Site Self Assessment Evaluation Tool for the Maine Health Access Foundation Integration Initiative

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(Adapted from the PCRS developed by the Robert Wood Johnson Foundation Diabetes Initaitive, www.diabetesinitiative.org, also adapted from the ACIC survey developed by the MacColl Institute for Heatlhcare Innovation, Group Health Cooperative.)

Background and Development of the Site Self Assessment (SSA) Instrument for the Maine Health Access Foundation's Integration Initiative

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The evaluation plan for Maine Health Access Foundation's (MeHAF's) Integration Initiative is designed to use multiple data collection methods, in order to provide on-going feedback about the status of implementation, as well as to promote collaboration among the grantee projects and external independent evaluators. A key evaluation question in the plan is, "Are grantees implementing the characteristics and components of patient/family-centered integrated care?" In order to collect data to address this question, an operational definition of the components of patient/family-centered integrated care is needed, that is, an explicit method to assess and measure these complex components. A substantial literature exists describing the desired characteristics of integrated primary and mental health care, but so far as we know, these characteristics have not been described via a check-list type instrument for evaluation use. The Site Self Assessment instrument detailed here will be used as one method to assess MeHAF sites' progress toward implementing patient/family centered integrated care, as well as to encourage on-site staff to reflect on the changes they have made and further changes needed to deliver all components of integrated care.

The format of the Site Self Assessment instrument is based on the format of the Assessment of Primary Care Resources and Supports for Chronic Disease Self-Management (PCRS) developed by the Diabetes Initiative of the Robert Wood Johnson Foundation (Brownson, et al., 2007). The PCRS was itself modeled after the Assessment of Chronic Illness Care (ACIC) instrument developed by the MacColl Institute for Healthcare Innovation, for the Improving Chronic Illness Care program funded by the Robert Wood Johnson Foundation. The PCRS is "a quality improvement instrument that is completed by primary health care teams to (1) help them self-evaluate their current delivery of resources and supports for self management, and (2) identify areas and ways in which they could enhance these services" (Brownson, et al, 2007, p. 408). The PCRS was developed iteratively from 2003 to 2006, by expert diabetes providers, researchers, and evaluators, using several waves of pilot and larger scale data testing. This testing indicated that "the PCRS has acceptable psychometric properties and is applicable across different types of primary care teams and chronic illness conditions" (Brownson, et al., 2007, p. 408). The PCRS instrument informed the question format shown for the MeHAF SSA,

with 16 dimensions for a site's self assessment, eight dimensions characterizing "patient support" and eight dimensions describing "organizational support."

The PCRS format was attractive for MeHAF evaluation planning for several reasons:

- It encourages self assessment by key staff of the grantee sites, along explicit and easily understood dimensions of patient care and organizational support;
- It describes the types of improvement needed to achieve enhanced levels of integrated care;
- It uses a format that is easily and quickly scored by the respondents;
- Numeric scores are easily aggregated across sites for evaluation purposes, and can show the extent and types of improvement over time;
- The format is amenable to administration via a web-based survey, to save time for both respondents and evaluators.

However, the specific dimensions and wording of the PCRS to characterize self management support for patients with chronic diseases were not all applicable to the key components of patient/family-centered integrated care. Therefore, the dimensions and wording were modified to the Site Self Assessment form shown in the Appendix, using a wide range of literature and other references describing the components of integrated primary and behavioral health care (see list of references following).

The current format of the SSA encompasses the following dimensions of integrated care, each with four quality levels of care:

I Integrated Services for Patient/Family Centered Care

1. Co-location of treatment for primary care and mental/behavioral health care
2. Emotional/behavioral health needs are assessed by primary care (needs for medical care assessed by MH/BH providers)
3. Treatment plans for primary care and behavioral/mental health care are integrated
4. Patient care is based on, or informed by, best practice evidence
5. Patients/family members are involved in decisions about care plans
6. Patient orientation and education about integrated care is provided
7. Follow-up occurs on assessments, tests, treatment, referrals and other services
8. Patients' access to social supports is addressed
9. Linking patients to community resources

II Organizational Supports for Practice Change Toward Integrated Services

1. Organizational leadership supports integrated care
2. Patient care team implements integrated care
3. Providers engaged and enthusiastic about integrated care
4. Continuity of care between primary care and behavioral/mental health
5. Coordination of referrals and specialists
6. Data systems/patient records document integrated care
7. Patient/family input to integration management
8. Physician, team and staff education and training for integrated care
9. Funding sources/resources support integrated care

Feedback on the draft SSA instrument from the MeHAF grantee sites has been positive during its first year of use. Pilot data collected from the MeHAF grantees show that it is feasible to use; most grantees view these dimensions as applicable to their projects. Several grantees report using it in team meetings for internal discussions of their progress in implementing integrated care. We hope that its continued use over several years of the MeHAF initiative, and by other similar initiatives, will demonstrate its usefulness in showing change in grantees' practices toward increased levels of integrated care.

Note for other users: The directions for administration on page 1 of the SSA are for MeHAF's administration with its grantees. Other users will need to modify these directions to fit their intended administration.

References Consulted in Developing the Site Self Assessment Instrument

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Instructions for Completing the Site Self Assessment (SSA) Survey

This form was adapted from similar formats used to assess primary care for chronic diseases. We would like you to focus on your site's *current* extent of integration for patient and family-centered primary care, behavioral and mental health care. The purpose of this assessment is to show you and the MeHAF staff your current status along several dimensions of integrated care. Future repeat administrations of the SSA form will help to show changes your site is making over time. Grantees working with more than one site should ask each *site* to complete the SSA.

Please respond in terms of your site's *current* status on each dimension, as of (date of administration). It is very desirable to obtain input from your team to complete this form, for example, by asking each team member to score it, then discussing the scores in a team meeting, and reaching consensus. If that is not feasible, then the site manager may complete it individually. Please rate your patient care team(s) on the extent to which they currently do each activity for the patients/clients in the MeHAF project. By "patient care team" we mean the staff members that work together to manage integrated care for patients. This often, but not always, involves health care providers, behavioral health specialists and possibly case managers or health educators and front office staff.

Using the 1-10 scale in each row, circle one numeric rating for each of the 18 characteristics. If you are unsure or do not know, please give your best guess, and indicate to the side any comments or feedback you would like to give regarding that item. NOTE: *There are no right or wrong answers. If some of this wording does not seem appropriate for your project, please suggest alternative wording that would be more applicable, on the form itself or in a separate email.*

Please submit completed SSA forms with your annual report **DATE**. If you have questions please contact . . .

Thank you!

Identifying Information:

Name of your site:_____Date:_____

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

Did you discuss these ratings with other members of your team? Yes_____ No_____

Are these your site's ratings for: _____Current status _____ Baseline status, as of about (month, year) _____

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

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	Levels			
1. Co-location of treatment for primary care and mental/behavioral health care	. . . does not exist; consumers go to separate sites for services **1**	. . . is minimal; but some conversations occur among types of providers; established referral partners exist **2 3 4**	. . . is partially provided; multiple services are available at same site; some coordination of appointments and services **5 6 7**	. . . exists, with one reception area; appointments jointly scheduled; one visit can address multiple needs **8 9 10**
2. Emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse) 2. (ALTERNATE: If you are a behavioral or mental health site, respond in terms of medical care needs)	. . . are not assessed (in this site) **1**	. . .are occasionally assessed; screening/assessment protocols are not standardized or are nonexistent **2 3 4**	. . .screening/assessment is integrated into care on a pilot basis; assessment results are documented prior to treatment **5 6 7**	. . . screening/assessment tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented. **8 9 10**
3. Treatment plan(s) for primary care *and* behavioral/mental health care	. . . do not exist **1**	. . . exist, but are separate and uncoordinated among providers; occasional sharing of information occurs **2 3 4**	. . .Providers have separate plans, but work in consultation; needs for specialty care are served separately **5 6 7**	. . . are integrated and accessible to all providers and care manager; patients with high behavioral health needs have specialty services that are coordinated with primary care **8 9 10**
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	. . . does not exist in a systematic way **1**	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases **2 3 4**	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers **5 6 7**	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently **8 9 10**
5. Patient/family involvement in care plan	. . . does not occur **1**	. . . is passive; clinician or educator directs care with occasional patient/family input **2 3 4**	. . . is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with *some* patients/families and their provider(s) **5 6 7**	. . . is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources **8 9 10**

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

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

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6. Data systems/patient records	. . . are based on paper records only; separate records used by each provider **1**	. . . are shared among providers on an *ad hoc* basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps **2 3 4**	. . . use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals **5 6 7**	. . . has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process **8 9 10**
7. Patient/family input to integration management	. . . does not occur **1**	. . . occurs on an *ad hoc* basis; not promoted systematically; patients must take initiative to make suggestions **2 3 4**	. . . is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consider-ation; patients/families are made aware of mechanism for input and encouraged to participate **5 6 7**	. . . is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information **8 9 10**
8. Physician, team and staff education and training for integrated care	. . . does not occur **1**	. . . occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic **2 3 4**	. . . is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation **5 6 7**	. . . is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration **8 9 10**
9. Funding sources/resources	. . . are only from MeHAF grant; no shared resource streams **1**	. . . separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies **2 3 4**	. . . separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training **5 6 7**	. . . fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly **8 9 10**

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