

Washington Integrated Care Assessment Implementation Guide for Behavioral Health Agencies



The following organizations support the Washington Integrated Care Assessment (WA-ICA): the Health Care Authority; the five MCOs that provide Apple Health coverage – Amerigroup Washington, Community Health Plan of Washington, Coordinated Care, Molina Health Care, UnitedHealthcare; and the nine Accountable Communities of Health - Better Health Together, Cascade Pacific Action Alliance, Elevate Health, Greater Columbia ACH, HealthierHere, North Central ACH, North Sound ACH, Olympic Community of Health, and Southwest ACH.

Introduction

The presence of comorbid chronic physical and behavioral health conditions makes it difficult for patients to manage mental and physical health and to navigate siloed systems. This is reflected in the higher morbidity and mortality burden seen in this population. For individuals with comorbidities, the relationship between behavioral and chronic physical health management is interdependent. This makes it imperative that primary care and behavioral health providers improve their capability to screen for and coordinate the management of both physical and behavioral health conditions, regardless of setting.

Acknowledging this reality, payer and provider agencies across Washington State have been working to advance integration for the past several years. This effort has revealed the unique challenges that different practices face along the road to integration and the need to standardize the integration assessment process throughout the state. A standardized assessment process minimizes duplication for providers, streamlines data collection, and optimizes provider opportunities for technical assistance related to integration.

In response, an Integration Assessment Workgroup was formed in 2020 with representation from the Washington State Health Care Authority (HCA), all five Managed Care Organizations (MCO) and Accountable Communities of Health (ACH). This workgroup has since identified and adapted an evidence-based framework developed by Henry Chung, MD into the Washington Integrated Care Assessment (WA-ICA).

The WA-ICA Implementation Guide and accompanying FAQ document are intended to assist practices in completing the assessment tool based on a practice's current state of integration. As the WA-ICA is rolled out statewide, more resources and technical assistance tools and/or opportunities are expected to be made available. This transition will support practices in understanding their current level of integration, as well as practice areas with the most potential to advance integration in service of expanding access to whole person care and improving patient outcomes.

For the most up-to-date information related to the WA-ICA please visit the [WA-ICA homepage](#).

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. You will assess your practice 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.

WA-ICA Assessment Domains



Receiving the Assessment

Your practice will receive a digital version of the assessment tool appropriate for your practice, an implementation guide and FAQ document to assist you in completing the assessment tool, and invitations to join or view a recorded introductory webinar. You will also receive a link to FormAssembly, the online platform where you will submit your assessment responses as well as responses to supplemental demographic and qualitative questions intended to support data collection and synthesis. The assessment should be completed on a site-specific basis for practices with multiple sites.

Your ACH or MCO contact will notify your practice when the assessment opens via FormAssembly. Your practice will have approximately six weeks to submit your responses.

Forming Your Assessment Team

The behavioral health assessment team should consist of:

- A clinic or site administrator
- A psychiatric provider (MD, DO, or NP) if available
- An otherwise medically trained professional (RN, MA, PharmD) if available
- A behavioral health therapist/counselor/social worker
- A quality improvement champion
- A primary care provider (PCP) if available
- Other recommended team members: certified peer counselor, practice manager, community health worker, care coordinator, front desk staff, other (as available)

When one or more of these team members do not exist or are unavailable, practices may make their best judgement to involve the most appropriate team members in the assessment process. Whenever possible, staff at all levels of the organization, including those with lived experiences (chronic physical and/or behavioral health conditions) are encouraged to participate in the assessment process to capture a breadth of perspective. Assessment teams should include a range of care team and staff members and be no larger than 7 people.

Meaningful completion of the assessment should take 3 – 4 hours total. Each member of the assessment team should review the assessment tool individually, noting their preliminary thoughts before convening as a team. This will allow space for the different perspectives throughout the team to emerge and inform a holistic picture of your current integration status. Teams should meet in person to discuss each assessment domain and to come to a mutual understanding of where the practice falls along the continuum in each domain. Team meetings are suggested to occur in two 90-minute meetings or three 1-hour meetings. Once consensus has been reached, the FormAssembly responses may be completed and submitted by one designated team member, which should take 20 – 60 minutes depending on your preparation and familiarity with the platform.

Your assessment process may look something like this:

1. Determine who will participate on your assessment team
2. Distribute the assessment tool to each individual team member (digitally or physically)
3. Each team member reviews the assessment tool individually, noting preliminary thoughts
4. Assessment team convenes over 1-3 meetings to discuss where the practice falls in each domain
5. One designated team member submits the responses via FormAssembly

Completing the Assessment Tool

The integration standards for each subdomain progress across categories to indicate improvements in integration. However, the advanced category standards are not intended to represent the ultimate target for every practice. The optimal and achievable state of integration will vary by a practice's clinical and fiscal

capacity. The evidence-base is strongest for the framework’s intermediate I and intermediate II integration standards. All practices, including those with financial and/or staffing limitations, are encouraged to respond based on the current state of their practice and to focus on domains with the most potential for progress and improved patient outcomes.

The appropriate category your practice should select for each subdomain is that for which your practice achieves the standards at least 70% percent of the time. This does not mean that 70% of a population is being impacted in the same way, but that an established workflow related to the subdomain is believed to be followed about 70% of the time. These determinations are intended to be based on the perception of your team, though should be informed by available data, such as the proportion of patients served who receive screening for tobacco use, or the number of referrals made to a particular agency within the last year.

The continuum is structured in such a way that meeting the standards of one category should mean that your practice meets the standards of the previous categories. In the event you feel there is an exception for your practice, choose the category that currently describes your practice and note the previous standards as potential areas of focus.

The following sections of the implementation guide will walk through each subdomain, expanding on and providing examples for the standards laid out in each category.

Domain 1: Screening, referral to care and follow-up

Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
1. Screening, 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.	

Domain 1 describes the standards related to screening, referral to care and follow-up for common preventive and general chronic health conditions. This refers primarily to diabetes, hypertension, hyperlipidemia, coronary artery disease, asthma, arthritis, gastrointestinal disease, and tooth and gum disease. General health risk factor screening appropriate for all patients includes PCP visit, screening for depression, alcohol/substance use (including opioid use), blood pressure, HIV, overweight/obesity, tobacco use, and cervical and colorectal cancer screening as indicated by age/history (Table 1). These screening measures will be referred to as universal risk factor screening. Appropriate screening based on patient characteristics and history includes screening for intimate partner violence, diabetes, cholesterol, sexually transmitted infections, hepatitis B, hepatitis C, tuberculosis, and immunizations, with mammogram and osteoporosis (Table 1). These screening measures will be referred to as targeted risk factor screening. Screening for both universal and targeted general health conditions and risk factors should be done with the use of evidence-based tools or measurements. Ability to screen for universal and targeted general health conditions will vary by a practice’s infrastructure, personnel, resources, and access to services such as primary care and laboratory services.

When a practice is unable to provide screening services internally, they may refer to external providers and resources though are expected to address screening results with the patient and document related measures/treatment in the patient’s chart.

Table 1

Universal General Health Risk Factor Screenings	Targeted General Health Risk Factor Screenings
<ul style="list-style-type: none"> • PCP visit • Depression • Alcohol and substance use (including opioid use) • Blood pressure • HIV • Colorectal screening (as indicated by age/history) • Cervical cancer screening (as indicated by age/history) • Overweight/obesity • Tobacco use 	<ul style="list-style-type: none"> • Intimate partner violence • Diabetes • Cholesterol • Immunizations (as indicated by age) • Sexually transmitted infection (STI) • Hepatitis B • Hepatitis C • Tuberculosis • Mammogram (as indicated by age) • Osteoporosis (as indicated by age)

Subdomain 1.1 describes the standards for screening and follow-up. In the **preliminary** category, practices perform reactive screening and assessment.

For instance, a patient on atypical antipsychotic medication comes into the behavioral health office reporting fatigue, extreme thirst, and frequent urination and the provider refers the patient for fasting blood sugar and HbA1c screening. The patient would not have received blood sugar screening prior to reporting these symptoms.

The **intermediate I** category describes the systematic screening of all patients for universal general health risk factors and support for patients who screen positive to decrease their risks. The measures included in the general health risk factor screenings are largely recommended by the United States Preventive Services Task Force and tend to be prevalent in the behavioral health setting. Your practice is meeting intermediate I category standards when systematically screening for at least three of the general health risk factors in the table above. In addition to universal health risk factor screening, **intermediate II** practices also screen or refer patients to screening for targeted health risk factors as indicated by patient characteristics. These practices track screening in the patient record and provide screening follow-up by a primary care provider either in person or via telehealth. Follow-up can be done by an internal, co-located, or external PCP with whom the behavioral health practice has a formal arrangement.

For example, the intermediate II practice demonstrates targeted health risk factor screening by referring the patient diagnosed with bipolar disorder, BMI of 36, and taking atypical antipsychotics for diabetes screening (before symptoms occur) and LDL cholesterol screening due to concern for metabolic syndrome.

A practice working on implementing, but that has not yet achieved consistency, with systematic screening for targeted health risk factors, though maintains consistent systematic screening for general health risk factors still achieves the intermediate II category standards. The **advanced** category standards describe the practice that utilizes registries to identify patients with complex comorbidity and/or high utilizers of the medical system to encourage internal, co-located, or external primary care engagement before screening identifies patient need.

Subdomain 1.2 describes how referrals are facilitated. The **preliminary** practice refers only to external primary care providers with no formal arrangement in place and no process for receiving feedback related to the referral. The **intermediate I** practice refers to external primary care providers through a formal arrangement

that details how feedback and communication processes related to the referral will occur. This arrangement may describe the feedback process that occurs when a patient does not show up for an appointment, or the results when a consultation is completed, etc. The **intermediate II** practice has access to internal or co-located primary care providers with the ability to perform quick transitions of care through warm handoffs (either in person or via telehealth). The practice that maintains formal arrangements with external primary care providers but does have some access to internal/co-located services still achieves the intermediate II category standards. The **advanced** category describes the practice that has access to internal, co-located, or closely integrated offsite primary care services (and may still utilize external referrals) with capacity to refer, share data, and follow-up on a referral via the electronic health record (EHR).

Domain 2: Evidence-based care for preventive interventions and common chronic health conditions

Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
2. Evidence based care for preventive interventions and common chronic health conditions	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 frequency and results.	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.	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.	Systematic tracking and reminder system (embedded in EHR) used to assess need for preventive screenings, workflows for f/u on availability of EB and outcomes driven programs to reduce or 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.	

Domain 2 describes the standards for the use of evidence-based interventions in the integrated care context.

Subdomain 2.1 refers to evidence-based guidelines for preventive general health interventions. Demonstration of evidence-based guidance to support clinical decision making includes organizational protocols, evidence-based treatment protocols or algorithms embedded into the EHR, and/or formal training opportunities. As an example, consider your organizations approach to tobacco cessation treatment. The **preliminary** behavioral health practice does not systematically utilize evidence-based guidelines or have access to training related to screening and treatment for common preventive general health conditions including screening frequency and interpretation of results. The **intermediate I** practice regularly utilizes evidence-based guidance to screen patients for universal general health risk factors, though may lack training regarding screening frequency and

interpretation of results. The **intermediate II** practice provides regular training regarding evidence-based guidelines for general health screening and uses guidelines to screen patients for general health risk factors *and* targeted health risk factors based on patient characteristics. Intermediate II behavioral health providers have received training on how frequently screening should occur and how to interpret results. The practice has also implemented a protocol for following up on positive screening results. The **advanced** practice not only utilizes evidence-based guidelines to inform screening and interpretation of screening results, but tracks screening needs and results in a systematic manner in the EHR or other data system using patient and population level dashboards. The advanced practice also has access to evidence-based resources and programs to assist patients in reducing any general health risk factors identified.

Subdomain 2.2 conveys the integration standards related to evidence-based treatment protocols for patients with existing chronic health conditions. The **preliminary** behavioral health practice has little to no training or access to evidence-based guidelines for the treatment of chronic health conditions, and thus is unable to assist patients with providing or accessing care to improve their condition. The **intermediate I** practice provides minimal provider training or access to resources related to the ongoing treatment of chronic health conditions and providers participate in minimal ongoing monitoring with occasional use of evidence-based workflows. The **intermediate II** practice provides regular training to behavioral health staff on the basics of chronic health condition monitoring and treatment. The practice has established protocols based in evidence which trained behavioral health providers or primary care providers utilize to monitor patient condition and treatment plan on an ongoing basis.

For instance, the provider in the intermediate II practice has received training on the basics of hypertension and hypertension treatment. The provider is working with a patient taking an atypical antipsychotic; knowing the risk for increased blood pressure, the provider has the patient's blood pressure checked at each visit per the agency's protocol. When the patient's blood pressure is elevated upon one visit, the provider has the patient monitor at home for the following week and report home readings back at the next visit. When 2 out of 4 at home readings are also elevated, the provider records readings in the patient's record and notifies the internal psychiatrist and refers the patient for a PCP visit, following the agency's protocol. The provider also explains the importance of healthy diet and activity for blood pressure management and discusses with the patient their readiness to focus on this approach.

In addition to ongoing monitoring of the patient's condition and treatment plan, the **advanced** practice behavioral health provider has access to clinical decision support tools within the EHR that provide evidence-based guidance for treatment intensification or other changes to the treatment plan.

Subdomain 2.3 identifies the integration standards related to use of medications for general health conditions by behavioral health prescribers. Subdomain 2.3 is intended to describe the way behavioral health providers with prescriptive authority can support patients in the management of their general health. In no way does it encourage behavioral health providers to assume primary responsibility for chronic condition medication management and decision making. Any case in which a behavioral health provider identifies a general health or medication related need they are unable to address, referral to primary care is encouraged. The **preliminary** category standards describe the behavioral health practice in which providers do not address any medication related chronic condition needs, leaving this to the primary care team. The **intermediate I** category standards describe the practice in which behavioral health providers regularly work with patients identified as smokers on smoking cessation by prescribing nicotine replacement therapy (NRT). In addition to NRT, **intermediate II** behavioral health practitioners also provide supportive chronic condition medication management for the patient, always informing the PCP when doing so.

For instance, the psychiatrist has regular appointments with a patient diagnosed with schizoaffective disorder as well as type 2 diabetes. During a regularly scheduled monthly phone visit with the psychiatrist the patient reports that he has been having difficulty getting in to see his primary care provider and is almost out of his metformin. The psychiatrist reviews the patient's last two HbA1c

values and agrees to temporarily refill his metformin prescription while he works on arranging a primary care visit. The psychiatrist notifies the patient's primary care provider about the refill and the patient's intention to schedule a future visit.

The **advanced** behavioral health practice provider builds on the competencies of the intermediate II provider by seeking consultation from the patient's primary care provider for initiating or making minor adjustments to the dosage of a medication for the patient's chronic health condition as indicated.

Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
	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 screening measures for trauma when indicated.	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.	

Subdomain 2.4 describes the principles of applying trauma-informed care practices in the context of integrated care. **Preliminary** practice providers have limited to no understanding of how a patient's trauma experience informs the care of their behavioral and general health care. The **intermediate I** practice has provided some level of training to behavioral health staff on trauma-informed care practices as laid out by the Substance Abuse and Mental Health Services Administration (SAMHSA). The **intermediate II** practice provides regular provider training on trauma-informed care which includes implementation strategies for reducing the risk of re-traumatization though may not include evidence-based screening tools used to identify trauma. The **advanced** practice has embedded trauma-informed principles into the organizations policies, procedures, and protocols which encourage staff to promote patient resilience and minimize the risk of re-traumatization. The advanced practice has trained providers on the use of evidence-based screening tools such as the ACEs questionnaire or PCL-C checklist to assess a patient's history of trauma and does so regularly.

Domain 3: Ongoing care management

Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
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.	

Domain 3 describes the integration standards related to ongoing care management.

Subdomain 3.1 defines care management as the process of longitudinal clinical monitoring and engagement for preventive health and/or chronic health conditions. The **preliminary** practice has minimal to no process for following up with patients who have been referred to or regularly get care from a physical health provider for a general medical condition. Practices meeting the standards in the **intermediate I** category can perform some form of follow-up after general health care. These providers regularly support patients with adhering to their

general health medication regimen and in overcoming barriers related to scheduling and getting to general health appointments. **Intermediate II** practices use some form of electronic tracking process where a designated member of the care team can document indicators of the patient's general health condition management and be alerted as to when patient follow-up is indicated. The intermediate II care team offers health management coaching in some form to assist patients in engaging with their behavioral and physical care teams. In addition to coaching and proactive follow-up, practices in the **advanced** category utilize some form of patient registry or tracking tool to document longitudinal data related to the patient's general health treatment and outcomes on an individual and population level.

Domain 4: Self-management support that is adapted to culture, socioeconomic and life experiences of patients

Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
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.	

Domain 4 describes the standards related to patient-centered self-management support.

Subdomain 4.1 defines patient-centered self-management support as the use of tools to promote patient activation and recovery using adaptations for literacy, language, and cultural norms. In the **preliminary** practice, behavioral health providers give patients little to no education regarding existing general health diagnoses, treatment, or management or the importance of understanding and screening for risk factors. Providers in the **intermediate I** category include culturally adapted materials and resources with patient education on general health and risk factor screening, though provide little to no education or assistance with self-management of general physical health beyond regular primary care visits and medication adherence. In addition to emphasizing general health principles and the importance of risk factor screening, the **intermediate II** practice provider works with the patient on self-management of their physical health as part of the treatment plan, monitoring behavior change and progress using motivational interviewing and goal setting that is patient-centered and adapted to community norms and life experiences.

For instance, the behavioral health provider working with the patient diagnosed with bipolar I who also has hypertension and a BMI of 37 has been discussing the importance of healthy eating and exercise habits for weight and hypertension management. The provider uses motivational interviewing techniques to assess the patient's readiness to work on self-management of blood pressure through healthy eating and activity. The patient explains that they really don't feel they have the energy to be exercising. They state they would like to eat healthier but feel they can't afford fresh produce because it is so expensive. The provider discusses some tips for healthy eating on a budget with the patient, such as purchasing frozen vegetables rather than fresh and how to look for generic brands and unit prices. The provider and patient come up with a goal to try to incorporate one vegetable in at least four meals throughout the following week before the next appointment.

In the **advanced** practice, behavioral health providers and/or care teams educate patients about physical health self-management and incorporate general health goal setting into the treatment plan similarly to intermediate II providers. However, advanced practice providers also provide opportunities for patient activation related to healthy eating and exercise. This may include group fitness classes, cooking classes, and access to peer support between behavioral health provider visits. The advanced practice provider also addresses and documents advanced directives as appropriate.

Domain 5: Multidisciplinary team (including patients) with dedicated time to provide general health care

Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
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.	

Domain 5 describes the integrated care standards as they relate to the multidisciplinary care team.

Subdomain 5.1 defines the composition of the care team. The care team in the **preliminary** practice consists of the behavioral health provider, the patient, and the family caregiver (if applicable). In the **intermediate I** practice the care team may also include a nursing staff member from within the behavioral health team or co-located/integrated primary care team. The **intermediate II** practice care team expands on that of the intermediate I practice by including a peer and co-located primary care provider. Lastly, the **advanced** practice includes an additional care manager dedicated to addressing general health needs.

Subdomain 5.2 describes the standards for systematic communication within the multidisciplinary care team. Among care team members in the **preliminary** practice, no regular, systematic care conferences occur, and any communication among the behavioral health and primary care team is minimal and informal. Behavioral health providers in the **intermediate I** practice may have regular communication exchange with an external primary care provider outside of the EHR, particularly as it relates to changes in the status of the patient's general health or treatment plan. This information exchange is informal and not documented. Behavioral health practices with co-location of or formal arrangements with external primary care providers will meet **intermediate II** standards if care team members regularly meet in person (including a morning huddle) or by phone in addition to written exchanges regarding patient care. Notes are visible electronically and/or exchanged as frequently as indicated between the behavioral and physical health provider. In addition to ad hoc written, phone, or in person communication, the **advanced** practice has established regular case

conferences among the behavioral health and primary care team members to discuss treatment planning for complex cases, supported by processes that encourage close communication, such as a shared care plan.

Subdomain 5.3 illustrates the standards related to training the behavioral health care team regarding the principles of integrated care. The **preliminary** practice provides little to no staff training on integration principles and whole person care. The **intermediate I** practice educates staff across the organization (patient and non-patient facing) about the principles of integrated care, including why and how it is impactful to providing whole person care. The **intermediate II** practice expands on the training provided by the intermediate I practice by defining the role of each care and staff team member in executing the principles of general health integration. In addition to defining roles and responsibilities, the **advanced** practice provides annual training on integration principles and identifies for the team areas of focus for improving integration with supportive resources.

Domain 6: Systematic quality improvement (QI)

Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
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 ability to regularly review performance against benchmarks.	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.	

Domain 6 identifies integrated care quality improvement standards.

Subdomain 6.1 describes quality improvement as the use of metrics to improve a program. The **preliminary** behavioral health practice utilizes informal measurements such as anecdotal stories, patient cases, or limited data to make program changes. The **intermediate I** practice utilizes evidence-based general health screening metrics identified by state or payer entities on an intermittent basis, with some ability to track data at the group level. Screening metrics may include smoking, substance use disorder, weight, blood pressure, HIV, cancer screening etc. The **intermediate II** practice regularly tracks screening rates similarly to the intermediate I practice in addition to metrics related to general health outcomes such as rates of obesity, smoking status, diabetes, hypertension, annual wellness visits, etc. The **advanced** practice applies routine tracking of both behavioral and general health related quality metrics in a systematic manner for entire populations using patient registries.

For instance, monitoring HbA1c, weight, and blood pressure for all patients using atypical antipsychotic medications.

Additionally, the advanced practice has a designated team or team member responsible for analyzing data metrics and conducting quality improvement initiatives using formal quality improvement strategies such as root cause analysis, PDSA cycling, Six Sigma, Lean processes, etc.

Domain 7: Linkages with community/social services that improve general health and mitigate environmental risk factors

Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
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.	

Domain 7 describes the integration standards related to linking patients to resources that can improve health and reduce environmental risk factors.

Subdomain 7.1 illustrates such resource linkages as housing, entitlement, or other social support services. Practices meeting **preliminary** category standards have limited or informal means of screening for social determinants of health (SDOH) rather than using an evidence-based screening tool. These practices have limited capability to refer patients to community or social services or to follow-up on service provision. Practices meeting **intermediate I** standards implement regular evidence-based screening for SDOH using tools such as the PRAPARE or DLA-20. These providers have the ability to refer to some agencies providing resources and services related to the social determinants of health (SDOH) with limited ability to exchange pertinent patient information or follow-up on referral status and service provision. **Intermediate II** practice providers expand on the intermediate I standards with processes to exchange pertinent patient information with community or social service agencies, usually through some type of formal arrangement. However, ability to follow-up after a referral is placed remains limited. Lastly, the **advanced** practice provider systematically performs psychosocial assessment that includes wide ranging SDOH needs and refers patients to community and social services to meet identified needs, with a formal process for information exchange and follow-up on referral status and service provision.

For instance, an advanced practice provider has gathered, using the [PRAPARE](#) questionnaire, that a patient with diagnosed Major Depressive Disorder has had trouble finding transportation to behavioral health counseling appointments on Thursday afternoons. The provider faxes a referral for the patient to a local social service agency that provides non-emergency medical transportation in the county with which the practice has a memorandum of understanding (MOU). Per the protocol defined in the MOU, the nurse care manager at the behavioral health practice calls the social service agency two weeks later to verify that the patient has established transportation services. The agency confirms that the patient has been established and will receive up to 5 round trip rides in the calendar year.

Domain 8: Sustainability

Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
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 on engagement, report on required blood work) of desired physical health services.	Consistent availability of primary care access, internal or external, with telehealth if appropriate that incorporate patient centered home services.	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.	

Domain 8 describes the standards related to sustainably providing integrated general health services in the behavioral health setting.

Subdomain 8.1 identifies the key components of sustainability as billing practices and outcome reporting. The **preliminary** practice has limited to no ability to bill for general health screening and related services such as immunizations, HIV screening, blood pressure, HbA1c, or substance use disorder screening. This practice may support such services through grant funding. The **intermediate I** practice utilizes fee for service billing codes to bill for general health related services, with an established process for tracking reimbursements. The **intermediate II** practice acquires quality incentive funding for general health service integration in addition to fee for service billing.

For instance, an intermediate II practice may be using fee for service billing for reimbursement for systematic blood pressure monitoring and receiving incentive payments for screening for tobacco use.

In addition to fee for service billing and quality incentives, the **advanced** practice receives value-based payment for achieving general and behavioral health outcomes which can then be used to further support integration.

For example, the advanced behavioral health practice may receive payments for high rates of screening for tobacco use and concurrent adoption of nicotine replacement therapy.

Subdomain 8.2 relates standards for incorporating processes intended to expand regulatory and licensure opportunities to continually improve behavioral health agency scope in providing integrated general health services. The **preliminary** practice does not have arrangements with providers of general health services. The **intermediate I** practice has informal arrangements with primary care practices which allow the behavioral health agency basic visibility and access to appointments, patient engagement, laboratory results, etc. The **intermediate II** practice can provide or refer patients to comprehensive primary care through internal or co-located services or through formal arrangements with external providers. Formal arrangements referring to written agreements or MOUs detailing how referral, feedback, and communication processes will occur. An

agency meeting the **advanced** practice category standards has dual licensure allowing the provision of general physical and behavioral health services in the same facility and same organization and keeps up with evolving licensure requirements.

Tips for Pediatric & Substance Use Disorder Providers

The WA-ICA assessment tool was created to be widely applicable across primary care and behavioral health provider types while fully acknowledging that each individual practice operates within a unique context.

Pediatric and substance use disorder (SUD) practices are encouraged to select the tool (primary care or behavioral health) that best aligns with their practice. In making this determination, consider the primary reasons for which people seek care at your site. Considerations include what services your site provides, what type of providers serve as primary prescribers, and the nature of any co-located or integrated services.

Behavioral health pediatric providers are encouraged to consider the framework from the lens of well child visits, immunizations, asthma, obesity, seat belt safety, STI prevention, etc., regarding Domain 2 and evidence-based treatment for common general health risk factors and conditions.

Feedback from pediatric and SUD providers who complete the WA-ICA assessment tool will inform future updates to the tool for improved applicability with these provider types.

What's Next?

The assessment tool, demographic, and qualitative responses you submit via FormAssembly will go directly to HealthierHere. HealthierHere is the designated organization that will be collecting and analyzing all data received from practices across Washington State for Cohorts 1 and 2. Following Cohorts 1 and 2, data collection and analysis may be assumed by a more long-term contractor. HealthierHere will be responsible for generating and distributing the following reports for the following types of organizations throughout the state:

Organization Type	Data Included in Report
HCA	Deidentified regional and state level data
MCO	Deidentified regional and state level data
ACH	Deidentified regional and state level data
Individual Practice	Identified practice level data

As reflected in the table above, you can expect to receive a practice-level report to further your understanding about your current level of integration and to inform future efforts, improvement projects, and resource allocation. Your practice may choose to share your practice-level report with other entities for technical assistance purposes. These reports are anticipated to be available 12-16 weeks after the submission deadline.

Your practice can consider the assessment framework as a roadmap for progression along the integration continuum. Consider starting with 1-2 of the domains where your practice can make the most actionable progress. For additional assistance related to integration you can contact your regional MCO or ACH representative and/or access the [WA-ICA Resources to Advance Integration](#).

The WA-ICA Implementation Guide has an accompanying Frequently Asked Questions Guide (FAQ) which can be found [here](#).

The implementation of the WA-ICA will occur across Washington State through 2024, during which time iterative improvements will be made to the assessment tool and data collection process, and opportunities for technical assistance related to general health integration will be made available.

For questions related to completing the assessment tool please contact tdonahue@healthierhere.org.

Glossary

Behavioral Health Provider – a professional with the ability and authority to diagnose and treat mental/behavioral health conditions. This can include a psychiatric MD, DO, or NP, psychologist, certified physician assistant, licensed clinical social worker, licensed professional counselor. These professionals may also be certified to provide Medication Assisted Therapy (MAT), be certified addiction specialists, and/or specialize in alcohol and drug use.

Co-located services – behavioral and physical health care services provided in the same facility or readily available via telehealth

Common behavioral health conditions – depression, anxiety, alcohol or substance misuse, and ADHD

Evidence-based – treatments, practices, and protocols that are informed by scientific literature that has been substantiated by the highest levels of scientific research, such as systematic review and randomized control trial, and that have undergone substantial evaluation. Usually available as clinical guidelines and/or algorithms approved by a respected regulatory or quality organization.

Follow-up – individuals who receive screening for a physical or behavioral health condition must receive follow-up by a trained behavioral health or primary care provider (MD, DO, PA, or NP) either by in person appointment, phone call, telehealth visit, and/or secure messaging through a client accessible portal

Formal arrangement – a written agreement or MOU with an agency which describes the nature of the relationship, the means through which patient referral shall occur, and any related expectations and processes

General health risk factor screening – visit with a PCP, depression, alcohol/substance use (including opioid use), blood pressure, HIV, overweight/obesity, tobacco use, and cervical and colorectal cancer screening as indicated by age/history

Information exchange – details shared across entities about an individual served by all parties with the purpose of addressing their social needs and quality of life. This can occur by email, phone, EHR, or via web-based Community Information Exchange (CIE) systems.

Patient activation – a measure of a patient's self-efficacy or confidence in managing their diagnosis

Preventive/general health conditions – include diabetes, hypertension, hyperlipidemia, coronary artery disease, asthma, arthritis, gastrointestinal disease, tooth and gum disease

Registry – electronic means of tracking pertinent patient information as it relates to health, condition, and symptom monitoring on an ongoing basis. This occurs at the individual and population level

Shared care plan – a single care plan that contains up-to-date key patient information, including short- and long-term goals, that is shared across multiple provider types

Social Determinants of Health (SDOH) – the factors that impact the spaces and ways in which people live, learn, work, play, and pray, and that have a large impact on wellbeing.

Targeted health risk factors – intimate partner violence, HbA1c, cholesterol, STI, hepatitis B, hepatitis C, tuberculosis, and immunizations, mammogram, and osteoporosis screening as indicated

Warm handoff – the quick transition of a patient's care from one member of care team to another in which the patient is involved