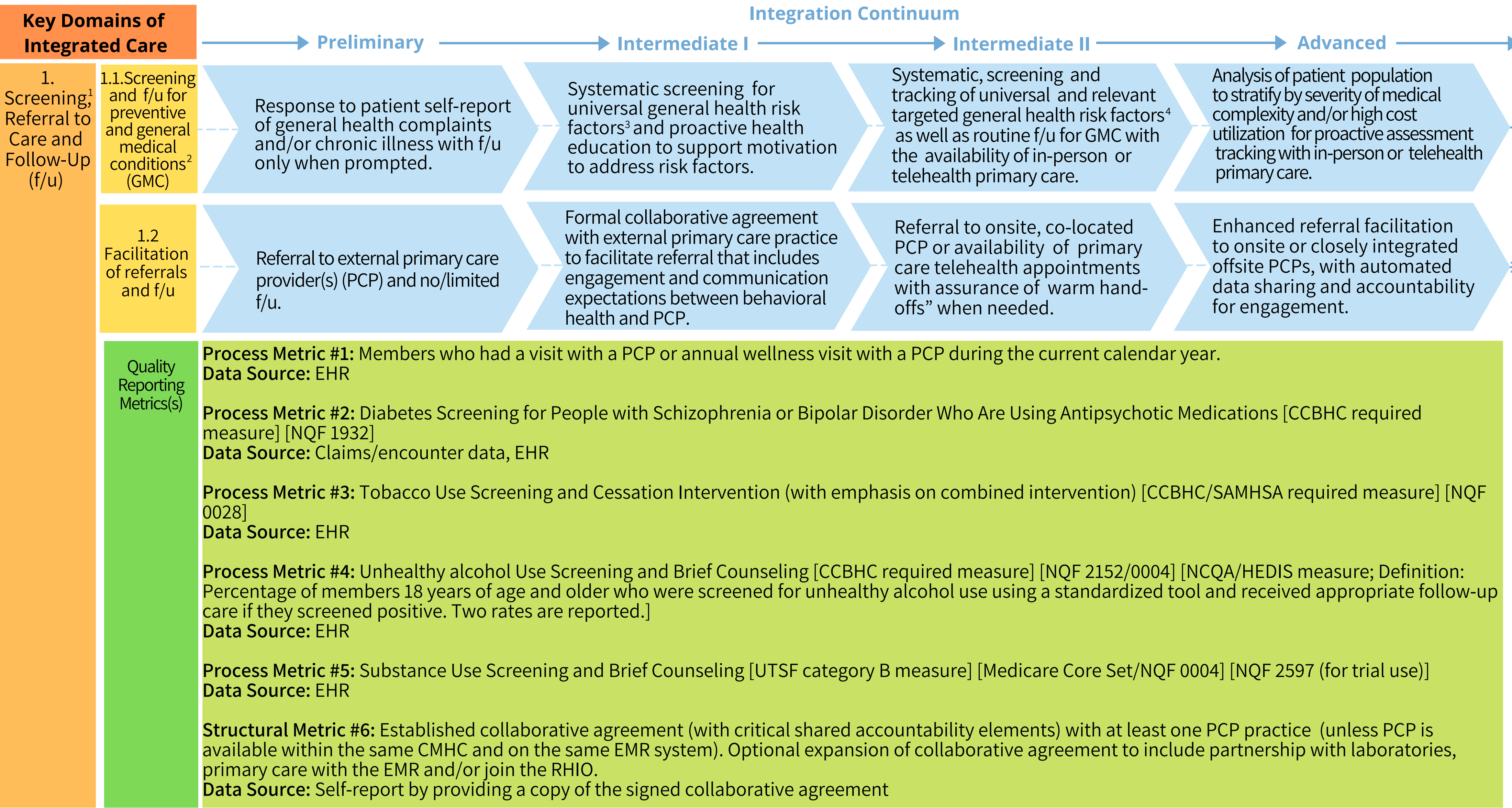
GENERAL HEALTH INTEGRATION (GHI) FRAMEWORK



Key Domains of Integrated Care		Preliminary	Intermediate I	Intermediate II	Advanced
1. Screening,[1] Referral to Care and Follow-Up (f/u)	1.1.Screening and f/u for preventive and general medical conditions[2] (GMC)	Response to patient self-report of general health complaints and/or chronic illness with f/u only when prompted.	Systematic screening for universal general health risk factors[3] and proactive health education to support motivation to address risk factors.	Systematic, screening and tracking of universal and relevant targeted general health risk factors[4] as well as routine f/u for GMC with the availability of in-person or telehealth primary care.	Analysis of patient population to stratify by severity of medical complexity and/or high cost utilization for proactive assessment tracking with in-person or telehealth primary care.
	1.2 Facilitation of referrals and f/u	Referral to external primary care provider(s) (PCP) and no/limited f/u.	Formal collaborative agreement with external primary care practice to facilitate referral that includes engagement and communication expectations between behavioral health and PCP.	Referral to onsite, co-located PCP or availability of primary care telehealth appointments with assurance of warm hand-offs" when needed.	Enhanced referral facilitation to onsite or closely integrated offsite PCPs, with automated data sharing and accountability for engagement.

Quality Reporting Metrics(s)

Process Metric #1: Members who had a visit with a PCP or annual wellness visit with a PCP during the current calendar year.
Data Source: EHR

Process Metric #2: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications [CCBHC required measure] [NQF 1932]
Data Source: Claims/encounter data, EHR

Process Metric #3: Tobacco Use Screening and Cessation Intervention (with emphasis on combined intervention) [CCBHC/SAMHSA required measure] [NQF 0028]
Data Source: EHR

Process Metric #4: Unhealthy alcohol Use Screening and Brief Counseling [CCBHC required measure] [NQF 2152/0004] [NCQA/HEDIS measure; Definition: Percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized tool and received appropriate follow-up care if they screened positive. Two rates are reported.]
Data Source: EHR

Process Metric #5: Substance Use Screening and Brief Counseling [UTSF category B measure] [Medicare Core Set/NQF 0004] [NQF 2597 (for trial use)]
Data Source: EHR

Structural Metric #6: Established collaborative agreement (with critical shared accountability elements) with at least one PCP practice (unless PCP is available within the same CMHC and on the same EMR system). Optional expansion of collaborative agreement to include partnership with laboratories, primary care with the EMR and/or join the RHIO.
Data Source: Self-report by providing a copy of the signed collaborative agreement

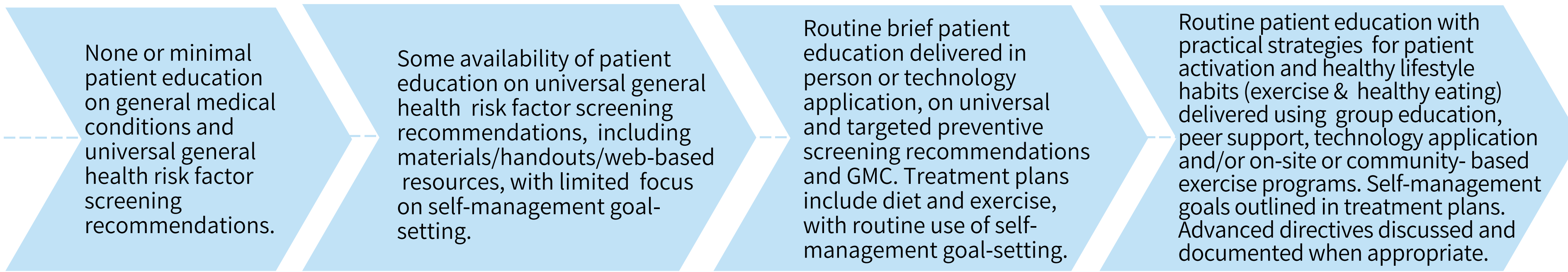
1 Individuals screened must receive follow up by a trained BH provider or PCP (external or co-located). For the purpose of the framework, primary care provider includes M.D., D.O., PA and NP.
2 Common general medical conditions include diabetes, hypertension, hyperlipidemia, coronary artery disease, asthma, arthritis, gastrointestinal disease, tooth and gum disease.
3 Universal general health risk factor screenings might include: visit with a PCP (defined as self-report of a usual source other than ED care with presence of one or more documented primary care visit during the past year), depression, alcohol and substance use (including opioid use), blood pressure measurement, HIV, overweight/obesity, tobacco use and age appropriate screenings for cervical and colorectal cancer.
4 Targeted general health risk factor screenings might include: intimate partner violence, HbA1c, cholesterol, STI, hepatitis B, hepatitis C, tuberculosis and age appropriate screenings for immunizations, mammogram and osteoporosis.

Key Domains of Integrated Care		Preliminary	Intermediate I	Intermediate II	Advanced
		Integration Continuum			
2. Evidence-based (EB) care for preventive interventions and common general medical conditions	2.1 EB guidelines or treatment protocols for preventive interventions	Not used or minimal guidelines or protocols used for universal general health risk factor screenings care. No/minimal training for BH providers on preventive screening frequency and results.	Routine use of EB guidelines to engage patients on universal general health risk factor screenings with limited training for BH providers on screening frequency and result interpretation.	Routine use of EB guidelines for universal and targeted preventive screenings with use of standard workflows for f/u on positive results. BH staff routinely trained on screening frequency and result interpretation.	Systematic tracking and reminder system (embedded in EHR) used to assess need for preventive screenings, workflows for f/u availability of EB and outcomes driven programs to reduce or mitigate general health risk factors (smoking, alcohol, overweight, etc.).
	2.2 EB guidelines or treatment protocols for GMC	Not used or with minimal guidelines or EB workflows for improving access to care for GMC.	Intermittent use of guidelines and/or EB workflows of GMC with limited monitoring activities. BH staff and providers receive limited training on GMC.	BH providers and/or embedded[5] PCP routine use of EB guidelines or workflows for patients with GMC, including monitoring treatment measures and linkage/navigation to medical services when appropriate. BH staff receives routine training in basics of common GMC.	Use clinical decision-support tools (embedded in EHR) with point of service guidance on active clinical management for BH providers and/or embedded PCPs for patients with GMC.
	2.3 Use of medications by BH prescribers for preventive and general medical conditions	None or very limited use of non-psychiatric medications by BH prescribers. Non-psychiatric medication concerns are primarily referred to primary care clinicians to manage.	BH prescriber routinely prescribes nicotine replacement therapy (NRT) or other psychiatric medications for smoking reduction.	BH prescriber routinely prescribes smoking cessation as above. May occasionally make minor adjustments to medications for GMC when indicated, keeping PCP informed when doing so.	BH prescriber can prescribe NRT as well as prescribe general medical medications with assistance and consultation of PCP.
	2.4 Trauma-informed care	BH staff have no or minimal awareness of effects of trauma on integrated health care.	Limited staff education on trauma and impact on BH and general health care.	Routine staff education on trauma-informed care model including strategies for managing risk of re-traumatizing. Limited use of validated screening measures for trauma when indicated.	Adoption of trauma-informed care strategies, treatment and protocols by BH clinic for staff at all levels to promote resilience and address re-traumatizing and de-escalation procedures. Routine use of validated trauma assessment tools such as adverse childhood experiences (ACES) and PTSD checklist (PCL-C) when indicated.
	Quality Reporting Metrics(s)	**Outcome Metric #1:** Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (SMI-PC) [NQF 2607] [NCQA] **Data Source:** Claims/encounter data, EHR, laboratory reporting **Outcome Metric #2:** Depression remission at 12 months [NQF 0710] **Data Source:** EHR			
3. Ongoing Care Manage-ment	3.1 Longitudinal clinical monitoring & engagement for preventive health and/or GMC	None or minimal f/u of patients referred to primary and medical specialty care.	Some ability to perform f/u of general health appointments, encourage medication adherence and navigation to appointments.	Routine proactive follow-up and tracking of patient medical outcomes and availability of coaching (in person or using technology application) to ensure engagement and early response.	Use of tracking tool (e.g., excel tracker or disease registry software) to monitor treatment response and outcomes over time at individual and group level, coaching and proactive f/u with appointment reminders.
	Quality Reporting Metrics(s)	**Structural Metric #1:** Utilize patient follow-up tracking tools for at least 2 preventive or general medical conditions **Data Source:** EHR; Self-report by providing a screen shot of tracking tool			

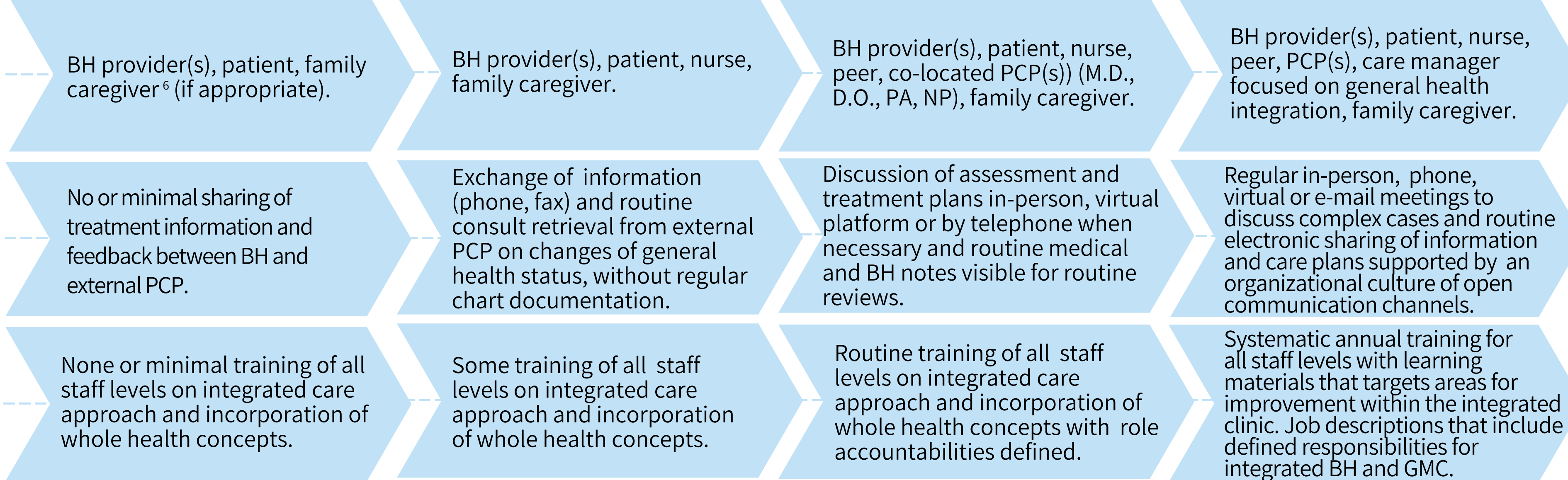
5 Embedded and co-located arrangements include PCPs available through telehealth services

Key Domains of Integrated Care

Integration Continuum: Preliminary → Intermediate I → Intermediate II → Advanced



Key Domains of Integrated Care		Preliminary	Intermediate I	Intermediate II	Advanced
4. Self-management support that is adapted to culture, socio-economic and life experiences of patients	4.1 Use of tools to promote patient activation & recovery with adaptations for literacy, economic status, language, cultural norms	None or minimal patient education on general medical conditions and universal general health risk factor screening recommendations.	Some availability of patient education on universal general health risk factor screening recommendations, including materials/handouts/web-based resources, with limited focus on self-management goal-setting.	Routine brief patient education delivered in person or technology application, on universal and targeted preventive screening recommendations and GMC. Treatment plans include diet and exercise, with routine use of self-management goal-setting.	Routine patient education with practical strategies for patient activation and healthy lifestyle habits (exercise & healthy eating) delivered using group education, peer support, technology application and/or on-site or community- based exercise programs. Self-management goals outlined in treatment plans. Advanced directives discussed and documented when appropriate.
	Quality Reporting Metrics(s)	**Structural Metric #1:** Patient access to treatment and prevention information, handouts or portals to review/download information on general medical condition for at least two target prevention categories. **Data Source:** EHR; Self-report by providing a copy of the handout/information sheet **Outcome Metric #2 [Optional]:** Improve patient self-efficacy for managing chronic disease (SEMCD). Use 6-item Scale to measure improvement of self-efficacy for those who score low. **Data Source:** Self-report, EHR; metric is optional for practice interested to pilot of SEMCD survey tool developed by Bandura			



Key Domains of Integrated Care		Preliminary	Intermediate I	Intermediate II	Advanced
5. Multi-disciplinary team (including patients) with dedicated time to provide general health care	5.1 Care Team	BH provider(s), patient, family caregiver[6] (if appropriate).	BH provider(s), patient, nurse, family caregiver.	BH provider(s), patient, nurse, peer, co-located PCP(s)) (M.D., D.O., PA, NP), family caregiver.	BH provider(s), patient, nurse, peer, PCP(s), care manager focused on general health integration, family caregiver.
	5.2 Sharing of treatment information, case review, care plans and feedback	No or minimal sharing of treatment information and feedback between BH and external PCP.	Exchange of information (phone, fax) and routine consult retrieval from external PCP on changes of general health status, without regular chart documentation.	Discussion of assessment and treatment plans in-person, virtual platform or by telephone when necessary and routine medical and BH notes visible for routine reviews.	Regular in-person, phone, virtual or e-mail meetings to discuss complex cases and routine electronic sharing of information and care plans supported by an organizational culture of open communication channels.
	5.3 Integrated care team training	None or minimal training of all staff levels on integrated care approach and incorporation of whole health concepts.	Some training of all staff levels on integrated care approach and incorporation of whole health concepts.	Routine training of all staff levels on integrated care approach and incorporation of whole health concepts with role accountabilities defined.	Systematic annual training for all staff levels with learning materials that targets areas for improvement within the integrated clinic. Job descriptions that include defined responsibilities for integrated BH and GMC.
	Quality Reporting Metrics(s)	**Structural Metric #1:** Training about team based care for general medical conditions for all staff, including trauma based training. **Data Source:** Self-report by providing a copy of the training material/attendance sheet; Project will define training expectations for GHI			

6 Family caregivers are part of team if appropriate to patient care.

Key Domains of Integrated Care		Preliminary	Intermediate I	Intermediate II	Advanced
6. Systematic quality improve-ment (QI)	61 Use of quality metrics for general health program improvement and/or external reporting	None or minimal use of general health quality metrics (limited use of data, anecdotes, case series).	Limited tracking of state or health plan quality metrics and some ability to track and report group level preventive care screening rates such as smoking, SUD, obesity or HIV screening, etc.	Periodic monitoring of identified outcome and GHI quality metrics (e.g., BMI, smoking status, alcohol status, presence of a PCP, medications and common chronic disease metrics, primary care indicators) and ability to regularly review performance against benchmarks.	Ongoing systematic monitoring of population level performance metrics (balanced mix of PC and BH indicators), ability to respond to findings using formal improvement strategies, and implementation of improvement projects by QI team/champion.
	Quality Reporting Metrics(s)	**Structural Metric #1:** At least 2 general medical metrics are selected for performance goals. **Data Source:** Self-report			
7. Linkages with community / social services that improve general health and mitigate environ-mental risk factors	7.1 Linkages to housing, entitlement, other social support services	No or limited/informal screening of social determinants of health (SDOH) and linkages to social service agencies, no formal arrangements.	Routine SDOH screening and referrals made to social service agencies, but no formal arrangements established.	Routine SDOH screening, with formal arrangements made to social service agencies, with limited capacity for f/u.	Detailed psychosocial assessment incorporating broad range of SDOH needs patients linked to social service organizations/ resources to help improve appointment adherence (e.g., childcare, transportation tokens), healthy food sources (e.g., food pantry), with f/u to close the loop.
	Quality Reporting Metrics(s)	**Process Metric #1:** Social needs screening included in annual assessment and/or during intake (at least housing, if possible: food insecurity)) **Data Source:** EHR, Self-report by providing a screen shot of screening tool **Structural Metric #2:** Percent of patients screened for social needs (at least housing, if possible: food insecurity)) [CCBHC/SAMHSA required measure] **Data Source**: URS (note: URS does not include food insecurity, it requires other data source)			
8. Sustainability	8.1 Build process for billing and outcome reporting to support sustainability of integration efforts	No or minimal attempts to bill for immunizations, screening and treatment. Services supported primarily by grants or other non-reimbursable sources.	Billing for screening and treatment services (e.g., HBA1c, preventive care, blood pressure monitoring) under fee-for-services with process in place for tracking reimbursements for general health care services.	Fee-for-service billing as well as revenue from quality incentives related to GHI (e.g., diabetes and CV monitoring, tobacco screening). Able to bill for both primary care services and BH services.	Receipt of value-based payments (shared savings) that reference achievement of BH and general health outcomes. Revenue helps support GHI services and workforce.
	8.2 Build process for expanding regulatory and/or licensure opportunities	No primary care arrangements that offer general health services through linkage or partnership.	Informal primary care arrangements that incorporate the basic array (e.g. appointment availability, feedback on engagement, report on required blood work) of desired GHI services.	Formalized primary care arrangements, internal or external, with telehealth if appropriate that incorporate patient centered home services.	Maintain a dual license (primary care/behavioral health) for GHI in a shared services setting and regularly assess the need for administrative or clinical updates as licensure requirements evolve.
	Quality Reporting Metrics(s)	**Structural Metric #1:** Define and track revenue/incentives for GHI at least monthly. **Data Source:** Self-report/attestation			