**KEY DOMAINS OF INTEGRATED CARE**

1. **Screening, Referral to Care and Follow-Up (f/u)**
   - **1.1.** Screening and f/u for preventive and general medical conditions (GMC)
     - Response to patient self-report of general health complaints and/or chronic illness with f/u only when prompted.
   - **1.2.** Facilitation of referrals and f/u
     - Referral to external primary care provider(s) (PCP) and no/limited f/u.

**INTEGRATION CONTINUUM**

- **Preliminary**
  - Systematic screening for universal general health risk factors and proactive health education to support motivation to address risk factors.
- **Intermediate I**
  - Formal collaborative agreement with external primary care practice to facilitate referral that includes engagement and communication expectations between behavioral health and PCP.
- **Intermediate II**
  - Referral to onsite, co-located PCP or availability of primary care telehealth appointments with assurance of “warm hand-offs” when needed.
- **Advanced**
  - 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.

**QUALITY REPORTING METRICS**

1. **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
2. **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
3. **Process Metric #3**: Tobacco Use Screening and Cessation Intervention (with emphasis on combined intervention) [CCBHC/SAMHSA required measure] [NQF 0028]
   - **Data Source:** EHR
4. **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
5. **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
6. **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

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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.
3. Ongoing conditions preventives

5 Embedded and co-located arrangements include PCPs available through telehealth services
### Key Domains of Integrated Care

<table>
<thead>
<tr>
<th>Integration Continuum</th>
<th>Preliminary</th>
<th>Intermediate I</th>
<th>Intermediate II</th>
<th>Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Self-management support that is adapted to culture, socioeconomic and life experiences of patients</strong></td>
<td>None or minimal patient education on general medical conditions and universal general health risk factor screening recommendations.</td>
<td>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.</td>
<td>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.</td>
<td>Routine patient education with practical strategies for patient activation and healthy lifestyle habits (exercise &amp; 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.</td>
</tr>
</tbody>
</table>

#### 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 |

| **5. Multidisciplinary team (including patients) with dedicated time to provide general health care** | BH provider(s), patient, family caregiver *(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. |

#### 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 |

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6 Family caregivers are part of team if appropriate to patient care.
### Key Domains of Integrated Care

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<tr>
<td>6. Systematic quality improvement (QI)</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
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</tr>
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</table>

#### Quality Reporting Metrics(s)

| Structural Metric #1: At least 2 general medical metrics are selected for performance goals. | Data Source: Self-report |

| Structural Metric #2: Percent of patients screened for social needs (at least housing, if possible: food insecurity) | Data Source: EHR, Self-report by providing a screen shot of screening tool |

| Structural Metric #3: Percent of patients screened for social needs (at least housing, if possible: food insecurity) | Data Source: URS (note: URS does not include food insecurity, it requires other data source) |

### 7. Linkages with community / social services that improve general health and mitigate environmental risk factors

| 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 |

| Quality Reporting Metrics(s) |

| Structural Metric #2: Percent of patients screened for social needs (at least housing, if possible: food insecurity) | Data Source: URS (note: URS does not include food insecurity, it requires other data source) |

### 8. Sustainability

| Quality Reporting Metrics(s) |

| Structural Metric #1: Define and track revenue/incentives for GHI at least monthly. | Data Source: Self-report/attestation |

| Quality Reporting Metrics(s) |

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### General Health Integration Framework

#### Integration Continuum

- Preliminary
- Intermediate I
- Intermediate II
- Advanced