SAMHSA-HRSA
Center for Integrated Health Solutions

Integrating Behavioral Health into Primary Care Innovation Community

Webinar #7

June 17, 2015

Today's Agenda

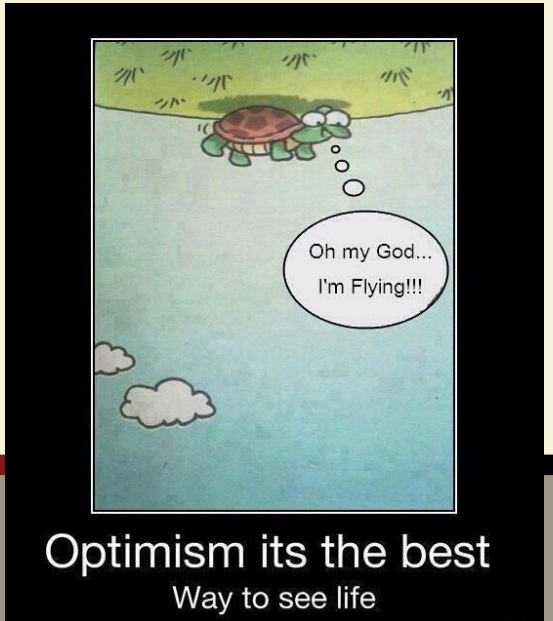
1. Updates, Reminders
2. *Guest Speaker: Andrea Auxier, PhD*

   Director of Integration, National Strategy and Development - Beacon Health Options
3. Resources & Next Steps

In May

- Amanda Christofferson, Bullhook CHC
  - Shared care planning… and ice cream

- Trish Staiger, STEPS at Liberty Center & Every Woman's House
  - Optimistic, new ways of thinking



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Measuring Integration: The Integrated Practice Assessment Tool (IPAT)

Andrea Auxier, PhD

Director of Integration | National Strategy and Development

What is Integration?

Who are the people?

Dual Eligibles

MH/SUD

MH/Medical

- SPMI with co-morbid medical (Health Homes)
- Primary medical with comorbid mental health (Medical Homes)
- Primary medical with no comorbid mental health; focus on modifiable health risk behaviors (Medical Homes)

What do we do for them?

Care Management

Care Delivery (pre-coordinated to fully integrated)

Care Management vs. Care Delivery

Care management includes care coordination, disease management, and case management; goal is to ensure access to appropriate levels of care by a provider or treatment team.

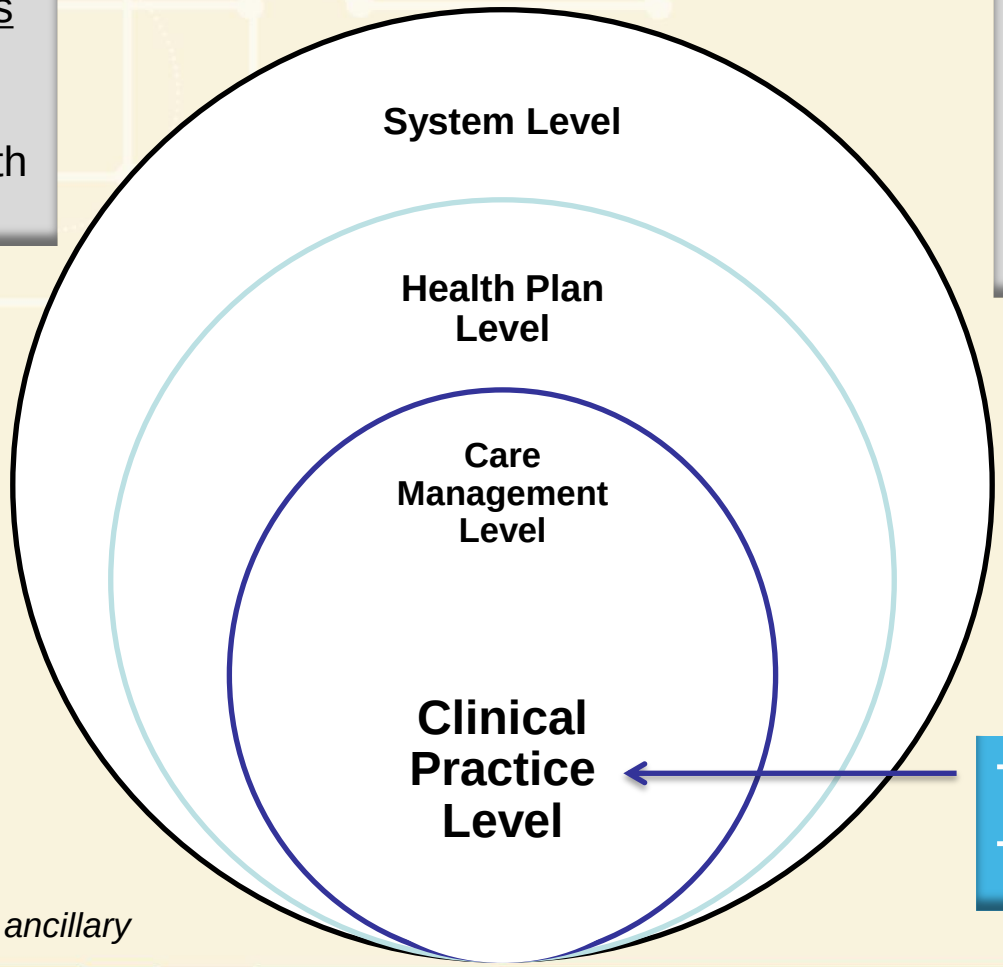
Care delivery is care that is provided directly to a person by a provider or treatment team, accompanied by legal responsibility for that person's care.

Integrated Care Approach

Where Integration Occurs

Primary Systems

Primary Care
Behavioral Health
Substance Use*



Additional Systems

Substance Use*
Specialty Care
LTSS
Social Service

Triple Aim Territory

**Can be primary or ancillary*

Integration in ACOs

Study design: mixed-methods (surveys & semi-structured interviews); n=257

Findings:

84% had at least one contract, covering both commercial and public payers, specifying responsibility for behavioral health care within the total cost of care.

<15 % had full or nearly full integration of primary and behavioral health care.

43% had some integration.

43% had little or no integration.

ACOs that offered comprehensive chronic care management, as well as those that included at least one participating FQHC, were more likely to have integrated care.

Factors associated with higher rates of integration: prevalence of BH issues in the patient population; a low number of BH providers in the surrounding area; pay-for-performance contracts that used quality measures related to BH; and inclusion of behavioral health costs in the ACO contract.

Lewis et al. Few ACOs Pursue Innovative Models That Integrate Care for Mental Illness and Substance Abuse with Primary Care. Health Affairs, October, 2014.

The Problem with Integration

"Uh oh. I measured the drywall in feet, but you measured it in metric."

A Standard Framework

Coordinated Care		Co-Located Care		Integrated Care	
1	2	3	4	5	6
Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration Onsite	Close Collaboration with Some System Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in a Transformed /Merged Practice

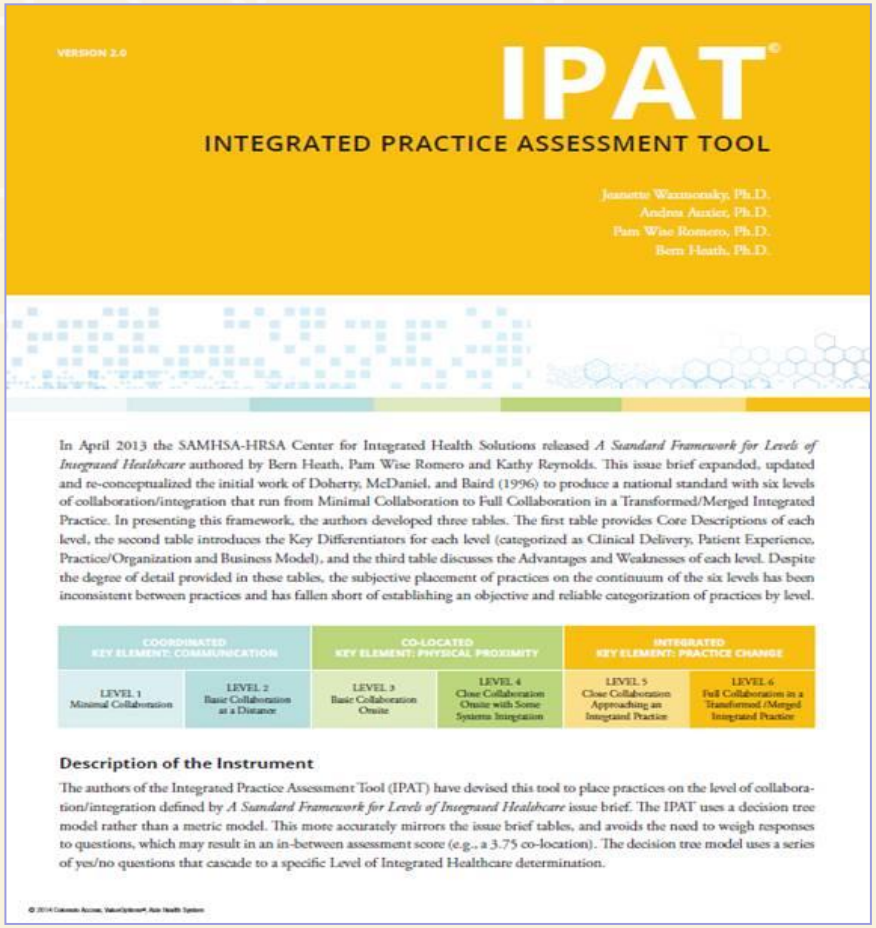
Heath B, Wise Romero P, and Reynolds K. A Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.

Assessing Integration

Pre-coordinated	Coordinated	Co-Located	Integrated
Medical and behavioral health care are provided in different settings, with little, if any, communication between providers regarding shared patients; limited, if any, protocols for sharing information; information technology to support registries or patient information exchange do not exist or are not utilized.	P2P communication about shared patients across agencies; some protocols and technology for sharing information exist and are routinely followed.	Behavioral and medical providers delivering services in the same physical facility; medical and behavioral care remain mostly divided; documentation of services often occurs in separate records; few-if any standard protocols for integrated service delivery exist.	Behavioral and medical providers practicing in a team-based fashion with attention to psychiatric conditions as well as health and behavior change, using real-time interventions, screening protocols, shared documentation, and open access to records.

We added a level

The Integrated Practice Assessment Tool



VERSION 2.0

IPAT®

INTEGRATED PRACTICE ASSESSMENT TOOL

Jeanette Waxmonsky, Ph.D.
Andrea Auxier, Ph.D.
Pam Wise Romero, Ph.D.
Bern Heath, Ph.D.

In April 2013 the SAMHSA-HRSA Center for Integrated Health Solutions released *A Standard Framework for Levels of Integrated Healthcare* authored by Bern Heath, Pam Wise Romero and Kathy Reynolds. This issue brief expanded, updated and re-conceptualized the initial work of Doherty, McDaniel, and Baird (1996) to produce a national standard with six levels of collaboration/integration that run from Minimal Collaboration to Full Collaboration in a Transformed/Merged Integrated Practice. In presenting this framework, the authors developed three tables. The first table provides Core Descriptions of each level, the second table introduces the Key Differentiators for each level (categorized as Clinical Delivery, Patient Experience, Practice/Organization and Business Model), and the third table discusses the Advantages and Weaknesses of each level. Despite the degree of detail provided in these tables, the subjective placement of practices on the continuum of the six levels has been inconsistent between practices and has fallen short of establishing an objective and reliable categorization of practices by level.

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice

Description of the Instrument

The authors of the Integrated Practice Assessment Tool (IPAT) have devised this tool to place practices on the level of collaboration/integration defined by *A Standard Framework for Levels of Integrated Healthcare* issue brief. The IPAT uses a decision tree model rather than a metric model. This more accurately mirrors the issue brief tables, and avoids the need to weigh responses to questions, which may result in an in-between assessment score (e.g., a 3.75 co-location). The decision tree model uses a series of yes/no questions that cascade to a specific Level of Integrated Healthcare determination.

Waxmonsky J, Auxier A, Heath B, Wise Romero P (2014)

IPAT Development

- IPAT is a descriptive, qualitative instrument intended to categorize practices along the integration continuum.
- Focuses on qualitative change; the elements that comprise a high degree of integration are difficult to tease apart and do not occur separately in the real world setting, but are intertwined.
- Designed to be user friendly, quick to administer, and equally applicable for both medical and behavioral health settings.
- Practices find that IPAT is a team undertaking to fill out, and serves a “conversation starter” for integration.

IPAT FAQs

What is IPAT? IPAT is a questionnaire used to determine how integrated a clinical practice is. It builds of the SAMHSA-HRSA standard framework for Levels of Integrated Healthcare.

How does IPAT work? IPAT asks a series of yes/no questions using a decision-tree model to arrive at the practice's current level.

Do I have to provide PHI? No. IPAT does not inquire about patient-level information.

Do I have to pay to use IPAT? No. IPAT is in the public domain and is provided free of charge.

How will my NPI number be used? The electronic version is linked to the NPI database, strictly for demographic analytic purposes.

Will IPAT work only in primary care settings? No. IPAT can be used in behavioral health or medical settings.

Who should actually complete the IPAT? IPAT can be completed by medical provider, a behavioral health provider, or a practice manager. Ideally, several members of the care team would collaborate on a joint response.

What if I have multiple clinics in my setting? Do I complete just one IPAT? No. Because IPAT is intended to assess clinical operations, a different IPAT should be completed for each clinic.

IPAT Potential Uses

- Tailor product solutions to client need
- Assess network readiness for integration
- Establish baseline and monitor performance over time
- Conduct comparative analysis
- Assess the association between integration and selected clinical, cost, or utilization outcomes
- Establish thresholds for differential payment structures

http://ipat.valueoptions.com/IPAT/

http://www.integration.samhsa.gov/operations-administration/assessment-tools

How Integrated am I?

- A part-time social worker in a primary care clinic receives warm-handoffs and provides treatment for mental illness
- A mental health center hires a psychiatric nurse practitioner
- A psychiatrist provides P2P consultation to a PCP via televideo
- A psychiatrist meets with a patient via televideo
- Psychologists work alongside primary care practitioners, but notes are kept separately and not shared
- A behavioral health care manager is co-located with a health plan care manager

Questions?

Resources

IPAT Online
http://ipat.valueoptions.com/IPAT/

Integrated Care Models – From the Field
http://www.integration.samhsa.gov/integrated-care-models/from-the-field

EHR's: Resource Guide for HIT, EHR Incentive Programs, EHR Contracts, etc.
http://www.integration.samhsa.gov/operations-administration/hit#EHR

Next Steps

- **July 22, 3-4pm EDT**

Webinar #8 – Squirrel Hill Health Center, IPAT

- **Aug 19, 3-4pm EDT**

Final webinar – IPAT results, summary learnings

SAMHSA-HRSA Center for Integrated Health Solutions

Slides for today's webinar are available on the CIHS website at:

www.Integration.samhsa.gov

under About Us/Innovation Communities