Washington State Integrated Care Assessment for Behavioral Health Settings

Based on the Continuum Based Frameworks for Integration in Behavioral Health and Primary Care Clinics - for Behavioral Health Settings by Dr. Henry Chung, et al, Montefiore Health System, NY. Used and modified with input from primary author (Chung). (https://www.thenationalcouncil.org/wp-content/uploads/2020/08/GHI-Framework-Issue-Brief_FINALFORPUBLICATION_7.24.20.pdf?daf=375ateTbd56)

Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
1. Screening[i], Referral to Care and Follow-up (f/u)	1.1 Screening and f/u for preventive and general health conditions[ii]	Response to patient self-report of general health complaints and/or chronic illness with f/u only when prompted.	Systematic screening for universal general health risk factors[iii] and proactive health education to support motivation to address risk factors.	Systematic, screening and tracking of universal and relevant targeted health risk factors[iv] as well as routine f/u for general health conditions with the availability of in-person or telehealth primary care	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.	
	1.2 Facilitation of referrals and f/u	Referral to external primary care provider(s) (PCP) and no/limited f/u.	Written collaborative agreement with external primary care practice to facilitate referral that includes engagement and communication expectations between behavioral health and PCP.	Referral to onsite, co-located PCP or availability of primary care telehealth appointments with assurance of "warm handoffs" when needed.	Enhanced referral facilitation to onsite or closely integrated offsite PCPs, with electronic data sharing and accountability for engagement.	
	2.1 Evidence-based guidelines or treatment protocols for preventive interventions	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	Routine use of evidence-based guidelines to engage patients on universal general health risk factor screenings with limited training for BH providers on	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	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	

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2. Evidence based care for preventive interventions and common chronic health conditions		frequency and results.	screening frequency and result.	screening frequency and result interpretation.	mitigate general health risk factors (smoking, alcohol, overweight, etc.).	
	2.2 Evidence-based guidelines or treatment protocols for chronic health conditions	Not used or with minimal guidelines or EB evidence-based workflows for improving access to care for chronic health conditions.	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.	BH providers and/or embedded[v] 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.	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.	
	2.3 Use of medications by BH prescribers for preventive and chronic health conditions	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.	BH prescriber routinely prescribes nicotine replacement therapy (NRT) or other psychiatric medications for smoking reduction.	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.	BH prescriber can prescribe NRT as well as prescribe chronic health medications with assistance and consultation of PCP.	
	2.4 Trauma-informed care	BH staff have no or minimal awareness of effects of trauma on integrated health care.	Limited staff education on trauma and impact on BH and general health care.	Routine staff education on trauma-informed care model including strategies for managing risk of re-traumatizing. Limited use of validated	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-	

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			screening measures for trauma when indicated.	escalation procedures. Routine use of validated trauma assessment tools such as adverse childhood experiences (ACES) and PTSD checklist (PCL-C) when indicated.	
3. Ongoing Care Management	3.1 Longitudinal clinical monitoring & engagement for preventive health and/or chronic health conditions.	None or minimal f/u of patients referred to primary and medical specialty care	Some ability to perform f/u of general health appointments, encourage medication adherence and navigation to appointments.	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.	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.	
4. Self-management support that is adapted to culture, socioeconomic and life experiences of patients	4.1 Use of tools to promote patient activation & recovery with adaptations for literacy, economic status, language, cultural norms	None or minimal patient education on general medical conditions and universal general health risk factor screening recommendations.	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.	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.	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.	

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5. Multidisciplinary team (including patients) with dedicated time to provide general health care	5.1 Care Team	BH provider(s), patient, family caregiver[vi] (if appropriate).	BH provider(s), patient, nurse, family caregiver.	BH provider(s), patient, nurse, peer, co-located PCP(s), (M.D., D.O., PA, NP), family caregiver.	BH provider(s), patient, nurse, peer, PCP(s), care manager focused on general health integration, family caregiver.	
	5.2 Sharing of treatment information, case review, care plans and feedback	No or minimal sharing of treatment information and feedback between BH and external PCP.	Exchange of information (phone, fax) and routine consult retrieval from external PCP on changes of general health status, without regular chart documentation.	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.	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.	
	5.3 Integrated care team training	None or minimal training of all staff levels on integrated care approach and incorporation of whole health concepts.	Some training of all staff levels on integrated care approach and incorporation of whole health concepts.	Routine training of all staff levels on integrated care approach and incorporation of whole health concepts with role accountabilities defined.	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.	
6. Systematic quality improvement (QI)	6.1 Use of quality metrics for general health program improvement and/or external reporting	None or minimal use of general health quality metrics (limited use of data, anecdotes, case series).	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.	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	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	

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				ability to regularly review performance against benchmarks.	improvement projects by QI team/champion.	
7. Linkages with community/social services that improve general health and mitigate environmental risk factors	7.1 Linkages to housing, entitlement, other social support services	No or limited/informal screening of social determinants of health (SDOH) and linkages to social service agencies, limited information exchange or follow-up.	Routine SDOH screening and referrals made to social service agencies, with limited information exchange or follow-up.	Routine SDOH screening, with information exchange with social service agencies, with limited capacity for follow-up.	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.	
8. Sustainability	8.1 Build process for billing and outcome reporting to support sustainability of integration efforts	No or minimal attempts to bill for immunizations, screening and treatment. Services supported primarily by grants or other non-reimbursable sources.	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.	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.	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.	
	8.2 Build process for expanding regulatory and/or licensure opportunities	No primary care arrangements that offer physical health services through linkage or partnership.	Informal primary care arrangements that incorporate the basic array (e.g. appointment availability, feedback	Consistent availability of primary care access, internal or external, with telehealth if	Maintain appropriate dual licensure (WAC chapter 246-320 & RCW 70.41 and RCW 71.24 & WAC 246-341) for integrated physical and behavioral	

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		on engagement, report on required blood work) of desired physical health services.	appropriate that incorporate patient centered home services.	health services in a shared services setting and regularly assess the need for administrative or clinical updates as licensure requirements evolve.	

[i] Individuals screened must receive follow up by a trained BH provider or PCP (external or co-located). For the purpose of the framework, primary care provider includes M.D., D.O., PA and NP.
[ii] Common general health conditions include diabetes, hypertension, hyperlipidemia, coronary artery disease, asthma, arthritis, gastrointestinal disease, tooth and gum disease.
[iii] Universal general health risk factor screenings might include: visit with a PCP (defined as self-report of a usual source other than ED care with presence of one or more documented primary care visit during the past
year), depression, alcohol and substance use (including opioid use), blood pressure measurement, HIV, overweight/obesity, tobacco use and age appropriate screenings for cervical and colorectal cancer.
[iv] Targeted general health risk factor screenings might include: intimate partner violence, HbA1c, cholesterol, STI, hepatitis B, hepatitis C, tuberculosis and age appropriate screenings for immunizations, mammogram and
osteoporosis.
[v] Embedded and co-located arrangements include PCPs available through telehealth services.
[vi] Family caregivers are part of team if appropriate to patient care.

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