

ATTACHMENT D  
ON-SITE STAFF INTERVIEW PROTOCOL

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## On-Site Staff Interview Protocol

### 1) Interviewee Role

- What are your key responsibilities in the PBHCI program? If you were previously at this agency, how has your role changed with the implementation of PBHCI?
- *(For providers)* What is your caseload (PBHCI vs. other)? What would be ideal?

### 2) Program Structure

- Does your program involve a **PC partner organization**? If yes, what is the collaborative service agreement between MH and PC?
  - No formal agreement
  - Informal, unwritten agreement
  - MOA
  - Letter of commitment
  - Other
- Details of the service agreement?
  - Guidelines on how rapidly clients will be seen
  - Policies detailing communication (i.e. sharing of clinical information about clients in a timely fashion)
  - Policies detailing coordination (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
- Describe the **behavioral health** services and programs that your agency provides for **adult clients with SMI**.
  - **Services:** psychotherapy, medication management, SUD treatment, support/wellness groups, care/case management, day treatment, partial hospitalization, education/employment, individual therapy
  - **Clients:**
    - o Which clients get which services? [e.g., Does obtaining Case Management depend on insurance status? How many get individual therapy / behavioral medicine?]
    - o Which clients are eligible for PBHCI? If all clients are eligible, are any prioritized? What are exclusion criteria?
  - **Organization:** Is the BH agency part of a larger health-care system or regional network? If yes, how does larger system influence PBHCI?
- Describe the **primary care** services that your program provides for **PBHCI clients**.
  - **Staff:** Who provides what services?
  - **Services:** Are **regular** PH visits scheduled?
  - **[If PC partner organization:]** Is the PC agency part of a larger health-care system or regional network? If yes, how does larger system influence PBHCI?
- Describe the **facilities** used for PBHCI programs:
  - Where are PC and MH services located? Are they co-located? Are pharmacy and laboratory also co-located?

- Describe size and space
- What is the distance between PC & MH service facilities? (if not co-located) How do consumers get from one location to another? How does the program assist (if at all)?

### SCHEDULING AND ACCESS

- What **hours/days** are various services available for PBHCI clients, **in person**?
  - Outpatient BH services
  - PC services
  - Care management
  - Urgent care (at your practice or another agency, **not including ER**)
  - Other (specify)
- What do your PBHCI clients do if they seek **routine or urgent-care** MH or PH appointments **outside regular business hours** (e.g., weekends / evenings)?
  - **If after-hours care is available at a site other than an ER**, are there written policies, defined standards, and performance monitoring about after-hours access? Is there continuity of medical record information for care and advice after hours?
- Does the program **reserve time** for PBHCI clients to get **same-day appointments or walk-ins** for MH, PH, or case management services? [Ad hoc appointments or adding to a fully-scheduled day **do not count**.]
  - If yes, does the program have relevant written policies, defined standards, and performance monitoring?
- Can appointments for MH and PC visits made during the same call, or scheduled for the same day?
- What **services** (e.g., MH / PH advice) are available to PBHCI clients **by phone** or **electronically**? During what hours?
  - **If clinical advice is provided** by phone or electronically, does the program have relevant written policies, defined standards, and performance monitoring about the timeliness of this advice?

### STAFF & PARTICIPANTS

- Which staff members make up **the care team** for PBHCI clients?
  - Staff type, number, and roles
  - Which staff positions are PBHCI-funded? (*Admin only*)
- What is the **leadership structure** of the care team?
- Is there **supervision** for integrated care activities? [Describe supervision format, frequency.]
- What kind of **training in integrated services** is provided for PBHCI staff?
  - For whom, how much, when, format: didactic vs. hands-on?
  - (*For providers*) Adequacy of training?
- Have there been **difficulties recruiting** appropriate staff?
- Have there been issues with **staff turn-over**?
- Have there been issues or changes related to **malpractice insurance**?
- What outreach programs are in place to attract potential clients in the community? Have there been any **difficulties enrolling or engaging clients** to participate in PBHCI? If yes, describe problems and solutions.

### 3) Screening and referral

- Among all clients who receive care at your MH clinic, **which clients are screened for PH conditions**? By screening, we mean getting measurements for clients' blood pressure, weight, waist circumference, or cholesterol.
  - When are initial screenings provided?
  - What screening tools do you use? [Evaluate whether screening tools are standardized and validated for the client population.]
- Among all clients who receive care at your MH clinic, **which clients are screened for SUD conditions**? By screening, we mean specific tools used to assess/monitor substance use.
  - When are initial screenings provided?
  - What screening tools do you use, for what substances, and for which clients? [Evaluate whether screening tools are standardized and validated for the client population.]
- Is **follow-up screening for PBHCI clients** conducted at regular intervals for PH conditions or SUD conditions? If so, what screenings and how often?
- Does your program have a systematic process to identify PBHCI clients who are **high-risk or complex** due to, for example, frequent hospitalizations, frequent ER visits, or non-compliance with medications? Describe.
- Does your PBHCI program have a system to **track and follow-up on lab test or imaging orders**?
  - If yes, is the system **paper or electronic**? Please describe.
  - Is there a documented process to **flag and follow-up** on overdue results and abnormal results
  - Is there a documented process for **notifying PBHCI clients** of normal and abnormal results?
- Referrals to External (Healthcare) Services
  - How are referrals to external services (e.g., specialists) managed? Are Care Managers involved, or other staff?
  - How are referrals tracked, with follow-up? [e.g., paper or electronically, sharing clinical information, tracking status of referrals, following up to obtain specialist reports] How often?
  - Which staff are responsible for follow-up with referrals?
- Non-Healthcare Community Linkages
  - How are client's non-healthcare needs (e.g., housing authority, transportation, child care, legal etc.) managed, and by whom?
  - How often are clients linked to community resources? Are these referrals tracked?
  - What kinds of partnerships do you have with community organizations? How does the integrated care team interface with other organizations in the community?

### 4) Registry/tracking

- Are **Electronic Health Records** used in the PBHCI program?
    - Are records shared between MH and PC? What information is shared and how?
    - Who uses records (MH, PC, CM)?
    - Describe the flow of information. Who collects what data, and when? Who enters data? Who checks data?
  - Is there a **clinical registry**—a system for tracking consumer information—used for documenting PBHCI clients' PC and/or MH conditions?
    - [If Y:]
    - Is the registry electronic or paper?
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- What types of information are included?
  - PC information:
  - MH information:
  - SUD information:
  - Social services information:
- **Describe the flow of information. Who collects what data, and when? Who enters data? Who checks data? (Specific to PBHCI & more generally.)**
- Who uses the registry, and for what purpose?
- Is the registry “searchable”? For example, can a clinician easily access to a list of individuals with a particular diagnosis for purposes of follow-up?  
[If Y:]
  - Is the registry used to generate lists of PBHCI clients and **proactively remind** them of necessary services (e.g., preventive care, or chronic care, or for those not recently seen by the program, or for specific medications. Describe.
- How often is the registry checked for accuracy and by whom?
- Is **electronic prescribing** used?
- What **information** and/or services are available to PBHCI clients through a **secure electronic system**? (e.g., health information, clinical visit summaries, 2-way communication with the practice, emails to notify clients about needs.) Is there an interactive website to support PBHCI client access?

#### 5) Cooperation/collaboration across MH and PC

- How often do **MH and PC providers meet**, in person, by phone, or electronically? Are there regular team meetings? What information is shared and how regularly?
- Are there separate **treatment plans** for MH and PC, or is there a single integrated treatment plan? How do MH and PC providers work together to make treatment plans? And SUD?
- How do MH, SUD and PC providers work together in ongoing **decision-making** about PBHCI clients?
- Is communication/coordination between MH, SUD and PC providers adequate? What could be improved? Any lessons learned?

#### 6) Evidence-Based Practices

- In your opinion, what are the **top 3 clinically important PH conditions** (e.g., diabetes, hypertension) **or risk factors** (e.g., smoking, obesity) that are **treated by your PBHCI program**?
  - Important conditions= common among your PBHCI clients, and have serious consequences if not managed
- Which **evidence-based guidelines** are used to treat each of the conditions above? How is fidelity to the EBP enforced?
  - Do you have a system in place that enables you to track the conditions above in your PBHCI client population?

#### Questions for staff who provide the EBP services:

- What EBP program services do you provide?
- Do the services involve meeting regularly with individuals or groups? How often? For how long?
- Do meetings involve interactive discussions and other activities? What type of activities are included?

- Do you require participants to monitor their weight, exercise, meals, or other factors? Do you provide participants feedback about their results?
- Do you provide any equipment, materials, or other concrete resources to participants to help them achieve their goals (e.g., rewards, memory aids, guides)? What do you provide?
- Do you give participants handouts, worksheets, or instructions about activities to complete at home between meetings?
- Do you use a manual or structured curriculum to guide the services you provide?
- How are patients selected to participate in the program? How long do participants typically stay in the program?
- What kind of training did you receive to implement the program? (probe for content covered, length, frequency)
- Do you receive supervision or feedback regarding the way you provide services or the outcomes participants in your program are achieving? If so, tell me about that (probe for who provides the feedback or supervision, how frequently, what information is provided)
- Do you feel the program is successful in helping participants to achieve their health goals? Why or why not?
- What do you think are the most important aspects of the program for helping participants to achieve their goals?
- What aspects of the program do you think could be improved or changed to make it more effective?

#### 7) Care Management and Continuity of Care

- How is client care coordinated (i.e., designated care manager, case manager, care coordinator; direct communication between providers)?
- What types of staff are involved in care management for your clients with PBHCI?
- What services do they provide and who gets which services? (Address following-up with clients re ER or hospital visits, and exchanging client information with other facilities)
- What is the **average caseload** of PBHCI clients for full-time care managers?
- What is done to **manage PBHCI clients' medications**? Does the program keep up-to-date lists of clients' current medications? Are safe-guards in place when multiple medications are prescribed?
- Are PBHCI clients expected to select a personal PC physician? If yes, is their choice documented? Does the program monitor the percentage of client visits with a specific clinician or team?

#### 8) Wellness, Illness Prevention, and Other Self-Management Support

- What types of preventive services are available for your PBHCI clients? (e.g., immunizations, mammograms, fasting blood sugar, stress test, sexual health services )
  - Do you collect measures of preventive service use, such the number of clients who have received appropriate immunizations? If yes, are these measures used for performance monitoring or quality improvement? How?
  - What wellness or self-management services does your practice provide for adults with SMI? Please describe.
- How do you decide which clients get these services? Is the format group or individual? When are the services available?
  - Peer facilitators/ Peer supports

- Nutrition
  - Exercise
  - Social support
  - Linkages to support groups
  - Stress management/ relaxation training
  - Other [Specify]
- Are PBHCI client referrals to wellness programs or documented in their treatment plan, with stated goals?
  - What services does the program offer to clients who have a PC provider elsewhere? Can clients participate in 'PBHCI' if they get their PC elsewhere but want/need wellness services at the PBHCI clinic? (e.g., smoking or weight or walking groups)? How are those individuals differentiated in the data?

### 9) Client (and family) Involvement

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

### 10) Performance Monitoring

- [For providers:] Do you receive feedback about your own performance or productivity? How about for PBHCI-specific measures? If yes, describe feedback and how it's used.
  - [For providers:] Do you receive information about the performance or productivity of the PBHCI program? If yes, describe feedback and how it's used.
  - [For admin:] How do you monitor the performance of your PBHCI program? [Open-ended, then prompt with the following:]
    - Do you track outcomes for PBHCI clients with chronic conditions (e.g., diabetes, heart disease, asthma)?
    - Do you track PBHCI clients' utilization information related to **health care costs**? (e.g., ER visits, hospital readmissions, generic vs. prescription medications)?
    - Do you get **feedback from PBHCI clients** about their experiences with the program and care? In what format?
    - Do you use any of the data you are required to collect for the PBHCI grant? How? And how often? (e.g., quarterly, bi-annual or annual presentations to the team?)
  - [For admin:] How are performance measures used to improve the quality of your program?
  - [For admin:] Does the program share PBHCI performance data within the program, to clients, or to external entities? What type of data is shared?
  - **Data Collection:**
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- What is the current method for collecting data on utilization and quality of care?
- What type of data is collected?
  - What other type(s) of data may be useful to collect based on your experience?
- Who has access to data?
- Describe any burdens/challenges associated with data collection?
  - What technical assistance tools would help?
- In what way is the data analyzed? What are plans for ongoing/future data analysis?
- Who is responsible for data analysis (e.g., internal staff member, contracted external evaluator, etc.)?
- How will data collection and analysis be used to benefit the program?
- Describe any challenges and solutions associated with data sharing and analysis?

### **11) 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?
- (For providers) Have you had any women or minority health cultural competency training? If yes, please describe.

### **12) Implementation**

- What have been your key PBHCI implementation successes to date?
- What aspects are you still working toward implementing?
- How are you paying for PBHCI client 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? (If necessary, prompt with: Types of barriers include problems hiring qualified staff, coordinating MH and PC leadership, billing/financing issues, and lack of client interest in the program.) What strategies have you used to overcome them?
- What policies have drive the way that you provide and sustain integrated care? These could include federal, state, local or agency-level policies.
- What have we missed? What else do we need to know that we haven't asked you?