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CENTER OF EXCELLENCE
for Integrated Health Solutions

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

Advancing Integration: Launching the Comprehensive Health Integration (CHI) Framework

February 25, 2025

2:00 – 3:30 PM ET

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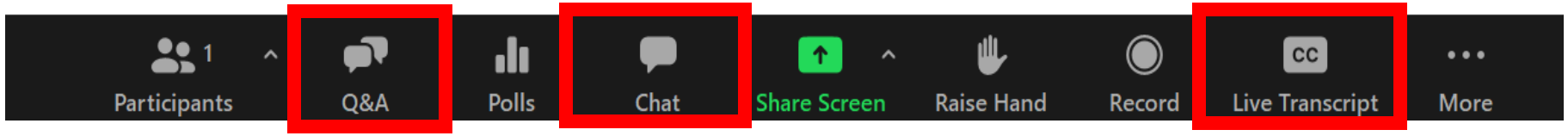
Questions, Comments & Closed Captioning

Type in a **comment** in the **chat box**



Type in a **question in the Q&A box**

Click **Live Transcript** and then select **“Show Subtitle”**

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Speaker Introduction

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Learning Objectives

Understand the CHI Framework: Gain insight into its purpose, structure, and how it supports integrated care.

Recognize the Need for Integration: Learn about challenges in current practices and how the CHI Framework addresses them.

Explore CHI Resources: Discover tools like the White Paper, Self-Assessment Guide, and Handbook to support your integration efforts.

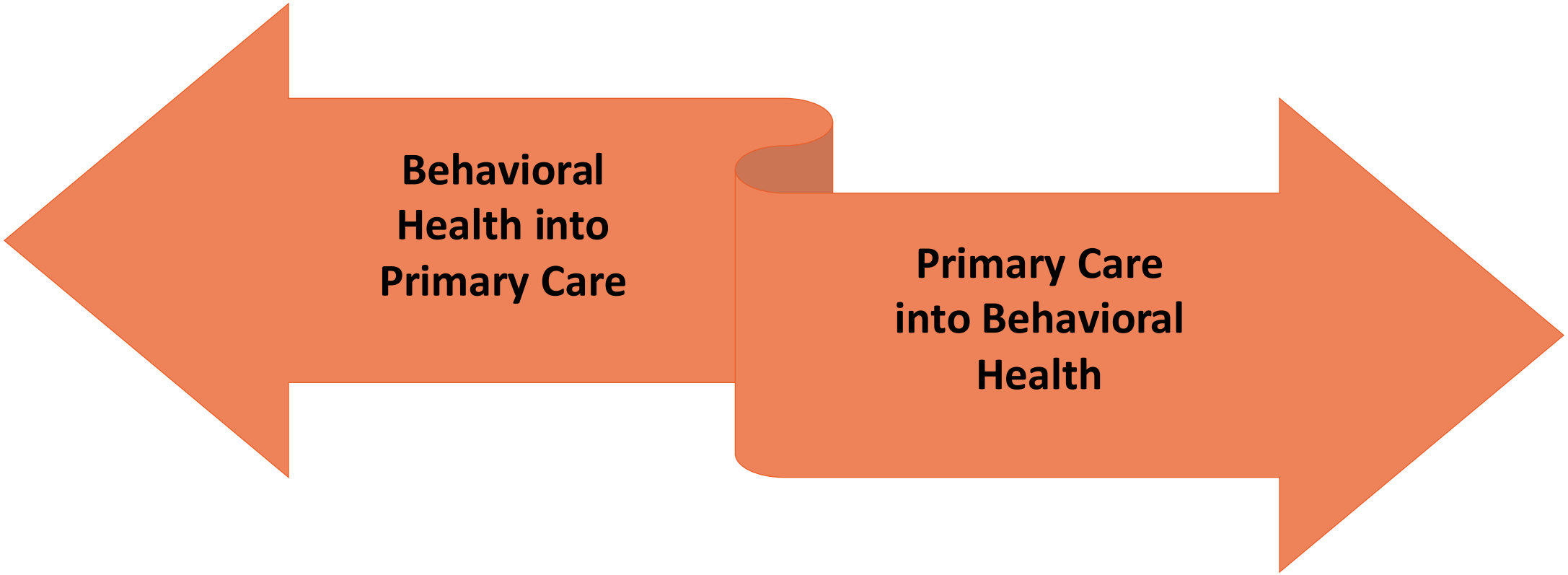
Learn Practical Applications: Understand how to use the CHI Framework to assess integration and plan for improvement.

Gain Implementation Strategies: Take away actionable steps to apply the CHI Framework in your organization.

Learn About Integrated Care Financing: Understand how the CHI Framework connects integration progress to value-based metrics and sustainable financing strategies.

Integrated Care Made Practical: Introducing the CHI Framework

Bi-Directional Integration is Critical



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Why Do We Need a New Framework Now?

People living with co-occurring physical health, behavioral health needs are:

- Highly prevalent and have higher costs yet experience poorer health outcomes
- Faced with significant challenges stemming from social and economic factors across all settings
- Likely to benefit from evidence-based integrated interventions in whatever setting they are best engaged

Source: National Council for Mental Wellbeing. (2025, February 13). The Comprehensive Health Integration Framework. https://www.thenationalcouncil.org/resources/the-comprehensive-health-integration-framework/.

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Why Do We Need a New Framework Now? (cont'd)

Despite progress of knowledge about PH/BH integration, broad uptake of PH/BH integration is very limited compared to the volume of need.

- Many healthcare organizations have not attempted to implement any PH/BH integration
- Implementation is often an isolated special project/service instead of a whole organization transformation
- Implementation is often not sustained or expanded beyond initial grant funding
- Many systems define integration incorrectly, through co-location, merger, or combining funding, without delivering scalable integrated services for people who need them

Policy and Implementation Barriers

Lack of flexibility in implementation of integrated services

Lack of connection of “integratedness” to value

Lack of appropriate bi-directional measures of progress in “integratedness”

Lack of financing to support either implementation or sustainability

Source: Barton, T., Donnellan, J., Harootunian, L., Harris, J., Hartnett, T., Hoagland, G. W., McDonough, D., Newell, B., Nguyen, M., O’Gara, B., Parekh, A., & Serafini, M. W. (2021, March 21). Tackling America’s mental health and addiction crisis through primary care integration. Bipartisan Policy Center. https://bipartisanpolicy.org/report/behavioral-health-2021/

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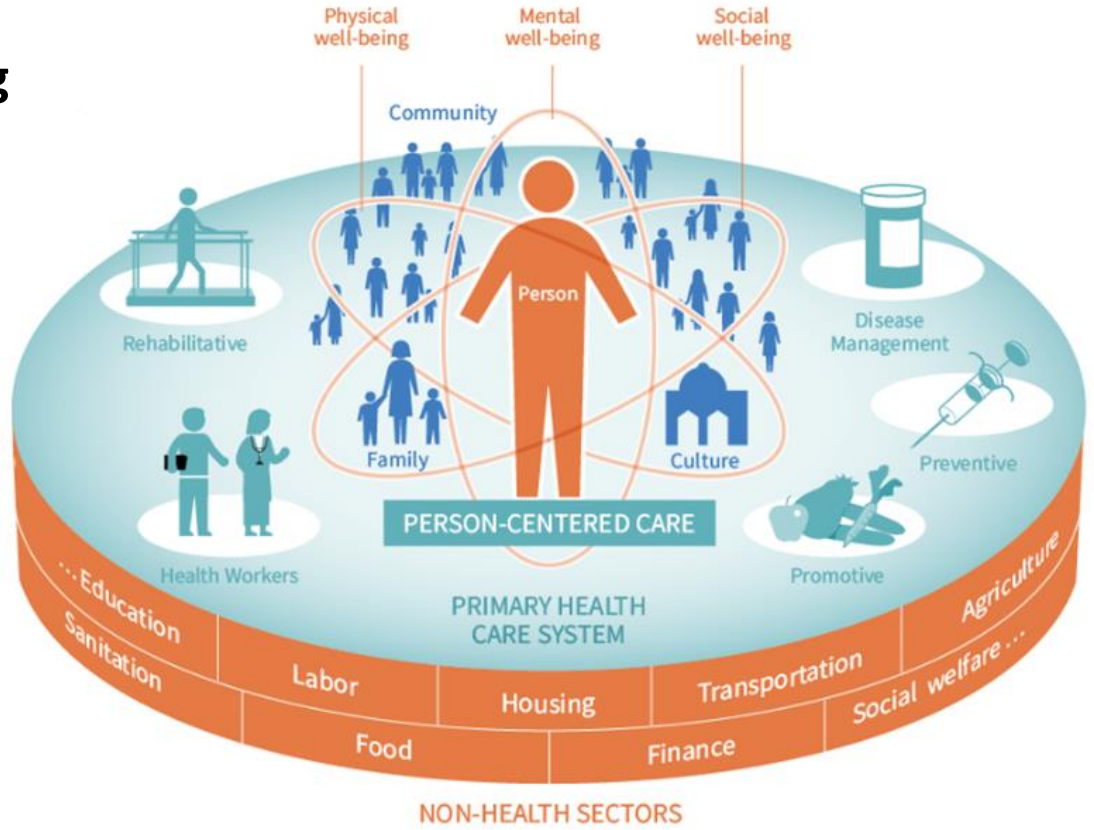
What is the CHI Framework?

The CHI Framework provides guidance on implementing the integration of physical health and behavioral health to help providers, payers and population managers:

- Measure progress and facilitate improvement in organizing delivery of integrated services (“integratedness”)
- Demonstrate the value produced by progress in integrated service delivery
- Provide initial and sustainable financing for integrated service delivery



Source: National Council for Mental Wellbeing. (2025, February 13). The Comprehensive Health Integration Framework. https://www.thenationalcouncil.org/resources/the-comprehensive-health-integration-framework/.

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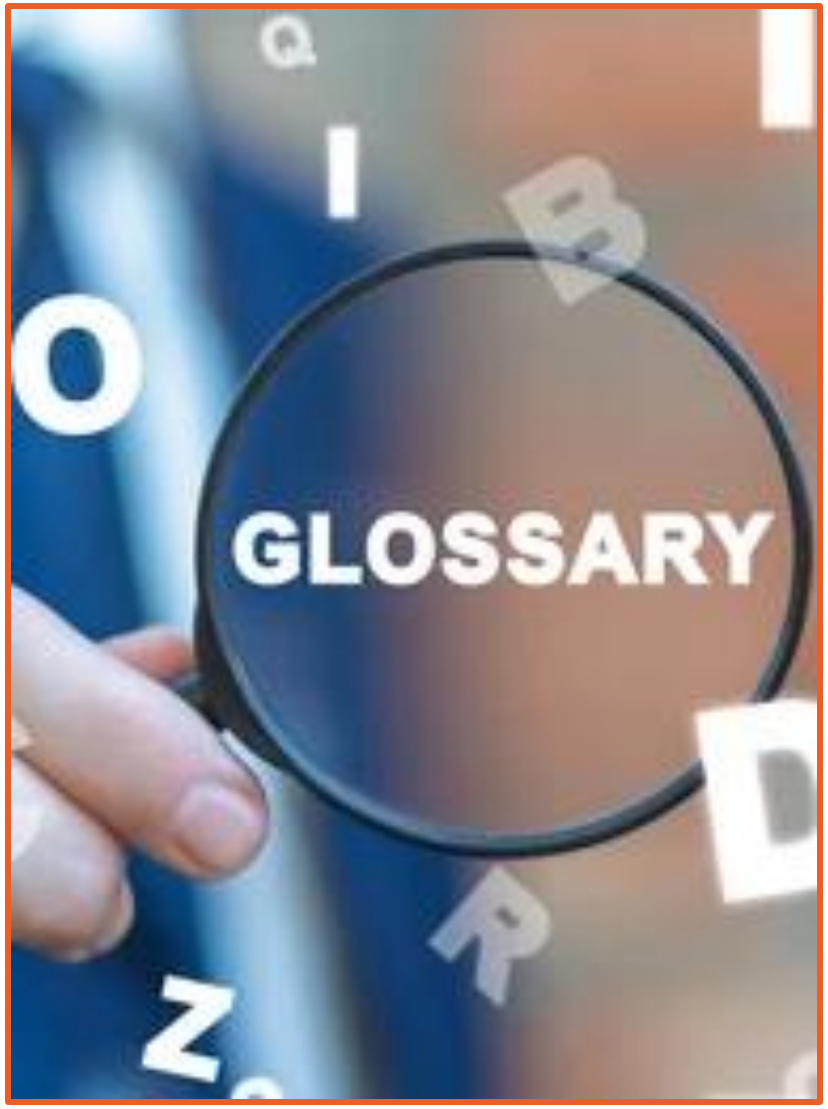


Integrated Services

- The provision and coordination by the treatment team of appropriately matched interventions for both PH and BH conditions in the setting in which the person is most naturally engaged.

Integratedness

- The degree to which programs or practices are organized to deliver integrated PH and BH prevention and treatment services to individuals or populations.
- A measure 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 served and delivered by service providers.

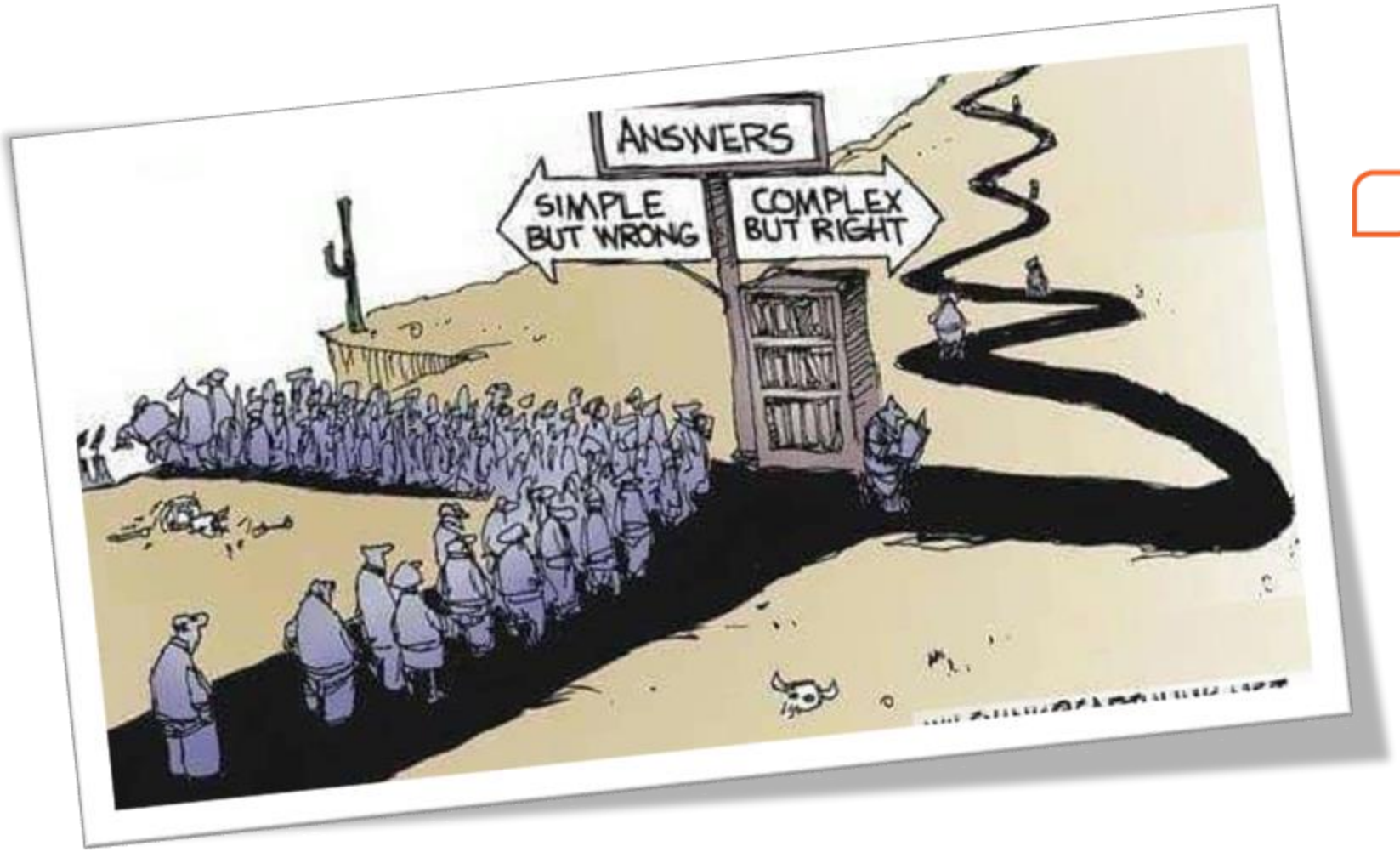
Integration Is Not Produced Or Defined By:

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

None of the above is either necessary or sufficient to produce meaningfully integrated services.

Policymakers, payers, and providers should NOT assume that, if they consolidate funding and authority at either the payer or provider level, integration will somehow occur due to market forces.

Achieving Integratedness



How CHI Supports Existing Integration Models

CHI is inclusive of ALL evidence-based approaches for PH-BH integration, such as CoCM, PCBH, and BHC

- Incorporates CoCM, PCBH, and BHC as part of an inclusive integration framework.
- Provides flexibility to use different models based on organizational needs and resources.

CHI Supports Multiple Evidence-Based Models

- Recognizes CoCM as a Stage 2 integration model but allows providers to implement Stage 1 integration in lower-resourced settings.
- Helps organizations scale efforts across programs and populations without requiring full CoCM implementation everywhere.

CHI Enables Scalable and Flexible Integration

- Aligns integration progress with long-term financing and reimbursement strategies.
- Helps states, payers, and providers track measurable improvements in integrated care.
- Supports system-wide implementation across different healthcare settings.

CHI Enables Sustainability and Value-Based Care

CHI Evaluation, Revision and Implementation

Feedback Session to Evaluate Original CHI Framework (2023)

State-Led Learning Collaborative (2024)

January 2025 Release of Finalized CHI Framework & Companion Resources

Scaling Nationally and Launching CHI TA and Resource Platform in 2025

Characteristics of the CHI Framework

Broad application to both physical and behavioral health settings, and adult and child populations

Provides guidance on implementing the integration of physical health and behavioral health, bidirectionally, to help providers, payers and population managers

Evidence-based domains and subdomains of integration

Measurable standards for and progress to achieve integration stages

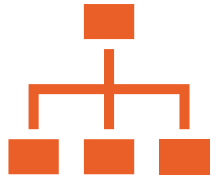
Self-Assessment and Planning Tool

Flexibility of achieving successful progress in integration

Connection of progress in integration to metrics demonstrating value

Connection of payment methodologies to improving value by improving and sustaining integration

Components of the CHI Framework



Eight Domains
(15 Subdomains)
of Integration

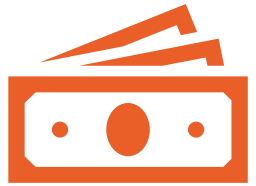
Care processes related specifically to addressing physical health and behavioral health issues in an integrated manner.

Three Integration Stages

Each Integration Stage describes an evidence-based approach to "integratedness" across the Eight Domains, allowing flexible implementation based on a provider's capabilities and population needs.

Integration Metrics

Measuring the degree of integratedness in care delivery and the improvement in outcomes from implementing integration that ties each Integration Construct to Value.



Integration Payment Methods

Demonstrating how to cover costs of implementing and sustaining integration for each Integration Construct, incentivizing creating value through financing integration.

Validation of CHI Builds off Previous Frameworks

BHI Framework Released 2016 + Evaluation Released in 2019

United Hospital Fund
Improving Health Care for Every New Yorker

NYS HEALTH FOUNDATION

Montefiore DOING MORE

Evaluation of a Continuum-Based Behavioral Health Integration Framework Among Small Primary Care Practices in New York State:

Practice and Policy Findings and Recommendations

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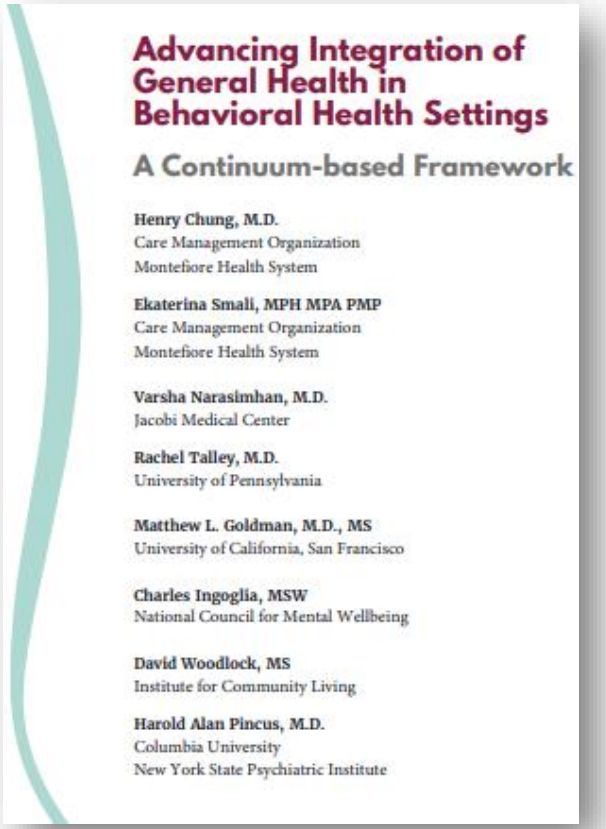
https://uhfnyc.org/publications/publication/continuum-based-bh-integration-among-small-primary-care-practices/

GHI Framework Released 2020 + Evaluation Release in 2025



Advancing Integration of General Health in Behavioral Health Settings

A Continuum-based Framework

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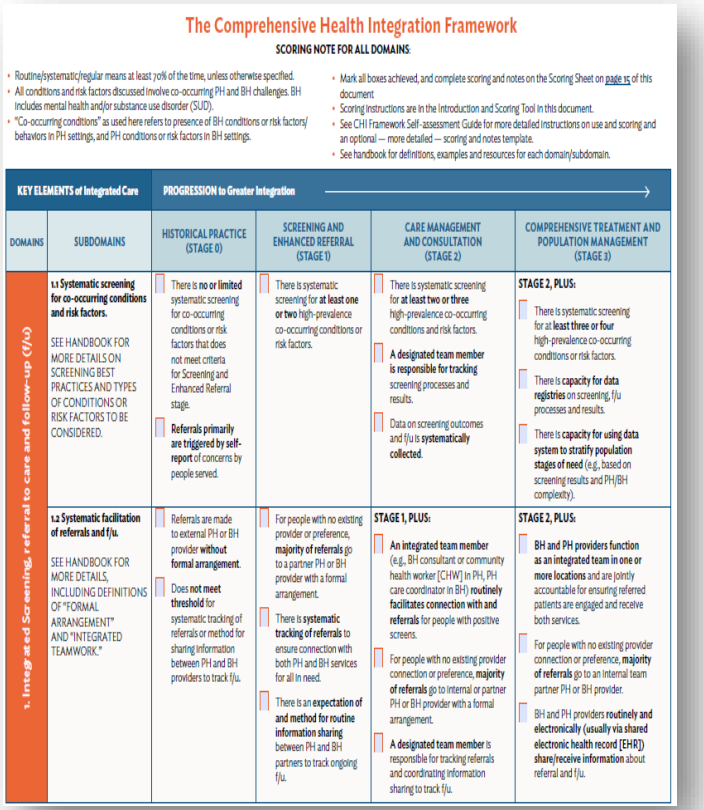
https://www.thenationalcouncil.org/wp-content/uploads/2021/12/GHI-Framework-Issue-Brief_FINALFORPUBLICATION_7.24.20.pdf

CHI Framework Released 2022 + Revised, Launched in Jan 2025



The Comprehensive Health Integration Framework

SCORING NOTE FOR ALL DOMAINS:

- Routine/systematic/regular means at least 70% of the time, unless otherwise specified.
- All conditions and risk factors discussed involve co-occurring PH and BH challenges. BH includes mental health and/or substance use disorder (SUD).
- "Co-occurring conditions" as used here refers to presence of BH conditions or risk factors/behaviors in PH settings, and PH conditions or risk factors in BH settings.
- Mark all boxes achieved, and complete scoring and notes on the Scoring Sheet on page xx of this document
- 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. Integrated Screening, referral to care 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 served.	☐ 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 patients 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.

https://www.thenationalcouncil.org/resources/the-comprehensive-health-integration-framework/

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Eight Domains of Integration

Screening, Referral, and Follow-up

Prevention and Treatment of Common Conditions

Continuing Care Management

Self-Management Support

Inter-Disciplinary Teamwork

Systematic Measurement and Quality Improvement

Linkage with Community and Social Services

Administrative and Financial Sustainability

The Three Integration Stages

Integration Stage 1:
Screening and Enhanced Referral

- Optimizes screening and "enhanced" referral processes
- Does not require significant investment
- Best practice for smaller practices/programs with fewer resources

Integration Stage 2:
Care Management and Consultation

- Includes robust program commitment to a set of screening and tracking processes with associated on-site care coordination and are management

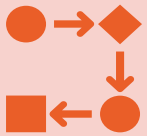
Integration Stage 3:
Comprehensive Treatment and Population Management

- Typically requires comprehensive PH and BH staffing in a single organization (hospital, independent clinical practice, FQHC, etc.)
- Measures improved health outcomes along the Domains

Note: A program would identify as Stage 0 if they have no or limited integration for a domain or subdomain also known as historical practice.

Three Integration Stages and Associated Elements

Each Stage describes an approach that has evidence-based or expert consensus supported core service elements/tasks drawn from the 8 Domains and 15 Subdomains for “integratedness”.



The names of the Stages are driven by the Domains’ and Subdomains’ primary "integratedness" workflows implemented to either measurably improve health outcomes or measurable processes that have been shown to directly result in improved health outcomes.

Each Stage generates metrics to demonstrate value, that in turn justifies investment by payers in methodologies to pay for the initiation and sustainability of that Stage. The metrics and payment methodologies are described in the White Paper.

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Three Integration Stages and Associated Elements

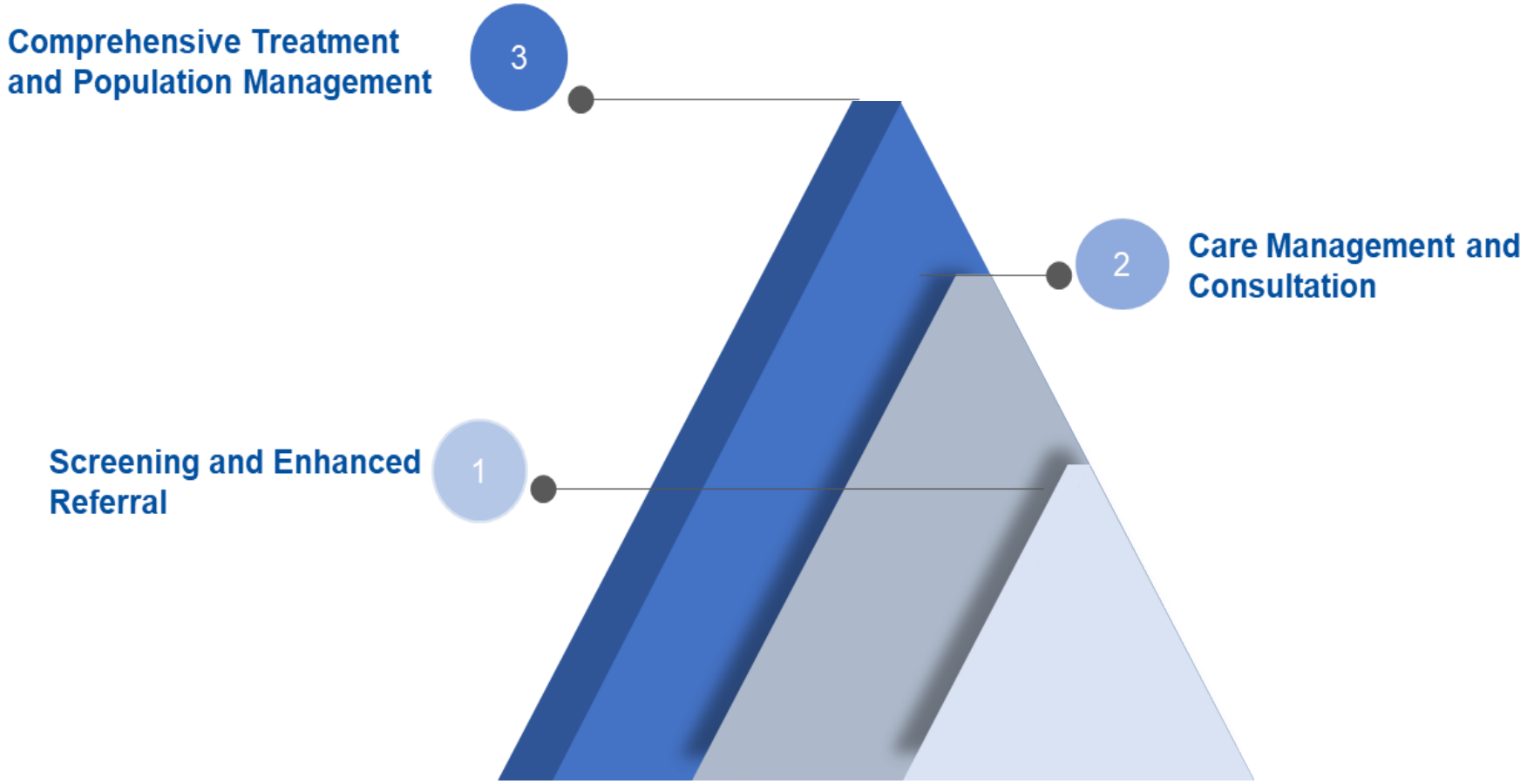
Each Stage can be implemented flexibly depending on the mission, resources, incentives and capabilities of a provider organization/program.

Each Stage is adaptable with some degree of consistency by provider organizations/programs whose initial targets may range from more basic (Stage 1) to more advanced (Stages 2 or 3) "integratedness" based on available resources.

The Integration Stages can be implemented to scale across large systems with flexibility to accommodate diverse PH and BH providers with diverse resources, challenges, and priorities.

The Three Integration Stages

The Stages build on each other as organizations make progress



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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 sheet on page 15 of this document will help you track your scores and note your ideas for improvement. Keeping track of both the scores and the ideas from the discussion about how to improve your integration efforts maximizes the value of the CHI Framework.

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

Last Updated: November 2024

Comprehensive Health Integration (CHI) Framework

SCORING NOTE FOR ALL DOMAINS: ROUTINE/SYSTEMATIC/REGULAR MEANS AT LEAST 70% OF THE TIME, UNLESS OTHERWISE SPECIFIED

Domain 1: Screening, referrals and follow-up; Subdomain 1.1: Systematic screening for co-occurring MH/SUD/PH conditions and risk factors.

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Domain 1: Screening, referrals and follow-up; Subdomain 1.2: Systematic facilitation of referrals and follow-up.

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)
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Using the CHI Framework Tools for Advancing Integrated PH/BH Care:

Implementation Strategies and Pathways to Progress

What is CoE's Role in Supporting CHI Adoption?

Key Responsibilities for Supporting CHI Implementation:

- Equip states, payers and system leaders with instructions and support on how to best use CHI to advance integration.
- Equip providers with practical tools and guidance to conduct CHI self-assessment.
- Facilitate interpretation of results and action planning.
- Encourage adoption of integrated care practices tailored to provider needs.
- Promote a culture of continuous quality improvement through tailored strategies.
- Use CHI data to illustrate progress and support decision-making that enhances patient and organizational outcomes.

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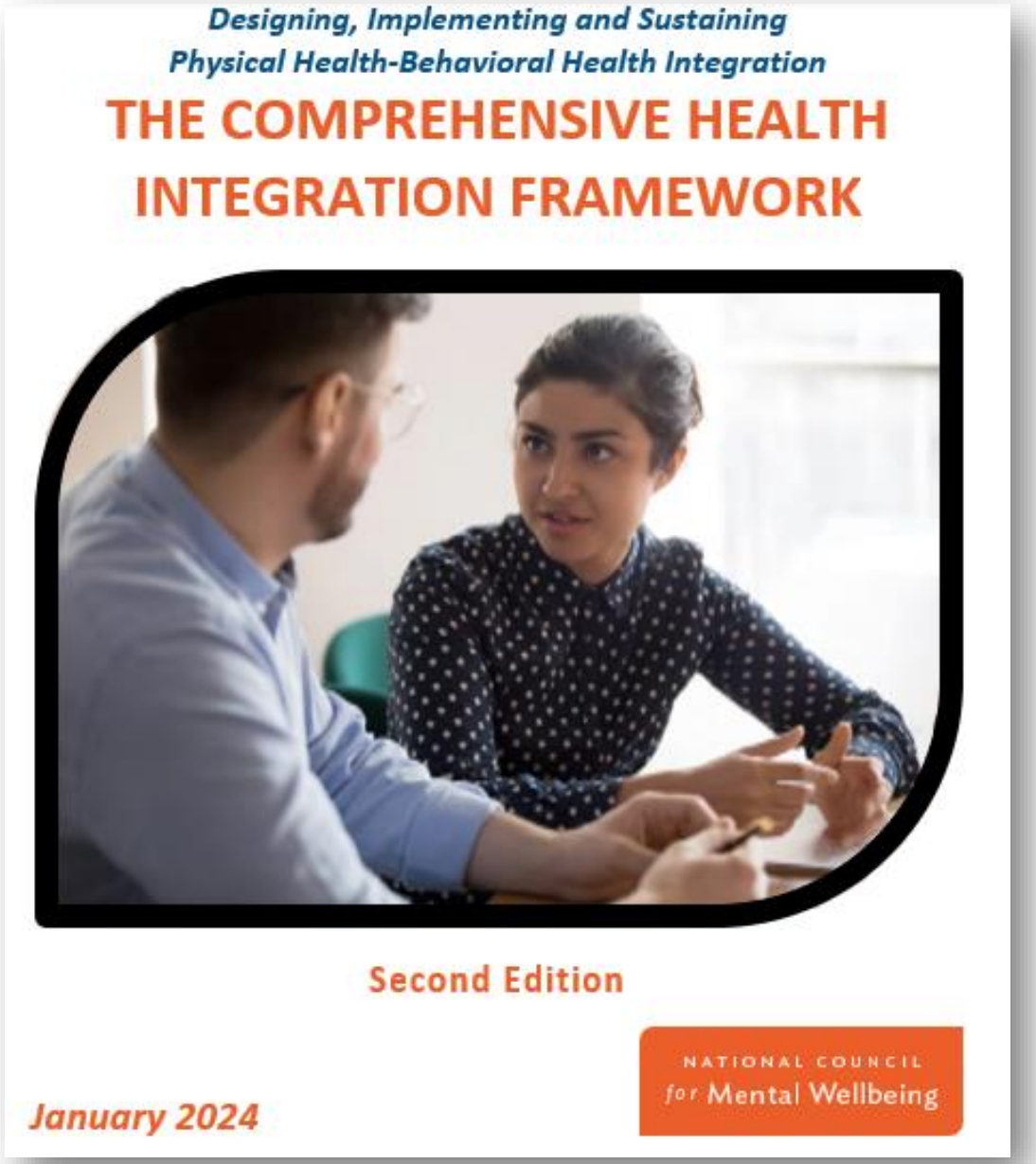
Recapping Resources for Implementing the CHI

Key Documents for Guiding Providers in Integrated Care Self-Assessment and Advancement

Revised White Paper	CHI Framework + Trackers	CHI Self-assessment Guide	Definitions and Examples Handbook
The narrative description of the CHI Framework defining its components (domains, stages, metrics, value, financing) and its application for states, providers and payers.	The CHI Framework self-assessment tool and accompanying CHI Trackers allow users to document their baseline and plan and measure progress.	The Guide provides step-by-step instructions to support interdisciplinary teams in using the CHI Framework self-assessment, ensuring consistent scoring and goal alignment.	The Handbook provides definitions and context-tailored examples to ensure consistent language and understanding of CHI process.



WHAT'S NEW IN THE WHITE PAPER 2nd EDITION

Two Learning Communities Conducted

- Evaluated CHI Framework feasibility.
- Gathered input from 13 national providers and CCBHCs in TX and KS.

Revised CHI Framework

- Scoring indicators are now bulleted and measurable.
- Updated terminology: "Constructs" changed to "Stages."

Enhanced Usability

- Enables better PH/BH integration across programs, practices, and systems of care.

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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 sheet on page 15 of this document will help you track your scores and note your ideas for improvement. Keeping track of both the scores and the ideas from the discussion about how to improve your integration efforts maximizes the value of the CHI Framework.

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

Last Updated: November 2024

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			

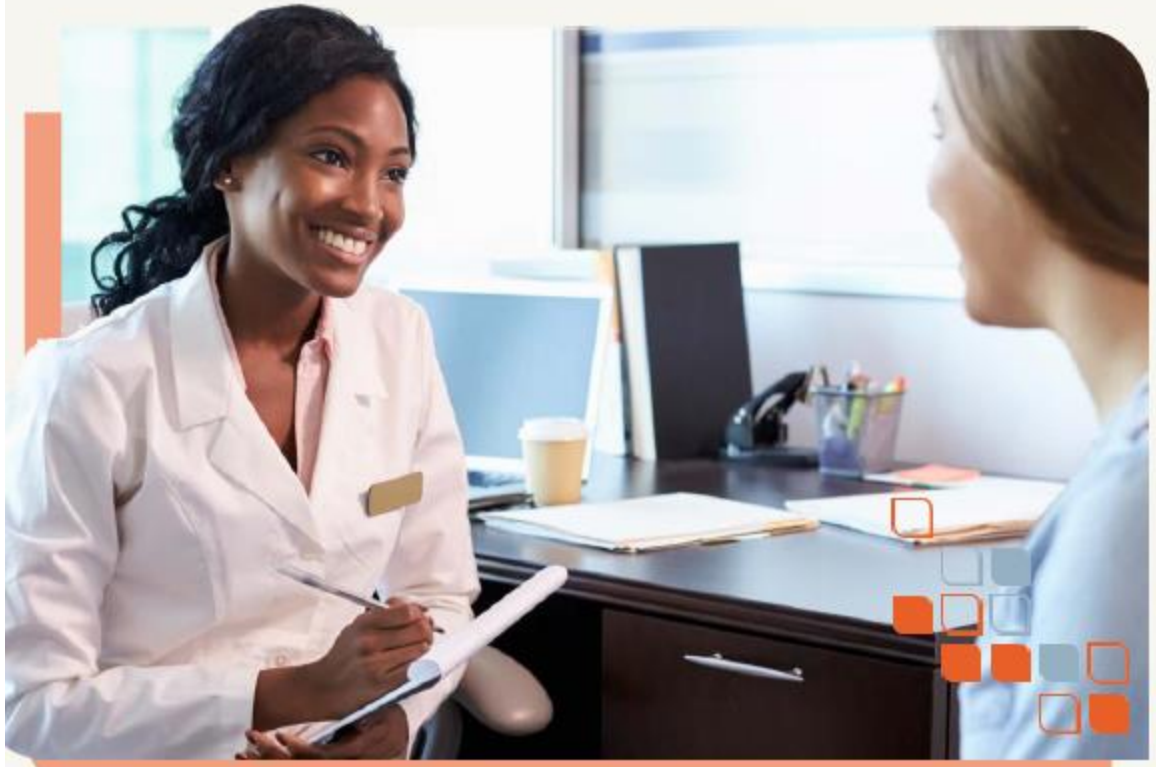
Comprehensive Health Integration Framework Planning for Advancement Worksheet

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					

COMPREHENSIVE HEALTH INTEGRATION FRAMEWORK

SELF-ASSESSMENT GUIDE



GENERAL SCORING INSTRUCTIONS FOR THE CHI SELF-ASSESSMENT TOOL

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

OPTIONAL DETAILED SCORING AND NOTES TEMPLATE - Subdomain Scoring and Notes – Domain 1

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

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

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

COMPREHENSIVE HEALTHCARE INTEGRATION FRAMEWORK

DEFINITIONS AND EXAMPLES HANDBOOK

DOMAIN 1 TERMINOLOGY: INTEGRATED SCREENING, REFERRAL TO CARE AND FOLLOW-UP.

TERM	DEFINITIONS/CRITERIA
Subdomain 1.1: Systematic screening for co-occurring MH/SUD/PH conditions and risk factors.	
Screening	As used here, screening is a procedure or process that can be implemented in one type of setting (PH or BH) to detect potential ("co-occurring", as defined below) conditions, disorders, risk factors, or prevention needs. The goal of screening is always associated with triggering a workflow designed to follow up on positive results. The goal of screening for prevention needs is often to determine whether recommended preventive interventions (e.g., mammograms, developmental evaluations, and so on) are needed. The goal of screening for potential conditions or disorders (e.g., with screening tools, blood tests, blood pressure or BMI measurement) is early detection to facilitate early and effective intervention and to reduce the risk of disease onset or progression. "Screening" as used here does NOT include more advanced procedures (such as mammograms or colonoscopies), even though those are often called "screenings" in common parlance. For the purpose of CHI, those more advanced procedures are "preventive interventions" that need to be referred out of the BH setting in order to be performed.[1]

DOMAIN 1 EXAMPLE/DESCRIPTION: INTEGRATED SCREENING, REFERRAL TO CARE AND FOLLOW-UP.

SETTING	DEFINITIONS/EXAMPLES
SCREENINGS AND ASSOCIATED CONDITIONS may include, but are not limited to:	
BH Setting: Screening for Adult General Health Needs	■ Diabetes (HbA1c or point of care blood sugar); hypertension (BP) ■ Metabolic syndrome (labs); obesity (BMI). 10-year ASCVD Risk Score ■ Nicotine use (Fagerstrom or other screens) ■ Infectious disease (Hepatitis, HIV labs) ■ Presence of a PCP with a visit in the last 12 months ■ Interpersonal violence
PH Setting: Screening for Adult BH Needs	■ Depression (PHQ 2 or 9) ■ Anxiety disorder (GAD 7) ■ SUD (TAPS 2 or 4, AUDIT, NM-ASSIST, TWEAK (for pregnancy)) ■ Nicotine use (included in TAPS and ASSIST) ■ Trauma history (ACES). Implementation resource found here. ■ Interpersonal violence ■ Cognitive screening (Mini MSE) ■ Presence of a BH provider if known SMI diagnosis
Child/Adolescent BH Setting: Screening for Child and Adolescent General Health Needs	■ Diabetes (HbA1c) ■ Asthma ■ Nicotine use (Fagerstrom or other screens) ■ Obesity (BMI) ■ Interpersonal violence in the home ■ Presence of a pediatrician
PH setting: Screening for Child and Adolescent BH Needs	■ Depression (PHQ 2 or 9) ■ Anxiety disorder (GAD 7) ■ ADHD ■ SUD (TAPS 2 or 4; NM-ASSIST, CRAFFT) ■ Nicotine use (included in TAPS and ASSIST) ■ Trauma history (ACES) ■ Interpersonal violence in the home ■ Developmental screening ■ Presence of a BH provider if known SED diagnosis

Setting the Stage for CHI Self-Assessments

- Emphasize that self-assessment done for a selected program with a team comprised of all roles and levels.
- Emphasize the self-assessment as a tool for growth, not evaluation or compliance.
- Encourage open dialogue and consensus among team members to ensure inclusion of diverse perspectives.
- Focus on incremental progress rather than achieving the highest stage immediately.
- Set realistic goals aligned with the provider's current capacity and resources.
- Document strengths, gaps, and opportunities for improvement.

How to keep providers engaged in the process of scoring:

- Highlight quick wins to build momentum and sustain engagement.
- Conduct 1-1 check in with full team to review scores and discuss challenges.
- Address barriers such as limited resources or resistance to change.
- Provide training and resources tailored to providers needs.
- Connect progress to patient and organizational outcomes

Step-by-Step Plan for CHI Implementation and Continuous Improvement

1. Appoint integration lead and **program-specific** interdisciplinary team made up of all levels.
2. Facilitate consensus scoring for domains and subdomains.
3. Use data and team input to determine integration stages for each domain/subdomain.
4. Use the scoring tracker to document results and plan improvements. When feasible, use SurveyMonkey to collect and digitize team responses
   - *Track partial progress using 'early' (*< 50%) *or 'late' (*≥ 50%) *indicators (optional).*
5. After self-assessment complete, calculate integration stages: Screening and Referral (Stage 1), Care Management (Stage 2), and Comprehensive Care (Stage 3) using tracker.
6. Align results with practical improvement opportunities.
7. Prioritize domains for improvement and create a Quality Improvement (QI) plan.
8. Encourage programs to reassess periodically to measure progress and set new goals.

Community Healthcore - Texas (CCBHC)

Best Performance Domains/Subdomains

- Systematic screening for co-occurring conditions and risk factors
- Community interventions

Domains/Subdomains for Improvement

- Financial Sustainability
- Systematic Quality Improvement

Plans for Improvement

- Addressed gaps in integration, such as self-management support skills, and referral coordination (Stage 1) for individuals who already had a PCP, as activities that could be measured and improved, and were financially sustainable.
- Informed the design of a risk stratification tool tailored to population-specific needs, ensuring that limited care coordination resources are directed to those who needed Stage 2 services.

Bert Nash Community Mental Health Center - Kansas (CCBHC)

Best Performance Domains/Subdomains

- Implementation of trauma- and resilience informed practices
- Use of evidence-based guidelines or protocols for prevention/risk mitigation

Domains/Subdomains for Improvement

- Systematic facilitation of referrals and follow up
- Integrated teamwork and sharing of clinical information

Plans for Improvement

- Enhanced collaboration with the Douglas County Public Health Department (which also did its own CHI self-assessment) to support bridging care gaps, improve screening processes, and reduce delays in access to primary care.
- Enhanced use of dashboards for real-time insights into quality measures, demographics, service hours, and financial metrics, enabling data-informed strategies.
- Identified gaps in tracking baseline client health measures to improve functional and quality-of-life outcomes over time.

Montana Healthcare Foundation -
Liz Davies, LCSW, SPO (Physical Heath)

Duration of Tracking

- Working with 22 rural hospitals
- Over 3 years, completing baseline, 12-month, 24-month, and 36-month assessments

Domains/Subdomains Performance Over Time

- Integrated teamwork and sharing of clinical information (best)
- Systematic facilitation of referrals and follow up (best)
- Implementation of trauma- and resilience informed practices (area of improvement)
- Financial Sustainability (area of improvement)

Impact of Long-term Reporting

- Using CHI helped the foundation focus its technical assistance efforts for rural hospitals functioning within limited resources.
- Informed Quality Improvement:
  - Increased integration of evidence-based practices over time.
  - Benchmarked progress to guide technical assistance and policy adjustments.
- Enhanced Sustainability Planning:
  - Implemented consistent billing practices and explored profitability models for Integrated Behavioral Health services.

2024 CHI 2.0 Self-Assessment Results

DATA FROM 22 GRANTEES

MONTANA HEALTHCARE FOUNDATION

	HISTORICAL PRACTICE		SCREENING & ENHANCED REFERRAL		CARE MANAGEMENT & CONSULTATION		COMPREHENSIVE TREATMENT & POPULATION MGMT	
DOMAINS	0	0.5	1	1.5	2	2.5	3	3.5
1.1	0%	5%	0%	36%	9%	23%	18%	9%
1.2	0%	5%	5%	23%	0%	14%	5%	50%
2.1	0%	14%	9%	27%	18%	27%	0%	5%
2.2	0%	14%	0%	18%	5%	59%	0%	5%
2.3	0%	5%	0%	27%	14%	32%	5%	18%
2.4	5%	45%	0%	23%	5%	14%	0%	9%
3.1	0%	23%	0%	32%	0%	27%	9%	9%
4.1	0%	9%	18%	14%	14%	27%	9%	9%
5.1	0%	9%	5%	14%	5%	23%	27%	18%
5.2	0%	14%	5%	18%	0%	18%	18%	27%
5.3	0%	18%	0%	32%	5%	36%	5%	5%
6.1	5%	41%	14%	18%	5%	18%	0%	0%
7.1	0%	23%	0%	23%	9%	27%	14%	5%
8.1	0%	32%	14%	41%	9%	0%	5%	0%
8.2	0%	45%	0%	14%	5%	23%	0%	14%

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Current CHI Implementation in Oklahoma

CHI learning collaborative for all CCBHCs led by Joan King, Senior Consultant, National Council.

Healthy Minds Initiative planning a potential CHI learning collaborative for payers and health providers.

Leveraging the CHI Framework for Financial and Administrative Sustainability:

Financing Strategies

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. 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 however (such as FQHC grant) does contribute.*** *SEE HANDBOOK FOR MORE DETAIL, 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 for this domain.* • *Payment for integrated health services is limited to one-time grant or gift funding opportunities and target specific services, staff type or populations.* • *Limited expertise in any billing or reimbursement opportunities for integrated health activities including Screening and Enhanced Referral.* • *Limited capacity to optimize workflows and staff roles with limited impacts on minimizing cost. conducted on site.*	• *Finance staff are collaborating 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.* • *Has initiated collaboration discussions re shared value with one or more providers or payers for whom improving integration would produce measurable value.* • *Optimizes workflows and staff roles to deliver Screening and Enhanced Referral services efficiently,* • *Has expertise and routine processes for FFS billing and receiving reimbursement for providing Screening and Enhanced Referral interventions.* • *Routine process in place for tracking and improving reimbursement for integrated PH/BH services provided.*	***SCREENING/ENHANCED REFERRAL PLUS:*** • *Active collaboration of finance staff and clinical staff in organized QI processes (Domain 6) for ongoing development of sustainable integration.* • *Has initiated collaborations with two or more providers or payers for whom improving integration would produce measurable value and has identified metrics that would demonstrate progress toward value and that could support actual or potential incentive payments.* • *Conducted landscape analysis of all available reimbursement or billing opportunities for Care Management and Consultation.* • *Integration QI team optimizes workflows and staff roles to deliver Care Management and Consultation services efficiently.* • *Has expertise in and routine processes for billing FFS, and (if available) bundled services and/or care management payments for providing the interventions in this Construct, and tracks reimbursement and cost for such services.* • *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.*	***CARE MANAGEMENT AND CONSULTATION PLUS:*** • *Clinical and financial leadership routinely provides shared 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.* • *Has worked with payer or provider (e.g., health system) collaborators to agree on and implement metrics that demonstrate value (improved outcomes relative to spend).* • *Demonstrates ability to continuously improve workflow optimization and track cost relevant to improving population PH/BH outcomes.* • *Participates in one or more value-based arrangements or incentives that reasonably cover relevant costs in relation to achievement of referenced PH/BH outcome metrics for the targeted population served.* • *At least 70% of costs of all integrated services provided are covered by generated revenue and incentive payments.*

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	SUBDOMAINS	HISTORICAL PRACTICE (Stage 0)	SCREENING AND ENHANCED REFERRAL (Stage 1)	CARE MANAGEMENT AND CONSULTATION (Stage 2)	COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT (Stage 3)
8. 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.*** *SEE HANDBOOK FOR MORE DETAIL, INCLUDING DEFINITIONS OF TERMINOLOGY SUCH AS PROVIDER LICENSURE AND PROGRAM LICENSURE AND REGULATORY STANDARDS.* ***NOTE: Re using 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 they experience themselves as tightly connected. Note that 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.*	• *Licensed and/or regulated as a PH OR BH provider with no or limited guidance for providing integrated interventions for people with co-occurring PH/BH conditions.* • *Does not meet criteria for Screening and Enhanced Referral for this subdomain.*	• *Within the scope of existing (usually a single type of) licensure for the program or practice, has 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, has established written instructions or procedures for providing and documenting integrated Screening and Enhanced Referral interventions.*	***SCREENING AND ENHANCED REFERRAL PLUS:*** • *Within the scope of existing licensure for program or practice, has written instructions or procedures for providing and documenting Integrated Care Management and Treatment.* • *Within the scope of practice of existing (usually single types of) licensure/certification for individual service providers, has established written instructions or procedures for providing and documenting the integrated processes and interventions included in this Construct.* • *Established procedures for documentation of internal consultation or service provision by a provider with the "other" license.* • *IF AVAILABLE: Meets requirements for state or payer certification for this Stage, such as CCBHC, BH Health Home, etc.*	***CARE MANAGEMENT AND CONSULTATION PLUS:*** • *Program/practice is part of an organization or organizational structure that provides both licensed PH AND BH services in shared physical and/or virtual service arrangements routinely throughout the continuum.* • *Program/practice is part of an organization that routinely provides documented instructions or guidelines for clinical staff with either PH or BH licenses/certifications for how to deliver and document any type of integrated services consistent with their jobs, Stages of training, and scopes of practice defined by their licenses or certifications.* • *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.*

Financing Goals

Financing implementation

- Initial implementation of an Integrated Stage: *example-staffing, care processes and infrastructure needed to provide Integration Stage 1 (Screening and Enhanced Referral).*
- Strengthening an existing Stage: *by adding more types of conditions or interventions, expanding access of those interventions 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*: supporting investment in necessary staffing, technology, infrastructure and change management to make progress in the relevant CHI Framework Domains.*

Financing sustainability

- 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

Current Procedural Terminology (CPT) Service Code Payments (usually fee-for-service)

- Single Service payment codes: (e.g., screening, individual care coordination, etc.)
- Bundled service payment codes: (e.g., COCM, Medication treatment for opioid use disorder, etc.)

Care Enhancement Payments (usually PMPM or PPS)

- A bundled payment for provision of specific service structures and processes, for the entire population served or (for per member per month) for a defined population.

Value-based Payments (VBPs)

- Usually, a supplemental payment for achieving a prospectively determined value target.
- Provides reward (and sometimes penalty) linked 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.

Examples of Currently Available CPT Codes Relevant to Integration

- HBAI codes – CPT 96156- 96171
- SBIRT CPT - codes 99406-99409
- Preventive Medicine (99401-99412)
- BH screens and repeat measures (96127)
- Developmental/Behavioral screens (96127)
- Adaptive Behavior Services (97151-97158)
- General Behavioral Health Integration Care
- Management – CPT 99484
- CPT codes for specialist consultation (99241-99245)

- CPT codes for health education, wellness coaching
- Collaborative Care codes
- Bundled payment for MAT
- Medicare – Chronic Care Management, Complex CCM, Principal CM, Transitional Care Management TCM
- Interprofessional Telephone/ Internet/Electronic Health Record Consultations codes 99446, 99447, 99448, 99449, 99451 to report interprofessional telephone/ Internet/electronic health record consultations

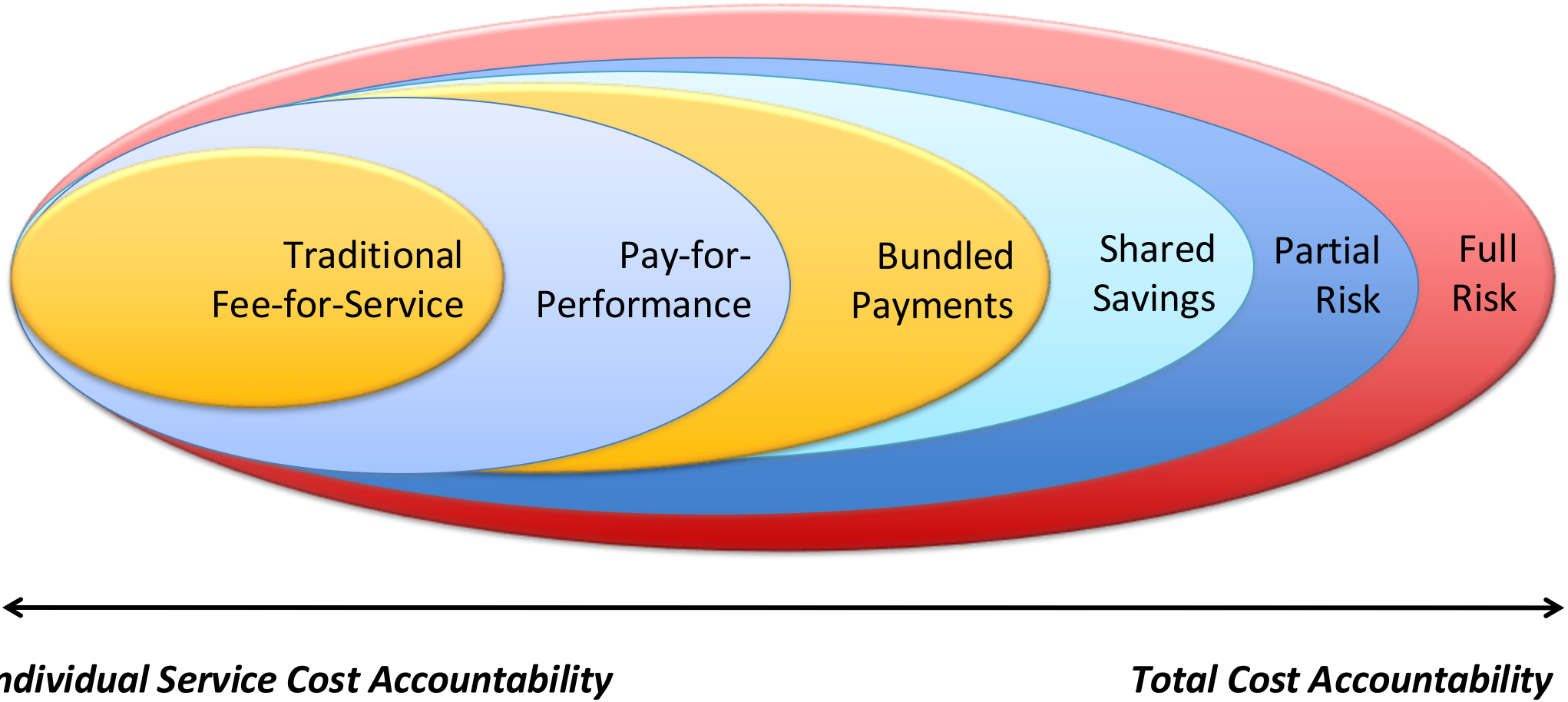
Currently Available Examples of Care Enhancement Payments May Include:

- **Per-member, per-month (PMPM) payments**
  - Person-Centered Medical Home (PCMH)
  - Medicaid Primary Care Management (PCCM)
  - Section 2703 health home for chronic conditions (behavioral health and physical health as well as SUD and child and adolescent populations)
- **Prospective Payment System (PPS)**
  - Certified Community Behavioral Health Center (CCBHC)
  - FQHC in some states
  - Primary Care First (Medicare)
- **Grant funding methodologies**

Currently Available Payment Methodologies That Include a Value-Based Component:

- Accountable Care Organizations (ACO) including sub-capitation
- Medicare Shared Savings Plan (MSSP)
- State-based Medicaid Savings Initiatives
- Merit-based Incentive Payment System (MIPS)
- Bundled or Episode-based Payments
- Performance-based Incentive Payments (PBIP), which are frequently included in the following programs:
  - Person-Centered Medical Home (PCMH) PMPM
  - Medicaid Primary Care Case Management (PCCM) PMPM
  - Certified Community Behavioral Health Center (CCBHC) PPS
  - FQHC
  - Section 2703 health home for chronic conditions – PMPM

Types of Payment Methodology



Payment Methodologies to Facilitate Implementation of Integrated Stages

Implementation Grants

- Initial costs of planning, consultants, new staff recruitment, training, IT costs, technical assistance.

CPT Code Payments

- Useful to incentivize implementation and utilization of selected specific interventions (developmental screening- 96127).
- Setting the rate above breakeven is often necessary to adequately incentivize the investments in staffing and infrastructure to implement.

Care Process Bundled Payments

- Useful to incentivize multidisciplinary care processes that are applied across multiple specific treatments such as care coordination and disease management.
- Usually requires reporting on staffing and processes for accountability.

Value-based Payments

- Versatile, can be applied to either implementation goals (Structure or process) or outcome goals.
- Easy to change over time as initial goals are met and new goals are chosen.

Matching Payment Methodology to Sustainability of Each Integration Stage

Integration Stage 1 – Screening and Enhanced Referral

- A time-limited start up grant to cover initial implementation costs
- CPT code services that specifically support integration with rates set to adequately cover costs and incentivize uptake
- Value-based incentive payment for timely implementation of the necessary screening and referral structures or performance measures related to screening and referral

Matching Payment Methodology to Sustainability of Each Integration Construct

Integration Construct 2 – Care Management and Consultation

- A time-limited grant to cover implementation costs of evidence-based integration programs
- Bundled Care Enhancement Payments with rates set to adequately costs of the specified staffing and integration processes

Matching Payment Methodology to Sustainability of Each Integration Stage

Integration Stage 3 – Comprehensive Treatment and Population Management

- Substantial access to Care Enhancement payment or risk-based capitation payment
- Value-based incentive payments for integration processes and outcomes

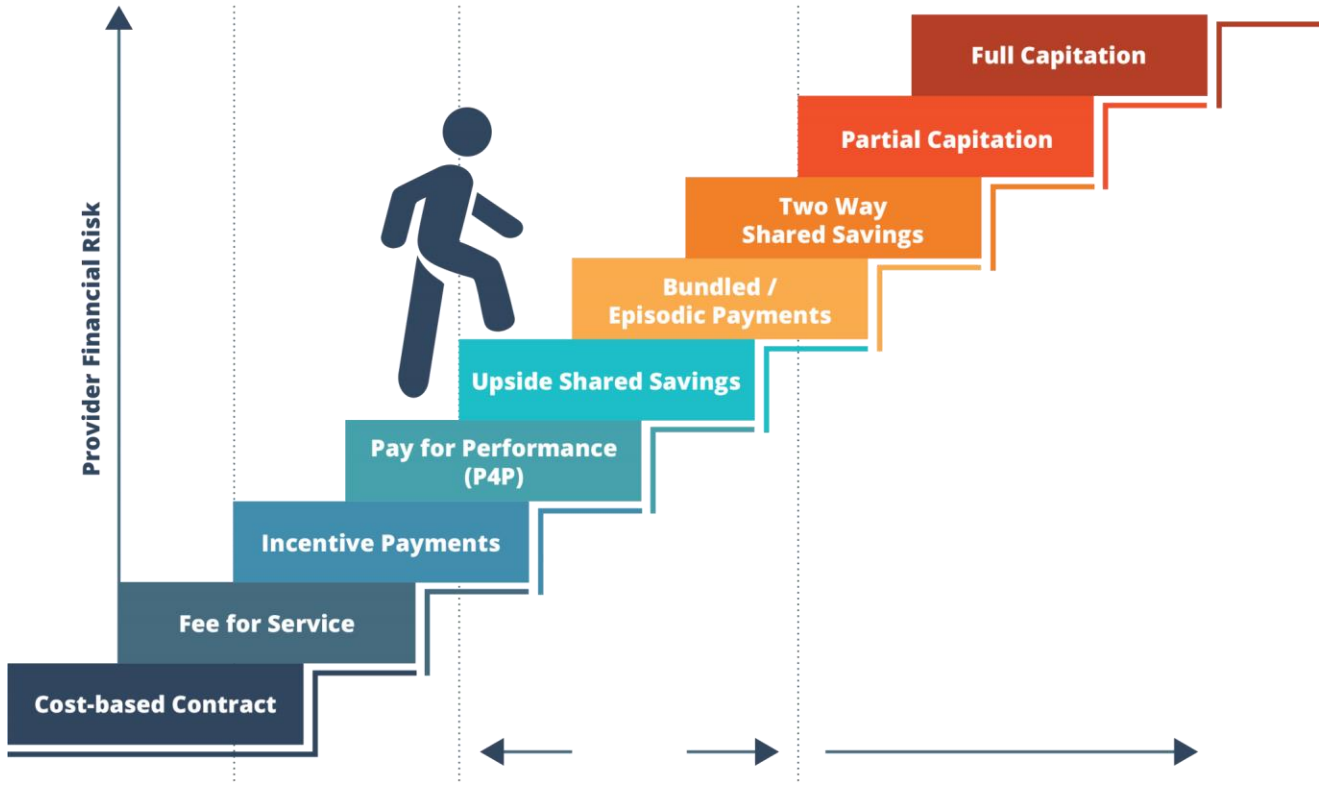


Image Source: Health Management Associates. (2023, September 16). *Value-based payment (VBP): Is your organization ready?* Health Management Associates. https://www.healthmanagement.com/blog/value-based-payment-vbp-is-your-organization-ready/

Recommendations for Policymakers

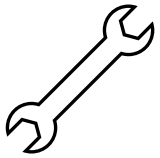
Eliminate all prohibitions on billing for a primary care and BH service on the same day.

Improve coverage and rates for CPT code payments that support integration.

Expand and incentivize CCBHCs and FQHCs to provide integrated care services and measures according to the CHI Framework and Stages.

Adopt all-payer integration initiatives using the CHI Framework to improve evaluation of processes and outcomes and reduce variability across payers.

Tools & Resources



National Council for Mental Wellbeing

- The Comprehensive Health Integration Framework and Companion Tools
- Center of Excellence for Integrated Health Solutions – Resource Home Page
- CIHS Standard Framework for Stages of Integrated Care
- CIHS Essential Elements of Effective Integrated Primary Care & Behavioral Health Teams
- General Health Integration Framework – Advancing Integration of General Health in BH Settings
- Behavioral Health Integration Framework – Advancing Integration of Behavioral Health in PH Settings
- Utilizing an Evidence-based Framework to Advance Integration of General Health in Mental Health and Substance Use Treatment Settings – Blog post
- Medical Director Institute – Home Page
- High-Functioning Team-Based Care Toolkit
- Organizational Assessment Toolkit for Primary & Behavioral Health Care Integration
- Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers

Other

- Agency for Healthcare Research & Quality – Implementing a Team-Based Model in Primary Care Learning Guide
- Health & Medicine Policy Research Group – Behavioral Health Primary Care Integration

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Questions and Discussion

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for Mental Wellbeing

End-of-Session Poll Questions

See pop up box for **poll questions.**

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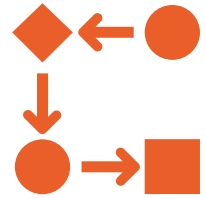
CHAT WITH AN EXPERT!

Schedule a free call with an integrated care expert to discuss:



Implementing Models of Integrated Care

Access to Integrated Care

Population Health in Integrated Care

Workforce Development

Integrated Care Financing & Operations

Addressing Ongoing Workforce Challenges

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Helpful Links

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Questions?

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HEALTHY MINDS
STRONG COMMUNITIES

Domain 2 Integrated prevention/ treatment for common co-occurring PH and/or BH conditions; Subdomain 2.1: Use of EB guidelines or protocols for prevention/ risk mitigation related to co-occurring PH, BH, and social conditions.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	SUBDOMAINS	HISTORICAL PRACTICE (Stage 0)	SCREENING AND ENHANCED REFERRAL (Stage 1)	CARE MANAGEMENT AND CONSULTATION (Stage 2)	COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT (Stage 3)
2. Integrated prevention/treatment for common co-occurring PH and/or BH conditions.	***2.1 Use of EB guidelines or protocols for prevention/ risk mitigation related to co-occurring PH, BH, and social conditions.*** *Prevention/risk mitigation interventions may include, but are not limited to:* • *Developmental and Adverse Childhood Experiences (ACES) screenings/education* • *One or more USPSTF screenings: education, referral, f/u* • *Education addressing screening that shows risk (e.g., borderline diabetes or risky substance use)* • *Reducing risk of suicide or overdose* *SEE HANDBOOK FOR MORE DETAIL, AND EXAMPLES OF CONDITIONS AND INTERVENTION/ RISK MITIGATION PROTOCOLS IN EACH SETTING*.*	• *Guidelines or protocols for initiating and following up recommended preventive/risk mitigation interventions are either absent or not followed routinely.* • *Frequency of recommended preventive/risk mitigation interventions for any issue is less than the threshold needed for Screening and Enhanced Referral stage criteria.*	• *There is education for staff on the importance of patient education and follow up on recommended prevention activities and on indications from screening for potential risk.* • *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 individuals receive the intervention and follow-up, as recommended.* • *There are systematic mechanisms and procedures for routine coordination and information sharing with outside providers that receive referrals to perform prevention or risk mitigation interventions.*	***SCREENING AND ENHANCED REFERRAL Criteria are met for TWO interventions/risk issues, PLUS:*** • *All staff are educated to understand the importance of patient education and follow up on recommended prevention activities and on indications from screening of potential risk.* • *There is a mechanism for tracking and/or care coordination for targeted preventive interventions that uses recommended standard workflows (using expert consensus guidelines when available) for f/u on positive results.* • *Preventive/risk mitigation intervention frequency and follow up are routinely monitored for adherence to the recommended protocols.*	***CARE MANAGEMENT AND CONSULTATION Criteria are met for THREE interventions/risk issues, PLUS:*** • *The program/practice/ organization tracks prevention/risk mitigation efforts for the population served and uses the data for feedback on continuously improving those efforts.*

Domain 2 Integrated prevention/ treatment for common co-occurring PH and/or BH conditions; Subdomain 2.2: Use of EB guidelines or protocols for NON-PHARMACOLOGIC professionally delivered/directed treatments for common diagnosable co-occurring PH or BH (MH/SUD, including nicotine) conditions and/or for addressing relevant health behaviors (e.g., diet, exercise) that may affect those conditions.

KEY ELEMENTS of Integrated Care		**PROGRESSION to Greater Integration** →			
DOMAINS	SUBDOMAINS	HISTORICAL PRACTICE (Stage 0)	SCREENING AND ENHANCED REFERRAL (Stage 1)	CARE MANAGEMENT AND CONSULTATION (Stage 2)	COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT (Stage 3)
2. Integrated prevention/treatment for common co-occurring PH and/or BH conditions.	***2.2 Use of EB guidelines or protocols for NON-PHARMACOLOGIC professionally delivered/directed treatments for common diagnosable co-occurring PH or BH (MH/SUD, including nicotine) conditions and/or for addressing relevant health behaviors (e.g., diet, exercise) that may affect those conditions.*** *SEE HANDBOOK FOR MORE DETAIL AND EXAMPLES OF CONDITIONS AND HEALTH BEHAVIORS, PLUS EXAMPLES OF ASSOCIATED INTERVENTION PROTOCOLS IN EACH TYPE OF SETTING.*	• *Protocols for initiating and continuing non-pharmacologic treatments, co-occurring conditions or health behaviors are either absent or not followed per the protocol.* • *Frequency of non-pharmacologic intervention for any co-occurring condition or health behavior is less than the threshold needed for Screening and Enhanced Referral stage criteria.*	• *There is evidence of training or competency defined within scope of practice (e.g., for skill teaching) for at least ONE team member in at least ONE non-pharmacologic intervention for a co-occurring condition or relevant health behavior.* • *At least 70% of individuals 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 EB or best practice non-pharmacologic interventions within their scope of practice (e.g., for skill teaching) for at least TWO co-occurring conditions and/or health behaviors.* • *At least 70% of individuals 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.*	***CARE MANAGEMENT AND CONSULTATION Criteria are met at the 70% stage for THREE conditions, PLUS:*** • *The program/practice/ organization tracks intervention outcomes for the population served and uses these data for continuous quality improvement.*

Domain 2 Integrated prevention/treatment for common co-occurring PH and/or BH conditions; Subdomain 2.3: Use of EB or recommended Guidelines or protocols for -PHARMACOLOGY interventions to treat or mitigate common co-occurring PH or BH (MH/SUD, including nicotine) conditions.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	SUBDOMAINS	HISTORICAL PRACTICE (Stage 0)	SCREENING AND ENHANCED REFERRAL (Stage 1)	CARE MANAGEMENT AND CONSULTATION (Stage 2)	COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT (Stage 3)
2. Integrated prevention/treatment for common co-occurring PH and/or BH conditions.	***2.3 Use of EB or recommended Guidelines or protocols for -PHARMACOLOGY interventions to treat or mitigate common co-occurring PH or BH (MH/SUD, including nicotine) conditions.*** *Examples may include but are not limited to: IN BH SETTINGS: metformin for HBA1c reduction/weight gain mitigation, tobacco/nicotine cessation medication support, or thyroid for Li-induced hypo-thyroidism; IN PH SETTINGS: common antidepressants, ADHD meds, tobacco/ nicotine medication support, and SUD/MOUD medication.* *SEE HANDBOOK FOR MORE DETAIL AND EXAMPLES.*	• *Limited prescribing for co-occurring PH or BH conditions that does not meet Screening and Enhanced Referral stage criteria.* • *Medications for co-occurring PH or BH conditions are almost always provided by referral to "other" type of prescriber to treat.*	• *For at least 1 co-occurring PH or BH conditions, there are protocols by which for selected individuals, prescribers will either initiate certain medications or continue to prescribe stable 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.*	***SCREENING AND ENHANCED REFERRAL 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 2 selected co-occurring conditions, using the consulting prescriber as needed for assistance with initiation or ongoing management.* • *There are care coordination workflows for tracking medication interventions and results for those individuals receiving them.* • *There are measures used to systematically document and monitor response to these interventions.*	***CARE MANAGEMENT AND CONSULTATION PLUS:*** • *Prescribers routinely work as a team (on-site or virtually) to initiate and manage a range of medications for common co-occurring PH or BH conditions, with routine collaboration with "co-occurring" team members to provide consultation as needed.* • *More than 70% of individuals receiving medication for both a PH and BH condition are receiving their medication from a single team.* • *The program/practice/ organization tracks medication intervention efforts and outcomes for the population served and uses the data for feedback on continuously improving those efforts.*

Domain 2 Integrated prevention/ treatment for common co-occurring PH and/or BH conditions; Subdomain 2.4: Implementation of trauma and resilience informed practices.

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/treatment for common co-occurring PH and/or BH conditions.	***2.4 Implementation of trauma and resilience informed practices.*** *Trauma-informed is used as shorthand in the CHI Framework too.* *SEE HANDBOOK FOR MORE DETAIL 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 would meet Screening and Enhanced Referral stage criteria.* • *Staff training in the impact of trauma on people experiencing BH and PH challenges has not been systematically implemented to the extent that would meet Screening and Enhanced Referral stage criteria.*	• *There is a systematic policy or process to create a welcoming, person-centered, trauma-informed culture, with priority to welcoming, non-traumatizing engagement of people with complex PH/BH needs.* • *All team members have received training on impact of trauma on people with PH/BH and on initiation of basic welcoming, person-centered, trauma-informed approaches to engaging people with complex needs.*	***SCREENING AND ENHANCED REFERRAL PLUS:*** • *Adoption in policy of trauma-informed care strategies, procedures, and protocols* • *Implementation of at least ONE measure of customer-experience (e.g., survey including question about experience in care of safety or traumatization) as part of continuous improvement of trauma-informed care.* • *Training and consultation for staff team on how to use trauma-informed, strength-based language and approaches for people with complex PH/BH needs who have difficulty with treatment adherence.* • *Access to consultation and/or referral for provision of evidence-based trauma-specific treatment for selected individuals.*	***CARE MANAGEMENT AND CONSULTATION PLUS:*** • *Implementation of person-centered trauma-informed care strategies, procedures, and protocols by treatment team at all stages.* • *Customer-oriented quality improvement efforts support ongoing implementation of the person-centered trauma-informed care practices for both new and continuing persons/people served.* • *Persons/people served have access to evidence-based trauma-specific treatment within the organization.* • *Capacity to provide trauma-informed behavioral interventions by the team for individuals who are struggling with experiencing safety in addressing their co-occurring PH/BH concerns.*

Domain 3 Ongoing Care Coordination and Care Management; Subdomain 3.1: Ongoing care coordination for monitoring progress in the prevention and intervention for co-occurring PH/BH conditions.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
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3. Ongoing Care Coordination and Care Management.	***3.1 Ongoing care coordination for monitoring progress in the prevention and intervention for co-occurring PH/BH conditions.*** *NOTE: Care coordination includes attention to coordinating resources and interventions addressing social determinants of health. This function is addressed specifically in Domain 7.* *SEE HANDBOOK FOR MORE DETAIL, INCLUDING DEFINITIONS AND GUIDANCE FOR SCORING IN EACH STAGE.*	• *Does not meet threshold for having a systematic process for ongoing engagement and 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 individuals who are referred for co-occurring PH or BH care.* • *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) with designated responsibility for care coordination for co-occurring conditions.* • *Team members (care coordinators) routinely provide continuing patient engagement to encourage and monitor the process of receiving prevention and/or ongoing treatment interventions for co-occurring conditions.* • *Team members (care coordinators) routinely monitor and report THE PROCESS AND OUTCOMES of ongoing prevention and/or treatment interventions for co-occurring conditions.*	***CARE MANAGEMENT AND CONSULTATION PLUS:*** • *Able to provide a continuum of intensities of care coordination based on different stages of need within the populations served.* • *For individuals with co-occurring conditions: utilization of tracking tool and/or disease registry to monitor OUTCOMES: prevention intervention results and/or treatment responses.* • *For identified cohort with co-occurring conditions: utilization a tracking tool and/or disease registry to monitor COHORT OUTCOMES: prevention intervention results and/or treatment responses.*

Domain 4 Self-management support that is adapted to patient's culture, socio-economic and life experiences; 3.1: Use of educational materials and skill teaching interventions to promote patient/family activation and self-management of co-occurring PH or BH conditions and risk factors, with adaptations for literacy, economic status, language, cultural norms.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	SUBDOMAINS	HISTORICAL PRACTICE (Stage 0)	SCREENING AND ENHANCED REFERRAL (Stage 1)	CARE MANAGEMENT AND CONSULTATION (Stage 2)	COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT (Stage 3)
4. Self-management support that is adapted to patient's culture, socio-economic and life experiences.	***4.1 Use of educational materials and skill teaching interventions to promote patient/family activation and self-management of co-occurring PH or BH conditions and risk factors, with adaptations for literacy, economic status, language, cultural norms.*** *"Family" as used here refers to both biological or chosen family, as well as other involved natural supports.* *"MATERIALS" INCLUDES HANDOUTS/PAMPHLETS/TOOLKITS/WEB-BASED RESOURCES AND SO ON. PATIENT ACTIVATION MAY INCLUDE USING ADVANCE DIRECTIVES FOR "CO-OCCURRING" CONDITIONS. SEE HANDBOOK FOR MORE DETAILS AND EXAMPLES.*	*Any materials or interventions for patient/family education on co-occurring PH or BH conditions or risk factor screening recommendations or for teaching PH and/or BH healthy behavior skills are not provided to meet Screening and Enhanced Referral stage criteria.*	• *Patient/family education materials are provided for at least 1 co-occurring PH (in a BH setting) or BH (in a PH setting) condition and at least 1 risk factor screening recommendation.* • *Basic materials for teaching PH and/or BH healthy behavior skills are available for at least 1 co-occurring PH or BH 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.* • *Materials provided are adapted for literacy, economic status, threshold languages, or cultural norms.*	*SCREENING AND ENHANCED REFERRAL PLUS:* • *Education materials are delivered routinely for at least 2 co-occurring PH or BH conditions and 1-2 risk factor screening recommendations.* • *Basic materials/interventions for teaching PH and/or BH healthy behavior skills are delivered routinely for at least 2 co-occurring conditions or risk factors.* • *All of the above materials is adapted for literacy, threshold languages, or culture for the population served.* • *Brief patient/family education using these materials is delivered via in-person or technology application.* • *Education 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 members of the treatment team.* • *70% of treatment plans include self-management goal setting for identified co-occurring PH/BH condition or risk factor.*	*CARE MANAGEMENT AND CONSULTATION PLUS:* • *Education materials are delivered routinely and ongoingly for at least 3 co-occurring PH or BH conditions and 1-2 risk factor screening recommendations.* • *Materials/interventions for teaching PH and/or BH healthy behavior skills are delivered routinely and ongoingly for at least 2 co-occurring conditions or risk factors, with practical strategies for patient activation and healthy lifestyle habits.* • *Education materials include information about access to integrated treatment for co-occurring conditions within the program, practice, or organization.* • *Self-management skills training and activation supports are routinely able to be provided by the team to scale (as indicated) through technology applications.* • *Materials are routinely adapted for literacy, threshold language, or culture for the population served.* • *Policies and training on using these materials and interventions is provided to all members of the treatment team. Including peers and/or CHWs.* • *Self-management skills and goals for co-occurring conditions and risk factors are routinely outlined in treatment plans, and progress is monitored as part of care management.*

Domain 5. Interdisciplinary team (including the patient) with dedicated time to provide integrated PH/BH care; Subdomain 5.1: Integrated Care Team Composition.

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 team (including the patient) with dedicated time to provide integrated PH/BH care.	***5.1 Integrated Care Team Composition.*** *INTEGRATED CARE REFERS TO ADDRESSING BOTH BH AND PH.* *SEE HANDBOOK FOR MORE DETAILS AND EXPLANATION OF TERMS.*	• *BH OR PH service provider with patient, and family caregiver (if appropriate).* • *Any integrated team composition or capacity does not meet Screening and Enhanced Referral stage criteria.*	• *BH OR PH service provider with patient, and family caregiver (if appropriate).* • *Other care team members may assist 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 Case Management and Consultation stage criteria.*	• *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 consultant(s) and/or BH care coordinators with dedicated time available to PH team. One or more PH consultant(s) (nurse/care coordinator) available to BH team.* • *Routine access to consultation from a BH psychiatrist/NP/PA in a PH setting or a PCP/NP/PA in a BH setting.*	*CARE MANAGEMENT AND CONSULTATION PLUS:* • *PH and BH staff, with care managers/coordinators, work as integrated teams in-person or virtually throughout the continuum with patients/ families.* • *Peer support or community health workers are routinely included on treatment teams throughout the continuum.*

Domain 5. Interdisciplinary team (including the patient) with dedicated time to provide integrated PH/BH care; Subdomain 5.2: Integrated teamwork and sharing of clinical information between members of the integrated team, including assessments, treatment interventions, case reviews, care plans and feedback.

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 team (including the patient) with dedicated time to provide integrated PH/BH care.	***5.2 Integrated teamwork and sharing of clinical information between members of the integrated team, including assessments, treatment interventions, case reviews, care plans and feedback.*** *SEE HANDBOOK FOR DESCRIPTION OF THE FIVE PRINCIPLES OF EFFECTIVE TEAMS, INFORMATION ON INFORMATION SHARING REGULATIONS, AND MORE DETAILS ON DEFINITIONS AND TERMINOLOGY.* *"Visibility" in records means the notes are present and easily located for review.*	*Sharing of treatment information and feedback between BH and PH providers in different settings is not routine and does not meet Screening and Enhanced Referral stage criteria.*	• *Organization policy and staff training facilitate proactive information sharing with designated referral partners, to the extent allowed by current HIPAA, 42CFR, and other regulations.* • *Routine requests for information are made directly to referral partners (and to HIEs if available).* • *Routine pro-active provision of information is made 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 on PH and BH issues for shared persons/people served.* • *Chart documentation of notes from referral providers is not routine and does not meet Care Management and Consultation stage criteria.*	*SCREENING AND ENHANCED REFERRAL PLUS:* • *There is discussion of co-occurring PH/BH issues in regular care team meetings or huddles.* • *Internal BH or PH consultants participate regularly in the care team meetings.* • *Interdisciplinary team members in varying roles routinely participate in delivering a range of interventions for co-occurring conditions or risk factors.* • *Referrals to outside providers routinely are accompanied by a summary of the assessment and care plan.* • *When necessary, there is routine discussion with co-occurring referral providers of assessment and treatment plans in-person, virtually or by telephone.* • *There is routine visibility and review of internal team PH and BH notes and information in the clinical record.* • *Care coordination processes monitor to ensure that documentation information from outside providers is incorporated into care planning.* • *Visibility (in the clinical record) and review of notes from co-occurring referral providers is present on occasion but does not meet criteria for COMPREHENSIVE TREATMENT.*	*CARE MANAGEMENT AND CONSULTATION PLUS:* • *Routine electronic sharing of integrated care plans, co-occurring PH/BH clinical notes and other information in the clinical record.* • *The interdisciplinary team incorporates technology strategies to communicate seamlessly with each other between patient visits to assign just in time action steps with persons/people served to enhance adherence/activation.* • *There is an organizational culture and associated policies and procedures that support uniform consent for open communication between PH and BH providers working as a team.* • *Regular in-person, phone, virtual or e-mail meetings to discuss complex co-occurring PH/BH cases.* • *Co-occurring PH/BH treatment providers are routinely informed (usually electronically) of any substantial treatment events or changes (e.g., ER visit, hospitalization, med change).*

Domain 5. Interdisciplinary team (including the patient) with dedicated time to provide integrated PH/BH care; Subdomain 5.3: Integrated care team training and competency development.

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 team (including the patient) with dedicated time to provide integrated PH/BH care.	***5.3 Integrated care team training and competency development.*** *TRAINING AS USED HERE CAN OCCUR IN A CLASSROOM SETTING OR DURING WORKFLOWS/TEAM MEETINGS/ HUDDLES.* *SEE HANDBOOK FOR MORE DETAILS AND INFORMATION ON TERMINOLOGY.*	*Any staff training or competency expectations regarding PH/BH integrated care is not consistent and does not meet Screening and Enhanced Referral stage criteria.*	• *Basic training of all staff stages on integrated care and how it is being applied in the program/practice.* • *All involved staff are trained to competency (including ongoing supervision or coaching) in implementing the required screening and enhanced referral workflows.*	• *Routine initial and continuing training of all staff stages on integrated team care approach and how it is being applied in the program/practice.* • *Routine training of all staff on how to participate in and document integrated care activities and integrated teamwork, with role accountabilities and competencies defined for each team member.* • *Routine training of all staff on how to work collaboratively using the principles of team-based care including BH or PH consultants and care coordinators as members of the team, and to use information obtained from care management processes to improve team-based care approaches (e.g., case reviews).*	*CARE MANAGEMENT AND CONSULTATION PLUS:* • *Systematic annual and continuing training for all staff at all stages on how all staff are integrated care providers and are expected to function as members of integrated care teams.* • *All categories of staff routinely have competency expectations in their job descriptions that are related to team-based integrated care workflows with learning materials that target areas for improvement in integrated teamwork principles and associated protocols as indicated.* • *There are processes in place to routinely evaluate the competency expectations of all categories of staff.*

Domain 6. Systematic quality improvement (QI); Subdomain 6.1: Use of QI Process.

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 (QI).	***6.1 Use of formal QI processes to:*** • ***Measure and report integration metrics,*** • ***Demonstrate improvement in integration metrics, and*** • ***Demonstrate improvement on disparities in integration affecting marginalized populations.*** *SEE HANDBOOK FOR MORE DETAIL, INCLUDING DEFINITIONS FOR DISPARITIES AND FOR INDIVIDUAL/ COHORT/ POPULATION OUTCOMES, AND DESCRIPTIONS OF THE ELEMENTS OF ORGANIZED QI PROCESSES.*	• *No or minimal use of Quality Improvement (QI) processes to measure, report, and improve integration metrics.* • *If QI processes are present, they do not meet for Screening and Enhanced Referral stages criteria (Stage 1).* • *No involvement of consumer advisory members or consumer feedback information in CQI processes.*	• *There is a QI process to regularly measure baseline and improve **PROCESS** metrics related to Screening & 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 consumer advisory council.* • *The QI process results in measurable improvement of 1-2 metrics.* • *The QI tracks at least one potential disparity in the above metrics related to underserved populations and actions have been taken to remediate the disparity.*	***SCREENING AND ENHANCED REFERRAL PLUS:*** • *Evidence of an organized QI process designed to regularly measure baseline and improve **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(s) with which care coordination is the focus of improvement.* • *There is a formal mechanism by which **PROCESS AND OUTCOME** QI metrics for co-occurring conditions are compared to benchmarks and compiled for reporting to internal or external quality monitoring entities.* • *There are routine QI processes that results in measurable improvement of the above metrics.* • *Routine QI efforts track and improve at least one potential disparities in the above metrics related to underserved populations.*	***CARE MANAGEMENT AND CONSULTATION PLUS:*** • *Routine incorporation of PH/BH improvement of processes and outcomes for individuals. cohorts, and populations into organizational QI processes.* • *Routine QI processes include identified integration teams and champions and systematic input at least quarterly from persons/people served.* • *Ongoing systematic monitoring of at least two **POPULATION STAGE OUTCOME** metrics related to PH-BH integration.* • *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.*

Domain 7. Integrated interventions plus linkages with community and social services to improve or mitigate impact on BH and PH of SDOH risk factors; Subdomain 7.1: Integrated interventions plus linkages with community and social services to improve or mitigate impact on BH and PH of SDOH risk factors. SDOH risks include but are not limited to food insecurity, cognitive limitation, housing instability, interpersonal violence, lack of insurance, language barriers, child/adult protective services, discrimination, immigrant status, and poverty.

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7. Integrated interventions plus linkages with community and social services to improve or mitigate impact on BH and PH of SDOH risk factors.	***7.1 Integrated interventions plus linkages with community and social services to improve or mitigate impact on BH and PH of SDOH risk factors. SDOH risks include but are not limited to 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 DETAIL ON EXAMPLES OF SDOH CONDITIONS, HANDBOOKLINES FOR SDOH SCREENING, AND RELEVANT INTERVENTIONS AND LINKAGES.*	*Identification of SDOH needs, and interventions for or linkage/referral to appropriate resources is not systematized and does not meet for Screening and Enhanced Referral stage criteria.*	• *Psychosocial assessment includes routine SDOH screening for at least 1-2 issues.* • *Referrals for identified issues are routinely made to relevant social service agencies.* • *Follow-up and referral coordination does not meet Care Management and Consultation stage criteria.* • *Interagency arrangements with commonly used social service agencies, if present, do not meet Care Management and Consultation stage criteria.*	***SCREENING/ENHANCED REFERRAL PLUS:*** • *Routine SDOH screening for 2-3 issues.* • *Care management interventions by treatment team routinely include direct efforts to assist with one or more identified SDOH issues.* • *Written or otherwise formalized collaboration agreements are in place with at least1 commonly used social service agency.* • *Follow-up tracking of SDOH interventions and referrals to and monitoring of service participation in the collaborating social service agency occurs routinely in team-based care and care coordination functions.*	***CARE MANAGEMENT AND CONSULTATION PLUS:*** • *Routine SDOH screening for 3 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, persons/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 "complexity care" partners sharing responsibility for an persons/people served.* • *There are at least biannual meetings where collaborating partner human service organizations serving the shared community and population come together at the leadership stage 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.*

Domain 8. Sustainability; Subdomain 8.1: Financial Sustainability.

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8. 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 however (such as FQHC grant) does contribute.* *SEE HANDBOOK FOR MORE DETAIL, 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 for this domain.* • *Payment for integrated health services is limited to one-time grant or gift funding opportunities and target specific services, staff type or populations.* • *Limited expertise in any billing or reimbursement opportunities for integrated health activities including Screening and Enhanced Referral.* • *Limited capacity to optimize workflows and staff roles with limited impacts on minimizing cost. conducted on site.*	• *Finance staff are collaborating 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.* • *Has initiated collaboration discussions re shared value with one or more providers or payers for whom improving integration would produce measurable value.* • *Optimizes workflows and staff roles to deliver Screening and Enhanced Referral services efficiently,* • *Has expertise and routine processes for FFS billing and receiving reimbursement for providing Screening and Enhanced Referral interventions.* • *Routine process in place for tracking and improving reimbursement for integrated PH/BH services provided.*	***SCREENING/ENHANCED REFERRAL PLUS:*** • *Active collaboration of finance staff and clinical staff in organized QI processes (Domain 6) for ongoing development of sustainable integration.* • *Has initiated collaborations with two or more providers or payers for whom improving integration would produce measurable value and has identified metrics that would demonstrate progress toward value and that could support actual or potential incentive payments.* • *Conducted landscape analysis of all available reimbursement or billing opportunities for Care Management and Consultation.* • *Integration QI team optimizes workflows and staff roles to deliver Care Management and Consultation services efficiently.* • *Has expertise in and routine processes for billing FFS, 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.* • *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.*	***CARE MANAGEMENT AND CONSULTATION PLUS:*** • *Clinical and financial leadership routinely provides shared 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.* • *Has worked with payer or provider (e.g., health system) collaborators to agree on and implement metrics that demonstrate value (improved outcomes relative to spend).* • *Demonstrates ability to continuously improve workflow optimization and track cost relevant to improving population PH/BH outcomes.* • *Participates in one or more value-based arrangements or incentives that reasonably cover relevant costs in relation 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.*

Domain 8. Sustainability; Subdomain 8.1: Administrative Sustainability.

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DOMAINS	SUBDOMAINS	HISTORICAL PRACTICE (Stage 0)	SCREENING AND ENHANCED REFERRAL (Stage 1)	CARE MANAGEMENT AND CONSULTATION (Stage 2)	COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT (Stage 3)
8. 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.* *SEE HANDBOOK FOR MORE DETAIL, INCLUDING DEFINITIONS OF TERMINOLOGY SUCH AS PROVIDER LICENSURE AND PROGRAM LICENSURE AND REGULATORY STANDARDS.* *NOTE: Re using 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 they experience themselves as tightly connected. Note that 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.*	• *Licensed and/or regulated as a PH OR BH provider with no or limited guidance for providing integrated interventions for people with co-occurring PH/BH conditions.* • *Does not meet criteria for Screening and Enhanced Referral for this subdomain.*	• *Within the scope of existing (usually a single type of) licensure for the program or practice, has 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, has established written instructions or procedures for providing and documenting integrated Screening and Enhanced Referral interventions.*	***SCREENING AND ENHANCED REFERRAL PLUS:*** • *Within the scope of existing licensure for program or practice, has written instructions or procedures for providing and documenting Integrated Care Management and Treatment.* • *Within the scope of practice of existing (usually single types of) licensure/certification for individual service providers, has established written instructions or procedures for providing and documenting the integrated processes and interventions included in this Stage.* • *Established procedures for documentation of internal consultation or service provision by a provider with the "other" license.* • *IF AVAILABLE: Meets requirements for state or payer certification for this Stage, such as CCBHC, BH Health Home, etc.*	***CARE MANAGEMENT AND CONSULTATION PLUS:*** • *Program/practice is part of an organization or organizational structure that provides both licensed PH AND BH services in shared physical and/or virtual service arrangements routinely throughout the continuum.* • *Program/practice is part of an organization that routinely provides documented instructions or guidelines for clinical staff with either PH or BH licenses/certifications for how to deliver and document any type of integrated services consistent with their jobs, stages of training, and scopes of practice defined by their licenses or certifications.* • *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.*