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CENTER OF EXCELLENCE for Integrated Health Solutions

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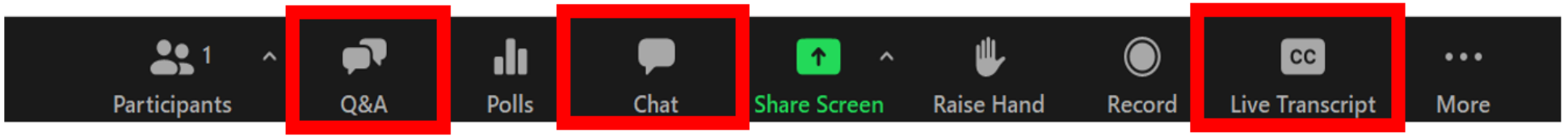
CoE-IHS Integration in Action: Leveraging the CHI Framework in Integrated Care Practices

April 17, 2025

3:00 – 4:00 p.m. ET

Questions, Comments & Closed Captioning

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



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

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

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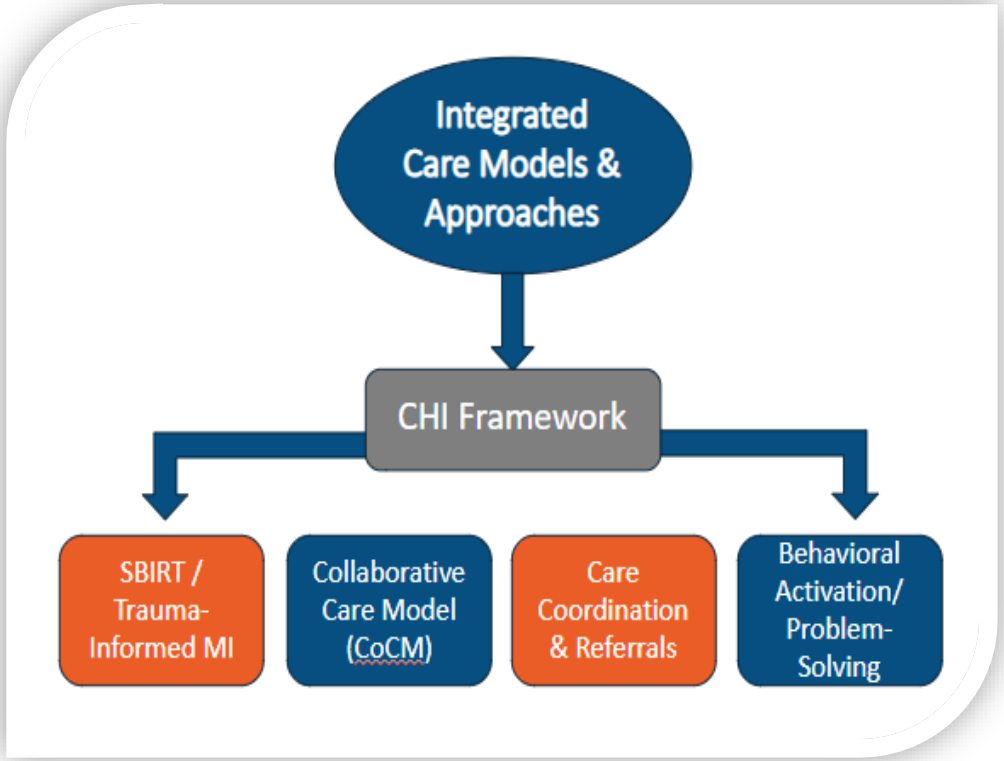
Integrated Care Models Webinar Series Schedule

Session Topic	Date/Time	Registration
Leveraging the CHI Framework in Integrated Care Practices	**April 17th, 3-4pm ET**	**You're here!**
Care Coordination and Referral Practices/Partnerships	**May 29th, 2:30-3:30pm ET**	Click here to register
Understanding CoCM in the Integrated Care Landscape	**June 25th, 1-2pm ET**	Click here to register
Trauma-Informed MI and SBIRT in Integrated Care	**July 15th, 12-1pm ET**	Click here to register
Using Behavioral Activation and Problem-Solving Treatment in Integrated Care	**August 14th, 1:30-2:30pm ET**	Click here to register
Sustainability and Future Consideration	**September 15th, 1-2pm ET**	Click here to register



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Introductions

Moderator: Jeff Capobianco, PhD, Senior Consultant, Practice Improvement & Consulting, NCMW

Integrated Health Consultants:

- **Renee Boak, *MPH***, Lead Consultant, Practice Improvement & Consulting, NCMW
- **Laura Leone, *DSW, MSS, LMSW,*** Lead Consultant, Practice Improvement & Consulting, NCMW
- **Ami Roeschlein, *DSW, MA, LMFT,*** Lead Consultant, Practice Improvement & Consulting, NCMW

Guest Speakers:

- **Kenneth Minkoff, *MD,*** Vice President and COO, ZiaPartners, Inc.
- **Katy Smali, *MPA, MPH, PMP*,** Project Director, CMS GUIDE Model, CMO, Montefiore Care Management

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Learning Objectives

- Participants can expect to learn about the Integrated Care Models Series and plan for their participation in the series.
- Participants will understand how various components, practices and models are supported and applied through the lens of the CHI Framework.
- Participants will evaluate how integrated care models can be adapted to address specific needs of different populations and service settings.

Leveraging the CHI Framework in Integrated Care Practices

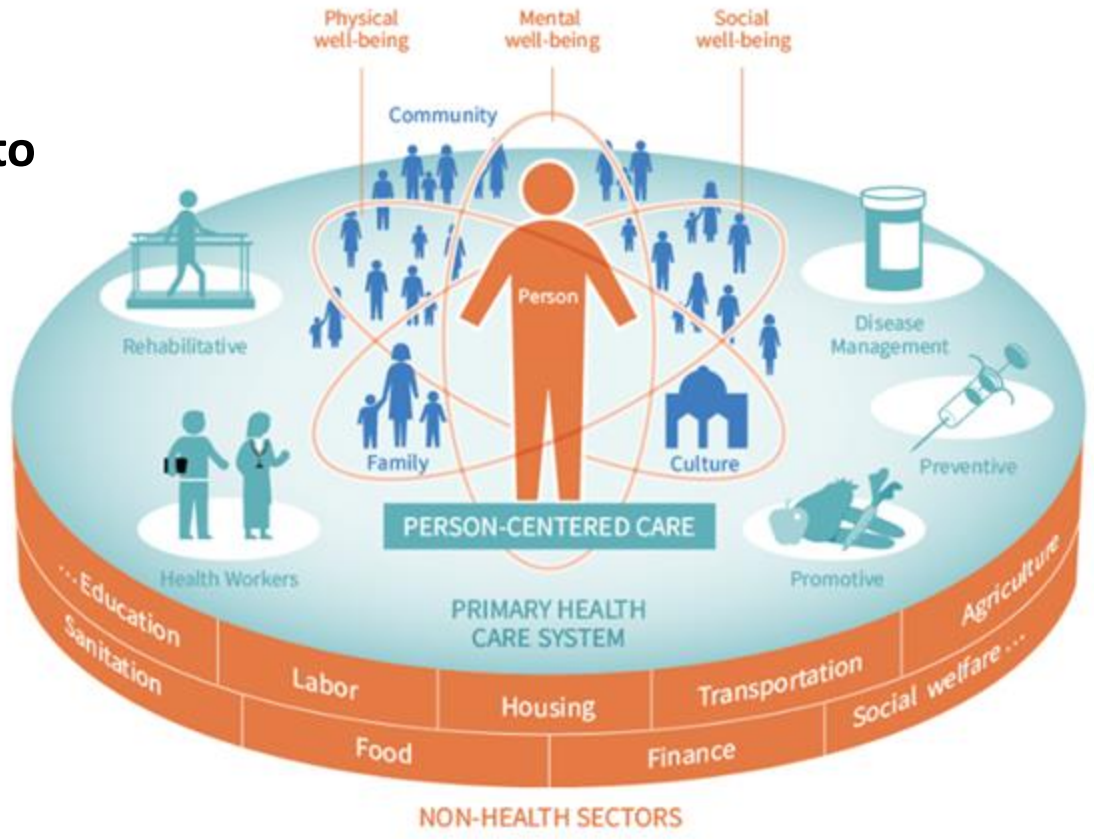
Let's explore ways the domains in the Comprehensive Health Integration (CHI) Framework are related to many common integrated care approaches and interventions, such as the Collaborative Care Model (CoCM), BHC, PCBH, Care Coordination, SBIRT, MAT, Behavioral Activation, and Trauma-Informed Motivational Interviewing, collectively, to enhance interprofessional collaboration in integrated health.

Experts will explore how each tool complements the others, creating a holistic, patient-centered approach to care.

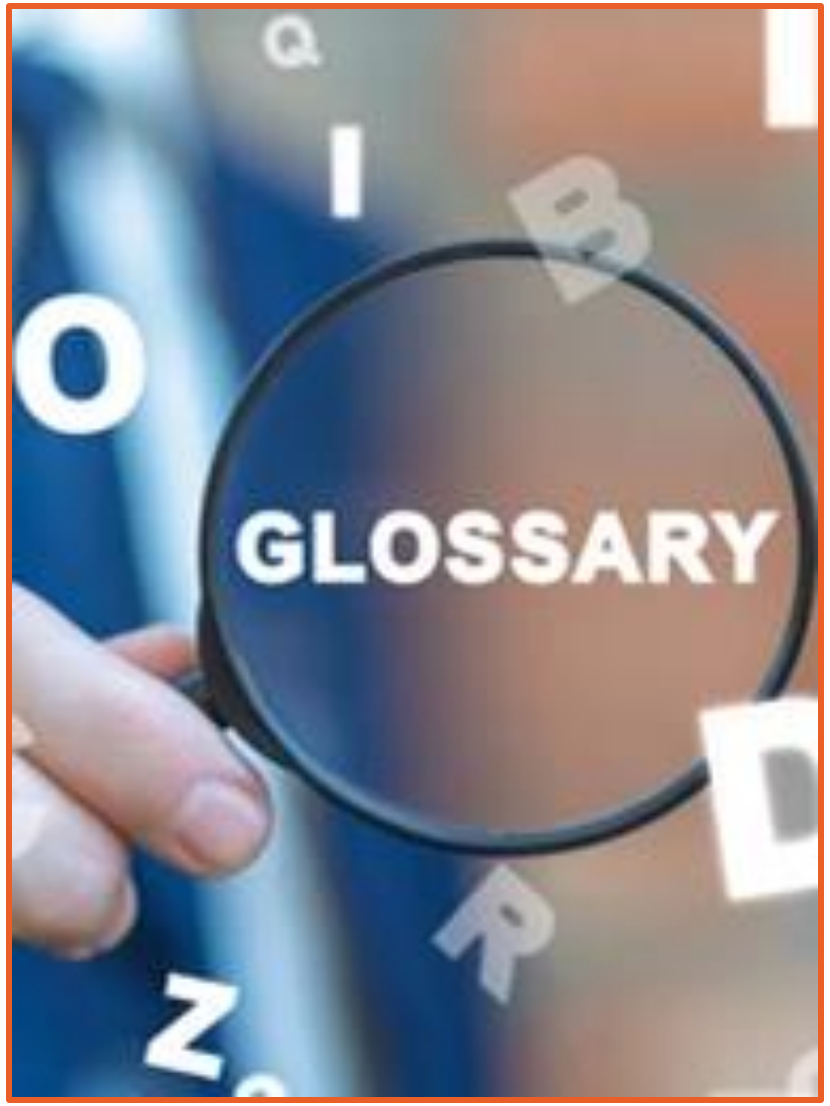
What is the CHI Framework?

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

- Demonstrate the value produced by progress in integrated service delivery
- Provide initial and sustainable financing for integrated service delivery
- Take integrated services to scale in a large network or system of care
- Measure progress and facilitate improvement in organizing delivery of integrated services (“integratedness”)



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



Integrated Services

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

Integratedness

- The degree to which programs or practices are organized to deliver integrated PH and BH prevention and treatment services to individuals or populations.
- A measure of both structural components (e.g., staffing) and care processes (e.g., screening) that support the extent to which “integrated services” in PH or BH settings are directly experienced by people served and delivered by service providers.

Eight Domains of Integration

Screening, Referral, and Follow-up

Prevention and Treatment of Common Conditions

Continuing Care Management

Self-Management Support

Inter-Disciplinary Teamwork

Systematic Measurement and Quality Improvement

Linkage with Community and Social Services

Administrative and Financial Sustainability

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The Three Integration Stages

Integration Stage 1:
Screening and Enhanced Referral

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

Integration Stage 2:
Care Management and Consultation

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

Integration Stage 3:
Comprehensive Treatment and Population Management

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

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

How CHI Supports Existing Integration Models

CHI is inclusive of ALL evidence-based approaches for PH-BH integration, e.g., CoCM, PCBH, BHC, SBIRT

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

CHI Supports Multiple Evidence-Based Models

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

CHI Enables Scalable and Flexible Integration

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

CHI Enables Sustainability and Value-Based Care

How Integration Models Map with CHI Domains and Stages: CHI includes all…

Integration Models	Domain	Stage	Impact
SBIRT, PHQ-9, Safety Planning, OD Prevention, MAT	D1: Screening, Referral and Follow-Up D2: Integrated Prevention and Treatment	1	• Early identification and prevention for individuals with mild or emerging BH needs. • Delivered by a range of providers at entry points to care. • Supports population-level screening and triage.
PCBH or BHC (BH Consultant) (integrates BH care into PH)	D1: Screening, Referral and Follow-Up D2 Integrated Prevention and Treatment D 3: Ongoing Care Coordination D 5: Interdisciplinary Team-Based Care	2	• Promotes same-day access and streamlined triage processes. • Consults to medical team on medication and non-med interventions. • Focus on warm hand-offs, teamwork, and shared accountability. • Emphasizes team huddles and shared care plans.
RN Care Coordination (integrates PH care into BH)	D1: Screening, Referral and Follow-Up D2 Integrated Prevention and Treatment D3: Ongoing Care Coordination D4: Self-Management Support D5: Interdisciplinary Team-Based Care	2	• Supports identification and intervention on medical issues by MH team. • Identifies and tracks measures of participation and progress on PH issues. • Functions as team consultant. • Provides and supports team provision of self-management support re PH issues.
CoCM (integrates BH care into PH)	D1: Screening, Referral and Follow-Up D2: Integrated Prevention and Treatment D3: Ongoing Care Management D6: Systematic Measurement and QI	2	• Ensures regular communication and tracking between team members. • Supports measurement-based care using standardized tools like PHQ-9. • Also supports registry use and population-level care tracking.

How CHI Domains Connect to Your Practice

This crosswalk links CHI Domains to tools from the Integrated Care Series and your Practice

Domain 1: Screening & Referrals

- Includes PHQ9, BMI, Screening, Brief Intervention, and Referral to Treatment (SBIRT), Adverse Childhood Experiences (ACEs) Screening, Risk Stratification

Domain 2: Prevention & Treatment

- Includes tracking routine prevention (developmental screening, colonoscopies) Motivational Interviewing, Problem Solving Treatment (Rx),HBAI, BH or PH meds, Medication Assisted Treatment (MAT), Behavioral Activation and brief interventions delivered by trained providers

Domain 3: Care Coordination

- Includes diabetes registry, Collaborative Care Model (CoCM) Registry, High and Low Touch Care Management

Domain 4: Self-Management Support

- Includes Patient Education Materials, Patient activation and goal-setting care plans, and collaborative, person-centered planning

Domain 5: Teamwork

- Includes Warm Handoffs, Interdisciplinary Collaboration, BHCs, and RN Care Coordinators as team members

Domains 6–8: QI, SDOH, and Sustainability

- Includes tools (metrics; cost management; billing) to strengthen, improve, evaluate, and sustain integration in any setting

Resources for Implementing the CHI

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

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Comprehensive Health Integration (CHI) Framework

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

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

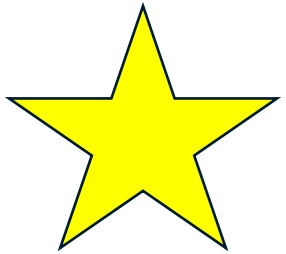
KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	SUBDOMAINS	HISTORICAL PRACTICE (Stage 0)	SCREENING AND ENHANCED REFERRAL (Stage 1)	CARE MANAGEMENT AND CONSULTATION (Stage 2)	COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT (Stage 3)
1. Screening, referrals and follow-up (f/u).	**1.1 Systematic screening for co-occurring MH/SUD/PH conditions and risk factors.** SEE HANDBOOK FOR MORE DETAIL ON SCREENING BEST PRACTICES AND TYPES OF CONDITIONS OR RISK FACTORS TO BE CONSIDERED FOR SCREENING.	• There is **no or limited** systematic screening for co-occurring conditions or risk factors that does not meet criteria for Screening and Enhanced Referral stage. • **Referrals primarily are triggered by self-report** of concerns by people receiving services.	• There is systematic screening for **at least one or two** high-prevalence co-occurring conditions or risk factors.	• There is systematic screening for **at least two or three** high-prevalence co-occurring conditions and risk factors. • **A designated team member is responsible for tracking** screening processes and results. Data on screening outcomes and f/u is **systematically collected.** SEE HANDBOOK FOR MORE DETAIL.	STAGE 2, PLUS: • There is systematic screening for **at least three or four** high-prevalence co-occurring conditions or risk factors. • There is **capacity for data registries** on screening, f/u processes and results. • There is **capacity for using data system to stratify population stages of need** (e.g., based on screening results and PH/BH complexity).

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

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	SUBDOMAINS	HISTORICAL PRACTICE (Stage 0)	SCREENING AND ENHANCED REFERRAL (Stage 1)	CARE MANAGEMENT AND CONSULTATION (Stage 2)	COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT (Stage 3)
1. Screening, referrals and follow-up (f/u).	**1.2 Systematic facilitation of referrals and follow-up.** SEE HANDBOOK FOR MORE DETAIL, INCLUDING DEFINITIONs OF "FORMAL ARRANGEMENT" AND "INTEGRATED TEAMWORK."	• Referrals are made to external PH or BH provider **without formal arrangement.** • Does **not meet threshold** for systematic tracking of referrals or method for sharing information between PH and BH providers to track f/u.	• For people with no existing provider or preference, **majority of referrals** go to a partner PH or BH provider with a formal arrangement. • There is **systematic tracking of referrals** to ensure connection with both PH and BH services for all in need. • There is an **expectation of and method for routine information sharing** between PH and BH partners to track ongoing f/u.	**STAGE 1, PLUS:** • **An integrated team member** (e.g., BH consultant or community health worker [CHW] in PH, PH care coordinator in BH) **routinely facilitates connection with and referrals** for people with positive screens. • For people with no existing provider connection or preference, **majority of referrals** go to internal or partner PH or BH provider with a formal arrangement. • **A designated team member** is responsible for tracking referrals and coordinating information sharing to track f/u.	**STAGE 2, PLUS:** • **BH and PH providers function as an integrated team in one or more locations** and are jointly accountable for ensuring referred individuals are engaged and receive both services. • For people with no existing provider connection or preference, **majority of referrals** go to an internal team partner PH or BH provider. • BH and PH providers **routinely and electronically (usually via shared electronic health record [EHR]) share/receive information** about referral and f/u.

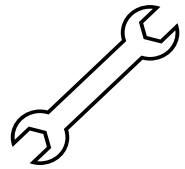
Questions and Discussion

Resources Shared in the Chat



- Optimizing the Psychiatric Workflow Within a Team-Based Care Framework
- High-Functioning Behavioral Health Team-Based Care
- The Comprehensive Health Integration Framework: White Paper & Companion Tools
- Financing the Future of Integrated Care: Decision Support Tool
- Developing Your Value Proposition: A Step-by-Step Guide for Behavioral Health Providers

Additional Tools & Resources



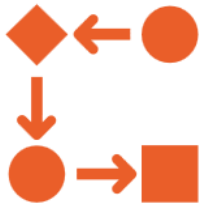
National Council for Mental Wellbeing

- Center of Excellence for Integrated Health Solutions – Resource Home Page
- The Comprehensive Health Integration Framework and Companion Tools
- Financing the Future of Integrated Care
- Financing the Future of Integrated Care: 2024 Updates
- Advancing Measurement-Informed Care in Community Behavioral Health
- SBIRT Protocol Development Guide
- Screening, Brief Intervention & Referral to Treatment (SBIRT) with Adults: Implications for Integrated Care Settings
- Motivational Interviewing Guide
- Motivational Interviewing – Tips for Providers
- CoE-IHS IA: Collaborative Care Model (CoCM) in Specialty Care – Recording & Slides

CHAT WITH AN EXPERT!

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

SCAN HERE



Implementing Models of Integrated Care

Access to Integrated Care

Population Health in Integrated Care

Workforce Development

Integrated Care Financing & Operations

Addressing Ongoing Workforce Challenges

Submit a Request!

Upcoming Events & Helpful Links

April
24
3:00 – 4:00 pm ET

CoE-IHS IA:
Collaborative Care in Rural Health Centers

Register Here

April
30
2:00 – 3:00 pm ET

CoE-IHS IA:
Overcoming Workforce Challenges in the Integrated Health Field

Register Here

May
29
2:30 – 3:30 pm ET

CoE-IHS Webinar:
Care Coordination and Referral Practices/ Partnerships

Register Here

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Questions?

Email integration@thenationalcouncil.org

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Key Responsibilities for Supporting CHI Implementation

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

Setting the Stage for CHI Self-Assessments

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

How to keep providers engaged in the process of scoring:

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

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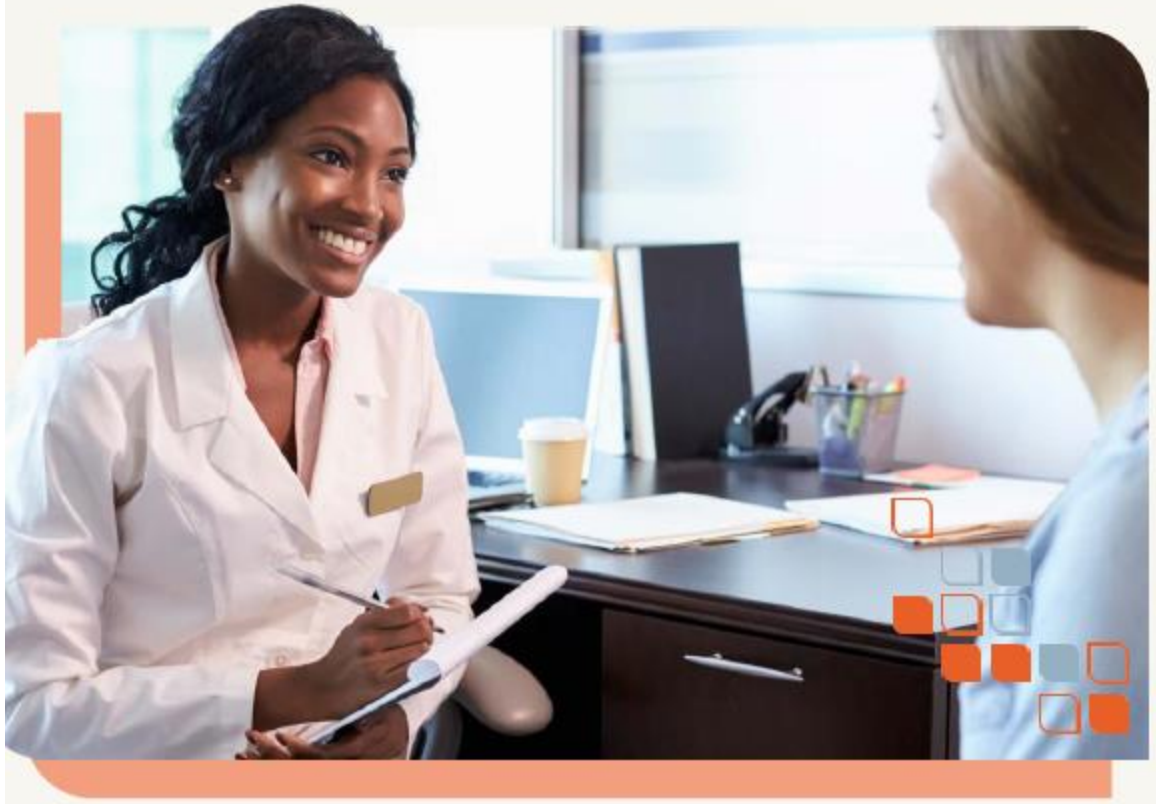
COMPREHENSIVE HEALTH INTEGRATION FRAMEWORK

SELF-ASSESSMENT GUIDE



GENERAL SCORING INSTRUCTIONS FOR THE CHI SELF-ASSESSMENT TOOL

CATEGORY	INSTRUCTIONS/DESCRIPTION
Bulleted criteria	Stage subdomain criteria are in bulleted lists. The criteria are specific and concrete enough to be accurately assessed by the team using the self-assessment. When using the tool, the team should consider and score each bullet to determine the appropriate stage for that subdomain.
Data requirements for scoring	Many subdomain criteria refer to specific data targets, such as "routine" (which means 70% unless otherwise specified — see definition below) or "50%." Data targets refer to performance on an indicator related to the denominator of all clients/patients who might be eligible for the intervention or program described. Important note: Teams using the self-assessment are *not* required to demonstrate that they meet the required targets by producing audit-quality data sets. Teams should use the data targets as guidance to evaluate their own performance in a way that is feasible and sufficiently accurate to satisfy the team that the data target is met. It is helpful to review a small sample of records to determine whether a particular target is met, but this is not possible in many domains, and a team consensus will generally suffice.
Stages	The CHI Framework describes three integration stages, the names of which each reflect a recognized

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

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

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

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

The Comprehensive Health Integration Framework and Companion Tools

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

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

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