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ATTACHMENT 1

Site Visit Protocol: Leadership

This version of the protocol is for program managers, medical directors, CFOs, key administrators, and evaluators/data managers for PBHCI.

The protocol may be administered to individuals or to groups, when scheduling allows and when individuals are at roughly the same level in the organizational hierarchy.

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

Introductory Question

- What are your key responsibilities in the PBHCI program?

1. **Cooperation/collaboration across MH and PC**
   - What is the collaborative service agreement between MH and PC?
     - □ No formal agreement
     - □ Informal, unwritten agreement
     - □ MOA
     - □ Letter of commitment
     - □ Other
   - What are the components of the service agreement? (Record open-ended response, also check all that apply)
     - □ Guidelines on how rapidly patients will be seen
     - □ Policies detailing communication between primary care and mental health (i.e. sharing of clinical information about patients in a timely fashion)
     - □ Policies detailing coordination between primary care and mental health (e.g., scheduling MH and PC visits on the same day, which group is responsible for providing certain services, etc.)
     - □ Specific instructions on the proper procedure for scheduling a PC consult
     - □ Other (Please specify)
   - What is the integrated team leadership structure?
   - In what format, and how often do MH and PC providers meet? 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**
   - Describe the facilities used for PBHCI programs.
     - Describe the size and space.
     - Describe the co-location of PC services in MH setting (if applicable).
     - What is the distance between PC & MH service facilities? (if not co-located)
   - What is the number of each type of staff in the PCBHI program?
     - Medical nurse practitioners/PC physicians located in MH settings
     - PC supervising physician
     - Embedded NCM
     - Other care manager
     - Other (specify)
   - How many hours per week do staff spend in each of the various program areas?
     - Screening and referral
     - Care management
     - Wellness/prevention/early intervention
     - Other (specify)
   - Have there been difficulties recruiting appropriate staff?
   - What kind of training is provided for PBHCI staff?
     - How much provider education for integrative care is provided? Didactic only vs. hands-on training? Ongoing supervision? What kinds of providers are trained in integrative care (e.g., psychiatrists, psychotherapists, case managers, nurse care managers, PC physicians, etc.)
   - Have there been issues with staff turn-over?
   - Have there been issues or changes related to malpractice insurance?
   - What hours/days are various services available for patients?
     - Outpatient mental health services
     - Primary care services
     - Care management
     - Urgent care
     - Other (specify)
   - 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. **Performance monitoring**

- Does the practice measure performance (e.g., service data, outcomes data, etc.)? If so, what factors are measured?
  - □ No
  - □ Yes, the practice measures or receives performance data by physicians or across the practice regarding: [Check all that apply.]
    - Clinical process
    - Clinical outcomes
    - Service data
    - Patient safety
- Does the practice collect data on patient experience?
  - □ No
  - □ Yes, the practice collects data on patient experience with: [Check all that apply.]
    - Access to care
    - Quality of physician communication
    - Patient/family confidence in self-care
    - Patient/family satisfaction with care
- Does the practice share performance data and patient experience data with providers?
- How does the practice use performance data? Is performance data used to…
    - Set goals based on measurement results?
    - Improve performance of individual physicians or of the practice as a whole?
- What measures are used in measuring performance and producing performance reports? [Evaluate whether the practice measures performance and produces reports using nationally approved clinical measures.]
- Are performance measures electronically reported to external entities?
  - □ No
  - □ Yes, the practice electronically transmits performance measures to external entities.

6. **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
  - □ 31-60 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
- What is the average caseload for a full-time PBHCI care manager?
  - □ No set caseload
  - □ 1-5 patients
  - □ 6-10
  - □ 11-15
  - □ 16-20
  - □ More than 20 patients
- 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.)

7. **Evidence-based practices**
- Which evidence-based practices are you using? (e.g., SBIRT)
- What treatment guidelines (if any) are used for chronic conditions? For patients with co-occurring mental and substance use disorders?

8. **Wellness/prevention/early intervention**
- What do the wellness programs consist of? [Check all that apply]
  - □ Peer facilitators/ Peer supports
  - □ Nutrition

- □ Exercise
- □ Social support
- □ Linkages to support groups
- □ Stress management/ relaxation training
- □ Vaccinations
- □ Sexual health
- □ Other [Specify]

- How are the wellness programs operated? (e.g., Staffing? Individual vs. group format? Located in MH or PC site?)
- How available are wellness services? When are they available? (e.g., during regular clinic hours, how many days and hours per week available)

9. **Self-management support**
   - Self-management support services help patients/families better handle self-care tasks while ensuring that effective medical, preventive and health maintenance interventions take place. Other than the wellness programs we already discussed, are other self-management support services available through your program? Which services are available? [Check all that apply]
     - □Self-management support groups (*other than AA and other 12-step programs*)
     - □Individual self-management support sessions
     - □Health education materials with personalized feedback
     - □Interactive instruction given by computer
     - □Other [Specify]
   - To what extent is there individualized assessment of patient's self-management educational needs?
   - Is there a system established to identify patients with unique communication needs?
   - How, if it all, does the practice facilitate self-management of care for patients with the clinically important conditions you previously identified? [Evaluate whether the practice works to facilitate self-management of care for patients with 1 of the 3 clinically important conditions.]
   - How often does patient self-management education occur? How central is in the the care plans for patients with chronic conditions?

10. **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.)

11. **Electronic capabilities**
    - Is electronic prescribing used?
      - □ No
      - □ Yes, the practice seeks to reduce medical errors and improve efficiency by eliminating handwritten prescriptions.
    - Are electronic drug safety alerts used when prescribing?
      - □ No

 Yes, the practice seeks to reduce medical errors and improve efficiency by using drug safety alerts when prescribing.

- Is cost taken into account when prescribing?
  - No
  - Yes, the practice seeks to improve efficiency by using cost information when prescribing.
- 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.

12. **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?
- Do you offer programs to train staff 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?
- What are the most prevalent non-English languages encountered in dealing with patients at your site?

  Language(s)
  1. _____
  2. _____
  3. _____
- What language services are available for the non-English languages most commonly encountered by your staff? [For each language, indicate if the following services are currently available. Check all that apply.]
  - Bilingual staff
  - Interpreter services
  - Key forms (privacy, informed consent) available in non-English languages
  - Patient educational brochures available in non-English languages

13. **Implementation**

- What have been your key PBHCI implementation successes to date?
- What aspects are you still working toward implementing?

- How are physicians' competing demands prioritized? How do sites ensure that physicians spend adequate time/build relationships with clients?
- How are staff engaged in providing integrated care?
- How are you paying for PBHCI patient care?
- What plans do you have for maintenance and sustainability of the program?
- 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?

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

- Database review to validate the following:
    - Number of individuals with SMI enrolled in the program
    - Average number of primary care, psychiatric, prevention/wellness/early intervention, and total visits
    - Number of individuals that received on-site and off-site primary care services, including physical health screenings, prevention/wellness/early intervention, care management, and treatment.