GATHER Reflection and Planning Tool

For use after Phase 1 Training

Name: **Date:**

<table>
<tr><th>Indicator (G.A.T.H.E.R.)</th><th>Actions taken or skills practicing</th><th>Plan for Next Steps</th></tr>
<tr><td>Generalist:
I see people with all health challenges, including physical, mental and social health challenges.
I am serving the entire practice population, including all ethnicities, races, and ages.
I adapt my approach to use language, models of health, and practices to ensure cultural responsiveness
I provide preventive, acute and chronic condition care.</td><td>-</td><td>-</td></tr>
<tr><td>Accessible:
I am visible during the day and inform teammates of my whereabouts.
My template is built and maintained to promote same-day access.
Warm handoffs are the default way patients get to me and they usually result in a same-day visit.
I understand and work to remove barriers patients or teammates might experience to accessing my services.
I complete most visits in 30 minutes or less.
For same-day patients with limited time, I flex visit length to accommodate them.
I plan follow-up only until patients are starting to improve and have a plan in place for continued improvement.</td><td>-</td><td>-</td></tr>
<tr><td>Team based:
I am involved in huddles, staff and clinical meetings.
I use the same resources as the team, including the EHR, exam rooms, workstations, reception and scheduling staff.
I am routinely involved in team efforts to plan and implement care for patients.
I assist the team with role-consistent tasks, such as making calls, reviewing records, and completing letters and forms for patients.</td><td>-</td><td>-</td></tr>
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• I know and routinely involve PCBH care extenders and community service providers in patient care.		
High impact: • My goal is to see a high patient volume, reaching many patients who likely would not otherwise engage behavioral health. • I provide "non-clinical" and/or well-being support to the practice team. • I have a ratio of initial to follow-up visits that shows a regular inflow of new patients. • I offer class-based services or have a plan to.	-	-
Educator: • I provide education to my team, both formal and informal. • I write chart notes in an accessible way so that team members might learn from reading them. • I provide resources to my team, such as patient education handouts, community services, etc. • I regularly staff patients with PCPs, partly to aid interprofessional learning.	-	-
Routine part of care: • I help develop prevention and intervention pathways that routinely include me in care. • I seamlessly work patients in after PCP visits, without additional paperwork. • My colleagues know how to introduce my role as a routine part of good care. • I use primary care language and practices and clinical spaces.	-	-
Visit Content: I consistently and effectively demonstrate the following in a first session, and adapt as appropriate based on clinical judgement, or for a follow-up session:- 1. Introduction 2. Outcome measure - *Pediatric Symptom Checklist 17* - *Health-related quality of life* - *Problem severity (1-10)* 3. Life context - *Love* - *Work* - *Play* - *Health*	-	Initial Visit: - Follow-up visit: - - General: -

4. Problem context ; Functional analysis - *Problem description and severity rating* - *Time* - *Triggers* - *Trajectory* 5. Workability of patient's efforts to address concern/problem 6. Summary and psychoeducation 7. Intervention (including use of fact pillars (open, aware, engaged), and FACT tools such as Life Paths, Bullseye, Four Square , and Choice Point) 8. Collaborative behavioral plan (Specific, Measurable, Attainable, Related to Values, Time-bound) 9. Rating Scales - *Confidence* - *Helpfulness* 10. Follow-up plan 11. Recommendations to PCP and team		

Copies sent to: **Review date:**

Fig. 7.8 GATHER Reflection and Planning Tool