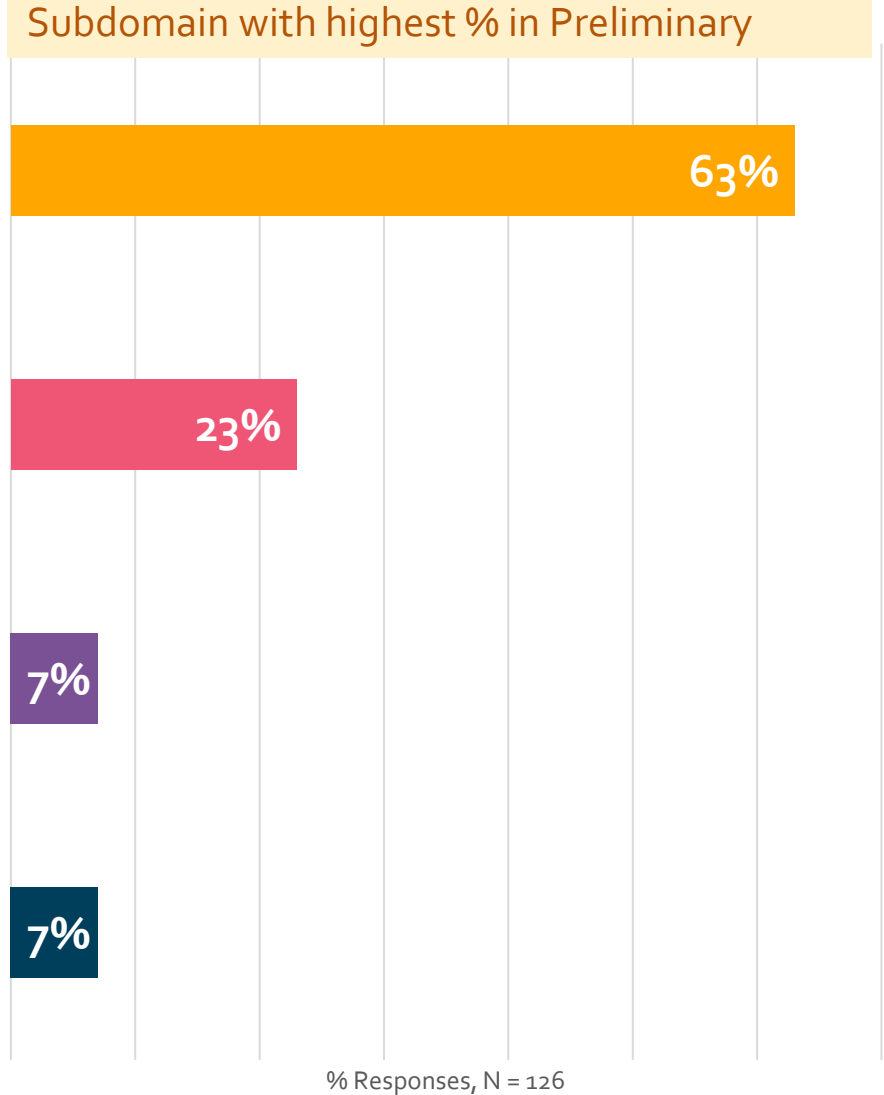
Question 15

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 = 126

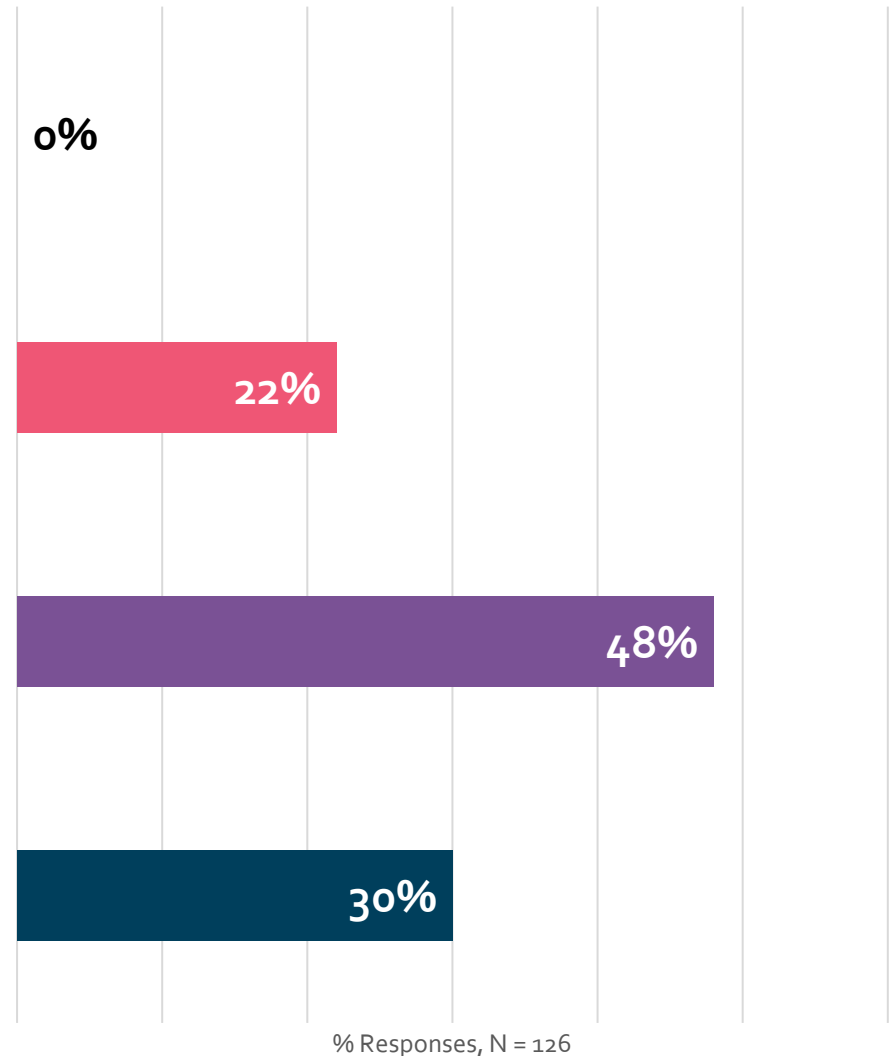
Question 16

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.



Domain
3. Ongoing care management

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

Behavioral Health

N = 126

Question 17

Care Management

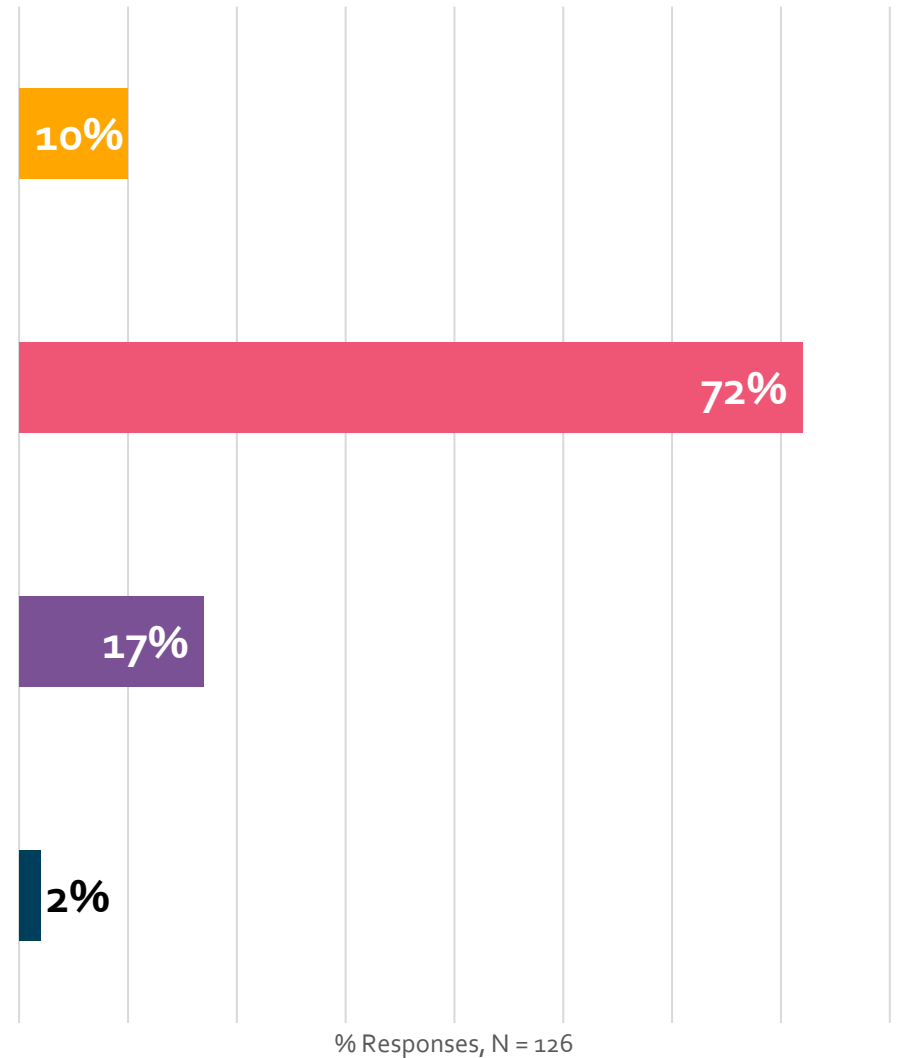
Preliminary: None or minimal follow-up of patients referred to primary and medical specialty care.

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.

Foundational Domain



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 = 126

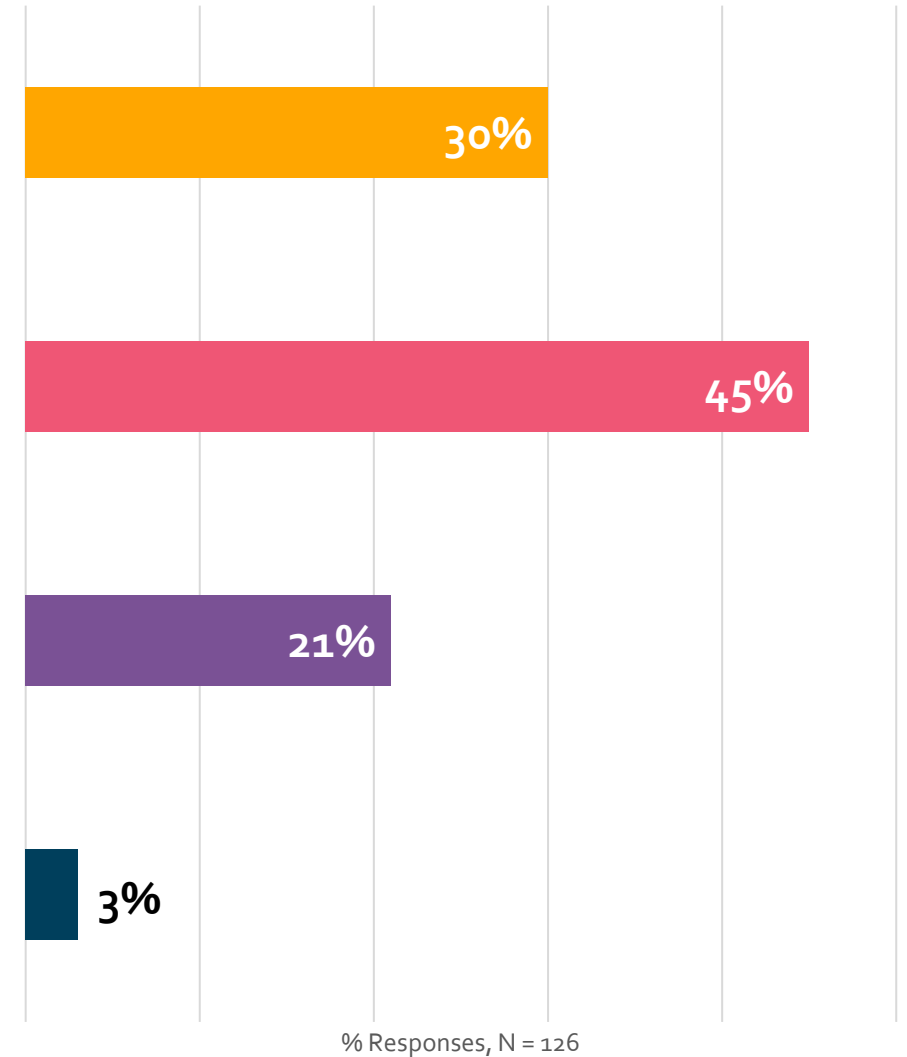
Question 18

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 = 126

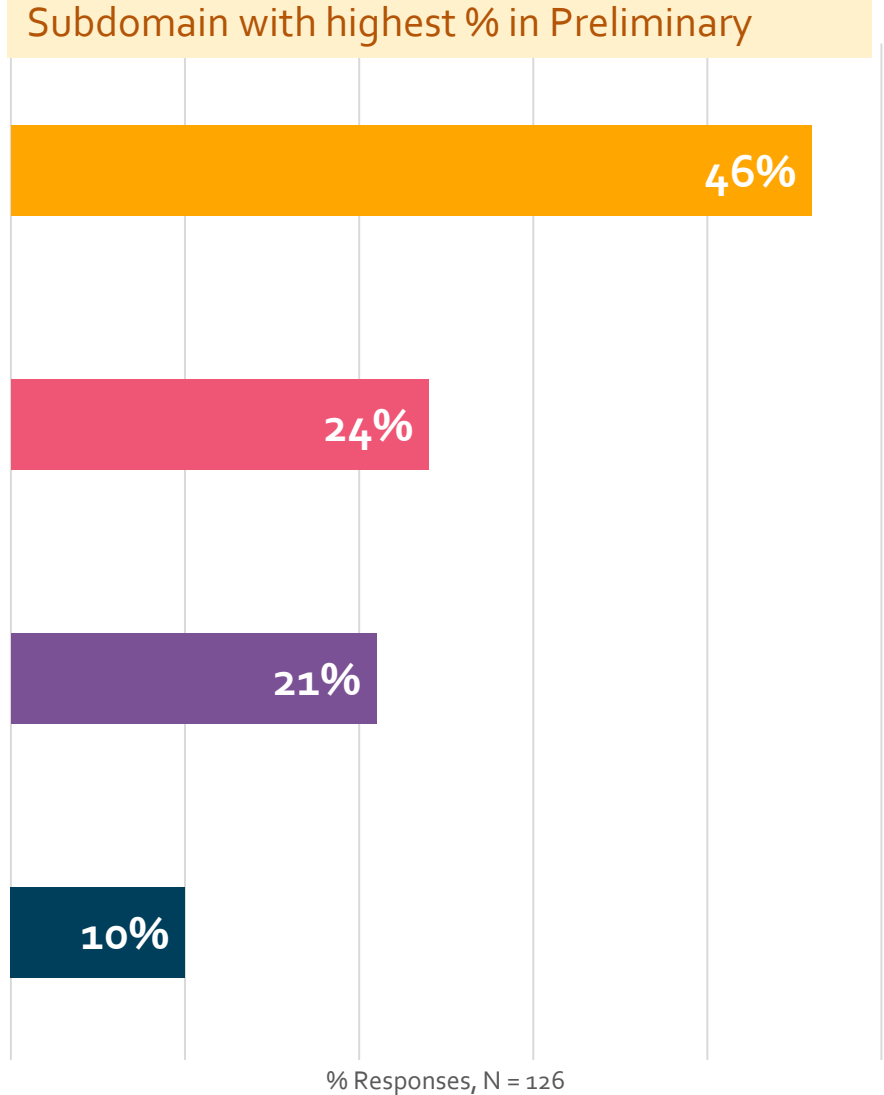
Question 19

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 = 126

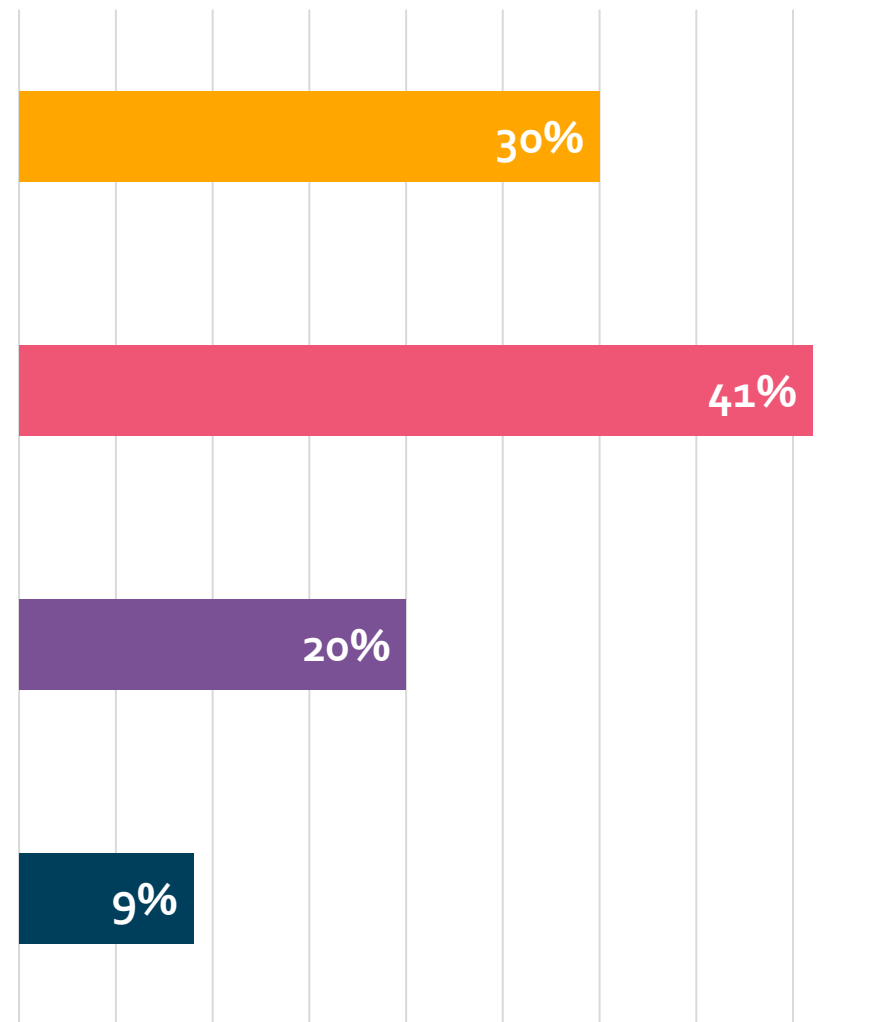
Question 20

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.



% Responses, N = 126

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 = 126

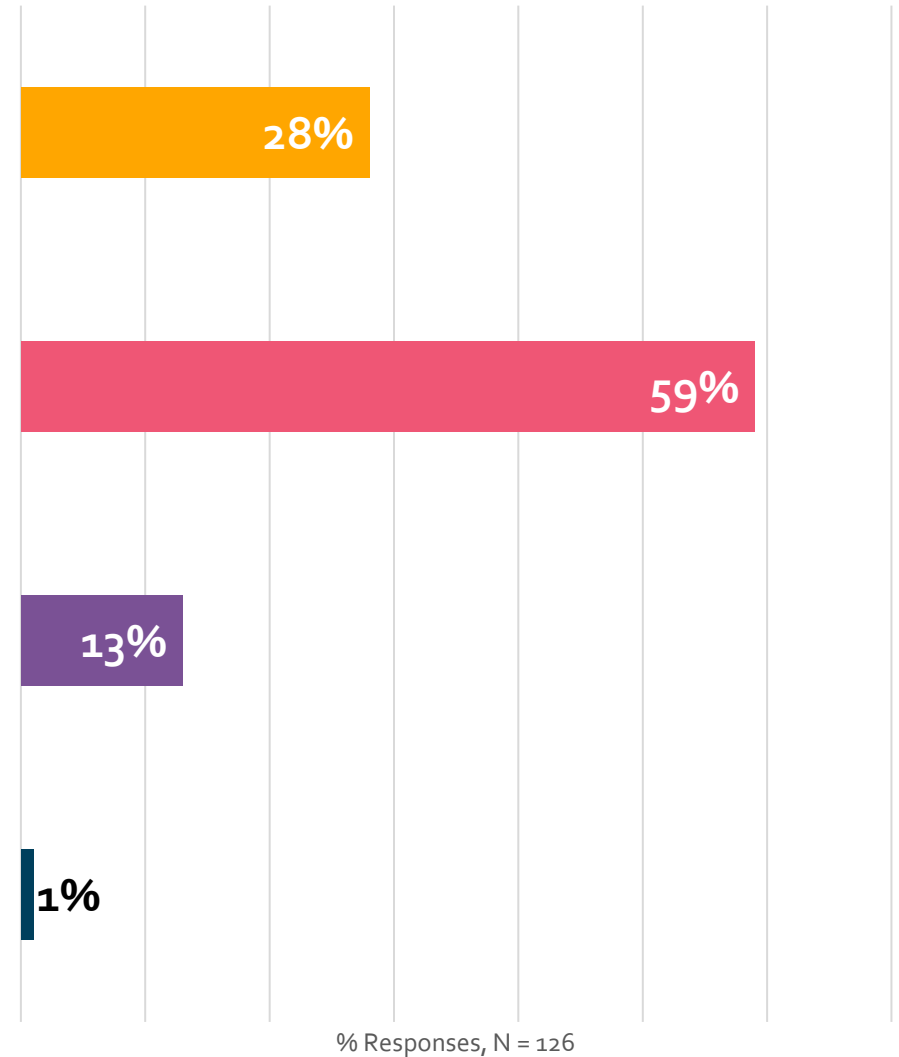
Question 21

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 = 126

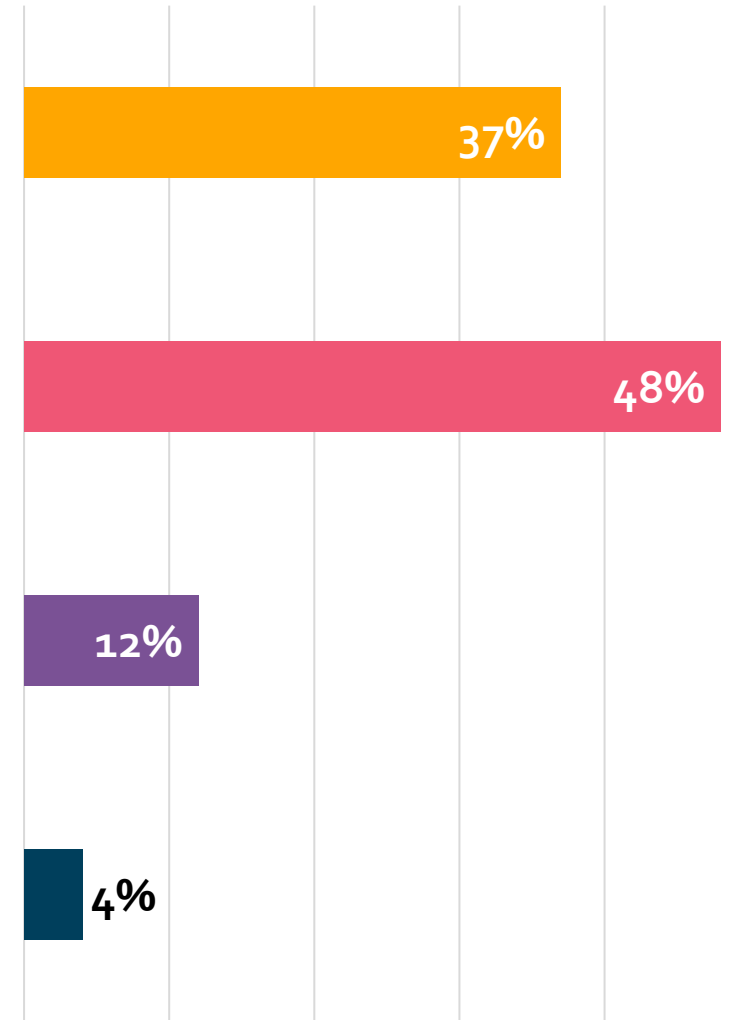
Question 22

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.



% Responses, N = 126

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 = 126

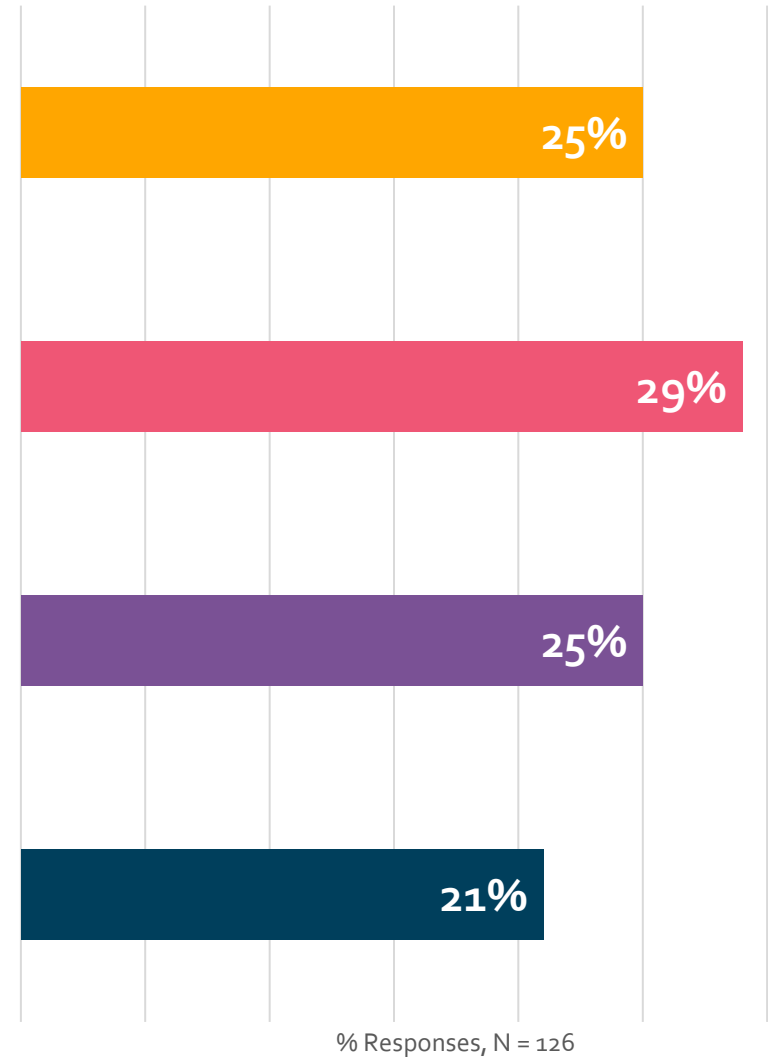
Question 23

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

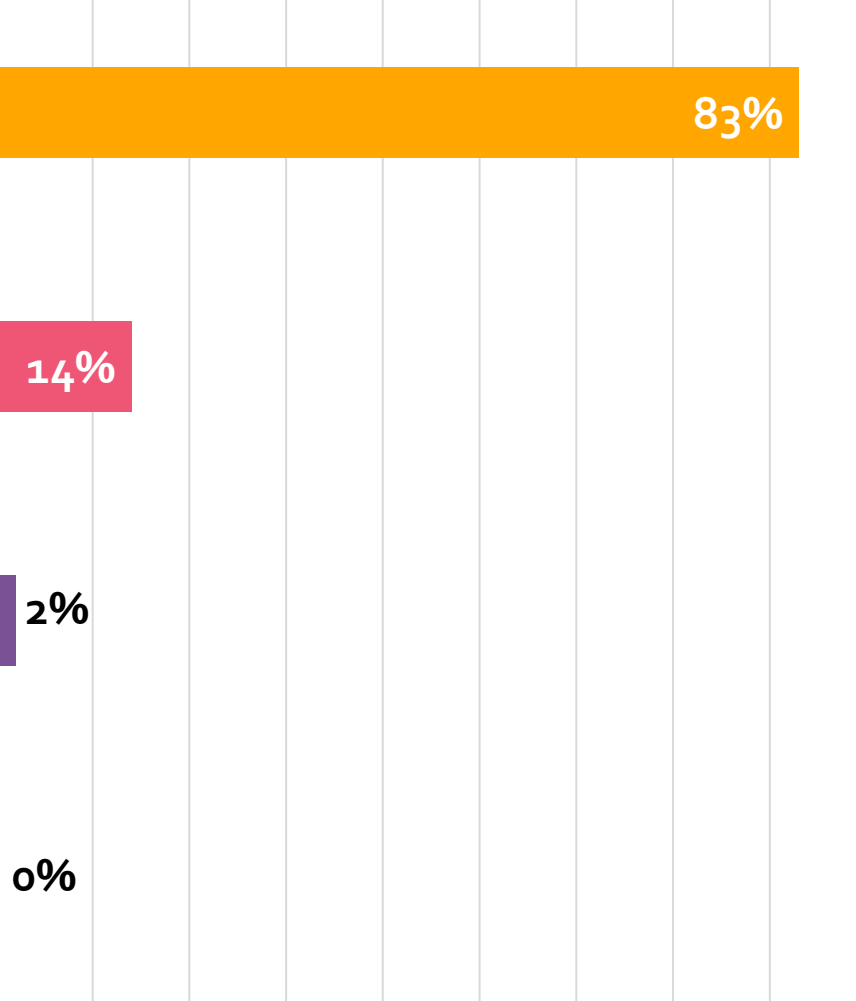
Preliminary: No or minimal attempts to bill for immunizations, screening and treatment. Services supported primarily by grants or other non-reimbursable sources.

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.

Subdomain with highest % in Preliminary



% Responses, N = 126

Domain
8. Sustainability

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

Behavioral Health

N = 126

Question 24

Regulatory/Licensure

Domain
8. Sustainability

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

Behavioral Health

N = 126

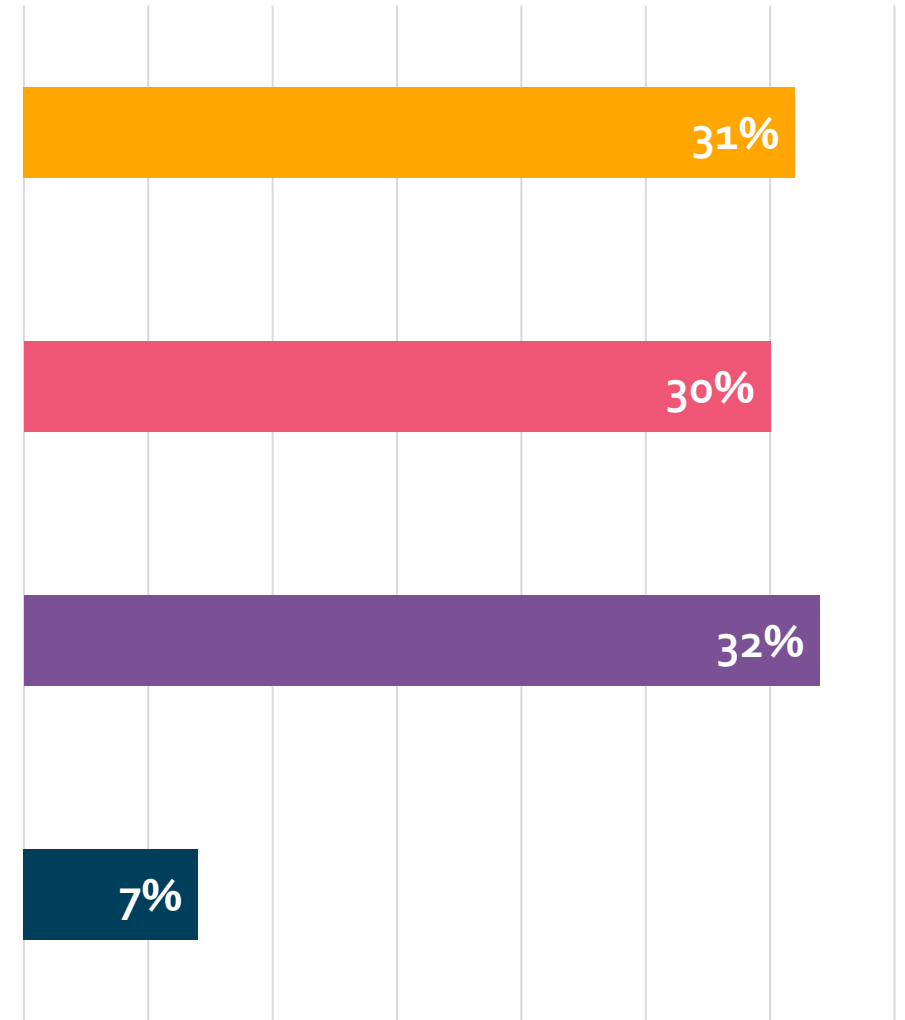
Question 25

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.



% Responses, N = 126

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

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

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