begin the process with average scores below "5" for some (or all) areas of the SSA. It is also common for teams to initially believe they are providing more client-centered care than they actually are.

- **Difficulty answering an item:** 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. 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 by **May 26, 2017**. If you have questions please contact **Lucyna Klinicka (lklinicka@ucsd.edu)**.

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_____

Adapted from Maine Health Access Foundation (MEHAF), 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 Client and Family-Centeredness (Select one NUMBER for each characteristic)

1. Co-location of services for primary care (PC), mental health (MH) care and substance abuse services

. . . does not exist; clients go to separate sites for physical health and substance abuse services.	. . . is minimal; but some conversations occur among types of providers; established referral partners exist.	. . . is partially provided; multiple services are available at same site; some coordination of appointments and services.	. . .exists, with one reception area; appointments can be jointly scheduled; clients can obtain services from multiple disciplines at one site (medical, mental health, substance abuse); primary care and BH exam/ consulting room are in close proximity or share rooms. One visit routinely addresses all healthcare needs.

How integrated are services? ☐ **Not integrated for any clients** ☐ **Only for BHICCI target population** ☐ **50% of clinic population** ☐ **Entire clinic population**

2. Medical care needs (e.g., diabetes, blood pressure levels, body mass index)

. . . are not screened in this site; Only mental health or substance use screening occurs.	. . . are occasionally screened; screening protocols are not standardized or are not audited to ensure consistent administration.	. . . screening for these conditions is integrated into care on a pilot or other limited basis; screening results are documented prior to treatment.	. . . screening tools are integrated into practice pathways to routinely assess MH/SUD/PC needs of all clients; standardized screening protocols are used and documented routinely to ensure consistent screening of all clients (including children) at requisite intervals.

Medical care screening: ☐ **oes not occur for any clients** ☐ **nly for BHICCI target population** ☐ **50% of clinic** ☐ **Entire clinic population**

Adapted from Maine Health Access Foundation (MEHAF), 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.

3. Substance abuse concerns (e.g., substance use, dependence)

. . . are not screened in this site; Only mental health or physical health screening occurs.	. . . are occasionally screened; screening protocols are not standardized or are not audited to ensure consistent administration.	. . . screening for substance use disorders (SUD) is integrated into care on a pilot or other limited basis; screening results are documented prior to treatment.	. . . screening tools are integrated into practice pathways to routinely assess MH/SUD/PC needs of all clients; standardized screening protocols are used and documented routinely to ensure consistent screening of all clients at requisite intervals.

Substance abuse screening: ☐ Not integrated for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

4. Shared care plan(s) for medical care, substance abuse care and mental health care

. . . do not exist.	. . . are separate and uncoordinated among service providers; occasional informal sharing of information occurs.	. . . providers have separate plans, but work in consultation; all services are documented in the same EMR or paper chart.	. . . are integrated and easily accessible and viewable as a single document to all providers on the healthcare team, as well as shared with clients and care manager. Plans are client-centered and include client's overall wellness goals and the intended role of providers to achieve those goals.

Shared care plans: ☐ Not used for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

Adapted from Maine Health Access Foundation (MEHAF), 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.

5. Client care that is informed by best practices

. . . does not exist in a systematic way.	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases.	. . . exists in the form of evidence-based guidelines, but are not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers.	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently. Processes are in place to ensure adherence to evidence-based practice guidelines.

Evidence-based care: ☐ Not used for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

6. Measurement of treatment and wellness outcomes, which are regularly tracked in a population health tool/registry

. . . does not occur.	. . . occurs, but site does not have standard procedure in place to ensure all clients are assessed regularly; Outcomes are not used for treatment or care planning.	. . . occurs regularly, but are not always reviewed and discussed with clients. Outcomes are tracked and used to provide integrated treatment plans that address co-occurring medical and MH/SUD concerns.	. . . occurs for each client's medical and BH/SUD condition(s) regularly. Outcomes are monitored and used in development of shared care plan; outcomes are accessible in electronic systems for entire healthcare team; Key providers meets with client on regular basis to review progress and adjust treatments when outcomes are not achieved as expected or desired.

Outcomes monitoring: ☐ Not occurring for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

Adapted from Maine Health Access Foundation (MEHAF), 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.

7. Client/family involvement in shared care plan

. . . does not occur.	. . . is passive; healthcare team directs care with occasional client/family input.	. . . is sometimes included informally in decisions about care; decisions about treatment are made collaboratively with some clients/families and their provider, but depends on preferences of individual providers.	. . . is an integral part of the system of care; collaboration occurs among client/family and team members and takes into account family, work or community barriers and resources. Formal tools and means for ensuring client and family involvement are integrated into practice, EMR and documents.

Client/family involvement: ☐ Not involved for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

8. Communication with clients about coordinated care

. . . does not occur.	. . . occurs sporadically, or only by use of printed material; no tailoring to client's needs, culture, language, or learning style.	. . . occurs as a part of client visits; team members communicate with clients about self-management and health literacy.	. . .is a systematic part of site's integration plans; is integrated into policies and protocols, including in release of information, consent to treat, and other client legal documents; is an integral part of interactions with all clients; team members trained in how to communicate with clients about self-management and provide self-care support.

Communication: ☐ Not integrated for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

Adapted from Maine Health Access Foundation (MEHAF), 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.

9. Follow-up of assessments, tests, treatment, referrals and other services

. . . is done at the initiative of the client/family members.	. . . is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up.	. . . is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to client inquiries; minimal outreach to clients who miss appointments.	. . . is done by a systematic process that includes monitoring client utilization; includes interpretation of assessments/lab tests for all clients; is customized to clients' needs, using varied methods; is proactive in outreach to clients who miss appointments.

Customized follow-up: ☐ Not integrated for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

10. Support for clients to implement recommended treatment and develop self-management skills

. . . is not addressed or available.	. . . is discussed in general terms, not based on an assessment of client's individual needs or resources.	. . . is encouraged through collaborative exploration of natural resources available (e.g., family members, peer-led education groups, support groups) to meet individual needs. Team provides self-management and self-care support at every visit.	. . . is part of standard practice, to assess needs, strengths, link clients with services and follow up on social support plans using family, community or other resources; Use of trained peer providers in wellness and self-management support roles; Providers collaborate with peer staff, clients and their families to identify and select evidenced based self-management support and tools, and encourage client's satisfaction and confidence obtaining resources.

Self-management skills: ☐ Not addressed for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

Adapted from Maine Health Access Foundation (MEHAF), 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.

11. Assessing clients strengths, preferences and social determinants of health (such as basic unmet needs)

. . . does not occur.	. . . is limited. Information on relevant resources to meet needs is often a list or pamphlet of contact information.	. . . is considered. Staff member discusses client needs, barriers, life goals and appropriate resources before making referral.	. . . is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and clients; Clients life goals and unmet needs are considered and the team systematically addresses and changes treatment and referrals.

Social determinants: ☐ Not considered for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

II. Practice/Organization (Select one NUMBER for each characteristic)

1. Integration of executive leadership

. . . does not exist or shows little interest; no integration at the leadership level (no PC leaders in behavioral health organizations).	. . . is limited; executive leadership is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care. Clinical leaders are mid-level managers or supervisors for the service being integrated.	. . . 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 or regular training on integration).	. . .Executive leadership is integrated, with clinical leaders from each discipline represented; leadership 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.

How integrated is leadership? ☐ Not integrated at organization ☐ Only for BHICCI care team ☐ 0% of organization ☐ ntire organization

Adapted from Maine Health Access Foundation (MEHAF), 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.

2. Integration practices at organizational level

. . . does not exist.	. . .support the concepts of integration and are working to develop relationships with other providers to better coordinate care.	. . .are moving towards integrated care as a key component of organization's strategic plan; Leadership hires staff members who have qualified skill set and are a 'right fit' to work in an integrated environment; Organization provides regular re-trainings/ booster trainings to teams on integration.	. . .Organization has a means for providers to communicate and systematically learn from each other. Integrated care is prominently displayed throughout the client areas (ie., health and mental health promotion); Organization participates in major community initiatives not only in their primary area of service but also in others, such as physical and mental health promotion, community well-being, anti-violence, domestic violence, and substance use campaigns.

Integration practices: ☐ Not integrated at organization ☐ Only for BHICCI care team ☐ 50% of organization ☐ Entire organization

3. Services are provided by a multidisciplinary healthcare team

. . . does not exist.	. . . but there is little cohesiveness among team members; not central to care delivery.	. . . that is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained and have complementary skills.	. . . and the concept is embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences and team meetings are regularly scheduled. The healthcare team is a 'flattened' hierarchy, and clients are aware of all members of their team.

Multidisciplinary team: ☐ Not integrated for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

Adapted from Maine Health Access Foundation (MEHAF), 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.

4. Providers' engagement with integrated care initiative

. . . is minimal.	. . . occurs some of the time, but some providers not enthusiastic about care coordination.	. . . is moderately consistent, but with some concerns; some providers not fully implementing intended integration components; Routinely assess team member engagement.	. . . occurs for all or nearly all providers; providers are enthusiastically implementing all components of integrated care initiative. Evidence of regularly scheduled (at minimum monthly) systematic-case review meetings on co-occurring chronic medical/behavioral health conditions, attended by multiple disciplines for the majority of practice teams and sites; Routinely assess team member engagement and use results to improve organizational culture.

Provider's engagement: ☐ Not considered for any providers ☐ Only for BHICCI care team ☐ 50% of clinic staff ☐ Entire clinic staff

5. Coordination of primary care and behavioral/mental health

. . . does not exist.	. . . is not always assured; clients with complex needs are often responsible for their own coordination and follow-up of referrals and specialists; EMR and/or care plan does not contain all records or are not fully integrated; little specialist contact with primary care team.	. . . is achieved for some clients, such as a pilot group, through the use of a care manager or other strategy for coordinating needed care; healthcare team is multidisciplinary and communicates often; specialists contribute to planning and adjusting treatment plans; report on referrals included in shared care plan.	. . . systems are in place to support continuity of care, to assure all clients are screened, assessed for treatment as needed, treatment scheduled, to refer, track incomplete referrals and follow-up with client and/or specialist to integrate referral into care plan; includes specialists' involvement in primary healthcare team training and quality improvement. Client's preferences are elicited and considered when making referrals.

Coordination of services: ☐ Not integrated for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

Adapted from Maine Health Access Foundation (MEHAF), 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.

6. Assessment of client and employee satisfaction with their experience

. . . does not occur.	. . . occurs for clients but not employees.	. . . is tracked for both clients and employees.	. . . is tracked regularly for both clients and employees; information provided by clients are used for QI purposes to improve services; employee experiences are used to create a culture of continuous feedback and maintain employee engagement and satisfaction.

Assessment of satisfaction: ☐ Not considered ☐ Only for BHICCI clients and care team ☐ 50% of clinic population/staff ☐ Entire clinic

7. Integrated data system(s) for client health records

. . . are based on paper records only; separate records used by each provider.	. . . are shared among providers on an ad hoc basis; multiple records exist for each client; no aggregate data used to identify trends or gaps.	. . . use a data system (paper or EMR) shared among the healthcare 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.	. . . has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of client outcomes and integration outcomes; indicators reported regularly to management; the EMR has templates that easily support the documentation of common occurring co-occurring, medical and BH conditions (diabetes/depression, schizophrenia/diabetes/obesity).

Data system(s): ☐ Not integrated for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

Adapted from Maine Health Access Foundation (MEHAF), 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.

8. Use of population health registries/tools

. . . does not occur.	. . . occurs inconsistently to select clients for review based on selected criteria.	. . . occurs regularly to identify clients with critical scores on clinical data such as high BMI/blood pressure, no-shows, ED use, and behavioral health measures; population-based caseload reviews are not multidisciplinary.	. . . occurs regularly to monitor and assess progress for clients with complex care needs; team uses population health data to support a continuous QI process; Providers conduct regular systematic population-based caseload reviews with multidisciplinary healthcare team, including care manager.

Population health tools: ☐ Not integrated for any clients ☐ Only for BHICCI target population ☐ 50% of clinic population ☐ Entire clinic population

9. Education and training on integrated care for healthcare team

. . . does not occur.	. . . occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic.	. . . is provided for some 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.	. . . 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 coordination and integration.

Education and training: ☐ Not considered for any providers ☐ Only for BHICCI care team ☐ 50% of clinic staff ☐ Entire clinic staff

Adapted from Maine Health Access Foundation (MEHAF), 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.

10. Plan for sustaining initiative changes

○	○	○	○	○	○	○	○	○	○
. . . does not exist.	. . . has not been explicitly documented, but executive leaders are committed to implementing practice changes into broader organizational culture.			. . . includes a formal plan for organization-wide quality improvement and integration of practice changes; leadership has a document plan for recruitment of additional staff suited to provide integrated services.			. . . includes a detailed plan for spreading complex care management and health homes to other healthcare organization programs or sites; plan for financial sustainability of initiative; invest in BH staffing at FQHC's to build additional MH/SUD capacity into current rate structure.		

Sustaining culture changes: ☐ Not occurring at organization ☐ Only for BHICCI care team ☐ 50% of organization ☐ Entire organization

Adapted from Maine Health Access Foundation (MEHAF), 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.