Washington State Integrated Care Assessment for <u>Primary Care Settings</u>

Based on the <u>Continuum Based Frameworks for Integration in Behavioral Health and Primary Care Clinics - for Primary Care Settings</u> by Dr. Henry Chung, et al, Montefiore Health System, NY. Used and modified with input from primary author (Chung). (https://uhfnyc.org/media/filer_public/61/87/618747cf-9f4b-438d-aaf7-6feff91df145/bhi_finalreport.pdf)

Role	Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
Clinical Workflow	1. Screening, referral to care and follow-up (f/u)	1.1 Screening, initial assessment, follow-up for common Behavioral Health (BH) conditions	Patient/clinician identification of those with BH symptoms—not systematic	Systematic BH screening of targeted patient groups (e.g., those with diabetes, CAD), with follow-up for assessment	Systematic BH screening of all patients, with follow-up for assessment and engagement	Analysis of patient population to stratify patients with high-risk BH conditions for proactive assessment and engagement	
		1.2 Facilitation of referrals, feedback	Referral only, to external BH provider(s)/ psychiatrist	Referral to external BH provider(s)/psychiatrist through a written agreement detailing engagement, with feedback strategies	Enhanced referral to internal/co-located BH clinician(s)/psychiatrist, with assurance of "warm handoffs" when needed	Enhanced referral facilitation with feedback via EHR or alternate data-sharing mechanism, and accountability for engagement	
	2. Evidence-based care for preventive interventions and common behavioral health conditions	2.1 Evidence-based guidelines/treatment protocols	None, with limited training on BH disorders and treatment	PCP training on evidence-based guidelines for common behavioral health diagnoses and treatment	Systematic use of evidence-based guidelines for all patients; tools for regular monitoring of symptoms	Systematic tracking of symptom severity; protocols for intensification of treatment when appropriate	
		2.2 Use of psychiatric medications	PCP-initiated, limited ability to refer or receive guidance	PCP-initiated, with referral when necessary to a prescribing BH prescriber/psychiatrist for medication follow-up	PCP-managed, with support of BH prescriber/ psychiatrist as necessary	PCP-managed, with care management supporting adherence between visits and BH prescriber(s)/ psychiatrist support	

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		2.3 Access to evidence-based psychotherapy with BH provider(s)	Supportive guidance provided by PCP, with limited ability to refer	Referral to external resources for counseling interventions	Brief psychotherapy interventions provided by co-located BH provider(s)	Broad range of evidence-based psychotherapy provided by co-located BH provider(s) as part of overall care team, with exchange of information	
	3. Information exchange among providers	3.1 Sharing of treatment information	Minimal sharing of treatment information within care team	Informal phone or hallway exchange of treatment information, without regular chart documentation	Exchange of treatment information through in-person or telephonic contact, with chart documentation	Routine sharing of information through electronic means (registry, shared EHR, shared care plans)	
	4. Ongoing care management	4.1 Longitudinal clinical monitoring and engagement	Limited follow-up of patients by office staff	Proactive follow-up (no less than monthly) to ensure engagement or early response to care	Use of tracking tool to monitor symptoms over time and proactive follow-up with reminders for outreach	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	
	5. Self-management support that is adapted to culture, socioeconomic and life experiences of patients	5.1 Use of tools to promote patient activation and recovery with adaptations for literacy, language, local community norms	Brief patient education on BH condition provided by PCP	Brief patient education on BH condition, including materials/handouts and symptom score reviews, but limited focus on self-management goal-setting	Patient education and participation in self-management goal setting (e.g., sleep hygiene, medication adherence, exercise)	Systematic education and self-management goal-setting, with relapse prevention and care management support between visits	

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Workforce	6. Multidisciplinary team (including patients) to provide care	6.1 Care Team	PCP, patient	PCP, patient, ancillary staff member	PCP, patient, ancillary staff member, care manager, BH provider(s)	PCP, patient, ancillary staff member, care manager, BH provider(s), psychiatrist (contributing to shared care plans)	
		6.2 Systematic multidisciplinary team-based patient care review processes	Limited written communication and interpersonal interaction between PC-BH provider(s), driven by necessity or urgency, or using patient as conduit	Regular written communication (notes/consult reports) between PCP and BH provider(s), occasional information exchange via ancillary staff, on complex patients	Regular in-person, phone, or e-mail communications between PCP and BH provider(s) to discuss complex cases	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)	
Management Support	7. Systematic Quality Improvement (QI)	7.1 Use of quality metrics for program improvement	Informal or limited use of BH quality metrics (limited use of data, anecdotes, case series)	Use of identified metrics (e.g., depression screening rates, depression response rates) and some ability to regularly review performance	Use of identified metrics, some ability to respond to findings using formal improvement strategies	Ongoing systematic quality improvement (QI) with monitoring of population-level performance metrics, and implementation of improvement projects by QI team/champion	
	8. Linkages with community/social services that improve general health and mitigate environmental risk factors	8.1 Linkages to housing, entitlement, other social support services	Few linkages to social services, no formal arrangements	Referrals made to agencies, some formal arrangements, but little capacity for follow-up	Screening for social determinants of health (SDOH), patients linked to community organizations/resources, with follow-up	Developing, sharing, implementing unified care plan between agencies, with SDOH referrals tracked	
	9. Sustainability	9.1 Build process for billing and	Limited ability to bill for	Billing for screening and treatment	Fee for service billing, and	Receipt of global payments that account	

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		outcome reporting to support sustainability of integration efforts	screening and treatment, or services supported primarily by grants	services (e.g., SBIRT, PHQ screening, BH treatment, care coordination) under fee for service, with process in place for tracking reimbursements	additional revenue from quality incentives related to BH integration.	for achievement of behavioral health and physical health outcomes	

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