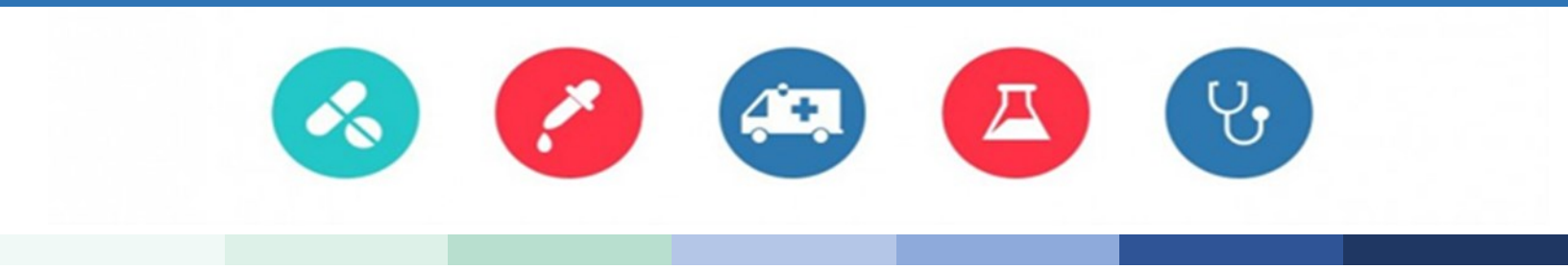
VERSION 3.3H

OHI Index

Opioid Use Disorder and HIV Integration Index

A modification of the Behavioral Health Integration in Medical Care (BHIMC)



The Opioid Use Disorder and HIV Integration (OHI) Index is a quantitative measure of the capacity and degree to which care settings have integrated opioid use disorder (OUD) and HIV services, along policy, clinical practice, and workforce domains. It is a modification of the Behavioral Health Integration in Medical Care (BHIMC, v3.3).

The OHI consists of 36 benchmark items across seven dimensions. The seven dimensions are: 1) Clinic Structure (i.e., organizational aspects such as mission, license or certifications, and financing); 2) Clinic Milieu (i.e., physical and social environment of an organization); 3) Identification & Triage (i.e., screening and assessment protocols); 4) Care Delivery (i.e., integrated care plan and procedures); 5) Monitoring & Coordination (i.e., treatment coordination, ongoing management and follow-ups); 6) Workforce (i.e., staff expertise and workflow for providing integrated services); and 7) Training (i.e., basic and specialized training in either or both conditions). Each item is rated on a scale from 1 (minimal integration) to 3 (partial integration) to 5 (full integration). Each item is also categorized according to prioritization: HIV only; OUD only; both HIV and OUD; or none.

Data are collected during site visits to primary care or other medical settings. OHI ratings are based on interviews with key informants, rapid ethnographic observations, and document review. Scores are then calculated for each item and dimension. An overall OHI score (mean of dimension scores) and the percent of OHI items overall prioritization are also derived.

DATE: _____/_____/____

AGENCY NAME: _____

PROGRAM NAME: _____

RATER: _____

TITLE: _____

TELEPHONE: _____

FAX: _____

EMAIL: _____

ADDRESS: _____

_____

STATE: _____

ZIP CODE: _____

REGION (RUCA CODE): _____

Please enter Y, N, or NA for all categories below— except for categories 'Program Activity' and 'On-site Care Providers' in which you will put a numerical value.

1. **Payments Received**
   _____ Self-Pay (e.g., patient payments)
   _____ Private Health Insurance (e.g., HMO, PPO, MBHO)
   _____ Medicaid
   _____ Medicare
   _____ State Financed Insurance (other than Medicaid; e.g., SCHIP, etc.)
   _____ Military Insurance (e.g., VA, Champus, TRICARE, etc.)

   Other Funding Sources:
   _____ Other Public Funds [(e.g., Federal, State, Local Grants (SAMHSR)]
   _____ Other Funds (e.g., Donations, Fundraising, Charities)

2. **Agency Type**
   _____ Private
   _____ Public
   _____ Non-Profit
   _____ For-Profit
   _____ Government Operated (e.g., Federal, State, Local, Tribal)

3. **Program Activity** (*numeric answers*)
   _____ Total number of patients in practice panel
   _____ Total number of new patient visits per month (on average)

4. **Care Setting**
   _____Outpatient
   _____ Inpatient Hospital
   _____ Acute Care/Emergency
   _____ Rehabilitation/Residential
   _____ Other (please specify)
   _____

5. **Practice Type/Specialty**
   _____ Federally Qualified Health Center
   _____ General Internal Medicine- adult only
   _____ Pediatrics
   _____ Emergency Department
   _____ Family Practice
   _____ Opioid Treatment Program
   _____ HIV clinic
   _____ AIDS Services Organization
   _____ Specialty Practice (please specify)
   _____
   _____
   _____
   _____

6. **On-site Care Providers**

Type	*#*	*FTE*	*# with Advanced Addiction Certification (e.g., ASAM, AAAP, Other) or Licensure (e.g., LADC)*	*# x-waivered*
MD/DO				
MD/DO- Psychiatry				
APRN				
APRN-Psychiatry				
RN/BSN				
PhD/PsyD				
LCSW/MSW				
PharmD				
Counselor				
Other (please specify)				

1. CLINIC STRUCTURE						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	Prioritization
1A. Primary focus of agency as stated in mission statement. What is the agency's mission statement? Does it imply that the agency addresses the care of people with HIV as well as opioid use disorder (OUD)? Does it explicitly state any goals with respect to these conditions?	HIV-related care or OUD-related care only.	Primary focus is on either HIV or OUD but the other may be treated; OR Generic focus on health and well-being.	Broad focus on HIV or OUD as primary, but with explicit mention of the other condition along with other aspects of well-being, or general focus on care that may include both disorders (general primary care).	More specific focus on both HIV- and OUD-related care, but not equivalent balance between the two.	A specific and equivalent focus on both HIV and opioid use disorder with explicit mention of co-occurring disorders.	_____ HIV _____ OUD _____ Both _____ Neither
1B. Organizational certification & licensure. What does licensure or certification permit? Are there impediments to providing either HIV or OUD-related services?	Permits only HIV or OUD-related services. Adherence to CFR 42 unclear.	Provides services for one condition and has no actual barrier to treatment the other, but staff report regulatory barriers, OR has no barrier but provides treatment for either HIV or OUD problems without formal license or certification. Adherence to CFR 42 unclear	Provides health care services for both HIV and OUD but has no specific formal HIV or SUD license or certification. Documented adherence to CFR 42.	Provides health care services for HIV and OUD, and has formal license or certification to provide HIV or OUD treatment, but not both. Policies in place for the sharing of information in compliance with CFR 42.	Is certified and/or licensed to provide health services for both HIV and OUD (and co-occurring disorders). Policies in place for the sharing of information in and outside organization in compliance with CFR 42.	_____ HIV _____ OUD _____ Both _____ Neither
1C. Coordination and collaboration with specialty HIV and/or OUD treatment services. How and where are HIV or OUD treatment services provided? Through loose relationships or integrated on-site? Are these relationships formalized and documented?	No formal relationship with HIV or OUD service providers.	Formalized consultative relationship with HIV or OUD service providers.	Formalized consultative or coordinated relationship with both HIV *and* OUD service providers.	More formalized coordinated and collaborative relationship with both HIV *and* OUD providers with regular inter-agency or inter-program meetings. (If relationship exists with HIV *or* OUD providers, then lower rating to "3').	Most services for HIV, OUD, *and* co-occurring disorders are integrated within the existing program, and routine inter-agency meetings for collaborative services (If integrated services exist for either HIV *or* OUD, then lower rating to a "4").	_____ HIV _____ OUD _____ Both _____ Neither

1. CLINIC STRUCTURE, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	Prioritization
1D. Financial incentives. How do billing structures limit or incentivize services for persons with HIV *and/or* OUD?	Bills for general health care services only.	Bills for either HIV *or* OUD services but not both.	Bills for both HIV *and* OUD, but not routinely. – Or – Partial reimbursement for HIV *or* OUD services available.	Routinely bills for HIV *and* OUD services but not for both at the same time or for the same patient.	Routinely bills for HIV *and* OUD treatments, and for combination and/or integration of HIV/OUD care for co-occurring patients.	_____ HIV _____ OUD _____ Both _____ Neither
2. CLINIC MILIEU						
2A. Routine expectation of and welcome to treatment for both disorders. How are patients with HIV and/or OUD expected and welcomed? Are the terms of treatment made clear to patients and feasible in their psychosocial context?	Documented expectation of HIV or OUD care needs only (or general medical care only); no acknowledgement of persons with HIV, OUD *or* co-occurring disorders, who are either referred or deflected. Terms of treatment are not defined or documented.	Documented expectation and welcoming of persons with either HIV or OUD (e.g. admission criteria, target population), but not both. Neither HIV *nor* OUD patients share common areas with other patients. Terms of treatment are documented for one or the other.	General expectation for both HIV *and* OUD, but differential documentation for one or the other. Either HIV *or* OUD (but not both) share common areas with other patients. Terms of treatment are documented for one or the other.	More equivalent and documented expectation for both HIV and OUD patients with some shared common areas. Terms of treatment are documented for one or the other, or both, but do not incorporate the psychosocial context of patients.	Clearly equivalent and documented expectation of HIV and OUD patients who share common areas (e.g. waiting rooms, exam rooms). Terms of treatment are documented for both and incorporate patients' psychosocial contexts.	_____ HIV _____ OUD _____ Both _____ Neither
2B. Display and distribution of educational information and patient perceptions of stigma. What kind of information is on display? Are efforts made to mitigate stigma in the environment and in agency materials?	No information available regarding HIV or OUD. Any punitive or stigmatizing materials and perceptions of stigma by patients.	Some information available for HIV *or* OUD disorders. Perceptions of stigma by patients.	Available for both HIV *and* OUD but not equivalently distributed, and significantly less than for other conditions. Patients do not perceive stigma.	Available for HIV and OUD disorders with equivalent distribution, but not their interaction. Patients perceive they are comfortable in the environment.	Available for both HIV and OUD, as well as the interaction between HIV and OUD. Distribution is equivalent with other health issues. Patients perceive they are comfortable and empowered in the environment.	_____ HIV _____ OUD _____ Both _____ Neither

3. IDENTIFICATION & TRIAGE						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	Prioritization
3A. Routine screening methods for HIV- and OUD-related symptoms. Are there routines or systems to screen for HIV and OUD depending on the primary focus of the clinical site?	No formal screening for HIV *or* OUD.	Routine screening for either HIV *or* OUD.	Routine screening for HIV and OUD, but not readily accessible or not utilized.	Standardized, formal screening measures for HIV and OUD that are readily accessible but not well integrated with other clinic functioning.	Standardized or formal screening measures for HIV and OUD, and both well-integrated other clinic functioning.	_____ HIV _____ OUD _____ Both _____ Neither
3B. Routine assessment if screened positive for HIV or OUD symptoms. If a patient screens positive, are more detailed assessments triggered? Are these assessments formalized and integrated into routine protocols?	No assessment or follow-up to positive screens for either HIV or OUD.	Assessment of HIV and OUD is variable, and typically a clinician drives follow-up to positive screens for either HIV or OUD.	Informal assessment of both HIV and OUD occurs but with some variation and neither is well-integrated with other clinic functioning. Documented in 50-69% of the records with a positive screen.	Formal assessment of both HIV and OUD, more integrated with other clinic functioning for HIV *or* OUD but not for both. Documented in 70-89% of the records with a positive screen.	Standardized or formal integrated assessment for HIV *and* OUD, routinely conducted, and well-integrated with clinic functioning. Documented in at least 90% of the records with a positive screen.	_____ HIV _____ OUD _____ Both _____ Neither
3C. HIV and OUD diagnoses made and documented. If assessments are conducted, are HIV and OUD diagnoses made and recorded?	Neither HIV *nor* OUD diagnoses are made or recorded.	Either HIV *or* OUD diagnoses are made variably.	HIV *and* OUD diagnoses are made variably, but neither diagnosis is well-integrated with provider documentation (i.e., not readily accessible or not utilized). Diagnoses are documented in 50-69% of records with a positive screen.	More routine diagnoses of both HIV *and* OUD, more integrated with provider documentation for HIV *or* OUD but not for both. Diagnoses are documented in 70-89% of records with a positive screen.	Systematic and routine diagnoses for HIV *and* OUD, routinely and well-integrated with provider documentation. Diagnoses are documented in at least 90% of records with a positive screen.	_____ HIV _____ OUD _____ Both _____ Neither

3. IDENTIFICATION & TRIAGE, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	Prioritization
3D. HIV *and* OUD history reflected in medical record. Are the chronologies and treatment courses of these disorders gathered and recorded?	General health history only.	Variable history of either HIV *or* OUD history in record in narrative section.	Variable recording of history and chronology of course of HIV *and* OUD and interaction with other problems, documented in 50-69% of possible records.	Consistent recording of history and chronology of course of HIV *and* OUD disorders and interaction with other health problems, documented in 70-89% of possible records.	Specific section in record devoted to history and chronology of course of HIV *and* OUD and the interaction with other health problems, documented in at least 90% of possible records.	_____ HIV _____ OUD _____ Both _____ Neither
3E. Access re: HIV *and* OUD symptom acuity: low, moderate, high. What happens to patients who present for services with stable HIV *or* OUD, or who are not in acute distress or intoxicated? What happens to patients who present with unstable symptoms or who are intoxicated or in withdrawal?	Continued access to services for persons with no to low acuity in HIV *or* OUD symptoms only.	Continued access to services for persons with low to moderate acuity in either HIV *or* OUD conditions, but not both.	Continued access to services for persons with low to moderate acuity in both HIV *and* OUD problems, but who are primarily stable.	Continued access to services for persons with co-occurring disorders who may be acute in either HIV *or* OUD problems, but not both.	Continued access to services for persons with relatively high acuity, including those unstable in their HIV condition *and* OUD.	_____ HIV _____ OUD _____ Both _____ Neither
3F. Access re: Severity and persistence of disability: low, moderate, high. What happens to patients who present with histories or reports of severe, uncontrolled, and/or persistent HIV or OUD?	Continued access to services for persons with no to low severity and persistence of disability from either HIV *or* OUD, but not both.	Continued access to services for persons with low to moderate severity and persistence of disability in either HIV *or* OUD disorder, but not both.	Continued access to services for persons with low to moderate severity and persistence of disability in both HIV *and* OUD.	Continued access to services for persons with co-occurring disorders who may have moderate to high severity and persistence of disability in either HIV *or* OUD problems, but not both.	Continued access to services for persons with moderate to high severity and persistence of disability in HIV, OUD *and* co-occurring disorders.	_____ HIV _____ OUD _____ Both _____ Neither

3. IDENTIFICATION & TRIAGE, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	Prioritization
3G. Stage-wise assessment. Is the stage of motivation assessed and documented? How does it influence treatment or how a patient is approached?	Not assessed or documented, OR assessed & documented variably by individual clinician, focus either HIV *or* OUD motivation.	Routinely assessed and documented stage of motivation for either HIV *or* OUD.	Variable assessment of stage of motivation for both HIV *and* OUD, documented in 50-69% of possible records.	Routinely but not systematically assessed for both HIV *and* OUD, documented in 70-89% of possible records.	Systematically assessed for both HIV *and* OUD motivation, documented in at least 90% of possible records.	_____ HIV _____ OUD _____ Both _____ Neither
4. CARE DELIVERY						
4A. Integrated treatment plans. Do treatment plans show an equivalent and integrated focus on both HIV *and* OUD (along with physical health conditions)?	Listing of general health disorder(s) only (neither HIV *nor* OUD listed).	Routine listing of either HIV or OUD as primary, variable listing of the other disorder.	HIV *and* OUD disorders variably listed.	HIV *and* OUD routinely listed.	Integrated treatment plan or problem list: Co-occurring HIV *and* OUD problems, like physical health problems, are listed as primary.	_____ HIV _____ OUD _____ Both _____ Neither
4B. Assess and monitor interactive courses of both disorders. Are changes and/or progress with status and symptoms of HIV and OUD followed (and documented)?	No attention or documentation of progress with either HIV *or* OUD disorders.	Systematic clinical focus in narrative (treatment plan or progress note) on either HIV *or* OUD; or more variable reports of progress on either HIV *or* OUD disorders.	Variable focus on interaction between HIV *and* OUD disorders or systematic focus on both HIV *and* OUD, but not their interaction or impact on overall health.	More routine but not systematic focus on interaction between HIV *and* OUD disorders, and impact on general health.	Clear, detailed, and systematic focus on change in both HIV *and* OUD, their interaction, and impact on general health.	_____ HIV _____ OUD _____ Both _____ Neither
4C. Procedures for OUD-related emergencies and crises. Are there definite protocols for opioid-related crises, and efforts made to expedite treatment entry?	No guidelines conveyed in any manner, OR verbally conveyed in-house guidelines.	Documented guidelines: Referral or collaborations for OUD (to local mental health or addiction treatment program, detoxification or emergency department).	Variable guidelines and capacity to address acute states for OUD.	Consistent guidelines and capacity to address acute states for OUD. Efforts made to expedite entry into treatment with medications for OUD.	Routine capability, or a process to ascertain risk for acute states; Can maintain patients in present medical service unless commitment is warranted.	_____ HIV _____ OUD _____ Both _____ Neither

4. CARE DELIVERY, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	Prioritization
4D. Stage-wise treatment Is stage of motivation assessed on an ongoing basis for both HIV and OUD-related behavior change? Can treatment be revised based upon changes in motivation?	Not assessed or explicit in treatment plan, OR documented variably.	Stage or motivation routinely incorporated into individualized plan for either HIV *or* OUD issues, but no specific stage-wise treatments.	Stage or motivation routinely incorporated into individualized plan for both HIV *and* OUD issues, but no specific stage-wise treatments.	Stage or motivation routinely incorporated into individualized plan for both HIV *and* OUD issues, and some indications of specific stage-wise treatments.	Stage or motivation for both HIV *and* OUD problems routinely incorporated into individualized plan, and formally prescribed and delivered stage-wise treatments.	_____ HIV _____ OUD _____ Both _____ Neither
4E. Policies and procedures for OUD medication evaluation, management, monitoring and compliance. Are medications acceptable and considered first-line for OUD by providers and patients? Are medications for OUD (e.g. buprenorphine, naltrexone, naloxone) routine and integrated?	No or variable use of OUD medications by specific prescribers.	Policies exist regarding the use of one OUD medication or harm reduction modalities.	Some policies exist regarding prescribing of medication for OUD *and* harm reduction modalities.	Policies, well-developed and consistently implemented, exist regarding the use of multiple medications for OUD (including buprenorphine and naltrexone) *or* harm reduction modalities.	Policies, well-developed and consistently implemented, exist regarding multiple options of medications (including buprenorphine and naltrexone) for OUD *and* harm reduction modalities.	_____ HIV _____ OUD _____ Both _____ Neither
4F. Specialized psychosocial interventions. Are therapies available that focus on HIV or OUD only, or that focus on HIV, OUD, and co-occurring disorders?	None or interventions for either HIV *or* OUD problems based on judgment by individual clinician.	Either HIV *or* OUD intervention in program format as generalized intervention, e.g., 12-step facilitation; Irregular penetration into routine services.	Both HIV *and* OUD intervention in program format as generalized intervention, e.g., 12-step facilitation; More regular penetration into routine services.	Some specialized integrated interventions by specifically trained clinicians, in addition to routine generalized interventions.	Routine co-occurring symptom management groups; Individual therapies focused on specific co-occurring disorders; Systematic implementation of an evidence-based integrated treatment.	_____ HIV _____ OUD _____ Both _____ Neither

4. CARE DELIVERY, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	Prioritization
4G. Patient education about HIV *or* OUD & treatments, or co-occurring HIV *and* OUD & treatments. Is patient education information available on how HIV impacts OUD and vice versa? Is information available about how either influences the course of other health problems, medications, or medical procedures?	For other health problems only.	Present for either HIV or OUD in generic format and content, and delivered in individual and/or group patient education formats.	Present for HIV *and* OUD but variably for co-occurring disorders and impact on general health.	Routine but not systematic for HIV and OUD issues, their interaction, and impact on general health.	Systematically delivered specific content for specific disorder comorbidities and impact on general health, including protocols for individual and/or group patient education formats.	_____ HIV _____ OUD _____ Both _____ Neither
4H. Family education and support. Do family members receive educational information available on HIV and/or OUD? Is information available about how either influences general health,, medications, or medical procedures? What kind of support is available for family members broadly defined?	For HIV or OUD only,, or variably for either, or by individual clinical judgment.	Either HIV or OUD regularly but informally incorporated into family education or support sessions. Available as needed.	Family education and support offered on-site for families on HIV *and* OUD but variably on co-occurring issues and impact on general health.	OUD or HIV family group exists but not integrated into standard program format, or with clear guidelines on impact on general health.	Routine and systematic HIV *and* OUD groups integrated into standard program format, with emphasis on impact on general health and treatment.	_____ HIV _____ OUD _____ Both _____ Neither

4. *CARE DELIVERY, CONT.*						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	Prioritization
4I. Specialized interventions to facilitate addressing social risk. Is there any effort to address social risk or social determinants of health, such as housing, food insecurity, transportation, or employment?	No efforts to address social risk among the population of people with HIV or OUD.	Generic format for assessing social risk for people with HIV or OUD, variably used.	Present, generic format for assessing social risk for people with HIV or OUD, used consistently.	Routine assessment and documentation of social risk for people with HIV or OUD, with some referrals to services for management.	Systematic assessment, documentation, and management (including via referrals and on-site services) of social risk for people with HIV or OUD.	_____ HIV _____ OUD _____ Both _____ Neither
4J. Peer supports for patients with co-occurring disorders. Are peer supports and/or role models (patient advocates, volunteers) available for patients with HIV and OUD or comorbid disorders (other substance use, HCV)?	Not present, or if present not recommended.	Off-site, recommended variably, some co-occurring focus, but primarily either HIV *or* OUD peer support.	Off-site and facilitated with contact persons or informal matching with peer supports in the community, co-occurring focus with HIV *and* OUD peer support.	Off-site, integrated into plan, and routinely documented with co-occurring focus.	On-site, facilitated and integrated into program (e.g., alumni groups; mentors; patient advocates); Routinely used and documented with co-occurring focus.	_____ HIV _____ OUD _____ Both _____ Neither
4K. Practices and policies for schedule III or IV medications, or medications for OUD, balance needs and risks for persons with HIV and OUD.	No to limited and restrictive use of schedule III or IV or medications for OUD for persons with HIV and OUD. (Either has or does not have policy restricting use of these medications).	Variable use of schedule III or IV and medications for OUD but some sensitivity to abuse potential for persons with HIV and/or OUD. (Either has or does not have policy restricting use of schedule IV medications).	Consistent use of schedule III or IV and medications for OUD and other medications with considerations for abuse potential for persons with HIV and OUD, but no formal policy.	Formal policy for schedule III or IV and medications for OUD for persons with HIV *and* OUD, but not routinely followed, or providers unaware of its existence.	Formal policy that is consistently implemented and monitored for schedule III or IV and medications for OUD for persons with HIV *and* OUD.	_____ HIV _____ OUD _____ Both _____ Neither

5. MONITORING & COORDINATION						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	Prioritization
5A. Ongoing management and monitoring of HIV *and* OUD. Throughout periods of HIV *and* OUD continua, are both conditions monitored? For patients on methadone, are strategies in place for the direct communication with OTPs including signed release of information to coordinate care?	Not addressed or monitored.	Either HIV *or* OUD is addressed or monitored when patient is symptomatic.	Both HIV *and* OUD are routinely managed during symptomatic periods, and variably monitored during periods of stability or remission. Efforts are made for communication between methadone prescribers and other providers.	Both HIV *and* OUD are routinely managed during symptomatic and asymptomatic periods, but not systematically.	Both HIV and OUD are routinely and systematically managed using a chronic disease model. Communication between methadone prescribers and other providers is expected and consistently documented.	_____ HIV _____ OUD _____ Both _____ Neither
5B. Capacity to continue care through acute episodes of HIV and OUD. Is treatment terminated or suspended for disruptive or obstreperous behavior?	No mechanism for managing either HIV *or* OUD acute episodes.	No formal protocol to manage either acute HIV *or* OUD issues, but some individual clinicians may provide extended care until appropriate linkage takes place; variable documentation.	Routine practice is to manage both HIV *and* OUD acute care needs indefinitely, but variable documented evidence that this is routinely practiced, typically within the same program or agency.	Routine and typical practice but no formal protocol to manage acute HIV *and* OUD or co-occurring needs indefinitely.	Formal protocol to manage acute HIV *and* OUD issues or co-occurring needs indefinitely and consistent documented evidence that this is routinely practiced, typically within the same program or agency.	_____ HIV _____ OUD _____ Both _____ Neither
5C. Focus on ongoing recovery issues for both disorders. Are HIV *and* OUD disorders seen as acute or chronic, short term or long term, primary or secondary? How is treatment planned?	Routine focus is on resolution of physical health issues; co-occurring issues are viewed (if at all) only as potential complicating issues for medical recovery.	Routine focus on either HIV *or* OUD management and recovery but not as interactive conditions that impact physical health.	Routine focus on both HIV *and* OUD management and recovery but not as interactive conditions that impact physical health.	Routine but not systematic focus on both HIV *and* OUD management and recovery, and as interactive conditions that impact physical health.	Routine and systematic focus on HIV illness management *and* OUD management, both seen as primary and ongoing, and critical to physical health and well-being.	_____ HIV _____ OUD _____ Both _____ Neither
5D. Facilitation of peer recovery support groups for HIV *and* OUD is documented. Is the potential for peer support linkage anticipated and planned?	No, or only rarely.	Routine focus on either HIV *or* OUD peer recovery support group connection (engagement in meetings or functions off-site).	Variable focus on both HIV *and* OUD peer support community connection (engagement in meetings or functions off-site).	Routine focus on both HIV *and* OUD peer support community connection (engagement in meetings or functions off-site).	Routine and systematic focus, at least 90% of the time, on HIV, OUD or co-occurring disorders peer support recovery support group connection.	_____ HIV _____ OUD _____ Both _____ Neither

5. MONITORING & COORDINATION, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	Prioritization
5E. Ongoing access to HIV and OUD medications and assessment of adherence. How is the need for medications post an acute treatment episode dealt with?	No HIV or OUD medications available. No providers with buprenorphine "x" waivers. Adherence not systematically assessed.	HIV or OUD (methadone or buprenorphine) medications available but variably by prescriber on-site, and necessitating off-site prescriber referral.	HIV and OUD medications typically available from on-site prescriber for acute episodes only (e.g. detox), and from an off-site prescriber for ongoing coordinated care.	HIV and OUD medications are available from on-site prescriber for acute and longer term care, but not systematically prescribed or monitored.	HIV and OUD medications are available from on-site prescriber for acute and longer term care, and monitored systematically in overall plan. Adherence is monitored systematically.	_____ HIV _____ OUD _____ Both _____ Neither
6. WORKFORCE						
6A. Physician specialist. What is the relationship with a certified HIV provider or addiction provider (addiction medicine, addiction psychiatry, "x" waivered provider)?	No board-certified or specialized HIV or OUD medicine prescriber on-site.	No board certified or specialized HIV or OUD medicine prescriber on-site but prescribing takes place.	Routine prescriber use of HIV and OUD medications, with formal board certification in psychiatry *or* addiction specialty, primarily in consultative role.	Routine prescriber use of HIV and OUD medications, advanced credentialed prescribers in addiction and psychiatric specialties, and some interaction and coordination with other medical staff members.	Routine prescriber use of HIV and OUD medications; advanced credentialed prescribers in addiction and psychiatric specialties, and integrated on-site for clinical, supervision, treatment team, and/or administration.	_____ HIV _____ OUD _____ Both _____ Neither
6B. On-site behavioral health clinicians with mental health and substance-related treatment (co-occurring) certification, licensure or expertise. Are any behavioral health licensed or certified to provide counseling services?	None.	1-24% of behavioral health clinicians can provide mental health *and* substance-related counseling services and have appropriate expertise.	25-33% of behavioral health clinicians can provide mental health *and* substance-related counseling services and have appropriate expertise.	34-49% of behavioral health clinicians can provide mental health *and* substance-related counseling services and have appropriate expertise.	50% or more of behavioral health clinicians can provide mental health *and* substance-related counseling services and have appropriate expertise.	_____ HIV _____ OUD _____ Both _____ Neither

6. WORKFORCE, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	Prioritization
6C. Access to integrated HIV *and* OUD supervision or consultation. What is the arrangement for existing staff to receive supervision/consultation regarding their patients' co-occurring HIV *and* OUD problems?	None.	Off-site contractor or consultant is available, but variable supervision in integrated HIV *or* OUD treatments.	Provided as needed or variably on-site by consultant, contractor or clinical supervisor with integrated treatment expertise.	Routinely provided (at least twice monthly) on-site by clinical supervisor with integrated HIV *and* OUD treatment expertise.	Regularly provided (weekly) on-site by clinical supervisor with integrated HIV *and* OUD expertise and utilizing direct observation, adherence/competence monitoring or other systematic practice reviews.	_____ HIV _____ OUD _____ Both _____ Neither
6D. Integrated treatment team or utilization review procedures emphasize and support integrated treatment. Is there a protocol to review the progress or process of treatments (or outcomes) for persons with co-occurring HIV *and* OUD?	No.	Variable review of cases, often precipitated by negative event or outcome.	Behavioral (e.g. substance-related) and physical health care (e.g. HIV) providers have integrated team meetings as needed to discuss specific cases.	Behavioral (e.g. substance-related) and physical health care (e.g. HIV)providers have regular integrated team meetings to discuss specific cases and agency policy issues.	Behavioral (e.g. substance-related) and physical health care (e.g. HIV)providers have regular integrated team meetings to discuss patient care issues, grand rounds or joint continuing medical education sessions, and sessions on agency policy issues.	_____ HIV _____ OUD _____ Both _____ Neither
6E. Peer/Alumni recovery supports are available for persons with HIV *and* OUD. Are role models available for persons with co-occurring HIV *and* OUD (volunteers, peer supports, advocates)?	No.	Informal peer network of individuals with HIV *or* OUD is utilized by some providers, typically by off-site referral.	List of peer volunteers or contact individuals with HIV *and* OUD recovery experience is available and frequently used by providers to facilitate connections on-site.	Volunteers or peer recovery specialists in HIV *and* OUD are available on-site, but not well-integrated or utilized by treatment team or providers.	Volunteers, peer recovery specialists or patient advocates with HIV *and* OUD recovery experience are available on-site, and routinely integrated into patient care, support and education.	_____ HIV _____ OUD _____ Both _____ Neither

7. TRAINING						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	Prioritization
7A. All agency staff members have basic training in stigma, prevalence, signs and symptoms, detection and triage for co-occurring HIV *and* OUD symptoms and disorders. What percentage of *all staff members* have a basic knowledge of co-occurring disorders? What percentage know how to screen and assess for these disorders? Is this training organized and documented?	No agency staff members are exposed to basic information (0% trained).	Variably exposed to basic information, not documented as part of systematic training plan, but encouraged by management (1-24% of staff trained).	Trained in basic HIV *and* OUD knowledge and skills per agency strategic training plan, but not universal or continuous (25-50% of staff trained).	Routinely but not systematically trained in basic HIV *and* OUD knowledge and skills, certain select staff but not universal training plan (51-79% of staff trained). Stigma may or may not be a feature of this training.	New employee in-service and/or annual renewal of knowledge and skill in basic HIV *and* OUD knowledge and skills, monitored and enforced by agency (80% or more of staff trained). Stigma is incorporated into these trainings.	_____ HIV _____ OUD _____ Both _____ Neither
7B. Clinicians who deliver *behavioral health services* have specialized training in knowledge and skill in integrated treatments for co-occurring HIV *and* OUD. Who is trained in integrated treatment approaches? (Advanced approaches include: medications, brief interventions, family interventions, other treatments). Is this training organized and documented?	No behavioral health clinicians have advanced training (0% trained).	Behavioral health clinicians are variably trained, and there is no systematic agency training plan for individual staff member election (1-24% of clinical staff trained).	Certain behavioral health clinicians are trained, encouraged by management and with systematic training plan (25-50% of clinical staff trained).	Many behavioral health clinicians are trained and monitored by agency strategic training plan (51-79% of clinical staff trained).	Most behavioral health clinicians are trained and periodically monitored by agency strategic training plan (80% or more of clinical staff trained).	_____ HIV _____ OUD _____ Both _____ Neither

BENCHMARK SUMMARY >>

Program: _____

Type: _____

Reviewer(s): _____

Date of Review: _____/_____/_____

1. Clinic Structure

A. _____
B. _____
C. _____
D. _____

Sum Total= _____
Total/4= _____

#HIV: _____ #Both: _____
#OUD: _____ #Neither: _____

2. Clinic Milieu

A. _____
B. _____

Sum Total= _____
Total/2= _____

#HIV: _____ #Both: _____
#OUD: _____ #Neither: _____

3. Identification & Triage

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____

Sum Total= _____
Total/7= _____

#HIV: _____ #Both: _____
#OUD: _____ #Neither: _____

4. Care Delivery

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____
H _____
I. _____
J. _____
K. _____

Sum Total= _____
Total/11= _____

#HIV: _____ #Both: _____
#OUD: _____ #Neither: _____

5. Monitoring & Coordination

A. _____
B. _____
C. _____
D. _____
E. _____

Sum Total= _____
Total/5= _____

#HIV: _____ #Both: _____
#OUD: _____ #Neither: _____

6. Workforce

A. _____
B. _____
C. _____
D. _____
E. _____

Sum Total= _____
Total/5= _____

#HIV: _____ #Both: _____
#OUD: _____ #Neither: _____

7. Training

A. _____
B. _____

Sum Total= _____
Total/2 = _____

#HIV: _____ #Both: _____
#OUD: _____ #Neither: _____

OHI CLINIC CATEGORY

% Criteria Met for MI (# of "1" scores/36): _____
% Criteria Met for PI (# of "3" scores/36): _____
% Criteria Met for FI (# of "5" scores/36): _____
Highest Level of DD Capability (80% or more): _____

PRIORITY

#HIV: _____ *% HIV (# of HIV/36)*
#OUD: _____ *% OUD (# of OUD/36)*
#Both: _____ *% Both (# of Both/36)*
#Neither: _____ *% Neither (# of Neither/36)*

Top Priority (Category with highest %): _____

Additional Site Visit Notes:

For more information on the OHI, please contact:

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