Organizational Assessment Toolkit for Primary and Behavioral Healthcare Integration

Section 1: Introduction to the Toolkit

The Organizational Assessment Toolkit for Primary and Behavioral Health Integration (OATI) was designed by the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) to help organizations adopt integrated care successfully to improve care, lower healthcare costs, and save lives. CIHS also wishes to acknowledge the contribution of ZiaPartners, Inc, and MTM Associates, Inc. to the development of the OATI as a whole, and to the creation of specific tools within the OATI.

This toolkit can support your entire organization as you assume the challenges of developing an integrated primary and behavioral health organization. It is specifically helpful for:

- Primary care providers of any type, including hospital-based health systems, federally qualified health centers (FQHCs), rural health centers (RHCs), community health centers, and private practice settings.
- Behavioral health organizations of any type or in any setting, including specialty addiction, mental health, developmental disabilities, and traumatic brain injuries providers; geriatric, adult, or youth services; homeless settings, criminal justice, outpatient, and inpatient/residential settings.
- Organizations working on integration independently, primary and behavioral health organizations working as partners, and/or teams of provider organizations working in an organized network collaboration.
- Organizations fully committed to becoming a person-centered medical home, specialty care health home, or person-centered health neighborhood and/or participating in an accountable care organization or regional health collaborative.
- Organizations that want to achieve better outcomes for individuals and families with complex health and/or behavioral health needs.
- Organizations just beginning the integration process as well as those well along in their integration projects and change processes.
- Organizations working within any resource base, funding model, or delivery system, regardless of whether or not they have co-located services, specialty onsite staff, financial incentives, or grant funding to support integration.

Key Concepts

This section summarizes the key concepts that contributed to the design of this toolkit:

- Organization-wide Assessment and Improvement
- Bidirectional Integration of Primary and Behavioral Healthcare services
- Customer-Oriented Continuous Quality Improvement

Organization-wide Assessment and Improvement

The OATI is designed to help entire organizations, or organizational partnerships, make progress in improving the delivery of integrated primary and behavioral health care to populations with complex needs. IT IS NOT DESIGNED TO FOCUS ONLY ON SPECIALTY PRIMARY AND BEHAVIORAL HEALTH INTEGRATION PROGRAMS. The premise of the OATI is that individuals with co-occurring primary health, behavioral health, and human service needs are an expectation in ALL programs in any primary health or behavioral health organization or organizational partnership. Therefore, ALL programs need to be assessing and improving their capability to deliver integrated services, within whatever resource base or staffing complement they currently have.

Frequently, the OATI will be initially utilized by a specialized "integrated program", such as a grant funded integrated primary and behavioral healthcare home (as might be funded by SAMHSA-HRSA PHBHI grants, as well as other grant programs). The OATI can certainly be helpful for the specialized program to use the tools (in Section 2 of the OATI) perform a baseline self-assessment of its integration capability, and then to develop an improvement plan for that program.

However, the more important purpose of the OATI is to help to leverage change in all the programs in the larger organization (or partnership) of which the specialized integrated program may be just a small part. The specialized program may be an "early adopter" that helps to bring the message to scale in order to support sustainability of primary and behavioral healthcare integration over time. The OATI helps the larger organization to answer the following questions:

- How will the larger organization(s) use the learning and experience from the pilot "specialty integration program" to support sustainable organizational improvement in the delivery of integrated services in all programs, within base resources?
- For example, how do "routine" case management services for adults or children with serious disabilities, or "routine" residential substance abuse services, or "routine" primary health clinics or urgent care centers improve their ability to deliver integrated primary and behavioral health care?

Further, the OATI is designed as well to support progress in any type of organization or any type of program whether or not that organization has obtained grant funding for a specialty integrated health home, whether or not that program can afford to hire additional specialty health or behavioral health staff, and whether or not the program in the near term has the ability to provide co-located health and behavioral health programming.

The OATI is designed so that any program in any primary health or behavioral health organization (and hopefully, every program in every primary health or behavioral health organization) can perform a range of self-assessments, establish a baseline, and proceed with successful, sustainable, and measurable improvements that result in improved integration of care and improved outcomes for individuals and families with co-occurring health and behavioral health needs.

Bidirectional Primary and Behavioral Healthcare Integration

Bidirectional integration[1] is the systematic coordination of mental health and substance abuse care (i.e., behavioral healthcare) with physical healthcare services (e.g., primary care). Since physical and behavioral health problems often occur simultaneously, integrating services to treat both types of problems achieves the best results, and people who receive integrated care prefer it, finding it the most acceptable, convenient, and effective approach to obtaining care.[2]

The hallmark of integrated service delivery is for primary and behavioral healthcare staff to work as integrated teams, in which each "team member" assumes responsibility for participating in integrated service delivery for the benefit of the person receiving care. Ideally, teams are organized so that primary health and behavioral health clinicians can work in the same setting. However, given the variability and complexity of organizational delivery systems, the "product" of integrated care can be organized and delivered in many different ways, with many different structures.

Organization-wide Bi-directional Primary and Behavioral Healthcare Integration involves two simultaneous processes:

1. The ongoing development of an organizational culture centered around high quality customer service that ensures every staff member's focus remains on the experiences and outcomes of customers with both physical and behavioral health needs.

2. A comprehensive, system-level transformation of different aspects of the organizational process, structure, programming, practice, and financing that ensures the provision of seamless integrated care.

Successful integration requires a complete review and redesign of an organization's service delivery. Assuming that most of the people you serve have both physical and behavioral health needs, you will need to review every program, policy, procedure, and practice, and staff member to implement integrated services that achieve the best outcomes at the lowest cost.

Hallmarks of Integration:

- Integration is a process that occurs over time in the *entire* organization.
- Integration activities create a system of care in which your organization operates.
- Integration is more than having a good referral partner, care capacity, or a co-located site. It is more than a behavioral health center becoming or acquiring an FQHC. It is more than an FQHC

[1] Throughout this toolkit, the word "integration" pertains to the bidirectional model of integration

[2] Lopez, M., et. al. (2008). Connecting Mind and Body: A Resource Guide to Integrated Healthcare in Texas and the United States. Hogg Foundation. Austin, Texas.

hiring mental health and substance abuse specialists or becoming certified as a community mental health center or substance abuse clinic. It is more than achieving certification as a person-centered medical home/health home (see below).

- Integration is more than a particular tool (e.g., PHQ 9), diagnostic combination (e.g., depression and diabetes), process (e.g., SBIRT), or evidence-based program (e.g., IMPACT).
- Integration involves multiple organizational components changing simultaneously in different timeframes. While some change process is linear, it also involves working through a series of rapid-cycle changes as you make progress.
- Integration is a fully articulated "customer-oriented continuous quality improvement process," not a time-limited project. The integration journey never ends because there are always new challenges, new populations, new improvement opportunities, and new partners.

Customer-Oriented Continuous Quality Improvement

Organization-wide change may seem daunting in complex organizations facing multiple clinical, organizational, and financial challenges. Fortunately, there is a well-established organizational process, termed customer-oriented continuous quality improvement, which can – and should - be utilized by organizations of any size to make progress within base resources. Further, as will be seen in the next section of this introduction, development of broad capability for utilizing continuous quality improvement strategies to improve care is a core feature of acquiring Person-Centered Medical Home Certification, as well as a core feature of the national movement to achieve the Triple Aim of Improved Customer Experience, Improved Cost, and Improved Health, as defined by the Institute for Healthcare Improvement.

The OATI is designed to help any organization or organizational partnership (and any program within that organization or partnership) to make progress by utilizing customer oriented continuous quality improvement strategies and techniques to improve integrated care delivery. Each tool in Section 2 of the OATI provides an opportunity for an "improvement team" to perform a baseline self-assessment to "study the process" of how care is currently delivered for individuals with both primary health and behavioral health needs. Once that baseline is established, the improvement team can then select improvements to target, engage in plan-do-study-act Rapid Change Cycles, and identify measurable indicators of progress to demonstrate success. The core elements of customer-oriented continuous quality improvement help to keep the process grounded and achievable:

- **Customer First**: Always focus on improving the customer experience for individuals who present with co-occurring health and behavioral health needs. This approach helps to stay on track when there are many competing priorities.
- **Progress Not Perfection**: The initial goal is not to improve everything at once. Continuous quality improvement is not a compliance audit. The initial goal is to select achievable improvements that can be accomplished within available resources in a reasonable time frame. Further, in a complex organization or system, each program can be working on its own improvements. This results in significant progress across the whole organization even though each program may only be making small steps.

- **Continuous Cycles of Change**: Finally, progress is achieved by continuous improvement over time. Once each rapid change cycle is completed, the organization (and its programs) then can choose the next improvement targets based on their self-assessments, develop new rapid change cycles with new indicators of progress, and keep going.

The tools in the OATI are designed to be used repeatedly – for example, at annual intervals - to help the organization monitor overall progress, as well as to use repeated self-assessments to select new improvement targets.

Further, an important section (Section 3) of the OATI is a Customer Oriented Continuous Quality Improvement Reference Guide. This section is not a "tool" per se, but instead is a set of materials that focus on the provision of basic guidance on how to do rapid cycle change, and some examples of common starting places for improvement, along with recommended indicators that any program or organization might use to guide development of its rapid cycle change activities. This section also identifies some common traps or barriers that organizations encounter, and provides guidance for how to avoid those traps. Finally, this section includes an optional tool (QI-IQ) for assessment and improvement of the organization's overall capability for utilizing customer-oriented continuous quality improvement to manage significant change.

Integration and Person-Centered Medical Home Certification

Many organizations working on integrating care seek certification as a person-centered medical home (PCMH). These organizations use the National Committee for Quality Assurance (NCQA) PCMH Accreditation Standards (*see more detailed definitions and references in the Appendix*). The current NCQA PCMH standards, as of November 2011, require attention to primary and behavioral healthcare integration for PCMH certification. However, achieving certification does NOT mean that a program has become "completely" integrated. Further, achieving certification in one program does not imply that there has been progress in an entire organization or organizational partnership. Finally, progress in integration can occur without seeking NCQA PCMH certification.

The NCQA PCMH Accreditation Standards are very helpful. They have six core focus areas with associated service delivery requirements. The following table outlines these, and provides a focus on how the standards related to provision of integrated services. Sections in bold italics can be adapted to address primary and behavioral health service provision. Regardless of whether an organization seeks PCMH status, these standards provide a valuable framework for integration.

NCQA Standards Focus Area	Key Service Delivery Requirements
Enhance Access and Continuity	a. Provides same day appointments, ***including access to primary and behavioral healthcare collaborative care*** b. Defines roles for clinical and nonclinical care team members ***in relation to provision of integrated care***

Identify and Manage Patient Populations	a. Maintains an up-to-date problem list for patients with current and active diagnoses, ***including physical and behavioral health conditions*** and allergies (i.e., medication allergies and adverse reactions more than 80% of the time) b. Measures blood pressure, height, weight, body mass index (BMI), and tobacco use in more than 50% of patients c. Uses standardized tools to conducts comprehensive integrated care assessments, including screening for behaviors that affect health, patient/family behavioral health history, developmental issues, and depression
Plan and Manage Care ***Each requirement specifically attends to co-occurring physical and behavioral health issues***	a. Systematically identifies and treats the three most important conditions b. Establishes criteria and systematic processes to identify high-risk or complex patients and determines percentage of high-risk patients in its population c. Collaborates with patient/family to develop and provide an individual care plan, including treatment goals that are reviewed and updated at each relevant visit
Provide Self-care Support and Community Resources	a. Develops and documents patients' self-management abilities ***for physical and behavioral health issues*** and develops plans that include providing self-management tools at least 50% of the time b. Counsels patients/families to adopt healthy behaviors at least 50% of the time c. Tracks referrals provided to patients/families, ***including for collaborative primary and behavioral healthcare care*** d. Offers opportunities for health/***behavioral health*** education and peer support
Track and Coordinate Care ***Each requirement specifically attends to co-occurring physical and behavioral health issues***	a. Coordinates specialists' reasons for referrals, establishing and documenting agreements with specialists for case co-management b. Demonstrates the capacity for electronic exchange of key clinical information between clinicians c. Demonstrates electronic exchange of key clinical information with another care facility
Measure and Improve Performance ***Each requirement specifically attends to co-occurring physical and behavioral health issues***	a. Receives data on at least three preventive care measures, three chronic or acute care measures, and two utilization measures affecting healthcare costs b. Stratifies performance data for vulnerable populations c. Conducts surveys to evaluate patient/family experiences on at least three of the following: access, communication, coordination, and whole person care d. Sets goals to improve at least three outcome measures e. Involves patients/families in quality improvement teams or on the practice's advisory council f. Tracks results over time and assesses the effect of its actions

The Major Components of This Toolkit and How They Fit Together

The Five Sections of the OATI

- **Section 1: Introduction (The Current Section)**
- **Section 2: The Four Major Self-Assessment Tools**
- **Section 3: Customer Oriented Continuous Quality Improvement Reference Guide**
- **Section 4: Addendum: Optional Tools and Materials for Change Management**
- **Section 5: Appendix: References and Materials on Primary and Behavioral Health Integration**

The Four Major Self-Assessment Tools

Section 2 of this toolkit provides organizational integration readiness and capability self- assessment tools.

While the 4 tools in this Section are designed to be used in order, each tool can stand alone as an integration aid.

For those working toward PCMH certification, this toolkit incorporates PCMH certification criteria throughout. To easily locate these items in the tools, note that:

1. Each item that specifically relates to PCMH certification is flagged as "**PCMH***"
2. The appendix contains a crosswalk that lists each of the PCMH criteria relevant to integration, and where it is addressed in the toolkit.

The four major building blocks for assessing organizational capability and readiness are:

1. **Partnership Checklist**: Assessing an organization's need for a partner, its potential contributions to the partnership, and identifying next steps for how to develop more effective partnerships
2. **Executive Walkthrough:** Defining a customer oriented change process by assessing and improving the "customer experience" of individuals who have health and behavioral health needs.
3. **Administative Readiness Tool (ART):** Assessing and improving key administrative practices and processes that are necessary for successful delivery of integrated care
4. **COMPASS Primary Health-Behavioral Health (COMPASS PH-BH):** Assessing and improving clinical policies, procedures, practices, and processes that contribute to successful delivery of integrated care – in any program - within base resources.

Section 2 includes the four tools, in order, with instructions for their use. It is recommended (but not required) that you use the tools in the sequence listed. Organizations (and programs) may choose which tool (or tools) is most useful as a starting place, and proceed from there.

Note that for an organization wide change process, it is usually helpful, before using any of the tools, for the organization leadership to articulate an overall vision of integration, engage the different parts of the organization as change partners, identify a "change team" to manage the process and to identify the best next step strategies for success, including how to best use the OATI Tools in Section 2. In addition, the organization can use the Partnership Checklist (either on its own or with a potential partner) to determine whether the change process (and use of the various tools) will proceed unilaterally, or will be done in the partnership.

It is common that different parts of the organization or the organizational partnership will be in different stages of readiness to proceed. Remember: Progress not perfection. Organizational change often proceeds most successfully by simply finding the best next step that the organization, its partners, and each of its programs can and will take. A key element of continuous quality improvement is to acknowledge and measure these small steps of success.

Customer Oriented Continuous Quality Improvement Reference Guide

As described earlier in the introduction, this section provides a brief overview of the basic approach to Plan-Do-Check-Act cycles and Rapid Cycle Change, and then illustrates the application of continuous quality improvement strategies to common improvement areas that are likely to emerge from the organizational self-assessment tools in Section 2.

These common starting places are listed below:

- **Creating a Relationship (PCMH 1)**
  - Customer service (welcoming, hope, and engagement)
  - Facilitating integrated access
  - Improving "rate of return" (continuity)
- **Seeing the Issues (PCMH 2)**
  - Screening and identification
  - Integrated assessment documentation
- **Providing Helpful Care (PCMH 3)**
  - Integrated Care Planning and Stage-Matched Interventions
  - Implementation of Collaborative Care and Disease Management Protocols
- **Providing Cost-effective Care**
  - Maximizing Revenue Flow for Integrated Care Delivery
  - Improving Outcomes for High Utilizers
- **Supporting Self-care (PCMH 4)**
  - Implementing self-management skills training
  - Providing access to peer health coaching and recovery support
- **Working as a Team (PCMH 5)**
  - Information Sharing
  - Cross Consultation, Collaboration, and Teamwork
- **Building a Capable Workforce (All PCMH)**
  - Workforce Development

It is suggested that each change team reviews this section after using the tools in Section 2 to help develop a successful, achievable and measurable improvement plan based on what it learned during the self-assessment process.

This section also includes an optional tool (**QI-IQ)** that an organization may use to assess and improve its overall capability to use customer oriented continuous quality improvement to manage complex change, with a specific focus on improving integrated care.

Addendum: Optional Tools and Materials for Change Management

This section includes additional materials developed by CIHS that OATI users can utilize, or not, at their discretion. The materials include a guide for strategic planning related to integration, as well as various project management templates and matrices. It is suggested that each organization review these materials quickly, to determine whether they address any gap the organization might have in strategic planning and implementation of complex organization-wide or system-wide change.

Appendix: Reference Materials on Primary and Behavioral Health Integration

These materials are provided in this section for the convenience of the user, and incorporate a range of useful clinical tools, program references, integration materials, and helpful links that have been collected by the Center for Integrated Health Solutions. Note that these materials are current as of the date of the release of the OATI, and are continuouly improving and expanding. Please feel free to contact CIHS for any information about updated materials.

Contact Information

For further information on the toolkit, or to explore the availability of technical assistance in using the tools, the following contact information may be helpful:

For CIHS

For MTM Associates

For ZiaPartners, Inc.: Kenneth Minkoff, MD kminkov@aol.com

Partnerships

What do we mean by "partner"?

A partner is a collaborator in service provision that works in another field than yours. For example, a primary care clinic may partner with a behavioral health organization, or vice versa. Programs within the same organization may also partner with each other, or a behavioral health organization may establish a health clinic at one of its sites. At the more advanced level, providers may partner in large networks to meet broader community needs.

Advanced Integrated Care Partnerships

- A network of community behavioral health partners may collaborate with other organizations to address a range of needs in a community. For example, a network of community-based organizations providing health and/or behavioral health services may partner with one or more hospitals.

- Many communities have formed networks to partner with emerging accountable care organizations, regional health partnerships, and other emerging funding and coordination structures that manage health and behavioral healthcare for large populations.

Whether or not you need a partner depends on your circumstances and community. FQHCs and community behavioral health organizations have compatible missions, and often, long histories of providing care in their communities. Their partnerships build on existing strengths cultivated through a history of community collaboration. In communities where there are existing public health and behavioral health providers, partnering is a good first option. Eventually, all health and behavioral health organizations will need to identify partners as part of each community's "integrated" system of care because it is likely that no single organization will provide all the services that the community needs in one place.

Do I need a partner to start my integration work?

You do not need a partner to get started on integration. This toolkit can guide you in indentifying a strategy to provide integrated care. Begin on your own, but determining if you need a partner is a first step.

How do I find a willing partner?

Many organizations report difficulty identifying partners for various reasons: their potential partners seem more competitive than collaborative; they have approached potential partners and received no response or have been put off indefinitely; they provide services in an isolated area where there are no obvious partners that share their population or mission. Keeping these possible obstacles in mind, the following checklist can help you develop a partnership.

Tool 1: Partnership Checklist

- ☐ Within the full array of primary and behavioral health services (e.g., types of services, levels of care), list the services that your organization already provides. Then, list the services that are needed but not provided, or provided only to a limited degree (e.g., a large behavioral health organization provides a range of mental health and substance abuse services, but would like to include primary care services for those without a primary care doctor).
- ☐ Identify all potential community provider partners that offer the services on your list.
- ☐ Prioritize potential partners that share your agency's mission, vision, and values, including those that focus on helping the neediest members of your community.
- ☐ If you do not recognize an obvious partner, identify where your customers currently receive those services. In a community with no community health clinic or FQHC, ask the people you serve where they receive primary care. The providers identified may be your best potential partners. Also consider the following:
    - If my organization offers assistance, can we actually deliver? For example, as a behavioral health organization offering to provide collaborative services to a potential partner, do we have a mechanism for providing timely access to consultation requests and referrals? If we are a primary health partner offering to provide collaborative services to a behavioral health provider, are we prepared to welcome and engage individuals who present for health services and have signs and symptoms of a behavioral health problem?
    - If we cannot currently deliver on what we would like to offer, are we willing to acknowledge our limitations and commit to working transparently to improve in order to better meet the our partner's needs?
    - Before approaching any potential partner, consider the following:
        - Is my organization providing services that a partner might perceive as a competitive threat? If so, are we prepared to be a supportive partner rather than a competitor?
        - What is my organization prepared to offer a potential partner? What is my organization's business case? Rather than asking what a partner can do for you, think about what they may need and express willingness to help them. The core value elements of a viable partner's business case suggests an organization should have:
            - Timely and cost effective access to collaborative treatment, including curbside consultation

- Efficient service capacity (i.e., providing high quality services at the lowest possible cost)
- Electronic health record capacity to connect with other providers and electronically transmit important clinical data
- Ability to focus on episodic care needs and treat to target models
- Ability and willingness to participate in bundled/shared risk payment models.
- Outcomes that demonstrate that the organization can:
    - Engage the people it serves in natural support networks
    - Help individuals self-manage their whole health, wellness, and recovery
    - Reduce the need for emergency and high cost services for complex populations

☐ When approaching a potential partner, identify small outcomes for the initial meetings. It may take several meetings to get to know one another. Remain focused on how your organization will provide value to your partner before focusing on how the partner will meet your needs. Consider job shadowing to gain perspective on how your potential partner operates day-to-day.

☐ Read and review this toolkit together as an initial partnership-building activity. The toolkit can start a valuable conversation about how much change is needed and how you can begin to help one another provide better services.

Do I need a partner to use this toolkit?

- If you do not currently have a partner, you can use this toolkit to progress the integrated services you already provide. This will position you as a better partner in the future.

- If you have a partnership, use the toolkit *internally* to perform a self-assessment and develop improvement plans within your own organization and *externally* to perform a collaborative self-assessment and develop collaborative improvement plans.

- If you are just beginning a partnership or are in early conversations with a potential partner, the toolkit can point to partnership-building activities to enhance openness and trust and identify starting points for collaboration.

THE EXECUTIVE WALKTHROUGH

This tool can help leadership see the organization(s) through a customer's eyes. It is helpful to perform this exercise for both your and your partner's organization. Customer-centered service orientation within delivery processes often represents a profound culture shift. This shift's depth and breadth cannot be underestimated. Your entire organization and that of your partner's must be involved in the shift, from top management to support staff. The goal is to stop viewing customers as a burden and start seeing them as your best partners. They can help you achieve inspired outcomes collectively. To succeed, everyone in the organization must view customers as essential partners in the change process.

Before adding primary health-behavioral health services or reaching out to collaborative partners, it is critical to understand how your clinical staff and support staff engage as a team to create a welcoming, efficient, and effective customer experience. You'll need to develop a shared customer service philosophy and analyze the functions that take place when customers contact your organization for help. It also involves individual staff attitudes and staff members' understanding of their roles within the organization.

A helpful starting place is to engage clinical and support staff in a conversation about their "customer service philosophy." Ask them how they view the organization's customer service philosophy. There are typically three customer service philosophies in use: client focus, consumer focus, and customer focus.

What's the difference between client, consumer, and customer focused philosophies?

Customer Service Focus Summary[3]

Client Focus	Consumer Focus	Customer Focus
They are not empowered	They are somewhat empowered	They are fully empowered
They usually don't know what they need	They tend to know what they need	They know what they want and need
They have little or no choice	They have choices	They have choices
They are here to receive treatment	They are here to utilize service opportunities	They are here to participate in their recovery
They Need Us!	**They Choose Us!**	**We Choose Each Other!**

[3] Lloyd, D. (2002). *How to Deliver Accountable Care.* Washington, DC: The National Council for Community Behavioral Healthcare.

When your staff begins discussing and defining each term, it invites exploration of current attitudes and helps your organization move from a client focus to a customer focus.

To help your senior management team, and that of your organization's partners, evaluate the current level of customer service, it is important to move beyond anecdotal information and to experience firsthand the level of customer service actually provided. That is the purpose of the executive walkthrough.

Purpose of the Executive Walkthrough

To assess the customer service levels your organization has achieved, it is important to use objective data in all phases of the measurement process. It is strongly recommended that you begin using this toolkit by using the executive walkthrough protocol.

Instructions

1. Plan to complete an executive walkthrough for each population served (e.g., one walkthrough as an adult customer, one as a child/adolescent). Alternatively, if you have multiple locations with varying access to treatment processes, use the executive walkthrough for those locations or programs. There can be significant variation in customer experience from one location to another. Pay particular attention to those settings that have a history of barriers to access.

2. All senior management team members should participate in at least one of the walkthroughs, including the executive director/CEO and clinical director. If your organization works with a partner, the management team members should walk through both their own organization and their partner's organization. This will provide better information on the access experience of a customer referred from one organization to the other.

3. Two individuals should pair up for each walkthrough, with one serving as the "test client" and the other as an "observer/recorder." The test client will actively engage in the process; the recorder will observe and collect data and not actively engage in the process.

4. Using adaptations of actual cases of customers accessing services at your center, each test client should develop a basic customer profile that team members can use to complete the walkthrough steps (e.g. presenting problem, demographics, insurance type, symptoms, functional deficits, needs). Given the focus is on primary and behavioral healthcare integration, your test client profile should have a combination of health and behavioral health issues that may be relevant to the initial contact with care. The walkthrough will not involve 'role playing' (i.e., 'acting' like a real client). However, to experience both the clinical and administrative aspects of the access process (e.g., screening questions, wait times, and documentation requirements), it will be important to possess clinical information to provide to clerical and clinical staff.

5. Call the access unit/primary access number, introduce yourself to the staff member using your actual name and title, and inform him or her that this is part of an executive walkthrough. Clarify that you want the person to continue in the same way he or she would with any referral. Ask that he or she not provide you with any special considerations. At this point, use a fictitious

name. Ask the staff member to use this name when setting up the initial contact and any future appointments and not tell other staff members the actual purpose of the appointment.

6. Indicate that you want to schedule an appointment.

7. As the walkthrough progresses, complete *all* paperwork normally required of a new customer.

8. The recorder will use the attached "Executive Walkthrough: Data Collection Instrument" to record time intervals, observations, etc. After each phase of the access process is completed, the test client and observer/ recorder will discuss and complete the rest of the questions for that particular section.

9. Upon completion of the walkthrough, senior management should discuss the experience from the test client and observer/record perspective and complete the following "Summary of Findings" form.

10. Your organization should use the findings in your integration process and repeated periodically to assess progress and identify continuing improvement opportunities.

Executive Walkthrough

Data Collection Instrument

Organization: _____

Walkthrough Participants: (Name and Title)

_____

_____

First Call for Service

Date of first call for service: ____/___/____

Was there a phone recording?	☐ Yes	☐ No
If yes, were menu options clear and useful?	☐ Yes	☐ No
Was it easy to access a *person* on the phone?	☐ Yes	☐ No
Was the person on the phone welcoming and respectful?	☐ Yes	☐ No
Were financial options explained to you?	☐ Yes	☐ No
Were you able to get an initial appointment date on the first call?	☐ Yes	☐ No
What was the date of the earliest offered intake appointment?	____/____/____	
What was the actual date of the appointment you made	____/____/____	

Comment on first call for service (please explain/describe any positive or negative observations:

As a customer with both primary health and behavioral health needs, did you experience the initial contact as "welcoming" you for help with *all* your needs? Comment on welcoming, unwelcoming, and neutral aspects of the experience.

Data Collection Instrument

Initial Appointment

Date of initial appointment ___/___/___ Time of arrival: ___:___ am pm

Were the intake/admin staff welcoming and respectful? ☐ Yes ☐ No

Were you asked to complete information forms on your own? ☐ Yes ☐ No

If yes were the forms you were asked to complete:

Easy to understand? ☐ Yes ☐ No

Well organized? ☐ Yes ☐ No

Efficient? (i.e., check off, short narrative or narrative focused) ☐ Yes ☐ No

Redundant? (i.e., required entering same information multiple times) ☐ Yes ☐ No

How many different forms and how many pages did you have to fill out?

Number of Forms _____ Number of pages_____

Number of signatures required? _____

How long did it take to complete these forms? _____ minutes

Were you offered assistance if necessary? ☐ Yes ☐ No

Did the forms ask you about BOTH health and behavioral health issues, including substance use? ☐ Yes ☐ No

Did you feel safe telling the truth about yourself on the forms? ☐ Yes ☐ No

Where did you complete the pre intake forms? (e.g., home, waiting area, office) _____

Please rate the waiting area environment: ☐ Excellent ☐Good ☐ Fair ☐ Poor

Were the chairs in good repair and comfortable? ☐ Yes ☐ No

Were there current magazines/periodicals to read? ☐ Yes ☐ No

What time were you called in for first face to face meeting with clinician? ___:___ am pm

Did you have to wait after you left the lobby within the clinical area? ☐ Yes ☐ No

If YES, please confirm secondary wait time _____ minutes

How long was the wait in exam room/clinical office before services began? _____ minutes

How long did the first face to face clinical encounter take? _____ minutes

Were you asked questions already answered in pre-intake forms? ☐ Yes ☐ No

Was the clinician welcoming and respectful? ☐ Yes ☐ No

Were you asked about ALL your behavioral health and health issues? ☐ Yes ☐ No

Did you feel that the clinician would welcome helping you with ALL your behavioral health and health issues? ☐ Yes ☐ No

At the end of the appointment, did you feel like you would want to return for help? ☐ Yes ☐ No

What was the first available date provided for your second appointment? ___/___/___

What was the actual date of the next appointment you made? ___/___/___

Was the appointment scheduling consistent with your needs? ☐ Yes ☐ No

Comment on intake process and waiting area (please also include observations of staff interactions with other clients present, as well as yourself, e.g., how promptly does staff attend to clients who enter, front desk staff attitudes and behaviors toward clients):

As a client with both primary health and behavioral health issues, did you experience the initial appointment as "welcoming" you for help with *all* your needs? Comment on welcoming, unwelcoming, and neutral aspects of the experience.

Summary of Findings Form

(Senior management team completes after discussing the experiences of the walkthrough participants)

Summary of Findings:

Was the 'Executive Walkthrough' useful in helping to identify potential barriers to customer service friendly access to services for clients with primary health/behavioral health needs in your organization?

☐ Extremely Helpful ☐ Helpful ☐ Not So Helpful ☐ Not At All Helpful

Did you identify any particular barriers to access and engagement posed by your agency administrative process/ forms/etc? ☐ Yes ☐ No

If yes, please list and describe:

Did you identify any particular barriers to access and engagement posed by your agency clinical process/ forms/etc? ☐ Yes ☐ No

If yes, please list and describe:

Based on the above, what changes would you like to see in your organizations intake, assessment, and initial service processes?

The ART (Administrative Readiness Tool) for Primary Health Behavioral Health Integration

Almost every behavioral or primary healthcare organization that begins the integration journey experiences a realization: it is almost impossible to implement integrated administrative processes successfully if your basic processes are weak to start and the executive team is unaware of the current baseline functioning of each integration process.

While you may invest resources for a grant or a specially funded pilot project to develop the administrative infrastructure capacity needed to support the project, this alone will not result in a sustainable organization-wide administrative infrastructure for integration. The ART (Administrative Readiness Tool) for Primary Health Behavioral Health Integration is designed to help you assess and improve the core administrative processes needed most to support primary and behavioral healthcare integration.

> *Note that this tool will not just ask you if you believe you can collect the data. It will actually ask you to find the data. That may seem challenging, but it is best to start building your foundation early so it is ready when you need it.*

A self-assessment tool, the ART requires your management team to schedule time to meet and work through the sections. Typically, the assessment takes 6-8 hours to complete.

The six cores "values" to successfully participate in an integrated healthcare service delivery are:

1. Be accessible (fast access to all needed services)
2. Be efficient (provide high quality services at lowest possible cost)
3. Electronic health record capacity to connect with other providers
4. Focus on episodic care needs and treat to target models
5. Ability/willingness to participate in bundled/shared risk payment models
6. Produce measurable outcomes
   - Engaged clients using natural support networks
   - Help clients self manage their health, wellness, and recovery
   - Reduce need for emergent and high cost services

As your management team prepares to use ART, consider the following:

1. It is important for your team to move away from anecdotal responses to the questions such as "I think the rate is…" and to understand the actual rate or data point.
2. If there are significant variances in response levels or service process data among the management team members, it is important to identify if an ART needs to be completed for specific programs or locations (e.g., children/adolescent/pediatric vs. adult/geriatric) to identify process variances with the clinic. If it is determined that multiple ART forms are needed to assess the organization's components, add and average the question and section scores to generate an overall score for the organization as a whole.

3. If the question and section scores have more than a one point difference, the key issue to identify is if your organization is operating coherently as a "group practice" or "program team" rather than as a "loosely held federation of individual practices."

   If variance is found within program practice, integrating primary care services will be more difficult. Therefore, the ART should be used to identify internal practice and administrative support variance to reduce the time and cost of service delivery processes prior to starting integrated care efforts.

4. The self-assessment scoring model for each question and section of the ART is based on a five point scale:

5	**4**	**3**	**2**	**1**
Not a Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

The following scoring parameters must support the level of concern that your team identifies:

a. If your team does not know the answer to a question, document the score as "1." (e.g., if your management team does not know the cost and average number of days to treatment)

b. If your team knows the response to the specific primary question on the left and does not know the answer to the identified secondary questions on the right, then the score should be "2."

c. If your team cannot readily identify the response to the question, but rather has to "research" the answer, the score should be a "2" or "3" based on how long it took to obtain the data needed to respond. Longer research means a lower score. The key concern in this case is that the management team members do not have an awareness level that will support their routine use of the data to make more objective decisions about the service delivery process or to support coaching/mentoring/improvements.

d. If your team identifies a level of practice variance within programs or locations, the score should be a "2" or "3" based on the level of variance identified and the amount of effort it will take to standardize the practice.

At the end of each section of the ART, there is a "total cumulative score" indicator that will allow your team to total all individual question scores in a section. Also, at the end of the ART, there is a scoring sheet that provides for transferring the sections' cumulative scores to an overall score summary with recommendations for next steps.

Outline of the ART Sections: (Sections A-G, K, M: PCMH*)

A.	Clinic has a time and cost effective **access to treatment** process
B.	Clinic has Centralized Electronic **schedule management** system
C.	Clinic has implemented **caseload management** to support appropriate utilization levels
D.	Clinic has **re-engagement/transition procedures** for current cases not actively in treatment.
E.	Clinic has **real time documentation support** processes
F.	Clinic has **cost based key performance indicators (KPIs)** for all staff and a measurement capacity to support coaching/mentoring activities by supervisors/managers
G.	Clinic has integrated KPIs into the job descriptions of all staff and into the **performance evaluation** model used
H.	Clinic has implemented **internal utilization management functions** including credentialing support for clinical staff; pre-certs, authorizations and re-authorizations; and referrals to clinicians credentialed on the appropriate third party/ACO/medical home/health home panels
I.	Clinic has a **diversified payer mix**
J.	Clinic has **appropriate revenue cycle management** including co-pay collections and claim submission
K.	Clinic has **outcome assessment capacity** and measurement tools to integrate achieved outcomes into support service delivery process change
L.	**Community awareness**, branding and market share
M.	Clinic has **decision making** and change management capacity including the use of Rapid Cycle Change models

Administrative Readiness Tool (ART)		
Clinic Name:		
Section A: Access to Services		
1. From the clinical providers' perspective, are the caseloads in the clinic "full" at this time?	☐ Yes ☐ No	

☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

2. Does the clinic measure/know the cost and average number of days from first call for help to initial appointment? Answer this both in general, and for referrals for collaborative PRIMARY AND BEHAVIORAL HEALTHCARE care.	☐ Yes ☐ No	If YES, please indicate the cost and average days: Cost: $ **Avg.** # Days Wait:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

3. Does the clinic have written access to care policies/procedures that establish benchmarks for access? (i.e., clients admitted into services within 3 days of request) Are there standards for access for collaborative primary health/behavioral health referrals?	☐ Yes ☐ No	If YES, is the clinic compliant with the standards in the policy and procedures: ☐ Yes ☐ No

☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

4. Is there a single-point-of-entry <u>system</u>, staffed by clinicians, for all clients to enter your service system? (*This can be an actual physical location, or a consistent function that is applied across locations.)*	☐ Yes ☐ No	**If YES**, which of the following does this system provide? (check all that apply) ☐ Clinical assessment ☐ Financial assessment ☐ Preauthorization for services ☐ Initial Treatment Plan ☐ Direct admission into the appropriate clinical service ☐ Other:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
5. In general, do the access processes support timely referral acceptance requirements and reduce redundant collection of information?		☐ Yes ☐ No	Comments:	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
6. Is there awareness within the clinic of the number of requests for services being made monthly? Number of requests for service from collaborative primary health /behavioral health providers?		☐ Yes ☐ No	If YES, indicate the average number of requests for service per month for: Adults: Child/Adolescent:	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
7. Does the clinic measure/monitor the number of requests for service (total scheduled) vs. the number of "kept" intakes/assessments?		☐ Yes ☐ No	If YES, indicate the "kept" percentage: **%**	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
8. Does the clinic have a waiting list for services (defined as a request for service or an assessed need for specific services that cannot be provided due to lack of appointment capacity)?		☐ Yes ☐ No	If YES, how many clients are waiting for the appropriate service(s)?	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

	Section A Total Cumulative Score:

Section B: Centralized Electronic Scheduling				
1. Do any clinical staff maintain their own individual schedules (in books or personal calendars)? ☐ Yes ☐ No			If YES, has there been a past attempt(s) to convert staff to an electronic capacity? ☐ Yes ☐ No	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

2. Does the clinic have a software based electronic scheduling capacity?		☐ Yes ☐ No	If YES, does has electronic capacity been fully implemented clinic-wide? ☐ Yes ☐ No	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
3. Does the clinic's front desk manage the schedule for ongoing appointments?		☐ Yes ☐ No	If YES, do clinicians also manage scheduling ongoing appointments? ☐ Yes ☐ No	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
4. Does the clinic manage new requests for services though a centralized scheduling process?		☐ Yes ☐ No	If NO, do clinical staffs manage scheduling new requests for service? ☐ Yes ☐ No	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
5. Does the clinic's staff call clients prior to their scheduled appointments?		☐ Yes ☐ No	If NO, does the clinic use an electronic reminder system? ☐ Yes ☐ No	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
6. Does the clinic have an appointment back fill process for all client canceled appointments?		☐ Yes ☐ No	If YES, what is the back fill percentage last quarter for canceled appointments? **%**	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
7. Does the clinic have a "Will Call" status/list for		☐ Yes ☐ No	If YES, do the clinicians submit the Will Call	

clients seeking appointments or for clinicians who want to work a client into their schedules?		lists to the scheduler? ☐ Yes ☐ No		
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
8. If the clinic has community based staff, are their scheduled activities incorporated into the centralized scheduling process?		☐ Yes ☐ No	If NO, how are schedules maintained for community based staff?	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
9. Does the clinic have a "standing appointment" requirement for all clinical staff (i.e., staff provide centralized scheduler when they will take PTO, annual leave, meetings, etc.)		☐ Yes ☐ No	If YES, how far in advance are the standing appointments required? ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days Other:	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
10. Does the clinic have a utilization management plan in place to ensure that they only schedule clients with appropriate clinicians on the appropriate funder panels?		☐ Yes ☐ No	If NO, last year what percentage of third party/insurance and Medicare funded clients are referred to clinical staff not credentialed to serve? **%**	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
11. Does the clinic identify the specific schedule rate for each direct care staff based on the level of billable hour/direct care performance required and the percentage of no show/cancellation each staff has experienced?		☐ Yes ☐ No	If NO, how does the clinic ensure that each direct care staff meets their respective billable hour/direct service standard? (i.e., double book, etc.):	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**

Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

12. Does the clinic calculate the daily schedule rate required per clinic location to support determination of centralized scheduling capacity needed?	☐ Yes ☐ No		If NO, how does the clinic calculate the schedule rate capacity needed per location/program?	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
		Section B Total Cumulative Score:		

Section C: Caseload Management

1. How many unduplicated clients does the clinic serve? How many have both primary health and behavioral health issues?	Monthly:	Yearly:	Percent Adults: **%**	Percent Child/ Adolescent: **%**

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

2. Does the clinic use caseload size key performance standards for each individual clinician or team?	☐ Yes ☐ No	If YES, indicate the top two caseload size criteria: 1. 2.

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

3. Does the clinic use engagement strategies to support no show reduction, medication adherence and retention in services?	☐ Yes ☐ No	If YES, indicate the top two most effective strategies: 1. 2.

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

4. Do clients in general routinely receive the amount, frequency and duration of services (including integrated services) ordered in the treatment plan?	☐ Yes ☐ No	If NO, what processes are in place to help ensure fidelity between the treatment ordered in the plan and the treatment delivered?

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

5. Does the clinic have specific transfer/ discharge protocol for cases that are not actively in treatment?		☐ Yes ☐ No	If YES, are these protocols effective in transitioning cases not actively in treatment out of the caseloads?: ☐ Yes ☐ No	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
		Section C Total Cumulative Score:		

Section D: Re-Engagement and Transition Principles and Practices

1. Does the clinic track Appointment/ Attendance Codes in terms of the daily occurrence patterns?	☐ Yes ☐ No	If YES, please check all attendance code types tracked? ☐ Kept/Scheduled/Show ☐ No Show ☐ Client Canceled ☐ Staff Canceled ☐ Unscheduled ☐ Other:

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

2. Does the clinic have a standard definition for No Show versus Cancel (Staff and Client Types)?	☐ Yes ☐ No	If YES, what is the definition for: No Show: **Client Cancel:** **Staff Cancel:**

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

3. Does the clinic track the number of no shows and cancels for each clinician?	☐ Yes ☐ No	If YES, please indicate the clinics overall target performance standards for No Show/Canceled levels for: No Shows: % Client Canceled: % Clinician Cancelled: %

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

4. Does the clinic track no shows/cancellations by individual case number?	☐ Yes ☐ No	If YES, how is this information used by clinical and scheduling staff?

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**

Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
5. Does the clinic track the number of staff cancellations?	☐ Yes ☐ No	If YES, how is this information used by the supervisors?		
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
6. Does the clinic have a specific no show/canceled appointment policy and procedure?	☐ Yes ☐ No	If YES, has the policy and procedure effectively reduced the no show/canceled rates? ☐ Yes ☐ No		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
7. Does the clinic use Engagement Specialist staff to contact clients to assist in re-engaging them in treatment?	☐ Yes ☐ No	If YES, has the Engagement Specialist model effectively reduced the no show/canceled rates? ☐ Yes ☐ No		
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
8. Does the clinic track daily staff or team activity in a format that can be used for data based supervision of efficient provision of services?	☐ Yes ☐ No	If YES, how often are the daily staff activities summarized into a composite report?		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
		Section D Total Cumulative Score:		

Section E: Documentation and Support Processes

1. Please confirm the documentation model used by the majority of direct care staff in the clinic:	☐ Post Documentation (documentation of clinical services provided after the service event has concluded) ☐ Collaborative Concurrent Documentation (documentation of clinical services is a collaborative engagement process completed at the time of service with client present)

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

2. If the clinic uses primarily a post documentation model (as per number one above) please confirm the overall performance levels of staff by indicating the percentage of direct care staff that meet the clinic's documentation submission standards	1. ☐ 95% to 100% compliant 2. ☐ 80% to 94% compliant 3. ☐ 70% to 79% compliant 4. ☐ Other level of compliance: **%**

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

3. Does the clinic measure the amount of time direct care staff spends individually on documentation of services provided?	☐ Yes ☐ No	If YES, what is the average direct service to documentation ratio last quarter? **Ratio: :**

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

4. Does the clinic have documentation completion and submission standards? (i.e., all clinical documentation is to be completed within 24 hours of service event)	☐ Yes ☐ No	If YES, what is the typical documentation submission standard in the clinic?

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**

Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

5. Does the clinic monitor documentation completion and submission as part of clinicians' performance standards?	☐ Yes ☐ No	If YES, does the monitoring include accuracy of documentation as well as submission? ☐ Yes ☐ No

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

6. What type of medical/health information record documentation system does the clinic use?	☐ Paper	☐ E-Forms	☐ Fully Electronic	☐ Combination Paper/ Electronic

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

7. Has the clinic implemented an electronic health record (EHR)?	☐ Yes ☐ No	If YES, what is the primary level of clinician acceptance/approval of the new EHR? ☐ Facilitates/supports service delivery ☐ Constitutes a barrier to service delivery
7a. If YES to number ten, has the EHR been fully implemented?	☐ Yes ☐ No	If NO, what primary documentation functions are not yet operable in the EHR?

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

	Section E Total Cumulative Score:

Section F: Cost Based Key Performance Indicators (KPIs) and Measurement Capacity

1. Does the clinic have defined key performance indicators for staff related to the following requirements:	Utilization Management/ Review ☐ Yes ☐ No	Direct Service/ Billable Hours? ☐ Yes ☐ No	Documentation Completion/ Submission? ☐ Yes ☐ No
1a. If YES to any part of number one, indicate the percentage based performance standards for each of the applicable requirement areas:	Utilization Management/ Review: % ☐ N/A	Direct Service/ Billable Hours: % which equals hours per year ☐ N/A	Doc. Completion/ Submission: % in hours ☐ N/A

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

2. Does the clinic track the amount of time staff members spend on documentation vs. direct care?	☐ Yes ☐ No
If YES, please indicate the documentation to direct service ratio last quarter: :	

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

3. Does the clinic monitor the actual costs of the individual services or integrated team-based services provided?	☐ Yes ☐ No	If YES, how accurate is this cost finding? ☐ Very Accurate ☐ Somewhat Accurate ☐ Estimation		
3a. If YES to number three above, please indicate the **cost** of the following services last quarter or year:	Diagnostic Assess (90801 Non-MD): $ per ☐ Unit ☐ Hr ☐ N/A	Physical Exam: $ per ☐ Unit ☐ Hr ☐ N/A	Pharm. Mgmt. (90862) $ ☐ Unit ☐ Hr	Psychiatric Eval (90801) : $ ☐ Unit

			☐ N/A	☐ Hr ☐ N/A

☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

4. Please indicate the **average rate billed** for each of the following services:	Diagnostic Assess (90801 Non-MD): $ per ☐ Unit ☐ Hr ☐ N/A	Physical Exam (99201): $ per ☐ Unit ☐ Hr ☐ N/A	Pharm. Mgmt. (90862) $ ☐ Unit ☐ Hr ☐ N/A	Psychiatric Evaluation (90801) : $ ☐ Unit ☐ Hr ☐ N/A

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

5. Please indicate the average net revenue received (not the average rate billed) for each of the following services:	Diagnostic Assess (): $ per ☐ Unit ☐ Hr ☐ N/A	Physical Exam ($ per ☐ Unit ☐ Hr ☐ N/A	Pharm. Mgmt. $ ☐ Unit ☐ Hr ☐ N/A	Psychiatric Evaluation $ ☐ Unit ☐ Hr ☐ N/A

☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

6. Does that clinic assess how staff resources are deployed and utilized across the clinic's cost centers or units (i.e., the clinic calculates the total number of clinical FTE's and associated client and staff times needed based on caseload service hour demand)?	☐ Yes ☐ No	If NO, what method(s) does the clinic use to ensure appropriate staff/resource deployment:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
7. Does the clinic have the ability to measure key performance indicators for all staff?		☐ Yes ☐ No	If YES, is the outcome of the key performance indicator data routinely shared with all staff members? ☐ Yes ☐ No	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
8. In the decision-making process does the clinic's management team rely more heavily on objective information from KPI measurement or more heavily on anecdotal/non-measured information?			☐ Objective Measurement ☐ Anecdotal Information	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
			Section F Total Cumulative Score:	

Section G: KPIs Integrated into Job Descriptions and Performance Evaluations

1. Are all of the (integrated) performance requirements/standards that the clinic has identified for each staff incorporated into his/her individual job descriptions?	☐ Yes ☐ No	If NO, is the job description model currently being used supportive of objective measurement of staff's performance requirements? ☐ Yes ☐ No		
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
2. Are the performance, behaviors, aptitude and attitude KPI requirements for each staff position provided to candidates during application process	☐ Yes ☐ No	If NO, how does the clinic ensure that new hires can obtain the KPI requirements of the position?		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
3. Do clinical supervisors/managers provide regular supervision to clinicians that include (integrated) performance requirements and needs?	☐ Yes ☐ No	If NO, how are clinical staffs held accountable for their KPIs?		
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
4. Are the performance evaluations used by the clinic supportive of holding staff accountable for required individual performance requirements?	☐ Yes ☐ No	If NO, what tools are used to hold staff accountable for their individual performance?		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

5. Do the annual staff evaluations truly and fully represent the performance, behavior, aptitude and attitude levels of staff in general? With regard to integration?	☐ Yes ☐ No	If NO, what seems to be the function of staff evaluations?		
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
	Section G Total Cumulative Score:			

Section H: Internal UM Processes, Credentialing and Authorizations for Services

1. What percent of the clinicians in the clinic by staff type are currently credentialed on a payer required provider panel? (All questions in this section should be answered with regard to both primary health staff and behavioral health staff, if both are present).	MDs/DOs: **%** ☐ N/A	NPs: **%** ☐ N/A	Ph.D.s: **%** ☐ N/A	Licensed Therapists: **%** ☐ N/A	RNs: **%** ☐ N/A	Pas **%** ☐ N/A	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**			
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge			

2. Does the clinic have a process in place to ensure that pre-certs, authorizations and re-authorizations are obtained in a timely manner?	☐ Yes ☐ No	If YES, what percent of claims were denied due to failure to obtain pre-certs, authorizations and/or re-authorizations during the past quarter? **%**		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

3. Does the clinic ensure that referrals are made to only clinicians credentialed on the appropriate payer panels?	☐ Yes ☐ No	If NO, what percent of the claims were denied due to referrals to clinicians that were not on the payer's panel during the past quarter? **%**

☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

4. Does the clinic collect all co-pays and self-pay fee amounts at the front desk prior to the delivery of services?		☐ Yes ☐ No	If NO, what percent of the co-pays and self-pay fee amounts were collected during the past quarter from a post service collection model? **%**	
☐ 1	**☐ 2**	**☐ 3**	**☐ 4**	**☐ 5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
5. Does the clinic have a financial fee assessment/agreement policy and protocol that requires production of the needed client financial income documentation verification prior to services beginning?		☐ Yes ☐ No	If YES, is this protocol uniformly applied to all appropriate clients that enter service? ☐ Yes ☐ No If YES, what percentage of clients began service last quarter without producing required financial verification? **%**	
☐ 5	**☐ 4**	**☐ 3**	**☐ 2**	**☐ 1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
6. Does the clinic have a requirement for clients with third party payer benefits to produce validation of insurance coverage prior to services beginning?		☐ Yes ☐ No	If YES, what percentage of clients began service last quarter without producing required third party insurance validation? **%**	
☐ 1	**☐ 2**	**☐ 3**	**☐ 4**	**☐ 5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
7. Does the clinic have timely/accurate claim submission to support payment for services provided?		☐ Yes ☐ No	If NO, what percent of the claims submitted last quarter were submitted more than 30 days after service date? **%**	
☐ 5	**☐ 4**	**☐ 3**	**☐ 2**	**☐ 1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

8. Does the clinic monitor the medical loss ratio that provides a summary of the actual cost of services vs. the reimbursement for those services	☐ Yes ☐ No	If YES, can the clinic differentiate the medical loss ratio by individual service types/codes? ☐ Yes ☐ No

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

	Section H Total Cumulative Score:

Section I: Diversified Payer Mix

1. FY2012 Revenue Budget: $	**FY2012 Expenditures Budget:** $

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

2. **Sources of Revenue as a %:**	Medicaid: **%**	Medicare: **%**	Private Third Party Insurance: **%**	Self-Pay/ State Grant: **%**	Other Funding: **%**

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

3. Does the clinic know the payer mix percentage of the general population within the clinic's service area?	☐ Yes ☐ No	If YES, please provide the payer mix percentages for the following payers?	
		Medicaid: **%** Medicare: **%**	Uninsured/Self Pay: **%** Third Party Insured: **%** Other payers: **%**

☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

4. Does the clinic monitor payer mix trends by month for individual clinicians?	Clinic based measurement: ☐ Yes ☐ No	Individual clinician based measurement: ☐ Yes ☐ No	How frequently is the payer mix monitored?

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

5. Does the clinic have service delivery contracts with any of the following healthcare reimbursement programs in the service area?	☐ Yes ☐ No	If YES, check all that apply: ☐ Federally Qualified Health Clinics (FQHCs) ☐ Accountable Care Clinics (ACOs) ☐ Primary Care Practice Medical Homes (PCPMHs) ☐ Health Maintenance Clinic (HMO) ☐ Preferred Provider Clinic (PPO) ☐ Managed Behavioral Health Program (MBHP) ☐ Behavioral Healthcare Organization (BHO) ☐ Employee Assistance Program (EAP ☐ Other (Describe):

☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

6. If YES to any of items above, please indicate the payment methodologies that the clinic received (check all that apply)?	☐ Capitation ☐ Case Rate ☐ Stratified Case Rate ☐ Fee for Service	☐ Discounted Fee for Service ☐ Episodic/Bundled Rate ☐ Pay for Performance (P4P) ☐ Other (Describe):		
☐ 1	**☐ 2**	**☐ 3**	**☐ 4**	**☐ 5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
		Section I Total Cumulative Score:		

Section J: Revenue Cycle Management

1. Does the clinic monitor billing error rates?	☐ Yes ☐ No	If YES, what was the billing error percentage rate during the past quarter? **%**		
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
2. Does the clinic have established billing policies, procedures and practices?	☐ Yes ☐ No	If YES, what is the most ineffective practice during past quarter (i.e., self-pay collection rates)?		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
3. Does the clinic monitor and report Key Financial Performance Indicators?	☐ Yes ☐ No	If YES, identify the top two financial KPIs: a. b.		
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
4. Does the clinic have specific enrollment and data refreshment protocols to ensure accurate collection of client financial data elements?	☐ Yes ☐ No	If YES, how often is the ability to pay financial re-assessments completed on current caseload members?		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

5. Does the clinic routinely monitor all payers in its service market to establish staff credentialing protocols and availability to add clinical team members on the panel?		☐ Yes ☐ No	If NO, how does the clinic confirm the credentialing requirements and panel availability for clinical staff?	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
6. Does the clinic experience late service encounter submissions for a given clinic month that miss the cut off/close out?		☐ Yes ☐ No	If YES, what is the average percent OR number of service events per clinic month that are submitted after the close out date for that clinic month? % **OR** Events of Service	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
7. Does the clinic capture all billing encounter data for all grants, payers, etc. and report the encounter levels by payer source on a routine basis?		☐ Yes ☐ No	If NO, which types of service encounters provided are not being recorded in the service encounter data base of the enterprise software on location within the clinic?	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

	Section J Total Cumulative Score:

Section K: Outcome Assessment Capacity

Does the clinic have the capacity to measure aggregate improvement in the following areas for the client population or population categories?				
1. Functioning level of client in daily living activities		☐ Yes ☐ No	If YES, what tools, measures do you use?	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

2. Reduction in the need for disruptive, high cost services (ER's ,Psychiatric Hospitalization, etc)		☐ Yes ☐ No	If YES, what tools, measures do you use?	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
3. Ability to self-manage or consistently use supports to manage chronic physical/behavioral conditions?		☐ Yes ☐ No	If YES, what tools, measures do you use?	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
4. Linkage with primary care or behavioral health services?		☐ Yes ☐ No	If YES, what tools, measures do you use?	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
5. Improved Change in Work, Independent Living, or Social Support Status		☐ Yes ☐ No	If YES, what tools, measures do you use?	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
6. Client Satisfaction		☐ Yes ☐ No	If YES, what tools, measures do you use?	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**

Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

Section K Total Cumulative Score:

Section L: Community Awareness, Branding and Market Share

1. Does the clinic have an annual budget to support public information sharing, marketing awareness and image building?	☐ Yes ☐ No	If YES, what percentage of clinic's total budget is spent on image building, public information and marketing? **%**

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

2. Does the clinic maintain a media contact list for all media in the service area?	☐ Yes ☐ No	If YES, how many contacts are on the current list?

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

3. Did the clinic originate any press releases and send them to members of the media in the service area last year?	☐ Yes ☐ No	If YES, how many releases were generated and sent to members of the media last year?

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

4. Has the clinic completed any "branding" or "image assessment" surveys in the service area with general residents during the past two years?	☐ Yes ☐ No	If YES, what was the most concerning brand or image information learned?

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

5. Does the clinic know the percentage of general population market share that is served by other providers in the clinic's service area?	☐ N/A ☐ Yes ☐ No	If YES, what is the clinic's share? **%** If YES, what is the market share for the next largest/smallest practice in the clinic's service area? **%**

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

6. Does the clinic monitor referrals by source and report/manage these data monthly, quarterly, annually?	☐ Yes ☐ No	If NO, how does the clinic monitor ongoing referral levels from each referral source?

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

7. Has the clinic provided each referral source a customer satisfaction survey within the past year to measure satisfaction levels?	☐ Yes ☐ No	If NO, how does the clinic monitor referral source satisfaction levels?

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

	Section L Total Cumulative Score:

Section M: Change Management and Decision Making

1. Does the clinic have a defined decision-making process/protocol that supports awareness of when a decision has been made?	☐ Yes ☐ No	If NO, what is the primary indicator that a decision has been made within the clinic (i.e. consensus is reached)?		
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
2. Does the clinic use a formalized annual planning process to identify annual and long term goals?	☐ Yes ☐ No	If YES, what percent of the goals/objectives incorporated into the FY2009 have been accomplished (meaning fully implemented)? **%**		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
3. Has the clinic used rapid cycle change management processes (Plan, Do, Study, Act)?	☐ Yes ☐ No	If YES, what percent of the goals/objectives incorporated into last rapid cycle change plan have been fully implemented? **%**		
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
4. The clinic develops a change management plan quickly and moves forward with timely decision-making about the solutions needed.	☐ True ☐ False	If FALSE, what is a more accurate statement:		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

5. When a decision is made to change, the clinic acts quickly to fully implement the change.		☐ True ☐ False	If FALSE, what is a more accurate statement:	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
6. When change is implemented, staff members in the clinic rarely retreat to the way things were done prior to the change.		☐ True ☐ False	If FALSE, what is a more accurate statement:	
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

7. The clinic does a great job evaluating changes implemented and modifying the changes as needed to ensure positive outcomes.		☐ True ☐ False	If FALSE, what is a more accurate statement:	
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

8. Staff members participating in the change process feel fully empowered through a sense of attainment based on the scope and timeliness of the decisions being made.		☐ True ☐ False		If FALSE, what is a more accurate statement:
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
9. Rate (from 1 to 10) the ease with which the clinic implements change in **areas of clinical practice**				Easy (1)……Difficult (10)
☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **1**
Not A Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge
10. Rate (from 1 to 10) how quickly the clinic implements changes in **clinical practices/standards**?				Rapid (1) ……Failure (10)
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
				Section M Total Cumulative Score:
				Total Cumulative Score Sections A - M:

ART Scoring SUMMARY:

1. Total number of questions is 97
2. Total Maximum Score at "5" level rating each is 485
3. Total Minimum Score at "1" level rating each is 97
4. Total Average Score at an average "3" level rating is 291
5. A cumulative clinic-wide score of less than 200 will require significant change management process support to effect changes needed.

ART Score and Priority Rating Sheet

Instructions:

A. **Average ART Section Score:** Below is a list of all Sections of the ART which includes a formula under each section to create and enter an average score per section in Column "B".

B. Importance Rating Determination: Enter a score of 1, 3 or 5 in Column "C" to identify the importance rating the management team gives to the any section that the readiness score indicates that a change is required based on the following rating values:

1 = High Importance: This item is very important to our clinic and potential partners and is a top priority

3 = Moderate Importance: This item is important but would never be a top priority for our clinic and potential partners

5 = Low Importance: This item is of little importance to our clinic or potential partners

c. **Change Need Score Column "D":** To render the total change need score, multiply the average ART Section score in column "B" by the change importance rating in column "C". **The three ART section(s) with the lowest change need score(s) in column "D" (and ties in lowest score) need to be the focus of change goals in a Rapid Cycle Change Plan for your clinic**

Sections	Column B Average Section Score	Column C Importance Rating	Column D Change Need Score (B Times C)
Section A: Access to Care Total Section Score = divided by 8 = Average Score enter in column "B" to the right			
Section B: Centralized Electronic Schedule Management Total Section Score = divided by 12 = Average Score enter in column "B" to the right			
Section C: Caseload Management including Levels of Care/Benefit Package Designs Total Section Score = divided by 5 = Average Score enter in column "B" to the right			
Section D: Re-engagement/transition procedures Total Section Score = divided by 8 = Average			

Score enter in column ”B” to the right			
Section E: Collaborative Concurrent Documentation model and documentation support processes Total Section Score = divided by 7 = Average Score enter in column ”B” to the right			
Section F: Cost Based Key Performance Indicators (KPIs) Total Section Score = divided by 8 = Average Score enter in column ”B” to the right			
Section G: Integrated KPIs into the job descriptions and performance evaluation model Total Section Score = divided by 5 = Average Score enter in column ”B” to the right			

Section H: Internal utilization management functions Total Section Score = divided by 8 = Average Score enter in column ”B” to the right			
Section I: Diversified payer mix including Third Party Payers Total Section Score = divided by 6 = Average Score enter in column ”B” to the right			
Section J: Revenue cycle management including co-pay collections and claim submission Total Section Score = divided by 7 = Average Score enter in column ”B” to the right			
Section K: Outcome assessment and measurement tools to integrate achieved outcomes Total Section Score = divided by 6 = Average Score enter in column ”B” to the right			
Section L: Community Awareness, Branding and Market Share Total Section Score = divided by 7 = Average Score enter in column ”B” to the right			
Section M: Change management capacity including the use of Rapid Cycle Change models Total Section Score = divided by 10 = Average Score enter in column ”B” to the right			

COMPASS- PRIMARY AND BEHAVIORAL HEALTHCARE™

Developing Integrated Physical Health/Behavioral Health Capability in Treatment Settings

A Self-assessment Tool for Behavioral Health and Primary Health Clinics and Programs

Clinic Name: _____

Program/Team Name: _____

COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™ Participants: _____

_____

_____

Date Completed: _____

COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™
User's Guide

What is the COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™?

A Continuous Quality Improvement Tool

The **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™** is a tool for clinics and treatment programs, whether working in their own integration process or in partnership with others, to organize themselves to develop core integrated capability to meet the needs of service populations with physical health and behavioral health conditions.

Outcomes

Designed to produce a number of key outcomes, the **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™**:

- Empowers organizations and staff to accomplish step-by-step goals to create integrated care for people and families with complex needs.
- Communicates a common language and understanding of integrated PRIMARY AND BEHAVIORAL HEALTHCARE capable services.
- Establishes an organizational baseline of integrated PRIMARY AND BEHAVIORAL HEALTHCARE capability so there is a rational foundation for a change process.
- Creates a shared process using a common tool that can be used in any system for an array of diverse programs working in partnership on integrated PRIMARY AND BEHAVIORAL HEALTHCARE capability development.
- Produces a universal continuous quality improvement framework for all types of programs in any system of care that serves individuals and families with complex needs.

Helpful Definitions

Comorbid Issues (Also Termed Co-occurring Conditions or Co-occurring Disorders)

An individual has comorbid physical and behavioral health issues if he has a combination of mental health issue and/or any substance- use problem and/or a cognitive disability with *a* physical health care need or needs, even if the issues have not yet been diagnosed. Many systems and programs also list trauma issues, problem gambling and nicotine dependence as comorbid issues. Comorbid issues also apply to families where one member has a problem, such as a child with serious emotional issues, and another member has another kind of problem, such as a significant physical health issue or disability.

CCISC

CCISC (Comprehensive Continuous Integrated System of Care) (Minkoff and Cline, 2004[1], 2005[2]) is both a framework and a process for designing a whole system of care to meet the needs of the individuals and families. In CCISC, **all programs engage in partnership with other programs, along with the leadership of the system and consumer and family stakeholders, to become welcoming, person-centered and "comorbid capable."** Every person delivering and supporting care is engaged to be welcoming, person-centered, and competent. The development of integrated PRIMARY AND BEHAVIORAL HEALTHCARE capability for programs and staff is one component of this larger system framework.

To successfully embed practices in any program the **Eight Core CCISC Principles** (See Minkoff and Cline, 2004[1], 2005[2]) may be placed in an integrated framework to create a common language throughout the whole system. The practices are:

1. **Co-occurring issues and conditions are an expectation, not an exception.**
2. **The foundation of a recovery partnership is an empathic, hopeful, integrated, strength-based relationship.**
3. **All people with co-occurring conditions are not the same, so different parts of the system have responsibility to provide co-occurring capable services for different populations**.
4. **When co-occurring issues and conditions co-exist, each issue or condition is considered to be primary.**
5. **Recovery involves moving through stages of change and phases of recovery for each co-occurring condition or issue**.
6. **Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition or issue**
7. **Recovery plans, interventions, and outcomes must be individualized. Consequently, there is no one correct dual diagnosis program or intervention for everyone**.
8. **CCISC is designed so that all policies, procedures, practices, programs, and clinicians become welcoming, recovery- or resiliency-oriented, and co-occurring capable.**

Through the use of COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™ (and other companion COMPASS™ tools for other kinds of providers), programs can learn how to apply

the CCISC principles to build all types of co-occurring capability, including integrated PRIMARY AND BEHAVIORAL HEALTHCARE capability, into all areas of services and programming.

Organization of the COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™

The COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™ is organized by sections that address aspects of integrated PRIMARY AND BEHAVIORAL HEALTHCARE capable program design:

- **Program Philosophy**
- **Program Administrative Policies**
- **Quality Improvement and Data**
- **Access**
- **Screening and Identification**
- **Integrated Assessment**
- **Integrated Person-centered Planning**
- **Integrated Treatment/Recovery Programming**
- **Integrated Treatment/Recovery Relationships**
- **Integrated and Welcoming Program Policies**
- **Medication Management**
- **Integrated Discharge/Transition Planning**
- **Program Collaboration and Partnership**
- **General Staff Competencies and Training**
- **Specific Staff Competencies**

What is the Best Way to Use the COMPASSPRIMARY AND BEHAVIORAL HEALTHCARE?

Self-Survey

COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™ is a program self-survey. The goal is for participants to discuss the items in the tool to identify the program baseline and opportunities for improvement.

Group Discussion

COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™ is designed to be used in a group discussion format that includes representation from *all* of the different perspectives in the program: **people representing all disciplines, managers, supervisors, front-line staff, support staff, and, when possible, representative "customers"—individuals and/or families who are or have been in service**. A typical group may have 10 to 15 participants, depending on the size of the clinic or setting. Your group size may be larger or smaller. One of the most important outcomes is the discussion among people who hold different perspectives. People in the same program often have very different opinions about what the "policies" *really* are regarding integrated care for physical health/behavioral health issues. This opportunity for a deep and rich discussion engages the **COMPASSPRIMARY AND BEHAVIORAL HEALTHCARE™** participants in learning about integrated PRIMARY AND BEHAVIORAL HEALTHCARE capability, often gets people excited about the opportunity to make real change and jumpstarts the process of improvement. The most common mistakes that programs make are to have a single manager complete the tool or to have individuals complete the tool without a discussion, and then average the scores. Proceeding this way is a missed opportunity to get maximum value out of the sharing of perspectives and ideas in a group conversation

Preparing the Group

A group should have some background about the clinic's participation in a process of integrated PRIMARY AND BEHAVIORAL HEALTHCARE capability development before using **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™**. If this is part of a formal collaboration or a larger system effort, this should be explained. If the agency or program is committing to make some changes, this should be explained and discussed as well. It may be helpful for group members to read through **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™** briefly (without answering the questions) to get ready to talk to each other.

Structuring the Discussion

A facilitator is not necessary for **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™**. Most programs organize themselves for a discussion quite well. One person, usually *not* the clinic manager, can be identified as a timekeeper to remind the group to come to closure and to stay on track. The same person, or a different person, may take notes to capture important parts of the conversation and write down scores. Everyone's opinion and perspective should count equally and contribute to the consensus score. This will be discussed further below in the scoring section.

Planning the Time

Completing the **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™** takes approximately two hours. Ideally, the whole tool should be done in a single session, but this is not always possible. Many programs set aside time in regular weekly meetings to go through a few sections at a time. This way the process has continuity and is

less disruptive of normal work activities.

Specifying the Program

COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™ is designed as a survey of a "program." In very small clinics or agencies, it is often easy to determine that the program is the whole clinic and everybody gets involved in the survey. In larger service settings, this may sometimes be harder to determine. Here are some guidelines:

- **A large service setting should plan to have each distinct program use COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™ to perform its own self-survey.**
- **A distinct program means that the program has a unique set of services, and/or that it is a distinct administrative unit that would be responsible for its own improvement activities.** For example, in a large primary health setting, the Walk-in Clinic, Urgent Services Clinic, each of the routine Outpatient Centers, Prevention Services Program, and the chronic disease management support team could each do their own survey. In a large behavioral health setting, the Crisis Team, Adult Outpatient Clinic, Child and Family Program, Women's Program, Residential Program, and Inpatient Unit might do their own survey process.
- **Sometimes it is helpful to bring representative teams (not just random individuals) from different programs together to share a common conversation and experience of doing the survey together. In this instance, the distinct programs might score differently from one another on various items and maintain a unique score sheet for each program, but would discuss the items as a group.**

Learning from the Experience

The most important outcome of using **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™** is the collective learning experience and translating that learning into an improvement plan. The scoring, described in the next section, is simply a method for focusing the conversation to facilitate a constructive discussion. It is important for someone to **take notes** to keep track of what is learned and what program members feel might be inspiring ideas for next steps. **These notes can be jotted down in the boxes labeled "Action Plan Notes" in each section.**

Scoring the COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™:

Read Each Item Aloud

The best scoring method is for each member in the discussion to have his or her own copy of the tool and to have reviewed it briefly before answering the questions. The timekeeper identifies one member of the group to read the first question aloud and then opens the discussion about what the group thinks the score should be for the program, based on a Likert scale of 1 to 5. This process is repeated, taking turns reading each successive question aloud.

Reach Consensus as a Group

Members of the group will have differing opinions. The group should discuss each item to achieve consensus and poll each member to come to a conclusion on the score. In fact, one of the most important reasons for specifying a score is to reinforce the importance of continuing the discussion until consensus is reached. If some group members remain in disagreement, note the rationale and be aware that often this indicates an important issue that might become a targeted improvement opportunity. Remind each other that you do not need to *solve* the issue during the **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™** process, just recognize there is one.

Follow "Evidence-based" Scoring

Just like an accreditation survey, the purpose of **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™** is to score based on "the evidence." The survey does not ask questions like: "How welcoming do we feel?" It asks about the content of welcoming in specific policies, procedures, practices, and documentation. The group should score based on objective content. This does not mean that the group should sit and read the policy manual or do chart reviews; it is enough to simply discuss the group members' understanding of the policies and procedures. Keep in mind that because many programs are not well organized in their approaches to integrated PRIMARY AND BEHAVIORAL HEALTHCARE capability, there will be much uncertainty and inconsistency in these perceptions within the group. While there will be inconsistencies in the types of practices the group members feel are delivered and what is actually written down, this is an important part of the learning experience.

Use the Likert Scale

Each item is rated on a Likert scale from 1 "Not at All" to 5 "Completely." The ratings are easy to interpret. There is no "0." Each program can give itself a 1 just for answering the question. When scoring by consensus, individual group members may be advocating for different numbers on the scale. The group should achieve closure by "picking a number." The group should choose a whole number whenever possible, though it is acceptable to split the difference and pick 1.5 or 2.5 and so on. Do not pick other decimals like 1.75. It is beyond the scope of the tool to have the score be that precise.

Score Honestly

The group should have an open and honest discussion of the program's current status of integrated PRIMARY AND BEHAVIORAL HEALTHCARE capability. The best score is the most accurate score. An honest "1" deserves a round of applause for recognizing an improvement opportunity. A "4" or "5" that is essentially overrated is much less helpful. Recognizing this is an important part of shifting the system culture to valuing efforts to improve. Give yourselves a big round of applause every time you discover program improvement opportunities

Focus on Individuals and their Families

Think about items not only in relation to the individual, but also in relation to family members or caregivers. This

is particularly true in child and adolescent services, but also may relate to older adults and disabled populations.

Consider Diverse Issues

As the group talks, it is likely that highly prevalent issues, like exposure to traumatic experiences or chronic pain, will naturally be identified as important issues. The same applies for addictive behaviors like gambling and substance use that are legal but very unhealthy, such as nicotine, alcohol and over-the-counter or prescription medications. It is a good idea to spell this out in the beginning and reinforce it during the conversation.

Take Notes and Identify Priorities for Change

During the discussion the group will generate ideas about next steps for action or questions to be followed up. The group should also prioritize improvement areas that are important to address as soon as possible. Take notes in each section to document these ideas. This is one of the most important outcomes of using the tool.

Summarize Section Scores

After completing **the survey**, summarize scoring in each section on the Score Sheet in back of the tool. Each section will have a Total Section Score and an Average Item Score. Scoring prompts are written at the bottom of each section to help with filling out the Score Sheet.

Do not Overemphasize the Score. Learn from the Experience.

Remember that the most important part of the **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™** process is the collective learning experience as a team, not the score.

After Completing the COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™:

Develop an Action Plan

Use the **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™** assessment, along with the other tools in this Toolkit, to identify and organize starting places for making progress. These starting places do not have to be numerous, but they should be connected to the **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™** conversation and the program's vision and values. . Many programs start by simply welcoming individuals and families with physical health/behavioral health issues. Another common starting place is working on improving screening and identification of physical health/behavioral health issues in individuals and families, both clinically and within the data system. Other programs choose to work on specific clinical strategies such as motivational engagement or disease management protocols. The goal is to begin an organized quality improvement process by creating a written action plan that helps the program continually improve.

Use the "Serenity Prayer of System Change"

Some programs mistakenly focus on issues over which they have no control, leading to frustration. The goal of the **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™** process is to identify areas of improvement that the program has some control over and to be capable of making progress. All items on the tool relate to improvement activities that can be accomplished within existing resources and can often result in more efficient use of those resources.

Be Thoughtful about Sharing the Scores

- If the program is part of a learning collaborative or larger organization or system, that larger entity may want the program to share its scores. If scores are collected, it may be helpful for programs to know where they have scored in relation to other similar programs, so it may be useful for the system to post average scores in each section for each type of program. If programs feel that sharing scores would inhibit their ability to have an open conversation,, it may be better to not share scores and just report when they have completed the tool
- Systems should resist the temptation to over-analyze the scores. The tools are designed to stimulate dialogue and quality improvement partnerships.
- This is a learning process and many programs find that the first time they use the tool they are still learning what integrated PRIMARY AND BEHAVIORAL HEALTHCARE capability means. Programs often work hard and make progress and then repeat **COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™** a year later, only to find that the scores went down slightly on certain items. This represents a situation in which increasing knowledge leads to more accurate scoring over time. This is GOOD.

Plan to Repeat the Process

In most instances, programs will use **the survey** about once a year for several years to support regular self-assessment in the quality improvement process. After repeated use, programs are more likely to demonstrate real progress on many of the items.

Section 1: Program Philosophy

The program (your agency, clinic, treatment setting, etc.) operates under a written vision, mission or goal statement that communicates to all staff and stakeholders the goal of becoming an integrated physical health/behavioral health program.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Written program descriptions specifically say that individuals with comorbid physical health and behavioral health conditions are welcomed for care.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program environment (i.e., waiting rooms, interview and exam rooms, offices, wall posters, flyers, etc.) creates a welcoming atmosphere and communicates that physical health, mental health and substance use issues are routinely addressed within the program setting.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program welcomes individuals with <u>active</u> physical, mental, and substance use conditions, and cognitive disabilities, without discrimination, in all admission areas and waiting areas.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 2: Program Administrative Policies

1. Billing instructions provided by the program to staff indicate how to bill, collect, and track revenue for integrated physical health/behavioral health interventions within the context of standard billable visits provided by the program.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program confidentiality or release of information policies and procedures are written to promote appropriate and routine sharing of necessary information between collaborative mental health providers, substance abuse treatment providers, and medical providers. (PCMH*)

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Clinical record-keeping policies support integrated documentation (e.g., in assessments, treatment plans, and progress notes) of attention to mental health, physical health, cognitive disability, and substance use issues in a *single* medical/clinical record or chart.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 3: Quality Improvement and Data (PCMH*)

1.

The program has a continuous quality improvement team with representation from all levels of staff and across disciplines that meets regularly, using a written plan to guide, track, and measure progress toward becoming an integrated physical health/behavioral health capable program.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program has identified and empowered front line and consumer change agents or champions to assist with the continuous quality improvement process to move toward integrated physical health/behavioral health capability.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Program management information systems routinely collect quality improvement data that is used to support progress on specific and measurable quality indicators that represent progress in achieving program-wide integrated physical health/behavioral health capability.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Program management information systems routinely collect accurate data on how many individuals in the program have co-occurring physical health, mental health, and/or substance use conditions, including those related to nicotine dependence, sexual abuse or emotional/physical abuse/neglect.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Program management information systems collect accurate data on how many individuals in the program are receiving physical health/behavioral health interventions within the program.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)

Action Plan Notes

Average Item Score (Total Section Score divided by number of items answered in the section)

Section 4: Access (PCMH*)

1. The program has "no wrong door" access policies and procedures that emphasize welcoming and engaging *all* individuals and families with physical health and behavioral health needs from the moment of initial contact.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Individuals and families receive welcoming access to appropriate care regardless of active issues in any area (e.g., infectious disease status, need for injections or oxygen, presence of physical disability, blood alcohol level, urine toxicology screen, length of sobriety, commitment to maintain sobriety, intellectual functioning, active mental health symptoms, type of psychiatric diagnosis, or type of prescribed psychiatric medications, such as antipsychotics, stimulants, benzodiazepines, or opiate maintenance).

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program has functional policies for facilitating routine (non-emergent) access to integrated primary health and behavioral health assessment and intervention for *all* individuals who need "same-day" care.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 5: Screening and Identification (PCMH*)

1. The program's screening *policy* states that all individuals are to be screened for issues and immediate risk in a welcoming and respectful manner for mental health issues (including trauma), substance use issues, cognitive issues, physical health issues, and basic safety and social needs.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program uses evidence based screening processes, checklists, or other tools that are appropriately matched to the person being screened.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program has an evidence screening process for identifying and documenting nicotine use/dependence.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program has procedures for providing evidence screening and intervention services for a full range of physical health and behavioral health conditions or behaviors (e.g., addiction, suicide, metabolic syndromes, infectious diseases such as HIV and Hepatitis C, domestic violence, child/elder abuse, and unsafe sexual practices).

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program has procedures for routine evidence based screening/re-screening, monitoring, and tracking a full range of basic indicators of health and well-being, such as substance use and gambling; common mental health conditions such as depression and anxiety disorders; health indicators such as weight, BMI, and waist circumference; blood pressure; and metabolic status (HbA1c or FBS, liver and kidney function, etc.).

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 6: Integrated Assessment (PCMH*)

1. Assessments document individual and/or family goals for hopeful, meaningful and "happy life" outcomes using the person/family's own words.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Integrated assessments identify specific time periods of recent strength or stability, and skills and supports the individual or family used in order to do relatively well during that time, including those used to manage physical health, mental health, cognitive, substance use issues, and other risk factors.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Integrated assessments include diagnostic criteria or supporting information to illustrate the presence of specific physical health conditions, mental health conditions, and substance use conditions, including distinguishing between use, abuse and dependence for each substance.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Integrated assessments for individuals taking prescribed opiates for chronic pain (or other potentially addictive medication for a medical condition) clearly identify if the person has a substance use disorder or is at risk of developing one.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Integrated assessments routinely document the diagnosis for *each* physical health/behavioral health condition, active or stable, when previously diagnosed or when identified/diagnosed during the current assessment.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Integrated assessments document the stage of change (i.e., precontemplation, contemplation, preparation, early action, late action, maintenance) the individual is in regarding *each* disorder, condition or issue (if appropriate to the individual's age and cognitive status).

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 7: Integrated Person-centered Planning (PCMH*)

1. Hopeful person-centered goals, recent successes and strengths are the foundation of the treatment/service plans for continuing care.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Treatment/service plans list all the relevant physical health/behavioral health issues in the plan.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

For each of the physical health/behavioral health issues listed in the plan, there is an identified individualized and matched intervention with achievable steps to help the person be successful (Examples include, but are not limited to stage-matched interventions and stepped care protocols.)

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Treatment/service plans regularly include *integrated* physical health/behavioral health interventions provided in the program setting, not just outside referrals for specialized care in other settings.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Person-centered (or, if appropriate, family-centered) plans focus on building whole health self-management skills and supports (e.g., "illness or disease management skills") for physical health and behavioral health conditions, using positive rewards for small steps of progress in learning and using the skills and supports.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 8: Integrated Treatment/Recovery Programming (PCMH*)

1. Multimedia and culturally appropriate educational materials about a wide array of physical health, mental health, trauma, cognitive disabilities, and substance use conditions are routinely provided to patients/clients and families.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

All patients/clients receive basic education and assistance with choices and decisions regarding *prevention* of physical health and behavioral health conditions and disorders, as appropriate.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The clinic/service setting uses evidence-based protocols to manage and track common physical and behavioral health conditions (e.g., major depression, anxiety disorders, alcohol abuse, opiate dependence, diabetes, obesity, hypertension, sexually transmitted diseases, and immunization status).

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program organizes the use of stage-matched interventions for treating nicotine dependence.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program has an organized protocol to address psychosocial issues related to pain management.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program routinely offers educational groups on physical health, mental health, trauma, and/or substance use issues to all patients/clients who are interested.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program has symptom management skill training manuals or materials that staff use to assist patients/clients who have common physical health, mental health, trauma, and substance use conditions.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

(continued on next page)

Section 8: Integrated Treatment/Recovery Programming (continued)

Individuals and families with physical health/behavioral health issues are helped to get involved with peer coaching, self-help or peer support groups for those issues, as appropriate.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 9: Integrated Treatment/Recovery Relationships

1. Each patient/client has a primary relationship with an individual (e.g., physician, nurse, care navigator, care coordinator, peer recovery coach) or an integrated team that integrates attention to physical health and behavioral health issues inside the relationship.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The primary clinician or team that is responsible for integrated care *continues* ongoing work with the patient/client on each physical health/behavioral health issue even when the person is having difficulty following one or more aspects of the treatment/service plan (e.g., may still be using substances, may not be following diet recommendations, may not be taking medications as prescribed).

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Physical health and behavioral health staff meet regularly as a team to promote routine collaboration in sharing care responsibility for integrating physical health/behavioral health services to clients/patients.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 10: Integrated and Welcoming Program Policies

1. Organization policies state clearly that individuals are *not* routinely discharged for problematic symptoms or behaviors, such as difficulty following medical recommendations, active substance use, displaying mental health symptoms during visits, cognitive and learning challenges, medication non-adherence, etc.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Organization policies and procedures are designed to *reward and reinforce* individuals for making progress in asking for help when they are having difficulty or are beginning to relapse with any issue, rather than focusing on providing "consequences for non-compliance."

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Organization policies reinforce that necessary treatment for <u>any condition</u> is initiated and maintained, with adaptations as indicated, even when individuals have active symptoms in another area (e.g., treatment of diabetes or depression in individuals with active substance use; treatment of complex medical conditions in individuals with active psychosis and/or developmental disability; treatment of mental illness or substance use disorders in individuals with active hepatitis, etc.).

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 11: Medication Management

1. The organization has procedures/forms/materials—adapted for individuals who may have cognitive disabilities—to help patients/clients learn about physical health and behavioral health medications, and communicate more easily with prescribers about medications and side effects.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The organization documents routine communication and facilitates cross consultation between behavioral health and physical health prescribers to ensure quality of care regarding prescribing practices.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

All prescribers have knowledge and capability in prescribing practices and medications for treatment of common physical health (e.g., antihypertensives, oral diabetic agents), mental health (e.g., antidepressants, anxiolytics), and substance conditions (e.g., anti-craving agents, buprenorphine).

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The organizations practice guidelines support access to medication *assessment* for any condition *without* requiring a mandatory period of sobriety or symptom remission for another condition.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Common risks associated with all medications, including risks of interaction between behavioral health and physical health medications, are routinely monitored by medical/nursing staff.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Policies or practice guidelines specify that <u>necessary</u> non-addictive medications for treatment of known serious medical or mental illness are appropriately continued (with close monitoring if necessary) even though the individual may continue to use substances.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Medications with addictive potential (e.g., benzodiazepines and opiates) are not routinely initiated nor routinely refused in ongoing treatment, including for individuals with substance dependence. Prescription of such medications is individualized based on careful evaluation and consultation, with second opinion when indicated.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

(continued on next page)

Section 11: Medication Management (continued)

The organization has an organized risk management protocol (including written contracts) for psychopharmacologic evaluation and management of individuals with chronic pain who may require ongoing opiate treatment.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 12: Integrated Discharge/Transition Planning

1. Discharge plan policies, procedures, and practices address specific matched continuing care needs for all physical health issues, behavioral health issues, and other risk factors.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Discharge summaries integrate attention to physical health and behavioral health concerns and are routinely provided in a timely manner to the receiving providers.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 13: Program/Organizational Collaboration and Partnership

1. The program/organization participates with one or more partner programs/organizations offering differing services in learning collaborative to develop physical health/behavioral health capability.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The program/organization has policies and procedures for documentation of care coordination and collaborative service planning for patients with physical health/behavioral health issues who receive services in collaborative programs.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

There is a routine process by which staff *provides* consultation to a collaborative program delivering complementary services.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

There is a routine process by which staff *receives* consultation from a collaborative program providing complementary services.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Designated staff participates in regularly scheduled physical health/behavioral health interagency care coordination meetings that address the needs of individuals or families with complex issues who use significant levels of service in multiple settings in the community.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 14: General Staff Competencies and Training

1. Human resource policies and job descriptions include identified integrated care competencies for all staff regarding welcoming, engaging, and serving individuals with complex physical health and behavioral health needs.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The organization has written procedures for routinely documenting integrated interventions provided by staff with any level of licensure or training.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The organization has a written plan for integrated competency development (e.g., supervision, practice monitoring, training activities, etc.) for all clinical and support staff.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Supervisors have the appropriate knowledge and skills to help staff become more capable of providing welcoming, hopeful, strength-based, trauma-informed and integrated physical health/behavioral health care.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Integrated physical health/behavioral health competencies are evaluated as part of all staff performance reviews.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Section 15: Specific Staff Competencies

1. The staff demonstrate competency to welcome and address the needs of patients/clients with physical health/behavioral health issues who are from different cultures and/or linguistic backgrounds.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The staff demonstrate specific competency in providing education to family members and caregivers regarding physical health and behavioral health issues.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The staff demonstrates specific competency in providing developmentally matched physical health/ behavioral health services to the age-specific populations that are served (e.g., older adults, adolescents, children, etc.).

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

The staff demonstrate specific competency in providing physical health/behavioral health care to patients/clients with cognitive impairments (e.g., learning disabilities, intellectual disabilities, traumatic brain injuries, thought processing difficulties, etc.).

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Action Plan: Summarize the notes from each section,

identifying and listing those items that have been prioritized as important areas to address in the change process, as well as identifying any creative change strategies.

COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™ Score Sheet

Sections	*Total Section Score*	*Average Item Score for Section*
1. Program Philosophy		
Program Administrative Policies		
Quality Improvement and Data		
Access		
Screening and Identification		
Integrated Assessment		
Integrated Person-centered Planning		
Integrated Treatment/Recovery Planning		
Integrated Treatment/Recovery Relationships		
Integrated and Welcoming Program Policies		
Medication Management		
Integrated Discharge/Transition Planning		
Program Collaboration and Partnership		
General Staff Competencies and Training		
Specific Staff Competencies		
Total COMPASS-PRIMARY AND BEHAVIORAL HEALTHCARE™ Score:		

Quality Improvement

A variety of change management models exist. However, this toolkit focuses on ensuring that you embed integration efforts into your existing quality improvement program. If integration transformation is to occur, then it must be an integral part of all of your quality improvement activities. The goal is to understand how to prioritize, plan, implement, and organize continuing improvements in primary and behavioral healthcare based on the results of the self-assessment tools in Part 2.

Basic Strategies of Quality Improvement

This toolkit emphasizes using customer-oriented continuous quality improvement (CQI) as the organizing methodology for managing a complex organizational change process like primary and behavioral healthcare integration.

Continuous Quality Improvement: Solution Vision and Focus

CQI processes are the evidence-based best practice for continually evaluating and improving the efficiency and effectiveness of your services to meet your customers' needs. Your organization's to create sustainable change requires a robust CQI (sometimes called performance improvement) process. As discussed in Part 2, a fundamental tenet of CQI is placing the organization's purpose and customers' needs and perspectives at the center of all change activities. A range of organizational structures and processes are necessary to implement a successful CQI approach to large-scale change. However, this section focuses on the specific techniques of CQI.

FOCUS-PDSA — CQI must be data driven and structured.

For any issue you want to improve, you must put your customer's experience at the center of your CQI team conversation and use that experience as the starting place to organize your improvement activity. Then, you must (1) identify measurable indicators for each improvement target; (2) measure the baseline for that target; (3) identify and analyze contributors to the baseline process; (4) select an intervention; and then (5) measure progress resulting from the intervention.

One of the best-known examples of how to organize this structured, data-driven change process is FOCUS-PDSA, based on the seminal work of Deming and others. FOCUS includes:

Find the improvement area and identify measurable improvement indicators.
Organize the improvement team (with multiple perspectives) to address the area
Clarify the knowledge about the process, including measuring the current baseline for the improvement indicators.
Understand the contributors to the process by analyzing all the possible contributors to the current baseline. (This is sometimes termed a fishbone or Ishikawa diagram in which all contributors are arrayed like fish bones).
Select one (or a few) contributors to address, and identify one (or a few) changes to make.

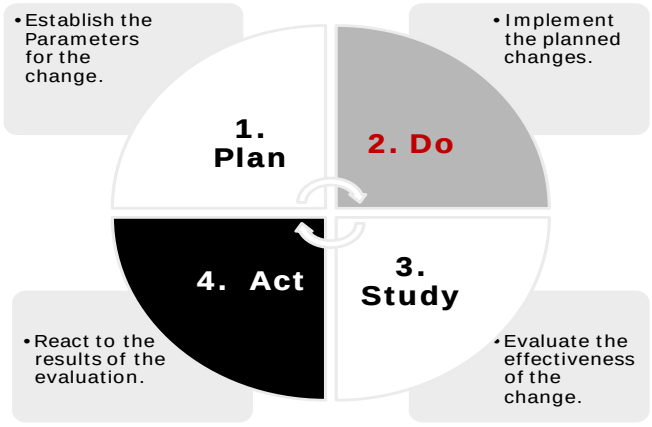
Then, you must move into the PDSA cycle (sometimes referred to as rapid cycle change) for each single improvement activity.

PDSA Rapid Cycle Change

The Plan-Do-Study-Act (PDSA) improvement cycle process is an iterative method for service and product development, delivery, and evaluation.

In the '**plan' stage** of the PDSA cycle, a problem's solution (e.g., a service flow redesign) is determined and an action plan established that will be used to monitor progress. The actual "doing" occurs during the **'do' stage** when the solution is implemented (e.g., the new service design is tried) and data gathered. Staff regularly collect and enter data related to the solution into a data set to analyze into a story about the solution's effectiveness. During the **'study' stage,** data collected is analyzed and a report issued and discussed. If all went as planned, the process continues because it worked and is monitored over time to ensure consistency. If the solution does not produce the desired result(s), it will need to be redesigned. This occurs during the **'act' stage** when the data/results gathered during the do stage and analyzed during the study stage are adopted and unproductive ideas and methods are abandoned and modifications are made. Once a new solution is designed, the process starts again with a new plan created and approved for testing.

Rapid cycle change PDSA typically used in publications focused on change management:



Challenges in Implementing Rapid Cycle Change

Many providers struggle with preventing the cycle's planning stage from becoming a long-term, extended process before any solutions are piloted. Prolonged planning phases in change management absorb energy and prevent teams from making change happen.

A short, focused plan cycle, supported by the capacity to integrate easily-gathered objective data (Study) will support a timely, solution-focused pilot plan that can be implemented quickly (Do). The key to relieving change team concerns about acting quickly with pilot implementation is to ensure that evaluation of the effectiveness of the change (Study) will be planned and executed, and that the change team will not be criticized if the recommendations do not solve the problem. Further, the team will need assurance that the study data results will be used to change (Act) the pilot, as needed, over and over in a "rapid cycle" of PDSA activities to continually progress toward desired outcomes.

This change process style supports more focused planning stages that cannot occur until an action step is taken (e.g., a pilot implementation). This helps the team to realize that they do not have to

create the perfect solution to move forward based on the assurance that the team will evaluate the pilot's outcomes and respond to those with procedural changes.

Finally, it is important that the provider change team stay focused on developing an implementable solution rather than spending too much time merely discussing a good idea. The difference between a good idea about a possible solution and the development of an implementable solution is that in the latter the change team has identifies the barriers to implementing the solution and creates action steps that overcome, minimize, or eliminate the barriers to successful implementation. Thinking out of the box as a team is critical to discover these possibilities.

PDSA Cycle Action Plans

It is helpful for each rapid cycle change team to document its objectives and activities in the PDSA process in a simple written action plan. For example, if a team creates a goal to change the treatment access process, it will need to identify the action steps needed. Action step identification might be based on outcomes of the self-assessment process in this Toolkit, including the Executive Walk-through findings, the ART results and the COMPASS PH-BH conversation.

Below is a sample action plan format that may be helpful for your team:

PDSA Cycle Action Plan Format

Goal	*Enhance access to treatment through reducing time delay to program entry*			
	Action Steps	*Lead Team Member*	*Start Date*	*Completion Date*
1	Assess time delay to treatment in each program			

2	Based on findings, develop a proposed alternative access process			
3	Pilot new access process			
4	Evaluate outcomes achieved in the pilot			
5	Re-Structure the access process based on evaluation outcomes			
6	Go through the cycle again.			

Selecting Indicators and Improvements (PCMH*)

Once you have accomplished the below steps in progressing toward integration:

- Articulated your vision
- Organized your internal CQI team and your external CQI collaborative partnerships
- Performed a walkthrough of customers' experience of service delivery
- Performed a self-assessment of your QI-IQ
- Identified strategic priorities using the SPIN
- Performed self-assessments of your administrative infrastructure and clinical practice for primary and behavioral health integration capability in one or more of your programs using the ART and the COMPASS

Now, you are ready to identify specific prioritized improvement targets in one or more programs and to organize specific PDSA cycles in each program. However, even though you may know what priorities you would like to address, unless you understand *how* to improve those priorities, it will be difficult to develop a reasonable assessment of your change management capacity.

There are four key questions to address:

Where do you begin?

This self-assessment tool helps you perform a virtual walkthrough of every aspect of your organization and identify potential areas of improvement in moving toward primary and behavioral healthcare integration. You cannot improve everything at once. Your job is to start by improving anything that helps your program make meaningful steps. Most programs choose three or four areas as starting points. The following list includes the most common places to begin.

- **Creating a Relationship (PCMH 1)**
  - Customer service (welcoming, hope, and engagement)
  - Facilitating integrated access
  - Improving "rate of return" (continuity)
- **Seeing the Issues (PCMH 2)**
  - Screening and identification
  - Integrated assessment documentation
- **Providing Helpful Care (PCMH 3)**
  - Integrated Care Planning and Stage-Matched Interventions
  - Implementation of Collaborative Care and Disease Management Protocols
- **Providing Cost-effective Care**
  - Maximizing Revenue Flow for Integrated Care Delivery
  - Improving Outcomes for High Utilizers
- **Supporting Self-care (PCMH 4)**
  - Implementing self-management skills training
  - Providing access to peer health coaching and recovery support

- **Working as a Team (PCMH 5)**
    - Information Sharing
    - Cross Consultation, Collaboration, and Teamwork
- **Building a Capable Workforce (All PCMH)**
    - Workforce Development

What do you measure?

For each change area, there are many possible measurable improvement indicators that might be chosen. The following list is intended as guidance.

- **Relevant**: the performance indicators align with the vision and mission of the organizations involved in the improvement process.

- **Manageable**: the number of indicators does not exhaust the organization's capacity to collect, analyze and act upon the data.

- **Practical**: the performance indicators are measureable in the context of the LC organization's day-to-day realities (e.g., workflow) (i.e., data collection, submission and analysis requirements are reasonable).

- **Reliable**: the performance indicator measures and the method to collect them can be standardized across participants.

- **Guides decisions**: the information from the performance indicators are likely to lead to actionable improvement efforts. The data enables participants to better understand the factors leading to poor, good, and great performance.

- **Easily Illustrated**: data in a form that can be easily graphed and shared with key stakeholders in a way that is understandable (i.e., it tells the story of progress over time).

  Benefit: the performance indicators include data that describes how the change process actually benefits one or more customers.

- **Creating a Relationship**
  Creating an inspiring, engaging experience for customers with complex challenges is a critical step. Measurable indicators are listed under each change area.
    - Welcoming, hope, and engagement
        - Customer surveys of welcoming client experience regarding integrated issues.
        - Surveys of welcoming experience from primary and behavioral health referral partners.
        - Customer/staff walkthrough teams that measure "welcoming" in both physical plant and process/procedure through all steps of the entry process.

        - Number of customers with complex problems that receive a hopeful communication that they are in the right place and will get help for both primary and behavioral health issues.
        - Number of customers that experience, upon first contact, a positive relationship that welcomes listening to both health and behavioral health needs.
        - Number of customers that experience a welcoming, helpful connection before filling out extensive paperwork.
        - Number of customers who experience (or do not experience) welcoming engagement that is culturally/linguistically matched.
    - Facilitating Integrated Access (See additional measures in the ART Tool)
        - Number of individuals referred for integrated or collaborative services that never get in the door.
        - Time from initial contact to first appointment or contact. (This can range from referral to a collaborative provider in another agency to a handoff to a team member right in the same office.)
        - Experience at first appointment (and resources used) from time of entry to time of contact with a welcoming provider
        - Number of individuals who come to the door who never get seen.
        - Number of individuals scheduled for intake that do not come.
        - Number of individuals who come to the door who are "turned away" because they don't fit the "rules" for entry.
    - Improving "Rate of Return"
        - Percentage of individuals with complex needs who return after the first appointment for continuing integrated care.
        - Percentage of individuals with complex needs who drop out of one "arm" of the collaborative care, or drop out altogether.
        - Percentage of individuals with complex needs who experience continued mismatch between "appointment driven services" and capability of keeping appointments.
        - Number of individuals that drop out of treatment after confrontation around administrative concerns (e.g., payment, lateness, missed appointments)

- **SEEING THE ISSUES**

  From the customer perspective, an integrated primary health/behavioral health setting MUST have the capability to SEE the l health issues in the population as a starting place for improving care to the overall population served. Most settings know that there are many people with co morbid issues, but have no organized data regarding how many and what kinds of issues. This is the starting place for improvement. Further, while it is better to screen for targeted issues (e.g., Depression, Alcohol, Diabetes, Hep C) than not to screen, it is more efficient- to think about screening as customer driven (What issues do our customers have?) rather than either diagnosis or tool driven (How many of our customers have depression and what are their PHQ 9 scores?)

- Screening and Identification
    - How many behavioral health customers have ANY co-occurring primary health issues? How many primary health customers have any MH and/or SA issues and/or trauma issues and/or cognitive issues?
    - Among the above, how many of those with co-occurring issues are recorded in our clinical data base registry? How many in our administrative data base?
    - How many new clients receive a co-occurring screening, and in what areas?
    - How many individuals who receive a positive screen have any appropriate next step intervention recorded?

- **PROVIDING COST-EFFECTIVE CARE**

  Integrated care must be both financially sustainable in the short run, and able to demonstrate value in the long run. Even if there is initial grant support or "startup" funding for an integration project, at some point the delivery of integrated services has to at least break even to continue. Addressing financial sustainability requires detailed examination of every component of service delivery that is relevant to integrated care, and exploring current mechanisms for reimbursement.

  Maximizing Revenue Flow for Integrated Care Delivery
    - The ART includes multiple indicators that are relevant to revenue and billing maximization for ANY services.
    - Identification of billing codes that can support integrated care
    - Development of billing and documentation instructions for staff regarding using those codes.
    - Number of integrated service "events" that are successfully billed and collected.
    - Comparison of revenue generation with cost of service delivery.
  - Improving Outcomes for High Utilizers
    - Identification high utilizer population with both medical and behavioral health needs with poor treatment engagement and frequent emergency visits.
    - Analyze the baseline population characteristics , including baseline cost
    - Measure the number of those individuals engaged in integrated services, and the amount of services received.
    - Measure reductions in emergency costs in relation to increase in integrated service engagement and care coordination.
- SUPPORTING SELF-CARE (PCMH 4)

  The "recovery" movement in behavioral health is aligning with the movement toward whole health and wellness in primary health, as both approaches emphasize empowerment of "consumers" as partners in care, supporting self-efficacy by teaching skills for self-care, and encouraging natural supports, peer supports, and health/wellness coaching activities as a critical element of improving outcomes and lowering costs.
  - Implementing self-management skills training
    - Self-management skills modules identified
    - Staff identified and trained

        - Number of consumers that receive self-management skills training
        - Demonstration of use of those skills by self-report and/or in documentation
        - Improved outcomes in chronic disease management for those consumers that are using those skills.
    - Providing access to peer health coaching and recovery support
        - Number of potential peer health coaches recruited for interest
        - Number of peer health coaches trained
        - Number of clients who receive peer coaching or support, either paid or volunteers
        - Number of clients who participate in community based support groups

- **WORKING AS A TEAM**

  Integrated care involves effective teamwork and collaboration between PH and BH settings and PH and BH providers. This collaboration may range from simple information sharing and cross communication, to regularly collaborative "parallel care", to working routinely as an integrated team in a single setting with regular cross consultation and collaboration. Note also that co-location is not the key indicator for teamwork. Individuals can work in the same office and never connect with each other and can work miles apart and be great teammates.
    - Information Sharing
        - How many individuals coming into one setting have a collaborative provider identified (e.g., how many individuals in the BH setting have a primary care provider?)
        - For those with collaborative providers, how many have provided signed releases of information? How many of those releases have been sent? Has the information been received back?
        - For individuals with both types of providers, has there been ANY communication between them? Is the communication documented? Is the communication ongoing?
    - Cross Consultation, Collaboration, and Teamwork
        - How often to PH and BH clinicians meet as a team? Do they meet as a team only on a case by case basis or do they meet as a team to share a caseload?
        - What percentage of BH team meetings have a PH consultant present, and vice versa?
        - For client receiving shared or collaborative care, how often do the PH and BH providers communicate? In what percentage of care plans is there identification of care provided by each party in the collaboration?
        - For what percentage of clients with co-occurring needs is cross consultation obtained?
        - What is the length of time that it takes for a PH provider to obtain a BH consultation (phone or in person), and vice versa?

        - What percentage of clients is referred to specialty care (e.g., dentist, podiatry, eye care)? How are the referrals monitored to insure the client attends the appointment and the clinical finds are shared between providers?

- **BUILDING A CAPABLE WORKFORCE**

  A key element of bi-directional integration is developing a workforce with integrated competency. This is not measured primarily by how many people are hired in the "other" domain. The measurement of competency development is the degree to which ALL staff sees themselves as an integrated PH/BH provider.

    - Workforce Development
        - Number/Percentage of staff who identify themselves as working to provide "integrated primary health/behavioral health care". Percentage of staff with "integrated PRIMARY AND BEHAVIORAL HEALTHCARE function" identified in their job title, job description, or performance evaluation. (Target is 100%)
        - Number/Percentage of staff who identify one or more areas in which they are working to improve their competency.
        - Number/Percentage of staff who have access to an integrated team or to integrated consultation/supervision to steadily improve their skills.
        - Number/Percentage of staff who document integrated interventions on a regular basis.
        - Number/Percentage of staff who can describe how they provide integrated interventions to current clients.
        - Number/Percentage of available MH specialty trained team members and the number of core PH staff they support on their team, as a percentage of total clients served with MH needs, and vice versa. (Target is every PH client with PRIMARY AND BEHAVIORAL HEALTHCARE needs should be attached to a team that is supported by a MH specialist, and vice versa).

A. <u>How do you improve?</u>

The first key component to the improvement process is using organized, data driven CQI teams and processes, and resisting the impulse to engage in random, seemingly quicker improvement activities. The second is engaging in customer oriented and vision driven PDSA rapid cycle change activities for each change target to ensure that the change itself is engaging all levels of staff and customers. Finally, an important maxim to remember is **PROGRESS NOT PERFECTION!!** You are constantly striving to improve and small steps forward that are sustainable count!

A simple PDSA plan for welcoming and hope might look like this:

<u>Vision: Where are we trying to go as an organization?</u> Insert the collective vision statement as adapted for your program.

<u>Focus on an Improvement Target</u>: Write the specific target area (e.g., Welcoming)

<u>Organize our team to have an Inspired Goal for our customers, in our own words</u>: We want every customer with primary health and behavioral health needs to be welcomed and inspired when they meet us that they are in the right place and we can help them with all types of issues to achieve a happy, healthy, productive life.

<u>Improvement Indicator:</u> Our customer service team (including customers with various types of issues and cultural backgrounds) will use a "walkthrough" check list to measure progress.

<u>Clarify the Baseline:</u> The first step has been that the team developed their check list and measured the baseline, and brought areas of strength and improvement opportunities back to the team.

<u>Understand the Current Baseline:</u> The team reviewed all the places where the baseline survey indicated strength, and several areas where there was need for improvement. The relative contribution and possibilities for improvement were discussed for each area.

<u>Select an Improvement:</u> The team decided that welcoming would be enhanced if there were improved signage about health and behavioral health in the waiting room, and if clients received a warm face-to-face greeting when they came in instead of just being handed paperwork to fill out.

<u>Plan:</u> The team – which includes both customers and reception staff – came up with a short welcoming PRIMARY AND BEHAVIORAL HEALTHCARE script to say to each client as they come in the door, and to put up "welcoming" signs in many languages. The team decided who would put up the signs, by when, and who would learn the script.

<u>Do:</u> The team picked a start date for the new approach and decided on an initial trial of 30 days.

<u>Check:</u> The customer service team performed a walkthrough in the midst of this "pilot test period" on a few different occasions, and also polled some brand new and returning customers to see how it was going. They discovered some things that worked and others that needed to be adjusted.

<u>Act:</u> The team got back together, reviewed the data, and made adjustments, then continued the cycle.

B. <u>How do we come up with CQI interventions that are effective?</u>

The above plan provides an organizing structure for any type of improvement activity and indicator. One challenge is that many CQI teams are so used to "being in the box" that they are unable to generate creative ideas that might bring significant progress. It is also important to not get stuck thinking change will come only when you have additional resources for more staff or more services. Getting stuck in this way will interfere with finding changes that actually work. To help you with your "out of the box" thinking, here are some common traps for most of the major areas listed above:

- **Welcoming:**
    - **"**We have to have a glass window to protect us from individuals who may be disruptive or intoxicated" or "We have to create rules that say we can't see you if you smell of alcohol". Glass barriers and rigid rules create an illusion of safety more than they actually improve safety. Generalizations must be challenged: everyone who smells of alcohol is not dangerous. Welcoming protocols are designed for individuals who may be "in crisis" and need an urgent and welcoming response.
    - "We don't have enough Hmong speaking staff to welcome the clients who speak Hmong." This issue might be addressed by identifying the number of clients who are Hmong speaking and organizing their visits on a particular day, as well as by identifying bilingual clients who might be willing to serve a client navigators.
    - "We can't improve the welcoming experience in our admitting area because we don't have enough space" If the management team determines that there are physical space needs s that are not solvable,, the next step is to determine "workarounds" to the barriers. This might include using rental office space as an interim solution or rearranging the way current space is used.
- **Access:**
    - **"**The clients just won't/can't keep appointments" or "We need a thorough intake appointment where all the paperwork gets filled out before we can assign anyone to care." Partnerships are finding more ways to open access for clients. This may involve establishing a time for new walk ins to get an initial contact without an appointment, with paperwork following the establishment of a relationship. Or it may involve having behavioral health team members available to drop in at any time in the health clinic upon request by a health care provider.
- **Rate of Return:**
    - **"**Clients don't come back because they don't have transportation or child care, or…." It is tempting to begin the change process by looking at external drivers, but this may lead to avoid focusing on issues that are more under the team's control. Did the client get a friendly reminder call from someone they know? Did the client's provider make eye contact before the client left and let them know how much he/she was looking forward to seeing them again? Did the scheduler take time to ask whether there were times that worked better for the clients' transportation and child care issues?
- **Integrated Planning and Stage Matching:**
    - **"**We can't develop a plan for each issue because we don't have a referral, a resource, or a program for each issue" or" We can't help you unless we have somewhere to send you." Improvement can start by organizing simple, brief interventions that help someone get to the next step. For example, if a patient is contemplating to stop smoking and there is no cessation program available (or the client is not willing to go), then an intervention might be: "Keep track of how many cigarettes you are smoking every day. That way if you decide to cut down, you will have a way to measure progress.

Next time you come tell us if you've made any progress." Something simple like that might help more people engage in small steps of progress.

- **Information Sharing:**
  - **"**We won't be able to improve information sharing until we get our brand new Electronic Health Record" or "The data are wrong so we need to work on getting perfect 'clean' data before we can make changes" Everyone wants the perfect data system, but it may be a long time coming and it's never perfect. While improvements in this area are critical, the data system itself is only as good as the platform that creates it and the data entered into it. Begin with the simplest possible focus on obtaining releases and improving the expectation of routine inter-provider communication in each record.
- **Workforce Development:**
  - "We can't have all of our staff cross-trained; that's too expensive and unwieldy." The underlying trap is that the only way staff will develop competency is through external training and credentialing. What works better is to engage in small steps on-the-job workforce development within a quality improvement framework

Quality Improvement-Intelligence Quotient (QI-IQ): *The Customer-Oriented Quality Improvement IQ Test for Leadership*

Organization-wide customer-oriented bidirectional primary and behavioral healthcare integration requires in-depth organizational cultural and structural changes. True transformation goes far beyond implementing an administrative rearrangement, physical co-location (e.g., mental health and/or substance abuse services operating in the same building as a primary health clinic), creation of a special program (e.g., obtaining a grant to implement an integrated health care home), or establishing a referral partnership. Customer-oriented integration of services requires an evolved framework of organization-wide customer-oriented quality improvement (CO-QI) to achieve both short- and long-range outcomes to move toward a broad vision of meeting the needs of customers in all settings and involving all staff.

CO-QI is a departure from traditional quality improvement (QI) and is different from processes such as compliance monitoring and quality assurance, often mislabeled as QI. Elements of successful CO-QI include:

- CO-QI moves organizations from seeing QI as a set of disconnected process improvements to a cohesive "way of being" for the organization that drives mission, vision, values, and principles (collectively referred to in this document as the organization's "purpose").
- CO-QI is a demonstration of an organization's capacity to strengthen and grow, to evolve as opposed to react, and to transform itself into a more purpose-driven organization to serve people better.
- In CO-QI, the purpose is defined in partnership with *all* of the people who make up the organization, including those who rely on the organization's effectiveness in fulfilling its purpose (i.e., customers and stakeholders).
- CO-QI is a strategic "weaving" process where multiple agendas and initiatives can be brought together to leverage resources more effectively, decrease distraction and misspent organizational energy, and improve overall efficiency and outcomes in multiple domains.
- CO-QI is built on the foundation of organized partnership structures that share responsibility for aligning the purpose with internal and external partners, developing measured and progressive improvement strategies, assessing objective progress, making "mid-course" corrections when needed, and demonstrating improved outcomes for those served.
- CO-QI creates and uses many forms of data, both to inform the improvement of customer-oriented processes and to improve the organization's relationships with external partners and its overall ability to perform its purpose.

The QI-IQ is designed to help leadership self-assess the organization's current capacity to engage in a transformational, vision-driven, customer-oriented continuous quality improvement process. This tool is designed to provide a benchmark to help you know whether your CO-QI framework is organized properly to begin the integration journey, and to guide you in continuing to build the elements of the CO-QI framework as you evolve.

Description of the QI-IQ Tool

The QI-IQ has 20 questions, each of which can be scored from "1" (not at all) to "5" (completely). Thus, the scoring range is from 20 to 100.

Benchmarking

If you score below the midpoint (60), it suggests that you should work directly on improving your QI-IQ before you go further with your integration effort. However, no matter what the score, it is important to continue to work on improving the agency's QI-IQ as integration (or any other transformation process) proceeds.

The QI-IQ is divided into four sections:

1. Leadership vision and values
2. QI structures and partnerships
3. Leadership QI skills and functions
4. Organizational QI infrastructure and capability

Using the QI-IQ Tool

The tool is designed to be a quick checklist. The CEO or program manager should gather a small team and establish consensus on each item. Evidence should back item scores; they should *not* relate to subjective feelings. It is also common for a leader's perception of the QI process to differ from individuals in other organizational levels. For that reason, *do not* allow each person to score the tool separately and then average the scores as this will interfere with the learning process. A group conversation is likely to lead to a more honest self-assessment and a more accurate score.

Also, do not use the tool to evaluate whether you are a "good" or "bad" organization, thinking that a high score means you are "better." This is a self-assessment. The only result that matters is that you score your organization accurately.

Using the Tool in a Partnership

If two organizations partner to integrate services, each organization's team should score the QI-IQ independently. The two teams should then come together to discuss their QI-IQ scores collaboratively to determine how to address the improvements uncovered to create more quality improvements for the partnership.

Finding Next Steps

You will not be able to do everything at once, but having a good conversation while using the tool should help you and your management team — and your organization's partners — to identify the best strategic short- and long-term next steps. It might be helpful to re-score the QI-IQ at intervals (e.g., every 6 months) to see if you remain on track.

Step 1: Leadership Vision and Values

1. Leadership (CEO, executive team, and management team) has communicated clearly and formally to staff and Board an inspired vision of organization-wide transformation to better meet the needs of clients or customers with complex (e.g., PRIMARY AND BEHAVIORAL HEALTHCARE) issues.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely _____

2. Leadership has taken formal steps to align this "initiative" with the organization's strategic plan and with other "initiatives" that are part of achieving that vision. (e.g., trauma informed care, MH/SA integration, chronic disease management, electronic health record, etc.)

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely

3. Leadership has clearly articulated that this initiative will be an organization wide CQI process that will involve all programs and staff in the CO-QI implementation process.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely

4. Leadership has clearly communicated a commitment to establishing an ongoing empowered QI partnership between senior management, middle management, front line clinical and support staff, and customers of service.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely

5. Leadership has demonstrated a commitment to and involves service recipients in all levels of the CO-QI process. (PCMH*)

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely

6. Leadership from all partnering organizations have come together to communicate to all internal staff and external stakeholders a shared vision and shared commitment to the CO-QI process.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely

TOTAL SECTION SCORE: _____

Step 2: QI Structures and Partnerships

1. There is an Executive Leadership Team that meets regularly across all the organizational partners to take responsibility for structuring the CO-QI process, monitor dashboard metrics and oversee policy implementation.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely _____

2. There is a CQI "Council" or "Steering Committee" for the integration process that meets regularly, and includes both horizontal representation (all programs) and vertical representation (all levels of staff and customers) to work in partnership to organize the change process.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely _____

3. There is an identified team or cadre of "change agents" or "champions" that represent front line staff of all types who are engaged and empowered in designing and implementing the transformation at the practice level.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely _____

4. Each program has its own change team and organizes and/or participates in one or more "rapid cycle change CQI processes" to achieve measurable objectives in relation to the overall vision.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely _____

TOTAL SECTION SCORE: _____

Step 3: Leadership QI Skills and Functions

1. Senior leadership participates <u>regularly and actively as a partner</u> with all levels of staff and customers in the CQI partnership structures and processes.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely _____

2. Senior leadership recognizes and demonstrates through decision making that improving customer experience and integrated practice requires changes in policy, procedure, and paperwork that organize service delivery.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely _____

3. Senior leadership provide direction and support to keep "customer experience" at the center of the change process and to reward programs and staff for small steps of progress toward the collective vision.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely _____

5. There is a clear mechanism for "project management" with identified responsibility for day to day coordination of activities, and a mechanism for regular communication of transformation activities, progress, and objectives to all staff and stakeholders.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely _____

TOTAL SECTION SCORE: _____

Step 4: Organizational CO-QI Infrastructure and Capability

1. The organization staff have direct experience and capability in using QI technology (rapid cycle change teams, PDSA, NIATX, etc.) to make meaningful and sustainable improvements in care.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely

2. The organization has internal experts in CO-QI that are available not to "do the QI" but to provide CO-QI support, consultation, and facilitation throughout the organization.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely _____

3. All organizations engaged in the integration efforts have a written CO-QI charter that organizes and outlines the vision, process, and objectives for each partner and each program.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely _____

4. The organization has developed a format or template for each program, and the organization as a whole, to document both agency-wide and unique program-specific CO-QI plans with measurable objectives that roll up to an organization level dashboard of metrics.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely

5. The organization has information system capacity to produce targeted CO-QI baseline data and routine Management of Information Systems (MIS) data for important indicators of progress that reflect the customer experience of integrated care.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely _____

6. The organization has demonstrated capacity to track performance improvement progress and outcomes across all components (i.e., all programs, all CO-QI teams) and to use that information to reinforce mutual accountability and guide next steps for all the partners.

   1. Not at all 2. Slightly 3. Somewhat 4. Mostly 5. Completely

TOTAL SECTION SCORE: _____

TOTAL QI-IQ SCORE: **_____**

Action Steps

If the total QI-IQ score is <u>less than 60</u>, identify immediate improvement areas (based on your item scores on the tool) to be well positioned to organize the PRIMARY AND BEHAVIORAL HEALTHCARE integration quality improvement process.

If the total QI-IQ score is <u>60 or above,</u> you are well enough organized to get started, but you should identify (based on the tool) improvement areas that need to be prioritized to continue to strengthen your QI-IQ as your integration process.

Spin: Strategic Planning Integration Checklist

This tool helps your organization — and your partners — quickly determine what "spin" to put on its plans for the future. After using this tool, you will have a clearer idea how to select priorities for change within a quality improvement process.

Every organization and/or program can develop integrated primary and behavioral health capability, but organizations will have somewhat different starting and end points.

Strategic planning, partnering, and prioritization is a mechanism by which each organization will identify its most critical strengths and weaknesses, = most urgent opportunities and threats, most compelling incentives for change, most important developing partnerships, and future business plan/model to best fit community and customer needs.

Instructions

The SPIN is a simple checklist to help organizational leadership, change teams, or collaboratives identify strategic priorities to guide the integration process.

The SPIN addresses the following major areas:

- Service population priorities
- Partnership priorities
- Certification priorities
- Funding/financing priorities
- Organizational change priorities

For an organization, the SPIN can be completed by any of the following:

- CEO, chief operations officer, or chief clinical officer
- Executive team or management Team
- Integration project manager
- Integration change team
- Any combination of the above

For partnering organizations, it is advisable that the partners meet to complete the SPIN together. In the discussion, each organization will fill out the tool separately to identify its own priorities, and then discuss the alignment of these priorities with its partners.

The SPIN goal is to identify priorities for attention in your integration improvement planning. The results will inform the prioritization exercise described later in this toolkit. The items in each section of the SPIN are self-explanatory. If you are uncertain about which answer best fits your organization, you should make your best approximation. In some instances, you may determine that your organization may meet criteria for more than one answer (or, in large organizations, different answers may apply to different components of your organization). In that case, you may conclude that the priorities that result from *each* answer will inform your integration planning.

Part I: Service Population Priorities

Which of the following best describes your program or organization's service population priority for bidirectional integration? Choose all that apply and comment on how they each apply.

1. We are a substance abuse treatment organization that wants to improve health outcomes for our substance abuse customers. _____. Comments:

2. We are a MH service organization that wants to improve health outcomes for our seriously mentally ill adults. _____. Comments:
3. We are a MH service organization that wants to improve health outcomes for children. _____. Comments:

4. We are a PH organization that wants to improve MH and/or SA outcomes for our primary health patients. _____. Comments:

5. We are a PH organization that wants to improve chronic disease management outcomes for our patients who have chronic medical conditions and comorbid behavioral health and social issues that affect their health. _____. Comments:

6. We are a behavioral health organization that is developing an in house primary health clinic, for the purpose of serving primarily our own behavioral health customers. _____. Comments:

7. We are a behavioral health organization that is developing an in house primary health clinic, both to serve our own customers, and to serve the community as a whole. _____. Comments:

8. We are a primary health provider that is developing in house behavioral health (MH and/or SA) services, primarily for service to our existing panel of primary health patients. _____. Comments:

9. We are a primary health organization that is developing in house behavioral health (MH and/or SA) services, both to serve our own customers and the community as a whole. _____. Comments:

10. We are an MH and/or SA organization that is partnering with a large primary health provider or a primary health/behavioral health network serving our community. _____. Comments:

11. We are a collaborative partnership between one or more primary health organizations and one or more MH or SA organizations who are working together to provide integrated services for our existing service populations._____. Comments:

12. We are a collaborative partnership between one or more primary health organizations and one or more MH and/or SA organizations who are working together to provide integrated services for both our existing service populations AND to develop an integrated continuum of care for our community as a whole. _____. Comments:

Answer Guide:

Regardless of your answer in this section, it is always important to address the fundamentals of integrated care in your change process (e.g., welcoming individuals with complex needs, screening, and identification, access to care, integrated planning and service delivery, collaboration, and teamwork, workforce development, and data monitoring/outcome tracking.)

However, your answers may affect your prioritization of issues, as follows:

- If you are working on integrating healthcare for a substance abuse treatment population, it is important to focus on those medical conditions that are highly prevalent in that population, particularly infectious diseases such as Hepatitis C and HIV, as well as general health promotion, nutrition, and nicotine use.
- If you are working on integrating healthcare for a serious mental illness population, it is important to focus on those medical conditions that are highly prevalent in that population, particularly diabetes, hypertension, obesity, metabolic syndrome, and nicotine use.
- If you are working on integrating behavioral healthcare into a primary health setting, it is important to focus on the range of diagnoses that are common in that setting, including mood disorders, anxiety disorders, trauma, ADHD, psychotic disorders, alcohol/drug use disorders, and nicotine use.
- If you are working on integrating behavioral health concerns into treatment of individuals with chronic medical conditions, it is important not only to address common diagnoses, but also to focus on integration of behavioral health expertise into the disease management team, and helping individuals with behavioral health challenges develop skills to follow medical recommendations.
- If your work focuses on meeting the needs of one or more external partners, then you need to prioritize partnership issues that are of concern to that partner: access, data sharing, information sharing, collaboration/consultation, communication, and teamwork.
- If your work focuses on developing integrated partnerships between internal components of your own organization, then in addition to all of the above, you need to attend to developing and sustaining internal team structures and collaborations.
- If your work focuses more on serving the whole community, rather than just addressing the internal needs of your current customers, then you need to prioritize addressing issues that are of concern to the community: welcoming, access, and creating an integrated experience for new populations.

Based on your answers to this section, list the issues you have identified that need to be prioritized in your organization's integration action plan:

1._____
2._____
3._____
4._____
5._____
6._____

Part 2. Partnering Priorities

Which of the following best describes your program or organization's partnering prioritization for integration? Choose all that apply and comment on how they each apply.

1. Our most important starting place for integration is to focus on improving integrated service delivery within our own organization to our own customers. We will develop partnerships to the extent necessary to achieve that goal. _____. Comments:

2. Our most important starting place for integration is to begin a successful partnership activity with one or more collaborative organizations in our community. We will initially focus on creating a successful joint project that strengthens that partnership, before we address integration throughout our organization as a whole. _____. Comments:

3. Our most important starting place for integration is to acquire multiple components of service delivery under our own administrative umbrella, and to focus on developing partnerships and collaborations between those internal components first. _____. Comments:

4. Our most important starting place for integration is to position ourselves to be part of our community network of PRIMARY AND BEHAVIORAL HEALTHCARE services in order to prepare for health care reform, accountable care organization development, regional health planning, or similar broad system transformation. _____. Comments:

Answer Guide:

Regardless of your answers in this section, it is important to address the fundamentals of integrated care in your change process (i.e., welcoming individuals with complex needs, screening and identification, access to care, integrated planning and service delivery, collaboration and teamwork, workforce development, and data monitoring/outcome tracking.)

However, your answers may affect prioritization of issues as follows:

- If you have an "internal" focus, you may begin with population based care needs, and focus on identifying current collaborators.

- If you have a partnering "project," you may begin with making sure your partner experiences success in that project, without becoming so focused on the project that you forget to work on more general improvements across both organizations.
- If you are coming to the table primarily to be a "good partner" with a larger organization or system, your starting place priorities will place relatively more (but not exclusive) emphasis on the needs of the partnership, in terms of access, data sharing, and collaboration.

Based on your answers to this section, list the issues you have identified that need to be prioritized in your organization's integration action plan:

1._____
2._____
3._____

Part III. Certification Priorities

Which of the following best identifies current organizational strategic priorities for certification? (Answer not with a wish list, but with actual priorities). Choose all that apply and comment on how they apply.

1. Our organization is seeking certification as a person-centered medical home. _____. Comments:

2. Our organization is seeking alternate federal, state, or local certification as an integrated health home, integrated health neighbor, or other designation. If yes, please specify or reference the criteria you will need to meet. _____. Comments:

3. Our primary health organization is seeking licensure or certification as a MH provider and/or a SA provider. If yes, please specify or reference the criteria you will need to meet. _____. Comments:

4. Our behavioral health organization is seeking licensure or certification as an FQHC, CHC, RHC, or state/local designation as a primary health provider. If yes, please specify or reference the criteria you will need to meet. _____. Comments:

5. Our organization is seeking Meaningful Use Certification for Health Information technology. _____. Comments:

Answer Guide:

Regardless of your answer in this section, it is important to address the fundamentals of integrated care in your change process (i.e., welcoming individuals with complex needs, screening and identification, access to care, integrated planning and service delivery, collaboration and teamwork, workforce development, and data monitoring/outcome tracking.)

However, your answers may affect prioritization of issues as follows:

- If you are seeking a particular type of certification, some — but not all — of your integration activities must address the criteria you need for that certification.

Always remember that integration is about the experience of your customers, so that your priorities must include a customer focus. Avoid the trap of thinking that "becoming certified" means that you are "integrated." Based on your answers to this section, and review of the applicable certification standards, list the issues you have identified that need to be prioritized in your organization's integration action plan:

1._____
2._____
3._____
4._____
5._____
6._____

Part IV: Funding/Financing Priorities

Which of the following best identifies your current funding/financing issues related to bidirectional integration? Choose all that apply and comment on how they apply.

1. Our organization has received or is expecting to receive *direct* grant funding to support integration. _____. Comments:

2. Our organization is participating as a partner in a local or regional integrated health/behavioral health innovation funding project. _____. Comments:

3. Our organization is planning to fund Integration primarily by delivering integrated services *within* our existing billing codes and funding streams. _____. Comments:

4. Our organization is developing new internal services that require new mechanisms of billing, tracking, funding, and payment. _____. Comments:

5. Our organization is working with partners and we will be seeking mechanisms of funding our services on site at our partner's location and/or vice versa. _____. Comments:

6. Our organization is planning to take advantage of newly developed funding opportunities for complex customer populations that are emerging at the state or local level. _____. Comments:

Answer Guide

Regardless of your answer in this section, it is important to address the fundamentals of integrated care in your change process, as described in the previous sections of this tool. However, your answers may affect prioritization of issues as follows:

- If you have grant funding or special project funding, you will need to prioritize attention to the deliverables connected to receiving the funding.
- Always remember that integration is about the experience of your customers, so that your priorities must include a customer focus. In fact, grant funded projects may create unanticipated restrictions that interfere with your larger mission (e.g., implementing an evidence-based practice that is restricted to certain diagnoses or age groups, when your population has much broader needs for similar services.) Consider those disconnects as opportunities for you to educate your funders as to the limitations of their approach, in order to prioritize expanding access to integrated care to the widest possible population.
- If your integration process involves new billing and reimbursement mechanisms, developing the infrastructure, capacity, and financial monitoring necessary for those new mechanisms must be one of your priorities for improvement in your integration process.

Based on your answers to this section, and review of the relevant funding requirements, list the issues you have identified that need to be prioritized in your organization's action plan:

1._____
2._____
3._____

Part V. Organizational Readiness Issues

Which of the following best describes your organization's general readiness to take on integration as a large-scale customer oriented vision driven organization wide culture shift involving all programs and all persons providing care? Please comment on your answer(s).

1. Our organization has experience with the change management technologies necessary to create vision driven change and/or experience with development of co-occurring MH/SA capability across the whole organization and is ready to take on integration as a next step toward our vision. _____. Comments:

2. Our organization is ready to take on the vision of integration across the whole organization, but we have limited experience in large scale change projects like this. _____. Comments:

3. Many parts of our organization (e.g., specific programs, teams) are very excited about working comprehensively on integration, but other parts of our organization would consider themselves uncertain about beginning or unready to begin this process. _____. Comments:

4. One or two small components of our organization are invested in a focused integration project, but the remainder of the organization is only thinking about integration and is not yet ready to make a commitment to change _____. Comments:

5. Our organization is undergoing significant organizational stress (e.g., merger, major financial losses), and while there is some focused interest in working on integration, there is little organization wide capacity for vision driven change at this time _____. Comments:

Answer Guide

Regardless of your answer in this section, it is important to address the fundamentals of integrated care in your change process as noted in the previous sections. However, your answers may affect prioritization of issues as follows:

- The more sophisticated your organization is about large scale change and the use of change management technology, the more likely you are to engage each organizational component as a partner (all programs, plus finance, MIS, HR) in setting its own priorities based on its own self-assessment of need.
- The more that your organization is experiencing significant challenges, the more that you will want to have the "early adopter" components of your organization choose priority targets that will provide useful guidance for the rest of the organization, and for the "later adopters" to have priority targets that are both heartfelt (e.g., welcoming and engagement) and relatively easy to improve, in order to make it easier for more parts of your organization to take some initial steps.

Based on your answers to this section, list the issues you have identified that need to be addressed in your organization's integration action plan:

1._____
2._____
3._____

Prioritization Instrument

	Score from the tool itself (if applicable)	Improvement Opportunity(ies) (Identify areas where you need to take action)	Priority of Importance (5 = Low Priority; 1 High Priority)	QI-IQ (5 = We cannot organize a QI project for this; 1 = We absolutely can do a QI Project for this)	Readiness Score (5 = We are not ready to address this; 1 = Let's address this now!)	KnowHow (5 = We do not know how to develop an indicator for this; 1 = We have the indicator identified)	Total Score/Opportunity - The lower the better!
Partnership Checklist							
Executive Walkthrough							
First Call for Service							
Initial Appointment							
Forms Number of							
Forms (BH and PH?)							
Waiting Area							
Second Appt Date							

ART: Admin. Readiness								
Access to Services								
Central, Electronic Sched								
Caseload Management								
Re-engagement								
Documentation								
KPIs/Measurement								
Job Descrip/Evals								
UM Processes								
Payer Mix								
Revenue Cycle Mgmt								
Outcome Assessment								
Branding/Mrkt Share								
Change Mgmt								
SUB SCORE - ART								
COMPASS PRIMARY AND BEHAVIORAL HEALTHCARE								
Program Philosophy								
Administrative Policies								
QI and Data								
Access								
Screening/Identification								
Integrated Assessment								
Person Centered Plan								

Integrated Recovery Prg								
Integrated Relationships								
Welcoming Policies								
Medication Management								
Integrated Discharge								
Program Collaboration								
Staff Competencies								
Specific Competencies								
SUB SCORE - COMPASS								
QI - IQ								
Leadership Vision/Values								
QI Struc/Principles								
Leadership QI-IQ								
Infrastructure/Capability								
SUB SCORE - QI-IQ								
SPIN - Strategic Planning								
Service Population								
Partnering Priorities								
Certification Priorities								
Funding/Financing								
Organizational Readiness								
Congratulations! You are ready!								

Integration Initiative Project Tracking Tool	**Program:** _____ **Reporting Period:**

If you are "progressing," please rate on a scale of 1-10, with 1 meaning just started and 10 meaning near completion.

Opportunity	Item Measured / Implementation Indicators	VerVer ofion	Date Completed	Progressing	Not Started	Comments
1						
2						
3						
4						

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2						
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