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ATTACHMENT 4

Site Visit Protocol: Care Coordinators

This version of the protocol is for care coordinators.

The protocol may be administered to individuals or to groups.

Multiple choices and checklists are to be completed by evaluators, not the interviewees.

Introductory Questions

- What are your key responsibilities in the PBHCI program?
- What is your average caseload?
  - □ No set caseload
  - □ 1-5 patients
  - □ 6-10
  - □ 11-15
  - □ 16-20
  - □ More than 20 patients
- What is the average number of clients you see per week?

1. **Cooperation/collaboration across MH and PC**
   - In what format, and how often do you meet with MH and PC providers? Are there regular team meetings? Regular information sharing?
   - How does the treatment team decide which specific problem to focus on? How are objectives set?
   - Who develops the treatment plan? Are there separate treatment plans for MH and PC, or is there a single integrated treatment plan? If there is an integrated plan, to what extent (if any) do MH and PC providers work together in constructing the plan? If there is not an integrated plan, do MH and PC consult with each other as they develop individual treatment plans?
   - How is decision-making shared between MH and PC providers?
   - More broadly, how much continuity of care is there between MH and PC service providers? Is there ongoing communication about goals for treatment progress? Do they work together on achieving specific goals (e.g., behavior change that impacts physical health)?
   - Are patient records integrated?
   - What is the appointment system like? (e.g., flexibility, facilitation of patient seeing multiple providers in a single visit, walk-in availability, etc.)
   - Are regularly planned visits for integrative care utilized? (e.g., regular visits for PH care management, wellness, etc.)

2. **Structure**
   - What kind of training were you provided?
     - How much education for integrative care is provided? Didactic only vs. hands-on training? Ongoing supervision?
   - What outreach programs are in place to attract consumers in the community?

3. **Screening and referral**
   - Which patients are screened for PH conditions?
   - When are initial screenings provided?

- What screening tools do you use? [Evaluate whether screening tools are standardized and validated for the client population.]
- How do you manage receipt of information on tests and results? [Evaluate whether the practice works to improve effectiveness of care by managing the timely receipt of information on all tests and results.]
- Can you order and view lab test and imaging results electronically, with electronic alerts?
- How often are referrals tracked, with follow-up? How are referrals tracked? [Evaluate whether the practice seeks to improve effectiveness, timeliness, and coordination of care by following through on critical consultations with other practitioners.]
- Are follow-up screening conducted at regular intervals? For what proportion of clients?
- Community Linkages
    - How are patients linked to outside resources?
    - What kinds of partnerships do you have with community organizations? How does the integrated care team interface with other organizations in the community? (e.g., housing authority, legal etc.)
    - How do you coordinate with regional health plans (if at all)?

4. **Registry/tracking**
    - Is there a clinical registry for documenting PC and/or MH conditions?
    - Is the clinical registry searchable? (i.e., Does your program have the ability to systematically monitor and track the care of all individual patients in your program who meet criteria for a specific physical health diagnosis? For example, can a clinician easily access to a list of individuals with a particular diagnosis for purposes of follow-up?)
        - □ No
        - □ Yes, the practice organizes patient-population data using an electronic system that includes searchable information.
            - [If Yes] Describe the system used to systematically monitor and track the care of all individual patients in your program who meet criteria for a specific physical health diagnosis or who have an elevated health risk.
            - Is the electronic registry used to manage patient care? (e.g., from information about relevant subgroups of patients needing services)
                - □ No
                - □ Yes, the practice's data system includes searchable clinical patient information that is used to manage patient care.
            - Are the data fields used in the electronic clinical registry consistently used in patient records?
                - □ No
                - □ Yes, the practice uses the data fields listed above consistently in patient records.
    - Are charting tools used to document clinical information in the medical record?
        - □ No
        - □ Yes, the practice uses electronic or paper-based charting tools to organize and document clinical information in the medical record.
    - What are the most frequently seen diagnoses in the PBHCI integration? What are the most important risk factors you are assessing? What are the top 3 clinically important conditions being treated by the PBHCI implementation? Do you have a system in place that enables you to track these diagnoses, risk factors, and conditions?
        - □ No
        - □ Yes, the practice uses electronic or paper-based system to indentify the following in the practice's patient population:
            - Most frequently seen diagnoses
            - Most important risk factors

Three clinically important conditions

- Is your electronic clinical registry used to generate reminders (i.e., automated “ticklers”) for patients or clinicians (e.g., about services or medications needed, follow-ups, etc.)?
  - □ No
  - □ Yes, the practice uses electronic information to generate patient lists and remind patients or clinicians about necessary services, such as specific medications or tests, preventive services, pre-visit planning, and follow-up visits.
- Do MH and PC providers use EMRs? Do CMs?
- How is attendance at external appointments (e.g., specialist appointments) tracked?
- How is data from disparate record systems integrated into the patient chart?
- How is the current medication list maintained? Are there steps taken to avoid polypharmacy?
- Who checks registry data for completion and accuracy? How often is it checked?

5. **Care management**

- Do you have written processes for scheduling appointments and communicating with patients?
- Do you have data showing that the practice meets these standards for scheduling and communicating with patients? [Evaluator should view evidence.]
- What are the clinically important conditions you are treating in the PCBHI program? Do you use evidence-based guidelines in treating these conditions?
  - □ No
  - □ Yes, the practice implements evidence-based guidelines for the three identified clinically important conditions. [Specify the three conditions and the guidelines used for each.]
- Do you have preventive service reminders for clinicians?
  - □ No
  - □ Yes, the practice uses guideline based reminders to prompt physicians about a patient’s preventive care needs at the time of the patient’s visit.
- What is the approach to managing patient care? Is it a team approach?
  - □ No
  - □ Yes, the practice maintains a team approach to managing patient care.
- What are the different components of care management used? Can you explain how various components of care management are used for one of the clinically important conditions you identified? [Evaluator: Indicate whether the practice demonstrates the use of various components of care management for patients with 1 or more of the clinically important conditions.]
- Is care coordinated with external organizations and other physicians? In other words, is there continuity of care with external organizations?
- Considering appointments in the last 60 days for all PCBHI patients in your program, how long does it typically take a patient who meets the criteria to get an initial appointment to see a care manager? [Evaluator: check one choice below.]
  - □ Same day
  - □ 1-7 days
  - □ 8-14 days
  - □ 15-30 days
  - □ 61 days or more
  - □ Never
- In a typical two-week period, what percentage of patients in the PCBHI program see more than one member of the treatment team?
  - □ ≤ 20% of PBHCI patients
  - □ 21-40%
  - □ 41-60%
  - □ 61-80%

□ ≥ 80%

- How frequently do PBHCI program staff (within or across sites) meet to plan and review services for each client?
  - □ Once a month or less
  - □ 2-3 times per month
  - □ 4-7 times per month
  - □ ≥ 8 times per month
- To what extent does care manager assess for and coordinate services to address needs beyond clinical care? How does the care manager interface with other organizations in the community? (e.g., SSI/SSDI, Medicaid, housing, income support, vocational rehabilitation, legal, etc.)

6. **Consumer involvement**
   - In what ways are consumers involved in the development, execution, and/or evaluation of the PBHCI program?
   - To what extent are consumers and their families involved in care?
     - Is there collaboration between providers and consumers?
     - To what extent are consumers involved in goal-setting and decision-making about their care? Is there shared decision-making?
     - How are patient preferences and patient readiness incorporated into the treatment plan?
   - What tools are used to involve consumers in their care? (e.g., patient access to health records, patient portals, medical report cards, charts and graphs to visually show progress, WRAPs, MH Advance Directives, etc.)

7. **Electronic capabilities**
   - Is an interactive website used to support patient access and self-management?
     - □ No
     - □ Yes, the practice maximizes electronic communication with patients via the Web to support patient access and self-management.
   - Are emails used to notify patients about specific needs or clinical alerts?
     - □ No
     - □ Yes, the practice maximizes use of electronic communication capability with emails that notify patients about specific needs and clinical alerts.
   - Is email communication used to support care management for patients with the clinically important conditions you previously identified?
     - □ No
     - □ Yes, the practice maximizes use of electronic communication among the care management team to support the care management process for patients with 1 of the 3 identified clinically important conditions.

8. **Women's and minority health cultural competency**
   - Is there a specialized women's health program at your site? If so, what services does it provide?
   - Does your program have a committee to address culture-related issues in treatment?
   - What cultural competency trainings are available for staff?
   - Have you received training in cultural competence pertaining to…
     - Gender?
     - Country of origin?
     - Race/ethnicity?
     - Age?
     - LGBT?
     - Religion?
   - Is cultural competency training required? Is a minimum number of hours of training required?

9. **Implementation**

- Who are the top three champions of integration in your organization?
- What role has the program leadership played in integration? What is the leadership style?
- What barriers have you faced in implementing the integration? What strategies have you used to overcome them?
- What have we missed? What else do we need to know that we haven't asked you?

10. **Validation of select quarterly report elements** [These are not questions per se, but rather things to look at and evaluate.]

- View data collection methods, including clinical registry/tracking system. Go through a case with a care manager to see how they use registry.
- Chart review
    - Review randomly selected MH and PC charts
        - Evaluate whether the two treatment teams demonstrate awareness of what the other is doing.
    - "Walk through" charts with PBHCI staff, with checklist approach, including:
        - Screening results documented
        - Functionality of registry
        - Care management
            - Follow-up
        - Wellness/prevention
        - MH notes mention medical conditions
        - Contact between MH and PC
        - Complementary action in MH and PC (e.g., psychiatrist adjusts meds in light of physical condition, therapist discusses weight management, etc.)