Washington Integrated Care Assessment
Frequently Asked Questions

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

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Introduction

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

The Shift to the WA-ICA Tool

How was the WA-ICA tool chosen?

The Clinical Integration Assessment Work Group (CIAWG) formed in 2020 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 SelfAssessment 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 at the Albert Einstein College of Medicine 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.

How was the WA-ICA tool updated from the 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?

The Washington State Integrated Care Assessments for Primary Care Settings and for Behavioral Health Settings were adapted for specificity to Washington State, readability, and minor verbiage changes all with approval from Dr. Chung. The wording of several domain names was updated to be more accessible, descriptive, and consistent as possible across both versions of the assessment. Domain 8 in the assessment for behavioral health settings was updated to reflect Washington State regulations via RCW and WAC rather than New York State regulations. Of the changes made, none are likely to impact the reliability or validity of the assessment tools.

Was this assessment tool reviewed and updated for WA State with an equity lens? How does this assessment consider equity in integration?

In the early stages of identifying an integration assessment tool for WA State, the workgroup established criteria to assess the nine tools and frameworks being reviewed. One of these criteria was "centers equity and is culturally relevant/responsive." A committee formed out of the workgroup thoroughly reviewed all tools with the criteria in mind and recommended the adoption of the companion integration assessment tools developed by Dr. Henry Chung which the WA-ICA assessment tools have been adapted from.
The assessment tools themselves each incorporate equity considerations in various domains including the use of tools and materials that are adapted for literacy, economic status, language, and cultural norms, as well as trauma informed

approaches, the use of quality metrics, and linkages to community/social services, all in service of improving health equity. Lastly, the supplemental questions that accompany the submission of the assessment tool itself include equity considerations that will assist in the analysis of the results.

Completing the Assessment Tool

What happens if we choose not to complete the assessment?
The WA-ICA assessment is not mandatory at this time and there are no penalties for lack of participation.

Why complete the assessment now?
Although not required, the WA-ICA assessment is highly encouraged by HCA, all 5 MCOs, and ACHs throughout the state, as it aligns greatly with the efforts of each to assess and promote integration.
Completing the assessment will support your practice in understanding your current level of integration, as well as practice areas with the most potential to advance integration in service of expanding access to whole person care and improving patient outcomes. Additionally, the integration standards identified in the assessment tool can assist your practice in building your capacity to enter into value-based payment contracts.

What if our team does not think the tool fits well for our practice?
The WA-ICA framework presents two assessment tools – one for outpatient primary care practices and one for outpatient behavioral health practices. The tools were created to be broadly applicable to both practice types, acknowledging that each individual practice operates within a unique context. To minimize administrative burden, ACH and/or MCO staff identified the tool believed to fit your practice environment best.
If you feel that the tool you received does not fit your practice, please reach out to tdonahue@healthierhere.org. We will work with you to determine whether the other WA-ICA assessment tool is a better fit, or to understand how to make sense of a particular domain or subdomain in your particular practice context.
For specific tips for pediatric and substance use disorder providers, please see the WA-ICA implementation guide.
Feedback from providers who complete the assessment will be used to inform future improvements to the assessment tools and data collection process.

Who should complete the WA – ICA?
The following are suggestions for composing your practice assessment team:

Primary Care	Behavioral Health
• A senior clinician executive • A primary care provider who champions behavioral health integration • A behavioral health provider, if already part of the team, including a psychiatric provider (MD, DO, NP, PA) psychologist, social worker, counselor, or therapist • A nursing staff or care management champion • A quality improvement champion • Other recommended: peer specialist, practice manager, community health worker, care coordinator, social worker, front desk staff, other (as available)	• A clinic or site administrator • A psychiatric provider (MD, DO, or NP) if available • An otherwise medically trained professional (RN, MA, PharmD) if available • A behavioral health therapist/counselor/social worker • A quality improvement champion • A primary care provider (PCP) if available • Other: certified peer counselor, practice manager, community health worker, care coordinator, front desk staff, other (as available)

When one or more of these team members do not exist or are unavailable, practices may make their best judgement to involve the most appropriate team members in the assessment process. Assessment teams should include a range of care team and staff members and be no larger than 7 people.

How long will the assessment take?
Meaningful completion of the assessment should take 3 – 4 hours total. This includes time for individual review and team convenings. Each member of the assessment team should review the assessment tool individually, noting their preliminary thoughts before convening as a team. This step invites multiple perspectives which can lead to deeper understanding and elicit opportunities for improvement. It is recommended that teams meet in person to discuss each assessment domain and to come to a mutual understanding of where the practice falls along the continuum in each domain. Team meetings are suggested to occur in two 90-minute meetings or three 1-hour meetings. Subsequent completion and submission of the assessment questions on FormAssembly should take 20 – 60 minutes depending on your preparation and familiarity with the platform.

How should my team approach the supplemental questions at the beginning of the assessment?
As you will see when reviewing the assessment materials, the full version of the assessment includes a series of supplemental questions before the continuum-based questions begin. Your responses to these supplemental questions will provide a deeper understanding of your clinical practice and other factors that impact integration (such as equity, leadership, workforce, and financing). The supplemental questions are likely best answered by an administrator with input from clinical leadership.

What are considered age-appropriate screening tools for pediatric providers? Both behavioral and general health screening tools.
Primary care pediatric practices integrating behavioral health may consider (for adolescents) using the PHQ-A or PHQ-M for depression screening, the Vanderbilt or Conners for ADHD screening, and the SB2I for substance use screening. For mental health disorder screening, consider using the PSC-17. For children under the age of 12, consider the ASQ-3 or ASQ:SE-2 and referral to a child behavioral health specialist for consultation.
Behavioral health pediatric practices integrating physical health may consider screening for weight/BMI, smoking, substance use, and STI screening.

How were the screening tools, measures, medical and behavioral health conditions identified in the framework selected?
Screening measures and medical conditions were identified using recommendations from the U.S. Preventive Services Task Force (USPSTF), expert consensus, and medical literature.

Which category should be selected when you are meeting some of the standards in a category, but only some of the time?
The appropriate category your practice should select for each subdomain is that for which your practice achieves the standards at least 70% percent of the time. This does not mean that 70% of a population is being impacted in the same way, but that an established workflow related to the subdomain is believed to be followed about 70% of the time. These determinations are intended to be based on the perception of your team and informed by available data. Developing specific reports to complete this assessment is not expected though it would be considered a best practice, particularly if the domain is a focus for improvement.

Which category should be selected when you meet the standards of a particular category, but not the standards of one before it?
The continuum is structured in such a way that meeting the standards of one category should mean that your practice meets the standards of the previous categories. In the event you feel there is an exception for your practice, choose the category that currently describes your practice and note the previous standards as potential areas of improvement.

For the WA-ICA behavioral health assessment tool domain 2.3, what is considered appropriate behavioral health provider management of medications for chronic/general health conditions?
Subdomain 2.3 identifies the integration standards related to the use of medications for general health conditions by behavioral health prescribers. This refers primarily to use of nicotine replacement therapy, smoking cessation medications such as bupropion or varenicline, and willingness to refill certain general health medications. Different

practices will meet different category standards for subdomain 2.3 depending on provider training, comfortability, and access to primary care provider support. Subdomain 2.3 is intended to describe the way behavioral health providers with prescriptive authority can support patients in the management of their general health. In no way does it encourage behavioral health providers to assume full or partial responsibility for chronic condition medication management and decision making beyond their expertise and comfortability. Any case in which a behavioral health provider identifies a general health or medication related need they are unable to address, referral to primary care is encouraged. It should be noted that national and regional standards for medication management for behavioral health prescribers continue to evolve with the evidence base.

For the WA-ICA primary care assessment tool domain 2.2, what is considered appropriate primary care provider (PCP) management of psychiatric medications?
Subdomain 2.2 describes the integration standards related to the prescription of psychiatric medications in the primary care setting. This refers primarily to different levels of initiating and managing basic antidepressant and antianxiety medications (as well as medications for ADHD for pediatric providers). Different practices will meet different category standards for subdomain 2.2 depending on provider training, comfortability, and access to behavioral health specialist support. Subdomain 2.2 is intended to describe the way primary care providers with prescriptive authority can support patients in the management of common behavioral health conditions such as depression and anxiety, following evidence-based guidelines. In no way does it encourage primary care providers to assume primary responsibility for behavioral health medication management and decision making outside of their expertise and comfortability. Any case in which a primary care provider identifies a behavioral health or medication related need they are unable to address, referral to a behavioral health provider is encouraged. It should be noted that national and regional standards for psychotropic medication management by primary care providers continue to evolve with the evidence base.

After Completing the Tool

What should we do with the results of the assessment?
Approximately 12-16 weeks following submission of your assessment, your practice will receive a practice-level report intended to help you better understand your current level of integration. Your practice is encouraged to consider the assessment framework as a roadmap for progression along the continuum. Consider starting with 1-2 of the domains where your practice can make the most actionable progress.

Where can we access resources to improve our practice integration efforts?
For resources related to advancing integration, visit our resources page or reach out to your regional ACH or MCO integration contact. As the WA-ICA is rolled out statewide, more resources and technical assistance tools and/or opportunities are expected to be made available.

Will we receive any technical assistance to improve our practice integration efforts?
At this time, there are no statewide technical assistance opportunities related to advancing integration. The WA-ICA tool itself can be used as a roadmap for your practice. Consider gathering your team to determine which subdomains are most achievable and where you might focus your attention and resources to advance integration. You may also reach out to your MCO or ACH integration contact for any opportunities they already provide related to integration support. New resources and opportunities are expected to become available as the WA-ICA is implemented over the next couple of years. Existing resources can be found here.

What data is being collected and what will be done with it?
The assessment tool, demographic, and qualitative responses your practice submits via FormAssembly will go directly to HealthierHere. HealthierHere is the designated organization that will be collecting and analyzing all data received from practices across Washington State for Cohorts 1 and 2. HealthierHere will be responsible for generating and distributing the following reports for the following types of organizations throughout the state:

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

As reflected in the table above, your practice can expect to receive a practice-level report that can be used to further your understanding about your current level of integration and to inform future integration efforts, improvement projects, and resource allocation. Your practice may choose to share your identified practice level report with other entities for technical assistance purposes. These reports are anticipated to be available approximately 12 – 16 weeks following submission.
Following Cohorts 1 and 2, data collection and analysis may be assumed by a more long-term contractor.

How often should we expect to be completing this assessment?
While the WA-ICA assessment is not required at this time, practices will be encouraged to complete the assessment on an annual basis.

Will our practice be expected to show improvement on the assessment overtime?
The WA-ICA assessment is voluntary at this time, and there are no expectations or incentives related to improvement. The assessment itself will provide your practice valuable information regarding your status of integration and the most actionable steps for improvement. More resources and technical assistance related to advancing integration will be made available in the future.

WA-ICA Terms & Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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