

Behavioral Health Performance Measure Study

Washington Health Care Authority

June 2021

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Glossary

Table 1. Abbreviations and Acronyms Used in this Report.

Abbreviation or Acronym	Definition
ACH	Accountable Communities of Health
BHP	Behavioral Health Provider
CMS	Centers for Medicare & Medicaid Services
ED	Emergency Department
EHR	Electronic Health Record
HEDIS	Healthcare Effectiveness Data and Information Set
HCA	Health Care Authority
ICN	Integrated Care Network
IMC	Integrated Managed Care
KCICN	King County Integrated Care Network
MCO	Managed Care Organizations
MOUD	Medication for Opioid Use Disorder
PCP	Primary Care Provider
RDA	Department of Social and Health Services Research and Data Analysis
SUD	Substance Use Disorder
VBP	Value-Based Payment

Executive Summary

In March 2021, the Washington Health Care Authority (HCA) contracted with Comagine Health to conduct a study analyzing performance measure variation across the state's managed care organizations (MCOs), Accountable Communities of Health (ACHs) and regional system partners. The study focused on establishing a baseline understanding why certain performance measures are performing better or worse and understand why performance has changed over time. The measures described within this report will be utilized on an ongoing basis to monitor performance and inform HCA's work.

HCA's ultimate goal for the study is to help inform and target quality improvement activities across regions and payors, including measures related to high-profile care coordination needs between physical health and behavioral health providers.

This report presents the results of this study, including background, methodology, study results organized by key themes identified in the surveys and interviews, and Comagine Health's conclusions and recommendations.

Performance Measure Review

HCA identified 12 behavioral health measures to focus on for this study. The Department of Social and Health Services Research and Data Analysis (RDA) and HCA provided Comagine Health with three years' worth of performance data for these measures. The data was provided for three one-year periods starting Q3 2017 and ending in Q2 2020.

Of note, Q1 2020 was the beginning of the COVID-19 pandemic and its impact on the performance as measured by the identified performance measures may begin to be visible in Q1 2020 and Q2 2020. Of the 12 quarters of performance measurement data provided for this study, 10 quarters were "pre-COVID-19."

Initial baseline measurement and data analysis included reviewing the data to identify specific areas with the greatest variation in performance between MCOs, ACHs and across time. The areas of focus were prioritized for study and data collection via surveys and interviews.

Surveys

In collaboration with HCA, Comagine Health developed a 16-question survey guided by the analysis of the behavioral health performance measures. Comagine Health administered the survey via SurveyMonkey during nine regional provider meetings conducted over the month of April 2021.

During each regional provider meeting, HCA provided data on the performance measures for the state and for that region prior to conducting the survey. Following the survey, HCA led an informal discussion to help understand some of the data for the region. Recordings of the meetings were provided to HCA.

Interviews

In collaboration with HCA, Comagine Health developed an interview tool guided by the analysis of the behavioral health performance measures. Comagine Health conducted interviews via Zoom with eight ACHs, five MCOs and King County ICN (KCICN) during April and May 2021, recording and later transcribing interviews for analysis.

Summary of Results

After compiling, reviewing and analyzing the results of the 195 surveys and 14 interviews, Comagine Health identified seven main themes listed below.

1. Workforce shortages
2. Health information technology
3. Challenges sharing patient information/data
4. Limited access to data to assess progress on performance measures
5. Limited access to services
6. Challenges with integration of behavioral and physical health
7. Challenges for children and youth in behavioral health treatment

This report presents survey and interview results for each theme, including strengths and areas for improvement. Comagine Health also identified strengths related to performance measures, such as what the ACHs and MCOs are doing well.

Recommendations

Based on the survey and interview results, Comagine Health identified areas for improvement and recommendations for HCA. These are meant to be starting points for further development and discussion toward the ultimate goal of improving behavioral health care and integration statewide. Table 2 shows these recommendations and corresponding measures.

- **Workforce Shortage:** The behavioral health provider workforce challenge is a multi-sector and multi-agency challenge. A statewide effort is needed to pull stakeholders together to address the issue and increase workforce capacity (access) and support clinical supervision and workforce development. Professionals and non-clinical workers (e.g., certified peer counselors, recovery coaches, other peer support workers, patient navigators and community health workers) are needed. A big picture approach to workforce shortages will help resolve many of these issues. These could include:
 - Focused efforts to recruit behavioral health professionals while they are in college.
 - Loan forgiveness for individuals with professional behavioral health degrees.
 - Supports to include adequate professional staff to provide training and clinical supervision for clinicians and non-clinical staff, including clinical supervision toward licensure.
 - Increased focus on statewide efforts to recruit, train, certify and support non-clinical workers throughout the state (Oregon offers a comprehensive model utilizing traditional health workers that is built into the State Plan Amendment¹).
 - Support increased pay for behavioral health providers and offer more funding for increased reimbursement as well as expanded payment for non-clinical workers.
 - Increased recruitment, hiring, training, credentialing and supervision of substance use disorder (SUD) workforce.

¹ State of Oregon. Oregon Administrative Rules: Medical Assistance Programs – Chapter 410. Traditional Health Workers. Available at: <https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1741>.

- Continue efforts to increase Medication for Opioid Use Disorder (MOUD) by primary care providers.
- Workforce development should include education, training and certification to increase the number of behavioral health providers for children and youth.
- Continue support for remote services, while providing multiple treatment modalities so patients can use the one that works best for them.

Of note: To address the shortage of behavioral health professionals and expand and diversify the workforce, in May 2021, the Washington state legislature earmarked funds for a training hospital; more behavioral health programs at 12 Washington state universities; and using dollars for scholarships, grants and loan forgiveness for this workforce. In addition to this legislation, the Ballmer Group provided \$38 million to support a broad, collaborative response to the state's behavioral health crisis.

- **Health Information Technology:**

- Support EMR improvements to improve clinical integration which may include increased funding for innovation and technology enabling bidirectional referrals between physical health and behavioral health.
- Work with providers and MCOs to address privacy concerns related to telehealth.

- **Patient Health Information Sharing:**

- HCA, ACHs and the MCOs (and their delegates) should connect all providers with Collective Medical regarding emergency department (ED) and hospitals in order to share patient information with providers. They should standardize implementation, training, support and learning collaboratives related to Collective Medical across MCOs and regions.
- HCA should implement a statewide effort to support providers and ensure consistent application and succinct processes, in compliance with 42 CFR Part 2, in order to increase the effectiveness of care coordination, improve health outcomes, decrease costs, and to truly integrate care for those experiencing SUD.
- HCA, ACHs and the MCOs (and their delegates) should share best practices, incentives, technical assistance and more across all regions of the state to encourage timely follow-ups after ED visits for behavioral health issues.

- **Limited Access to Data:** The availability of complete, consistent, accurate and timely data is critical for performance measure and quality improvement efforts. Providers have limited capacity to staff this work (working with MCOs to identify how they can receive the data transfer) and have capacity and systems to support value-based purchasing to incentivize outcomes. MCOs need to work closely with providers (of all sizes) and providers need to be willing to work closely with MCOs.

- HCA should assist MCOs, ACHs and providers in identifying and addressing operational and administrative barriers to timely sharing of data.
- Standardization of data gathering and information sharing by all MCOs would assist providers in streamlining processes.

- **Access to Services:** In order to improve access to behavioral health services, it is recommended that the state:
 - Address workforce issues as outlined above.
 - Continue to provide telehealth services when appropriate and desired.
 - Extra attention should be paid to additional issues affecting access, including social determinants of health, such as transportation, housing and economic stability. The state should explore options to help ensure members have resources to access transportation for Medicaid covered services.
- **Challenges for Children and Youth in Behavioral Health Treatment:** In addition to the workforce issues identified for children and youth, recommendations include:
 - Providing choices regarding virtual vs. in-person treatment may help youth engage in treatment in a manner that works best for them.
 - Schools are the primary referral source for behavioral health services for children and youth. While schools were closed to in-person learning during the pandemic, referrals suffered. When schools are not open, ACHs and MCOs should increase regular well-child check-ups, screenings and connections with pediatricians and primary care providers. Further outreach may include identifying culturally effective solutions and reaching out to community-based organizations or partners who may serve as a support for families in need of resources.
 - Changes in school discipline policy implemented by the State Office of Superintendent of Public Instruction has impacted the ability of schools to mandate substance use screenings and assessments to avoid suspension/expulsion.

Regional Differences

Although each region of the state has its unique strengths and needs, rural issues include:

- Lack of broadband for telehealth
- Lack of access to certified peer program training
- Different levels of access to training and ongoing support for Collective Medical
- Lack of transportation to/from Medicaid covered services

Areas for Future Study

Future study highlighted may include a deeper dive into:

- How regions successfully addressing homelessness and employment.
- How providers, ACHs and MCOs are working together to maximize the use of health information technology.
- Identification of which regions, providers and MCOs can be targeted for improvements, including operational support and administrative simplification.
- What providers are doing to address these metrics.

- Collect and compile innovations and best practices that are leading to improved outcomes with these measures.
- Regional MCO cooperation to align processes, contracting and incentives to help minimize administrative burden on providers and also ensure equity of services provided to members across MCOs.

Table 2. Performance Measures and Corresponding Recommendations.

Measures		Recommendation Areas					
		Workforce Shortage	Health Information Technology	Patient Health Information Sharing	Limited Access to Data	Access to Services	Challenges for Children and Youth
Adults With SMI	Follow-up After Hospitalization for Mental Illness – Within 7 Days	X	X	X	X	X	NA
	Follow-up After Hospitalization for Mental Illness – Within 30 Days	X	X	X	X	X	NA
	Follow-up After ED Visit for Mental Illness – Within 7 Days	X	X	X	X	X	NA
Children/Adolescents (6-17) With Mental Health Needs	Follow-up After ED Visit for Mental Illness – Within 7 Days	X	X	X	X	X	X
	Mental Health Service Penetration (Broad)	X	X	X	X	X	X
Children/Adolescents (10-17) With SUD Treatment Needs	Substance Use Disorder Treatment Penetration	X	X	X	X	X	X
Adult Medicaid	Homeless, Narrow Definition	NA	NA	X	X	X	NA
	Percent Employed	NA	NA	X	X	X	NA
Adults With SUD Treatment Needs	Substance Use Disorder Treatment Penetration	X	X	X	X	X	NA
Adult SUD	Follow-up After ED Department Visit for Alcohol/Other Drug – 7 Day	X	X	X	X	X	NA
Adults and Children/Adolescents	Psychiatric Inpatient 30-Day Readmission (18+)	X	X	X	X	X	NA
	Psychiatric Inpatient 30-Day Readmission (6-17)	X	X	X	X	X	X

Background

The purpose of this study is to establish a baseline understanding why behavioral health performance measures vary across regions (ACHs) and MCOs, and over time. An important part of this understanding is the status of the integration of behavioral and physical health Apple Health Medicaid services in Washington state, including accountabilities, responsibilities and regions.

There are five MCOs in Washington state, who contract with the Washington State Health Care Authority (HCA) to provide integrated managed care. Integrated managed care (IMC) responsibilities include coordinating physical health, mental health and SUD treatment services to help provide whole-person care under one health plan.

ACHs are independent, regional organizations that work with communities on projects and activities related to specific health and social needs. They focus on integrating physical and behavioral health care and coordinating care between providers and organizations. There are nine ACHs covering the state, each serving a specific region. Although each ACH is unique, they share a common approach to improving the health of their communities and changing health care delivery.²

ACHs are not responsible for the performance measures addressed in this study. However, they can and do impact these measures due to the nature of their work. ACHs receive approval from HCA to work on specific projects aimed at meeting Medicaid transformation goals, including integration.

KCICN, a delegate of the MCOs for behavioral health services in King County, followed the MCO interview guide for this study.

The MCOs, ACHs and regional service areas are listed below.

The MCOs include:

- Amerigroup Washington (AMG)
- Community Health Plan of Washington (CHPW)
- Coordinated Care of Washington (CCW)
- Molina Healthcare of Washington (MHW)
- UnitedHealthcare Community Plan (UHC)

The ACHs (and corresponding regional service area) include:

- Better Health Together (Spokane)
- Cascade Pacific Action Alliance (Thurston-Mason and Great Rivers)
- Elevate Health (Pierce)
- Greater Columbia ACH (Greater Columbia)
- HealthierHere (King)
- North Central ACH (North Central)

² Washington State HCA. [Accountable Communities of Health \(ACHs\)](https://www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/accountable-communities-health-achs): <https://www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/accountable-communities-health-achs>.

- North Sound ACH (North Sound)
- Olympic Community of Health (Salish) (did not opt to participate in the interview portion of this study)
- Southwest ACH (Southwest)

The regional service areas are defined as follows:

- **Great Rivers** includes Cowlitz, Grays Harbor, Lewis, Pacific and Wahkiakum counties
- **Greater Columbia** includes Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Whitman and Yakima counties
- **King** includes King County
- **North Central** includes Chelan, Douglas, Grant and Okanogan counties
- **North Sound** includes Island, San Juan, Skagit, Snohomish and Whatcom counties
- **Pierce** includes Pierce County
- **Salish** includes Clallam, Jefferson and Kitsap counties
- **Southwest** includes Clark, Klickitat and Skamania counties
- **Spokane** includes Adams, Ferry, Lincoln, Pend Oreille and Stevens counties
- **Thurston-Mason** includes Mason and Thurston counties

Managed Care Integration

Under the direction of Senate Bill E2SSB 6312, behavioral health benefits were integrated into the Apple Health managed care program, providing Medicaid enrollees with access to both physical and behavioral health services through a single managed care program by January 1, 2020. The transition to an integrated system began in 2016, with behavioral health services previously purchased and administered by regional behavioral health organizations (BHOs) being transferred to Apple Health MCOs via a two-step process.

Before 2016, Apple Health Medicaid clients with physical and behavioral health treatment needs had to navigate three separate systems to access the physical and behavioral health services they needed to stay healthy. Under this approach, stakeholders reported poor coordination of care and health outcomes for individuals with co-occurring conditions, as the delivery systems for physical health, mental health and SUD services were not designed to share information across systems.³

To address this siloed system of health care delivery, Washington state began integrating Medicaid managed care regionally in 2016. Table 3 shows the integration dates for each of the 10 regional service areas.

³ Center for Health Care Strategies. Washington State's Transition to Integrated Physical and Behavioral Health Care. September 2020. Available at: https://www.chcs.org/media/WA-BH-Integration-Case-Study_091620.pdf.

Table 3. Washington State Medicaid Managed Care Integration Dates by Region.

Region	Integration Date	Integration Phase (Early, Mid, On-Time)
Great Rivers	January 1, 2020	On-Time
Greater Columbia	January 1, 2019	Mid
King	January 1, 2019	Mid
North Central	July 1, 2018	Mid
North Sound	July 1, 2019	Mid
Pierce	January 1, 2019	Mid
Salish	January 1, 2020	On-Time
Southwest	April 1, 2016	Early
Spokane	January 1, 2019	Mid
Thurston-Mason	January 1, 2020	On-Time

By January 1, 2020, all 10 regions of the state had completed the transition to an integrated system for physical health, mental health and SUD services within the Apple Health program. Most services for Apple Health clients are provided through MCOs with a subset served by the fee-for-service program.

The regions that adopted integration earlier have had more opportunity to work on clinical integration, while the mid- to on-time adopters have primarily addressed financial integration and are moving toward more clinical integration.

Methodology

To understand the variation in behavioral health measure performance among ACHs and MCOs and over time, Comagine Health analyzed performance measure data, surveyed providers from each region, and interviewed ACH, MCO and KCICN staff. Through the analysis, Comagine Health identified themes that may be considered baseline information from which efforts to improve performance may begin. Our processes for each component of this study are described below.

Performance Measures

HCA identified 12 measures for this study based on the initial RDA measure data from three years' worth of performance data from Q3 2017 to Q2 2020. Six of these measures had worsening statewide trends and four measures were stable or improving statewide during the timeframe of the data supplied to Comagine Health (Table 4).

In early March 2021, HCA and RDA provided Comagine Health with information related to these measures broken down by ACH and MCO. Comagine Health stored all data and information from HCA and RDA on a secure network drive, keeping it confidential and not accessible by those outside the study team.

In order to inform this study, Comagine Health analyzed aggregated statewide measure data for three one-year periods starting Q3 2017 and ending in Q2 2020. This assessment visually compared real rates in line charts and visual matrices based on the comprehensive aggregate of numerators and denominators across the entire state (see Appendix D).

This comparison provides a descriptive indication of which measures are doing better and worse. Statistical tests were not performed because there were not enough data points (i.e., there were only three) to perform valid statistical tests.

Table 4. Statewide Trends of Performance Measure.

Abbreviation	Measure	Age Group	HCA Assessment
HEDIS-FUH-7D	Adults With Serious Mental Illness (SMI): Follow-up After Hospitalization for Mental Illness – Within 7 Days	18+	Worse
HEDIS-FUH-30D	Adults With SMI: Follow-up After Hospitalization for Mental Illness – Within 30 Days	18+	Worse
HEDIS-FUM-7D	Adults With SMI: Follow-up After ED Visit for Mental Illness – Within 7 Days	18+	Worse
HEDIS-FUM-7D	Children/Adolescents (6-17) With Mental Health Needs: Follow-up After ED Visit for Mental Illness – Within 7 Days	6–17	Worse
SUPPL-MH-B	Children/Adolescents (6-17) With Mental Health Needs: Mental Health Service Penetration (Broad)	6–17	Worse
SUPPL-SUD	Children/Adolescents (10-17) With SUD Treatment Needs: Substance Use Disorder Treatment Penetration	10–17	Worse
SUPPL-HOME-N	Adult Medicaid, Homeless, Narrow Definition	18–64	Stable or Improving
SUPPL-EMP	Adult Medicaid: Percent Employed	18–64	Stable or Improving
SUPPL-SUD	Adults With SUD Treatment Needs: Substance Use Disorder Treatment Penetration	18+	Stable or Improving

Abbreviation	Measure	Age Group	HCA Assessment
HEDIS-FUA-7D	Adult SUD: Follow-up After ED Department Visit for Alcohol/Other Drug – 7 Day	18+	Stable or Improving
HEDIS-PCR-P	Psychiatric Inpatient 30-Day Readmission	18+	For future study
HEDIS-PCR-P	Psychiatric Inpatient 30-Day Readmission	6–17	For future study

HEDIS stands for Healthcare Effectiveness Data and Information Set.⁴

Provider Survey

Determination of Survey Questions

After the performance measures were chosen, Comagine Health analysts reviewed the MCO and ACH performance measure results to help form survey questions. Comagine Health and HCA collaborated to finalize a set of 16 survey questions (see Appendix A for the provider survey).

Survey Administration Process

Comagine Health administered the survey via SurveyMonkey during nine regional provider meetings conducted in April 2021. These meetings were either regularly scheduled or held in addition to regular regional provider meetings. The ACHs were the primary hosts in addition to one meeting hosted by another regional stakeholder. Meetings were held virtually via Zoom and recorded.

Providers, ACH staff and MCO staff were the primary attendees at these meetings. Participation in these regional meetings was voluntary. Below is the process for how the surveys were administered during these meetings:

- First, HCA presented data on 12 performance measures by region and state.
- After presentation of the data, Comagine Health asked health care providers to complete the survey via a SurveyMonkey link which was placed in the chat bar, which took approximately 10 minutes to complete during the approximately one-hour meeting. Comagine Health asked that only providers, and not ACH or MCO staff, complete the survey.
 - A total of 195 providers completed the survey (see Table C-1 in Appendix C).
 - A total of 108 providers responded practicing in an outpatient SUD clinic/office setting, while 43 providers responded practicing in an outpatient PCP clinic/office setting. In addition, 139 providers responded to practicing in other settings for a total of 290 setting responses. Note: respondents were able to choose multiple practice settings (see Table C-3 in Appendix C).
- The survey was kept open until the end of April to try and obtain responses from additional providers who did not attend these meetings. (See Appendix A for the survey questions and the script used in introducing the survey.)
- After the survey was completed within each meeting, HCA led a discussion regarding some of the measures within each region, as well as other areas of interest or concern. The recordings and transcripts of these discussions were provided to HCA and are not incorporated into this report.

⁴ The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

Survey Analysis: Survey Data Acquisition and Processing

SurveyMonkey data files were imported into SAS® Enterprise Guide (SAS Corporation, Carey, NC). All the separate regional files were appended together, transformed and characterized in SAS®. The data was aggregated into frequency counts and exported from SAS to Microsoft Excel. The distribution of responses was analyzed but no statistical tests were performed. The survey data were analyzed descriptively. See the Study Limitations section of this report for additional explanation.

The aggregate statewide data tables, one for each survey question, are provided in Appendix C.

Additional frequency counts were generated to allow comparison of specific groupings for selected questions:

- King County vs. the rest of Washington state
- Behavioral health providers (BHPs) vs. primary care providers (PCPs)
- Administrative/management roles vs. provider role

Key findings from these subset comparisons are highlighted in the Survey Results section of this report.

Interviews

Determination of Interview Questions

Comagine Health and HCA collaborated to finalize a set of 13 questions for the interviews. Due to the nature of their work, separate but similar interview guides were developed for ACHs and MCOs. Being a delegate of the MCOs in King County, KCICN was interviewed using the MCO interview guide.

Appendix B contains the interview questions and facilitator script/guide.

Interview Process

Comagine Health worked with the ACHs and MCOs to identify interview participants, requesting at a minimum one participant with a role in behavioral health integration, performance measurement and policy. The one-hour interviews were conducted virtually via Zoom during April and May 2021. They included one to six representatives from the following:

- Five MCOs
- Nine regional stakeholders including eight ACHs and KCICN

In order to respect confidentiality, individual participants and their organizations are not identified in this report.

If all questions were not answered during the one-hour interview, the remaining questions were emailed to the MCO or regional stakeholder to complete and return. Of the 14 organizations interviewed, 13 responded to all questions either within the interview time or after through follow-up email.

Appendix B contains the ACH Interview Guide and MCO Interview Guide.

Interview Analysis

All interviews were recorded and transcribed. The Comagine Health team used the qualitative software NVivo to organize and analyze interview data. After coding, the team grouped interview information into themes through a consensus process.

Study Limitations

This study on performance measure outcomes for behavioral health and physical health providers will provide a baseline understanding for HCA of some factors influencing quality measure performance across the state. It is not a comparative study between MCOs or ACHs, but rather provides a comprehensive statewide view of the challenges faced by multiple-payors and ACHs transitioning to an integrated system while providing mental health and SUD services within the state's Medicaid program.

Further, the study was undertaken at a relatively early point in integration for the state. Medicaid managed care contracts were not fully integrated in Washington state until January 1, 2020.

As such, considerable effort has been expended supporting behavioral and physical health providers and payors with payment integration. As integration continues to be implemented in Washington, ongoing focus and efforts are needed to support clinical integration of physical health and behavioral health service delivery.

Survey Limitations

Comagine Health developed the survey in collaboration with HCA. The time available to administer the survey was limited, and access to all regional providers' contact information was not possible so HCA and Comagine Health agreed to administer the survey to a convenience sample of provider participants present at regional meetings convened by each ACH. As such, the survey results summarize the feedback from the clinical and administrative experts across the state who attended the meetings. It should also be noted that survey respondents self-identified their roles within their organizations.

These results provide valuable insight into drivers of quality measure performance following integration of mental and physical health and should be used to inform future efforts. The results may not accurately represent the entire clinical provider population of the state because the survey was not administered to a random sample. With a convenience sample, it is not appropriate to weight results nor to apply statistical tests because these methods assume an underlying representative sample and it would not be appropriate to extrapolate results.

Interview Limitations

Interviews were limited to one hour. If all answers were not answered during the interview, the remaining questions were sent to the MCO or regional stakeholder to complete and return via email. This approach did not allow for follow-up questions that could have been possible had the questions been asked in a live interview. Comagine Health did not have the opportunity to ask follow-up questions to responses provided via email so some of the richness of responses may be limited for those questions, and response information to questions later in the interview guide may overrepresent respondents who answered those questions in the live interview format.

COVID-19

The COVID-19 pandemic has impacted health care in many ways. Some of the quality measure data was collected early in the pandemic, possibly affecting the results. See COVID-19 section under Study Results for more information.

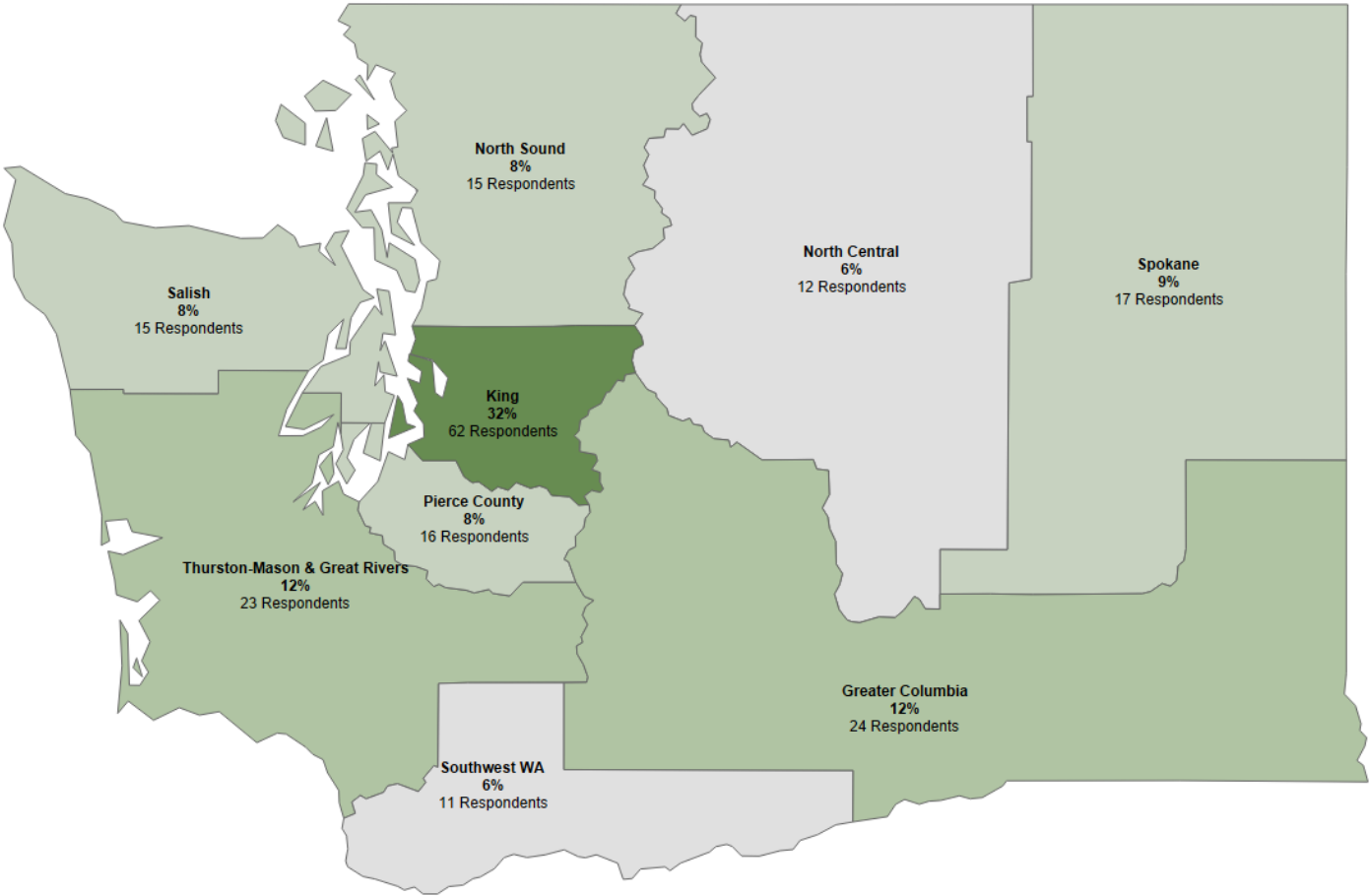
Study Results

This section presents results of the survey and interviews with ACH and MCO representatives.

Overview of Survey Respondents

Providers from all regions of the state participated in the regional meetings where information on performance of these measures was presented followed by the survey. Respondents were primarily in administration. The following map (Figure 1) shows the percentage of respondents by region of the state. King County had the most at 32%.

Figure 1. Distribution of Survey Participants by Region.*



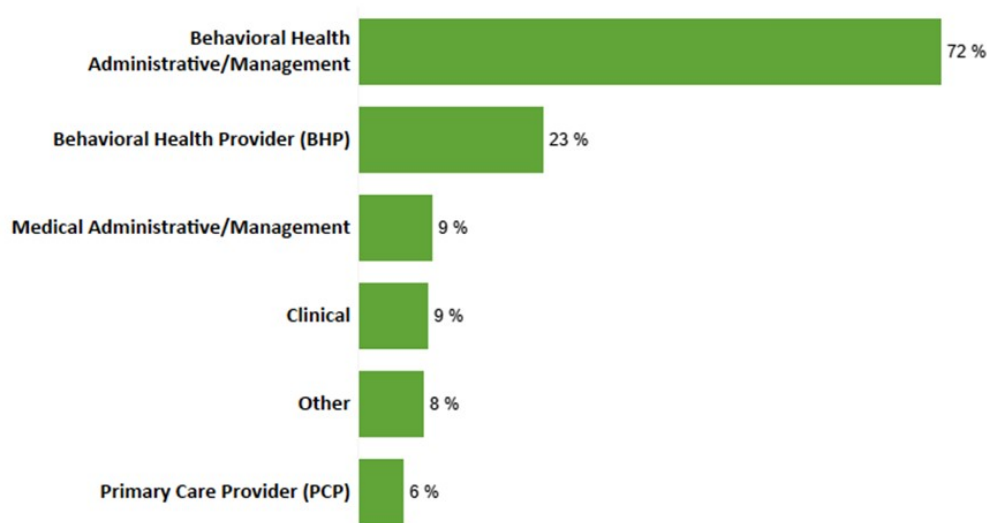
**Thurston-Mason and Great Rivers regions were combined for the purposes of this survey.*

Role(s) at Organization

Despite the efforts of HCA to recruit behavioral health and physical health providers who provide direct patient care to participate in the survey, the majority of survey respondents worked in behavioral health administration (72%). Figure 2 shows respondents' roles; they could select all that applied.

Figure 2. Distribution of Respondent Roles Statewide.

Question #1: What is your role at your organization? (check all that apply)



The following chart (Figure 3) shows the care settings respondents worked in. Respondents were primarily in behavioral health administrative/management positions. These individuals lead their agencies/providers on quality improvement efforts and have firsthand knowledge of the challenges around integration.

Figure 3. Distribution of Respondent Practice Settings.

Question #2: What setting do you practice in? (check all that apply)

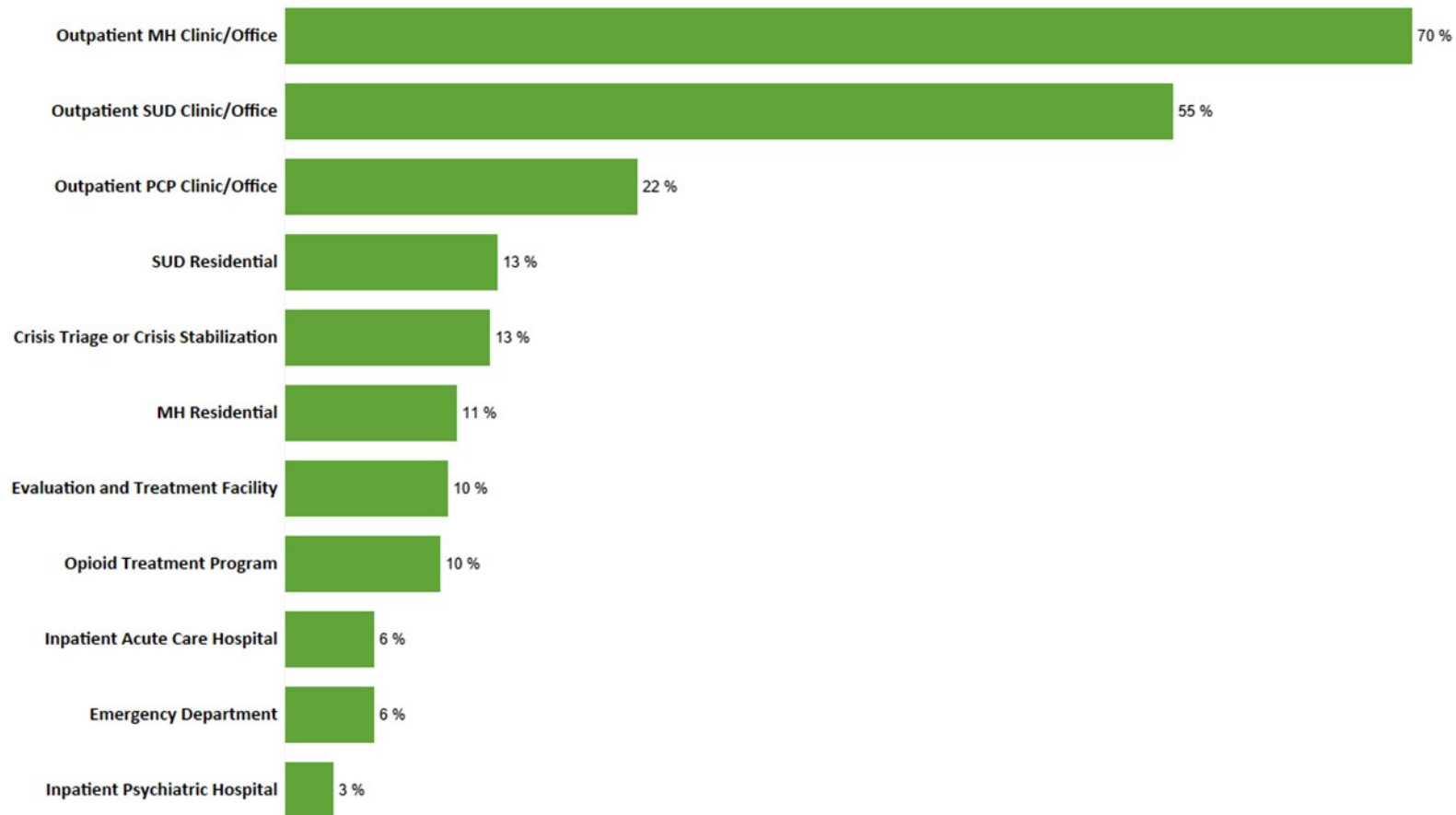


Figure 4 shows the number of responses from mental health, SUD and other treatment settings.

Figure 4. Distribution of Respondent Practice Settings.



(Labels indicate number of responses, not percentage)

Mental Health includes: Outpatient MH Clinic/Office, Inpatient Psychiatric Hospital, MH Residential

SUD Includes: Outpatient SUD Clinic/Office, SUD Residential, Opioid Treatment Program

Other Includes: Outpatient PCP Clinic/Office, Inpatient Acute Care Hospital, Emergency Department, Evaluation and Treatment Facility, Crisis Triage or Crisis Stabilization

Overview of Interview Respondents

Comagine Health conducted a total of 14 interviews with representatives of the MCOs and regional stakeholders.

Key Themes

Comagine Health identified seven key themes impacting progress on the performance measures across the survey and interview data, including:

1. Workforce shortages
2. Health information technology
3. Challenges sharing patient information/data
4. Limited access to data to assess progress on performance measures
5. Limited access to services
6. Challenges with integration of behavioral and physical health
7. Challenges for children and youth in behavioral health treatment

Focusing on areas for improvement, the related results from the surveys and interviews are included below. Comagine Health's recommendations to address these areas for improvement are included in the Recommendations section in the Executive Summary.

Theme 1: Workforce Shortages

Both survey respondents and interviewees reported workforce shortages, especially in behavioral health, as the primary concern that impacts access and can cause service gaps. Specifically, the number of credentialed behavioral health staff may be too low to meet the service needs for members with SUD or mental health needs.

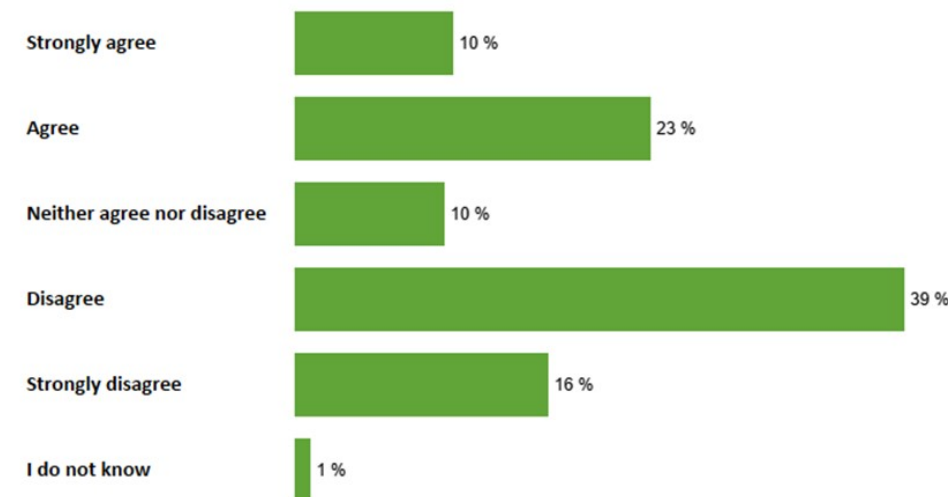
Survey Results

Adequate staffing

When asked whether their organization had adequate staff to see clients without long wait times (i.e., wait times for appointments or wait times for urgent/emergent care) over the past year, 39% of respondents disagreed and 16% strongly disagreed, while 23% agreed and 10% strongly agreed (Figure 5).

Figure 5. Proportions of Responses on Staffing and Wait Times.

Question #3: “Over the past year my clinic/health system/practice has had adequate staff to see clients without long wait times (i.e., wait times for appointments or wait times for urgent/emergent care).”

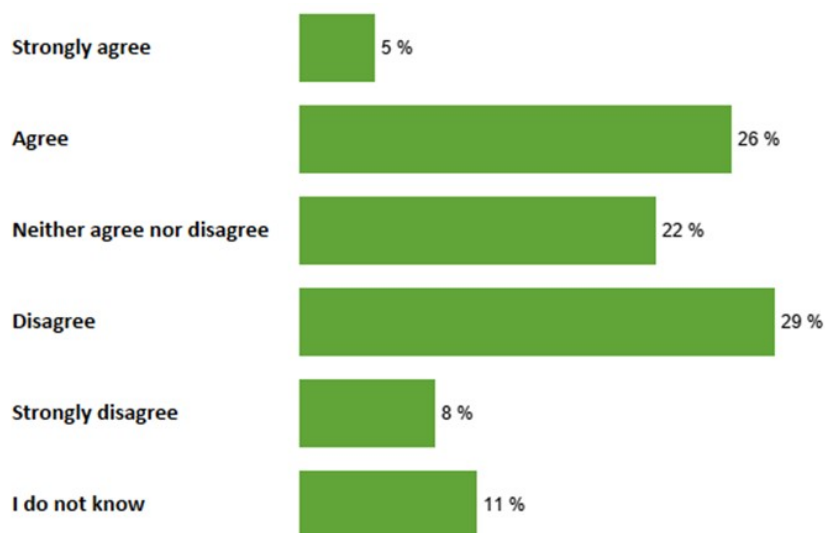


Referrals

The survey asked whether referred patients were able to see providers in a timely manner (i.e., referrals to physical health providers by behavioral health providers, and referrals to behavioral health providers by physical health providers). Figure 6 shows that 29% of respondents disagreed, while 26% agreed.

Figure 6. Proportions of Timely Referrals to Different Provider Types.

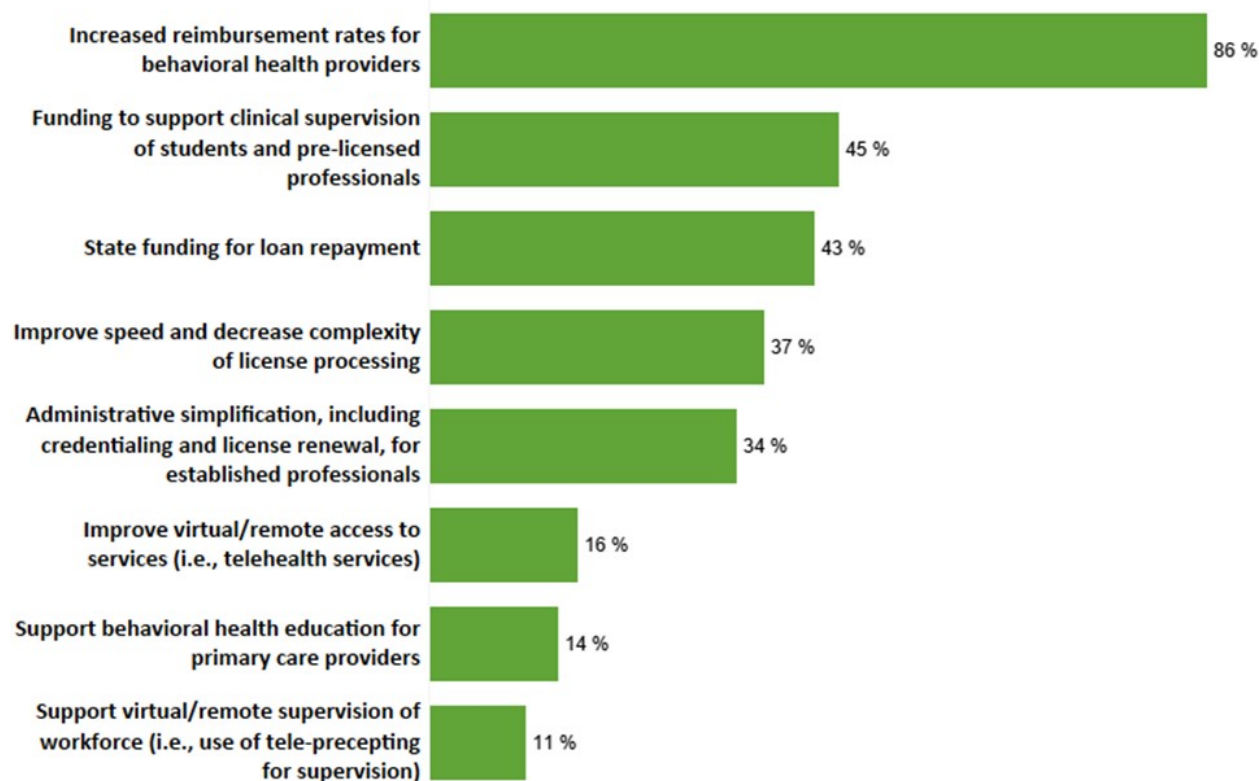
Question #5: "When I refer patients to a behavioral health provider (if you are a physical health provider) or physical health provider (if you are a behavioral health provider), my patients are usually seen by that provider in a timely manner."



The majority of survey respondents (86%) favored increased reimbursement for behavioral health providers and other influx of funds as a way to address behavioral workforce shortages in their regions (Figure 7). Respondents also favored improvements to license processing and other administrative simplification.

Figure 7. Proportions of Survey Responses to Address Behavioral Health Workforce Shortages.

Question #4: "Of the below actions, select up to three that would best help address behavioral health workforce shortages in your region (check up to three)."



Interview Results

The number of credentialed staff may be too low to meet the service needs for members with SUD or mental health needs. The workforce shortage appears to be even more dire for credentialed providers who can provide services for children with mental health needs.

Interviewees identified these specific issues related to workforce challenges:

- No certification process for community health workers and the ability to bill Medicaid for these services.
- The need for additional individuals to provide SUD treatment and supervision.
- The need for an increase in the mental health professional workforce.
- Although Washington state has peer services in the State Plan Amendment, certification and training are not readily available in all areas of the state.
- Challenges related to Medication for Opioid Use Disorder MOUD:

- Primary care providers are not interested in providing MOUD
 - Training/certification process for MOUD is a challenge. The time it takes to become certified to provide MOUD and the stigma may be contributing to the lack of PCPs providing MOUD.
- Some behavioral health providers are moving away from behavioral health clinics to higher-paying primary care clinics, or from lower paying behavioral health agencies to higher paying agencies. Some respondents suggested that this contributes to the behavioral health workforce shortage. Without an increase in qualified behavioral health providers, there is constant pressure on the system to recruit, hire and train behavioral health providers.
- There are an inadequate number of behavioral health professionals available to provide training and supervision, as well as provide client services.

Theme 2: Health Information Technology

Since the beginning of integration, there have been significant changes to medical records systems, billing systems and referral systems for behavioral health providers. Most behavioral health providers now use EHRs. However, these EHR systems are not as sophisticated as those often used by PCPs, leading to challenges with referrals (bi-directional and closed-loop referrals), receipt of Collective Medical notifications and billing.

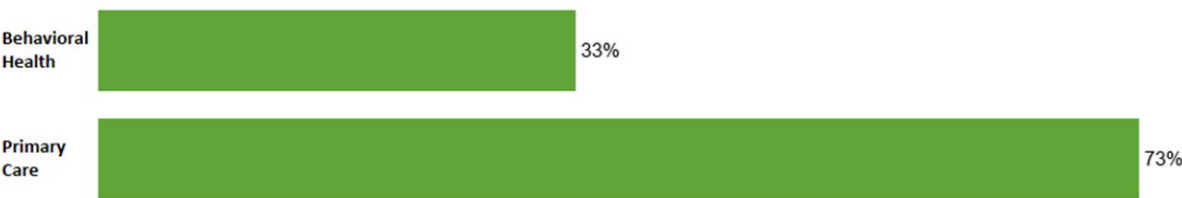
Survey Results

Although the vast majority (95%) of respondents are using EHRs to document visits, exchange of referral information remains a challenge. Only about a third of respondents have an EHR that supports electronic referrals to a different provider type.

The difference between PCPs (N=11) and behavioral health providers (N=43) was notable. Behavioral health providers were much less likely to have EHRs that support referrals to PCPs (Figure 8).

Figure 8. Proportions of PCPs and BHPs that Have EHRs Supporting Referrals.

Question #9: Does your clinic use an EHR/EMR system that supports electronic referrals to a behavioral health provider (if you are a physical health provider) or physical health provider (if you are a behavioral health provider)?



Additionally, few respondents statewide (18%) have an EHR that can receive an electronic response to a referral (Figure 9). PCPs are more than twice as likely to have EHRs that can receive an electronic response to a referral (Figure 10).

Figure 9. Proportions of Respondents that Can Receive Electronic Responses to Referrals.

Question #10: Does your (clinic/health system/practice) use an EHR/EMR that can receive electronic responses to your referrals (e.g., a response that the provider accepts or declines the referral, a response that the patient was seen by the provider, a response that communicates the outcome of the referral)? (check all that apply)

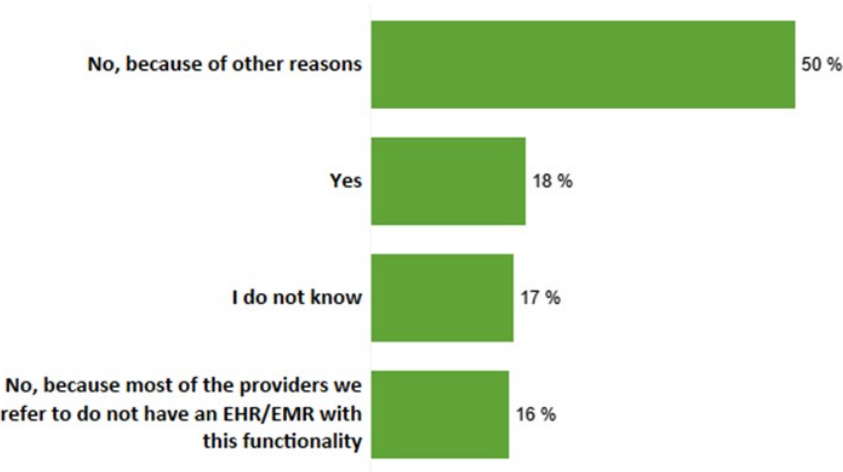
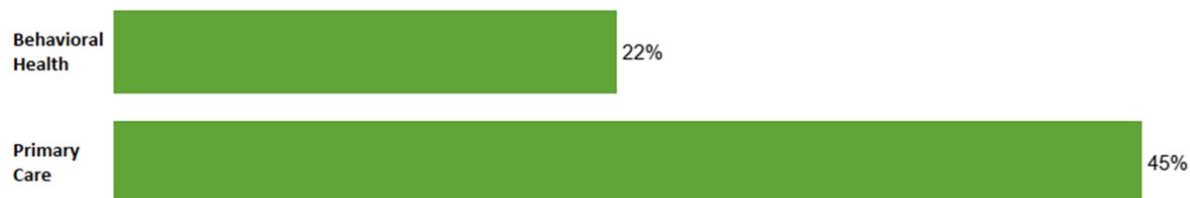


Figure 10. Proportions of Behavioral Health Providers vs. Primary Care Providers that Can Receive Electronic Responses to Referrals (“Yes” responses).

Question #10: Does your (clinic/health system/practice) use an EHR/EMR that can receive electronic responses to your referrals (e.g., a response that the provider accepts or declines the referral, a response that the patient was seen by the provider, a response that communicates the outcome of the referral)? (check all that apply)



Interview Results

Many behavioral health providers do not have sophisticated systems to exchange information.

“[It is difficult to do] immediate follow-up after hospitalization if you don’t have some sort of data system through ADT technology.”

- Interview participant

Theme 3: Challenges Sharing Patient Health Information

The ability to send and receive patient information is an issue identified in both the surveys and interviews. The use of the Collective Medical care management tool ⁵ to receive information from EDs and hospitals is increasing across care settings in Washington state. However, it is not universal and not implemented by all EDs, hospitals and providers. 42 CFR Part 2 has been identified as a barrier to exchange of patient information.

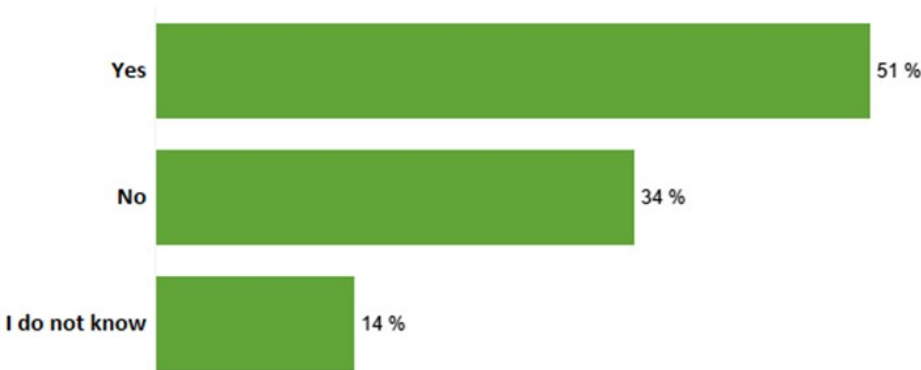
Survey Results

Fewer than half of all respondents statewide are aware of when their patients have been in the ED or hospital in a timely fashion. This proportion is consistent between King County and the rest of Washington state.

About half of respondents statewide indicated they use Collective Medical (Figure 11). Adoption of Collective Medical is about the same for PCPs and BHPs. However, there is a markedly higher use of Collective Medical in King County compared to the rest of Washington state (74% of respondents in King County selected “Yes” versus 44% in the remainder of the state).

Figure 11. Adoption of Collective Medical Among Statewide Respondents.

Question #12: Do you use Collective Tools (formerly known as Collective Medical Technology, Premanage) to find out when your patient was seen or treated in the hospital or emergency department?



Interview Results

The infrastructure for sharing patient information is still in development or is not set up to support seamless data sharing or timely reimbursement. Providers, depending on where they are located, have different levels of access to training and ongoing support for Collective Medical, particularly for providers in rural communities.

One participant reported that the Collective Medical system lacks what they need to be able to follow a member’s path better. “Generally, that platform is not set up for behavioral health diagnoses and sharing clinical notes that are more based in integrated care.” In addition, they would like more of a bed tracking functionality where they can identify open beds for a member and help enable timely, appropriate placement.

⁵ Collective Medical’s care management tool delivers real-time notifications with insights at the point of care that combines information from participating health care partners, including hospitals and EDs, primary care practices and behavioral health agencies, and synthesizes the information. Collective Medical tools provide real-time information on ED and inpatient admissions and discharges to health plans, MCOs, care managers and providers.

Challenges Specific to SUD Treatment

Most interviewees identified 42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Records, as a significant barrier to integrating care due to the federal requirements for consent on exchange of information for individuals with substance use disorders. Providers are cautious with the interpretation of this regulation to protect patient confidentiality and avoid significant legal consequences for not following the rule. This impacts the ability of EDs, hospitals and treatment providers to support care coordination for whole person care. A lack of health information exchange makes it difficult to get information and connect the dots with these populations.

Respondents from ACHs reported that follow-up after emergency department (ED) visits can be challenging for members with alcohol and other drug dependencies, particularly if there are not the financial or human resources in place to support follow-up activities.

“...you are never going to be able to improve on these behavioral health measures if we can't also figure out a way to share behavioral health data more consistently and that's really challenging, especially with SUD data being protected, and we know that, but it's hard to make improvement on measures when the data itself can't actually be shared to improve upon.”

- MCO interview participant

Theme 4: Limited Access to Data to Assess Progress on Performance Measures

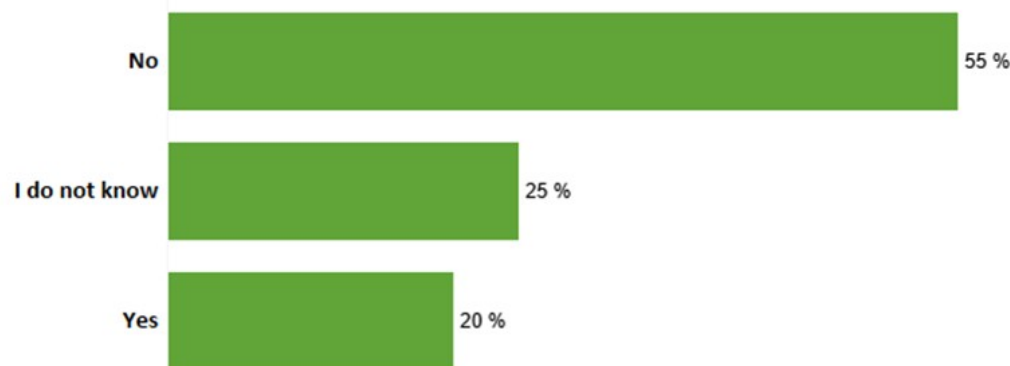
Receiving timely data in order to assess progress on performance measures is a challenge for MCOs, ACHs and providers for a variety of reasons, including the time lag due to the period of time encounter data may be submitted after the encounter has occurred (claims runout). In addition, some providers may not have the administrative support within their organization to process data and focus on quality improvement efforts.

Survey Results

Performance data sharing

Only 20% of respondents reported receiving performance data from MCOs (Figure 12). When data were split by administrators and managers, fewer administrators (15%) acknowledged receiving data from MCOs (not shown in chart).

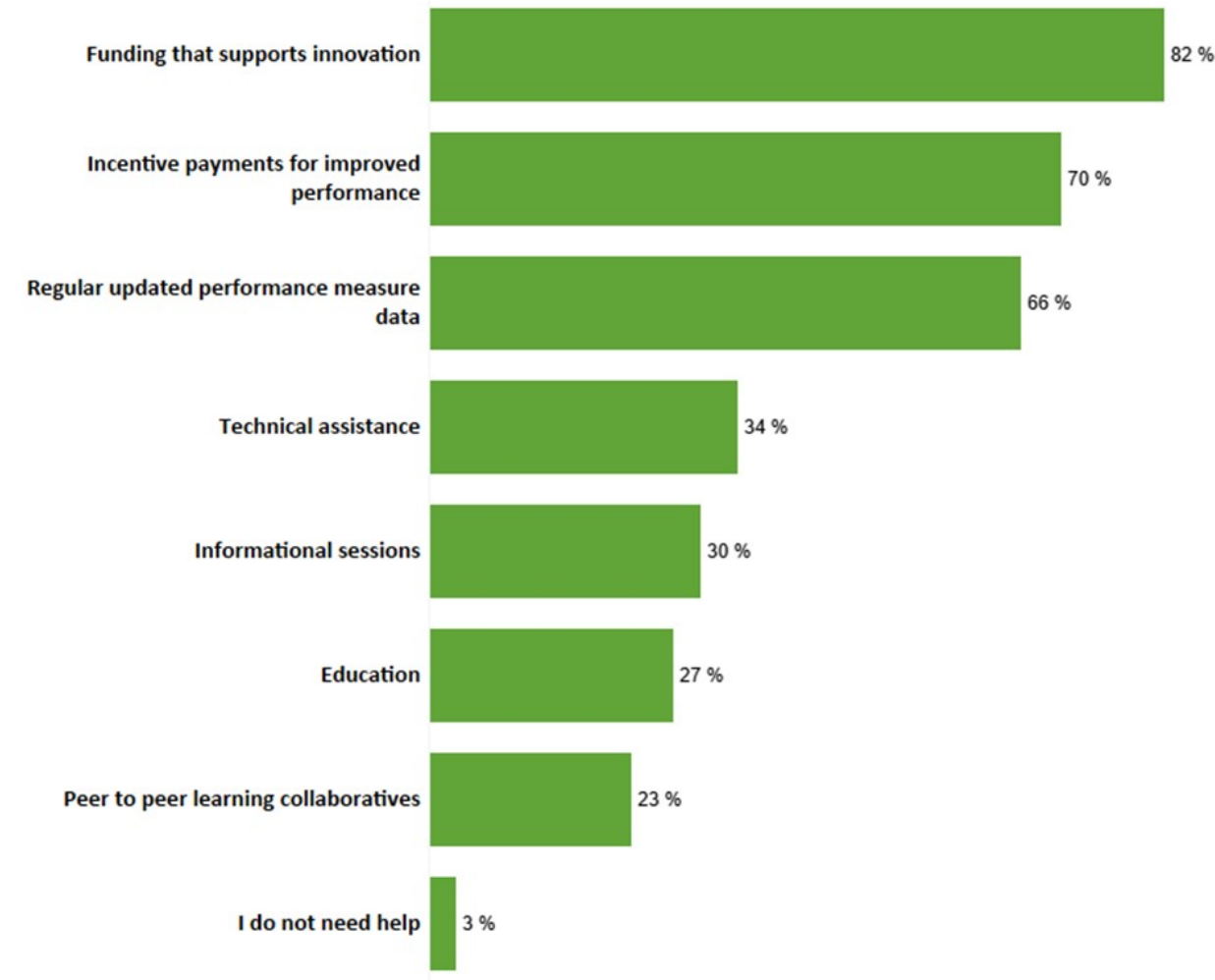
Figure 12. Proportion of Survey Respondents Receiving Performance Measure Data from MCOs.
Question #14: Do you receive updates and/or data from the managed care organizations (MCO) on the performance measure rates for your clinic/health system/practice?



The majority of survey respondents would like assistance to help their clinics improve performance on behavioral health measures (Figure 13).

Figure 13. Leading Types of Assistance Desired by All Survey Respondents.

Question #15: What kind of assistance would you like to help your clinic improve its performance on behavioral health measures? (check all that apply)



Interview Results

Data sharing issues

Overall, MCOs use a data-driven decision-making process that includes monitoring data via dashboard, reviewing regular data reports (e.g., weekly or monthly), and then identifying either providers or members for follow-up on areas of concern.

However, receiving and communicating consistent and timely data is a challenge for MCOs, ACHs and providers. MCOs may be able to create some timely data based on claims and encounter data reporting, but there is a significant time lag of complete and accurate claims/encounter data coming from HCA and RDA due to the time allowed for claims runout/encounter data submission. Final data coming from HCA and RDA is 12–18 months after service delivery due to the time it takes for complete claims/encounter data submission from the provider to MCO to HCA. Some MCOs may share HEDIS data and additional performance data with ACHs and providers on a regular and timely basis to provide information necessary to impact performance. However, this information is not shared consistently or with all stakeholders for a variety of reasons (including operational limitations of providers).

MCOs and ACHs recognize the value of data and collecting as much as possible to trend the network and agencies in the right direction. Timely claims data and performance measurement outcomes data assist with value-based purchasing agreements with the MCOs. A big piece of these agreements is selecting measures to incentivize to promote improvement of measure outcomes. One MCO interviewee noted the value-based payment program (VBP) was particularly advantageous as provider groups are very interested in the incentives. In addition, the organization has provider incentives aside from VBP as motivation for provider groups to engage with quality management.

“...I don't necessarily think it's not going well, I just think it could be better and if we had a single repository that the entire system could work through and share these different gaps. I think it would be a lot more efficient and we would just be a lot better. But right now, you know, you've got five managed care organizations, you got all these different providers, and some providers are SUD, some are mental health, some are both. And you know, I think there's a way to do it, we just haven't figured it out and obviously it's a huge monetary investment. But if we could think a little bit more out of the box and just try some different things, I think that would help.”

- MCO participant

Theme 5: Limited Access to Services

As discussed under workforce, the lack of credentialed providers to serve individuals with behavioral health needs is a major challenge impacting access to care.

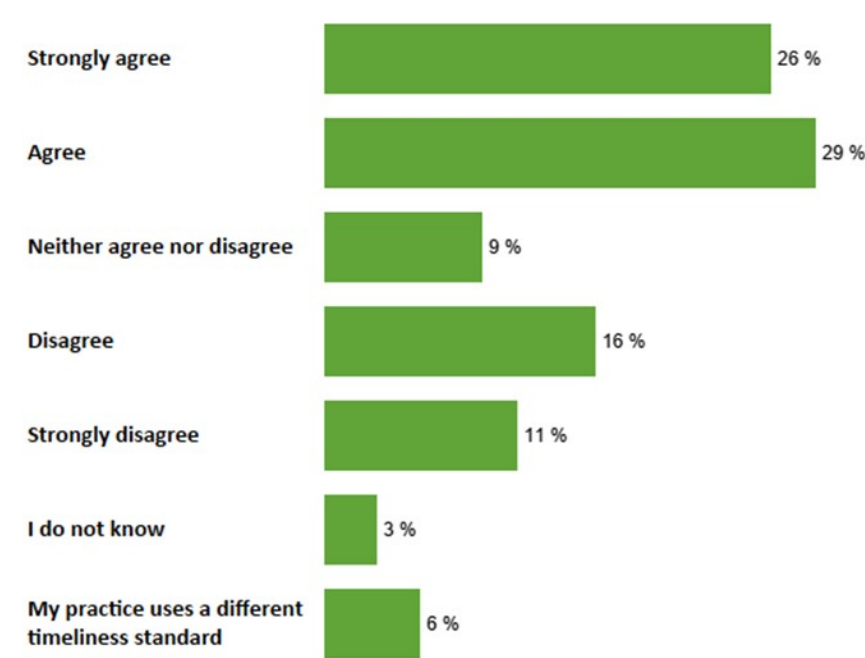
The lack of technology for telehealth in more rural areas also impacts patient access.

Survey Results

Just over half of the practices surveyed reported they are able to see new patients within 10 business days of their request for an appointment (Figure 14). Primary care providers may be somewhat more likely to see new patients within 10 days.

Figure 14. Proportions of Practices Able to See New Patients Within 10 Days.

Question #7: My (clinic/health system/practice) is able to see most new patients within 10 business days of their request for an appointment related to behavioral health symptoms.



Interview Results

Access to services in general, particularly in rural communities

As noted previously, workforce issues greatly affect access to behavioral health services. With a limited number of providers available, access to timely services is a constant challenge.

Clients in rural communities face even greater access to services, with telehealth not always being an option due to lack of adequate broadband. Telehealth has proven successful for many populations. However, some individuals lack the technology or may not have a private space at home for telehealth appointments.

- Transportation to appointments is an issue affecting access.
- Although the metric on homelessness is noted as stable or improving, housing is a significant issue pre- and post-COVID-19 and affects many of these measures. It is difficult to coordinate care, make and attend appointments if one does not have stable housing.
- Some interviewees stated that there has been an increase in behavioral health screenings, but access post-screening has not increased (due to workforce issues).

"We try to engage the member any way we can. By phone or in some letters and, you know, sometimes that's challenging, especially if the folks are homeless."

- MCO interview participant

Theme 6: Challenges with Integration of Behavioral and Physical Health

Providers have experienced several challenges as integration has been initiated and proceeds. Respondents from ACHs, who may have had efforts to support providers during the beginning of integration, referred to billing challenges (e.g., rates, virtual visits not covered, no infrastructure for billing, and general confusion about billing); health data not coordinated across providers; a lag between implementation and when data were received; and contracting challenges.

Many behavioral health providers needed to implement EHRs and move from paper documentation. In choosing EHRs, many behavioral health providers chose systems that were not as costly or functional as those in physical health/primary care settings (such as EPIC). Behavioral health providers need to contract and bill multiple payors, where previously billing had been a much simpler process.

Interview Results

Resistance and lack of trust at the beginning of integration may still persist in some communities.

Interview participants identified several challenges they have faced during the ongoing integration process.

- Primary care is not necessarily integrating behavioral health.
- So far, integration has been primarily financial—especially for those MCOs that have been “on-time” adopters. Now things are moving more toward clinical integration.
- Behavioral health agencies have had challenges moving from one payment method to contracting with multiple payors. Many agencies struggle with respect to contracting and billing systems, and they lack quality improvement staff and/or the ability to receive and address performance data.
- Billing before integration was easy due to prior global budgets and a single payor. Billing after integration is more complex due to multiple MCO/payor contracts and billing requirements specific to each MCO/payor, etc.
- Change management and change fatigue related to IMC, payments, EHRs, workflows and billing rates.

One MCO respondent described some challenges due to integration: “During the process of implementation of probably the first year and even in some regions it went on longer than a year and because we had to be so operationally focused, even to a certain extent try to align our clinical operations with the expectations of the provider community, we couldn’t focus specifically on the movement and metrics. It’s like we were just getting our feet under us. It just makes it really challenging to do specific activities that would actually focus on moving metrics up the ladder where they need to be.”

MCO respondents mentioned that it is difficult to target and measure improvement projects or some sort of performance improvement project on a specific measure when just a few providers are not performing. MCOs work to manage the integration process while focusing on supports they can provide to assist providers with managing their operations in a managed care structure.

MCOs are working to provide support to all providers. One MCO respondent described support to both their large and smaller providers, “With our existing large provider organizations that already have behavioral health integrated within their system, we conduct ‘provider engagement’ and we do a lot of work on a monthly basis whereby we upload the HEDIS data for all of the reportable HEDIS metrics...every month, the provider organization will receive how they are doing on an aggregate basis and then on a much more micro level, including very specific member level data...Prior to the pandemic, we worked to conduct outreach to all behavioral health provider organizations to see if they wanted to engage with our MCO and some of the just pure behavioral health practices were not interested. They had some operational issues internally. They couldn’t

connect with us on an EMR basis...then the pandemic hit; and really, we didn't get much beyond those groups. With our large groups, we have had a well-entrenched program and we follow the metrics...For smaller groups, it has been more of a challenge because they haven't wanted to participate. So, in order to participate, we have to have a secure mechanism to give them member level data...We actually have an established schedule for meetings...we have meetings and then we talk about best practices...about strategies that could be employed to improve. We also ask about barriers and challenges. Have they had providers leave their practice, so they are resource limited? Did they furlough their staff? Or are they having challenges with transportation for their members? What are the issues that they are encountering? So that we can work on an individual basis with those organizations."

Theme 7: Challenges for Children and Youth in Behavioral Health Treatment

The ACHs and MCOs identified issues for children and youth that they believe have impacted the behavioral health performance measures for this population.

Interview Results

According to those interviewed, changes in school discipline policy implemented by the State Office of Superintendent of Public Instruction has impacted the ability of schools to mandate substance use screenings and assessments to avoid suspension/expulsion. Interviewees also noted that the legalization of marijuana may have decreased the significance of its use in the eyes of parents.

Schools have always been a major source of referrals for mental health and substance use disorder services. With children and young adults not attending in-person education due to COVID-19, referrals to services are significantly decreased. Telehealth appears to be well-received by younger children. However, for adolescents, there has been decreased participation in telehealth counseling/therapy services because they have been in front of a computer all day for school and also the lack of privacy in their homes.

“There’s just a lot of work we are trying to do with the youth, and doing that in a way that is communicating at their level because we know that we can’t just use standard communication methods with youth. I mean they are so technology focused and based.”

- Interview participant

The workforce shortage appears significant for credentialed providers who can provide services for children and youth with mental health and/or SUD needs. One MCO participant said, “SUD as you know, not only is individual support that works but the group setting and with COVID we were unable to provide a lot of group services. Where they get that support, where they get that connection with their peers. So really they can adapt and change what they needed to be able to do that.”

Another interview participant said, “We have a whole team that works on prevention for youth. There is a significant impact of the opioid situation with our communities and our kids...[we’re] really trying to get the word out there, communicating the dangers of opioids and fentanyl. We work with providers and other parts of our community to make sure that information is out there.”

COVID-19 Impact on Progress on Performance Measures

The COVID-19 pandemic has impacted health care in many ways. Many providers implemented or expanded telehealth capabilities in order to meet patient needs remotely.

Telehealth

According to interview respondents, the shift to telehealth benefits some populations but was a challenge for others.

Telehealth increased access to services for clients who may not have been comfortable seeking services in-person. On the other hand, telehealth is not as useful for clients in rural communities without broadband access or for clients who do not have the technology to access telehealth.

“We have seen a decline in in-person care, but again telehealth has been quite remarkably good for some metrics and we hope to see that continue despite the pandemic hopefully subsiding.”

- MCO interview participant

Adolescents who have been on Zoom all day for school did not really want to be on telehealth calls. Adolescents also are concerned that their sessions might be recorded without their knowledge and that their discussions might not be all that private with family members in the home.

Substance Use and Mental Health

According to interview respondents, substance use and mental health challenges may have increased during the pandemic, and, with reduction in face-to-face/in-person services, youth and adult members may not be receiving the support they need.

ACH respondents indicated that with schools closed, it has been more difficult to identify youth in need of services—particularly because referrals most often came from schools. While telehealth was one avenue to stay connected to youth, it was not ideal for all youth. Some youth were concerned that what was shared via telehealth could go “viral” or “that their peers would somehow find out about their appointment.”

For adults, ACH respondents discussed discomfort with going to an ED during COVID-19 which may lead to a decrease in ED utilization. In addition, tracking members during the pandemic became more difficult due to providers either reducing their services or reducing the number of staff who would be able to provide services.

Strengths Identified by Participants

The following are strengths/progress noted by participants regarding the process of integration.

- **Integration:**
 - The state has made enormous strides implementing payment reform for integration through the MCOs.
 - Several primary care settings have integrated or co-located behavioral health providers within their clinics, leading to greater coordination of care and follow-up on referrals to specialty care.
- **Data and information sharing:** Providers, ACHs and MCOs see Collective Medical's tools as significant care management tools for all Washingtonians. Adoption of Collective Medical technologies was particularly strong in one area of Washington state (see survey data, King County).
 - Some MCOs work closely with providers regarding their performance on specific metrics.
- **Adoption of EHR:** Penetration of EHRs and analytic systems has been successful in all primary care, and the vast majority of behavioral health. PCPs have been successful in adopting bi-directional referrals to various provider types. ACHs have provided significant technical assistance to support behavioral health providers in the process of choosing and implementing EHRs.
- **Workforce:**
 - The workforce providing MOUD is increasing.
- **Data:** Providers, ACHs and MCOs all recognize the need for accurate and timely exchange of data.
- **Improvement Mindset:** Most providers consider their practices to be highly focused on improving care coordination and service delivery. This could be through a combination of their own work, collaboration with ACHs and others.
 - A majority of survey respondents (87%) reported their clinics engage in improvement efforts for coordination and service delivery.
- **Access:**
 - Telehealth has improved access for many individuals.
 - Many primary care settings are integrating or co-locating behavioral health providers within their clinics.
 - More primary care providers are providing MOUD services.

Conclusions

In conclusion, all regions of Washington state have integrated physical health and behavioral health as of January 2020. It had been expected that behavioral health performance measures would show improvements as integration proceeded. However, many performance measures have not performed in the expected manner. In conducting this study, Comagine Health surveyed a variety of providers and interviewed MCO and regional stakeholder staff to identify baseline understanding of variation in these performance measures.

As previously stated, this report does not describe a comparative study between MCOs or ACHs, but rather provides a comprehensive statewide view of the challenges faced by multiple payors and ACHs transitioning to an integrated system while providing mental health and SUD services within the state's Medicaid program.

Further, the study was undertaken at a relatively early point in integration for the state. Medicaid managed care contracts were not fully integrated in WA state until January 1, 2020.

The themes were identified by the study participants as areas for further development and exploration. Statewide efforts addressing these themes will likely tap innovations developed by ACHs, MCOs, the KCICN and their communities, and assist with brainstorming solutions while supporting those who may need additional ideas and direction. Comagine Health has offered recommendations to address these themes.

Much growth and development has occurred during this period of implementing integration of physical health and behavioral health. Integration has been a heavy lift for behavioral health providers. As such, considerable effort has been expended supporting behavioral and physical health providers and payors with payment integration. As integration continues to be implemented in Washington, ongoing focus and efforts are needed to support clinical integration of physical health and behavioral health service delivery. Continued and focused efforts to address the areas highlighted by the study participants will further improve these performance measures with respect to quality, access and timeliness.

Appendix A: Survey and Related Script

Provider Survey

Demographics and Workforce Questions

1. What is your role at your organization? **(check all that apply)**
 - ☐ Behavioral Health Provider (BHP)
 - ☐ Primary Care Provider (PCP)
 - ☐ Behavioral Health Administrative/Management
 - ☐ Medical Administrative/Management
 - ☐ Clinical
 - ☐ Other
2. What setting do you practice in? **(check all that apply)**
 - ☐ Outpatient MH Clinic/Office
 - ☐ Outpatient SUD Clinic/Office
 - ☐ Outpatient PCP Clinic/Office
 - ☐ Inpatient Acute Care Hospital
 - ☐ Inpatient Psychiatric hospital
 - ☐ Emergency Department
 - ☐ Evaluation and Treatment Facility
 - ☐ Crisis Triage or Crisis Stabilization
 - ☐ SUD Residential
 - ☐ MH Residential
 - ☐ Opioid Treatment Program
3. Over the past year my clinic/health system/practice has had adequate staff to see clients without long wait times (i.e., wait times for appointments or wait times for urgent/emergent care).
 - ☐ Strongly disagree
 - ☐ Disagree
 - ☐ Neither agree nor disagree
 - ☐ Agree
 - ☐ Strongly agree
 - ☐ I do not know
4. Of the below actions, select up to **three** that would best help address behavioral health workforce shortages in your region: **(check up to three)**
 - ☐ Increased reimbursement rates for behavioral health providers
 - ☐ Funding to support clinical supervision of students and pre-licensed professionals
 - ☐ State funding for loan repayment programs for behavioral health education
 - ☐ Improve virtual/remote access to services (i.e., telehealth services)
 - ☐ Support virtual/remote supervision of workforce (i.e., use of tele-precepting for supervision)
 - ☐ Support behavioral health education for primary care providers
 - ☐ Improve speed and decrease complexity of license processing
 - ☐ Administrative simplification, including credentialing and license renewal, for established professionals

Coordination of Care Post Integration and Access Questions

5. When I refer patients to a behavioral health provider (if you are a physical health provider) or physical health provider (if you are a behavioral health provider), my patients are usually seen by that provider in a timely manner.
 - ☐ Strongly disagree
 - ☐ Disagree
 - ☐ Neither agree nor disagree
 - ☐ Agree
 - ☐ Strongly agree
 - ☐ I do not know
6. Do you know, in a timely manner, when a client of yours has been in the hospital or emergency department?
 - ☐ Yes, we know, and we have procedures to ensure a follow up appointment is scheduled within five business days
 - ☐ Yes, we know, but we do not have procedures to ensure a follow up appointment is scheduled within five business days
 - ☐ Yes, we know, and have procedures in place but not capacity to see a client within five business days
 - ☐ No
 - ☐ I do not know
7. My (clinic/health system/practice) is able to see most **new** patients within 10 business days of their request for an appointment related to behavioral health symptoms.
 - ☐ Strongly disagree
 - ☐ Disagree
 - ☐ Neither agree nor disagree
 - ☐ Agree
 - ☐ Strongly agree
 - ☐ I do not know
 - ☐ My practice uses a different timeliness standard

Availability of Health Information Technology Questions

8. Does your (clinic/health system/practice) use an electronic health record (EHR)/electronic medical record (EMR) to document physical health and/or behavioral health care/visits? **If you answer “No” or “We do not use an EHR/EMR”, skip questions 9 and 10 below.**
 - ☐ Yes
 - ☐ No
 - ☐ We do not use an EHR/EMR
 - ☐ I do not know

9. Does your clinic use an EHR/EMR system that supports electronic referrals to a behavioral health provider (if you are a physical health provider) or physical health provider (if you are a behavioral health provider)?
- ☐ Yes
 - ☐ No
 - ☐ I do not know
10. Does your (clinic/health system/practice) use an EHR/EMR that can receive electronic responses to your referrals (e.g., a response that the provider accepts or declines the referral, a response that the patient was seen by the provider, a response that communicates the outcome of the referral)? **(check all that apply)**
- ☐ Yes
 - ☐ No, *because* most of the providers we refer to do not have an EHR/EMR with this functionality
 - ☐ No, *because of other reasons*
 - ☐ I do not know
11. Does your (clinic/health system/practice) use health information technology to support data analytics (e.g., to track outcomes of referrals or outcomes for individuals with SUD and/or MH conditions; and/or provider alerts/reminders for certain populations)? **(check all that apply)**
- ☐ Yes, for referrals
 - ☐ Yes, for patient outcomes
 - ☐ Yes, for alerts/reminders
 - ☐ No, we do not use technology for analytics
 - ☐ I do not know
12. Do you use Collective Tools (formerly known as Collective Medical Technology, Premanage) to find out when your patient was seen or treated in the hospital or emergency department?
- ☐ Yes
 - ☐ No
 - ☐ I do not know

Measurement Questions

13. My (clinic/health system/practice) engages in ongoing efforts to improve coordination and service delivery across medical and behavioral health care.
- ☐ Strongly disagree
 - ☐ Disagree
 - ☐ Neither agree nor disagree
 - ☐ Agree
 - ☐ Strongly agree
 - ☐ I do not know
14. Do you receive updates and/or data from the managed care organizations (MCO) on the performance measure rates for your clinic/health system/practice?
- ☐ Yes
 - ☐ No
 - ☐ I do not know

15. What kind of assistance would you like to help your clinic improve its performance on behavioral health measures? **(check all that apply)**

- ☐ Informational sessions
- ☐ Technical assistance
- ☐ Regular updated performance measure data
- ☐ Education
- ☐ Peer to peer learning collaboratives
- ☐ Funding that supports innovation
- ☐ Incentive payments for improved performance
- ☐ Other ***(please specify)***
- ☐ I do not need help

Additional Input

16. Do you have any additional input?

(This input will not be included in the study analysis but will be provided to HCA in non-aggregate form. Your input will be identifiable as a meeting date and location only; no additional identifiers will be attached to your comments.)

Comagine Health Survey Introduction Script

We asked that only providers and not ACH or MCO staff complete the survey.

"I am _____ (name) with Comagine Health.

HCA has asked us to conduct a study of the 12 BH PM to understand how these measures vary across region, by MCO and over time.

Based on information provided during these regional provider meetings and interviews with ACHs and MCOs, we will identify factors contributing to desirable outcomes that can be expanded – and factors contributing to lower performance in need of intervention.

As you can see from our project timeline,

- o HCA and CH worked together in **March** to identify 12 measures, analyze data on these measures to design survey and interview questions and schedule these regional meetings and interviews.
- o During the month of **April** we are conducting these regional meetings and interviews of the ACHs and MCOs.
- o In **May** we will analyze the data and provide a report to HCA by the end of **June**. Information will be available in **July**.

We will now conduct our survey – there are four domains with 15 total questions:

- o Demographics and Workforce
- o Coordination of Care Post Integration, and Access
- o Availability of Health Information Technology
- o Measurement

We will give you 10 minutes to complete the survey – the link is in chat – We will regroup after 10 minutes and HCA will lead us in further discussion.

We are primarily interested in those who work with behavioral health or primary care, and in other direct care settings. (so ACHs and MCOs – please don't take the survey as we will interview you later)

We will send the survey link along with the slide deck after the meeting so you can send to providers who were unable to attend today and will keep the survey open until April 30th."

Appendix B: ACH and MCO Interview Questions and Related Guides

ACH Interview Guide

“Hi, I am _____ (*name*) of Comagine Health. I’d like to introduce my colleagues, _____ (*Comagine Health staff names*), as well. We are conducting this together and they will join in occasionally to ask questions or clarify.

We appreciate you taking the time to participate in this interview. As you know, HCA requested that Comagine Health conduct a study that will analyze behavioral health performance measure variation across MCOs and ACHs. The goal of the study is to gain insight into why performance varies across integrated managed care plans/payors, ACH region, and over time.

Our primary interest is to gather information from you to understand [ACH]’s performance on selected behavioral health measures. We are hoping to add context to the performance measures through information gathered in these interviews. We are interested in how behavior health integration at your ACH has impacted progress on the selected measures.

I have some questions for you, broken into two sections – **impacts of integration, and progress on performance measures** by population. We understand that COVID-19 has had a big impact on healthcare over the past year. We will ask about how you think COVID-19 may have impacted progress on selected measures. Everything you tell me will be kept confidential and we will not share your name with anyone except study staff. We would, however, like to identify best practices – and, with your permission – share your ACHs name with any emerging best practices. We will record these interviews to help with remembering the information you share. Stop me at any time if you have any questions for me as we go through, if anything is unclear, or if you would prefer to skip a question. **There are no wrong answers.**

The interview will take about 60 minutes. We will do an occasional time check to make sure we are on track.

I would like to encourage everyone to have your cameras on and stay off mute throughout this discussion (kids, dogs are OK).

You may wish to have chat open as we will share some information there throughout.

Any questions before we begin?”

Introductions

We would like to start off with introductions.

1. Please tell us your name(s), your title, and a brief description of your role.

Impact of Integration

These next questions ask about how the integration may have impacted your ACH's policies, practices, and progress on the selected performance measures. As you know physical health, mental health and substance use disorder have been integrated into the MCOs within all regions of the state as of January 2020.

2. From the start of IMC in 2016 until COVID started (3/2020), what were the biggest barriers for providers in your region that may have impacted progress on the selected performance measures?

[Comagine Health staff], will you share your screen with the 12 performance measures? We will show these measures again via chat throughout our interview as we discuss each measure area.

- a. How has COVID-19 further impacted progress on these performance measures?
- b. What resources has your ACH provided to practices related to integration that may have contributed to success on the selected performance measures?

Performance Measures Discussion

Thank you for sharing your thoughts and experiences about the impact integration may have had on progress of performance measures. Our project includes several measures that are included in the MCO contracts and quarterly reports (*we know that ACHs don't need to report on measures – but can/do impact them*).

Now we would like to ask you some questions about the performance of these measures for those with serious mental illness and substance use disorder by population to better understand what might be driving the performance.

*Thinking specifically about with the three measures that fall under the **Children ages 6 – 17 with mental health needs** population.*

Children Ages 6 – 17 with Mental Health Needs Measures:

17. Children age 6-17 with mental health needs: Mental Health Treatment Penetration - Broad Definition
18. Children age 6-17 with mental health needs: Psychiatric Inpatient 30-Day Readmission
19. Children age 6-17 with mental health needs: Follow-up after Emergency Department Visit for Mental Illness - Within 7 Days of ED Visit

3. Can you tell me what you are doing for this population?

- a. discuss what is going well
- b. discuss what is not going well

Is there anything more I could have asked or information you would like to share on these measures?

*Thinking specifically about the measure that falls under the **Children age 10 – 17 with SUD** population:*

- Children Age 10-17 with SUD: Substance Use Disorder Treatment Penetration (SUD)

4. Can you tell me what you are doing for this population?
 - a. discuss what is going well
 - b. discuss what is not going well

Is there anything more I could have asked or information you would like to share on these measures?

*Thinking specifically about the four measures that fall under the **Adult SMI population (age 18 to 64 including dual eligible)** population.*

Adult SMI Population (ages 18 to 64 including dual eligibles) Measures:

20. Adult SMI Population: Psychiatric Inpatient 30-Day Readmission
21. Adult SMI Population: Follow-Up After Hospitalization for Mental Illness - Within 7 Days of Discharge
22. Adult SMI Population: Follow-Up After Hospitalization for Mental Illness - Within 30 Days of Discharge
23. Adult SMI Population: Follow-up after Emergency Department Visit for Mental Illness - Within 7 Days of ED Visit

5. Can you tell me what you are doing for this population?
 - a. discuss what is going well
 - b. discuss what is not going well

Is there anything more I could have asked or information you would like to share on these measures?

*Thinking specifically about two measures that fall under the **Adult SUD (ages 18 to 64 including dual eligible)** population. Measures:*

24. Adult SUD Population: Substance Use Disorder Treatment Penetration
25. Adult SUD Population: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence - Within 7 Days of ED Visit

6. Can you tell me what you are doing for this population?
 - a. what is your approach to improve SUD services?
 - b. discuss what is going well
 - c. discuss what is not going well

Is there anything more I could have asked or information you would like to share on these measures?

*Thinking specifically about the two measures that fall under the **Adult Medicaid population (ages 18 to 64 including dual eligible)** population. Measures:*

- 26. Overall Adult Medicaid: Percent Homeless - Narrow Definition
- 27. Overall Adult Medicaid: Percent Employed

- 7. What supports, if any, are you providing to individuals experiencing homelessness/housing insecurity?
 - a. What barriers have you encountered in providing supports?

- 8. What supports, if any, are you providing to individuals experiencing financial hardship, including unemployment?
 - a. What barriers have you encountered in providing supports?

Is there anything more I could have asked or information you would like to share on these measures?

WITH RESPECT TO ALL OF THESE MEASURES: (*“Please, let me know if we need to share the measures again”*)

- 9. Next, we are going to talk about any special projects you may be working on that may have impacted these measures.
 - a. can you tell us about any special projects you are working on with providers and MCOs?

Other Comments

Thank you for sharing that information. We just have a couple final questions before wrapping up.

- 10. (can skip this question if running out of time) How have you responded to barriers created by the COVID-19 pandemic to meet BH needs?
- 11. That is all of the questions we have for you, is there anything else you would like us to know about the work you are doing to address outcomes for this project?

Closing

Thank you so much for talking with us today – we really appreciate it. If you have any concerns or questions, please don’t hesitate to reach out!

Table B-1. Performance Measure List.

Population: Work List Description/Measure Name
Overall adult Medicaid population (ages 18 to 64 including dual eligibles)
Overall Adult Medicaid: Percent Homeless - Narrow Definition (HOME-N)
Overall Adult Medicaid: Percent Employed (EMP)
Adult SMI population (ages 18 to 64 including dual eligibles)
Adult SMI Population: Psychiatric Inpatient 30-Day Readmission (HEDIS-PCR-P)
Adult SMI Population: Follow-Up After Hospitalization for Mental Illness - Within 7 Days of Discharge (HEDIS-FUH-7D)
Adult SMI Population: Follow-Up After Hospitalization for Mental Illness - Within 30 Days of Discharge (HEDIS-FUH-30D)
Adult SMI Population: Follow-up after Emergency Department Visit for Mental Illness - Within 7 Days of ED Visit (HEDIS-FUM-7D)
Adult SUD population (ages 18 to 64 including dual eligibles)
Adult SUD Population: Substance Use Disorder Treatment Penetration (SUD)
Adult SUD Population: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence - Within 7 Days of ED Visit (HEDIS-FUA-7D)
Children Ages 6 – 17 with mental health needs
Children age 6-17 with mental health needs: Mental Health Treatment Penetration - Broad Definition (MH-B)
Children age 6-17 with mental health needs: Psychiatric Inpatient 30-Day Readmission (HEDIS-PCR-P)
Children age 6-17 with mental health needs: Follow-up after Emergency Department Visit for Mental Illness - Within 7 Days of ED Visit (HEDIS-FUM-7D)
Children Ages 10 – 17 with SUD
Children Ages 10-17 with SUD: Substance Use Disorder Treatment Penetration (SUD)

MCO Interview Guide

“Hi, I am _____ (*name*) of Comagine Health. I’d like to introduce my colleagues, _____ (*names*), as well. We are conducting this together and they will join in occasionally to ask questions or clarify.

We appreciate you taking the time to participate in this interview. As you know HCA requested that Comagine Health conduct a study that will analyze behavioral health performance measure variation across MCOs and ACHs. The goal of the study is to gain insight into why performance varies across Integrated Managed Care (IMC) plans and ACH region, and over time.

Our primary interest is to gather information from you to understand [MCO]’s performance on selected behavioral health measures. We are hoping to add context to the performance measures through information gathered in these interviews. We are interested in how integrating behavioral health services into the MCO benefit package has impacted progress on the selected measures.

I have some questions for you, broken into two sections – ***impacts of integration***, and ***progress on performance measures*** by population. We understand that COVID-19 has had a big impact on healthcare over the past year. We will ask about how you think COVID-19 may have impacted progress on selected measures. Everything you tell me will be kept confidential and we will not share your name with anyone except study staff. We would, however, like to identify best practices – and - with your permission, share your MCOs name with any emerging best practices.

We will record these interviews to help with remembering the information you share. Stop me at any time if you have any questions for me as we go through, if anything is unclear, or if you would prefer to skip a question. There are no wrong answers. The interview will take about 60 minutes. We will do an occasional time check to make sure we are on track.

I would like to encourage everyone to have your cameras on and stay off mute throughout this discussion – kids, dogs are OK.

You may wish to have chat open as we will share some information there throughout....

Any questions before we begin?”

Introductions

We would like to start off with introductions.

1. Please tell us your name(s), your title, and a brief description of your role.

Impact of Integration

These next questions ask about how Integrated Managed Care implementation may have impacted your MCO’s policies, practices, and progress on the selected performance measures. As you know physical health, mental health and substance use disorder services have been integrated into the MCOs within all regions of the state as of January 2020. Can you tell us when you integrated?

2. From the start of your integration in _____ until COVID started (3/2020), what were the biggest barriers for your contracted providers that may have impacted progress on the selected performance measures? _____ (*Comagine Health staff names*) will you share your screen with the 12 performance measures? We will show these measures again via chat throughout our interview as we discuss each measure area.
 - a. How has COVID-19 further impacted progress on these performance measures?
 - b. What resources has your MCO provided to practices related to integration that may have contributed to success on the selected performance measures?

Performance Measures Discussion

Thank you for sharing your thoughts and experiences about the impact integration may have had on progress of performance measures. Our project includes several measures that are included in the MCO contracts and quarterly reports and now we would like to ask you some questions about the performance of these measures for those with Serious Mental Illness & Substance Use Disorder by population to better understand what might be driving the performance.

As I mentioned, our project includes several measures that are included in the MCO contracts and quarterly reports

3. Overall, how do you monitor progress on these measures? (can you give examples?)
 - a. Have you noticed trends that concern you over the past two years?
 - b. We will discuss specific interventions for specific measures next, but can you share what you do if you see a trend going the wrong way?

*Thinking specifically about with the three measures that fall under the **Children ages 6 – 17 with mental health needs** population. Measures:*

28. Children ages 6-17 with mental health needs: Mental Health Treatment Penetration - Broad Definition
29. Children ages 6-17 with mental health needs: Psychiatric Inpatient 30-Day Readmission
30. Children ages 6-17 with mental health needs: Follow-up after Emergency Department Visit for Mental Illness - Within 7 Days of ED Visit

4. Can you tell me what you are doing for this population?
 - a. who is managing care coordination/care transitions for this population?
 - b. discuss what is going well
 - c. discuss what is not going well

Is there anything more I could have asked or information you would like to share on these measures?

*Thinking specifically about the measure that falls under the **Children age 10 – 17 with SUD** population. Measure:*

31. Children Age 10-17 with SUD: Substance Use Disorder Treatment Penetration (SUD)

5. Can you tell me what you are doing for this population?
 - a. what is your approach to improve SUD services?
 - b. How are you measuring improvements in this area?
 - c. discuss what is going well
 - d. discuss what is not going well

Is there anything more I could have asked or information you would like to share on these measures?

*Thinking specifically about the four measures that fall under the **Adult SMI population (ages 18 to 64 including dual eligible)** population. Measures:*

32. Adult SMI Population: Psychiatric Inpatient 30-Day Readmission
33. Adult SMI Population: Follow-Up After Hospitalization for Mental Illness - Within 7 Days of Discharge
34. Adult SMI Population: Follow-Up After Hospitalization for Mental Illness - Within 30 Days of Discharge
35. Adult SMI Population: Follow-up after Emergency Department Visit for Mental Illness - Within 7 Days of ED Visit

6. Can you tell me what you are doing for this population?
 - a. who is managing care coordination/care transitions for this population?
 - b. discuss what is going well
 - c. discuss what is not going well

Is there anything more I could have asked or information you would like to share on these measures?

*Thinking specifically about two measures that fall under the **Adult SUD (ages 18 to 64 including dual eligible)** population. Measures:*

36. Adult SUD Population: Substance Use Disorder Treatment Penetration
37. Adult SUD Population: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence - Within 7 Days of ED Visit

7. Can you tell me what you are doing for this population?
 - a. what is your approach to improve SUD services?
 - b. how are you measuring improvements in this area?
 - c. discuss what is going well
 - d. discuss what is not going well

Is there anything more I could have asked or information you would like to share on these measures?

WITH RESPECT TO ALL OF THESE MEASURES:

8. Can you tell me what is happening with respect to information exchange related to these measures?
 - a. Discuss how technology is being used to support follow-up after ED/hospital visits, referrals in care and social services.
 - b. Discuss barriers to the use of technology for these purposes.
9. Next, we are going to talk about any special projects you may be working on that may have impacted the measures.
 - a. can you tell us about any special projects you are working on with providers & ACHs?

*Thinking specifically about the two measures that fall under the **Adult Medicaid population (ages 18 to 64 including dual eligible)** population. Measures:*

38. Overall Adult Medicaid: Percent Homeless - Narrow Definition
39. Overall Adult Medicaid: Percent Employed
10. What supports, if any, are you providing to individuals experiencing homelessness/housing insecurity?
 - a. What barriers have you encountered in providing supports?
11. What supports, if any, are you providing to individuals experiencing financial hardship, including unemployment?
 - a. What barriers have you encountered in providing supports?

Other Comments

Thank you for sharing that information. We just have a couple final questions before wrapping up.

12. (can skip this question if running out of time) How have you responded to barriers created by the COVID-19 pandemic to meet BH needs?
13. That is all of the questions we have for you, is there anything else you would like us to know about the work you are doing to address outcomes for this project?

Closing

Thank you so much for talking with us today – we really appreciate it. If you have any concerns or questions, please don't hesitate to reach out! If we run out of time, we will send the remaining questions for you to answer if you are able.

Table B-2. Measure List.

Population: Work List Description/Measure Name
Overall adult Medicaid population (age 18 to 64 including dual eligibles)
Overall Adult Medicaid: Percent Homeless - Narrow Definition (HOME-N)
Overall Adult Medicaid: Percent Employed (EMP)
Children ages 6–17 with mental health needs
Children age 6-17 with mental health needs: Mental Health Treatment Penetration - Broad Definition (MH-B)
Children age 6-17 with mental health needs: Psychiatric Inpatient 30-Day Readmission (HEDIS-PCR-P)
Children age 6-17 with mental health needs: Follow-up after Emergency Department Visit for Mental Illness - Within 7 Days of ED Visit (HEDIS-FUM-7D)
Children ages 10–17 with SUD
Children Age 10-17 with SUD: Substance Use Disorder Treatment Penetration (SUD)
Adult SMI population (ages 18 to 64 including dual eligibles)
Adult SMI Population: Psychiatric Inpatient 30-Day Readmission (HEDIS-PCR-P)
Adult SMI Population: Follow-Up After Hospitalization for Mental Illness - Within 7 Days of Discharge (HEDIS-FUH-7D)
Adult SMI Population: Follow-Up After Hospitalization for Mental Illness - Within 30 Days of Discharge (HEDIS-FUH-30D)
Adult SMI Population: Follow-up after Emergency Department Visit for Mental Illness - Within 7 Days of ED Visit (HEDIS-FUM-7D)
Adult SUD population (age 18 to 64 including dual eligibles)
Adult SUD Population: Substance Use Disorder Treatment Penetration (SUD)
Adult SUD Population: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence - Within 7 Days of ED Visit (HEDIS-FUA-7D)

Appendix C: Full Survey Results

This appendix contains responses for each survey question in table form.

Table C-1. Respondents from each ACH.

ACH Name	Count	Percent
King County	62	31.8
Greater Columbia	24	12.3
Cascade Pacific	23	11.8
Spokane	17	8.7
Pierce County	16	8.2
North Sound	15	7.7
Salish	15	7.7
North Central	12	6.2
Southwest WA	11	5.6
Total	195	100.0

Table C-2. Q1: “What is your role at your organization? (check all that apply)”

Role	Count	Percent
Behavioral Health Administrative/Management	141	72.3
Behavioral Health Provider (BHP)	45	23.1
Medical Administrative/Management	18	9.2
Clinical	17	8.7
Other	16	8.2
Primary Care Provider (PCP)	11	5.6
Sum of reported roles (not individuals)	248	127.2

Table C-3. Q2: “What setting do you practice in? (check all that apply)”

Setting	Count	Percent
Outpatient SUD Clinic/Office	108	55.4
Outpatient PCP Clinic/Office	43	22.1
SUD Residential	26	13.3
Crisis Triage or Crisis Stabilization	25	12.8
MH Residential	21	10.8
Evaluation and Treatment Facility	20	10.3
Opioid Treatment Program	19	9.7
Inpatient Acute Care Hospital	11	5.6
Emergency Department	11	5.6
Inpatient Psychiatric Hospital	6	3.1
Total	290	148.7

Table C-4. Q3: “Over the past year my clinic/health system/practice has had adequate staff to see clients without long wait times (i.e., wait times for appointments or wait times for urgent/emergent care).”

Response	Count	Percent
Disagree	77	39.5
Agree	45	23.1
Strongly disagree	32	16.4
Strongly agree	20	10.3
Neither agree nor disagree	19	9.7
I do not know	2	1.0
Total	195	100.0

Table C-5. Q4: “Of the below actions, select up to three that would best help address behavioral health workforce shortages in your region: (check up to three).”

Response	Count	Percent
Increased reimbursement rates for behavioral health providers	167	85.6
Funding to support clinical supervision of students and pre-licensed professionals	88	45.1
State funding for loan repayment programs for behavioral health education	83	42.6
Improve speed and decrease complexity of license processing	72	36.9
Administrative simplification, including credentialing and license renewal, for established professionals	66	33.8
Improve virtual/remote access to services (i.e., telehealth services)	32	16.4
Support behavioral health education for primary care providers	28	14.4
Support virtual/remote supervision of workforce (i.e., use of tele-precepting for supervision)	21	10.8
Total	557	285.6

Table C-6. Q5: “When I refer patients to a behavioral health provider (if you are a physical health provider) or physical health provider (if you are a behavioral health provider), my patients are usually seen by that provider in a timely manner.”

Response	Count	Percent
Disagree	56	28.7
Agree	51	26.2
Neither agree nor disagree	42	21.5
I do not know	21	10.8
Strongly disagree	16	8.2
Strongly agree	9	4.6
Total	195	100

Table C-7. Q6: “Do you know, in a timely manner, when a client of yours has been in the hospital or emergency department?”

Response	Count	Percent
Yes, we know, and we have procedures to ensure a follow up appointment is scheduled within five business days	93	47.7
No	50	25.6
Yes, we know, and have procedures in place but not capacity to see a client within five business days	22	11.3
I do not know	20	10.3
Yes, we know, but we do not have procedures to ensure a follow up appointment is scheduled within five business days	10	5.1
Total	195	100.0

Table C-8. Q7: “My (clinic/health system/practice) is able to see most new patients within 10 business days of their request for an appointment related to behavioral health symptoms.”

Response	Count	Percent
Agree	56	28.7
Strongly agree	51	26.2
Disagree	31	15.9
Strongly disagree	22	11.3
Neither agree nor disagree	18	9.2
My practice uses a different timeliness standard	11	5.6
I do not know	6	3.1
Total	195	100.0

Table C-9. Q8: “Does your (clinic/health system/practice) use an electronic health record (EHR)/electronic medical record (EMR) to document physical health and/or behavioral health care/visits? If you answer “No” or “We do not use an EHR/EMR,” skip questions 9 and 10 below.”

Response	Count	Percent
Yes	186	95.4
I do not know	3	1.5
No	3	1.5
We do not use an EHR/EMR	3	1.5
Total	195	100.0

Table C-0. “Q9: Does your clinic use an EHR/EMR system that supports electronic referrals to a behavioral health provider (if you are a physical health provider) or physical health provider (if you are a behavioral health provider)?”

Response	Count	Percent
No	102	52.3
Yes	60	30.8
I do not know	28	14.4
Missing	5	2.6
Total	195	100.0

Table C-3. Q10: “Does your (clinic/health system/practice) use an EHR/EMR that can receive electronic responses to your referrals (e.g., a response that the provider accepts or declines the referral, a response that the patient was seen by the provider, a response that communicates the outcome of the referral)? (check all that apply)”

Response	Count	Percent
No, because most of the providers we refer to do not have an EHR/EMR with this functionality	32	16.4
I do not know	33	16.9
Yes	36	18.5
No, because of other reasons	98	50.3
Total	199	102.1

Table C-4. Q11: “Does your (clinic/health system/practice) use health information technology to support data analytics (e.g., to track outcomes of referrals or outcomes for individuals with SUD and/or MH conditions; and/or provider alerts/reminders for certain populations)? (check all that apply)

Response	Count	Percent
I do not know	21	10.8
No, we do not use technology for analytics	27	13.8
Yes, for referrals	75	38.5
Yes, for alerts/reminders	77	39.5
Yes, for patient outcomes	117	60.0
Total	317	162.6

Table C-53. Q12. “Do you use Collective Tools (formerly known as Collective Medical Technology, Premanage) to find out when your patient was seen or treated in the hospital or emergency department?”

Response	Count	Percent
Yes	100	51.3
No	67	34.4
I do not know	28	14.4
Total	195	100

Table C-6. Q13: My (clinic/health system/practice) engages in ongoing efforts to improve coordination and service delivery across medical and behavioral health care.

Response	Count	Percent
Agree	94	48.2
Strongly agree	75	38.5
Strongly disagree	17	8.7
Neither agree nor disagree	6	3.1
I do not know	2	1.0
Disagree	1	0.5
Total	195	100

Table C-7. Q14: Do you receive updates and/or data from the managed care organizations (MCOs) on the performance measure rates for your clinic/health system/practice?

Response	Count	Percent
No	108	55.4
I do not know	48	24.6
Yes	39	20.0
Total	195	100.0

Table C-86. Q15: What kind of assistance would you like to help your clinic improve its performance on behavioral health measures? (check all that apply)

Response	Count	Percent
I do not need help	6	3.1
Peer to peer learning collaboratives	44	22.6
Education	53	27.2
Informational sessions	59	30.3
Technical assistance	67	34.4
Regular updated performance measure data	128	65.6
Incentive payments for improved performance	137	70.3
Funding that supports innovation	159	81.5
Other (please specify)*	—	—
Total	653	334.9

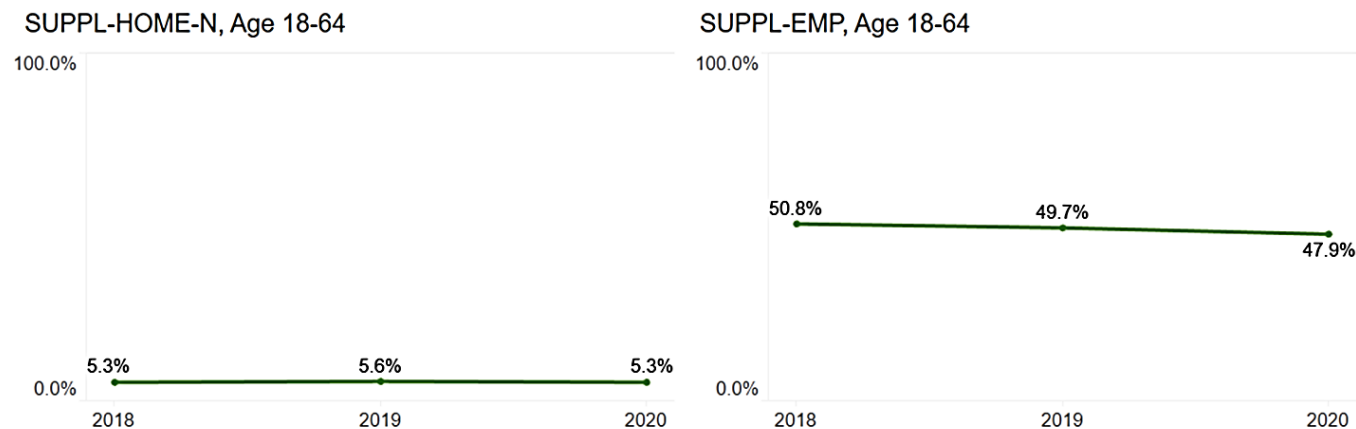
**Analyzed separately.*

Appendix D: Aggregated Statewide Performance Measure Data

For internal purposes, Comagine Health compared performance measure data, provided by RDA, in the following charts, grouped by measure category.

Category 1. Overall adult Medicaid population (age 18 to 64 including dual eligibles)

Statewide rates for 3x 1-year periods ending Q2 2020



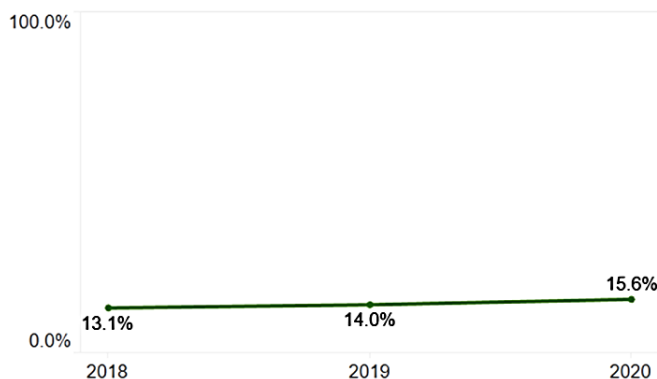
Measures (left to right):

- Overall Adult Medicaid: Percent Homeless – Narrow Definition (HOME-N)
- Overall Adult Medicaid: Percent Employed (EMP)

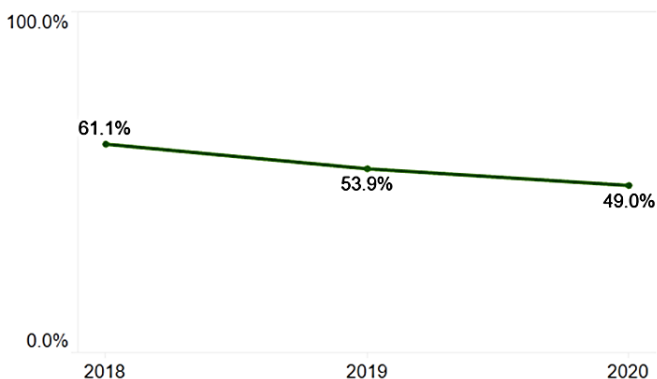
Category 2. Adult SMI population (age 18 to 64 including dual eligibles)

Statewide rates for 3x 1-year periods ending Q2 2020

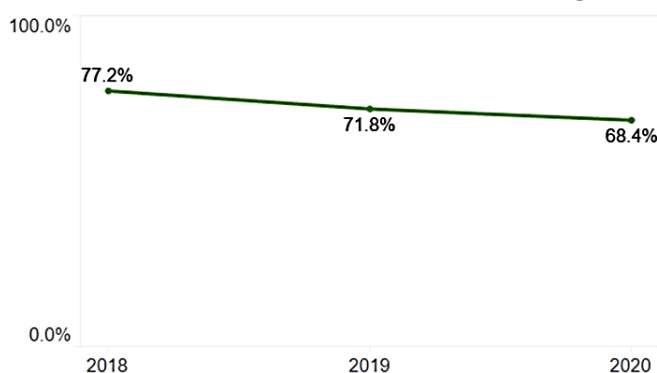
Statewide Rates with Q2 Data: HEDIS-PCR-P, Age 18+



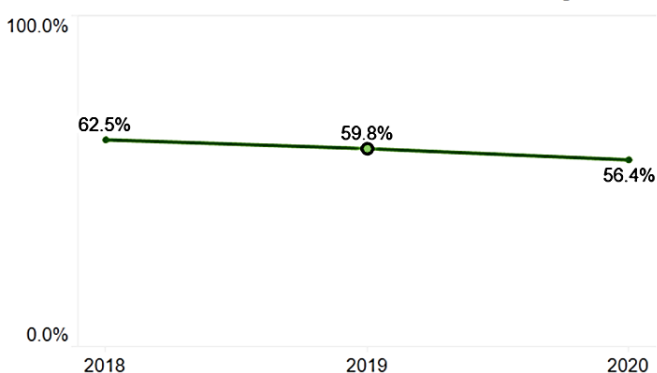
Statewide Rates with Q2 Data: HEDIS-FUH-7D, Age 18+



Statewide Rates with Q2 Data: HEDIS-FUH-30D, Age 18+



Statewide Rates with Q2 Data: HEDIS-FUM-7D, Age 18+



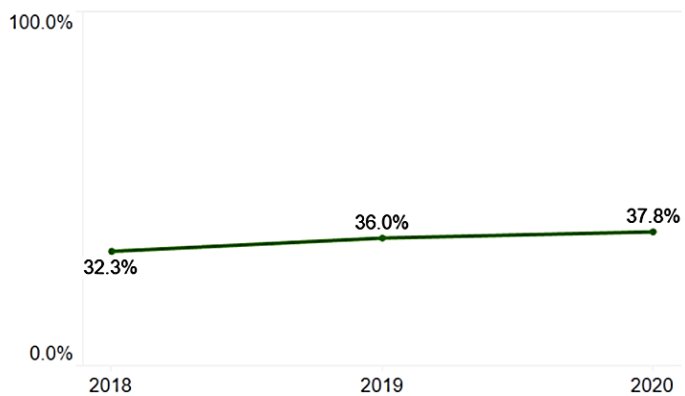
Measures (from left to right):

- Adult SMI Population: Psychiatric Inpatient 30-Day Readmission (HEDIS-PCR-P)
- Adult SMI Population: Follow-Up After Hospitalization for Mental Illness – Within 7 Days of Discharge (HEDIS-FUH-7D)
- Adult SMI Population: Follow-Up After Hospitalization for Mental Illness – Within 30 Days of Discharge (HEDIS-FUH-30D)
- Adult SMI Population: Follow-up after Emergency Department Visit for Mental Illness – Within 7 Days of ED Visit (HEDIS-FUM-7D)

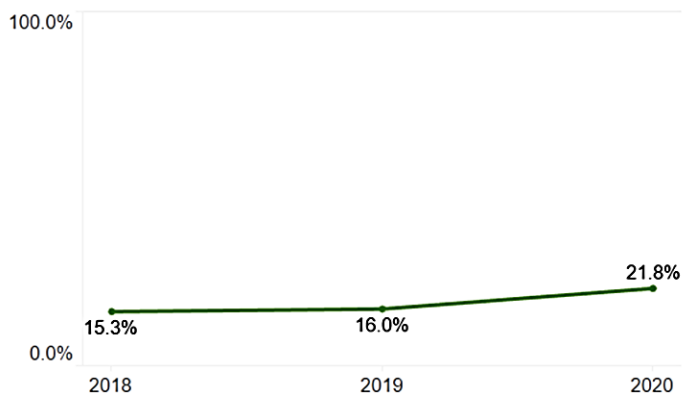
Category 3. Adult SUD population (age 18 to 64 including dual eligibles)

Statewide rates for 3x 1-year periods ending Q2 2020

Statewide Rates with Q2 Data: SUPPL-SUD, Age 18+



Statewide Rates with Q2 Data: HEDIS-FUA-7D, Age 18+



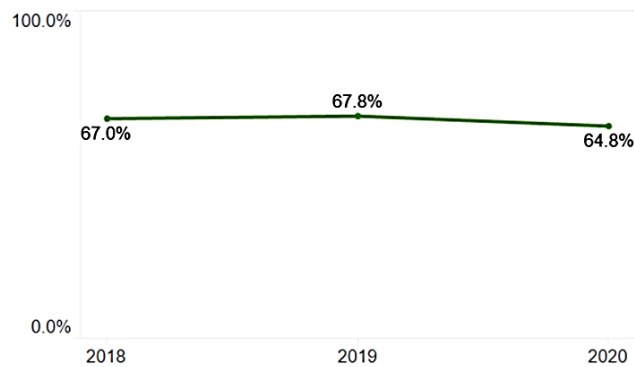
Measures (left to right):

- Adult SUD Population: Substance Use Disorder Treatment Penetration (SUD)
- Adult SUD Population: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence - Within 7 Days of ED Visit (HEDIS-FUA-7D)

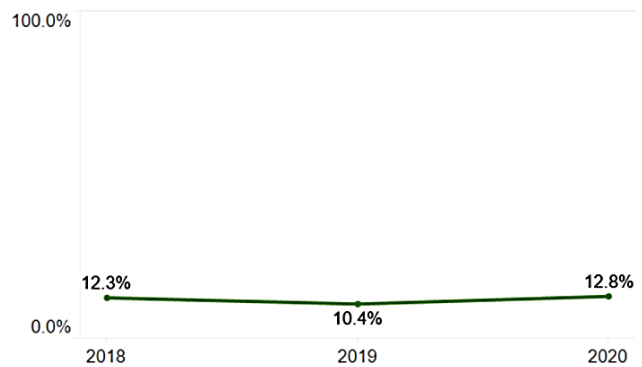
Category 4. Children age 6 – 17 with mental health needs

Statewide rates for 3x 1-year periods ending Q2 2020

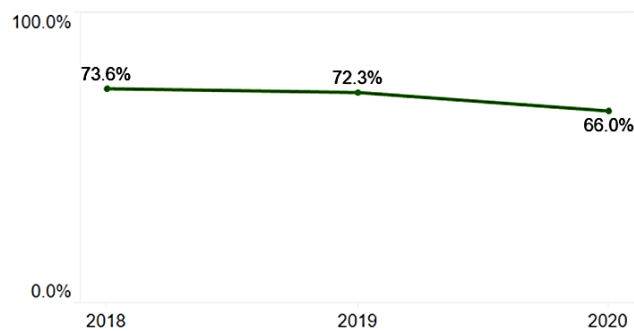
Statewide Rates with Q2 Data: SUPPL-MH-B, Age 06-17



Statewide Rates with Q2 Data: HEDIS-PCR-P, Age 06-17



Statewide Rates with Q2 Data: HEDIS-FUM-7D, Age 06-17



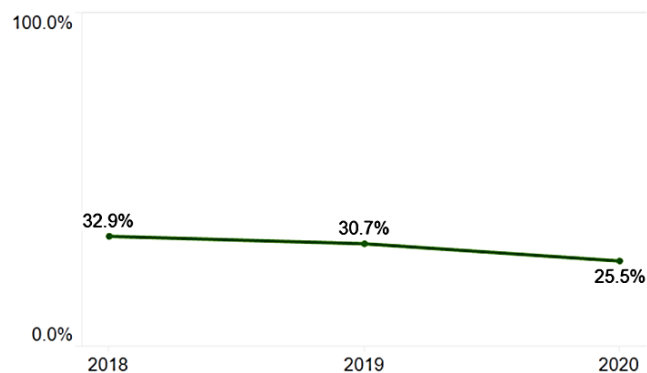
Measures (left to right):

- Children age 6-17 with mental health needs: Mental Health Treatment Penetration – Broad Definition (MH-B)
- Children age 6-17 with mental health needs: Psychiatric Inpatient 30-Day Readmission (HEDIS-PCR-P)
- Children age 6-17 with mental health needs: Follow-up after Emergency Department Visit for Mental Illness – Within 7 Days of ED Visit (HEDIS-FUM-7D)

Category 5. Children age 10 – 17 with SUD

Statewide rates for 3x 1-year periods ending Q2 2020

Statewide Rates with Q2 Data: SUPPL-SUD, Age 10-17



Measure: Children Age 10-17 with SUD: Substance Use Disorder Treatment Penetration (SUD)