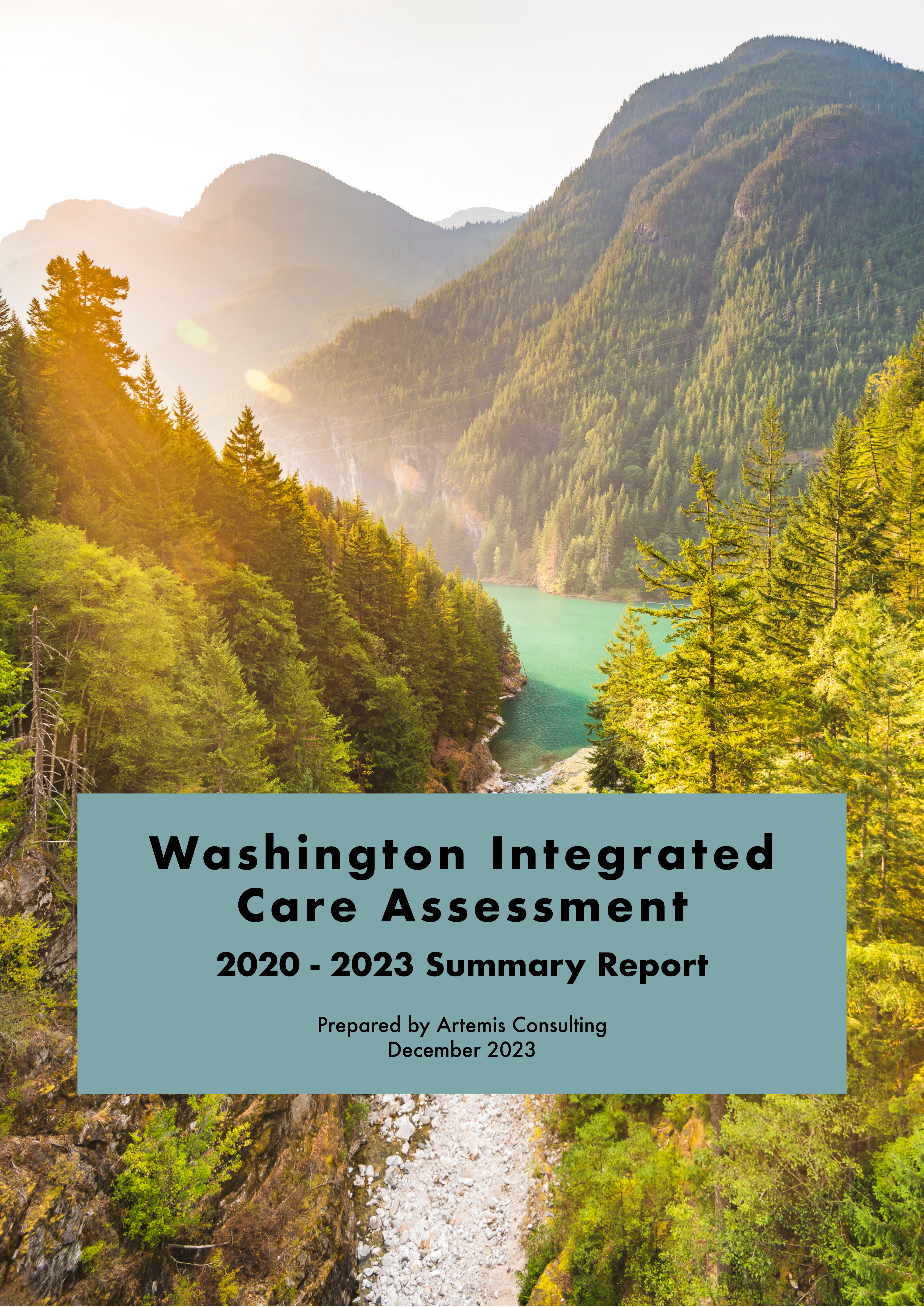

Washington Integrated Care Assessment

2020 - 2023 Summary Report

Prepared by Artemis Consulting

December 2023

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Acknowledgements

Many individuals and organizations have contributed to the advancement of an integrated care assessment in Washington. The report authors would like to thank the following organizations for providing leadership and funding to support and accelerate the work:

- Washington State Health Care Authority (HCA)

- Washington's nine Accountable Communities of Health (ACH):
    - Better Health Together
    - CHOICE
    - Elevate Health
    - Greater Health Now
    - HealthierHere
    - North Sound ACH
    - Olympic Community of Health
    - Southwest Washington ACH
    - Thriving Together NCW

- Washington's five Managed Care Organizations that serve the state's Medicaid program:
    - Amerigroup Washington
    - Community Health Plan of Washington
    - Coordinated Care of Washington
    - Molina Healthcare of Washington
    - United Healthcare

HealthierHere, the Accountable Community of Health for King County, served as the centralized data entity and helped catalyze much of the work to launch the effort. Results and language from their quantitative and qualitative analyses of the first cohort of practice sites to participate in the WA-ICA is used throughout this report.

Special thanks to Dr. Henry Chung, MD, Professor of Psychiatry, Albert Einstein College of Medicine, for supporting Washington's Integrated Care Assessment over the last several years.

We also want to acknowledge the passion and persistence of Colette Rush, RN, BSN, Behavioral Health & Integration Clinical Consultant in Quality Oversight and Program Alignment, Medicaid Programs Division at HCA. Colette's contributions to advancing integration in the state will have a lasting impact.

Washington Integrated Care Assessment Workgroup

The WA-ICA Workgroup had a variety of members over its duration from 2020 through 2023. The 2023 members are listed below.

ACHs:

- Better Health Together: Sarah Bolling Dorn
- HealthierHere (WA-ICA Centralized Data Entity): Thuy Hua-Ly,* Michael McKee,* and Madelyn Devoe
- North Sound ACH: Liz Baxter and Lindsay Knaus
- Thriving Together NCW: John Schapman
- Olympic Community of Health: Celeste Schoenthaler

MCOs:

- Amerigroup: Caitlin Safford and Mattie Osborn
- Community Health Plan of Washington: Siobhan Brown and Tawnya Christiansen
- Coordinated Care: Katie Ramos
- Molina Healthcare of Washington: Tory Gildred*
- United Healthcare: Dee Brown

HCA

- Mary Franzen*
- Jennie Harvell*
- Colette Rush*

Artemis Team

- Diana Bianco
- Cathy Kaufmann

*Member of the tri-chair leadership group.

Background

This report is meant to provide a high-level overview of the work of the Washington Integrated Care Assessment (WA-ICA) Workgroup, with a particular focus on the time period between September 2021 and November 2023 (following the Phase I and II reports). The report is not a detailed cataloguing of the Workgroup's meetings and deliberations but is meant to memorialize the major recommendations the Workgroup made; to outline decisions that need to be revisited and/or finalized; and to highlight the Workgroup's recommendations for next steps for the WA-ICA.

Since 2014, Washington State has been transitioning to fully integrated managed care for physical and behavioral health care (including mental health and substance use treatment) within the Medicaid program. By January 1, 2020, the state completed financial integration for most Medicaid members across the state. Through integration, the state seeks to support whole-person integrated care and hopes to reduce the complexity of separate systems for physical and behavioral health; to improve provider communication and coordination and reduce unnecessary duplication of services; to expand access to behavioral health services; and to link clients with community services such as housing and employment support.

Washington's Health Care Authority (HCA), the five Medicaid Managed Care Organizations (MCOs) and the nine Accountable Communities of Health (ACHs) determined that a standardized clinical integration assessment tool and process that assesses the level of integration of physical and behavioral health providers was needed to support the priorities of HCA to increase equitable access to whole person, integrated care for individuals enrolled in Medicaid.

A standardized assessment and process would provide opportunities to:

- Develop an improvement roadmap for practices to advance integration;
- Reduce provider administrative burden by minimizing duplication; and
- Consistently and uniformly understand the level of, and progress toward, bidirectional clinical integration within behavioral health and primary care outpatient practices and its subsequent impact on health outcomes, across regions and the state.

Summary of Work

The Washington Integrated Care Assessment (WA-ICA) Workgroup (previously called the Integration Assessment Workgroup and referred to in this report as "Workgroup") was formed in mid-2020 and included representatives from HCA, all five MCOs and five representatives of the ACHs. The Workgroup met regularly from June 2020 through December 2023. The Workgroup initially was established to identify a common tool that would be used statewide to assess provider level of integration. Once they selected a tool, the Workgroup focused on the following:

- Defining a standardized process/logistics around the assessment of clinical integration to streamline data collection and reduce duplication, including defining the roles and responsibilities of various partners (HCA, ACHs, MCOs).
- Developing standardized reports and determining how the data and information that resulted from the assessment would be utilized.
- Recommending a sustainable mechanism for ongoing assessment and continuous quality improvement.
- Establishing a roadmap for advancing clinical integration, building on previous initiatives undertaken by HCA and the Washington Legislature (i.e., Integrated Managed Care).

The Workgroup was supported by a tri-chair leadership group representing HCA, ACHs and MCOs and by Artemis Consulting (Diana Bianco & Cathy Kaufmann).

In the fall of 2020, the Workgroup identified and selected a standardized, evidence-based provider self-assessment tool that could be used to assess the level of integrated care in primary and behavioral healthcare settings across the state: *General Health in BH Settings Framework and the Continuum-Based Behavioral Health Integration Framework for Primary Care Setting*'.[1] This tool, which was developed by Henry Chung, MD, has versions developed specifically for behavioral health and primary care settings, and is available in the public domain with no fees associated with its use. The continuum-based model is made of nine domains and 13 subdomains. The Foundational domains are those considered core to advancing integration and can be an opportunity to focus improvement when a practice is in the preliminary stage. In addition to assessing a practice's current level of integration, the assessment framework serves as a roadmap for progress. For more information on the ICA framework and a other related materials, see the [WA-ICA webpage.]

With a potential tool identified, HCA provided funding for the first two phases of work to advance testing of the tool and development of implementation strategies and recommendations. The Workgroup selected the *Washington Integrated Care Assessment (WA-ICA) Initiative* as the title of the undertaking.

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1 https://www.thenationalcouncil.org/wp-content/uploads/2020/08/GHI-Framework-Issue-Brief_FINALFORPUBLICATION_7.24.20.pdf?daf=375ateTbd56

Phase I (Sept. 2020 - June 2021)

Phase I began in the fall of 2020, but the work was funded by HCA starting in February 2021 through June 30, 2021. HCA contracted with HealthierHere, the Accountable Community of Health for King County, to lead the work. In Phase I, HealthierHere piloted each version of the tool with a sample of providers from across the state. These sites included three primary care clinics (one of which was a pediatric care clinic) and three behavioral health agencies, including one provider that delivers Medication for Opioid Use Disorder (MOUD). Results of the pilot project provided significant insights into provider needs and capacity to complete the tool and its use to inform quality improvement, as well as mechanisms for distribution, data collection, analysis, and reporting.

While the pilot testing was underway, the Workgroup began to develop an implementation framework to address logistics and roles and responsibilities for statewide implementation of the standardized assessment tool among HCA, MCOs, ACHs, and other stakeholders. The Workgroup submitted initial recommendations to HCA in June 2021 for a statewide framework for implementation, including input on who should disseminate the tool, who should collect the data and synthesize it, what the data would be used for, and a high-level description of the types of training and technical assistance that would be needed for implementation. A copy of the full report and recommendations from Phase I can be found on the WA-ICA webpage.

Phase II (July - September 2021)

Building off the work of Phase I and the recommendations from the Workgroup, HCA funded a Phase II project from July 1, 2021, through September 30, 2021. For this phase, HealthierHere was contracted to engage providers, across the state (primary care, pediatric practices, FQHCs and behavioral health providers (including mental health and substance use disorder providers), their representative associations (i.e., WSHA, WSMA, Washington Council for Behavioral Health), and other key stakeholder organizations (i.e., Bree Collaborative, UW AIMS Center, etc.) to provide guidance to the Workgroup. Their input informed the Workgroup's efforts to understand the unique needs and requirements for implementation of the standardized assessment tool by provider type and develop an implementation framework, including milestones and timelines for full implementation across the state. As the Workgroup moved through Phase II of the work, they identified four priorities: 1) phasing of the rollout of the tool; 2) scoring of the tool and reports that could be generated; 3) principles around data use and the flow of data; and 4) provider engagement. The Phase II report is available on the WA-ICA webpage.

Phase III (October 2021 - December 2023)

HCA informed the Workgroup that it would not be able to continue to fund WA-ICA implementation planning nor the activities of the Workgroup for a third phase until an anticipated $6 million was approved as part of Washington's 1115 Waiver Renewal (Medicaid Transformation Waiver 2.0) application. This created a funding gap beginning October 2021, as the Waiver Renewal would not begin until July 2023. Because of the importance of this work and a shared commitment, the five MCOs and nine ACHs agreed to provide a collective total of $394,000 ($253,000 from the ACHs and $141,000 from the MCOs) to continue the Workgroup and WA-ICA planning and implementation efforts in Phase III, initially anticipated to last October 2021 through June 2023.

Work accomplished in Phase III included testing the WA-ICA with a group of practices (Cohort 1), conducting the qualitative analysis of Cohort 1 assessments, updating the WA-ICA based on Cohort 1 learnings and feedback, refining the role of the Workgroup and the tri-chairs, and determining a methodology for provider assignments to future cohorts. The Workgroup identified roles and responsibilities of partners / planned entities (e.g., HCA, MCOs, ACHs, a centralized data entity and centralized coaching entity). The Workgroup also facilitated collaboration and sharing on existing technical assistance efforts across MCOs and ACHs.

In June 2023, HCA informed the Workgroup tri-chairs that the request to fund the WA-ICA through the Medicaid Transformation Waiver 2.0 was pended by CMS. Given that, HCA decided not to further pursue funding for the WA-ICA under the waiver renewal application. This meant the funding source that the Workgroup and HCA had anticipated for continued implementation was not available. HCA made clear that it continues to prioritize clinical integration and will continue to explore options for funding. It also requested that the Workgroup continue as an advisory group and all participants agreed. Given the lack of funds to support the ongoing effort, the Workgroup recommended pausing any further rollout of the WA-ICA until additional future structure and/or funds are identified. Final efforts for this phase of work include the development of this report and recommendations for future rollout of the WA-ICA.

Timeline

June 2020

Workgroup Formed

Fall 2020

WA-ICA Tool Selected

Fall 2020 - June 2021

Phase I:

- HCA funds work starting in February 2021
- Tool piloted and refined
- Workgroup developed implementation framework

July - Sept. 2021

Phase II:

- Engagement of providers
- Workgroup identified priorities

Oct. 2021 - Dec. 2023

Phase II:

- ACHs and MCOs fund Phase III planning and implementation efforts
- Cohort 1 assessment (Summer 2022)
- HCA announced no funds for next phase of work (Oct. 2023)
- Final summary report and recommendations (Dec. 2023)

Provider Engagement and Feedback

From its inception, the Workgroup discussed how to engage providers in the WA-ICA process to get their input on the assessment tool, the process for implementing the WA-ICA, and avenues for communication and collaboration.

In Phase I, HealthierHere worked closely with six providers to pilot the WA-ICA. The findings and lessons learned from those pilots are detailed in the Phase I report. Their input included the following:

- The experience with the WA-ICA was positive and without fatal flaws
- Specific tools could facilitate provider completion, including an Implementation Guide and FAQ document
- The tool should be adjusted for pediatric providers

In Phase I, the Workgroup's Communications Subcommittee met with representatives from statewide associations to engage them in the planning process, get input on substantive issues, and begin socializing the WA-ICA. The associations had a high level of interest in advancing integration and agreed that centralizing and standardizing the distribution and collection of information was a positive development. They requested that providers have the education, resources, tools, and support to do the work of integration and that they be at the table for implementation planning.

As a result of this input as well as feedback from the WA-ICA Workgroup, the Workgroup recommended several ways to engage providers, starting with the formation of a Provider Advisory Group and engagement of other key groups.

In Phase II, the Workgroup convened a Provider Advisory Group that met three times in the summer and fall of 2021 and provided input and feedback on communicating with providers, details that are important to share with practices, the implementation process, and training and technical assistance needs. The Communications Subcommittee also continued to meet with related organizations and initiatives engaged in integration in Washington, including the Bree Collaborative, Comagine, AIMS, and the Behavioral Health Institute. In Phase II, the Subcommittee drafted a one-pager, an FAQ document, and an introductory slide deck to share information about the WA-ICA. Additional details are included in the Phase II report.

Provider engagement continued to be a strong emphasis in Phase III. The Communications Subcommittee met in the first half of 2022 to discuss how to best communicate with Cohort 1 and how to spread the word about the WA-ICA. The Subcommittee met again with provider associations in April 2022 to provide updates and get their input about how to share information about the tool. The Subcommittee also sought opportunities to speak at conferences, presenting at the ACH Learning Symposium in the fall of 2021 and the UW AIMS Integrated Care Conference in June 2023.

In the spring of 2023, the Workgroup (through the Artemis Team) reached out to providers to conduct interviews with practices that had completed the assessment as well as those who had the opportunity but chose not to participate. While very few practices volunteered to be interviewed (5), those that did offered helpful insight. Practices that took the assessment found it very valuable, but also strained to find resources to focus on integration. Those that chose not to take the assessment also had financial and time constraints. Some practices felt they had already focused on integration and weren't sure how much the assessment would advance their work. Other practices felt that some kind of compensation for the time completing the assessment would have been valuable. A key takeaway from the interviews was that clear, ongoing, and consistent communication about the WA-ICA is critical.

Summary of Key Workgroup Decisions

To ensure clarity of its vision and to guide its work, the Workgroup articulated that the purpose of the WA-ICA is to:

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

The Workgroup used these goals as guideposts for their discussions and decisions.

From its inception in 2020 through 2023, the Workgroup made a number of decisions and recommendations to HCA. The Workgroup modeled collaboration and consensus decision making and served as a sounding board and thought partner for the agency and each other. The key decisions the Workgroup made together include the following:

- Chose an integration tool (renamed the Washington Integrated Care Assessment (WA-ICA)) created by Henry Chung, MD
- Created an implementation framework to address logistics and roles and responsibilities for statewide implementation of the WA-ICA
- Developed an Implementation Roadmap to highlight key milestones and timelines to advance implementation of the WA-ICA
- Determined initial phasing and implementation rollout for the WA-ICA
- Drafted recommendations about scoring and reporting on the WA-ICA
- Agreed to principles on use and flow of data
- Developed communication materials
- Drafted supplemental questions for the WA-ICA, including a focus on equity and demographics
- Made recommendations about technical assistance and support, based on information gathered from MCOs and ACHs about the type of TA they provided, and their lessons learned
- Reviewed and provided input to reports from HealthierHere on Cohort 1
- Determined domains for focus: screening and referral, care coordination, and self-management
- Agreed to content for the WA-ICA website
- Advocated for alignment with all related HCA transformation priorities, particularly the Primary Care Transformation Model

Summary of Pending Decisions

While the WA-ICA made numerous decisions/recommendations over the course of their work, a number of decisions need to be revised or finalized. Some decisions need to be revised because of changed circumstances (funding, timing, etc.). Others were in process of being decided when the Workgroup learned that there wouldn't be funding under the second waiver. The Workgroup paused its work as soon as it learned about the funding changes. The list below also is informed by interviews with Workgroup members conducted by the Artemis Team in the fall of 2023.

The following topics need to be revisited/addressed in the future:

Provision of support and technical assistance (TA) to practices
The Workgroup spent many months discussing roles and responsibilities across ACHs, MCOs, HCA and two centralized entities. Their consensus recommendations are in Appendix A. This set of recommendations needs to be revisited based on the changed funding environment.

Provision of stipend/financial incentive for completion of the WA-ICA
The Workgroup had numerous discussions about whether practices should receive a stipend or incentive for completing the assessment. Opinions varied, though most Workgroup members felt that if there was sufficient funding, a stipend/incentive would make sense. There also was not agreement about whether this would be a stipend to compensate practices for the work necessary to complete the assessment (though it was clear that it would only be partial compensation) or whether it would serve as an incentive. Overall, the Workgroup acknowledged that stipends/incentives would consume far too much of the available budget and recognized that limited finances require difficult decisions. In this discussion, there was an ongoing tension between supporting all providers versus a targeted group, such as small or rural practices. The group did agree that whatever decision is made, it must be standardized across the state, rather than be done region by region.

Site vs. organizational completion of the WA-ICA
While the original approach was to implement the WA-ICA by practice, not by organization, the Workgroup began to reconsider this decision based on feedback from providers and subject matter experts. A Workgroup subcommittee met to discuss whether the approach should be changed. While this subcommittee did not land on a recommendation, it laid out pros and cons for future consideration. See Appendix B.

Roll out of WA-ICA
The Workgroup considered how to roll out the WA-ICA to practices and discussed an approach in July 2022. See Appendix C. This approach must be reconsidered due to timing and funding changes. The Workgroup looked at potential data use agreements but did not complete this work. A draft Data Use Agreement is included in Appendix D.

A guide for practices to help them move along the integration continuum

The Workgroup had several names for a document which would help practices move along the integration continuum, including a TA Guide, a "change package," and a Quality Improvement Resource Guide. Two Workgroup members (United and Molina) drafted an initial version. The document was being reviewed and revised when the Workgroup learned of the funding decision. Based on feedback from the Workgroup, the document will need to be rewritten and will require attention and resources to be redrafted to best meet the needs of providers.

Data collection and analysis

A WA-ICA Data Subject Matter Expert workgroup made recommendations around data collection and analysis for future cohorts, including revising the supplemental equity question, changing the assessment data collection window, and reconsidering approaches on the analysis of practice size and rural/urban differentiation. These recommendations are in Appendix E.

Potential revision of WA-ICA for specific groups

The Workgroup received feedback throughout its process about tailoring the WA-ICA to specific groups, particularly for pediatric practices. While there is current work in Washington to utilize the WA-ICA for pediatric practices, the Workgroup did not make a recommendation on altering the WA-ICA for pediatrics.

Messaging around the WA-ICA

The Workgroup did a fair bit of work around communications about the WA-ICA. This work must continue (see recommendations below).

Tribal engagement

The Workgroup discussed how to best engage Tribal partners but didn't advance that body of work.

Cohort 1: Summary and Findings

Cohort 1 Implementation
The first cohort of practices participated in the WA-ICA in Summer 2022. The practices included in Cohort 1 were those that had been identified by the nine ACHs as active participants in their integration activities and/or projects during the MTP 1.0 Medicaid Waiver.

As the centralized data entity, HealthierHere led the efforts to roll out the WA-ICA to the first cohort of practice sites. They coordinated with the Workgroup to finalize the questions in the assessment tool and developed a data collection instrument in an electronic platform that allowed for seamless data collection from participating practice sites.

HealthierHere also developed messaging and materials and worked with the other eight ACHs on implementation of the tool. As trusted local messengers, all nine ACHs provided the direct communication about the WA-ICA to Cohort 1 practices in their regions. Given existing contract obligations and past practices, ACHs in some regions also provided practices with modest financial incentives/support, as well as technical assistance for completing the assessment.

HealthierHere developed training materials (including an Implementation Guide, FAQs, and a training slide deck) to ensure primary care and behavioral health providers in Cohort 1 were appropriately trained and ready to complete the assessment tool. Healthier Here also conducted live webinar-based trainings (four total, two for primary care providers and two for behavioral health providers) in the months leading up to implementation. These webinars were also recorded and made available and easily accessible to Cohort 1 providers. These webinars are on the WA-ICA webpage.

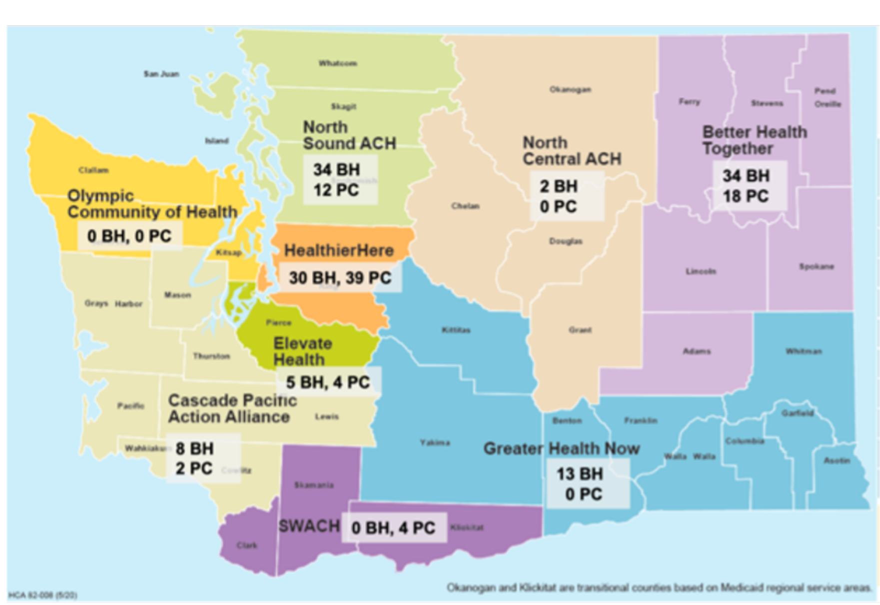
HealthierHere provided technical assistance to Cohort 1 primary care and behavioral health providers as needed (primarily through standing office hours and responding to questions as they came in through a dedicated email) to complete the assessment tool during the prescribed data collection period.

Cohort 1 WA-ICA Assessments were collected between July 11 – August 22, 2022. The WA-ICA included two companion tools: behavioral health and primary care (See Appendix F for WA-ICA qualitative questions). Sites were instructed to complete the assessment on behalf of their site, rather than the organization as a whole. HealthierHere conducted quantitative and qualitative analyses of the Cohort 1 assessment results. Detailed reports are included in Appendix G and key findings are outlined below.

Characteristics of Cohort 1
A total of 369 sites (174 primary care sites representing 55 different organizations and 195 behavioral health sites representing 102 different organizations) were invited to complete the assessment. More than half (55% of the organizations and 56% of the sites invited) submitted a response. Behavioral health

	Org. Response Rate (responded/invited)	**Site Response Rate** (responded/invited)
Behavioral Health	57% (58/102 orgs.)	65% (126/195 sites)
Primary Care	51% (28/55 orgs.)	45% (79/174 sites)
ALL	**55%** (86/157 orgs.)	**56%** (205/369 sites)

sites had a much higher response rate (65%) than primary care sites (45%). There were also significant regional variations in the response rate. One region had zero provider participation (Olympic Community of Health). Two regions had behavioral health provider participation, but zero primary care providers participation (Thriving Together NCW and Greater Health Now). One region had some primary care provider participation but no behavioral health provider responses (Southwest Washington ACH). Three regions (HealthierHere, Better Health Together and North Sound ACH) accounted for 81% of provider responses (though 59% of invited providers were in these three regions). This higher-level response rate is likely due to the availability of financial support provided to practices/sites for participation in the WA-ICA. A related contributing factor for varying response rates might be the lack of a statewide standardized protocol for engaging practices in the WA-ICA.



Practice sizes for participating sites ranged from 50 to 15,000 patients per month for primary care sites (with a median of just under 1,500) and 9 to 4,030 for behavioral health sites (with a median of 228).

Payor mix differed significantly between behavioral health and primary care sites. Median Medicaid for behavioral health was double that of primary bare (89% vs. 44%). Medicare and commercial representation were higher at primary care than behavioral sites. Primary care sites were significantly more advanced than behavioral health sites in their payment arrangements to support integration. Only 11% of behavioral health sites reported value-based payments (VBP) for their efforts compared to 44% of primary care sites reporting VBP arrangements to support integration. Collaborative Care codes support only 2% of behavioral health sites for integration versus 28% for primary care sites. Nearly three-quarters (73%) of behavioral health sites reported grants as a source for support of integration efforts, compared to 49% of primary care sites.

Cohort 1 Assessment Results: Key Findings

The table on the following page shows a summary of Cohort 1 response across the nine domains and fifteen sub-domains of the WA-ICA. It should be noted that some sub-domains apply only to primary care sites or behavioral health sites. There are also differences in language used for some of the shared sub-domains. Lastly, one domain (Information Exchange Among Providers) is applicable to primary care sites only. These differences are noted throughout the table. Because of the variation in the assessment tool by practice site type, direct comparisons between primary care and behavioral health site responses should be viewed cautiously.

Cohort 1 Assessment: Domain and Subdomain Results

	PC	BH	PC	BH	PC	BH
Domain 1: Screening, Referral to Care & Follow-Up						
1.1 Screening and follow-up for: common behavioral health conditions (PC sites) or preventive and general health conditions (BH sites)	13%	24%	66%	74%	22%	2%
sites)	22%	46%	54%	34%	25%	20%
Domain 2: Evidence-based Care						
2.1 Evidence-based guidelines or treatment protocols for: preventive interventions and common behavioral health conditions (PC sites) or preventive interventions (BH sites)	5%	31%	65%	59%	30%	10%
2.2(PC) Use of psychiatric medications **(PC sites only)**	13%	N/A	71%	N/A	16%	N/A
2.3(PC) Access to evidence-based psychotherapy with BH provider(s) **(PC sites only)**	5%	N/A	66%	N/A	29%	N/A
only)	N/A	37%	N/A	54%	N/A	8%
2.5(BH) Trauma-informed care **(BH sites only)**	N/A	0%	N/A	70%	N/A	30%
Domain 3: Information Exchange Among Providers (Primary Care Sites Only)						
3.1 Sharing of treatment Information **(PC sites only)**	15%	N/A	31%	N/A	53%	N/A
Domain 4: Ongoing Care Management						
conditions	18%	10%	58%	89%	24%	2%
Domain 5: Self-Management Support						
5.1 Use of tools to promote patient activation & recovery with adaptations for literacy, economic status, language, cultural norms	6%	30%	69%	66%	25%	3%
Domain 6: Multi-disciplinary Care Team						
6.1 Multidisciplinary team (including patients) with dedicated time to provide general health care	5%	46%	64%	45%	32%	10%
6.2 Systematic multidisciplinary team-based patient care review processes (PC sites) or Sharing of treatment information, case review, care plans and feedback (BH sites)	22%	30%	71%	61%	8%	9%
6.3 Integrated care team training **(BH sites only)**	N/A	28%	N/A	72%	N/A	1%
Domain 7: Systemic Quality Improvement (QI)						
7.1 Use of quality metrics for: program improvement (PC sites) or general health programs improvement and/or external reporting (BH sites)	24%	37%	41%	60%	35%	4%
Domain 8: Social Service Links						
community/ social services that improve general health and mitigate environmental risk factors (BH sites)	9%	25%	91%	54%	0%	21%
Domain 9: Sustainability						
9.1 Build process for billing and outcome reporting to support sustainability of integration efforts	13%	83%	83%	16%	5%	0%
9.2BH Build process for expanding regulatory and/or licensure opportunities **(BH Sites Only)**	N/A	31%	N/A	62%	N/A	7%
N= 129 PC sites and 79 BH sites						

Barriers to Integration

Both primary care and behavioral health sites overwhelmingly identified workforce and financial support as their top two barriers to advancing integration. HealthierHere's analysis of the WA-ICA Cohort 1 qualitative data identified the following key themes in these areas.

Workforce Challenges Identified by both BH and PC Sites

- High staff turnover and low rentention
- Varying vision for integrated care
- Insufficient care coordination staff
- COVID-19-related burnout and workflows

Challenges Identified by BH Sites Only	Challenges Identified by both PC Sites Only
• Staff education on general health • Varying access to on-site prescribers • Unclear role and expectations • Compensation and hiring	• Time constraints due to high caseload • Inconsistent use of screening tools among providers

Financial Challenges Identified by both BH and PC Sites Only

- Proper reimbursement needed for indirect minutes, particularly for care coordination and outreach
- Complex structure with probitively low reimbursement rates
- Ability to hire staff & invest in needed resources

Challenges Identified by BH Sites Only	Challenges Identified by both PC Sites Only
• Cannot bill for preventive care (inc. vaccines) due to billing codes	• N/A

Partnerships with other clinical providers was another commonly cited challenge by both primary care sites (49%) and behavioral health sites (48%). Behavioral health sites reported challenges with technology at almost triple the rate of primary care sites (59% versus 22%), reflecting the historical underinvestment in behavioral health technology and EHR use.

Technology Challenges Identified by both BH and PC Sites	
• Lack of expertise in tracking & EHR-based tools -> difficulty in tracking for reimbursement	• Insufficient care coordination staff • Lack of interoperable EHR systems
Challenges Identified by BH Sites Only	**Challenges Identified by both PC Sites Only**
• Cost of EHR setup & maintenance • Unresponsiveness from primary care • 42 CFR Part 2 limits SUD record sharing • Ability to capture release of information	• Difficulty completing EHR-based tools during patient visit due to high caseload • Inability to share records with external BH providers

Lessons learned from Cohort 1 rollout

A September 2023 focus group discussion with ACH program leads (staff who led efforts to communicate and support WA-ICA rollout with Cohort 1 practices in their regions), identified the following key lessons learned that should be taken into consideration for implementation of the WA-ICA with future cohorts.

Timing needs to work for providers

The timing of Cohort 1 implementation (Summer 2022) was a significant challenge for providers and was a likely cause of lower participation rates in some regions. Summer doesn't work well for practice sites and the timing was compounded by the impact of COVID in 2022. Early Spring (February – April) was recommended as a better time for optimal practice participation and reduced burden on practice sites. It's also important to allow practices three months to complete the assessment. Cohort 1 had approximately six weeks to complete their assessments. There was some feedback that this was an insufficient amount of time and may have impacted the quality of data provided.

One-on-one support is beneficial

One-on-one support for practices was beneficial in the regions where it was provided. Some ACHs met with behavioral health practice sites and went through the assessment questions with them. This allowed practices to clarify any confusion about how to answer certain questions. It also helped assure responses reflected the perspective of the whole practice, not just the opinion of the staff person completing the assessment.

Financial support helps

Completing the WA-ICA takes practices away from reimbursable time. Providing some level of financial incentive, even if it is minimal, acknowledges the value of provider effort and could significantly improve response rates.

Consistency and clear communication are important

Timelines for WA-ICA rollout have changed multiple times, which impacts provider trust. Changing timelines and cancelled plans are challenging for providers and contribute to the sense that the assessment is not something providers need to take seriously. When it comes to implementation to future cohorts, it's important to only promise what can be delivered.

Overarching vision for integration needs to be clear
HCA needs to help providers understand the overarching vision for integration and how the WA-ICA helps support that vision. Many practices, particularly behavioral health care sites, indicated that they preferred the WA-ICA to previously-utilized tools, but practices will not be motivated to complete the tool if it isn't tied to a broader vision about what success looks like. Future rollout of the tool should include communication about the state's view of what it means to be integrated and why participating in the WA-ICA is important and valuable for both the state and practices. Sharing assessment results with providers will also help reinforce a connection to a broader purpose.

Need realistic expectations for rural practice sites
Future rollout of the WA-ICA and the vision for integration needs to have realistic expectations for rural areas. For example, due to workforce limitations, co-location can't be the only model for successful integration. Rural practice sites also struggle with the site vs. organizational level approach to completing the assessment. Allowing them to respond at an organizational level may make more sense and provide more meaningful responses.

"Integration, ultimately will help [us] ensure better care outcomes for those left behind by the mainstream health systems."
-Cohort 1 provider response to a narrative question on the WA-ICA

Workgroup Recommendations

The Artemis Consulting team conducted interviews with Workgroup members September – December 2023 to identify lessons learned over the first three phases of work and recommendations for the future. The following key themes and recommendations emerged from these interviews and other input from the Workgroup.

Communicate a broader vision for integration
HCA should develop and communicate a broader vision for integration so that providers and stakeholders can understand how the WA-ICA assessment fits into that vision. Future rollout of the tool should include communication about the state's view of what it means to be successfully integrated and why participating in the WA-ICA is important and valuable for both the state and practices. For providers to buy-in, they need to feel like there's a reason for the assessment. Part of this is understanding (and repeatedly hearing from HCA about) the desired goals and long-term vision for integration. The HCA vision should allow for integration to look different in rural areas with workforce shortages.

Connect the WA-ICA to broader transformation efforts
The work around integration should be tied to other transformation efforts at HCA, including the state's health equity work, the Multi-Payer Collaborative and Making Care Primary.

Technical assistance / coaching to wrap around the WA-ICA assessment is essential
The WA-ICA is intended to help advance integration in the state, but providers can't be expected to improve without technical assistance and support. Given the worries expressed about the WA-ICA being a tool for "assessment for assessment's sake," assuring providers that support will be provided based on assessment results strengthens the case for participation in the WA-ICA.

It's important that the continued roll out of the WA-ICA be certain so that trust can be built with providers expected to participate in the assessment
Changing timelines and cancelled plans were frustrating for providers and contributed to the sense that the state would not remain committed to the WA-ICA over the long-term. Timelines for future cohorts should be certain before they are communicated to practice sites.

The timing of the assessment must work for providers
The HCA should check with providers on the right timing for rolling out future cohorts and establishing a regular rhythm for the assessment. Early Spring (February – April) was recommended as a better time for optimal practice participation and reduced burden on practice sites. It's also important to give practices a significant amount of time (three months) to complete the assessment.

Funding for providers doing the assessment would increase participation and convey that the state recognizes the value of their time
It is important to recognize that completing the WA-ICA takes practices away from reimbursable time. Providing some level of financial incentive, even if it is minimal, demonstrates that the state values providers' time and will significantly improve response rates.

Clear and consistent communication with practices is important
HCA should be transparent with practices and other stakeholders about the WA-ICA, including its importance to the agency and the agency's commitment to its widespread adoption.

The WA-ICA Workgroup should continue as it can help the state be successful with future implementation
Although there is currently no funding to continue to support the Workgroup with staffing and facilitation, the Workgroup should continue as an advisory group to HCA. The MCOs and ACHs can provide input and guidance to the HCA on future implementation of the WA-ICA.

Conclusion

Since 2020, the WA-ICA Workgroup accomplished a significant body of work to advance the integration of physical and behavioral health in Washington. The Workgroup exemplified a collaborative and consensus-driven process that resulted in clear decisions and actions. Its work will inform the future of integration in the state.

Appendices

- **A** WA-ICA Practice Support Recommendations
- **B** Site vs. Organizational Assessment Discussion Summary
- **C** WA-ICA Rollout Recommendations (July 2022)
- **D** Draft Principles of Data Use Agreement
- **E** Summary of Recommendations for Cohort 2
- **F** WA-ICA Supplemental Questions
- **G** WA-ICA Cohort 1 Reports

Support to Practices Using the Washington Integrated Care Assessment
Recommendations to the Washington Health Care Authority
Submitted by the Washington Integrated Care Assessment Workgroup
October 3, 2022

The Washington Integrated Care Assessment (WA-ICA) Workgroup, comprised of representatives from the Accountable Communities of Health (ACHs), Managed Care Organizations (MCOs) and the Health Care Authority (HCA), has had numerous discussions since its inception about the provision of support and technical assistance to practices completing the WA-ICA. Below are the Workgroup's consensus recommendations to the Health Care Authority.

Goals

Goals for providing support to practices underlie the recommendations. The provision of support to practices should:

- Advance integrated care through education, training, and technical assistance (TA), and other assistance to practices
- Improve patient outcomes through the delivery of clinically integrated care
- Identify and implement complementary, non-duplicative and coordinated roles for MCOs and ACHs to support practices

Principles

The Workgroup relied on the following principles as it crafted recommendations:

- Improved patient outcomes are the ultimate result
- TA and coaching should align with a statewide vision for integration
- Support should reach as many practices as possible within available resources utilizing different levels of support
- ACHs, MCOs and HCA should work together to coordinate and align resources
- Existing resources for support should be leveraged
- We should utilize practices to share and spread learnings within their organization and across organizations
- Support should be provider-centered and, to the extent possible, meet the unique needs of individual practices
- We should ensure equitable access to support across practices and target resources where they are most needed

Funding recommendations

The Workgroup based their recommendations on the following budget from HCA's waiver renewal application.

Year 7 (2023)	Year 8 (2024)	Year 9 (2025)	Year 10 (2026)	Year 11 (2027	Total
$3,870,000 *With some carry over from 2022*	$6,120,000	$6,660,000	$6,660,000	$6,660,000	$29,970,000

Recommendation: Utilize waiver dollars primarily to fund support and technical assistance to help practices advance integration. Such assistance could include:

- Practice coaching (limited provision of one-on-one coaching)
- Peer learning/learning collaboratives/affinity groups
- Webinars/quickinars/trainings
- Development of a Technical Assistance Guide to accompany the WA-ICA
- Annual Integration Summit

Recommendation: Fund a centralized data entity to distribute and collect the WA-ICA, collect, clean and analyze data, and develop and distribute reports. (Approximately $300-$400K/year.) *See below for details on the role of this entity.*

Recommendation: Fund a centralized entity for coordination of delivery of TA and coaching to support alignment, leverage existing resources, and avoid duplication. (Necessary resources TBD.) *See below for details on the role of this entity.*

Recommendation: Allocate a nominal amount of dollars for project management and support of the WA-ICA Workgroup.

- The Workgroup will continue to provide ongoing coordination of the WA-ICA roll out through mid-2023. Whether and how the Workgroup transitions to an oversight/advisory group for the WA-ICA will be determined in 2023.
- The Workgroup will review lessons learned and other information gained from the roll out and consider additional recommendations to HCA and potentially make a legislative request in 2024. The legislative ask will be coordinated with other HCA initiatives and legislative asks (e.g., multi-payer).

Recommendation: Given the limited resources dedicated to the WA-ICA, dollars ideally should not be utilized to provide financial support to practices for completing the WA-ICA. Instead, funding should go to training and technical assistance. The Workgroup believes that, over time, the incentive to participate should be the opportunity for practices to receive technical assistance and improve. In the short term, it may be that some practices receive financial support to complete the assessment. However, if this occurs, the Workgroup should have additional discussion about how to ensure that resources from other statewide transformation initiatives are leveraged and that there is equity and consistency in the approach across the state.

Recommendation: Leverage existing supports and resources that help practices advance integration, especially those currently provided by MCOs.

Recommendations for roles and responsibilities with regards to support to practices

Through our recommendations regarding roles, the Workgroup sought to leverage the strengths of entities, provide clarity about responsibilities, encourage collaboration, and reduce duplication.

⇒ **HCA**

Strengths: Statewide presence; holder of contracts; view across initiatives; policy approach; subject matter expertise

- Lead statewide strategic approach to integration, with input from providers, MCOs, and ACHs

- Lead alignment across other initiatives (e.g., Multi-payer Primary Care Transformation Model, etc.)
- Oversee and monitor progress on integration through MCO and ACH contracts
- Provide funding where appropriate
- Facilitate policy change to support advancement of integration
- Communicate importance, value, and requirements to practices in alignment and in coordination with MCOs and ACHs
- Seek opportunities to collaborate with and align resources and investments across HCA, ACHs, and MCOs

⇒ **ACHs**

Strengths: Trusted, regional entities; non-payer relationships with practices; history of Quality Improvement efforts; view across plans in region; can braid and direct resources across region

- Serve as primary point of contact for practices on WA-ICA[1], utilizing a standardized framework, including shared language
- Work with centralized data entity to distribute the WA-ICA and communicate with practices to get them to complete the assessment
- Work with practices to determine level of support and connect practices to different types of available support
- Coordinate with other ACHs, MCOs, and the statewide coordinator in the provision of support to practices
- Provide TA to individual practices in coordination with other ACHs and MCOs
  - This technical assistance should not supplant TA currently provided by some MCOs
- Coordinate regional support to practices
  - Identify tailored regional level supports, based on regional data
- Coordinate with MCOs and HCA to identify Medicaid practices and points of contact that have not historically engaged with ACHs
- Seek opportunities to collaborate with and align resources and investments across ACHs, MCOs, and HCA

⇒ **MCOs**

Strengths: Expertise in Quality Improvement; hold provider contracts; experience advancing integration; view across VBP and integration work; can leverage funding to practices

- Coordinate with other MCOs, ACHs, and the statewide coordinator in the provision of support to practices to advance integration
- Provide TA to individual practices in coordination with the statewide entity that provides coordination for support and TA, as well as other MCOs and ACHs
- Support practice participation in WA-ICA using levers such as incentives, coordinating and promoting the value of integrated care, etc.
- Monitor practice performance and review trends across practices/population analytics
- Provide subject matter expertise and technical assistance offerings
- Work across MCOs to reduce administrative barriers and provider abrasion related to integration

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[1] The ACH acting as the primary point of contact does not preclude MCO relationships with practices nor does it supplant MCO Quality Improvement activities.

- Seek opportunities to collaborate with and align resources and investments across MCOs, ACHs, and HCA

⇒ **Statewide centralized data entity**

Strengths: Neutral entity; coordination function

- Lead training, distribution, and support for completion of WA-ICA
- Receive WA-ICA data
- Clean and analyze WA-ICA data
- Create provider-level (by type), ACH-level, MCO-level, and statewide reports
- Disseminate reports to practices, ACHs, MCOs, and HCA
- Manage cohort lists and practice participation status (e.g., WA-ICA completion)
- Regularly communicate results to practices that have completed WA-ICA to remind them of their results at different points during the year
- Provide information to inform statewide and regional approaches to support and TA
- Serve as neutral source of information about the WA-ICA
- Align and coordinate with statewide centralized support/TA entity

⇒ **Statewide entity that provides coordination for support and TA**

Strengths: Neutral entity (no interest in a specific model for integration); coordination function

- Research, maintain and triage support and TA resources on a statewide level
- Identify available trainings (webinars, quickinars) and relevant ACH and MCO efforts and initiatives
- Lead creation of Technical Assistance Guide in partnership with HCA, ACHs, and MCOs
- Standardize written materials to meet statewide needs
- Offer and/or contract with others to provide statewide events/trainings
- Convene ACH and MCO integration leads
- Compile information about needs/barriers, both regionally and statewide, based on assessment data, feedback from practices, ACHs, and MCOs to inform support and TA
- Maintain WA-ICA website
- Serve as neutral source of information about the WA-ICA
- Align and coordinate with statewide centralized data entity

Additional recommendations regarding the provision of support and TA

Recommendation: Offer deeper support for fewer practices and target those that have the greatest needs. Provide different levels of support, ranging from attendance at an Integration Summit to webinars to peer learning/affinity groups.

Recommendation: For cohorts beginning in March 2023, there should be two to three statewide focus areas for integration. These focus areas will inform support and TA offerings.

- The Workgroup will identify two to three statewide focus areas and will consider the following:
  - Recommendations from Dr. Chung who describes four domains as foundational: Screening and referral loop; Care Management/Coordination; Self-Management Support; Sustainability
  - Alignment with multi-payer and CCBHC initiatives

WA-ICA Subgroup Meeting Summary
May 22, 2023

Background
A small group met to discuss whether the WA-ICA can be completed at an organizational level and still serve the goals of advancing integration and assessing Washington state's progress on integration. The group did some preliminary thinking about the considerations and potential approaches.

Participants were Dee Brown (United), Tawnya Christiansen (CHPW), Henry Chung (author of ICA), Michael McKee (HealthierHere), Collette Rush (HCA) and Diana Bianco and Cathy Kaufmann from the Artemis Team.

The options discussed were:
1. Continue with assessments at the site level.
2. Have all assessments done on an organizational level.
3. Allow entities to choose whether to complete ICA at a site or organizational level.

Context and considerations
- Henry shared that so far, the assessment has always been taken at a site level.
- Henry believes it must be a coalition of the willing – practices have to want to do the assessment.
- Diana shared that in her four interviews with practices, two organizations shared that they didn't complete the assessment because they each had over 25 sites and it was too onerous. Another organization shared that they thought it was more helpful having it completed at the site level, though it was hard to get individual sites (25) to complete the assessment.
- It may not have been clear in Cohort 1 whether every organization had to have all of their sites complete the assessment or whether they could choose just to have a smaller group of sites take the assessment.
- We need to align the data with how we want to utilize it – what are the questions we want to answer and would completion at an organizational level answer those questions.
- We want assessment results to be actionable and amenable to TA.

Pros and cons of organizational level assessment
Pros:
- Could increase participation in the WA-ICA
- Could help maximize limited TA/support dollars
- Meet organizations/practices where they are at
- Would address complex "unique site identifier" issue by not requiring it
- Payers reimburse providers at an organizational level, not a site level
- We could still do TA/support on regional basis if we knew the specific sites organizations completed the assessment for and asked them about TA/support needs (see below)

Cons:
- We would lose granularity of data at site level
- We would lose regional reports because organizations might be completing the assessment for practices from different regions

- We might lose smaller and/or rural practices if organizations only complete it for larger, more integrated sites (to maximize their scores)
- Organizations might not complete it for same sites every year. We could look for change over time by organization, but not by site.
- Switching to organizational assessments could create challenges in comparing Cohort 1 to subsequent cohorts.

Potential approach
If organizations had the option of doing it by site or by organization, we would set parameters and ask specific questions.

- We could offer organizations the option of doing it by site or organization, but urge them to complete it by site if possible.
- We could ask organizations to attest that workflows are the same across their sites.
- We could ask that the team of people completing the assessment for the organization represent diverse perspectives and/or sites.
- We could provide guidelines for assessing organizational progress (e.g., only rate your organization as intermediate if 70% of the sites are at that level).
- We could have organizations come up with an average (e.g., for 25 sites) so we could compare the scores to Cohort 1.
    - In any reports, we'd have to be clear that data was collected under different circumstances.
- We could ask them to suggest practices that might benefit from TA/support.

Next steps

- We want to bring this discussion to the Workgroup on June 5th.
- Collette will consult with HCA on data needs and get back to us by 5/31.
- HealthierHere will do some preliminary thinking on losses and differences in data and will share with the Workgroup on June 5th or beforehand with the subgroup.

Note: This discussion didn't come before the full Workgroup because of the funding shift in June/July 2023.

WA-ICA Workgroup

Initial recommendation for roll out of WA-ICA to future cohorts

July 2022

- Ultimately move to an annual assessment
- Open next round it to any interested practice sites (primary care and behavioral health)
- Might need to put a cap on how many assessments can be processed
- Initially do six-month assessments to roll in new practices
- Change timing for next cohort from January 2023 to March 2023
- Next cohort would come on in October 2023
- Ultimately March would become new regular timing for annual assessment
- Cohort 1 will skip March 2023 assessment but start annual assessments beginning March 2024 (need clarification on timing around PCTM)

Note: It is difficult to know the full universe of providers who could complete the WA-ICA.

<u>DRAFT</u>
Principles of Data Use Agreement
Washington Integrated Care Assessment

This document is intended to be signed by the ACHs, MCOs, and the HCA with HealthierHere as the Data Collection and Reporting entity. Once signed, it would influence the revision of the "consent statement" that Cohort 2 practices will agree to. It is meant to be a tool to document what all the ICA workgroup members have already agreed to and give our partners some agency in how it is implemented, including a complaint process if they would like to log one.

Background

Since 2014, Washington State has been transitioning to fully integrated managed care for physical and behavioral health care (including mental health and substance use treatment) within the Medicaid program. In 2020 a workgroup (now known as the WA-ICA Workgroup) was formed to facilitate the progress toward integration and specifically the development of a standardized clinical integration assessment tool and process for assessing integration status on the practice level. The Workgroup includes representatives from all five Managed Care Organizations (MCOs), three Accountable Communities of Health (ACH), and representatives from the Washington State Health Care Authority (HCA).

Since its formation, the Workgroup has adapted and adopted the Washington Integrated Care Assessment (WA-ICA) as the integration assessment tool for Washington. The Workgroup has also determined a process for ushering in cohorts of primary care and behavioral health providers to participate in assessing their practice level of integration using the new WA-ICA tool. As determined by current processes, practices that participate in taking the WA-ICA submit their assessment data to a contracted agency for data analysis. As the contracted agency, HealthierHere is the acting data steward for WA-ICA and is responsible for the collection, analysis, reporting, and access management of WA-ICA data.

This agreement is intended to support trust and transparency between the MCO, ACH, and HCA entities involved in the assessment process, as well as the organizations, practices, and sites responding to the assessment tool. MCOs and ACHs participating on the WA-ICA Workgroup provide insight and feedback to practices as it relates to the WA-ICA assessment tool itself, WA-ICA assessment and data collection processes, and how data is used to inform quality improvement processes and technical assistance for advancing integration. However, final decision-making authority rests with HCA.

Commented [a1]: We need some sort of language defining what "involved in the process" means - is this workgroup membership? Contracted payment? Any MCO or ACH? Is HCA the only included government entity?

Principles for Data Use

The WA-CIA Workgroup has agreed to the following principles for the use and flow of data. This document formalizes this agreement. There is an expectation that over time, practices will make progress on integration. The following principles and uses are established to support this expectation and progress.

1. Data to be collected from practices includes data from the WA-ICA, supplemented with information on barriers to integration, provider demographic data (e.g., practice type, location, size), and additional topical questions that will evolve over time.

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2. Data about specific practices will be used by:
   - ACHs and MCOs to provide training and technical assistance to individual practices to advance the delivery of integrated care and improve patient outcomes; and
   - HCA to inform value-based payment models and rates for practices electing to participate in these models.

   In the case that practice-specific data is used for any additional purpose, practices will be informed of the purpose for which their data will be used, and by whom, prior to assessment completion.
3. Analyses of the practice-level data will include comparisons among "like" practice types across regions, plans, and statewide. Analyses will include areas of success/best practices and opportunities for improvement.
4. There will be transparency within the Workgroup and with assessment respondents about how information and data gathered through the WA-ICA will be used by each stakeholder type in the process (ACH, MCO and/or HCA)
5. Practices, ACHs, MCOs, and the HCA will receive only the data and/or reports that each entity needs to fulfill their respective responsibilities.
6. Analyses will result in the following reports:
   - Practice-level reports: Each participating practice will receive reports that include practice level data and comparisons (using aggregated data) to Like-practices, practices in the region, practices by plan, and practices statewide. Practice may use the information to enhance their practice's ability to take advantage of increased referrals, alternative payment models, and other opportunities for practices with advanced integration. ;
   - ACH reports: Each ACH will receive reports for practices within their ACH region. These reports will include practice level data and comparisons to like-practices across regions, plans, and the statewide.
   - MCO reports: Each MCO will receive reports for practices within each MCO network. These reports will include practice level data and comparisons to like-practices across regions and the statewide.
   - HCA reports: HCA will receive reports that include:
     - Practice-level reports to inform value-based payment models and rates (e.g., the Primary Care Transformation Model) for practices choosing to participate in those models; and
     - Reports using aggregated, de-identified data of like-practice types across regions, plans, and statewide. These reports will be posted to a publicly available HCA website.

       De-identified practice-level data will be utilized to:
       - assess progress towards clinical integration across the state, regions, and by plan; and
       - identify and inform statewide improvement strategies and ensure resources are targeted where they are needed most.

7. Practice level data will not be publicly disclosed without practice permission.

Data Misuse and/or Mishandling

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Commented [a2]: Will there be different "allowable" uses for the stakeholder types or will they all be the same once this document is in effect? If so I would suggest tweaking the language slightly - the wording now makes it sound like there are various permissible uses depending on the stakeholder type

Commented [a3]: Do we have a description of what each group's responsibilities are? Is it just their responsibilities regarding the workgroup and ICA or their responsibilities more broadly?

Commented [a4]: I would suggest we add a few more explicit "will not" scenarios on here - can the data be used to negatively impact a practice's payment/contract rates? Can it be used to determine their standing with HCA? Etc. etc.

Commented [a5]: We need to be specific about what public means - does that mean any entity outside of those participating in the workgroup? Does that mean any MCO or ACH regardless of their workgroup participation?

Commented [a6]: I tried to keep this section fairly high level, but we do need to have some sort of complaint/grievance process for people to report issues to. Feel free to make changes - this is just a suggestion

If any individual and/or entity believes WA-ICA data has been misused and/or mishandled according to the principles listed above, they may file a complaint directly to HealthierHere by emailing report@healthierhere.org.

HealthierHere will investigate using the information provided in the complaint and by contacting involved parties, with the complainant's permission. If misuse and/or mishandling is confirmed, the findings will be reported to the WA-ICA Workgroup Tri-chairs.

Depending on the severity of the misuse/mishandling and/or if misuse/mishandling is confirmed on multiple occasions, appropriate action will be taken by HealthierHere, with approval from the Chairs, up to and including termination of access to WA-ICA data.

If any individual and/or entity believes WA-ICA data has been misused and/or mishandled by HealthierHere, they may file a complaint either directly to HealthierHere or directly to the Workgroup Chairs – whose contact information can be found at website? [and the HCA?].

Commented [a7]: If you agree with this process we can have Tanet set up the inbox

Commented [a8]: Is the chair information public?

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WA-ICA Cohort 2 Data Collection & Analysis Recommendations

The WA-ICA Data SME workgroup met in November of 2022 and January of 2023 to discuss specific topics around the data analysis for Cohort 1 and to make recommended adjustments to data collection and/or analysis for future cohorts.

Summary of Recommendations:

1. Revise the supplemental equity question to read: "What do you see as gaps at your practice site, if any, in meeting the health equity needs of your patient population? What integration activities might help meet these needs, if any? *For examples of specific integration activities, please refer to the Washington Integrated Care Assessment (WA-ICA) subdomains."*
2. Reduce the assessment data collection window to 4 weeks.
3. Practice size analysis: provide ranges of practice size for practices to select without labeling them "small, medium, large." Identify ranges by natural breaks after data collection.
4. Rural/urban analysis: use RUCA data which will classify "ruralness" over a 4-gradient scale (Metropolitan, Micropolitan/Large Town, Small Town, Rural).
5. Practice site identification: this will not be easy and there are no existing means to use. The best option is likely to assign each practice site a unique practice ID.
    a. The interest in practice site identification comes from a desire to be able to track practice change/progress over time. This is of interest particularly for policy/advocacy purposes as well as to evaluate the impact of TA efforts.
    b. Assigning unique site identifiers will place increased responsibility and burden on the centralized data entity and will involve significant preparation and discussion to put in place.

Next steps:

1. The above recommendations should be brought forth to the tri-chairs and/or workgroup for discussion and adoption.
    a. The recommendations above, specifically 3-4 increase the data analysis responsibilities of the centralized data entity, as they were not included in the Cohort 1 data analysis. This may have implications on the resourcing needed for this entity, the data analysis timeline, and/or subsequent cohort size. The tri-chairs and/or workgroup need to discuss those implications.
2. The tri-chairs and/or workgroup need to discuss the need and cost/benefit of attempting to apply unique site identification for subsequent cohorts as the lift to do this will be significant and not as straightforward as the other recommendations.

Supplemental Questions for WA-ICA

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.

Demographic Questions:

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 (CAH)
   - Rural Health Clinic (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

Qualitative Questions:

Equity:

5. How will advancing integration help you address health equity? *(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 (AHC) tool (also known as the Health-Related Social Needs (HRSN) tool)
- Daily Living Activities—20 (DLA-20)
- Health Leads Social Needs Screening
- PRAPARE
- WellRx
- Other (write in answer, if selected)
- None of the above – our site does not currently use a screening tool

Financing:

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

- Capitated PMPM rate
- Collaborative Care codes
- 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)*

Technology:

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
- Electronic referrals to outside services
- Closed loop referral systems with outside services
- Registries
- Health information exchanges (HIE)
- Community information exchanges (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

Challenges *(after completing survey)*

11. 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).

12. 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.

Statewide Baseline Report
Cohort 1
Washington Integrated Care Assessment (WA-ICA)

Qualitative and Quantitative Reports on Primary Care and Behavioral Health Practice Sites

Analysis and Reports completed by HealthierHere in collaboration with the Health Care Authority, all 9 ACHs, and the 5 MCOs

Data Collection Period: July – Aug 2022

Statewide Baseline Report
Cohort 1
Washington Integrated Care Assessment (WA-ICA) for Behavioral Health Settings

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

Data Collection Period: July – Aug 2022

About the Assessment Framework

- 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 8 domains and 15 subdomains, the assessment framework lays out the key elements of general health integration into the behavioral health setting. **Foundational domains** are those considered core to advancing integration 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.

Table of Contents

- 1. Summary
- 2. Response Rate and Characteristics
- 3. Narratives: Equity, Licensing and Reimbursement, Support
- 4. Results by ICA Framework Subdomains (Distribution of Site Responses)

Summary

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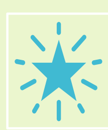
Executive Summary

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

1. **Most behavioral sites are in earlier stages of integration compared to primary care.**
(126) Behavioral Health sites across Washington state responded in Cohort 1, representing a 65% site response rate.



2. **Foundational Areas of Strength***:

Screening (subdomain 1.1)
Care Management – tracking and monitoring (3.1)
Patient Self-management (4.1)

3. **Opportunities for Improvement:**

Financial Sustainability (8.1) & Medication Management (2.3)
Subdomains with most improvement potential are consistent across ACH and MCO regions.
Both behavioral and primary orgs use EHRs, but the use of other population health tools like external referrals and shared care plans is significantly less at behavioral orgs.

4. **Opportunities for Foundational Improvement***:

Referral facilitation and engagement (1.2)
Patient Self-management (4.1) is mostly passive at Intermediate I stage. Progress further by moving to active goal-setting and goal incorporation into care plan.

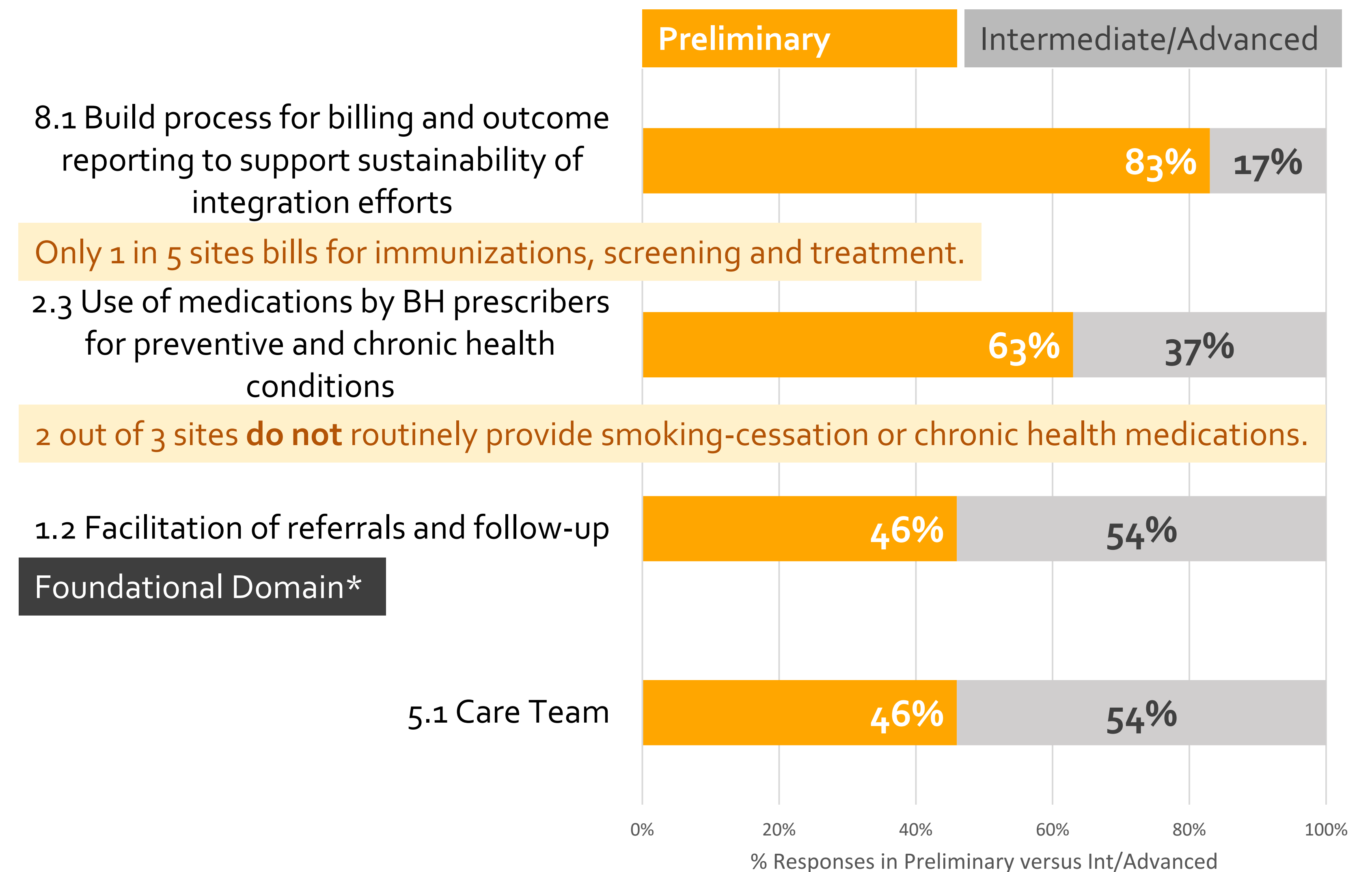
Opportunities for Improvement

Subdomains with Highest % Sites in **Preliminary**

Behavioral Health

Subdomains with 3 highest percentages of sites in Preliminary integration stage
-
N = 126

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



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

Foundational Domains

Subdomains with % Sites in **Preliminary**

Behavioral Health

Foundational Domains* – Sites in Preliminary integration stage
-
N = 126

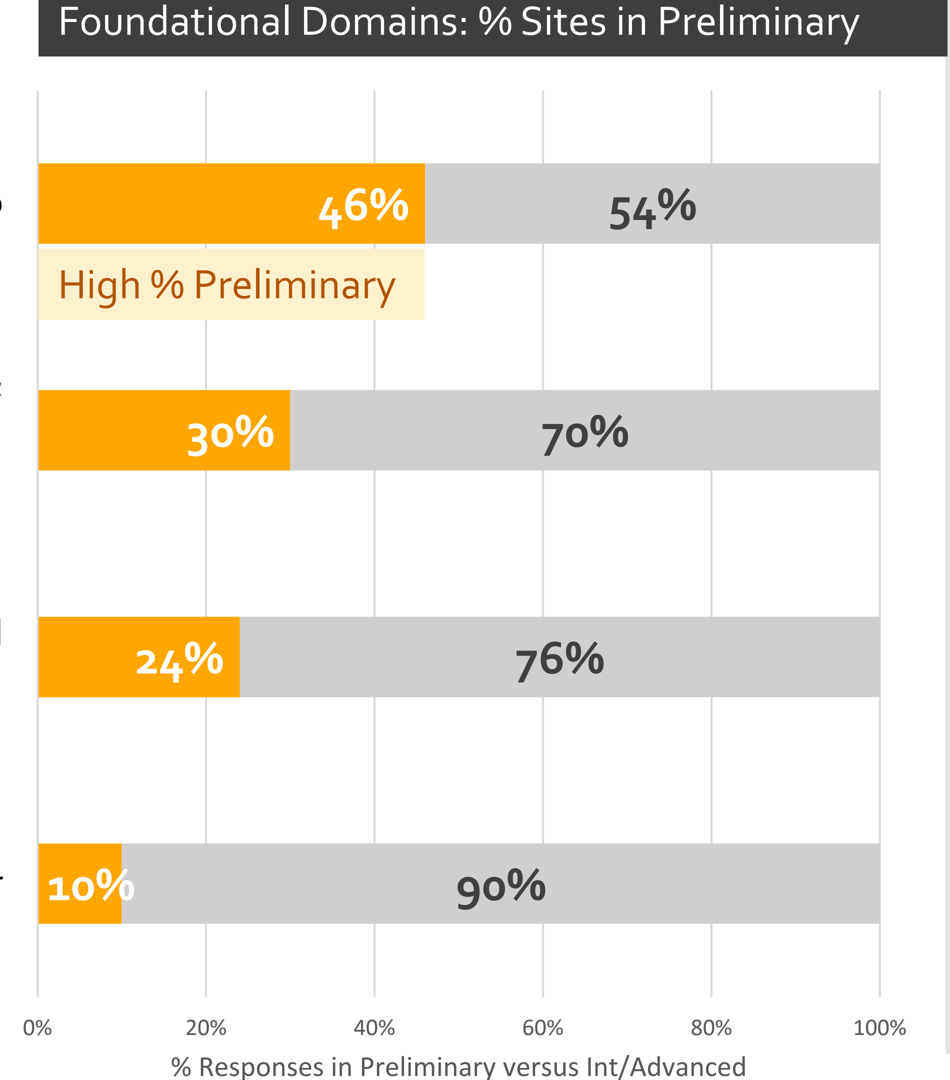
* **Foundational Domain.** Sites in preliminary stages can focus on these areas to establish a foundation for advancing integrated care.

1.2 Facilitation of referrals and follow-up

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

1.1 Screening and follow-up for preventive and general health conditions

3.1 Longitudinal clinical monitoring & engagement for preventive health and/or chronic health conditions.



Response Rate & Characteristics

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Behavioral Health

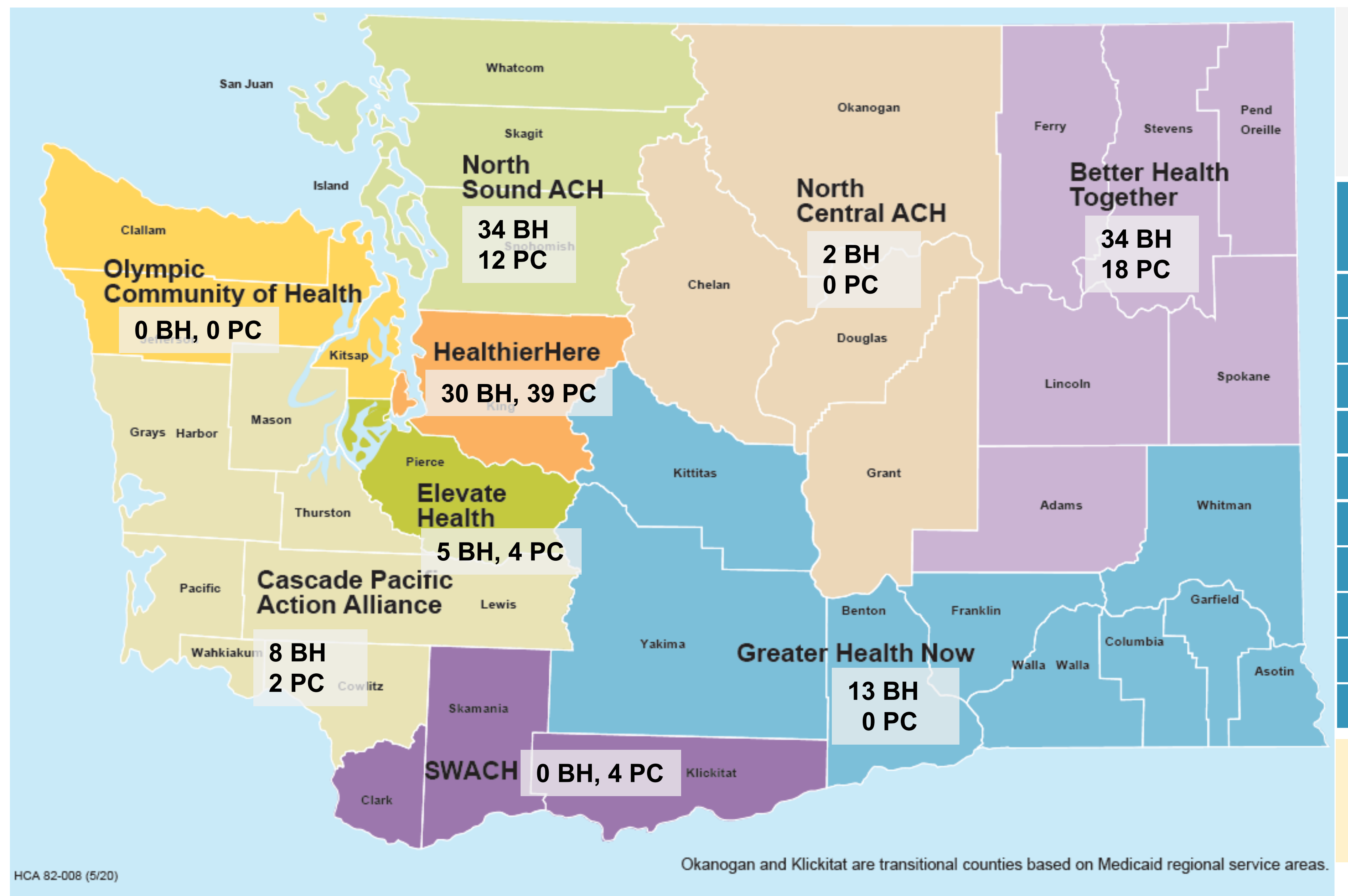
Statewide Response Rate

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

- 195 behavioral health sites representing 102 behavioral health organizations were invited to complete the assessment
- 58 orgs responded / 102 orgs invited = **57%** Org Response Rate
- 126 sites responded / 195 sites invited = **65%** Site Response Rate

	Org Response Rate (responded / invited)	**Site Response Rate** (responded / invited)
Behavioral Health	57% (58/102 orgs)	65% (126/195 sites)
Primary Care	51% (28/55 orgs)	45% (79/174 sites)
All	55% (86/157 orgs)	56% (205/369 sites)

ACH Region Response Count



Key

BH: Behavioral Health Site Responses

PC: Primary Care Site Responses

Region	BH	PC	% Total (BH+PC)
HealthierHere	30	39	34%
Better Health Together	34	18	25%
North Sound ACH	34	12	22%
Greater Columbia ACH	13	0	6%
Cascade Pacific Action Alliance	8	2	5%
Elevate Health	5	4	4%
Southwest ACH	0	4	2%
North Central ACH	2	0	1%
Olympic Community of Health	0	0	0%
Total	126	79	100%

Three regions account for 81% of site responses.

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

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

Behavioral Health

Characteristics of Cohort 1 Responses
-
N = 126

Supplemental Questions

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

	# Sites	% of Sites
Both	65	52%
Adults	47	37%
Pediatrics	14	11%
Total	126	100%

Behavioral Health

Characteristics of Cohort 1 Responses

-

N = 126

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

Clinic Type	Count	% of Sites (count / N)
Behavioral Health (mental health only)	52	41%
Behavioral Health (mental health AND SUD)	46	37%
Co-located Behavioral Health and Primary Care	25	20%
Opioid Treatment Program (OTP)	15	12%
Behavioral Health (SUD only)	12	10%
Other	4	3%
Primary Care	3	2%
Rural Health Clinic	2	2%

Behavioral Health

Characteristics of Cohort 1 Responses -

BH Sites N = 126*
PC Sites N = 79*

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

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

	Min	25% Percentile	Median	75% Percentile	Max
BH Sites - Monthly Patients	9	83	228	587	4,030
Primary Care Sites - Monthly Patients	50	781	1,461	2,000	15,000

Behavioral Health

Characteristics of Cohort 1 Responses

-

N = 126*

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

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

	Min	25% Percentile	Median	75% Percentile	Max
Medicaid	20%	75%	89%	96%	100%
Medicare	0%	0%	1%	3%	22%
Commercial Insurance	0%	0%	4%	11%	55%
Uninsured	0%	0%	1%	3%	63%
Fee for Service	0%	0%	0%	1%	100%
Other	0%	0%	0%	1%	56%

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 lower at Behavioral Sites than Primary Care.
Medicare median is 1% for Behavioral vs 17% for Primary Care.
Commercial median is 4% for Behavioral vs 21% for Primary Care.

Behavioral Health

Characteristics of Cohort 1 Responses

-

N = 126

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

Type	Count	% Sites (count / N)
Other	79	63%
None of the above – our site does not currently use a screening tool	34	27%
Daily Living Activities—20 (DLA-20)	14	11%
PRAPARE	2	2%
Health Leads Social Needs Screening	1	1%
Accountable Health Communities (AHC) tool (also known as the Health-Related Social Needs (HRSN) tool)	0	0%
WellRx	0	0%

'Other' is the **top screening tool** cited by sites.

A quarter of sites do not use any SDoH screening tool.

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

Behavioral Health

Characteristics of Cohort 1 Responses

-

N = 126

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

Type	Count	% Sites (count / N)
Grants	92	73%
Fee for service billing	72	57%
Capitated PMPM rate	49	39%
Other	24	19%
Value based payment arrangements	14	11%
None	7	6%
Collaborative Care codes	3	2%

Grants support integrated care efforts for **three-quarters of Behavioral Health sites.**

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.

Behavioral Health

Characteristics of Cohort 1 Responses

-

N = 126

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

Type	Count	% Sites (count / N)
Electronic Health Records	125	99%
Health information exchanges (HIE)	52	41%
Registries	39	31%
Shared care plans	35	28%
Electronic referrals to outside services	29	23%
Closed loop referral systems with outside services	19	15%
Community information exchanges (CIE)	7	6%

Nearly all sites use an EHR system.

1 in 4 sites uses shared care plans and external electronic referrals.

Both behavioral and primary care orgs use EHRs, but the relative use of other population health tools is significantly less at behavioral orgs.

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

Behavioral Health

Characteristics of Cohort 1 Responses -

N = 126*

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

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

	Min	25% Percentile	Median	75% Percentile	Max
% Virtual (video)	0%	5%	15%	30%	92%
% Virtual (telephone only)	0%	1%	7%	20%	71%
% In-Person	5%	49%	73%	91%	100%

Most sites reported significantly more in-person visits than virtual.
Among virtual visits, video is used more than telephone-only.
Behavioral Health sites use more virtual video patient visits than Primary Care sites.

Behavioral Health

Characteristics of Cohort 1 Responses
-

N = 126

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

Type	Count	% Sites (count / N)
Workforce	115	91%
Financial Support	97	77%
Technology	74	59%
Partnerships with other clinical providers	60	48%
Other	20	16%
Leadership Support	12	10%

Workforce and Financial Support are the top challenges to advancing integration. These were the top challenges for both Behavioral Health and Primary Care sites.

Behavioral Health providers reported challenges with technology at almost triple the rate of Primary Care (59% vs 22%). This is reflective of historical underinvestment in Behavioral Health technology and EHR use.

Narratives: Equity, Licensing and Reimbursement, Support

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Summary of Narrative Themes

Behavioral Health

Cohort 1 Narrative Response Summary

-

N = 79

- 5. How will advancing integration help you address health equity?

1. Address Whole-Person Care
2. Improved Cultural Responsiveness and Trust in Healthcare
3. Effective Advocacy and Referrals

- 8a. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts?

1. SUD/MH Integration
2. Capitated Contract Funding
3. Provider Relationships with ACHs and MCOs
4. Support from ACHs

- 8b. Where is there room for improvement?

1. Licensure Requirements and Timing
2. Payment Structures and Reimbursement

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

1. Support with EHR Technology
2. Payment Reform
3. Workforce Support
4. Shared Vision and Executive Buy-in
5. Clinical Partnerships
6. Technical Assistance for Integration

Behavioral Health

Cohort 1 Narrative Responses and Themes

-

N = 126

• 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. Address Whole-person Care

"Integration, ultimately will help [us] ensure better care outcomes for those left behind by the mainstream health systems."

"Equitable access to high quality healthcare is negatively impacted by transportation, family/childcare, timeliness of appointments for working parents, multiple appointments over many days and different locations. Integrated care delivery - physical, behavioral and oral health - in a single location or co-location would address many of these identified equity issues. Integrated or co-located healthcare sites could be designed to be more culturally welcoming, multiple language friendly, and create friendly community-based care (as opposed to institutionally designed settings)"

"The individuals in the community that we work with are primarily the underserved, Medicaid, low SES, have significant impacts of mental health symptoms, poor physical health and hygiene. With the capacity to offer integrated healthcare for primary care and behavioral health in the same location, we are able to make a bigger impact on helping individuals address not only their mental health but also their physical health and help them learn how the two are intertwined."

Behavioral Health

Cohort 1 Narrative Responses and Themes

-

N = 126

- **5. How will advancing integration help you address health equity?**

2. Improved Cultural Responsiveness and Trust in Healthcare

"Integration will allow us to strengthen our ability to...ensure that clients can start working on whichever health issues that are most relevant to them with the providers they most trust. Integration will close the loop when physical health is not being effectively addressed, will reduce the burden on the individual seeking services, and will allow positive transfer of reputation when a trusted agency refers to another partner with confidence. Taken together, these efforts should increase trust in the healthcare system, which is particularly important for system-weary clients. Integration may help reduce discrimination, bias, and stigma experienced within the healthcare system."

"Our clients often mistrust traditional medical institutions and if we are able to assess the type of support they need and can refer directly to an office that we have a relationship with it would be a huge benefit. Training us to help clients navigate the medical system improves their long-term health by providing them a trusted resource to rely on throughout their journey."

3. Effective Advocacy and Referrals

"Advancing integration will help our agency staff understand and recognize obstacles to equitable access to services...and will create a basis for effective advocacy and referral within and between systems."

Behavioral Health

Cohort 1 Narrative Responses and Themes

-

N = 126

- **8a. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts?**

1. SUD/MH Integration

"SUD/MH integration and reimbursement for coordination efforts"

"The expansion of approved education and experience for credentialing of mental health professionals (MHPs) under WAC 246-341-0515 has allowed the agency to address shortages in qualified mental health professionals."

2. Capitated Contract Funding

"Without capitated payments, we would not be able to remain in business."
"Capitation funding model is excellent for integrated care efforts."
"Capitated contract is good for stability during transition to value-based care."

3. Provider Relationships with ACHs and MCOs

"Relationships with GCACH (Greater Health Now) and MCOs in the region make it easier to communicate and problem solve. The quarterly GCACH reporting helps give staff as a whole a better visual of the great work that they are doing at our weekly staff meetings."

4. Support from ACHs

"BHT (Better Health Together ACH) provides licensing reimbursement which is very helpful and works well."
"Our ACH BHT is the sole supporter of integration efforts for a BHA in this region."

Behavioral Health

Cohort 1 Narrative Responses and Themes

-

N = 126

- **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. Licensure Requirements and Timing

"Recognition and allowance to practice for providers with non-USA certifications and licensure for healthcare providers from other countries."

"HCA department of licensing has been slow in licensing new providers. For example for the WISe (Wraparound with Intensive Services) program, some providers have been waiting for their license for the last 3 months."

"Most insurances (especially commercial) do not backdate paneling. We would like to see a standard for backdating paneling to capture reimbursement for services provided while (sometimes lengthy) paneling decisions are made."

"Increase reimbursement for licensure renewals would improve provider retention. 3 training days per year per clinician and 5 training days per med provider, and funds available towards training. Consortium trainings available to staff would be helpful."

Behavioral Health

Cohort 1 Narrative Responses and Themes

-

N = 126

- **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. Payment Structures and Reimbursement

"Medicaid payment models do not reimburse for engagement efforts and travel time related to outreach activities. Additionally, current behavioral health Medicaid payment models do not allot funding specifically for medical staff positions or preventative health interventions such as vaccinations, wound care, or health screenings."

"The Collaborative Care codes were developed for delivery of mental health in a primary care setting and there is not a parallel set of codes or process for behavioral health care providers. Few payers have developed value based payment arrangements for behavioral health and those that have been tried are not sustainable (e.g., Pathways Community HUB through ACH), fee for service billing does not adequately account for the amount of care coordination needed for behavioral health clients."

"The current payment structure in King County is not conducive to integrated care delivery. Payment in KC is siloed without clear incentive, or opportunity to explore alternative payment models."

"There is no funding model for or license/credential for care navigator (like community health worker) positions for mental health providers."

Behavioral Health

Cohort 1 Narrative Responses and Themes

-

N = 126

- **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. Payment Structures and Reimbursement (continued)

“Direct funding for our self-identified integrated care implementation goals has been most helpful as it provides incentives for us to choose goals that are relevant to the clients we serve and feasible with our service delivery models. We might benefit from being able to make bespoke integrated targets, where the amount of reimbursement is proportional to the significance of the effort as well as the efforts required to implement it.”

“Collaborative care codes...has proven very difficult to implement through our EHR system (Epic), and we haven't been able to bill yet due to the complications building it in our EHR.”

“Expanding SERI for SUD providers to [be] able to bill for integrated services. Currently we can only bill for a certain number of codes.”

“We have asked to include primary care in our MCO contracts, but there never seems to be an opportunity to negotiate the contracts to open it up. We receive very poor reimbursement for our medical care and get paid less than it takes to maintain a provider.”

Behavioral Health

Cohort 1 Narrative Responses and Themes

-

N = 126

- **27. What resources/support does your clinical site need to advance integration?**
  See page 18 for a breakdown of top challenges faced by behavioral health practices.

1. Support with EHR Technology
"An HLN7 interoperability framework that would bridge multiple EHR systems, allowing for sharing or integration of client information across the spectrum of integrated healthcare systems."

"Funding for data analysis and software development positions to build EHR interoperability with other community healthcare organizations, electronic drug prescription and medication management, integration of additional health metric tracking, and workflow improvement and automation (our ... Innovation projects are still using spreadsheets to manage the workflow and track metrics for much of their work)."

"We are not able...to utilize our school nurses in a way that aligns with integration. If we were able to implement an HIE with local hospitals, that would be a way to connect our agency to physical health providers in a meaningful way."

"We would also like to update our system to include a more prescriber friendly interface."

2. Payment Reform
"Advocacy for billable codes for behavioral health integrated into primary care and billing options for multiple types of licenses."

"Reimbursement for integrated training that would include underwriting the salary of the staff attending AND underwriting the revenue generation lost by attending training rather than providing client care."

3. Workforce Support
"Workforce shortage continues to be a challenge, so information or support around recruiting, hiring, and retaining employees."

Behavioral Health

Cohort 1 Narrative Responses and Themes

-

N = 126

- **27. What resources/support does your clinical site need to advance integration?** See page 18 for a breakdown of top challenges faced by behavioral health practices.

4. Shared Vision and Executive Buy-in
"It could be helpful for staff to hear leaderships plan/vision for what integrated healthcare will look like as an agency and what it could look like for each program. Additional trainings available to staff which highlight the importance of how physical and behavioral health are interconnected could get buy in from clinicians who might be cautious with offering general healthcare information to clients."

"Internal prioritization from our executive leadership."

5. Clinical Partnerships
"In a rural community, it would be really helpful to have a partnership or linkage with a medical clinic (most clients utilize the same local clinic), in order to increase communication and collaboration."

"Start having meetings with local PCP [Primary Care] agencies on establishing mutual understanding for each other's protocol and expectations on coordination of care process"

"More formal partnerships re: integration, workforce available, technology"

6. Technical Assistance for Integration
"Staff training and time for evidence-based practices including systematic screening tool for universal general health risk factors, guidelines to engage patients universal general health risk factor screening, guideline and treatment protocols for chronic health conditions, culturally competent tools to promote patient activation and recovery, general health quality metrics, etc."

Results by ICA Framework Subdomains (Distribution of Site Responses)

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Index of ICA Framework Domains

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

ICA Framework Domains

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

Screening

Foundational Domain

Domain
1. Screening , Referral to Care and Follow-up

Subdomain
1.1 Screening and follow-up for preventive and general health conditions

Behavioral Health

N = 126

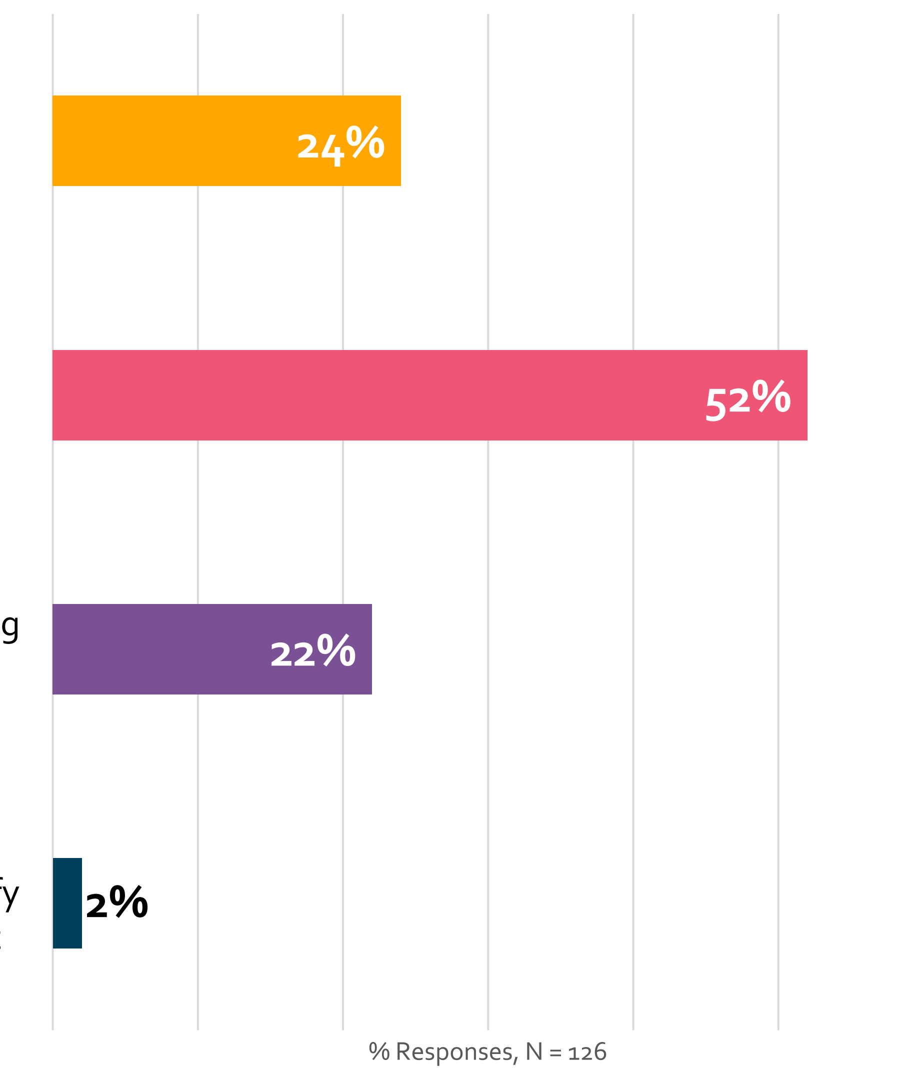
Question 11

Preliminary: Response to patient self-report of general health complaints and/or chronic illness with f/u only when prompted.

Intermediate I: Systematic screening for universal general health risk factors[iii] and proactive health education to support motivation to address risk factors.

Intermediate II: Systematic, screening and tracking of universal and relevant targeted health risk factors as well as routine f/u for general health conditions with the availability of in-person or telehealth primary care.

Advanced: 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.



Referrals

Domain
1. Screening , Referral to Care and Follow-up

Subdomain
1.2 Facilitation of referrals and follow-up

Behavioral Health

N = 126

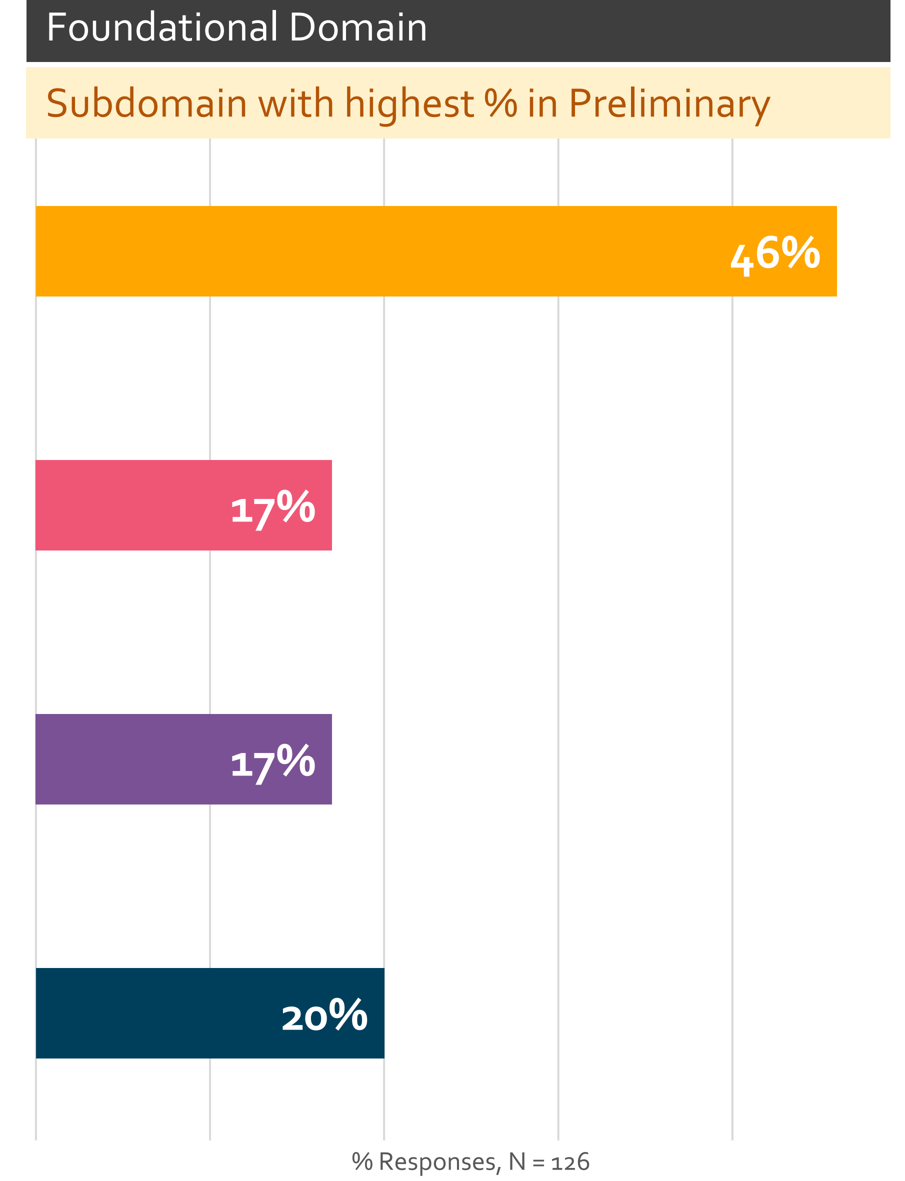
Question 12

Preliminary: Referral to external primary care provider(s) (PCP) and no/limited f/u.

Intermediate I: Written collaborative agreement with external primary care practice to facilitate referral that includes engagement and communication expectations between behavioral health and PCP.

Intermediate II: Referral to onsite, co-located PCP or availability of primary care telehealth appointments with assurance of "warm handoffs" when needed.

Advanced: Enhanced referral facilitation to onsite or closely integrated offsite PCPs, with electronic data sharing and accountability for engagement.



Evidence-based Guidelines for Prevention

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

Subdomain
2.1 Evidence-based guidelines or treatment protocols for preventive interventions

Behavioral Health

N = 126

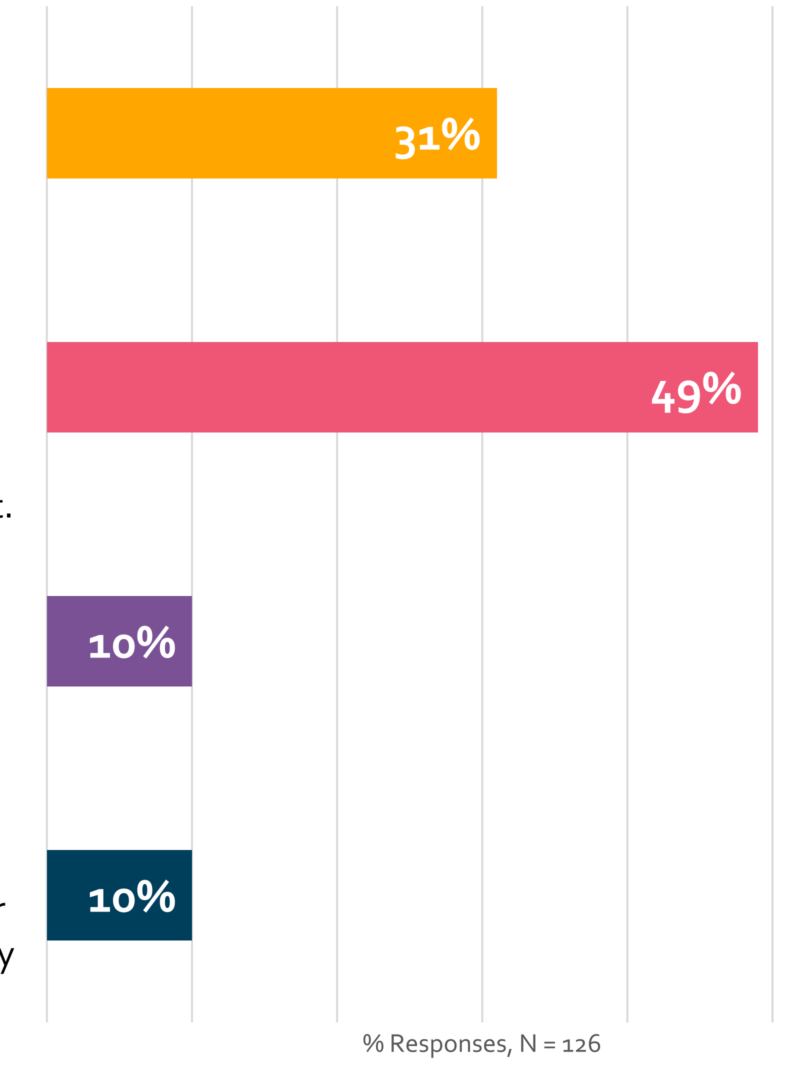
Question 13

Preliminary: 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.

Intermediate I: 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.

Intermediate II: 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.

Advanced: 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.).



Evidence-based Guidelines for General Medical Conditions

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

Subdomain
2.2 Evidence-based guidelines or treatment protocols for chronic health conditions

Behavioral Health

N = 126

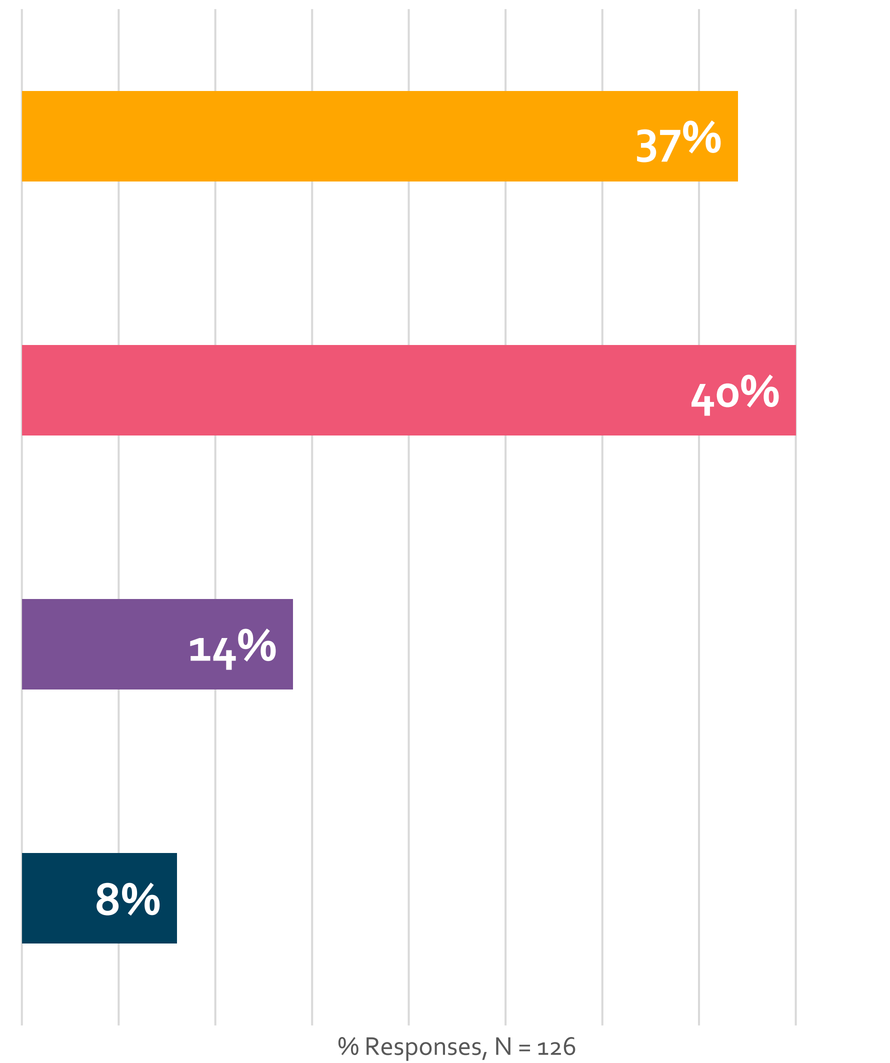
Question 14

Preliminary: Not used or with minimal guidelines or EB evidence-based workflows for improving access to care for chronic health conditions.

Intermediate I: 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.

Intermediate II: BH providers and/or embedded 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.

Advanced: 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.



Medication Management

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

Subdomain
2.3 Use of medications by BH prescribers for preventive and chronic health conditions

Behavioral Health

N = 126

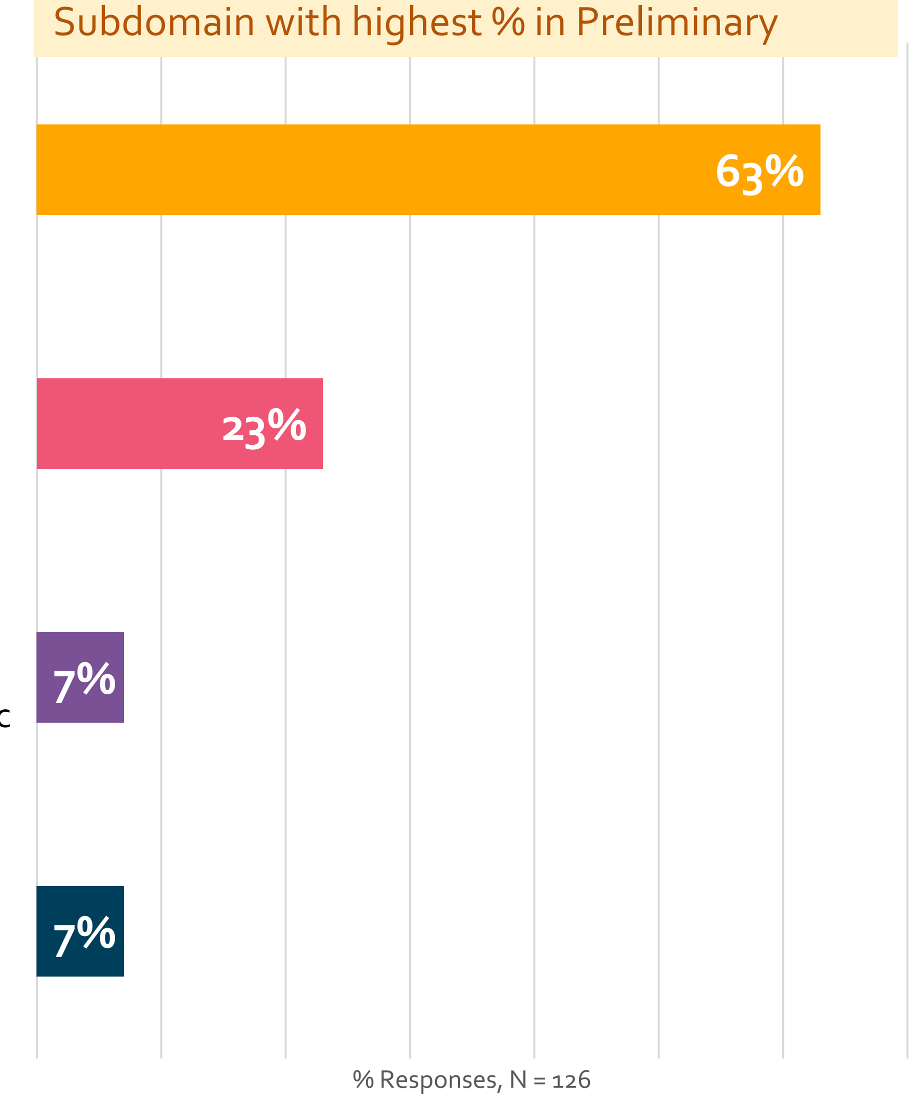
Question 15

Preliminary: 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.

Intermediate I: BH prescriber routinely prescribes nicotine replacement therapy (NRT) or other psychiatric medications for smoking reduction.

Intermediate II: 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.

Advanced: BH prescriber can prescribe NRT as well as prescribe chronic health medications with assistance and consultation of PCP.



Trauma-informed Care

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

Subdomain
2.4 Trauma-informed care

Behavioral Health

N = 126

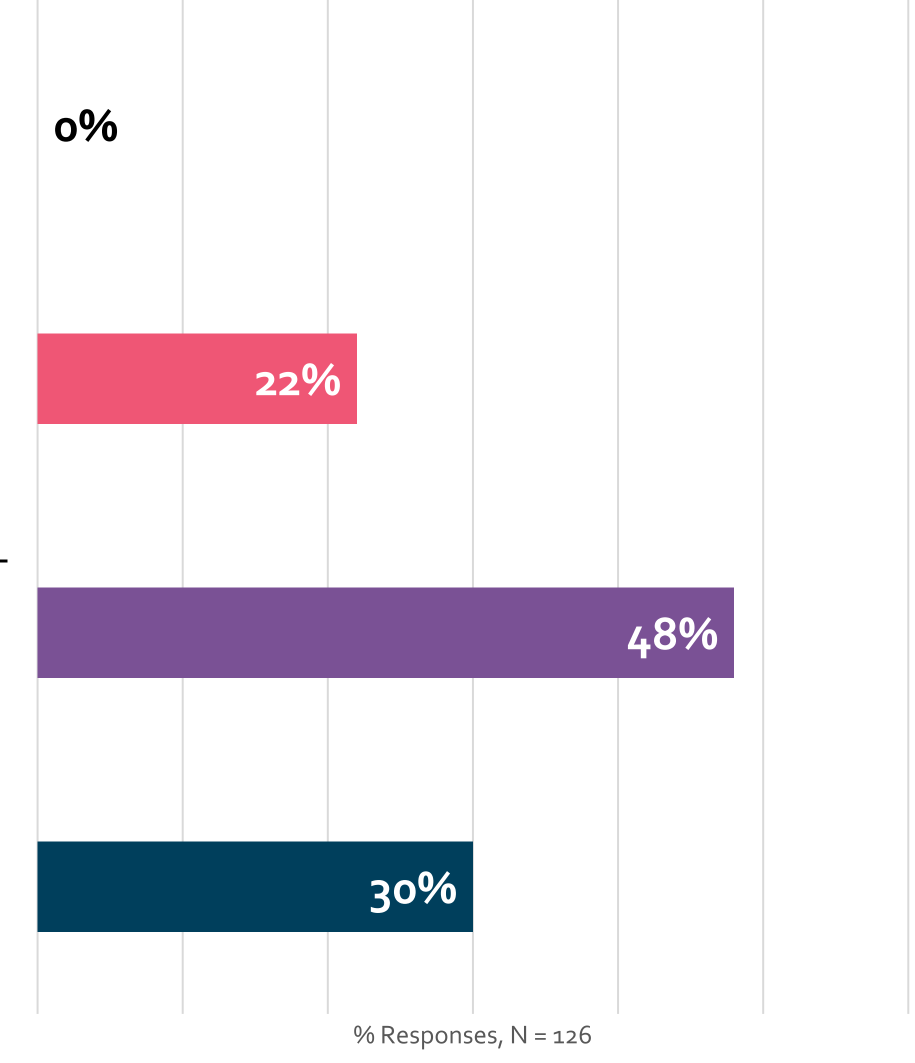
Question 16

Preliminary: BH staff have no or minimal awareness of effects of trauma on integrated health care.

Intermediate I: Limited staff education on trauma and impact on BH and general health care.

Intermediate II: 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.

Advanced: 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.



Care Management

Foundational Domain

Domain
3. Ongoing care management

Subdomain
3.1 Longitudinal clinical monitoring & engagement for preventive health and/or chronic health conditions.

Behavioral Health

N = 126

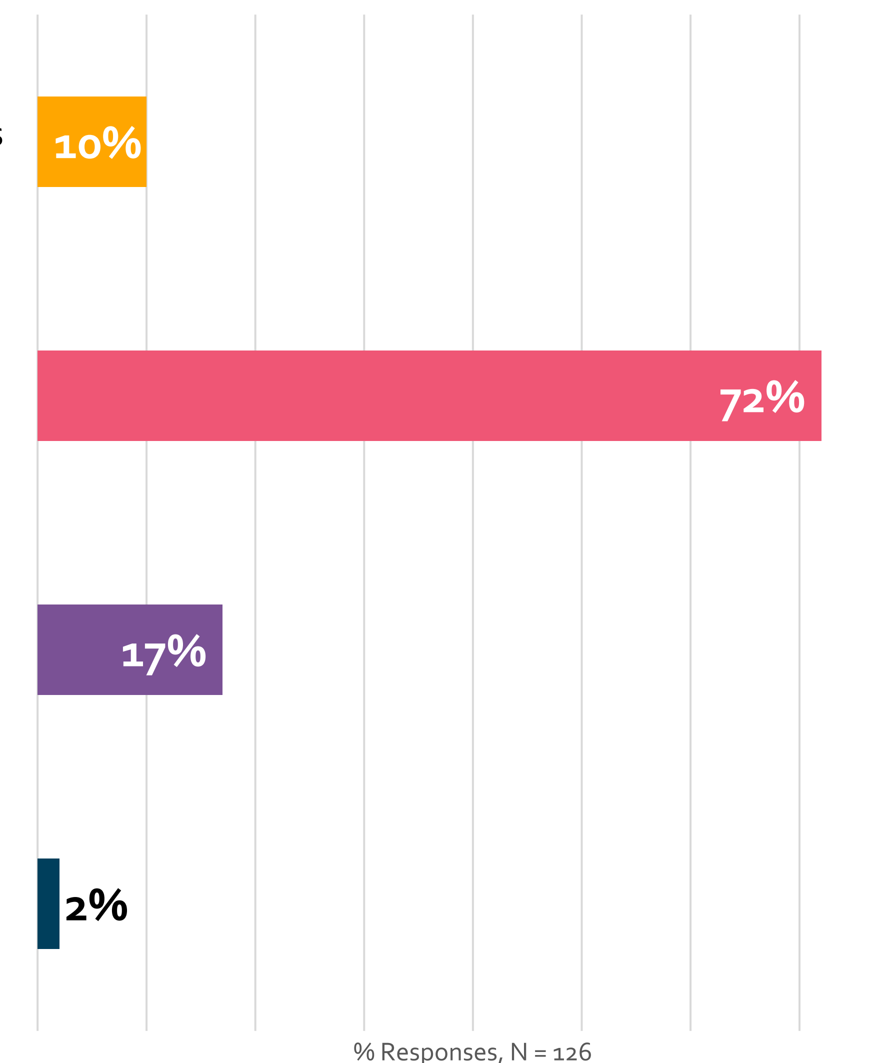
Question 17

Preliminary: None or minimal follow-up of patients referred to primary and medical specialty care.

Intermediate I: Some ability to perform follow-up of general health appointments, encourage medication adherence and navigation to appointments.

Intermediate II: 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.

Advanced: 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.



Self-management Support

Foundational Domain

Domain
4. Self-management support that is adapted to culture, socioeconomic and life experiences of patients

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

Behavioral Health

N = 126

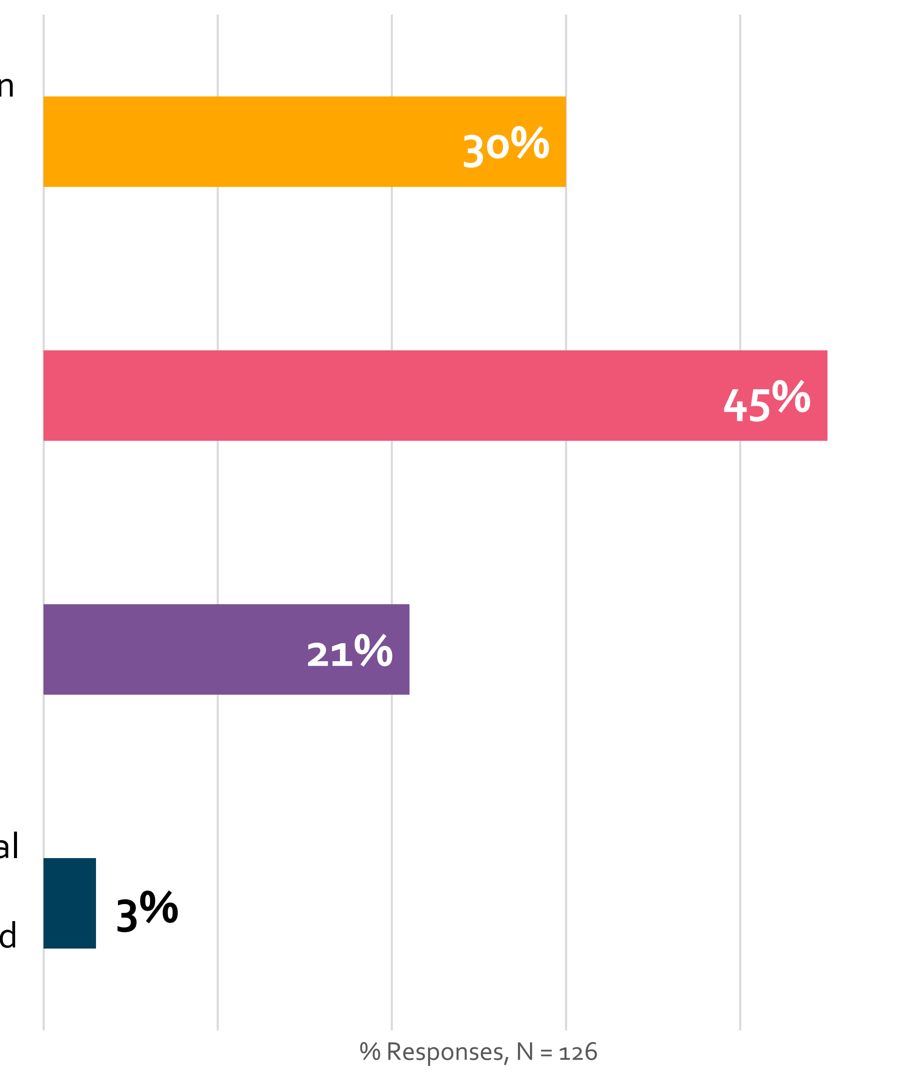
Question 18

Preliminary: None or minimal patient education on general medical conditions and universal general health risk factor screening recommendations.

Intermediate I: 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.

Intermediate II: 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.

Advanced: 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.



Care Team

Domain
5. Multidisciplinary team (including patients) with dedicated time to provide general health care

Subdomain
5.1 Care Team

Behavioral Health

N = 126

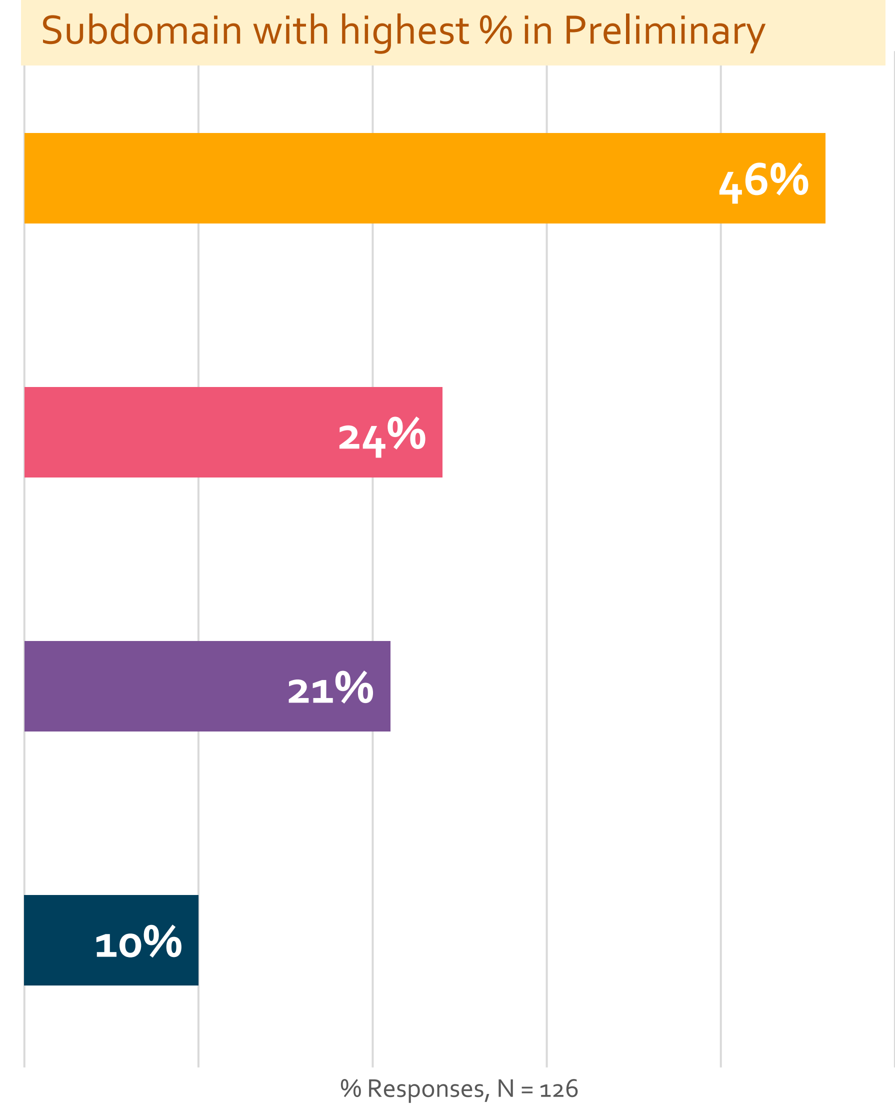
Question 19

Preliminary: BH provider(s), patient, family caregiver (if appropriate).

Intermediate I: BH provider(s), patient, nurse, family caregiver.

Intermediate II: BH provider(s), patient, nurse, peer, co-located PCP(s), (M.D., D.O., PA, NP), family caregiver.

Advanced: BH provider(s), patient, nurse, peer, PCP(s), care manager focused on general health integration, family caregiver.



Sharing Treatment Info

Domain
5. Multidisciplinary team (including patients) with dedicated time to provide general health care

Subdomain
5.2 Sharing of treatment information, case review, care plans and feedback

Behavioral Health

N = 126

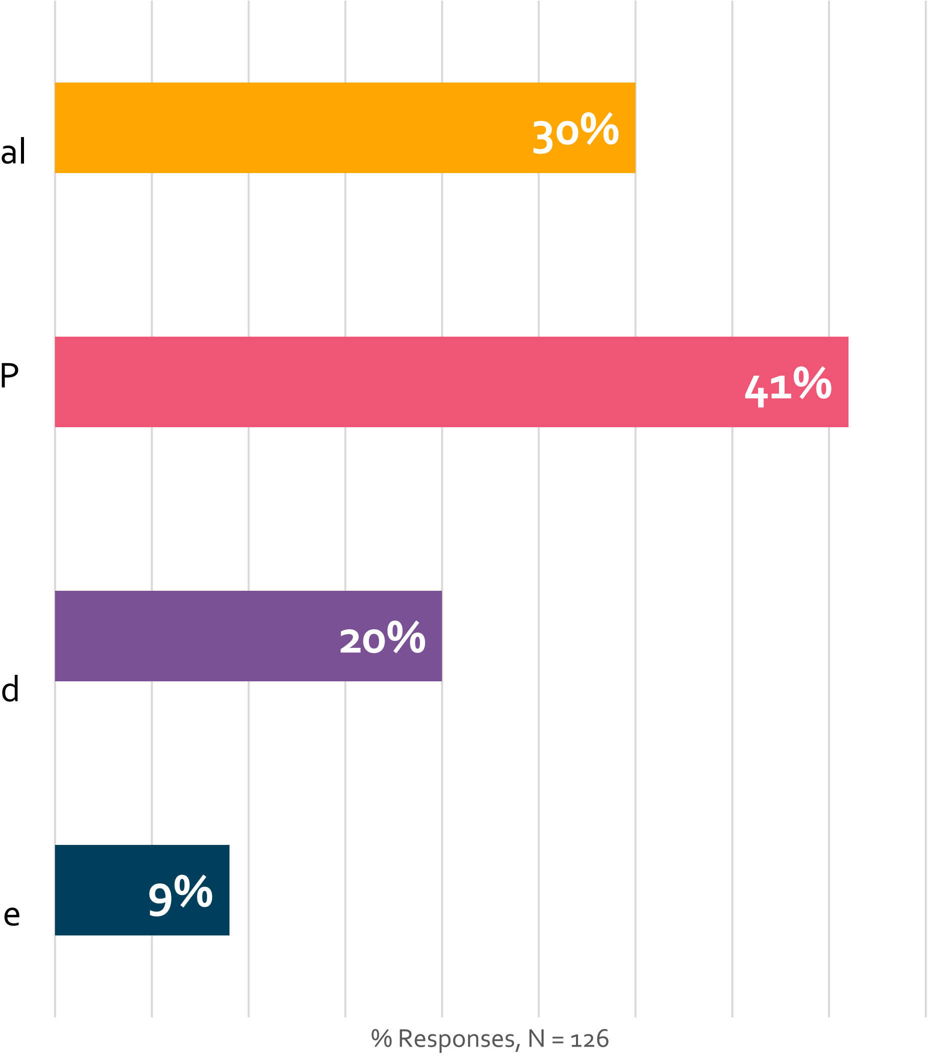
Question 20

Preliminary: No or minimal sharing of treatment information and feedback between BH and external PCP.

Intermediate I: Exchange of information (phone, fax) and routine consult retrieval from external PCP on changes of general health status, without regular chart documentation.

Intermediate II: 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.

Advanced: 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.



Integrated Care Training

Domain
5. Multidisciplinary team (including patients) with dedicated time to provide general health care

Subdomain
5.3 Integrated care team training

Behavioral Health

N = 126

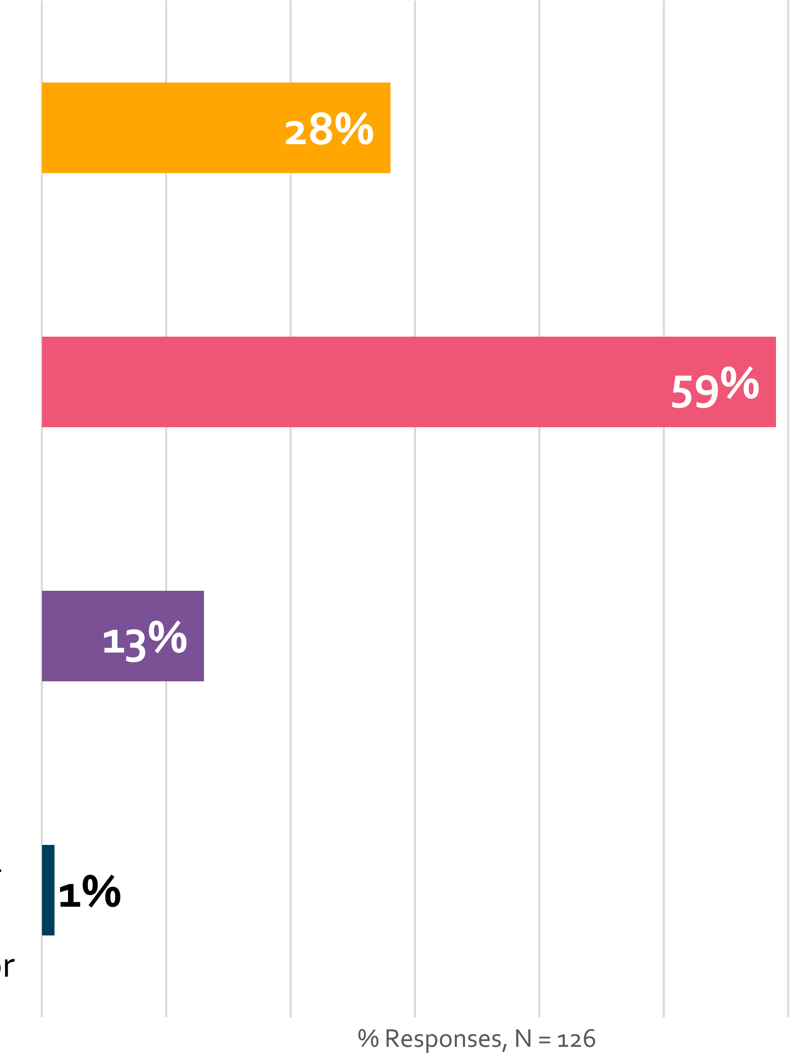
Question 21

Preliminary: None or minimal training of all staff levels on integrated care approach and incorporation of whole health concepts.

Intermediate I: Some training of all staff levels on integrated care approach and incorporation of whole health concepts.

Intermediate II: Routine training of all staff levels on integrated care approach and incorporation of whole health concepts with role accountabilities defined.

Advanced: 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.



Quality Improvement

Domain
6. Systematic Quality Improvement (QI)

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

Behavioral Health

N = 126

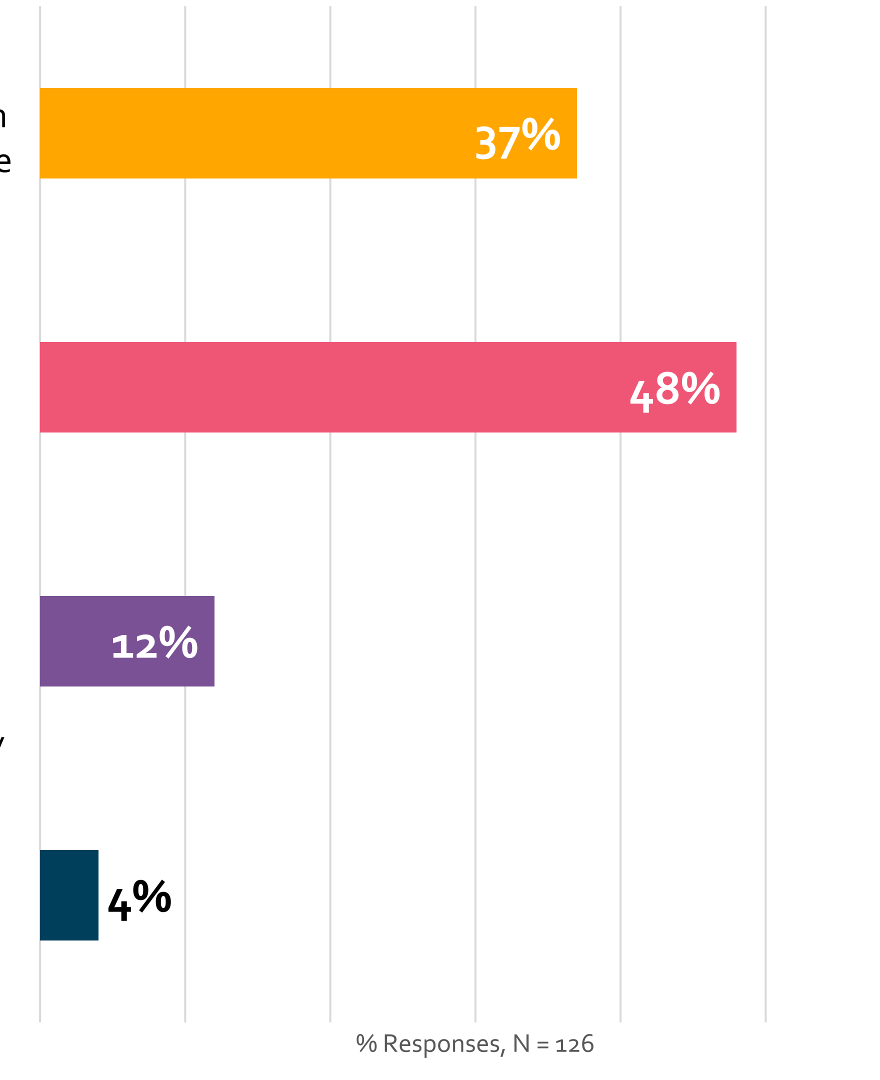
Question 22

Preliminary: None or minimal use of general health quality metrics (limited use of data, anecdotes, case series).

Intermediate I: 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.

Intermediate II: 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.

Advanced: 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.



Social Service Links

Domain
7. Linkages with community/social services that improve general health and mitigate environmental risk factors

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

Behavioral Health

N = 126

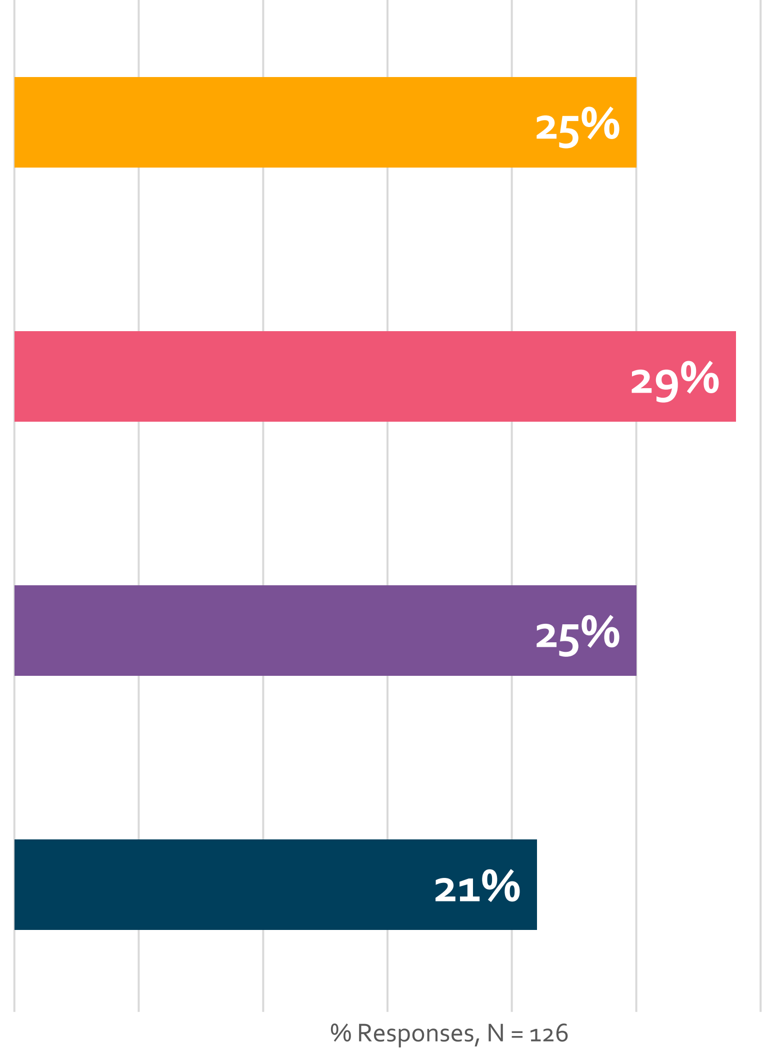
Question 23

Preliminary: No or limited/informal screening of social determinants of health (SDOH) and linkages to social service agencies, limited information exchange or follow-up.

Intermediate I: Routine SDOH screening and referrals made to social service agencies, with limited information exchange or follow-up.

Intermediate II: Routine SDOH screening, with information exchange with social service agencies, with limited capacity for follow-up.

Advanced: 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.



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Billing Sustainability

Domain
8. Sustainability

Subdomain
8.1 Build process for billing and outcome reporting to support sustainability of integration efforts

Behavioral Health

N = 126

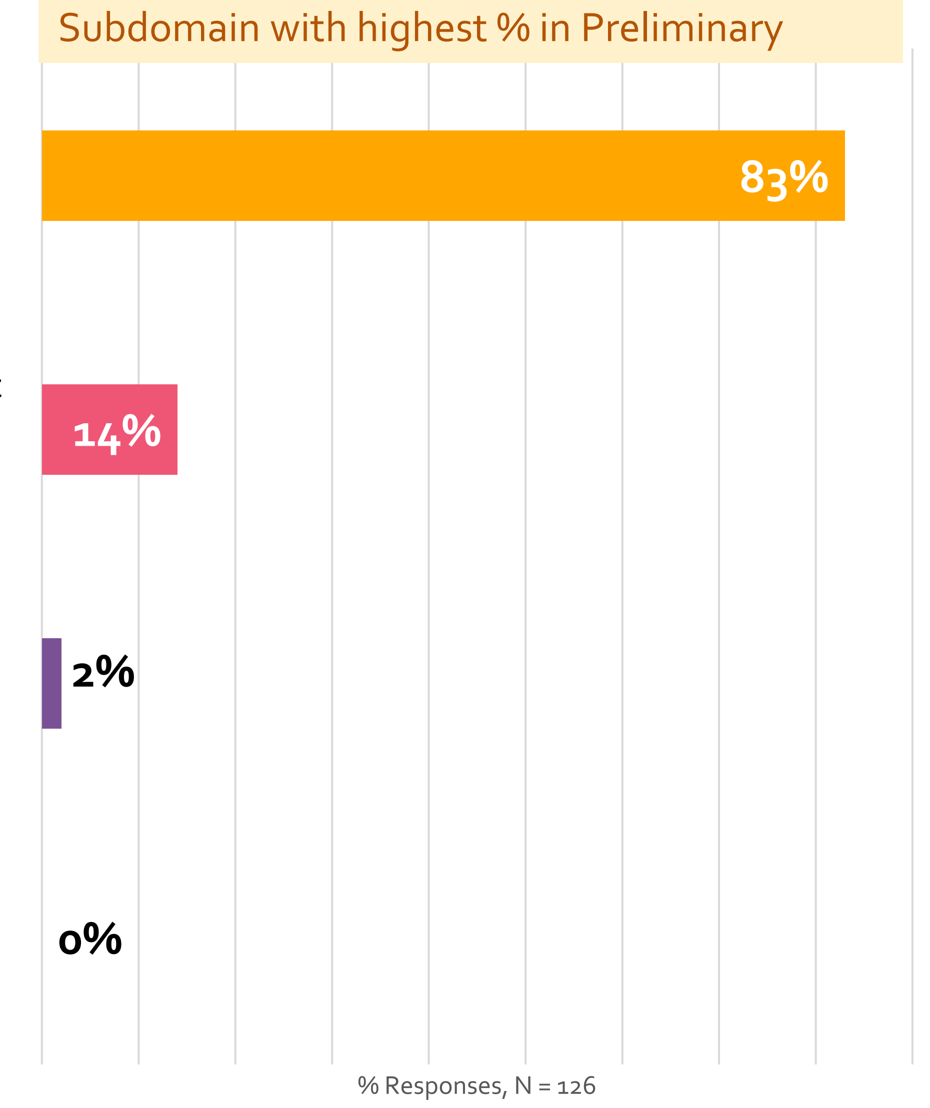
Question 24

Preliminary: No or minimal attempts to bill for immunizations, screening and treatment. Services supported primarily by grants or other non-reimbursable sources.

Intermediate I: 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.

Intermediate II: 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.

Advanced: 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.



Regulatory/Licensure

Domain
8. Sustainability

Subdomain
8.2 Build process for expanding regulatory and/or licensure opportunities

Behavioral Health

N = 126

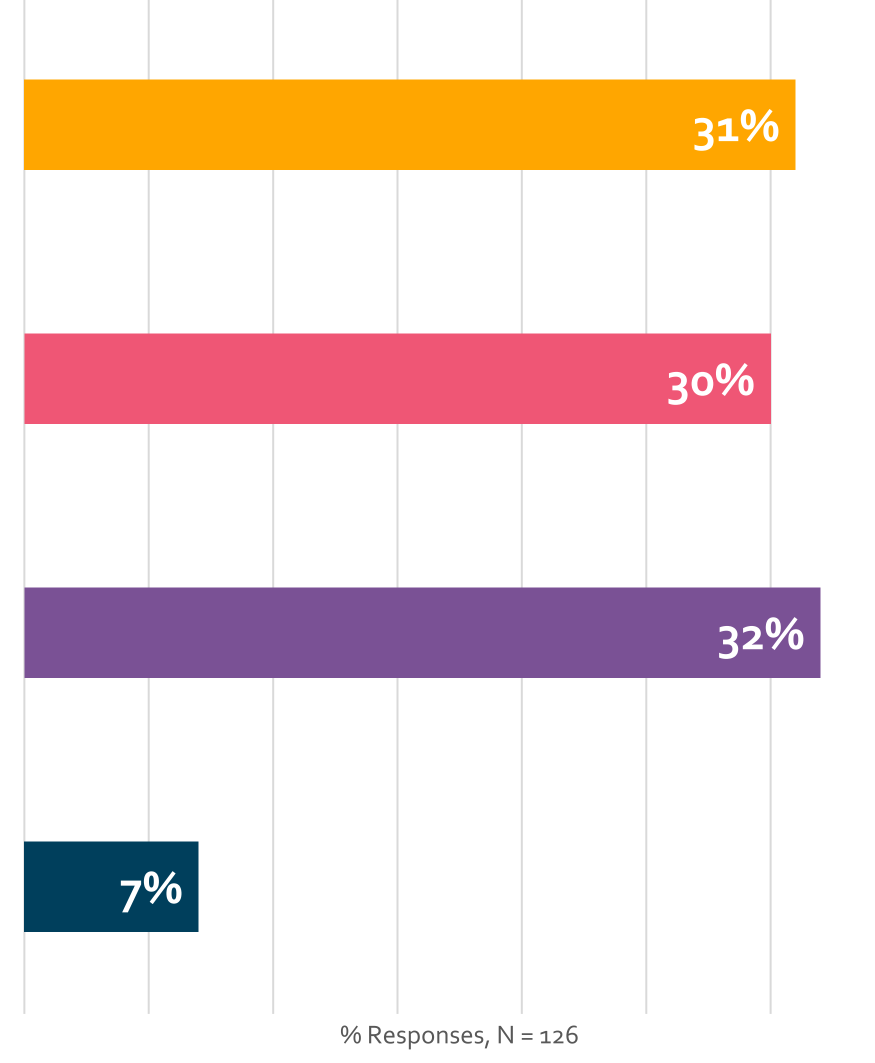
Question 25

Preliminary: No primary care arrangements that offer physical health services through linkage or partnership.

Intermediate I: 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.

Intermediate II: Consistent availability of primary care access, internal or external, with telehealth if appropriate that incorporate patient centered home services.

Advanced: Maintain appropriate dual licensure (WAC chapter 246-320 & RCW 70.41 and RCW 71.24 & WAC 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.



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

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

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

About the Assessment Framework

- 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.

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- 1. Summary
- 2. Response Rate and Characteristics
- 3. Narratives: Equity, Licensing and Reimbursement, Support
- 4. Results by ICA Framework Subdomains (Distribution of Site Responses)

Summary

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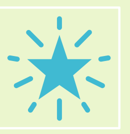
Executive Summary

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.

Opportunities for Improvement

Primary Care

Subdomains with 3 highest percentages of sites in Preliminary integration stage

–

N = 79

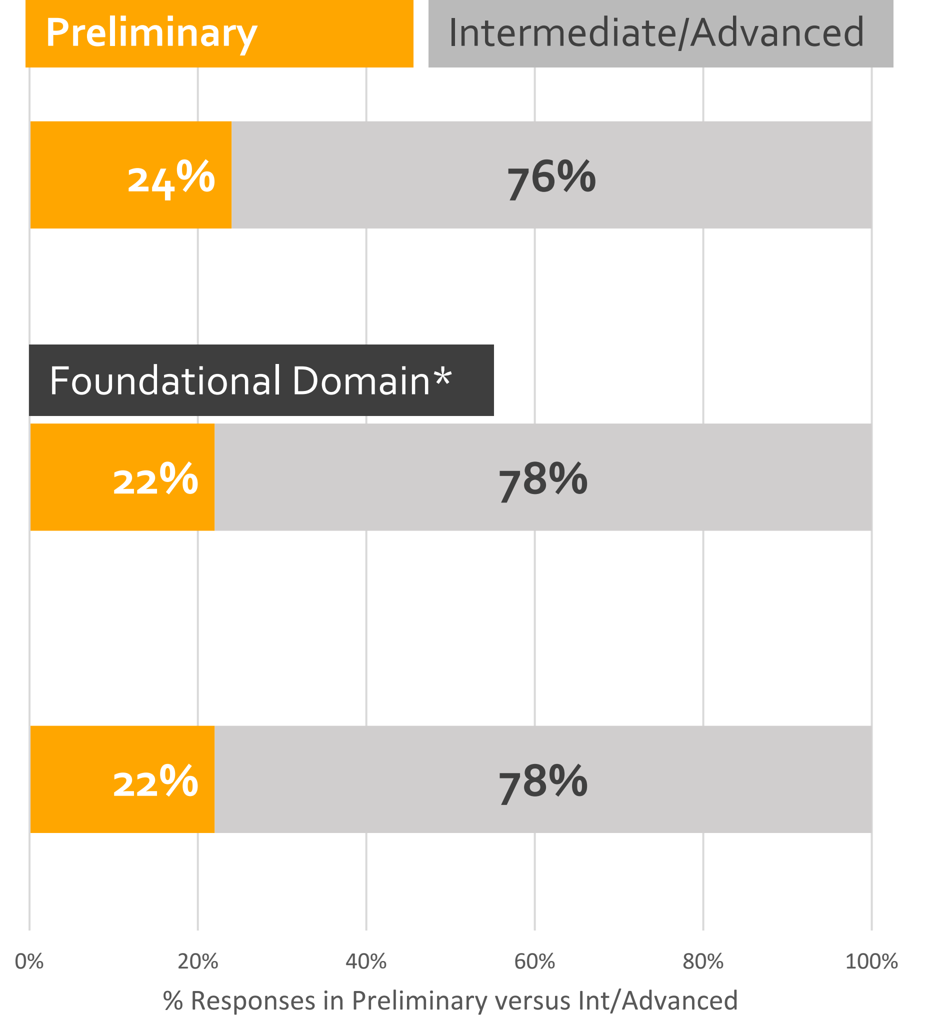
* **Foundational Domain.** Sites in preliminary stages can focus on these areas to establish a foundation for advancing integrated care.

Subdomains with Highest % Sites in **Preliminary**

7.1 Use of quality metrics for program improvement

1.2 Facilitation of referrals, feedback

6.2 Systematic multidisciplinary team-based patient care review processes



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Foundational Domains

Subdomains with % Sites in **Preliminary**

Primary Care

Foundational Domains* – Sites in Preliminary integration stage

-

N = 79

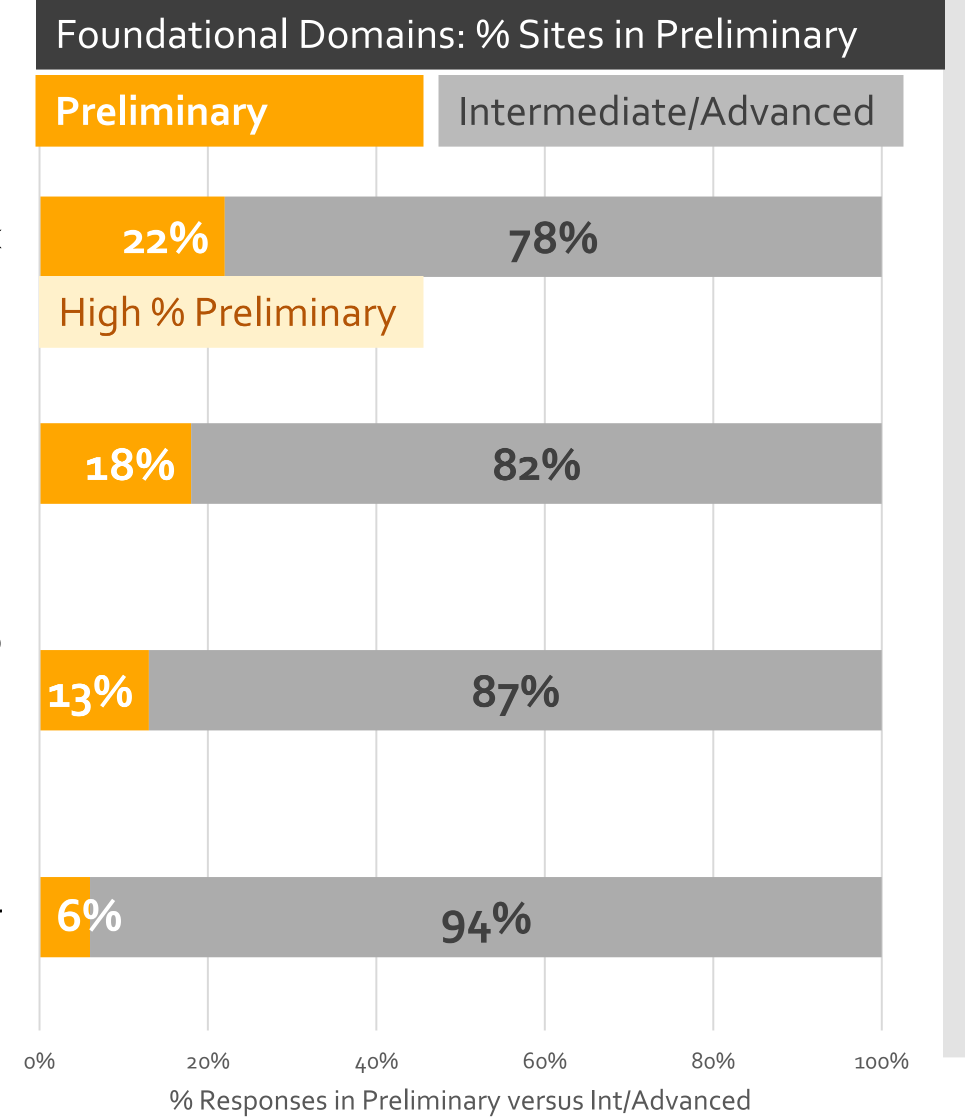
* **Foundational Domain.** Sites in preliminary stages can focus on these areas to establish a foundation for advancing integrated care.

1.2 Facilitation of referrals, feedback

4.1 Longitudinal clinical monitoring and engagement

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

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

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Primary Care

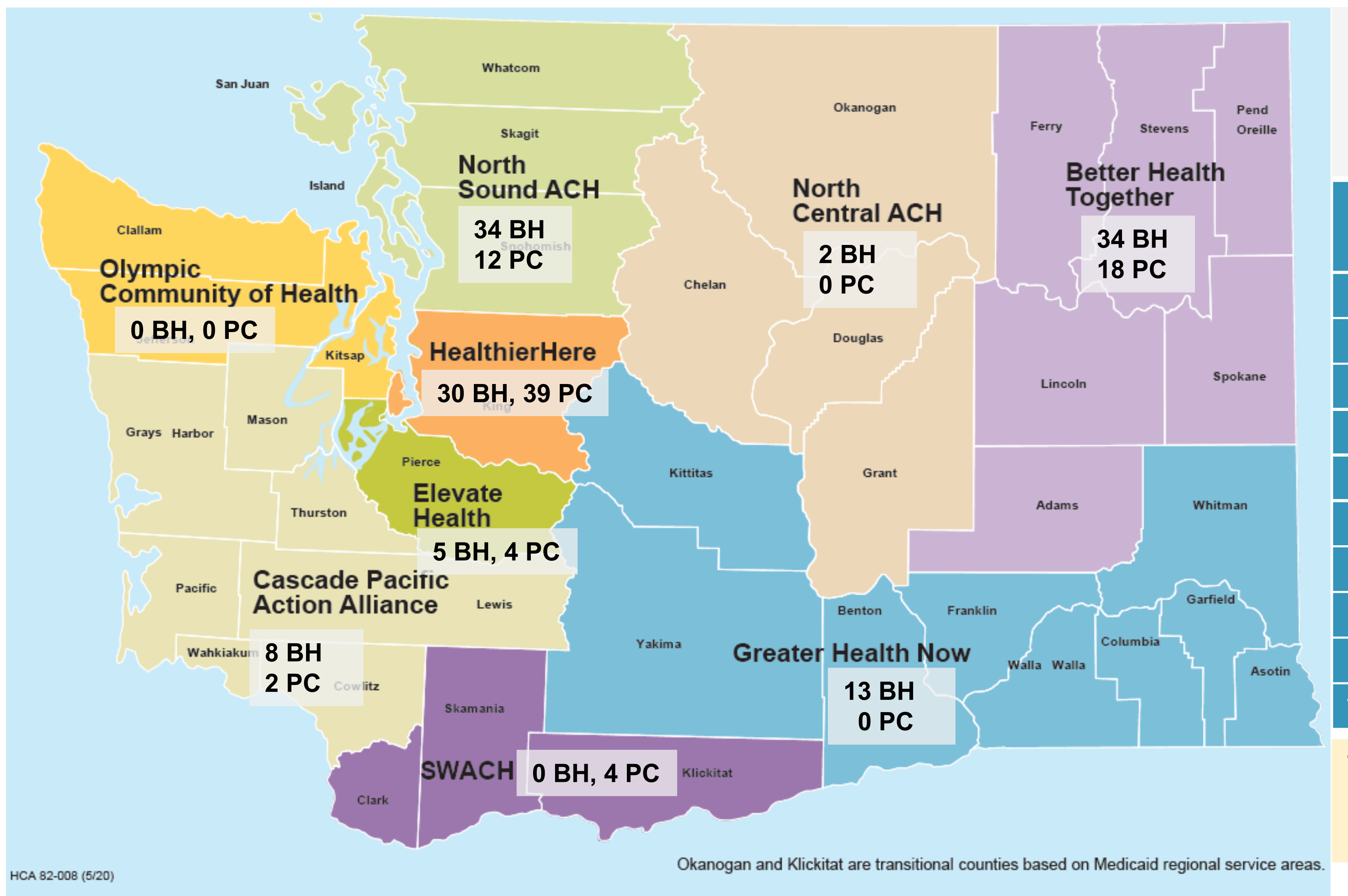
Statewide Response Rate

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

	Org Response Rate (responded / invited)	**Site Response Rate** (responded / invited)
Behavioral Health	57% (58/102 orgs)	65% (126/195 sites)
Primary Care	51% (28/55 orgs)	45% (79/174 sites)
All	55% (86/157 orgs)	56% (205/369 sites)

ACH Region Response Count



Key

BH: Behavioral Health Site Responses

PC: Primary Care Site Responses

Region	BH	PC	% Total (BH+PC)
HealthierHere	30	39	34%
Better Health Together	34	18	25%
North Sound ACH	34	12	22%
Greater Columbia ACH	13	0	6%
Cascade Pacific Action Alliance	8	2	5%
Elevate Health	5	4	4%
Southwest ACH	0	4	2%
North Central ACH	2	0	1%
Olympic Community of Health	0	0	0%
Total	126	79	100%

Three regions account for 81% of site responses.

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

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

Primary Care

Characteristics of Cohort 1 Responses - N = 79

Supplemental Questions

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

	# Sites	% of Sites
Both	54	68%
Adults	21	27%
Pediatrics	4	5%
Total	79	100%

Primary Care

Characteristics of Cohort 1 Responses
-
N = 79

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

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

Primary Care

Characteristics of Cohort 1 Responses - BH Sites N = 126* PC Sites N = 79*

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

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

	Min	25% Percentile	Median	75% Percentile	Max
BH Sites - Monthly Patients	9	83	228	587	4,030
Primary Care Sites - Monthly Patients	50	781	1,461	2,000	15,000

Primary Care

Characteristics of Cohort 1 Responses

-

N = 79*

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

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

	Min	25% Percentile	Median	75% Percentile	Max
Medicaid	7%	21%	44%	65%	85%
Medicare	0%	7%	17%	25%	75%
Commercial Insurance	0%	16%	21%	39%	77%
Uninsured	0%	2%	5%	12%	38%
Fee for Service	0%	0%	1%	10%	100%
Other	0%	0%	0%	0%	39% ("Self-pay")

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.

Primary Care

Characteristics of Cohort 1 Responses
-
N = 79

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

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

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

A quarter of sites do not use any SDoH screening tool.

Primary Care

Characteristics of Cohort 1 Responses - N = 79

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

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

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.

Primary Care

Characteristics of Cohort 1 Responses - N = 79

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

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

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.

Primary Care

Characteristics of Cohort 1 Responses
-
N = 79*

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

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

	Min	25% Percentile	Median	75% Percentile	Max
% Virtual (video)	0%	1%	5%	10%	90%
% Virtual (telephone only)	0%	0%	4%	10%	50%
% In-Person	0%	77%	87%	93%	100%

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.

Primary Care

Characteristics of Cohort 1 Responses
-

N = 79

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

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

Workforce and **Financial Support** are the top challenges to advancing integration.

These were the top challenges across both BH and primary care sites.

Narratives:
Equity, Licensing and Reimbursement, Support

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Summary of Narrative Themes

Primary Care

Cohort 1 Narrative Response Summary -

N = 79

- 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

Primary Care

Cohort 1 Narrative Responses and Themes

-

N = 79

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."

Primary Care

Cohort 1 Narrative Responses and Themes

-

N = 79

- **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."

Primary Care

Cohort 1 Narrative Responses and Themes

-

N = 79

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.

Primary Care

Cohort 1 Narrative Responses and Themes

-

N = 79

- **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."

Primary Care

Cohort 1 Narrative Responses and Themes

-

N = 79

- **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."

Primary Care

Cohort 1 Narrative Responses and Themes

-

N = 79

- **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"

Primary Care

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."

Primary Care

Cohort 1 Narrative Responses and Themes

-

N = 79

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

4. Community Collaboration and Idea-Sharing
"Continued collaboration with other organizations in the community working to implement integration, to brainstorm and share ideas."

5. CIE for Centralized Behavioral Health Service Directory
"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)

6. Technical Assistance for Integration
"Social Determinant screening guidance and IT support to capture the data, track and monitor progress"
"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."

Results by ICA Framework Subdomains (Distribution of Site Responses)

Return to Table of Contents

Index of ICA Framework Domains

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

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.
9. Sustainability.

Screening

Foundational Domain

Domain
1. Screening , Referral to Care and Follow-up

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

Primary Care

N = 79

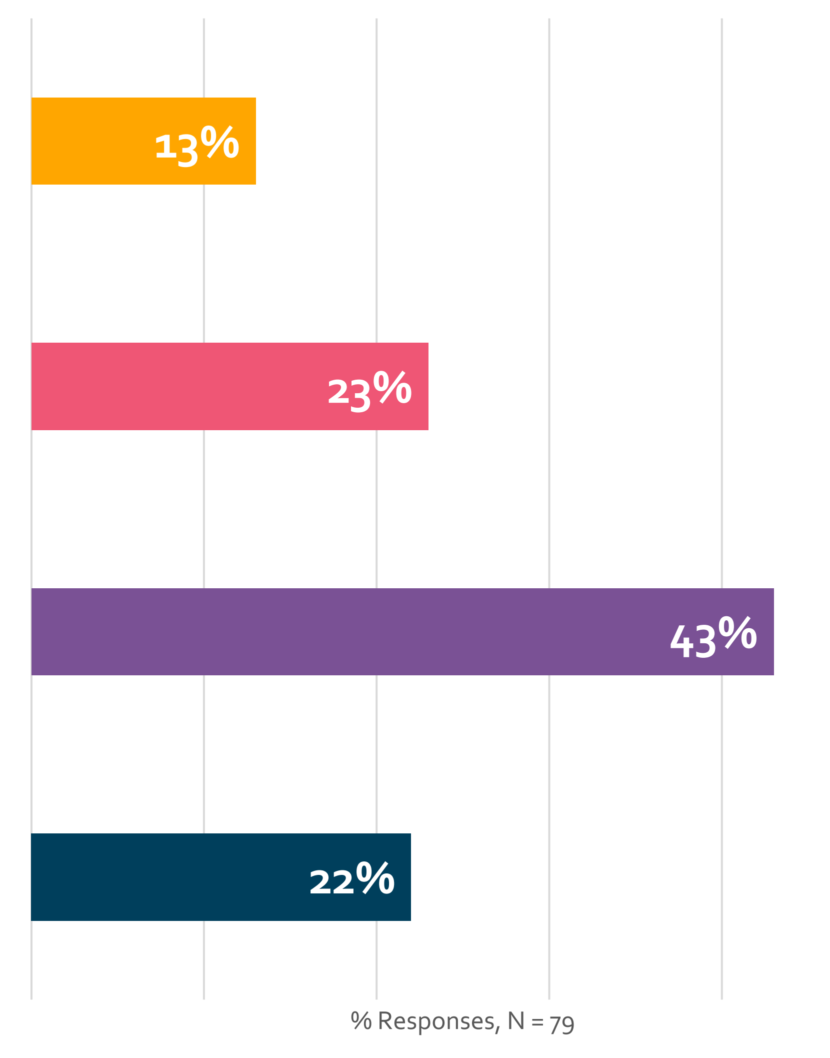
Question 11

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



Referrals

Domain
1. Screening , Referral to Care and Follow-up

Subdomain
1.2 Facilitation of referrals, feedback

Primary Care

N = 79

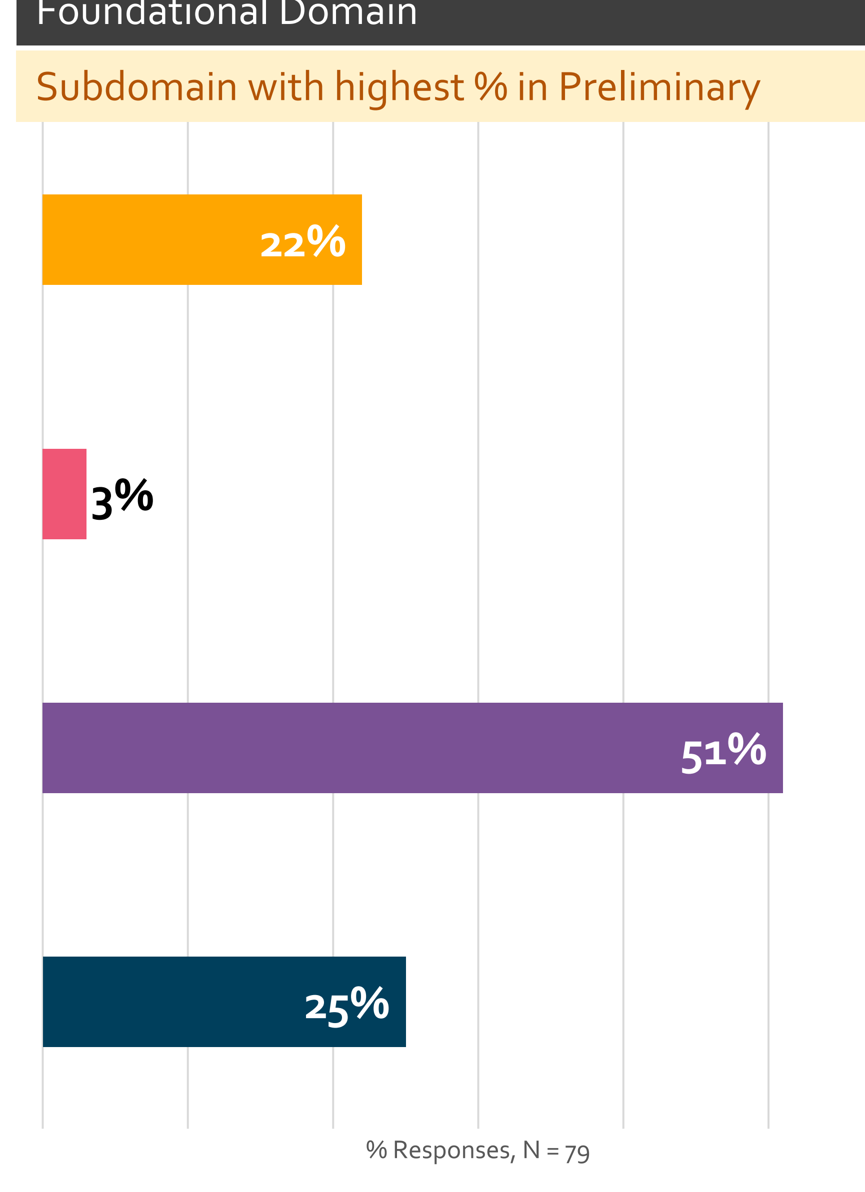
Question 12

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



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

Evidence-based Care

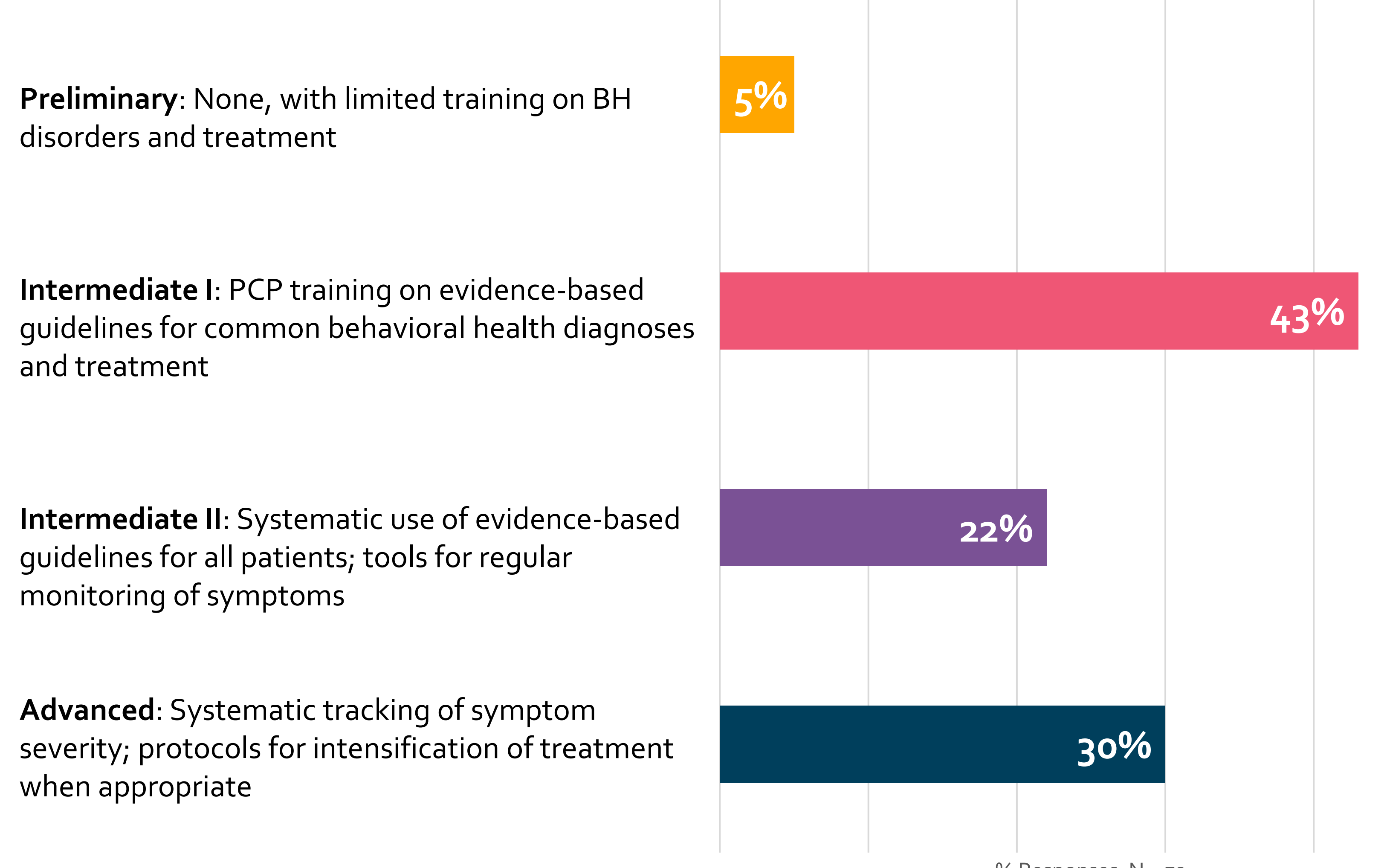
Domain
2. Evidence- based care for preventive interventions and common behavioral health conditions

Subdomain
2.1 Evidence-based guidelines/treatment protocols

Primary Care

N = 79

Question 13



Medication Management

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

Subdomain
2.2 Use of psychiatric medications

Primary Care

N = 79

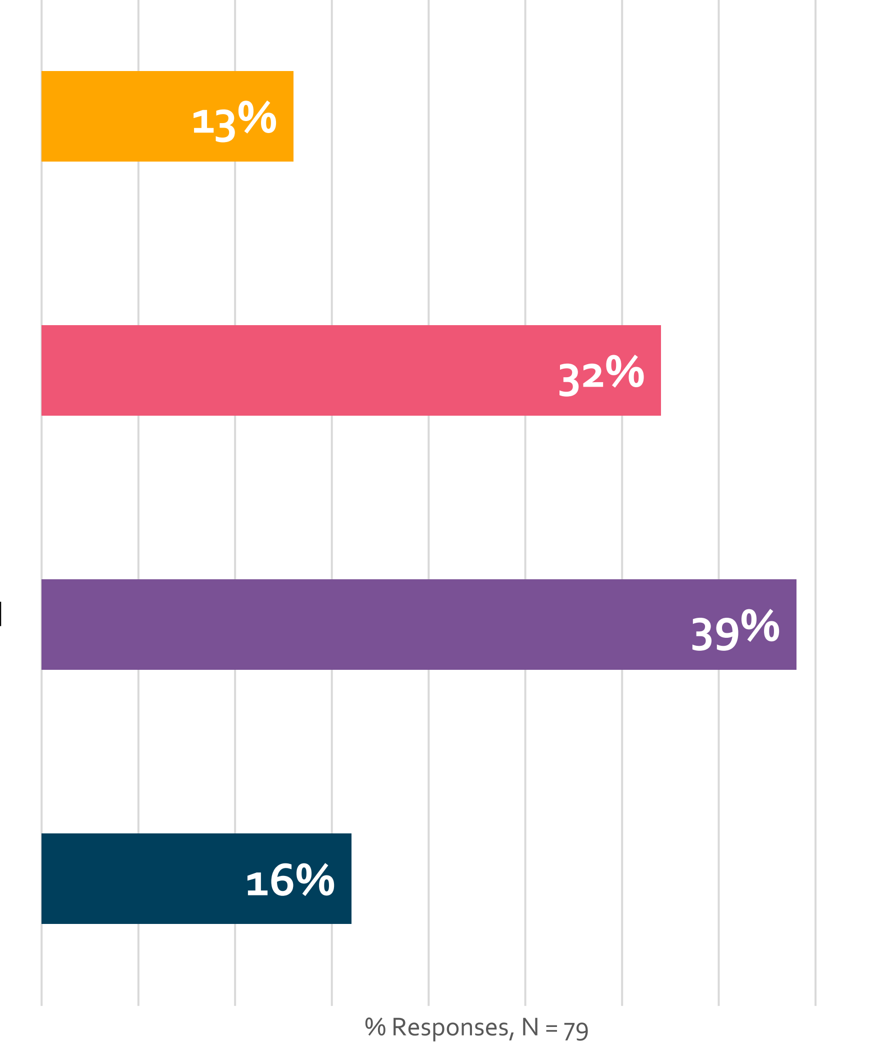
Question 14

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



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Therapy Access

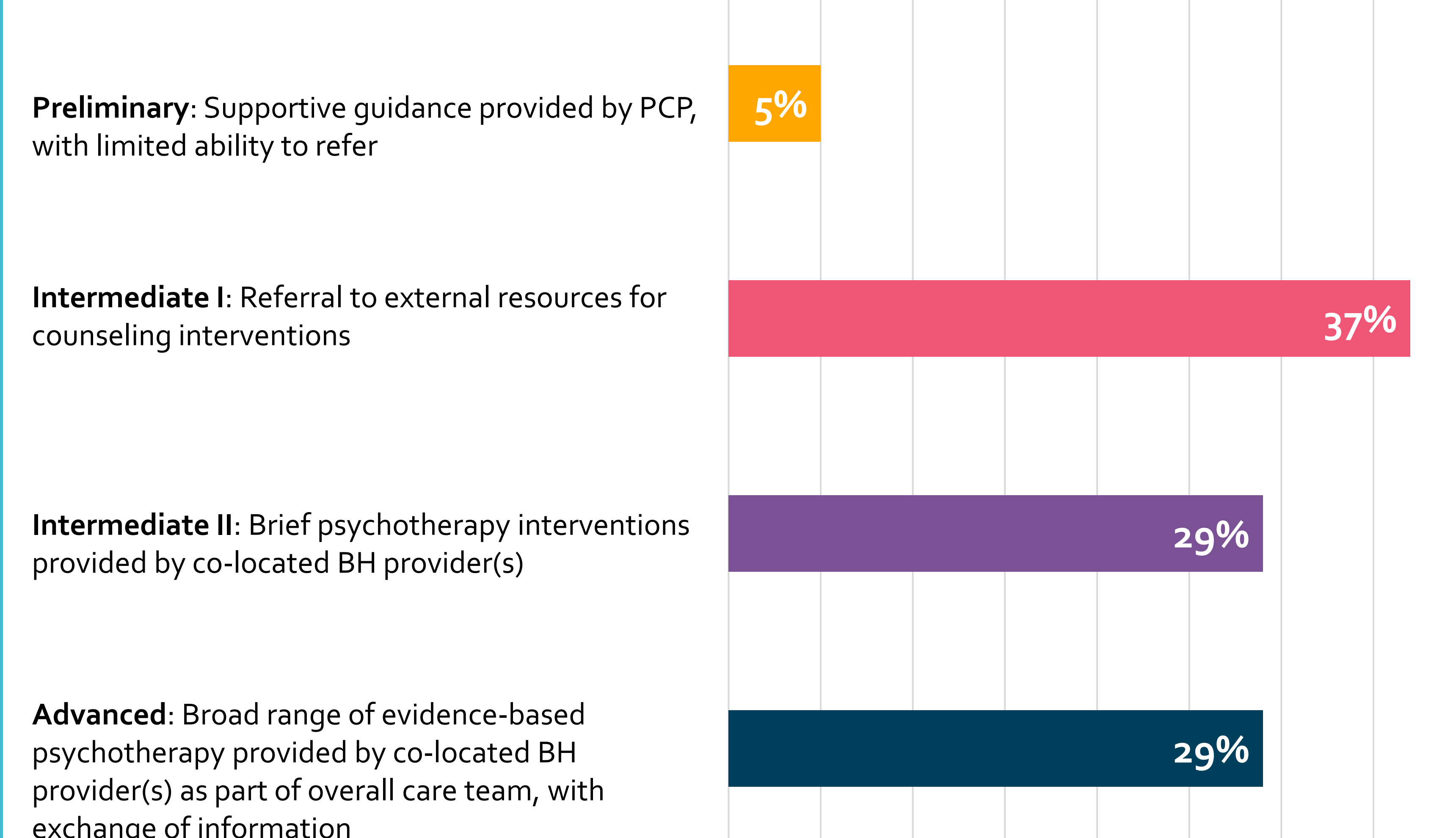
Domain
2. Evidence- based care for preventive interventions and common behavioral health conditions

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

Primary Care

N = 79

Question 15



Information Sharing

Domain
3. Information exchange among providers

Subdomain
3.1 Sharing of treatment information

Primary Care

N = 79

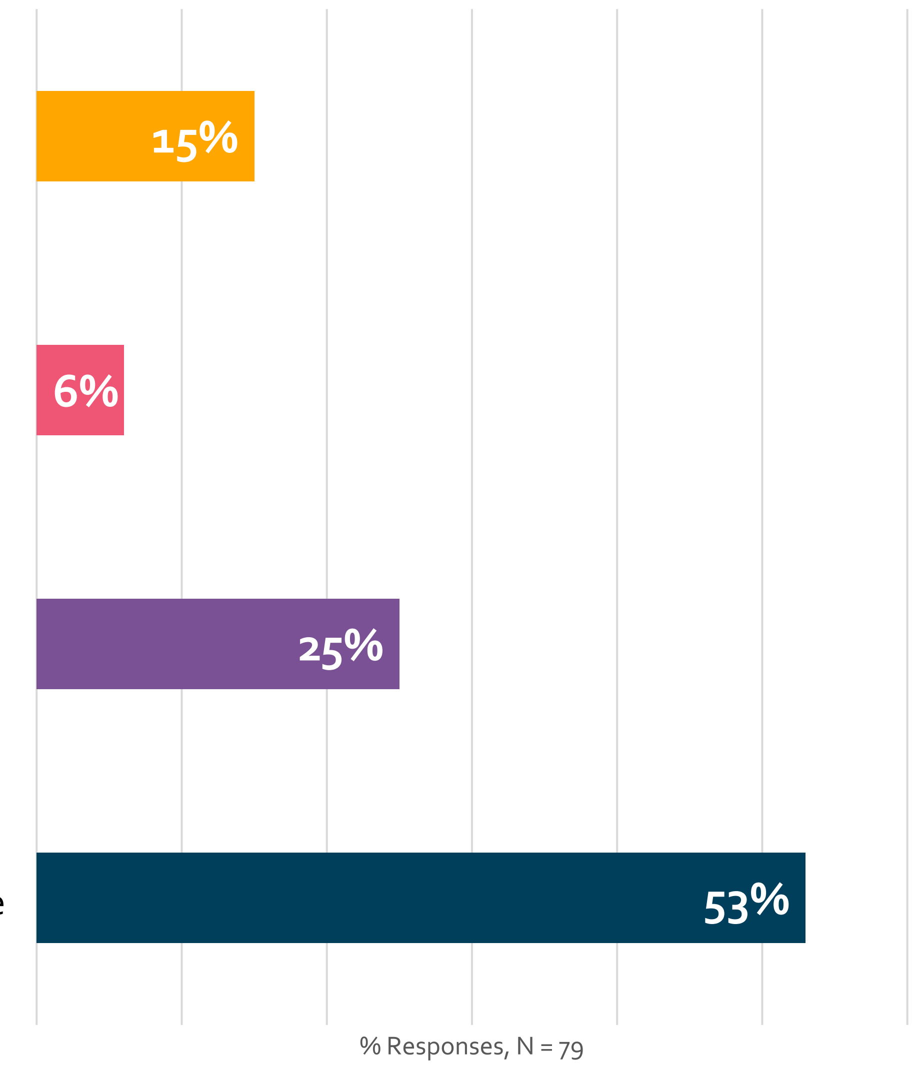
Question 16

Preliminary: Minimal sharing of treatment information within care team

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

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

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



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Patient Tracking

Foundational Domain

Domain
4. Ongoing care management

Subdomain
4.1 Longitudinal clinical monitoring and engagement

Primary Care

N = 79

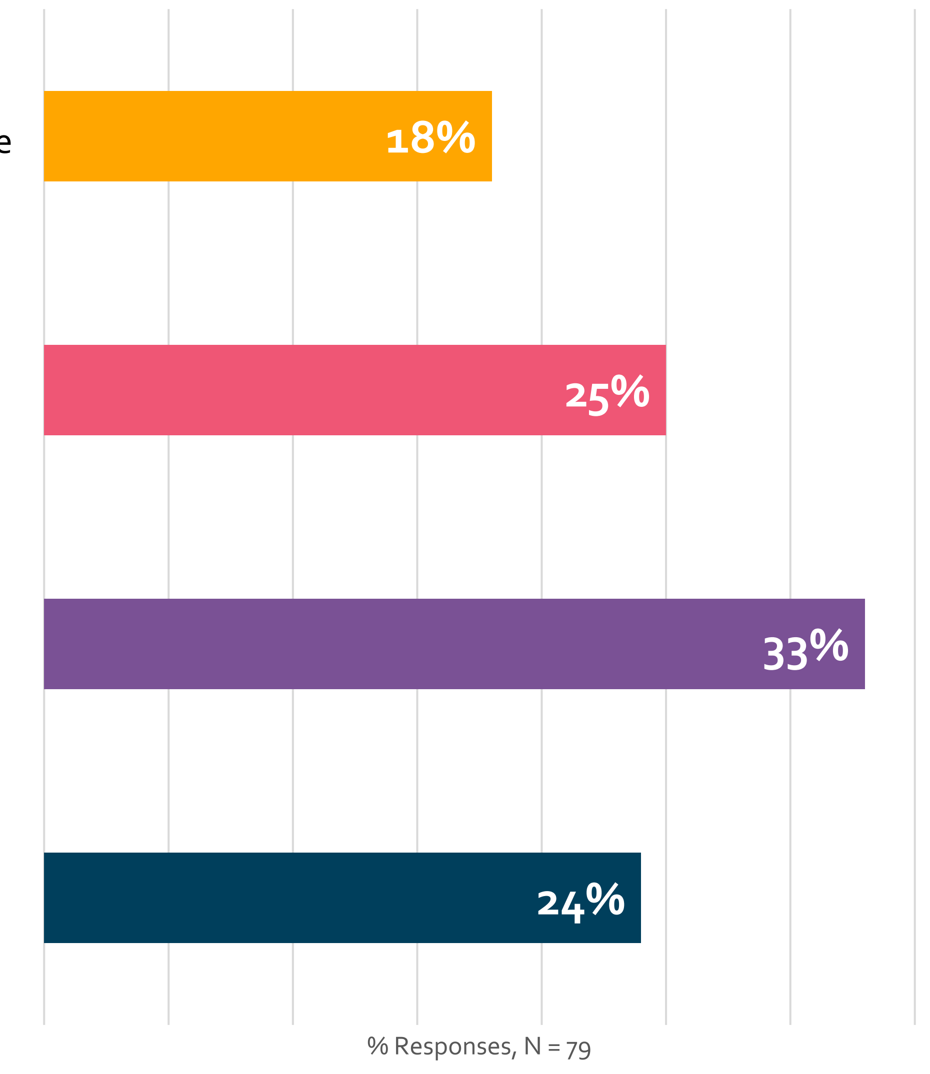
Question 17

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



Self-Management Support

Foundational Domain

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

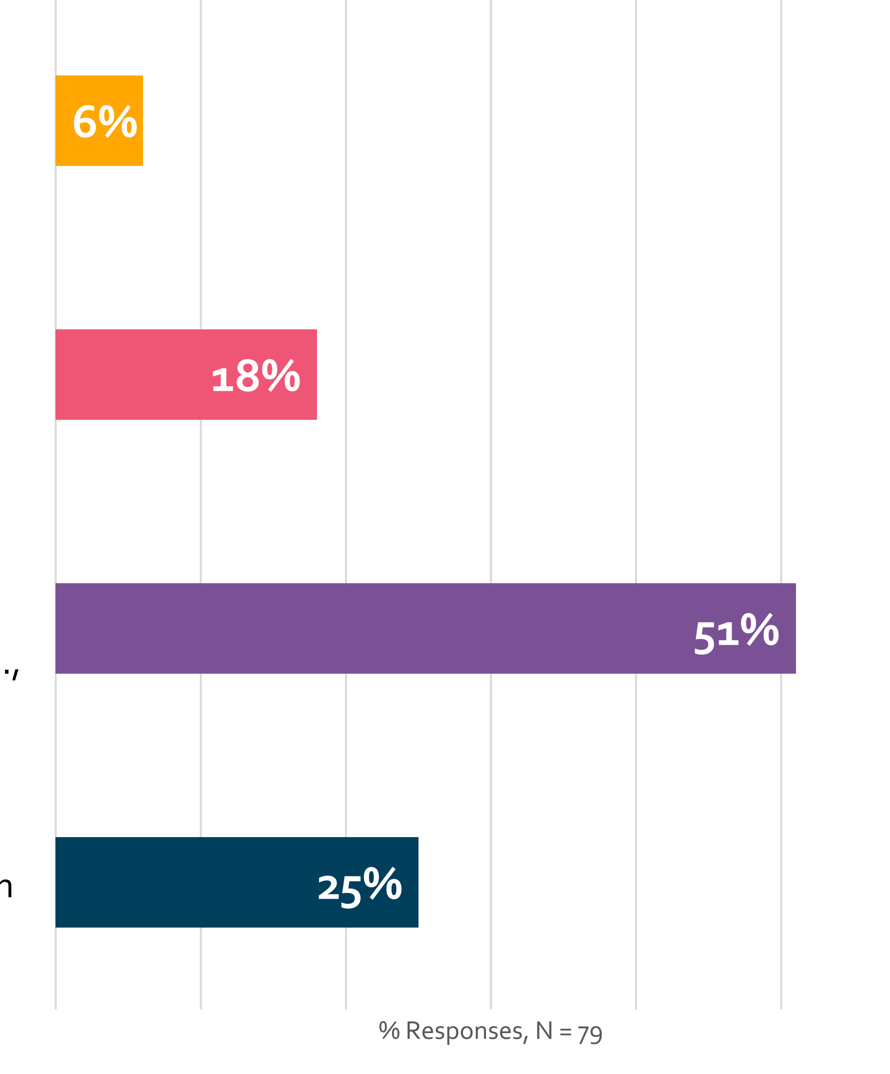
Question 18

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



Care Team

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

Subdomain
6.1 Care Team

Primary Care

N = 79

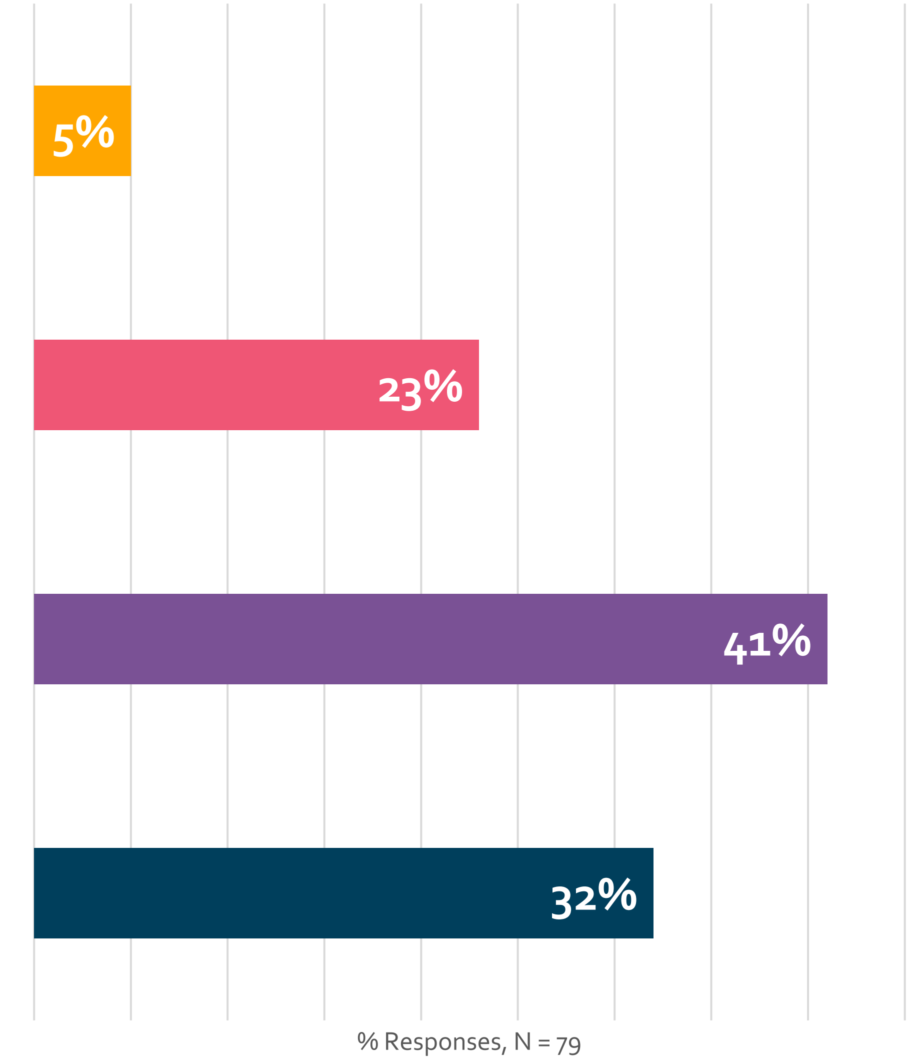
Question 19

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)



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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

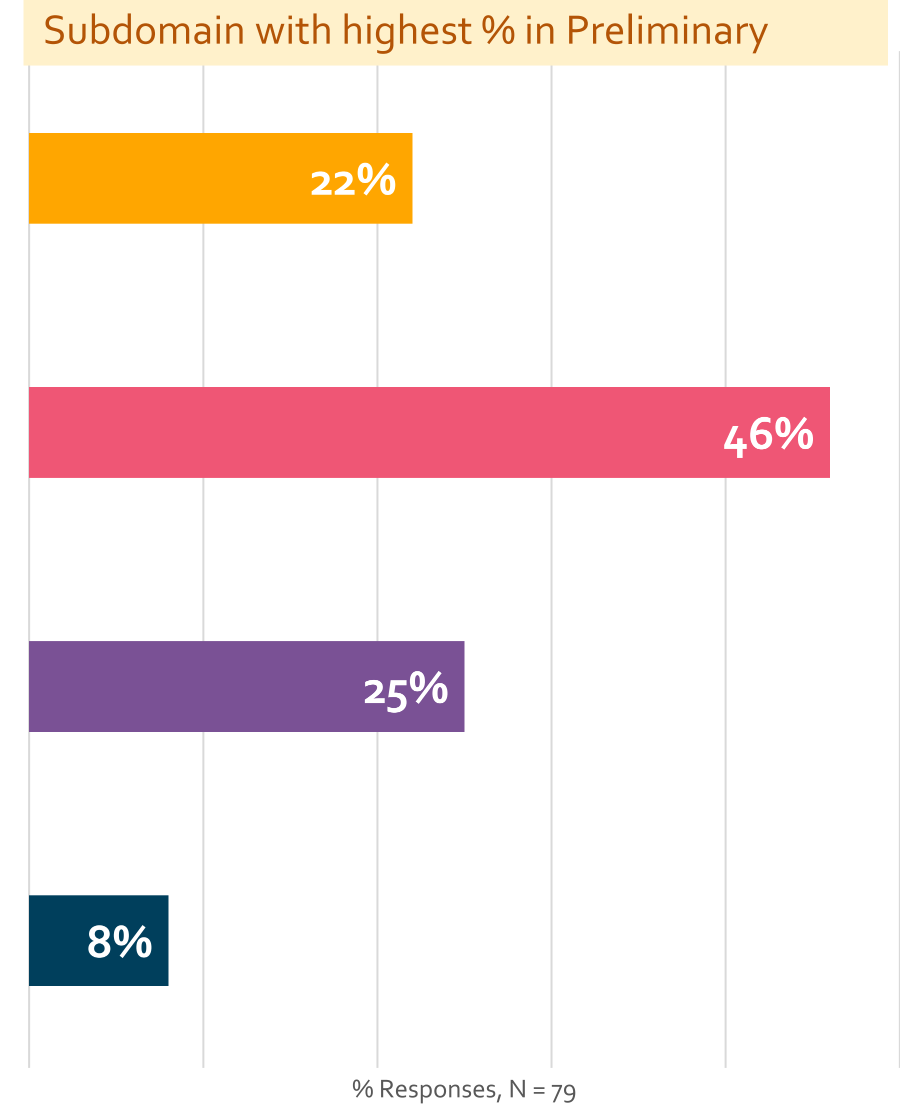
Question 20

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

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

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

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)



Quality Improvement

Domain
7. Systematic Quality Improvement (QI)

Subdomain
7.1 Use of quality metrics for program improvement

Primary Care

N = 79

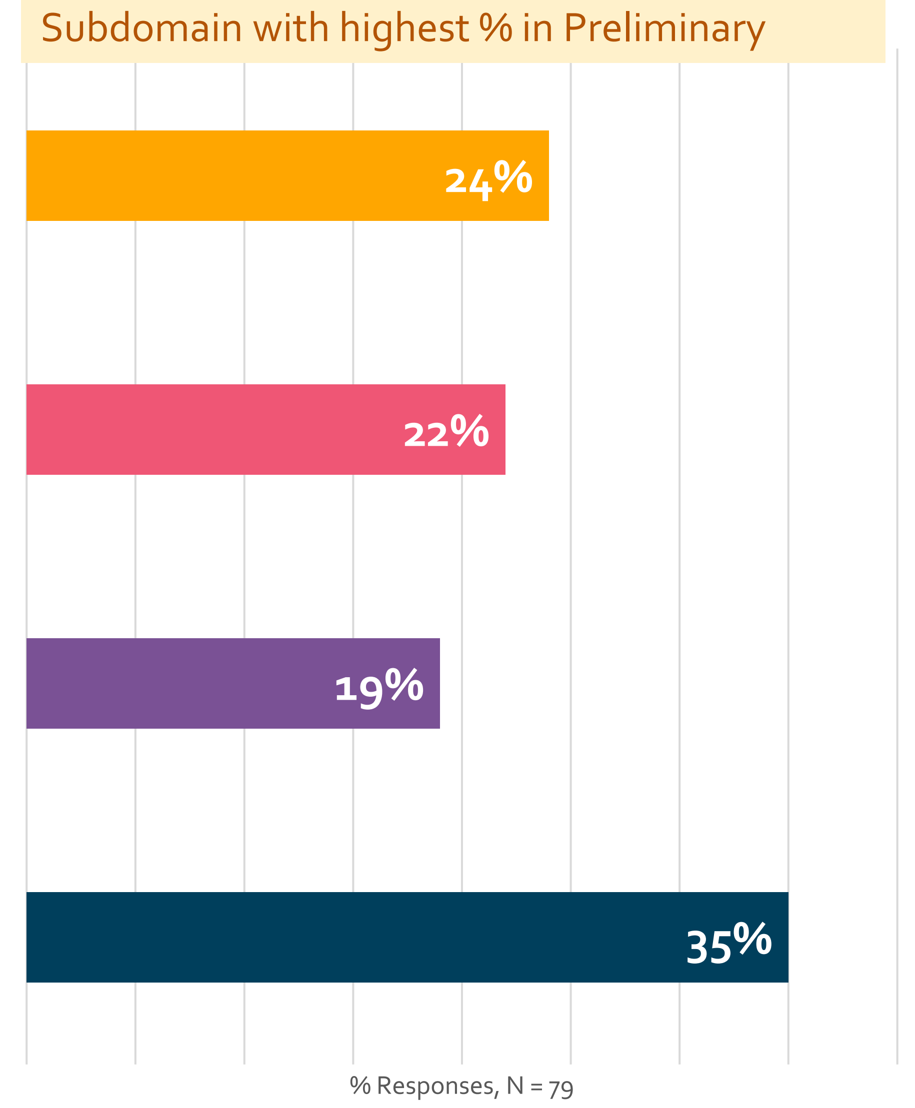
Question 21

Preliminary: Informal or limited use of BH quality metrics (limited use of data, anecdotes, case series)

Intermediate I: Use of identified metrics (e.g., depression screening rates, depression response rates) and some ability to regularly review performance

Intermediate II: Use of identified metrics, some ability to respond to findings using formal improvement strategies

Advanced: Ongoing systematic quality improvement (QI) with monitoring of population-level performance metrics, and implementation of improvement projects by QI team/champion



Social Service Links

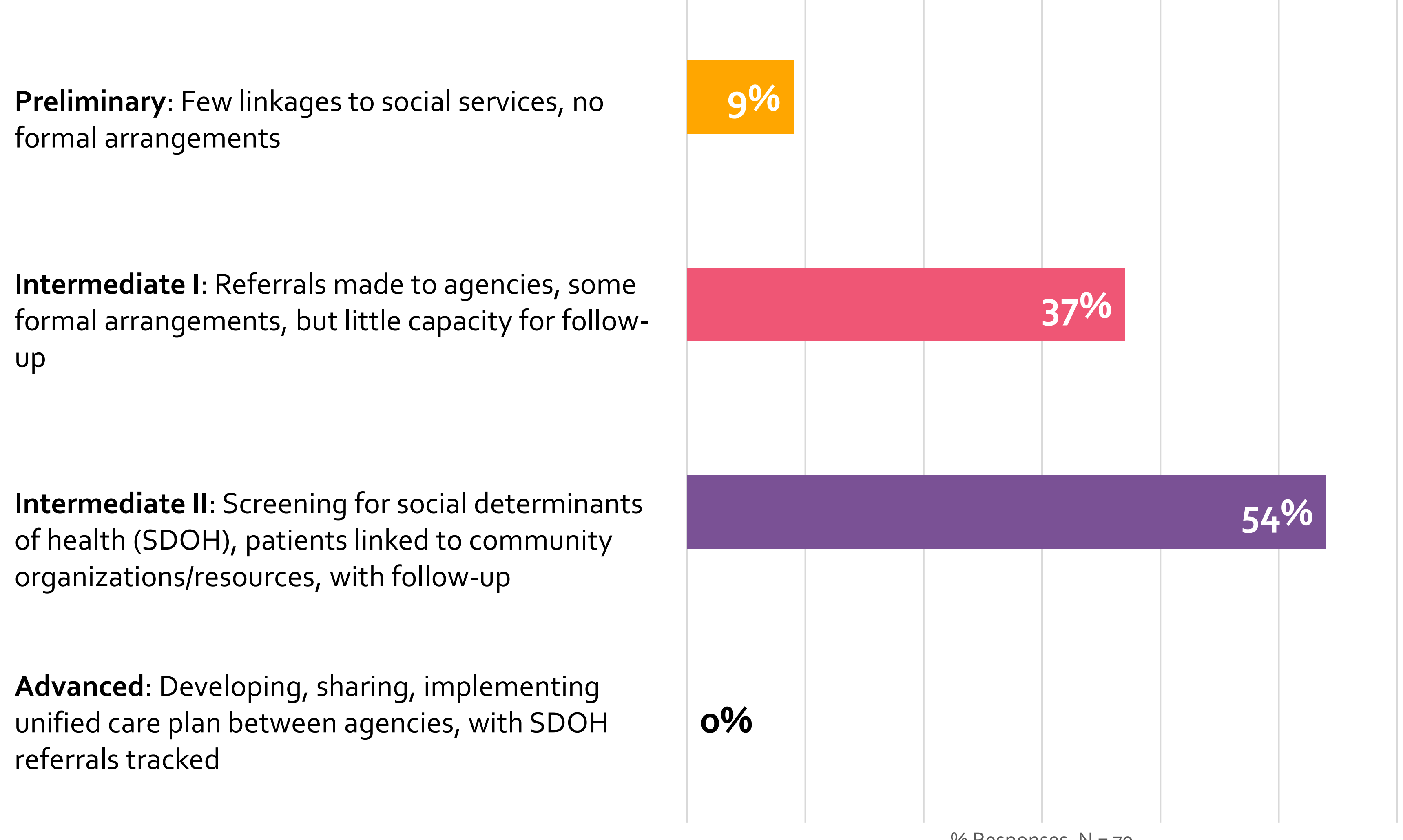
Domain
8. Linkages with community/social services that improve general health and mitigate environmental risk factors

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

Primary Care

N = 79

Question 22



Billing Sustainability

Domain
9. Sustainability

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

Primary Care

N = 79

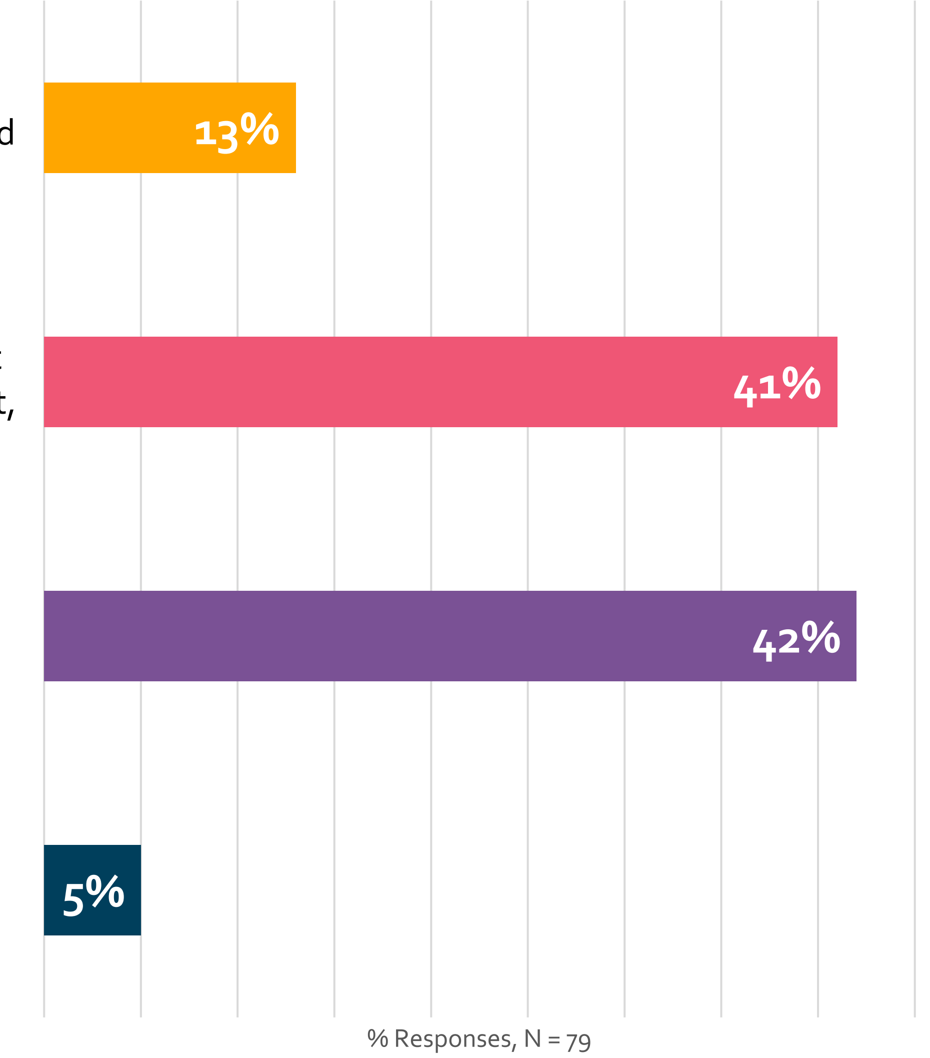
Question 23

Preliminary: Limited ability to bill for screening and treatment, or services supported primarily by grants

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

Intermediate II: Fee for service billing, and additional revenue from quality incentives related to BH integration

Advanced: Receipt of global payments that account for achievement of behavioral health and physical health outcomes



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

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

WASHINGTON INTEGRATED CARE ASSESSMENT (WA-ICA)

Cohort 1 Qualitative Analysis (July - August 2022)

Prepared by Lindsey McClellan in collaboration with HealthierHere

ASSESSMENT BACKGROUND: COHORT 1

126 Behavioral Health (BH) sites **79** Primary Care (PC) sites

- The WA-ICA included two companion tools: behavioral health and primary care (See Appendix A for WA-ICA qualitative questions)
  - **Subdomain questions**: sites were asked to review each domain and sub-domain on the continuum of integration and select their level that corresponds to their clinical site (Preliminary, Intermediate I, Intermediate II, Advanced)
    - Sites had the option to complete an explanatory short-response for each subdomain level selection
    - BH: 15 subdomain questions (430 responses) & PC : 13 subdomain (210 responses)
  - **Narrative questions:** involved questions a variety of integrated care topics
    - 4 narrative questions (435 BH responses) & (242 PC responses)
- Sites were instructed to complete the assessment on behalf of their site, rather than organization
  - ~25% of short-response questions in both assessments contained duplicate responses

ANALYSIS METHODOLOGY

- Analysis for both assessments were conducted separately with the use of Dedoose analysis software
  - Results were compared to complete thematic analysis for this summary
- Duplicate responses were maintained for subdomain related questions, but were not used for analysis for non-subdomain questions
- Responses not pertaining to integrated care were not utilized
- Subdomain questions were used to find cited barriers & facilitators to integrated care efforts
- Narrative questions were used to develop additional codes and subsequent themes, including ideas about requested areas of support to advance integration

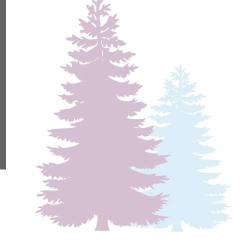
ANALYSIS OVERVIEW

Compare the identified barriers and facilitators of integrated care found in subdomain-related questions in both the Behavioral Health (BH) and Primary Care (PC) assessments by navigating to Visual A

TOP BH THEMES	TOP PC THEMES
Workforce *(barrier)*	Workforce *(barrier)*
EHR *(barrier)*	Finances *(barrier)*
Finances *(barrier)*	Tools *(facilitator)*

WA-ICA: COHORT 1

Qualitative Analysis Themes



WORKFORCE

BEHAVIORAL HEALTH

barriers

- Staff education (general health)
- Varying access to on-site prescribers
- Unclear role and expectations
- Compensation and hiring

> *A guideline or clear expectation of a scope of BH prescribers' role related to treatment protocols for chronic health conditions, needs to be established.*
> *- Behavioral Health site member*

PRIMARY CARE

barriers

- Time due to high caseload
- Inconsistent use of screening tools between providers

> *We are not therapists, so we do not set self-management goals...anything more than a warm handoff is an unrealistic dream*
> *- Primary Care site member*

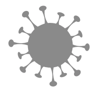
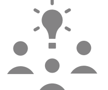
shared workforce barriers (BH & PC)

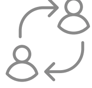
High staff turnover and low retention

Varying vision for integrated care

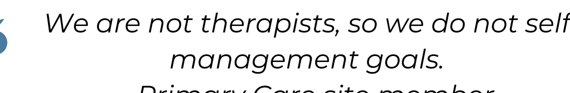
Insufficient care coordination staff

COVID-19 related-burnout & workflows



> *We used to have staff more trained in this area, but post COVID have not gotten back to this and have almost an entirely new group of staff now who have not had specific training in this area -BH site member*



> *We are not therapists, so we do not self management goals.*
> *- Primary Care site member*

CAPITAL RESOURCES & PAYMENT REFORM

shared barriers (BH & PC)

1. Proper reimbursement needed for indirect minutes, particularly for care coordination and outreach
2. Complex structure with reimbursement rates being prohibitive to efforts
3. Ability to hire staff & invest in necessary resources

> *There are no reimbursable interpreter services available for Medicaid patients who walk into the clinic...If providers use a different interpreter service for Medicaid patients, it is not reimbursable*
> *- Behavioral Health site member*

BEHAVIORAL HEALTH

barriers

- Cannot bill for preventative care due to billing codes, including vaccines

> *It is apparent that behavioral health and social service workers' wage is inadequate to recruit and retain qualified workers*
> *- Behavioral Health site member*

TECHNOLOGY & INFORMATION SHARING

barriers

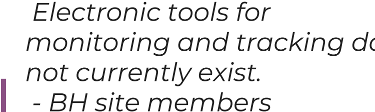
BEHAVIORAL HEALTH

Cost of EHR set up & maintenance

Unresponsiveness from primary care

42 CFR Part 2 limits SUD record sharing

Ability to capture release of information

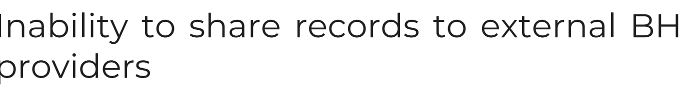


Electronic tools for monitoring and tracking do not currently exist.
- BH site members

CFR. 42 continues to be a barrier for information exchange
- Behavioral Health site member

PRIMARY CARE

Difficulty completing EHR-based tools during patient visit due to high case load

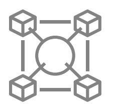


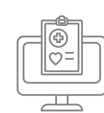
Inability to share records to external BH providers

For patients referred externally, we have limited capacity for exchange of data
- Primary Care site member

shared barriers (BH & PC)

1. Lack of expertise in tracking & EHR-based tools → difficulty tracking for reimbursement
2. Insufficient care coordination staff
3. Lack of interoperable EHR systems





LICENSURE

shared barriers (BH & PC)

1. Long wait time for state licensure
2. Expansive licensure requirements
3. Barriers related to international licensing

...Recognition and allowance to practice for providers with non-USA certifications and licensure for healthcare providers from other countries
- Behavioral Health site member

Licensing requirements for LISW's are rigorous and expensive, prohibiting some from obtaining full licensure...
- Primary Care site member

BEHAVIORAL HEALTH

facilitator

- Policy changes easing licensure processes for mental health & substance use certifications

The expansion of approved education and experience for credentialing of mental health professionals (MHPs) under WAC 246-341-0515 has allowed the agency to address shortages
- Behavioral Health site member

PRIMARY CARE

barrier

- Concerns primarily associated with time to obtain licensure

State licensure for LICSW took over 4 months to complete.. Licensure and licensure requirements for billing all payers is a huge drawback to providing clinical care..
- Primary Care site member

TRAINING & EDUCATION

shared barriers (BH & PC)

1. Incorporating training time into workflow
2. Maintaining staff training given high turnover
3. Loss of revenue and compensation for staff

> *Reimbursement for integrated training that would extend beyond covering salary and include the lost-opportunity costs to an agency of a provider being lost to production*
> *- Behavioral Health site member*

top requested training areas

BEHAVIORAL HEALTH

Evidence-based workflows & guidelines

Coaching & engagement

Trauma informed care

Electronic health record-based tools

> *Resources for educating staff on coaching and engagement will be useful to advancement.*
> *- Behavioral Health site member*

PRIMARY CARE

Internal training (workflow, use of tools)

Evidence-based tools & guidelines

> *....training for staff on how best to integrate BH services...*
> *- Primary Care site member*

LOOKING AHEAD: FUTURE CONSIDERATIONS

Future project: Development of an online integrated care toolkit for health sites with resources ranging from suggested workflows and evidence-based tools (Social Determinant of Health screening tool), training videos (including technical assistance), and patient-facing pamphlet resources

Continuing education: Development of trainings in requested areas of integration topics for Behavioral Health and Primary Care. Consider investing in reimbursement strategies to combat loss of revenue to increase site adherence

Clarifying vision: Cohort 1 responses demonstrate varying perceptions on the capacity, role, and plausibility of complete integrated care. Communicating the future of integration to sites will be integral for longevity

WA-ICA QUALITATIVE QUESTIONS

SUBDOMAIN QUESTION FORMAT

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. *

Key Domains of Integrated Care	Sub-Domain	Preliminary	Intermediate I.	Intermediate II.	Advanced
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 you would like, 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.

NARRATIVE QUESTIONS

1. How will advancing integration help you address health equity? *
   a. *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.*
2. What is working well in regard to staff/provider licensing and reimbursement structures for your integrated care efforts? Where is there room for improvement? *
3. What resources/support does your clinical site need to advance integration? *
4. What are the top three challenges your clinical site faces in advancing integration?* If you would like to share more about the challenges you have selected, please do so here (no more than 250 words).

* Required question

APPENDIX B
Cohort 1 Standout Qualitative Responses

BEHAVIORAL HEALTH

Without radically addressing compensation and value and respect for the human service workers from society, funders, individuals in need will be left without quality services.on
- Behavioral Health site member

Since we are a behavioral health group, our focus is not systematic tracking of health issues, but clinicians do advise their clients to go to PCPs
- Behavioral Health site member

Without a stable workforce it has been incredibly difficult to expand the scope of Sounds whole person care efforts due to the inability to continuously develop staff. Efforts are further complicated by the lack of financial support for these efforts in our current financial payment structure
- Behavioral Health site member

PRIMARY CARE

Our workforce is not trained, or have the desire to do things like screenings
- Primary Care site member

The barrier to advancing on the continuum toward the use of quality metrics for program improvement is the lack of resources to employ a care coordinator with sufficient IT skills to do population health management, performance metrics, and quality improvement projects.
- Primary Care site member

Part of this work is changing the mindset and culture around care... BH providers are a part of every patient's care team, not just the ones who have been identified with a mental health diagnosis. BH is a resource for all patients and we must start to think like that all the time, which means breaking more standard ideas of what BH interventions are and who receives them
- Primary Care site member

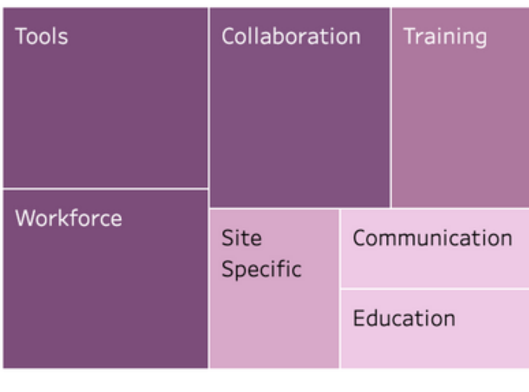
[Visual A] displays the barriers and facilitators found in the Behavioral Health and Primary Care Assessment through the analysis of the subdomains. The full interactive visual can be found at: https://public.tableau.com/app/profile/lindsey.mcclellan/viz/WA-ICAProjectOverview/PCBH

[Visual A]: Workforce, Finances, and EHR cited as top barriers to Integrated Care

Behavioral Health Barriers

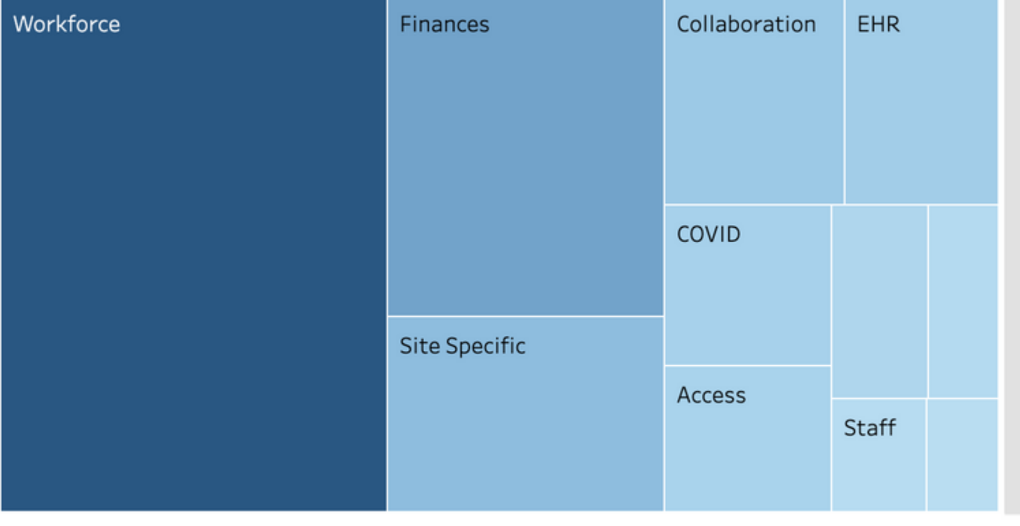
Workforce
EHR
Finances
Collaboration
Site Specific
Technology
Access
Staff Education
Time
Willingness
Licensure

Behavioral Health Facilitators

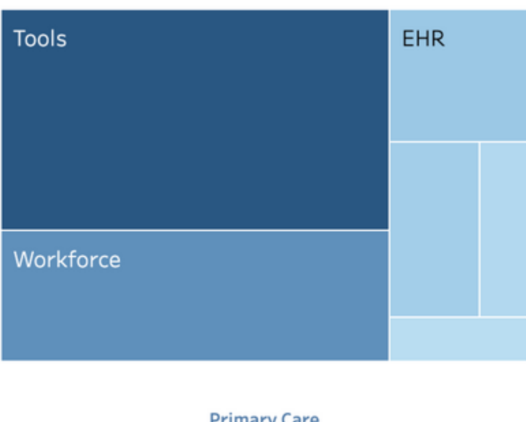


Behavioral Health
N = 126 sites
15 Subdomain Questions
430 Subdomain Short Responses

Primary Care Barriers



Primary Care Facilitators



Primary Care
N = 79 sites
13 Subdomain Questions
210 Subdomain Short Responses