# The Comprehensive Health Integration Framework

## Introduction to the Comprehensive Health Integration Framework

The Comprehensive Health Integration (CHI) Framework is designed for self-assessment and quality improvement (QI) of physical health (PH) and behavioral health (BH) programs, assessing their capacity to deliver integrated PH and BH services to their populations.

## Using the CHI Framework for Self-assessment

This self-assessment is intended to be completed at the program level within an organization, because different programs within the same organization may be at different levels of progress. To facilitate meaningful discussion, common understanding of integration efforts and accurate consensus scoring, programs should assemble a diverse interdisciplinary team to conduct the self-assessment. These teams may include licensed staff (e.g., physicians, nurses, BH specialists), non-licensed staff (e.g., medical assistants, community health workers, care coordinators, peers) and administrative staff (e.g., managers, QI staff, billing coordinators). One person should be identified as the team leader for conducting the self-assessment, and that person should orient the team to the CHI Framework in advance and review the **CHI Self-assessment Guide** and **CHI Definitions and Examples Handbook**, which offer detailed criteria and tools to support the self-assessment process.

## Consensus Scoring of the CHI Self-assessment

The CHI Framework is organized into eight domains with 15 subdomains, each representing a key component of integrated care. In each subdomain, there are criteria associated with progress through the stages of integration. Each team member should be able to view the CHI tool physically or digitally. For each subdomain, the team leader facilitates team consensus on — and *marks* — all criteria that accurately reflect the state of progress for that program within that subdomain. Each team member's perspective is solicited to help achieve consensus for each subdomain.

## Progress Through Stages

There are three integration stages measured in the CHI Framework, each of which can reflect progress and value. The stages are progressive, but Stage 3 is not usually the goal. The integration stage to be achieved is unique to each program's goals, resources and efforts. For many organizations, achieving Stage 1 or Stage 2 is more appropriate. The emphasis should be on using the CHI Framework to support continuous improvement in integration, rather than on trying to achieve the highest stage in every subdomain.

## Instructions for Scoring Stage Achievement for Subdomains, Domains and the Program as a Whole

To achieve a stage for a particular domain or subdomain fully, *all* criteria for that stage on the self-assessment must be achieved. At your discretion, to facilitate QI, you may give partial credit for a subdomain or domain as follows:

- **Early Progress:** More than 0% but less than 50% of the criteria in a stage are achieved for a subdomain or domain.
- **Late Progress:** 50% or more but less than 100% of the criteria in a stage are achieved for a subdomain or domain.

If there is "scatter" in the scoring across several stages for a subdomain, you can use your discretion as to how best to rate your progress.

To indicate full achievement of a stage, all the criteria for the stage must be met in at least six of the eight domains, and no more than one stage lower in the other two domains. The program can score Early or Late Progress as well, based on less or more than 50% of subdomains to achieve the next higher stage. If a program does not meet criteria for Stage 1 for a subdomain or domain, then it is scored Stage 0. **The Scoring and Notes Worksheet** helps document scores and teamwork discussions, maximizing the value of the CHI Framework. The Scoring Tracker summarizes self-assessment results (page 15) and Planning for Advancement Worksheet (page 16) establishes an action plan for integration progress.

SEE GUIDE FOR INSTRUCTION ON SCORING AND TO IMPROVE UNDERSTANDING OF FRAMEWORK STAGES AND SELF-ASSESSMENT PROCESS.
SCORING AND PLANNING FOR ADVANCEMENT TRACKING TOOL AND WORKSHEET ARE PROVIDED AT END OF THIS DOCUMENT.

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**SCORING NOTE FOR ALL DOMAINS**:

- Routine/systematic/regular means at least 70% of the time, unless otherwise specified.
- All conditions and risk factors discussed involve co-occurring PH and BH challenges. BH includes mental health and/or substance use disorder (SUD).
- "Co-occurring conditions" as used here refers to presence of BH conditions or risk factors/behaviors in PH settings, and PH conditions or risk factors in BH settings.
- Mark all achieved boxes, then document scores and key takeaways from team discussions using the CHI Scoring and Notes Worksheet. To summarize self-assessment results and establish an action plan to advance integration, use the CHI Scoring Tracker and CHI Planning for Advancement Worksheet.
- Scoring instructions are in the Introduction and Scoring Tool in this document.
- See CHI Framework Self-assessment Guide for more detailed instructions on use and scoring and an optional — more detailed — scoring and notes template.
- See handbook for definitions, examples and resources for each domain/subdomain.

| KEY ELEMENTS of Integrated Care | | PROGRESSION to Greater Integration → | | | |
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| **DOMAINS** | **SUBDOMAINS** | **HISTORICAL PRACTICE (STAGE 0)** | **SCREENING AND ENHANCED REFERRAL (STAGE 1)** | **CARE MANAGEMENT AND CONSULTATION (STAGE 2)** | **COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT (STAGE 3)** |
| **1. Screening, referrals and follow-up (f/u)** | **1.1 Systematic screening for co-occurring conditions and risk factors.**<br><br>SEE HANDBOOK FOR MORE DETAILS ON SCREENING BEST PRACTICES AND TYPES OF CONDITIONS OR RISK FACTORS TO BE CONSIDERED. | ☐ There is **no or limited** systematic screening for co-occurring conditions or risk factors that does not meet criteria for Screening and Enhanced Referral stage.<br><br>☐ **Referrals primarily are triggered by self-report** of concerns by people receiving services. | ☐ There is systematic screening for **at least one or two** high-prevalence co-occurring conditions or risk factors. | ☐ There is systematic screening for **at least two or three** high-prevalence co-occurring conditions and risk factors.<br><br>☐ **A designated team member is responsible for tracking** screening processes and results.<br><br>☐ Data on screening outcomes and f/u is **systematically collected**. | **STAGE 2, PLUS:**<br><br>☐ There is systematic screening for at **least three or four** high-prevalence co-occurring conditions or risk factors.<br><br>☐ There is **capacity for data registries** on screening, f/u processes and results.<br><br>☐ There is **capacity for using data system to stratify population stages of need** (e.g., based on screening results and PH/BH complexity). |
| | **1.2 Systematic facilitation of referrals and f/u.**<br><br>SEE HANDBOOK FOR MORE DETAILS, INCLUDING DEFINITIONS OF "FORMAL ARRANGEMENT" AND "INTEGRATED TEAMWORK." | ☐ Referrals are made to external PH or BH provider **without formal arrangement**.<br><br>☐ Does **not meet threshold** for systematic tracking of referrals or method for sharing information between PH and BH providers to track f/u. | ☐ For people with no existing provider or preference, **majority of referrals** go to a partner PH or BH provider with a formal arrangement.<br><br>☐ There is **systematic tracking of referrals** to ensure connection with both PH and BH services for all in need.<br><br>☐ There is an **expectation of and method for routine information sharing** between PH and BH partners to track ongoing f/u. | **STAGE 1, PLUS:**<br><br>☐ **An integrated team member** (e.g., BH consultant or community health worker [CHW] in PH, PH care coordinator in BH) **routinely facilitates connection with and referrals** for people with positive screens.<br><br>☐ For people with no existing provider connection or preference, **majority of referrals** go to internal or partner PH or BH provider with a formal arrangement.<br><br>☐ **A designated team member** is responsible for tracking referrals and coordinating information sharing to track f/u. | **STAGE 2, PLUS:**<br><br>☐ **BH and PH providers function as an integrated team in one or more locations** and are jointly accountable for ensuring referred individuals are engaged and receive both services.<br><br>☐ For people with no existing provider connection or preference, **majority of referrals** go to an internal team partner PH or BH provider.<br><br>☐ BH and PH providers **routinely and electronically (usually via shared electronic health record [EHR]) share/receive information** about referral and f/u. |

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| 2. Integrated prevention and treatment | **2.1 Use of evidence-based guidelines or protocols for prevention/risk mitigation related to co-occurring conditions.**<br><br>Prevention/risk mitigation interventions may include, but are not limited to:<br>• Developmental and adverse childhood experiences (ACES) screenings/education.<br>• One or more United States Preventive Services Task Force screenings: education, referral, f/u.<br>• Education on screening results indicating risk (e.g., borderline diabetes or risky substance use).<br>• Suicide or overdose risk reduction.<br><br>SEE HANDBOOK FOR MORE DETAILS AND EXAMPLES OF CONDITIONS AND INTERVENTION/RISK MITIGATION PROTOCOLS IN EACH SETTING. | ☐ Guidelines or protocols for initiating and following up on recommended preventive/risk mitigation interventions are either **absent or not followed** routinely.<br><br>☐ Frequency of recommended interventions does **not meet threshold needed** for Screening and Enhanced Referral stage. | ☐ **Staff are educated** on the importance of education for people receiving services, as well as f/u for recommended prevention activities and for potential risks identified through screening.<br><br>☐ There is a protocol consistent with evidence-based guidelines for at least **ONE relevant prevention/risk mitigation intervention**. **The intervention can be performed by members of the current clinical team.**<br><br>☐ The guideline or protocol is followed routinely, so that at **least 70% of eligible people are receiving the recommended intervention and f/u.**<br><br>☐ There are systematic mechanisms and procedures for **routine coordination and information sharing with outside providers** who receive referrals to perform prevention or risk mitigation interventions. | **STAGE 1 CRITERIA ARE MET FOR TWO INTERVENTIONS/RISK ISSUES, PLUS:**<br><br>☐ **All staff are educated to** understand the importance of education for people receiving services, as well as f/u on recommended prevention activities and on indications of potential risk identified through screening.<br><br>☐ There is a **mechanism for tracking and/or care coordination** for targeted preventive interventions, using standard workflows and expert consensus guidelines (when available) for f/u on positive results.<br><br>☐ **Preventive/risk mitigation intervention frequency and f/u are routinely monitored** for adherence to the recommended protocols.<br><br>. | **STAGE 2 CRITERIA ARE MET FOR THREE INTERVENTIONS/RISK ISSUES, PLUS:**<br><br>☐ The program /organization **tracks population-wide prevention/risk mitigation efforts** and uses the data to continuously improve these efforts. |

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| 2. Integrated prevention and treatment | **2.2 Use of evidence-based guidelines/protocols for nonpharmacologic treatment for co-occurring conditions.**<br>Nonpharmacologic intervention are professionally delivered/ directed treatments for common diagnosable co-occurring conditions (including nicotine use), and/ or for addressing relevant health behaviors (e.g., diet, exercise) that may affect those conditions.<br>SEE HANDBOOK FOR MORE DETAILS AND EXAMPLES OF CONDITIONS AND HEALTH BEHAVIORS, PLUS EXAMPLES OF ASSOCIATED INTERVENTION PROTOCOLS IN EACH TYPE OF SETTING. | ☐ Protocols for initiating and continuing nonpharmacologic treatments for co-occurring conditions or health behaviors are either **absent or not followed** routinely.<br>☐ Frequency of nonpharmacologic intervention for any co-occurring condition or health behavior is **less than the threshold** for Screening and Enhanced Referral stage. | ☐ There is evidence of training or competency defined within scope of practice (e.g., skill teaching) for at least ONE team member in at least **ONE nonpharmacologic intervention** for a co-occurring condition or relevant health behavior.<br>☐ At least **70% of people** who are eligible to receive that intervention have documentation that the intervention was provided **at least once**. | ☐ Provider team members, including embedded BH or PH consultant (if any), have training or competency in evidence-based or best practice nonpharmacologic interventions within their scope of practice (e.g., skill teaching) for at least **TWO co-occurring conditions and/or health behaviors**.<br>☐ At least **70% of people** who are eligible to receive those interventions have documentation that the intervention was provided **at least once**.<br>☐ There are monitored **care management workflows for tracking** interventions and results.<br>☐ There are **measures used to systematically document and monitor response/feedback to these interventions**. | **STAGE 2 CRITERIA ARE MET AT THE 70% STAGE FOR THREE CONDITIONS, PLUS:**<br>☐ The program/organization **tracks intervention outcomes** for the population served and uses the data for continuous QI. |
| | **2.3 Use of evidence-based guidelines/protocols for pharmacologic treatments for co-occurring conditions.**<br>Examples **in BH settings** may include metformin for HBA1c reduction/weight gain mitigation, tobacco/nicotine cessation medication support, or thyroid for Li-induced hypothyroidism.<br>Examples **in PH settings** may include common antidepressants, ADHD medication, tobacco/nicotine medication support and SUD/ opioid use disorder medication.<br>SEE HANDBOOK FOR MORE DETAILS AND EXAMPLES. | ☐ There is limited prescribing for co-occurring conditions that **does not meet** criteria for Screening and Enhanced Referral stage.<br>☐ Medications for co-occurring conditions are **almost always prescribed by referral to "other" type of prescriber**. | ☐ **For at least one co-occurring condition, there are protocols** by which, for **selected individuals**, prescribers will either initiate certain medications or continue prescribed medications that have been stabilized by a provider in the "other" domain.<br>☐ At least **70% of prescribers in the practice/program have at least some individuals** for whom they are initiating or providing **continuing medications** for a co-occurring condition. | **STAGE 1, PLUS:**<br>☐ There is a **formal relationship or mechanism for access to "co-occurring" prescriber consultation that is available to all prescribers**.<br>☐ There are protocols for prescribers to **routinely initiate and continue medications for at least two selected co-occurring conditions, using the consulting prescriber** as needed for assistance with initiation or ongoing management.<br>☐ **Care coordination workflows track these medication interventions** and results for people receiving them.<br>☐ There are **measures used to systematically document and monitor response** to these interventions. | **STAGE 2, PLUS:**<br>☐ **Prescribers routinely work as a team (on-site or virtually) to initiate and manage a range of medications** for common co-occurring conditions, with routine collaboration with "co-occurring" team members to provide consultation as needed.<br>☐ More than **70% of people** receiving medication for both a PH and BH condition are **receiving their medication from a single team**.<br>☐ The program/organization **tracks medication interventions and outcomes** for the population served, using the data for continuous QI of those efforts. |

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| 2. Integrated prevention and treatment | **2.4 Implementation of trauma- and resilience-informed practices.**<br><br>NOTE: "Trauma-informed" is used as shorthand for both terms.<br><br>SEE HANDBOOK FOR MORE DETAILS ON DEFINITIONS OF INTEGRATED TRAUMA-INFORMED PRACTICES AND METHODOLOGIES FOR IMPLEMENTATION IN INTEGRATED SERVICE SETTINGS. | ☐ The program/ practice **has not implemented** a systematic approach to trauma-informed care that meets the criteria for Screening and Enhanced Referral stage.<br><br>☐ Staff training on the impact of trauma on people experiencing co-occurring challenges **has not been systematically implemented** to the extent that it would meet criteria for Screening and Enhanced Referral stage. | ☐ There is a systematic **policy or process to create a welcoming, person-centered, trauma-informed culture,** with a focus on non-traumatizing engagement of people with complex co-occurring needs.<br><br>☐ All team members have received **training on the impact of trauma on people with co-occurring conditions and on initiation of basic welcoming,** person-centered, trauma-informed approaches to engaging people with co-occurring conditions. | **STAGE 1, PLUS:**<br><br>☐ **Policies are adopted regarding trauma-informed care strategies, procedures and protocols.**<br><br>☐ At least **one measure of customer-experience** (e.g., a survey including a question about the experience of safety or traumatization in care) is implemented **as part of continuous improvement of trauma-informed care.**<br><br>☐ There is staff training and consultation on using **trauma-informed, strengths-based language and approaches** for people with complex co-occurring conditions who struggle with treatment adherence.<br><br>☐ There is access to **consultation and/or referral for provision of evidence-based, trauma-specific treatment** for selected individuals. | **STAGE 2, PLUS:**<br><br>☐ **Person-centered, trauma-informed care strategies, procedures and protocols are implemented by treatment team at all levels.**<br><br>☐ **Person-centered QI efforts support ongoing implementation** of **trauma-informed care practices** for both new and continuing people served.<br><br>☐ People served have access to **evidence-based, trauma-specific treatment within the organization.**<br><br>☐ Team has the capacity to provide **trauma-informed behavioral interventions** for people who are struggling with experiencing safety in addressing their co-occurring conditions. |

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| 3. Ongoing care coordination | **3.1 Ongoing care coordination for monitoring progress in the prevention of and intervention for co-occurring conditions.**<br><br>NOTE: Care coordination includes attention to resources and interventions addressing SDOH. This function is addressed specifically in Domain 7.<br><br>SEE HANDBOOK FOR MORE DETAILS, INCLUDING DEFINITIONS. SEE GUIDE FOR INSTRUCTION ON SCORING AND TO IMPROVE UNDERSTANDING OF FRAMEWORK STAGES AND SELF-ASSESSMENT PROCESS. | ☐ **Does not meet threshold** for having a systematic process for ongoing engagement and/or care coordination contacts for people with co-occurring conditions.<br><br>☐ **Does not meet threshold** for having a systematic process for tracking progress in receiving prevention or ongoing treatment interventions for co-occurring conditions. | ☐ **Treatment team has a routine process** for ongoing care coordination contacts with referral partners for people referred for treatment of their co-occurring conditions.<br><br>☐ **Treatment team has a mechanism for routinely improving the PROCESS** of referrals and engagement for co-occurring conditions. | ☐ Assigned team member(s) or care coordinator(s) have **designated responsibility** for care coordination of co-occurring conditions.<br><br>☐ Team members who are care coordinators **routinely provide continuing engagement to encourage and monitor** people receiving services regarding their participation in prevention and/or ongoing treatment interventions for co-occurring conditions.<br><br>☐ Assigned team members who are care coordinators **routinely monitor and report the PROCESS AND OUTCOMES** of ongoing prevention and/or treatment interventions for co-occurring conditions. | **STAGE 2, PLUS:**<br><br>☐ There is the ability to **provide a continuum of care coordination** intensities based on different levels of need within the populations served.<br><br>☐ For people with co-occurring conditions, **a tracking tool and/or disease registry is used to monitor OUTCOMES** for prevention/intervention results and/or treatment responses.<br><br>☐ For identified cohorts with co-occurring conditions, **a tracking tool and/or disease registry is used to monitor COHORT OUTCOMES** for prevention/intervention results and/or treatment responses. |

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| 4. Personalized self-management support | **4.1 Use of personalized educational materials and skill-teaching interventions for people receiving services and their families.**<br><br>"Interventions" focus on promoting self-management and activation, with adaptations for literacy, economic status, language and cultural norms.<br><br>"Family" as used here refers to both biological and chosen family, as well as other involved natural supports.<br><br>"Materials" includes handouts, pamphlets, toolkits and web-based resources.<br><br>"Activation" may include using advance directives for co-occurring conditions.<br><br>SEE HANDBOOK FOR MORE DETAILS AND EXAMPLES. | ☐ Materials or interventions provided for people/families receiving education on co-occurring conditions, risk factor screening recommendations or teaching healthy behavior skills **do not meet** criteria for Screening and Enhanced Referral stage. | ☐ People/families receiving **educational** materials are available for at least one co-occurring PH (in a BH setting) or BH (in a PH setting) condition and at least one risk factor screening recommendation.<br><br>☐ Basic materials for **teaching healthy behavior skills** are available for at least one co-occurring condition or risk factor.<br><br>☐ **Policies/procedures/ guidelines for using these materials have been developed.**<br><br>☐ Staff members of any type who may be assigned to use these materials have **received basic training** on how to do so.<br><br>☐ Materials are provided for indicated conditions **about 70% of the time** and are adapted for literacy, economic status, threshold languages and cultural norms. | **STAGE 1, PLUS:**<br><br>☐ Educational materials are delivered **routinely for at least two co-occurring conditions and one or two risk factor screening recommendations.**<br><br>☐ Basic materials/interventions for teaching healthy behavior skills are **delivered routinely for at least two co-occurring conditions or risk factors.**<br><br>☐ All the above materials **are adapted for literacy, threshold languages and culture for the population served.**<br><br>☐ Brief people/families receiving education on the materials is **provided in-person or via technology.**<br><br>☐ Materials include information about **access to integrated care management and/or consultation,** as appropriate.<br><br>☐ Policies and training on using these materials and interventions, including roles and accountability for providing self-management support, is provided to **all team members.**<br><br>☐ **At least 70% of treatment plans include self-management goal setting** for identified co-occurring condition or risk factor. | **STAGE 2, PLUS:**<br><br>☐ Educational materials are delivered on a **routine and ongoing basis for at least three co-occurring conditions and one or two risk factor screening recommendations.**<br><br>☐ Materials/interventions for teaching healthy behavior skills are **delivered on a routine and ongoing basis for at least two co-occurring conditions or risk factors,** with practical strategies for activation and healthy lifestyle habits.<br><br>☐ Materials include information about **access to integrated treatment for co-occurring conditions within the program, practice or organization.**<br><br>☐ The team can provide **self-management skills training and activation supports routinely and to scale (as indicated) through technology applications.**<br><br>☐ Materials are routinely **adapted for literacy, threshold language and culture for the population served.**<br><br>☐ Policies and training on using these materials and interventions are provided to all members of the treatment team, **including peers and CHWs.**<br><br>☐ Self-management skills and goals for co-occurring conditions and risk factors are **routinely included in treatment plans, and progress is monitored** as part of care management. |

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| 5. Interdisciplinary Teamwork | **5.1 Integrated care team composition.**<br><br>"Integrated care" refers to addressing co-occurring PH and BH conditions.<br><br>"Family" as used here refers to both biological and chosen family, as well as other involved natural supports.<br><br>SEE HANDBOOK FOR MORE DETAILS AND EXAMPLES. | ☐ Care team includes BH **OR** PH service provider, **people and family receiving services** (if appropriate).<br><br>☐ The composition or capacity of the integrated team **does not meet** criteria for Screening and Enhanced Referral stage. | ☐ Care team includes BH **OR** PH service provider, **person receiving services and their family** (if appropriate), with additional care team members assisting the primary provider with screening and referral coordination..<br><br>☐ Care manager or referral coordinator functions **may be present, but amount of dedicated time does not meet** criteria for Case Management and Consultation stage. | ☐ There is an **interdisciplinary care team that routinely has multiple members involved** in providing integrated screenings, interventions and/or care coordination.<br><br>☐ One or more BH consultants and/or BH care coordinators are available, **with dedicated time** for the PH team. Similarly, one or more PH consultants (e.g., nurse or care coordinator) are available to BH team.<br><br>☐ There is **routine access to consultation** from a BH psychiatrist, nurse practitioner or physician assistant in a PH setting or a primary care physician, nurse practitioner or physician assistant in a BH setting. | **STAGE 2, PLUS:**<br><br>☐ PH and BH staff, with care managers/coordinators, **work with people receiving services and their families as integrated teams in-person or virtually throughout the continuum** of care.<br><br>☐ **Peers and/or CHWs are routinely included on treatment teams** throughout the continuum of care. |

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| 5. Interdisciplinary Teamwork | **5.2 Integrated teamwork and sharing of clinical information.**<br><br>NOTE: This refers to sharing assessments, treatment interventions, case reviews, care plans and feedback regarding co-occurring conditions among members of integrated team.<br><br>"Visibility" in records means the notes are present and easily located for review.<br><br>SEE HANDBOOK FOR DESCRIPTION OF THE FIVE PRINCIPLES OF EFFECTIVE TEAMS, DETAILS ON INFORMATION-SHARING REGULATIONS AND MORE DEFINITIONS AND EXAMPLES. | ☐ Sharing of treatment information and feedback between BH and PH providers in different settings is **not routine and does not meet** criteria for Screening and Enhanced Referral stage. | ☐ Organization policy and staff training **facilitate proactive information sharing** with designated referral partners, to the extent allowed by current HIPAA, 42 CFR Part 2 and other regulations.<br><br>☐ Routine **requests for information are made directly** to referral partners and to health information exchanges (HIEs), if available.<br><br>☐ **Information is routinely and proactively provided** directly to referral partners and to HIEs, if available.<br><br>☐ There is **prompt response to information requests and routine exchange** of information (e.g., phone, secure email, HIE, fax) between PH and BH referral providers for shared people receiving services.<br><br>☐ Chart documentation of notes from referral providers **is not routine and does not meet** criteria for Care Management and Consultation stage. | **STAGE 1, PLUS:**<br><br>☐ Co-occurring issues are **discussed regularly in care team meetings or huddles.**<br><br>☐ Internal BH or PH consultants **participate regularly** in the care team meetings.<br><br>☐ **Interdisciplinary team members in varying roles routinely** deliver interventions for co-occurring conditions or risk factors.<br><br>☐ Referrals to external providers are **routinely accompanied by a summary** of the assessment and care plan.<br><br>☐ **Routine discussions** with co-occurring referral providers regarding assessment and treatment plans occur in-person, virtually or by phone, as necessary.<br><br>☐ Internal team PH and BH notes and information are **routinely visible and reviewed** in the clinical record.<br><br>☐ Care coordination **processes are monitored** to ensure that **documentation from external providers is incorporated into care planning.**<br><br>☐ Visibility (in the clinical record) and review of notes from co-occurring referral providers **occur occasionally but do not meet criteria for Comprehensive Treatment and Population Management stage.** | **STAGE 2, PLUS:**<br><br>☐ **Routine electronic sharing** of integrated care plans, co-occurring clinical notes and other information is part of the clinical record.<br><br>☐ **Interdisciplinary team uses technology** to communicate seamlessly between service visits, assigning just-in-time action steps to enhance adherence and activation.<br><br>☐ **Organizational culture and associated policies and procedures support uniform consent** for open communication between PH and BH providers working as a team.<br><br>☐ There are **regular in-person, phone or virtual meetings or email exchanges** to discuss complex co-occurring cases.<br><br>☐ Co-occurring treatment providers are **routinely informed (usually electronically) of significant treatment events or changes** (e.g., ER visit, hospitalization, medication change). |

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| 5. Interdisciplinary Teamwork | **5.3 Integrated care team training and competency development.**<br><br>"Training" as used here can occur in a classroom setting or during workflows or team meetings/huddles.<br><br>SEE HANDBOOK FOR MORE DETAILS AND INFORMATION ON DEFINITIONS. | ☐ Staff training or competency expectations regarding integrated care **are not consistent and do not meet** criteria for Screening and Enhanced Referral stage. | ☐ **Basic training is provided to all staff** on the integrated care approach and how it is being applied in the program/practice.<br><br>☐ **All involved staff are trained to competency** (including ongoing supervision or coaching) in implementing required Screening and Enhanced Referral workflows. | ☐ **Routine initial and continuing training is provided to all staff** on the integrated team care approach and how it is being applied in the program/practice.<br><br>☐ **Routine training is provided to all staff** on how to participate in and document integrated care activities and on integrated teamwork, with roles, accountabilities and competencies defined for each team member.<br><br>☐ **Routine training is provided to all staff** on **working collaboratively using team-based care principles,** including involvement of BH or PH consultants and care coordinators as members of the team and using information from care management processes to improve team-based care (e.g., through case reviews). | **STAGE 2, PLUS:**<br><br>☐ **Systematic annual and continuing training is provided to all staff at all levels,** emphasizing that every staff member is an integrated care provider and is expected to function as part of integrated care team.<br><br>☐ **Competency expectations related to team-based integrated care workflows are routinely included in job descriptions** for all staff categories, with learning materials that **target areas for improvement** in integrated teamwork principles and associated protocols.<br><br>☐ **Processes are in place to routinely evaluate the integrated care competency expectations** of all staff **categories.** |

| KEY ELEMENTS of Integrated Care | | PROGRESSION to Greater Integration → | | | |
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| 6. Systematic quality improvement | **6.1 . Use of quality metrics for improvement of integrated services.**<br><br>**Quality improvement (QI) process include:**<br><br>• Measure and report integration metrics.<br>• Demonstrate improvement in integration metrics.<br>• Demonstrate improvement in integrated care disparities that affect marginalized populations.<br><br>SEE HANDBOOK FOR MORE DETAILS, INCLUDING DESCRIPTIONS OF THE ELEMENTS OF ORGANIZED QI PROCESSES AND DEFINITIONS FOR DISPARITIES AND FOR INDIVIDUAL/ COHORT/POPULATION OUTCOMES. | ☐ There is **no or minimal use** of QI processes to measure, report and improve integration metrics.<br><br>☐ If present, QI processes **do not meet** criteria for Screening and Enhanced Referral stage.<br><br>☐ **Any consumer advisory input or use of consumer feedback** in continuous QI processes **does not meet** criteria for Screening and Enhanced Referral stage. | ☐ **QI process is in place to regularly measure baseline** and improve process metrics related to Screening and Enhanced Referral.<br><br>☐ QI process includes a method for **soliciting input from people served.**<br><br>☐ **PROCESS** QI metrics related to Screening and Enhanced Referral are **compiled for reporting** to internal or external quality monitoring entities, including a consumer advisory council.<br><br>☐ QI process **results in measurable improvement of one or two metrics.**<br><br>☐ **At least one potential disparity in the above metrics** related to underserved populations is tracked, and actions have been taken to remediate the disparity. | **STAGE 1, PLUS:**<br><br>☐ There is evidence of an **organized QI process that regularly measures baseline and improves PROCESS and OUTCOME metrics** related to interventions for individuals and cohorts with targeted co-occurring conditions.<br><br>☐ The QI process includes **a mechanism for involving an interdisciplinary QI team.**<br><br>☐ The **interdisciplinary team includes representation from multiple categories of staff** (e.g., CHWs, medical assistants and peer staff) and — as indicated — members from an agency or agencies with which care coordination is the focus of improvement.<br><br>☐ There is a formal mechanism to compare **PROCESS and OUTCOME** QI metrics for co-occurring conditions **against benchmarks, with reporting** to internal or external quality monitoring entities.<br><br>☐ Routine QI **processes result in measurable improvement in the tracked metrics.**<br><br>☐ **Routine QI efforts track and improve at least one potential disparity in the above metrics** related to underserved populations. | **STAGE 2, PLUS:**<br><br>☐ PH/BH improvement of **PROCESS and OUTCOME improvements for individuals, cohorts and populations are routinely incorporated** into organizational QI processes.<br><br>☐ **Routine QI processes** include identified integration teams and champions and systematic input at least quarterly from people receiving services.<br><br>☐ There is **ongoing, systematic monitoring of at least two POPULATION OUTCOME metrics** related to PH/BH integration.<br><br>☐ There is evidence of a formal mechanism by which **POPULATION OUTCOME QI metrics** for people with co-occurring conditions are **compared to benchmarks and compiled for reporting** to internal or external quality monitoring entities.<br><br>☐ **Routine QI processes** result in measurable improvement of the **above metrics.**<br><br>☐ **Routine QI efforts track and continuously improve** disparities in the **above metrics** related to underserved populations. |

| KEY ELEMENTS of Integrated Care | | PROGRESSION to Greater Integration | | | |
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| 7. Community interventions to address social determinants of health (SDOH) | **7.1 Leveraging community services to reduce SDOH impact on BH and PH.**<br><br>Community interventions include establishing connections to social services and resources designed to address the impact of SDOH.<br><br>SDOH risks include food insecurity, cognitive limitation, housing instability, interpersonal violence, lack of insurance, language barriers, child/adult protective services, discrimination, immigrant status and poverty.<br><br>SEE HANDBOOK FOR MORE DETAILS ON EXAMPLES OF SDOH CONDITIONS, DEFINITIONS FOR SDOH SCREENING AND RELEVANT INTERVENTIONS AND LINKAGES. | ☐ Identification of SDOH needs and interventions for or linkages/referrals to appropriate resources are **not systematized and do not meet** criteria for Screening and Enhanced Referral stage. | ☐ Psychosocial assessment includes **routine SDOH screening for at least one or two issues.**<br><br>☐ **Referrals for identified issues are routinely made** to relevant social service agencies.<br><br>☐ F/u and referral coordination **do not meet** criteria for Care Management and Consultation stage.<br><br>☐ Interagency arrangements with commonly used social service agencies, if present, **do not meet** criteria for Care Management and Consultation stage. | **STAGE 1, PLUS:**<br><br>☐ There is routine SDOH **screening for two or three issues.**<br><br>☐ Care management interventions by treatment team **routinely include direct efforts to assist with at least one identified SDOH issue.**<br><br>☐ Written or otherwise formalized **collaboration agreements are in place with at least one commonly used social service agency.**<br><br>☐ There is routine **f/u tracking of SDOH interventions, referrals** to and monitoring of service participation in the collaborating social service agency in team-based care and care coordination functions. | **STAGE 2, PLUS:**<br><br>☐ There is routine SDOH **screening for three or more issues.**<br><br>☐ Care management interventions by the treatment team **routinely include assisting with multiple identified SDOH issues.**<br><br>☐ Written **collaboration agreements are in place with enough agencies to assist all populations who may screen positive** for any of the SDOH needs.<br><br>☐ For each identified need, people and families served are **routinely linked to collaborating social service agencies** and provided resources to help improve appointment adherence, with f/u to close the loop.<br><br>☐ **Care coordination planning meetings occur routinely,** when indicated, with "complex care" partners sharing responsibility for people served.<br><br>☐ There are **at least biannual meetings** where leadership from collaborating partner human service organizations serving the shared community and population come together to strengthen collaborative efforts.<br><br>☐ There is **routine capacity for tracking SDOH and clinical outcomes for populations affected by at least one SDOH issue,** as part of population-based performance improvement. |

| KEY ELEMENTS of Integrated Care | | PROGRESSION to Greater Integration → | | | |
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| 8. Financial and administrative sustainability | **8.1 Financial sustainability.**<br><br>Development of processes that support cost efficiencies, reimbursement and demonstration of value to achieve financial sustainability of integration efforts.<br><br>Revenue can include direct payments to the provider or its partners, as well as intra-organizational transfers from other revenue lines or cost centers and inter-organizational transfers from collaborators.<br><br>NOTE: Time-limited grants are helpful in the short term but for this domain are not regarded as contributing to long-term sustainability. Enduring grant funding (such as a Federally Qualified Health Center grant), however, does contribute.<br><br>SEE HANDBOOK FOR MORE DETAILS, INCLUDING DEFINITIONS OF TERMS AND APPROACHES TO DEMONSTRATING VALUE, MANAGING COST AND ENHANCING REIMBURSEMENT. | ☐ Financial sustainability processes **do not meet criteria** for Screening and Enhanced Referral stage.<br><br>☐ Payment for integrated health services is **limited mainly to one-time grant or gift funding opportunities that target specific services, staff types or populations.**<br><br>☐ There is **limited expertise** in any billing or reimbursement opportunities for integrated health activities, including Screening and Enhanced Referral.<br><br>☐ There is **limited capacity** to optimize workflows and staff roles, with limited impacts on minimizing cost. | ☐ **Finance staff collaborate with the clinical operations team** working on integration and have conducted landscape analysis of all available reimbursement or billing opportunities for Screening and Enhanced Referral.<br><br>☐ **Collaboration discussions** regarding shared value have been initiated **with at least one provider or payer** for which improving integration would produce measurable value.<br><br>☐ **Workflows and staff roles are optimized** to deliver Screening and Enhanced Referral services efficiently.<br><br>☐ There is **expertise in and routine processes for fee-for-service billing** and receiving reimbursement for providing Screening and Enhanced Referral interventions.<br><br>☐ Routine process is in place for **tracking and improving reimbursement** for integrated PH/BH services provided. | **STAGE 1, PLUS:**<br><br>☐ Finance and clinical staff **actively collaborate** in organized QI processes (Domain 6) for ongoing development of sustainable integration.<br><br>☐ Collaborations have been initiated **with two or more providers or payers** for whom improving integration would produce measurable value, and **metrics have been identified that would demonstrate progress toward value and that could support actual or potential incentive payments.**<br><br>☐ **Landscape analysis** of all available reimbursement or billing opportunities for Care Management and Consultation has been conducted.<br><br>☐ Integration QI team **optimizes workflows and staff** roles to deliver Care Management and Consultation services efficiently.<br><br>☐ There is **expertise in and routine processes for fee-for-service billing and, if available, bundled services and/or care management payments** for providing the interventions in this stage, and tracks reimbursement and cost for such services.<br><br>☐ There is a demonstrated ability (either directly or through partners) to **bill and collect reimbursement for services by consulting providers with the "other" license.**<br><br>☐ **At least 50% of costs** of all integration processes and services provided are covered by generated revenue or other sustainable sources. | **STAGE 2, PLUS:**<br><br>☐ Clinical and financial leadership **routinely collaborate to provide direction** on how to optimize workflows and staff roles to maximize efficiency of integrated service delivery and maximize use of available billing and reimbursement opportunities.<br><br>☐ There is collaboration with payer or provider (e.g., health system) partners to **agree on and implement metrics that demonstrate value** (i.e., improved outcomes relative to spend).<br><br>☐ There is a demonstrated ability to **continuously improve workflow optimization and track cost** relevant to improving population PH/BH outcomes.<br><br>☐ There is participation in one or more **value-based payment arrangements or incentives** that reasonably cover relevant costs related to achievement of referenced PH/BH outcome metrics for the targeted population served.<br><br>☐ **At least 70% of costs** of all integrated services provided are covered by generated revenue and incentive payments. |

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| 8. Financial and administrative sustainability | **8.2 Administrative Sustainability.**<br><br>Enhancement of policies and procedures to support capacity to deliver integrated services in the context of existing provider/program licensure rules and regulations.<br><br>NOTE: Regarding use of the term "organization or organizational structure," this is a reminder that it is possible to deliver administratively sustainable Comprehensive Treatment and Population Management through a tightly connected partnership between separately incorporated organizations. However, this requires great attention to detail on policies and procedures to define that collaboration and provide administrative sustainability of "integratedness" throughout all the programs and practices of both organizations, so that they function as a cohesive unit.<br><br>NOTE: It is NOT sufficient to simply say that there are two separately licensed services under a common corporation or that there is a simple collaboration agreement for information sharing or cross referral.<br><br>SEE HANDBOOK FOR MORE DETAILS, INCLUDING DEFINITIONS FOR PROVIDER LICENSURE, PROGRAM LICENSURE AND REGULATORY STANDARDS. | ☐ Program/practice is licensed and/or regulated as a PH **OR** BH provider, with **no or limited guidance** for providing integrated interventions for people with co-occurring conditions.<br><br>☐ Program/practice **does not meet criteria** for Screening and Enhanced Referral stage. | ☐ Within the scope of existing (usually a single type of) licensure for the PROGRAM, there are **established written instructions or procedures for providing and documenting integrated Screening and Enhanced Referral interventions.**<br><br>☐ Within the scope of practice of existing (usually single types of) licensure for INDIVIDUAL SERVICE PROVIDERS, there are **established written instructions or procedures for providing and documenting integrated Screening and Enhanced Referral interventions.** | **STAGE 1, PLUS:**<br><br>☐ Within the scope of existing (usually a single type of) licensure for PROGRAM, there are **written instructions or procedures for providing and documenting Integrated Care Management and Consultation.**<br><br>☐ Within the scope of practice of existing (usually single types of) licensure/ certification for INDIVIDUAL SERVICE PROVIDERS, there are **established written instructions or procedures for providing and documenting the integrated processes and interventions included in this stage.**<br><br>☐ There are **established procedures for documentation** of internal consultation or service provision by a provider with the "other" license.<br><br>☐ IF AVAILABLE: Program/ practice **meets requirements** for state or payer certification for this stage, such as Certified Community Behavioral Health Clinic, BH Health Home or Collaborative Care Model. | **STAGE 2, PLUS:**<br><br>☐ Program/practice is part of an organization or organizational structure that routinely **provides both licensed PH AND BH services in shared physical and/or virtual service arrangements** throughout the continuum of care.<br><br>☐ Program/practice is part of an organization or organizational structure that **routinely provides documented instructions or guidelines** for clinical staff with either PH or BH licenses/certifications on how to deliver and document any type of integrated services, consistent with job, stage of training and scope of practice defined by their licenses or certifications.<br><br>☐ Program/practice **regularly adapts and continuously improves instructions to programs and staff** for how to work within state and federal licensure requirements and regulatory standards to support and enhance program/practice capacity to provide integrated care for the population served. |

**Last Updated: January 2025**

# Comprehensive Health Integration Framework Scoring Tracker

**INSTRUCTIONS**

- Document the results of your self-assessment for each domain and subdomain.
- For each domain, mark the stage completed (0-3) based on whether all the criteria for that stage have been achieved. If more than one stage has been completed, mark the furthest stage that has been fully achieved. If you have not yet met all Stage 1 criteria in a domain, mark Stage 0.
- In the Progress column, you can indicate partial advancement toward the next stage after completing a stage within a domain. This allows your program to reflect progress toward the next stage (also known as goal stage). To do this, indicate Early (E) if less than 50% of the criteria for that stage have been achieved, or Late (L) if 50% or more have been achieved. For example, if less than 50% of the criteria for Stage 2 have been completed, mark it as 2E; if 50% or more have been completed, mark it as 2L. Progress tracking is flexible and can be adjusted at your program's discretion.
- To calculate the total integration score for the program:
  - The program/practice must meet all the criteria for the same stage in at least six of the eight domains.
  - It must be no more than one stage lower in the other two domains.
  - For example, if six domains achieve Stage 2 and the other two domains are at Stage 1, the program's overall integration level is Stage 2.

| DOMAIN/SUBDOMAIN | STAGE SCORE (0-3) | NEXT STAGE PROGRESS<br>INDICATE STAGE (1-3) AND PROGRESS (EARLY/ LATE): 1E, 1L,2E, 2L, 3E, 3L | NOTES, KEY FINDINGS AND/OR FOCUS AREAS FOR IMPROVEMENT |
|---|---|---|---|
| **1.1 — Systematic Screening** | | | |
| **1.2 — Systematic facilitation of referrals and follow-up** | | | |
| **2.1 — Interventions for prevention/risk mitigation** | | | |
| **2.2 — Integrated nonpharmacologic interventions** | | | |
| **2.3 — Integrated pharmacologic intervention** | | | |
| **2.4 — Trauma- and resilience-informed practices** | | | |
| **3 — Ongoing care coordination** | | | |
| **4 — Personalized self-management supports** | | | |
| **5.1 — Integrated care team composition** | | | |
| **5.2 —Integrated teamwork and information sharing** | | | |
| **5.3 — Integrated care team training/competency** | | | |
| **6 — Systematic quality improvement** | | | |
| **7 — Community interventions to address SDOH** | | | |
| **8.1 — Financial sustainability** | | | |
| **8.2 — Administrative sustainability** | | | |
| **TOTAL PROGRAM INTEGRATION SCORE** | | | |

# Comprehensive Health Integration Framework Planning for Advancement Worksheet

The Planning for Advancement Worksheet is designed to help your program outline an action plan for reaching the desired level of integration. For each subdomain, specify your goal stage, which is usually one stage higher than the current stage. Identify the key criteria from the CHI Framework Self-assessment that need to be improved to progress to the next stage. Document the specific action steps needed, along with corresponding time frames for completion, and assign responsible team members to each task.

| DOMAIN/SUBDOMAIN | GOAL STAGE (1-3) | CRITERIA TO ADDRESS | ACTION STEPS | TIME FRAMES | ASSIGNED TEAM MEMBERS |
|---|---|---|---|---|---|
| **1.1 — Systematic screening** | | | | | |
| **1.2 — Systematic facilitation of referrals and follow-up** | | | | | |
| **2.1 — Interventions for prevention/risk mitigation** | | | | | |
| **2.2 — Integrated nonpharmacologic interventions** | | | | | |
| **2.3 — Integrated pharmacologic interventions** | | | | | |
| **2.4 — Trauma- and resilience-informed practices** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **3 — Ongoing care coordination** | | | | | |
| **4 — Personalized self-management supports** | | | | | |
| **5.1 — Integrated care team composition** | | | | | |
| **5.2 — Integrated teamwork and information sharing** | | | | | |
| **5.3 — Integrated care team training/ competency** | | | | | |
| **6 — Systematic quality improvement** | | | | | |
| **7 — Community interventions to address SDOH** | | | | | |
| **8.1 — Financial sustainability** | | | | | |
| **8.2 — Administrative sustainability** | | | | | |