COMPREHENSIVE HEALTH INTEGRATION (CHI) FRAMEWORK

Definitions and Examples Handbook

Clarifying Terminology and Providing Sample Resources for CHI Users

NATIONAL COUNCIL *for* Mental Wellbeing

CENTER OF EXCELLENCE
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INTRODUCTION: HOW TO USE THIS HANDBOOK

The Comprehensive Health Integration (CHI) Definitions and Examples Handbook is designed to support your team throughout the self-assessment process by providing clear definitions and practical examples for each domain and subdomain in the CHI Framework. This handbook is a valuable reference to ensure that your team fully understands the key components of integrated care outlined in the framework as you conduct your Self-assessment.

The handbook is organized by subdomain, allowing your team to refer directly to the relevant sections as you progress through the self-assessment. Each subdomain includes definitions that clarify the elements of integrated care, along with examples tailored to different care settings. These examples will help your team apply the framework across a wide range of health care settings:

- Adult behavioral health
- Child behavioral health
- Adult physical health
- Child physical health

The examples for each type of setting focus on tools, materials and resources to address the needs of people with co-occurring conditions who are seen in that setting, ensuring that the handbook is broadly applicable to the varied needs of the populations you serve. By using this handbook in conjunction with the **CHI Self-assessment Guide**, your team can effectively navigate the self-assessment process and make informed decisions that align with your program's integrated care goals.

THE COMPREHENSIVE HEALTH INTEGRATION DEFINITIONS AND EXAMPLES HANDBOOK

The CHI Definition and Examples Handbook aims to elucidate the principles, definitions and practical implementations of the CHI Framework. Within these pages, you will find not only clear definitions and explanations but also a wealth of domain-specific examples that illustrate how the CHI Framework can be seamlessly woven into clinical practice. These examples underscore the tangible benefits of integration, highlighting its potential to improve care for people receiving services, streamline processes and drive innovation across health care domains.

We define domain and subdomain-specific terms to provide a comprehensive understanding of how integration principles can be tailored to address the unique challenges and opportunities that each health care domain presents. We have organized the subdomain terms to follow the order established in the CHI Framework Self-assessment continuum. This deliberate sequencing allows users to easily reference where a particular term is located within the broader stage found in each subdomain of the CHI Framework, facilitating a more intuitive understanding of its context and significance. By organizing definitions in this manner, we aim to create a cohesive narrative that mirrors the logical progression of integration principles within each CHI Framework subdomain.

As we embark on this journey through the CHI Framework, let us explore its transformative potential, guided by a shared understanding of its fundamental principles and the real-world possibilities it presents within the realm of health integration.

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DOMAIN 1 TERMINOLOGY: SCREENING, REFERRALS AND FOLLOW-UP

TERM	DEFINITIONS/CRITERIA
Subdomain 1.1: Systematic screening for co-occurring 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) 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]
Systematic screening	The screening procedure needs to be evidence based or recommended for the specific target of the screening. Examples may include blood tests (e.g., HbA1c for diabetes); screening tools (PHQ 2 or 9 for depression); or — in some cases — structured questions (Do you have a PCP? When was your last mammogram?). ***NOTE:*** *A simple yes/no question will not suffice when there is a recommended evidence-based tool that should be used. In other words, simply having a check box for depression on a health questionnaire does not constitute adequate screening.* Systematic screening implies that there is a procedure or policy that guides the screening process, so that eligible people receiving services are screened in a predictable fashion. Systematic screening procedures instructions for the frequency of routine screenings for individuals who have previously screened negative or at risk. Systematic screening is measured by the percentage of people receiving services who are screened over the denominator of all those eligible; unless otherwise noted the required percentage is 70%. Systematic screening as used here is different from repeating measures (e.g., PHQ-9, HbA1c) as a part of monitoring progress in treatment response for those who have previously screened positive and are receiving interventions. Using repeated measures for monitoring progress in treatment (which sometimes uses the same measures or tools as used for screening) is covered in Domain 2. ***NOTE:*** *The required threshold for the* ***number*** *of issues for which there is* ***systematic*** *screening is relatively low, even at the most advanced stage. Most settings will screen for many things but may not screen "systematically" according to the expectations here. Nonetheless, it is always desirable to screen systematically for ALL relevant co-occurring issues in the population served, even when the number of issues that are screened for is significantly more than the required threshold in the CHI Framework.* ***NOTE:*** *Screening for social and environmental factors that affect health and other social needs is addressed in Domain 7. Interventions in response to positive screening are addressed in Domain 2.* Examples of screening issues and screening processes for adult and child PH and BH settings for THIS DOMAIN are described below.

Co-occurring conditions/risk factors	As noted previously, screening is an evidence-based or otherwise structured procedure that is designed to identify a "co-occurring" issue (that is, a BH issue in a PH setting, and a PH issue in a BH setting) that requires intervention. For Domain 1, a "co-occurring" issue that requires intervention may be any of the following categories: conditions/diagnoses; risk or risk factors; needs. To illustrate the difference, some examples of each of these three categories are listed below for PH and BH settings. These examples are not by any means exclusive. More examples are listed further below in the section on "examples/ resources." However, these too are not exclusive: ■ **Co-occurring diagnosis** (e.g., depression in a PH setting; diabetes in a BH setting; tobacco or nicotine use in either type of setting). ■ **Co-occurring risk** (e.g., in PH: unhealthy substance use, high level of ACEs, developmental milestones not being met; in BH: elevated BMI, metabolic syndrome; in either: current interpersonal violence). ■ **Co-occurring need** (e.g., in BH: no PCP, no vaccinations, not receiving recommended preventive cancer screenings; in PH: no BH treater for someone with known SMI/SED).
Subdomain 1.2: Systematic facilitation of referrals and follow-up.	
Systematic tracking and data collection re: screening and follow-up interventions	This means that there are defined processes and responsibilities for determining whether required screenings have occurred, collecting and reporting data on whether screenings have occurred and if follow-up is needed, and reporting that information to the care team so that the screenings and follow-up activities (referrals and/or integrated interventions by the care team) do in fact occur.
Enhanced referral	This involves a combination of utilization of "co-occurring" referral partners with whom there is some sort of "formal arrangement" (see below) AND the capacity for facilitation of the referral, tracking of the referral to ensure that it occurs, and ongoing coordination and communication about the progress of the referral intervention. Ideally the referral is experienced as a "warm connection" or "warm hand ON" rather than simply a "hand off."

Formal arrangement	As used here, formal arrangement is intended to describe any organized collaboration between a primary BH or PH provider/practice/program and "co-occurring" referral partners with whom there is an expectation of receiving referrals and a method for coordinating and communicating about ongoing care for shared people receiving services. Formal arrangements may include written "care compacts" or "MOUs," but also may also be established relationships where there is organized collaboration and communication without a written document. Written documents (see below for guidance documents and examples for developing formal arrangement and MOUs), may help with sustaining the formal arrangement when circumstances or personnel change, and therefore may be worth pursuing over time. ***NOTE:*** *Co-located PH and BH programs/practices in the same organization are understood to have a "formal arrangement" even if there is nothing written, as long as those PH and BH practices/programs work regularly together (in person or virtually) and communicate about shared people receiving services.*
Teamwork	All references to teamwork are intended to be inclusive of both in-person and virtual connections, provided they occur consistently enough so that the participants experience themselves as part of a care team. *See the Five Principles of Integrated Teamwork in Domain 5 of this handbook.*
Information sharing	This can occur through any method (faxed notes, routine phone discussions, curbside consultations, electronic health records) unless an electronic information sharing capacity is specified in the stage.
No established connection or preference	The measurement of this indicator is made easier because the denominator excludes people receiving services who are already connected to a previously established "co-occurring" provider, OR who express a preference for a provider that may not be the one with whom there is a formal arrangement. ***NOTE:*** *In some circumstances a person receiving services may be "auto enrolled" with a designated primary care provider by a payer or MCO. This may or may not qualify as an "established connection or preference." In order to determine this, it is incumbent on the team to work with the person to determine if they are aware of their enrollment status, if they have seen the designated provider within the last year and, if so, if they like this provider and want to continue to see them.*
Facilitates connection	The responsible integrated care team member **does not have to personally make every connection**; they may also delegate to others and facilitate the process so that the connections do occur.
Risk stratification	The capacity to quantify the degree of need or risk according to how many and how serious the person's issues are, as identified in the screening process. Risk stratification is a formal way of combining PH and BH diagnoses and risk factors to determine who has greatest need. Any risk stratification that may occur using Domain 1 screening should be combined with screening information for social and environmental factors that affect health as gathered in the processes described in Domain 7.

DOMAIN 1 EXAMPLE/DESCRIPTION: SCREENING, REFERRALS 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
GUIDANCE DOCUMENTS AND EXAMPLES OF FORMAL ARRANGEMENTS AND COLLABORATIVE AGREEMENTS may include, but are not limited to:	
For application in any of the above settings, if appropriate	■ Toolkit For Memorandums of Understanding https://www.usf.edu/cbcs/mhlp/tac/documents/florida-main/florida-specific/mou-toolkit-florida-certification-board-june-2020.pdf ■ Primary Care – Behavioral Health Collaborative Guidelines https://www.acponline.org/sites/default/files/documents/clinical_information/high_value_care/clinician_resources/hvcc_training/behavioral-health-collaborative-guidelines.pdf ■ Primary Care – Behavioral Health Collaborative Agreement Template https://depts.washington.edu/fammed/wp-content/uploads/2017/10/CCA-BH.pdf ■ Partners in Health for Primary Care and County Mental Health Collaboration (includes sample MOUs and Contracts) https://www.umassmed.edu/contentassets/9de6d756a2744a3e8c4bfbb382dc7321/ibhp-took-kit-for-primary-care--mental-health-collaboration.pdf • ***NOTE:*** *This is a comprehensive document from 2009 that covers much more than screening tools and guidelines for collaboration; some of the other material may be outdated, but the guidelines for screening, referral and collaboration are helpful.*

For application in any of the above settings, if appropriate	■ A Guide to Building Collaborative Mental Health Care Partnerships in Pediatric Primary Care https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_to_building_collaborative_mental_health_care_partnerships.pdf ■ Creating Effective Partnerships to Improve Behavioral Health Outcomes https://www.kdhe.ks.gov/DocumentCenter/View/2924/Creating-Effective-Partnerships-for-Improving-Behavioral-Health-Outcomes-Guide-PDF

DOMAIN 2 TERMINOLOGY: INTEGRATED PREVENTION AND TREATMENT

TERM	DEFINITIONS/CRITERIA
Subdomain 2.1: Use of evidence-based guidelines/protocols for prevention and risk mitigation.	
Systematic tracking and data collection	This language means that there are defined processes and responsibilities for each of the following: ■ Determining whether protocols have been followed and whether required interventions in response to screening findings or identified diagnoses or risk factors have occurred. ■ Collecting and reporting data on whether further follow-up is needed and reporting that information to the care team so that follow-up activities (referrals and/or integrated interventions by the care team) do in fact occur, and/or are modified if necessary. This language is also used in Subdomains 2.2 and Subdomain 2.3.
Prevention	Prevention (or prevention interventions) as used here relates to a variety of activities designed to prevent onset of a diagnosable condition, mitigate risk of developing a diagnosable condition for individuals who are exhibiting sub-diagnostic signs and symptoms, and prevent morbidity through very early detection of emerging disorders. Prevention interventions may also include building on strengths and resiliency and enhancing protective factors. When used in the CHI Framework, prevention and prevention interventions are almost always referencing prevention of "co-occurring" PH or BH conditions, depending on the setting. Prevention as used here includes both "primary" and 'secondary" prevention. Primary prevention refers to actions aimed at avoiding the onset manifestation of a disease (this may include actions to improve health through changing the impact of economic, social and environmental factors that affect health, the provision of information on behavioral and medical health risks, and clinical preventive services such as immunization and vaccination). Secondary prevention deals with early detection when there is pathology, but symptoms and signs may not be overt — including "pre-diagnostic" risk such as unhealthy substance use or pre-diabetes — when this improves the chances for positive health outcomes. Prevention also refers to interventions to prevent adverse events that may occur in individuals with a co-occurring condition. Important examples from a public health perspective include prevention of suicide and opioid overdose.[2] See below for full prevention interventions definition.
Risk mitigation	Risk mitigation includes a set of "prevention interventions" (as previously defined) that specifically target evidence of emerging risk such as addressing unhealthy substance use, suicidal ideation, unhealthy diet, emerging obesity, pre-diabetes or hypertension, or emerging social risks like potential housing loss. By intervening quickly when the situation is risky but not yet fully emergent, the "risk" can be lessened or "mitigated." See below for risk mitigation interventions definition.

Prevention/ risk mitigation interventions	Prevention/risk mitigation interventions are referenced together throughout. As used here, these terms refer to interventions that occur AFTER screening with the purpose of either preventing the emergence of a co-occurring condition that is not present or reducing risk from a co-occurring condition that is emerging or on the borderline of being diagnosed. **NOTE:** *The focus is on **co-occurring** conditions (PH conditions or risks in BH settings and vice versa). Screenings that may lead to prevention/risk mitigation interventions include Domain 1 screening for co-occurring conditions or risk factors, and prevention/risk mitigation education or intervention can often be provided by various members of the treatment team, including peers, CHWs, and medical assistants (depending on the type of intervention), provided those team members are trained and supervised in adherence to recommended protocols. The subdomain references "evidence-based" or "recommended" interventions, understanding that there needs to be some standard of care that is being followed, but there are not always applicable evidence-based guidelines to be followed.*
Prevention/risk mitigation for population served	This refers to tracking and improving the extent to which the whole population for which the organization is responsible is monitored for adherence to recommended prevention/risk mitigation interventions. Examples percentage of individuals in our population or community are receiving cancer prevention interventions or procedures, or interventions for developmental concerns.

DOMAIN 2 EXAMPLE/DESCRIPTION: INTEGRATED PREVENTION AND TREATMENT

Subdomain 2.1: Use of evidence-based guidelines/protocols for prevention and risk mitigation.

SETTING	DEFINITIONS/EXAMPLES
GUIDELINES OR PROTOCOLS FOR PREVENTION/RISK MITIGATION **may include, but are not limited to:**	
Adult BH (MH or SUD)	■ Disease management training for diabetes, hypertension, asthma, etc. ■ Education and/or diet/exercise interventions addressing elevated BMI in a person with diagnosed diabetes. ■ Ensuring the person receiving services with a serious medical condition is connected to ongoing primary and/or specialty care. ■ Cognitive-behavioral interventions for tobacco cessation. ■ Cognitive-behavioral and other interventions for chronic pain.
Adult PH	■ Brief cognitive behavioral interventions for depression or anxiety. ■ Cognitive behavioral interventions for SUD (may or may not have abstinence as a goal). ■ Ensuring the person receiving services with serious mental illness is connected to a specialty mental health provider.

Child and adolescent BH	■ Disease management training for diabetes, asthma, etc. ■ Education and/or diet/exercise interventions addressing elevated BMI. ■ Ensuring the person receiving services with a serious medical condition is connected to ongoing primary and/or specialty care. ■ Cognitive-behavioral interventions for tobacco cessation.
Child and adolescent PH	■ Brief behavioral interventions for ADHD. ■ Brief cognitive behavioral interventions for depression or anxiety. ■ Cognitive behavioral interventions for SUD (may or may not have abstinence as a goal). ■ Bright Futures developmental milestone monitoring. https://www.aap.org/en/practice-management/bright-futures

DOMAIN 2 TERMINOLOGY: INTEGRATED PREVENTION AND TREATMENT

TERM	DEFINITIONS/CRITERIA
Subdomain 2.2: Use of evidence-based guidelines/protocols for non-pharmacologic treatments for co-occurring conditions.	
Treatment	Treatment as used in the CHI Framework refers to specific (and ideally evidence informed) pharmacologic and non-pharmacologic interventions for diagnosed co-occurring PH or BH conditions. Prevention and risk mitigation by contrast are usually utilized when there is only a risk of a diagnosis. Treatment of co-occurring conditions may be delivered by the PH or BH treatment team and/or provided by a specialty referral provider.
Non-psychopharmacologic interventions for co-occurring conditions	This subdomain focuses on professionally delivered or professionally directed and supervised treatment interventions (other than medication) for diagnosable co-occurring conditions and/or interventions to address unhealthy behaviors or risk factors that may directly affect those diagnosable conditions. These are not just ancillary interventions but an essential part of good treatment. ***NOTE:*** *Focus once again is on* ***co-occurring*** *conditions (PH conditions in BH settings and vice versa).* ***NOTE:*** *Professionally delivered or directed does* ***not*** *mean that the person doing the intervention needs to be a specialist in the "other" domain; many skill teaching or cognitive behavioral interventions can be done within scope by anyone who is appropriately trained or supervised. (Tobacco cessation or dietary interventions are only a few of many examples.)*

Non-psychopharmacologic interventions for co-occurring conditions	The difference between this subdomain and Subdomain 2.1 can be illustrated by the following: Subdomain 2.1 addresses unhealthy substance use that is not diagnosed as an SUD; Subdomain 2.2 addresses diagnosed SUD (including nicotine). Subdomain 2.1 may address diet and exercise concerns that may be associated with risky weight when there is no diagnosed health condition that is affected; Subdomain 2.2 addresses diet and exercise that are important interventions for obesity in the context of a diagnosed disorder like diabetes. This subdomain specifically focuses on non-medication interventions for co-occurring conditions that are provided by the practice or program in an integrated manner — that is, by members of the program/practice care team. The subdomain references "evidence-based" or "recommended" interventions, understanding that there needs to be some standard of care that is being followed, but there are not always applicable evidence-based guidelines. ***NOTE:*** *The criteria indicate that in most instances the recommended intervention must be delivered* ***at least twice.*** *This is based on data showing that benefit only accrues when interventions are repeated; twice is the lowest threshold that could be considered a minimal standard. One exception may be Brief Intervention for SUD by a primary care provider, where evidence suggests that even ONE intervention may have a positive impact.*

DOMAIN 2 EXAMPLE/DESCRIPTION: INTEGRATED PREVENTION AND TREATMENT

Subdomain 2.2: Use of evidence-based guidelines/protocols for non-pharmacologic treatments for co-occurring conditions.

SETTING	DEFINITIONS/EXAMPLES
NON-PSYCHOPHARMACOLOGIC INTERVENTIONS AND ASSOCIATED CONDITIONS may include, but are not limited to:	
Adult BH (MH or SUD)	■ Education and referral for USPTF recommended cancer testing (mammography, colon cancer testing) after finding that these have not occurred. ■ Assistance with asking the PCP for referrals for appropriate cancer or other screenings. ■ Education and/or diet/exercise interventions addressing screening that shows risk of a medical condition such as pre-diabetes, or a risky condition such as elevated BMI.
Adult PH	■ Education or resiliency building interventions following positive ACEs screening. ■ Education/Interventions to mitigate risk from screening showing unhealthy substance use (SBIRT interventions) or borderline depression. ■ Education/intervention to mitigate risk from screening findings showing unstable housing, food insecurity, risk of interpersonal violence in the home and so on. ■ Individuals with evidence of suicide risk receive additional evidence-based screening (e.g., CSSRS, P4), safety planning, education about 988 suicide prevention lifeline and connection to services/ support. ■ Individuals with risky opioid use receive education and intervention for overdose prevention (naloxone, fentanyl test strips).

Child and adolescent BH	■ Education and/or diet/exercise interventions addressing screening that shows a risky condition such as elevated BMI.
Child and adolescent PH	■ Education or further assessment following developmental screening concerns. ■ Bright Futures developmental milestone monitoring. https://www.aap.org/en/practice-management/bright-futures ■ Education or resiliency building interventions following positive ACEs screening. ■ Individuals with evidence of suicide risk receive additional evidence-based screening (e.g., CSSRS, P4), safety planning, education about 988 suicide prevention lifeline and connection to services and support. ■ Individuals with potential for risky opioid use receive education and intervention for overdose prevention (naloxone, fentanyl test strips).

DOMAIN 2 TERMINOLOGY: INTEGRATED PREVENTION AND TREATMENT

TERM	DEFINITIONS/CRITERIA
Subdomain 2.3: Use of evidence-based guidelines/protocols for pharmacologic treatments for co-occurring conditions.	
Psychopharmacologic interventions for co-occurring conditions	This subdomain focuses on medication (and medication education) treatment interventions for **diagnosable** co-occurring conditions and/or interventions to address unhealthy behaviors or risk factors that may directly affect those diagnosable conditions. The difference between this subdomain and Subdomain 2.1 can be illustrated by the following: ■ Subdomain 2.1 addresses unhealthy substance use that is not diagnosed as an SUD. ■ Subdomain 2.3 addresses diagnosed SUD (including nicotine). ■ Subdomain 2.1 may address diet and exercise concerns that may be associated with risky weight when there is no diagnosed health condition that is affected. ■ Subdomain 2.3 addresses medications for weight management when that is an important intervention for obesity in the context of a diagnosed disorder like diabetes or as a medication side effect of treatment for a diagnosed psychiatric condition. This subdomain specifically focuses on medication interventions for co-occurring conditions that are provided by the practice or program in an integrated manner — that is, by prescribers on the program/practice care team. The subdomain references "evidence-based" or "recommended" interventions, understanding that there needs to be some standard of care that is being followed, but there are not always applicable evidence-based guidelines to be followed. ***NOTE:*** *Focus is on* ***co-occurring*** *conditions (PH conditions in BH settings and vice versa).* ***NOTE:*** *The criteria in this subdomain vary in terms of expectation of how medications are initiated or continued, with a lower threshold to continue medications that have been stabilized by a "co-occurring" prescriber, vs. initiating new medications (with or without access to an integrated consultant).*

Psychopharmacologic interventions for co-occurring conditions	***NOTE TO MH PROGRAMS:*** *Provision of medications for integrated treatment of SUD/MOUD in MH settings is an important priority, even though not specifically addressing co-occurring PH/BH conditions. MH programs that have successfully implemented routine availability of SUD/MOUD have the option to give themselves credit for that accomplishment.*
BH and PH prescribers working (on-site or virtually) as a (single) team	As used here, this is intended to describe an organization in which prescribers in the same organization — whether or not they are in different locations — are organized so that their collaborative work and their routine communication, usually electronically, are experienced by themselves and by their people receiving services, as functioning as a single "integrated" team.
Formal consultation relationship or arrangement	An organized connection with one or more "co-occurring" consultant professionals, with defined processes and workflows for how their services can be accessed by the treatment team when needed, and how their input can be documented in the record of the person receiving services, as appropriate. This is distinctly different from the treatment team having to seek out consultants on a case-by-case basis. The "consultant" — as used here — is not a regular member of the treatment team, unlike the role of the "BHC" defined below. The role of the consultant here is to partner (when needed) with the treatment team to provide formal guidance on some aspect of the care and treatment for the person receiving services.

DOMAIN 2 EXAMPLE/DESCRIPTION: INTEGRATED PREVENTION AND TREATMENT

Subdomain 2.3: Use of evidence-based guidelines/protocols for pharmacologic treatments for co-occurring conditions.

SETTING	DEFINITIONS/EXAMPLES
PHARMACOLOGICAL INTERVENTIONS, GUIDELINES AND PROTOCOLS may include, but are not limited to:	
Adult BH (MH or SUD)	■ Medication interventions for tobacco cessation. ■ Weight management medications (e.g., metformin) for diabetes or pre-diabetes, or for mitigation of psychotropic medication-associated weight gain. ■ Thyroid medication for associated (including lithium-induced) hypothyroidism, but not solely for antidepressant augmentation. ■ Statins for elevated cholesterol/triglycerides; anti-hypertensives.
Adult PH	■ Medication interventions for mood or anxiety disorders or insomnia. ■ Medication interventions for tobacco cessation. ■ Medication interventions for SUD/OUD (may or may not have abstinence as a goal).
Child and adolescent BH	■ Medication interventions for tobacco cessation. ■ Weight management medications (e.g., metformin) including for mitigation of psychotropic medication-associated weight gain.
Child and adolescent PH	■ Medication interventions for mood or anxiety disorders or insomnia. ■ Medication interventions for tobacco cessation. ■ Medication interventions for SUD/OUD (may or may not have abstinence as a goal).

DOMAIN 2 TERMINOLOGY: INTEGRATED PREVENTION AND TREATMENT

TERM	DEFINITIONS/CRITERIA
Subdomain 2.4: Implementation of trauma- and resilience-informed practices.	
Trauma- and resilience-informed care and practices	This subdomain is not about simply screening for trauma and being aware of trauma. The intent of this subdomain is to define progressive efforts to "integrate" trauma-informed interventions and access to trauma-specific treatments into the core culture of the program or practice, as well as create a culture that supports staff health and wellness and mitigates staff trauma. This domain applies equally to BH and PH settings. The importance of this subdomain is based on the recognition that individuals with co-occurring PH and BH conditions are highly likely to have experienced and/or are experiencing trauma in their lives that contribute to the onset of their challenges and interfere with their ability to form trusting connections that may be needed to work with care providers to get help for their multiple needs. Further, individuals with co-occurring conditions in either PH or MH settings may be more likely to experience "trauma" from care providers in those settings, because they may be experienced as more challenging, difficult, hopeless or treatment "resistant" or "noncompliant." People receiving services have further indicated that a welcoming experience, that is safe and engaging, and certainly not re-traumatizing, is one of their priorities for care. As described in this subdomain, there is a progression of expectations: ■ **Screening and Enhanced Referral:** Indicating a policy "intent" to create a trauma-informed culture, with staff training on what that means, how to be aware of and informed of the likelihood of trauma in people receiving services, and training on how to be proactively welcoming to people experienced as complex. ■ **Care Management and Consultation:** Formal adoption of protocols for trauma-informed procedures and practices, more extensive education of staff about those protocols, measuring impact through customer surveys leading to continuous improvement, and specific efforts to not re-traumatize individuals who are having a hard time following recommendation(s), by focusing on their strengths (what have they done right) and helping them to do it better rather than confronting them negatively about being "non-compliant." In addition, at this level, the program would have access to specialty evidence-based trauma treatments (for example, trauma-focused CBT, DBT, EMDR) for identified individuals who can benefit. ■ **Comprehensive Treatment and Population Management:** At this stage, there is advancement from simply having protocols and teaching staff about them to having an organized process of implementation where all staff are supported and expected to demonstrate competencies in practicing trauma-informed interventions. Further, there is a routine approach to applying a trauma-informed set of approaches to individuals who have complex needs who are clearly struggling with adherence and engagement, and yet remain at high risk. Finally, at this stage, evidence-based trauma-specific treatment is integrated INTO the organization's service array rather than only available through outside consultation and referral. This does not mean that the internal capacity is sufficient to meet the total volume of need, only that it is available to some degree.

DOMAIN 2 EXAMPLE/DESCRIPTION: INTEGRATED PREVENTION AND TREATMENT	
Subdomain 2.4: Implementation of trauma- and resilience-informed practices.	
SETTING	**DEFINITIONS/EXAMPLES**
TRAUMA- AND RESILIENCE-INFORMED INTERVENTIONS may include, but are not limited to:	
Adult BH (MH or SUD) AND PH	■ The ACEs questionnaire for adults, is adapted from the work of Kaiser Permanente and the Centers for Disease Control and Prevention https://www.acesaware.org/learn-about-screening/screening-tools/ ■ The Attitudes Related to Trauma-informed Care (ARTIC) Scale https://www.traumainformedcare.chcs.org/resource/the-attitudes-related-to-trauma-informed-care-artic-scale/ ■ A Clinician's Tip Sheet for Working With Trauma https://www.ctacny.org/uploads/Clinicians%20Tip%20Sheet%20for%20Working%20with%20Trauma_English%20(CTAC).pdf
Child and adolescent BH AND PH	■ Pediatric ACEs and Related Life-events Screener (PEARLS) used to screen children and adolescents ages 0–19 https://www.acesaware.org/learn-about-screening/screening-tools/ ■ A Clinician's Tip Sheet for Working with Child Trauma Survivors https://www.ctacny.org/uploads/Clinicians%20Tip%20Sheet%20for%20Working%20with%20Trauma_English%20(CTAC).pdf

DOMAIN 3 TERMINOLOGY: ONGOING CARE COORDINATION

TERM	DEFINITIONS/CRITERIA
Care coordination	Care coordination is a subcomponent or part of care management, which is defined below. Works directly with the person receiving services and their family in helping to organize and monitor care activities — including participation in treatment and tracking of results — and sharing relevant information among all the participants on the care team and others concerned with a person's care to achieve safer and more effective care. This means as well that the needs and preferences of the person receiving services are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate and effective care to the person receiving services.[3] Care coordination may include tracking treatment participation, encouraging self-management and monitoring progress through specific measures (scales) when applicable, for the purpose of determining whether additional interventions may be needed. Care coordination in this domain applies to care coordination of referrals, prevention and/or treatment interventions for co-occurring PH or BH (depending on the setting) or social conditions. Including assuring that the care team — as well as both BH and PH providers — are aware of any pertinent changes in the person's condition or treatment being managed by other providers such as diagnosis, treatments, lab results and ER/hospital events. Care coordination here refers to a combination of "direct relationship or connection with the person (or cohort) served" and "tracking information about the person's (or cohort's) services and progress" to both monitor what is happening to them as well as to directly encourage them to continue to participate in the needed services. Care coordination is used here to describe a "function" and "set of activities." Only in the more advanced levels/stages is it expected that these functions and activities are carried out by one or more individuals with a designated job that includes the role of co-occurring "care coordinator." Care coordination can involve — but is not limited to — automated sharing of information. Finally, although care coordination involves a relationship (which may have varying degrees of intensity and connection — see below), this domain does not expect that every care coordination activity with the person receiving services is performed directly by the care coordinator. Whether the care coordinator is in touch with the person directly, or whether they are prompting someone else on the treatment team (e.g., a direct service provider) to do so will depend on the individual needs of the person receiving services as well as the level of intensity of care coordination being provided. ***NOTE:*** *Team members who are responsible for "care coordination" may be termed care coordinators, care navigators or care managers.* ***In the CHI Framework, the term "care coordinator" is used.*** ***NOTE****: Care coordination may be used for addressing all types of conditions in all types of settings.* ***In the CHI Framework, unless otherwise noted, "care coordination" refers specifically to coordination of integrated PH (in a BH setting) or BH (in a PH setting) and interventions and information related to social and environmental factors that affect health.***
Care management	Care management is a collective responsibility for the care team delivering services and includes processes in multiple domains of the CHI framework.[4] Examples of care management services include, but are not limited to: - Screening and assessment - Care planning - Increasing health literacy through education - Medication adherence - Measurement tracking - Risk stratification - Care coordination

Process vs. outcomes	In this subdomain, a distinction is made between the "process" of receiving a service (attending a referral appointment, receiving medication or non-medication intervention for a co-occurring conditions) and the "outcome" of the intervention itself (measurable progress in depression, substance use, diabetes, hypertension or housing stability).
Individual vs. cohort vs. population	Most of this subdomain refers to care coordination for individuals. In the Comprehensive Treatment and Population Management Stage (Level 3), some of the indicators refer to "Cohort Process and Outcomes." Cohort as used here refers to a specific subpopulation of people receiving services who have a defined set of co-occurring conditions that are being monitored and tracked. Examples might include (but are not limited to) all people in the BH setting who have screened positive for diabetes or for obesity or for asthma; all people in the adult PH setting who have screened positive for depression or for anxiety, or for SUD; all people in the child PH setting who have screened positive for ADHD or for developmental risk. Having the capacity to provide care coordination for one or more cohorts requires having both the technological capacity to identify and track data on services and outcomes for a cohort, as well as having assigned care coordination responsibility to engage the cohort members and monitor and report on their progress. In summary, these terms are defined as: • **Individual:** Refers to individual people receiving services (and their families or other supports). For children, this will naturally include attention to parents or caregivers. • **Cohort:** Refers to specifically subpopulations defined by type of co-occurring issues. Examples may include cohorts of individuals with SMI and diabetes; cohorts of individuals with hypertension and depression; cohorts of adolescents in a pediatric practice with ADHD and nicotine use; cohorts of children with asthma and any behavioral health issue. • **Population:** Refers to a broader population of people receiving services. This could refer to all people in an assigned (attributed) panel, all people in the program's catchment/service area, all children or all older adults. Population may also apply to particular social circumstances, such as the population of people experiencing homelessness.
Disease registry	A disease registry is a special database that contains information about people diagnosed with a specific type of disease. Most disease registries are either provider based or population based. provider-based registry contains data on all the people receiving services with a specific type of disease diagnosed and treated by that provider organization. A population-based registry contains records for people diagnosed with a specific type of disease who reside within a defined geographic region. For example, a health provider can have a diabetes registry with records for all the people receiving services in their diabetes treatment program. The provider-based registry would not include all the people with diabetes in the community since some may go elsewhere for treatment. A population-based registry, on the other hand, would contain data on all the people with diabetes who live in a certain area, regardless of where they receive their treatment. [5] For the CHI Framework, the focus in this domain is on disease registries specific for **co-occurring conditions**, such as a "depression registry" in a PH provider or a "diabetes registry" in a BH provider. This domain is mostly referencing provider-based registries; only in the Comprehensive Treatment and Population Management Stage is there any consideration of the possibility of having a population-based registry for a co-occurring condition.

DOMAIN 3 GUIDANCE: ONGOING CARE COORDINATION	
STAGE	**SCORING CRITERIA FOR THIS DOMAIN FOR EACH STAGE**
Screening and Enhanced Referral	To achieve this stage in Domain 3, it is NOT necessary to hire a "care coordinator." The following are required: ■ Someone on the "treatment team," such as a case manager, medical assistant, nurse, social worker or CHW, is assigned the following responsibilities: **1.** To keep track of people who have received positive screening for the co-occurring condition(s) that have been flagged in Domain 1. **2.** To follow up (including with the people themselves) whether they have received a referral, made an appointment, attended the appointment and received an intervention (a prevention/risk mitigation intervention as in Subdomain 2.1 and/or treatment interventions as in Subdomains 2.2, 2.3). ■ This function can be distributed across multiple staff as long as there is some level of clarity on who is going to be responsible for which people receiving services and which conditions. ■ There needs to be some data collection, but in a "small" practice or program data can be collected by hand if there is not access to an appropriate EHR.
Care Management and Consultation	To achieve this stage in Domain 3, the following are required: ■ A designated "co-occurring" staff person who is assigned to perform or perform/oversee care coordination functions, AND/OR generic "care coordinators" who have been given specific time, training and instructions on specified co-occurring conditions (which may include social conditions) that are being tracked and monitored. ■ Generally, there is some need for electronic data collection. ■ A formal disease registry may be present but is not required for this level. What is required is the ability to track and report outcomes in addition to process — that is, not only did the person receive the internal or external (by referral) prevention/risk mitigation or treatment intervention, but did they demonstrate progress because of that intervention. ■ Progress can include improvement in targeted outcome measures (labs, PHQ-9 scores, weight, smoking, etc.), as well as receipt of necessary prevention/risk mitigation interventions (mammograms, developmental assessment/education, etc.). ■ Reporting to the treatment team on process and outcomes should also be associated with follow-up responses to the person receiving services to improve what is happening — this is a fundamental component of care coordination.

Comprehensive Treatment and Population Management	To achieve this stage for Domain 3, the requirement is to meet the criteria for level 2, plus: ■ To have the technologic and staff capability to track entire specified cohorts collectively. ■ The data needs for this level are greater and require more sophisticated information systems as well as the inclusion of disease registries that are used for the cohort or cohorts that are being tracked and monitored. An important element in this level is: *Availability of a continuum of intensities of care coordination based on stratification of need within the population served.* This bullet is connected to the expectation in Domains 1 and 7 about having formal mechanisms for risk stratification (see above). An important component of a programmatic response to risk stratification is to have the ability to match the level of intensity of care coordination and care provision to the level of risk or need. The following is an example of risk stratification (See definition on page 7.) ■ "Routine" people receiving services may respond to "routine" "low touch" (low-frequency contact) care coordination, even by phone or text. ■ "Moderate risk" people receiving services may have a higher level of coordination that has more direct personal contact and somewhat higher frequency (once/month, once every two weeks). ■ "High risk" people receiving services may have very complex needs and high costs (frequent ED visits and/or hospitalizations) and have "high-touch" care coordination contacts one or more times per week.

DOMAIN 4 TERMINOLOGY: PERSONALIZED SELF-MANAGEMENT SUPPORT

TERM	DEFINITIONS/CRITERIA
Activation and self-management	The focus of this domain is activities that are designed to mobilize people served to participate actively in addressing their co-occurring conditions and risk factors ("activation") and providing them the education, information and skills to do so ("self-management support"). For Domain 4, the items refer only to self-management for co-occurring conditions. That is, helping people receiving services in a PH setting learn self-management for diabetes is laudable, but it is not what is being measured here.
Education and skill building	Various items in this domain focus on different components of self-management training. Some items focus on having defined sets of materials to improve "health literacy" and educate people about conditions and risks, as well as recommended treatments and interventions. Other items focus on the more active process of teaching people how to develop and practice the skills they need to be successful. As an example, education (in a BH setting) to teach people about the disease of diabetes and the importance of blood sugar monitoring, diet and medication is an example of the first focus. Teaching people how to self-administer insulin, keep track of their meds, monitor their blood sugar and/or change their diet would be an example of the second. Similarly in a PH setting, providing education about the need to change risky substance use and where help might be provided for that is an example of the first focus, while teaching people specific self-management skills (e.g., avoiding risky situations) for reducing their use of substances and/or for reducing harm from substance use is the second.

Materials	In this domain, the use of the term "materials" is intended to emphasize the importance of some level of consistent structure and formality in self-management training and support, including both education and skill-building. There is no expectation, however, that programs/practices must develop their own materials for each condition that they target for self-management support. In most instances, materials are readily available in the public domain, usually online, that have been developed by professional organizations and related groups specifically for the purpose of education and skill building. For the most part, these are the types of materials that this domain requires programs/practices to obtain and use. In addition, most programs and practices will need to obtain and adapt "local" materials as well, particularly regarding education and facilitation of referrals. Examples include brochures and associated referral instructions regarding co-occurring providers with which the program/practice has a formal collaboration agreement, or similar information about commonly used resource partners that address human services needs like food insecurity and housing instability.
Adaptation for literacy, economic status, threshold languages and cultural norms	The expectation here is — at minimum — to ensure that the materials are matched to the literacy level of the population served (usually recommended as 4th or 5th grade level) and to address translations of key materials for "threshold" languages. **See definition for "threshold languages" below.** Most (BUT NOT ALL) available "self-management" materials designed for lay audiences have already been adapted, so it is always important to check. The requirements regarding culture and economic status are that the program/practice review the materials (ideally with input from community members and people receiving services) to ensure that the materials are acceptable. What this requires depends on the population served, of course, but the expectation is that the practice/program has made sure that whatever materials are being used are acceptable to significant portions of their populations.
Threshold languages	Beneficiaries with threshold languages are those who represent 5% of the target population in an identified geographic service area, whose primary language is other than English and for whom information and services shall be provided in their primary language.
Materials provided for indicated conditions	In each stage, there are requirements for how many conditions or risk factors are addressed with education and how many with skill building, as well as (starting in Care Management and Consultation Stage) diet and exercise. The requirements for "materials" (as well as policies, procedures, protocols and training) are intended to apply just to those conditions or risk factors that are intended (or "indicated") to meet the requirements, NOT for every possible condition or risk factor.
Training for "staff of any type"	Self-management training can be provided, with proper training and guidance, by any type of staff on the treatment team: medical assistants, community health workers, case managers, peers. The interventions addressed here — while they may be professionally developed — are not limited to the "professional" interventions described in Subdomain 2.2; these are interventions that can be provided by individuals without professional certification, provided they are properly trained with appropriate protocols and clearly delineated roles and expectations. ***NOTE**: For Screening and Enhanced Referral, the expectation is that there is a selected subset of staff on the treatment team who are trained to do this, while at the higher stages, the expectation is that all staff on the treatment team will be trained to do this.*

Technology applications	Using technology facilitates self-management (through apps on a cell phone for example) and education (using videos, for example) as well as scaling interventions for a large population. In this domain, expectation of using technology in some form begins at the Care Management and Consultation Stage, and then expands to an expectation of scalability in Comprehensive Treatment and Population Management.
Treatment plans	As used here, this term refers to whatever format or documentation the program or practice uses to document "care plans" for people receiving services. In many BH settings, this will take the form of formal treatment plans that meet payer requirements, but most PH settings do not have that level of requirement, and therefore document "care plans" more flexibly. In either instance, the language describes documenting self-management interventions and goals, including demonstration of skill acquisition and use, for diet, exercise and other conditions when indicated.
Advance directives	As described in the CHI Framework Self-assessment Tool, this term is shorthand for health care proxies and living wills regarding medical care, as well as BH treatment advance directives for those individuals at risk of severe decompensation. This language is inserted as a prompt for consideration along with other "co-occurring" self-management skills, tools and supports. Routine attention to addressing "co-occurring" advance directives is only an expectation at the Comprehensive Treatment and Population Management Stage. ***NOTE**: Advance directives are not usually an issue in settings focused on children. In those rare instances where an organization is operating at that stage and ONLY managing a child population, this expectation does not have to be met.*

DOMAIN 4 EXAMPLE/DESCRIPTION: PERSONALIZED SELF-MANAGEMENT SUPPORT	
SETTING	**DEFINITIONS/EXAMPLES**
CO-OCCURRING SELF-MANAGEMENT MATERIALS may include, but are not limited to:	
Adult BH (MH or SUD)	■ SAMSHA evidenced-based resources https://www.samhsa.gov/co-occurring-disorders ■ Overdose Prevention and Response Toolkit https://library.samhsa.gov/product/overdose-prevention-response-toolkit/pep23-03-00-001 ■ American Lung Association's My COPD Action Plan https://www.lung.org/getmedia/c7657648-a30f-4465-af92-fc762411922e/copd-action-plan.pdf.pdf https://www.lung.org/lung-health-diseases/lung-disease-lookup/copd/living-with-copd/copd-management-tools
Adult PH	■ National Council for Mental Wellbeing resources https://www.thenationalcouncil.org/program/center-of-excellence/resources/ ■ A PCDC-led project to better address and overcome the challenges related to implementing and delivering chronic care management (CCM) in a primary care setting https://www.pcdc.org/resources/delivering-team-based-chronic-care-management-overcoming-barriers/
Child and adolescent BH	■ SAMHSA Tips for Teens https://store.samhsa.gov/?search_api_fulltext=tips%20for%20teens&sort_bef_combine=search_api_relevance_ ■ DESC Guided Self-management tools for ADHD Teens https://www.pediatricassociatesct.com/storage/app/media/handouts/adhd/CN-Guided-Self-Management-Tools-for-ADHD-Teens-13-17.pdf
Child and adolescent PH	■ Developing Health Literacy Skills in Children and Youth (National Academies) https://nap.nationalacademies.org/catalog/25888/developing-health-literacy-skills-in-children-and-youth-proceedings-of ■ Teen Toolkit for Diabetes https://www.jdrf.org/wp-content/uploads/2013/10/JDRFTEENTOOLKIT.pdf
EXAMPLES OF SELF-MANAGEMENT TOOLS may include, but are not limited to:	
For application in any of the above settings, if appropriate	**EXAMPLE 1: ER Prevention Questionnaire** No one likes going to the emergency room but sometimes it's necessary. Let's explore your habits with using the emergency room. Please answer the following questions. 1. Number of times you have been at the ER within the past 12 months: 2. How many times were you admitted to the hospital after going to the ER?

For application in any of the above settings, if appropriate

3. Chief complaint in ER (Why did you go?) (e.g., dyspnea, SOB, cough, chest pain, back pain, fall, injury, suicidal ideation).
4. What options did you try before going to the ER (e.g., PCP, Urgent Care, Calling Family/Friend/Caregiver/None/Other)?
5. Why do you think those options didn't work out (e.g., I prefer ER, need too urgent, no/or can't reach PCP/Family/Friend/Caregiver, Transportation difficulties)?
6. What actually happened at the ER? Did they meet your needs?
7. Is there anything you could have done or had in the hours or days before going to the ED that could have prevented the visit?
8. Did you discuss your decision to go to the ER with anyone before going? Did you have anyone to go with you?
9. Would it have been helpful to have a firsthand guide or health guide to talk to or go with you (e.g., yes/no/both).
10. If you didn't need to go to the ER so much, how would your life be different?
11. Explore some ways other than by going to the ER that could meet your needs?
12. What can you do to stay out of the ER? (Provide when and how you can explanation.)
13. What can others do to help you stay out of the ER? (Provide when and how others can explanation.)

EXAMPLE 2: Pain Self-management Tool

When: *I feel pain*

I can: *Take Motrin or Tylenol*

I can: *Use heating pad*

Others can: *Call to check in on me*

DOMAIN 5 TERMINOLOGY: INTERDISCIPLINARY TEAMWORK	
TERM	**DEFINITIONS/CRITERIA**
Subdomain 5.1: Integrated care team composition.	
Integrated team	Because "integrated" can have many meanings, it is important to reinforce that for the purpose of scoring this domain, "integrated" refers to team composition and activities specifically targeting the delivery of integrated health and behavioral health services. Integrating MH and SUD alone in a BH setting, for example, is valuable, but not what this domain is measuring.
Person-centeredness	The values, preferences, needs and culture of each person receiving services are respected. The goals and priorities of people receiving services and their families drive the treatment, and the treatment team works as a partner with the person receiving services in order to help them address their PH and BH issues in order to achieve their personal goals, rather than emphasizing just "complying" with what the treatment team wants.[6]
Interdisciplinary	This domain uses the term "interdisciplinary" rather than "multidisciplinary" to emphasize that what is being measured is not just the presence of a team with different disciplines, but also that the team works together to combine their efforts to accomplish the delivery of integrated care. ***NOTE:*** *"Disciplines" here can include medical assistants, community health workers, case managers, care coordinators and peer support workers, not just traditional team members with traditional professional licenses.*
Dedicated time	This term as used here is meant to indicate that the roles of BHC, RN consultant or care coordinator have designated time in their job descriptions to fulfill the integrated care delivery functions described within the domain. A BH program in the Screening and Enhanced Referral Stage, for example, might have a psychiatric nurse on the team who can provide consultation from time to time on medical issues, but in order to meet criteria for Care Management and Consultation, that nurse would have to have dedicated time in their job just to focus on providing PH consultation to the program. Similarly, in a PH program, there may be a care coordinator assigned to manage a diabetes registry, or a medical assistant that coordinates referrals, that in Screening and Enhanced Referral would from time-to-time assist with referral coordination and tracking for BH issues, but in order to meet criteria for Care Management and Consultation, the care coordinator or other staff would have to have dedicated time for the BH coordination function. The minimum amount of dedicated time is not specified here, but a minimum of eight hours per week would be a reasonable guideline to use in the self-assessment process. ***NOTE:*** *Integrated care functions at the more advanced stages require some investment of dedicated time by ALL team members (as for team huddles), and because that time produces "value," it should be defined and counted toward any productivity expectations.*
BH consultant (BHC)	A licensed behavioral health professional (such as a psychiatrist, psychiatric nurse practitioner, psychologist, licensed clinical social worker, LMHC, LPC or LMFT) who can diagnose BH conditions and — usually — bill for services independently and who functions as a BHC and is a core member of the primary care team. The BHC contributes (directly and through consultation to other team members) to the implementation of practice-wide prevention and early identification and intervention strategies, as well as offers targeted treatment for behavioral health conditions, unhealthy behaviors exacerbating physical health concerns and chronic health conditions across the lifespan (i.e., pediatric, adult and older adult populations). As a member of the primary care team, the behavioral health professional shares in the responsibility and liability of care for people receiving services.[7]

Nurse care coordinator (NCC)	RN who specializes in organizing care and treatments for people receiving services by including all care team members. The NCC specifically relates to having a team member with medical training as part of the BH treatment team or program. In the BH setting working on integration, the NCC focuses on medical conditions such as diabetes, congestive heart failure, asthma, chronic obstructive pulmonary disease (COPD). The NCC develops a therapeutic relationship that "facilitates the continuity and integration of care for people receiving services with co-occurring health problem, and their significant others. Interventions will include the provision of a single point of access, timely needs assessment, symptom management, ongoing referral, information provision, coordination of multidisciplinary input, transition and discharge planning, and ongoing support to negotiate the complexities of the health system." [8]
Access to consultation from a BH or PH prescriber	The intent of this item is to measure the presence of a formal arrangement with one or more consultants so that team members can routinely obtain access to specialty consultation when needed. If such an arrangement is not present, then it is likely that individual team members need to figure out how to obtain their own access to consultants, and the criteria for "routine access" would likely not be met.
Integrated interdisciplinary teamwork	This is the primary focus of Subdomain 5.2. The specific bulleted indicators in this subdomain are ways of addressing some of the functional processes of integrated interdisciplinary teamwork, which relate to sharing information (verbally 1:1 or team meetings, in writing in referral forms or charting and/or electronically), identifying activities and performing assigned roles in implementing an integrated care plan (in person and/or electronically), and working collectively to address challenging clinical situations (in person and/or electronically). There is a progression in this subdomain across the stages in all these dimensions of activity. To accomplish these functions successfully, teams will ideally create a safe culture for teamwork that facilitates success. The creation of this culture goes beyond simply written policies, and although "team culture" is not specifically identified in the bulleted indicators, it is recommended that teams work to implement the Five Principles of Integrated Teamwork as described below.
Five principles of integrated teamwork	Team-based Care Principles [9] **1.** Established, open and psychologically safe communication patterns. **2.** Well-defined and appropriate team goals. **3.** Clear role definitions and expectations for team members. **4**. A real-time, structured yet flexible decision-making process. **5.** The ability of the team to treat itself (e.g., celebrate accomplishments and address breakdowns).
Subdomain 5.2: Integrated teamwork and sharing of clinical information.	
Proactive information sharing	Recent (2022) changes in HIPAA regulations are intended to create more proactive expectations on providers to share information with other providers working with the same person receiving services. This means that "integrated teamwork," whether working internally or with referral partners, should establish that information WILL BE SHARED routinely, unless the person receiving services specifically refuses consent, or unless one of the providers "holds itself out" as a specific SUD treatment program, and is therefore covered by the limitations of 42 CFR Part 2. The bullets in this subdomain are intended to guide programs and practices to create the policy and procedure infrastructure to support this proactive information sharing regarding integrated care.

Interdisciplinary roles and "just-in-time action steps"	These items relate first to team members understanding that integrated care delivery is more than either a referral or a prescription, but rather that all team members can play a role in CQI, education, skill building, activation, care coordination, addressing social and environmental factors that affect health, and internal consultation to other team members. Medical assistants, peers, and CHWs may be more familiar with the person receiving services' day-to-day struggles in their family and inform the team on how to help the person manage their issues in that context. In organizations working toward Comprehensive Treatment and Population Management, taking this to scale often involves moving beyond what can be discussed in team meetings and huddles, to having capacity for electronic communication between team members, so that one team member can notify another team member "just in time" to follow through with action steps that have been negotiated with the person receiving services.
Subdomain 5.3: Integrated care team training and competency development.	
Training to competency	As used here, the intent of the term "training" in all the stages is to go beyond "basic training" (which is just an introductory education) to designing a combination of training, supervision, coaching and (ultimately) evaluation that help to ensure that all involved staff (depending on the stage) not only are informed about what integrated care should be but are assisted to have the skills and supports to accomplish their roles. Formal development of integrated care competency expectations in job descriptions is not a defined expectation until Comprehensive Treatment and Population Management Stage, but there is an implication at all stages that some level of competency development is part of the training process. ***NOTE:*** *"Training" as used here does NOT require sending staff to outside training events. How programs and practices accomplish "training" can be variable and flexible. Some of the best "training to competency" occurs when programs and practices build the instruction and coaching into day-to-day activities like team meetings, shadowing, skill review and coaching support, huddles, case discussions, treatment plan meetings and supervision.*

DOMAIN 5 EXAMPLE/DESCRIPTION: INTERDISCIPLINARY TEAMWORK	
SETTING	**DEFINITIONS/EXAMPLES**
INTERDISCIPLINARY TEAM COMPOSITION, INFORMATION EXCHANGE AND TRAINING RESOURCES may include, but are not limited to:	
Adult BH (MH or SUD)	■ Making the Case for High Functioning Team-based Care https://www.thenationalcouncil.org/resources/making-the-case-for-high-functioning-team-based-care-in-community-behavioral-health-care-settings/
Adult PH	■ PCDC and SAMSHA Integration Webinar Series focus on integration at work and how to empower professionals within the integrated health field with critical knowledge — from navigating upskilling on multidisciplinary expertise to scaling operations. ■ Collaborative Care Model definition https://aims.uw.edu/collaborative-care ■ NCQA Population Health Management Resource Guide for Behavioral Health https://www.ncqa.org/wp-content/uploads/2021/04/20200422_NCQA_Behavioral_Health_Resource_Guide.pdf ■ 10 Ways Behavioral Health Staff can Positively Influence Team Huddles in Primary Care https://www.thenationalcouncil.org/wp-content/uploads/2021/04/Top_10_Ways_BH_Staff_can_Positively_Influence_Team_Huddles_in_PC.pdf
Child and adolescent BH	■ Making the Case for High Functioning Team-based Care https://www.thenationalcouncil.org/resources/making-the-case-for-high-functioning-team-based-care-in-community-behavioral-health-care-settings/
Child and adolescent PH	■ Team-based Care in the Pediatric Office https://www.aap.org/en/practice-management/patient-scheduling-and-office-workflow/team-based-care-in-the-pediatric-office/

RESOURCE EXAMPLE OF TEAM HUDDLE PLAN may include, but is not limited to:

For application in any of the above settings, if appropriate

Team Huddles

(Adapted from Lighthouse Behavioral Wellness Centers)

Purpose: To promote communication and integration between all [Organization] care team members to efficiently provide coordinated behavioral health and chronic disease management.

Objectives:

- Promote open, safe communication and align team members for a more engaged workforce.
- Define shared responsibilities for the individualized plan of care.
- Build team culture for efficient problem solving of consumer needs.
- Shared consumer care coordination and decision making.

Definition of a Huddle: A brief meeting of the [Organization] care team to increase efficiency and access to care.

Length of Huddles: 20-30 minutes.

When does the Huddle take place? At regular, consistent scheduled times, usually before first consumer of the day.

How many days of the week does the Huddle take place? Every workday.

Who attends the Huddle? Relevant team members may include case managers, care coordinators, licensed behavioral health provider, nurse care managers, wellness coaches, family support providers, recovery support specialists and support staff, if available.

Who leads the Huddle? The huddle is led by a staff member who has been identified by the team.

Where does the Huddle take place? Convenient location within each clinic with access to the Scheduler.

What are some of the benefits of the Huddle? Helps build team culture; enhances communication between team members; prepares staff for consumer visits to anticipate the needs of people receiving services; allows for planning of the day, identifying spots for additional consumer access; and reviews potential staffing issues in the clinic.

What topics are addressed in the Huddle? (RRIC)

- **Reflect** on continued or newly identified needs from the previous day.
- **Review** the scheduled consumers for the day (including physician's schedules), allowing the team to anticipate possible needs of these people receiving services.
- **Identify** and prioritize significant care gap needs using reporting tools such as care coordination, 90 not seen and case load and ETPS reports.
- **Connect** with familiar faces or people receiving services who often no-show appointments that may be on that day's schedule.

For application in any of the above settings, if appropriate	**How is the huddle documented?** All participants sign in and document specific tasks on the Sign-in Sheet. Afterwards, a copy can be made to be disseminated to all staff. The time spent in huddle is not billable. However, the activities that are identified as needing to be completed may be billable. Documentation may follow the SBAR format which facilitates inter-staff communication by streamlining communication and capturing pertinent information between staff to staff. 1. **S**ituation — Identify what is going on with the person receiving services in 5-10 seconds. Include the person's identification information and concerns. 2. **B**ackground — Identify what clinical context, objective data and numbers (registry). 3. **A**ssessment — What is the problem? 4. **R**ecommendation — What do we do? Huddle video example: https://www.youtube.com/watch?v=Wttxm7jAnb4

DOMAIN 6 TERMINOLOGY: SYSTEMATIC QUALITY IMPROVEMENT

See above definitions for Process vs. Outcome and Individual vs. Cohort vs. Population.

TERM	DEFINITIONS/CRITERIA
Quality improvement (formal or systematic)	Quality improvement (or performance improvement) as used here involves the program or practice using some type of formal or organized process to systematically improve processes and outcomes of care. Quality improvement is not the same as quality assurance or compliance monitoring. The goal of quality improvement is always to put the primary customers (people receiving services) and secondary customers (referral partners) at the center of the discussion, and to evaluate and improve their experience and results. This domain does not require a specific type of QI process but does expect that there will be a systematic approach. An example of a systematic approach is described in **FOCUS-PDCA** definition in this domain.
Metrics	Specific and measurable elements of health and social care that can be used to assess quality of care.
FOCUS-PDCA (Find, Organize, Clarify, Understand, Select, Plan, Do, Check and Act)	This is one common example of a systematic approach to QI. **Find** a process that needs improvement. **Organize** a representative team that is involved in the process to work on it. **Clarify** the baseline performance with data. Understand the contributors to why the baseline performance is suboptimal (Fishbone diagram). **Select** one or more contributor processes to improve. Then engage in rapid cycle change using **Plan-Do-Check-Act cycles** to make incremental progress. **NOTE:** *PDCA may also be referred to as PDSA: Plan – Do – Study – Act*
Imbalances	Populations that experience imbalances are one important target of QI efforts. Individuals with co-occurring PH/BH issues are themselves a population that experience discrepancies in care compared to those with only one type of challenge, but this item expects each program or practice to go further and address other common contributors to health discrepancies in populations served. These may include imbalances based on **language, economic status (including being uninsured) or social circumstances (e.g., homelessness).** The imbalance issues that are relevant may vary from setting to setting, but each setting should recognize where there are risks of imbalances occurring for people with complex needs and dedicate their QI efforts to address them.
Soliciting input from people receiving services	Getting information directly from customers is essential to understanding their experience. For this domain, this can begin (in Stage 1, Screening and Enhanced Referral) simply by surveying a sample of people receiving services regarding the process(es) being addressed. This does not have to be complicated or overwhelming. More systematic engagement of the perspective of people receiving services is expected in the more advanced stages. For Stage 2 (Care Management and Consultation) that input is also included on the interdisciplinary QI team. For Stage 3 (Comprehensive Treatment and Population Management), systematically including the perspective of people receiving services involves developing multiple routine processes for gathering that input through surveys, formal advisory councils and/or activities such as simulated walk-throughs.

Internal or external quality monitoring	This item references the expectation that the QI activity is organized for sharing with either an external oversight entity (payer, regulator, ACO, etc.) OR with an internal oversight entity, such as quality council. For larger organizations (including but not limited to CMHCs, CCBHCs, FQHCs) that may have patient or consumer advisory councils, these data should be shared with those councils as part of the formal QI process. For practices or programs in agencies which do not have such councils, the language about reporting to those councils **does not apply.**
Interdisciplinary QI team composition	This criterion is required beginning with the Care Management and Consultation Stage. Best practice QI requires involvement of multiple perspectives within the program or practice. That always includes different disciplines (MD, RN, MSW, etc.) as well as different staff (care managers, medical assistant, receptionist) depending on the process being addressed. This also includes the expectation of including team members who reflect the perspective of people receiving services. Examples include peer support staff and CHWs, where those are present. If there are no such staff, other staff who can better reflect how the program or practice is perceived by the community (e.g., receptionists) should be intentionally included. In addition, if the process being addressed involves coordination with another agency or provider, then a representative of that provider or agency should be represented on the QI team whenever possible.
Benchmarks	A point of reference or standard by which something can be measured. Benchmarking is a process of comparing the cost, cycle time, productivity or quality of a specific process or method to another that is widely considered to be an industry standard or best practice.[10] Process and outcome data for certain conditions should be compared to identified benchmarks when those are available and relevant. Common benchmarks may include those established by HEDIS and NCQA, as well as by specific payers or regulators appropriate to the practice or program.
Integration teams and champions	This is a more robust and systematic QI process which can be applied to many transformational activities including PH/BH integration. The typical approach in a large organization is that each significant component of the organization as an identified interdisciplinary integration team that is responsible for organizing all the QI processes associated with integration (as illustrated in the CHI Framework) and includes designated "champions" who may lead the team, but also may represent the different programs or practices involved in the process. The role of champions often includes "championing" the process not only when they are engaged with the Integration Team, but also with their colleagues in their own setting and/or discipline.
Organization QI processes	In an organization in the Comprehensive Treatment and Population Management Stage, measuring and improving processes and outcomes related to overlapping PH/BH conditions and social risk factors is not just assigned to a "special" QI team, but is also part of the organization's overall QI plan and routine QI processes, such as QI committees and peer review activities.

DOMAIN 6 EXAMPLE/DESCRIPTION: SYSTEMATIC QUALITY IMPROVEMENT	
SETTING	**DEFINITIONS/EXAMPLES**
QUALITY IMPROVEMENT RESOURCES may include, but are not limited to:	
Adult BH (MH or SUD)	■ Quality Improvement Toolkit https://www.thenationalcouncil.org/wp-content/uploads/2022/05/Quality-Improvement-Toolkit-1.pdf
Adult PH	■ Integration at Work: Quality Improvement Tips for Integrated Care Settings https://www.pcdc.org/resources/integration-at-work-quality-improvement-tips-for-integrated-care-settings/
Child and adolescent BH	■ Quality Improvement Toolkit https://www.thenationalcouncil.org/wp-content/uploads/2022/05/Quality-Improvement-Toolkit-1.pdf
Child and adolescent PH	■ Integration at Work: Quality Improvement Tips for Integrated Care Settings https://www.pcdc.org/resources/integration-at-work-quality-improvement-tips-for-integrated-care-settings/

DOMAIN 7 TERMINOLOGY: COMMUNITY INTERVENTIONS TO ADDRESS SOCIAL AND ENVIRONMENTAL FACTORS THAT AFFECT HEALTH

TERM	DEFINITIONS/CRITERIA
Risk factors for social and environmental factors that affect health	A wide range of social and environmental factors and stressors can adversely affect physical and behavioral health. The CHI Framework Self-assessment Tool lists common examples, but there may be others which impact specific populations. Common examples include housing instability or homelessness, food insecurity, criminal justice involvement, involvement with child or adult protective services, transportation challenges, medical indigence and poverty. Social and environmental factors that affect health may relate as well to family stressors at home, such as the need to care for a disabled relative or significant childcare challenges. Each of these issues may contribute to poorer health outcomes both because of the direct effect of stress, as well as because they interfere with prevention, treatment and self-management of PH and BH issues.
Interpersonal violence (IPV)	As used here, this is intended to be a generic term covering multiple types of risk, including child abuse or neglect, domestic or partner violence of any type and elder abuse. This is included as a significant health risk indicator in Domain 1 rather than a social risk indicator in Domain 7 because at least one type of IPV is recognized by the USPSTF as a significant issue to be addressed. For the CHI, we have therefore included all forms of IPV in the same way.[11]
Integrated interventions for social and environmental factors that affect health	In addition to the expected focus on referrals to and coordination with social service agencies that are or need to be involved with individuals and families experiencing risks related to social and environmental factors that affect health, this domain also emphasizes the importance of "integrating interventions" into the work of the treatment team in order to provide direct assistance to the individual/family served. Direct assistance does not mean directly providing (for example) food or housing (although some advanced health systems are beginning to do just that) so much as working directly to help with "activation" and skill acquisition to make best use of available resources to address needs related to social and environmental factors that affect health.
Screening for social and environmental factors that affect health	Screening for social and environmental factors that affect health as defined here can be any systematic and standardized effort to inquire about one or more relevant risk factors, and to document positive responses in order to facilitate appropriate response. Adopting "evidence-based" screening tools for social and environmental factors that affect health is not required, as there is not sufficient consensus on particular methodologies for screening to justify such a requirement.
Collaboration agreements	As with formalizing relationships with PH or BH referral partners in Domain 1, this domain requires similarly formalized relationships with one or more social service agencies that address common risk factors for social and environmental factors that affect health. A written collaboration agreement is one way to demonstrate that such a relationship is formal, but other methods include (but are not limited to) a structure for regular meetings between key team members and/or organized procedures for cross-referral and case sharing.

"Complexity care" partners care coordination meetings	Complexity care is a term referring to the multiplicity of needs — and multiplicity of agency involvement — that need to be proactively organized for effective response, particularly for those individuals that may have the most complex and costly challenges. For this domain, one indicator in the Comprehensive Treatment and Population Management Stage is that the relationships with the collaborating social service agencies are sufficiently strong so that there is routine ability to set up case-specific care coordination meetings to build "integrated" cross-agency service plans to help those individuals best address their complex needs.
"Community care hub" — leadership level meetings	In addition to capacity to set up case-specific care coordination, another requirement for Comprehensive Treatment and Population Management is to establish at least a foundation for what is being termed a "Community Care Hub."[12,13,14] For this domain, the minimum requirement is that there are regular (2-4x/year) meetings at the leadership level between agencies that share responsibility for the population served in their community, specifically for the purpose of delineating shared procedures and continuously improving the delivery to their population of interventions for PH, BH and the social and environmental factors that affect health.

DOMAIN 7 EXAMPLE/DESCRIPTION: COMMUNITY INTERVENTIONS TO ADDRESS SOCIAL AND ENVIRONMENTAL FACTORS THAT AFFECT HEALTH	
SETTING	**DEFINITIONS/EXAMPLES**
LINKAGE TO CARE RESOURCES may include, but are not limited to:	
Adult BH (MH or SUD)	■ Creating Effective Partnerships to Improve Behavioral Health Outcomes https://www.kdhe.ks.gov/DocumentCenter/View/2924/Creating-Effective-Partnerships-for-Improving-Behavioral-Health-Outcomes-Guide-PDF
Adult PH	■ Community-Clinical Linkages for the Prevention and Control of Chronic Diseases https://www.cdc.gov/dhdsp/pubs/docs/ccl-practitioners-guide.pdf ■ RUSH 2019 Community Health Needs Assessment and 2020 Community Health Implementation Plan https://www.rush.edu/sites/default/files/2020-09/CHNA-CHIP-ONLINE-REV8-8_FNL.pdf

DOMAIN 8 TERMINOLOGY: FINANCIAL AND ADMINISTRATIVE SUSTAINABILITY

TERM	DEFINITIONS/CRITERIA
Subdomain 8.1: Financial sustainability.	
Financial Sustainability	As used here, progress toward financial sustainability refers to activities that can be done by the program/practice and/or its parent organization to ensure that there is continuing financial capability to support the delivery of integrated services. Financial Sustainability involves three interrelated components. The bullets that define achievement of each stage in this subdomain reflect steps of progress in each of these three components, recognizing the importance of attending to each of these simultaneously in order to best achieve financial sustainability: ■ **Cost efficiency:** Understanding current and marginal costs for various activities, services and interventions, and reviewing workflows and staff roles to maximize the degree to which integrated care can be delivered efficiently, by incorporation into existing workflows, staff roles and other processes. ■ **Reimbursement:** Maximizing the ability to receive reimbursement on a routine basis for services provided. Reimbursement generally involves some type of billing for services and can include Fee-for-Service (FFS) billing for individual service codes, as well as bundled service billing (See definition) for service packages (e.g., MAT or COCM). ■ **Value-based Arrangements:** Engaging with payer or provider partners or collaborators to receive funding or other resources, directly or indirectly, that support the ability of the program/practice/organization to improve outcomes in relation to the investment of resources for a particular cohort or population. See definition below for more detail. ■ There is detailed discussion of the relationship of various types of payment methods to the achievement and financial sustainability of each of the three stages in the **CHI White Paper**.[15] In addressing financial sustainability, it is important to work toward **continuing** balance of revenue and cost. Short-term grants and payments may be helpful and may contribute toward the time needed to build more enduring processes, but a time-limited grant alone is not what is meant by "sustainability" here. By contrast, an open-ended or continuing grant (like the FQHC grant) would be a contributor to financial sustainability. Finally, financial sustainability may involve a variety of types of "indirect" or "inter-organizational" payments or resource transfers. A simple example might be a BHC or NCC who is donated by "another type" of organization and for whom the cost for the donating organization is supported by a combination of direct reimbursement and generated value. ***NOTE:*** *We know there are many things over which the provider has no control, and therefore we have not set a target of "perfect" sustainability (100% coverage of all costs) even at the Comprehensive Treatment and Population Management Stage. Instead, we identify specific action steps in each bullet that are achievable objectives connected to the delivery of each stage.*

Value-based arrangements

As defined in the CHI Framework, value is about demonstrating improved outcomes in relationship to resources expended.[16] Value does not routinely mean saving money: If a process has additional cost but produces substantially better outcomes in relation to the amount of the additional investment, that process has "value." Therefore, metrics that demonstrate value are not just about cost, but usually involve measuring both the cost of the intervention and the intended health outcomes achieved.

Value-based arrangements are a method for connecting direct payment or provision of resources or other incentives to the quality of care provided. They therefore reward providers for investments in capacity and processes that improve both efficiency and effectiveness. Value-based care models center outcomes for people receiving services and how well health care providers can improve quality of care based on specific measures, whether diagnostic specific (improvements in PHQ-9 scores or HbA1c, or on more general population goals, such as reducing hospital readmissions and improving preventative care).[17,18]

In the CHI Framework, providers can demonstrate that integrated services can produce value for individuals and populations served, and for payers and other partners, at any stage. Being able to demonstrate value to partners/collaborators with resources to "invest" in "value-based arrangements" of all kinds is therefore an important element of sustainability.

As noted above, "value-based arrangements" are developed by providers through engaging with payer or provider partners or collaborators to receive funding or other resources, directly or indirectly, that support the ability of the program/practice/organization to improve outcomes in relation to the investment of resources for a particular cohort or population.

The types of value-based arrangements — many of which are described in the **CHI White Paper** — can be quite variable and creative. Some examples may include:

- Incentive payments (or in-kind incentives) by a payer for a provider to develop and sustain the necessary infrastructure to deliver integrated care coordination (Care Management/Consultation) for a population of people with SMI who have diabetes (in a BH setting) or a population of people with medical needs who have depression (in a PH setting).
- Resources provided by a hospital system to a collaborating behavioral health organization to support the development of "integratedness" in the hospital's affiliated clinics or practices.
- Resources provided (perhaps through a Designated Collaborating Organization relationship) by a CCBHC to a collaborating health center to support access to integrated health services for the BH center's people receiving services.
- Incentive payments (or in-kind resources) provided by a hospital partner to a community provider to offer intensive integrated interventions to a cohort of individuals with complex PH/BH needs who are frequent users of the ER.

Sub-capitation payments or resource sharing from a payer or an accountable care organization for a provider organization to "care manage" a designated population of people with co-occurring PH/BH conditions to achieve certain metrics of progress that demonstrate value.

Time-limited grants	Typically have a single end date and a special allocation of funds.[19]
Bundled FFS payments	Bundled payments — as used here — refer to payments by third-party payers for service bundles provided by a service team, rather than traditional FFS payment which is for individual procedures or interventions. Bundled payments can be very helpful in supporting integrated service delivery because they can also incorporate payment for indirect service costs and for activities of supportive team members (care coordinators, community health workers, peers, medical assistants) who may not be eligible for individual reimbursement. Bundled payments in integrated care are commonly associated with payment for specific service packages, such as paying for "bundled" opioid medication treatment in a primary care setting or paying for bundled Collaborative Care Management (CoCM) for a particular target population (e.g., people with depression in a primary care setting). Another type of bundled payment is an episode of care payment or case rate payment, where a payer establishes a fixed payment rate for everyone presenting with a particular diagnosis or needing a particular procedure. One example that is relevant to integrated care is that some states are piloting Medicaid payments in pediatric settings for children and adolescents with ADHD. This type of arrangement, if priced properly, can support the development of an integrated team approach to working with the affected children and families. It is common that these payments may or may not be "turned on" or available in a particular state or community or may be available only through certain payers. That is why the language in the CHI Framework uses the term "If available" in relation to these types of payments. It is important for providers to be ready to access these payment types if they do become available, but there is no expectation in the CHI Framework to be able to bill for service codes or service bundles that do not exist in your community.
Subdomain 8.2: Administrative sustainability.	
Administrative sustainability	As used here, this term refers to developing administrative structures — policies and procedures generally — that help the organization deliver integrated services smoothly and consistently in a way that aligns with whatever its outside regulatory environment happens to be. This process is intended to combat the sense that integration is a special process that works around existing regulatory guidance or requires staff to work outside of their existing scopes of practice or licensure requirements. Rather, administrative sustainability emphasizes for any program/practice/organization that there are activities that can be taken to continually align the delivery of integrated services — in any stage — with the existing program rules and the existing provider rules, so that those integrated activities can continue indefinitely. Many programs experience the lack of appropriately developed external regulatory guidance to be a barrier to sustainability, and often wish for new categories of program licensure or new rules about scope of practice in order to proceed. However, this subdomain emphasizes that there are almost always activities within the provider's control that can improve administrative sustainability within the available (and always imperfect) regulatory guidance provided.

Consulting providers with the "other" license	As used here, this refers to both treatment team members (BHCs, NCCs) or outside consultants who are licensed to provide services in the "co-occurring" domain as part of the services offered in the practice or program. Specifically, this means an individual providing potentially billable BH services in a PH setting, or an individual providing potentially billable PH services in a BH setting. The focus in this item is usually on "co-occurring" services that are intended to be billed by the "primary" treatment team, practice or program (the one using the CHI Framework tool), as opposed to services by an outside specialty referral provider that are provided and billed in a different of setting. However, it is also possible to meet the criteria for this bullet by having the provider with the "other license" be "donated" — and billed — by a partner program in a way that supports the cost of that donated provider. For example, a BH clinic might donate a BHC clinician to a partner FQHC and do direct billing for their services or include their cost in a CCBHC prospective payment system cost report.
Program licensure/ regulation	Rules or requirements by government agencies and/or payers that require providers to meet specific standards of quality, equity and cost-effective care in order to provide or bill for services. Program licensure requirements are generally defined for PH clinics OR for BH clinics/programs. MH and SUD licensing may also be separate. Usually, existing licensure, regulation and credentialing standards do not provide guidance for appropriate integrated attention/intervention for co-occurring conditions, and therefore require clarification at the organization, practice or program level. Some states have "integrated" licensure options, but these often are less about integrated care than about allowing for operation of both PH and BH services in the same physical location to facilitate meeting physical plant and other administrative requirements. It cannot be assumed that having an "integrated license" therefore provides clear instructions for the delivery of integrated PH/BH services within any program or practice as defined in the CHI Framework.
Individual provider licensure or certification	Individual who is licensed or otherwise authorized by a government entity to provide health care services (or any individual who, without authority, holds themself out to be so licensed or authorized). Certification indicates a staff has successfully completed a course of study/skill development for a practice and may be authorized by a private or public certifying entity to engage in that practice.[20,21]
Scope of practice	Defines those health care services a physician or other PH or BH practitioner is authorized to perform by virtue of professional license, registration or certification. Scope of practice descriptions for individual practitioners may be silent or vague on the extent to which they can provide interventions beyond screening and referral for co-occurring PH or BH conditions, and therefore may create barriers for individual clinicians who want to participate in integrated service delivery but don't want to do anything that might violate their licensure requirements. In addition, health care professionals' scopes of practice often overlap reflecting shared competencies and activities that may facilitate integrated care. In this subdomain, the CHI Framework is requiring that the organization, practice or program provides helpful guidance so that all licensed practitioners understand how the services provided are appropriate within their scope of practice. Examples include making it clear that a BH practitioner can help a person receiving services follow instructions for managing a health condition as provided by a PH practitioner, and a PH practitioner can provide medication for depression or motivational interviewing to address risky substance use.
Instructions or procedures for providing and documenting integrated services	This item refers to policies, procedures, guidelines or other formalized materials that indicate how members of a BH or PH treatment team can provide and document integrated services for co-occurring issues within the scope of the program's PH or BH licensure and within the scope of practice of the individual's delivering the service. This addresses how a licensed BH clinic (and clinician) can provide medication for hypertension and/ or instruction on diabetes management even though the program is not PH licensed, or the clinician may not be a specialized PH practitioner, and VICE VERSA.

DOMAIN 8 EXAMPLE/DESCRIPTION: FINANCIAL AND ADMINISTRATIVE SUSTAINABILITY	
SETTING	**DEFINITIONS/EXAMPLES**
SUSTAINABILITY RESOURCES may include, but are not limited to:	
Adult BH (MH or SUD)	■ Financing the Future of Integrated Care https://www.thenationalcouncil.org/resources/financing-the-future-of-integrated-care/ ■ Health Home Information Resource Center https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html
Adult PH	■ Health Care Expansion Funding Options: Weighing Pros/Cons ■ Diabetes self-management education and support (DSMES) services: Sustainability https://www.cdc.gov/diabetes-toolkit/php/reimbursement/sustainability.html ■ Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-based Payment https://www.chcf.org/wp-content/uploads/2018/03/PartneringtoSucceed.pdf
Child and adolescent BH	■ Health Home Information Resource Center https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html
Child and adolescent PH	■ Health Care Expansion Funding Options: Weighing Pros/Cons ■ Diabetes self-management education and support (DSMES) services: Sustainability https://www.cdc.gov/diabetes-toolkit/php/reimbursement/sustainability.html

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