**Phase 1.2: Launch the Journey**

**Self-Assessment Tool**

|  |  |
| --- | --- |
| Team name |  |

* The purpose of this assessment is to show your current status along several dimensions of integrated care and to stimulate conversations among your integrated care team members about where you would like to be along the continuum of integrated care. Please focus on your site’s current extent of integration for patient and family-centered primary care, behavioral and mental health care.
* Please respond in terms of your organization’s current status in each dimension and rate your patient care teams on the extent to which they currently do each activity for the patients/clients at the integrated site.
  + The patient care team includes staff members who work together to manage integrated care for patients.
  + This often, but not always, involves health care providers, behavioral health specialists, specialty care providers, case managers or health educators and front office staff.
* Using the 1–4 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 under “Team Notes” 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. This form was adapted from similar formats used to assess primary care for chronic diseases.

**Self Assessment Tool**

*Adapted with permission from the Maine Health Access Foundation*[*’s Site Self-Assessment Survey Facilitation Guide*](https://waportal.org/sites/default/files/resources/MeHAF-Facilitation-Guide-Tool_190128.pdf)

| 1. **Integrated Services and Patient and Family-Centeredness** (select 1 number for each characteristic) | | | | |
| --- | --- | --- | --- | --- |
| **Select one** | **1** | **2** | **3** | **4** |
| **1.** Level of integration: primary care and mental/ behavioral health care | . . . none;  consumers go to  separate sites for  services | . . . are coordinated;  separate sites and  systems, with some  communication  among different  types of providers;  active referral  linkages exist | . . . are co-located; both are available at the same site; separate systems, regular communication  among different  types of providers;  some coordination  of appointments and  services | . . . are integrated, with  one reception area;  appointments jointly  scheduled; shared site  and systems, including  electronic health record  and shared treatment  plans. Warm hand-offs  occur regularly; regular  team meetings. |
| *Example:* |  | *Behavioral health providers are located at a separate site; there is some communication and coordination, but  teams are separate.* | *Behavioral health providers are located on site; staff meet and communicate regarding clients.* | *The behavioral health provider and primary care provider (PCP) are in the same location, using the same electronic  health record (EHR), and both are considered part of the care team* |
| **Team notes:** | | | | |
| 1. **Integrated Services and Patient and Family-Centeredness** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **2.** Screening and assessment for emotional/behavioral health needs (e.g., stress, depression,  anxiety, substance abuse) | . . . are not done (in this site) | . . . are occasionally done; screening/ assessment protocols are not  standardized or  are nonexistent | . . .are integrated  into care on a pilot basis; assessment  results are documented prior to  treatment | . . . tools are integrated  into practice pathways  to routinely assess  MH/BH/PC needs of all  patients; standardized  screening/ assessment  protocols are used and  documented. |
| *Example:* |  | *Some screenings are completed on an occasional or as-needed basis, but there is no established or routine process in place to screen patients.* | *A process has been implemented to screen patients at regular intervals (e.g., annually) or for a certain patient*  *population (e.g., patients with diabetes), and scores are documented in the client record.* | *There is a standardized workflow in place to ensure that screenings are completed and documented for all patients, and there are care pathways in place to address the needs of patients. The processes and protocols are followed uniformly.* |
| **Team notes:** | | | | |
| 1. **Integrated Services and Patient and Family-Centeredness** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **3.** Treatment  plan(s) for primary care and behavioral/ mental health care | . . . do not  exist | . . . exist, but are  separate and  uncoordinated  among providers;  occasional sharing  of information  occurs | . . .Providers have  separate plans, but  work in consultation;  needs for specialty  care are served  separately | . . . are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care |
| *Example:* |  | *When issues are brought up by the patient, staff reach out to the patient’s behavioral health provider to gather more information and request treatment plans, and primary care staff share their separate treatment goals.* | *When a patient has ongoing behavioral health needs, the behavioral health provider is always contacted and*  *information regarding treatment goals is requested. Treatment plans are stored on separate EHR systems or different parts of the*  *EHR. On occasion, primary care providers reach out to behavioral health providers to discuss patient goals.* | *Treatment plans are stored in the same, easy-to-access place in the EHR for all providers to see. Regular (e.g.,*  *monthly) meetings are scheduled between behavioral health and primary care providers to review and re-align the shared treatment*  *plan if treatment has stalled. The BHA and PCP work together to coordinate care and support patients with primary care and*  *behavioral health needs.* |
| **Team notes:** | | | | |
| 1. **Integrated Services and Patient and Family-Centeredness** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **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 | . . . depends on  each provider’s own use of the evidence; some shared evidence-based approaches occur in individual cases | . . .evidence-based  guidelines available, but 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 |
| *Example:* |  | *Providers use some evidence-based approaches, but it is up to their discretion to choose which best practices to use and when to use them. Some providers refer patients to behavioral health providers, but there is no clear process in place for when to refer a patient to a behavioral health provider. Referrals are made on a case-by-case basis.* | *Providers use appropriate treatment guidelines for a patient’s diagnosis, but there are no standard treatment best practices utilized, and the individual provider chooses which evidence-based treatment approach to use.All clients are screened for behavioral health needs, but the provider chooses which patient screening scores and situations should prompt a referral to a behavioral health provider.* | *The clinic uses a set of evidence-based guidelines that all providers follow. Team members are trained in best practices, and the EHR has alerts and reminders in place for follow-up and ongoing patient care. For example, the clinic has a protocol in place that requires a behavioral health referral for patients who score 10 or above on the PHQ-9.* |
| **Team notes:** | | | | |
| 1. **Integrated Services and Patient and Family-Centeredness** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **5.** Patient/Family involvement in care plan | . . . does not  occur | . . . is passive;  provider or educator directs  care with occasional patient/  family input | . . . is sometimes included in decisions about integrated care; decisions  about treatment are done collaboratively  with some patients/  families and their  provider(s) | . . . 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 |
| *Example:* |  | *Providers do not always ask for the patient’s input when creating their plan of care, do not regularly ask if patients*  *want their family/ supports involved in treatment planning, and do not make an effort to include them.* | *Providers develop care plans with patients and/or their families when they are proactive in their health care.* |  |
| **Team notes:** | | | | |
| 1. **Integrated Services and Patient and Family-Centeredness** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **6.** Communication  with patients about  integrated care | . . . does not  occur | . . . occurs  sporadically, or  only by use of  printed material;  no tailoring to  patient’s needs,  culture, language,  or learning style | . . . 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 | . . .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 |
| *Example:* |  | *On occasion, staff briefly discuss the connection between physical and behavioral health, hand out written*  *materials and/or refer the patient to a website. Information is not individualized for the patient.* | *Team members routinely discuss the connection between physical and behavioral health with the patient.*  *Information is customized to the individual’s culture and level of understanding. Patients and families are empowered to be active partners on the integrated care team.* | *Team members are trained in talking with patients about integrated health care and consistently discuss the*  *connection between their physical and mental health. Providing individualized, whole-person care is ingrained in the clinic’s standard*  *processes and workflows.* |
| **Team notes:** | | | | |
| 1. **Integrated Services and Patient and Family-Centeredness** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **7.** Follow-up of  assessments, tests, treatment, referrals and other services | . . . is done  at the initiative  of the patient/  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 patient inquiries; minimal outreach to patients who miss appointments | . . . 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 |
| *Example:* |  | *Staff occasionally follow up on referrals, appointments and test results, but there is no mechanism in place to ensure staff follow-up with patients.* | *Staff follow up with patients and assist them in understanding test results and medications, when indicated, but there is not a set process in place for follow-up or for reaching out to patients who miss an appointment.* | *The clinic has a systematic process (e.g., flags in the EHR) for following up with patients on appointments and test*  *results; there is also a process in place to re-engage with patients who miss an appointment. Follow-up and outreach is tailored to the individual patient.* |
| **Team notes:** | | | | |
| 1. **Integrated Services and Patient and Family-Centeredness** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **8.** Social support (for patients to  Implement recommended  treatment) | . . . is not addressed | . . . is discussed  in general terms,  not based on an  assessment of  patient’s individual  needs or resources | . . . is encouraged through collaborative exploration of resources available (e.g., significant others, education  groups, support groups) to meet individual needs | . . . 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 |
| *Example:* |  | *Using social supports and support groups are sometimes discussed as a way to improve the patient’s well-being,*  *e.g., when a patient has been newly diagnosed with depression and type 2 diabetes.* | *Someone from the care team usually asks the patient if they have anyone to support their treatment goals, e.g.,*  *when a patient has been newly diagnosed with depression and type 2 diabetes. The patient would then be provided with information about diabetes management support and education groups.* | *There is a system in place to ensure that each patient’s social and emotional needs are assessed. When indicated*  *a plan for support is created with the patient, and someone from the care team follows up with the patient on progress toward goals. For example, if a patient is newly diagnosed with depression and type 2 diabetes, a plan is created for the patient and a friend to walk for 30 minutes two times a week, and the patient is assisted in enrolling in a diabetes education group at a community center that is easily accessible to them.* |
| **Team notes:** | | | | |
| 1. **Integrated Services and Patient and Family-Centeredness** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **9.** Linking to Community | . . . does not occur | . . . is limited to a  list or pamphlet of  contact information for relevant resources | . . . occurs through a  referral system; staff  member discusses patient needs, barriers, 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 patients |
| *Example:* |  | *If a patient expresses a need for a community resource, staff provide the patient with a list of resources. However,*  *staff do not provide any direct linkage or assistance in connecting with the resources.* | *If a patient states that they cannot afford to buy groceries on a regular basis, a staff member works with the patient to discuss resource options and together they create a plan for the patient to go to the food bank.* | *Patients are routinely assessed for basic resource needs. For example, if a patient reports that they cannot afford to provide enough food for their family, staff work with the patient to create a plan to ensure the patient is able to obtain food. Staff may work with the food bank to arrange a time for the patient to go the food bank and provide assistance to ensure the patient has transportation to and from the food bank. Staff may then follow up with the patient either via phone call or at the next visit.* |
| **Team notes:** | | | | |
| 1. **Integrated Services and Patient and Family-Centeredness** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **10.** Patient care that is based on (or  informed by) best practice evidence for  prescribing of psychotropic  medications | … 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 | . . .evidence-based  guidelines available,  but 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; support provided by consulting  psychiatrist or comparable expert |
| *Example:* |  | *The prescriber does use evidence-based practices in some instances of prescribing, e.g. using medications for specific conditions/populations as indicated by label. The clinic does not have standardized prescribing practice guidelines.* | *The clinic has a set of practice guidelines accessible to prescribers. These guidelines may be used, but treatment is based on provider preferences.* | *Providers always use set guidelines (e.g., FDA) when prescribing and review medications and side effects with the*  *patient. These may include guidelines on titrating medications at a specific interval due to patient demographics, other health care*  *conditions, and other medications they may be taking, or a follow-up protocol for starting a new medication or changing dosage of a*  *current medication. Providers receive ongoing education on prescribing best practices. Prescribers can consult with providers who*  *have expertise in prescribing best practices.* |
| **Team notes:** | | | | |
| 1. **Integrated Services and Patient and Family-Centeredness** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **11.** Tracking of vulnerable patient groups that require  additional monitoring and  intervention | … does not occur | … is passive;  provider may track individual patients based on circumstances | … patient lists exist and individual providers/ care managers have  varying approaches  to outreach with no  guiding protocols or  systematic tracking | … patient lists (registries) with  specified criteria and outreach protocols are monitored on a regular basis and outreach is performed consistently with information flowing back to the  care team |
| *Example:* |  | *Staff know their patients and are generally aware of which patients have high-risk issues.* | *Staff from specific care teams keep a list of patients identified as potentially high risk, e.g., whose PHQ-9 score was greater than 10, who has an HbA1c level greater than 9 and/or who have high emergency department usage.* | *The clinic has created and regularly updates a list/registry of patients who have a PHQ-9 score greater than 10 and*  *an HbA1c level greater than 9 in order to reach out to them every few weeks to review their mood and medication use by phone. Staff regularly assess for change in the indicators.* |
| **Team notes:** | | | | |
| 1. **Integrated Services and Patient and Family-Centeredness** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **12.** Accessibility  and efficiency of behavioral health  providers | … behavioral  health provider(s)  are not readily  available | … is minimal; access may occur at times but is not defined by protocol or formal agreement; unclear  how much population penetration behavioral health has into primary care population | … is partially present; behavioral health providers  may be available for warm handoffs for some of the open clinic hours and may  average less than 6 patients per clinic day per provider  (or comparable number based on clinic volume) | … is fully present;  behavioral health  providers are available  for warm handoffs at  all open clinic hours  and average over 6  patients per clinic  day per provider (or  comparable number  based on clinic volume) |
| *Example:* |  | *The practice has some access to behavioral health providers, but there is no clear process in place to*  *refer patients.* | *Behavioral health providers are sometimes available for referrals or warm handoffs. There is a process or informal*  *agreement in place for behavioral health referrals.* | *Behavioral health providers are fully accessible for patient referrals; they may be co-located at the practice, or there may be a memorandum of understanding (MOU) in place for seamless patient referrals.* |
| **Team notes:** | | | | |

| 1. **Practice/Organization** (select 1 number for each characteristic) | | | | |
| --- | --- | --- | --- | --- |
| Select one | 1 | 2 | 3 | 4 |
| **1.** Organizational  leadership for  integrated care | . . . does not exist or shows little  interest | . . . is supportive  in a general way, but views this initiative as a “special project” rather than a change in usual care | . . . 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) | . . . 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 |
| *Example:* |  | *Leadership supports the concept of integrated care, but no resources or staff time have been allotted to focus on*  *Practice transformation.* | *Leadership is generally supportive of integrated care, and a minimal amount of internal resources have been invested in practice transformation.* | *Leadership fully embraces the concept of integrated care and has provided the necessary internal and external*  *resources to support the organization’s practice transformation efforts.* |
| **Team notes:** | | | | |
| 1. **Practice/Organization** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **2.** Patient care team for implementing  integrated care | . . . does not exist | . . . exists but has  little cohesiveness  among team members; not central to care  delivery | . . . is well defined, each member has defined roles/ responsibilities;  good communication  and cohesiveness among members; members are cross- trained, have complementary skills | . . . 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 |
| *Example:* |  | *Patient care teams are present, but there is no sense of teamness. The care team is not an integral part of*  *patient care.* | *Each member of the care team has clear and distinct roles and responsibilities. Team members are aware of each other’s roles, and staff regularly communicate with one another. As appropriate to licensing, staff members are cross-trained.* | *Care teams are strongly supported by the organization’s leadership. The use of care teams is ingrained in the*  *organization’s culture. Huddles, consults, case conferences and team meetings are regularly scheduled.* |
| **Team notes:** | | | | |
| **II. Practice/Organization** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **3.** Providers’  Engagement with integrated care (“buy-in”) | . . . is minimal | . . . engaged some  of the time, but  some providers not  enthusiastic about  integrated care | . . . is moderately  consistent, but with some concerns; some providers  not fully implementing  intended integration  components | . . . all or nearly  all providers are  enthusiastically  implementing all  components of your site’s integrated care |
| *Example:* |  | *Staff are somewhat engaged, but many have questions and concerns about implementing integrated care.* | *Most staff understand the value of integrated care, but there are concerns about potential changes in workflow and*  *Additional responsibilities. Integrated care is not fully implemented, and workflows are inconsistently utilized.* | *Staff fully support the concept of integrated care and consistently implement all aspects of the organization’s*  *integrated care workflows.* |
| **Team notes:** | | | | |
| **II. Practice/Organization** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **4.** Continuity of care between primary care and behavioral/  mental health | . . . does not exist | . . . is not always  assured; patients with multiple needs are responsible for their own coordination and  follow-up | . . 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 | . . . 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 |
| *Example:* |  | *The organization has no clear process to share or receive patient information or to ensure ongoing coordination*  *and follow-up.* | *There is some mutually agreed-upon information sharing with designated points of contact. For example, a care*  *manager or clinic social worker may reach out to a patient they are already working with about a recent psychiatric hospitalization or*  *emergency department (ED) visit to ensure prompt follow-up.* | *The clinic has a process in place to ensure patient follow-up occurs, e.g., the clinic receives real-time PreManage/ EDIE\* notifications when any of its patients visit the ED/hospital. There is a system in place for the care manager or clinic social worker to follow up with the patient within 24 to48 hours, depending on the acuity of the ED/hospital visit.*  *\* EDIE = Emergency Department Information Exchange | PreManage = real-time notifications for patients being admitted to hospital (ED and/or inpatient).* |
| **Team notes:** | | | | |
| **II. Practice/Organization** (select 1 number for each characteristic) | | | | |
| Select one | 1 0- | 2 | 3 | 4 |
| **5.** Coordination  of referrals and  specialists | . . . does not exist | . . . is sporadic,  lacking systematic  follow-up, review  or incorporation  into the patient’s  plan of care; little  specialist contact  with primary care  team | . . . 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 | . . . 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 |
| *Example:* |  | *Staff inconsistently follow up on referrals, review results and recommendations, and/or include specialists’ care*  *plans into the clinic’s care plan. Specialists are not regularly contacted or included as part of the patient care team.* | *Clinic staff work as a team to coordinate specialist referrals and follow-up. The clinic shares patient information as*  *part of the referral. Specialists regularly work with the patient’s primary care team to create a care plan.* | *There is a systematic process in place to ensure patients receive appropriate referrals and follow-up.* |
| **Team notes:** | | | | |
| **II. Practice/Organization** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **6.** Data systems/  patient 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 patient; no aggregate data used to identify trends or gaps | . . . 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 | . . . 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 |
| *Example:* |  | *Patient information is not stored in an easily accessible, centralized location. Patient data is not input in a way that it can be extracted from the record and utilized for quality improvement (QI) purposes.* | *All staff have access to the same client information, and data is aggregated for specific QI initiatives.* | *The organization has a fully functional EHR that is accessible to all care team members, and patient data is regularly aggregated for trends and key indicator reports. Patient data can be pulled into a registry to track population health outcomes.* |
| **Team notes:** | | | | |
| **II. Practice/Organization** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **7.** Patient/ family input to integration  management | . . . does not occur | . . . occurs on  an ad hoc basis;  not promoted  systematically;  patients must take initiative to make suggestions | . . . is solicited through advisory groups, membership  on the team, focus groups, surveys, suggestion boxes,  etc. for both current services and delivery improvements under consideration; patients/families are made aware of  mechanism for input and encouraged to participate | . . . 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 |
| *Example:* |  | *There is no clear process for patients to provide input and only occurs when patients or family members make an effort to share suggestions.* | *The clinic encourages patient input through one or more mechanisms, e.g., patient surveys, advisory groups,*  *suggestion boxes, etc.* | *The clinic’s processes and procedures are informed by input from patients and families.* |
| **Team notes:** | | | | |
| **II. Practice/Organization** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **8.** Physician,  team and staff  education and  training for integrated care | . . . does not occur | . . . occurs on a limited basis without routine follow-up or  monitoring; methods mostly  didactic | . . . 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 | . . . 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 |
| *Example:* |  | *Educational materials and information on integrated care are available for staff to review, but information is largely*  *theoretical. There are no regular opportunities to put the learned knowledge into practice.* | *The organization provides standardized integrated care training to all staff; i.e., integrated care training occurs as a*  *part of a new employee’s orientation. Training includes theory and practical application of integrated care protocols and workflows.* | *The organization provides ongoing education and encourages staff to pursue additional training opportunities on integrated care and evidenced-based practices. All staff are trained on job-specific integrated care competencies, and expectations are incorporated into job descriptions.* |
| **Team notes:** | | | | |
| **II. Practice/Organization** (select 1 number for each characteristic) | | | | |
| Select one | 1 | 2 | 3 | 4 |
| **9.** Funding sources/  resources | . . . a single grant or funding source; no shared  resource streams | . . . separate PC/  MH/BH funding  streams, but all  contribute to costs  of integrated care;  few resources  from participating  organizations/  agencies | . . . 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 | . . . fully integrated  funding, with resources shared across providers; maximization of billing for all types of treatment; resources  and staffing used  flexibly |
| *Example:* |  | *Primary care and behavioral health departments have their own funding sources to support integrated care. There is little sharing of funds or resources, including staff.* | *Primary care and behavioral health departments have their own funding sources to support integrated care, but there are some shared resources for staff and training. Integrated care codes are available to cover some of the costs of integrated care. Primary care and behavioral health may share costs of the on-site space when the behavioral health provider is in the clinic.* | *Funding resources for integrated care are shared among departments. Integrated care billing codes are used whenever possible and staff are shared among departments to support patients as needed.* |
| **Team notes:** | | | | |