IPBH

INTEGRATED PRIMARY & BEHAVIORAL HEALTHCARE

Integrated Treatment Tool

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Integrated Treatment Tool
"IT"
A Tool to Evaluate the Integration of Primary and Behavioral Health Care

This tool is to evaluate the presence and extent of a Person-Centered Healthcare Home Model that integrates primary and behavioral healthcare services. The target population for this model is the grossly underserved group of people who meet criteria for severe and persistent mental health conditions who may have any range of primary and/or behavioral health care needs. An integrated holistic approach to care requires a structured approach to the coordination of all aspects of a patient's life (including behavioral, physical, and spiritual health in addition to basic needs of safety, security, and social/sense of belonging). The goal of this approach is to increase health outcomes, improve quality of life, and decrease fragmentation of care.

While the platform for the model is the concept of a "Medical" or "Healthcare Home," there are several areas that needed to be added or adapted to meet the needs of people who meet criteria for severe and persistent mental health conditions. As evidenced by the fact that people who meet criteria for severe and persistent mental health conditions die on average 25 years younger than their non-ill counterparts, existing approaches have not been effective with this population.

Guiding Principles:

- Person-centered
- Recovery focused
- Integrated approach (integration of the three domains of care: mental health, substance related, and other medical conditions) – care within and among these domains is well coordinated
- Multi-disciplinary health care team
- Stage-based and motivational
- Holistic
- Stepped care

An integrated approach addresses not only the needs that fall within the larger domains of care – mental illness, substance use (including tobacco), and other medical conditions – but addresses how each of these conditions and their treatment impacts the other conditions and treatment. An integrated approach occurs when all clinicians are well trained in mental health, substance use (including tobacco), and other health conditions and the interactions among the conditions and their treatments. In addition to training, their individual interventions are

based on the knowledge of the whole person, his/her goals and readiness to address behavior change, what conditions and treatments are present, and address the interaction of each of these domains on the others.

This tool is separated into three sections to highlight the need for attention to these distinct aspects of implementing an integrated approach to care for this population.

Section I. *Organizational* Characteristics – the structural aspects of implementation.

Section II. *Treatment* Characteristics – the clinical components of implementation. It is important to pay attention to the presence as well as the quality of services and interventions employed.

Section III. *Care Coordination/Management* Characteristics – a critical aspect to an integrated approach. Care coordination/management is a set of activities designed to increase access, improve health-related outcomes, and decrease fragmentation of care.

The tool was developed incorporating the best available evidence – combining theoretical, empirical, and practice based knowledge. It is important to note that while several models that address pieces and components of this tool exist, the combined model/approach does not rise to the level of an evidence based practice. While each element presents gradations toward a theoretical ideal (rating of 5 based on a continuum of 1 through 5), it is possible that "lower" levels within an element may be sufficient to produce significant results.

For more information about the Tool, its development and application please contact:

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The IT Tool was developed, in part, with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) Grant Number: 1H79SM059555-01. Its content are solely the responsibility of the authors and do not necessarily represent the official views of SAMHSA.

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Part I: Organizational Characteristics

O1. Organizational Philosophy

Definition: Organization stakeholders understand and accept core elements of the integrated health care model and are committed to a strategic plan for its implementation. Core elements understood and accepted by the organization should include: (a) a person-centered medical home; (b) a health care team (including one person who leads the team); (c) stepped care (levels of care based on need and severity); (d) a motivational approach based on the patient's readiness to engage in health behavior change; (e) "integrating" primary and behavioral clinical care; and (f) a whole health approach (including mind/body/spirit). The expectation is that stakeholders will clearly articulate and convey *intention* to implement core elements. The organization displays written postings (e.g., brochures, bulletin boards, posters) about primary health care and integrated health care services that clearly reflect core principles.

One or more representative(s) from a given source group count(s) as one source (e.g., two case managers, a therapist, and the CEO = 2 source groups); where perspectives within a source group differ, calculate an average for the group.

Sources:

1. Senior Leadership
2. Medical professionals (e.g. MD, DO, APN, RN, LPN)
3. Clinical staff (e.g. case managers/Community Psychiatric Supportive Treatment, counselors/therapists, and peer support specialists)
4. Written Materials (e.g. policies, brochures, service menus/descriptions, literature, posters, advertising, and/or other sources of health information throughout the facility or on the website)
5. Patients and families

1	One or fewer of the sources displays a clear understanding of and intent to implement core elements of the Model
2	2 of the 5 sources display a clear understanding of and intent to implement core elements of the Model
3	3 of the 5 sources display a clear understanding of and intent to implement core elements of the Model
4	4 of the 5 sources display a clear understanding of and intent to implement core elements of the Model
5	All 5 sources display a clear understanding of and intent to implement core elements of the Model

O2. Organizational Policies and Procedures

Definition: The organization develops ***written*** policies and standardized procedures for each component of the integrated health care Model (outlined in this measure). These policies and procedures define how these components are implemented at the organization.

Components of the model addressed/supported through written policies and procedures include:

Integrated Health Information/Technology, Multi-Disciplinary Health Care Approach, Interdisciplinary Communication, Care Manager, Peer Supports, Organization-Wide Training, Clinical Supervision, Guidance and Monitoring, Continuous Quality Improvement (CQI), Patient-Centered Approach, Patient Access and Scheduling, Executive Leadership Team Involvement, Integrated Approach, Comprehensive Identification, Holistic Integrated Care Plan, Integrated Stage-Appropriate Treatment, Outreach, Stepped Care, Use of Motivational Interventions, Self-Management Skill Development, Pharmacological Approaches, Involvement of Social Support Network, Care Coordination, Laboratory and Test Tracking, Referral Tracking, Medication Reconciliation, Reminders, Transitions between settings/levels of care, and Assessing the effectiveness/quality of care received

1	Organization has less than half of the components in written policy
2	Organization has written policies and procedures for all components
3	Staff are oriented to all policies and procedures within 30 days of hire and/or within 30 days of institution of a new policy or procedure
4	Practice accurately reflects written policies and procedures
5	Policies are revised and reviewed as the practice changes

O3. Integrated Health Information/Technology

Definition: The organization maintains a structure for integrating documentation, prescribing, and retrieval of all patient information that supports comprehensive, integrated patient care and ongoing effective care management and coordination It includes but is not limited to: problem lists, care plans, progress notes, prescriptions, test orders and results. In addition, the system allows for population management and retrieval (i.e., disease/risk registries and/or registry management). The system provides a secure interactive website/portal that allows patients to: a) request appointments, referrals, test results, prescription refills; b) see elements of their medical record; and c) import elements of their medical record into a personal health record. Electronic Health Records meet certification standards and follow all applicable laws as well as guidelines for Health Information Technology and Meaningful Use guidelines.

The structure includes the following elements:

1. systematic patient data management
2. tracking of clinical outcomes
3. creation and tracking of clinical registries
4. billing

5. is readily accessible to the integrated health staff in real time
6. provides a secure interactive website/portal for patients

1	The organization's Information Technology structure includes 1 or fewer elements.
2	The organization's Information Technology structure includes 2 elements.
3	The organization's Information Technology structure includes 3 or 4 elements.
4	The organization's Information Technology structure includes 5 elements.
5	The organization's Information Technology structure includes 6 elements.

O4. Multi-Disciplinary Health Care Approach

Definition: Services are provided by primary and behavioral health care staff representing a range of professional disciplines. At minimum, areas represented by health care staff include: physicians (generalists and psychiatrists), addictions, nurses, social workers/counselors, care/case coordinators/managers, peer specialist, other specialty care providers (e.g., nutritionist, exercise specialist/wellness coach, podiatrists, dentists), and other providers (e.g. pharmacists, housing managers, employment staff, and court liaison). These areas could be represented by people with cross training and strong clinical skills in multiple domains. These clinicians demonstrate use of the cross training/clinical skills working in multiple areas/domains throughout the organization. All healthcare staff work collaboratively.

Roles should be well defined in policies and procedures (see O2) and a structure exists to support excellent communication and collaboration.

Staffing configuration consists of:

1	Medical staff only
2	At least one medical provider (physician or nurse) with primary care specialty and at least one clinician with mental health or addictions specialty (e.g., could be a social worker or counselor)
3	At least one medical provider (physician or nurse) with primary care specialty and at least one medical provider (physician or nurse) with psychiatric specialty and at least one clinician with behavioral health specialty (either mental health or addictions)
4	At least one medical provider (physician or nurse) with primary care specialty and at least one medical provider (physician or nurse) with psychiatric specialty, at least one clinician with mental health specialty, and at least one clinician with addictions specialty OR one clinician who has co-occurring capability
5	At least one medical provider (physician or nurse) with primary care specialty and at least one medical provider (physician or nurse) with psychiatric specialty, at least one clinician with mental health specialty, and at least one clinician with addictions specialty OR one clinician who has co-occurring capability **and** at least one peer specialist

O5. Interdisciplinary Communication

Definition: Communication among all practitioners occurs frequently and includes information such as the status of all health conditions, patients' readiness for and levels of treatment across conditions, psychosocial and pharmacological interventions employed, tests ordered and test results, and patient response to treatment. Verbal, electronic, and/or written communication may occur in the context of regularly scheduled meetings or informally. Modes of communication should be easily accessible, reliable, confidential, timely, and utilized by all staff, including psychiatrists/primary care physicians, nurses, care coordinators, case managers, social workers, counselors, therapists, nutritionists, dieticians, pharmacy, lab, wellness coaches, peer specialists, and other supports (e.g., peer supports, employment specialists, housing liaison, and group facilitators).

Excellent communication is critical because it ensures that: 1) presenting symptoms and complaints are interpreted properly, (e.g., symptoms of nicotine withdrawal might be incorrectly interpreted as psychiatric de-compensation if the clinician is unaware that the patient has stopped tobacco use); 2) motivational-based treatment approaches are appropriate to the patients' stage and coordinated such that they support the change process rather than patient interventions and procedures be viewed by patients as bothersome or harassing; 3) strengths and/or challenges to treatment are known and addressed; and (4) all staff are employing a person-centered, integrated, holistic approach to care.

Evidence of integration via excellent interdisciplinary communication includes attention to these elements:

1. Includes all staff involved in patient care;
2. All relevant health information is documented in an integrated medical record;
3. Information is accessible in real time by all staff;
4. Staff utilize information in team meetings, individually with other staff, and in supervision

1	None of the four elements is present
2	One of the four elements is present
3	Two of the four elements are present
4	Three of the four elements are present
5	All four communication elements are present

O6. Care Manager

Definition: One of the guiding principles of the Person-Centered Healthcare Home is the presence of one person with whom the patient can develop a trusting relationship who will help the patient navigate and fully participate in his/her own healthcare. Each patient has one person identified as his/her "care manager." (Note: the title is referred to in varying ways: e.g., care manager, care coordinator, care navigator, etc. The title is less critical than the functions of this person.) It is expected that the majority of care management and coordination activities with the patient are face-to-face (with the availability of telemedicine, as needed). The care manager facilitates communication among all providers as well as empowers the patient to be as active a participant in the multi-disciplinary approach as possible. While it is

not the responsibility of the care manager to do all of the services and communications amongst the care providers, it is the role of the care manager to ensure all needs and services are addressed and followed up on.

The role of the care manager includes the following duties/expectations:

1. is to be the single point of contact for the patient
2. ensures communication among all internal staff
3. ensures communication among all external providers (including referrals, laboratories, and/or testing facilities)
4. develops and maintains the care plan
5. ensures that appropriate providers follow-up on information from other providers
6. communicates with the Executive Leadership Team (including Quality Improvement staff) to identify obstacles and be a part of the CQI process to enhance and improve services

1	The organization does not have an identified “care manager” for each patient or only one of the 6 duties/expectations are delineated for this role
2	2 of the 6 duties/expectations are delineated for this role
3	3 or 4 of the 6 duties/expectations are delineated for this role
4	5 of the 6 duties/expectations are delineated for this role
5	All 6 of the duties/expectations are delineated for this role

O7. Peer Supports

Definition: The organization employs individuals who posses the lived experience of the patients served by the practice. Peer supports provide an array of services including (but not limited to) wellness and/or nutrition coach, health educator, travel training, benefits access and navigation, self-management skill development, mentoring, self-help access and facilitation, and offer cross-training to other team members in recovery principles and strategies. Peer support selection is based on established criteria and they receive training and supervision in order to develop skills and abilities while fulfilling their many roles. The facility may choose to adopt existing peer specialist certification standards where appropriate.

Elements of peer supports include:

1. Peer support personnel are members of the multi-disciplinary health care team (participate in treatment team meetings, are included in interdisciplinary communications, participate in treatment plan development and support, document their interactions in the integrated health record)
2. Peers receive adequate training in the conditions, approaches, treatments, side effects, and interactions among mental health, substance related, and other health conditions
3. Peers receive regular supervision
4. Peers are employed by the organization commensurate with their skills, abilities, and education and commensurate with the organization’s Human Resources policies and procedures

1	No peer supports are employed by the organization or none of the four key elements is present
2	One of the four key elements is present
3	Two of the four key elements are present
4	Three of the four key elements are present
5	All four of the key elements are present

O8. Organization-Wide Training

Definition: All organizational personnel receive standardized training in mental illness, substance use (including tobacco), and other medical conditions for professional development in knowledge and skills appropriate to their roles and functions. Personnel roles included in the training are clinical as well as support, fiscal, MIS, and other personnel who come in contact with patients or patient information: e.g., psychiatrists/advanced practice nurses with psychiatric specialty, primary care physicians/ advanced practice nurses with family practice specialty, nurses, psychologists, social workers, counselors, therapists, care/case managers, care coordinators, peer support specialists, and other specialists such as housing supervisors, employment staff, court liaison.

Targets of the training include (but are not limited to) the patient population-specific high risk diseases:

- signs and symptoms
- risk factors
- treatments (including both medications/prescriptions, psychosocial, and alternative methods – delineating the knowledge and strength of evidence behind their effectiveness)
- knowledge about the interactive effects of mental illness, substance use (including tobacco), and other medical conditions and implications for holistic illness/wellness management.
- Preventative and monitoring tests and assessments related to the patient population-specific high risk diseases (especially as it related to co-occurring chronic conditions – e.g. schizophrenia, diabetes, and alcohol dependence).

Skill development should target motivational and active treatment approaches to assist patients with self-management and health behavior change. Skill development should also target cultural, religious, spiritual, and behavioral needs associated with this population. Self-directed training methods are used as a supplement (not the sole) method of skill development. Supervision is used as another naturally-occurring method of skill development.

Elements of organization-wide training include:

1. Training requirements include mental health, substance use (including tobacco), other health conditions, and the interactions amongst all of these
2. Organization has competency standards for professional development for each staff person according to role and function

3. All staff have a training plan developed within 90 days of hire according to role and function
4. Organization has implemented a plan for monitoring and evaluating competency standards annually
5. Booster training is provided according to role and function

1	The organization meets 1 or fewer elements
2	The organization meets 2 elements
3	The organization meets 3 elements
4	The organization meets 4 elements
5	The organization meets 5 elements

O9. Clinical Supervision, Guidance and Monitoring

Definition: Staff members receive supervision, guidance and monitoring of clinical care on a regular basis from a practitioner knowledgeable and/or experienced in the model appropriate to their roles and functions and in accordance with discipline-specific licensing, credentialing, or regulatory requirements. Lines of supervision are clearly delineated in the table of organization. The supervision can be provided in groups or individually and might occur in the context of naturally occurring activities. Examples of competencies to be monitored and addressed in supervision include: work with people with mental health, substance use (including tobacco), and other medical conditions, patient self-management skill-building, professionally accepted guideline/evidence-based interventions, motivational/stage-appropriate approaches, group facilitation, and skilled use of relevant curricula.

Patient-specific clinical supervision, guidance, and monitoring includes:

1. Supervision for core primary and behavioral treatment staff at a frequency needed to adequately guide clinical care
2. Patient case review (versus administrative tasks) as the focus
3. Use of observation during naturally occurring activities of all health care staff
4. Review of patient care documented in the integrated medical record
5. Access to supervision, guidance, and monitoring for all organization staff, including non-clinical personnel

1	The supervisory structure includes one or fewer of the components.
2	The supervisory structure includes two of the five components.
3	The supervisory structure includes three of the five components.
4	The supervisory structure includes four of the five components.
5	The supervisory structure includes all five of the five components.

O10. Continuous Quality Improvement

Definition: The organization's QI structure includes an explicit plan to review clinical and organizational components of the integrated primary and behavioral health care services. This review is part of routine QI procedures.

Clinical components of the model are monitored through the use of patient-level outcomes and indicators across all healthcare domains. Change over time in mental illness, substance use (including tobacco), and other medical conditions is tracked using a standardized set of outcomes indicators. This set includes specific health measures (e.g. vital signs, lab results) as well as scales, questionnaires, or tools that can assist in tracking change over time in the targeted outcomes indicators. Individual patient-level outcomes are shared with clinicians and patients and used to demonstrate progress, help maintain motivation for treatment adherence, and/or encourage patients to try new approaches. Aggregated outcomes are shared with key stakeholders (e.g. funders, agency administrators, patients and organization staff).

Organizational components of the model are monitored through implementation process measures. Members of the organization's executive leadership team and clinical program leaders monitor the process of implementing the model with intensity commensurate with the needs of the practice – e.g., annual evaluation using a standardized tool and then monthly process monitoring from program initiation for the first year with frequency adjusted according to need (minimally, every six months). Process data are used to improve the program. Effective process monitoring involves a standardized approach, e.g., use of a fidelity scale and/or model guidelines to assess the presence/absence of model components. Monitoring methods include review of patient records, training records, supervision logs, patient satisfaction survey data, and use of feedback on individual clinician performance as well as appointment lengths, no show rates, referral tracking, and other clinic management indicators as recommended for the practice.

The expectation is that a specific Action Plan based on data and/or evaluation findings is developed that includes documentation and prioritization of action steps, time frames, responsible parties, and results. The Action Plan is based on input from all key stakeholders (including steering committee, executive leadership, staff, patients, and other key stakeholders). The CQI data are used to improve effectiveness, efficiency, timeliness and other aspects of quality by generating performance reporting, allowing comparison to national benchmarks, giving practitioners regular feedback, and informing action plans for next steps.

CQI should include the following elements for both clinical and organizational components:

1. An Action Plan based on data and/or evaluation findings including specific steps, time frames, responsible parties, and results
2. Standardized outcomes and indicators across all domains (mental health, substance use including tobacco, and other medical conditions)
3. CQI Action Plan review/monitoring occurs frequently enough to adequately and proactively assess and respond to implementation CQI needs as well as to correspond with time frames identified in the Action Plan (minimum every six months)
4. Information is used for program improvement
5. Information is used for patient improvement (results are shared with clinicians and patients)

1	The CQI plan/procedures contain one or fewer of the five elements
2	The CQI plan/procedures contain 2 of the five elements
3	The CQI plan/procedures contain 3 of the five elements
4	The CQI plan/procedures contain 4 of the five elements

5	The CQI plan/procedures contain all of the five elements

O11. Patient-Centered Approach

Definition: All services are patient-centered. The patient is to be actively involved in all aspects of his/her care planning and management. All patients are offered choices that include referral to, provision of, as well the choice to refuse treatment. All patients are offered a range of individual and group interventions (psychosocial and pharmacological) with no arbitrary exclusion criteria or time limits. Practitioners consider and abide by (a) patient preferences for the type, duration, and frequency of services; (b) patient needs based on strengths, challenges, stage of change readiness and motivation; and (c) accessibility, language, and communication preferences (and provide necessary accommodations, where appropriate – e.g. vision, hearing, or other physical limitations). Information about the expectations and responsibilities of both the practitioner and the patient are clear and understandable. The practice communicates risks and benefits that facilitate informed consent and shared decision making.

The practice provides written information and empowers patients (and their support network members, as appropriate) to access the integrated primary and behavioral health care services offered at the organization including information about the role and functions of the medical home.

Key components:

1. Patients are informed of the range of services available – as evidenced by readily accessible materials for patients and members of their support network (e.g. brochure, "menu" of services shared at intake and throughout the course of involvement in services, on the organization's website, flyers/posters in lobby and other public areas)
2. A range of services are available and reflect the range of needs, stages of change readiness, and motivation for behavior change
3. No arbitrary exclusion criteria or arbitrary time limits on services
4. Evidence of respect and accommodation for the range of communication, accessibility, and cultural needs of the patient population
5. Evidence of shared decision making

1	A patient-centered approach is evident in one or fewer of the five elements.
2	A patient-centered approach is evident in 2 of the five elements.
3	A patient-centered approach is evident in 3 of the five elements.
4	A patient-centered approach is evident in 4 of the five elements.
5	A patient-centered approach is evident in all of the five elements.

O12. Patient Access and Scheduling

Definition: The organization uses multiple methods to support patients' access to care. The intent is to support patient access during and after regular business hours. Determinations for scheduling are based on patient need (especially urgency of need) as well as continuity of care, patient preference, convenience, and resource management. Methods include the following:

1. Admission: has a specific protocol that delineates how one becomes a patient of the practice (including self-referral)
2. Triage of presenting problems: has a well-defined, documented triage protocol (that includes, for example, how soon a patient needs to be seen and in what setting; same day appointments; and criteria for referral to specialty care)
3. Response to request for care: provides response within a specific time (either via phone or secure e-mail)
4. Availability: after hours (24 hours a day, 7 days a week)
5. Schedules each patient with a personal clinician for continuity of care
6. Convenience: coordinates visits with multiple clinicians and/or diagnostic tests during one office visit
7. Has a protocol to address warm hand off
8. Has a protocol to address walk-in
9. Provides a secure interactive website/portal that allows patients to request appointments (e.g. by reviewing clinicians' schedules)
10. Provides telemedicine services via interactive video technology in accordance with professional and/or regulatory parameters

1	The organization utilizes up to 2 methods to support patient access
2	The organization utilizes 3 or 4 methods to support patient access
3	The organization utilizes 5 or 6 methods to support patient access
4	The organization utilizes 7 or 8 methods to support patient access
5	The organization utilizes 9 or 10 methods to support patient access

O13. Executive Leadership Team Involvement

Definition: Organization Executive Leadership Team members (e.g., CEO/Executive Director, Chief Operating Officer, QI Director, Chief Financial Officer, Clinical Director, Medical Director, and Human Resources Director) are actively involved in the implementation of the Integrated Health Care model and in ensuring sustainability of the services.

The following are evident:

1. Members of the Executive Leadership Team demonstrate knowledge regarding the core principles of the model
2. The organization's CEO/Executive Director communicates how the model supports the mission of the organization and articulates clear and specific goals for services to all agency staff, (e.g., at a kickoff event, all-staff meetings, via agency newsletters, etc.) and these functions are not delegated to another administrator

3. The Integrated Health Care program leader shares information about implementation facilitators and barriers with the Executive team (including the CEO) at least twice each year. The Executive team helps the program leader identify and implement solutions to barriers
4. Representatives from the Executive Leadership Team actively participate in the committee/group monitoring the process of model implementation (including but not limited to penetration targets and rates achieved)
5. The Executive team has primary responsibility for monitoring the fiscal status of the services and developing specific strategies to ensure sustainability

1	One or fewer of the elements of Executive Leadership Team involvement is/are present
2	2 of the 5 elements of Executive Leadership Team involvement are present
3	3 of the 5 elements of Executive Leadership Team involvement are present
4	4 of the 5 elements of Executive Leadership Team involvement are present
5	All 5 of the 5 elements of Executive Leadership Team involvement are present

O14. Integrated Approach

Definition: An integrated approach addresses not only the needs that fall within the three larger domains of care – 1) mental illness, 2) substance use (including tobacco), and 3) all other medical conditions – but addresses how each of these conditions and their treatment impacts the other conditions and treatment. An integrated approach occurs when all clinicians are well trained in mental health, substance use (including tobacco), and other health conditions; and the interactions among them and their treatments. In addition to training, their individual interventions are based on the knowledge of the whole person, what conditions are present and treatments provided, and address the interaction of each of these domains on the others.

1	All three service domains are addressed by different clinicians (typically from different entities/organizations); information-sharing only occurs via occasional release of information where assessments, chart notes, and/or treatment summaries are sent between entities (no integration/separate treatment)
2	Though still separate entities, organizations, or departments, direct communication about issues and treatments occurs; such communication is sporadic or unstructured (parallel treatment/partnership)
3	Though still separate entities, organizations, or departments, clinicians have a specific protocol for ongoing communication with other providers about all shared patients (parallel treatment/partnership or co-located)
4	2 of the 3 domains of care are at the same entity/organization in the same physical location and intervention planning and services involve coordination among the providers (co-located or integrated)
5	All 3 domains of care are at the same entity/organization in the same physical location and intervention planning and services involve coordination among the providers (integrated)

Part II: Treatment Characteristics

T1. Comprehensive Identification

Definition: The organization has a mechanism to *identify* the immediate and long-term needs of its patients. The identification of needs includes history and current status of all mental health, substance-related, and other physical health condition status (symptoms and diagnoses) at minimum including the following information: Demographic and family characteristics; patient medical history including all diagnoses; patient behavioral conditions, behavioral risks; status of age-appropriate preventive services (e.g. well woman or prostate exam; immunizations); dates of most recent medical visits (including dental); identification of all medications (prescribed and over-the-counter – including dose); allergies and adverse reactions; advanced care plans; barriers to communication (e.g., language preferences), and vision/hearing impairment. In addition, the identification needs assessment includes height, weight, calculated body mass index (BMI), waist circumference, determination of risk for metabolic syndrome, pulse, blood pressure, lipid profile, glucose; mental status exam, assessed risk of danger to harm self or others, current and past substance use (e.g. through the use of CAGE, CAGE-AID, DAST, UNCOPE); and other tests and assessments deemed necessary. The needs assessment also includes basic needs (e.g. housing, entitlements), psychosocial, and spiritual needs.

Documentation of the following critical elements:

1. History and current mental health status
2. History and current substance use status
3. History and current physical health status
4. Information is used to inform intervention (not just documented in the medical record)

1	One or fewer of the elements of the comprehensive identification process is present
2	Two of the elements of the comprehensive identification process are present
3	Three of the elements of the comprehensive identification process are present
4	All four of the elements of the comprehensive identification process are present
5	All four of the elements of the comprehensive identification process are present AND information is updated as clinically indicated by mental health, substance use disorder, and/or physical health status changes (and minimally annually)

T2. Holistic Integrated Care Plan

Definition: The holistic integrated care plan is the road map followed by all involved in the patients' care. First and foremost, it respects the patients' goals and objectives and readiness to address individual needs identified. The care planning process also includes consideration of current and past symptoms/diagnoses, treatments, and response to treatment for all mental health, substance-related, and other physical health conditions. Minimally, the care plan identifies all care providers; the needs and goals they are addressing; and is accessible

to all involved in the patient's care to help facilitate coordination of care. It explicitly addresses the impact and interaction of psychiatric illness, substance use, and other medical conditions as well as the patient's level of motivation/readiness to make necessary health behavior changes. The impact of all health conditions on multiple life areas (e.g. housing, social support, employment) is addressed. Substance use, including nicotine, is addressed using a standardized protocol. Numerous sources of information are important for a holistic integrated care plan. The plan is reviewed regularly and modified according to the patient's status (including but not limited to transitions between levels/settings of care, identification of new risks or conditions, test, laboratory, or referral results, and changes in readiness for health behavior change).

The following elements are addressed:

1. Identification of all care providers and the needs/goals each is addressing
2. Interaction of all health conditions and treatments
3. Impact of health conditions on multiple life domains, e.g. self care, family/other/peer relationships and support; work and meaningful activity; housing; access to resources (including insurance coverage)
4. Facilitators of recovery (e.g., patient strengths; family/support network) and perceived barriers to recovery for all health conditions (e.g., inadequate housing, lack of social supports, lack of monetary resources/entitlements; access and communication barriers)
5. Readiness for health behavior change

1	None or one of the elements of the holistic integrated care plan is present
2	Two of the elements of the holistic integrated care plan are present
3	Three of the elements of the holistic integrated care plan are present
4	Four of the elements of the holistic integrated care plan are present
5	All five of the elements of the holistic integrated care plan explicitly address mental health, substance-related, and other health conditions

T3. Integrated Stage-Appropriate Treatment

Definition: Patient treatment delivery matches the identified need(s), goals, objectives, and interventions outlined in the integrated medical record. Treatment follows a whole health approach that addresses mental health, substance use, and other health treatment needs in a stage-appropriate manner. Treatment recommendations identify both the target of the intervention (e.g., specific symptoms, social problems, and/or substance use behaviors) and the intervention itself. All treatment is integrated – that is, treatment recommendations and interventions address the interactions among mental illness, substance use, and other health conditions. An example of such integration would be to help a patient in contemplation understand how reducing heavy tobacco smoking could alleviate COPD. Another example is providing nutritional counseling to help a patient in the action stage address weight gain that may be associated with psychotropic medications. Wherever possible, clinical care follows accepted expert clinical guidelines in the context of patient preference, choice, and stage of readiness.

Critical components of individualized and integrated treatment include:

1. Treatment goals clearly take into account the interaction of the patient's primary and behavioral health conditions
2. There is clear evidence that treatment interventions match the patient's readiness to change and patient choice
3. The treatment interventions maximize patient self-management skills and/or skill development
4. Treatment is stage-appropriate across all practitioners

1	There is evidence of one or fewer of the critical components
2	There is evidence of two of the critical components
3	There is evidence of three of the critical components
4	There is evidence of four of the critical components
5	There is evidence of all four of the critical components and the treatment approach is modified overtime, as needed according to changes in the patient's status

T4. Outreach

Outreach combines a focus on the physical location of services with the philosophical understanding of the therapeutic alliance. Outreach is used to engage the patient and build a trusting relationship. Outreach services are provided in the environment most comfortable for the patient – typically in his/her home, the home of a trusted person, or other location outside of the treatment facility. Outreach can also encompass "street outreach" where staff go to parks, the streets, or shelters and provide basic needs (e.g. blankets or food) or to engage the patient in conversation with the goal of meeting practical needs of the patient and build a trusting relationship. In addition (though not exclusively), outreach could entail primary care providers meeting with patients in the care manager's office, peer support center, or other non-traditional medical settings.

Outreach is an effective approach to help patients who:

- Are in earlier stages of readiness to engage in health behavior change
- Have cognitive and/or psychiatric challenges that interfere with independent functioning
- Live in rural areas
- Have transportation difficulties
- Have physical conditions making independent or assisted travel more difficult
- Have dependent care or other home-related barriers
- Do not routinely or easily keep scheduled appointments
- Do not follow through with appointments, tests, or referrals

Elements of outreach include:

1. The organization has a method in place to assess the need for outreach
2. Identify and link personnel to provide and/or coordinate outreach
3. Elements of the care plan identify and address underlying needs for outreach

4. The organization has a system in place for periodic reassessment of the ongoing need for outreach

1	None of the four key elements are present
2	One of the four key elements are present
3	Two of the four key elements are present
4	Three of the four key elements are present
5	All four of the key elements are present

T5. Stepped Care

Definition: Treatments and services reflect the patients' level of care needs. Level of care is determined using a standard set of criteria based on accepted published guidelines and clinical assessment. Level of care needs are re-assessed on a regular basis and the intensity of services are adjusted (stepped up or down) to match the patients' assessed need, self-management skills, and readiness for change. The integrated medical record must reflect the level of care indicated for each condition as well as the patient's readiness to engage in treatment across conditions.

Critical components of Stepped Care include:

1. Treatment interventions account for levels of care for each condition appropriate to the individual
2. Level of care is assessed using a standardized set of criteria (based on accepted guidelines)
3. Level of care is based on patients' self management skills
4. Level of care is based on patients' readiness for change
5. Level of care/intensity of services is adjusted based on ongoing assessment

1	There is evidence of one or fewer of the critical components
2	There is evidence of two of the critical components
3	There is evidence of three of the critical components
4	There is evidence of four of the critical components
5	There is evidence of all five of the critical components

T6. Use of Motivational Interventions

Definition: Motivational Interviewing (MI) is a collaborative, person-centered, form of guiding to elicit and strengthen motivation for change. MI is a way of being with the patient that is non-confrontational. It enables patients to develop discrepancy between what they want in life and what keeps them from achieving their goals. Staff members who work with patients who are ambivalent about any part of their treatment embrace the spirit and philosophy of a motivational approach and use strategies such as: expressing empathy; developing discrepancy between personal goals and continued behaviors; avoiding argumentation/rolling with resistance; and instilling self-efficacy and hope.

Successful motivational interventions require that the majority of staff interacting with patients are knowledgeable and skilled in its delivery. All staff who interact with patients understand and utilize stage-appropriate MI principles and strategies. In addition, all staff are observed in practice by skilled providers who offer constructive feedback to advance the practice. Motivational interventions are documented in the clinical record.

At a minimum, a majority of staff who interact with patients meet one of the criteria below:

1	Staff knowledge of MI is negligible or limited to a very basic understanding of the philosophy of motivational interventions only as demonstrated by interview with staff and observation of interactions with patients.
2	Staff have received training in basic principles and strategies
3	Staff can articulate how basic principles are applied in practice
4	Staff demonstrate application of basic principles as observed during field mentoring
5	Appropriate interventions are applied and documented in the clinical record

T7. Self-Management Skill Development

Definition: Self-management skill development builds on personal strengths and resources to empower patients to manage and monitor their individual health conditions (e.g. patient is able to monitor blood sugar levels and adjust insulin, diet, and other health behaviors, as necessary), medications, and self-care behaviors (e.g. exercise, proper nutrition/meal preparation, sleep hygiene, medication reminders including pill boxes or checklists). The organization recognizes that there is a range of situations, conditions, and needs across the major domains for which patients need self-management skills (e.g. medication administration, emotional regulation, activities of daily living) as well as a range of personal preferences for methods by which people access resources for self-management (i.e. verbal and/or written; culturally specific; gender specific; individual and/or group; professional and/or peer based). Staff assess and document in the integrated health record patient's self-management needs, skills, readiness, and preferences. This assessment includes, wherever possible, direct observation of the patient engaging in the self management skill in the environment best suited to accurate assessment.

The organization makes the following activities available to patients and their families to support patient/family self-management for all health conditions in a systematic manner, including mental illness, substance use, as well as other health conditions. The intent is to foster skill development for self-management within a whole health approach that utilizes evidence based guidelines for self-management of specific conditions. It also appreciates the patient's readiness to employ self-management skills. There is evidence of integration of all curricular and support program content to address concurrence and interaction of mental illness, substance use disorder, and other health conditions. All self-management skill development activities are reflected in the integrated care plan. Available activities will include:

1. Identification of patient/family self-management skills and/or needs
2. Identification of personal preferences for self-management skills development and

methods
3. Provision of self-monitoring tools or personal health record, or work with patients' self- monitoring tools or health record, to support patient/family recording of results in the home setting where applicable
4. Provision of or connection to self-management educational classes taught by qualified instructors and/or support programs for patients/families
5. Ongoing monitoring of self-management skills with the ability to intervene as needed

1	Evidence of one or no activity for supporting development of self-management skills
2	Evidence of 2 activities for supporting development of self-management skills
3	Evidence of 3 activities for supporting development of self-management skills
4	Evidence of 4 activities for supporting development of self-management skills
5	Evidence of 5 activities for supporting development of self-management skills with documentation in the integrated care plan

T8. Pharmacological Approaches

Definition: Physicians and/or nurses prescribing medications apply informed prescribing approaches that follow current state of the art treatment guidelines for people with SMI who are taking psychotropic medications, who may also use substances including nicotine, and who have other health conditions requiring medication. All prescribers have access in real time to documentation of all medications prescribed for each patient. Prescribers assess and monitor medication dosages and side effects for patients treated for multiple conditions.

Pharmacological approaches are employed according to the prescribers' function and within their scope of practice. Where indicated, prescribers may consult with or refer to specialty care. Such consultation or referral is based on patient need, extent or complexity of clinical presentation, and/or practitioner scope of practice, knowledge, and comfort in addressing the clinical presentation. Consultation may entail providing care within one's scope of practice after discussing medical issues with other medical professionals or providing referral and communicating with the other medical professionals providing care.

Key elements of pharmacological treatment:
1. All prescribers utilize real time documentation of all medications prescribed for each patient
2. All prescribers utilize real time documentation of all known health conditions and/or risk factors for each patient when making treatment decisions
3. All prescribing practices are based on a strong working knowledge of the interactions among these conditions, their treatments, and side effects
4. All prescribers are active participants in multi-disciplinary treatment planning and communication
5. QI has a plan to monitor and evaluate appropriate pharmacological treatment including guideline-based approaches, consultation with, or referral to specialty care

1	One or fewer of the five key elements is present

2	Two of the five key elements are present
3	Three of the five key elements are present
4	Four of the five key elements are present
5	All five of the key elements are present

T9. Involvement of Social Support Network

Definition: Staff encourage patients to identify members of their social support networks (e.g., family members, significant others, members of local Consumer Operated Services, employer, coworkers, sponsor, group home operator). Staff make meaningful attempts to engage identified supportive individuals in the treatment process. Involvement is intended to educate supports about health care, engage them to support the patient's recovery, provide problem-solving skills related to the conditions faced by the patient, provide guidance and resources to react to situations that may arise that are consistent with the overall treatment planning approach, and to promote collaboration with practitioners.

Involvement of social support network members includes:

1. Participation in the treatment planning process
2. Education about mental illness, substance use, and other medical conditions and their interaction
3. Learning how to actively support the patient's development of self-management skills
4. Linkage with external resources (i.e. disease-specific information/resources; internet sites; National Alliance for Mental Illness (NAMI); 12-step programs)
5. Communication about the patient's progress

1	One or fewer strategies to include social support network members is employed
2	Two strategies are employed
3	Three strategies are employed
4	Four strategies are employed
5	All five strategies are employed

Part III: Care Coordination/Management Characteristics

Patients with chronic health conditions typically require tests, referrals, regular follow-up, periodic changes to prescription regimens, and varying levels of care as conditions change. Care coordination seeks to eliminate the fragmentation of care and information that has traditionally been associated with the healthcare experience of patients with multiple chronic conditions.

Definition: Care coordination/management is a set of activities necessary to provide a whole health approach to care. To adequately facilitate quality care coordination/ management, strong working relationships need to exist between and among all involved in the patient's life. These activities are applied across all levels of care; ensure identification, preventative, wellness, and ongoing disease management needs are met; and supports the integrated approach. The organization addresses each of these activities and ensures that all members of the interdisciplinary treatment team have real-time access to all information about the patients' status and care. The activities may be carried out by any of the staff at the organization and/or through electronic means, wherever possible.

The organization has a structured standardized approach to the following Care Coordination /Management activities along with clear delineation of responsible parties. This structured standardized approach uses technology wherever possible – respecting patient preferences and access regarding technology.

C1. Care Coordination: Activities, Elements, and Domains

The organization has a protocol that facilitates coordination and management of care between and among all involved in the patients' care (whether internal or external to the organization). The purpose of this coordination/management is to ensure the patient's needs are being met while avoiding fragmentation. This item measures the presence or absence of protocols for key care coordination/management activities.

The organization has a protocol to facilitate the elements of Care Coordination/Management:

1. Lab and test tracking
2. Referral tracking
3. Medication reconciliation
4. Reminder system
5. Transitions between levels of care

1	One of the five key elements is present
2	Two of the five key elements are present
3	Three of the five key elements are present
4	Four of the five key elements are present
5	All five of the key elements are present

C2. Laboratory and Test Tracking

Patients diagnosed with or at risk of developing other chronic health conditions typically require periodic tests to identify and track conditions and response to intervention. When multiple providers are involved with a patient's care, tests may be repeated and/or the results may not be available to all involved in the patient's care. Care coordination seeks to eliminate the fragmentation of care and information that has traditionally accompanied treatment approaches to this population.

Definition: Care coordination as it relates to laboratory and test tracking involves policies, procedures, and practices that facilitate the patient's ability to carry out the necessary tests and the providers' ability to use the results in a timely manner.

Key elements of laboratory and test tracking include:

1. Identifying the location of facility/provider able to carry out the test
2. Assistance to patient to access testing site/facility
3. Someone at organization verify that patient completed test/lab work
4. Tracking of timely receipt of results and/or communicating with the provider until results are received
5. Mechanism to process normal and abnormal results
    a. communicate normal/abnormal results to all involved in patient's care
    b. communicate normal/abnormal results to the patient
    c. develop and enact appropriate response and follow-up to normal/abnormal results

1	One of the five key elements is present
2	Two of the five key elements are present
3	Three of the five key elements are present
4	Four of the five key elements are present
5	All five of the key elements are present

C3. Referral Facilitation and Tracking

Due to the scope of practice and complex presentations, patients diagnosed with or at risk of developing other chronic health conditions may need referral to specialty providers (either within or outside of the organization). A referral might entail a single session or might require short- or long-term care. The referral may be initiated by the provider or by the patient.

Definition: Care coordination/management as it relates to referrals involves policies, procedures and practices that facilitate the patient's ability to carry out the necessary referrals and the providers' ability to use the results in a timely manner.

Key elements of referral facilitation and tracking include:

1. Accessing appropriate specialty care, including monitoring and/or assistance with:
    - finding the appropriate provider with the needed specialty and who takes insurance/payor status of patient

    - scheduling the appointment
    - arranging/confirming that the patient has reliable transportation
2. Sending necessary information to the referral source to ensure continuity of care (including reason for referral and relevant recent test results)
3. Follow-up with the patient and referral source that referral appointment was completed
4. Tracking results and/or follow-up needs (including other referrals)
5. Developing and enacting appropriate response and follow-up based on results of referral(s)

1	One of the five key elements is present
2	Two of the five key elements are present
3	Three of the five key elements are present
4	Four of the five key elements are present
5	All five of the key elements are present

C4. Medication Reconciliation

Patients with multiple chronic conditions may be prescribed medications from more than one prescriber. In addition, these patients may be seen in multiple settings including other outpatient facilities, inpatient (physical or psychiatric), jail/prison, residential, detoxification, crisis care units, emergency departments, and hospice. There is the ongoing potential that any prescriber could change medications, dose, frequency, or route of administration. This potential is heightened at changes in functioning and/or transitions between settings/levels of care (e.g. discharge from an acute inpatient stay).

Definition: The organization has a standardized approach for identifying the following:

- All current medications, dose, frequency, and route of administration (including Prescribed, over the counter, and herbal/supplements)
- Changes in medications (including dose, frequency, and route of administration)
- New medications started
- Previous medications discontinued
- Any adverse reactions and/or allergies

Key elements of medication reconciliation include:

1. The organization has a standardized approach to identify the need for medication reconciliation:
    a. relationship with all providers involved in the patients' care
    b. regular and consistent questions are asked of the patient regarding recent changes and/or institutional care episodes
2. A system or template for receiving information
3. The system or template includes all of the elements listed above
4. This information is communicated among all involved in the patient's care
5. The patient is educated on all changes, there is a system in place to ensure the patient understands the current medication regimen, and there is assistance available to facilitate following the current regimen

6. The organization has a system in place to assist in the proper removal/disposal of old and/or expired medications

1	None or one of the six key elements are present
2	Two of the six key elements are present
3	Three of the six key elements are present
4	Four of the six key elements are present
5	Five or six of the key elements are present

C5. Reminders

Patients diagnosed with or at risk of developing other chronic health conditions typically require complex, multi-stepped care plans in order to effectively identify, monitor, treat, and recover from chronic health conditions, health conditions for which they are at risk, and/or episodic symptoms or conditions that require an integrated holistic approach to care. To facilitate this integrated holistic approach, there needs to be a systematic approach to reminding all involved in the patients' care of activities, appointments, tests, or other aspects of care that require periodic attention.

Definition: Care coordination/management as it relates to reminders involves policies, procedures and practices that facilitate the patient's ability to carry out the necessary tasks and the providers' ability track the ordering/scheduling of these tasks in a timely manner. In addition, the policies, procedures and practices follow guideline-based approaches to the prevention, assessment, diagnosis, monitoring, and treatment of known conditions and the patient population-specific high risk conditions.

Among the domains for which a systematic reminder approach may be applied are:

- appointments within the organization;
- appointments with outside facilities, testing centers, laboratories, and/or specialty care sites;
- the need to get labs or tests done before an appointment;
- and any special instructions related to these tasks (e.g. the need to fast, take or not take certain medications, and/or other instructions necessary to carry out the task)

An appropriate reminder system addresses two categories of tasks: (a) reminders regarding existing or known appointments, tests, procedures, etc. and (b) future tasks (e.g. a system to remind providers that someone is due for a test, procedure, lab work, or follow-up based on test results; or, based on medication-specific or disease-specific guidelines, i.e., a patient with diabetes who needs annual eye and foot exams).

The organization has a systemized approach to deliver reminders to the patient the day before/day of an appointment or test. Reminders to the patient include: (a) location; (b) name of facility, provider, and/or contact at the facility; and (c) any special pre-appointment instructions (e.g. fasting, do not take medications the morning of, bring copy of x-rays). Reminders may be delivered in person, over the phone, and/or electronically (e.g. email, text message) – respecting the patient's preferences and access to available technology as well as abiding by all privacy protection requirements.

Key elements of reminders to patients and providers include:

1. Reminders of appointments
2. Reminders of scheduled/ordered tests
3. Reminders of special instructions
4. Established protocols for preventative monitoring of tests and assessments related to the patient population-specific high risk conditions
5. Tracking of preventive care appointments, condition- or medication-related monitoring, or tests

1	One of the five key elements is present
2	Two of the five key elements are present
3	Three of the five key elements are present
4	Four of the five key elements are present
5	All five of the key elements are present

C6. Transitions between settings/levels of care

Patients with multiple chronic conditions may receive care from multiple providers and in a variety of settings. It is essential that all involved in the patient's care know of the current care plan – especially at points of transition between levels of care. Different levels of care include but are not limited to: inpatient (physical or psychiatric), emergency department, jail/prison, detoxification, crisis stabilization unit, residential, intensive case management (e.g. Integrated Dual Disorders Treatment (IDDT), Assertive Community Treatment (ACT)), partial hospitalization, group home, adult care facility, home health care, rehabilitation facility, nursing home, and hospice. Transitions occur between and among more and less intensive levels of care as well as between providers both within and outside of the organization. Transitions may also occur when the patient transfers to a different provider.

Definition: Care coordination/management for transitions between settings/levels of care needs to happen in a timely manner to facilitate quality and continuity of care.

Elements of care coordination/management regarding transitions include:

1. Communication to the admitting facility or new level of care: patient's current medications, diagnoses, needs, allergies and adverse reactions, lab test and/or procedure results (to avoid unnecessary duplication), advanced directives, and other information necessary for continuity of care.
2. Receiving information from the discharging facility or previous level of care: current/changes in medications (e.g., if injectable medications – date of last injection and date next injection due), reason for admission, discharge diagnosis, status upon discharge, allergies and adverse reactions identified, tests/procedures performed, results of those tests (especially those that require follow-up, monitoring, or repeat), and test results still pending at time of discharge/transition
3. A standardized discharge summary/communication template that includes space for each item outlined in element #2
4. Ensuring that the patient understands home-going instructions, changes in

medications, recommendations, and any follow-up needs
5. Standardized policies and procedures for transitions between care

1	One of the five key elements is present
2	Two of the five key elements are present
3	Three of the five key elements are present
4	Four of the five key elements are present
5	All five of the key elements are present

C7. Assessing the effectiveness/quality of care received

In addition to the completeness of services offered and the tracking of which services, tests, and/or referrals are occurring, it is critical to evaluate the patient's perception of the quality of the care being delivered and whether or not it is meeting her/his needs/goals.

Definition: The organization has a protocol to assess the patient's perceptions of care for the purpose of care coordination and management. Such protocol would include assessment of:

- the patient's belief that the care is relevant to his/her needs
- the patient's comfort with each and all providers involved in her/his care
- sufficient communication between the patient and the provider exists to facilitate a collaborative relationship that builds the patient's recovery
- the presence of interventions and/or skill-building that could be added to the care plan to facilitate the collaborative relationship (e.g., staff accompany patient to the appointment, practice role plays of the encounter to build patient skills in communication and/or assertiveness, teach relaxation techniques)
- the need for an alternative provider

Essential elements in assessing the effectiveness/quality of care received include:

1. A written protocol that includes the items listed above
2. A structured approach to assess the effectiveness and quality of care received. This approach involves feedback from the patient, the patient's social support members, and other staff involved in the patient's care
3. The patients' care plans include skill building to assist patients in advocating for the highest quality of care where appropriate/necessary
4. The organization advocates and assists in change of provider, where necessary
5. The assessment of effectiveness/quality of care received is part of the organizations' continuous quality improvement

1	One of the five key elements is present
2	Two of the five key elements are present
3	Three of the five key elements are present
4	Four of the five key elements are present
5	All five of the key elements are present