Statewide Baseline Report

Cohort 1

Washington Integrated Care Assessment (WA-ICA) for Primary Care Settings

A Collaboration with the Health Care Authority, all 9 ACHs, and the 5 MCOs

Data Collection Period: July – Aug 2022
The WA-ICA has been adapted from the work of Dr. Henry Chung and the framework for Continuum-Based Behavioral Health Integration and General Health Integration in Behavioral Health Settings. This framework was developed using extensive literature review and stakeholder expertise.

With 9 domains and 13 subdomains, the assessment framework lays out the key elements of behavioral health integration into the primary care setting. Foundational domains are those considered core to advancing integrations and can be an opportunity to focus improvement when a practice is in the preliminary stage.

Practices assess their integrated care delivery along a continuum which identifies standards for a practice in the preliminary, intermediate I, intermediate II, and advanced categories of integration for each subdomain. This continuum-based model acknowledges that many practices range in their implementation of integration standards across domains, depending on population served, location, size, funding types/sources, workforce capacity, physical space, etc. This means that different practices may find that while they meet the advanced or intermediate category standards in some domains, they meet the preliminary standards in others.

The framework allows practices to assess their readiness for advancement in any given domain or subdomain and to prioritize goals and resource allocation accordingly. Thus, in addition to assessing a practice’s current level of integration, the assessment framework serves as a road map for progress.
The Washington Integrated Care Assessment (WA-ICA) is a collaboration of the Health Care Authority, all 9 ACHs, and the 5 MCOs

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The Washington Integrated Care Assessment (WA-ICA) is a collaboration of the Health Care Authority, all 9 ACHs, and the 5 MCOs
1. Integration readiness is stronger at primary care than behavioral health sites. Most primary care sites are in intermediate stages and above. (79) Primary Care sites across Washington state responded in Cohort 1, representing a 45% site response rate.

2. Foundational Areas of Strength*: Strengths are evident across all of the foundational domains. Referral facilitation (1.2) is the greatest opportunity for improvement.

3. Opportunities for Improvement: Quality Improvement (7.1) Team-based care review (6.2) Subdomains with most improvement potential vary by ACH/MCO region.

4. Opportunities for Foundational Improvement*: Referrals facilitation and feedback (1.2)

* Foundational Domain. Sites in preliminary stages can focus on these areas to establish a foundation for advancing integrated care.

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**Opportunities for Improvement**

**Subdomains with Highest % Sites in Preliminary**

1.2 Facilitation of referrals, feedback

6.2 Systematic multidisciplinary team-based patient care review processes

7.1 Use of quality metrics for program improvement

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- **Primary Care**

**Subdomains with 3 highest percentages of sites in Preliminary integration stage**

- N = 79

*Foundational Domain.* Sites in preliminary stages can focus on these areas to establish a foundation for advancing integrated care.

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*The Washington Integrated Care Assessment (WA-ICA) is a collaboration of the Health Care Authority, all 9 ACHs, and the 5 MCOs*
Primary Care

Foundational Domains* – Sites in Preliminary integration stage
- N = 79

* Foundational Domain. Sites in preliminary stages can focus on these areas to establish a foundation for advancing integrated care.

1.1 Screening, initial assessment, follow-up for common Behavioral Health (BH) conditions

4.1 Longitudinal clinical monitoring and engagement

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

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Response Rate & Characteristics

The Washington Integrated Care Assessment (WA-ICA) is a collaboration of the Health Care Authority, all 9 ACHs, and the 5 MCOs.
Statewide Response Rate

Cohort 1 - Responses received July 11 - August 22, 2022

- 174 primary care sites representing 55 primary care organizations were invited to complete the assessment
- 28 orgs responded / 55 orgs invited = 51% Org Response Rate
- 79 sites responded / 174 sites invited = 45% Site Response Rate

<table>
<thead>
<tr>
<th></th>
<th>Org Response Rate (responded / invited)</th>
<th>Site Response Rate (responded / invited)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>57% (58/102 orgs)</td>
<td>65% (126/195 sites)</td>
</tr>
<tr>
<td>Primary Care</td>
<td>51% (28/55 orgs)</td>
<td>45% (79/174 sites)</td>
</tr>
<tr>
<td>All</td>
<td>55% (86/157 orgs)</td>
<td>56% (205/369 sites)</td>
</tr>
</tbody>
</table>

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ACH Region Response Count

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Three regions account for 81% of site responses.

59% of Cohort 1 invitees were in these 3 regions.
Supplemental Questions

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

<table>
<thead>
<tr>
<th></th>
<th># Sites</th>
<th>% of Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both</td>
<td>54</td>
<td>68%</td>
</tr>
<tr>
<td>Adults</td>
<td>21</td>
<td>27%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>4</td>
<td>5%</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>100%</td>
</tr>
</tbody>
</table>

The Washington Integrated Care Assessment (WA-ICA) is a collaboration of the Health Care Authority, all 9 ACHs, and the 5 MCOs.
2. Please select **any/all** categories that apply to your clinical site:

<table>
<thead>
<tr>
<th>Clinic Type</th>
<th>Count</th>
<th>% of Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>40</td>
<td>51%</td>
</tr>
<tr>
<td>Co-located Behavioral Health and Primary Care</td>
<td>35</td>
<td>44%</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>22%</td>
</tr>
<tr>
<td>Behavioral Health (mental health only)</td>
<td>11</td>
<td>14%</td>
</tr>
<tr>
<td>Behavioral Health (mental health AND SUD)</td>
<td>6</td>
<td>8%</td>
</tr>
<tr>
<td>Rural Health Clinic</td>
<td>3</td>
<td>4%</td>
</tr>
<tr>
<td>Opioid Treatment Program (OTP)</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>Rural Health Clinic</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

Characteristics of Cohort 1 Responses - N = 79

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3. Approximately how many patients are seen at your clinical site each month?

<table>
<thead>
<tr>
<th></th>
<th>BH Sites - Monthly Patients</th>
<th>Primary Care Sites - Monthly Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>15,000</td>
<td>79*</td>
</tr>
<tr>
<td>25% Percentile</td>
<td>7,587</td>
<td>4,030</td>
</tr>
<tr>
<td>Median</td>
<td>2,000</td>
<td>783</td>
</tr>
<tr>
<td>75% Percentile</td>
<td>2,463</td>
<td>50</td>
</tr>
<tr>
<td>Max</td>
<td>9,830</td>
<td>15,000</td>
</tr>
</tbody>
</table>

*Actual number of responses used in analysis may vary to account for data quality or missing data.

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Primary Care Characteristics of Cohort 1

PC Sites N = 79*
BH Sites N = 126*
4. What is the approximate payor mix of patients seen at your clinical site in an average month?

<table>
<thead>
<tr>
<th>Payor</th>
<th>Min</th>
<th>25% Percentile</th>
<th>Median</th>
<th>75% Percentile</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>7%</td>
<td>21%</td>
<td>44%</td>
<td>65%</td>
<td>85%</td>
</tr>
<tr>
<td>Medicare</td>
<td>0%</td>
<td>7%</td>
<td>17%</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>Commercial Insurance</td>
<td>0%</td>
<td>16%</td>
<td>21%</td>
<td>39%</td>
<td>77%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>0%</td>
<td>2%</td>
<td>5%</td>
<td>12%</td>
<td>38%</td>
</tr>
<tr>
<td>Fee for Service</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>10%</td>
<td>100%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>39% (“Self-pay”)</td>
</tr>
</tbody>
</table>

Payor mix differs significantly between Behavioral Health and Primary Care sites. Median Medicaid for Behavioral Health is double that of Primary Care (89% vs. 44%).

Medicare and commercial representation is higher at Primary Care than Behavioral Sites. Medicare median is 1% for Behavioral vs 17% for Primary Care. Commercial median is 4% for Behavioral vs 21% for Primary Care.
6. Does your clinical site currently use any of the following Social Determinants of Health (SDOH) screening tools? (select all that apply):

<table>
<thead>
<tr>
<th>Type</th>
<th>Count</th>
<th>% Sites (count / N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>40</td>
<td>51%</td>
</tr>
<tr>
<td>None of the above – our site does not currently use a screening tool</td>
<td>19</td>
<td>24%</td>
</tr>
<tr>
<td>Accountable Health Communities (AHC) tool (also known as the Health-Related Social Needs (HRSN) tool)</td>
<td>18</td>
<td>23%</td>
</tr>
<tr>
<td>PRAPARE</td>
<td>12</td>
<td>15%</td>
</tr>
<tr>
<td>Daily Living Activities—20 (DLA-20)</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>WellRx</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Health Leads Social Needs Screening</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

‘Other’ (internal and EPIC-based) is the top screening tool cited by sites.

A quarter of sites do not use any SDoH screening tool.
7. What funding sources support your integrated care efforts? (select all that apply):

<table>
<thead>
<tr>
<th>Type</th>
<th>Count</th>
<th>% Sites (count / N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for service billing</td>
<td>64</td>
<td>81%</td>
</tr>
<tr>
<td>Grants</td>
<td>39</td>
<td>49%</td>
</tr>
<tr>
<td>Value based payment arrangements</td>
<td>35</td>
<td>44%</td>
</tr>
<tr>
<td>Capitated PMPM rate</td>
<td>28</td>
<td>35%</td>
</tr>
<tr>
<td>Collaborative Care codes</td>
<td>22</td>
<td>28%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>5%</td>
</tr>
<tr>
<td>None</td>
<td>2</td>
<td>3%</td>
</tr>
</tbody>
</table>

Only 11% of BH sites reported value-based payments for their efforts vs. 44% of PC sites. VBP supports 1 in 10 Behavioral Health sites, compared to half of all Primary Care sites.

Collaborative Care codes support only 2% of BH sites for integration versus 28% for PC sites. CoCM codes support only 1 in 50 Behavioral Health sites, compared to 1 in 3 Primary Care sites.
9. Which of the following IT and/or population health tools are in use at your clinical site? (select all that apply): 

<table>
<thead>
<tr>
<th>Type</th>
<th>Count</th>
<th>% Sites (count / N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Health Records</td>
<td>79</td>
<td>100%</td>
</tr>
<tr>
<td>Electronic referrals to outside services</td>
<td>56</td>
<td>71%</td>
</tr>
<tr>
<td>Registries</td>
<td>51</td>
<td>65%</td>
</tr>
<tr>
<td>Shared care plans</td>
<td>46</td>
<td>58%</td>
</tr>
<tr>
<td>Health information exchanges (HIE)</td>
<td>42</td>
<td>53%</td>
</tr>
<tr>
<td>Closed loop referral systems with outside services</td>
<td>26</td>
<td>33%</td>
</tr>
<tr>
<td>Community information exchanges (CIE)</td>
<td>15</td>
<td>19%</td>
</tr>
</tbody>
</table>

100% of sites use an EHR system, and about 3 out of 4 sites use electronic external referrals.

Community Information Exchanges are used by 1 in 5 primary care sites, in contrast to about 1 in 20 behavioral health sites.
10. Approximately what percentage of patient visits at your clinical site are virtual vs. in-person in an average month?

<table>
<thead>
<tr>
<th></th>
<th>Min</th>
<th>25% Percentile</th>
<th>Median</th>
<th>75% Percentile</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Virtual (video)</td>
<td>0%</td>
<td>1%</td>
<td>5%</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>% Virtual (telephone only)</td>
<td>0%</td>
<td>0%</td>
<td>4%</td>
<td>10%</td>
<td>50%</td>
</tr>
<tr>
<td>% In-Person</td>
<td>0%</td>
<td>77%</td>
<td>87%</td>
<td>93%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Most sites reported much more in-person patient visits than virtual. Behavioral Health sites use virtual video for patient visits more than Primary Care sites.

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24. What are the top three challenges your site faces in advancing integration? (select three)

<table>
<thead>
<tr>
<th>Type</th>
<th>Count</th>
<th>% Sites (count / N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce</td>
<td>74</td>
<td>94%</td>
</tr>
<tr>
<td>Financial Support</td>
<td>72</td>
<td>91%</td>
</tr>
<tr>
<td>Partnerships with other clinical providers</td>
<td>39</td>
<td>49%</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>23%</td>
</tr>
<tr>
<td>Technology</td>
<td>17</td>
<td>22%</td>
</tr>
<tr>
<td>Leadership Support</td>
<td>6</td>
<td>8%</td>
</tr>
</tbody>
</table>

Workforce and Financial Support are the top challenges to advancing integration. These were the top challenges across both BH and primary care sites.
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Summary of Narrative Themes

- 5. How will advancing integration help you address health equity?
  1. Culturally-Responsive Healthcare for BIPOC, non-English primary, and Refugee Communities
  2. Address Whole-Person Care
  3. Increase Access and Reduce Stigma

- 8a. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts?
  1. Warm Hand-offs
  2. Telehealth and Virtual Care
  3. Collaborative Care Billing Codes (CoCM)

- 8b. Where is there room for improvement?
  1. Workforce Support
  2. Licensure Requirements
  3. Payment Reimbursement Models

- 25. What resources/support does your clinical site need to advance integration?
  1. Payment Structures and Reimbursement
  2. Workforce Support
  3. Integration Model for Pediatrics
  4. Community Collaboration and Idea-Sharing
  5. CIE for Centralized Behavioral Health Service Directory
  6. Technical Assistance for Integration
5. How will advancing integration help you address health equity?

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.

1. Culturally-Responsive Healthcare for BIPOC, non-English primary, and Refugee Communities

“Onsite, integrated behavioral health allows us to meet more urgent patient care needs that may not be accessible to certain populations if services are offsite. Data supports that referrals to services and specialists are less likely to be completed in BIPOC populations or individuals with a non-English primary language. In an integrated model, patients with significant barriers to care (transportation, language, cultural stigma, financial concerns, etc.) can engage in behavioral health services following a warm handoff, often same day or within the week.”

“We are able to stratify data and understand which populations are thriving (or not) in our clinics. We know, for example, that we have work to do with populations that are recent refugees and have PTSD and a chronic condition. That knowledge led to the development of a new refugee clinic that approaches care for refugees differently than care in our general population and combines the expertise of medical providers, social workers, and behavioral health care.”

“We hope that advancing integration will allow us to continue to serve underserved communities of color. We want to hire more clinicians and staff that are bilingual in order to better serve our patients. There is a high need for mental health providers in our area especially providers that speak Spanish.”
5. How will advancing integration help you address health equity?

2. Address Whole-Person Care

“Advancing integration would...allow patients to be seen more frequently by behavioral health providers for health conditions such as hypertension, diabetes, and smoking cessation, disorders that have a basis in behavior change and impact an individual’s life-long functioning.”

“Advancing integration leads to more opportunities for universal screening and immediate responses to universal screening. One of the most equitable ways to determine the needs of patients is to screen universally in order to ensure that all patients are given the chance to express needs and are given support to address those needs.”

3. Increase Access and Reduce Stigma

“It is much easier to engage patients at their primary care office and not have to ask them to schedule with an outside provider or go to a new location.”

“In our co-located clinic, we are able to reach the underserved populations here in Spokane that find behavioral health intimidating and create a more welcoming, inclusive environment.”
8a. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts?

1. Warm Hand-offs
   “Warm handoffs are working really well, and we know this is incredibly beneficial for the patient.”

2. Telehealth and Virtual Care
   “We have seen audio-only telephone care become essential to integration and health equity over the past two years through the expansion of telehealth laws during the pandemic. Tightening restrictions on these will hurt patient access to services and provider flexibility. Not only have we seen no show rates decline with the use of telephone based encounters, but staff also report a quality of life improvement when allowed to work remotely for a portion of their clinical week, which has been vital in battling burnout. We hope to see the expansion of these services continue and for the reimbursement to remain equal or close to a standard face-to-face office visit.”
   “The flexibility to do more of our care via telehealth due to the COVID pandemic waivers has been helpful to reach more of our families where they are.”

3. Collaborative Care Billing Codes (CoCM)
   “The clinician at this clinic started using the Collaborative Care billing codes in 2021, starting with 1-2 patients...it provided billing and coding departments a chance to monitor the new process. In turn this allowed for adjustments and corrections as the clinician continued to move toward billing all Collaborative Care codes...Three months in to using CoCM billing codes exclusively, it appears that the Collaborative Care program as a whole will be sustainable using the codes.”

Primary Care sites listed using CoCM codes as a strength.
In contrast, Behavioral Health sites cited CoCM Codes as an area needing improvement.
• 8b. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts? Where is there room for improvement?

1. Workforce Support

“We have the need for more mental health providers at our health center. We struggle to find providers in our area.”

“Healthcare as an industry has struggled to grow wages in accordance with ever growing cost of living and we are finding it more difficult than ever to offer competitive wages to mental health clinicians that have an abundance of job opportunities and live in one of the most robust and expensive cities in the country. Being able to offer behavioral healthcare provider wages closer to those of medical provider peers would help to entice people into the field (because we need more clinicians) and help attract quality clinicians to our community health setting and keep them here for continuity of care.”

“Reimbursement methods alone cannot cover the costs to add critical staffing resources to the clinic.”

“There is currently not a clinician in this clinic.”
8b. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts? Where is there room for improvement?

2. Licensure Requirements
“If Medicare were to expand their reimbursement to LMHC and LMFT license types, we would significantly broaden the pool of potential clinicians to serve our patient population.”

“Licensing requirements for LISWs are rigorous and expensive, prohibiting some from obtaining the full licensure. One must complete a Master’s degree then obtain 3000 hours of supervised work before they can qualify to take the state licensing exam. During the time they are obtaining their 3000 hours they can have an Associates license, however their employer has to provide a supervisor and the supervisor needs to be on the premises whenever the Associates therapist is seeing patients. Supervisory Clinical Therapists are in high demand with limited supply. Other BH types should be able to provide BH billable BH services, or their work should be valued/funded with alternate funding sources.”

3. Payment Reimbursement Models
“Reimbursement for [associates] is so low or non-existent...If we could get a system in place where we can help associates complete their clinical hours + receive reimbursement, that would be ideal.”

“Reimbursement is insufficient to cover the cost of care coordination. The care coordination work required to ensure open access, long-term engagement, a no-show rate of less than 10%, and continued tracking of patient outcomes is largely unreimbursed. We need CPT codes for complex chronic behavioral health care with allowed amounts sufficient to cover the cost of care coordination. Presently, there is no reimbursement for the first 40 minutes of care coordination each month for the 25% of our total patient population with a behavioral health diagnosis.”
25. What resources/support does your clinical site need to advance integration?

1. Payment Structures and Reimbursement

“The interpreter process for Medicaid patients is broken. Currently, there is only one vendor contracted to provide reimbursable interpreter services for Medicaid patients. There is limited availability for interpreters - in the last 18 months we’ve had 1,154 denials because there wasn’t an interpreter available. There are ongoing issues of interpreters no-showing for scheduled appointments and certain languages not being available, especially indigenous languages. A good example is that American Sign Language was not previously available. A process was just recently implemented to offer ASL, however it is scheduled through a separate portal and has very limited availability. Additionally, there are no reimbursable interpreter services available for Medicaid patients who walk into the clinic for an urgent need, because the Medicaid-approved interpreter services must be scheduled in advance. If providers use a different interpreter service for Medicaid patients, it is not reimbursable. The result is compromised service to patients and cost burden to providers. We need to revise regulations to allow providers to choose the interpreter services that meet their patient and operational needs, and to receive reimbursement for these services.”

“Billing mechanism to move beyond grant funded initiative to support care coordination, peer navigation and nursing outreach services.”

“More BH providers, BH funding, better reimbursements for BH services”
Cohort 1 Narrative Responses and Themes

N = 79

• 25. What resources/support does your clinical site need to advance integration?

2. Workforce Support
“We have tools within our EHR to build registries and proactively outreach, but no individual within a case management role to lead or track this. We also do not have internal staff capability to add this piece of work to an existing staff person (PSR, MA, RN, etc). A dedicated person to manage this piece of work would be the primary resource needed to advance integration.”

“Hiring and retention of clinical BH providers is the biggest challenge. We would benefit from...financial support strategies for non-clinical care positions that would advance integration activities, including case/care management and social work.”

3. Integration Model for Pediatrics
“ Asking about integration is like asking someone with no food to try to eat healthier. Who are we trying to integrate with? There are not enough BH providers and they have no need to integrate...
We consult with a variety of specialists in many areas. We do not have the ancillary staff to have multidisciplinary meetings. We provide a very wide range of services from well-care, to behavioral health, to seeing acutely ill patients, And, we do it for approximately 10-15% of the cost of an ER visit. Hospitals and ERs have lots of ancillary staff, such as social workers, care coordinators, care managers, and other staff. They use RNs (we use MAs). A multidisciplinary integrated health team is what ought to happen in the hospital with very ill and complex patients. There is not a model to use for outpatient, primary care pediatrics.”

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## Cohort 1 Narrative Responses and Themes

- **N = 79**

### 25. What resources/support does your clinical site need to advance integration?

<table>
<thead>
<tr>
<th><strong>4. Community Collaboration and Idea-Sharing</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>“Continued collaboration with other organizations in the community working to implement integration, to brainstorm and share ideas.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>5. CIE for Centralized Behavioral Health Service Directory</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>“A shared location to find all behavioral health services and the type of insurance they accept in the county would be beneficial. Our clinic, as well as community would benefit from a CIE that is available to healthcare providers in the region.” (King and Pierce counties)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>6. Technical Assistance for Integration</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>“Social Determinant screening guidance and IT support to capture the data, track and monitor progress”</td>
</tr>
<tr>
<td>“Continued identification of patients that could benefit from behavioral health services and more routine pathways and assessments of patients not presenting with concerns to help catch underlying behavioral health difficulties and/or focus on preventative work.”</td>
</tr>
</tbody>
</table>
Results by ICA Framework Subdomains
(Distribution of Site Responses)
ICA Framework Domains

1. Screening, referral to care and follow-up.*
2. Evidence-based care for preventive interventions.
3. Information exchange among providers.
4. Ongoing care management.*
5. Self-management support that is adapted to culture, socioeconomic and life experiences of patients.*
6. Multi-disciplinary team (including patients) to provide care.
7. Systematic quality improvement.
8. Linkages with community/social services that improve general health and mitigate environmental risk factors.

* Foundational Domain. Sites in preliminary stages can focus on these areas to establish a foundation for advancing integrated care.
Screening

Preliminary: Patient/clinician identification of those with BH symptoms—not systematic

Intermediate I: Systematic BH screening of targeted patient groups (e.g., those with diabetes, CAD), with follow-up for assessment

Intermediate II: Systematic BH screening of all patients, with follow-up for assessment and engagement

Advanced: Analysis of patient population to stratify patients with high-risk BH conditions for proactive assessment and engagement

Foundational Domain

Preliminary: 13%
Intermediate I: 23%
Intermediate II: 43%
Advanced: 22%

% Responses, N = 79

The Washington Integrated Care Assessment (WA-ICA) is a collaboration of the Health Care Authority, all 9 ACHs, and the 5 MCOs
Referrals

**Preliminary**: Referral only, to external BH provider(s)/psychiatrist

**Intermediate I**: Referral to external BH provider(s)/psychiatrist through a written agreement detailing engagement, with feedback strategies

**Intermediate II**: Enhanced referral to internal/co-located BH clinician(s)/psychiatrist, with assurance of “warm handoffs” when needed

**Advanced**: Enhanced referral facilitation with feedback via EHR or alternate data-sharing mechanism, and accountability for engagement

---

**Foundational Domain**

**Subdomain with highest % in Preliminary**

- **Preliminary**: 22%
- **Intermediate I**: 3%
- **Intermediate II**: 51%
- **Advanced**: 25%

% Responses, N = 79

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Evidence-based Care

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

Subdomain
2.1 Evidence-based guidelines/treatment protocols

Primary Care
N = 79

Question 13

Preliminary: None, with limited training on BH disorders and treatment

Intermediate I: PCP training on evidence-based guidelines for common behavioral health diagnoses and treatment

Intermediate II: Systematic use of evidence-based guidelines for all patients; tools for regular monitoring of symptoms

Advanced: Systematic tracking of symptom severity; protocols for intensification of treatment when appropriate

% Responses, N = 79

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Medication Management

**Preliminary**: PCP-initiated, limited ability to refer or receive guidance

**Intermediate I**: PCP-initiated, with referral when necessary to a prescribing BH prescriber /psychiatrist for medication follow-up

**Intermediate II**: PCP-managed, with support of BH prescriber/ psychiatrist as necessary

**Advanced**: PCP-managed, with care management supporting adherence between visits and BH prescriber(s)/ psychiatrist support

% Responses, N = 79

The Washington Integrated Care Assessment (WA-ICA) is a collaboration of the Health Care Authority, all 9 ACHs, and the 5 MCOs
## Therapy Access

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

### Subdomain
2.3 Access to evidence-based psychotherapy with BH provider(s)

### Primary Care
N = 79

### Question 15

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preliminary</td>
<td>Supportive guidance provided by PCP, with limited ability to refer</td>
<td>5%</td>
</tr>
<tr>
<td>Intermediate I</td>
<td>Referral to external resources for counseling interventions</td>
<td>37%</td>
</tr>
<tr>
<td>Intermediate II</td>
<td>Brief psychotherapy interventions provided by co-located BH provider(s)</td>
<td>29%</td>
</tr>
<tr>
<td>Advanced</td>
<td>Broad range of evidence-based psychotherapy provided by co-located BH provider(s) as part of overall care team, with exchange of information</td>
<td>29%</td>
</tr>
</tbody>
</table>

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Domain
3. Information exchange among providers

Subdomain
3.1 Sharing of treatment information

Primary Care
N = 79

Question 16

Information Sharing

- **Preliminary**: Minimal sharing of treatment information within care team
  - 15%

- **Intermediate I**: Informal phone or hallway exchange of treatment information, without regular chart documentation
  - 6%

- **Intermediate II**: Exchange of treatment information through in-person or telephonic contact, with chart documentation
  - 25%

- **Advanced**: Routine sharing of information through electronic means (registry, shared EHR, shared care plans)
  - 53%

% Responses, N = 79
Patient Tracking

**Preliminary**: Limited follow-up of patients by office staff

**Intermediate I**: Proactive follow-up (no less than monthly) to ensure engagement or early response to care

**Intermediate II**: Use of tracking tool to monitor symptoms over time and proactive follow-up with reminders for outreach

**Advanced**: 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

% Responses, N = 79

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The Washington Integrated Care Assessment (WA-ICA) is a collaboration of the Health Care Authority, all 9 ACHs, and the 5 MCOs
Domain
5. Self-management support that is adapted to culture, socioeconomic and life experiences of patients

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

Primary Care
N = 79

Question 18

Preliminary: Brief patient education on BH condition provided by PCP

Intermediate I: Brief patient education on BH condition, including materials/handouts and symptom score reviews, but limited focus on self-management goal-setting

Intermediate II: Patient education and participation in self-management goal setting (e.g., sleep hygiene, medication adherence, exercise)

Advanced: Systematic education and self-management goal-setting, with relapse prevention and care management support between visits

% Responses, N = 79
The Washington Integrated Care Assessment (WA-ICA) is a collaboration of the Health Care Authority, all 9 ACHs, and the 5 MCOs

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

Subdomain
6.1 Care Team

Primary Care

N = 79

Question 19

Care Team

Preliminary: PCP, patient

Intermediate I: PCP, patient, ancillary staff member

Intermediate II: PCP, patient, ancillary staff member, care manager, BH provider(s)

Advanced: PCP, patient, ancillary staff member, care manager, BH provider(s), psychiatrist (contributing to shared care plans)

% Responses, N = 79

5%

23%

41%

32%
### Sharing Treatment Info

**Domain**
6. Multidisciplinary team (including patients) to provide care

**Subdomain**
6.2 Systematic multidisciplinary team-based patient care review processes

**Primary Care**

**N = 79**

**Question 20**

#### Preliminary: Limited written communication and interpersonal interaction between PC-BH provider(s), driven by necessity or urgency, or using patient as conduit

- **22%**

#### Intermediate I: Regular written communication (notes/consult reports) between PCP and BH provider(s), occasional information exchange via ancillary staff, on complex patients

- **46%**

#### Intermediate II: Regular in-person, phone, or e-mail communications between PCP and BH provider(s) to discuss complex cases

- **25%**

#### Advanced: 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)

- **8%**

**% Responses, N = 79**

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Quality Improvement

**Domain**
7. Systematic Quality Improvement (QI)

**Subdomain**
7.1 Use of quality metrics for program improvement

**Primary Care**
N = 79

**Question 21**

- **Preliminary**: Informal or limited use of BH quality metrics (limited use of data, anecdotes, case series) - 24%
- **Intermediate I**: Use of identified metrics (e.g., depression screening rates, depression response rates) and some ability to regularly review performance - 22%
- **Intermediate II**: Use of identified metrics, some ability to respond to findings using formal improvement strategies - 19%
- **Advanced**: Ongoing systematic quality improvement (QI) with monitoring of population-level performance metrics, and implementation of improvement projects by QI team/champion - 35%

The Washington Integrated Care Assessment (WA-ICA) is a collaboration of the Health Care Authority, all 9 ACHs, and the 5 MCOs.
Domain 8. Linkages with community/social services that improve general health and mitigate environmental risk factors

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

Primary Care N = 79

Question 22

Social Service Links

- **Preliminary**: Few linkages to social services, no formal arrangements
  - 9%

- **Intermediate I**: Referrals made to agencies, some formal arrangements, but little capacity for follow-up
  - 37%

- **Intermediate II**: Screening for social determinants of health (SDOH), patients linked to community organizations/resources, with follow-up
  - 54%

- **Advanced**: Developing, sharing, implementing unified care plan between agencies, with SDOH referrals tracked
  - 0%

% Responses, N = 79

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Billing Sustainability

- **Preliminary**: Limited ability to bill for screening and treatment, or services supported primarily by grants (13%)

- **Intermediate I**: 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 (41%)

- **Intermediate II**: Fee for service billing, and additional revenue from quality incentives related to BH integration (42%)

- **Advanced**: Receipt of global payments that account for achievement of behavioral health and physical health outcomes (5%)

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• For more information on the WA – Integrated Care Assessment and for resources to advance integrated care:

https://waportal.org/partners/home/WA-ICA