Organizational Structure

1. Please provide the name of your organization and names of affiliates and facilities under your ownership.

[   ]

2. Are clinicians a part of your organization's leadership structure?

○ Yes

○ No

3. Infrastructure: What investments in infrastructure has your organization made to prepare for practice transformation (e.g., new payment systems, behavioral health integration)

☐ Initial conversations

☐ Leadership buy-in

☐ Staff training

☐ EMR, with registry feature to track population health and quality indicators

☐ Standardized patient risk assessment (e.g., of social determinants of health)

☐ N/A

☐ Other (please specify)

[   ]

Value-Based Purchasing

Definition: Paying health care providers, hospitals, and systems based on measures of quality and value, such as structure, care process, outcomes, access, patient experience, and cost or resource use and away from volume, fee-for-service-based care. These types of models can include pay for performance/quality, shared savings models typically in the form of accountable care organizations, and bundled payments for episodes of care.

4. Process: Is your organization participating in the following to prepare for new payment systems that provide incentives for demonstrated improvement in patient health outcomes:

- [ ] Accountable Care Organization or Program
- [ ] Patient-Centered Medical Home Model (PCMH)
- [ ] Population health management
- [ ] Tracking of quality indicators
- [ ] None
- [ ] Other (please specify)

5. Barriers: From the following list please rank each of the following as barriers to adoption of value-based purchasing

	1-strong barrier	2-medium barrier	3-slight barrier	4-not a barrier	N/A
Lack of understanding of VBP	○	○	○	○	○
Lack of appropriate reimbursement mechanism	○	○	○	○	○
Receiving health plan data/Giving health plan data to clinics	○	○	○	○	○
Consensus on quality of care definitions	○	○	○	○	○
Availability and credibility of data	○	○	○	○	○
Provider feedback mechanisms	○	○	○	○	○
Internal data collection	○	○	○	○	○
External quality indicator reporting	○	○	○	○	○
Limited data sharing and interoperability	○	○	○	○	○
Lack of community-based nurses	○	○	○	○	○
Evidence that investments in VBP worthwhile	○	○	○	○	○
Selective contracting with high-quality partners	○	○	○	○	○

	1-strong barrier	2-medium barrier	3-slight barrier	4-not a barrier	N/A
Clinical provider involvement in planning VBP activities	○	○	○	○	○
Existing forum for talking about quality and VBP.	○	○	○	○	○
Promoting structured programs for minimizing errors and waste.	○	○	○	○	○
Leadership commitment	○	○	○	○	○
Organization-wide culture	○	○	○	○	○
Legislative and political limitations (e.g., HIPAA)	○	○	○	○	○
N/A	○	○	○	○	○

Other (please specify)

6. Enablers: From the following list please rank each of the following factors as "enablers" or factors that help with adoption

	1-strong enabler	2-medium enabler	3-slight enabler	4-not an enabler	N/A
Reimbursement	○	○	○	○	○
Receiving health plan data/Giving health plan data to clinics	○	○	○	○	○
Consensus on quality of care definitions	○	○	○	○	○
Availability and credibility of data	○	○	○	○	○
Provider feedback mechanisms	○	○	○	○	○
Internal data collection	○	○	○	○	○
Standard set of quality measures for external reporting	○	○	○	○	○
Having a strong case that investments are worthwhile	○	○	○	○	○
Contracting with high-quality partners	○	○	○	○	○
Clinical involvement	○	○	○	○	○
Existing forum for talking about quality and VBP	○	○	○	○	○
Promoting structured programs for minimizing errors and waste	○	○	○	○	○
Leadership commitment	○	○	○	○	○
Organization-wide culture	○	○	○	○	○
Legislative and political support	○	○	○	○	○
N/A	○	○	○	○	○

Other (please specify)

[   ]

7. Is your organization producing and using timely data at the group/provider/patient level (quality, patient experience, utilization and cost) to continually evaluate and improve care?

○ Yes

○ No

○ N/A

○ Other (please specify)

[   ]

Behavioral Health Integration

Definition: Care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.[i]

[i] Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.p

8. Has your organization made steps to integrate behavioral health care into primary care or primary care into behavioral health care?

○ Yes, we offer fully integrated (one treatment plan with behavioral and medical elements), co-located (medical services and behavioral health services located in the same facility) care

○ Yes, we have a system in place to coordinate care outside of our organization

○ In-process of implementing behavioral health integration plan

○ No, but we have plan to move toward an integrated behavioral health model in the future

○ No, we do not have plans to move toward an integrated behavioral health model

○ N/A

○ Other (please specify)

[   ]

9. Do you have an organizational definition for behavioral health integration?

○ No

○ N/A

○ Yes (please specify)

[   ]

10. Does your organization have an integrated electronic health record (EHR) that includes both the medical record and behavioral health record?

○ Yes, we have an integrated EHR that allows us to share bi-directional information between both primary care and behavioral health providers in real time

○ No, we have separate EHR systems, however we have a process for sharing information that we manually input into patient records

○ No, we do not currently have a process for sharing patient information between both primary care and behavioral health providers

○ N/A

○ Other (please specify)

[   ]

11. Barriers: From the following list please rank each of the following as barriers to integration of behavioral health

	1-strong barrier	2-medium barrier	3-slight barrier	4-not a barrier	N/A
Conducting either behavioral and physical health screening assessments	○	○	○	○	○
Partnerships or coordination with community resources	○	○	○	○	○
Billing/network issues from health plans	○	○	○	○	○
Lack of appropriate reimbursement mechanism.	○	○	○	○	○
Receiving health plan data/Giving health plan data to clinics	○	○	○	○	○
Care teams that include behavioral health personal	○	○	○	○	○

	1-strong barrier	2-medium barrier	3-slight barrier	4-not a barrier	N/A
Care manager or behavioral health specialist to follow-up with patients	○	○	○	○	○
Medical provider's ability to deal with behavioral health care issues	○	○	○	○	○
Behavioral health care provider's ability to deal with medical care issues	○	○	○	○	○
Consensus on quality of care definitions	○	○	○	○	○
Availability and credibility of data	○	○	○	○	○
Provider feedback mechanisms	○	○	○	○	○
Internal data collection	○	○	○	○	○
External quality reporting	○	○	○	○	○
Limited data sharing and interoperability	○	○	○	○	○
Legislative and political limitations (e.g., 42 CFR)	○	○	○	○	○
Evidence that investments in behavioral health Integration are worthwhile	○	○	○	○	○
N/A	○	○	○	○	○

Other (please specify)

[   ]

12. Enablers: From the following list please rank each of the following factors as "enablers" or factors that help with integration of behavioral health

	1-strong enabler	2-medium enabler	3-slight enabler	4-not an enabler	N/A
Conducting patient assessments (either behavioral health assessments within primary care or physical health assessments within behavioral health care)	○	○	○	○	○

	1-strong enabler	2-medium enabler	3-slight enabler	4-not an enabler	N/A
Partnerships or coordination with community resources	○	○	○	○	○
Integrated payment system	○	○	○	○	○
Receiving health plan data/Giving health plan data to clinics	○	○	○	○	○
Care teams that include dedicated behavioral health personal	○	○	○	○	○
Care manager or behavioral health specialist to follow-up with patients	○	○	○	○	○
Medical provider's ability to deal with behavioral health care issues	○	○	○	○	○
Behavioral health care provider's ability to deal with medical care issues	○	○	○	○	○
Consensus on quality of care definitions	○	○	○	○	○
Availability and credibility of data	○	○	○	○	○
Provider feedback mechanisms	○	○	○	○	○
Internal data collection	○	○	○	○	○
Standard set of quality measures for external reporting	○	○	○	○	○
Legislative and political support	○	○	○	○	○
Evidence that investments in behavioral health Integration are worthwhile	○	○	○	○	○
N/A	○	○	○	○	○

Other (please specify)

[   ]

Clinical-Community Linkages

Definition: Creating sustainable, effective linkages between the clinical and community settings can improve patients' access to preventive and chronic care services by developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live. These linkages connect clinical providers, community organizations, and public health agencies.[i]

[i] Clinical-Community Linkages. June 2015. Agency for Healthcare Research and Quality, Rockville, MD.

http://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

13. Does your organization have a dedicated staff person who provides care coordination services both internal and external to your clinical sites?

○ No

○ In process

○ N/A

○ Yes. Please describe (e.g., main duties, including any coordination with community-based services):

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┌─────────────────────────────────────┐
│                                     │
│                                     │
└─────────────────────────────────────┘
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14. Do providers in your organization have an opportunity to regularly interact with other providers of health care services in community-based settings?

○ Yes

○ No (skip to question 16)

○ N/A (skip to next section)

○ Other (please specify)

```
┌─────────────────────────────────────┐
│                                     │
│                                     │
└─────────────────────────────────────┘
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15. If so, what are some strategies that help you facilitate these interactions? (end of section)

☐ Formalized referral processes

☐ Regular provider networking opportunities

☐ Integrated health information technology

☐ Use of care coordinator(s) or community health worker(s)

☐ Using population level data to identify high risk clients

☐ Other (please specify)

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┌─────────────────────────────────────┐
│                                     │
│                                     │
└─────────────────────────────────────┘
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16. If not, what are the barriers?

☐ Limited knowledge of community resources

☐ Lack of time/dedicated staff person to coordinate services

☐ Service silos

☐ Language differences between different types of providers

☐ Other (please specify)

[   ]

Other Transformation Initiatives

17. Does your organization participate in local or state-wide quality improvement programs or collaboratives (not internal programs) such as with the Foundation for Health Care Quality?

○ N/A

○ No

○ Yes (please list)

[   ]

18. Please indicate if your organization is part of the following practice transformation grants or programs

○ Practice Innovation Network (e.g., Cardiac learning and action network, PQRS reporting/meaningful use support)

○ Healthy Hearts Northwest

○ CMS - Practice Transformation Networks

○ CMS - Medicare Access and CHIP Reauthorization Act (MACRA) Quality Improvement Direct Technical Assistance (MQIDTA)

○ N/A

○ Other (please specify)

[   ]

19. Has your organization implemented recommendations developed by the Bree Collaborative?

○ Yes – have fully implemented at least one recommendation

○ Yes - working to adopt at least one recommendation

○ In process

○ No

○ N/A

○ Other (please specify)

_____

20. What type of education, training, consulting or other support would you find beneficial to your organization to assist with other transformation activities?

☐ Comprehensive website

☐ Educational webinars

☐ In-person seminars

☐ On-site practice coaching

☐ Other (please specify)

_____