COMPREHENSIVE HEALTH INTEGRATION (CHI) FRAMEWORK

White Paper

Roadmap to Design, Implement, and Sustain Physical Health–Behavioral Health Integration

Second Edition

NATIONAL COUNCIL for Mental Wellbeing

CENTER OF EXCELLENCE
for Integrated Health Solutions

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Preamble:

About the National Council for Mental Wellbeing and the Medical Director Institute

The National Council for Mental Wellbeing is a membership organization that drives policy and social change on behalf of more than 3,400 mental health and substance use treatment organizations and the more than 10 million children, adults and families they serve. The National Council established the Medical Director Institute (MDI), which convenes medical directors from member organizations to contribute their expertise on clinical practices and policy priorities to enhance mental health and substance use services. Each year, the MDI establishes priorities and develops a publication and supporting resources to help advance the field. Previous topics have included access to psychiatric care, adherence to medications and mass violence and mental health.

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I. Glossary of Abbreviations

BH	behavioral health	**MDI**	Medical Director Institute
BHC	behavioral health consultant	**NCQA**	National Committee for Quality Assurance
BPCR	Bipartisan Policy Center report	**NQF**	National Quality Forum
CCBHC	Certified Community Behavioral Health Clinic	**OUD**	opioid use disorder
CHI	comprehensive health integration	**PCP**	primary care provider
CHW	community health worker	**PH**	physical health
CMHC	community mental health center	**PHI**	protected health information
CMS	Centers for Medicare and Medicaid Services	**PMPM**	per member per month
CoCM	collaborative care model	**PPS**	prospective payment system
CPT	current procedural terminology	**QI**	quality improvement
EHR	electronic health record	**SAMHSA**	Substance Abuse and Mental Health Services Administration
FQHC	Federally Qualified Health Center	**SBIRT**	Screening, Brief Intervention and Referral to Treatment
GHI	general health integration	**SDOH**	social determinants of health
HEDIS	Healthcare Effectiveness Data and Information Set	**SMI**	serious mental illness
HTN	hypertension	**SUD**	substance use disorder
MCO	managed care organization	**VBP**	value-based payment

II. Executive Summary

PURPOSE OF THIS PAPER

This paper presents the Comprehensive Health Integration (CHI) Framework, a tool to guide implementation of physical health (PH) and behavioral health* (BH) integration, which can help providers, payers and population managers measure progress in organizing delivery of integrated services — referred to in this report as "integratedness." It also can demonstrate the value produced by progress in integrated service delivery and provide initial and sustainable financing for integration. "Integration" as used herein also includes attention to social determinants of health (SDOH) and health equity for underserved populations.

This paper uses "person-centered" definitions:

- **Integrated services:** In any PH or BH setting, the provision and coordination by the treatment team of appropriately matched interventions for both PH and BH conditions, along with attention to SDOH, in the setting in which the person is most naturally engaged.
- **Bidirectional integration:** Integration of PH services into BH settings and vice versa.

The CHI Framework is intended to advance beyond current commonly used frameworks, such as SAMHSA's Six Levels and the Integrated Practice Assessment Tool, and to guide bidirectional integration. It is applicable to child and adult populations, small and large providers, rural and urban locations and organizations with varying levels of resources.

WHAT'S NEW IN THE SECOND EDITION

Since the release of the original white paper in 2022, the Center of Excellence for Integrated Health Solutions at the National Council for Mental Wellbeing has conducted two evaluation learning communities to explore the feasibility of using CHI Framework, as well as to gather input for improving the framework's utility. One learning community included 13 providers from across the nation, involving multiple adult and child PH and BH clinics. The second learning community involved multiple CCBHC providers from Texas and Kansas, as well as several county health departments in Kansas. The CHI Framework proved to be a valuable tool. The input received led to the creation of the revised CHI Framework, in which the scoring indicators for each subdomain are bulleted and more clearly measurable, as well as a Self-assessment Guide for how to organize a continuous quality improvement (QI) team and score the CHI Framework, and a Definitions and Examples Handbook for reference during the process. The term "constructs" was updated to "stages" throughout. This second edition uses the updated terminology and references the revised CHI materials. This will allow users to apply the CHI Framework much more successfully, to improve PH/BH integration in their programs, practices, provider organizations and systems of care.

WHY NOW?

During the past several decades, understanding of integration has progressed considerably, including research defining different methods or models of service delivery, research delineating tools and procedures that support these models, and evidence demonstrating improved outcomes and value for diverse populations.

The evidence strongly suggests that people of all ages living with co-occurring PH, BH and SDOH needs have higher health costs, yet they experience poorer health outcomes. Additionally, these individuals and families are faced with significant inequities based on racial, ethnic and economic challenges in both PH and BH settings and are likely to benefit from evidence-based, integrated interventions in whatever setting they are best engaged, with more complex and high-cost populations generally requiring higher levels of service intensity.

**This term encompasses mental health and substance use conditions.*

Nonetheless, despite extensive progress in recognizing the value of integrated services and demonstrating approaches for implementation, broad uptake of integrated services for people with co-occurring PH/BH/SDOH needs remains much more limited than the need for those services would suggest.

The CHI Framework addresses the following implementation barriers:

- **Lack of flexibility in implementation of integrated services.**
- **Lack of appropriate bidirectional measures of integratedness.**
- **Lack of metrics connecting progress in integratedness to value.**
- **Lack of financing to support either implementation or sustainability.**

THE CHI FRAMEWORK: CHARTING A PATH FORWARD

The new CHI Framework concretely addresses the barriers mentioned above. It is an adaptation and expansion of the previously published General Health Integration (GHI) Framework for BH organizations (Chung et al., 2020). In CHI, there are eight evidence-based domains of integration processes or services, applicable to both PH and BH settings and to adult, adolescent and child populations. Measurement of progress across the domains correlates to three "integration stages," each of which demonstrates value. The CHI Framework can function as a measurement tool for integratedness that permits practices, programs and provider organizations to delineate to themselves, payers and population managers their progress in delivering integrated services to people receiving services. (See Characteristics of the CHI Framework on page 51.)

The Eight Domains of Integration

Available evidence on the contributors to successful integrated service delivery was used to create eight domains of integratedness that guide service design. These domains incorporate best practices and are designed to be consistent with a wide range of integrated service models.

Each of these broad domains specifically addresses PH, BH and SDOH issues 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 domain and subdomain, the CHI Framework adds four columns, ranging from historical practice through the three progressive integration stages, each with specific markers for achievement of the standard in that stage. (See example on page 15.)

Definition of Value:

Measurable improvement in individual or population health, BH or PH outcome measures and/or increased equity and quality in relation to expenditure.

The CHI Framework helps PH and/or BH providers measure and improve integratedness across one or more domains using continuous QI.

The Three Integration Stages

The integration stages provide guidance on achieving benchmarks of progress, while still permitting flexibility in the implementation process. Each stage describes an organized approach with several evidence-based or consensus-supported core service elements for integratedness that can be implemented flexibly, depending on the capabilities of a provider organization. The three stages are:

- **Screening and Enhanced Referral**
- **Care Management and Consultation**
- **Comprehensive Treatment and Population Management**

The names of the stages describe the primary integratedness workflows that the successful provider organization implements within one or more of the domains. The stages allow a provider organization to select one or more of the domains for a focused effort to advance its integration state, and to identify one or more issues or conditions for which metrics can be selected to demonstrate the value of the integrated services provided. The optimal choice of a specific stage will vary by a particular organization's current development, resources, capacity and incentives.

Specific implementation examples of the three integration stages can be found in Appendix 6, Table and Charts of Integrated Programs and Measures, on page 75.

Using the CHI Framework: Improving Integratedness

Measuring integratedness using the domains of the CHI Framework allows organizations to demonstrate progress in implementation of the stages, which can guide identification of improvement targets and objectives (for providers) and provide objective indication of implementation success (for payers and regulators).

For a description of the recommended steps, see Appendix 4, Getting Started With the CHI Framework: Self-assessment and Planning for Change and Implementation, on page 69. Additionally, refer to the CHI Definitions and Examples Handbook for further clarification of key terms and examples that support the proper application of the framework.

Integration Stages: Demonstrating Value

The key connection between integratedness, the three stages and payment is that each integration stage incorporates an organized set of integrated services and metrics with the capacity to demonstrate value. The CHI Framework provides the opportunity to demonstrate to population managers or payers the value produced by addressing key PH/BH/SDOH conditions for the population served within each stage.

The measurable indicators of integratedness help a provider organization and each of its component programs to identify one or more co-occurring conditions and/or populations to address through integrated service delivery. Organizations can then demonstrate the value of those integrated services in each program, through ongoing measurement and reporting on the relevant outcome metrics for those conditions in the populations receiving integrated services within that stage.

Each of the three stages relies on a different set of the eight domains to achieve integratedness and create value. For each stage, it is necessary to define how value is produced and what metrics are used to demonstrate value, as detailed in Section VI, Integrated Services and Integration Stages: Financing Implementation and Sustainability.

Integrated Services and Integration Stages: Financing Implementation and Sustainability

This section of the report examines how the value produced by each stage is connected to financing the implementation and sustainability of that stage. First, it looks at the two types of financing goals:

- **Financing implementation:**
  - Initial implementation or strengthening of an integration stage.
  - Incentivizing progress from one stage to the next.
- **Financing sustainability:**
  - Financing or payment methodologies that provide continued support for maintaining current provision of a specific integration stage for a particular set of issues in a defined population.

This section then goes on to present three broad categories of payment methodologies (also summarized in Appendix 5 on page 71):

- **Current procedural terminology (CPT) service code payments (usually fee-for-service)**
- **Care enhancement payments (usually per-member per-month or prospective payment)**
- **Value-based payments (VBPs)**

All financing and payment methodologies are tied to value produced, and each payment methodology can be used to incentivize implementation. For each integration stage there is a payment methodology, justified by the value produced, that is particularly suited for its sustainability.

This section closes by matching payment methodologies to the implementation and sustainability of each stage.

RECOMMENDATIONS

The CHI Framework represents a significant step forward in guiding broad dissemination and implementation of integrated services. It provides a common language to guide the next generation of implementation research. Our Expert Panel recommends broad adoption of the CHI Framework to guide implementation, dissemination and sustainability of integrated service delivery nationwide, as well as to build the future knowledge base.

Providers (individual PH and/or BH provider organizations) should utilize the CHI Framework to:

- **Measure their current baseline state of integratedness.**
- **Identify their next steps regarding their chosen integration stage(s).**
- **Delineate relevant metrics for demonstrating value.**
- **Define a QI process to achieve their integratedness targets.**

Providers should improve their ability to measure performance and costs related to integratedness, not only to improve performance, but to have the ability and confidence to contract with payers using the payment methodologies described in this white paper.

Collectively, providers, provider networks and provider associations should advocate for public and private payers and policymakers to adopt the CHI Framework to create a common language for improving integration.

Payers (public or private, including grantmakers) should formally recommend the CHI Framework for measuring integratedness and demonstrating value across their networks. Payers and grantmakers should:

- **Partner with their provider networks and grantees to delineate the current baseline state of integratedness.**
- **Identify recommended targets for improvement.**
- **Outline implementation of specific elements within the CHI Framework to improve the health of the populations served.**
- **Define appropriate consensus metrics for accountability, value and outcomes.**

Payers should implement both initial implementation funding and, where applicable, sustainable reimbursement to support providers in making progress using the CHI Framework. They should support startup costs for achieving desired integration stages, as well as provide for sustainability through reimbursement of support services with CPT codes and building a VBP foundation, including bundled payments that reflect all provider costs. Payers should strengthen their oversight by training management staff on the CHI Framework and best practices. Network management can include training of providers in the CHI Framework and how to use the framework to improve the delivery of integrated care.

Policymakers should adopt the CHI Framework as a guide for measuring and implementing progress in integrated service delivery for payers and providers at the state and local level. The CHI Framework should be used to guide policy development and published regulations to support progress through the domains and stages, to make it easier to align reimbursement mechanisms for integration activities. The Centers for Medicare and Medicaid Services should review the degree to which existing regulations support or inhibit implementation of the CHI Framework, and then reduce existing billing prohibitions and site limitations for certain services. Federal and national entities such as the National Quality Forum should simplify the many measurements of health care services by selecting key measures of integration aligned with the eight domains and three integration stages.

III. Introduction

PURPOSE OF THIS PAPER

This paper presents the Comprehensive Health Integration (CHI) Framework, which has been designed to advance the integration of physical health (PH) and behavioral health (BH) services across the nation. This framework can help providers, payers and population managers measure progress in organizing delivery of integrated services — referred to in this report as "integratedness" — demonstrating the value produced by improving integrated service delivery and providing initial and sustainable financing for integrated services.

Although "integration" can refer to many aspects of health and human services, in this paper the term is used exclusively to refer to integration of PH and BH. PH refers to primary and specialty medical services for all types of physical health conditions for adults and/or children and adolescents, and BH refers to services for mental health and/or substance use conditions. Integration as used herein also includes attention to social determinants of health (SDOH) and health equity for underserved or marginalized populations.

Further, this paper uses person-centered definitions of "integrated services" and "integrated programs."

Key Definitions

Integrated Services: In any PH or BH setting, the provision and coordination by the treatment team of appropriately matched interventions for both PH (including dental) and BH conditions.

Integrated Program: One that is organized so that all people receiving services have access to a comprehensive array of integrated services and interventions (including primary and secondary prevention) for their PH and BH needs.

Integratedness: The degree to which programs are organized to deliver integrated PH and BH prevention and treatment services to individuals or populations, as well as to address SDOH. Integratedness is a measure of development of both structural components (e.g., staffing) and care processes (e.g., screening) that support the extent to which integrated services in PH or BH settings are directly experienced by people receiving services and delivered by service providers.

Exclusions

"Integration" as used here is not produced or defined by:

- Consolidating separate funding for PH and BH care.
- Putting PH and BH services under the same lines of authority in the organizational chart.
- Co-locating PH and BH services in the same building.
- Contracting with a managed care organization (MCO) to manage both PH and BH services.

None of the above is either necessary or sufficient to produce meaningfully integrated services. Policymakers and payers should not assume that, if they consolidate funding and authority at either the payer or provider level, integration will automatically occur due to market forces.

The CHI Framework builds on and advances comprehensive application of previously used frameworks:

- **The Four Quadrant Model** provides a framework for integrating BH and primary care services, outlining key challenges and opportunities for state mental health authorities (Parks & Pollack, 2005).
- **SAMHSA's Six Levels of Collaboration/Integration** offers a structured guide for assessing integration in health care settings (Center for Integrated Health Solutions [CIHS], 2020).
- **The Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration (OATI)** can be useful for evaluating the integration of care (CIHS, 2014).
- **The Behavioral Health Integration Capacity Assessment (BHICA)** offers another useful tool for assessing integration capacity. (CIHS, 2014).
- **The Integrated Practice Assessment Tool (IPAT)** provides a framework for evaluating integrated practices. (Waxmonsky et al., 2019).
- **Agency for Healthcare Research and Quality's Framework for Measuring Integration of Behavioral Health and Primary Care** provides useful insights into integration measurement (2019).
- **The Site Self-assessment Evaluation Tool** supports integration efforts for the Maine Health Access Foundation (MeHAF) initiative (Scheirer et al., 2010).
- **National Committee for Quality Assurance's (NCQA) Distinction in Behavioral Health Integration** includes a self-assessment tool and process for improving integration for practices with existing person-centered medical home accreditation (2017).
- **Behavioral Health Integration (BHI) Framework** focuses on primary care integration in BH settings using a continuum-based model (Chung et al., 2019).
- **General Health Integration (GHI) Framework** focuses on integrating general health services into BH settings using a continuum-based model (Chung et al., 2020).

The CHI Framework is intended to be responsive to the aspirations, concerns and challenges facing people served, providers, public/private payers and population health managers with regard for how to best meet the needs of individuals with complex PH, BH and SDOH challenges in a clinically effective and cost-effective manner.

Definition

Comprehensive Health Integration (CHI) Framework

The CHI Framework is an adaptation and expansion of the previously published Evaluation of a Continuum-based Behavioral Health Integration Framework Among Small Primary Care Practices in New York State (Chung et al., 2019) and Advancing Integration of General Health into Behavioral Health Settings: A Continuum-based Framework (Chung et al., 2020). In CHI, the eight evidence-based GHI domains have been updated to be applicable to both PH and BH settings and to both adult and child populations, and measurement of progress has been organized through defining three "integration stages," with performance metrics that provide opportunities to demonstrate value. The CHI Framework is a measurement tool for integratedness that permits practices, programs and provider organizations to delineate to themselves, payers and population managers their progress in delivering integrated care to people receiving services.

The purpose of the CHI Framework is to establish a broad and practical framework to guide bidirectional integration (integration of PH into BH settings and BH into PH settings), as well as be applied and/or adapted to child and adult populations, small and large providers, rural and urban locations, and organizations with varying levels of resources.

WHY NOW?

During the past several decades, understanding of PH/BH integration has progressed considerably, through research defining different methods or models of service delivery, research delineating tools and procedures that support these models, evidence demonstrating improved outcomes and value for diverse populations and in multiple settings, and expanded understanding of both facilitators and barriers to implementation of integrated services in different types of programs, practices and organizations.

The evidence strongly suggests that people of all ages living with co-occurring PH, BH and SDOH needs have higher health care costs yet experience poorer health outcomes. Additionally, these people receiving services and their families are faced with significant inequities based on racial, ethnic and economic challenges in both PH and BH settings. Emerging evidence suggests that more coordinated or integrated oral, mental health and substance use treatment services can increase access to care, improve outcomes and potentially reduce health care costs (Bowling & Matulis, 2020). The evidence further suggests that populations with co-occurring PH, BH and SDOH needs are likely to benefit from evidence-based integrated interventions in whatever setting they are best engaged, with more complex and high-cost populations generally requiring higher levels of service intensity. As one example, people with serious mental illness (SMI) who have unmet PH needs can achieve demonstrably improved health outcomes if evidence-based PH interventions are integrated into BH service settings (Cook et al., 2021). Further, numerous projects have demonstrated successful implementation of various types of integrated services and programs in a variety of PH and BH practice settings, systems and populations, such as SAMHSA's Primary Care Behavioral Health Integration grant programs and Missouri's Healthcare Home model (Parks et al., 2014; Cook et al., 2021).

Nonetheless, despite extensive progress in recognizing the value of integrated services and demonstrating approaches for implementation, broad uptake of integrated services for people with co-occurring PH/BH/SDOH needs remain much more limited than the need for those services — and the human and financial costs of not providing those services — would suggest.

A recent Bipartisan Policy Center report (BPCR) recognized policy barriers that prevent the advancement of integrated care, along with recommendations to address those barriers (Barton et al., 2021). The CHI Framework presented in this paper provides more specific guidance to address many barriers identified by the BPCR:

- **Define a set of core service elements necessary for provision of integrated PH and BH services.**
- **Identify a set of standardized quality and performance metrics for programs integrating PH and BH services.**
- **Incentivize Certified Community Behavioral Health Clinics (CCBHCs) and Federally Qualified Health Centers (FQHCs) to strengthen integration of PH and BH services.**
- **Incentivize Medicaid and Medicare (including through contracted MCOs) to strengthen funding and regulation that supports support implementation and sustainability of integrated PH and BH services.**
- **Develop core integrated care measures and ensure accountability, particularly with respect to health disparities.**

This paper endorses the BCPR's broad policy guidance. The CHI Framework addresses the following policy and implementation barriers identified in the BCPR:

- **Lack of flexibility in implementation of integrated services:** Many grant-funded PH/BH implementation projects require specific evidence-based models to be implemented with fidelity. However, sustainability is difficult once the grant or other special funding ends, because adequate continuing financing and reimbursement are not available. Further, improving integratedness requires a significant cultural adaptation — and significant non-billable time and resource commitment to achieve that adaptation — among clinicians and administrators in most PH and BH organizations. In addition, "fidelity to model" implementation can be challenging because provider configurations vary greatly by geography, payer mix and payment options, as well as federal, state and other regulatory support. There is a need for pathways for improving integrated services that are both specific enough to operationalize and flexible enough to adapt to each organization's resources and populations served.

- **Lack of appropriate, evidence-based, bidirectional measures of progress in integration:** While there are existing tools for measuring progress in integration — such as SAMHSA's Six Levels (CIHS, 2020), the Integrated Practice Assessment Tool (Michigan Health Endowment Fund, 2019), the Organizational Assessment Toolkit (CIHS, 2014), the Site Self-assessment Evaluation Tool (Scheirer et al., 2010) and the Behavioral Health Integration Capacity Assessment (Resources for Integrated Care, 2014) — these tools may not fully capture bidirectional measures of progress in integratedness. The CHI Framework presented in this paper provides more specific guidance — for all types of physical health and behavioral health settings — than the tools previously available.

- **Lack of connection of integratedness to value:** Existing tools for measuring integratedness do not include measurable indicators that document progress while also tracking process and outcome metrics relevant to demonstrating value. Thus, payers are reluctant to fully commit to investing in processes measured by these tools. Providers and payers may be focused on reporting on external requirements (e.g., Healthcare Effectiveness Data and Information Set [HEDIS] measures) that are not directly relevant to successful outcomes related to integration activities. Assignment of accountability for tracking metrics by responsible providers can also be unclear. For example, is a BH provider or PH provider responsible for monitoring HbA1c for people receiving atypical antipsychotic medications when these individuals are assigned to primary care providers (PCPs) in risk-based relationships? Relevant metrics tied to the value of developing integrated services for defined populations in each type of PH and BH setting are needed in order to demonstrate value and justify payment.

- **Lack of financing to support either implementation or sustainability:** While there is growing policy support for integration, opportunities for sustainable operations remain limited. For example, transitory grant funding, low reimbursement rates and lack of an all-payer reimbursement approach have resulted in limited use of the Collaborative Care Model (CoCM) codes that can pay for the evidence based CoCM care coordination, consultation and service packages (Phelps et al., 2020). Complex documentation requirements for billing of screening, care management and care coordination activities, in addition to varying requirements among PH and BH payers and regulators, increase administrative costs and prevent providers from developing an efficient integrated services infrastructure. This may be especially true in settings serving children and adolescents. Further, currently available payment methodologies often cannot support the inclusion of important team members, such as certified peer specialists and community health workers (CHWs). Innovative funding models, like the prospective payment system (PPS) that can be used in certain state Medicaid programs to fund CCBHC implementation, have demonstrated value. (See Appendix 6, Table and Charts of Integrated Programs and Measures, on page 75.) However, these programs currently have limited reach and applicability. Improved methods are needed for all payers to finance both implementation efforts and sustainable integrated service provision in all types of settings.

CHARTING A PATH FORWARD

The new CHI Framework described in this paper supports broader efforts to improve integration by providing a structure for implementing integrated services and demonstrating the value of integrated services through relevant process and outcome metrics, as well as payment methodologies for improving and sustaining integrated services. Together, these elements translate to practical and progressive guidance for providers, payers and population managers and can thus guide improved performance of the system to better serve children, adolescents and adults with co-occurring PH, BH and SDOH needs and their families.

In the following sections of this paper, we will describe CHI Framework in more detail and show how it concretely addresses the barriers referenced earlier in this report.

Characteristics of the CHI Framework

- **Broad application to adult and child PH and BH settings:** Allows a range of providers to match community needs, payer priorities and organizational capacity to implement meaningful improvements regardless of size, stage of integration and type of payer. Can be applied to all settings and populations: PH/BH, adult/child, rural/urban.
- **Evidence-based domains of integration:** Available evidence on the contributors to successful integrated service delivery is used to create eight domains of integratedness 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.
- **Measurable standards for integration:** Define progressive and measurable "core service elements" for each of the eight domains that permit measurement of organizational progress.
- **Self-assessment tool:** Can be used to assess the current state of integration in a program/clinic, as well as to plan improvement and measure progress in integration.
- **Flexibility of achieving progress in integration:** Identifies three integration stages — each of which has the capacity to demonstrate value — in order to provide flexible targets of progress.
- **Connection of progress in integration to metrics demonstrating value:** Delineates metrics that can be used by providers to demonstrate value for each level of progress in integratedness (i.e., each integration stage) in a range of settings.

IV. The Comprehensive Health Integration Framework

The CHI Framework consists of eight evidence-based domains of integration and associated subdomains, along with stages of progressively advancing implementation elements by specific domain and subdomains (Chung et al., 2020; Chung et al., 2019; Chung et al., 2016).

The domains are evidence-based in that there is published evidence for most of the individual integration interventions within the eight domains, showing that each of the interventions that increases integration results in improved quality of care and/or outcomes. A general reading of the literature suggests that multicomponent models generally are more effective than single intervention models, but they are more difficult to implement with fidelity. Our expert consensus is that combining multiple integration interventions is highly likely to improve the quality of care and/or outcomes, as compared to relying on a single integration intervention.

Each domain represents structural and process elements within a program, practice or provider organization that support delivery of integrated care to people receiving services. (See Appendix 3 on page 51 for a full depiction of the revised CHI Framework tool and detailed descriptions of the eight domains.) The domains emphasize integrated service processes that are directly connected to the services that people experience. Progression in each domain or subdomain thus improves the integratedness of the program, practice or organization. Full definitions of the domains are in Appendix 2 on page 47.

Eight Domains of Integration

All the processes identified in each domain are related specifically to addressing PH and BH issues in an integrated manner. The eight broad domains are:

1. **Screening, referral 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**

CHI Framework Domains and Subdomains

1. Screening, referrals and follow-up

- **1.1** Systematic screening for co-occurring conditions and risk factors.
- **1.2** Systematic facilitation of referrals and f/u.

2. Integrated prevention and treatment

- **2.1** Use of evidence-based guidelines/protocols for prevention and risk mitigation.
- **2.2** Use of evidence-based guidelines/protocols for nonpharmacologic treatment for co-ocurring conditions.
- **2.3** Use of evidence-based guidelines/protocols for pharmacologic treatment for co-ocurring conditions.
- **2.4** Use of trauma-and resilience-informed practices.

3. Ongoing care coordination

- **3.1** Ongoing care coordination for monitoring progress in the prevention and intervention for co-occurring conditions.

4. Personalized self-management support

- **4.1** Use of personalized educational materials and skill-teaching interventions for people receiving services and their families.

5. Interdisciplinary teamwork

- **5.1** Integrated care team composition.
- **5.2** Integrated teamwork and sharing of clinical information.
- **5.3** Integrated care team training and competency development.

6. Systematic quality improvement

- **6.1** Use of quality metrics for improvement of integrated services.

7. Community interventions to address social determinants of health

- **7.1** Leveraging community services to reduce SDOH impact on BH and PH.

8. Financial and administrative sustainability

- **8.1** Financial sustainability.
- **8.2** Administrative sustainability.

The CHI Framework presented in this paper advances the previously published separate GHI and BHI frameworks to create a single framework to support bidirectional integration. The CHI Framework identifies core services in the eight domains that permit measurement of progress in integratedness in any type of adult or child, BH or PH program. This change is intended to produce a framework that is more broadly applicable and addresses the barriers identified by the BCPR and others. The CHI Framework can be found in Appendix 3 on page 51.

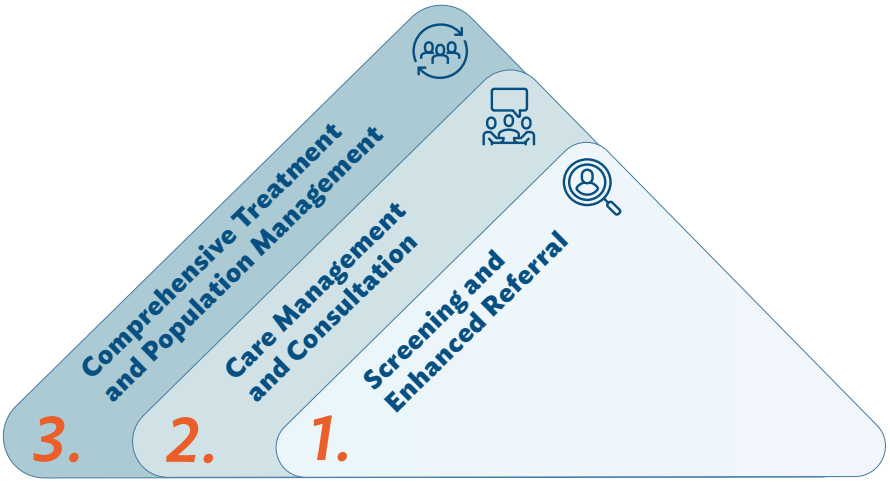
There is more than one way to deliver integrated services that represent measurable improvement compared to historical practice. Different provider organizations have implemented integrated services in different ways, due to variations in organization size, resources and local health care environment. Using expert clinical consensus to review the evidence associated with each domain, we have specified three integration stages to delineate how organizations can progress within each domain, which allow for flexible targets of progress in integratedness for providers of different levels of development, resources and capacity. For each domain and subdomain there are four columns ranging from historical practice to more comprehensive integration, and for each column there are specific markers for the types of structures and processes that would represent achievement of the standard in that column. Figure 1 illustrates how this works for Domain 1, "Screening, referrals and follow-up." For a more complete picture of the framework, see Appendix 3 on page 51, which includes the full tool that lists all eight domains and 15 subdomains.

Figure 1. Domain 1 — Screening, referrals and follow-up — and the first of two subdomains: Systematic screening for co-occurring conditions and risk factors

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).

THREE INTEGRATION STAGES

Each integration stage describes an organized approach with several evidence-based or expert consensus-supported core service elements drawn from the eight domains for integratedness, which can be implemented flexibly depending on a provider organization's mission, resources, incentives and capabilities. The term "stage" is defined as an idea or theory containing various conceptual elements, and it implies that the core elements of integratedness in each stage can be adapted with some degree of consistency by organizations whose initial targets may range from more basic to more advanced integratedness based on available resources.



The Three Integration stages are:

1. **Screening and Enhanced Referral**
2. **Care Management and Consultation**
3. **Comprehensive Treatment and Population Management**

The names of the stages are driven by the domains' primary integratedness workflows, which the provider organization must implement to be successful in demonstrating value, either by showing measurably improved health outcomes or by implementing measurable processes that have been shown to result in improved health outcomes directly. Each of the three stages is connected to specific progress within the domains and has measurable standards that are identified in one of the four columns in the CHI Framework tool (including Stage 0, Historical Practice). This section will define and discuss the measurement of value for each integration stage.

Each stage reflects greater capacity for integrated service delivery compared to historical practice and, as described below, is associated with evidence demonstrating that implementation of that stage produces the organizational processes needed to demonstrate measurable value with regard to specific co-occurring conditions, interventions and/or populations. Further, the integration stages are progressive: Each progressively advancing integration stage from 1 to 3 requires the implementation of the elements of the prior stage. That is, if an organization rates itself as achieving Integration Stage 3 (Comprehensive Treatment and Population Management), it is expected to have accomplished or exceeded the elements of Stages 1 and 2 across all its programs and practices for each domain.

However, although the stages are progressive, this paper does not assert that for a particular program, practice or organization, one integration stage is necessarily more desirable than another. The optimal choice for a particular organization at a particular time will vary by the organization's current development, resources, capacity and incentives. The best match for an organization may be to implement Integration Stage 1, if it is able to demonstrate measurable value for people receiving services, payers and population managers. 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 organizations and systems.

Figure 2. Examples of Program Implementation Within the Three Integration Stages

SCREENING AND ENHANCED REFERRAL	CARE MANAGEMENT AND CONSULTATION	COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT
• Primary Care Access, Referral and Evaluation (Druss et al., 2010) • PRISM-E (Krahn et al., 2006; Bartels et al., 2004) • Primary Care Case Management (Kaye, 2021)	• Primary Care Behavioral Health Model (Reiter et al., 2018) • ACA Section 2703 Health Homes for chronic conditions • Collaborative Care Model (Unützer et al., 2020) • CCBHCs	• Primary Care-Mental Health Integration (U.S. Department of Veterans Affairs, n.d.) • Montefiore Accountable Care Organization • Services for the Underserved — combining FQHC and Community Mental Health Center (CMHC) programs in New York City

INTEGRATION STAGE 1: SCREENING AND ENHANCED REFERRAL

This stage optimizes screening and enhanced referral processes. Implementation of this stage, using the specific services appropriate to it from the eight domains, results in 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 and planned partnership between PH and BH practices, with a guarantee to work together to improve referrals.

The express purpose of the partnership is to collaborate to improve access, timeliness and quality of care for shared people receiving services. This integration stage is often a good place to begin, as it does not require significant investment in on-site PH in a BH setting or on-site BH in a PH setting. This can be the best stage for smaller practices/programs that may have fewer resources for expanded staffing or infrastructure.

People's experience receiving services: In Integration Stage 1, people receiving services and their families will experience providers in different locations working as an integrated team to address co-occurring needs. In the PH setting, the adult, adolescent or child receiving services and their family will experience the provider as being interested in identifying the BH condition, facilitating connection to a BH partner and ensuring proactive communication and follow-up with the BH partner, to ensure the BH condition is being addressed successfully. In the BH setting, the corresponding experience will occur in identification, connection, communication and follow-up for assessment, prevention and treatment of relevant PH conditions.

INTEGRATION STAGE 2: CARE MANAGEMENT AND CONSULTATION

This integration stage includes robust program commitment to a set of screening and tracking processes with associated on-site care coordination and care management. It also includes integrated teamwork that involves routine consultative collaboration with a PH specialist in a BH setting (or a BH specialist in a PH setting), which allows the practice/program to provide integrated prevention and treatment services and interventions for common conditions — and monitor outcomes of those interventions — for a significant cohort of its population. This stage typically requires some in-organization PH (if BH) or BH (if PH) infrastructure support (e.g., access to consultation, additional staff resources for care coordination, registries) for treatment and care management, with an emphasis on certain prevalent conditions that can be entirely prevented (primary prevention) or, if present, can be stabilized and prevented from worsening (secondary prevention or basic treatment). Examples in adult or child/adolescent PH settings may include major depression, alcohol use disorder, opioid use disorder (OUD), anxiety disorder and ADHD. Examples in adult or child BH settings may include diabetes, hypertension (HTN), childhood obesity, asthma, tobacco cessation and colon cancer screenings.

People's experience receiving services: In Integration Stage 2, people receiving services and their families will experience integrated teamwork in a single location (e.g., a behavioral health consultant [BHC] 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 CHW) that establishes a caring relationship with the person receiving services and their family to help them follow through with needed services, track whether the services are working and assist with service improvements if needed. People receiving services and their families in Integrated Stage 2 will experience regular and proactive outreach from their integrated team members to address prevention and treatment of a more comprehensive set of co-occurring conditions, as well as issues related to improving overall wellness, such as addressing lifestyle changes (diet, exercise) and SDOH (food insecurity, housing). This type of outreach and engagement contributes to a truly integrated experience of care. The additional level of integrated service complements the communication and coordination between BH and PH providers (some of whom may be in different locations or organizations), which is particularly helpful for those whose level of need or complexity makes it harder for them to follow through with all the needed services without additional support, encouragement, monitoring and coordination of care.

INTEGRATION STAGE 3: COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT

This stage typically requires comprehensive PH and BH staffing in a single organization, such as a hospital, independent clinical practice, FQHC or large CMHC, or by two partnering organizations in very close proximity, with shared protocols and information systems (e.g., FQHC and CMHC, or within a large health system, particularly one that is managing a defined population, such as an Accountable Care Organization). This stage implies a high level of shared accountability for a population with complex needs, with the organization(s) taking primary (or shared) responsibility for providing PH and BH care to a significant number of people in the community. In this stage, almost all people receiving services have access to appropriately integrated PH and BH primary prevention services, as well as integrated treatment for a wide range of PH and BH conditions (e.g., HIV, diabetes, coronary artery disease, HTN and asthma, as well as depression, anxiety, ADHD, substance use disorder [SUD], schizophrenia and bipolar disorder). An organization at Integration Stage 3 is addressing more issues for more people and providing more integrated treatment services than an organization at Integration Stage 2. Organizations that have achieved some level of implementation of Integration Stage 3 have demonstrated their ability to measure improved overall health outcomes for their populations along a variety of domains, take shared risk for cost and outcomes in some instances, and demonstrate improvements in both cost and outcomes for identified populations with very complex needs that are using high levels of acute services but not making progress in health and wellbeing (Chang et al., 2021; Cook et al., 2021).

People's experience receiving services: In Integrated Stage 3, people receiving services and their families will 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 people receiving services and their families experience everyone working together and having routine access to shared information and service plans for co-occurring conditions. People receiving services and their families in Integrated Stage 3 (as in Stage 2) will receive regular and proactive outreach from members of their integrated team (which often will include peers and/or CHWs) to address prevention and treatment of a more comprehensive set of co-occurring conditions, as well as issues related to improving overall wellness, such as addressing lifestyle changes (diet, exercise) and SDOH (food insecurity, housing). This type of outreach and engagement may in turn contribute to an experience of being cared for in a truly integrated health care home. Finally, people receiving services and their families in Integrated Stage 3 will experience the care team as reaching out to them proactively in a caring manner, even when the person receiving services does not show up or is at risk of losing contact entirely, rather than letting them drop out and wait for a crisis before they are reengaged. This experience of engagement in Integrated Stage 3 is particularly valuable for individuals and families who experience overwhelming challenges, great difficulties in participating in routine (vs. emergency) services, and high levels of marginalization and/or geographic, cultural, racial and linguistic barriers to receiving needed help and support.

Broad application to adult and child PH and BH settings: The CHI Framework is designed to be applicable to all settings and populations. It can be used in both PH and BH service settings, in settings serving children and adolescents as well as adults, and in settings that are smaller or larger, in various geographies (rural, urban) and with varying levels of resources. A unitary framework has significant advantages, as many PH organizations are increasingly adding BH services and vice versa. A framework that can be used by multiple types of PH and BH programs or practices, whether in the same or different organizations, has advantages for integratedness goal setting and for providing a common language to communicate value internally and externally, with the potential to simplify and accelerate integration adoption.

Flexibility of achieving successful progress in integratedness: One of the most important advances of the CHI Framework is intentionally identifying that different degrees of progress in integratedness have the capacity to demonstrate value — both for people receiving services and for payers — thereby providing all stakeholder partners (including funders) who share responsibility for populations with flexible markers of success that are adaptable to local priorities and needs. This adaptability addresses some of the barriers previously identified by the BPCR.

V. Using the CHI Framework:

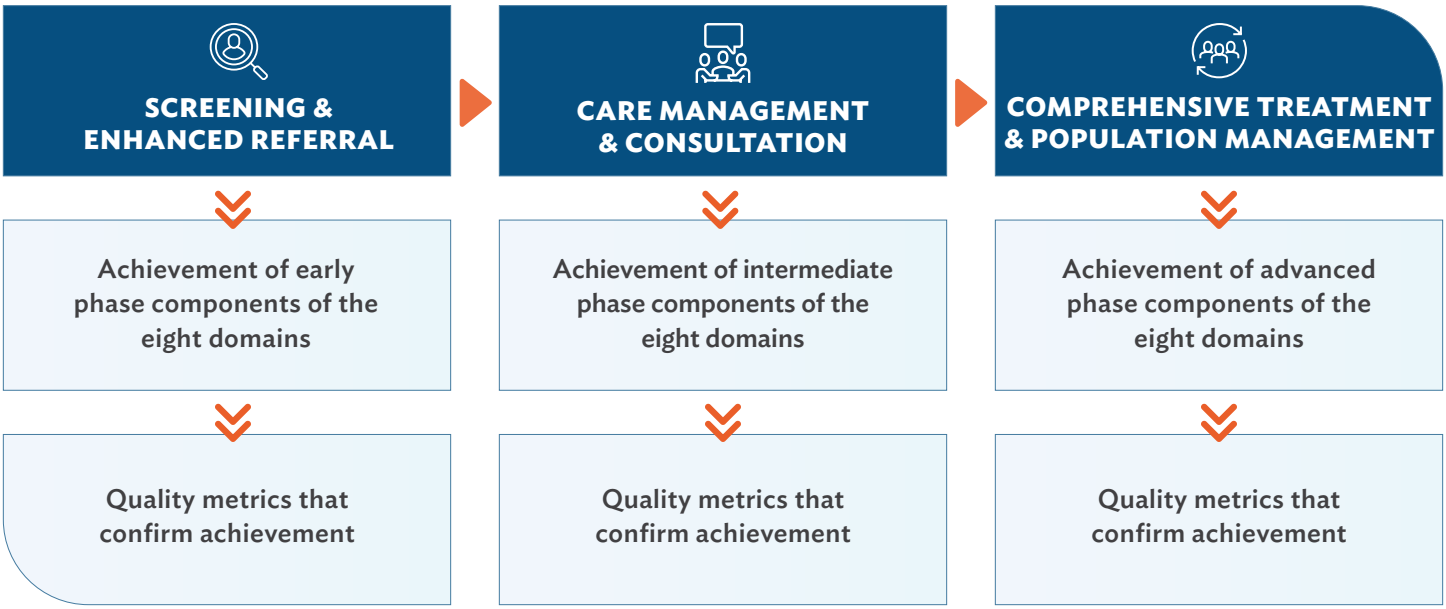
Improving Integratedness and Achieving Implementation of Integration Stages

Measuring integratedness using the eight domains of the CHI Framework allows for demonstration of progress in the implementation of integration stages, which can guide identification of improvement targets and objectives (for providers) and provide objective indication of implementation success (for payers and regulators).

Using the CHI Framework helps address the following questions for a program, practice or provider organization:

- **For the eight domains:** What is the program/clinic's level of measurable progress in each domain? What improvement targets (e.g., increasing capacity for integrated structure, care processes and measurement/tracking) are most appropriate for guiding progress in that domain?
- **For the three integration stages:** Which integration stage currently best represents the program/clinic across all the domains? Which stage goal is likely to be the best fit? What improvement steps help the program/practice/provider organization either strengthen the delivery of its current integration stage or help it progress from one stage to the next, depending on its goal?

Figure 3. Eight Evidence-based Integration Domains Within Each of the Three Integration Stages



For payers and regulators, the CHI Framework can help answer similar questions regarding the baseline level of integratedness of individual providers and programs, as well as potentially the entire network. It then can guide discussions with providers regarding the appropriate domain targets for progress in integratedness, the desired integration stages to be achieved to meet standards and/or receive payment incentives, and the relevant metrics providers can use to demonstrate value in each integration stage.

These measurable standards of progress can provide a common language, not only for provider organizations, but also for payers and population managers seeking confirmation that the services they are funding or regulating can demonstrate progress in each domain.

Further, the CHI Framework offers a structure within which each organization or stakeholder is prompted to collect more detail on the reach of efforts to improve integratedness. For each domain of integratedness in the framework, a program, practice, provider organization, payer or population manager has opportunity to ask the following questions:

- **What is the program, practice or organization's level of progress in the process addressed by this domain?**
- **What is its level of progress for various target populations (adults, children and adolescents, Medicaid recipients, indigent, homeless, vulnerable minorities, etc.)?**
- **What is its level of progress for populations with various issues (depression, SUD, diabetes, HTN, etc.)?**
- **What percentage of each population of interest is receiving the process addressed by this domain?**

For example, if rating Domain 1, "Screening, referrals and follow-up," a potential marker to show that a program or practice is performing better than "historical practice" and achieving the standard defined by the next higher column is the ability to report the screening rate for depression, track follow-up for those with a positive screen and perform these processes at a reasonable standard (i.e., meet or exceed a local benchmark).

For a complete description of the recommended steps to use the CHI Framework, please see Appendix 4, Getting Started With the CHI Framework: Self-assessment and Planning for Change and Implementation, on page 69. For more in-depth guidance and specific examples, refer to the CHI Framework Self-assessment Guide and the CHI Framework Definitions and Examples Handbook. These resources provide detailed instructions and examples that can help further refine and support your integration efforts.

INTEGRATION STAGES: DEMONSTRATING VALUE

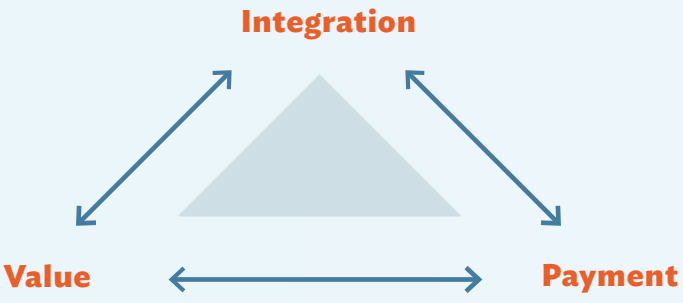
The key connection between integratedness, the three integration stages and payment is that each integration stage incorporates organized processes to support integrated services that can demonstrate value.

By using the CHI Framework to guide measurement of the eight domains of integratedness and identify achievement of one of the three integration stages in any practice or program, organizations can demonstrate value to population managers or payers for the issues addressed and the population served. Although moving from Integration Stage 1 (Screening and Enhanced Referral) to Stage 2 (Care Management and Consultation) to Stage 3 (Comprehensive Treatment and Population Management) represents a progression in the depth and breadth of integrated services, one important new assertion in the CHI Framework is that implementation of any of the stages can produce value for the people receiving services in that stage.

A practice that provides only Integration Stage 1 is still capable of producing value. Practices, programs and organizations that provide Integration Stage 2 or Integration Stage 3 can provide value as well, usually impacting more complex populations and addressing a greater number of clinical issues, issues related to SDOH and/or issues related to health equity.

Demonstrating value within each integration stage will usually require shared identification and selection of metrics that are relevant to both the priorities of payers and the needs of the population served. For each stage, the selected metrics and targets can be used to demonstrate the value of the integrated services provided and thereby support implementation of payment methodologies (learn more about specific methodologies on page 28), which in turn supports implementation and sustainability of the integration stage. When progress on the issues addressed for those populations is measured and reported, payers and population managers can use the demonstration of measurable value to support investments in implementation, infrastructure and sustainability. By sharing with payers the appropriately matched process and outcome metrics associated with each stage, providers are in position to show that measurable efforts to improve integratedness are consistent with payer/regulator priorities of demonstrating value within the larger health care management structure. Working within the CHI Framework will give payers and population health managers a better way of understanding and justifying resource allocations and regulatory frameworks that support integrated services.

Defining Value in Integrated Care



Value can be defined as a measurable improvement in individual or population PH and/or BH outcome measures in relation to expenditure. For most services and populations, integrated care may involve increased cost, but the improved health outcomes outweigh the additional payment and therefore provide value. For populations that already have high costs and poor outcomes, value may include both improved health outcomes and equivalent or reduced expense.

The satisfaction and experience of both the provider and the people receiving services can also be incorporated into value-based payment (VBP) arrangements. All providers are accountable for identifying and addressing disparities in both BH and PH outcomes, as appropriate to the integration stage provided, preferably aligned with targeted efforts to improve equity for traditionally marginalized populations.

Defining how each integration stage produces value also provides guidance on what to measure (process or health outcomes) and how to finance the implementation and sustainability of that integration stage most effectively.

For **each** Integration stage, therefore, it is necessary to define:

- **How is value produced?**
- **What metrics are used to demonstrate value?**
- **How is the value produced by each stage connected to financing the implementation and sustainability of that stage?**

The first two questions will be addressed in this section. The third question will be addressed in Section VI, on financing and sustainability.

Answering these questions for any integration stage first requires a general discussion of identifying and tracking outcome metrics in any PH or BH setting, followed by a discussion of the application of those metrics for each stage.

IDENTIFYING AND USING METRICS TO DEMONSTRATE VALUE

There is an important difference between measuring progress in integration using the CHI Framework and identifying and using targeted quality metrics to demonstrate value for population managers, payers and people receiving services.

- **When using the CHI Framework to measure and improve integratedness and identify achievement of integration stages,** the focus is on demonstrating implementation of integrated staffing and care processes.
- **When identifying and using targeted quality metrics to demonstrate value,** the focus is on measuring the results of the integrated services (in any integration stage) on the health and resource usage of the people who benefit from these services — specific to the issues addressed — whether through improved care processes (e.g., "Did you see the PCP or the BH specialist?" "Did you receive the colorectal or hepatitis C screen?") or improved results (e.g., "Did you receive the appropriate intervention, and do you demonstrate improved health as a result, as measured by changes in your PHQ-9, BAM, weight or HbA1c?").

It is important to note that measures of structure and process to attain a certain level of integratedness within a stage are the means **but not the end** of demonstrating value through improved outcomes for people receiving services. For payers, the connection between improved care processes and metrics that demonstrate value justifies the necessary financial investments to help providers improve and sustain integrated service delivery.

CHOOSING METRICS THAT DEMONSTRATE VALUE

Ideally, selection of metrics and targets for those metrics will be a shared process between providers and payers. In many instances, however, providers or payers may begin by selecting metrics unilaterally and then work to have those metrics adopted by others.

In either case, metrics for demonstrating value in an integration stage in any setting should include one or more in each of the following areas:

1. **Prevention and/or treatment of PH conditions.**
2. **Prevention and/or treatment of BH conditions.**
3. **Prevention and/or treatment of both (e.g., follow-up within seven days of hospital discharge, all-cause readmissions, medication reconciliation and cross-communication).**

Practices, programs and provider organizations should choose measures appropriate to the needs of the population served (including disparities), aligned with the priorities of payers and population managers in their community, and matched to implementation of whichever integration stage(s) they have selected, and the associated domain-specific care processes want to improve.

PH providers must hold themselves accountable for demonstrating value by measuring BH outcomes, and vice versa. Identifying and achieving metrics of accountability for the results of integrated service delivery can strengthen the processes needed to establish and maintain achievable standards of care for all providers.

Many providers and payers try to simplify this process by choosing measures that reflect the reporting requirements of external quality organizations, such as the National Quality Forum (NQF), National Committee for Quality Assurance (NCQA) or HEDIS. However, implementing any integration stage usually requires staffing and work process changes that do not have standard NQF- or NCQA-defined performance measures. While payers' incentives often are based only on such measures, it is important to recognize that such metrics generally are not suited for operational management. **Therefore, from a provider or payer perspective, it may be better to start with metrics that fit the needs of the local population, rather than those that fit the needs of external quality organizations**. Further, if using the external quality organization metrics, it is often easier to apply these formal measures generally and ignore many of the usual exclusions (e.g., screen **all** people for hepatitis B, hepatitis C and HIV instead of only people with SUD, or screen **all** people for metabolic syndrome instead of only individuals with schizophrenia on antipsychotic medications and people with diabetes).

Metrics that reflect value produced by each of the three Integration Constructs require:

- **Identification of relevant prevention screenings (e.g., colonoscopies, mammograms) and relevant PH, BH or other health issues/conditions to measure (e.g., diabetes, childhood asthma, depression, OUD, SDOH and health equity).** Start with the issues that are most relevant and achievable and continue to add other issues within the current integration stage, or within the next higher stage as integratedness progresses.

- **Identification of relevant domains in which to measure progress** (e.g., Screening, referrals and follow-up; Integrated prevention and treatment; Personalized self-management support).

- **Identification of achievable processes for systematic measurement and tracking of metrics (for each issue and/or domain) across settings.** Completing the measures, aggregating them, tracking the results and initiating efforts to improve the results within key domains will provide more robust evidence of the provider's progress in demonstrating the value of the integration stage.

- **Progression of metrics through the integration stages.** Each higher stage will require new and expanded metrics, as well as continuing to use and demonstrate value through the metrics for the preceding stage(s). For example, Integration Stage 2 metrics would include attention to measures from continuing processes consistent with Integration Stage 1.

METRICS FOR EACH INTEGRATION STAGE

The following are illustrations of how each integration stage is supported by evidence of how it produces value, along with examples of metrics that could be used to demonstrate that value. (See Appendix 6, Table 2, on page 74.) The metrics selected as examples for each of the three stages are based on a combination of metrics for use in evidence-based processes for care and some elements of metrics from the Core Quality Measures Collaborative, HEDIS, NQF and the Centers for Medicare and Medicaid Services (CMS) Meaningful Measures Hub. These metrics are not intended to include all possibilities. Systems will have to select from a broad array of similar metrics based on their current internal baseline capacities, the populations they serve (e.g., adult, child and adolescent, substance use, mental health, primary care, specialty care) and the issues being prioritized for attention. Once metrics are identified, providers, payers and population managers can work collaboratively to set quality benchmarks according to local baseline data and published national guidelines. Benchmarks should be set through the lens of health equity, with proactive measurement of disparities in achievement of each benchmark.

METRICS FOR INTEGRATION STAGE 1 — SCREENING AND ENHANCED REFERRAL

The key strategy of this stage is systematic identification of co-occurring issues of concern, as well as ongoing tracking of connection to care, participation in care and progress in care for those issues — conducted by the PH provider, the BH provider or both — rather than just referral without active tracking should a problem emerge. The research demonstrates that, with additional investment to produce the relatively small infrastructure support for these processes, many people receiving services have better overall engagement with PH or BH care and better corresponding outcomes. That is, the improvement in health is worth the necessary investment of additional resources. For example, in the Primary Care Access, Referral and Evaluation study (Druss et al., 2010), individuals living with SMI who were served by BH clinics, and who had navigation support to access PCP appointments to ensure adherence, had greater engagement with PCPs, received more recommended preventive services and lowered their cardiovascular risk score compared to those who simply received advice to seek PCP appointments with a list of available providers (historical practice). Moreover, in a multisite study comparing primary care integrated care sites to BH clinics for older adults with depression, individuals randomized to BH specialty sites had a 49% engagement rates, as compared to a 71% engagement rate among those in integrated care sites (Bartels et al., 2004; Krahn et al., 2006). The relatively high engagement rate in BH specialty care after referral was attributed to the enhanced navigation protocols put in place by the primary care sites. Individuals referred and engaged for depression treatment in BH clinics were more likely to improve.

The process measure of establishing a screening and referral workflow is a first step; the tracking and measurement of effective referrals and engagement is the pathway to demonstrate value to payers.

METRICS FOR INTEGRATION STAGE 2 — CARE MANAGEMENT AND CONSULTATION

The additional requirement of this stage is that, rather than just systematic screening and tracking, the program/practice has a robust care coordination infrastructure for a defined population, covering multiple co-occurring prevention and intervention targets, possibly including SDOH, and using registries to track progress in an organized way. Further, there is an integrated team member in the program or practice, such as a nurse care coordinator in a BH program or a BHC in a PH program, who provides consultation at minimum and supports some direct treatment of co-occurring conditions within that setting. The research demonstrates that, with additional investment to produce the more robust teamwork and associated infrastructure support for these integrated services, targeted people with multiple complex conditions who may not do well with less support have better overall PH and/or BH outcomes and more efficient usage of PH and/or BH funds. One example of this stage is the widely cited and replicated Improving Mood — Promoting Access to Collaborative Treatment model (often referred to as IMPACT/Collaborative Care), which results in improved depression, anxiety and SUD outcomes (Unützer et al., 2002).

This model is a core component of CoCM, developed and supported by the AIMS Center at the University of Washington, which provides evidence-based guidance on integrating BH into primary care settings to achieve better health outcomes. In addition, programs that have provided improved PH care coordination in BH settings have been shown to improve overall health screenings and outcomes, such as the award-winning Missouri BH Healthcare Home program ("Gold Award," 2015; Parks et al., 2014; Raney, 2015).

The presence of a BHC or nurse care coordinator is a structural improvement, but measuring the outcome of their participation in interventions addressing co-occurring PH and BH issues can demonstrate value to payers as well as to primary care and/or BH providers.

INTEGRATION STAGE 3 — COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT

The key to this stage is that each program/practice (usually within a larger organization) includes a greater number of or more advanced integration services from each of the eight domains, providing routine capacity for integrated teamwork that involves not only care coordinators and BHCs, but also comprehensive BH and PH prevention and treatment (prescribers and non-prescribers). This teamwork, whether on-site or virtual, creates an integrated experience for both providers and people receiving services. Further, in addition to the Integration Stage 2 care coordination infrastructure to support a designated Health Home population, there is commonly expanded infrastructure capacity to address a broader population in the community, and a broader range of issues relevant to that population, including assigned individuals who do not show up for recommended wellness visits. With additional investment to produce robust teamwork and associated infrastructure support, populations with any range of multiple complex conditions (beyond the specific designations covered by, for example, an Integrated Stage 2 Health Home) have better overall PH and/or BH outcomes and more efficient usage of PH and/or BH funds. For those populations that are experiencing high costs and poor outcomes when assigned, this may save money, but for other populations with complex needs this may simply produce better health for relatively cost-effective additional investment.

Although evidence population health improvement in this stage is limited and still emerging, there are some promising signs that comprehensive integrated care for common co-occurring BH and PH conditions can yield improved outcomes. In a randomized controlled trial to determine the cost-effectiveness of a co-occurring condition collaborative care intervention, comprehensive care was provided to individuals with depression, anxiety and chronic medical conditions by both internal medicine specialists and psychiatrists, with nurse care managers providing care between visits, treatment adjustments provided by PCPs and psychiatrists, and structured self-management to improve adherence and activation of people receiving services (Katon et al., 2012). Results were impressive, yielding improved outcomes for individuals with depression, diabetes, dyslipidemia and HTN, with cost savings from reduced emergency department and inpatient care usage.

Some emerging real-world comprehensive treatment models are integrated partnerships between an FQHC and a CMHC. These partnerships, whether occurring through evolution, mergers or alliances, have significant potential to advance population health, provided that the organizational partnership is more than just a change in ownership or structure and is used to improve all the necessary care processes identified in the eight domains of the CHI Framework. One example is the NYC HUB program in East New York, where Institute for Community Living (the CMHC) and Community Healthcare Network (the FQHC) have joined forces to provide comprehensive care in a shared space, with progressive advancement of the elements in the CHI domains (Kingman et al., 2021).

VI. Integrated Services and Integration Stages: *Financing Implementation and Sustainability*

BACKGROUND

Effective financing can be a powerful force for achieving implementation and sustainability of integrated services. A major barrier to achieving greater advances in integration is inadequate and ineffective payment methodologies that don't sufficiently incentivize implementation and sustainability. Time-limited grant funding has proven to be effective for the implementation of integration efforts but usually ineffective at maintaining sustainability. As noted earlier in this report, effective financing has been hampered by payers' inability to justify investments in integrated service delivery by connecting financing methodologies to demonstrable measures of progress in integrated service delivery (i.e., integratedness) and to the corresponding value produced by integrated services provided. The CHI Framework offers an organized approach to connecting progress in integratedness and implementation of integration stages to the measurable demonstration of value for each stage and the justification for financing and payment strategies to help achieve and sustain each stage.

This section focuses on tying financing to value and integratedness, addressing the following question:

- ***How is the value produced by each stage connected to financing the implementation and sustainability of that stage?***

To address this question, we have identified two major financing or payment goals and three types of payment methodologies.

TYPES OF FINANCING GOALS FOR INTEGRATION

Financing implementation: This refers to financing or payment methodologies that incentivize providers to make progress in integratedness to achieve or strengthen provision of one or more stages in various programs or practices, or that support them in doing so. This includes any or all of the following:

- **Initial implementation of an integration stage:**This could be incentives to help a program or practice move from historical practice to implement the CHI Framework domain-specific staffing, care processes and infrastructure needed to provide Integration Stage 1 (Screening and Enhanced Referral).
- **Strengthening an existing stage:**This would commonly involve supporting a provider to expand the reach of an integration stage by adding more types of conditions or interventions, expanding access to a higher percentage of the population served and/or increasing the outcome targets for the interventions provided.
- **Incentivizing progress from one stage to the next:**This would commonly involve incentivizing or funding a provider to move from Integration Stage 1 to Integration Stage 2, or from Integration Stage 2 to Integration Stage 3 by supporting investment in necessary staffing, technology, infrastructure and change management to make progress in the relevant CHI Framework domains.

Financing sustainability: This refers to financing or payment methodologies that provide continued support for maintaining an existing level of integratedness via current provision of a specific stage for a particular set of issues in a defined population.

TYPES OF PAYMENT METHODOLOGIES FOR INTEGRATION

Payment methodologies can be usefully grouped into three broad categories, each with different advantages and disadvantages:

Current Procedural Terminology (CPT) Service Code Payments (usually fee-for-service). These can include either:

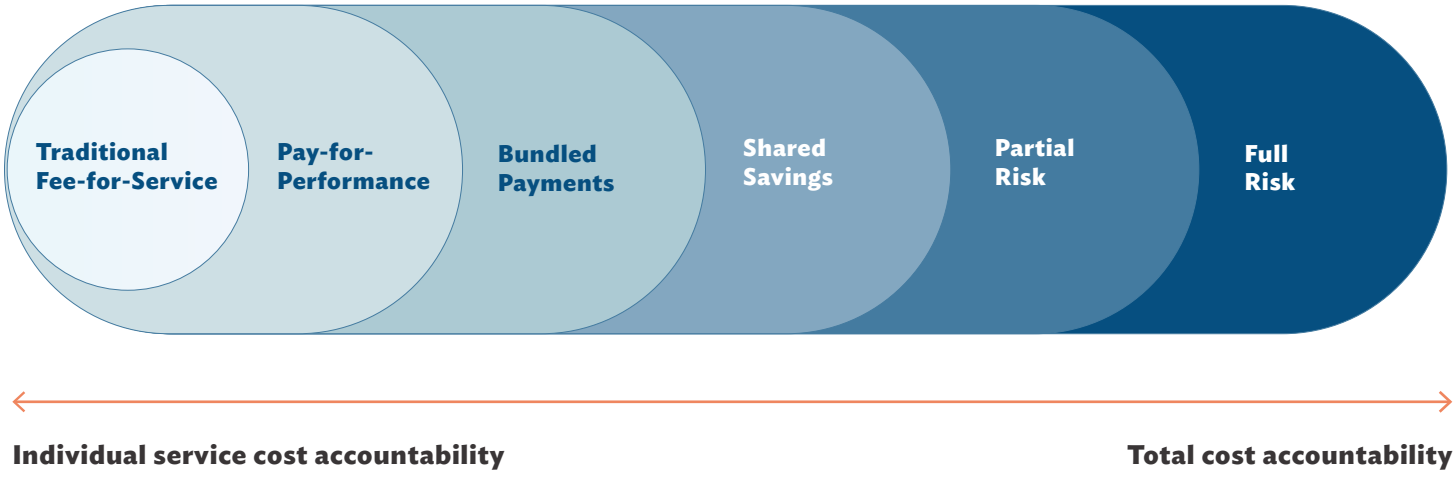
- **Single service payment codes** (e.g., screening, individual care coordination)
- **Bundled service payment codes** (e.g., CoCM, medication treatment for OUD)

Care Enhancement Payments (usually per member per month [PMPM] or prospective payment): This ties an aggregated payment methodology to the demonstrated provision of specific service structures and processes by the provider organization or program, for the entire population served or (for PMPM) for a defined population.

Value-based Payments (VBPs) (usually a supplemental payment for achieving a prospectively determined value target, or a "total cost of care" initiative such as Maryland's AHEAD Model under the CMS Innovation Center): This usually connects opportunities for reward (and sometimes penalty) to achieving clinical quality process or outcome goals and/or cost savings goals. For entities engaged in population management, this approach usually also involves capitation payments with some level of risk sharing.

Note that although only the last methodology is commonly referred to as VBP, from a payer perspective all financing and payment methodologies are tied at some level to value produced for the payer. That is why the CHI Framework's ability to connect value to all types of payment is so important.

Figure 4. Types of Payment Methodologies



PAYMENT METHODOLOGIES TO FACILITATE IMPLEMENTATION OF INTEGRATION STAGES

As will be described in the next section, there is a recommended predominant payment methodology to support sustainability at each integration stage. For financing any of the three types of integration financing goals listed above, however, any of the three payment methodologies can be used — and should be considered by payers — as an opportunity to collaborate with providers to incentivize progress and improve value. A "readiness" approach helps payers and providers work together to prepare to use all three complementary payment approaches for flexibility, particularly as provider organizations work on improving the necessary CHI Framework domain processes to advance or achieve a particular integration stage desired by the payer.

The following examples illustrate a progression of complexity in the application of the various payment methodologies to incentivize progress along the integration stages.

Incentivizing Progress with CPT Code Payments

Providers that are either relatively small with limited resources or new to implementing integrated services usually will start by focusing on the implementation of Integration Stage 1 (Screening and Enhanced Referral) using CPT code payments. (See Appendix 5 on page 70.) In these situations, payers who want providers to make progress in this stage to increase value for people receiving services should set relevant CPT code rates high enough to incentivize uptake, understanding that small practices lack economies of scale. To incentivize wary practices to take action, it may be necessary to set rates above simple break-even and facilitate investments in staffing and infrastructure. Unbundling fees for particular services that are deemed to provide the most value, setting an attractive and effective rate, and allowing that code and rate to be billed separately can result in faster and broader uptake. An example of this would be offering separate payment for the code for developmental/BH screens (96127), rather than expecting it to be done as part of an overall initial assessment. Successful implementation of capacity to improve integratedness using specific individual service code payments can set the stage for the provider to advance integration stages by using care enhancement or VBPs in the future. Once the new care process attached to the code is fully implemented and mature, it may be appropriate to reduce the rate to break-even, since less resource investment will be needed for sustainability than for initial implementation.

Incentivizing Progress With Care Process Payments

Implementing systematic integrated care coordination and management for people with co-occurring conditions (Integration Stages 2 and 3) almost always requires developing interdisciplinary teamwork (Domain 5) and data systems (Domains 3 and 6) that are best supported by care enhancement payments, as well as continued support of other domain processes through CPT code payments. For provider organizations that are on the path to achieving Integrated Stage 2 or 3, it will therefore be appropriate and useful for payers to help them implement a mix of all three payment methodologies. For example, a practice may combine a Health Home for chronic conditions, PMPM bundled payment with incentive bonuses for initiation of SUD treatment within 30 days of diagnosis (process), and reduction of emergency room usage (outcome); to help achieve the SUD treatment process target, the provider may need a separate fee at an attractive rate for CPT code payment for initial implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT). Taken together, this package of payment methodologies focuses the provider organization's attention on implementing more services for people who need integrated interventions for SUD and provides the necessary resources to deliver those interventions successfully and set the stage for sustainability.

Incentivizing Progress With Value-based Payments

In most situations, VBPs, usually in combination with care enhancement and CPT code payments, are a useful tool for implementation across any of the three integration stages. Since the VBP goals or targets commonly change or are readjusted over time, they are well-suited to address the startup cost problem by providing a substantial incentive to change work processes and retrain whenever a particular new aspect of integration is desired. Further, VBPs for structure and process measures can be extremely useful when providers are still implementing new care integration processes and learning to optimize them.

Referring again to the example of SBIRT, instead of using the CPT code payment methodology described above, a payer could leave SBIRT provision as part of a bundled care enhancement payment and instead offer a VBP performance bonus for delivering the service to a given percentage of individuals in the practice. Note that incentivizing providers based on outcomes alone is usually not effective until the providers have implemented and optimized the care processes that are expected to achieve the desired outcomes. This is why it is important for both payers and providers to use the CHI Framework to identify and operationalize necessary care processes, rather than only paying for outcomes.

Case Study: VBP Payer Innovation

As health plans further mature into PH/BH integration, they are considering alternative payment models with innovative providers, for both BH and PH savings. One health plan has contracted with an innovative SUD care provider that uses a multidisciplinary team providing continuity of care — including integrated care coordination — through multiple levels in a one-year program for people with SUD who have been frequent recipients of both PH and BH services. Acknowledging that people with SUD who frequently access services also have medical costs at least two times greater than those without SUD, the health plan has established a VBP that assesses overall improvement, including improved PH costs. The SUD provider also recognizes that the total cost of care for this population is excessive and employs an RN to coordinate care with the individual's PCP and other medical specialists. The willingness of the person receiving services to sign a release of information for all their providers is key to admission into the program, which has had outstanding results compared to other SUD treatment for this level of severity. The satisfaction and experience of both the provider and the people receiving services can also be incorporated into VBP arrangements. All providers are accountable for identifying and addressing disparities in both BH and PH outcomes, as appropriate to the integration stage provided, preferably aligned with efforts to improve equity for traditionally marginalized populations.

Implementing VBPs for process measures will result in a provider becoming more skilled in collecting, aggregating, analyzing and using data to make treatment and management decisions, which over time will have a ripple effect on improving the quality and efficiency of care throughout the organization.

For payers and providers that have a bit more sophistication in both integrated service delivery and more innovative payment methodologies, CPT code payments and care enhancement payments can be combined with VBP performance incentives to facilitate progress through the integration stages. In this approach, sometimes termed "enhanced care bundled payment," an increasingly substantial portion of the total payment varies based on performance, as the provider makes continued progress in integratedness. These types of bundled payments reduce implementation barriers and provide creative latitude for adapting activities and staffing to best fit an organization, region or population. One example of this approach is the medication-assisted treatment bundled payments introduced by Medicare in 2020.

When the payer designs the bundle, it can lay out the necessary components of care and set the total payment rate and the performance incentives (ideally using real baseline data) to drive quality. This gives the provider flexibility in how to implement services and workflows for staff and people receiving services, but it also ensures program quality by requiring "minimum necessary components of care" which can be service specific (for medication-assisted treatment or Health Homes, for example), but can also be tied to measurable progress on the domains of the CHI Framework.

MATCHING PAYMENT METHODOLOGY TO SUSTAINABILITY OF EACH INTEGRATION STAGE

For each integration stage there is a payment methodology, justified by the value produced, that is particularly suited for its sustainability. As described in the above examples for implementation, sustainability for Stages 2 and 3 incorporates the payment methodologies used to sustain the preceding stages.

Integration Stage 1 — Screening and Enhanced Referral

Screening and Enhanced Referral benefits from a time-limited startup grant to cover initial implementation costs. Early implementation should use CPT code services that specifically support integration, with rates set to adequately cover costs and incentivize uptake. A value-based incentive payment for timely implementation of the necessary screening and referral structures should also be considered. This facilitates implementation for provider organizations that have more limited fiscal infrastructure resources or are just getting started. Sustainability of Stage 1 is best achieved by a combination of offering rates adequate to incentivize provider usage for screening CPT codes (e.g., CPT 96110, 96127, 96160) in conjunction with VBPs for performance measures related to screening and referral (e.g., NQF 0421, 0418, 1932, 0004).

Integration Stage 2 — Care Management and Consultation

Care Management and Consultation also benefits from a time-limited startup grant to cover initial implementation costs in evidence-based integration programs. Sustainability of this integration stage requires using bundled care enhancement payments, with rates set to adequately cover costs of the specified staffing and integration processes required, along with CPT code payments. VBPs are useful to support and focus efforts to implement specific high-value processes initially and then important outcomes as the program matures. For example, key Domain 3 care coordination activities in Integration Stage 2 typically cannot be captured or billed using CPT codes; in addition, the current rate for CPT code billing for activities such as chronic care management and transitional care management usually is not adequate to cover the staffing required to carry out these care processes at an Integration Stage 2 level. One exception is the CPT codes for Psychiatric Collaborative Care Management. When these codes are adequately funded (at or above the Medicare rate), they have demonstrated the ability to cover costs and provide, at minimum, payment incentives for achieving selected quality process metrics tied to care management and consultation (as defined in the domains of the CHI Framework), along with the collection of outcome metrics for demonstrating value.

Integration Stage 3 — Comprehensive Treatment and Population Management

Sustainability of this stage usually requires sophistication in maximizing revenue from CPT code payments, substantial access to care process payment methodologies for various issues (e.g., SUD, as described on page 29) or populations (e.g., an assigned Health Home population under the state's Medicaid plan), and a robust VBP component with various forms of shared savings models and/or limited or full risk capitation. Center for Medicare and Medicaid Innovation's Total Cost of Care models at the state level are one potential example of aligning payment incentives with outcomes for populations with co-occurring PH/BH needs.

Once care processes are in place and performance and financial data aggregation and proficiency have been achieved, the organization is ready to switch to partial or full capitation with a value-based performance incentive payment for selected outcomes or new services. Overall, a provider organization demonstrates through the CHI Framework that they have implemented a program structure within Integration Stage 3 to manage a complex population with a shared risk or sub-capitation payment arrangement, as well as demonstrating the value metrics described in Appendix 6, Table 2, on page 75. This shows payers that the investment in this provider is associated with better clinical outcomes and more efficient resource usage, showing that the improvement in value is worth the investment of resources for both implementation and sustainability.

Stage 2 Case Study

CCBHC PPS Supports Integration

The PPS used by CCBHC Demonstration states can be used to support and incentivize multiple integration requirements with both care enhancement payments (the PPS) and VBPs based on performance. CCBHC integration requirements include:

- **CCBHC coordinates care across the spectrum of health services, including PH, BH and other social services.**
- **Enhanced screening requirements.**
- **Partnerships or care coordination agreements with:**
  - FQHCs/rural health clinics
  - Inpatient acute care hospitals and hospital outpatient clinics
  - Department of Veterans Affairs facilities
  - Inpatient psychiatry and detoxification
  - Post-detoxification or withdrawal management step-down services
  - Residential programs
  - Other social services providers, including:
    - Schools.
    - Child welfare agencies.
    - Juvenile and criminal justice agencies and facilities.
    - Indian Health Service youth regional treatment centers.
    - Child placing agencies for therapeutic foster care service.
- **CCBHC establishes or maintains electronic health record (EHR).**
- **CCBHC Health IT system is used for managing population health, improving quality, reducing disparities and conducting research and outreach.**
- **CCBHC required integration performance measures:**
  - All-cause readmission rates
  - Preventive care BMI screening and follow-up
  - Weight assessment and counseling for nutrition and physical activity for children/adolescents
  - Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications

In addition to these requirements, the CHI Framework may provide valuable guidance for CCBHC certification. The CHI Framework offers structured approaches to integration that align with many of the CCBHC requirements. Programs seeking CCBHC certification can use the CHI Framework to assess their current state of integration and identify actionable steps to meet or exceed CCBHC standards.

VII. Recommendations for Action

The CHI Framework presented in this paper represents significant progress in guiding broad dissemination and implementation of integrated services. It also provides a common language to guide the next generation of implementation research, including more detail on the connection between the eight domains and three corresponding integration stages, with specific co-occurring PH/BH/SDOH conditions and interventions, selected outcome metrics connected to those conditions, further refinement of payment methodologies for initiation and sustainability, and demonstration of value to payers, population managers and people receiving services.

The Expert Panel overall recommends broad adoption of the CHI Framework to advance both the future knowledge base and current efforts in implementation, dissemination and sustainability of integrated service delivery nationwide.

The recommendations are subdivided and prioritized to specific stakeholder groups but can be useful to providers, policymakers and payers generally to inform system, practice and payment design.

These recommendations may not reflect — and should not be construed as representing — the views of each member of the Expert Panel nor the organizations to which they belong.

Providers (health care treatment organizations and their state and national trade organizations) should use the CHI Framework to measure their current baseline state of integratedness, to identify their next steps regarding their chosen integration stage(s), to delineate relevant metrics for demonstrating value and to define QI process to achieve their integratedness targets.

Collectively, providers, provider networks and provider associations should advocate for public and private payers and policymakers to adopt the CHI Framework to create a common language for improving integration more widely.

- **Assess your current stage of integration across all the domains and subdomains both for your own programs and in collaboration with community partners who provide PH and/or BH services.** Then, identify the goal stage that is the best fit for the programs within your organization and use QI methods to advance and achieve the desired result.
- **Improve proficiency in quality metric selection relevant to framework domains and stages, workflow improvements and progress to goal.** For a selected performance measure, providers must be proficient in implementing improved or new workflows, using the data collected for both individual- and group-level improvement and then reporting the data for both internal monitoring and to relevant external parties to report aspects of quality treatment and incentives.
- **Implement BH and PH enhanced referral pathways per CHI Framework Domain 1.** Develop and implement standardized referral/engagement/consultation mechanisms within EHRs, paired with workflows to follow up on people receiving services who fall through the cracks.
- **Improve proficiency in using the available billing and coding procedures and visit types.** Providers should review and use available billing codes for integration services (screening, treatment, monitoring, care management) and reimbursement requirements.

- **Include primary care and behavioral staff in joint integration training.** Use the framework to prioritize the training topics and implement workflows resulting from the training with QI monitoring processes in place. This will require dedicated time for training, as well as staff accountability to lead and monitor integration improvements.
- **Proactively exchange protected health information (PHI) with other health care providers to ensure integration of care to the extent allowable under current regulation.** The people most in need of integrated care have multiple chronic conditions and see multiple providers. Providers should educate and encourage people receiving services to permit sharing their PHI to better integrate their care.

Payers (public or private, including grantmakers) should formally identify the CHI Framework as the recommended approach to measuring integratedness and demonstrating value across their networks. Over time, the utility of the CHI Framework will increase with further evaluation and refinement, and other frameworks and tools will likely be phased out.

- **Use the CHI Framework to organize continuous QI for integrated service delivery.** Engage in mutual discussions with provider networks and grantees to delineate the current baseline state of integratedness; identify recommended targets for improvement; outline implementation of specific elements within the CHI Framework to improve the health of populations served; define appropriate consensus metrics for accountability, value and outcomes; and correspondingly provide both initial implementation funding and, where applicable, sustainable reimbursement to support providers making progress using the CHI Framework.
- **Use payment methodologies that cover integration startup costs.** There is a range of mechanisms to support startup costs for achieving desired integration stages, while also providing for sustainability through reimbursement of support services with CPT codes and a VBP foundation that includes bundled payments that reflect all provider costs. Getting providers to implement and sustain a new service (e.g., health behavior assessments, bundled services such as CoCM, or a Health Home for people with chronic conditions that is eligible for a bundled PMPM payment) requires offering a more attractive rate with a better margin than is required for providers to sustain an existing traditional service or treatment. Implementing integration, particularly through care enhancement and VBPs, has significant startup costs, including both training and infrastructure. Providers' rate negotiations with payers should calculate the time and effort necessary to repay the initial startup investment costs.
- **Use payment methodologies that provide sustainability of integration:**
  - **Build upon the funding of time-limited grants**. Integration initiatives are commonly funded — in part or entirely — through time-limited grants. Providers cannot fully commit to reorganizing their staffing, care processes, documentation and data collection for time-limited initiatives. This leads to superficial implementation that is dependent on provider-unfriendly workarounds and temporary staff reassignments, making the integration implementation more difficult to sustain beyond grant funding.
  - **Set care management and/or bundled rates that are adequate to cover costs.** Rates are too often set by benchmarking against prevailing historical rates for similar services. Often, the historical rates for similar services are less than the actual cost of delivering the service. Rate setting for bundled services should be based on a specific staffing and caseload ratios that account for the prevailing salaries of the particular staff required, the local prevailing fringe and overhead costs, and any new IT infrastructure and training required. As with much of the history of payment innovation, payer discounting — almost reflexive in payer cultures — detracts from the optimal outcomes of innovative payment methodologies.
  - **Match the payment methodology to the integration stage, as described on page 31.**

- **Improve network management to support integration.** Payers can strengthen oversight by training utilization-review staff in the CHI Framework and best practices. Network management can include training of providers in the CHI Framework and expanding current arrangements in integrated care.
- **Eliminate or reduce co-pays that obstruct integration.** Because integrated care must be embedded in workflows at clinic offices on-site, integrated care services are not necessarily perceived as distinct billable services separate from a routine primary care or BH visit. Yet, many fee-for-service payment methods for integrated BH care require co-pays separate from those of the primary care visits. Understandably, people receiving services are confused and object to receiving bills for co-pays for these services when they occur (e.g., co-pays by some payers for administration of screening and measurement tools, such as the PHQ-9). This can result in people receiving services refusing to engage in integrated services in the future. We recommend that payers educate and work with state authorities and employers to reduce co-pays that create barriers for people receiving integrated care services. Both MCOs and large employers designing their own plans should lower these barriers. Co-pays for high-value integration services make it difficult to keep costs down and improve the quality of care.
- **Proactively exchange relevant PHI with your contracted health care providers to support integration efforts as allowable under current regulation.** The people most in need of integrated care have multiple conditions and see multiple providers. Payers should proactively share information with providers (e.g., labs, medications, involvement of other treatment providers, recent acute [emergency department and inpatient] events) to ensure integrated care. Payers should rely on coordination of HIPAA care provisions to share PHI, and they should educate people receiving services about the value of proactively sharing such information to improve integration of care and health outcomes.
- **Provide equitable eligibility for integration payments.** Some codes, enhanced care payments and VBPs are designed or paid only for certain providers, often PCPs rather than BH providers, even though integration tasks can be similarly implemented by both provider groups.
- **Educate providers on billing codes available to support integration.** Payers should clearly communicate to providers which services and codes are reimbursable in the realm of integrated care (e.g., codes that BH providers can use to monitor health status and provide PH preventive services, as detailed in Integration Stages 2 and 3). Payers can benefit from increased and more accurate diagnosis coding of both BH and PH conditions, which supports both integrated care and accurate risk adjustments for plan premiums.
- **Expand implementation of integrated care models that align with CHI Framework integration stages.** Payers should encourage their BH providers and PCPs to use the CHI Framework and help the providers to review incentives/payments that will advance to one of the integration stages that is realistically attainable, to provide value for people receiving services and payers.

Policymakers (federal and state governments, other regulators and system leaders) should adopt the CHI Framework as a guide for payers and providers to measure and implement progress in integrated service delivery at the federal, state, tribal and local level. All stakeholders should receive consistent education on the value of the CHI Framework and guidance for how to use it under federal, state and other system leadership. Over time, the utility of the CHI Framework will increase with further evaluation and refinement, and other frameworks and tools will likely be phased out.

- **Use the CHI Framework as guidance for policy development and regulatory support.** The CHI Framework can guide development of robust published policies and regulations to support progress through the eight domains and corresponding three integration stages, which in turn can make it easier to align reimbursement mechanisms for integration activities. CMS and corresponding state Medicaid programs and Medicare intermediaries can use the CHI Framework to review the degree to which existing regulations inhibit implementation of progress and can subsequently reduce existing barriers around billing prohibitions and site limitations for certain services.

- **Use the CHI Framework at the state and local level to understand and remove challenges to implementation of integratedness and revise regulatory requirements obstructing integration.** Some states have separate program licensure requirements for programs providing PH or BH treatment. This creates additional administrative burden and expense to meet multiple requirements with separate reviews. At times, some of the specific licensure requirements can be mutually exclusive. Licensure requirements should be designed to foster integrated service delivery for each person with co-occurring needs, as well as improved access, consistent data sharing, care management continuity and achievement of quality outcome measures across PH and BH, including SUD.
- **Eliminate policy and regulatory barriers to integrated services.** Eliminate all prohibitions on billing for a primary care and BH service on the same day. These prohibitions present a major obstacle to implementing the CHI Framework and the more advanced integration stages.
- **Use the CHI Framework as a guide for measuring progress.**
  - » CMS should establish a core set of integration measures for use in Medicaid and Medicare.
  - » Federal and national entities, such as the NQF, can simplify the many measurements of health care services by selecting key measures of integration aligned with the eight domains and three integration stages of the CHI Framework.
  - » Include CHI Framework-aligned measures of network integratedness in the Medicaid managed care and Medicare Advantage quality rating systems, and recommend that states set a minimum rating for MCOs on performance measures.
  - » Adopt all-payer integration initiatives using the CHI Framework, to improve evaluation of processes and outcomes and reduce variability across payers. Use care enhancement payments (for both PH and BH providers) in these all-payer initiatives to improve and simplify standards of documentation and outcomes.
- **Use the CHI Framework to improve regulatory guidance for FQHCs and CCBHCs.**
  - » Review, enhance and align FQHC and CCBHC integrated care services and measures according to the CHI Framework domains and stages. Ensure accountability, particularly with respect to health disparities.
  - » Using the CHI Framework, incentivize CCBHCs and FQHCs to strengthen integration of BH and primary care through clear standards, and measure reporting through a voluntary integration bonus payment.
- **Improve standards for CPT code payments that support integration.** CMS should require broader coverage of Medicare and Medicaid CPT codes and enhanced care payments at rates adequate to support integration, including:
  - » CoCM CPT codes.
  - » CCBHC PPS methodology, including converting grant-based CCBHCs to full PPS-based CCBHCs for improved integration and sustainability.
- **Incorporate the CHI Framework into consultation and technical assistance at the federal, state, tribal and local levels.** Use the CHI Framework and integration stages to continue and expand technical assistance on integrating care for PCPs and BH providers.
- **Enhance regulatory support for telehealth in integrated service delivery.** Promote the use of EHRs, telehealth and other technology, using additional incentives to support integrated care providers. These supports are critical to advancing integration; paired with the CHI Framework approach, they can advance organizations toward the population health stage.

VIII. Conclusions and Next Steps

Even with scattered and uneven implementation, integrated care delivery has demonstrated improved access, better quality of care, lower usage of more restrictive services and reductions in total cost of care. Adoption and use of the CHI Framework provides a roadmap to deliver evidence-based practices in integrated services, validated by metrics that are directly related to value. Delivering services within this framework will help providers, payers and policymakers measure progress in integration and demonstrate its value. Adopting the related recommendations regarding regulatory barriers and financing methodology will support robust implementation of sustainable integration models that can be flexibly optimized to the specific needs of individual practices, providers and people receiving services.

IX. References

Agency for Healthcare Research and Quality. *A framework for measuring integration of behavioral health and primary care.* https://integrationacademy.ahrq.gov/products/old/behavioral-health-measures-atlas/integration-framework

Bartels, S. J., Coakley, E. H., Zubritsky, C., Ware, J. H., Miles, K. M., Areán, P. A., Chen, H., Oslin, D. W., Llorente, M. D., Costantino, G., Quijano, L., McIntyre, J. S., Linkins, K. W., Oxman, T. E., Maxwell, J., & Levkoff, S. E. (2004, August). Improving access to geriatric mental health services: A randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *The American Journal of Psychiatry,* 161(8), 1455–1462. https://doi.org/10.1176/appi.ajp.161.8.1455

Barton, T., Donnellan, J., Harootunian, L., Harris, J., Hartnett, T., Hoagland, G. W., Newell, B., Nguyen, M., O'Gara, B., Parekh, A., Werber Serafini, M. W., Burgos, A., & McDonough, D. (2021, March 30). *Tackling America's mental health and addiction crisis through primary care integration*. Bipartisan Policy Center. https://bipartisanpolicy.org/report/behavioral-health-2021/

Berkowitz, S. A., Parashuram, S., Rowan, K., Andon, L., Bass, E. B., Bellantoni, M., Brotman, D. J., Deutschendorf, A., Dunbar, L., Durso, S. C., Everett, A., Giuriceo, K. D., Hebert, L., Hickman, D., Hough, D. E., Howell, E. E., Huang, X., Lepley, D., Leung, C., … Lu, Y. (2018). Association of a care coordination model with health care costs and utilization: The Johns Hopkins Community Health Partnership (J-CHiP). *JAMA Network Open, 1*(7), Article e184273. https://doi.org/10.1001/jamanetworkopen.2018.4273

Bowling, J., & Matulis, R. (2020). *Oral health, mental health and substance use treatment: A framework for increased coordination and integration.* National Council for Mental Wellbeing. https://www.thenationalcouncil.org/wp-content/uploads/2021/09/NC_ CoE_OralhealthMentalHealthSubstanceUseChallenges_Toolkit.pdf

Bui, L. N., Yoon, J., & Hynes, D. M. (2021, July). A reduction in health care expenditures linked to mental health service use among adults with chronic physical conditions. *Psychiatric Services, 72*(7), 766–775. https://doi.org/10.1176/appi.ps.202000161

Center for Integrated Health Solutions. (2014, September). *Organizational assessment toolkit for primary and behavioral health care integration*. Substance Abuse and Mental Health Services Administration & Health Resources and Services Administration. https://www.thenationalcouncil.org/wp-content/uploads/2020/01/OATI_Overview_FINAL.pdf?daf=375ateTbd56

Center for Integrated Health Solutions. (2020). *Standard framework for levels of integrated health care*. Substance Abuse and Mental Health Services Administration & Health Resources and Services Administration. https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf

Chang, D., Carlo, A. D., Khor, S., Drake, L., Lee, E. S., Avery, M., Unützer, J., & Flum, D. R. (2021, February). Transforming population-based depression care: A quality improvement initiative using remote, centralized care management. *Journal of General Internal Medicine, 36*(2), 333–340. https://doi.org/10.1007/s11606-020-06136-y

Chapman, E., Chung, H., & Pincus, H. A. (2017, August). Using a continuum-based framework for behavioral health integration into primary care in New York state. *Psychiatric Services, 68*(8), 756–758. https://doi.org/10.1176/appi.ps.201700085

Chung, H., Smali, E., Narasimhan, V., Talley, R., Goldman, M. L., Ingoglia, C., Woodlock, D., & Pincus, H. A. (2020). Advancing integration of general health in behavioral health settings: A continuum-based framework. National Council for Mental Wellbeing. https://www.thenationalcouncil.org/resources/advancing-integration-of-general-health-in-behavioral-health-settings-a-continuum-based-framework/

Chung, H., Smali, E., Goldman, M. L., & Pincus, H. A. (2019). *Evaluation of a continuum-based behavioral health integration framework among small primary care practices in New York state*. United Hospital Fund. https://uhfnyc.org/publications/publication/continuum-based-bh-integration-among-small-primary-care-practices/

Chung, H., Rostanski, N., Glassberg, H., & Pincus, H. A. (2016). *Advancing integration of behavioral health into primary care: A continuum-based framework*. United Hospital Fund. https://uhfnyc.org/media/filer_public/a6/8e/a68eb9d0-514c-4198-8225-c1c195264c28/framework_052616_final1.pdf

Cook, J. A., Jonikas, J. A., Steigman, P. J., Glover, C. M., Burke-Miller, J. K., Weidenaar, J., O'Neill, S., Pavick, D., Jami, A., & Santos, C. J. (2021, August). Registry-managed care coordination and education for patients with co-occurring diabetes and serious mental illness. *Psychiatric Services, 72*(8), 912–919. https://doi.org/10.1176/appi.ps.202000096

Daumit, G. L., Stone, E. M., Kennedy-Hendricks, A., Choksy, S., Marsteller, J. A., & McGinty, E. E. (2019, January). Care coordination and population health management strategies and challenges in a behavioral health home model. *Medical Care, 57*(1), 79–84. https://doi.org/10.1097/MLR.0000000000001023

Druss, B. G., von Esenwein, S. A., Compton, M. T., Rask, K. J., Zhao, L., & Parker, R. M. (2010, February). A randomized trial of medical care management for community mental health settings: The Primary Care Access, Referral, and Evaluation (PCARE) study. *The American Journal of Psychiatry,167*(2),151–159. https://doi.org/10.1176/appi.ajp.2009.09050691

Gold award: Community-based program: A health care home for the "whole person" in Missouri's community mental health centers. (2015, October). *Psychiatric Services, 66*(10), e5–e8. https://doi.org/10.1176/appi.ps.661013

Goldman, M. L., Smali, E., Richkin, T., Pincus, H. A., & Chung, H. (2020, June). A novel continuum-based framework for translating behavioral health integration to primary care settings. *Translational Behavioral Medicine,10*(3), 580–589. https://doi.org/10.1093/tbm/ibz142

Goldman, M. L., Smali, E., Richkin, T., Pincus, H. A., & Chung, H. (2022, January). Implementation of behavioral health integration in small primary care settings: Lessons learned and future directions. *Community Mental Health Journal, 58*(1), 136–144. https:// doi.org/10.1007/s10597-021-00802-z

Katon, W., Russo, J., Lin, E. H. B., Schmittdiel, J., Ciechanowski, P., Ludman, E., Peterson, D., Young, B., & Von Korff, M. (2012, May). Cost-effectiveness of a multi-condition collaborative care intervention: A randomized controlled trial. *Archives of General Psychiatry, 69*(5), 506–14. https://doi.org/10.1001/archgenpsychiatry.2011.1548

Kaye, N. (2021, August 30). *Primary care case management in Medicaid: A strategy for supporting primary care in rural areas.* National Academy for State Health Policy. https://nashp.org/primary-care-case-management-in-medicaid-a-strategy-for-supporting-primary-care-in-rural-areas/

Kingman, E., Ramos, G., Liss, M., & Institute for Community Living. (2021, January 1). *The East New York Health Hub: A model for addressing social determinants of health.* Behavioral Health News. https://behavioralhealthnews.org/the-east-new-york-health-hub-a-model-for-addressing-social-determinants-of-health/

Krahn, D. D., Bartels, S. J., Coakley, E., Oslin, D. W., Chen, H., McIntyre, J., Chung, H., Maxwell, J., Ware, J., & Levkoff, S. E. (2006, July). PRISM-E: Comparison of integrated care and enhanced specialty referral models in depression outcomes. *Psychiatric Services, 57*(7), 946–953. https://doi.org/10.1176/ps.2006.57.7.946

McGinty, E. E., Stone, E. M., Kennedy-Hendricks, A., Bandara, S., Murphy, K. A., Stuart, E. A., Rosenblum, M. A., & Daumit, G. L. (2020, November). Effects of Maryland's Affordable Care Act Medicaid Health Home waiver on quality of cardiovascular care among people with serious mental illness. *Journal of General Internal Medicine, 35*(11), 3148–3158. https://doi.org/10.1007/s11606-020-05690-9

McGinty, E. E., Kennedy-Hendricks, A., Linden, S., Choksy, S., Stone, E., & Daumit, G. L. (2018, March-April). An innovative model to coordinate healthcare and social services for people with serious mental illness: A mixed-methods case study of Maryland's Medicaid health home program. *General Hospital Psychiatry, 51,* 54–62. https://doi.org/10.1016/j.genhosppsych.2017.12.003

Michigan Health Endowment Fund. (2019). *Integrated practice assessment tool.* https://mihealthfund.org/wp-content/uploads/2019/11/HealthFund_IPATPacket.pdf

National Council for Mental Wellbeing. (2024). *Financing the future of integrated care*. https://www.thenationalcouncil.org/resources/financing-the-future-of-integrated-care/

National Committee for Quality Assurance. (n.d.). *Patient-centered medical home*. Retrieved November 8, 2024, from https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

National Committee for Quality Assurance. (2017, November 30). *NCQA adds new distinction for behavioral health integration*. https://www.ncqa.org/news/ncqa-adds-new-distinction-for-behavioral-health-integration/

Parks, J., Leung, K., Schuffman, D., & Heaps, J. (2014). Second meeting on patient reported outcomes and person-centered care in mental health: Diagnosis, prevention and treatment in mental health: Effectiveness and comparative effectiveness. *The Journal of Mental Health Policy and Economics, 17*(supplement 1). http://www.icmpe.org/test1/journal/issues/v17s1toc.html

Parks, J., & Pollack, D. (2005, January). Integrating behavioral health and primary care services: *Opportunities and challenges for state mental health authorities*. http://www.ibhpartners.org/wp-content/uploads/2016/04/Integ-care-State-DMH-policy-financial-issues-Natl-Assoc-State-MH-Dir.pdf

Phelps, J., Bale, J., Squires, K., III, & Pipitone, O. (2020, November). Bipolarity in a collaborative care model variation: Detection, prevalence, and outcomes. Psychiatric Services, 71(11), 1098–1103. https://doi.org/10.1176/appi.ps.202000024

Possemato, K., Johnson, E. M., Beehler, G. P., Shepardson, R. L., King, P., Vair, C. L., Funderburk, J. S., Maisto, S. A., & Wray,

L. O. (2018, July-August). Patient outcomes associated with primary care behavioral health services: A systematic review. General Hospital Psychiatry, 53, 1–11. https://doi.org/10.1016/j.genhosppsych.2018.04.002

Raney, L. E. (Ed.). (2015). Integrated care: Working at the interface of primary care and behavioral health. American Psychiatric Association Publishing. https://doi.org/10.1176/appi.books.9781615370009

Reiter, J. T., Dobmeyer, A. C., & Hunter, C. L. (2018, June). The Primary Care Behavioral Health (PCBH) model: An overview and operational definition. *Journal of Clinical Psychology in Medical Settings, 25*(2), 109–126. https://doi.org/10.1007/s10880-017-9531-x

Resources for Integrated Care. (2014, August 26). *Behavioral health integration capacity assessment introductory webinar*. https://www.thenationalcouncil.org/wp-content/uploads/2020/03/Behavioral-Health-Integration-Capacity-Assessment-BHICA-Introductory-Webinar-8.26.14.pdf

Scheirer, M. A., Leonard, B. A., Ronan, L., & Boober, B. H. (2010, April). *Site self assessment tool for the Maine Health Access Foundation integration initiative*. Maine Health Access Foundation. https://integrationacademy.ahrq.gov/sites/default/files/2020-07/8_MEHAF_SSA.pdf

U.S. Department of Veterans Affairs. (n.d.). *Primary care-mental health integration (PC-MHI)*. Retrieved November 5, 2024, from https://www.patientcare.va.gov/primarycare/PCMHI.asp

Unützer, J., Carlo, A. C., Arao, R., Vredevoogd, M., Fortney, J., Powers, D., & Russo, J. (2020, November). Variation in the effectiveness of collaborative care for depression: Does it matter where you get your care? *Health Affairs, 39*(11), 1943–1950. https://doi.org/10.1377/hlthaff.2019.01714

Unützer, J., Katon, W., Callahan, C. M., Williams, J. W., Hunkeler, E., Harpole, L., Hoffing, M., Della Penna, R. D., Hitchcock Noël, P., Lin, E. H. B., Areán, P. A., Hegel, M. T., Tang, L., Belin, T. R., Oishi, S., & Langston, C. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *JAMA, 288*(22), 2836–2845. https://doi.org/10.1001/jama.288.22.2836

Waxmonsky, J., Auxier, A., Romero, P. W., & Heath, B. (2019). IPAT: Integrated practice assessment tool. Michigan Health Endowment Fund. https://mihealthfund.org/wp-content/uploads/2019/11/HealthFund_IPATPacket.pdf

X. Case Studies

ILLUSTRATED APPLICATIONS OF THE COMPREHENSIVE HEALTH INTEGRATION FRAMEWORK

The CHI Framework can be used to improve integrated services delivery by both behavioral health (BH) and physical health (PH) providers, can be applied to both adult and child service settings and can be useful for both providers and payers.

Consider a community with a BH clinic and PH clinic serving overlapping populations. Each one serves both adults and children. Each one is seeking to achieve a level of integratedness that would earn incentive payments for integrated service delivery from Medicaid and commercial payers. These incentives are tied to addressing anxiety, depression, smoking, diabetes and obesity among adults, and ADHD, anxiety, asthma, substance use initiation and obesity among children. However, each one is in a different starting place for integrated service delivery, and those differences extend to different levels of development for their adult and child populations.

The two clinics can work as partners and use the CHI Framework to help them improve both individually and collectively. They can use the CHI Framework to perform a baseline assessment using the eight domains and can target that assessment separately to adult and child services, as well as targeting the health outcomes of most interest to their payers. Then, each clinic can identify (ideally in collaboration with the payer) which stages they will achieve for adults and children respectively. Note that the BH clinic might choose a different stage for adults than for children and a different stage for either population than the PH clinic. Nonetheless, the clinics can work collaboratively to help each other succeed.

The following examples illustrate how a BH program and a PH program might operationalize each stage to serve an adult with common co-occurring conditions who might access services in either location.

CASE DESCRIPTION

Susan is a middle-aged woman who has low energy and frequent anxiety, leaving her unable to attend to daily tasks, falling behind on her rent and afraid of losing her housing. She has a family history of bipolar disorder. She smokes up to one pack of cigarettes per day. Her PCP informed her two years ago that she may be developing early diabetes.

APPLICATION OF THE THREE INTEGRATION STAGES IN A BEHAVIORAL HEALTH SETTING

Susan presents in a BH setting asking for help with her low energy and frequent anxiety. Her stated goals at intake are to have the energy to maintain her housing, resume her social contacts in the community and have a clean and tidy house where she can invite friends and family.

When presenting in a BH setting, the person receiving services can expect these interventions to occur in programs organized under each stage, following a standard intake, psychosocial intake and mental status exam by the BH clinician.

Integration Stage 1 — Screening and Enhanced Referral

Susan can expect to receive standardized screenings for PCP involvement and medical history, as well as screenings for depression, anxiety and alcohol use and a tobacco assessment. After learning about Susan's history of early diabetes and lack of continuing monitoring by her PCP, the clinician will give her a handout describing diabetes risk factors and how to take steps toward basic self-management. In addition, staff will work with Susan to make a specific appointment with her PCP within four weeks — or help in finding a PCP if she needs a new one — for a wellness visit, with full exchange of information from the BH provider upon Susan's signed consent prior to her PCP visit. The PCP will also be informed about the potential prediabetes history and current smoking and a request to provide the BH clinic with a diagnosis/treatment plan and bloodwork values, including an HbA1c. Aligning with Susan's goal of improving energy and expanding social contacts, the clinician will reinforce how the integrated approach benefits her health care. The clinician records their initial diagnostic impression of depression, with a PHQ9 score of 12, negative MDQ and GAD score of 10, and elects to start brief therapy.

Follow-up: Susan is seen by the off-site PCP, who notes the MDD and GAD diagnosis and care plan. Exam and bloodwork indicate diabetes, with an HbA1c of 8.5 and a diagnosis of obesity. Susan agrees to start a nicotine replacement trial to attempt to cut down on smoking. She is started on diabetes medication, with a recommendation to see a nutritionist and follow up with the PCP in six weeks. The BH care plan is provided to Susan and faxed to the BH agency. The BH clinician, prescriber and office staff apply motivational interviewing techniques to reinforce the PCP's care plan with Susan, as a pathway to achieve her goals. The clinician updates the BH care plan to include the focus on diabetes medication adherence and reinforce attending the nutrition appointment and the smoking reduction trial. The BH office staff record the appointments with the PCP, and the clinician reinforces the adherence in line with Susan's stated goals.

Under Integration Stage 1, the BH provider follows up on a referral to the PCP, ensures that the appointment is kept, coordinates the PCP's work with the BH treatment plan, documents Susan's attendance at the PCP appointment, obtains the PCP visit records and supports continuing adherence as part of Susan's stated goal at intake.

Integration Stage 2 — Care Management and Consultation

Susan is introduced to her health care team, which could include a support staff person (e.g., CHW, care coordinator, peer navigator), a nurse, the prescriber, the BH clinician and, when needed, a health educator to support her in reaching her wellness goals. There is also direct linkage to a PCP. The team can address Susan's concern about losing her housing and how this may be contributing to her anxiety, with follow-up by the support staff to develop a plan to maintain her housing.

All activities undertaken in Stage 1 are initiated, with an additional screening for risk of housing instability, income instability and food insecurity. In Stage 2, the nurse completes a medical history, takes vital signs and draws bloodwork, including relevant general health labs such as HbA1c, thyroid and vitamin levels, ordered by the BH provider. The nurse develops a general health care plan with Susan that includes her goals for wellness and needs for support from the team to meet those goals. The peer/CHW coordinates referral to the PCP, who is directly affiliated with a partner FQHC that has electronic access to the BH record and vice versa. Based on the wellness plan, a member of the team can provide education on diabetes, obesity and smoking reduction as a follow-up to Susan's self-management care plan. The CHW/peer works with Susan on a referral to a social service agency to work on potential housing needs identified on screening.

Ongoing care coordination includes a review of the assessment and plan by the clinic psychiatrist, with a summary email as an e-consult to the PCP. In turn, the PCP supports the psychiatrist, initiating metformin as well as nicotine replacement, with bupropion ruled out because of the family history of bipolar diagnosis. The team members work with Susan to align her wellness goals and understand that her HbA1c and her weight will be routinely monitored to achieve a response goal, much like what she is told about trying to lower her PHQ9 to an achievable target. The plan is recovery oriented and customized to Susan's wellness goals.

Follow-up: The team conducts a formal review after six weeks, with notes from the PCP visit. The peer/CHW reports that, through their weekly contact, Susan is taking her prescribed metformin but having trouble following through on her diet and exercise regimen, and also reports that the nicotine replacement therapy is not helping with smoking reduction. The peer/CHW reviews the wellness plan and discusses how to align better with Susan's strengths and goals by revising the wellness goal for exercise and diet to make it more achievable. This also includes making sure there is alignment with Susan's cultural preferences. The psychiatrist decides to offer Susan varenicline to help with her smoking reduction program.

Under Integration Stage 2, Susan has the involvement of a full care team, with clear accountability from each member for carrying out her treatment and wellness plan; the role of each team member is matched to Susan's needs and preferences. The peer/CHW provides additional support to address SDOH related to housing insecurity. There is also more direct communication with the PCP through emails and electronic record sharing.

Integration Stage 3 — Comprehensive Treatment and Population Management

Susan can expect all the screens in Stages 1 and 2, with the possibility of a team member assisting her in filling them out via the BH clinic portal prior to her upcoming visit. At Susan's intake appointment, the nurse will provide education on her risk factors for diabetes and an approach to smoking education, and Susan is then introduced to a care manager and peer/CHW who will work together to develop a goal-based self-management plan for her depression, anxiety, diabetes and smoking reduction that can address her chief complaint of low energy, feeling paralyzed at home and fear of losing her housing, to help her attain her goal of increasing social contacts and having a tidy household.

The team will encourage Susan to fill out relevant symptom questionnaires monthly through a portal or smartphone reminders, to measure her progress and help the team address any new issues based on the symptom scores. Measures will be tracked in a registry or other database to ensure engagement; the team can aggregate various individuals' documented progress to measure population health improvement, showing progress toward internal QI and payer performance benchmarks. Susan's PCP appointment is provided within the same organization, and a shared EHR makes it easy for all parties to track appointments and adherence. Her housing need is addressed directly by social services, which is also available in the clinic, and progress in obtaining housing is tracked through the shared care plan visible to all care team members. Her diabetes treatment is mainly provided by the PCP in the organization, while the psychiatrist provides smoking cessation treatment, since the motivational support is best provided by the BH team.

Follow-up: As part of routine follow-up, Susan shares with the care manager that she is having difficulty taking her diabetes medication, as it causes some side effects, including times when she reports "foggy memory." The care manager reports this to both the PCP and psychiatrist. The PCP and psychiatrist exchange messages in the EHR and agree that the PCP needs to see Susan next, to rule out hypoglycemia and/or worsening diabetes. Once bloodwork is completed and she is assessed, the psychiatrist can assess mental status and see if a new psychiatric syndrome is developing. Shared treatment and care management plans are available for review and updating by both the PCP and the BH clinicians, as any adjustments to the diabetes medications or new psychotropic medication may alter Susan's blood glucose and weight. The team reviews the self-assessments and progress of the peer/CHW in addressing the housing instability, to determine if resolution of the social determinant reduces anxiety and other psychiatric symptoms and if Susan has improved social contacts.

Under Integration Stage 3, Susan takes a more active role in monitoring and measuring improved health, and the documentation is aggregated for the provider to report on population health improvements, rates of adherence and usage of more restrictive services. The communication between the BH provider and PCP occurs within one EHR, with more frequent and effective information sharing to address new concerns. Data for the service population is addressed at the individual, provider and organizational levels to demonstrate progress toward established goals and improve care pathways as needed.

APPLICATION OF THE THREE INTEGRATION STAGES IN A PHYSICAL HEALTH SETTING

In this example, Susan presents initially to a PH setting (e.g., her PCP), with a chief complaint of low energy and discomfort that prevents her from attending to daily tasks, as well as self-acknowledged poor diet. She shares that she smokes up to one pack per day and was told two years ago by her PCP that she may be developing early diabetes, but she hasn't been back for care since. Her stated goals at intake are to have the energy to maintain her housing, resume her social contacts in the community and have a clean and tidy house where she can invite friends and family.

If presenting in primary care setting, Susan can expect the following to occur in each stage, in addition to standard history and physical exam and bloodwork by the PCP.

Integration Stage 1 — Screening and Enhanced Referral

Susan can expect to receive screening for depression and anxiety using validated screening tools, along with an alcohol screen and tobacco assessment. When the results of the depression and anxiety scores indicate high likelihood of meeting diagnostic criteria for depression, the nurse can provide education about the conditions and assess if Susan is willing to accept a referral to a BH provider that has a collaborative agreement with the PCP. Within the next two weeks, the BH provider completes a BH assessment and then the findings are shared with the PCP. Assessment for tobacco cessation/reduction occurs, and although Susan is interested, the PCP holds off on potential cessation interventions until she is assessed by a BH professional. Susan also has an abnormal HbA1c; further workup and initial treatment begins.

Follow-up: The office staff follow up to verify that Susan is seen by an off-site BH provider, who reports a diagnosis of major depressive disorder and initiates antidepressant medication treatment. After eight weeks of treatment, the BH provider reports improvement based on Susan's improved activity at home and reduction in PHQ9 score. When Susan returns to the PCP, she appears to show signs of increased irritability and decreased need for sleep. The PCP informs the BH provider, who assesses Susan over the phone and then in person or on video the following day. The major depressive disorder diagnosis is updated to bipolar disorder, and medications are adjusted to prevent development of full mania. The BH provider report is faxed to the PCP and included in the PCP care plan.

Under Integration Stage 1, Susan is screened for BH conditions in the primary care setting. The results are interpreted by the PCP, and the scores trigger a referral to a BH provider, who initiates treatment and maintains contact with the PCP, including an adjustment to the diagnosis and medications. The PCP office ensures that Susan keeps the appointment with the BH provider and documents the follow-up in her EHR. Records from the BH provider visit are received and reviewed by the PCP.

Integration Stage 2 — Care Management and Consultation

Susan can expect to receive all the screens, assessments and education above, with the addition of SDOH screening and bipolar disorder screening. In this model, she is introduced to a care team that could include a care manager, care coordinator, peer/CHW or BH consultant and an assigned nurse, all of whom work with the PCP. The BH consultant can speak to the PCP in an informal consultation and explore the BH symptoms with Susan during her PCP visit.

The care coordinator and peer/CHW introduce themselves to Susan to further explore her wellness goals and assess any environmental stressors that may impact her health. Susan shares that she has fallen behind in her rent and has growing anxiety about losing her housing. These staff provide education on community resources in support of her goals. Based on the screens and BH provider assessment, the team develops an initial self-management care plan for Susan, including a referral to a social service agency to work on potential housing and a plan to support her in the process.

With no prior history of mania in Susan, a bipolar screen that suggests a low probability of bipolar symptoms and a history of past use of antidepressants that have helped her, the PCP initiates low-dose antidepressant treatment to help with depression and anxiety symptoms and also sends an e-consult request through the shared EHR to a psychiatric consultant who works with the care manager and is part of the PCP practice team. The consultation allows the PCP to be the ongoing prescriber of the psychiatric medications. Susan also understands that her symptoms will be routinely monitored to achieve a response target, much like what she is told about trying to lower her HbA1c to an achievable target. Measurements are tracked in a registry, to monitor engagement and progress. The BH provider also works with the PCP to actively support tobacco cessation/reduction treatment. The peer/CHW supports Susan through motivational interviewing and continually helps her to recognize and access her strengths as part of her recovery.

Follow-up: As in Stage 1, through routine follow-up, the care manager identifies a new onset of hypomanic symptoms. The BH provider and PCP are alerted, and the psychiatric consultant recommends an adjustment in medications to the PCP and a visit in next 48 hours with the BH provider. The BH provider gives a consult, suggesting that Susan will benefit from BH specialty care over the longer term, and begins to work with the care manager to expedite an external referral.

Under Integration Stage 2, Susan has the support of a team that includes a care manager, a peer/CHW and/or a BH consultant, who work in the same program as the PCP and coordinate care that includes addressing SDOH. The ongoing monitoring provides an early identification of new symptoms and results in timely intervention to adjust the medications and avert an emergency department or inpatient admission. The care manager and peer/CHW provide ongoing support to Susan on her wellness goals and self-management plan, using motivational interviewing skills to help her access her strengths.

Integration Stage 3 — Comprehensive Treatment and Population Health

Susan can expect all the screens in Integration Stage 2 and may fill out the surveys via data entry in the practice portal prior to her visit to the PCP. At the appointment, she is given wellness education and introduced to a care manager and a peer/CHW, who will work together to develop a goal-based self-management plan for depression and anxiety and teach her how to self-monitor for signs and symptoms, such as emergence of any hypomanic/manic symptoms. Susan can expect to fill out relevant symptom questionnaires monthly through portal or smartphone reminders, with symptom scores used both for her clinical care and in aggregate for QI by the practice to meet performance benchmarks. The plan also addresses Susan's housing need, with a referral to social services that are available through the practice and follow-up support by team members. Progress in obtaining housing is tracked through the shared care plan visible to all care team members. Susan's depression and anxiety treatment are mainly provided by the PCP with the support of the integrated BH team. Her tobacco cessation/reduction efforts are also managed collaboratively by the practice team. With regular reports on wellness entered in the agency portal, the provider is able to aggregate results for the full population of people receiving services managed in this stage and report outcomes to payers.

Follow-up: As part of routine follow-up, the care manager suspects an onset of hypomanic symptoms. The BH provider and PCP are alerted, and the psychiatric consultant recommends an adjustment in medications to the PCP and a visit in next 48 hours with the BH provider. The BH provider gives a consult, suggesting that Susan will benefit from BH specialty care over the longer term, and starts an expedited transfer process to the organization's BH specialty department, where her entire treatment record can be reviewed by the BH specialty team. Susan is accepted into the BH treatment program, where psychotherapy and medication management can be provided (along with group therapy offered for individuals with bipolar disorder). Shared treatment and care management plans are available for review and updating by both the PCP and the BH specialty department, as medication adjustment may alter her blood glucose and weight. Susan's care manager and peer/CHW remain part of the team and continue to support her self-management plan and follow up with the social service referral for housing support.

Under Integration Stage 3, Susan is more actively involved with the care team in tracking progress on standardized questionnaires and in developing her own self-management plan. The provider collects more data on her improvement and aggregates it with similar people receiving services to demonstrate an improvement across a broader population and to identify opportunities for improvement in service delivery.

X. Appendices:

Appendix 1: Expert Panel

A small group of co-editors who are leading experts in integration assembled an Expert Panel made up of providers, fellow National Council Medical Director Institute members, trade association representatives, researchers in behavioral health, federal policy experts and payers. The panel met over five virtual conference sessions to help develop the initial version of the CHI Framework published in 2022. The co-editors also facilitated subgroups with several members of the Expert Panel to further develop content.

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Appendix 2:

Definitions

OVERVIEW

These definitions cover key terminology as part of the guidance to providers, payers and regulators on using the CHI Framework to design, implement and evaluate individual integration programs.

Please note that more detailed explanations and practical examples of the terms used in this section, refer to the CHI Framework Definitions and Examples Handbook, which offers further clarification to support the effective application of the CHI Framework.

Comprehensive Health Integration (CHI) Framework: The CHI Framework is an adaptation and application of the previously published Advancing Integration of General Health in Behavioral Health Settings: A Continuum-based Framework (Chung et al., 2020). In CHI, the eight evidence-based domains and the integration elements of the general health integration framework have been revised be applicable to physical health (PH) and behavioral health (BH) settings and to both adult and child populations. The CHI Framework is a roadmap that can function as a measurement tool for "integratedness," permitting PH and/or BH programs and provider organizations to rate their progress in delivering integrated services along the eight evidence-based domains.

Eight Domains of the Bidirectional CHI Framework:

1. **Screening, referrals and follow-up.** This domain encompasses developing methods and systems to identify people receiving services with preventable risk factors for PH conditions in BH settings and risk factors for BH disorders in PH settings, assessing their symptoms and effectively referring to and/or ensuring engagement in care.
2. **Integrated prevention and treatment.** This domain covers the use of evidence-based guidelines and treatment protocols, including tools for ongoing symptom monitoring and strategies for intensifying treatment for people receiving services who do not show improvement. Workflows are developed to reduce and mitigate PH risk factors such as smoking, alcohol use and obesity, as well as common disorders such as depression, anxiety, substance use, diabetes and hypertension, with follow-up mechanisms in place to track outcomes and progress.
3. **Ongoing care coordination.** Ongoing, proactive and relentless follow-up with people receiving services is essential to decrease fragmentation between providers and engage individuals in their care. This domain encompasses the development of tools for electronically tracking and coordinating information, including the use of registries.
4. **Personalized self-management support.** Beyond a focus on medication adherence, this domain covers self-management approaches that support active discussion of improving life quality and function, symptom management and behavior change to help people receiving services and their families understand and manage their condition and promote shared decision-making.

5. **Interdisciplinary teamwork.** Integrated settings foster interdisciplinary teams that share responsibility for treatment, including people receiving services, peers, prescribers, therapists, families and caregivers, as appropriate. Individuals involved in the care team vary depending on a clinic's level of integration. As the care team evolves (including members who work with the person receiving services across different sites), changes in workflow are necessary to break down the silos that frequently exist, so the team can communicate and exchange information on conditions, care and outcomes of the person receiving services with other providers, people receiving services and their families in nearly real time. These changes are not just about breaking down silos but about adapting to and evolving individual roles within the team, which requires everyone to think differently about their clinical identity. Teams often need dedicated time to review the management plans and share information and recommend changes to treatment, when indicated.

6. **Systematic quality improvement.** Effective, continuous quality improvement is another key domain to increasing the capacity and competence of integrated settings. These domain elements are important aspects of moving toward a population health approach. Using and monitoring quality metrics encompassing both process and outcomes is essential to guiding these efforts.

7. **Community interventions to address social determinants of health.** Effective integrated care involves addressing the key social influences and determinants of health, along with PH conditions. This domain focuses on fostering effective linkages to housing, vocational and supportive social services, community organizations and other resources. It also deals with addressing and incorporating relevant social determinants into care plans, addressing disparities and helping to mitigate the impacts of systemic discrimination.

8. **Financial and administrative sustainability.** To ensure integration efforts are sustained, cost monitoring and efficiencies and billing and outcome reporting processes must be developed, with progression to value-based arrangements, as well as provider adaptation to (and state and payer support for changes in) regulatory, payment and licensure requirements, as needed.

Integrated Program: A program organized so that all people served by that program (team, practice) receive a comprehensive array of integrated services and interventions for their PH and BH needs, including both primary and secondary prevention, which in its most advanced form provides comprehensive treatment.

NOTE : There is no one approach to designing a successful integrated program. In fact, there are various organizational and program quality improvement and practice improvement strategies that can be successfully applied to match the needs of the people receiving services within the structure, resources and mission of the program.

Integration is not:

- **Consolidation of separate funding for PH care and BH care.**
- **Putting PH care and BH care under the same lines of authority in the table of the organization.**
- **Having a contract with a managed care organization to manage both PH and BH services.**

These structures are neither necessary nor sufficient to produce meaningful integrated care. Policymakers and payers frequently — and incorrectly — assume that consolidating funding and authority at either the payer or provider level will somehow result in integration simply due to market forces.

Integratedness: The degree to which programs are organized to deliver integrated PH and BH prevention and treatment interventions to individuals or populations, as well as to address social determinants of health. Integratedness is a measure of the integration of structural components (e.g., staffing) and processes directly experienced by people receiving services and providers in PH or BH care settings.

Integration Stage: Three stages are defined by using the evidence-based and conceptual elements of successful integrated care within the eight domains of the framework. PH and BH settings can strive to advance their integration by choosing a stage for which to aim. Progress in implementation of each stage can be measured using the stage-aligned elements in each of the domains. The stages are:

1. **Integration Stage 1: Screening and Enhanced Referral**
2. **Integration Stage 2: Care Management and Consultation**
3. **Integration Stage 3: Comprehensive Treatment and Population Management**

Stages 2 and 3 generally require evidence of proficiency of the elements of the preceding stage (e.g., Stage 2 is achieved when all the elements of the eight domains are achieved for both Stage 1 and Stage 2). While the framework does not require organizations that are implementing integrated care to choose to aim for a particular stage, we believe that the articulation of integration progress in the context of these stages provides value for people receiving services, providers and payers in terms of improved quality in structures, processes and outcomes.

Person-centered Integrated Care: Person-centered care begins with a provider commitment to knowing the people they serve, aligning care with the preferences of the person receiving services and their family and accessing their strengths and skills. In person-centered integrated care, the person with PH and BH (and related human services) needs receives integrated interventions in any setting in which they are regularly engaged, where their trust of the provider is greatest and where they feel that their strengths are best acknowledged. In a PH setting, the integration emphasis is defined by the level of BH services received. In a BH setting, the integration emphasis is defined by the level of PH services received. BH and PH services include efforts to match the needs of the populations served (e.g., depression, anxiety, ADHD, substance use, tobacco use, overweight and obesity, diabetes, hypertension).

Delivery of person-centered integrated services means providing interventions that are matched to the individual's strengths and preferences for prevention and/or treatment of a spectrum of PH and BH health conditions, and addressing related human services needs in settings in which the person prefers to receive care.

Payment Methodologies for Each Integration Stage: Each integration stage requires adequate financing for initial implementation, continued improvement and sustainability. Providers are given options on specific payment methodologies that can support each stage, with an emphasis on how integration activities associated with each stage can produce value for payers and population managers.

Physical Health-Behavioral Health Integration: Integrated care denotes PH-BH integration. PH refers to the prevention and/or treatment of physical conditions and disorders (e.g., hypertension, asthma, diabetes, cancer), including attention to physical disabilities and challenges. BH refers to mental health, substance use disorders, neurodiversity (including intellectual and developmental disabilities, autism spectrum disorder, brain injury) and trauma. Integrated care includes attention to social determinants of health and efforts to address health disparities that create barriers to PH and BH treatment, and it promotes justice and equity in health services.

Quality Measures: Quality measures are standards for measuring the performance of health care providers in caring for people receiving services and populations. Quality measures can identify important aspects of care, like safety, effectiveness, timeliness and fairness. The following terms are applied consistently throughout this paper:

- **Structural measure** — a measure of the characteristics of the environment in which care is delivered (e.g., physical location, virtual/digital and telehealth access, organizational structure, resources, staffing).
- **Process measure** — a measure of a desirable clinical process or practice, such as follow-up within seven days of hospital discharge, most screening measures or adherence to the frequency of measuring treatment response over time (e.g., obtaining HbA1c measures).
- **Outcome measure** — a measure of individual clinical health, treatment or wellbeing, such as diabetes control, blood pressure control or depression response and remission.

Value: Value is defined by measurable improvement in individual or population PH and/or BH outcome measures in relation to expenditure. Relevant outcomes for determining value include quality of care, cost of care, people's experience receiving services and provider experience. For most services and populations, value may involve increased cost, but the improved health outcomes from integrated care outweigh the additional payment. For populations that already have high costs and poor outcomes, value may include both improved health outcomes and equivalent or reduced spending. The satisfaction and experience of both the provider and the people receiving services can also be incorporated into value-based arrangements.

Value Metrics for Each Integration Stage: To demonstrate value for people receiving services, payers and population managers, the framework provides self-rated measures of integratedness in each domain, as well as by integration stage, if desirable. Selected metrics drawn from organizations like the National Quality Forum and the National Committee for Quality Assurance also are provided and are linked to each of the stages to more easily support quality improvement processes and measures that translate to value for key stakeholders such as payers, state authorities and consumers.

Appendix 3:

The Comprehensive Health Integration Framework, Scoring Tracker and Planning for Advancement Worksheet

The Comprehensive Health Integration Framework

Introduction to the Comprehensive Health Integration Framework

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

Using the CHI Framework for Self-assessment

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

Consensus Scoring of the CHI Self-assessment

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

Progress Through Stages

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

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

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

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

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

To indicate full achievement of a stage, all the criteria for the stage must be met in at least six of the eight domains, and no more than one stage lower in the other two domains. The program can score Early or Late Progress as well, based on less or more than 50% of subdomains to achieve the next higher stage. If a program does not meet criteria for Stage 1 for a subdomain or domain, then it is scored Stage 0. **The Scoring and Notes Worksheet** helps document scores and teamwork discussions, maximizing the value of the CHI Framework. The Scoring Tracker summarizes self-assessment results (page 66) and Planning for Advancement Worksheet (page 67) 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.

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 →			
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3. Ongoing care coordination	**3.1 Ongoing care coordination for monitoring progress in the prevention of and intervention for co-occurring conditions.** 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 →			
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4. Personalized self-management support	**4.1 Use of personalized educational materials and skill-teaching interventions for people receiving services and their families.** "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 →			
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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.

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					

Appendix 4:

Getting Started With the CHI Framework: Self-assessment and Planning for Change and Implementation

The Comprehensive Health Integration (CHI) Framework is a measurement tool for assessing the stage of "integratedness" of programs. (View full tool in Appendix 3 on page 51.) It serves to foster an open, quality improvement (QI) conversation that engages team members in understanding the current baseline level of integratedness and in planning specific next steps for improvement.

It is essential that organizations and programs using the CHI Framework refer to the CHI Self-assessment Guide to properly perform self-assessments and accurately score their level of integratedness. The information in this detailed guide is crucial for ensuring correct use of the CHI Framework during the self-assessment process.

The following is a summary of how the self-assessment process is intended to operate. This process is led by a QI team composed of representatives from various programs or service components, as well as different levels of the organization. The team uses the CHI Framework to discuss and assess the program's level of progress for the structure and process elements in each domain and subdomain. Descriptors for each domain guide this discussion, helping the program identify its current stage of integratedness and map out actionable steps for improvement.

Although this discussion on planning change is focused primarily on providers, it is recommended that payers and regulators who wish to use the CHI Framework participate in a QI partnership with their provider networks, as well. One key advantage is the establishment of a common language for payers and regulators to measure progress, assess the value of services and align payment structures accordingly. This creates the opportunity for open discussion about administrative, clinical and financial barriers to progress and provides a much more honest and collaborative assessment of both current state and achievable targets.

To set the stage for this QI process before using the CHI Framework for self-assessment, provider organizations should prepare for the transformation inherent in advancing integration. It is essential to ensure that senior leadership within the organization is committed to improving integratedness and the underlying work needed to achieve that improvement. Equally important is educating staff on how to engage in organized QI and change management and to establish structures and processes to support success. Integration champions from various disciplines can play a vital role in driving the adoption of quality initiatives, co-leading integration training and facilitating self-assessment discussions within the CHI Framework. Evidence from organizational integration success stories also highlights the benefits of non-provider administrative support staff as champions or co-leaders, tapping both their influence and their unique perspective to overcome organizational challenges on the integration journey.

Forming inclusive QI teams that involve all those impacted by these changes is key not only to effectively using the CHI Framework, but also to fostering strong relationships across the organization. This collaborative approach enhances the development of new workflows and ensures that care process changes identified during self-assessment discussions are implemented and sustained over time. By addressing the specific needs of each domain, the organization can make measurable progress in improving its level of integrated care, with the support and participation of a diverse and inclusive QI team.

DEVELOPING IMPROVEMENT PLANS

The CHI Framework is designed primarily to support continuous QI for integratedness. Based on the baseline scoring and mapping, each organization should develop a formal, measurable QI plan that addresses specific achievable opportunities (i.e., SMART goals) for progress. As noted previously, it is strongly recommended that organizations using the CHI Framework map their actual status with as much sensitivity as possible at the appropriate program and population level, rather than trying to pick one number to represent the whole organization. Part of the utility of the framework is to develop a common language for providers, payers and regulators to describe and measure integratedness on a continuum of progress across multiple domains, issues and populations. Providers should engage in a conscious QI effort to measure the baseline, set targets for improvement, measure progress over time and report results to individual providers, agency leadership, community stakeholders, regulators and payers to improve understanding and promote better outcomes for people receiving services.

In the context of the CHI Framework, successful implementation of integratedness supports flexible QI planning. Planning for progress for any program, practice or organization may involve one or more of the following:

- Strengthening the current integration stage: An example would be strengthening Integration Stage 1 by screening for more issues in a greater percentage of people receiving services, or strengthening Integration Stage 2 by adding additional issues to care coordination, registry and outcome tracking.
- Advancing from one integration stage to the next: An example would be not only strengthening Integration Stage 1, but actively seeking to develop processes in several domains that would permit movement of that program from Integration Stage 1 to Integration Stage 2, or from Integration Stage 2 to Integration Stage 3.
- Multiple targets of progress: It is likely that a complex organization with multiple programs, payers and populations may have an improvement plan that includes various targets for different components.

Furthermore, payers, regulators and providers in any system should work collaboratively to identify the best improvement targets for each program, as well as for the provider network and population. Based on types of issues (e.g., depression, substance use disorder, diabetes, hypertension), payer mix, population density, resources, incentives, space limitations and workforce capacity, providers will likely vary in the domains and subdomains they can reasonably expect to advance. Similarly, payers and population managers may vary in the issues that are most important to prioritize, based on overall data on cost and outcomes in the population served (e.g., endemic diabetes, childhood asthma, high prevalence of opioid overdose, significant homelessness with active behavioral health conditions and frequent emergency department visits).

This may in turn determine which integration stages are appropriate for which providers in the network, as well as what types of processes will be incentivized for which prioritized physical health or behavioral health issues or conditions. For example, providers with fewer resources may need to aim for domain elements and associated value metrics within Integration Stage 1 (Screening and Enhanced Referral) and may benefit from near-term payment incentives or direct resources to implement the required interventions for populations or issues (e.g., opioid use disorder) that are prioritized by their payer partners. In the same geography, more well-resourced clinics, such as those embedded in larger organizational structures and those with existing capacity for flexible value-based reimbursement approaches, may be incentivized to achieve more progressed elements (Integration Stage 2 or 3) across more domains — and more types of physical health or behavioral health issues — more readily.

Appendix 5:
Payment Methodology Concepts

CPT CODE SERVICE PAYMENTS

There are Current Procedural Terminology (CPT) service codes that cover a limited number of specific integrated services (either direct care or care coordination) that take place either on a specific date or within a certain time period. Their implementation does not require a practice-wide infrastructure or a minimum volume of people receiving services. These services are usually assigned codes and billed in the same way as other fee-for-service codes. Their specificity allows payers to incentivize or prioritize the particular integration interventions they see as most valuable. Additionally, payers and providers alike can easily track usage of these codes across their client population by provider and by cohort of people receiving services, providing a simple baseline for quality improvement efforts within any of the integration domains.

At the same time, their specificity to a direct service can be a barrier to effective dissemination of evidence-based, effective integrated care. The single code, or even the combination of all specific codes currently available, does not commonly cover costs of many essential elements of integrated service delivery. Meanwhile, the rates are often too low to justify the added documentation and billing burdens. Finally, even when the rates are potentially sustainable, there are regulatory, contractual or vendor-specific limits on billing, which create burdens that disincentivize providers from implementing or maintaining integrated care services.

To ensure the most up-to-date and comprehensive billing information for integrated care, we recommend referring to Financing the Future of Integrated Care (National Council for Mental Wellbeing, 2024). This resource offers extensive guidance on billing, including codes and reimbursement strategies.

Services with Healthcare Common Procedure Coding System (HCPCS) codes (including but not limited to CPT codes) such as those listed below can be found in detail within the Financing the Future of Integrated Care resource:

- **Evaluation and Management**
- **Psychotherapy**
- **Health Behavior Assessment and Intervention**
- **Screening, Brief Intervention and Referral to Treatment**
- **Preventive Medicine**
- **Developmental and Behavioral Screening and Testing**
- **Adaptive Behavior Services**
- **General Behavioral Health Integration Care Management**
- **Specialist Consultation**
- **Health Education, Wellness Coaching**
- **Collaborative Care**
- **Bundled Payment for MAT**
- **Complex Chronic Care Management**
- **Principal Care Management**
- **Transitional Care Management**
- **Interprofessional Telephone/Internet/Electronic Health Record Consultation**

CARE ENHANCEMENT PAYMENTS

This category groups payments that are for a bundle of services, processes, capacities or improvements to the way a practice operates. In addition to reimbursing for specific services or treatments, these payments are intended to improve the overall quality of care. They are useful for ensuring funding of infrastructure for necessary staffing and IT capabilities that are not typically covered through service-specific individual payments. They support a wider and more flexible range of specific processes essential for integration, such as care coordination, team-based care and the presence of behavioral health staff in primary care or the presence of non-reimbursable peer counselors and recovery coaches in a behavioral health clinical setting. Because the payments support a wider range of services/functions with fewer specific requirements, they allow for innovation. The provider has a great deal of flexibility to use resources creatively for each population, allowing providers to allocate the right level of resources to the right people receiving services at the right time, based on need.

However, this also allows implementations to vary greatly across providers. This variability makes it difficult for payers to ensure that payments have been used as intended or to benchmark process indicators across providers. Because the intricacies of upstream improvements to care pathways are not captured by specific codes, it can be difficult or impossible to connect specific changes to improved outcomes or reduced costs downstream. Meanwhile, documentation or periodic reporting to ensure compliance with delineated components can add new or different burdens.

Currently available examples of care enhancement payments include:

- **Per member per month**
  - Person-centered Medical Home
  - Primary Care Case Management (Medicaid)
  - Section 2703 Health Homes
- **Prospective payment system**
  - Certified Community Behavioral Health Clinic
  - Federally Qualified Health Center (in some states)
  - Primary Care First (Medicare)
- **Grant funding methodologies**

VALUE-BASED PAYMENTS

Value-based payments (VBPs) reward providers for improved quality in processes or outcomes and reduced costs (or both), and they are assessed independently from the direct services provided and billed for by a provider. This is typically accomplished through successful demonstration of a minimum set of quality standards. Notably, few providers currently carry downside risk — in which they would lose money for failing to demonstrate minimum standards of quality or exceeding preset spending caps but can achieve significantly higher reimbursement for improved value. Glide paths for moving providers toward downside risk are seen as the evolutionary destination of VBP models, thus transferring responsibility for achieving better quality at lower costs from the payer to the provider.

Currently, all VBPs are rewarded supplementally to individual service payments or care enhancement payments. Providers bill codes or collect payments as usual, and this continues to constitute the majority of provider income. The total VBP being rewarded is often (though not always) codified in a value-based contract, with defined floors and ceilings limited to around 10% of total cost of care being eligible for additional VBP or subject to penalties. VBP arrangements are limited to an attributed population, which can encompass all people receiving services covered by a specific payer, those served by an entire practice, or a subpopulation defined by risk, complexity or specific diagnoses (e.g., serious mental illness or substance use disorder).

On the upside, payers can choose to incentivize adoption of specific care processes that they believe are particularly valuable for integration, or they can reward specific outcomes on which they are most focused (usually those they believe will provide the greatest value). The provider, meanwhile, has substantial flexibility to use whatever portion of the payment is above the actual cost of care for innovation and improvements, in whatever way they see fit. The VBP methodology pushes providers to become more skilled in collecting, aggregating, analyzing and using data to make treatment and management decisions, which will have a ripple effect over time, improving the quality and efficiency of care throughout the organization. Essentially, they are rewarded not just for achieving specific outcomes in the present, but also for becoming more skillful and competent in delivering care in the future.

VBPs also have unique disadvantages. Substantial time lags between service delivery and performance payments — which sometimes are delayed by more than a year while payers collect and aggregate all paid claims from the entire prior year — can dampen enthusiasm and blunt the impact of such models. These lags may create financial hardship for primary care and behavioral health providers who traditionally operate on slim margins. Such lags sap providers' motivation to perform the extra work involved in pursuing process or outcome metrics, while inhibiting innovation and risk-taking by provider entities who can't know if they will receive money — or how much — in the future, to justify expanding valuable services in the present.

Additionally, the rate methodologies to set baseline costs, measure impact and calculate savings and value are extremely complicated, making the administrative burden significant for both payers and providers. Because most value-based contracts are individually negotiated with each payer, and because measures of these costs and quality outcomes, as well as the size of the reward itself, may vary across populations and among payers, providers can be overwhelmed and unable to meet the standards of the contracts. Many providers will not have the financial or data analytic expertise to participate, and payers will be unable to support this detailed level of management with more than a small subgroup of their contracted providers. Since the performance measures vary widely and are highly specific to each VBP contract, providers will not be able to manage the contract effectively unless the contract covers a relatively large share of their overall population served. Payers are unlikely to find this method effective in improving provider performance outside of communities where they have a large market share of all covered people. Inefficiencies and ambiguities inherent to attribution of clearly defined people receiving services and to how data is collected and analyzed can leave providers without a clear sense of who they serve or by what standard they are being measured.

Currently available payment methodologies that include a value-based component include:

- **Accountable Care Organization, including sub-capitation**
- **Medicare Shared Savings Plan**
- **State-based Medicaid savings initiatives**
- **Merit-based Incentive Payment System**
- **Bundled or episode-based payments**
- **Performance-based incentive payments, which are frequently included in the following programs:**
  - Person-centered Medical Home (per member per month)
  - Medicaid Primary Care Management (per member per month)
  - Certified Community Behavioral Health Clinic (prospective payment system)
  - Federally Qualified Health Center (prospective payment system)
  - Section 2703 Health Homes (per member per month)
  - CMS Center for Medicare and Medicaid Innovation Total Cost of Care initiative pilots, which aim to incentivize providers to manage and reduce the overall cost of care while maintaining or improving quality outcomes. These pilots are part of broader efforts by CMS to transition to value-based care.

Appendix 6:

Table and Charts of Integrated Programs and Measures

Abbreviations

ADA: Americans With Disabilities Act
ADD: attention deficit disorder
APA: American Psychiatric Association
BH: behavioral health
BMI: body mass index
ED: emergency department
HEDIS: Healthcare Effectiveness Data and Information Set
MAT: medication-assisted treatment
MOU: memorandum of understanding
NQF: National Quality Forum
OUD: opioid use disorder
PH: physical health
SBIRT: Screening, Brief Intervention and Referral to Treatment
SMI: serious mental illness

Table 1. Examples of Metrics for Each Integration Stage

STAGE	TITLE	BH SETTING EXAMPLE	PH SETTING EXAMPLE
1.	**Screening and Enhanced Referral**	Screening rates for cardiovascular disease or diabetes in people with SMI (per ADA/APA guidelines and HEDIS). Demonstration of at least one care compact or MOU with a PH provider to provide PH care, and percentage with completed referral (clinical documentation of labs and notes) received from referral organization.	Screening rates for select groups (e.g., depression in adults and adolescents, ADD in children and adolescents, anxiety disorders in children, adolescents and adults). Substance use disorders in adults and adolescents (SBIRT approach). Demonstration of at least one care compact or MOU with a BH provider to provide BH care, and percentage with completed referral (clinical documentation of notes) from referral organization.
2. **INCLUDES METRICS FROM STAGE 1**	**Care Management and Consultation**	Percentage of child and adolescent with elevated BMI offered nutritional counseling. Percentage of people receiving services with OUD prescribed MAT within six, 12, 18 months (could be in PH or BH column). Percentage of people receiving services with SMI and diabetes demonstrating control (HbA1c < 9).	Percentage of people receiving services (adult and adolescent) diagnosed with depression with a 50% reduction in depression symptoms using a validated tool (e.g., PHQ9) at six and 12 months (NQF 1884 and 1885). Percentage of the above that reach remission by six and 12 months (NQF 710 and 711).
3. **Includes metrics from Stages 1 and 2**	**Comprehensive Treatment and Population Health**	Reduced usage of ED and inpatient care, improved follow-up post ED, inpatient reduction in 30-day readmissions and total cost of care.	Reduced usage of ED and inpatient care, improved follow-up post ED, inpatient reduction in 30-day readmissions and total cost of care.

Table 2. Alignment of Integration Stages in the CHI Framework for all Ages and Populations

INTEGRATION STAGE	1- SCREENING AND ENHANCED REFERRAL	2- CARE MANAGEMENT AND CONSULTATION	3- COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT
Service scope	Interventions and practices	Program/team	Organization
People served	Individuals	1 + cohorts	2 + populations
Co-occurring issues addressed	At least one (prevention and/or treatment)	Several, according to design	All relevant
Measurement	Mainly screening and referral process measures	Process and some outcome measures	Comprehensive process and outcome measures
Value (health)	Improved health for individuals	Improved health and equity for cohort(s) with complex needs	Improved population health and health equity
Value (cost)	Cost neutral or slightly higher	Reduced cost for high-complexity cohorts	Reduced per capita cost
Payment	Enhanced fee-for-service and quality incentives	1 + care management payment	2 + Shared risk payment