PRACTICE INTEGRATION PROFILE (PIP2) INTERPRETATION GUIDE

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This guide is intended to provide users with a broad overview of PIP2 domains, how to interpret scoring, and general recommendations for clinic-specific improvements.

It is important to note that practice integration is complex and that PIP domains are interrelated. While we have outlined key considerations, this is not a comprehensive step-by-step guide to increase practice integration. Rather, these suggestions and resources can guide your clinic's plans to align multiple stakeholder perspectives and practice improvement efforts.

Research in this area remains ongoing to establish best practices and effective implementation strategies. Since the science continues to evolve, the PIP2 cannot guarantee that the practice's performance on the survey corresponds to evidence-based practice or improved patient outcomes.

The behavioral health issues of patients in primary care include those beyond mental health and substance use:

Integrated primary care addresses the behavioral health issues of individuals and populations of patients.

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BACKGROUND ON THE PRACTICE INTEGRATION PROFILE: MEASURING PRACTICE-LEVEL INTEGRATION

The online *Practice Integration Profile (PIP2)* is an organizational, self-assessment survey that operationalizes the ideas and Defining Clauses in the Lexicon of Collaborative Care (AHRQ, 2013).

The Lexicon defines integration as:

> *The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic 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 healthcare utilization.*

The PIP2 is a free tool for clinics to measure practice-level integration that incorporates items addressing each of the following five domains:

- ***Workspace and Integration Methods*** - Physical location of behavioral health (BH) clinicians in the primary care practice, sharing of documentation in patients' charts, exchange of patient information between BH and medical clinicians in addition to their joint participation in educational activities and opportunities to interact with each other.
- ***Patient Identification*** - Screening routines implemented in the primary care practice, specifically the use of screening approaches to identify patients with unmet behavioral health or health behavior change needs.
- ***Clinical Services*** - Relative presence of BH clinicians in the practice and the variety of BH services that are available.
- ***Patient Engagement*** - Processes for identification, engagement, and retention of patients in behavioral health services in addition to training in patient engagement approaches for the entire primary care team.
- ***Practice Workflow*** - Established processes for tracking patients with known BH needs, coordinating care, referrals to specialty services, and documenting self-management goals.

- PIP2 aggregate score - This is a composite score that averages the mean scores of all the domains described above.

The PIP2 can be found at the following link: http://practiceintegrationprofile.com. Teams can gather and compare the data from multiple respondents to assess the practice from varied perspectives.

INTERPRETATIVE GUIDE FOR EACH PIP2 DOMAIN

Workspace and Integration Methods (WI)

Physical location of BH clinicians in the primary care practice, sharing of documentation in patients' charts, exchange of patient information between BH and medical clinicians in addition to their joint participation in educational activities and opportunities to interact with each other.

Definition of domain

The PIP2 Workspace and Integration Methods domain includes the degree to which behavioral and medical providers work collaboratively regarding patients needing integrated behavioral and medical care, including patient-focused meetings, shared documentation, shared treatment plans, shared workspace, and shared educational activities.

Purpose

WI items assess the degree to which providers caring for the same patient work together, with shared resources and information, whether engaged in-person or through the patient health record. The domain does NOT address boundaries that may limit collaboration, such as legal requirements pertaining to shared health record information or organizational structural requirements related to employment vs. contractual relationships, or membership on the medical staff.

How to interpret results

Low scores or scores that vary widely across WI items may suggest the need to examine structural and process-based boundaries affecting medical and behavioral providers' ability to collaborate as part of a single healthcare team. Review the suggestions below and decide whether data on patient needs and provider availability to meet those needs could help inform personnel policies.

Suggestions to consider

- Evaluate how well behavioral health patient visits, and medical and behavioral provider meetings/conversations in support of these visits, are organized around non-crisis patient care in order to find opportunities to enhance collaboration.
- Determine whether patients are getting "lost" in the handoff between clinic providers (e.g., appointments never scheduled, cancellations, no shows). Consider how to reach out to patients that have not been served to find out why and evaluate follow up processes. Consider developing a registry to identify patients who may need follow up in the future.
- Review the patients in need of integrated healthcare by diagnosis and determine if the reason is primarily medical or behavioral or a combination and if the diagnoses are acute or chronic. Identify the educational needs of the providers and create joint educational sessions to meet those needs and build collaborative care processes.
- Redesign workspace to support shared, co-located work units.
- Redesign care documentation for access by all providers, including patient goals and shared treatment plans.

Domain Resources

- Integrating Behavioral Health and Primary Care website: https://sites.google.com/view/ibhpc/home

Patient Identification (PI)

Screening routines implemented in the primary care practice, specifically the use of screening approaches to identify patients with unmet behavioral health or health behavior change needs.

Definition of domain

PI includes the proportion of total clinic patients whose mental health, lifestyle behaviors, and substance use are identified as well as the clinic's use of population health approaches to identify patients with behavioral health needs.

Purpose

The PI domain addresses the degree to which the clinic *systematically* identifies patients needing behavioral health support through screening practices and analyses of the clinic's patient-related data sources. This domain does NOT address the subsequent care that may be offered when positive screens or other patient identification occurs.

How to interpret results

Low scores on each of the first three items (screening for mental health concerns, lifestyle behavior concerns, substance use disorder) may suggest that practice workflows or team members' current expertise constrains the use of screening practices.

Low scores on the fourth item (review of retrospective data) may suggest that the team has limited access or expertise to analyze and provide reports on patient data sources.

Suggestions to consider

- Determine screening focus - Identify specific patient BH issues that your team has the expertise, time, and resources to address
    - For each BH issue that your team is prepared to effectively address:
        - Identify which team members will be assigned to perform each of the following tasks: pre-screening; administering, scoring, and interpretation of full screens; providing BH interventions; and patient monitoring, follow-ups, and rescreenings.
        - Identify specific points within a patient visit where the steps of the screening practice would be included in the established workflow
        - Identify the validated measure that will be used to assess the BH issue, where data from the measure will be recorded, and how that data will be shared among the care team
    - For those BH issues that your team is unable to effectively address:
        - Consider specific future clinic initiatives and efforts designed to train team members and build team capacity over time
- Screen based on selected focus and capacity to follow up with care
    - Train providers to identify patient concerns and symptoms that indicate when a screening should occur
    - Train providers to pre-screen for selected mental health, lifestyle behaviors, and substance use issues
    - Revise practice workflows to include screening during patient visits
    - Review the team's capacity and/or training needed to perform regular screenings
    - Train the providers on ways to incorporate screening results within their scope of practice

- Address population health
    - Review existing EHR data to identify subpopulations of patients with common comorbid medical and BH needs
    - Identify thresholds for each condition to be used for extracting the data from the EHR that meet defined thresholds
    - Consult with IT/data management representative for assistance with data access, extraction, and reporting tasks from electronic health records and other patient-related data sources
    - Consult with team to review the report
        - Examine the quality of the data reported and consider any changes in data entry processes
        - Identify changes to practice workflows that may be needed to screen and support ongoing care with the population

Domain Resources

- Meyer, D., Lerner, E., Phillips, A., & Zumwalt, K. (2020). Universal screening of social determinants of health at a large US academic medical center, 2018. *Am J Public Health*, *110*(S2), S219-s221. https://doi.org/10.2105/ajph.2020.305747
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Clinical Services (CS)

Relative presence of BH clinicians in the practice and the variety of available BH services.

Definition of domain

CS includes a variety of treatment options based on the behavioral health needs of the patient. Services include non-pharmacological treatment for common behavioral health needs, serious mental illness, substance use disorders, crisis or urgent behavioral health needs, and chronic medical conditions. Services may also include specialized therapies (e.g., Dialectical Behavioral Therapy) and medications for mental health, substance use, and serious mental illness.

Purpose

The purpose of the CS domain is to measure the range of behavioral health treatment options available to patients in your clinic. Treatment options vary depending on staff expertise, patient population needs, and clinic mission. Clinic leaders can use the CS domain score to make decisions about adding, expanding, or removing behavioral health services based on organizational needs and resources. This domain does NOT measure how a clinic matches a patient with the right clinic service, how it engages a patient in treatment, or how it monitors treatment outcomes.

How to interpret results

Low scores or scores that vary across CS items may suggest the need to add or expand behavioral health services. Please note that clinical services should match patient population needs and clinic resources. Adding a new service or expanding an existing one should be considered in light of clinical, financial, and operational factors.

Review the suggestions below and consider whether supplemental data are needed to best inform your decision-making process.

Suggestions to consider

- Clinic team capacity for clinical services
    - Identify and list the behavioral health expertise (e.g., specific diagnoses and treatment models) of your clinic team as an inventory of your available services.
    - Calculate the percentage of your patient population with common mental health needs (e.g., stress, depression) or chronic medical conditions (e.g., diabetes management). This percentage will likely be your primary target for behavioral health services. If the patient need exceeds your available services, plan for a method of triage or serving those patients with highest priority.
    - Calculate the percentage of your patient population with serious mental illness and/or substance use disorders. Decide if you want to establish a referral process for these patients or if you want to develop internal resources to meet their behavioral health needs.
    - You should only offer clinical services that meet the demands of your patient population and your available resources. In some areas (e.g., rural or underserved), you may consider developing more internal resources for behavioral health services.

- BH integration encompasses more than delivery of specialty mental health treatment in primary care! Examples of less “traditional” BH services may include:
    - Having a BH clinician join DSME classes to address more effective strategies for lifestyle behavior change
    - Support groups that target coping with the diagnosis or self-management of chronic illness
    - Introducing Community Health Workers or Promotores de Salud to build rapport with patients and address barriers to seeking care (including stigma of BH care)
- Financial and operational considerations
    - Identify reimbursement codes available in your state for expanding clinical services.
    - Determine the reimbursement level you will need to support adding or expanding services.
    - New clinical services require changes in clinic work. Decide the operational changes you will need to make any new clinical service successful.

Domain Resources

- SAMHSA (2021). Psychosocial Interventions for Older Adults With Serious Mental Illness. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-05-001.pdf
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Patient Engagement (PE)

Processes for the identification, engagement, and retention of patients in behavioral health services in addition to training in patient engagement approaches for the entire primary care team.

Definition of domain
PE includes clinic level policies and procedures promoting population health management for patients with identified BH needs across the continuum of care: initial reach, progress monitoring, follow-ups for missed appointments, and re-assessment of BH needs for subsequent episodes of care as needed.

Purpose
PE items assess the reach of current clinic infrastructure and workflows to monitor and follow-up with patients with an identified BH need. This domain does NOT directly assess individual engagement at the patient or provider level. Supplementary data assessing patient activation, satisfaction with care, therapeutic alliance, and/or other specific treatment barriers may be necessary for those looking for data at the individual patient level.

How to interpret Results
Low scores or score discrepancies across PE items may suggest the need to review/modify clinic workflows to improve the continuity of BH care. Review the considerations below and determine whether suggested supplemental data above are needed to best inform revised workflows/policies.

Suggestions to consider
- The PE domain involves evaluation of workflows that (1) *identify* those needing BH care, (2) *facilitate initiation* of appropriate BH services, and (3) provide intentional *monitoring/follow-up* regarding BH needs. All workflows should be aligned with clinic priorities for BH care. In the case of discrepancies, determine whether the issue resides with workflows or a mismatch between services and patient needs.
- Use the evaluation of workflows described above to facilitate a gap analysis, comparing where these processes are currently with clinic goals. Prioritize aspects for expansion based on available capacity and resources, and remember to incorporate training for team members. Be sure to consider approaches across multiple treatment modalities. For example:
    - *Health IT*: May include use of patient portals, electronic health records (EHR) or other clinical information systems for patient registries/tracking tools, provider messaging, automated visit reminders, missed appointment flags, screening summaries, decision aids, wearable devices, health apps, remote patient monitoring, etc.
    - *Patient aids*: May include pre-visit planning, self-management support, communication skill building (e.g., Ask Me 3/Teach Back), care plan/visit summaries, health literacy support, BH warm handoffs
    - *Staff training*: to facilitate pre-visit planning, shared decision making, improve patient/provider communication, address health literacy, promote cultural competency, BH warm handoffs
    - *Community partnerships*: increase access to resources that address structural and social determinants of health (e.g., housing and food

insecurity, limited transportation, low levels of education, domestic violence)
    - *Automation of operational processes*: (e.g., online patient scheduling, computer adaptive screening), can increase clinic efficiency, but often comes with an upfront cost as folks are trained and learn to adapt to new workflows. Consider who needs training, what type and how much training, who will provide it, and when.
    - We recommend *strategic and systematic implementation of change* (whether this is a revision of workflows or addition of new strategies) *using rapid continuous quality improvement cycles* to increase likelihood of success and support sustainability.

- Choose specific metrics for assessing engagement that are aligned with your clinic's identified priorities (e.g., specific diagnoses or patient populations, patient satisfaction, key lab values). Develop an evaluation plan outlining what metrics you will use, when and how the data will be collected, and how it will inform next steps.
    - Prioritize what you have resources for and have already invested in.

- Review current workflows for opportunities to increase efficiency. Be sure to consider any workflow changes from multiple perspectives, identifying who will be impacted by the change, how communication about the change will occur, and when/how change processes will be assessed. Be sure all team members are updated on any shifting responsibilities for key actions.

Domain Resources

- AHRQ - EvidenceNOW: Tools and Resources
- WHO - Patient Engagement - technical series on safer primary care
- AMA Steps Forward: Team-based care: Improve patient care and team engagement through collaboration and streamlined processes
- CMSHHSgov - Using data to identify patients with behavioral health needs
- Primary Care Collaborative: Recommendations on increasing the uptake of shared decision making in integrated behavioral health care

Peer-reviewed publications:

- Aboumatar et al (2022). Patient engagement strategies for adults with chronic conditions: An evidence map.
- Bombard et al (2018) Engaging patients to improve quality of care: a systematic review
- Davis et al. (2019) Clinical workflows and the associated tasks and behaviors to support delivery of integrated behavioral health and primary care.
- Miller-Rosales et al. (2022). Pathways for primary care practice adoption of patient engagement strategies.
- Raney et al (2017). Digitally driven integrated primary care and behavioral health: How technology can expand access to effective treatment.
- Young & Nesbitt (2017) Increasing the capacity of primary care through enabling technology

Practice Workflow (WF)

Established processes for tracking patients with known BH needs, coordinating care, referrals to specialty services, and documenting self-management goals.

Definition of domain

The WF domain includes clinic activities that support consistent delivery of evidence-based services for patients in need of integrated behavioral health services, including arranging access to external mental health services and substance use disorder services, arranging access to non-clinical community resources, communications with external mental health and substance use disorder clinicians, and sharing patient goals with team members.

Purpose

WF items assess effective access to needed external services, including follow up communications, and effective communication within the clinic among health team members. This domain does NOT address efficiency of clinic workflow and systems. Supplementary data assessing value-added care, standardization of care, or reduction of wasted effort may be necessary for those looking for operational measurement data.

How to interpret results

Low scores or scores that vary across WF items may suggest the need to examine workflows that connect the clinic to external mental health and substance use disorder services and that facilitate communications within the practice team. Review the suggestions below, which are organized into “patient-centered” and “clinic workflow” strategies, and decide whether supplemental data are needed to best inform revised workflows/policies.

Suggestions to consider

Patient-centered Strategies

- Check to see if the clinic’s referral process to external providers and community resources has a smooth, seamless process to help patients access needed resources. Delays or incomplete process steps will result in more need for services in the clinic, further delaying other care.
- Review the patients in need of integrated healthcare by diagnosis and whether the reason for care is primarily medical or behavioral or a combination, and acute or chronic. Tailor care protocols to the most common needs with the support of the entire health care team, allowing team members to operate at the top of their licenses or service capability.
- Determine whether patients are getting “lost” in the handoff to external providers and back to the clinic. Consider how to reach out to patients that have not been served to find out why and evaluate follow up processes. Consider developing a registry to identify patients who may need follow up in the future.

Clinic Workflow Strategies

- Ensure that all healthcare team members can access needed patient information in the shared record system, consistent with state law.
- Supplementary data that may be needed for operational measurement:
    - Workload balancing: consider how the work of health team members is organized so that it does not cause bottlenecks or long wait times that delay patient care

    - Standardizing work across providers and staff: consider what activities (referrals to external providers) could follow a single protocol (no differences among internal providers or among staff) for smooth, efficient processes
    - Workflow analysis: consider evaluating workflows as a system of process steps and redesigning to reduce wasted effort

Domain Resources

- Integrating Behavioral Health and Primary Care website
    - https://sites.google.com/view/ibhpc/home
- Workflow
    - Anderson JB, Marstiller H, Shah K. Lean Thinking for Primary Care. Prim Care. 2019;46(4):515-27.
    - Bard JF, Shu Z, Morrice DJ, Wang DE, Poursani R, Leykum L. Improving patient flow at a family health clinic. Health Care Manag Sci. 2016;19(2):170-91.
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    - Stoeckle JJ, Cunningham A, Al-Hawarri D, Silverio A, Valko G. The Effect of Primary Care Team Realignment on Point-of-Care Screening. Popul Health Manag. 2019;22(2):108-12.
- Team-based care
    - Williams A, Tewell, R., Polaha, J., Wykoff, M., Holt, J. 2019;Pages. Accessed at CFHA Annual Conference at https://www.integratedcareconference.com/wp-content/uploads/2019/09/A5_Williams.pdf on 6/22/22 2022.

RESOURCES

Agency for Healthcare Research Quality (AHRQ): EvidenceNOW Tools and Resources

https://www.ahrq.gov/evidencenow/tools/search/index.html?f%5B0%5D=%3A14474&f%5B1%5D=key_drivers%3A14473

Agency for Healthcare Research Quality (AHRQ): Patient and Family Engagement in Primary Care

https://www.ahrq.gov/patient-safety/reports/engage/interventions/index.html

AMA Ed hub: Team Based Care: Improve Patient Care and Team Engagement through Collaboration and Streamlined Processes

https://edhub.ama-assn.org/steps-forward/module/2702513

CMSHHSgov: Using Data to Identify Patients with Behavioral Health Needs

https://www.youtube.com/watch?v=G6s7AuHyIQs

IBH-PC Website

https://sites.google.com/view/ibhpc/home

IBH-PC: Patient Partner Guide

https://sites.google.com/view/ibhpc/workbooks/patient-partnering

PIP2 Website

www.practiceintegrationprofile.com

Primary Care Collaborative: Recommendations on Increasing the Uptake of Shared Decision-Making in Integrated Behavioral Health Care

https://www.pcpcc.org/resource/SDMrecsweb

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