**Washington State Integrated Care Assessment for Primary Care Settings**

*Based on the 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 and modified with input from primary author (Chung). (*[*https://uhfnyc.org/media/filer\_public/61/87/618747cf-9f4b-438d-aaf7-6feff91df145/bhi\_finalreport.pdf*](https://uhfnyc.org/media/filer_public/61/87/618747cf-9f4b-438d-aaf7-6feff91df145/bhi_finalreport.pdf)*)*

**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%2BNC%2BLunch%2Band%2BLearn%2BDLA-20%2BPresentation%2B%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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Clinical Workflow**  | 1. Screening, referral to care and follow-up (f/u) | 1.1 Screening, initial assessment, follow-up for common Behavioral Health (BH) conditions | Patient/clinician identification of those with BH symptoms—not systematic | Systematic BH screening of targeted patient groups (e.g., those with diabetes, CAD), with follow-up for assessment | Systematic BH screening of all patients, with follow-up for assessment and engagement | Analysis of patient population to stratify patients with high-risk BH conditions for proactive assessment and engagement |  |

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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Clinical Workflow**  | 1. Screening, referral to care and follow-up (f/u) | 1.2 Facilitation of referrals, feedback | Referral only, to external BH provider(s)/ psychiatrist | Referral to external BH provider(s)/psychiatrist through a written agreement detailing engagement, with feedback strategies | Enhanced referral to internal/co-located BH clinician(s)/psychiatrist, with assurance of “warm handoffs” when needed | Enhanced referral facilitation with feedback via EHR or alternate data-sharing mechanism, and accountability for engagement |  |

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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Clinical Workflow**  | 2. Evidence- based care for preventive interventionsand common behavioral healthconditions | 2.1 Evidence-based guidelines/treatmentprotocols | None, with limited training on BH disorders and treatment | PCP training on evidence-based guidelines for common behavioral health diagnoses and treatment | Systematic use of evidence-based guidelines for all patients; tools for regular monitoring of symptoms | Systematic tracking of symptom severity; protocols for intensification of treatment when appropriate |  |

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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Clinical Workflow**  | 2. Evidence- based care for preventive interventionsand common behavioral healthconditions | 2.2 Use of psychiatric medications | PCP-initiated, limited ability to refer or receive guidance | PCP-initiated, with referral when necessary to a prescribingBH prescriber /psychiatrist formedication follow-up | PCP-managed, with support of BH prescriber/ psychiatrist as necessary | PCP-managed, with care management supporting adherence between visits and BH prescriber(s)/ psychiatrist support |  |

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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Clinical Workflow**  | 2. Evidence- based care for preventive interventionsand common behavioral healthconditions | 2.3 Access to evidence-based psychotherapy with BH provider(s) | Supportive guidance provided by PCP, with limited ability to refer | Referral to external resources for counseling interventions | Brief psychotherapy interventions provided by co-located BH provider(s) | Broad range of evidence-based psychotherapy provided by co-located BH provider(s) as part of overall care team, with exchange of information |  |

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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Clinical Workflow**  | 3. Information exchange among providers | 3.1 Sharing of treatment information | Minimal sharing of treatment information within care team | Informal phone or hallway exchange of treatment information, without regular chart documentation | Exchange of treatment information through in-person or telephonic contact, with chart documentation | Routine sharing of information through electronic means (registry, shared EHR, shared care plans) |  |

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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Clinical Workflow**  | 4. Ongoing care management | 4.1 Longitudinal clinical monitoring and engagement | Limited follow-up of patients by office staff | Proactive follow-up (no less than monthly) to ensure engagement or early response to care | Use of tracking tool to monitor symptoms over time and proactive follow-up with reminders for outreach | Tracking integrated into EHR, including severity measurement, visits, care management interventions (e.g., relapse prevention techniques, behavioral activation), proactive follow-up; selected medical measures (e.g., blood pressure, A1C) tracked when appropriate |  |

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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Clinical Workflow**  | 5. Self-management support that is adapted to culture, socioeconomic and life experiences of patients | 5.1 Use of tools to promote patient activation and recovery with adaptations for literacy, language, local community norms | Brief patient education on BH condition provided by PCP | Brief patient education on BH condition, including materials/handouts and symptom score reviews, but limited focus on self-management goal-setting | Patient education and participation in self-management goal setting (e.g., sleep hygiene, medication adherence, exercise) | Systematic education and self-management goal-setting, with relapse prevention and care management support between visits |  |

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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Workforce**  | 6. Multidisciplinary team (including patients) to provide care | 6.1 Care Team | PCP, patient | PCP, patient, ancillary staff member | PCP, patient, ancillary staff member, care manager, BH provider(s) | PCP, patient, ancillary staff member, care manager, BH provider(s), psychiatrist (contributing to shared care plans) |  |

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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Workforce**  | 6. Multidisciplinary team (including patients) 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 using patient as conduit | Regular written communication (notes/consult reports) between PCP and BH provider(s), occasional information exchange via ancillary staff, on complex patients | Regular in-person, phone, or e-mail communications between PCP and BH provider(s) to discuss complex cases | Weekly team-based case reviews to inform care planning and focus on patients not improving behaviorally or medically, with capability of informal interaction between PCP and BH provider(s) |  |

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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Management Support** | 7. Systematic Quality Improvement (QI) | 7.1 Use of quality metrics for program improvement | Informal or limited use of BH quality metrics (limited use of data, anecdotes, case series) | Use of identified metrics (e.g., depression screening rates, depression response rates) and some ability to regularly review performance | Use of identified metrics, someability to respond to findings using formal improvementstrategies | Ongoing systematic quality improvement (QI) with monitoring of population-level performance metrics, 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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Management Support** | 8. Linkages with community/social services that improve general health and mitigate environmental risk factors | 8.1 Linkages to housing, entitlement, other social support services | Few linkages to social services, no formal arrangements | Referrals made to agencies, some formal arrangements, but little capacity for follow-up | Screening for social determinants of health (SDOH), patients linked to community organizations/resources, with follow-up | Developing, sharing, implementing unified care plan between agencies, with SDOH referrals tracked |  |

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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| **Role** | **Key Domains of Integrated Care**  | **Sub-Domain** | **Preliminary** | **Intermediate I.** | **Intermediate II.** | **Advanced** | **Self-Assessed Level** |
| **Management Support** | 9. Sustainability  | 9.1 Build process for billing and outcome reporting to support sustainability of integration efforts | Limited ability to bill for screening and treatment, or services supported primarily by grants | Billing for screening and treatment services (e.g., SBIRT, PHQ screening, BH treatment, care coordination) under fee for service, with process in place for tracking reimbursements | Fee for service billing, and additional revenue from quality incentives related to BH integration | Receipt of global payments that account for achievement of behavioral health and physical health outcomes |  |

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.

24. 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).*

25. 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.*