UMASS MEDICAL SCHOOL

CIPC

Center for Integrated Primary Care

Introduction to the Practice Integration Profile

www.practiceintegrationprofile.com

Daniel Mullin, PsyD MPH
Center for Integrated Primary
University of Massachusetts Medical School

June 15, 2021

To access the Practice Integration Profile version 2:

www.practiceintegrationprofile.com

or

umassmed.edu/cipc

Learning Objectives

By the conclusion of this presentation learners will be able to…

1. …describe the origin and development of the PIP2
2. …compare and contrast the PIP2 with other tools such as the IPAT, MeHAF, AHRQ Playbook, or fidelity checklists
3. …outline a strategy for using the PIP2 for their own practice improvement or research efforts

PIP Team

Stephanie Brennhofer, MPH MS RDN - University of Virginia

Juvena R. Hitt, MPH - University of Vermont School of Medicine

Rodger Kessler, PhD, ABPP - University of Colorado School of Medicine

Benjamin Littenberg, MD - University of Vermont School of Medicine

C.R. Macchi, PhD, LMFT - Arizona State University

Matthew Martin, PhD, LMFT - Arizona State University

Mindy McEntee, PhD - Arizona State University

Tara Weldon - Arizona State University

Daniel Mullin, PsyD, MPH - University of Massachusetts Medical School

Gail Rose, PhD - University of Vermont School of Medicine

Connie van Eeghen - University of Vermont School of Medicine

How do we measure the integration of primary care and behavioral health services?

Sample "Report Card" for Integrated Primary Care Behavioral Health Programs

Dimension	Inadequate Grade	Passing Grade	Superior Grade
1. Program planning approach	No research or public health basis, little connection to health care delivery system objectives, no assessment of priority behavioral health needs in resource planning	Uses some research and public health concepts; system design only partially addresses priority population needs; resources support some low impact programs	Population-based care planning framework based in epidemiological assessments, priority behavioral health needs addressed first in resource allocations
2. Integration models employed	Isolated programmatic effort; no critical pathways or general behavioral health services models used	System uses either at least one critical pathways or general behavioral health services approach	System employs both at least one critical pathway and general behavioral health services
3. Predicted population impact	Low impact on both health costs and behavioral health of the primary care population; services in free standing program for small segment of population, cost returns small relative to total health care budget	Some population impact possible; however, it is limited to a specific segment of the primary care population or service density is too light to address existing needs in a particular area; only modest cost returns possible	High population impact, services target high areas of behavioral health need; service density great enough to service a variety of behavioral health needs; large cost returns possible because of multiple population targets
4. Service locations	Off-site services or programs for physician referred patients; phone consultation available with off-site behavioral care	On-site service delivered in a space separate from medical practice area; often a "mental health wing"	On-site services delivered within medical practice area as part of general health care process
5. Service philosophy	Behavioral health constructed as a specialty service; service goal is to treat patient by delivering mental health specialty services; physicians kept informed at	Behavioral health viewed as a special to service, practiced in collaboration with physician; goal is to resolve patient problems via delivery of specialty	Behavioral health part of primary medical practice; both services integrated in primary care team; goals consistent with primary mental health care model

Strosahl, K. (1997). Building primary care behavioral health systems that work: A compass and a horizon. In N.A. Cummings, J.L. Cummings, & J.N. Johnson (Eds.), Behavioral Health in Primary Care: A Guide for Clinical Integration (pp. 37-58). Madison, WI: Psychosocial Press.

SAMHSA-HRSA 6 Levels of Integration Framework

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 System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice

Integrated Practice Assessment Tool

DECISION TREE FOR IPAT©

1. Are behavioral health & medical providers in (physically or virtually) one facility?

NO → **Pre-Coordinated or Coordinated**

4. Is information (written or electronic) routinely exchanged?

NO → **Pre-Coordinated (Exchange of information[1] without communication)**

YES → 5. Is the communication interactive?

NO → **Coordinated**

YES → 6. Do providers communicate on a regular basis to address specific patient treatment issues?

NO → Level 1

YES → Level 2

YES → **Co-Located or Integrated**

2. Are the medical and behavioral health providers equally involved in the approach to individual patient care and practice design?

NO → **Co-Located**

7. Do provider relationships go beyond increasing successful referrals with an intent to achieve shared patient care?

NO → Level 3

YES → Level 4

YES → 3. Are behavioral health and medical providers involved in care in a standard way across all providers and all patients?[2]

YES → **Integrated**

a. Are resources balanced, truly shared, and allocated across the whole practice?
b. Is all patient information equally accessible and used by all providers to inform care?
c. Have all providers changed their practice to a new model of care?
d. Has leadership adopted and committed to integration as the model of care for the whole system?
e. Is there only 1 treatment plan for all patients and does the care team have access to the treatment plan?
f. Are all patients treated by a team?
g. Is population-based screening standard practice, and is screening used to develop interventions for both populations and individuals?
h. Does the practice systematically track and analyze outcomes for accountability and quality improvement?

NO TO ANY

YES TO ALL

[1] The mere exchange of information (e.g., HIE), is not sufficient for coordination.
[2] All get the tools and resources (including staff) needed to practice.

Maine Health Access Foundation (MeHAF)
Site Self-Assessment Survey

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)									
Characteristic	**Levels**								
1. Level of integration: primary care and mental/behavioral health care	. . . none; consumers go to separate sites for services **1**	. . . are coordinated; separate sites and systems, with some communication among different types of providers; active referral linkages exist **2** **3** **4**			. . are co-located; both are available at the same site; separate systems, regular communication among different types of providers; some coordination of appointments and services **5** **6** **7**			. . . are integrated, with one reception area; appointments jointly scheduled; shared site and systems, including electronic health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings. **8** **9** **10**	
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse) 2. (ALTERNATE: If you are a behavioral or mental health site, screening and assessment for medical care needs)	. . . are not done (in this site) **1**	. . .are occasionally done; screening/assessment protocols are not standardized or are nonexistent **2** **3** **4**			. . .are integrated into care on a pilot basis; assessment results are documented prior to treatment **5** **6** **7**			. . . tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented. **8** **9** **10**	
3. Treatment plan(s) for primary care *and* behavioral/mental health care	. . . do not exist **1**	. . . exist, but are separate and uncoordinated among providers; occasional sharing of information occurs **2** **3** **4**			. . .Providers have separate plans, but work in consultation; needs for specialty care are served separately **5** **6** **7**			. . . are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care **8** **9** **10**	
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	. . . does not exist in a systematic way **1**	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases **2** **3** **4**			. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers **5** **6** **7**			. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently **8** **9** **10**	

AHRQ Integration Playbook Self-Assessment Checklist

Establish Protocols to Identify Patients Who Could Benefit from Integrated Care

21. We have <u>developed a protocol</u> to identify patients who could benefit from integrated care.

☐ No ☐ We are working on it ☐ Yes

22. We <u>use the established protocol</u> to identify patients who could benefit from integrated care.

[If your practice does not have an established protocol, please skip to question 23.]

☐ Never ☐ Sometimes ☐ Usually ☐ Always

Tailor the Care Team to Meet the Needs of Patients Identified for Integrated Care

23. We <u>have developed a process</u> for creating an integrated care team matched to the needs of the identified patient.

☐ No ☐ We are working on it ☐ Yes

Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ-2)

Center for Integrated Healthcare

Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ) Toolkit

PPAQ Worksheet

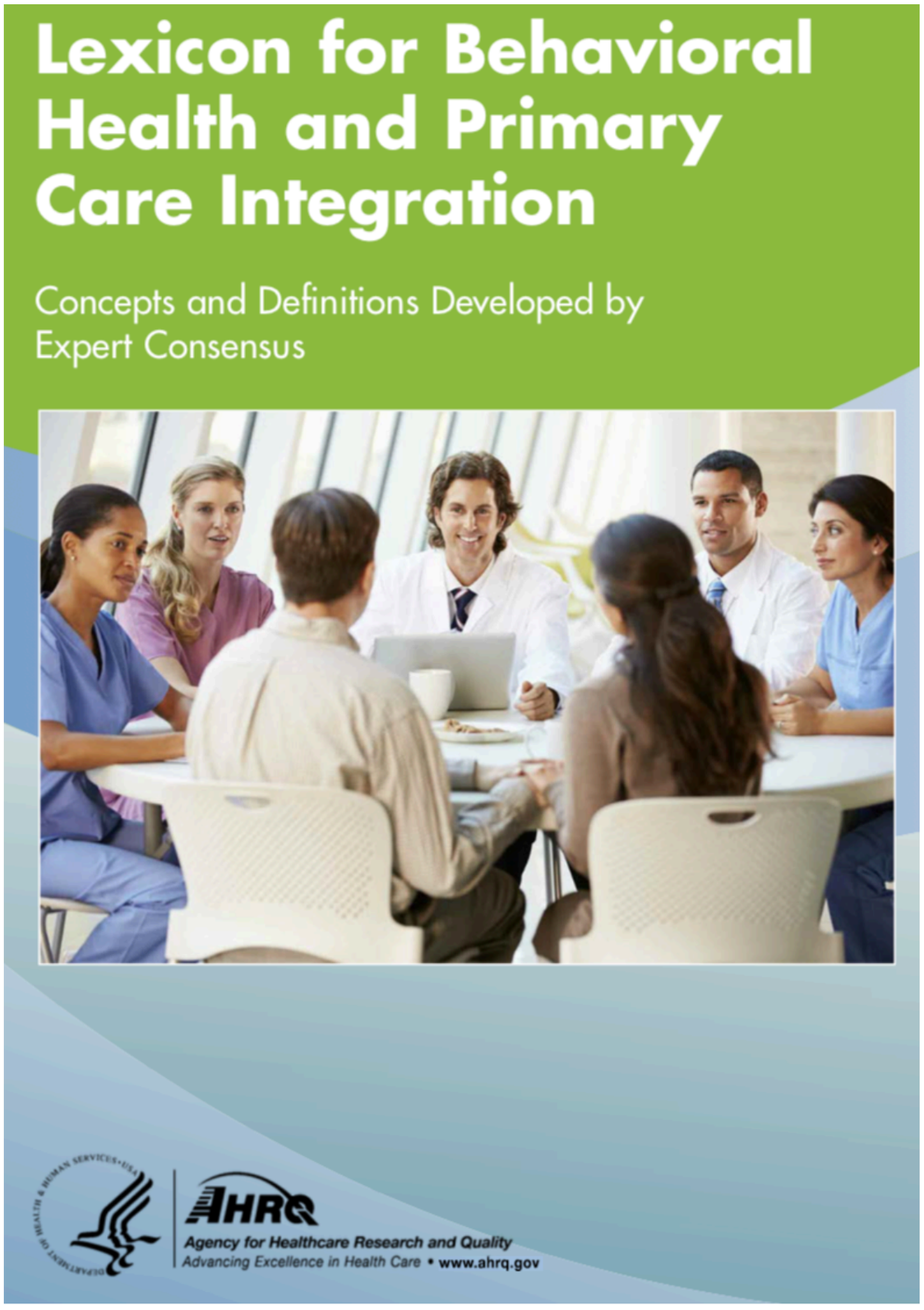
Provider:		**Date:** 6/14/21
Clinic and Location:		

Instructions: For each item below, please indicate the frequency with which you typically engage in the behavior described while providing behavioral health services in primary care. Please do not leave any question blank. Click on the answer box next to each question to open the drop down box. Select your answer based on the PPAQ Response Categories.

PPAQ Response Categories: 1=Never 2=Rarely 3=Sometimes 4=Often 5=Always

Question	Answer
1. During clinical encounters with patients, I see patients for 30 minutes or less.	
2. I manage patients reporting mild and moderate symptoms in primary care, and I refer those with more severe symptoms to specialty mental health services when possible.	
3. During patient appointments, I discuss barriers to implementing a plan or adhering to treatment recommendations.	
4. I accept referrals for patients with common mental health problems (i.e., depression, anxiety, etc.).	
5. During clinical encounters with a patient, I implement behavioral and/or cognitive interventions.	
6. In introducing my role in the clinic to patients, I explain that I want to get an idea of what is and what is not working for the patient and then together develop a plan to help them manage their concerns.	
7. During clinical encounters with patients, I triage patients to determine if they can be treated in primary care or should be referred to a specialty mental health or a community agency.	
8. I accept referrals for patients who might benefit from brief, targeted behavioral health interventions for chronic pain.	

Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus



- Prepared by: C.J. Peek, Ph.D. and The National Integration Academy Council
- Funded by the Agency for Healthcare Research and Quality, published in 2011, updated in 2013
- Lexicon was developed using methods for defining complex subject matters. These methods led to creation of:
- Six ‘paradigm case’ defining clauses that map similarities and differences in genuine integrated behavioral health AND
- Twelve parameters: a vocabulary for how one instance of integrated behavioral health might differ from another

Building the Practice Integration Profile from the AHRQ Lexicon for Behavioral Health

University of Massachusetts Medical School

ASU College of Health Solutions
Arizona State University

The University of Vermont
LARNER COLLEGE OF MEDICINE

School of Medicine
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

- The Lexicon was used as the foundation of the PIP, as no validated, gold-standard measure of behavioral health and primary care integration was available

- In 2014 the authors of the Practice Integration Profile (PIP) began with a detailed review of the Lexicon's defining clauses, alternatives, and parameters and then developed questions organized into six domains of integrated behavioral health

- We specified a domain for each of the Lexicon's clauses, and generated one or more items and a scoring method for each domain as well as a total score for overall level of integration

What is the PIP?

Is it a measurement tool, for research?

Is it a tool for supporting practice improvement?

Yes and yes

Who Completes the PIP?

Any member of a primary care team can complete the PIP survey to assess the degree of integration of behavioral health and primary care services in their practice.

Making Comparisons With PIP

- The PIP can be used to make comparisons between two or more primary care practices in terms of their integration activities.
- The PIP can also be used to measure change in a practice's integration activities over time.

PIP 1 Domains - Factor Analysis

- The PIP 1 had 6 domains
- In a 2019 study, five of the six domains perform surprisingly well, with measures of internal consistency that are more than adequate for measures of primary care practice
- In a proposed five-domain PIP, all Cronbach's alpha coefficients were higher than 0.80, which is more than adequate for making group comparisons
- In this proposed model, most of the alpha coefficients approached or exceeded 0.90, which has been proposed as a threshold suggesting redundancy
- This analysis suggested the PIP2 should have 5 domains rather than 6

Mullin, D., Hargreaves, L., Auxier, A., Brennhofer, S., Hitt, J., Kessler, R., Littenberg, B., Macchi, C., Martin, M., Rose, G., Trembath, F., Eeghen, C. (2019). Measuring the integration of primary care and behavioral health services. Health Services Research 54(2), 379 389. https://dx.doi.org/10.1111/1475-6773.13117

Five Factor Model (Revised PIP)

Distribution of 30 items in 5 factor model (each box is an item)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
1	.6	.6	.7	.6	.6	.6	.8	.8								.4	.4													
2					.4					.5	.7	.5	.4			.6	.6	.7	.5						.4		.5			
3																				.7	.7	.7	.6	.7	.6					
4																										.7	.6	.8	.8	.6
5									.6			.4	.6	.8	.8															

PIP Domain Names
Clinical Services
Practice Workflow
Patient Engagement
Integration and Sharing Methods
Case Identification

- Factor loadings < 0.40 are not presented
- Extraction Method: Principal Component Analysis
- Rotation Method: Varimax with Kaiser Normalization
- Rotation converged in 7 iterations
- Six factors account for 65.3% of total variance

Internal Consistency Reliability (Cronbach's alpha)

Original	PIP Domain Names	Revised
0.91	Clinical Services	0.91
0.86	Practice Workflow	0.86
0.85	Patient Engagement	0.85
0.59	Workspace Arrangement and Infrastructure	
0.87	Integration and Sharing Methods	0.87
0.87	Case Identification	0.87

What do we already know about PIP

- The PIP is internally consistent and produces interpretable results that can be used for the standardized comparisons needed to establish practice level performance and to provide a foundation for policy development and health care reform.
- The PIP offers multiple stakeholders who use the opportunity to track changes in integration activities over time, gaining additional understanding on how the characteristics of integration affect health care costs, outcomes, and patient satisfaction.”

Hitt, Brennhofer, Martin, Macchi, Mullin, van Eeghen, Littenberg, Kessler. (2021) Further Experience with the Practice Integration Profile: A Measure of Behavioral Health and Primary Care Integration. Under review.

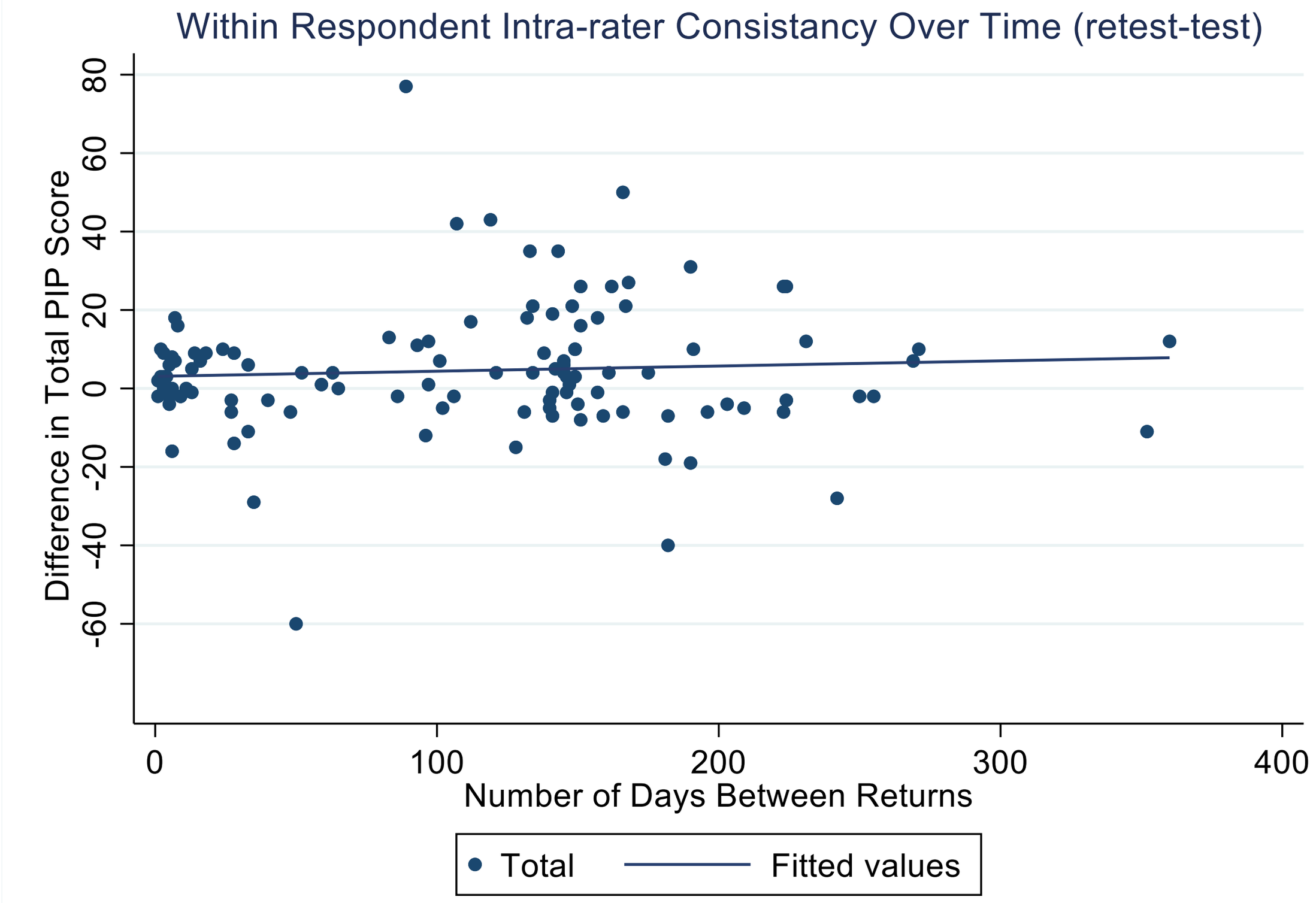


Figure 2: Within respondent intra-rater consistency over time (retest - test). N = 113 unique respondents from 87 unique practices. Each point represents the difference between their test and their retest in Practice Integration Profile total score plotted against the number of days between tests. The solid black is the least-squares linear fit with difference in total PIP score vs. number of days between returns.

University of Vermont IBH-PC Study

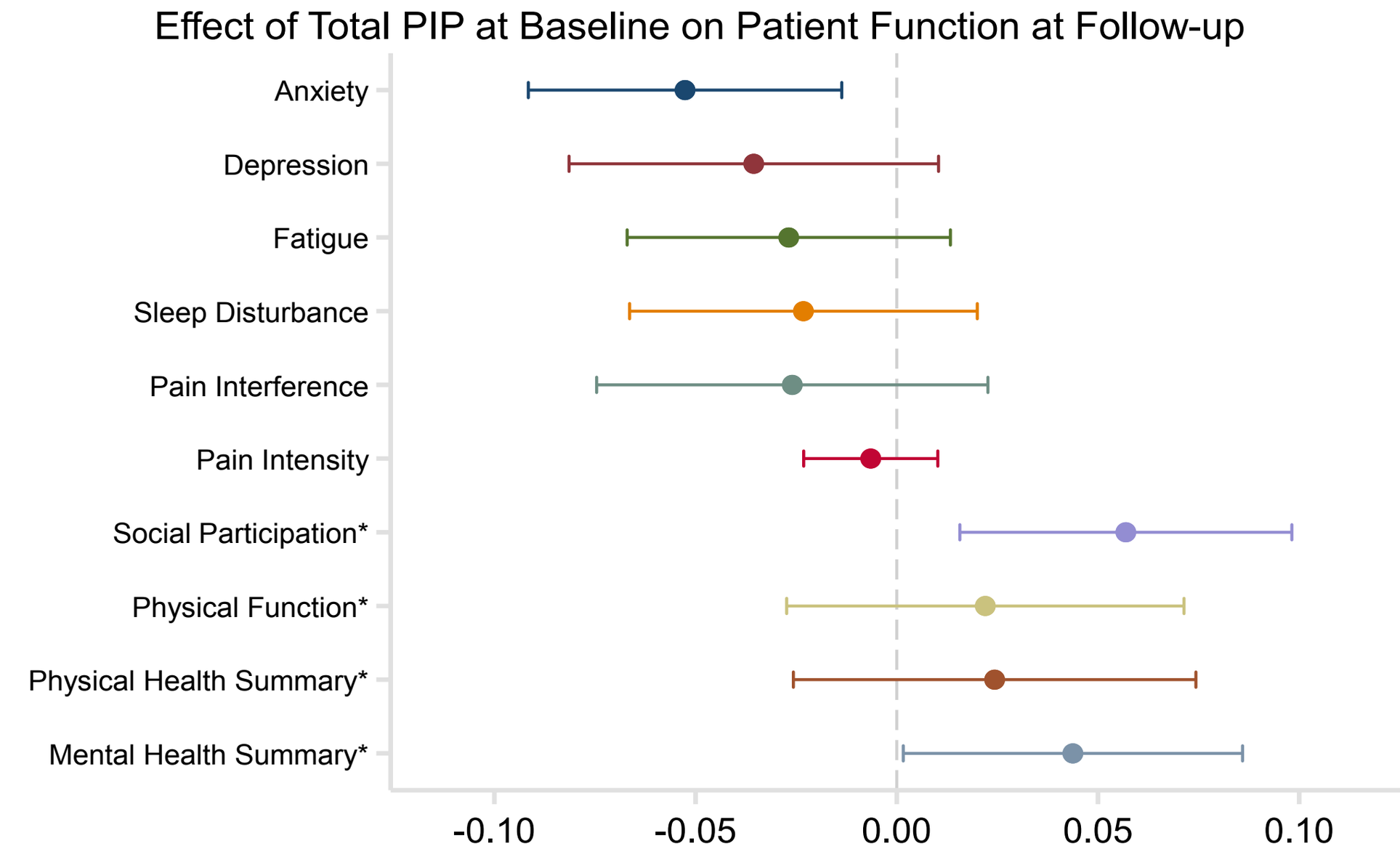
- Patient Centered Outcomes Research Institute (PCORI) grant
- University of Vermont lead, Ben Littenberg (PI)
- Randomized trial with 3,000 patients from 44 practices around the country
- 5 year project (2016-2021), ~ $18 million in funding
- PIP used as an outcome measure in this study

Crocker, A. et al. (2021). Integrating Behavioral Health and Primary Care (IBH-PC) to improve patient-centered outcomes in adults with multiple chronic medical and behavioral health conditions: study protocol for a pragmatic cluster-randomized control trial. Trials, 22(1), 200. https://doi.org/10.1186/s13063-021-05133-8

IBH-PC and the PIP

- PIP 1 was used
  - 6 domains, consisting of 30 total items
  - A total score is generated on a scale from 0 - 100
- PIP was used to confirm eligibility, needed to have total score of < 75 to begin trial
- Practices were asked to have 4 individuals complete the PIP at each time point, 3 time points were used in analysis

Higher integration was associated with improved outcomes



Development of the PIP2

Revisions occurred from 2018 - 2021, PIP1 authors plus expanded team

- Weekly meetings to review items and PIP1 database
- Cognitive interviews with PIP1 (Martin)
- Factor analyses (Mullin and Hargraves)
- Repeat cognitive interviews with draft PIP2 (Weldon)

PIP2 Questions

Begin by reading the question stem

WI3. In our practice, behavioral health and medical clinicians **actively collaborate** about patients when needed.

PIP2 Questions

Examples help clarify the question

Examples: Collaboration could include meetings, discussions, or messaging that goes beyond the routine sharing of the medical record.

PIP2 Questions

Definition:

Number of patients with active collaboration ← Numerator

Number of patients with behavioral health and medical needs ← Denominator

This is a ratio. Of the patients in the denominator, what percentage are in the numerator? You don't need exact numbers, give your best estimate based on experience.

PIP2 Questions

0% (Never)	10%	20%	30%	40%	50%	60%	70%	80%	90%	100% (Always)

Respond by selecting your best estimate

PIP2 Questions

Begin by reading the question stem

Examples help clarify the question

WI3. In our practice, behavioral health and medical clinicians **actively collaborate** about patients when needed.

Examples: Collaboration could include meetings, discussions, or messaging that goes beyond the routine sharing of the medical record.

Definition:

Number of patients with active collaboration ← Numerator

Number of patients with behavioral health and medical needs ← Denominator

This is a ratio. Of the patients in the denominator, what percentage are in the numerator? You don't need exact numbers, give your best estimate based on experience.

0% (Never)	10%	20%	30%	40%	50%	60%	70%	80%	90%	100% (Always)

Respond by selecting your best estimate

Comparing the PIP1 and the PIP2

	PIP1	PIP2
Items	30	28
Domains	6	5
Response Options	5 point likert	11 point likert
Platform	Redcap	Qualtrics
Years active	2015 - 2020	2021 - present

How might your practice use the PIP2?

How does your team view your integration activities differently?

Consider completing the PIP2 as a practice leadership team

How do various practices you are affiliated with differ in terms of integration activities?

Consider having a group of practices you work with complete the PIP2

How does your practice's integration activities changing over time?

Consider having a 4-5 members of your practice complete the PIP2 each year, and monitor changes over time

Questions and Comments

To access the Practice Integration Profile version 2:

www.practiceintegrationprofile.com

or

umassmed.edu/cipc