Pennsylvania Project LAUNCH

Pediatric Provider Integration Assessment

HARD COPY ADMINISTRATION GUIDE

Date: ______________________ Time:________________ Location: _________________________________

Practice Name: ____

LAUNCH Team Member(s) Administering Assessment: ____

Practice Team Members Completing Assessment

Name, credentials:	**Practice Role** (*Administrator, Health Provider, Mental Health provider, Other*)**:**

The Pediatric Practice Integration Assessment Tool (PPIA) was created by modifying and combining material from the following instruments:

American Academy of Pediatrics. (2010). Appendix S3: Mental Health Practice Readiness Inventory. *Pediatrics, 125*, S129 -S132. doi: 10.1542/peds.2010-0788I.

Waxmonsky, J., Auxier, A., Romero, P.W., & Heath, B. (2014). Integrated Practice Assessment Tool (IPAT) Version 2.0. *Colorado Access, Value Options Axis Health Systems.*

PPIA Measures

Part 1: Integrated Practice Assessment Tool (IPAT)

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	
1. Do you have behavioral health and medical providers physically or virtually located at your facility? ❒"No", then pre-coordinated or coordinated – Go to question 4 ❒ "Yes", then co-located or integrated – 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", then co-located – Go to question 7 ❒"Yes", then co-located or integrated – 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", then co-located - Go to question 7 ❒"Yes", then integrated – Go to question 8	EXAMPLE: All patients are considered for appropriate behavioral health consultation or intervention, regardless of insurance provider, primary language or ability to pay
4. Do you routinely exchange patient information with other provider types (primary care, behavioral health, other)? ❒"No", then **pre-coordinated** - STOP ❒"Yes", then pre-coordinated or coordinated – 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-coordinated** - STOP ❒"Yes", then coordinated – Go to question 6	In other words, is the exchange interactive? Is there follow up between provider types to discuss course of treatment and any progress or results?
6. Do providers personally communicate on a regular basis to address to 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 the behavioral health provider 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?	EXAMPLES can include: coordinated service planning, shared training, team meetings, use of shared patient registries to monitor treatment progress.
❐"No", then **Level 3** co-located - STOP	
❐"Yes", then **Level 4** co-location – STOP	

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) get 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 ____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 everyone has 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 pushed to both and accessible in real time by all providers.
f. Are all patients treated by a team?	Team in this context requires membership from all disciplines.
g. Is population-based screening standard practice and used to develop interventions for both the populations and individuals?	EXAMPLE: All patients are screened for body mass index (BMI) and then offered weight loss interventions by their primary care provider or a referral to a health coach or wellness program.
h. Does the practice systematically track and analyze outcomes related for accountability and quality improvement?	Population based measures and outcomes are used in improving population health.
❐"No" to any, then **Level 5** integration - STOP	
❐"Yes" to all, then **Level 6** integration – STOP	

Use the scoring sheet on page 10 to calculate total score.

Part 2: Mental Health Practice Readiness Inventory [MHPRI; Modified]

Directions: The purpose of this tool is to help primary care clinicians assess the extent to which their office systems promote and support mental health practice. It is recommended that the entire practice team complete this tool together, select priority areas (building on strengths) and stage practice improvements incrementally. You may wish to recall your score on the previous round of the MHPRI to reflect on the progress made since that time.

Use the following rating system to evaluate your practice:
1 = We do not do this well (significant practice change is needed)
2 = We do this to some extent (improvement is needed)
3 = We do this well (substantial improvement is NOT needed)

MHPRI			
1	Collaborative Relationships	1 2 3	Primary care practice team has collaborative relationships with school- and community-based providers of key services.
Previous Score:		*Previous/Planned Change for Improvement:*	
2	Mental Health Promotion	1 2 3	Primary care practice team promotes the importance of mental health through posters, practice web sites, newsletters, handouts, or brochures and by incorporating conversations about mental health into each office visit.
Previous Score:		*Previous/Planned Change for Improvement:*	
3	Engagement	1 2 3	Primary care practice team actively elicits mental health and substance abuse concerns; assesses patients' and families' readiness to address them; and engages children, adolescents, and families in planning their own mental health care at their own pace.
Previous Score:		*Previous/Planned Change for Improvement:*	
4	Referral Assistance	1 2 3	Primary care practice is prepared to support families through referral assistance and advocacy in the mental health referral process.
Previous Score:		*Previous/Planned Change for Improvement:*	
5	Care Coordination	1 2 3	Primary care practice routinely seeks to identify children and adolescents in the practice who are involved in the mental health specialty system, ensuring that they receive the full range of preventive medical services and monitoring their mental health or substance abuse condition.
Previous Score:		*Previous/Planned Change for Improvement:*	

6	Special Populations	1 2 3	Primary care practice team is prepared to address mental health needs of special populations within the practice (e.g., minority and immigrant populations, those in foster care, those whose families have experienced disasters, those with parents deployed in military service).
Previous Score:		*Previous/Planned Change for Improvement:*	
7	Quality Improvement	1 2 3	Primary care practice periodically assesses the quality of care provided to children and adolescents with mental health problems and takes action to improve care, in accordance with findings.
Previous Score:		*Previous/Planned Change for Improvement:*	
8	Registry	1 2 3	Primary care practice has a registry in place identifying children and adolescents with mental health or substance abuse problems (including those not yet ready to address problems)
Previous Score:		*Previous/Planned Change for Improvement:*	
9	Recall and Reminder Systems	1 2 3	Recall and reminder systems are in place to identify missed appointments and ensure that children and adolescents with mental health or substance abuse concerns (including those not ready to take action) receive appropriate follow up and routine health supervision services.
Previous Score:		*Previous/Planned Change for Improvement:*	
10	Information Exchange	1 2 3	Primary care practice has office procedures to support collaboration (e.g., routines for requesting parental consent to exchange information with specialists and schools, faxback forms for specialist feedback, psychosocial history accompanying foster children).
Previous Score:		*Previous/Planned Change for Improvement:*	
11	Tracking Systems	1 2 3	Primary care practice has systems in place and staff roles assigned to monitor patients' progress (e. g., check on referral completion, periodic telephone contact with family and therapist, periodic functional assessment, periodic behavioral scales from classroom teachers and parents, communication to and from care coordinators).
Previous Score:		*Previous/Planned Change for Improvement:*	

12	Care Plans	1 2 3	Primary care practice includes youth, family, school, agency personnel, and any involved specialists in developing a comprehensive plan of care for a child or an adolescent with mental health problems, including definition of respective roles.
Previous Score:		*Previous/Planned Change for Improvement:*	
13	Screening Assessment Tools	1 2 3	Office systems are in place to collect and score validated mental health and substance abuse screening and assessment tools at or prior to scheduled routine health supervision visits and visits scheduled for a mental health concern.
Previous Score:		*Previous/Planned Change for Improvement:*	
14	Functional Assessment	1 2 3	Primary care clinicians use validated functional assessment scales to identify and evaluate children and adolescents with mental health problems and monitor their progress in care.
Previous Score:		*Previous/Planned Change for Improvement:*	
15	Clinical Guidance	1 2 3	Primary care clinicians have access to reliable, current sources of information concerning diagnostic classification of mental health and substance abuse problems; evidence about safety and efficacy of psychosocial and psychopharmacological treatments of common mental health and substance abuse disorders; and information about the safety and efficacy of complementary and alternative therapies often used by children and families.
Previous Score:		*Previous/Planned Change for Improvement:*	
16	Protocols	1 2 3	Primary care practice has tools and protocols in place to guide assessment and care and to foster self-management of children and adolescents with common mental health and substance abuse conditions.
Previous Score:		*Previous/Planned Change for Improvement:*	
17	Screening and Surveillance	1 2 3	Primary care clinicians routinely use psychosocial history and validated screening tools at preventive visits and brief mental health updates at acute care visits to elicit mental health and substance abuse problems and to identify family strengths and risks.
Previous Score:		*Previous/Planned Change for Improvement:*	

Use the scoring sheet on page 17 to calculate total score.

Part 3: Supplemental Questions

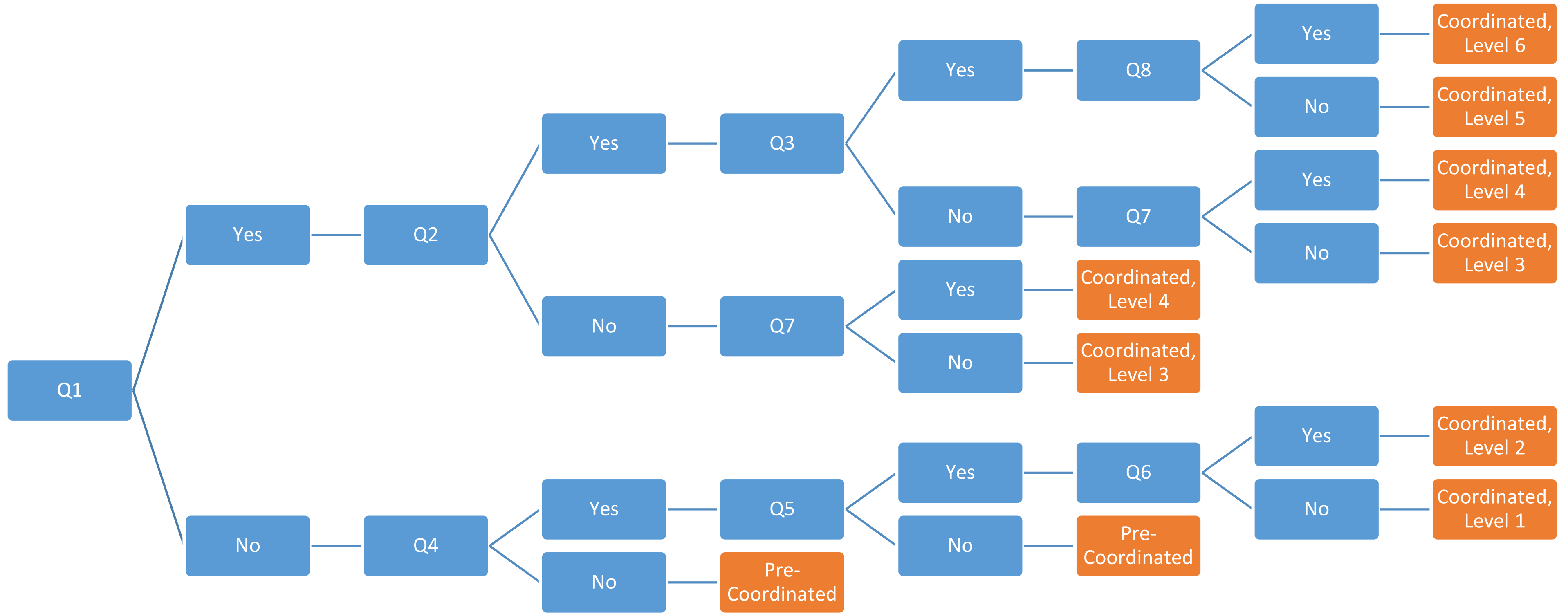
(To allow ample time for these interview questions, make sure to reach this point in the interview ***by the 40-minute mark****.)*

PPIA Supplemental Questions		
	QUESTION	**RESPONSES**
1	What changes related to behavioral health integration have been made in the past four years and what influenced those changes?	
2	Did participating the in the PPIA contribute to decisions to make those changes? If yes, to what extent?	
3	Are the changes you made sustainable, that is, do you foresee maintaining the changes in the years to come?	
4	What are the major obstacles you currently are encountering that, if eliminated, would make your goals for BH integration in your practice a reality?	
5	Have you made any structural or procedural changes related to behavioral health integration that were later abandoned? If yes, what happened?	

Use the Action Planning sheet on Page 19 to integrate insights from these responses into your PPIA Action Plan.

PPIA Scoring Guide

IPAT Scoring Flow Chart



IPAT Scoring Sheet

IPAT Score: *Circle the Current Level of Integration per IPAT. See designated page for Leveled Action Planning Guides.*

Pre-Coordinated	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

Pre:Co-ord.:	Level 1:	Level 2:	Level 3:	Level 4:	Level 5:	Level 6:
See p. 11	See p. 11	See p. 12	See p. 13	See p. 14	See p. 15	See p. 16

IPAT Leveled Action Planning Guides

Find the *Leveled Action Planning Guide* that corresponds to your IPAT score. Each guide gives a summary of the level and more information on the different IPAT components. Use the sheet to identify current strengths and areas for future growth.

IPAT Level 1 Action Planning Guide

Summary of IPAT Pre-Coordinated Level and Level 1: Scores at the pre-coordinated level of fully integrated care indicate that behavioral health (BH) and physical health (PH) providers work in separate facilities with separate systems, with no coordination. To move to the next level of integrated pediatric care, practices need to begin discussions between BH and PH providers about patient information.

Level 1 : Minimal Collaboration Practice Components		Strength	To Grow
Overview	Separate systems		
	Separate facilities		
	Communication is rare		
	Little appreciation of each other's culture		
Collaboration/ Communication	Behavioral health, primary care and other healthcare professionals work in **separate facilities**, where they:		
	• Have separate systems		
	• Communicate about cases only rarely and under compelling circumstances		
	• Communicate, driven by provider need		
	• May never meet in person		
	• Have limited understand of each other's roles		
Clinical Delivery	Screening and assessment done according to separate practice models		
	Separate treatment plans		
	EBPs implemented separately		
Patient Experience	Patient physical and behavioral health needs are treated as separate issues		
	Patients must negotiate separate practices and sites on their own with varying degrees of success		
Practice/ Organization	No coordination or management of collaborative efforts		
	Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow		
Business Model	Separate funding		
	No sharing of resources		
	Separate billing practices		
Advantages	Each practice can make timely and autonomous decisions about care		
	Readily understood as a practice model by patients and providers		
Weaknesses	Services may overlap, be duplicated, or even work against each other		
	Important aspects of care may not be addressed or a take a long time to be diagnosed		

IPAT Level 2 Action Planning Guide

Summary of IPAT Level 2: Providers at Level 2 have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. Providers view each other as resources. To move to the next level, BH and PH providers should be located in the same facilities.

Level 2: Basic Collaboration at a Distance		Strength	To Grow
Overview	Separate systems		
	Separate facilities		
	Periodic focused communication; most written		
	View each other as resources		
	Little understanding of each other's culture or sharing of influence		
Collaboration/ Communication	Behavioral health, primary care and other healthcare professionals work in **separate facilities**, where they:		
	• Have separate systems		
	• Communicate periodically about shared patients		
	• Communicate, driven by specific patient issues		
	• May meet as part of a larger community		
	• Appreciate each other's roles as resources		
Clinical Delivery	Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges		
	Separate treatment plans shared based on established relation-ships between specific providers		
	Separate responsibility for care/EBPs		
Patient Experience	Patient health needs are treated separately, but records are shared, promoting better provider knowledge		
	Patients may be referred but a variety of barriers prevent many patients from accessing care		
Practice/ Organization	Some practice leadership in more systematic information sharing		
	Some provider buy-in to collaboration and value placed on having needed information		
Business Model	Separate funding		
	May share resources for single projects		
	Separate billing practices		
Advantages	Maintains each practice's basic operating structure, so change is not a disruptive		
	Provides some coordination and information-sharing that is helpful to both patients and providers		
Weaknesses	Sharing information may not be systematic enough to effect overall patient care		
	No guarantee that information will change plan or strategy of each provider		
	Referrals may fail due to barriers, leading to patient and provider frustration		

IPAT Level 3 Action Planning Guide

Summary of IPAT Level 3: At Coordination Level 3, mental health and other healthcare professionals have separate systems, but share facilities. Proximity supports at least occasional face-to- face meetings and communication improves and is more regular. To move to the next level, BH and PH should begin to share systems, such as patient scheduling.

Level 3: Basic Collaboration Onsite		Strength	To Grow
Overview	Separate systems		
	Same facilitates		
	Regular communication, occasionally face-to-face		
	Some appreciation of each other's role and general sense of large picture		
	Mental health usually has more influence		
Collaboration/ Communication	Behavioral health, primary care and other healthcare professionals work in **the same facilities**, not necessarily the same offices, where they:		
	• Have separate systems		
	• Communicate regularly about shared patients, by phone or email		
	• Collaborative, driven by need for each other's services and more reliable referral		
	• Meet occasionally to discuss cases due to close proximity		
	• Feel part of a larger yet non-formal team		
Clinical Delivery	May agree on a specific screening or other criteria for more effective in-house referral		
	Separate service plans with some shared information that informs them		
	Some shared knowledge of each other's EBPs, especially for high utilizers responsibility for care/EBPs		
Patient Experience	Patient health needs treated separately at the same location		
	Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider		
Practice/ Organization	Organization leaders supportive but often co-location is viewed as a project or program		
	Provider buy-in to making referrals work and appreciation of onsite availability		
Business Model	Separate funding		
	May share facility expenses		
	Separate billing practices		
Advantages	Co-location allows for more direct interaction and communication among professionals to impact patient care Referrals more successful due to proximity Opportunities to develop closer professional relationships		
Weaknesses	8 Proximity may not lead to greater collaboration, limiting value		
	Effort is required to develop relationships		
	Limited flexibility if traditional roles are maintained		

IPAT Level 4 Action Planning Guide

Summary of IPAT Level 4: Scores for Level 4 Coordination are in the close collaboration/co-located care level. This model often involves embedding behavioral health providers and some shared systems. To move to next level, Level 4 practices need to move towards equally involving medical and behavioral health providers in a standard way across ALL patients.

Level 4 : Close Collaboration/Partially Integrated Practice Components		Strength	To Grow
Overview	Some shared systems		
	Same facilities		
	Face-to-face consultation; coordinated treatment plans		
	Basic appreciation of each other's role and cultures		
	Collaborative routines difficult; time and operation barriers		
	Influence sharing		
Collaboration/ Communication	Behavioral health, primary care and other healthcare professionals work in the **same space** within the **same facility**, where they:		
	• Share some systems, like scheduling or medical records		
	• Communicate in person as needed		
	• Collaborate, driven by need for consultation and coordinated plans for difficult patients		
	• Have regular face-to-face interactions about some patients		
	• Have basic understanding of roles and culture		
Clinical Delivery	Agree on specific screening, based on ability to respond to results		
	Collaborative treatment planning for specific patients		
	Some EBPs and some training shared, focused on interest or specific population needs		
Patient Experience	Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers		
	Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services		
Practice/ Organization	Organization leaders strongly support integration through mutual problem-solving of some system barriers		
	More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components		
Business Model	Separate funding, but may share grants		
	May share office expenses, staffing costs, or infrastructure		
	Separate bulling due to system barriers		
Advantages	Removal of some system barriers, like separate records, allows closer collaboration to occur		
	Both behavioral health and medical providers can become more well-informed about what each can provide		
	Patients are viewed as shared which facilitates more complete treatment plans		
Weaknesses	System issues may limit collaboration		
	Potential for tension and conflicting agendas among providers as practice boundaries loosen		

IPAT Level 5 Action Planning Guide

Summary of IPAT Level 5: Scores at the Coordination Level 5 demonstrate that mental health and other healthcare professionals share the same sites, vision, and systems. All providers are on the same team and have developed an in-depth understanding of each other's roles and areas of expertise. To move to the next level, the BH and PH systems should merge into a single system.

Level 5 : Close collaboration approaching an integrated practice		Strength	To Grow
Overview	Shared systems and facilities in seamless bio-psychosocial web		
	Consumers and providers have same expectations of system(s)		
	In-depth appreciation of roles and culture		
	Collaborative routines are regular and smooth		
	Conscious influence sharing based on situation and expertise		
Collaboration/ Communication	Behavioral health, primary care and other healthcare professionals work in the **same space** within the **same facility** (some shared space), where they:		
	• Actively seek system solutions together or develop work-a-rounds		
	• Communicate frequently in-person		
	• Collaborate, driven by desire to be a member of the care team		
	• Have regular team meetings to discuss overall patient care and specific patient issues		
	• Have an in-depth understanding of roles and culture		
Clinical Delivery	Consistent set of agreed upon screenings across disciplines, which guide treatment interventions		
	Collaborative treatment planning for all shared patients		
	EBPs are shared across system with some joint monitoring of health conditions for some		
Patient Experience	Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others		
	Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop		
Practice/ Organization	Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced		
	Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers		
Business Model	Blended funding based on contracts, grants or agreements		
	Variety of ways to structure the sharing of all expenses		
	Billing function combined or agreed upon process		
Advantages	High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans		
	Provider flexibility increases as system issues and barriers are resolved		
	Both provider and patient satisfaction may increase		
Weaknesses	Practice changes may create lack of fit for some established providers		
	Time is needed to collaborate at this high level and may affect practice productivity or cadence of care		

IPAT Level 6 Action Planning Guide

Summary of IPAT Level 6: Scores at the highest level of fully integrated care indicate that providers and patients view the practice as a single health system treating the whole person. This includes integration across resources, team and provider models, the entire patient population, screening, and information sharing.

Level 6 : Fully Integrated Practice Components		Strength	To Grow
Overview	Shared systems and facilities in seamless bio-psychosocial web		
	Consumers and providers have same expectations of system(s)		
	In-depth appreciation of roles and culture		
	Collaborative routines are regular and smooth		
	Conscious influence sharing based on situation and expertise		
Collaboration/ Communication	Behavioral health, primary care and other healthcare professionals work in the **same space** within the **same facility**, **sharing all practice space**, where they:		
	• Have resolved most or all system issues, functioning as one integrated system		
	• Communicate consistently at the system, team and individual levels		
	• Collaborate, driven by shared concept of team care		
	• Have formal and informal meetings to support integrated model of care		
	• Have roles and cultures that blur or blend		
Clinical Delivery	Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place		
	One treatment plan for all patients		
	EBPs are team selected, trained and implemented across disciplines as standard practice		
Patient Experience	All patient health needs are treated for all patients by a team, who function effectively together		
	Patients experience a seamless response to all healthcare needs as they present, in a unified practice		
Practice/ Organization	Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development		
	Integrated care and all components embraced by all providers and active involvement in practice change		
Business Model	Integrated funding, based on multiple sources of revenue		
	Resources shared and allocated across whole practice		
	Billing maximized for integrated model and single billing structure		
Advantages	Opportunity to truly treat whole person		
	All or almost all system barriers resolved, allowing providers to practice as high functioning team		
	All patient needs addressed as they occur		
	Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue		
Weaknesses	Sustainability issues may stress the practice		
	Outcome expectations not yet established		
	Few models at this level with enough experience to support value		

MHPRI Scoring Sheet

MHPRI Items		Item score		
		1	2	3
Question	**Topic**	We do *not* do this well	We do this to some extent	We do this well
1	Collaborative Relationships	☐	☐	☐
2	Mental Health Promotion	☐	☐	☐
3	Engagement	☐	☐	☐
4	Referral Assistance	☐	☐	☐
5	Care Coordination	☐	☐	☐
6	Special Populations	☐	☐	☐
7	Quality Improvement	☐	☐	☐
8	Registry	☐	☐	☐
9	Recall and Reminder Systems	☐	☐	☐
10	Information Exchange	☐	☐	☐
11	Tracking Systems	☐	☐	☐
12	Care Plans	☐	☐	☐
13	Screening Assessment Tools	☐	☐	☐
14	Functional Assessment	☐	☐	☐
15	Clinical Guidance	☐	☐	☐
16	Protocols	☐	☐	☐
17	Screening and Surveillance	☐	☐	☐

Tally the Total Number of *1*s, *2*s and *3*s.

_______ + _______(x2) + _______(x3) =

Example: a practice that scored 3 *1*s, 8 *2*s and 6 *3*s has a score of: 3 + 16 (8x2) + 18 (6x3) = 37.

Final MHPRI Score ________

PPIA Action Planning Guide

PPIA Action Planning

Providers should look across the PPIA subsections and identify several *priority areas for growth* (e.g., 2-3 items from the "*to grow*" section of the IPAT Leveled Planning Guides, 2-3 items where they scored a 1 or 2 on the MHPRI, priority themes from the supplemental questions section). Priority areas are those where progress can be made relatively quickly, and where barriers to improvement are surmountable.

Once priority areas are identified, providers should work with their team to develop an action plan for each priority area.

IPAT Considerations	*IPAT Priority Areas*
IPAT Action Plan:	
MHPRI Considerations:	*MHPRI Priority Areas*
MHPRI Action Plan:	
Supplemental Questions Considerations	*Supplemental Questions Priority Areas*
Supplemental Questions Action Plan:	