NATIONAL COUNCIL
for Mental Wellbeing

Appendix 3:

The New Comprehensive Healthcare Integration Framework

NOTE: For BH settings, emphasis is on co-occurring PH, and for PH settings, emphasis is on co-occurring BH. Prioritized issues will vary based on age and other population variables.

KEY ELEMENTS of Integrated Care		**PROGRESSION to Greater Integration** →			
DOMAINS	**SUBDOMAINS**	**HISTORICAL PRACTICE**	**SCREENING AND ENHANCED REFERRAL**	**CARE MANAGEMENT AND CONSULTATION**	**COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT**
1. Integrated Screening, referral to care and follow-up (f/u).	**1.1** Screening and follow-up for co-occurring behavioral health (MH, SUD, nicotine), PH conditions and preventive risk factors. **1.2** Facilitation of referrals and f/u.	Response to patient self-report of co-occurring behavioral health and/or PH complaints and/or chronic illness with f/u only when prompted. Referral to external BH or primary care provider(s) (PCP) and no systematic f/u.	Systematic screening for high prevalence BH and/or PH conditions and risk factors and proactive health/BH. Identify PCP and BH providers (if any) for all. Formal agreement between PH practice and BH providers to routinely facilitate referrals and share information about progress. Measurement of referrals to assess show rate and information exchange with the referral source.	Systematic screening and education for BH and/or PH conditions and risk factors PLUS systematic data collection and tracking of positive results to ensure engagement in appropriate services. Capacity for integrated teamwork, such as a nurse or care coordinator for a BH team, or a BHC for a primary care team, to ensure follow-up and coordination re positive screens, with access to well-coordinated referrals to internal or external PH and/or BH service providers.	Systematic screening and tracking for BH and/or PH conditions PLUS routine capacity for registries and analysis of patient population stratified by severity of PH/BH complexity and/or utilization and measuring the level of intensity of integrated care coordination. In addition to integrated teamwork, there is a systemic collaborative and consulting partnership with PH and BH services in one or more locations that can help meet population needs internally through both integrated service delivery and enhanced referral facilitation to both internal and external partners, with automated data sharing and accountability for engagement.

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2. Evidence-based (EB) care for prevention/ intervention for common PH and/or BH conditions.	**2.1** EB guidelines or protocols for preventive interventions such as health risk screenings, suicide risk screening, opioid risk screening, developmental screening. **2.2** EB guidelines or treatment protocols for common PH or BH conditions (as well as for addressing relevant health behaviors that affect the conditions being addressed). **2.3** Use of medications by prescribers for common PH and/ or BH conditions, including tobacco cessation. **2.4** EB or consensus approaches to addressing trauma and providing trauma-informed care.	Not used or minimal guidelines or protocols used for universal PH or BH preventive screenings. No/ minimal training for providers on recommended preventive screening frequency and response to results. Not used or with minimal guidelines or EB workflows for improving access to care for PH and/or BH conditions. None or limited use by prescribers of medications for co-occurring PH or BH conditions. Medications for co-occurring PH or BH conditions are primarily referred to other type of prescriber to treat. Staff have no or minimal awareness of effects of trauma on PH and BH care and do not have systematic application of person-centered trauma-informed practice.	Routine use of EB or consensus guidelines for performing or referring for risk factor screenings with basic training for providers on screening frequency and result interpretation. Coordination with outside providers for any preventive activities. Intermittent or limited use of EB/consensus guidelines and/or workflows for treatment of common PH and/or BH conditions with limited monitoring. Team receives basic training on PH and/or BH interventions. Prescribers routinely provide NRT or other medications for tobacco cessation and will continue to prescribe stable medications for co-occurring PH or BH conditions for a limited number of individuals. Coordinate referrals to outside providers otherwise. Basic education of provider team on impact of trauma on PH and BH and initiation of basic welcoming, person-centered, trauma-informed approaches to engaging people with complex needs. Coordinate referrals for trauma services.	Routine use of EB or consensus guidelines for universal and targeted preventive screenings with use of standard workflows for f/u on positive results. Provider team monitored on screening frequency and follow up on results. Demonstrated use of common preventive screening guidelines to screen for at least one BH or PH condition. Provider team, including embedded BH or PH consultant if any, routinely use EB/consensus guidelines or workflows for patients with PH and/ or BH conditions. Systematic measurement of symptoms completed for percentage of patients. In addition to Integration Construct 1: Prescribers will occasionally initiate medications for selected co-occurring conditions, including medication treatment for SUD, and will consult with "co-occurring" prescriber for assistance with ongoing management. Evidence of initiation of first line antidepressants, antianxiety and attention deficit disorder medications by most PCPs in a practice. Documentation or formal contract with psychiatric consultant. In addition to Integration Construct 1: Ongoing implementation of person-centered trauma-informed care models.	Prescribers more regularly initiate and manage a range of medications for common co-occurring PH or BH conditions, including medication treatment for SUD, with routine consultation and collaboration with "co-occurring" consultant. See Integration Construct 2 plus evidence of treating more than one condition (in collaboration with a consulting psychiatric or physical health provider). In addition to Integration Construct 2: Adoption of trauma-informed care strategies, treatment and protocols by treatment team at all levels. Routine use of validated trauma assessment tools.

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3. Ongoing Care Coordination and Care Management.	**3.1** Longitudinal clinical monitoring and engagement for addressing prevention and intervention for co-occurring PH and/or BH conditions.	None or minimal mechanisms for routine coordination and f/u of patients referred to PH or BH care.	Provider team has a basic mechanism for tracking f/u to appointments with PH or BH referrals, navigating or assisting with appointments and encouraging/ prompting adherence to medications and other co-occurring treatment recommendations.	Team members who can provide data analysis to guide care and plan. Assigned team member(s) who can provide routine care coordination and monitor routine proactive follow-up and tracking of patient engagement, adherence and progress in co-occurring PH and/or BH services, whether provided by the team or by referral. Availability of coaching by assigned care coordinator or others to ensure engagement and early response.	In addition to Integration Construct 2: Availability of a continuum of care coordination, involvement of consulting specialists like a BHC or RN care manager based on stratification of need across the full range of populations served. Use of tracking tool to monitor treatment response and outcomes over time at individual and group level, coaching and proactive f/u with appointment reminders.
4. Self-management support that is adapted to culture, socio-economic and life experiences of patients.	**4.1** Use of tools to promote patient activation and recovery from co-occurring PH and/ or BH conditions with adaptations for literacy, economic status, language, cultural norms.	None or minimal patient/ family education on PH and/ or BH conditions, PH and/or BH healthy behavior skills and PH and/or BH risk factor screening recommendations.	Some availability of patient/ family education on PH and/ or BH conditions, PH and/or BH healthy behavior skills and PH and/or BH risk factor screening recommendations. Includes materials/ handouts/web-based resources, with focus on referral to outside resources.	Routine brief patient/family education delivered in-person or technology application on selected PH and/or BH conditions, PH and/ or BH healthy behavior skills and PH and/or BH risk factor screening recommendations. Treatment plans include diet and exercise, with common but not routine use of self-management goal setting for both PH and BH conditions.	Routine and ongoing patient/family education on PH and/or BH conditions, PH and/or BH healthy behavior skills and PH and/or BH risk factor screening recommendations throughout the service continuum, with practical strategies for patient activation and healthy lifestyle habits. Self-management skills and goals routinely outlined and monitored in treatment plans. Advance directives discussed and documented when appropriate.
5. Multi-disciplinary team (including patients) with dedicated time to provide integrated PH/BH care.	**5.1** Care team. **5.2** Sharing of treatment information, case review, care plans and feedback. **5.3** Integrated care team training and competency development.	Provider team, patient, family caregiver (if appropriate). No or minimal routine sharing of treatment information and feedback between BH and PH providers in different settings. None or minimal training of all staff levels on integrated care approach and incorporation of PH/BHI concepts.	Provider team patient, family caregiver. Possibly care coordinator or manager. Routine release and exchange of info (phone, fax) between PH and BH referral providers on PH and BH issues, without regular chart documentation. Basic training of all staff levels on integrated care approach and incorporation of Integrated Care concepts and screening/referral workflows.	BH consultant(s) and care coordinators available to PH team. PH consultant (nurse/care manager) available to BH team. Should be access to a BH psychiatrist/NP or a PCP. Discussion of assessment and treatment plans in-person, virtual platform or by telephone when necessary and routine PH and BH notes visible for routine reviews. Routine training of all staff levels on integrated care approach and incorporation of Integrated Care activities into integrated teamwork, with role accountabilities defined for each team member.	PH/BH staff, with care managers, peers/CHWs, working as integrated teams throughout the continuum with patients/families. Regular in-person, phone, virtual or e-mail meetings to discuss complex cases and routine electronic sharing of information and care plans supported by an organizational culture of open communication. Routine integrated team processes like huddles and care meetings. Systematic annual and continuing training for all staff levels with learning materials that target areas for improvement with integrated teamwork for all categories of staff.

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6. Systematic quality improvement (QI).	**6.1** Use of quality metrics for PH/BH integration improvement and/or external reporting. Ability to measure baselines for processes and outcomes and apply QI activities to demonstrate improvements for one or more co-occurring PH and/or BH Domains.	None or minimal use of PH and/or BH quality metrics (limited use of data, anecdotes, case series).	Limited tracking of co-occurring PH and/or BH quality metrics for people served and/or for state or health plan reporting. Some ability to report and track improvement for group level issues. Include tracking of disparities in metrics as relates to marginalized and underserved populations.	Routine periodic QI monitoring of identified PH and/or BH quality process and outcome metrics, ability to regularly review performance against benchmarks and attempt to improve performance as needed. Include tracking of disparities in metrics as relates to marginalized populations with targeted efforts to address disparities as a key part of performance improvement.	Routine incorporation of PH/BH measurement into organizational QI with ongoing systematic monitoring of population level performance metrics, ability to respond to findings using formal improvement strategies and routine implementation of improvement projects by QI team/champions, with demonstration of progress. Include tracking of disparities in metrics as relates to marginalized populations with routine implementation of QI efforts specifically targeted to address disparities.
7. Linkages with community and social services that improve BH and PH and/or mitigate environmental risk factors.	**7.1** Linkages to housing, employment, education, DD/BI, child/adult protective, domestic violence, financial entitlement, home care, immigration, other social support services.	No or limited/informal screening of social determinants of health (SDOH) and linkages to social service agencies, no formal arrangements.	Routine SDOH screening and referrals made to social service agencies. Some referral and follow-up, but few if any formal interagency arrangements established.	Routine SDOH screening, with formal collaboration arrangements and contacts established with commonly used social service agencies. Some capacity for follow-up tracking and service monitoring as part of team-based care and care coordination functions.	Detailed psychosocial assessment incorporating broad range of SDOH needs. Patients and families routinely linked to collaborating social service organizations/resources to help improve appointment adherence, healthy food sources, with f/u to close the loop. Routine meetings with "complexity care" partners to continuously improve collaborative efforts.
8. Sustainability	**8.1** Build process for billing and – where applicable – process and outcome reporting to support financial sustainability of integration efforts. **8.2** Build process for expanding regulatory and/or licensure opportunities.	No or minimal attempts to bill for co-occurring PH and/or BH screening, prevention, intervention conducted on site. May have "special" services supported by grants or other non-sustainable funding. Licensed and/or regulated as a PH OR BH provider with no or limited understanding of how to provide or document integrated interventions for co-occurring diagnoses.	Billing for PH or BH screening and treatment services under fee-for-services with process in place for tracking reimbursements for PH and/or BH services. Established procedures for providing and documenting integrated screening and interventions, whether on-site or through collaboration, that support what is allowed within single license.	Revenue from payments for developing capacity or for improving processes through quality incentives related to PH or BH. Able to bill some bundled rates for specialized services such as COCM or MAT. Formalized ability to provide some level of integrated PH and BH services within a single license, as well as to coordinate and document internal or external service provision by a provider with the "other" license. Meets PCMH or BH Health Home standards.	In addition to Integration Construct 2: Receipt of value-based payments that reference achievement of BH and PH outcomes for the population served. Revenue helps support necessary staffing, services and infrastructure to support the continuum. Provides licensed PH and BH services in shared services settings throughout the continuum and regularly works to improve design and application of administrative or clinical licensure requirements and regulatory standards to meet evolving capacity to support integrated care for the population served.