Instructions for Completing the MeHAF Site Self Assessment (SSA) Survey

The purpose of this assessment is to show your current status along several dimensions of integrated care and to stimulate conversations among your integrated care team members about where you would like to be along the continuum of integrated care. Please focus on your site's *current* extent of integration for patient and family-centered primary care, behavioral and mental health care. Future repeated administrations of the SSA form will help to show changes your site is making over time. Organizations working with more than one site should ask each *site* to complete the SSA.

Please respond in terms of your site's *current* status on each dimension. Please rate your patient care teams on the extent to which they currently do each activity for the patients/clients in the integrated site. The patient care team includes staff members who work together to manage integrated care for patients. This often, but not always, involves health care providers, behavioral health specialists, specialty care providers, case managers or health educators and front office staff.

Using the 1-10 scale in each row, circle (or mark in a color or bold, if completing electronically) one numeric rating for each of the 21 characteristics. If you are unsure or do not know, please give your best guess, and indicate to the side any comments or feedback you would like to give regarding that item. NOTE: *There are no right or wrong answers. If some of this wording does not seem appropriate for your project, please suggest alternative wording that would be more applicable, on the form itself or in a separate email.*

This form was adapted from similar formats used to assess primary care for chronic diseases.

Identifying Information:

Name of your site:_____ Date:_____

Name of person completing the SSA form:_____ Your job role:_____

Did you discuss these ratings with other members of your team? YES NO

I. Integrated Services and Patient and Family-Centeredness				**(Circle one NUMBER for each characteristic)**
Characteristic	**Levels**			
1. Level of integration: primary care and mental/behavioral health care	. . . none; consumers go to separate sites for services **1**	. . . are coordinated; separate sites and systems, with some communication among different types of providers; active referral linkages exist **2 3 4**	. . are co-located; both are available at the same site; separate systems, regular communication among different types of providers; some coordination of appointments and services **5 6 7**	. . . are integrated, with one reception area; appointments jointly scheduled; shared site and systems, including electronic health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings. **8 9 10**
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse) 2. (ALTERNATE: If you are a behavioral or mental health site, screening and assessment for medical care needs)	. . . are not done (in this site) **1**	. . .are occasionally done; screening/assessment protocols are not standardized or are nonexistent **2 3 4**	. . .are integrated into care on a pilot basis; assessment results are documented prior to treatment **5 6 7**	. . . tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented. **8 9 10**
3. Treatment plan(s) for primary care *and* behavioral/mental health care	. . . do not exist **1**	. . . exist, but are separate and uncoordinated among providers; occasional sharing of information occurs **2 3 4**	. . .Providers have separate plans, but work in consultation; needs for specialty care are served separately **5 6 7**	. . . are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care **8 9 10**
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	. . . does not exist in a systematic way **1**	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases **2 3 4**	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers **5 6 7**	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently **8 9 10**

5. Patient/family involvement in care plan	. . . does not occur **1**	. . . is passive; clinician or educator directs care with occasional patient/family input **2** **3** **4**	. . . is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with *some* patients/families and their provider(s) **5** **6** **7**	. . . is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources **8** **9** **10**
6. Communication with patients about integrated care	. . . does not occur **1**	. . . occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style **2** **3** **4**	. . . occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/family cultures and learning styles is frequent **5** **6** **7**	. . .is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in *how* to communicate with patients about integrated care **8** **9** **10**
7. Follow-up of assessments, tests, treatment, referrals and other services	. . . is done at the initiative of the patient/family members **1**	. . . is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up **2** **3** **4**	. . . is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments **5** **6** **7**	. . . is done by a systematic process that includes monitoring patient utilization; includes interpretation of assessments/lab tests for all patients; is customized to patients' needs, using varied methods; is proactive in outreach to patients who miss appointments **8** **9** **10**
8. Social support (for patients to implement recommended treatment)	. . . is not addressed **1**	. . . is discussed in general terms, not based on an assessment of patient's individual needs or resources **2** **3** **4**	. . . is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs **5** **6** **7**	. . . is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources **8** **9** **10**
9. Linking to Community Resources	. . . does not occur **1**	. . . is limited to a list or pamphlet of contact information for relevant resources **2** **3** **4**	. . . occurs through a referral system; staff member discusses patient needs, barriers, and appropriate resources before making referral **5** **6** **7**	. . . is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and patients **8** **9** **10**

Adapted from the PCRS – Developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesintiative.org; Also adapted from the ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative.

MeHAF Plus Items									
10. Patient care that is based on (or informed by) best practice evidence for prescribing of psychotropic medications	… does not exist in a systematic way **1**	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases **2** **3** **4**		. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers **5** **6** **7**			. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently; support provided by consulting psychiatrist or comparable expert **8** **9** **10**		
11. Tracking of vulnerable patient groups that require additional monitoring and intervention	… does not occur **1**	… is passive; clinician may track individual patients based on circumstances **2** **3** **4**		… patient lists exist and individual clinicians/care managers have varying approaches to outreach with no guiding protocols or systematic tracking **5** **6** **7**			… patient lists (registries) with specified criteria and outreach protocols are monitored on a regular basis and outreach is performed consistently with information flowing back to the care team **8** **9** **10**		
12. Accessibility and efficiency of behavioral health practitioners	… behavioral health practitioner(s) are not readily available **1**	… is minimal; access may occur at times but is not defined by protocol or formal agreement; unclear how much population penetration behavioral health has into primary care population **2** **3** **4**		… is partially present; behavioral health practitioners may be available for warm handoffs for some of the open clinic hours and may average less than 6 patients per clinic day per clinician (or comparable number based on clinic volume) **5** **6** **7**			… is fully present; behavioral health practitioners are available for warm handoffs at all open clinic hours and average over 6 patients per clinic day per clinician (or comparable number based on clinic volume) **8** **9** **10**		

II. Practice/Organization	**(Circle one NUMBER for each characteristic)**			
Characteristic	**Levels**			
1. Organizational leadership for integrated care	. . . does not exist or shows little interest **1**	. . . is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care **2 3 4**	. . . is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings) **5 6 7**	. . . strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models **8 9 10**
2. Patient care team for implementing integrated care	. . . does not exist **1**	. . . exists but has little cohesiveness among team members; not central to care delivery **2 3 4**	. . . is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills **5 6 7**	. . . is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences and team meetings are regularly scheduled **8 9 10**
3. Providers' engagement with integrated care ("buy-in")	. . . is minimal **1**	. . . engaged some of the time, but some providers not enthusiastic about integrated care **2 3 4**	. . . is moderately consistent, but with some concerns; some providers not fully implementing intended integration components **5 6 7**	. . . all or nearly all providers are enthusiastically implementing all components of your site's integrated care **8 9 10**
4. Continuity of care between primary care and behavioral/mental health	. . . does not exist **1**	. . . is not always assured; patients with multiple needs are responsible for their own coordination and follow- up **2 3 4**	. . is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only **5 6 7**	. . . systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained **8 9 10**

5. Coordination of referrals and specialists	. . . does not exist **1**	. . . is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team **2** **3** **4**	. . . occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care **5** **6** **7**	. . . is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement **8** **9** **10**
6. Data systems/patient records	. . . are based on paper records only; separate records used by each provider **1**	. . . are shared among providers on an *ad hoc* basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps **2** **3** **4**	. . . use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals **5** **6** **7**	. . . has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process **8** **9** **10**
7. Patient/family input to integration management	. . . does not occur **1**	. . . occurs on an *ad hoc* basis; not promoted systematically; patients must take initiative to make suggestions **2** **3** **4**	. . . is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consideration; patients/families are made aware of mechanism for input and encouraged to participate **5** **6** **7**	. . . is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information **8** **9** **10**
8. Physician, team and staff education and training for integrated care	. . . does not occur **1**	. . . occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic **2** **3** **4**	. . . is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation **5** **6** **7**	. . . is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration **8** **9** **10**

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9. Funding sources/resources	. . . a single grant or funding source; no shared resource streams		. . . separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies			. . . separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training			. . . fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly
	1		**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**