**Washington State Integrated Care Assessment for Behavioral Health Settings**

*Based on the 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 and modified with input from primary author (Chung). (*[*https://www.thenationalcouncil.org/wp-content/uploads/2020/08/GHI-Framework-Issue-Brief\_FINALFORPUBLICATION\_7.24.20.pdf?daf=375ateTbd56*](https://www.thenationalcouncil.org/wp-content/uploads/2020/08/GHI-Framework-Issue-Brief_FINALFORPUBLICATION_7.24.20.pdf?daf=375ateTbd56)*)*

**Supplemental Questions**

*The following questions are supplemental to the WA-ICA assessment and will help with data disaggregation and analysis, as well as to give context to the level of integration at your clinical site and across the state so that HCA, MCOs, and ACHs can better support your integration journey.*

1. Does your clinical site serve adults, pediatrics, or both?

* Adults
* Pediatrics
* Both

2. Please select any/all categories that apply to your clinical site:

* + Primary care
  + [Critical Access Hospital](https://www.ruralhealthinfo.org/topics/critical-access-hospitals) (CAH)
  + [Rural Health Clinic](https://www.ruralhealthinfo.org/topics/rural-health-clinics) (RHC)
  + Co-located Behavioral Health and Primary Care
  + Behavioral Health (mental health only)
  + Behavioral Health (substance use disorder (SUD) only)
  + Behavioral Health (mental health AND SUD)
  + Opioid Treatment Program (OTP)
  + Other (fill in the blank)

3. Approximately how many patients are seen at your clinical site each month? (fill in the blank)

4. What is the approximate payor mix of patients seen at your clinical site in an average month?

* + %\_\_\_ Medicaid
  + %\_\_\_ Medicare
  + %\_\_\_ Commercial Insurance
  + %\_\_\_ Uninsured
  + % \_\_\_Fee for Service
  + %\_\_\_ Other

5. How will advancing integration help you address [health equity](https://www.hca.wa.gov/about-hca/health-equity#:~:text=To%20the%20Health%20Care%20Authority,be%20as%20healthy%20as%20possible.)? *(short narrative)*

*Health equity means that everyone has a fair and just opportunity to be as healthy as possible and clinical sites have a responsibility to create a welcoming and accountable environment meant for people of color, all gender identities and sexual orientations, and people with disabilities.*

6. Does your clinical site currently use any of the following Social Determinants of Health (SDOH) screening tools? (select all that apply):

* + [Accountable Health Communities](https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf) (AHC) tool (also known as the Health-Related Social Needs (HRSN) tool)
  + [Daily Living Activities—20](https://static1.squarespace.com/static/59c005cd8a02c7dae8cd5e80/t/5ca23ed24785d3b98ad60980/1554136809111/2019+NC+Lunch+and+Learn+DLA-20+Presentation+%28002%29.pdf) (DLA-20)
  + [Health Leads Social Needs Screening](https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/)
  + [PRAPARE](https://prapare.org/)
  + [WellRx](https://www-alpha.kpwashingtonresearch.org/screening-tools/well-rx)
  + Other (write in answer, if selected)
  + None of the above – our site does not currently use a screening tool

7. What funding sources support your integrated care efforts? (select all that apply)

* Capitated PMPM rate
* [Collaborative Care codes](https://aims.uw.edu/sites/default/files/Billing%20Scenario%20Only%20Color.pdf)
* Fee for service billing
* Grants
* Value based payment arrangements
* None
* Other (please specify)

8. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts? Where is there room for improvement? *(short narrative)*

9. Which of the following IT and/or population health tools are in use at your clinical site? (select all that apply):

* + Electronic Health Records
  + [Shared care plans](https://integrationacademy.ahrq.gov/products/playbooks/behavioral-health-and-primary-care/implementing-plan/develop-shared-care-plan#:~:text=A%20shared%20care%20plan%20is,including%20the%20patient%20and%20providers.)
  + [Electronic referrals to outside services](https://digital.ahrq.gov/ahrq-funded-projects/use-electronic-referral-system-improve-outpatient-primary-care-specialty-care)
  + [Closed loop referral systems](https://innovation.cms.gov/files/x/tcpi-san-pp-loop.pdf) with outside services
  + [Registries](https://www.healthit.gov/faq/what-diseaseimmunization-registry)
  + [Health information exchanges](https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-hie) (HIE)
  + [Community information exchanges](https://www.hca.wa.gov/assets/program/advancing-cie.pdf) (CIE)

10. Approximately what percentage of patient visits at your clinical site are virtual vs. in-person in an average month?\*

* + %\_\_\_ virtual (video)
  + %\_\_\_ virtual (telephone only)
  + %\_\_\_ in-person

**With your care team, please review each domain and sub-domain on the continuum of integration and select the level that best corresponds to the reality at your clinical site. Implementation support materials for the primary care assessment are available here (will link to website)**

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 1. Screening[[1]](#endnote-1), Referral to Care and Follow-up (f/u) | 1.1 Screening and f/u for preventive and general health conditions[[2]](#endnote-2) | 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[[3]](#endnote-3) and proactive health education to support motivation to address risk factors. | Systematic, screening and tracking of universal and relevant targeted health risk factors[[4]](#endnote-4) as well as routine f/u for general health conditions with the availability of in-person or telehealth primary care | Analysis of patient population to stratify by severity of medical complexity and/or high-cost utilization for proactive assessment tracking with in-person or telehealth primary care. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 1. Screening, Referral to Care and Follow-up (f/u) | 1.2 Facilitation of referrals and f/u | Referral to external primary care provider(s) (PCP) and no/limited f/u. | Written collaborative agreement with external primary care practice to facilitate referral that includes engagement and communication expectations between behavioral health and PCP. | Referral to onsite, co-located PCP or availability of primary care telehealth appointments with assurance of "warm handoffs” when needed. | Enhanced referral facilitation to onsite or closely integrated offsite PCPs, with electronic data sharing and accountability for engagement. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 2. Evidence based  care for preventive  interventions  and common chronic health conditions | 2.1 Evidence-based guidelines or treatment  protocols for preventive  interventions | Not used or minimal guidelines or protocols used for universal general health risk factor screenings care. No/minimal training for BH providers on preventive screening frequency and results. | Routine use of evidence-based guidelines to engage patients on universal general health risk factor screenings with limited training for BH providers on screening frequency and result. | Routine use of evidence-based guidelines for universal and targeted preventive screenings with use of standard workflows for f/u on positive results. BH staff routinely trained on screening frequency and result interpretation. | Systematic tracking and reminder system (embedded in EHR) used to assess need for preventive screenings, workflows for f/u availability of EB and outcomes driven programs to reduce or mitigate general health risk factors (smoking, alcohol, overweight, etc.). |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 2. Evidence based  care for preventive  interventions  and common chronic health conditions | 2.2 Evidence-based guidelines or treatment protocols for chronic health conditions | Not used or with minimal guidelines or EB evidence-based workflows for improving access to care for chronic health conditions. | Intermittent use of guidelines and/or evidence-based workflows of chronic health conditions with limited monitoring activities. BH staff and providers receive limited training on chronic health conditions. | BH providers and/or embedded[[5]](#endnote-5) PCP routine use of evidence-based guidelines or workflows for patients with chronic health conditions, including monitoring treatment measures and linkage/navigation to medical services when appropriate. BH staff receives routine training in basics of common chronic health conditions. | Use clinical decision-support tools (embedded in EHR) with point of service guidance on active clinical management for BH providers and/or embedded PCPs for patients with chronic health conditions. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 2. Evidence based  care for preventive  interventions  and common chronic health conditions | 2.3 Use of medications by BH prescribers for preventive and chronic health conditions | None or very limited use of non-psychiatric medications by BH prescribers. Non-psychiatric medication concerns are primarily referred to primary care clinicians to manage. | BH prescriber routinely prescribes nicotine replacement therapy (NRT) or other psychiatric medications for smoking reduction. | BH prescriber routinely prescribes smoking cessation as previously. May occasionally make minor adjustments to medications for chronic health conditions when indicated, keeping PCP informed when doing so. | BH prescriber can prescribe NRT as well as prescribe chronic health medications with assistance and consultation of PCP. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 2. Evidence based  care for preventive  interventions  and common chronic health conditions | 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. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 3. Ongoing care management | 3.1 Longitudinal clinical monitoring & engagement for preventive health and/or chronic health conditions. | None or minimal f/u of patients referred to primary and medical specialty care. | Some ability to perform f/u of general health appointments, encourage medication adherence and navigation to appointments. | Routine proactive follow-up and tracking of patient medical outcomes and availability of coaching (in person or using technology application) to ensure engagement and early response. | Use of tracking tool (e.g., excel tracker or disease registry software) to monitor treatment response and outcomes over time at individual and group level, coaching and proactive f/u with appointment reminders. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 4. Self-management support that is adapted to culture, socioeconomic and life experiences of patients | 4.1 Use of tools to promote patient activation & recovery with adaptations for literacy, economic status, language, cultural norms | None or minimal patient education on general medical conditions and universal general health risk factor screening recommendations. | Some availability of patient education on universal general health risk factor screening recommendations, including materials/handouts/web-based resources, with limited focus on self-management goal-setting. | Routine brief patient education delivered in person or technology application, on universal and targeted preventive screening recommendations and chronic health conditions. Treatment plans include diet and exercise, with routine use of self-management goal-setting. | Routine patient education with practical strategies for patient activation and healthy lifestyle habits (exercise & healthy eating) delivered using group education, peer support, technology application and/or on-site or community-based exercise programs. Self-management goals outlined in treatment plans. Advanced directives discussed and documented when appropriate. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 5. Multidisciplinary team (including patients) with dedicated time to provide general health care | 5.1 Care Team | BH provider(s), patient, family caregiver[[6]](#endnote-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. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 5. Multidisciplinary team (including patients) with dedicated time to provide general health care | 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. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 5. Multidisciplinary team (including patients) with dedicated time to provide general 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 behavioral and physical health. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 6. Systematic quality improvement (QI) | 6.1 Use of quality metrics for general health program improvement and/or external reporting | None or minimal use of general health quality metrics (limited use of data, anecdotes, case series). | Limited tracking of state or health plan quality metrics and some ability to track and report group level preventive care screening rates such as smoking, SUD, obesity, or HIV screening, etc. | Periodic monitoring of identified outcome and general health quality metrics (e.g., BMI, smoking status, alcohol status, annual wellness visits, medications and common chronic disease metrics, primary care indicators) and ability to regularly review performance against benchmarks. | Ongoing systematic monitoring of population level performance metrics (balanced mix of PC and BH indicators), ability to respond to findings using formal improvement strategies, and implementation of improvement projects by QI team/champion. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 7. Linkages with community/social services that improve general health and mitigate environmental risk factors | 7.1 Linkages to housing, entitlement, other social support services | No or limited/informal screening of social determinants of health (SDOH) and linkages to social service agencies, limited information exchange or follow-up. | Routine SDOH screening and referrals made to social service agencies, with limited information exchange or follow-up. | Routine SDOH screening, with information exchange with social service agencies, with limited capacity for follow-up. | Detailed psychosocial assessment incorporating  broad range of SDOH needs  patients linked to social  service organizations/  resources to help improve  appointment adherence (e.g.,  childcare, transportation  tokens), healthy food  sources (e.g., food pantry),  with f/u to close the loop. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 8. Sustainability | 8.1 Build process for billing and outcome reporting to support sustainability of integration efforts | No or minimal attempts to bill for immunizations, screening and treatment. Services supported primarily by grants or other non-reimbursable sources. | Billing for screening and treatment services (e.g., HbA1c, preventive care, blood pressure monitoring) under fee-for-services with process in place for tracking reimbursements for general health care services. | Fee-for-service billing as well as revenue from quality incentives related to physical health (e.g., diabetes and CV monitoring, tobacco screening). Able to bill for both primary care services and BH services. | Receipt of value-based payments (shared savings) that reference achievement of BH and general health outcomes. Revenue helps support integrated physical health services and workforce. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

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| **Key Domains of Integrated Care** | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| 8. Sustainability | 8.2 Build process for expanding regulatory and/or licensure opportunities | No primary care arrangements that offer physical health services through linkage or partnership. | Informal primary care arrangements that incorporate the basic array (e.g. appointment availability, feedback on engagement, report on required blood work) of desired physical health services. | Consistent availability of primary care access, internal or external, with telehealth if appropriate that incorporate patient centered home services. | Maintain appropriate dual licensure ([WAC chapter 246-320](https://apps.leg.wa.gov/WAC/default.aspx?cite=246-320) & [RCW 70.41](https://app.leg.wa.gov/rcw/default.aspx?cite=70.41) and [RCW 71.24](https://app.leg.wa.gov/rcw/default.aspx?cite=71.24) & [WAC 246-341](https://apps.leg.wa.gov/WAC/default.aspx?cite=246-341)) for integrated physical and behavioral health services in a shared services setting and regularly assess the need for administrative or clinical updates as licensure requirements evolve. |  |

If applicable, please share your thoughts or comments on this question, including any barriers you may have encountered as you assessed your organization on this subdomain and what resources are needed to advance on the continuum.

26. What are the top three challenges your clinical site faces in advancing integration?

* + - Financial Support
    - Leadership support
    - Partnerships with other clinical providers
    - Technology
    - Workforce
    - Other (please specify)

*If you would like to share more about the challenges you have selected please do so here. (free text box for short narrative).*

27. What resources/support does your clinical site need to advance integration? *(short narrative)*

*Please share any other comments or feedback you may have after completing the assessment tool.*

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. [↑](#endnote-ref-1)
2. Common general health conditions include diabetes, hypertension, hyperlipidemia, coronary artery disease, asthma, arthritis, gastrointestinal disease, tooth and gum disease. [↑](#endnote-ref-2)
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. [↑](#endnote-ref-3)
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. [↑](#endnote-ref-4)
5. Embedded and co-located arrangements include PCPs available through telehealth services. [↑](#endnote-ref-5)
6. Family caregivers are part of team if appropriate to patient care. [↑](#endnote-ref-6)