VERSION 2.0

IPAT©

INTEGRATED PRACTICE ASSESSMENT TOOL

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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

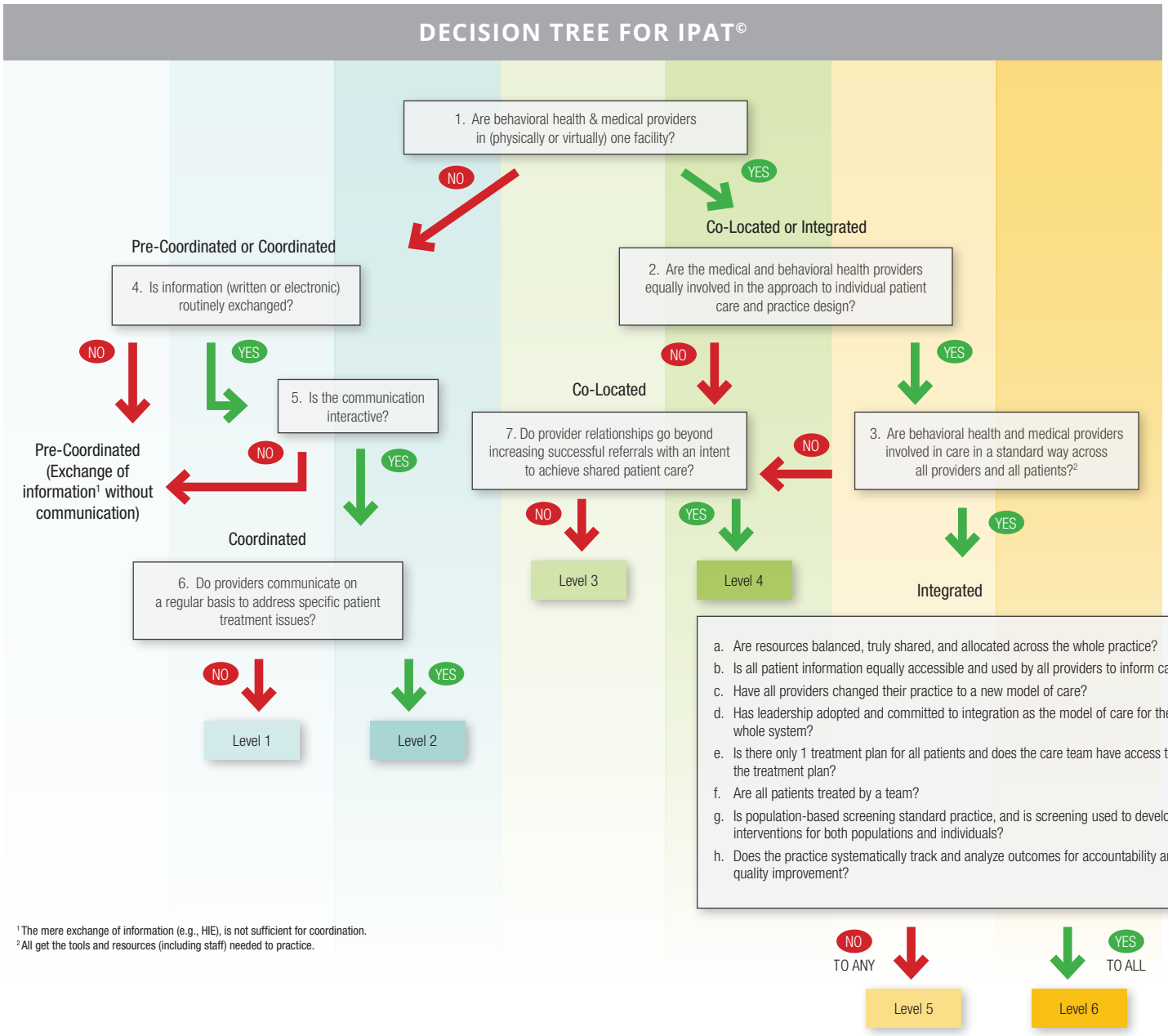
Description of the Instrument

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.

Directions >>

Responses to the questions can vary depending upon the level of knowledge of both on-the-ground operation and conceptual understanding of integration. The questions are framed as yes/no but will raise the question; "Is this 'partially', 'mostly' or 'completely' a yes or a no response?" A "yes" response is recorded only if it is *completely* a yes response. Anything less must be considered a "no" response – even understanding that there is good progress toward a "yes."

The IPAT is designed to be simple to use. There are a total of 8 questions (the 8th being a compound question) in the full decision tree, but responses to no more than 4 questions will determine the level of integration. The IPAT is best completed collaboratively by 2 or more persons (whether or not a formal care team), who are intimately knowledgeable about the operation of the practice.



INTEGRATED PRACTICE ASSESSMENT TOOL (IPAT)© VERSION 2.0

1. Do you have behavioral health and medical providers physically or virtually located at your facility? ☐ "No" - Go to question 4 ☐ "Yes" - Go to question 2	"Virtual" refers to the provision of telehealth services; and the "virtual" provider must provide direct care services to the patient, not just a consult, meaning that the provider visually sees the patient via televideo and vice versa.
2. Are medical and behavioral health providers equally involved in the approach to individual patient care and practice design? ☐ "No" - Go to question 7 ☐ "Yes" - Go to question 3	EXAMPLE: Is there a team approach for patient care that involves both behavioral health and medical health providers?
3. Are behavioral health and medical providers involved in care in a standard way across ALL providers and ALL patients? ☐ "No" - Go to question 7 ☐ "Yes" - Go to question 8	EXAMPLE: Does the practice use the PHQ-9 to systematically screen for depression, and then assure that every patient with a PHQ-9 > or = 15 receives behavioral health treatment and medical care? All get the tools and resources (including staff) needed to practice.
4. Do you routinely exchange patient information with other provider types (primary care, behavioral health, other)? ☐ No", then pre-coordination - **STOP** ☐ "Yes" - Go to question 5	EXAMPLE: Behavioral health provider and medical provider engage in a "two way" email exchange or a phone call conversation to coordinate care.
5. Do providers engage in discussions with other treatment providers about individual patient information? ☐ "No", then pre-coordination - **STOP** ☐ "Yes" - Go to question 6	In other words, is the exchange interactive?
6. Do providers personally communicate on a regular basis to address specific patient treatment issues? ☐ "No", then Level 1 coordinated - **STOP** ☐ "Yes", then Level 2 coordinated - **STOP**	EXAMPLE: Some form of ongoing communication via weekly/monthly calls or conferences to review treatment issues regarding shared patients: use of a registry tool to communicate which patients are not responding to treatment, so that behavioral health providers can adjust treatment accordingly based on evidenced based guidelines.
7. Do provider relationships go beyond increasing successful referrals with an intent to achieve shared patient care? ☐ "No", then Level 3 co-located - **STOP** ☐ "Yes", then Level 4 co-located - **STOP**	EXAMPLES can include: coordinated service planning, shared training, team meetings, use of shared patient registries to monitor treatment progress.
8. Has integration been sufficiently adopted at the provider and practice level as a principal/ fundamental model of care so that the following are in place?	
a. Are resources balanced, truly shared, and allocated across the whole practice?	NOTE: In other words, all providers (behavioral health AND medical) receive the tools and resources they need in order to practice.
b. Is all patient information equally accessible and used by all providers to inform care?	EXAMPLE: All providers can access the behavioral health record and medical record.
c. Have all providers changed their practice to a new model of care?	EXAMPLES: Primary Care Providers (PCPs) are prescribing antidepressants and following evidenced based depression care guidelines; PCPs are trained in motivational interviewing; behavioral health providers are included in the PCP visit.
d. Has leadership adopted and committed to integration as the model of care for the whole system?	EXAMPLES: Leadership ensures that system changes are made to document all PHQ-9 scores in the electronic health record (EHR); leadership decides to hire a behavioral health provider for a primary care clinic after grant funding ends.
e. Is there only 1 treatment plan for all patients and does the care team have access to the treatment plan?	NOTE: Treatment plan includes behavioral AND medical health information. EXAMPLE: Even though there may be a medical record and a behavioral health record (separate EHRs),the treatment plan is included in both and is accessible in real time by all providers.
f. Are all patients treated by a team?	A care team requires membership from all disciplines.
g. Is population-based screening standard practice, and is screening used to develop interventions for both populations and individuals?	EXAMPLE: All patients are screened for tobacco use, and then offered tobacco cessation at the facility. All patients are screened for body mass index (BMI) and then offered weight loss interventions by their primary care provider, or referred to a health coach or wellness program. EXAMPLE: Facility reviews cardio-metabolic monitoring for all patients on atypical antipsychotics and determines which patients need screening and additional supports to reduce cardio-metabolic risk factors; primary care clinic screens all diabetics for depression and refers to behavioral health provider, then primary care provider.
h. Does the practice systematically track and analyze outcomes related for accountability and quality improvement? ☐ "No" to any, then Level 5 integrated - **STOP** ☐ "Yes" to all, then Level 6 integrated - **STOP**	Population-based measures and outcomes are used in improving population health.

Assessment Summary >>

Practice/Location:_____Date:_____

Current Level of Integration: (Circle one)

Pre-Coordinated	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

Assessment Team Completing IPAT: (Names/Position at Practice)

Name:_____Position :_____

Name:_____Position :_____

Name:_____Position :_____

Name:_____Position :_____

Notes/Comments:

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