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SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Step by Step: Strengthening Integration and Moving Along the Continuum with the Integrated Practice Assessment Tool (IPAT)

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SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Jeanette Waxmonsky, Ph.D.
Director of Research Innovation
Jefferson Center for Mental Health
Denver, CO

Andrea Auxier, Ph.D.
Vice President, Health Plan Sales
New Directions Behavioral Health

Dalveer Kaur
Program Director
Community Counseling and Mediation
Brooklyn, NY

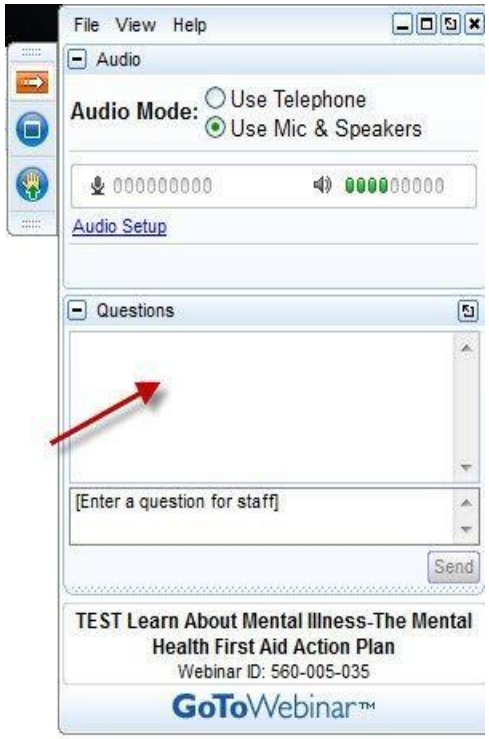
Slides for today's webinar are available on the CIHS website at:

http://www.integration.samhsa.gov/mai-coc-grantees-online-community/webinars

How to ask a question during the webinar

If you dialed in to this webinar on your phone please use the "raise your hand" button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**



Jefferson Center
for mental health

Step by Step: Strengthening Integration and Moving Along the Integration Continuum with the IPAT

Jeanette Waxmonsky, PhD,
Director of Research Innovation, Jefferson Center

Andrea Auxier, PhD,
Vice President, Health Plan Sales
New Directions Behavioral Health

Objectives

- Articulate the integrated care needs of persons with HIV+
- Become conversant in using the Integrated Care Practice Assessment Tool or IPAT

- Explain SAMHSA framework for levels of integrated care
  - Explain coordinated care
  - Explain co-located care
  - Explain integrated care
  - Differentiate the clinical delivery, health information data sharing and financial components of various levels of integration

- Evaluate hypothetical and real world scenarios via the IPAT

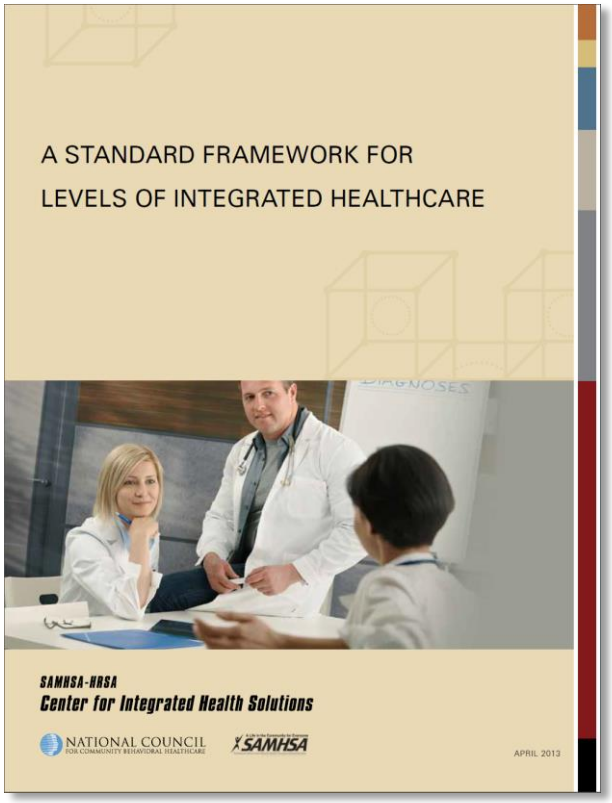
Goals of Integrated Care

- Increase access to care
- Improve overall health and wellness
- Increase communication across providers (internal and external)
- Reduce overall health care costs
- Improve patient and provider satisfaction

How to get there?

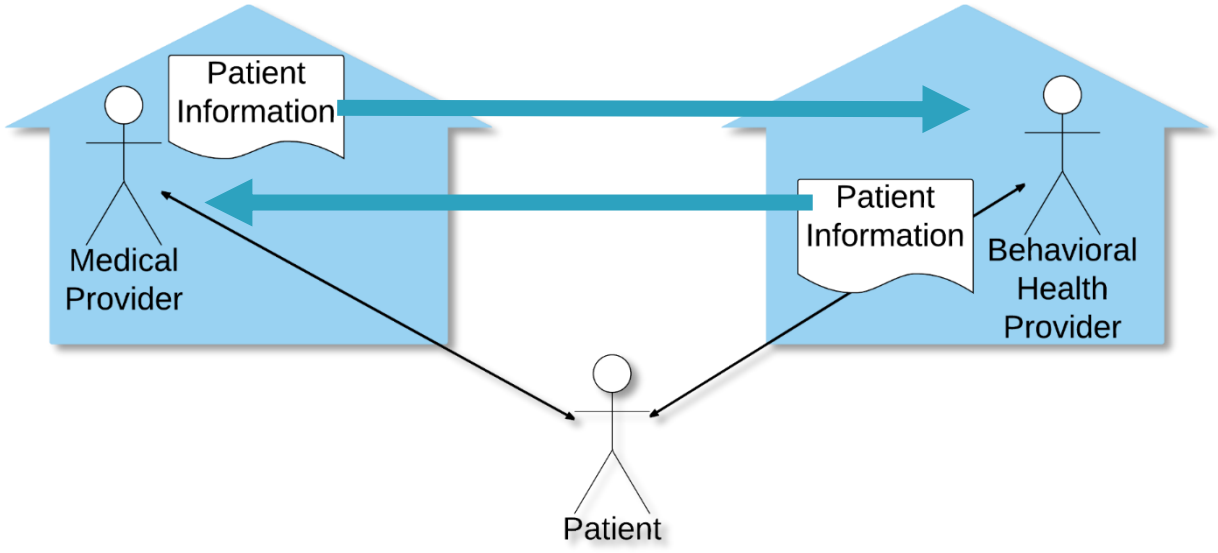
The Standard Framework

- National standard
- Six levels of integration
- Three main categories
  - Coordination
  - Co-location
  - Integration
  - Two levels each



http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

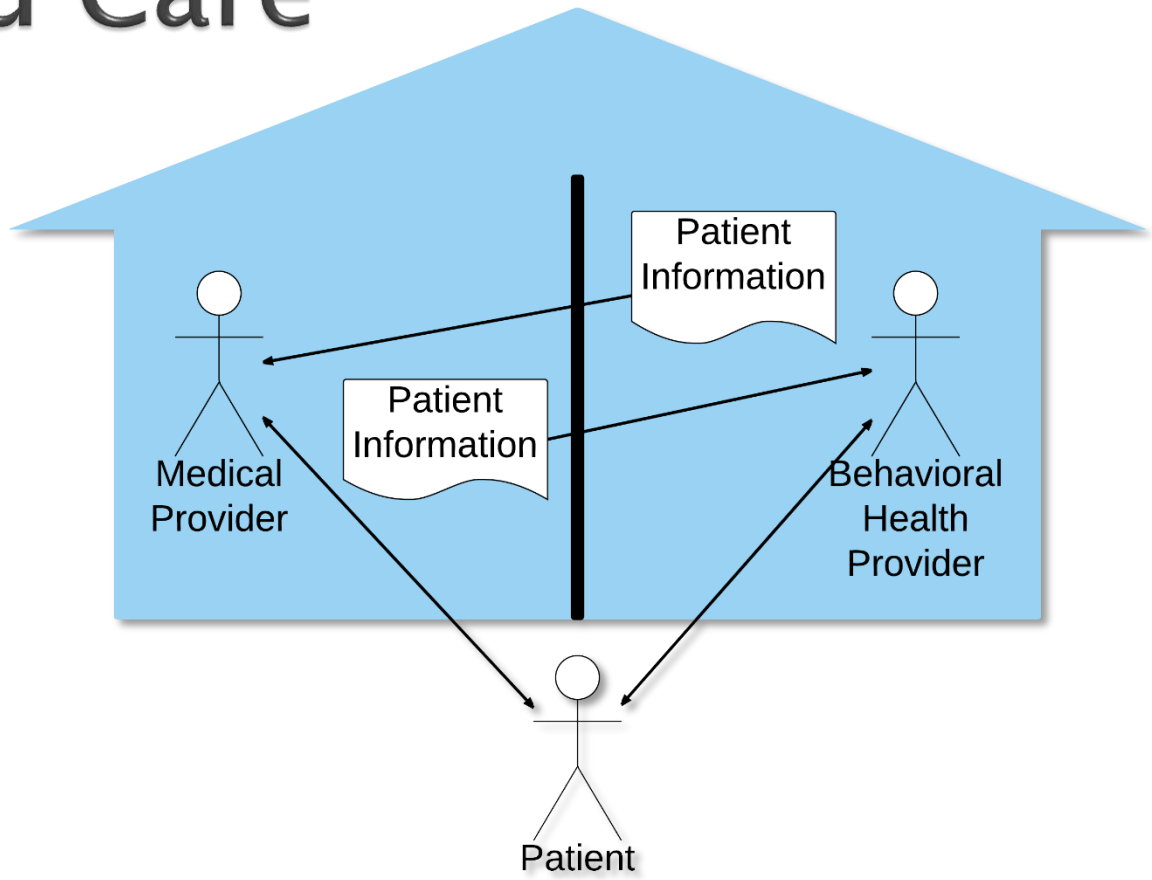
Coordinated Care



- Bi-directional exchange of information, usually written or electronic
- Protocols or health IT may be in place
- Level 1: occasional information sharing
- Level 2: routine information sharing

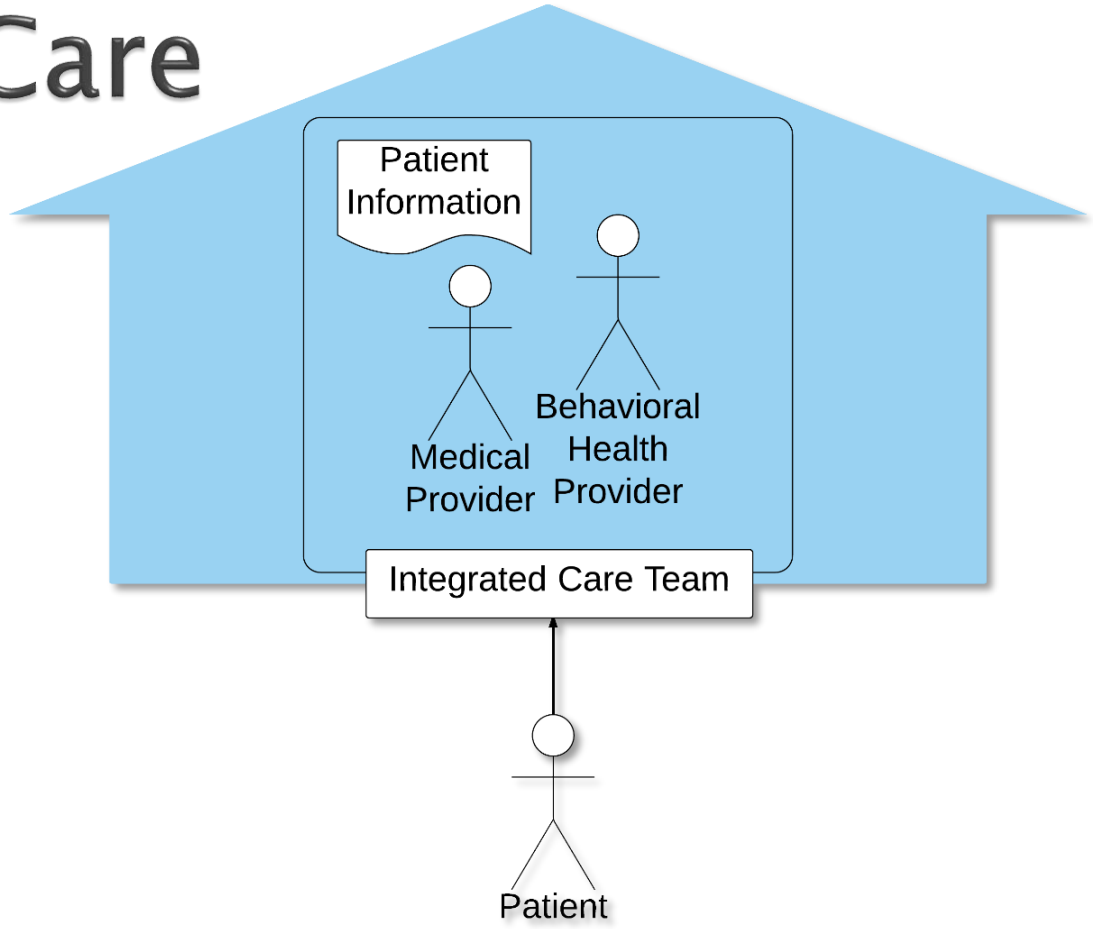
Co-Located Care

- Physical or virtual co-location
- Care delivered separately
- Separate documentation
- Few or no standard protocols for integration



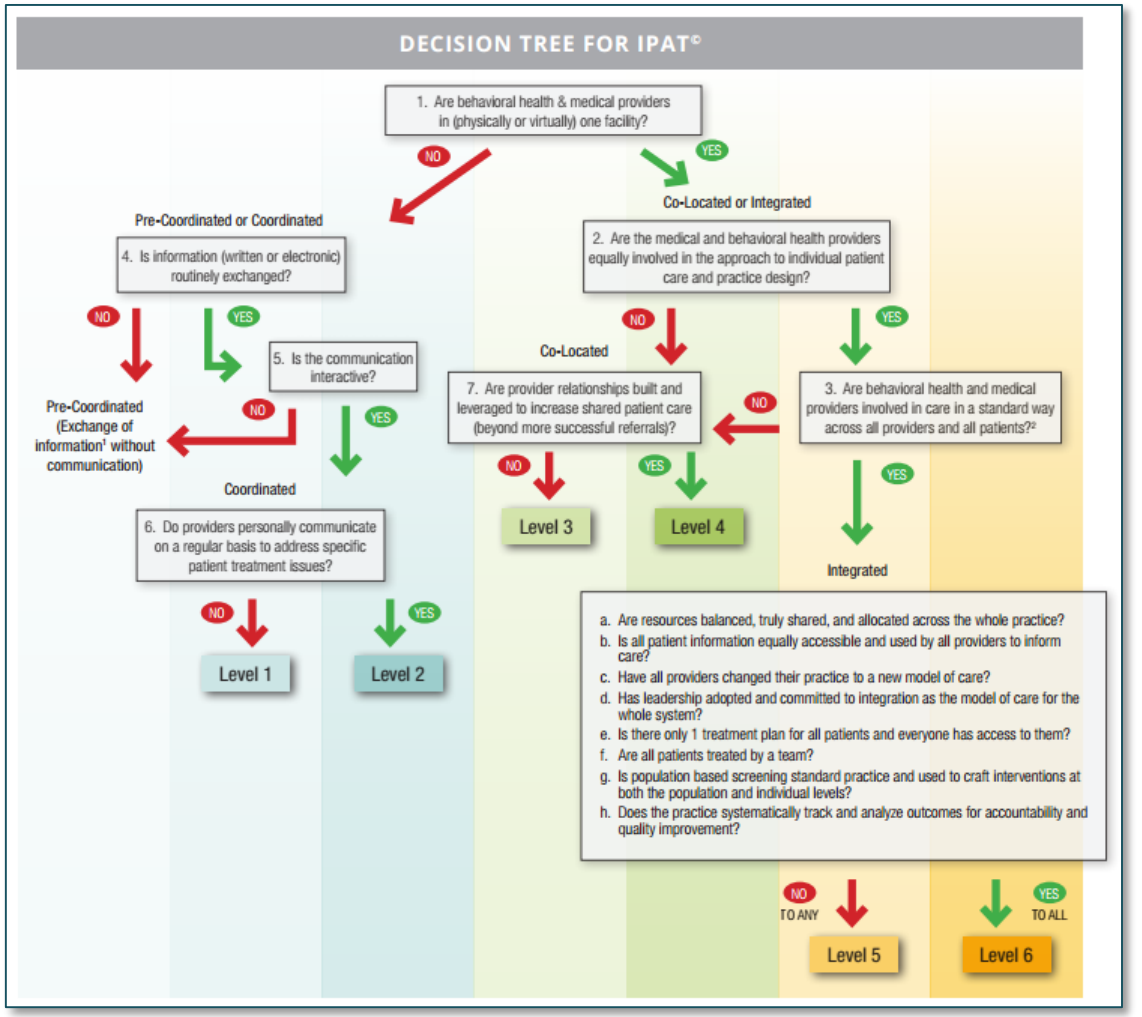
Integrated Care

- Team based approach
- Virtual or actual co-location
  - Attention to psychiatric as well as health and behavior change using:
    - Real time interventions
    - Screening protocols
    - Shared documentation
    - Open access to records



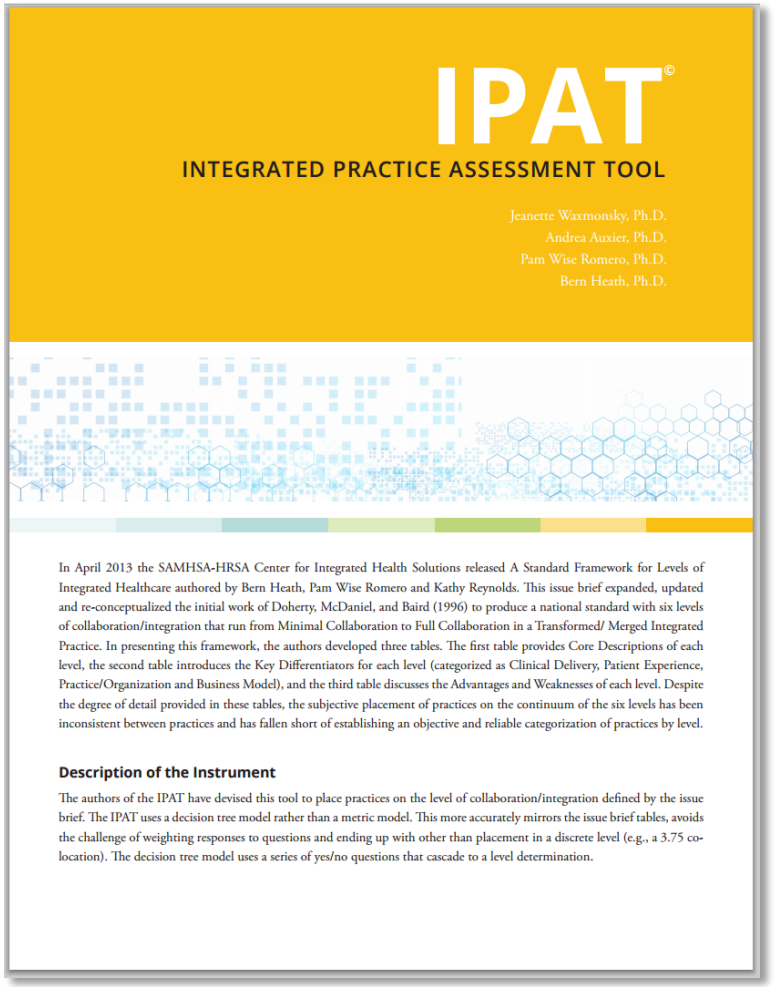
Decision Tree

- Descriptive, qualitative applied tool which is meant to be intuitive and practical for users of all backgrounds
- Instead of a complex metric assessment, IPAT© uses a simple decision tree model
- Practices can easily and objectively determine their current level, and outline their next steps



The IPAT

- Health care providers were having difficulty determining exactly where they were along the integration continuum
- To help practices easily identify the level of integration that best fit their current practice, a quick, easy to use assessment tool was developed



IPAT©

INTEGRATED PRACTICE ASSESSMENT TOOL

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

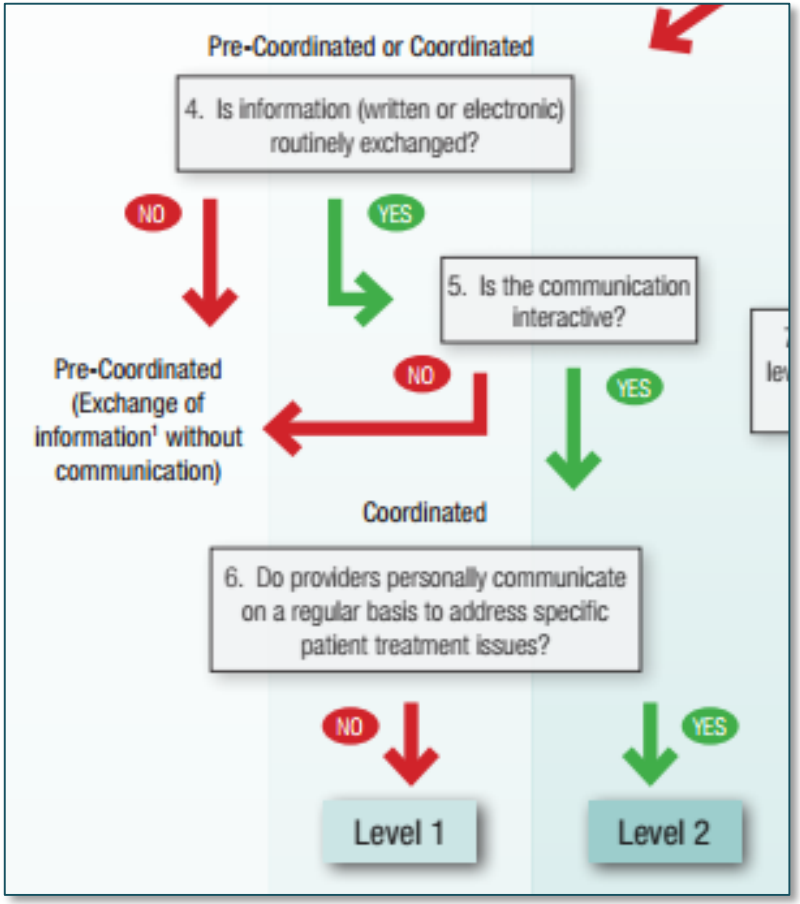
In April 2013 the SAMHSA-HRSA Center for Integrated Health Solutions released A Standard Framework for Levels of Integrated Healthcare authored by Bern Heath, Pam Wise Romero and Kathy Reynolds. This issue brief expanded, updated and re-conceptualized the initial work of Doherty, McDaniel, and Baird (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.

Description of the Instrument

The authors of the IPAT have devised this tool to place practices on the level of collaboration/integration defined by the issue brief. The IPAT uses a decision tree model rather than a metric model. This more accurately mirrors the issue brief tables, avoids the challenge of weighting responses to questions and ending up with other than placement in a discrete level (e.g., a 3.75 co-location). The decision tree model uses a series of yes/no questions that cascade to a level determination.

Yes, No, Maybe?

- Responses to the IPAT© questions can vary
- "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"
- Eight questions in the full decision tree; responses to no more than 4 questions will determine the level of integration
- The IPAT is best completed collaboratively by two or more persons



IPAT FAQs

- **What is 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. IPAT©
- **Will 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.

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
- Behavioral health practitioners 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

Step by Step: Strengthening Integration and Moving Along the Continuum with IPAT

MOCHA Program
Dalveer Kaur, Project Director

COMMUNITY COUNSELING & MEDIATION
CCM

MOCHA
MINORITY OUTREACH COMMUNITY HEALTH ACCESS

CCM

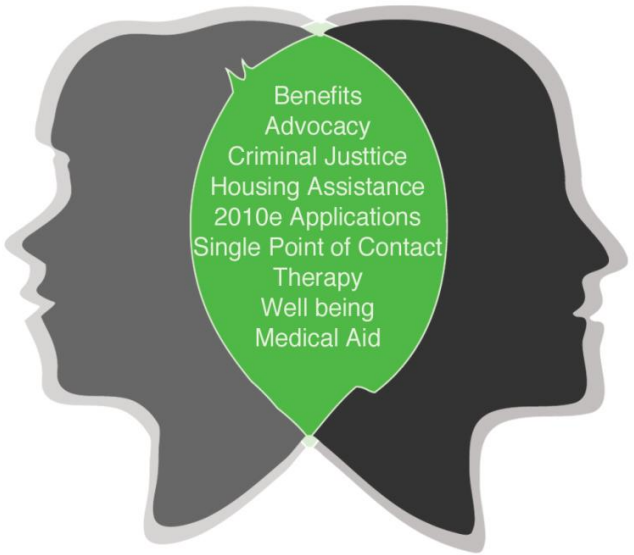
Community Counseling and Mediation (CCM) is a well established nonprofit social service organization that provides a broad spectrum of services in the boroughs of Brooklyn and Manhattan. CCM offers a range of culturally sensitive and quality services in five major core areas:

- Mental Health and Substance Abuse Licensed Outpatient Clinics
- After School Education and Youth Development Services
- Child Welfare Prevention Services for Youth and Families
- HIV, Health and Wellness Services
- Housing Services

MOCHA
MINORITY OUTREACH COMMUNITY HEALTH ACCESS

ABOUT MOCHA

- CCM's MOCHA program is a co-located and partially integrated case management outreach wellness targeted program targeted towards minority populations.
- Our aim is to provide an array of different services to best support our clients with co-occurring disorders to reach physical and psychological health, stability and well being.
- The primary goal of MOCHA is to serve individuals who may lack the resources and support to be fully functioning and healthy members of society.
- Support individuals in need of comprehensive case management services and behavioral health and HIV and Hepatitis care coordination.



MOCHA
MINORITY OUTREACH COMMUNITY HEALTH ACCESS

Identifying Need

How the MAI – COC program was conceived

- CCM identified a need for the program from serving the community for over 30 years
- CCM recognized that their therapists were already extending their services to provide case management support.
- In the years of serving the population, CCM identified the need for person focused care

How did you select the partner?

- CCM had a history of working with SUNY Downstate hospital
- From our previous collaborations, CCM felt that they had the experience of working with the population group we are serving.
- SUNY Downstate hospital's passion to provide wrap-around care, particularly in relation to treating HIV and Hepatitis

Program Structure

- Co-located in our behavioral health clinic to provide on site out patient a full range of behavioral health and substance abuse therapy, groups, medication management and case management services.
- Use evidence based models; e.g. Motivational Interviewing, CBT and culturally competent care
- Provide HIV and Hepatitis screenings in all our clinics and integrated medical care through our partner SUNY Downstate hospital
- Case conference to treatment plan and routinely with all providers involved in care
- Regular meetings with SUNY Downstate hospital
- Peer educator run workshops

How integration was achieved?

- Provide screening in a safe space and understanding the community needs
- On going trainings and conversations throughout the agency
- Therapists identify high risk clients and situations
- Community screening events
- Ongoing education workshops
- Assist clients to confirmatory tests and treatment sessions
- Provide assistance with travels
- Case conference with all care providers

Lessons Learned

- Awareness of Hepatitis is low in our population, yet incidence is high
- High incidence of individuals who have not completed treatment or had no follow up more frequent
- Our population has unstable housing or is homeless, therefore setting appointments to coincide with therapy treatments increases retention
- To increase retention in care takes patience, and relapse is common
- Treatment or ongoing compliance with treatment for HIV and Hepatitis is not a priority for the community if they cannot secure stability of income or housing
- Nicotine dependence is high amongst our population

Dalveer Kaur, Program Director
Tel: (718) 802-0666
Email: dkaur@ccmnyc.org

Questions

Additional Questions

Jeanette Waxmonsky, Ph.D.
Director, Office of Healthcare Transformation
(303) 432-5019
JeanetteW@jcmh.org

Andrea Auxier, Ph.D.
VP, Heath Plan Sales
(816) 994-1565
aauxier@ndbh.com

Dalveer Kaur
Project Director
(718) 802-0666
dkaur@ccmnyc.org

Additional Comments?
Contact the SAMHSA-HRSA Center for Integrated Health Solutions
integration@thenationalcouncil.org or MAI-COC-TA@mayatech.com

For More Information & Resources

Visit www.integration.samhsa.gov or
e-mail integration@thenationalcouncil.org

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Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today's webinar.