

Washington Integrated Care Assessment Implementation Guide for Primary Care Settings



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 9 domains and 13 subdomains, the assessment framework lays out the key elements of behavioral health integration into the primary care 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

1. Screening, referral to care and follow-up

- 1.1 Screening, initial assessment, follow-up for common behavioral health conditions
- 1.2 Facilitation of referrals, feedback

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

- 2.1 Evidence-based guidelines/treatment protocols
- 2.2 Use of psychiatric medications
- 2.3 Access to evidence-based psychotherapy with BH providers

3. Information exchange among providers

- 3.1 Sharing of treatment information

4. Ongoing care management

- 4.1 longitudinal clinical monitoring and engagement

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

7. Systematic quality improvement

- 7.1 Use of quality metrics for program improvement

6. Multidisciplinary team (including patients) to provide care

- 6.1 Care team
- 6.2 Systematic multidisciplinary team-based patient care review processes

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

9. Sustainability

- 9.1 Build process for billing and outcome reporting to support sustainability of integration efforts



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 primary care assessment team should consist of:

- A senior clinician executive
- A primary care provider champion (clinician who spends at least 50% of their time seeing patients and who is seen as an advocate for behavioral health integration)
- A behavioral health provider, if already part of the team, including a psychiatric provider (MD, DO, NP, PA) psychologist, social worker, counselor, or therapist
- A nursing staff or care management champion (this could be an RN, medical assistant, referral specialist, or other personnel who is primarily responsible for referral/care follow-up)
- A quality improvement champion
- Other recommended team members: peer specialist, practice manager, community health worker, care coordinator, social worker, 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 behavioral health screening, 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

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		

Domain 1 describes the standards related to screening, referral to care and follow-up for common behavioral health conditions. This refers primarily to depression, anxiety, substance use disorder, and ADHD. Appropriate screening tools include the PHQ2 or [PHQ9](#) for depression, the [GAD7](#) for anxiety, the [Vanderbilt](#), Conners, ACDS, or ASRS for ADHD, the [AUDIT C](#) or [NIDA Quick Screen](#) questionnaires for alcohol/drug screening, or other evidence-based screening tools used by your practice.

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 comes in reporting low motivation, little energy, and trouble getting out of bed in the morning and the provider screens for depression using a PHQ questionnaire. The patient

would not have received depression screening had they not reported these symptoms. There is not necessarily a practice workflow for following up on positive screening results.

The **intermediate I and II** categories describe systematic screening for target populations and then all patients respectively. In both intermediate categories the practice has a workflow for following up on positive screening results. The practice that identifies and screens all patients with diabetes using the PHQ, knowing that this population has a higher prevalence of depression, falls into the intermediate I category. The practice that screens *all* patients using the PHQ falls into the intermediate II category. A practice working on implementing systematic screening for anxiety or substance misuse, while maintaining consistent systematic screening for depression would achieve the intermediate II category standards. The **advanced** practice takes screening further by using a registry to identify patients with existing behavioral health diagnoses (depression, anxiety, substance use disorder) or patients taking antidepressants or anti-anxiety medications without a clear behavioral health diagnosis. The advanced practice proactively assesses symptom severity using evidence-based screening tools, with a workflow to engage patients in reducing symptom severity as indicated.

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

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

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

Subdomain 2.1 refers to evidence-based treatment protocols for common behavioral health conditions. The **preliminary** primary care practice does not utilize evidence-based guidelines or have access to training related to the diagnosis and treatment of common behavioral health disorders. The **intermediate I** practice has trained or trains providers on a regular basis regarding evidence-based treatment for behavioral health conditions. This training is CME approved. The **intermediate II** practice not only trains providers on evidence-based guidelines but has implemented processes and protocols for their use in a systematic way with all patients for symptom monitoring.

For example, a practice annually screens all patients for depression using the PHQ questionnaire. When a patient initially screens positive, the primary care provider (PCP) initiates a treatment plan tailored to the patient’s symptoms that includes symptom monitoring at more frequent intervals.

The **advanced** practice not only utilizes evidence-based guidelines to monitor symptoms but tracks screening results in a systematic manner in the EHR or other data system. The advanced practice also utilizes systematic symptom monitoring and evidence-based guidelines to inform changes to the patient’s treatment plan and prevent relapse.

Subdomain 2.2 conveys the integration standards related to the prescription of psychiatric medications in the primary care setting. Within the **preliminary** practice, providers are comfortable starting patients on basic antidepressant or anti-anxiety medications. However, these practices have limited access to guidance related to medication intensification/ongoing management and limited ability to refer to behavioral health providers for follow-up. In an **intermediate I** practice providers are comfortable starting patients on basic psychiatric medications with access to behavioral health providers for ongoing medication management. **Intermediate II** practice providers are comfortable initiating *and* managing basic psychiatric medications (including treatment escalation and augmentation as indicated) for depression and anxiety using evidence-based guidelines, with support as needed from behavioral health prescribers. The provider in the **advanced** practice manages the patient’s basic psychiatric medications with specialist support as needed and has care management support between PCP visits for medication monitoring and adherence.

Subdomain 2.3 relates the standards for access to psychotherapy. **Preliminary** practice providers do not have the ability to refer patients to psychotherapy externally or internally; providers may utilize supportive measures such as motivational interviewing, goal setting, etc. Providers in the **intermediate I** practice can refer patients to external behavioral health providers for psychotherapy interventions. Practices meeting **intermediate II** standards can refer patients to co-located behavioral health providers for short term intervention, while they may still refer to some external providers as capacity dictates. **Advanced** practices can refer patients to co-located behavioral health providers who are part of the practice’s care team for a wide range of psychotherapy services. These providers have established processes for communication between the primary care and behavioral health provider regarding the patient’s condition and treatment.

Domain 3: Information exchange among providers

Role	Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
Clinical Workflow	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)	

Domain 3 describes the standards for communication throughout the care team as it relates to behavioral health integration. The care team may include the primary care provider, the patient, ancillary staff, care manager, and behavioral health provider/psychiatrist. Members of the care team may be internal or external to the organization.

Subdomain 3.1 illustrates that in a **preliminary** practice, providers rarely if ever share information related to behavioral health treatment across the care team either in person, by phone, or electronic means. Practices that meet the **intermediate I** standards communicate treatment information informally without documenting information exchange in the patient’s chart. Practices that meet the **intermediate II** standards formally share treatment information followed by documentation in the patient’s chart. These practices are thus able to utilize billing codes for interprofessional consultation or e-consults. **Advanced** practices share treatment information across team members at regular intervals throughout the patient’s treatment with documentation in the patient’s chart or shared care plan as well as population-level documentation in the EHR or shared registries.

Domain 4: Ongoing care management

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

Domain 4 describes the standards of care management as it relates to behavioral health integration.

Subdomain 4.1 defines care management as the process of longitudinal clinical monitoring and patient engagement. The **preliminary** practice has minimal to no standard process for following up with patients who have behavioral health related symptoms and/or diagnoses. Practices meeting the standards in the **intermediate I** category have a specific process for identifying a patient with a positive behavioral health screen and follow-up by a designated member of the care team with the patient at least once per month (in person, electronically, by phone) while symptoms persist. **Intermediate II** practices use some form of registry or electronic tracking process where a designated member of the care team can document longitudinal screening results and is prompted to follow-up with patients at regular intervals. Practices in the **advanced** category document care management measures in the EHR and integrate pertinent behavioral health measures (screening scores, interventions, visits, etc.) with related physical health measures such as blood pressure or HbA1c to monitor the interdependent relationship of the patient’s management of their chronic physical and behavioral health conditions.

Domain 5: Self-management support that is adapted to culture, socioeconomic and life experiences of patients

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

Domain 5 describes the standards related to patient-centered self-management support.

Subdomain 5.1 defines patient-centered self-management support as the use of tools to promote patient activation and recovery using adaptations for literacy, language, and local community norms. In the **preliminary** practice, providers who diagnose, initiate, or intensify treatment for common behavioral health conditions educate the patient briefly on their diagnosis, prognosis, and expected course of treatment. Providers in the **intermediate I** category include materials and resources with patient education which are culturally adapted. These providers also review screening questionnaires such as the PHQ or GAD, with the patient to explain how the diagnosis is informed and how symptoms will be monitored by the care team on an ongoing basis. Intermediate I providers provide little to no education or assistance with self-management of the behavioral health condition beyond medication adherence. In addition to materials and resources, the **intermediate II** practice provider works with the patient on self-management of their behavioral health condition through motivational interviewing and goal setting that is patient-centered and adapted to community norms and life experiences.

For instance, for the patient newly diagnosed with depression and scoring a 15 on the PHQ9, the provider reviews the PHQ responses with the patient, educates the patient about clinical depression and discusses a treatment plan with the patient that includes starting fluoxetine 20 mg daily and ongoing symptom monitoring. The provider explains they would like to see the patient back in a month and spends some time discussing an exercise goal, which the patient expressed had helped in the past. Because the patient cannot afford a gym membership and lives in a neighborhood lacking green space and safe sidewalks, the provider and patient set a goal for completion of a 15 minute online aerobic workout three times per week until the next appointment.

In the **advanced** practice, providers and/or care teams support patients with self-management similarly to intermediate II providers, while also providing care management support between provider visits. This may include phone or virtual visits with a registered nurse or care manager between provider visits to discuss medication adherence, medication side effects, symptom monitoring, goal setting, and motivational interviewing. In the advanced practice, the care team also works with the patient to prevent relapse once stability is achieved, focusing on building the patient’s skills related to independent self-management and/or creating an action plan related to relapse symptom identification.

Domain 6: Multidisciplinary team (including patients) to provide care

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

Domain 6 describes the integrated care standards as they relate to the multidisciplinary care team.

Subdomain 6.1 defines the composition of the care team. The care team in the **preliminary** practice consists of the primary care provider and the patient. In the **intermediate I** practice, the care team may also include an ancillary staff member from within the clinical team or the behavioral health team, such as a registered nurse,

licensed practical nurse, medical assistant, nutritionist or registered dietician, social worker, clinical pharmacist, peer support specialist, or community health worker. The **intermediate II** practice care team expands on that of the intermediate I practice by including a care manager and internal or external behavioral health provider. Lastly, the **advanced** practice includes an additional internal or external psychiatric provider.

Subdomain 6.2 describes the standards for systematic patient review within the multidisciplinary care team. Among care team members in the **preliminary** practice, no regular, systematic care conferences occur, and any communication among team members is precipitated by an urgent patient event or need such as patient suicide attempt, severe medication side effects, medication change, or important life changes such as moving or job loss. In these events, the patient is often the one to relay information across care team members. Providers in the **intermediate I** practice may have regular written communication exchange with an external behavioral health provider for complex patients. This communication may be initiated by ancillary staff members to the behavioral health provider or behavioral health team. Primary care practices with co-located or internal behavioral health providers will meet **intermediate II** standards if care team members regularly meet in person or by phone in addition to written exchanges regarding care for complex patients. This may include information exchanged via a morning huddle. In addition to ad hoc written, phone, or in person communication, the **advanced** practice has established regular weekly case conferences among the primary care and behavioral health team members to discuss treatment planning for complex cases.

Domain 7: Systematic quality improvement (QI)

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

Domain 7 identifies integrated care quality improvement standards.

Subdomain 7.1 describes quality improvement as the use of metrics to improve a program. The **preliminary** practice utilizes informal measurements such as anecdotal stories, patient cases, or limited data to make program changes. The **intermediate I** practice tracks evidence-based data metrics on a regular basis and uses them to evaluate provider and practice performance at least on a semi-annual basis. Metrics may include rates related to behavioral health screening and re-screening (PHQ, GAD, AUDIT C, NIDA), medication refill status, care plans, referral to behavioral health, patient satisfaction, etc. The **intermediate II** practice tracks evidence-based metrics similarly to the intermediate I practice and uses the data to inform program changes using quality improvement strategies such as root cause analysis, PDSA cycling, Six Sigma, Lean processes, etc. The **advanced** practice applies these previous standards in a systematic manner, monitoring evidence-based metrics for entire populations, using metrics quarterly or monthly to evaluate provider and practice performance, and performing regular quality improvement projects throughout the year.

For instance, monitoring depression screening rates for the entire population of patients with a coronary artery disease diagnosis.

Additionally, the advanced practice has a designated team or team member responsible for analyzing data metrics and initiating quality improvement projects site or organization wide.

Domain 8: Linkages with community/social services that improve general health and mitigate environmental risk factors

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

Domain 8 describes the integration standards related to linking patients to resources that can improve health and reduce environmental risk factors.

Subdomain 8.1 illustrates such resource linkages as housing, entitlement, or other social support services. Practices meeting **preliminary** standards have limited to no capability to refer patients to community or social services and do not have any formal arrangements with community-based organizations. Practices meeting **intermediate I** standards can refer to some agencies providing resources and services related to the social determinants of health (SDOH) using formal arrangements some or most of the time. Formal arrangements refer to a written agreement with an agency which describes the nature of the relationship, the means through which patient referral shall occur, and any related expectations and processes. Intermediate I practice providers have limited to no ability to follow-up on referrals made to these agencies. **Intermediate II** practice providers systematically screen patients for SDOH needs, utilizing screening tools such as the PRAPARE, DLA-20, or AHC HRSN questionnaires. These practices utilize screening results to inform referrals made to community or social services and have formal arrangements that include processes for following up on referrals made.

For instance, an intermediate II practice provider uses the [PRAPARE](#) questionnaire with a patient who has Major Depressive Disorder. Using the questionnaire, the provider identifies that the patient 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 and with which the practice has a memorandum of understanding (MOU). Per the protocol defined in the MOU, the nurse care manager at the primary care 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.

Lastly, in addition to screening, referral, and follow-up, the **advanced** practice has established processes with community and social service agencies detailing the establishment and communication of a shared care plan across agencies to track patient needs, strengths, goals, and treatment.

Domain 9: Sustainability

Role	Key Domains of Integrated Care		Preliminary	Intermediate I.	Intermediate II.	Advanced	Self-Assessed Level
Management Support	9. Sustainability	9.1 Build process for billing and outcome reporting to support sustainability of integration efforts	Limited ability to bill for screening and treatment, or services supported primarily by grants	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	Fee for service billing, and additional revenue from quality incentives related to BH integration.	Receipt of global payments that account for achievement of behavioral health and physical health outcomes	

Domain 9 describes the standards related to sustainably providing integrated behavioral health services in the primary care setting.

Subdomain 9.1 identifies the key components of sustainability as billing practices and outcome reporting. The **preliminary** practice has limited to no ability to bill for behavioral health related services such as screening or treatment. This practice may support such services through grant funding. The **intermediate I** practice utilizes fee for service billing codes or behavioral health integration codes (e.g., Psychiatric Collaborative Care) to bill for behavioral health related services, with an established process for tracking reimbursements. The **intermediate II** practice receives quality incentive funding for behavioral health service integration in addition to fee for service billing.

For instance, an intermediate II practice may be using fee for service billing for PHQ reimbursement and receiving incentive payments for opioid use disorder screenings.

In addition to fee for service billing and quality incentives, the **advanced** practice receives global payments for achieving behavioral health outcomes.

For example, the advanced practice may receive per member per month payments which include accountability for behavioral health outcomes including PHQ follow-up for all patients with a depression diagnosis.

Tips for Pediatric & Substance Use Disorder (SUD) 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 practices are encouraged to select the tool (primary care or behavioral health) that best aligns with their practice. In making this determination, a practice should consider the primary reasons for which people seek care at their 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.

Primary care pediatric providers are encouraged to consider the framework from the lens of attention deficit hyperactivity disorder (ADHD) and adolescent depression and anxiety regarding Domain 2 and evidence-based treatment for common behavioral health 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 your practice submits 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 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, a process through which iterative changes will be made to improve the assessment tool and data collection process. Throughout this time additional materials and opportunities for technical assistance related to behavioral health integration will be made available.

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

Glossary of Terms

Ancillary staff member – in the clinic setting this refers to a registered nurse, licensed practical nurse, medical assistant, nutritionist or registered dietician, social worker, clinical pharmacist, peer support specialist, or community health worker

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, or 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 collaborative 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

High-risk behavioral health conditions – bipolar disorder, schizophrenia spectrum and other psychotic disorders, trauma and stressor-related disorders, dissociative disorders, feeding and eating disorders, conduct disorders, personality disorders, and others that usually require behavioral health provider attention

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

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

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

Glossary of Assessment Tools

ACDS – The Adult ADHD Clinical Diagnostic Scale is a screening tool used to assess for ADHD symptoms in adults

AHC HRSN – The Accountable Health Communities Health-Related Social Needs screening tool is used to assess patient needs related to SDOH

ASRS – The Adult Self-Report Scale is a screening tool used to assess for ADHD symptoms in adults

AUDIT – C – The Alcohol Use Disorders Identification Test-Concise is a screening tool used to assess for alcohol use disorders

Conners – A behavior rating scale used to assess ADHD symptoms in children and adolescents

DLA-20 – The Daily Living Activities – 20 is used to assess what components of everyday life may be impacted by mental illness or disability

GAD-7 – Generalized Anxiety Disorder – 7 is an evidence-based self-report screening tool used to assess patients for generalized anxiety disorder

NIDA Quick Screen – the National Institutes of Drug Abuse Quick Screen tool is used to assess drug/substance use in adults

PHQ-2 – Patient Health Questionnaire – 2 is an abbreviated depression screening tool which includes the first 2 questions of the PHQ-9. Patients who screen positive on the PHQ-2 should be assessed further with the PHQ-9

PHQ-9 – Patient Health Questionnaire – 9 is an evidence-based self-report screening tool used to assess patients for depression

PRAPARE – Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences is used to assess SDOH

Vanderbilt – A set of assessment scales used to screen for ADHD symptoms in children