Comprehensive Health Integration
Part 2: Domains and Constructs

Wednesday, May 25th, 1-2pm ET
Questions, Comments & Closed Captioning

- Type in a question in the Q&A box
- Type in a comment in the chat box
- Click Live Transcript and then select “Show Subtitle”
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Poll #1: What best describes your role?

- Clinician
- Administrator
- Policy Maker
- Payer
- Other (specify in chat box)
Poll #2: What best describes your organization? (check all that apply)

- Primary Care Provider
- Mental Health Provider
- Substance Use Treatment Provider
- Other (specify in chat box)
Poll #3: Where is your organization in the process of integration?

- Learning/Exploring
- Beginning Implementation
- Advanced/Full Implementation
- Ongoing Quality Improvement
- Other (specify in chat box)
Today’s Presenters

Henry Chung, M.D.,
Director, General Health Integration Learning Collaborative,
Professor of Psychiatry,
Albert Einstein College of Medicine

Ken Minkoff, M.D.
ZiaPartners
Senior System Consultant
Learning Objectives

▪ Identify domains of integration applicable to both primary care and behavioral health care.

▪ Discuss how to use the integration framework to assess the “integratedness” of a particular program.

▪ Categorize which integration construct is currently the closest fit for their organization.
Expert Panel and Editors
Why Integrated Care?
Where are we going and how do we get there?
The Comprehensive Health Integration Framework
Why Integrated Care?

The Value

- Behavioral health and primary care providers have shared responsibility
- $293B added costs due to unaddressed mental health/substance use co-morbidity with medical disorders
- Individuals with mental health and substance use needs have higher prevalence of preventable diseases
- Individuals with physical health needs have higher prevalence of MH/SU challenges
- SMI have less access to preventive care/care management for comorbid general illnesses
- Decreased life span due to untreated or undertreated chronic medical conditions

SMI have less access to preventive care/care management for comorbid general illnesses

Individuals with mental health and substance use needs have higher prevalence of preventable diseases

Individuals with physical health needs have higher prevalence of MH/SU challenges

Why Integrated Care?

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Advancing Integrated Care Through Training and Technical Assistance

To advance the implementation of high quality, evidence-based treatment for individuals with co-occurring physical and mental health conditions, including substance use disorders.

Provide training, resources, and technical assistance to health practitioners and other stakeholders addressing the needs of individuals with co-occurring physical and mental health conditions, including substance use disorders.
Comprehensive Healthcare Integration (CHI) Framework
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 in organizing delivery of integrated services (“integratedness”)
- Demonstrate the value produced by progress in integrated service delivery
- Provide initial and sustainable financing for integration
Integrated Services

• The provision and coordination by the treatment team of appropriately matched interventions for both physical health (PH) and behavioral health (BH) conditions, along with attention to social determinants of health (SDOH), 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, as well as to address SDOH.

• 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.
Achieving Integratedness
Characteristics of the CHI Framework

✓ Broad application to both physical health (PH) and behavioral health (BH) settings, and adult and child populations
✓ Evidence-based domains of integration
✓ Measurable standards for integration
✓ Self-Assessment 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** – Care processes related specifically to addressing physical health and behavioral health issues in an integrated manner.

• **Three Constructs** - Each Integration Construct describes an organized approach that has several evidence-based or consensus supported core service elements for “integratedness” tied to the indicators on the Eight Domains, each of which can be implemented flexibly depending on the capabilities of a provider organization and the priority needs of the population served.

• **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.
Eight Domains of Integration

- Screening, Referral, and Follow-up
- Prevention and Treatment of Common Conditions
- Continuing Care Management
- Self-Management Support
- Multi-Disciplinary Teamwork
- Systematic Measurement and Quality Improvement
- Linkage with Community and Social Services
- Sustainability
Three Integration Constructs: Core Components

- Describes an approach that has several evidence-based or expert consensus supported core service elements drawn from the eight domains for “integratedness.”
- Can be implemented flexibly depending on the mission, resources, incentives and capabilities of a provider organization.
- Are adaptable with some degree of consistency by organizations whose initial targets may range more basic to more advanced integratedness based on available resources.
- The names of the Constructs are driven by the Domains’ primary integratedness workflows implemented to either measurably improve health outcomes or measurable processes that have been shown to directly result in improved health outcomes.
The Three Integration Constructs

Integration Construct 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 Construct 2: Care Management and Consultation
- Includes robust program commitment to a set of screening and tracking processes with associated on-site care coordination and care management

Integration Construct 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

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Eight Evidenced-Based Integration Domains Within Each of the Three Integration Constructs

SCREENING & ENHANCED REFERRAL

ACHIEVEMENT OF EARLY PHASE COMPONENTS OF THE EIGHT DOMAINS

Quality Metrics That Confirm Achievement

CARE MANAGEMENT & CONSULTATION

ACHIEVEMENT OF INTERMEDIATE PHASE COMPONENTS OF THE EIGHT DOMAINS

QUALITY METRICS THAT CONFIRM ACHIEVEMENT

COMPREHENSIVE TREATMENT & POPULATION MANAGEMENT

ACHIEVEMENT OF ADVANCED PHASE COMPONENTS OF THE EIGHT DOMAINS

QUALITY METRICS THAT CONFIRM ACHIEVEMENT
The Three Integration Constructs

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

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Examples of Program Implementation Within the Three Integration Constructs

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<thead>
<tr>
<th>Screening and Enhanced Referral</th>
<th>Care Management and Consultation</th>
<th>Comprehensive Treatment and Population Management</th>
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<tr>
<td>Pcare (Druss, 2010)</td>
<td>Primary Care Behavioral Health Model PC</td>
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<td>PRISM-e (Krahn, 2006; Bartels, 2004)</td>
<td>ACA Section 2307 health homes for chronic conditions</td>
<td>Primary Care-Mental Health Integration (PC-MHI) in the U.S. Veteran’s Administration</td>
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<td>Primary Care Case Management</td>
<td>Collaborative Care Model</td>
<td>Montefiore Health System ACO</td>
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<td>Certified Community Behavioral Health Centers</td>
<td>Services for the Underserved (New York City) – combining FQHC and Community Mental Health Center (CMHC) programs</td>
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<td>DOMAINS</td>
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<td>HISTORICAL PRACTICE</td>
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<tr>
<td>1.1</td>
<td>Screening and follow-up for co-occurring behavioral health (MH), substance use disorder [SUD], nicotine, physical health (PH) conditions and preventive risk factors.</td>
<td>Response to patient self-report of co-occurring behavioral health (BH) and/or PH complaints.</td>
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<td>1.2</td>
<td>Facilitation of referrals and f/u.</td>
<td>Referral to external BH or primary care provider(s) (PCP) and no systematic f/u.</td>
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<td>2.1</td>
<td>2.1 EB guidelines or protocols for preventive interventions such as health risk screening, suicide risk screening, opioid risk screening, developmental screening.</td>
<td>No/minimal guidelines or protocols used for universal PH or BH preventive screenings. No/ minimal training for providers on recommended preventive screening.</td>
<td>Routine use of EB or consensus guidelines for performing or referring for risk factor screenings with basic training for providers on screening and result interpretation. Coordination with outside providers for any preventive activities.</td>
<td>Routine use of EB or consensus guidelines for universal and targeted preventive screenings with use of standard workflows for f/u on positive results.</td>
<td>Prescribers more regularly initiate and manage a range of medications for common co-occurring PH or BH conditions, including medication treatment for SUD, with routine consultation and collaboration with “co-occurring” consultant.</td>
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<td>2.2</td>
<td>2.2 EB guidelines or treatment protocols for common PH or BH conditions.</td>
<td>No/minimal guidelines or EB workflows for improving access to care for PH and/or BH conditions.</td>
<td>Intermittent/ limited use of EB guidelines and/or workflows for treatment of common PH and/or BH conditions, with limited monitoring.</td>
<td>Provider team including embedded BH or PH consultant, if any, routinely use EB/consensus guidelines or workflows for patients with PH and/or BH conditions. Systematic measurement of symptoms used.</td>
<td>See Integration Construct 2 plus evidence of treating more than one condition (in collaboration with a consulting psychiatric or physical health provider).</td>
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<td>2.3</td>
<td>2.3 Use of medications by prescribers for common PH and/or BH conditions, including tobacco cessation.</td>
<td>No/limited use by prescribers of medications for co-occurring PH or BH conditions.</td>
<td>Prescribers routinely provide medications for tobacco cessation and will continue to prescribe stable medications for co-occurring PH or BH conditions for a limited number of individuals.</td>
<td>Prescribers will occasionally initiate medications for selected co-occurring conditions, including medication treatment for SUD. Initiation of first line antidepressants, anti-anxiety and attention deficit disorder medications by most PCPs in a practice. Documentation or formal contract with psychiatric consultant.</td>
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<td>2.4</td>
<td>2.4 EB or consensus approaches to addressing trauma and providing trauma-informed care.</td>
<td>Staff have no/minimal awareness of effects of trauma on PH and BH care and no systematic application of person-centered trauma-informed practice.</td>
<td>Basic education of provider team on impact of trauma on PH and BH and use of person-centered, trauma-informed approaches to engaging people with complex needs.</td>
<td>Ongoing implementation of person-centered trauma-informed care models.</td>
<td>Adoption of trauma-informed care strategies, treatment and protocols by treatment team at all levels. Routine use of validated trauma assessment tools.</td>
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<td>3. Ongoing Care Coordination</td>
<td>3.1 Longitudinal clinical monitoring and engagement for addressing prevention and intervention for co-occurring PH and/or BH conditions.</td>
<td>No/minimal mechanisms for routine coordination and f/u of patients referred to PH or BH care.</td>
<td>Provider team has mechanism for tracking f/u to appointments with PH/BH referrals, navigating to appointments encouraging adherence to care</td>
<td>Team members who use measures to guide care and plan. Assigned team member(s) who can provide routine care coordination and monitor routine proactive f/u and tracking of patient engagement, adherence and progress in co-occurring PH and/or BH services to ensure engagement and response.</td>
<td>Availability of a continuum of care coordination, involvement of consulting specialists like a BHC or RN care manager based on stratification of need for populations served. Use of tracking tool to monitor treatment response and outcomes at individual and group levels.</td>
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<td>4.1 Use of tools to promote patient activation and recovery from co-occurring PH and/or BH conditions with adaptations for literacy, economic status, language, cultural norms.</td>
<td>No/minimal patient/family education on PH/BH conditions, PH/BH healthy behavior skills and PH/ BH risk factor screening recommendations.</td>
<td>Some availability of patient/family education (handouts, web-based, etc.) on PH/ BH conditions, PH/ BH healthy behavior skills and PH/ BH risk factor screening recommendations.</td>
<td>Routine brief patient/family education delivered in-person or technology application on selected PH/BH conditions, PH/BH healthy behavior skills and PH/BH risk factor screening recommendations.</td>
<td>Routine and ongoing patient/family education on PH/BH conditions, PH/BH healthy behavior skills and PH/BH risk factor screening recommendations throughout the service continuum with strategies for patient activation and healthy lifestyle habits.</td>
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<td>5.1 Care team.</td>
<td>Provider team, patient, family caregiver (if appropriate).</td>
<td>Provider team patient, family caregiver. Possibly care coordinator or manager.</td>
<td>BH consultant(s) and care coordinators available to PH team. PH consultant (nurse/care manager) available to BH team. Should have access to a BH psychiatrist/nurse practitioner (NP) or a PCP.</td>
<td>PH/BH staff, with care managers, peers/community health workers (CHWs), working as integrated teams throughout the continuum with patients/families.</td>
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<td>5.2 Sharing of treatment information, case review, care plans and feedback.</td>
<td>No/minimal routine sharing of treatment information and feedback between BH and PH providers in different settings.</td>
<td>Routine release and exchange of information (phone, fax) between PH and BH referral providers without regular chart documentation.</td>
<td>Discussion of assessment and treatment plans in-person, virtual or by telephone when necessary and routine PH and BH notes in EHR visible for routine reviews.</td>
<td>Regular in-person, phone, virtual or e-mail meetings to discuss complex cases and routine electronic sharing of information and care plans.</td>
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<td>5.3 Integrated care team training and competency development.</td>
<td>No/minimal training of all staff levels on integrated care approach and incorporation of PH/BHI concepts.</td>
<td>Basic training of all staff levels on integrated care approach and incorporation of integrated care concepts and screening/referral workflows.</td>
<td>Routine training of all staff levels on integrated care approach and incorporation of integrated care activities into integrated teamwork with role accountabilities defined for each team member.</td>
<td>Routine integrated team processes like huddles and care meetings. Systematic continuing training for all staff levels that target areas for improvement.</td>
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<td>6. Systematic quality improvement (QI)</td>
<td>6.1 Use of quality metrics for PH/ BH integration improvement and/or external reporting.</td>
<td>No/minimal use of PH and/or BH quality metrics</td>
<td>Limited tracking of co-occurring PH and/or BH quality metrics for people served and/or for state or health plan reporting. Some ability to report and track improvement for group level issues.</td>
<td>Routine periodic QI monitoring of identified PH and/or BH quality process and outcome metrics, ability to regularly review performance against benchmarks and attempt to improve performance as needed.</td>
<td>Routine incorporation of PH/BH measurement into organizational QI with ongoing systematic monitoring of population level performance metrics, ability to respond to findings using formal improvement strategies and routine implementation of improvement projects by QI team/champions with demonstration of progress.</td>
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<td>7.1 Linkages to housing, employment, education, developmental disabilities and brain injuries (DD/BI), child/adult protective, domestic violence, financial entitlement, home care, immigration, other social support services.</td>
<td>No/informal screening of social determinants of health (SDOH) and linkages to social service agencies, no formal arrangements.</td>
<td>Routine SDOH screening and referrals made to social service agencies. Some referral and follow up, but few formal interagency arrangements established.</td>
<td>Routine SDOH screening, with formal collaboration arrangements and contacts established with commonly used social service agencies. Some capacity for follow-up tracking and service monitoring</td>
<td>Detailed psychosocial assessment incorporating broad range of SDOH needs. Patients and families routinely linked to collaborating social service organizations/resources to help improve appointment adherence, with f/u to close the loop.</td>
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<td>8. Sustainability</td>
<td>8.1 Build process for billing and process and outcome reporting to support financial sustainability of integration efforts.</td>
<td>No/minimal attempts to bill for co-occurring PH and/or BH screening, prevention, intervention conducted onsite. May have grants or other non-sustainable funding.</td>
<td>Billing for PH or BH screening and treatment services under fee-for-services with process in place for tracking reimbursements for PH and/or BH services.</td>
<td>Revenue from payments for developing capacity or for improving processes through quality incentives related to PH or BH. Able to bill some bundled rates for specialized services such as collaborative care management (COCM) or medication-assisted treatment (MAT).</td>
<td>Receipt of value-based payments that reference achievement of BH and PH outcomes for the population served. Revenue helps support necessary staffing, services and infrastructure to support the continuum.</td>
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<td>8.2 Build process for expanding regulatory and/or licensure opportunities.</td>
<td>Licensed and/or regulated as a PH or BH provider with no or limited understanding of how to provide integrated interventions for co-occurring diagnoses.</td>
<td>Established procedures for providing and documenting integrated screening and interventions that support what is allowed within single license.</td>
<td>Formalized ability to provide some level of integrated PH and BH services within a single license, as well as to coordinate and document internal or external service provision. Meets patient-centered medical home (PCMH) or BH health home standards.</td>
<td>Provides licensed PH and BH services in shared services settings throughout the continuum and regularly works to improve design and application of administrative or clinical licensure requirements and regulatory standards to support integrated care for the population served.</td>
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Demonstrating Value Using CHI

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

Identify one or more co-occurring conditions and/or populations to address through integrated service delivery.

Implementation of measurable indicators of integratedness and relevant outcome metrics for those conditions.
Defining how EACH Integration Construct Produces Value
## Provider Recommendations

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<tr>
<th>Utilize</th>
<th>Improve</th>
<th>Implement</th>
<th>Improve</th>
<th>Include</th>
<th>Exchange</th>
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<tr>
<td>Utilize the CHI framework at a program/population level to assess your current state of integration.</td>
<td>Improve proficiency in quality metric selection relevant to Framework Domains and Constructs, workflow improvements and progress to goal.</td>
<td>Implement BH and PH enhanced referral pathways per the CHI Framework screening and referral Domain</td>
<td>Improve proficiency in using the available billing and coding procedures and visit types.</td>
<td>Include primary care and behavioral staff in joint integration training.</td>
<td>Proactively exchange PHI with other healthcare providers to assure integration of care to the extent allowable under current regulation.</td>
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<td>Payer Recommendations</td>
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<td>Utilize the CHI Framework to organize continuous quality improvement for integrated services delivery.</td>
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<td>Utilize payment methodologies that cover integration start-up costs.</td>
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<td>Utilize payment methodologies that provide sustainability of integration. Set care management and/or bundled rates that are adequate to cover costs.</td>
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<td>Match payment methodology to the Integration Construct.</td>
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<td>Eliminate or reduce patient co-pays that obstruct integration.</td>
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<td>Proactively exchange relevant Protected Health Information (PHI) with your contracted healthcare providers to support integration efforts as allowable under current regulation</td>
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<td>Provide equity for BH provider eligibility for integration payments.</td>
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<td>Educate providers on billing codes available to support integration.</td>
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Recommendations for Policymakers

- Leverage the CHI Framework at the state and local level to understand and remove challenges to integratedness implementation and revise regulatory requirements obstructing integration.

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

- Use the CHI Framework as guidance for measuring progress.

- 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 Constructs.

- Incorporate the CHI Framework into consultation and technical assistance at the federal, state, tribal and local levels.

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

Available to download now: https://www.thenationalcouncil.org/resources/the-comprehensive-healthcare-integration-framework/

- **Spring 2022 CoE Webinars:**
  - June 28, 2022 - *Comprehensive Health Integration Part 3: Measuring Integration & Choosing Metrics*
  - July 2022, - *Comprehensive Health Integration Part 4: Payment Models for Comprehensive Health Integration*

  *Visit the Events Page, on the COE-IHS to register!*
  [https://www.thenationalcouncil.org/program/center-of-excellence/](https://www.thenationalcouncil.org/program/center-of-excellence/)

- Winter 2022 ECHO - Learning Community
Questions & Comments?
Tools & Resources

National Council for Mental Wellbeing

• CHI Framework
• Center of Excellence for Integrated Health Solutions – Resource Home Page
• CIHS Standard Framework for Levels 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
  • 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 (OATI)
• 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

TheNationalCouncil.org/Interated-Health-CoE
Upcoming CoE Events:

CoE-IHS Office Hour: Health Equity in Perinatal Health
Register for the Webinar on Thursday, May 26, 2-3pm ET

CoE-IHS Webinar: Perinatal Health Part 3: Addressing Serious Mental Illness
Register for the Webinar on Thursday, June 23, 2-3 pm ET

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