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A Framework for Implementation of a Statewide Clinical Integration Assessment Tool

Phase I Summary Report

Prepared by HealthierHere on behalf of the Clinical Integration Assessment Workgroup

June 30, 2021

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This summary report is dedicated to

<u>Christopher James Green, MSPT, CHPQ (1963 – 2021)</u>

Chris was a Practice Transformation Manager at HealthierHere and provided valuable leadership and oversight to the Integration Assessment Pilot Project described in this report. As with all things, Chris approached the work with enthusiasm and unwavering commitment to provide the highest quality products. He was a natural leader of people – making our Pilot Partners feel comfortable and supported. And, he had a knack for creating tools that assisted our partners in doing their work as seamless as possible.

Chris was an accomplished professional, bringing significant experience and expertise to HealthierHere, our clinical partners and system transformation work in King County. His commitment to equity and working to end health disparities was evident in all that he did. Additionally, he was an incredible human and brought joy, passion, humor, enthusiasm, kindness, and friendship to many. We lost him too soon and we will forever be grateful to him and the impact he made to advance whole person integrated care and improve health outcomes for the people of King County and across Washington State.

Chris was truly dedicated to serving others and whole-heartedly believed in and embodied the words of one of his favorite quotes below:

> *I shall pass through this world but once. Any good therefore that I can do or any kindness that I can show to any human being, let me do it now. Let me not defer or neglect it for I shall not pass this way again.*

- Stephen Grellet (from *Collecting Courage*, in a chapter by Nicole Salmon)

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A Framework for Implementation of a Statewide Clinical Integration Assessment Tool (CIAT)

Executive Summary

As part of the transition to Integrated Managed Care and the Medicaid Transformation Project supported by the 1115 Medicaid Waiver, clinical practices across Washington State were completing integration assessments for multiple stakeholders, often with different tools, and at inconsistent and potentially redundant frequencies. The result was that there was not a clear way to compare progress and develop a statewide picture of how providers were doing and if their efforts resulted in improved outcomes. To address these issues and concerns, staff from the Health Care Authority (HCA), all five Managed Care Organizations (MCOs) and representatives from three of the Accountable Communities of Health (ACHs) convened a Clinical Integration Assessment Work Group (CIAWG) in mid-2020 to streamline efforts and to:

- identify a common Clinical Integration Assessment Tool (CIAT) to use statewide to assess provider level of integration,
- define a standardized process/logistics around the assessment of integration to streamline data collection and reduce duplication, including roles and responsibilities of various partners (HCA, ACHs, MCOs),
- determine how the data and information that results from the assessment will be utilized, and
- recommend a sustainable mechanism for ongoing assessment and continuous quality improvement.

The workgroup identified seven unique tools and/or frameworks in use in Washington State to assess provider level of integration: the *UnitedHealthcare Assessment Tool* © developed by United Healthcare, *Molina – Physical and Behavioral Health Provider Integrated Care Self-Assessment Tool* developed by Molina Health Care, the *Maine Health Access Foundation (MeHAF)* assessment tool, the *Behavioral Health Integration Report and Recommendations* developed by Bree Collaborative, the *Standard Framework for Levels of Integrated Care* developed by the Substance Abuse Mental Health Services Administration (SAMHSA), *Collaborative Care Implementation Guide* developed by the UW AIMS Center Collaborative Care framework, and *Traditions of Health: The Culturally Relevant Integration Model* developed by the California Consortium for Urban Indian Health. Finally, a complementary set of tools, not in use in Washington State, was also identified*: Continuum Based Framework for Behavioral Health Integration into Primary Care* and *Continuum Based Framework for General Health Integration into Behavioral Health* developed by Dr. Henry Chung and colleagues.

Following a thorough review and upon the recommendation of the CIAWG to adopt the companion tools - *Continuum Based Framework for Behavioral Health Integration into Primary Care* and *Continuum Based Framework for General Health Integration into Behavioral Health* – the workgroup implemented a small field test in early 2021 with six pilot partners representing diverse perspectives and organizational types. Pilot partners included: Consejo Counseling and Referral Service (linguistically and culturally tailored) site in Shelton, WA; Ideal Option (MOUD/MAT) site in Mount Vernon, WA; SeaMar Community Health Centers (FQHC) site in Vancouver, WA; Skagit Pediatrics (primary care specialty) in Mount Vernon, WA; Quality Behavioral Health (rural BHA) in Clarkston, WA; and Valley Medical Primary Care Clinic in Covington, WA. Pilot partners assessed the tool's clarity, applicability and provided insights into resources needed to ensure a successful statewide implementation.

Concurrently, members of the CIAWG developed recommendations for a framework to address the standardization of data collection and its use. The methodologies and instruments used for both the pilot and framework discussions are further detailed in the full report.

Recommendations from the pilot partners focused on the following:

- Feedback specific to the CIAT, such as updating to reflect Washington Administrative Code, simplifying complex concepts with multiple elements, and tailoring to specific populations (i.e. pediatrics).
- Additionally, the partners recommended the development of an "implementation guide" that could address the following: common terms, frequently asked questions, provide examples and case studies, and assist practices with advancing integration through continuous quality improvement methods.

Recommendations for moving forward with framework for statewide adoption of the CIAT, include:

1. **HCA support adoption of the modified CIAT** based on recommendations from the pilot partners.
2. HCA, in collaboration with MCOs and ACHs, **identify and implement opportunities to communicate to providers** about the CIAT and expectation that the CIAT will be implemented statewide
3. **Form a Provider Advisory Group** to ensure robust provider input from across the state, including rural providers and across provider types.
4. **Identify opportunities to implement and socialize the CIAT in HCA, MCO, and provider programs**. For example: consider the integration of the CIAT in;
   - MCO contract requirements
   - emerging Alternative Payment Models (APMs) and other initiatives
   - MCO and provider conferences
5. **Consider a phased approach to the implementation and adoption** of the new integration assessment by practice and provider types over 12 – 18 months in a manner

that considers the unique situation/needs of providers and provider types across the state, meeting providers where they are at

6. **Connect implementation of the CIAT to other HCA initiatives** such as the new multipayer primary care initiative and value-based payment models.
7. **Identify and/or develop resources to support training, technical assistance and implementation of the tool**.
8. **Identify and/or develop resources to support Quality improvement** (QI) coaching and technical assistance to assist practices in advancing whole person integrated care.
9. **Focus on 2 – 3 provider-driven and state defined priority domains of integrated care**.
10. HCA should **encourage Tribal partners to consider applicability of a standardized CIAT** and engage in CIAT planning activities as quickly as possible and develop mechanisms to ensure alignment with the Clinical Integration Assessment Workgroup planning.
11. **Keep informed of and aligned with national (SAMHSA, NBHC and CCBHC) activities** to implement the CIAT and link the CIAT with quality metrics.

Further work will be needed to detail a comprehensive "implementation roadmap" to guide the statewide adoption of a new CIAT and its application in Washington State. Specifically, the CIAWG should advance and accelerate communication opportunities with providers and professional associations representing them. Develop a phased implementation plan and timeline that takes into consideration the unique needs/timing of different provider types (short term, mid-term, long term perspective/strategy). Identify which cohort of providers could begin implementation of the CIAT first, and develop a plan for how other providers and provider types should be phased in (including what is happening with other provider types if they are not in the first implementation cohorts).

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Introduction

Since 2014, Washington State has been transitioning to fully integrated managed care for physical and behavioral health care (including mental health and substance use treatment) within the Medicaid program. By January 1, 2020, the state completed the financial integration for most Medicaid members (certain subgroups remain in fee for service for some or all of their care) across all regions of the state. Through integrated managed care contracting, the state Health Care Authority (HCA) requires Medicaid managed care organizations (MCOs) to support primary care and behavioral health providers to advance integrated care at the clinical level, including requiring MCOs to provide quarterly assessments of progress toward integrated care for their provider networks.

In January 2017, Washington State was awarded an 1115 Medicaid Waiver and one of the core strategies of the waiver was to support providers in the transition to integrated managed care and to develop and advance models of bidirectional clinical integration (Project 2A) to improve client outcomes. Under the 1115 Medicaid Waiver, the HCA contracts with 9 Accountable Communities of Health (ACHs) across the state to work with clinical providers (both primary care and behavioral health) in their respective regions to support clinical integration. ACHs do this in a variety of ways, including conducting a semi-annual assessment of level of integration and supporting training, technical assistance and practice coaching as well as using waiver funds to support infrastructure and capacity building at the provider level.

According to HCA data, there are approximately 5348 unique provider sites (outpatient primary care and behavioral health agencies) reported by MCOs in Q4 2020. By the second half of 2020, 981 (or 18%) of those sites, were actively participating with ACHs in Project 2A: Bi-directional Integration of Physical and Behavioral Health. Of the sites participating in Project 2A, 68% submitted integration assessment data in December 2020. This accounts for approximately 13% of the total unique provider sites in the state. The MCOs are also collecting integration assessment data from their networks. At the time of this report, MCO reporting data was not available. However, these data will continue to be processed to determine the total number of sites to be assessed statewide as well as the current number participating in assessment and integration efforts as part of state initiatives.

Despite some overlap in provider networks/partners, the roles and responsibilities of the MCOs and ACHs in supporting clinical integration have not been clearly defined, including how and when providers are assessed for level of integration. Consequently, there has been significant overlap and duplication with some provider practices being asked to complete multiple integration assessments using different tools and some practices with sites in multiple regions or in networks with multiple plans have had more than one guideline to follow. The result was inconsistent data on the progress that practices were making toward the shared goal of behavioral and physical health integration, as well as unintended and unnecessary administrative burdens on providers that were already under significant constraints due to

workforce shortages and limited capacity to respond to the increasing demands of healthcare reform and change management. Additionally, with everyone using different tools and processes, there was not a clear way to compare results and develop a statewide picture of how providers are doing and if the efforts were improving care and outcomes. Finally, the reach to all outpatient primary care and behavioral health provider sites remains relatively small. To get a complete picture of statewide progress toward integration, an increase in provider sites assessed will be needed.

To address these issues and concerns, a Clinical Integration Assessment Workgroup was formed in summer 2020 that included representatives from HCA, all 5 Medicaid MCOs, and 3 representatives of the ACHs. The purpose of the workgroup was to:

- identify a common tool to use statewide to assess provider level of integration,
- define a standardized process/logistics around the assessment of integration to streamline data collection and reduce duplication, including roles and responsibilities of various partners (HCA, ACHs, MCOs),
- determine how the data and information that results from the assessment will be utilized, and
- recommend a sustainable mechanism for ongoing assessment and continuous quality improvement.

Selecting a Shared Clinical Integration Assessment Tool (CIAT)

The initial work of the workgroup was to inventory clinical integration tools that were currently being used in Washington State as well as any other evidence-based tools that were available in the public domain. The workgroup identified seven unique tools and/or frameworks in use in Washington State to assess provider level of integration: the *UnitedHealthcare Assessment Tool*[1] © developed by United Healthcare, *Molina – Physical and Behavioral Health Provider Integrated Care Self-Assessment Tool*[2] developed by Molina Health Care, the *Maine Health Access Foundation*[3] *(MeHAF)* assessment tool, the *Behavioral Health Integration Report and Recommendations*[4] developed by Bree Collaborative, the *Standard Framework for Levels of*

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[1] *D. Brown, personal* email communication, June 28, 2021

[2] *V. Evans, personal email communication,* June 28, 2021

[3] https://waportal.org/resources/mehaf-facilitation-guide

[4] https://www.qualityhealth.org/bree/wp-content/uploads/sites/8/2020/01/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf

Integrated Care[5] developed by the Substance Abuse Mental Health Services Administration (SAMHSA), *Collaborative Care Implementation Guide*[6] developed by the UW AIMS Center Collaborative Care framework, and *Traditions of Health: The Culturally Relevant Integration Model*[7] developed by the California Consortium for Urban Indian Health. Finally, a complementary set of tools, not in use in Washington State, was also identified: *Continuum Based Framework for Behavioral Health Integration into Primary Care*[8] and *Continuum Based Framework for General Health Integration into Behavioral Health*[9] developed by Dr. Henry Chung and colleagues.

The workgroup established the following criteria to assess the nine identified tools/frameworks and select a common tool to use statewide to assess provider level of integration:

1. Helps create common language and vision for integration across provider types.
2. Assures whole person screening occurs in every setting, regardless of where a person enters the system. Screening includes MH, SUD, physical health, and SDOH – as standard "vital signs" using a patient centered approach.
3. Works in both primary care and behavioral healthcare settings (both MH and SUD) to assess for bidirectional integration.
4. Is relevant for all ages and their unique needs.
5. Assesses for team-based care as a cornerstone of integrated care.
6. Can be used to guide continuous quality improvement (i.e., helps providers advance their level of integration).
7. Minimizes burden to providers and supports them in the best way possible.

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[5] https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56

[6] https://aims.uw.edu/collaborative-care/implementation-guide

[7] https://ccuih.org/wp-content/uploads/2019/12/Integration-Model_May_2016-2.pdf

[8] **Chung H**, Rostanski N, Glassberg H, Pincus HA: Advancing Integration of Behavioral Health into Primary Care: A Continuum Based Framework. United Hospital Fund. 2016; https://uhfnyc.org/publications/publication/advancing-integration-of-behavioral-health-into-primary-care-a-continuum-based-framework/

[9] **Chung, H**, Smali, E, Narasimhan, V, Richkin, T, Goldman, ML, Ingoglia, C, Woodlock, D, and Pincus, HA: Advancing integration of general health in behavioral health settings. New York Community Trust 2020. https://www.thenationalcouncil.org/wp-content/uploads/2020/08/GHI-Framework-Issue-Brief_FINALFORPUBLICATION_8.21.20.pdf?daf=375ateTbd56

8. Allows for ease of analysis/summarization and understanding of where a provider is with regard to integration and where they want to go relative to advancing integration.
9. Centers equity and is culturally relevant/responsive.
10. Based on most current best practices for integration.
11. Aligns with other HCA and other practice transformation initiatives that are happening across the state.

A sub-committee of work group members was organized to do a cross walk between the tools and apply the 11 criteria in service of making a recommendation to the larger work group.

In addition to meeting the criteria developed by the larger work group, sub-group members determined that advancing whole person integrated care in WA State would necessitate a tool that:

- was based on current research/testing in primary care and behavioral health settings (most tools were developed for primary care settings only).
- would advance integration into the next five years and onward.
- was stream-lined around well-established integration elements yet does not complicate with more than is needed.
- would work for the novice, as well as sophisticated enough to support those with expertise who still want to 'stretch'.
- most clearly addresses equity, cultural differences and SDOH.
- provides the clearest direction to teams of next integration steps to drive state-wide integration and serve as a practice quality improvement tool (i.e., has a continuum-based structure).
- provides data that could be retrieved at the practice level for continuous quality improvement as well as aggregated to provide information on progress toward integration by provider type, by region and statewide.

With all this in mind, the sub-group recommended that the state, including the HCA, MCOs and ACHs adopt the companion tools developed by Dr. Henry Chung and colleagues: *Continuum Based Framework for Behavioral Health Integration into Primary Care* and *Continuum Based Framework for General Health Integration into Behavioral Health*. (For the purposes of this report, these two companion documents are referred to as the clinical integration tool (CIAT) throughout the remainder of this report). These CIATs allow for bi-directional assessment of integration by including separate yet complementary tools for physical and behavioral health providers. The CIATs were independently reviewed and evaluated with providers, and they built on previous knowledge while updating the CIAT to meet current day priorities such as trauma informed care, sustainability, and acknowledgement that the goal/destination could/should be

data informed by the practice's patient/client population profile. The CIATs are available in the public domain and there are no fees associated with use of the CIATs.

The other tools were eliminated by the work group for a variety of reasons that include:

- Potential proprietary issues
- Potential for change in Medicaid MCOs over time
- Did not offer a continuum-based framework that allowed for measuring progress and continuous improvement (i.e., Likert scaling)
- Did not address equity and cultural differences
- Did not address best practices at all or as clearly as other tools
- Sent inaccurate or unclear message about the expectations for integration (i.e., framework-based tools that imply expectations of co-location or a particular model)
- Was not comprehensive in coverage of all important elements of integration
- Did not specifically address SDOH

Following the selection of the tool by the Integration Assessment Workgroup, HCA contracted with HealthierHere (from February 24 – June 30, 2021) to conduct a pilot of the selected integration tool, gather lessons learned and utilize those lessons learned to inform the development of a framework for scaling and sustaining a standardized clinical integration assessment process across Washington State. The scope of work for this project included two parts:

➢ Conduct a pilot of the selected tool with a broad range of provider types, gather lessons learned and use those lessons learned to inform the development of an implementation framework; and

➢ Begin development of a framework for statewide implementation of a standardized CIAT, making recommendations to the HCA regarding roles and responsibilities of various stakeholders in the distribution, data collection, and data analysis support for the tool as well as training and technical assistance support to providers to advance integration. Given the limitations of the funding cycle, all work needed to be done by June 30th and the workgroup knew that they would not be able to develop a full framework in such a short time but would get started and get as much done as possible and outline next steps to complete an Implementation Roadmap.

The remainder of this reports details the process and lessons learned from each part of the scope of work and provides recommendations and next steps to the HCA for how to continue to advance planning for statewide implementation in 2022.

PILOT PROJECT

The purpose of the pilot project was to conduct a pilot of the selected CIAT with a broad range of provider types, gather lessons learned and use those lessons learned to inform the development of a framework.

Integration Assessment Pilot Partners

The workgroup members were keenly aware of the need for a diverse group of providers that could represent multiple perspectives, including pediatric primary care, hospital based primary care, Federally Qualified Health Centers (FQHCs) – primary care, Medication for Opiate Use Disorder (MOUD)/Medication Assisted Treatment (MAT) providers, behavioral health providers with and without substance use disorder (SUD) treatment services, as well as practices representing different geographical parts of Washington State in urban, rural, and culturally/linguistically specific organization types. To this end, the workgroup convened a convenience sample of six practices that were willing and able to participate in a pilot to assess the two continuum-based CIATs and provide feedback on their potential use across the state, including ideas to mitigate challenges and improve opportunities for successful deployment. The following six practices were selected:

Consejo Counseling and Referral Service

This smaller provider of mental health and SUD services offers a wide variety of programs for adults, youth, and families, serving mostly the Latinx and Spanish-speaking population in King, Pierce, Mason, and Thurston counties. For this pilot, Consejo engaged with their clinic located in Shelton, WA to help provide a rural and culturally tailored service provider perspective. This clinic is integrated through a co-location arrangement with Peninsula Community Health Services.

Ideal Option

This large organization, located in 10 states, has locations across the state of Washington in rural, suburban, and urban settings. They specialize in medication-assisted treatment for addiction to opioids, alcohol, and other substance use disorders (SUD). Ideal Option focused the study on their clinic in Mount Vernon, WA.

Sea Mar Community Health Centers

This large FQHC has locations in 13 counties in Washington, and has a particular focus serving the Latinx and Spanish-speaking populations. For purposes of this study, they focused on their Vancouver, WA location, to provide another suburban perspective. They are experienced with behavioral health integration at their primary care clinics, as well as through their behavioral health locations. They will be representing the FQHC primary care perspective.

Skagit Pediatrics

This mid-size provider of pediatric primary care services in Mount Vernon, WA, has been recommended by several members of the Integration Assessment Workgroup, due to their activity and experience with behavioral health integration. They have engaged with North Sound ACH and received some consultation from the UW AIMS Center. Additionally, they are a participating provider in HealthierHere's Testing Models for Integrated Care partnership between Seattle Children's Care Network and Seattle Children's. They bring a pediatric primary care perspective to the project.

Quality Behavioral Health

This smaller provider of behavioral health and SUD services to adults and youth is based in Clarkston, WA, and serves Asotin and Garfield Counties in Eastern Washington. They were recommended to HealthierHere for this study by the Greater Columbia ACH based on their experience with helping to provide integrated care. They bring a smaller, rural BHA perspective.

Valley Medical Center

Valley Medical Center (VMC) is the largest nonprofit healthcare provider between Seattle and Tacoma, serving over 600,000 residents. In addition to the hospital, the Medical Center operates a network of more than two dozen primary care, urgent care and specialty clinics. VMC's primary care clinic in Covington, WA was the focus of this integration assessment study bringing the hospital – based primary care perspective.

Data Collection

Survey Process and Structure

All six pilot partners participated in two 90-minute webinars hosted by HealthierHere and supported by Dr. Henry Chung. At least one person from each pilot partner was required to participate in the training, although in most cases several team members participated. The first webinar introduced the integration assessment continuum-based companion tools and how to complete them. Practices were then instructed to go back to their practices, review the integration assessment tool with the team that would be completing it and return in two weeks for a joint discussion designed to address questions and concerns. During the second webinar, practices were given the opportunity to ask clarifying questions about the tool and were trained on the survey and data collection method. For purposes of this pilot, HealthierHere used Form Assembly to collect data from pilot partners.

Team members recommended to be involved in the integration assessment included: a senior clinical executive, clinician champion, nursing and/or care management champion, quality improvement champion, and others (i.e., peer support specialist, practice manager). In practice, the team composition and process for input varied by practice. For example, one behavioral

health agency convened an integration assessment team of 10 staff representing all programs within the organization over multiple two-hour meetings, while one physical health provider gathered team input individually through informal check-ins then convened the team once to ground truth the summary. A third partner developed an internal survey that team members completed on their own and submitted to a project lead. This process ensured that all team members had completed the review and "pre-work". The initial findings were then summarized and used to facilitate conversations about where there was agreement and to clarify issues and domains where there were significant variations in perspective.

Pilot partners were offered additional training and technical assistance throughout the course of completion of the tool as needed. They were instructed to complete the assessment as a team, then have one team member upload the agreed upon answers and summarize the discussion in the Form Assembly data collection portal. Pilot partners were given approximately six weeks to complete the assessment survey.

The data collection tools (see Appendix 1 and 2) included the providers response/rating on each of the domains included in the tool. In addition, pilot partners were asked clarifying questions following each domain and sub-domain within the continuum-based framework to help identify any barriers they encountered understanding or interpreting the domain and if so, to provide clarification and/or ideas on how to improve the question's relevancy. At the end of the survey, additional questions were asked using a Likert scale (1 – 5) related to the ease of use, understanding of the domain components and what the participants thought about its practical application in continuous quality improvement planning. Open ended questions addressed the following: what other changes or additions would improve clarity, what support might the practice need to adopt the continuum-based tool, what additional training was recommended, and what the practice thought about the strengths and/or gaps in the content of the assessment and domains.

Debrief Questions

Following the submission of the pilot partners integration assessment and survey, all six practices were convened to collectively debrief the experience. Based on feedback from the pilot partners during a mid-point process check-in, the practices were convened separately with physical health providers meeting for a 90-minute session and behavioral health providers meeting for a separate 90-minutes session.

The debrief was designed to ground truth what was learned through the survey responses and to inform a possible statewide implementation. Questions included the following:

- Do these themes capture what you meant to communicate?
- Are there any that you would like to expand on?

- Have you thought of anything that you wished you had shared AFTER you submitted your data?
- How much time did it take your practice's care team to complete this assessment tool?
- What are the benefits of completing this assessment tool compared to other tools (i.e., MeHAF) that you have used to assess behavioral health integration?
- What are the burdens with completing this assessment tool and how do these compare to other tools that you have used?
- How could these burdens be mitigated?
- How could this assessment framework help inform integration at the provider, MCO and state level as compared to other integration assessment tools that you have used (i.e., MeHAF)?
- What concerns, if any, do you have about the use of this assessment framework to provide information about the level of integration and how could these concerns be mitigated?

Pilot Partner Feedback and Debrief

General Themes

Most partners, including behavioral and physical health, had a positive experience with the framework and reported no fatal flaws. Partners already familiar with MeHAF either liked the continuum-based CIATs better or shared that their experience was similar. Although not specific to the continuum-based assessment, there were several comments regarding workforce shortages, which influences how providers experience the process of managing change and moving toward whole person integrated care. Additionally, changing roles within the existing workforce remains challenging. For example, both physical and behavioral health providers cited hesitation and reluctance for psychiatrists to consider prescribing general medications for diabetes or high blood pressure, and conversely for primary care providers to take on medication management for most psychiatric medications. There was an acknowledgement that this type of cultural shift in practice will take time and resources for training.

Feedback specific to the CIATs

Pilot partners also recommended specific changes to questions on the tools themselves to facilitate provider completion. Please refer to Appendix 3 and 4 for copies of each of the tools used. Specific Recommendations include:

➢ Add an open-ended comments section to all domains. Specifically, add the question, "What needs to happen to improve on this domain?" to document organizational and system-level barriers/challenges. There are times when the reason is internal to the

practice and other times that it may be a system – level barrier. Documenting the system – level barriers could inform policy review and refinement.

- ➢ Adopt an existing or develop an Implementation Guide and FAQ document, tailored to specific provider types, to assist practice teams in the use of the CIAT and facilitate the dialogue and assessment process. This guide should include definitions of terms, provide examples and/or case studies to illustrate the domains as well as to describe in more detail the differences between preliminary, intermediate 1 and 2, and advanced practices. In should also answer the top 10 most frequently asked questions by providers.
- ➢ Clarify if the assessment applies to internal integrated programs only or if it includes integration with external programs/specialty providers.
- ➢ Simplify complex domains with multiple components embedded in one. For example, one domain speaks to "screening, initial assessment, and follow up for BH conditions," which could become three independent sub-domains as practices can be in different stages of integration for each.
- ➢ Work with pediatric providers and subject matter experts to refine questions using language and processes specific to serving children, youth and families.
- ➢ Update domains to specifically reference WA state regulations (i.e. WACs and RCWs) that govern staffing, licensure, and billing, if applicable.

Create an Implementation Guide and FAQ to accompany the CIATs

Pilot partners strongly recommended that an "implementation guide" be developed, tailored to specific provider types, to assist practice teams in the use of the integration assessment framework and facilitate the dialogue and assessment process. This guide should include definitions of terms, provide examples and/or case studies to illustrate the domains as well as to describe in more detail the differences between preliminary, intermediate 1 and 2, and advanced practices. Pilot partners also suggested including a "frequently asked questions" section in the implementation guide to include the top 10 questions practices had while completing the integration assessment.

Some of the specific requests for information to be included in an implementation guide included:

- Define what is included in "general health". For example, is this term inclusive of all preventive health screens (i.e., mammography, osteoporosis, diabetes, high blood pressure, immunizations). Include examples that may vary by the age range of the focus population (i.e., children, adolescents, adults, patients >50 years old).
- Provide examples of Evidence Based Guidelines for general health conditions and define the scope for which the behavioral health practice needs to consider.

- Clarify who is included in the denominator. For example, many behavioral health agencies provide an array of services to address the social determinants of health (SDOH). Clients served in these SODH focused programs may not be the same as those served in the behavioral health (mental health and SUD) programs. Additionally, pediatric physical health providers have specific screenings recommended based on the patient's age, thus clarity around the population of focus is relevant to assessing the practice's integration.
- Define what is meant by "follow-up" either in a glossary of terms, through case study examples, or both. Some practices might consider a phone call with a detailed message as meeting the standard, while others may define it only as a scheduled and kept appointment.
- Clarify what is meant by a "tool" to promote patient activation. For example, is there a standard "tool" that should be adopted or is a tool developed by the practice sufficient?
- To the extent possible, define the focus population. Pilot partners acknowledged that the level of achievement varied whether it was for the "general patient population" versus the patients enrolled in the "behavioral health integration program," as well as age-appropriate screenings, especially for pediatric providers.
- Define what is meant by the "care team" by providing a definition, a case study example or both. Physical and behavioral health providers have different conceptions of who is on the care team and some standardization might be needed.

Feedback and recommendations from the six Pilot Partners were synthesized and brought to the Clinical Integration Assessment Workgroup to inform the development of a framework for statewide implementation as described below.

DEVELOPING A FRAMEWORK FOR STATEWIDE IMPLEMENTATION

Simultaneous to the pilot of the CIAT, the Clinical Integration Assessment Workgroup was tasked with developing a framework for statewide implementation of a standardized CIAT that included making recommendations to the HCA regarding roles and responsibilities of various stakeholders in the distribution, data collection, and data analysis support for the tool as well as training and technical assistance support to providers to advance integration. Given the limitations of the funding cycle, all work needed to be done by June 30th and the workgroup knew that they would not be able to develop a full framework in such a short time but would get started and get as much done as possible and outline next steps to complete an Implementation Roadmap.

Process for Framework Development

The framework development occurred through the Clinical Integration Assessment Workgroup. Since the inception of the workgroup in summer 2020, the workgroup had been developing a series of questions that would require answers/agreements in order to implement a statewide CIAT. In March 2021, HealthierHere contracted with Artemis Consulting to assist in the facilitation of workgroup meetings and to help achieve agreement on processes, roles, and responsibilities of various stakeholders to allow for recommendations to the state HCA on statewide implementation.

Knowing that it would be faced with a number of recommendations to make, the Workgroup decided on principles for decision-making. The Workgroup agreed their decisions should:

- Advance integration
- Keep solutions as simple as possible
- Build on strengths
- Foster transparency
- Reflect provider voice in decision-making
- Center provider/patient needs and benefits (each entity has organizational interests that should be respected, but we need to have a broader view)

The Workgroup also articulated that, once a decision is made, it will not revisit decisions without a compelling reason.

Inputs into the Process for Framework Development

There have been numerous inputs into the Workgroup's efforts to develop an initial framework for statewide implementation. Themes from the various inputs informed the prioritization of topics to be discussed to build the framework as well as to inform Workgroup recommendations.

The inputs thus far include:

Workgroup member interviews

The Artemis Team interviewed each workgroup member individually and posed the following questions:

- What are your aspirations for the integration assessment work?
- What are your goals for the system in 2022?
- What is your recommendation for sequencing the work leading up to and in 2022 (i.e., what would you do first, second, third, etc.)?
- What concerns do you have about this collaborative undertaking?

- What are your preliminary ideas around roles and responsibilities for administering the tool, for sorting the data, for providing TA and supporting practices, etc.? Which entities should do what?

Workgroup surveys

The Artemis Team surveyed workgroup members twice to gather additional input/feedback to inform the implementation framework. Survey questions are included in Appendix 5.

- The first survey (Appendix 5) asked Workgroup members to prioritize a specific list of questions compiled up to April (the list has since expanded). The survey also asked about whether there should be standardization or flexibility in the answers to specific questions (e.g., should there be a standardized vision for the use of the tool).
- The second survey was a targeted inquiry conducted through email, focused on the following four questions:
    1. The Workgroup agreed that providers should submit the completed assessment to one centralized entity. Do you have an opinion as to whether this centralized entity should be HCA or whether it should be a single third-party vendor that HCA contracts with? Please share the reasoning behind your opinion. It's anticipated that there would need to be additional resources for HCA or a contracted entity to do this work.
    2. What would address concerns you have with either HCA or a single third-party vendor receiving the completed tool/framework (depending on your response to #1)?
    3. At our last Workgroup meeting, we were moving toward agreement that there should be an identified single entity that coordinates the distribution of the tool, supported by ACHs and MCOs. Do you agree with this approach? If not, what are your concerns?
    4. Finally, it seems to make sense for the same entity (HCA or a single third-party vendor) both distribute the assessment and receive the completed assessment. Do you agree with this? If not, please share your perspective.

Consultation with Dr. Henry Chung

HealthierHere contracted with Dr. Henry Chung, MD, Senior Medical Director, Behavioral Health Integration Strategy, Montefiore Health System and Professor of Psychiatry - Albert Einstein College of Medicine, the developer of the selected clinical integration assessment tool, to provide consultation and strategic guidance to the workgroup on implementation of the tool. Dr. Chung participated in meetings with the Artemis Team, the tri-chair planning team, as well as attending a Workgroup meeting to inform the implementation framework.

HealthierHere

Data and debrief from Pilot Partners

The information gathered from the pilot partners (described in more detail earlier in this report) was also used to provide valuable input into a number of questions under consideration by the Workgroup.

Workgroup Deliberations

The Workgroup met eight times under the current HCA contract (March 1, 2021 through June 30, 2021). During these meetings, information from the various inputs was synthesized and shared with Workgroup members for discussion. The Workgroup deliberated on the prioritized list of questions to come to agreement on a recommendation for statewide implementation. A feedback loop was created between the workgroup and the policy teams comprised of HCA leadership and HCA staff to ensure the workgroup questions and recommendations were in alignment with HCA's vision for the CIAT and to allow HCA to inform the recommendations and ask additional questions of the Workgroup to support the development of the framework.

Table 1 below lists the questions that have been gathered, categorized by topic. The table also indicates the Workgroup's collective prioritization for answering the questions, recognizing some questions need to be addressed sooner than others. The table documents inputs thus far (where it exists) and/or any decisions/inclinations/recommendations from the Workgroup.

Table 1: Questions that need to be addressed to support statewide implementation of the framework/tool to advance integration

Prioritization of questions was determined by the Integration Assessment Workgroup using the following categorization of phases:

Timing	Description
Phase 1	*These questions should be answered as soon as possible. Implementation can't start without them being answered.*
Phase 2	*Implementation could start, but we should ideally answer these questions as soon possible.*
Phase 3	*While these questions are important, we have a bit of time to answer them and could even wait until after implementation.*

Vision and General Approach	Input/Decision
What's the goal for using the tool?	A consistent, statewide clinical integration assessment tool to:

Timing: Phase 1	• Assess the level of, and progress toward, bidirectional clinical integration within behavioral health and primary care outpatient practices; • Serve as a quality improvement roadmap for practices to advance integration; • Improve patient/client outcomes; and • Provide regional and statewide data to drive policy/funding decisions.

Distribution and completion of the tool	Input/Decision
How is the tool distributed? Timing: Phase 1	The Workgroup recommends that the tool be distributed through a central entity that works in partnership with HCA, ACHs, and MCOs. Furthermore, the Workgroup recommends the same entity receive the completed assessments. The selected entity must have the appropriate capabilities to both distribute and collect the tool from providers. *For consideration: is single coordinating entity HCA or third party entity?*
How will the tool be distributed and collected? Timing: Phase 1	The assessment tool will be distributed electronically in a survey format easily responded to by providers.
What outpatient provider types will be asked to complete the tool on an ongoing basis? Timing: Phase 1	The tool is appropriate for use with all types of adult outpatient providers including: Primary Care; Adult Mental Health; SUD; SUD + MAT; MAT + Methadone; Primary care + MAT; SUD + Mental Health. The tool should also be collected for pediatric practices including pediatric primary care as well as children and youth mental health and substance use services. Modifications will need to be made to adopt the tool for pediatric practices.
Will the tool be completed by site, for the organization as a whole, or some other way? Timing: Phase 1	The tool is designed to be collected at the site level. *For consideration: is the expectation that 100% of practice sites are assessed or would some sampling be done? What would the formula for sampling look like?*

Should we do a phased approach to rolling out the tool to providers? If so, how? What should be taken into consideration for a phased roll out? **Timing:** Phase 1	A variety of inputs indicate a phased approach makes the most sense. The Workgroup will make recommendations about how the roll out would be phased, including the need for consistency with MCO contracts. The Workgroup recommends that the roll out build on current strengths and infrastructure within the system and meet providers where they are.
Who will assist providers needing assistance to complete the tool? **Timing:** Phase 1	The coordinating entity should provide training and technical assistance on completion of the tool and support providers in completion.
What, if any, incentives are available to support providers to complete the tool? **Timing:** Phase 1	This will be a funding/resource question. Pilot partners have noted the need to "buy out" provider time to participate in completing the tool so it is recommended that some incentive resource be made available if possible, to increase participation/completion.
How often should the tool be completed? **Timing:** Phase 2	

The Tool	Input/Decision
How will the tool be scored? **Timing:** Phase 1	
If a practice is integrated (with BH and PCP), which tool do they use? **Timing:** Phase 1	Providers should make this determination based on the primary reasons for which people seek care at that clinic. If people are largely coming with behavioral health disorders, the practice should complete the behavioral health version. SUD providers, particularly MOUD/MAT providers could choose either depending on their service/care model.
How will the tool be completed for practices that have both an integrated	

program for certain patients/conditions AND also refer out to services for other patients/conditions? **Timing:** Phase 1	
What adaptations should we make to the tool (e.g., pediatrics)? **Timing:** Phase 1	See recommendations from pilot partners. Workgroup recommends adopting those recommendations AND further informing adaptations based on further, more robust provider input.
What additional questions should be added to the tool for data collection purposes? What are the specific data elements we want to ensure are included (e.g., address, NPI, etc.)? **Timing:** Phase 1	This needs to be answered in partnership with HCA and all stakeholders to ensure comprehensive data is obtained to conduct data analysis, inform quality improvement efforts, and add any additional information that would enhance the assessment process. Ideas include leadership support and equity.
What key questions do we want to answer using the tool? **Timing:** Phase 2	

Data	Input/Decision
Where does the data get submitted once the tool is completed (i.e., centralized, regionalized, etc.)? Should it be HCA or a contracted entity? **Timing:** Phase 1	The Workgroup recommends that the data be submitted to one centralized entity – the same entity that sends the tool out and coordinates the distribution. The entity must have adequate infrastructure and capacity to do the work. In addition, there needs to be sufficient funding to support the coordination of distribution and data collection. Transparency is also critical to success.

![HealthierHere logo]

How does the data get submitted once the tool is completed (i.e., online, paper copy, other)? What platform is used to collect, organize and analyze the data? (Consider platform requirements, rather than a specific platform) **Timing:** Phase 1	The data will be submitted electronically by a single person at each provider site. Form and platform to be determined by coordinating entity and must include the ability to transfer data, as needed and determined, to other stakeholders (i.e., HCA, MCOs, and/or ACHs) as needed to support goals.
How is data synthesized and analyzed and by whom? Would a third party analyze and/or would they export to those who want to utilize data? **Timing:** Phase 1 or 2	
How do we and providers compare previously used tools to the new one? **Timing:** Phase 2	
Who needs to receive which data and for which regions? **Timing:** Phase 2	
How will we measure clinic/agency progress and set expectations of what they need to achieve? **Timing:** Phase 2	

How will organizational level data be utilized for continuous improvement and by whom? **Timing:** Phase 3	
How will the data be used statewide and regionally to demonstrate progress? **Timing:** Phase 3	The Workgroup recommends that the state choose no more than two or three focus areas (for example, NCQA-endorsed metrics) for improvement across the state at any one time.
How will the aggregate results be presented and shared (how, when and by whom)? **Timing:** Phase 2	
How will we measure clinical outcomes/patient improvement over time and connect to level of integration? **Timing:** Phase 3	

Funding/Sustainability	Input/Decision
What funding/resources are available to implement statewide assessment and sustain it over time? **Timing:** Phase 1	To be answered by HCA.
What funding/resources are	To be answered by HCA.

available for training/TA/CQI to providers? **Timing:** Phase 1	
Where will ongoing funding come from to support practices to continue to integrate? How do we fund gaps/needs? **Timing:** Phase 3	To be answered by HCA.

TA/Coaching	Input/Decision
What is the process for providing ongoing TA/coaching to practices for continuous improvement and who manages this process? **Timing:** Phase 2	High quality, accessible, and ongoing QI coaching must be provided and tailored to the needs of providers. The Workgroup recommends that the "system" (providers, stakeholders, HCA, etc.) select no more than two or three priority domains, which will be the initial focus of integration efforts. The tool shouldn't be used without coaching – it shouldn't be optional. Technical assistance and practice coaching should come from a third party entity/entities and not through payers (i.e., HCA or MCOs).
How will we measure clinical outcomes/patient improvement over time and connect to level of integration? **Timing:** Phase 3	

Stakeholder Coordination (HCA, ACHs, MCOs)	Input/Decision
What legal agreements amongst parties are needed to do this work (MOUs, contracts, DSAs, etc)?	

Timing: Phase 1	
What specific roles/responsibilities will MCOs and ACHs have and how will these roles be shared/divided so as not to create duplication of effort? **Timing:** Phase 1	

Communications and Provider Engagement

As the Workgroup progressed with making recommendations regarding statewide implementation of a CIAT, it became clear that there was increased need for broad communication about the HCA's intent to implement a standardized CIAT statewide and more deeply engage providers in the implementation planning. The Clinical Integration Assessment Workgroup formed a Communications subcommittee and started reaching out to providers and stakeholders and working on a communications plan.

Meetings with association representatives

The Communications Subcommittee set up discussions with representatives from statewide associations to engage them in the planning process, get input on substantive issues, and to begin socializing the assessment tool. Themes from those meetings influenced the recommendations below on how to continue to engage providers. There were three meetings, with low attendance for the first two and solid attendance at the third. Attendees included representatives from Association of Alcoholism and Addiction Programs, Washington State Hospital Association, Washington Council for Behavioral Health, Washington State Medical Association, Washington Chapter of the American Academy of Pediatrics, and Washington Association for Community Health. Attendees were asked the following questions:

- What are your thoughts about how to best engage your members about this work, both to inform them and get input?
- What are the best ways to reach providers in a meaningful way that isn't burdensome to them?
- Do you have thoughts on whether it should be a state agency (HCA) or a contracted entity receiving provider-level data?

Major themes from the meetings include:

- A high level of interest in advancing integration
- Agreement that centralizing and standardizing the distribution and collection of information is a positive development
- Request that as deliberations continue, all are mindful of challenges within the provider environment (i.e., SUD providers struggling, workforce issues, etc.)
- Providers need education, resources, tools and support to do this work (Resources at practices will be a challenge - who will complete the framework, meeting providers where they are, etc.)
- Providers must be at the table for implementation planning
- Outcomes should be focused on people served (are we improving health?)
- Suggestion to engage provider groups/providers to choose a couple of priorities for advancing integration within the entire system (versus working on many things all at once)
- Questions about what ACHs, MCOs and HCA can do to support providers in this work

Recommendations

1. **HCA support adoption of the modified CIAT** based on recommendations from both physical and behavioral health pilot partners as described on pages 14 – 15 of this report.
2. HCA, in collaboration with MCOs and ACHs, **identify and implement opportunities to communicate to providers** about the CIAT and expectation that the CIAT will be implemented statewide.
3. **Form a Provider Advisory Group** to include representatives from the associations and one team member from each of the pilot partners. Provider engagement will be a critical aspect of the next several months. The goals of engaging the group are to involve providers in the planning process; get ongoing input; help spread the word about the tool; and possibly gain some champions of the work. Partner with the Provider Advisory Group to obtain robust provider input from across the state, including rural providers and across provider types.
4. **Identify opportunities to implement and socialize the CIAT in HCA, MCO, and provider programs**. For example: consider the integration of the CIAT in;
   - MCO contract requirements
   - emerging Alternative Payment Models (APMs) and other initiatives
   - MCO and provider conferences
5. **Consider a phased approach to the implementation and adoption** of the new integration assessment by practice and provider types over 12 – 18 months in a manner that considers the unique situation/needs of providers and provider types across the state, meeting providers where they are at. A variety of inputs suggest that a phased

approach makes the most sense. Work with the Clinical Integration Assessment Workgroup, providers and other key stakeholders to determine the optimal phased approach, taking into consideration the need for consistency with MCO contracts and building off of current strengths and infrastructure across the state.

6. **Connect implementation of the CIAT to other HCA initiatives** such as the new multipayer primary care initiative and value-based payment models, looking for opportunities for alignment as well as potential opportunities for implementation within those initiatives, and as appropriate, consider the use of financial and non-financial incentives (e.g. technical assistance) to support providers in the successful implementation of the CIAT within these initiatives.

7. **Identify and/or develop resources to support training, technical assistance and implementation of the tool**. This includes such things as gathering existing materials and/or developing needed materials to support the training and technical assistance of providers statewide on how to use the tool, development and distribution of an Implementation Guide and FAQ, and incentives/resources to providers to support staff time to complete the assessment.

8. **Identify and/or develop resources to support Quality improvement** (QI) coaching and technical assistance to assist practices in advancing whole person integrated care. Resources are needed to help practices develop QI Action Plans following the Integration Assessment, as well as resources to help them practice QI on the ground. This need is especially true for behavioral health practices.

9. **Focus on 2 – 3 provider-driven priority domains of integrated care**. Providing whole person integrated care requires significant and ongoing training, particularly for behavioral health providers. In the current environment, all providers have limited capacity to take on new initiatives. To help practices focus, it will be beneficial for providers and stakeholders to work together to define no more than three priorities. This would allow resources to be invested in a focused, intentional way resulting in a more aligned healthcare system that supports collectively advancing whole person integrated care across physical and behavioral health providers while meeting providers where they are. Priority areas can evolve over time to align with policy and programmatic goals.

10. HCA should **encourage Tribal partners to consider applicability of a standardized CIAT** and engage in CIAT planning activities as quickly as possible and develop mechanisms to ensure alignment with the Clinical Integration Assessment Workgroup planning.

11. **Keep informed of and aligned with national (SAMHSA, NBHC and CCBHC) activities** to implement the CIAT and link the CIAT with quality metrics.

Next Steps

- The Clinical Integration Assessment Workgroup will continue to address the remaining questions outlined in Table 1 to support additional recommendations to the HCA related to implementation of the standardized tool.
- The communications subgroup will develop a communications and provider engagement plan to engage provider associations and partners in the planning and implementation strategy.
- The communications subgroup will outreach to local integration organizations/initiatives including, at a minimum, Bree Collaborative, Comagine, AIMS and the Behavioral Health Institute to provide an update and ask for their input moving forward.
- Obtain existing implementation, training, QI and other materials that could support implementation of the CIAT statewide from Dr. Chung and other NY providers using the tool.
- Support HCA, upon request, to engage Tribal partners and obtain their input/feedback on the CIAT tools and assessment and reporting methodology
- Develop an Implementation Roadmap that provides specific recommendations (based on provider input/feedback) for Behavioral Health Agencies (that provide MH and SUD services), SUD only providers, FQHCs/primary care, and pediatric providers that includes:
  - A phased implementation plan and timeline that takes into consideration the unique needs/timing of different provider types (short term, mid-term, long term perspective/strategy) including which cohort of providers to begin implementation of the CIAT with and how other providers and provider types should be phased in (including what is happening with other provider types if they are not in the first implementation cohorts).
  - Consideration of refinements needed to the CIAT tools to assess clinical integration of providers serving pediatric populations.
  - Provide milestones and a timeline for implementation, including how to get started building on current system strengths and infrastructure, interim solutions, and longer-term solutions for implementation.
  - Activities associated with and supports needed for implementation such as development and implementation of training and technical assistance and resources needed at the state and provider levels.
  - Recommendations for actions the state, MCOs, and providers can undertake to keep this work moving forward beginning on and after October 1.

Appendix 01

Integration Assessment Pilot - Behavioral Health Integration for Primary Care

Pilot Organization

Name and location of clinical site included in
this assessment:

Integration Lead First Name:

Integration Lead Last Name:

Integration Lead E-Mail Address:

Please provide a list of the names and titles of
all care team members who contributed to this
assessment:

Does your practice utilize an electronic health
record (EHR)? If yes, please provide the name
of the EHR vendor and date of initial use:

Use and capacity of EHR system (check all that
apply):

1.1 Screening, initial assessment, followup for
BH conditions PH 1.1

1.1.a. Describe any barriers you may have
encountered as you assessed your
organization on this component...

1.1.b. If yo encountered any barriers assessing
your organization on this component, describe
why (please specify if the component is not
applicable to your practice setting AND/OR if
there is language that shouldbe changed to
make the component easier to assess)...

1.2. Facilitation of referrals, feedback PH 1.2

1.2.a. Describe any barriers you may have encountered as you assessed your organization on this component...

1.2.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

2.1 Evidence-based (EB) guidelines/treatment protocols PH 2.1

2.1.a. Describe any barriers you may have encountered as you assessed your organization on this component...

2.1.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

2.2 Use of psychiatric medications PH 2.2

2.2.a. Describe any barriers you may have encountered as you assessed your organization on this component...

2.2.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

2.3 Access to EB psychotherapy with BH provider(s) PH 2.3

2.3.a. Describe any barriers you may have encountered as you assessed your organization on this component...

2.3.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

3.1 Sharing of treatment information PH 3.1

3.1.a. Describe any barriers you may have encountered as you assessed your organization on this component...

3.1.b. If you encountered any barriers assessing your organization on this component. describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

4.1 Longitudinal clinical monitoring and engagement PH 4.1

4.1.a. Describe any barriers you may have encountered as you assessed yourorganization on this component...

4.1.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

5.1 Use of tools to promote patient activation and recovery with adaptations for literacy, language, local community norms PH 5.1

5.1.a. Describe any barriers you may have encountered as you assessed your organization on this component...

5.1.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

6.1 Care team PH 6.1

6.1.a. Describe any barriers you may have
encountered as you assessed your
organization on this component...

6.1.b. If you encountered any barriers
assessing your organization on this
component, describe why (please specify if the
component is not applicable to your practice
setting AND/OR if there is language that should
be changed to make the component easier to
assess)...

6.2 Systematic multidisciplinary team-based
patient care review processes PH 6.2

6.2.a. Describe any barriers you may have
encountered as you assessed your
organization on this component...

6.2.b. If you encountered any barriers
assessing your organization on this
component, describe why (please specify
if the component is not applicable to your
practice setting AND/OR if there is language
that shouldbe changed to make the component
easier to assess)...

7.1 Use of quality metrics for program
improvement PH 7.1

7.1.a. Describe any barriers you may have
encountered as you assessed your
organization on this component...

7.1.b. If you encountered any barriers
assessing your organization on this
component, describe why (please specify if the
component is not applicable to your practice
setting AND/OR if there is language that should
be changed to make the component easier to
assess)...

8.1 Linkages to housing, entitlement, other social support services PH 8.1

8.1.a. Describe any barriers you may have encountered as you assessed your organization on this component...

8.1.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

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

9.1.a. Describe any barriers you may have encountered as you assessed your organization on this component...

9.1.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)

Likert Scale 1 - 5, 1 = Least Favorable and 5 = Most Favorable

Ease of use of the framework to describe your current behavioral health integration state:

Ease of understanding the domains and components of the framework within a continuum structure:

Ease of using the framework for planning to advance your behavioral health integration:

What other changes or additions would you like to see to improve the clarity or utility of the framework?:

What supports would you need to be able to adopt the framework in your organization? Please explain:

What additional training or other support would you recommend to an organization completing this assessment?:

What do you consider to be strengths and/or gaps in content of the assessment? Are there items that you feel should be modified somehow?:

Are there any other recommendations you would make to inform a strategy for using this assessment statewide?:

Appendix 02

Integration Assessment Pilot - General Health Integration for Behavioral Health

GENERAL INFORMATION

Pilot Organization

Name and location of clinical site
included in this assessment:

Integration Lead First Name:

Integration Lead Last Name:

Integration Lead E-Mail Address:

Please provide a list of the names and titles of
all care team members who
contributed to this assessment:

Does your practice utilize an electronic
health record (EHR)? If yes, please
provide the name of the EHR vendor
and date of initial use:

Use and capacity of EHR system (check
all that apply):

1.1. Screening and follow-up (f/u)
for preventive and general medical
conditions (GMC) BH 1.1

1.1.a. Describe any barriers you may
have encountered as you assessed
your organization on this
component...

1.1.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that shouldbe changed to make the component easier to assess)...

1.2. Facilitation of referrals and follow-up (flu)BH 1.2

1.2.a. Describe any barriers you may haveencountered as you assessed your organization on this component...

1.2.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

2.1. EB guidelines or treatment protocols forpreventive interventions BH 2.1

2.1.a. Describe any barriers you may haveencountered as you assessed your organization on this component...

2.1.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that shouldbe changed to make the component easier to assess)...

2.2 EB guidelines or treatment protocols forGMC BH 2.2

2.2.a. Describe any barriers you may haveencountered as you assessed your organization on this component...

2.2.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if thecomponent is not applicable to your practice setting AND/OR if there is language that shouldbe changed to make the component easier to assess)...

2.3 Use of medications by BH prescribers for preventive and general medical conditions BH2.3

2.3.a. Describe any barriers you may have encountered as you assessed your organization on this component...

2.3.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to as sess)...

2.4 Trauma-informed care BH 2.4

2.4.a. Describe any barriers you may have encountered as you assessed your organization on this component...

2.4.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

3.1 Longitudinal clinical monitoring &
engagement for preventive health
and/or GMC

BH 3.1

3.1.a. Describe any barriers you may
haveencountered as you assessed
your organization on this
component...

3.1.b. If you encountered any barriers
assessing your organization on this
component, describe why (please
specify if thecomponent is not
applicable to your practice setting
AND/OR if there is language that should
be changed to make the component
easier to assess)...

4.1 Use of tools to promote patient activation &
recovery withadaptations for literacy,
economic status, language, cultural
norms

BH4.1

4.1.a. Describe any barriers you may
haveencountered as you assessed
your organization on this
component...

4.1.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that shouldbe changed to make the component easier to assess)...

BH 5.1

5.1 Care team

5.1.a. Describe any barriers you may haveencountered as you assessed your organization on this component...

5.1.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that shouldbe changed to make the component easier to assess)...

5.2 Sharing of treatment information, casereview, care plans and feedback BH 5.2

5.2.a. Describe any barriers you may have encountered as you assessed yourorganization on this component...

5.2.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess) ...

BH 5.3

5.3 Integrated care team training

5.3.a. Describe any barriers you may have encountered as you assessed your organization on this component...

5.3.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

BH 6.1

6.1 Use of quality metrics for general health program improvement and/or external reporting

6.1.a. Describe any barriers you may have encountered as you assessed your organization on this component...

6.1.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if thecomponent is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

7.1 Linkages to housing, entitlement, othersocial support services BH 7.1

7.1.a. Describe any barriers you may haveencountered as you assessed your organization on this component...

7.1.b. If you encountered any barriersassessing your organization on this

component, describe why (please specify if the component is not applicable to your practice setting AND/OR if there is language that should be changed to make the component easier to assess)...

8.1 Build process for billing and outcomereporting to support sustainability of integration efforts BH 8.1

8.1.a. Describe any barriers you may haveencountered as you assessed your organization on this component...

8.1.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if thecomponent is not applicable to your practice setting AND/OR if there is language that shouldbe changed to make the component easier to assess)...

8.2 Build process for expanding regulatoryand/or licensure opportunities BH 8.2

8.2.a. Describe any barriers you may haveencountered as you assessed your organization on this component...

8.2.b. If you encountered any barriers assessing your organization on this component, describe why (please specify if thecomponent is not applicable to your practice setting AND/OR if there is language that shouldbe changed to make the component easier to assess)...

8.2.c.

Likert Scale 1 – 5, 1 = Least Favorable and 5 = Most Favorable

Ease of use of the framework to describe yourcurrent general health integration state:

Ease of understanding the domains and components of the framework within a continuum structure:

Ease of using the framework for planning toadvance your general health

integration:

What other changes or additions would you liketo see to improve the clarity or utility of the framework?:

What supports would you need to be able toadopt the framework in your organization? Please explain:

What additional training or other support would you recommendto an organization completing this assessment?:

What do you consider to be strengths and/orgaps in content of the assessment? Are thereitems that you feel should be modified somehow?:

Are there any other recommendations you would make to inform *a* strategy for using this assessment statewide?:

Appendix 03

Continuum Based Frameworks for Integration in Behavioral Health and Primary Care Clinics - for Primary Care Settings

By Dr. Henry Chung, et al, Montefiore Health System, NY. Used by permission. *(https://uhfnyc.org/media/filer_public/61/87/618747cf-9f4b-438d-aaf7-6feff91df145/bhi_finalreport.pdf)*

Assess attainment of each element based on quality improvement (QI) measurement with a standard of performing that element consistently (at least 70% of the time)…

Role	Key Domains of Integrated Care		Preliminary	Intermediate I	Intermediate II	Advanced	SELF ASSESSED LEVEL	Notes
Clinical Workflow	1. Case finding, screening, referral to care	1.1 Screening, initial assessment, followup for 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 formal agreement detailing engagement, with feedback strategies	Enhanced referral to internal/co-located BH provider(s)/psychiatrist, with assurance of "warm handoffs" when needed	Enhanced referral facilitation with feedback via EHR or alternate data-sharing mechanism, and accountability for engagement		
	2. Decision support for measurement-based stepped care	2.1 Evidence-based (EB) guidelines/treatment protocols	None, with limited training on BH disorders and treatment	PCP training on EB guidelines for common behavioral health diagnoses and treatment	Standardized use of EB 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 prescribing BH provider(s)/psychiatrist for medication follow-up	PCP-managed, with support of prescribing BH provider(s)/psychiatrist as necessary	PCP-managed, with care management (CM) supporting adherence between visits and BH prescriber(s)/ psychiatrist support		
		2.3 Access to EB 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)	Range of evidence-based psychotherapy provided by co-located BH provider(s) as part of overall care team, with exchange of information		
	3. Information exchange among providers	3.1 Sharing of treatment information	Minimal sharing of treatment information within care team	Informal phone or hallway exchange of treatment information, without regular chart documentation	Exchange of treatment information through in-person or telephonic contact, with chart documentation	Routine sharing of information through electronic means (registry, shared EHR, shared care plans)		
	4. Ongoing care management	4.1 Longitudinal clinical monitoring and engagement	Limited follow-up of patients by office staff	Proactive follow-up (no less than monthly) to ensure engagement or early response to care	Use of tracking tool to monitor symptoms over time and proactive follow-up with reminders for outreach	Tracking integrated into EHR, including severity measurement, visits, CM interventions (e.g., relapse prevention techniques, behavioral activation), proactive follow-up; selected medical measures (e.g., blood pressure, A1C) tracked when appropriate		
	5. Self-management support that is culturally adapted	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 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 CM support between visits		

Assess attainment of each element based on quality improvement (QI) measurement with a standard of performing that element consistently (at least 70% of the time)…

Role	Key Domains of Integrated Care		A. Preliminary	B. Intermediate I	C. Intermediate II	D. Advanced	SELF ASSESSED LEVEL	Notes
	6. Multidisciplinary	6.1 Care Team	PCP, patient	PCP, patient, ancillary staff member	PCP, patient, ancillary staff member, care manager (CM), BH provider(s)	PCP, patient, ancillary staff member, CM, BH provider(s), psychiatrist (contributing to shared care plans)		

Category	Item	Sub-item						
Workforce	team (including patients) used to provide care	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 patient as conduit	Regular written communication (notes/consult reports) between PCP and BH provider(s), occasional information exchange via ancillary staff or labs, on complex patients	Regular in-person, phone, or e-mail meetings between PCP and BH provider(s) to discuss complex cases	Weekly team-based case reviews to inform care planning and focus on patients not improving behaviorally or medically, with capability of informal interaction between PCP and BH provider(s)		
Management Support	7. Systematic Quality Improvement (QI)	7.1 Use of quality metrics for program improvement	Informal or limited use of BH quality metrics (limited use of data, anecdotes, case series)	Use of identified metrics (e.g., depression screening rates, depression response rates) and some ability to regularly review performance	Use of identified metrics, some ability to respond to findings using formal improvement strategies	Ongoing systematic quality improvement (QI) with monitoring of population-level performance metrics, and implementation of improvement projects by QI team/champion		
	8. Linkages with community/social services	8.1 Linkages to housing, entitlement, other social support services	Few linkages to social services, no formal arrangements	Referrals made to agencies, some formal arrangements, but little capacity for follow-up	Screening for social determinants of health (SDOH), patients linked to community organizations/resources, with follow-up	Developing, sharing, implementing unified care plan between agencies, with SDOH referrals tracked		
	9. Sustainability	9.1 Build process for billing and 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 FFS, with process in place for tracking reimbursements	FFS billing, and revenue from quality incentives related to BHI	Receipt of global payments that reference achievement of behavioral health and general health outcomes		

Appendix 04

Continuum Based Frameworks for Integration in Behavioral Health and Primary Care Clinics - for Behavioral Health Settings

By Dr. Henry Chung, et al, Montefiore Health System, NY. Used by permission. *(https://www.thenationalcouncil.org/wp-content/uploads/2020/08/GHI-Framework-Issue-Brief_FINALFORPUBLICATION_7.24.20.pdf)*

Assess attainment of each element based on quality improvement (QI) measurement with a standard of performing that element consistently (at least 70% of the time)…

Key Domains of Integrated Care		Preliminary	Intermediate I	Intermediate II	Advanced	SELF ASSESSED LEVEL
1. Screening[1], Referral to Care and Follow-up (f/u)	1.1 Screening and f/u for preventive and general medical conditions[2] (GMC)	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 and proactive health education to support motivation to address risk factors.	Systematic, screening and tracking of universal and relevant targeted health risk factors as well as routine f/u for GMC 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.	Formal 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 automated data sharing and accountability for engagement.	
2. Evidence based (EB) care for preventive interventions and common general medical conditions	2.1 EB 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 EB 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 EB 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 availability of EB and outcomes driven programs to reduce or mitigate general health risk factors (smoking, alcohol, overweight, etc.).	
	2.2 EB guidelines or treatment protocols for GMC	Not used or with minimal guidelines or EB workflows for improving access to care for GMC.	Intermittent use of guidelines and/or EB workflows of GMC with limited monitoring activities. BH staff and providers receive limited training on GMC.	BH providers and/or embedded[5] PCP routine use of EB guidelines or workflows for patients with GMC, including monitoring treatment measures and linkage/navigation to medical services when appropriate. BH staff receives routine training in basics of common GMC.	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 GMC.	
	2.3 Use of medications by BH prescribers for preventive and general medical 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 above. May occasionally make minor adjustments to medications for GMC when indicated, keeping PCP informed when doing so.	BH prescriber can prescribe NRT as well as prescribe general medical medications with assistance and consultation of PCP.	

| | 2.4 Trauma-informed care | BH staff have no or minimal awareness of effects of trauma on integrated health care. | Limited staff education on trauma and impact on BH and general health care. | Routine staff education on trauma-informed care model including strategies for managing risk of re-traumatizing. Limited use of validated 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. | |

[1] Individuals screened must receive follow up by a trained BH provider or PCP (external or co-located). For the purpose of the framework, primary care provider includes M.D., D.O., PA and NP.

[2] Common general medical conditions include diabetes, hypertension, hyperlipidemia, coronary artery disease, asthma, arthritis, gastrointestinal disease, tooth and gum disease.

[3] Universal general health risk factor screenings might include: visit with a PCP (defined as self-report of a usual source other than ED care with presence of one or more documented primary care visit during the past year), depression, alcohol and substance use (including opioid use), blood pressure measurement, HIV, overweight/obesity, tobacco use and age appropriate screenings for cervical and colorectal cancer.

[4] Targeted general health risk factor screenings might include: intimate partner violence, HbA1c, cholesterol, STI, hepatitis B, hepatitis C, tuberculosis and age appropriate screenings for immunizations, mammogram and osteoporosis.

[5] Embedded and co-located arrangements include PCPs available through telehealth services.

Assess attainment of each element based on quality improvement (QI) measurement with a standard of performing that element consistently (at least 70% of the time)…

Key Domains of Integrated Care		A. Preliminary	B. Intermediate I	C. Intermediate II	D. Advanced	SELF ASSESSED LEVEL
3. Ongoing Care Management	3.1 Longitudinal clinical monitoring & engagement for preventive health and/or GMC	None or minimal f/u of patients referred to primary and medical specialty care.	Some ability to perform f/u of general health appointments, encourage medication adherence and navigation to appointments.	Routine proactive follow-up and tracking of patient medical outcomes and availability of coaching (in person or using technology application) to ensure engagement and early response.	Use of tracking tool (e.g., excel tracker or disease registry software) to monitor treatment response and outcomes over time at individual and group level, coaching and proactive f/u with appointment reminders.	
4. Self management support that is adapted to culture, socioeconomic and life experiences of patients	4.1 Use of tools to promote patient activation & recovery with adaptations for literacy, economic status, language, cultural norms	None or minimal patient education on general medical conditions and universal general health risk factor screening recommendations.	Some availability of patient education on universal general health risk factor screening recommendations, including materials/handouts/web-based resources, with limited focus on self-management goal-setting.	Routine brief patient education delivered in person or technology application, on universal and targeted preventive screening recommendations and GMC. 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.	
5. Multidisciplinary team (including patients) with dedicated time to provide general	5.1 Care Team	BH provider(s), patient, family caregiver[6] (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.	

						SELF ASSESSED LEVEL
health care	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 BH and GMC.	
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 GHI quality metrics (e.g., BMI, smoking status, alcohol status, presence of a PCP, 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.	

[6] Family caregivers are part of team if appropriate to patient care.

Assess attainment of each element based on quality improvement (QI) measurement with a standard of performing that element consistently (at least 70% of the time)…

Key Domains of Integrated Care		A. Preliminary	B. Intermediate I	C. Intermediate II	D. 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, no formal arrangements.	Routine SDOH screening and referrals made to social service agencies, but no formal arrangements established.	Routine SDOH screening, with formal arrangements made to social service agencies, with limited capacity for f/u.	Detailed psychosocial assessment incorporating broad range of SDOH needs patients linked to social service organizations/ resources to help improve appointment adherence (e.g., childcare, transportation tokens), healthy food sources (e.g., food pantry), with f/u to close the loop.	
8. Sustainability	8.1 Build process for billing and outcome reporting to support sustainability of integration efforts	No or minimal attempts to bill for immunizations, screening and treatment. Services supported primarily by grants or other non-reimbursable sources.	Billing for screening and treatment services (e.g., HBA1c, preventive care, blood pressure monitoring) under fee-for-services with process in place for tracking reimbursements for general health care services.	Fee-for-service billing as well as revenue from quality incentives related to GHI (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 GHI services and workforce.	
	8.2 Build process for expanding regulatory and/or licensure opportunities	No primary care arrangements that offer general 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 GHI services.	Formalized primary care arrangements, internal or external, with telehealth if appropriate that incorporate patient centered home services.	Maintain a dual license (article 28 and 31) for GHI in a shared services setting and regularly assess the need for administrative or clinical updates as licensure requirements evolve.	

Provider Integration Assessment Workgroup

1. Provider Integration Assessment Workgroup Survey

We've created a survey to help prioritize the topics and questions the Provider Integration Assessment Workgroup has to address. The most important part of the survey is to indicate how you would prioritize addressing each of the questions in terms of timing. This will help determine which questions must be answered before 1/1/22 implementation. We've also given you an opportunity to share your organization's perspective on each set of questions if you have an opinion about certain topics at this point. If you don't, you can just skip those boxes. Again- the priority is to sort the questions right now, rather than solve them.

The second part of the survey asks for your preliminary assessment on whether certain components of implementation should be standardized or allow for flexibility. These are many of the same questions asked in the first part, but answers are focused on standardization vs. flexibility. This is just the first step to get a sense of the sentiment of the workgroup - we will discuss all of these topics in the future.

The questions we've listed aren't perfect. At this point, we want to gather information quickly rather than getting every word right. But if you don't understand a question, please let us know in the comments section.

Feel free to consult with other staff from your organization on your responses, but please submit only one survey from your organization. If you have any questions, contact Diana Bianco (diana@artemispdx.com) or Cathy Kaufmann (cathy@kaufmannstrategies.com).

Thank you!

1. Your Name:

2. Your Organization:

3. **Vision and General Approach**

	Phase 1: We cannot start implementation without this question being answered	Phase 2: We can start implementation, but this question needs to be answered quickly after the start	Phase 3: We have to answer this question, but we have a bit of time post-implementation	I don't know/I defer to the group
1. What is our goal for using the tool? How will we use it to inform integration efforts across the state?	○	○	○	○
2. How will we measure clinic/agency progress and set expectations of what they need to achieve by way of integration?	○	○	○	○
3. How will we measure clinical outcomes/improved health of clients/patients over time and connect to level of integration?	○	○	○	○
4. How will the data be used statewide and regionally to demonstrate progress?	○	○	○	○
5. How will the aggregate results be presented and shared (how, when and by whom)?	○	○	○	○

Share any comments/thoughts you have on the Visions and General Approach section here.

4. **The Tool**

	Phase 1: We cannot start implementation without this question being answered	Phase 2: We can start implementation, but this question needs to be answered quickly after the start	Phase 3: We have to answer this question, but we have a bit of time post-implementation	I don't know/I defer to the group
1. Who distributes the assessment?	○	○	○	○
2. How often is the assessment completed?	○	○	○	○
3. How will the tools be scored?	○	○	○	○
4. If a practice is integrated (with BH and PCP), which tool do they use?	○	○	○	○
5. What outpatient provider types will be asked to complete the tool(s) on an ongoing basis?	○	○	○	○
6. How will the tool be distributed? (paper copies, online survey style or combination)?	○	○	○	○
7. Will the tool be completed by site, for the organization as a whole, or some other way?	○	○	○	○
8. Do we want to add questions or make modifications to the tool (i.e., Leadership Support is not in tool)?	○	○	○	○

Share any comments/thoughts you have on The Tool section here.

5. **Data**

	Phase 1: We cannot start implementation without this question being answered	Phase 2: We can start implementation, but this question needs to be answered quickly after the start	Phase 3: We have to answer this question, but we have a bit of time post-implementation	I don't know/I defer to the group
1. Where does the data get submitted once the tool is completed (i.e., centralized place, regionalized, etc.)	○	○	○	○
2. How does the data get submitted once the tool is completed (i.e., online, paper copy, other)?	○	○	○	○
3. Who manages the data collection process?	○	○	○	○
4. What platform is used to collect, organize and analyze the data?	○	○	○	○
5. How is data synthesized and analyzed and by whom?	○	○	○	○
6. How will organizational level data be utilized for continuous improvement and by whom?	○	○	○	○
7. Who needs to receive which data and for which regions?	○	○	○	○
8. Should there be quantitative and qualitative data gleaned from the tool (i.e., actual assessment data plus narrative information about barriers within domains)?	○	○	○	○
9. How do we and providers compare previously used tools to the new one?	○	○	○	○

Share any comments/thoughts you have on the Data section here.

6. **Funding / Sustainability**

	Phase 1: We cannot start implementation without this question being answered	Phase 2: We can start implementation, but this question needs to be answered quickly after the start	Phase 3: We have to answer this question, but we have a bit of time post-implementation	I don't know/I defer to the group
1. Where does this work fit within the state's priorities and how much time, effort and resources will get applied to this effort?	○	○	○	○
2. What funding/resources are available to implement statewide assessment and sustain it over time?	○	○	○	○
3. What funding/resources are available for training/TA/CQI to providers?	○	○	○	○
4. Where will ongoing funding come from to support practices to continue to integrate? How do we fund gaps/needs?	○	○	○	○

Share any comments/thoughts you have on the Funding/Sustainability section here.

7. Ongoing TA/Coaching

	Phase 1: We cannot start implementation without this question being answered	Phase 2: We can start implementation, but this question needs to be answered shortly after the start	Phase 3: We have to answer this question, but we have a bit of time post-implementation	I don't know/I defer to the group
1. What is the process for providing ongoing TA/coaching to practices for continuous improvement and who manages this process?	○	○	○	○

Share any comments/thoughts you have on Ongoing TA/Coaching here.

8. **Stakeholder (HCA, ACHs, MCOs) Coordination**

	Phase 1: We cannot start implementation without this question being answered	Phase 2: We can start implementation, but this question needs to be answered shortly after the start	Phase 3: We have to answer this question, but we have a bit of time post-implementation	I don't know/I defer to the group
1. How will the data be shared among key stakeholders?	○	○	○	○
2. Do we need legal agreements amongst parties to do this work?	○	○	○	○
3. How are the MCO/ACHs incentivized (i.e., who are the focus providers for ACHs, MCOs)?	○	○	○	○
4. What providers and how many clinics are within those entities ("focus providers" from previous question)?	○	○	○	○
5. What should happen for clinics with multiple sites (large IPAs)?	○	○	○	○
6. How will we approach providers who operate in multiple regions (one entity assesses all sites or different entities assess sites in their region)?	○	○	○	○

Share any comments/thoughts you have on the Stakeholder Coordination section here.

The next section asks for your preliminary opinion on whether certain topics/items should be standardized or allow for flexibility. For example, in the Vision and General Approach section, as you think about how would answer the questions listed, would you tend to answer that there should be a standard approach or should it be a flexible approach?

9. **Vision and General Approach: Standardized or Flexible?**

	Standardized	Flexible	Don't Know or Doesn't Apply
1. What is our goal for using the tool? How will we use it to inform integration efforts across the state?	○	○	○
2. How will we measure clinic/agency progress and set expectations of what they need to achieve by way of integration?	○	○	○
3. How will we measure clinical outcomes/improved health of clients/patients over time and connect to level of integration?	○	○	○
4. How will the data be used statewide and regionally to demonstrate progress?	○	○	○
5. How will the aggregate results be presented and shared (how, when and by whom)?	○	○	○

Share any comments/thoughts you have on standardization of items in Visions and General Approach section here.

10. The Tool: Standardized or Flexible?

	Standardized	Flexible	Don't Know or Doesn't Apply
1. Who distributes the assessment?	◯	◯	◯
2. How often is the assessment completed?	◯	◯	◯
3. How will the tools be scored?	◯	◯	◯
4. If a practice is integrated (with BH and PCP), which tool do they use?	◯	◯	◯
5. What outpatient provider types will be asked to complete the tool(s) on an ongoing basis?	◯	◯	◯
6. How will the tool be distributed? (paper copies, online survey style or combination	◯	◯	◯
7. Will the tool be completed by site, for the organization as a whole, or some other way?	◯	◯	◯
8. Do we want to add questions or make modifications to the tool (i.e., Leadership Support is not in tool)?	◯	◯	◯

Share any comments/thoughts you have on standardization of items in The Tool section here.

11. **Data: Standardized or Flexible?**

	Standardized	Flexible	Don't Know or Doesn't Apply
1. <u>Where</u> does the data get submitted once the tool is completed (i.e., centralized place, regionalized, etc.)?	○	○	○
2. <u>How</u> does the data get submitted once the tool is completed (i.e., online, paper copy, other)?	○	○	○
3. Who manages the data collection process?	○	○	○
4. What platform is used to collect, organize and analyze the data?	○	○	○
5. How is data synthesized and analyzed and by whom?	○	○	○
6. How will organizational level data be utilized for continuous improvement and by whom?	○	○	○
7. Who needs to receive which data and for which regions?	○	○	○
8. Should there be quantitative and qualitative data gleaned from the tool (i.e., actual assessment data plus narrative information about barriers within domains)?	○	○	○
9. How do we and providers compare previously used tools to the new one?	○	○	○

Share any comments/thoughts you have on standardization of items in the Data section here.

12. Ongoing TA/Coaching: Standardized or Flexible?

	Standardized	Flexible	Don't Know or Doesn't Apply
1. What is the process for providing ongoing TA/coaching to practices for continuous improvement and who manages this process?	○	○	○

Share any comments/thoughts you have on standardization of the item in Ongoing TA/Coaching.

13. Thanks for completing this survey. If you'd like to provide further feedback or input, use the space below.