COMPREHENSIVE HEALTH INTEGRATION (CHI) FRAMEWORK

Self-Assessment Guide

Detailed Guidance on Using CHI to Improve Physical Health/ Behavioral Health Integration

NATIONAL COUNCIL *for* Mental Wellbeing

CENTER OF EXCELLENCE
for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

LAST UPDATED: JANUARY 2025

ACKNOWLEDGMENTS

KENNETH MINKOFF, MD

Co-lead: Vice President and Chief Operating Officer, Zia Partners, Member, Medical Director Institute, National Council for Mental Wellbeing

EKATERINA (KATY) SMALI, MPA, MPH, PMP

Co-lead: Sr. Project Manager, Care Management Organization, Montefiore Medical Center

WHITNEY SEREBOUR, MHIM, PMP

Project Coordinator, Practice Improvement & Consulting, National Council for Mental Wellbeing

JOE PARKS, MD

Medical Director, National Council for Mental Wellbeing

NICK SZUBIAK, MSW, LCSW

Integrated Care Consultant, NSI Strategies

HENRY CHUNG, MD

Associate Professor of Clinical Psychiatry & Behavioral Sciences, Albert Einstein College of Medicine, Member, Medical Director Institute, National Council for Mental Wellbeing

JOAN KENERSON KING, RN, MSN, CS

Sr. Consultant, Practice Improvement & Consulting, National Council for Mental Wellbeing

JEFF CAPOBIANCO, PHD

Sr. Consultant, Practice Improvement & Consulting, National Council for Mental Wellbeing

ALICIA KIRLEY, MBA

Sr. Director, Practice Improvement & Consulting, National Council for Mental Wellbeing

JESSE SIEGER-WALLS, PHD, MSW, LCSW

Owner and Managing Principal, Wellbeing in Action

HENRIETTA CROSWELL, MPH

Owner and Principal, HC Consulting Solutions LLC

We would like to acknowledge the following participating clinics for their contributions to the CHI Framework Definitions and Examples Handbook during the first CHI Evaluation Learning Collaborative:

Abbe Center for Community Mental Health (Iowa)

Wyandot Behavioral Health Network (Kansas)

Community Healthlink (Massachusetts)

Mineral Community Hospital (Montana)

CarePlus New Jersey (New Jersey)

Westchester Jewish Community Center (New York)

Southeast Healthcare (Ohio)

Sistema de Salud Menonita (Puerto Rico)

This document is supported by the National Council for Mental Wellbeing's Center of Excellence for Integrated Health Solutions, funded by a grant award from the Substance Abuse and Mental Health Services Administration (SAMHSA) and managed by the National Council. The views, opinions and content expressed in this presentation do not necessarily reflect the views, opinions or policies of the Center for Mental Health Services, SAMHSA or the U.S. Department of Health and Human Services.

WHY USE COMPREHENSIVE HEALTH INTEGRATION FRAMEWORK AS A SELF-ASSESSMENT AND PLANNING TOOL?

The Comprehensive Health Integration (CHI) Framework is a program self-assessment and quality improvement (QI) planning tool that provides guidance for improving bidirectional integration of physical health (PH) — i.e., primary and specialty health, including dental — and behavioral health (BH) — i.e., mental health and substance use. The use of the framework as an assessment and planning tool helps providers, payers and population managers measure progress in organizing delivery of integrated services, referred to as "integratedness." Integration as used herein also includes attention to social determinants of health (SDOH) and health equity for underserved populations. The CHI Framework is designed to be applicable to any type of PH or BH setting, including settings serving adults and/or children, providing primary and/or specialty health care and providing mental health and/or substance use disorder (SUD) services.

The CHI Framework takes into consideration that provider organizations are composed of many programs and that each program may be at a different starting place with regard to integration. The CHI Framework's stepwise approach meets provider organizations and their component primary care and BH programs where they are — recognizing that there is latitude in how far to advance specific components of integration, and presenting a more feasible, practical, incremental process for doing so. While the framework provides a roadmap to help organizations and their component programs make wise investments in time, training, workforce and other resources, it also recognizes that achieving the most advanced state of each domain and its subdomains might not be the ultimate target for every program or the organization as a whole. The term "program" is used consistently throughout to represent a variety of settings, including BH programs and PH clinics and practices. Patients in need of BH treatment in primary care or vice versa will benefit from many of the intermediate elements associated with the framework. Still, all programs should strive to achieve as many, if not necessarily all, of the advanced elements of integratedness as possible, to achieve meaningful improvements in quality and outcomes for the individuals and families with co-occurring PH, BH and/or SDOH challenges who are routinely served in those settings.

THE CHI DOMAINS AND STAGES: MEASURING ADVANCEMENT IN INTEGRATED CARE

Note: When reading this section of the guide, it might be helpful to have the CHI Framework available for reference. Further explanation of the domains, subdomains and stages is also available in the CHI White Paper and CHI Definitions and Examples Handbook. Please use these documents for more background information on these concepts.

The CHI Framework is composed of eight domains of integratedness and 15 subdomains to guide service design. These domains incorporate best practices in integrated services and are designed to be consistent with a wide range of integrated service models. The domains emphasize integrated service structures and processes that are directly connected to the services provided. Progression in each domain or subdomain thus improves the integratedness of the program.

Each of these broad domains specifically addresses PH, BH and SDOH challenges in an integrated manner:

1. **Screening, referrals and follow-up**

2. **Integrated prevention and treatment**

3. **Ongoing care coordination**

4. **Personalized self-management support**

5. **Interdisciplinary teamwork**

6. **Systematic quality improvement**

7. **Community interventions to address social determinants of health**

8. **Financial and administrative sustainability**

For each of those domains (listed in the far-left column, with subdomains to the right), the framework identifies historical practice (i.e., usual care) and three integration stages as "steps" in the columns proceeding from left to right. The rows represent parallel paths toward integration — with specific markers for achievement of the standard — that can be prioritized for implementation based on a program's resources, current stage of integration and desired speed of change. Programs can identify their current status and set goals within each domain to achieve a sense of momentum along a pathway — increasing capabilities in different aspects of integrated care at different rates based on the program's structure and resources. It's a flexible process, rather than one that rigidly anchors programs to a specific stage of integration across domains.

The integration stages provide guidance on achievement of progress benchmarks, while still permitting flexibility in the implementation process. Each describes an organized approach that has several evidence-based or consensus-supported core service elements for integratedness that can be implemented flexibly depending on the capabilities of a program. Each stage can be associated with producing value for individuals and families with co-occurring PH, BH and/ or SDOH needs served within that stage. Each of the more advanced stages is assumed to include the capabilities of the earlier stage, plus additional capabilities. The three integration stages are:

1. Screening and Enhanced Referral	Optimizes screening and enhanced referral processes to improved routine screening of basic PH or BH conditions and — when those conditions are present — improved navigation and enhanced referral to ensure that referrals are tracked, appropriate high-quality treatment is provided and results are communicated. Enhanced referral requires developing a purposeful, planned partnership between PH and BH practices with an agreement to work together to improve referrals. As a result, the individual and their family members or other natural supports will experience providers in different locations working as an integrated team to address co-occurring needs.
2. Care Management and Consultation	Commits to a set of screening and tracking processes with associated on-site care coordination and care management. This stage also includes integrated teamwork that involves routine consultative collaboration with a PH specialist in a BH setting (or vice versa), which allows the program to provide routine integrated prevention and treatment services and interventions for common conditions — and monitoring outcomes of those interventions — for a significant cohort of its population. Individuals and their families will experience integrated teamwork in a single location (e.g., a BH consultant in the PH setting; a nurse and/or care coordinator in the BH setting), as well as a designated person or team (which may include a peer or a community health worker) that establishes a caring relationship to help them follow through with needed services, track whether the services are working and assist with service improvements if needed.
3. Comprehensive Treatment and Population Management	Delivers comprehensive PH and BH staffing in a single organization, such as a hospital; independent group practice; Federally Qualified Health Center (FQHC), large community mental health center (CMHC) or Certified Community Behavioral Health Clinic (CCBHC); or by two partnering organizations (e.g., an FQHC and a CMHC or CCBHC); or by a large health system with multiple provider organizations, especially a health system that is managing a defined population (e.g., an Accountable Care Organization [ACO]), where the partnering organizations work in very close alignment, using shared protocols and information systems. This stage implies a high level of shared accountability for a population with complex needs, in which the organization takes primary (or shared) responsibility for PH and BH care for a significant number of people. Individuals and their families experience a higher level of integrated teamwork and more proactive engagement and coordination of care. BH and PH treatment providers (not just consultants and care coordinators) function as a complete team, often in a single location, so that individuals and families experience collaboration and access to shared information and service plans on a routine basis for co-occurring conditions.

The term "stage" is used to reflect the fact that progress in delivering integrated services can be organized conceptually around different levels of development, each of which is supported by evidence and associated with the capacity to produce added value both for payers and people served. The core elements of integratedness in each stage can be adapted with some degree of consistency by programs whose initial targets may range from more basic to more advanced, based on available resources. The names of the stages describe the primary integratedness workflows which the programs should implement within one or more of the domains to be successful. They allow a program to select one or more domains for a focused effort to advance the state of integration, and then to identify one or more issues for which metrics can be selected to demonstrate the value of the integrated services provided. The optimal stage choice for a program, as well as the number and type of co-occurring conditions addressed within that stage, will vary by the program's current development, resources, capacity and incentives, as well as by the nature of the population served (e.g., adults vs. children, specialty care vs. primary care, mental health vs. SUD).

Each stage provides a higher level of integratedness than historical practice and, as described below, is associated with evidence demonstrating that its implementation produces the processes needed to show (e.g., to payers) measurable value with regard to specific co-occurring conditions, interventions and/or populations. Further, the integration stages are progressive: Advancing each stage requires implementation of the elements of the prior stage. That is, if a program rates itself as achieving Comprehensive Treatment and Population Management, it is expected to have exceeded or accomplished the elements of the preceding stages — Screening and Enhanced Referral and Care Management and Consultation — for each domain.

However, although the stages are progressive, the CHI Framework does not assert that one integration stage is necessarily more desirable than another for a particular program. The optimal choice at a particular point in time will vary by the program's current development, resources, capacity and incentives. In this way, the CHI Framework — using the eight domains and the three integration stages — provides a roadmap for improvement in integratedness that can be applied by a wide variety of programs, practices, organizations and systems. Further, within a particular community or population, different providers can achieve different integration stages to collectively provide the most effective integrated service array for that population, all within the context of the CHI Framework.

HOW TO USE THE CHI FRAMEWORK AS A SELF-ASSESSMENT AND PLANNING TOOL

The CHI Framework can be used to assess the current state of integration in a program, as well as to plan improvement and measure progress in integration. Using the eight domains of the CHI Framework helps measure the current state of integration and demonstrate progress toward implementation of integration stages. Within a QI approach, this measurement identifies the program's current level of integratedness, which can guide identification of improvement targets and objectives (for providers) and provide objective indication of implementation success (for payers and regulators).

We recommend that one or more designated integration QI teams within the program initially use the framework to self-assess (and improve) the current integratedness of specific programs. Relevant organizational leadership should formally charter such teams for this purpose. Once each team understands its baseline stage of integration, it can use the self-assessment findings to begin developing future-state goals.

To help you prepare your organization and individual programs for this activity, we have developed guidance for CHI Framework self-assessment and future-state planning on page 6 of this document.

GETTING STARTED: ESTABLISHING COMMITMENT FROM SENIOR LEADERSHIP AND IDENTIFY INTEGRATION CHAMPION(S)

- To effectively manage change, it is crucial to secure visible, ongoing support from senior leadership at the earliest stages of integration. Leadership commitment helps prioritize resources, overcome resistance and sustain momentum over time. With this support, identify one or more integration champions within the program. An integration champion, distinct from leadership, is critical because they inspire and engage staff, drive day-to-day momentum and help manage and track the progress of integration efforts through peer influence and hands-on advocacy. These champions, whether from clinical or administrative roles, will be key to navigating organizational barriers, rallying support from colleagues and reinforcing the importance of integrated care at every level. Creating opportunities for feedback loops between leadership and staff ensures that challenges are addressed and progress is celebrated, reinforcing a culture of continuous improvement and adaptability.

COMMUNICATING CHANGE TO ALL INVOLVED COMPONENTS OF THE ORGANIZATION

- This includes letting all program leaders and staff know that the organization is working in an intentional QI partnership to improve the organization's ability to deliver integrated services to individuals and families with co-occurring PH, BH and/or SDOH conditions, in order to improve the experience and outcomes of care, in accordance with the organization's mission and values. It also may be important to communicate this intention to current and future stakeholder partners that can contribute to the change process.

IDENTIFY HOW AND WHEN EACH PARTICIPATING COMPONENT OF THE ORGANIZATION WILL USE THE FRAMEWORK

- The CHI Framework is designed to be applied to specific programs within an organization. This recognizes that, in a large organization, different components may serve different populations, have different policies and procedures and/or be in different places with regard to progress toward integratedness. In a BH organization, the adult case management team may be in a different place than the early childhood program or the outpatient SUD program providing buprenorphine. In a PH organization, the adult primary care clinic may be in a different place than the pediatric clinic or the OB/GYN clinic. A large FQHC that contains a CMHC may offer a wide variety of service modalities. Even within one FQHC, different practices or satellite sites may be at different levels integratedness. The CHI Framework empowers any organization to design a QI process that is matched to the specific capabilities of each program, as well as to adapt its pace of progress accordingly. The CHI Framework allows an organization to focus on one program or many programs and to engage them all at once or in a sequence over time — whatever makes most sense for the organization's resources, capabilities and incentives.

  It is recommended that large organizations identify an overarching quality improvement team. This team will manage the process of improving integratedness for the whole organization, and then it will help each involved program identify and organize its own cross-discipline integration-implementation QI team. When multiple programs are using the framework, the organization's QI team can collect the various self-assessment results and QI action plans, and work with teams — individually and collectively in a learning community — to make progress.

The following instructions apply to each program using the CHI Framework for self-assessment.

THE FRAMEWORK STEP-BY-STEP

- **ASSEMBLE AN APPROPRIATELY REPRESENTATIVE STAFF TEAM TO ASSESS THE CURRENT STATE OF INTEGRATION.** For example, in a PH practice, a team comprising a primary care provider (PCP) or pediatrician, a behavioral health specialist, a practice administrator, a member of the nursing staff, a medical assistant and a staff member providing care management support (e.g., a community health worker) is important for assessing the current stage of practice within each domain/subdomain of the framework. Similarly, for a BH program, the team may include the program manager, prescriber, nurse care coordinator and one or more of the following: clinicians, case managers or care coordinators, peers and support staff. For any setting, the team should include different types and levels of staff, but it should not be so large as to make the process of using the framework unwieldy.

- **PREPARE THE TEAM BY PROVIDING EDUCATION ON THE CHI FRAMEWORK AHEAD OF TIME AND GIVING EACH TEAM MEMBER A CHANCE TO REVIEW AND THINK ABOUT THE ITEMS.** It is also important to connect the use of the CHI Framework to the organization's goals and expectations regarding improvement of integratedness. Then, meet as a team to perform the self-assessment, using the CHI Framework and the associated scoring elements for each subdomain. The best approach is for the team to meet in person to discuss each item and arrive at a consensus regarding which integration stage best fits the program. There is value in the discussion itself, so teams should avoid the temptation to simply have each team member score separately and average their results. Each team member should identify their own opinion about which integration stage best fits the subdomain being discussed, then the group should talk through each item to arrive at consensus.

- **SCORE THE ORGANIZATION.** *See detailed general scoring instructions in the next section on page 9, and refer to the CHI Definitions and Examples Handbook for detailed information and resources on scoring and improving each domain and subdomain.* Wherever possible, the team should use available data to determine the current status of integration in each of the criteria within each subdomain of the CHI Framework. Each bullet includes one or more measurable criteria for achieving the indicator. Scoring should be "strength-based" whenever possible, and the program should receive credit where it is due. To achieve a particular stage in any subdomain, the program must achieve all the bullets in that stage. To provide a comprehensive view of the program's integration, teams can calculate a total integration score by determining the highest stage achieved in at least six of the eight domains. Teams can also track partial progress toward the next stage by noting early or late progress in a subdomain, helping to identify where additional efforts are needed. However, it is very important that, in addition to marking a "stage score" for each subdomain, the team also documents written comments and notes that describe what they have learned, where there are deficiencies and what they want to work on to improve. It may also be helpful to include a "parking lot" for identified issues that will not be addressed at the present time. It is unfortunately common that teams simply document the score and forget the most important aspects of what they learned in their self-assessment discussion when they return to the tool to plan improvement efforts.

- **CONDUCT ACTION PLANNING.** The purpose of using the CHI Framework for self-assessment is to identify a baseline for developing a QI action plan. One of the first steps in action planning is to identify enablers and barriers to achieving particular targets. The team can perform an environmental scan to identify potential external resources for facilitating integration efforts: Is there a payer that is providing financial incentives to reach Care Management and Consultation? Is there a partner in the "other" domain that is (or is not) available and willing to strengthen the collaboration? These discussions can occur during and/or after the self-assessment process and should be documented as a guide for how the team can ultimately identify next-step goals and objectives that are appropriately matched to the program using the framework, forming the foundation of its integration QI action plan.

- **CREATE A WRITTEN QUALITY IMPROVEMENT ACTION PLAN, WITH DOCUMENTED GOALS AND OBJECTIVES FOR THE PROGRAM AS A WHOLE.** Using a formal structure such as SMART (Specific, Measurable, Achievable, Relevant/Realistic, Timebound) goals is strongly recommended for keeping the action plan on track. Within that action plan (as in a treatment plan for an individual client), prioritize domains and/or subdomains for change. While programs will develop individualized goals, they should prioritize and focus on the following domains, which are key to developing meaningful integration:

- Integrated Screening, Referral and Follow-up
- Integrated Prevention and Treatment of Common Co-occurring Conditions
- Ongoing Care Coordination and Management
- Self-management Supports
- Interdisciplinary Teamwork
- Systematic Quality Improvement

- **AFTER PERFORMING A SELF-ASSESSMENT, SET (AND DOCUMENT) SPECIFIC, MEASURABLE AND ACHIEVABLE THREE- TO 12-MONTH GOALS.** This should be done for each domain or subdomain. Programs should consider their population served and their available resources, developing goals and objectives that are achievable and realistic. They should consider whether their goal is primarily to strengthen the stage that they are currently in (such as by adding more issues to address) or to progress from one stage to the next. Within a large organization, there may be common targets for all types of services, as well as individualized targets for each program. Note that value can be produced at each stage, so the CHI Framework emphasizes that different programs may define success based on their unique priorities and capacities.

- **IDENTIFY METRICS:** As part of its progress, each program should identify metrics of success that are relevant to its own integration targets, the population served, the issues addressed and — where applicable — the priorities of external payers or population managers. The CHI Framework White Paper identifies potential progress metrics that are relevant to each integration stage, but individual settings may adapt these to their own needs. For example, a PH practice working on Screening and Enhanced Referral may work toward routinely demonstrating the percentage of people with depression, anxiety, SUD and tobacco use that are identified (or, for a pediatric practice, perhaps ADHD and developmental challenges), receive successful referrals and/or are engaged in appropriate interventions. An adult BH practice working on the Care Management and Consultation stage may work on similar metrics for addressing diabetes, for example, but in addition would be able to track progress in achieving HbA1c targets through the activities of its care coordination team. Note that there are always more things to measure and address than most settings will be able to work on at the beginning. As programs make progress within each integration stage and/or from one integration stage to the next, they will naturally improve the consistency of progress measurement for each type of co-occurring issue, as well as steadily expand the number of co-occurring issues that are identified.

- **ASSESS EXISTING AND NECESSARY RESOURCES FOR ACHIEVEMENT OF INTEGRATION GOALS, INCLUDING CAPITAL INVESTMENTS, PERSONNEL AND TECHNOLOGY COSTS.** Programs will need to consider resources — existing and potential — necessary for implementation and achievement of goals in the components selected, including capital investments, technology costs and staff expansion, training and time. Resources may be provided by external payers or the larger organization, or they may be developed within the program itself. Note that the CHI Framework will help identify ways of making progress even within existing resources, so it is important not to get stuck when additional resources are not immediately available. It is better to improve what can be improved with the resources you have, and then use your progress to attract more resources over time.

- **ASSESS ATTAINABILITY OF GOALS TO ENSURE THEY ARE REALISTIC AND APPROPRIATE.** While identifying goals, programs should assess how attainable each goal is within their three- to 12-month time frames, on a scale of 1 (lowest) to 10 (highest), to ensure that goals are realistic and appropriate based on the current state of practice and available resources. If a practice determines that its confidence level in reaching a goal is below 70% (7 on the scale of 1 to 10), then evidence and experience suggest that the goal may be too ambitious and should be reassessed.

- **PERFORM CONTINUOUS QUALITY IMPROVEMENT.** Once your program has achieved the first iteration of progress, it is appropriate to use the framework again to reassess and then develop a new set of goals and objectives. In large organizations, the overarching QI team ideally will be keeping track of the progress of each organizational component and helping each component celebrate, document and measure success, including appropriate metrics of progress, and develop new goals and objectives. It is important for all parts of the organization to keep progressing in small increments over time.

GENERAL SCORING INSTRUCTIONS FOR THE CHI FRAMEWORK

This section of the CHI Self-assessment Guide provides detailed **general scoring instructions** that apply to scoring all the domains and subdomains in the CHI Framework. Your designated QI teams should refer to the CHI Definitions and Examples Handbook for information that supports understanding of the CHI Framework elements. The handbook provides examples tailored to different types of settings, including adult and/or child PH and adult and/or child BH (mental health and/or SUD). At least one team member (usually the integration team leader and/or integration champion) should become familiar with both this guide and the CHI Definitions and Examples Handbook prior to the whole team meeting to complete the self-assessment using the CHI Framework. Additionally, all team members should review the scoring instructions outlined in the table below. The team should also have the Definitions and Examples Handbook readily available during the self-assessment process, so that relevant material for each domain and subdomain can be referenced in real time during discussions.

GENERAL SCORING INSTRUCTIONS FOR THE CHI SELF-ASSESSMENT TOOL

CATEGORY	INSTRUCTIONS/DESCRIPTION
Bulleted criteria	Stage subdomain criteria are in bulleted lists. The criteria are specific and concrete enough to be accurately assessed by the team using the self-assessment. When using the tool, the team should consider and score each bullet to determine the appropriate stage for that subdomain.
Data requirements for scoring	Many subdomain criteria refer to specific data targets, such as "routine" (which means 70% unless otherwise specified — see definition below) or "50%." Data targets refer to performance on an indicator related to the denominator of all clients/patients who might be eligible for the intervention or program described. Important note: Teams using the self-assessment are not required to demonstrate that they meet the required targets by producing audit-quality data sets. Teams should use the data targets as guidance to evaluate their own performance in a way that is feasible and sufficiently accurate to satisfy the team that the data target is met. It is helpful to review a small sample of records to determine whether a particular target is met, but this is not possible in many domains, and a team consensus will generally suffice.
Stages	The CHI Framework describes three integration stages, the names of which each reflect a recognized evidence-supported "package" of integration activities that can produce value for the population served. The stages reflect meaningful progress in advancing integration for each setting, and this understanding informs the importance of scoring each bullet within each subdomain in the right-hand column. For convenience and ease of discussion, we have also labeled each of the columns with a number: Stage 0 (Historical Practice), Stage 1 (Screening and Enhanced Referral), Stage 2 (Care Management and Consultation) and Stage 3 (Comprehensive Treatment and Population Management). Teams may find it easier and more practical to refer to the numbers when using the tool, but they should nonetheless remember that the numbers are just a shorthand for the carefully described integration stages they represent. This guide will use the names of the stages (rather than numbers) for consistency throughout these instructions.
Routine/Regular/ Systematic	These terms are used throughout the CHI self-assessment tool. Unless otherwise specified, these terms indicate that criteria are met 70% of the time.

GENERAL SCORING INSTRUCTIONS FOR THE CHI SELF-ASSESSMENT TOOL

CATEGORY	INSTRUCTIONS/DESCRIPTION
Scoring domains and subdomains using consensus-driven approach	To meet the criteria for a particular stage in any domain or subdomain, the team must reach consensus that the program meets all the bulleted criteria in that domain or subdomain for that stage. If the team does not agree, the domain or subdomain should be scored one stage lower, to reflect the collective assessment. Consensus-driven scoring ensures that all perspectives are considered, and that the final evaluation accurately represents the team's shared understanding.
Scoring Progress	If the program is actively working toward the next stage but hasn't fully completed it, you can document incremental advancements using the "early progress" or "late progress" options. Early progress for a subdomain or domain indicates that less than 50% of the bullets for the next stage have been completed, while late progress reflects that 50% or more of the bullets have been achieved. This approach allows you to capture partial progress and maintain momentum toward achieving the next stage. Tracking this progress ensures that efforts are recognized, even when a stage has not yet been fully reached.
Scoring the Program	To calculate total integration score for a program, the criteria for a specific stage must be met in at least six of the eight domains and no more than one stage "lower" on the other two domains. The total score represents the program's overall level of integration.
Taking Notes while Scoring	It is important to take notes when scoring each subdomain, to record any ideas about was is missing and next steps needed to make progress. Be as specific as possible: e.g., "We missed meeting criteria for the stage in this domain because our percentage was below 70%," or "... because we were focusing on too few co-occurring issues," or "... because our care tracking system was missing specific elements," or "We achieved the stage we wanted, but we see the need to strengthen that subdomain by increasing... ."
Using scoring to guide improvement priorities.	The combination of stage scores, plus the detailed scoring notes, will help the team to determine its QI objectives and priorities. If the goal for the program is to advance to the next stage, specific targets in each relevant domain or subdomain can be identified based on the bulleted framework criteria. A similar approach would apply if the goal were to strengthen the current stage. Refer to the Planning for Advancement Worksheet to support this effort.

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** (page 25) helps document scores and teamwork discussions, maximizing the value of the CHI Framework. The Scoring Tracker summarizes self-assessment results (page 34) and Planning for Advancement Worksheet (page 35) 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.

Last Updated: January 2025

The Comprehensive Health Integration Framework

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 →			
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.** 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. ☐ **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. ☐ **A designated team member is responsible for tracking** screening processes and results. ☐ Data on screening outcomes and f/u is **systematically collected**.	**STAGE 2, PLUS:** ☐ There is systematic screening for at **least three or four** high-prevalence co-occurring conditions or risk factors. ☐ There is **capacity for data registries** on screening, f/u processes and results. ☐ 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. 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**. ☐ 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. ☐ There is **systematic tracking of referrals** to ensure connection with both PH and BH services for all in need. ☐ There is an **expectation of and method for routine information sharing** between PH and BH partners to track ongoing f/u.	**STAGE 1, PLUS:** ☐ **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. ☐ 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. ☐ **A designated team member** is responsible for tracking referrals and coordinating information sharing to track f/u.	**STAGE 2, PLUS:** ☐ **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. ☐ For people with no existing provider connection or preference, **majority of referrals** go to an internal team partner PH or BH provider. ☐ BH and PH providers **routinely and electronically (usually via shared electronic health record [EHR]) share/receive information** about referral and f/u.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
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)**
2. Integrated prevention and treatment	**2.1 Use of evidence-based guidelines or protocols for prevention/risk mitigation related to co-occurring conditions.** Prevention/risk mitigation interventions may include, but are not limited to: • Developmental and adverse childhood experiences (ACES) screenings/education. • One or more United States Preventive Services Task Force screenings: education, referral, f/u. • Education on screening results indicating risk (e.g., borderline diabetes or risky substance use). • Suicide or overdose risk reduction. 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. ☐ 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. ☐ 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.** ☐ The guideline or protocol is followed routinely, so that at **least 70% of eligible people are receiving the recommended intervention and f/u.** ☐ 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:** ☐ **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. ☐ 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. ☐ **Preventive/risk mitigation intervention frequency and f/u are routinely monitored** for adherence to the recommended protocols. .	**STAGE 2 CRITERIA ARE MET FOR THREE INTERVENTIONS/RISK ISSUES, PLUS:** ☐ The program /organization **tracks population-wide prevention/risk mitigation efforts** and uses the data to continuously improve these efforts.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
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)**
2. Integrated prevention and treatment	**2.2 Use of evidence-based guidelines/protocols for nonpharmacologic treatment for co-occurring conditions.** 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. 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. ☐ 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. ☐ 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**. ☐ At least **70% of people** who are eligible to receive those interventions have documentation that the intervention was provided **at least once**. ☐ There are monitored **care management workflows for tracking** interventions and results. ☐ 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:** ☐ 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. Examples **in BH settings** may include metformin for HBA1c reduction/weight gain mitigation, tobacco/nicotine cessation medication support, or thyroid for Li-induced hypothyroidism. Examples **in PH settings** may include common antidepressants, ADHD medication, tobacco/nicotine medication support and SUD/opioid use disorder medication. 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. ☐ 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. ☐ 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:** ☐ There is a **formal relationship or mechanism for access to "co-occurring" prescriber consultation that is available to all prescribers**. ☐ 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. ☐ **Care coordination workflows track these medication interventions** and results for people receiving them. ☐ There are **measures used to systematically document and monitor response** to these interventions.	**STAGE 2, PLUS:** ☐ **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. ☐ More than **70% of people** receiving medication for both a PH and BH condition are **receiving their medication from a single team**. ☐ The program/organization **tracks medication interventions and outcomes** for the population served, using the data for continuous QI of those efforts.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
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)**
2. Integrated prevention and treatment	**2.4 Implementation of trauma- and resilience-informed practices.** NOTE: "Trauma-informed" is used as shorthand for both terms. 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. ☐ 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. ☐ 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:** ☐ **Policies are adopted regarding trauma-informed care strategies, procedures and protocols.** ☐ 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.** ☐ 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. ☐ There is access to **consultation and/or referral for provision of evidence-based, trauma-specific treatment** for selected individuals.	**STAGE 2, PLUS:** ☐ **Person-centered, trauma-informed care strategies, procedures and protocols are implemented by treatment team at all levels.** ☐ **Person-centered QI efforts support ongoing implementation** of **trauma-informed care practices** for both new and continuing people served. ☐ People served have access to **evidence-based, trauma-specific treatment within the organization.** ☐ Team has the capacity to provide **trauma-informed behavioral interventions** for people who are struggling with experiencing safety in addressing their co-occurring conditions.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
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)**
3. Ongoing care coordination	**3.1 Ongoing care coordination for monitoring progress in the prevention of and intervention for co-occurring conditions.** NOTE: Care coordination includes attention to resources and interventions addressing SDOH. This function is addressed specifically in Domain 7. 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. ☐ **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. ☐ **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. ☐ 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. ☐ 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:** ☐ There is the ability to **provide a continuum of care coordination** intensities based on different levels of need within the populations served. ☐ 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. ☐ 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.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
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)**
4. Personalized self-management support	**4.1 Use of personalized educational materials and skill-teaching interventions for people receiving services and their families.** "Interventions" focus on promoting self-management and activation, with adaptations for literacy, economic status, language and cultural norms. "Family" as used here refers to both biological and chosen family, as well as other involved natural supports. "Materials" includes handouts, pamphlets, toolkits and web-based resources. "Activation" may include using advance directives for co-occurring conditions. 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. ☐ Basic materials for **teaching healthy behavior skills** are available for at least one co-occurring condition or risk factor. ☐ **Policies/procedures/ guidelines for using these materials have been developed.** ☐ Staff members of any type who may be assigned to use these materials have **received basic training** on how to do so. ☐ 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:** ☐ Educational materials are delivered **routinely for at least two co-occurring conditions and one or two risk factor screening recommendations.** ☐ Basic materials/interventions for teaching healthy behavior skills are **delivered routinely for at least two co-occurring conditions or risk factors.** ☐ All the above materials **are adapted for literacy, threshold languages and culture for the population served.** ☐ Brief people/families receiving education on the materials is **provided in-person or via technology.** ☐ Materials include information about **access to integrated care management and/or consultation,** as appropriate. ☐ Policies and training on using these materials and interventions, including roles and accountability for providing self-management support, is provided to **all team members.** ☐ **At least 70% of treatment plans include self-management goal setting** for identified co-occurring condition or risk factor.	**STAGE 2, PLUS:** ☐ 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.** ☐ 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. ☐ Materials include information about **access to integrated treatment for co-occurring conditions within the program, practice or organization.** ☐ The team can provide **self-management skills training and activation supports routinely and to scale (as indicated) through technology applications.** ☐ Materials are routinely **adapted for literacy, threshold language and culture for the population served.** ☐ Policies and training on using these materials and interventions are provided to all members of the treatment team, **including peers and CHWs.** ☐ 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.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
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)**
5. Interdisciplinary Teamwork	**5.1 Integrated care team composition.** "Integrated care" refers to addressing co-occurring PH and BH conditions. "Family" as used here refers to both biological and chosen family, as well as other involved natural supports. SEE HANDBOOK FOR MORE DETAILS AND EXAMPLES.	☐ Care team includes BH **OR** PH service provider, **people and family receiving services** (if appropriate). ☐ 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.. ☐ 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. ☐ 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. ☐ 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:** ☐ 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. ☐ **Peers and/or CHWs are routinely included on treatment teams** throughout the continuum of care.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
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)**
5. Interdisciplinary Teamwork	**5.2 Integrated teamwork and sharing of clinical information.** NOTE: This refers to sharing assessments, treatment interventions, case reviews, care plans and feedback regarding co-occurring conditions among members of integrated team. "Visibility" in records means the notes are present and easily located for review. 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. ☐ Routine **requests for information are made directly** to referral partners and to health information exchanges (HIEs), if available. ☐ **Information is routinely and proactively provided** directly to referral partners and to HIEs, if available. ☐ 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. ☐ Chart documentation of notes from referral providers **is not routine and does not meet** criteria for Care Management and Consultation stage.	**STAGE 1, PLUS:** ☐ Co-occurring issues are **discussed regularly in care team meetings or huddles.** ☐ Internal BH or PH consultants **participate regularly** in the care team meetings. ☐ **Interdisciplinary team members in varying roles routinely** deliver interventions for co-occurring conditions or risk factors. ☐ Referrals to external providers are **routinely accompanied by a summary** of the assessment and care plan. ☐ **Routine discussions** with co-occurring referral providers regarding assessment and treatment plans occur in-person, virtually or by phone, as necessary. ☐ Internal team PH and BH notes and information are **routinely visible and reviewed** in the clinical record. ☐ Care coordination **processes are monitored** to ensure that **documentation from external providers is incorporated into care planning.** ☐ 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:** ☐ **Routine electronic sharing** of integrated care plans, co-occurring clinical notes and other information is part of the clinical record. ☐ **Interdisciplinary team uses technology** to communicate seamlessly between service visits, assigning just-in-time action steps to enhance adherence and activation. ☐ **Organizational culture and associated policies and procedures support uniform consent** for open communication between PH and BH providers working as a team. ☐ There are **regular in-person, phone or virtual meetings or email exchanges** to discuss complex co-occurring cases. ☐ Co-occurring treatment providers are **routinely informed (usually electronically) of significant treatment events or changes** (e.g., ER visit, hospitalization, medication change).

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
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)**
5. Interdisciplinary Teamwork	**5.3 Integrated care team training and competency development.** "Training" as used here can occur in a classroom setting or during workflows or team meetings/huddles. 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. ☐ **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. ☐ **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. ☐ **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:** ☐ **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. ☐ **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. ☐ **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 →			
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)**
6. Systematic quality improvement	**6.1 . Use of quality metrics for improvement of integrated services.** **Quality improvement (QI) process include:** • Measure and report integration metrics. • Demonstrate improvement in integration metrics. • Demonstrate improvement in integrated care disparities that affect marginalized populations. 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. ☐ If present, QI processes **do not meet** criteria for Screening and Enhanced Referral stage. ☐ **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. ☐ QI process includes a method for **soliciting input from people served.** ☐ **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. ☐ QI process **results in measurable improvement of one or two metrics.** ☐ **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:** ☐ 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. ☐ The QI process includes **a mechanism for involving an interdisciplinary QI team.** ☐ 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. ☐ 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. ☐ Routine QI **processes result in measurable improvement in the tracked metrics.** ☐ **Routine QI efforts track and improve at least one potential disparity in the above metrics** related to underserved populations.	**STAGE 2, PLUS:** ☐ PH/BH improvement of **PROCESS and OUTCOME improvements for individuals, cohorts and populations are routinely incorporated** into organizational QI processes. ☐ **Routine QI processes** include identified integration teams and champions and systematic input at least quarterly from people receiving services. ☐ There is **ongoing, systematic monitoring of at least two POPULATION OUTCOME metrics** related to PH/BH integration. ☐ 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. ☐ **Routine QI processes** result in measurable improvement of the **above metrics.** ☐ **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 →			
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)**
7. Community interventions to address social determinants of health (SDOH)	**7.1 Leveraging community services to reduce SDOH impact on BH and PH.** Community interventions include establishing connections to social services and resources designed to address the impact of SDOH. 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. 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.** ☐ **Referrals for identified issues are routinely made** to relevant social service agencies. ☐ F/u and referral coordination **do not meet** criteria for Care Management and Consultation stage. ☐ Interagency arrangements with commonly used social service agencies, if present, **do not meet** criteria for Care Management and Consultation stage.	**STAGE 1, PLUS:** ☐ There is routine SDOH **screening for two or three issues.** ☐ Care management interventions by treatment team **routinely include direct efforts to assist with at least one identified SDOH issue.** ☐ Written or otherwise formalized **collaboration agreements are in place with at least one commonly used social service agency.** ☐ 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:** ☐ There is routine SDOH **screening for three or more issues.** ☐ Care management interventions by the treatment team **routinely include assisting with multiple identified SDOH issues.** ☐ Written **collaboration agreements are in place with enough agencies to assist all populations who may screen positive** for any of the SDOH needs. ☐ 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. ☐ **Care coordination planning meetings occur routinely,** when indicated, with "complex care" partners sharing responsibility for people served. ☐ 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. ☐ 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 →			
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)**
8. Financial and administrative sustainability	**8.1 Financial sustainability.** Development of processes that support cost efficiencies, reimbursement and demonstration of value to achieve financial sustainability of integration efforts. 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. 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. 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. ☐ Payment for integrated health services is **limited mainly to one-time grant or gift funding opportunities that target specific services, staff types or populations.** ☐ There is **limited expertise** in any billing or reimbursement opportunities for integrated health activities, including Screening and Enhanced Referral. ☐ 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. ☐ **Collaboration discussions** regarding shared value have been initiated **with at least one provider or payer** for which improving integration would produce measurable value. ☐ **Workflows and staff roles are optimized** to deliver Screening and Enhanced Referral services efficiently. ☐ There is **expertise in and routine processes for fee-for-service billing** and receiving reimbursement for providing Screening and Enhanced Referral interventions. ☐ Routine process is in place for **tracking and improving reimbursement** for integrated PH/BH services provided.	**STAGE 1, PLUS:** ☐ Finance and clinical staff **actively collaborate** in organized QI processes (Domain 6) for ongoing development of sustainable integration. ☐ 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.** ☐ **Landscape analysis** of all available reimbursement or billing opportunities for Care Management and Consultation has been conducted. ☐ Integration QI team **optimizes workflows and staff** roles to deliver Care Management and Consultation services efficiently. ☐ 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. ☐ There is a demonstrated ability (either directly or through partners) to **bill and collect reimbursement for services by consulting providers with the "other" license.** ☐ **At least 50% of costs** of all integration processes and services provided are covered by generated revenue or other sustainable sources.	**STAGE 2, PLUS:** ☐ 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. ☐ 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). ☐ There is a demonstrated ability to **continuously improve workflow optimization and track cost** relevant to improving population PH/BH outcomes. ☐ 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. ☐ **At least 70% of costs** of all integrated services provided are covered by generated revenue and incentive payments.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
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)**
8. Financial and administrative sustainability	**8.2 Administrative Sustainability.** Enhancement of policies and procedures to support capacity to deliver integrated services in the context of existing provider/program licensure rules and regulations. 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. 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. 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. ☐ 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.** ☐ 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:** ☐ 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.** ☐ 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.** ☐ There are **established procedures for documentation** of internal consultation or service provision by a provider with the "other" license. ☐ 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:** ☐ 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. ☐ 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. ☐ 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.

Appendix 1: CHI Framework Self-Assessment Scoring and Notes Worksheet

Introduction

CHI Framework Self-Assessment Scoring and Notes Template is designed to support your team in assessing each subdomain within a specific domain of the CHI Framework. This template allows you to track detailed progress, document important observations and identify areas for improvement as part of your self-assessment process.

For each subdomain, teams will:

- Identify the highest integration stage achieved and, if applicable, whether early or late progress has been made toward the next stage.
- Provide a brief explanation of why the team selected the identified stage and reflect on key learnings from the discussion.
- Record additional comments, important discoveries from the discussion, priorities for action or improvement and any parking lot items that may require further exploration.

Reminder: To meet the criteria for a given stage, all bullets for that stage must be completed. If a subdomain has not fully met the criteria for Stage 1, it should be scored as Stage 0. Refer to the scoring instructions for marking early or late progress toward the next stage.

This template can be used in conjunction with the Scoring and Planning for Advancement Tracker to provide a comprehensive view of both your current progress and future goals for integration.

This template is intended to be used for each subdomain in a domain, ensuring a structured and thorough review of your program's level of integratedness. If additional space is needed for your responses and notes, feel free to use a separate sheet of paper.

CHI FRAMEWORK SELF-ASSESSMENT SCORING AND NOTES WORKSHEET FOR DOMAIN 1

INSTRUCTIONS:This page is completed for each subdomain in Domain 1 .

REMINDER: For a subdomain to meet criteria for a stage, all bullets in that stage must be met. If Stage 1 is not fully met, score Stage 0 for that subdomain. See instructions for scoring early or late progress on the next higher stage on any subdomain.

1. Screening, referrals and follow-up		
	Q. IDENTIFY HIGHEST STAGE ACHIEVED, AND — IF DESIRED — WHETHER EARLY OR LATE PROGRESS HAS BEEN ACHIEVED ON THE NEXT HIGHER STAGE.	1.1
		1.2
	Q. PLEASE BRIEFLY DESCRIBE WHY YOUR TEAM SELECTED THIS STAGE AND/OR WHAT YOU LEARNED ABOUT THIS SUBDOMAIN.	1.1
		1.2
	COMMENTS ABOUT THE SUBDOMAIN SCORE(S):	
	IMPORTANT DISCOVERIES FROM THE DISCUSSION:	
	PRIORITIES FOR ACTION OR IMPROVEMENT:	
	PARKING LOT ITEMS.	

If you need additional space for your responses, please feel free to use a separate sheet of paper to complete your assessment.

CHI FRAMEWORK SELF-ASSESSMENT SCORING AND NOTES WORKSHEET FOR DOMAIN 2

INSTRUCTIONS:This page is completed for each subdomain in Domain 2.

REMINDER: For a subdomain to meet criteria for a stage, all bullets in that stage must be met. If Stage 1 is not fully met, score Stage 0 for that subdomain. See instructions for scoring early or late progress on the next higher stage on any subdomain.

2. Integrated prevention and treatment	Q. IDENTIFY HIGHEST STAGE ACHIEVED, AND – IF DESIRED – WHETHER EARLY OR LATE PROGRESS HAS BEEN ACHIEVED ON THE NEXT HIGH-ER STAGE. IDENTIFY HIGHEST STAGE	**2.1**
		2.2
		2.3
		2.4
	Q. PLEASE BRIEFLY DESCRIBE WHY YOUR TEAM SELECTED THIS STAGE AND/ OR WHAT DID YOU LEARN ABOUT THIS SUBDOMAIN?	**2.1**
		2.2
		2.3
		2.4
	COMMENTS ABOUT THE SUBDOMAIN SCORE(S):	
	IMPORTANT DISCOVERIES FROM THE DISCUSSION:	
	PRIORITIES FOR ACTION OR IMPROVEMENT:	
	PARKING LOT ITEMS.	

If you need additional space for your responses, please feel free to use a separate sheet of paper to complete your assessment.

CHI FRAMEWORK SELF-ASSESSMENT SCORING AND NOTES WORKSHEET FOR DOMAIN 3

INSTRUCTIONS:This page is completed for each subdomain in Domain 3.

REMINDER: For a subdomain to meet criteria for a stage, all bullets in that stage must be met. If Stage 1 is not fully met, score Stage 0 for that subdomain. See instructions for scoring early or late progress on the next higher stage on any subdomain.

3. Ongoing care coordination	Q. IDENTIFY HIGHEST STAGE ACHIEVED, AND – IF DESIRED – WHETHER EARLY OR LATE PROGRESS HAS BEEN ACHIEVED ON THE NEXT HIGHER STAGE.	**3.1**
	Q. PLEASE BRIEFLY DESCRIBE WHY YOUR TEAM SELECTED THIS STAGE AND/ OR WHAT DID YOU LEARN ABOUT THIS SUBDOMAIN?	**3.1**
	COMMENTS ABOUT THE SUBDOMAIN SCORE(S):	
	IMPORTANT DISCOVERIES FROM THE DISCUSSION:	
	PRIORITIES FOR ACTION OR IMPROVEMENT:	
	PARKING LOT ITEMS.	

If you need additional space for your responses, please feel free to use a separate sheet of paper to complete your assessment.

CHI FRAMEWORK SELF-ASSESSMENT SCORING AND NOTES WORKSHEET FOR DOMAIN 4

INSTRUCTIONS:This page is completed for each subdomain in Domain 4.

REMINDER: For a subdomain to meet criteria for a stage, all bullets in that stage must be met. If Stage 1 is not fully met, score Stage 0 for that subdomain. See instructions for scoring early or late progress on the next higher stage on any subdomain.

4. Personalized self-management support	Q. IDENTIFY HIGHEST STAGE ACHIEVED, AND – IF DESIRED – WHETHER EARLY OR LATE PROGRESS HAS BEEN ACHIEVED ON THE NEXT HIGHER STAGE.	**4.1**
	Q. PLEASE BRIEFLY DESCRIBE WHY YOUR TEAM SELECTED THIS STAGE AND/ OR WHAT DID YOU LEARN ABOUT THIS SUBDOMAIN?	**4.1**
	COMMENTS ABOUT THE SUBDOMAIN SCORE(S):	
	IMPORTANT DISCOVERIES FROM THE DISCUSSION:	
	PRIORITIES FOR ACTION OR IMPROVEMENT:	
	PARKING LOT ITEMS.	

If you need additional space for your responses, please feel free to use a separate sheet of paper to complete your assessment.

CHI FRAMEWORK SELF-ASSESSMENT SCORING AND NOTES WORKSHEET FOR DOMAIN 5

INSTRUCTIONS:This page is completed for each subdomain in Domain 5.

REMINDER: For a subdomain to meet criteria for a stage, all bullets in that stage must be met. If Stage 1 is not fully met, score Stage 0 for that subdomain. See instructions for scoring early or late progress on the next higher stage on any subdomain.

5. Interdisciplinary Teamwork	Q. IDENTIFY HIGHEST STAGE ACHIEVED, AND – IF DESIRED – WHETHER EARLY OR LATE PROGRESS HAS BEEN ACHIEVED ON THE NEXT HIGHER STAGE.	**5.1**
		5.2
	IDENTIFY HIGHEST STAGE	**5.3**
	Q. PLEASE BRIEFLY DESCRIBE WHY YOUR TEAM SELECTED THIS STAGE AND/ OR WHAT DID YOU LEARN ABOUT THIS SUBDOMAIN?	**5.1**
		5.2
		5.3
	COMMENTS ABOUT THE SUBDOMAIN SCORE(S):	
	IMPORTANT DISCOVERIES FROM THE DISCUSSION:	
	PRIORITIES FOR ACTION OR IMPROVEMENT:	
	PARKING LOT ITEMS.	

If you need additional space for your responses, please feel free to use a separate sheet of paper to complete your assessment.

CHI FRAMEWORK SELF-ASSESSMENT SCORING AND NOTES WORKSHEET FOR DOMAIN 6

INSTRUCTIONS:This page is completed for each subdomain in Domain 6.

REMINDER: For a subdomain to meet criteria for a stage, all bullets in that stage must be met. If Stage 1 is not fully met, score Stage 0 for that subdomain. See instructions for scoring early or late progress on the next higher stage on any subdomain.

6. Systematic quality improvement	Q. IDENTIFY HIGHEST STAGE ACHIEVED, AND – IF DESIRED – WHETHER EARLY OR LATE PROGRESS HAS BEEN ACHIEVED ON THE NEXT HIGHER STAGE.	**6.1**
	Q. PLEASE BRIEFLY DESCRIBE WHY YOUR TEAM SELECTED THIS STAGE AND/ OR WHAT DID YOU LEARN ABOUT THIS SUBDOMAIN?	**6.1**
	COMMENTS ABOUT THE SUBDOMAIN SCORE(S):	
	IMPORTANT DISCOVERIES FROM THE DISCUSSION:	
	PRIORITIES FOR ACTION OR IMPROVEMENT:	
	PARKING LOT ITEMS.	

If you need additional space for your responses, please feel free to use a separate sheet of paper to complete your assessment.

CHI FRAMEWORK SELF-ASSESSMENT SCORING AND NOTES WORKSHEET FOR DOMAIN 7

INSTRUCTIONS:This page is completed for each subdomain in Domain 7.

REMINDER: For a subdomain to meet criteria for a stage, all bullets in that stage must be met. If Stage 1 is not fully met, score Stage 0 for that subdomain. See instructions for scoring early or late progress on the next higher stage on any subdomain.

7. Community interventions to address social determinants of health (SDOH)		
	Q. IDENTIFY HIGHEST STAGE ACHIEVED, AND – IF DESIRED – WHETHER EARLY OR LATE PROGRESS HAS BEEN ACHIEVED ON THE NEXT HIGHER STAGE.	**7.1**
	Q. PLEASE BRIEFLY DESCRIBE WHY YOUR TEAM SELECTED THIS STAGE AND/ OR WHAT DID YOU LEARN ABOUT THIS SUBDOMAIN?	**7.1**
	COMMENTS ABOUT THE SUBDOMAIN SCORE(S):	
	IMPORTANT DISCOVERIES FROM THE DISCUSSION:	
	PRIORITIES FOR ACTION OR IMPROVEMENT:	
	PARKING LOT ITEMS.	

If you need additional space for your responses, please feel free to use a separate sheet of paper to complete your assessment.

CHI FRAMEWORK SELF-ASSESSMENT SCORING AND NOTES WORKSHEET FOR DOMAIN 8

INSTRUCTIONS:This page is completed for each subdomain in Domain 8.

REMINDER: For a subdomain to meet criteria for a stage, all bullets in that stage must be met. If Stage 1 is not fully met, score Stage 0 for that subdomain. See instructions for scoring early or late progress on the next higher stage on any subdomain.

8. Financial and administrative sustainability	Q. IDENTIFY HIGHEST STAGE ACHIEVED, AND – IF DESIRED – WHETHER EARLY OR LATE PROGRESS HAS BEEN ACHIEVED ON THE NEXT HIGHER STAGE.	8.1
		8.2
	Q. PLEASE BRIEFLY DESCRIBE WHY YOUR TEAM SELECTED THIS STAGE AND/ OR WHAT DID YOU LEARN ABOUT THIS SUBDOMAIN?	8.1
		8.2
	COMMENTS ABOUT THE SUBDOMAIN SCORE(S):	
	IMPORTANT DISCOVERIES FROM THE DISCUSSION:	
	PRIORITIES FOR ACTION OR IMPROVEMENT:	
	PARKING LOT ITEMS.	

If you need additional space for your responses, please feel free to use a separate sheet of paper to complete your assessment.

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 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					