Statewide Baseline Report
Cohort 1
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. **Integration readiness is stronger at primary care than behavioral health sites. Most primary care sites are in intermediate stages and above.**
(79) Primary Care sites across Washington state responded in Cohort 1, representing a 45% site response rate.

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

Strengths are evident across all of the foundational domains.
Referral facilitation (1.2) is the greatest opportunity for improvement.

3. **Opportunities for Improvement**:

Quality Improvement (7.1)
Team-based care review (6.2)
Subdomains with most improvement potential vary by ACH/MCO region.

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

Referrals 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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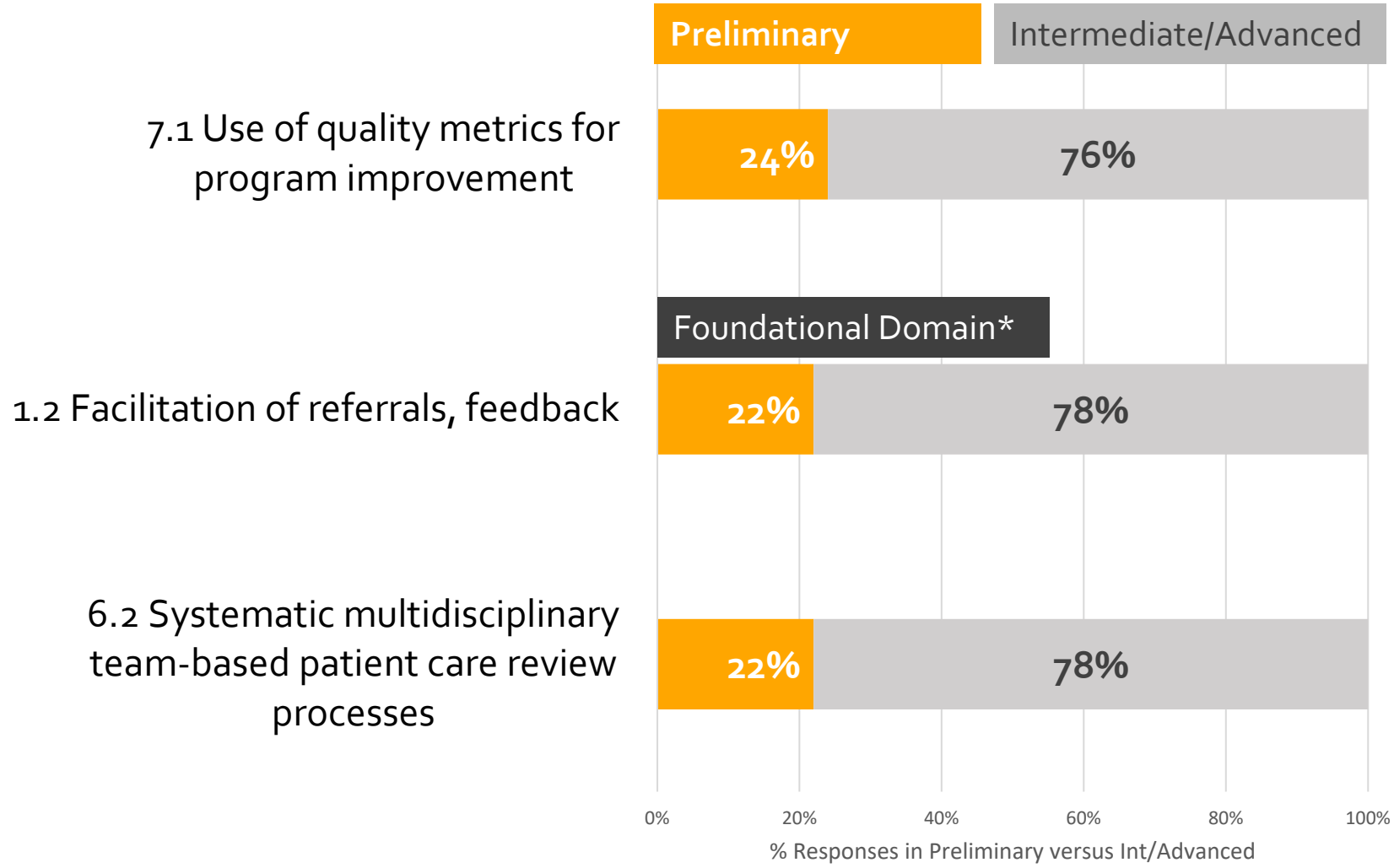
N = 79

* **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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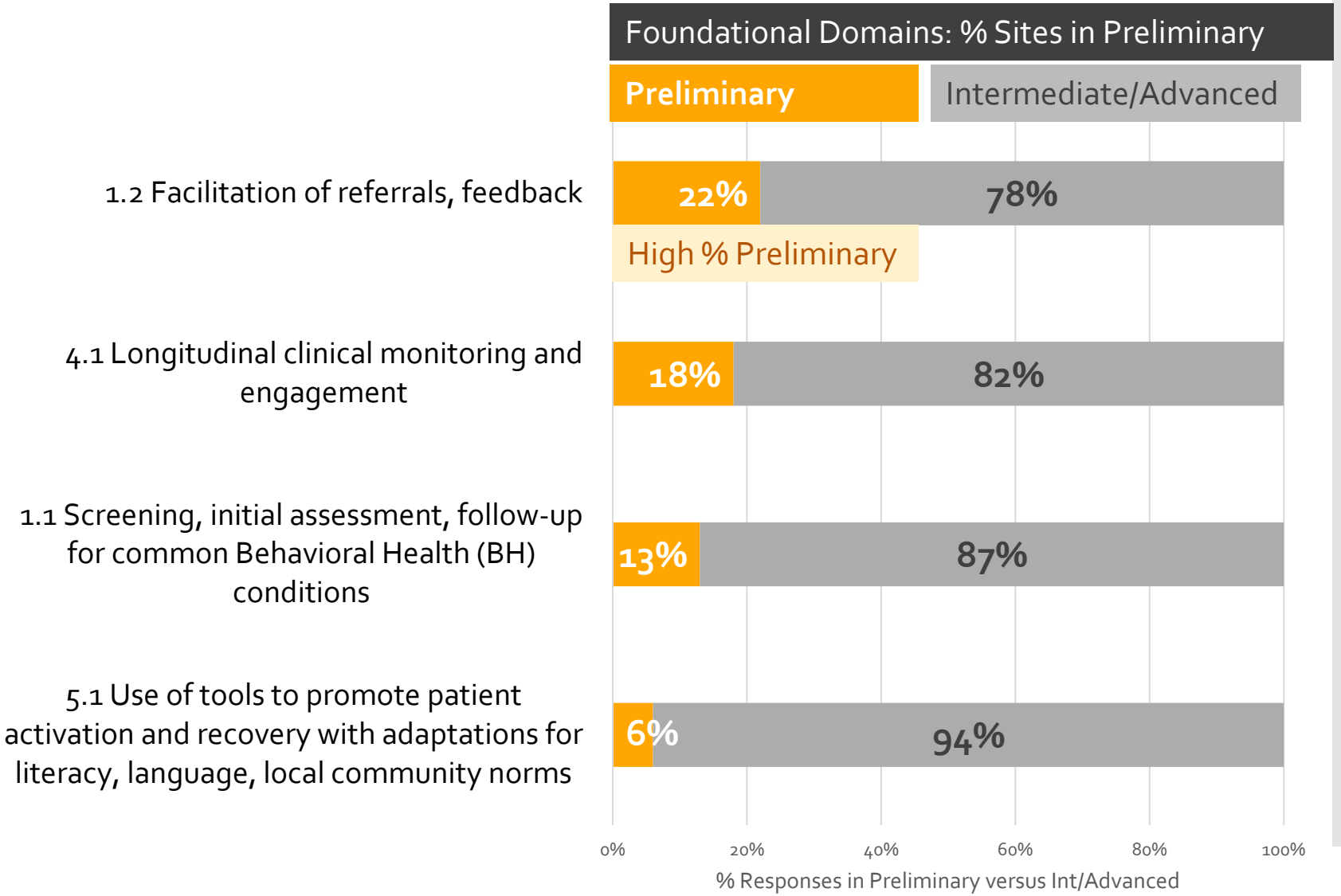
N = 79

* **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

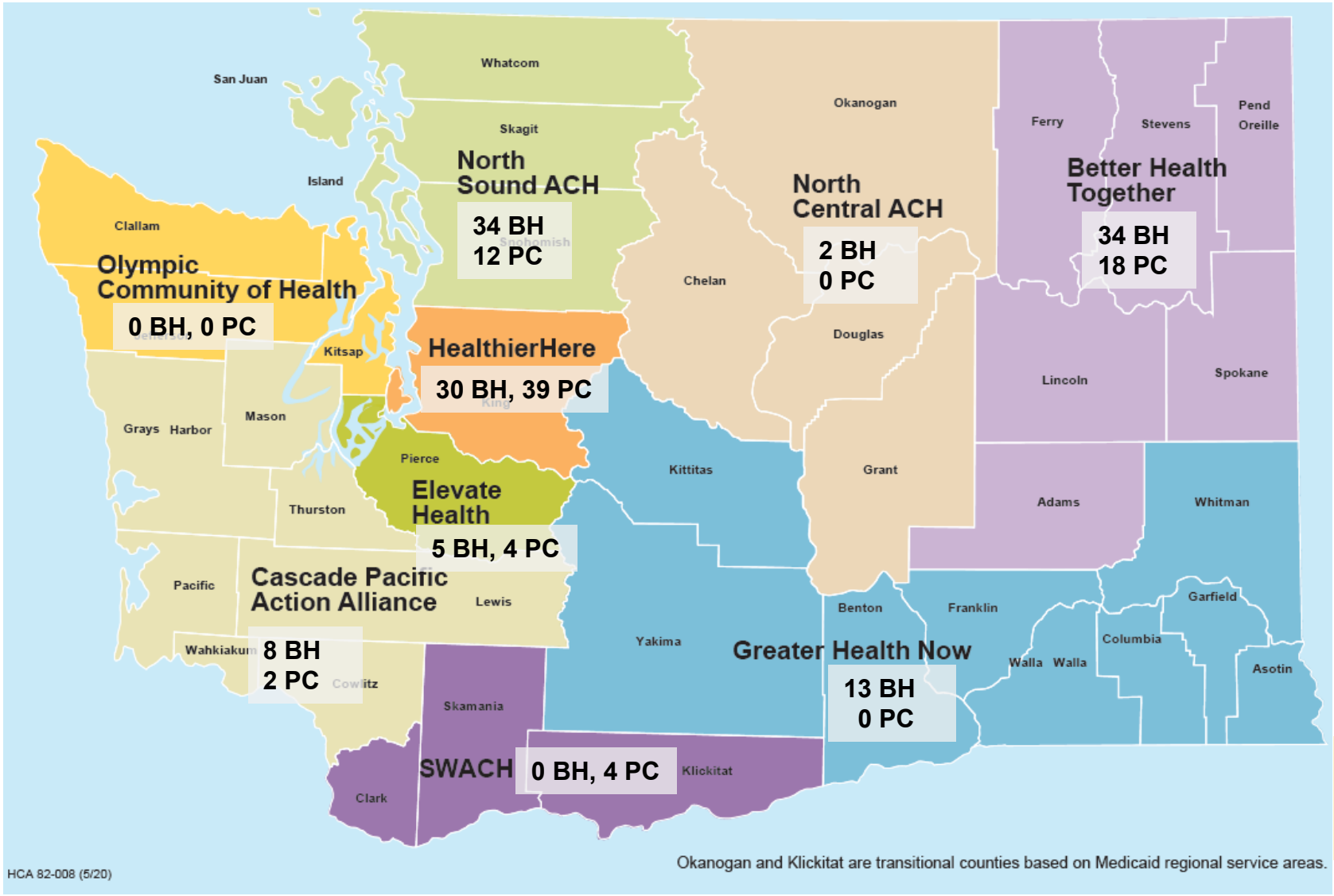
Statewide Response Rate

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

- 174 primary care sites representing 55 primary care organizations were invited to complete the assessment
- 28 orgs responded / 55 orgs invited = **51%** Org Response Rate
- 79 sites responded / 174 sites invited = **45%** 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.

Primary Care

Characteristics of Cohort 1 Responses - N = 79

Supplemental Questions

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

	# Sites	% of Sites
Both	54	68%
Adults	21	27%
Pediatrics	4	5%
Total	79	100%

Primary Care

Characteristics of Cohort 1 Responses - N = 79

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

Clinic Type	Count	% of Sites (count / N)
Primary Care	40	51%
Co-located Behavioral Health and Primary Care	35	44%
Other	17	22%
Behavioral Health (mental health only)	11	14%
Behavioral Health (mental health AND SUD)	6	8%
Rural Health Clinic	3	4%
Opioid Treatment Program (OTP)	2	3%
Rural Health Clinic	0	0%

Primary Care

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

Primary Care

Characteristics of Cohort 1 Responses

-

N = 79*

*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	7%	21%	44%	65%	85%
Medicare	0%	7%	17%	25%	75%
Commercial Insurance	0%	16%	21%	39%	77%
Uninsured	0%	2%	5%	12%	38%
Fee for Service	0%	0%	1%	10%	100%
Other	0%	0%	0%	0%	39% ("Self-pay")

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 higher at Primary Care than Behavioral Sites.
Medicare median is 1% for Behavioral vs 17% for Primary Care.
Commercial median is 4% for Behavioral vs 21% for Primary Care.

Primary Care

Characteristics of Cohort 1 Responses - N = 79

- **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	40	51%
None of the above – our site does not currently use a screening tool	19	24%
Accountable Health Communities (AHC) tool (also known as the Health-Related Social Needs (HRSN) tool)	18	23%
PRAPARE	12	15%
Daily Living Activities—20 (DLA-20)	2	3%
WellRx	1	1%
Health Leads Social Needs Screening	0	0%

'Other' (internal and **EPIC-based)** is the **top screening tool** cited by sites.

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

Primary Care

Characteristics of Cohort 1 Responses - N = 79

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

Type	Count	% Sites (count / N)
Fee for service billing	64	81%
Grants	39	49%
Value based payment arrangements	35	44%
Capitated PMPM rate	28	35%
Collaborative Care codes	22	28%
Other	4	5%
None	2	3%

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.

Primary Care

Characteristics of Cohort 1 Responses - N = 79

- **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	79	100%
Electronic referrals to outside services	56	71%
Registries	51	65%
Shared care plans	46	58%
Health information exchanges (HIE)	42	53%
Closed loop referral systems with outside services	26	33%
Community information exchanges (CIE)	15	19%

100% of sites use an EHR system, and about 3 out of 4 sites use electronic external referrals.

Community Information Exchanges are used by 1 in 5 primary care sites, in contrast to about 1 in 20 behavioral health sites.

Primary Care

Characteristics of Cohort 1 Responses

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N = 79*

*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%	5%	10%	90%
% Virtual (telephone only)	0%	0%	4%	10%	50%
% In-Person	0%	77%	87%	93%	100%

Most sites reported much more in-person patient visits than virtual.
Behavioral Health sites use virtual video for patient visits more than Primary Care sites.

Primary Care

Characteristics of Cohort 1 Responses

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N = 79

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

Type	Count	% Sites (count / N)
Workforce	74	94%
Financial Support	72	91%
Partnerships with other clinical providers	39	49%
Other	18	23%
Technology	17	22%
Leadership Support	6	8%

Workforce and **Financial Support** are the top challenges to advancing integration.

These were the top challenges across both BH and primary care sites.

Narratives: Equity, Licensing and Reimbursement, Support

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Summary of Narrative Themes

Primary Care

Cohort 1 Narrative Response Summary -

N = 79

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

1. Culturally-Responsive Healthcare for BIPOC, non-English primary, and Refugee Communities
2. Address Whole-Person Care
3. Increase Access and Reduce Stigma

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

1. Warm Hand-offs
2. Telehealth and Virtual Care
3. Collaborative Care Billing Codes (CoCM)

- **8b. Where is there room for improvement?**

1. Workforce Support
2. Licensure Requirements
3. Payment Reimbursement Models

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

1. Payment Structures and Reimbursement
2. Workforce Support
3. Integration Model for Pediatrics
4. Community Collaboration and Idea-Sharing
5. CIE for Centralized Behavioral Health Service Directory
6. Technical Assistance for Integration

Primary Care

Cohort 1 Narrative Responses and Themes

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N = 79

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. Culturally-Responsive Healthcare for BIPOC, non-English primary, and Refugee Communities

"Onsite, integrated behavioral health allows us to meet more urgent patient care needs that may not be accessible to certain populations if services are offsite. Data supports that referrals to services and specialists are less likely to be completed in BIPOC populations or individuals with a non-English primary language. In an integrated model, patients with significant barriers to care (transportation, language, cultural stigma, financial concerns, etc.) can engage in behavioral health services following a warm handoff, often same day or within the week."

"We are able to stratify data and understand which populations are thriving (or not) in our clinics. We know, for example, that we have work to do with populations that are recent refugees and have PTSD and a chronic condition. That knowledge led to the development of a new refugee clinic that approaches care for refugees differently than care in our general population and combines the expertise of medical providers, social workers, and behavioral health care."

"We hope that advancing integration will allow us to continue to serve underserved communities of color. We want to hire more clinicians and staff that are bilingual in order to better serve our patients. There is a high need for mental health providers in our area especially providers that speak Spanish."

Primary Care

Cohort 1 Narrative Responses and Themes

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N = 79

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

2. Address Whole-Person Care

"Advancing integration would...allow patients to be seen more frequently by behavioral health providers for health conditions such as hypertension, diabetes, and smoking cessation, disorders that have a basis in behavior change and impact an individual's life-long functioning."

"Advancing integration leads to more opportunities for universal screening and immediate responses to universal screening. One of the most equitable ways to determine the needs of patients is to screen universally in order to ensure that all patients are given the chance to express needs and are given support to address those needs.**"**

3. Increase Access and Reduce Stigma

"It is much easier to engage patients at their primary care office and not have to ask them to schedule with an outside provider or go to a new location."

"In our co-located clinic, we are able to reach the underserved populations here in Spokane that find behavioral health intimidating and create a more welcoming, inclusive environment."

Primary Care

Cohort 1 Narrative Responses and Themes

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N = 79

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

1. Warm Hand-offs
"Warm handoffs are working really well, and we know this is incredibly beneficial for the patient."

2. Telehealth and Virtual Care
"We have seen audio-only telephone care become essential to integration and health equity over the past two years through the expansion of telehealth laws during the pandemic. Tightening restrictions on these will hurt patient access to services and provider flexibility. Not only have we seen no show rates decline with the use of telephone based encounters, but staff also report a quality of life improvement when allowed to work remotely for a portion of their clinical week, which has been vital in battling burnout. We hope to see the expansion of these services continue and for the reimbursement to remain equal or close to a standard face-to-face office visit."

"The flexibility to do more of our care via telehealth due to the COVID pandemic waivers has been helpful to reach more of our families where they are."

3. Collaborative Care Billing Codes (CoCM)
"The clinician at this clinic started using the Collaborative Care billing codes in 2021, starting with 1-2 patients...it provided billing and coding departments a chance to monitor the new process. In turn this allowed for adjustments and corrections as the clinician continued to move toward billing all Collaborative Care codes...Three months in to using CoCM billing codes exclusively, it appears that the Collaborative Care program as a whole will be sustainable using the codes."

Primary Care sites listed using CoCM codes as a strength.
In contrast, Behavioral Health sites cited CoCM Codes as an area needing improvement.

Primary Care

Cohort 1 Narrative Responses and Themes

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N = 79

- **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. Workforce Support

"We have the need for more mental health providers at our health center. We struggle to find providers in our area."

"Healthcare as an industry has struggled to grow wages in accordance with ever growing cost of living and we are finding it more difficult than ever to offer competitive wages to mental health clinicians that have an abundance of job opportunities and live in one of the most robust and expensive cities in the country. Being able to offer behavioral healthcare provider wages closer to those of medical provider peers would help to entice people into the field (because we need more clinicians) and help attract quality clinicians to our community health setting and keep them here for continuity of care."

"Reimbursement methods alone cannot cover the costs to add critical staffing resources to the clinic."

"There is currently not a clinician in this clinic."

Primary Care

Cohort 1 Narrative Responses and Themes

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N = 79

- **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. Licensure Requirements

"If Medicare were to expand their reimbursement to LMHC and LMFT license types, we would significantly broaden the pool of potential clinicians to serve our patient population."

"Licensing requirements for LISWs are rigorous and expensive, prohibiting some from obtaining the full licensure. One must complete a Master's degree then obtain 3000 hours of supervised work before they can qualify to take the state licensing exam. During the time they are obtaining their 3000 hours they can have an Associates license, however their employer has to provide a supervisor and the supervisor needs to be on the premises whenever the Associates therapist is seeing patients. Supervisory Clinical Therapists are in high demand with limited supply. Other BH types should be able to provide BH billable BH services, or their work should be valued/funded with alternate funding sources."

3. Payment Reimbursement Models

"Reimbursement for [associates] is so low or non-existent...If we could get a system in place where we can help associates complete their clinical hours + receive reimbursement, that would be ideal."

"Reimbursement is insufficient to cover the cost of care coordination. The care coordination work required to ensure open access, long-term engagement, a no-show rate of less than 10%, and continued tracking of patient outcomes is largely unreimbursed. We need CPT codes for complex chronic behavioral health care with allowed amounts sufficient to cover the cost of care coordination. Presently, there is no reimbursement for the first 40 minutes of care coordination each month for the 25% of our total patient population with a behavioral health diagnosis."

Primary Care

Cohort 1 Narrative Responses and Themes

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N = 79

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

1. Payment Structures and Reimbursement
"The interpreter process for Medicaid patients is broken. Currently, there is only one vendor contracted to provide reimbursable interpreter services for Medicaid patients. There is limited availability for interpreters - in the last 18 months we've had 1,154 denials because there wasn't an interpreter available. There are ongoing issues of interpreters no-showing for scheduled appointments and certain languages not being available, especially indigenous languages. A good example is that American Sign Language was not previously available. A process was just recently implemented to offer ASL, however it is scheduled through a separate portal and has very limited availability. Additionally, there are no reimbursable interpreter services available for Medicaid patients who walk into the clinic for an urgent need, because the Medicaid-approved interpreter services must be scheduled in advance. If providers use a different interpreter service for Medicaid patients, it is not reimbursable. The result is compromised service to patients and cost burden to providers. We need to revise regulations to allow providers to choose the interpreter services that meet their patient and operational needs, and to receive reimbursement for these services."

"Billing mechanism to move beyond grant funded initiative to support care coordination, peer navigation and nursing outreach services."

"More BH providers, BH funding, better reimbursements for BH services"

Primary Care

Cohort 1 Narrative Responses and Themes

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N = 79

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

2. Workforce Support
"We have tools within our EHR to build registries and proactively outreach, but no individual within a case management role to lead or track this. We also do not have internal staff capability to add this piece of work to an existing staff person (PSR, MA, RN, etc). A dedicated person to manage this piece of work would be the primary resource needed to advance integration."

"Hiring and retention of clinical BH providers is the biggest challenge. We would benefit from...financial support strategies for non-clinical care positions that would advance integration activities, including case/care management and social work."

3. Integration Model for Pediatrics
"Asking about integration is like asking someone with no food to try to eat healthier. Who are we trying to integrate with? There are not enough BH providers and they have no need to integrate...
We consult with a variety of specialists in many areas. We do not have the ancillary staff to have multidisciplinary meetings. We provide a very wide range of services from well-care, to behavioral health, to seeing acutely ill patients, And, we do it for approximately 10-15% of the cost of an ER visit. Hopsitals and ERs have lots of ancillary staff, such as social workers, care coordinators, care managers, and other staff. They use RNs (we use MAs). A multidisciplinary integrated health team is what ought to happen in the hospital with very ill and complex patients. There is not a model to use for outpatient, primary care pediatrics."

Primary Care

Cohort 1 Narrative Responses and Themes

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N = 79

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

4. Community Collaboration and Idea-Sharing
"Continued collaboration with other organizations in the community working to implement integration, to brainstorm and share ideas."

5. CIE for Centralized Behavioral Health Service Directory
"A shared location to find all behavioral health services and the type of insurance they accept in the county would be beneficial. Our clinic, as well as community would benefit from a CIE that is available to healthcare providers in the region." (King and Pierce counties)

6. Technical Assistance for Integration
"Social Determinant screening guidance and IT support to capture the data, track and monitor progress"
"Continued identification of patients that could benefit from behavioral health services and more routine pathways and assessments of patients not presenting with concerns to help catch underlying behavioral health difficulties and/or focus on preventative work."

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 = 79

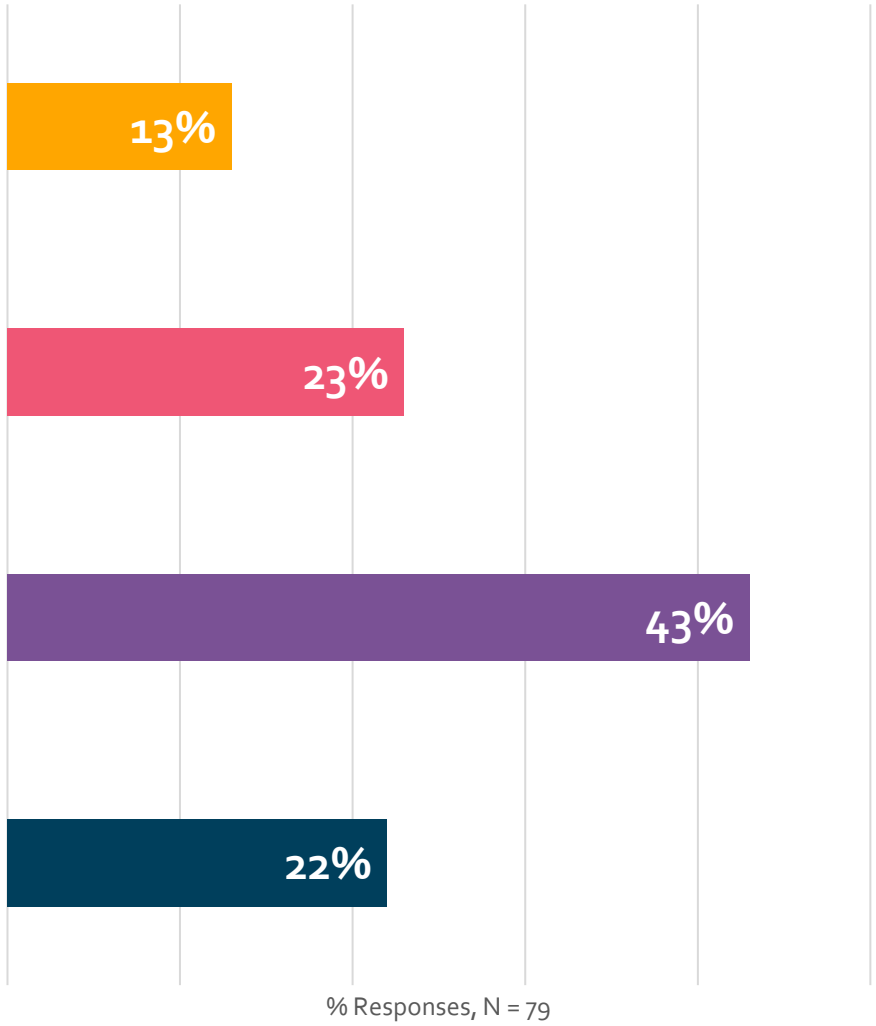
Question 11

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 = 79

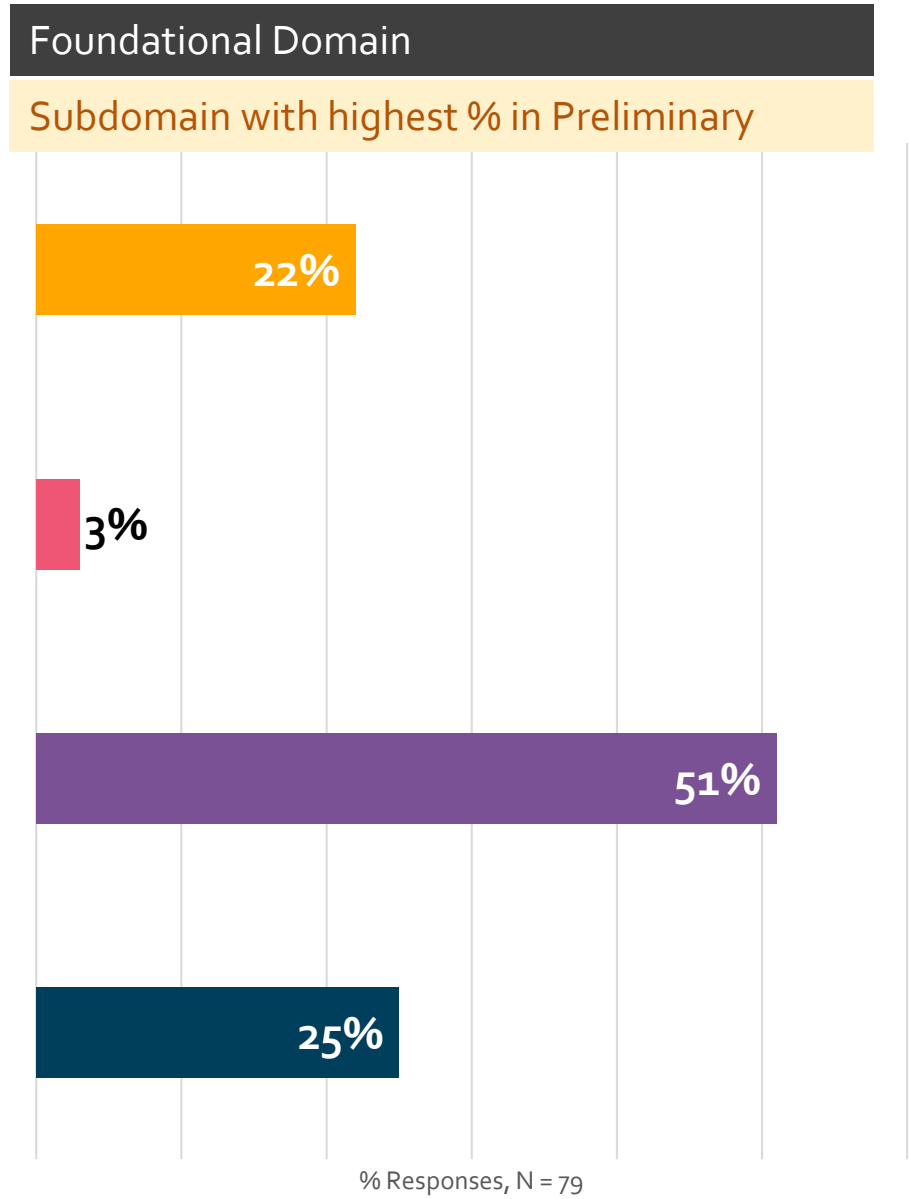
Question 12

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 = 79

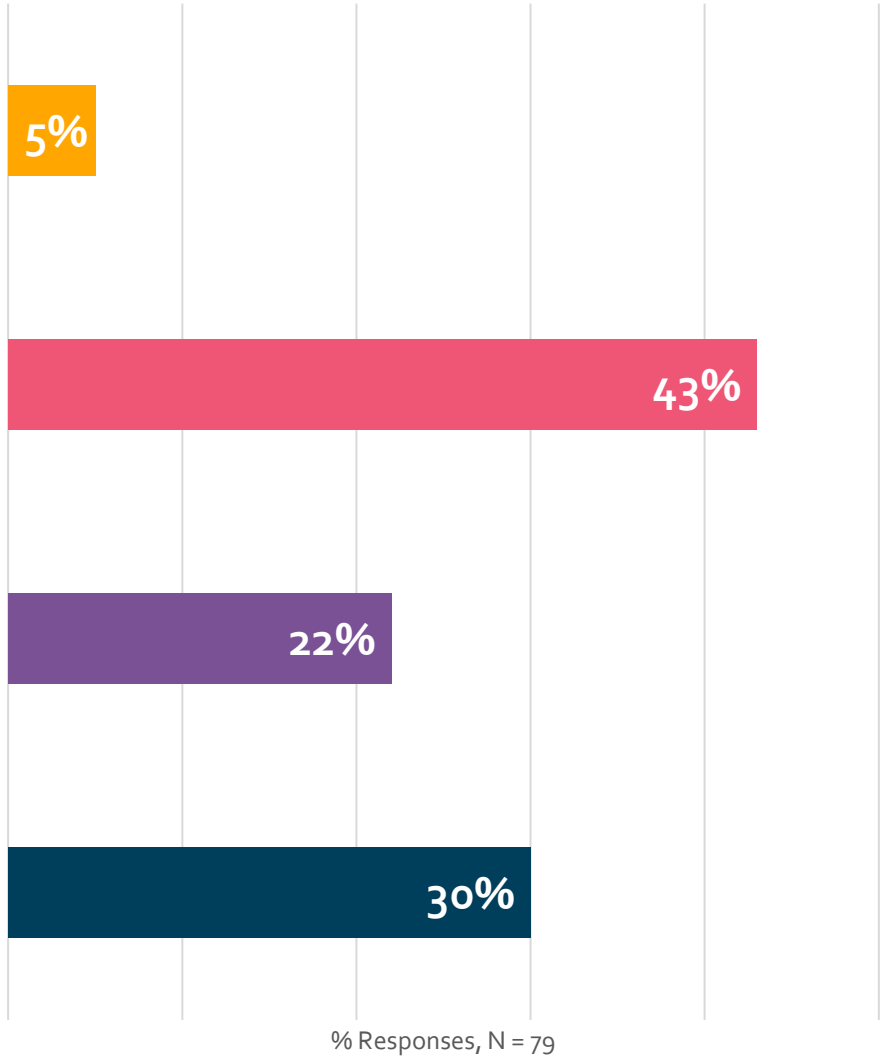
Question 13

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

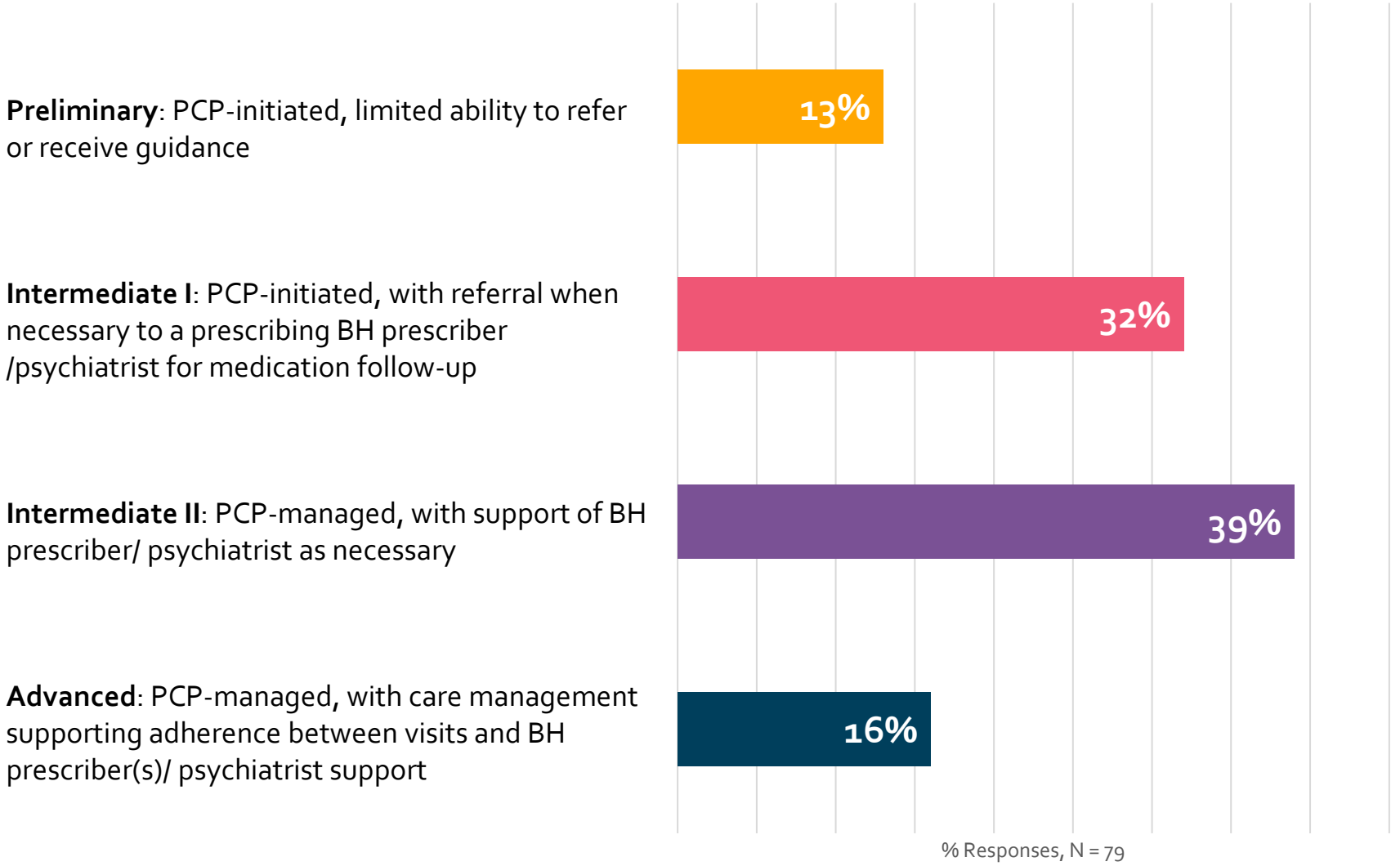
Domain
2. Evidence- based care for preventive interventions and common behavioral health conditions

Subdomain
2.2 Use of psychiatric medications

Primary Care

N = 79

Question 14



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 = 79

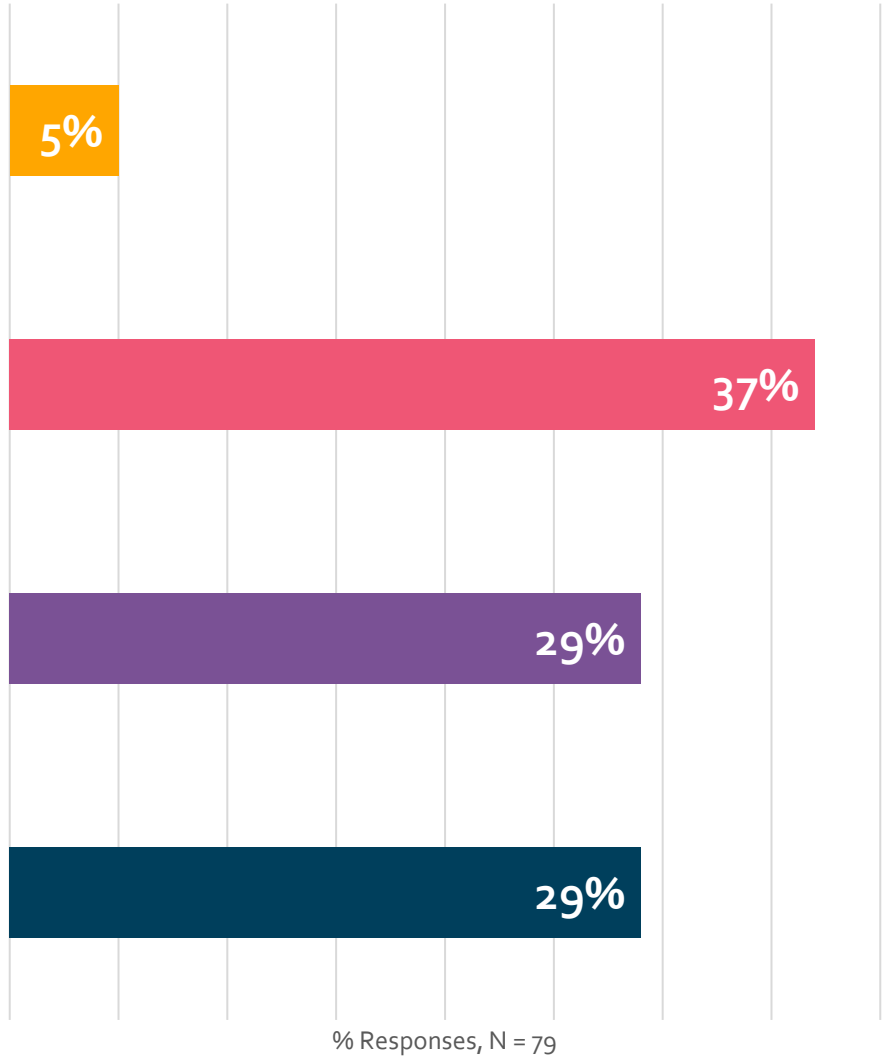
Question 15

Preliminary: Supportive guidance provided by PCP, with limited ability to refer

Intermediate I: Referral to external resources for counseling interventions

Intermediate II: Brief psychotherapy interventions provided by co-located BH provider(s)

Advanced: Broad range of evidence-based psychotherapy provided by co-located BH provider(s) as part of overall care team, with exchange of information



Information Sharing

Domain
3. Information exchange among providers

Subdomain
3.1 Sharing of treatment information

Primary Care

N = 79

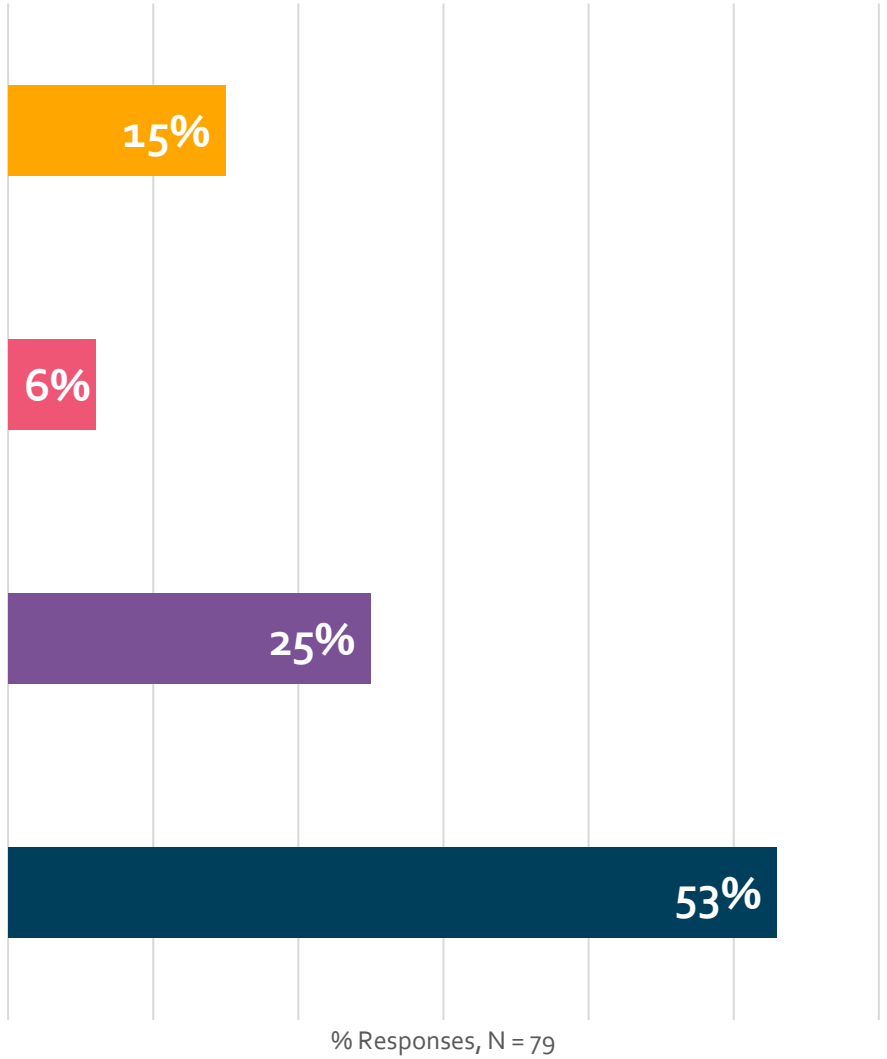
Question 16

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 = 79

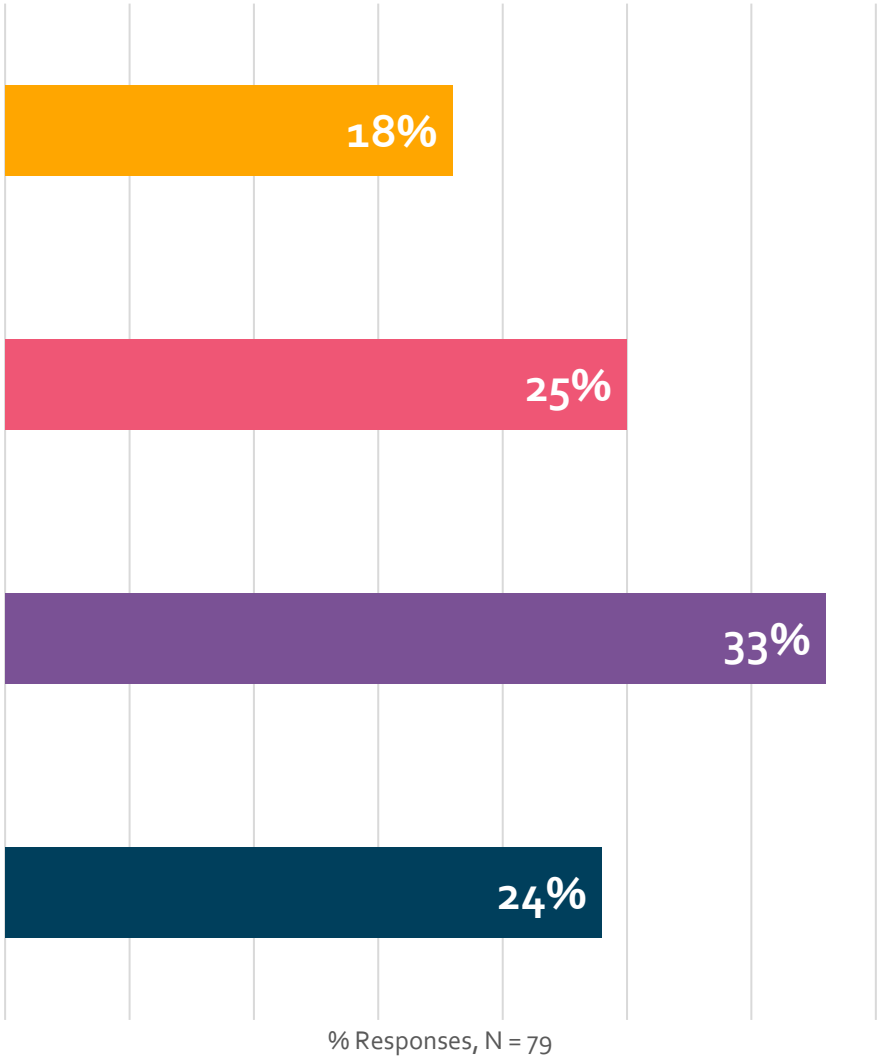
Question 17

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 = 79

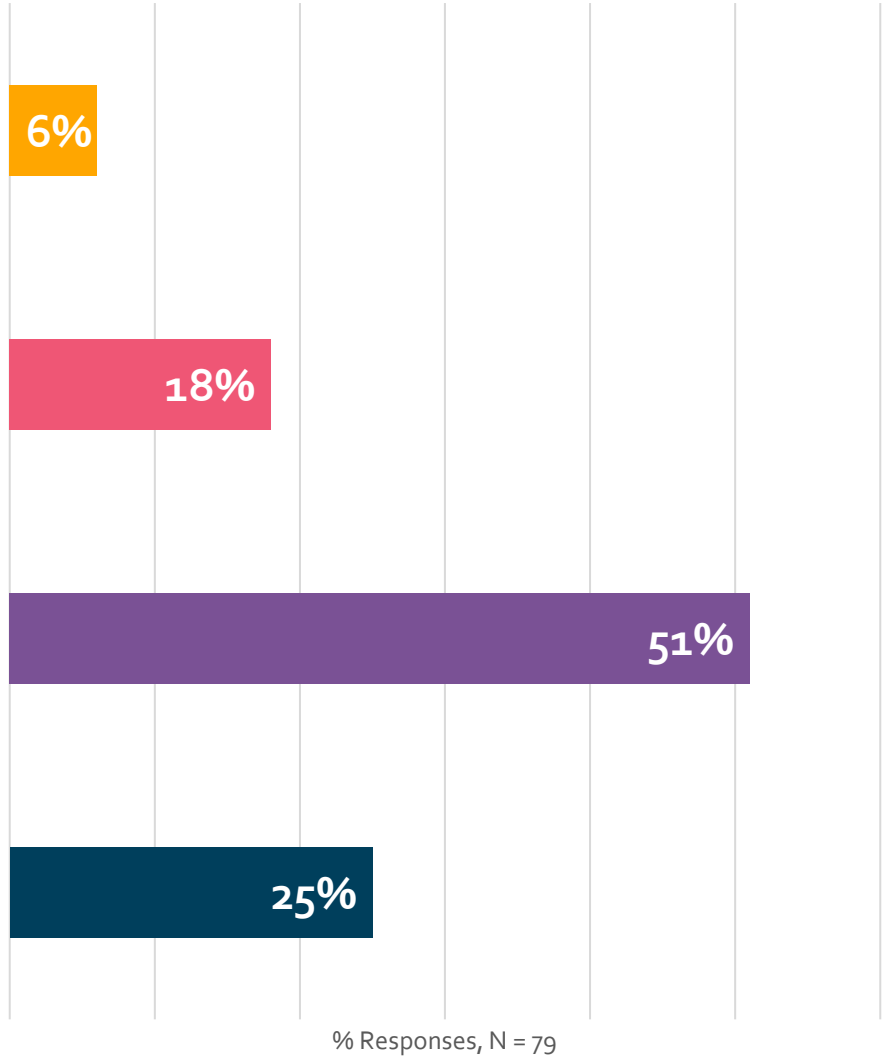
Question 18

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 = 79

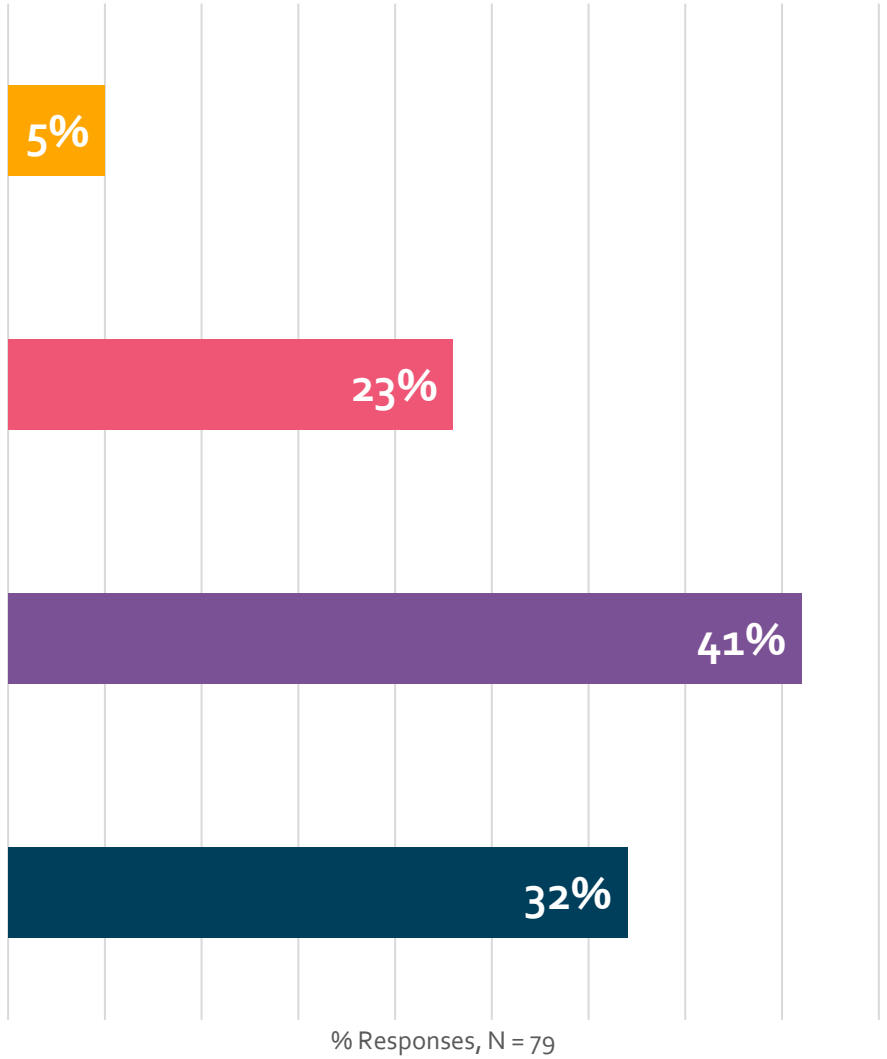
Question 19

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 = 79

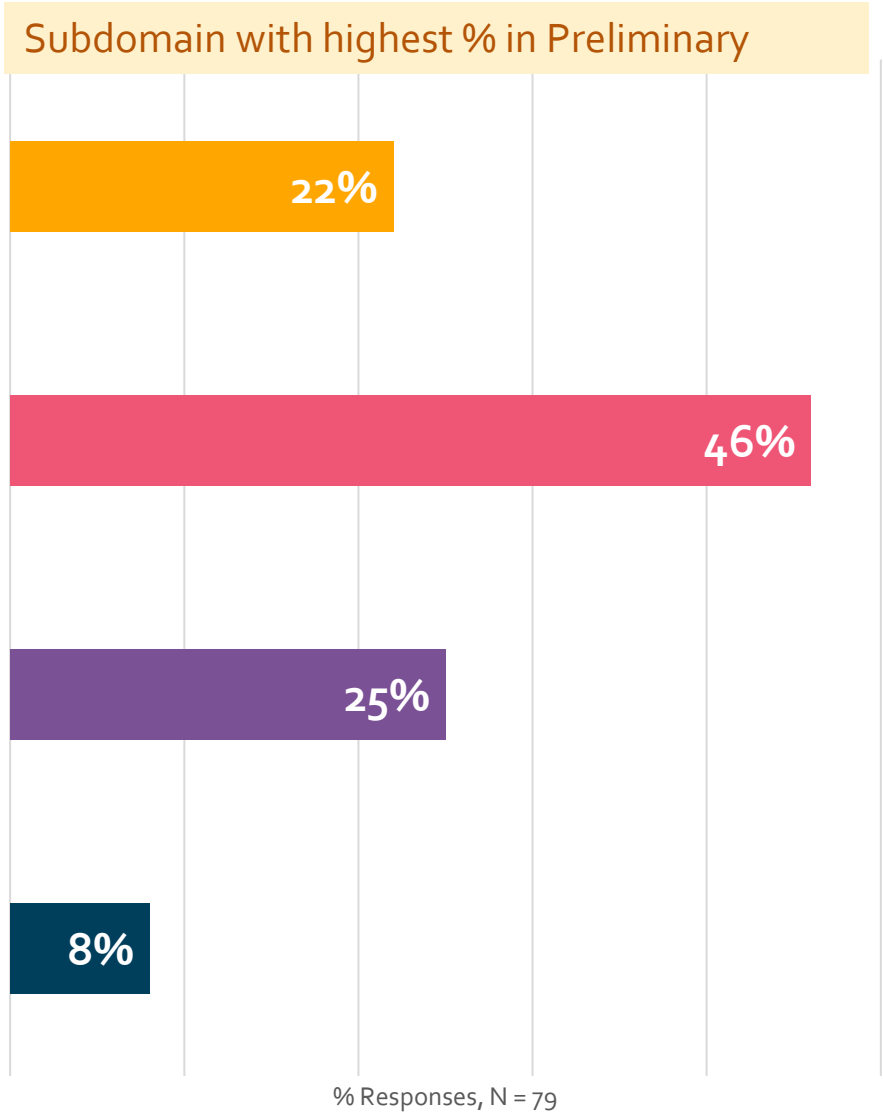
Question 20

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 = 79

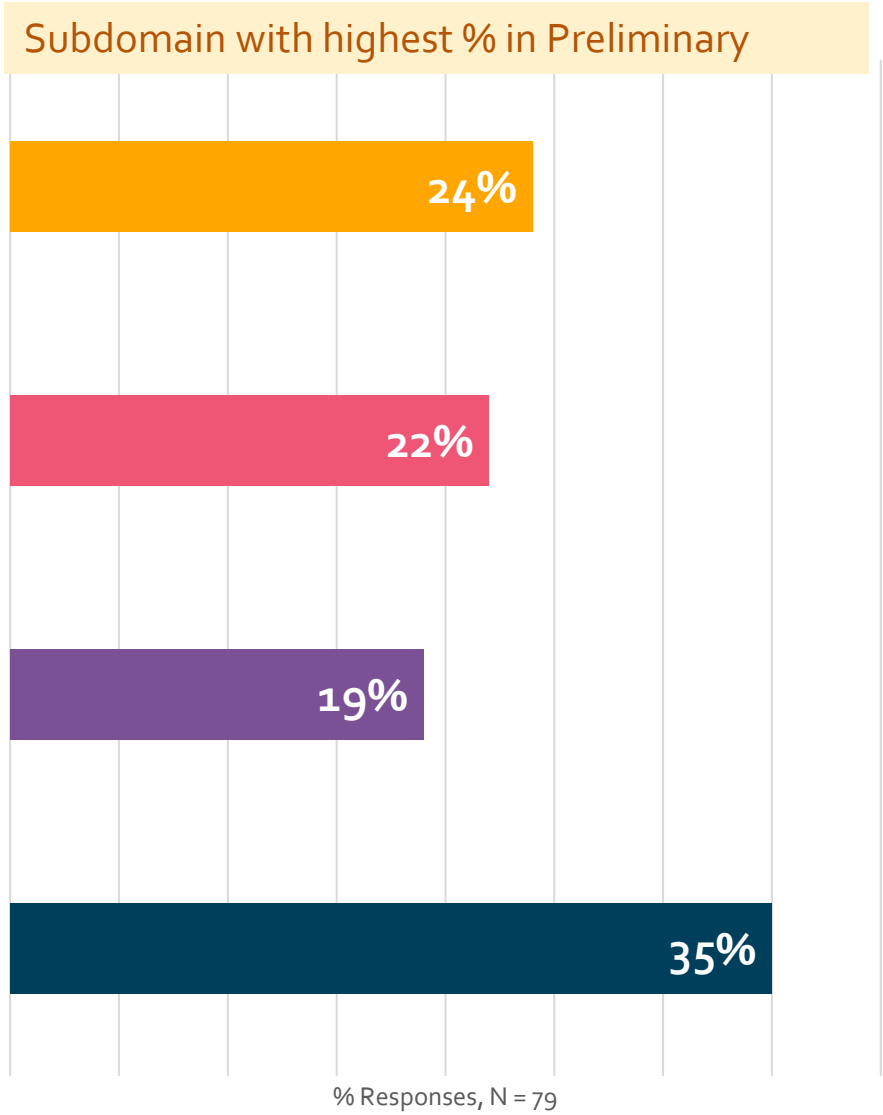
Question 21

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 = 79

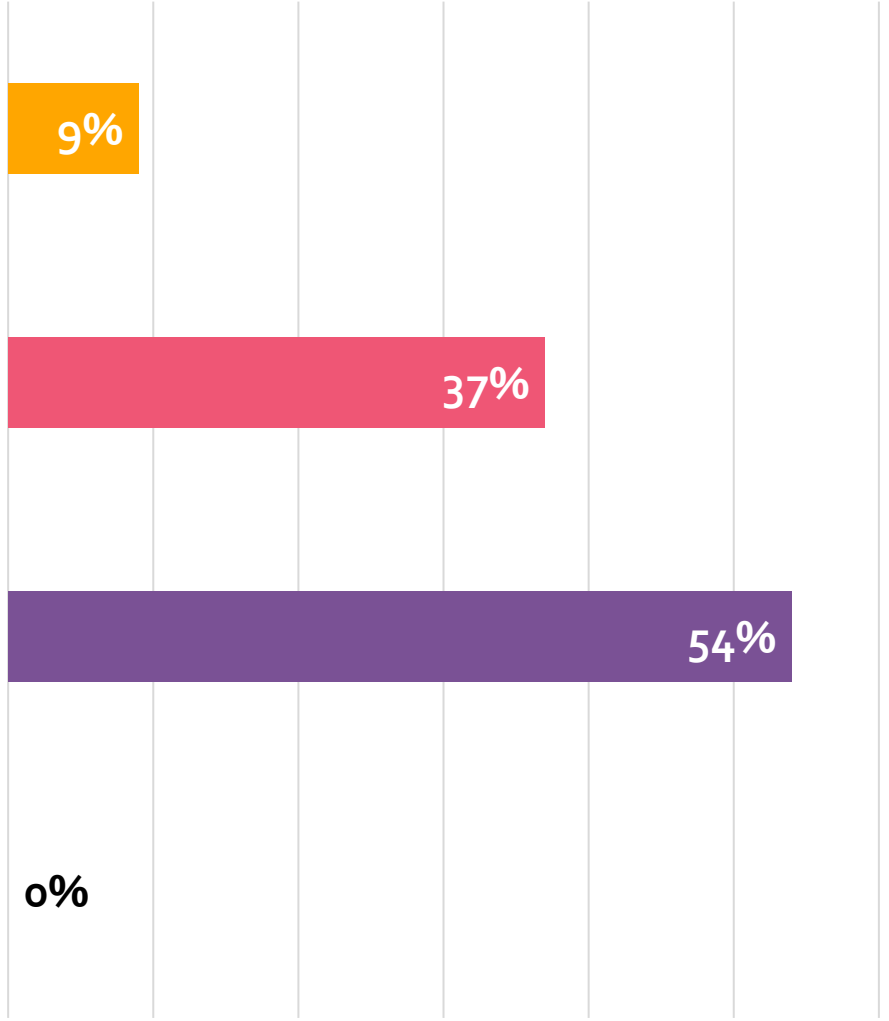
Question 22

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 = 79

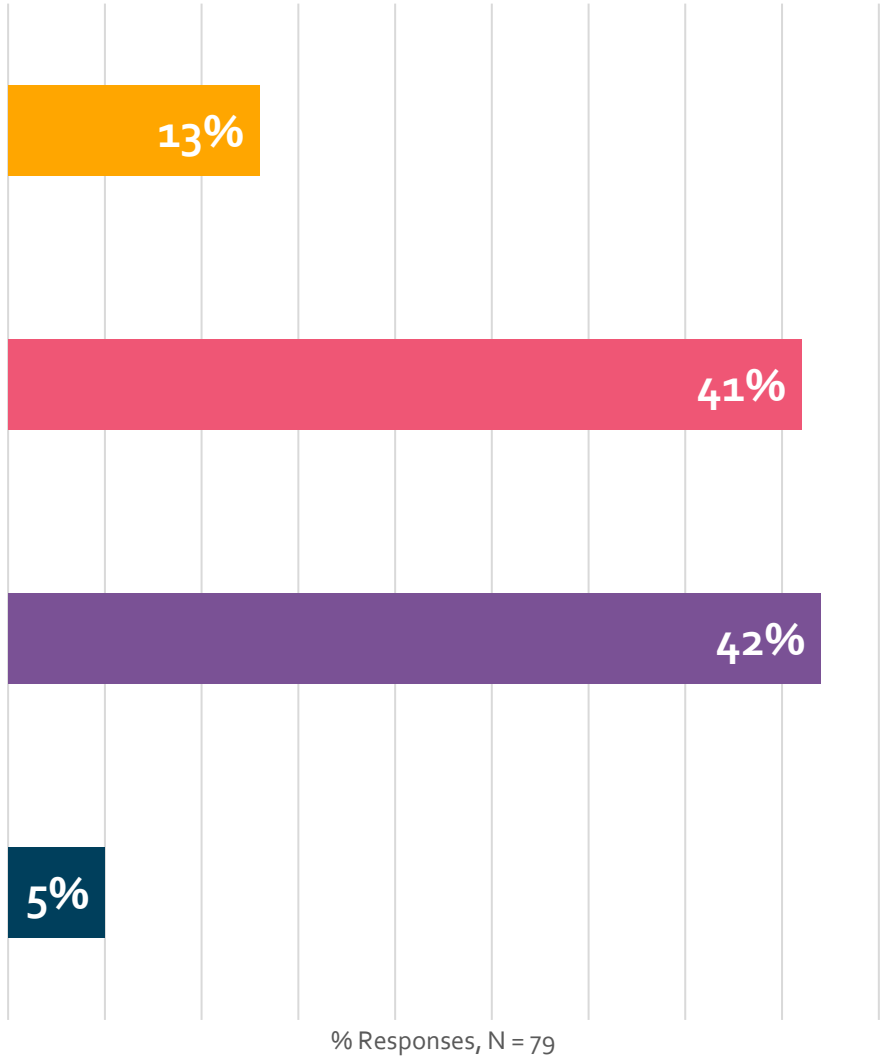
Question 23

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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Vinaka
Kiitos
Maake
Manana
Dankon
Matondo
Kasih
Terima
Taiku
Tack
Diolch i Chi
Chokrane
Grazie
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Matur Nuwun
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