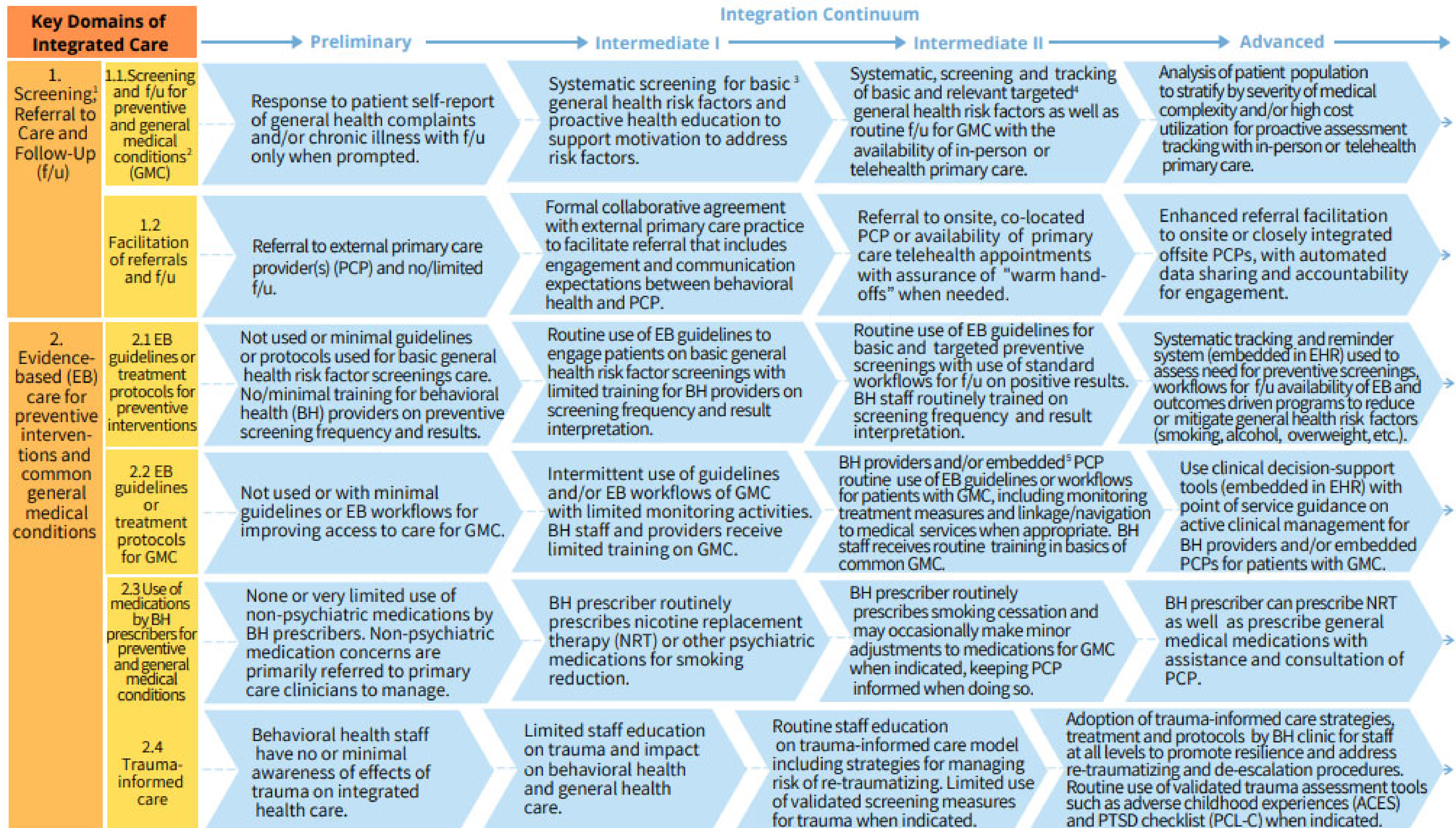
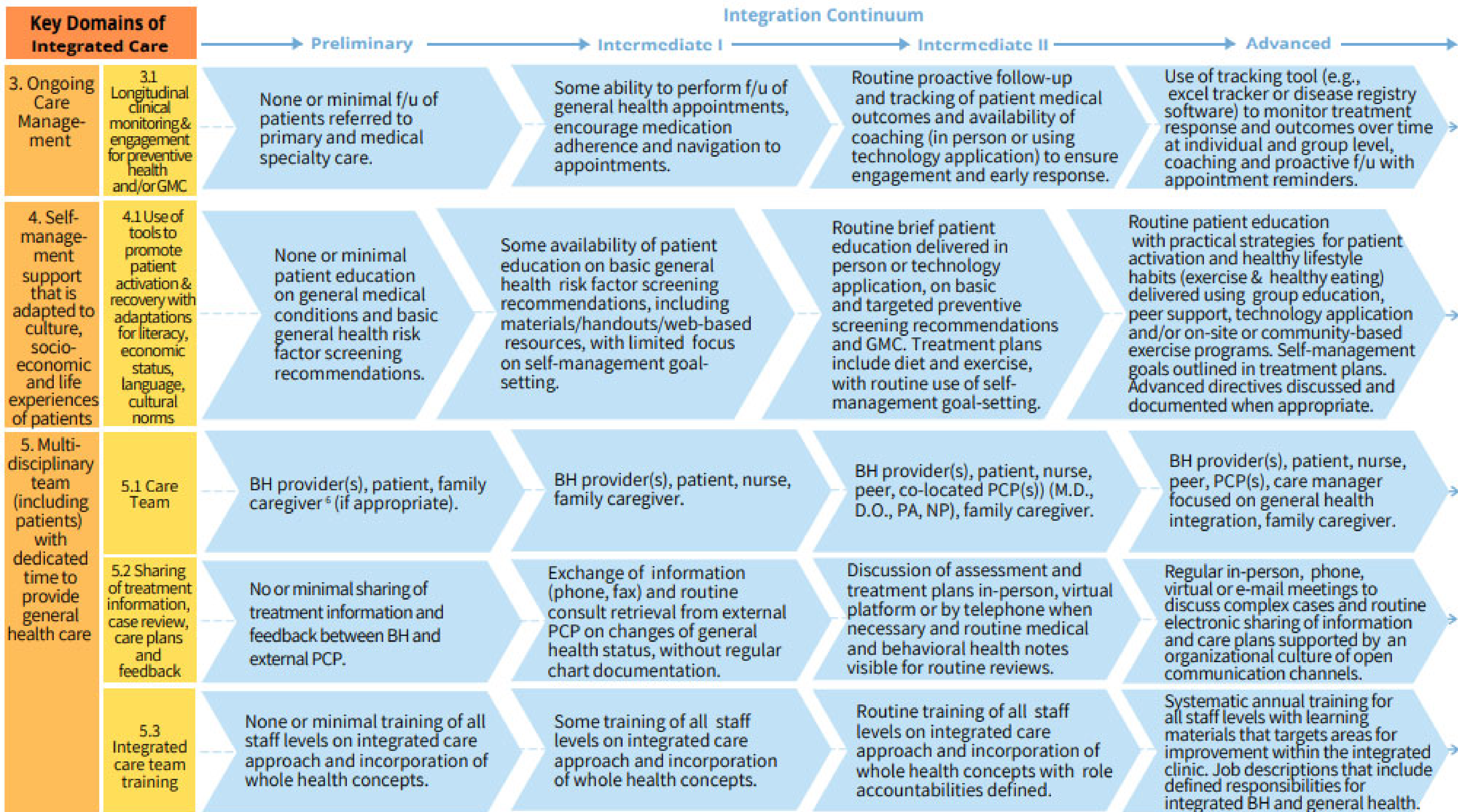
Online supplement for DOI 10.1176/appi.ps.202000708

S1: Framework to Advance General Health Integration in Behavioral Health Settings



Key Domains of Integrated Care		Preliminary	Intermediate I	Intermediate II	Advanced
1. Screening,[1] Referral to Care and Follow-Up (f/u)	1.1 Screening and f/u for preventive and general medical conditions[2] (GMC)	Response to patient self-report of general health complaints and/or chronic illness with f/u only when prompted.	Systematic screening for basic[3] general health risk factors and proactive health education to support motivation to address risk factors.	Systematic, screening and tracking of basic and relevant targeted[4] general health risk factors as well as routine f/u for GMC with the availability of in-person or telehealth primary care.	Analysis of patient population to stratify by severity of medical complexity and/or high cost utilization for proactive assessment tracking with in-person or telehealth primary care.
	1.2 Facilitation of referrals and f/u	Referral to external primary care provider(s) (PCP) and no/limited f/u.	Formal collaborative agreement with external primary care practice to facilitate referral that includes engagement and communication expectations between behavioral health and PCP.	Referral to onsite, co-located PCP or availability of primary care telehealth appointments with assurance of "warm hand-offs" when needed.	Enhanced referral facilitation to onsite or closely integrated offsite PCPs, with automated data sharing and accountability for engagement.
2. Evidence-based (EB) care for preventive interventions and common general medical conditions	2.1 EB guidelines or treatment protocols for preventive interventions	Not used or minimal guidelines or protocols used for basic general health risk factor screenings care. No/minimal training for behavioral health (BH) providers on preventive screening frequency and results.	Routine use of EB guidelines to engage patients on basic general health risk factor screenings with limited training for BH providers on screening frequency and result interpretation.	Routine use of EB guidelines for basic and targeted preventive screenings with use of standard workflows for f/u on positive results. BH staff routinely trained on screening frequency and result interpretation.	Systematic tracking and reminder system (embedded in EHR) used to assess need for preventive screenings, workflows for f/u availability of EB and outcomes driven programs to reduce or mitigate general health risk factors (smoking, alcohol, overweight, etc.).
	2.2 EB guidelines or treatment protocols for GMC	Not used or with minimal guidelines or EB workflows for improving access to care for GMC.	Intermittent use of guidelines and/or EB workflows of GMC with limited monitoring activities. BH staff and providers receive limited training on GMC.	BH providers and/or embedded[5] PCP routine use of EB guidelines or workflows for patients with GMC, including monitoring treatment measures and linkage/navigation to medical services when appropriate. BH staff receives routine training in basics of common GMC.	Use clinical decision-support tools (embedded in EHR) with point of service guidance on active clinical management for BH providers and/or embedded PCPs for patients with GMC.
	2.3 Use of medications by BH prescribers for preventive and general medical conditions	None or very limited use of non-psychiatric medications by BH prescribers. Non-psychiatric medication concerns are primarily referred to primary care clinicians to manage.	BH prescriber routinely prescribes nicotine replacement therapy (NRT) or other psychiatric medications for smoking reduction.	BH prescriber routinely prescribes smoking cessation and may occasionally make minor adjustments to medications for GMC when indicated, keeping PCP informed when doing so.	BH prescriber can prescribe NRT as well as prescribe general medical medications with assistance and consultation of PCP.
	2.4 Trauma-informed care	Behavioral health staff have no or minimal awareness of effects of trauma on integrated health care.	Limited staff education on trauma and impact on behavioral health and general health care.	Routine staff education on trauma-informed care model including strategies for managing risk of re-traumatizing. Limited use of validated screening measures for trauma when indicated.	Adoption of trauma-informed care strategies, treatment and protocols by BH clinic for staff at all levels to promote resilience and address re-traumatizing and de-escalation procedures. Routine use of validated trauma assessment tools such as adverse childhood experiences (ACES) and PTSD checklist (PCL-C) when indicated.

1 Individuals screened must receive follow up by a trained BH provider or PCP (external or co-located). For the purpose of the framework, primary care provider includes M.D., D.O., PA and NP.
2 Common general medical conditions include diabetes, hypertension, hyperlipidemia, coronary artery disease, asthma, arthritis, gastrointestinal disease, tooth and gum disease.
3 Basic general health risk factor screenings might include: visit with a PCP (defined as self-report of a usual source other than ED care with presence of one or more documented primary care visit during the past year), depression, alcohol and substance use (including opioid use), blood pressure measurement, HIV, overweight/obesity, tobacco use and age appropriate screenings for cervical and colorectal cancer.
4 Targeted general health risk factor screenings might include: intimate partner violence, HbA1c, cholesterol, STI, hepatitis B, hepatitis C, tuberculosis and age appropriate screenings for immunizations, mammogram and osteoporosis.
5 Embedded and co-located arrangements include PCPs available through telehealth services



Integration Continuum

Key Domains of Integrated Care		Preliminary	Intermediate I	Intermediate II	Advanced
3. Ongoing Care Manage-ment	3.1 Longitudinal clinical monitoring & engagement for preventive health and/or GMC	None or minimal f/u of patients referred to primary and medical specialty care.	Some ability to perform f/u of general health appointments, encourage medication adherence and navigation to appointments.	Routine proactive follow-up and tracking of patient medical outcomes and availability of coaching (in person or using technology application) to ensure engagement and early response.	Use of tracking tool (e.g., excel tracker or disease registry software) to monitor treatment response and outcomes over time at individual and group level, coaching and proactive f/u with appointment reminders.
4. Self-manage-ment support that is adapted to culture, socio-economic and life experiences of patients	4.1 Use of tools to promote patient activation & recovery with adaptations for literacy, economic status, language, cultural norms	None or minimal patient education on general medical conditions and basic general health risk factor screening recommendations.	Some availability of patient education on basic general health risk factor screening recommendations, including materials/handouts/web-based resources, with limited focus on self-management goal-setting.	Routine brief patient education delivered in person or technology application, on basic and targeted preventive screening recommendations and GMC. Treatment plans include diet and exercise, with routine use of self-management goal-setting.	Routine patient education with practical strategies for patient activation and healthy lifestyle habits (exercise & healthy eating) delivered using group education, peer support, technology application and/or on-site or community-based exercise programs. Self-management goals outlined in treatment plans. Advanced directives discussed and documented when appropriate.
5. Multi-disciplinary team (including patients) with dedicated time to provide general health care	5.1 Care Team	BH provider(s), patient, family caregiver [6] (if appropriate).	BH provider(s), patient, nurse, family caregiver.	BH provider(s), patient, nurse, peer, co-located PCP(s)) (M.D., D.O., PA, NP), family caregiver.	BH provider(s), patient, nurse, peer, PCP(s), care manager focused on general health integration, family caregiver.
	5.2 Sharing of treatment information, case review, care plans and feedback	No or minimal sharing of treatment information and feedback between BH and external PCP.	Exchange of information (phone, fax) and routine consult retrieval from external PCP on changes of general health status, without regular chart documentation.	Discussion of assessment and treatment plans in-person, virtual platform or by telephone when necessary and routine medical and behavioral health notes visible for routine reviews.	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 channels.
	5.3 Integrated care team training	None or minimal training of all staff levels on integrated care approach and incorporation of whole health concepts.	Some training of all staff levels on integrated care approach and incorporation of whole health concepts.	Routine training of all staff levels on integrated care approach and incorporation of whole health concepts with role accountabilities defined.	Systematic annual training for all staff levels with learning materials that targets areas for improvement within the integrated clinic. Job descriptions that include defined responsibilities for integrated BH and general health.

6 Family caregivers are part of team if appropriate to patient care.

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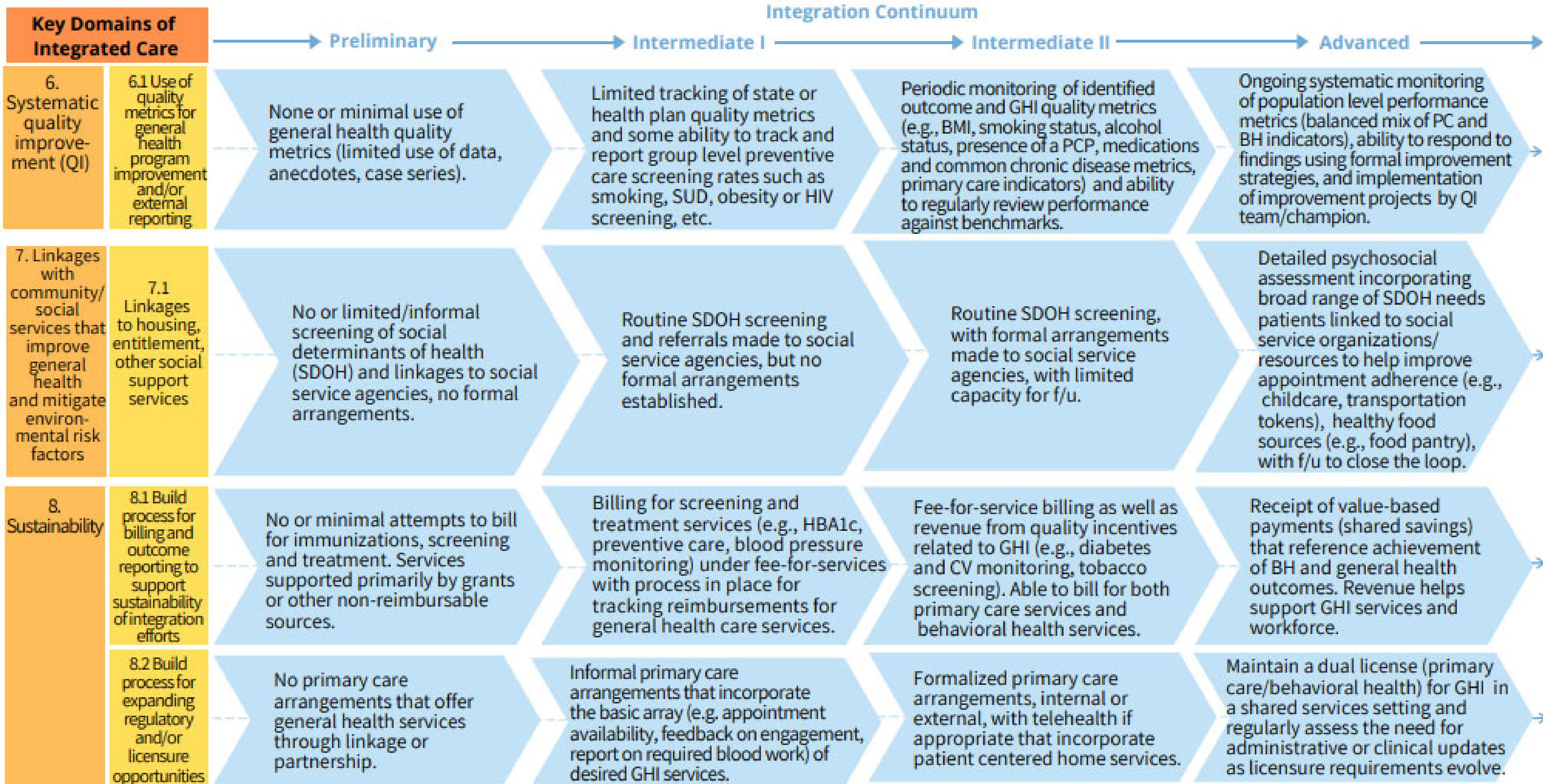

Key Domains of Integrated Care		Integration Continuum: Preliminary	Intermediate I	Intermediate II	Advanced
6. Systematic quality improve-ment (QI)	6.1 Use of quality metrics for general health program improvement and/or external reporting	None or minimal use of general health quality metrics (limited use of data, anecdotes, case series).	Limited tracking of state or health plan quality metrics and some ability to track and report group level preventive care screening rates such as smoking, SUD, obesity or HIV screening, etc.	Periodic monitoring of identified outcome and GHI quality metrics (e.g., BMI, smoking status, alcohol status, presence of a PCP, medications and common chronic disease metrics, primary care indicators) and ability to regularly review performance against benchmarks.	Ongoing systematic monitoring of population level performance metrics (balanced mix of PC and BH indicators), ability to respond to findings using formal improvement strategies, and implementation of improvement projects by QI team/champion.
7. Linkages with community/ social services that improve general health and mitigate environ-mental risk factors	7.1 Linkages to housing, entitlement, 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, but no formal arrangements established.	Routine SDOH screening, with formal arrangements made to social service agencies, with limited capacity for f/u.	Detailed psychosocial assessment incorporating broad range of SDOH needs patients linked to social service organizations/ resources to help improve appointment adherence (e.g., childcare, transportation tokens), healthy food sources (e.g., food pantry), with f/u to close the loop.
8. Sustainability	8.1 Build process for billing and outcome reporting to support sustainability of integration efforts	No or minimal attempts to bill for immunizations, screening and treatment. Services supported primarily by grants or other non-reimbursable sources.	Billing for screening and treatment services (e.g., HBA1c, preventive care, blood pressure monitoring) under fee-for-services with process in place for tracking reimbursements for general health care services.	Fee-for-service billing as well as revenue from quality incentives related to GHI (e.g., diabetes and CV monitoring, tobacco screening). Able to bill for both primary care services and behavioral health services.	Receipt of value-based payments (shared savings) that reference achievement of BH and general health outcomes. Revenue helps support GHI services and workforce.
	8.2 Build process for expanding regulatory and/or licensure opportunities	No primary care arrangements that offer general health services through linkage or partnership.	Informal primary care arrangements that incorporate the basic array (e.g. appointment availability, feedback on engagement, report on required blood work) of desired GHI services.	Formalized primary care arrangements, internal or external, with telehealth if appropriate that incorporate patient centered home services.	Maintain a dual license (primary care/behavioral health) for GHI in a shared services setting and regularly assess the need for administrative or clinical updates as licensure requirements evolve.

S2: Key Literature and its Linkage to General Health Integration Framework Domains and Subdomains

Subdomain	Bartels (2018)	Bouchery (2018)	Daumit (2019)	Druss (2001, 2010, 2018)	Kilbourne (2008, 2016)	Krupski (2016)	Storholm (2017)	Sweeney (2018)
1.1 Screening and follow-up for preventive and general medical conditions			X	X	X			
1.2 Facilitation of referrals and follow-up		X	X	X	X	X		
2.1 Evidence-based guidelines or treatment protocols for preventive interventions			X	X	X			
2.2 Evidence-based guidelines or treatment protocols for general medical conditions			X	X				
2.3 Use of targeted medications by BH prescribers for preventive and general medical conditions							X	
2.4 Trauma-informed care								X
3.1 Longitudinal clinical monitoring and engagement	X	X	X	X	X			
4.1 Use of tools to promote patient activation and recovery with adaptations for literacy, language, local norms	X	X	X	X	X			
5.1 Care team		X	X	X		X		
5.2 Sharing of treatment information			X					
5.3 Integrated care team training		X	X	X	X	X		
6.1 Use of quality metrics for program improvement		X		X	X	X		
7.1 Linkages to housing, entitlement, social support services				X				
8.1 Build process for billing and outcome reporting to support sustainability of integration efforts		X	X	X		X	X	
8.2 Build process for expanding regulatory and/or licensure opportunities		X	X	X		X	X	

Key Literature Reference List

1. Bartels SJ, Aschbrenner KA, Pratt SI, et al: Implementation of a lifestyle intervention for people with serious mental illness in state-funded mental health centers. Psychiatric Services 2018; 69(6);664-670
2. Bouchery EE, Siegwarth AW, Natzke B, et al: Implementing a whole health model in a community mental health center: impact on service utilization and expenditures. Psychiatric Services 2018; 69(10):1075-1080
3. Daumit GL, Stone E, Kennedy-Hendricks A, et al: Care coordination and population health management strategies and challenges in a behavioral health home model. Med Care 2019; 69(2):147-153
4. Druss BG, Esenwein SA, Compton MT, et al: budget impact and sustainability of medical care management for persons with serious mental illnesses. American Journal of Psychiatry 2011; 168(11):1171-1178
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6. Druss BG, Von Esenwein SA, Compton MT, et al: The Primary Care Access Referral, and Evaluation (PCARE) study: a randomized trial of medical care management for community mental health settings. Am J Psychiatry 2010; 167(2):152-159
7. Druss BG, Zhao L, Esenwein SA, et al: The Health and Recovery Peer (HARP) program: A peer-led intervention to improve medical self-management for persons with serious mental illness. Schizophrenia Research 2010; 118(1-3):264-270
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9. Druss BG, Singh M, Esenwein SA, et al: Peer-led self-management of general medical conditions for patients with serious mental illnesses: a randomized trial. Psychiatric Services 2018; 69(5):529-535
10. Kilbourne AM, Barbaresso MM, Lai Z, et al: Improving physical health in patients with chronic mental disorders. The Journal of Clinical Psychiatry 2016; 78(01):129-137
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13. Storholm ED, Ober AJ, Hunter SB, et al: Barriers to integrating the continuum of care for opioid and alcohol use disorders in primary care: a qualitative longitudinal study. J Subst Abuse Treat 2017; 83:45-54
14. Sweeney A, Filson B, Kennedy A, et al: A paradigm shift: relationships in trauma-informed mental health services. BJ Psych Adv 2018; 24(5):319–333

S3: Key Stakeholders Providing Input in GHI Framework Development Process

Name	Title	Organization	Key Informant Interviews	Attended Multi-Stakeholder Advisory Meeting
Thomas Betzler, M.D.	Executive Director	Montefiore Behavioral Health Community Mental Health Center	X	X
Jean-Marie Bradford, M.D.	Director	Washington Heights Community Service		X
Brian Byrd, MPA	Program Officer	New York State Health Foundation		X
Stephanie Cuskley, MBA	President and CEO	Hemsley Charitable Trust		X
Amy Dorin, MS, ACSW	President and CEO	Coalition for Behavioral Health		X
Rose Duhan, MPH	President and CEO	Community Health Care Association of New York State		X
Judith Feld, M.D., MPH, MMM	Vice President, Behavioral Health	MVP Health Plan	X	X
Douglas Fish, M.D.	Medical Director, Division of Program Development and Management	Office of Health Insurance Programs, NYS Department of Health		X
Marcus Friedrich, M.D., MBA	Chief Medical Officer	Office of Quality and Patient Safety, NYS Department of Health		X
Irfan Hasan, MPA	Program Director, Health and Behavioral Health	New York Community Trust		X
Chuck Ingoglia, MS	President and CEO	National Council for Behavioral Health		X
Sachin Jain, M.D.	Chief CTO and Acting CMO	Community Health Network		X
Patricia Lincourt	Clinical Services Director	New York State OASAS	X	
Patricia Lemp, LCSW	Assistant Executive Director	Westchester Jewish Community Services		X
Juan Martinez, LCSW	Administrative Director	The Einstein Division of Substance Abuse, Montefiore Medical Center	X	
Trish Marsik	Chief Operating Officer	Services for the Under Served	X	X
Keith McCarthy	Director	NYS Office of Mental Health	X	
Robin Melén, MS	Program Officer	Westchester Community Foundation, a Division of The New York Community Trust		X
Robert Myers, Ph.D.	Senior Deputy Commissioner and Division Director	Adult Services, State Hospitals and Managed Care, NYS Office of Mental Health	X	X
Bianca Nguyen, M.D., MPH	Chief Resident, Department of Psychiatry	NYP/Columbia University Medical Center		X
Varsha Narasimhan, M.D.	Director of Ambulatory Consultative Service, GHI Project Team Member	Jacobi Medical Center		X
Tracy Perizzo, MS	Program Officer	Hemsley Charitable Trust		X
Jorge Petit, M.D.	President and CEO	Coordinated Behavioral Care	X	X

Amanda Saake, LMSW, CPRP	Special Assistant to Commissioner	Consumer Affairs, Office of Mental Health		X
Chad Shearer, JD, MHA	Vice President for Policy	United Hospital Fund		X
Tara Seeley, JD, M.Div.	Senior Program Officer	Westchester Community Foundation, a division of The New York Community Trust		X
Ian Shaffer, M.D.	Executive Medical Director	Health First Health Plan	X	X
Thomas Smith, M.D.	Medical Director	NYS Office of Mental Health	X	
Melissa Stein, M.D.	Internal Medicine	The Einstein Division of Substance Abuse, Montefiore Medical Center	X	X
Tony Trahan	Deputy Director	Consumer Affairs, Office of Mental Health		X
Jeanie Tse, M.D.	Associate Chief Medical Officer	Institute for Community Living, Inc.	X	X

S4: General Health Integration Status Survey

General Health Integration Status Survey
- Learning Collaborative Project

Introduction

This survey assesses Learning Collaborative participants' integration status based on the evidence-based framework for general health integration (GHI), Advancing Integration of General Health in Behavioral Health Settings: A Continuum-Based Framework. The GHI Framework aims to support physical and behavioral health integration in behavioral health settings. This survey collects baseline information on your organization, including characteristics of your clinic, patient demographics, and current care processes and protocols. We will ask you to describe your site's current level of general health integration using the Framework domains and components. In addition, the survey will ask questions about your experience utilizing and interpreting the Framework and its components. Please have the project lead and relevant team members at your practice answer all of these questions using the GHI Framework for reference. Project

Background Information

* 1. Organization Name

2. Facility Name and Address: For organizations with multiple sites, this would be the participating site's name and address. If the site doesn't have an official name, use a nickname (e.g. a clinic at 123 Tulip St, may be referred to as "Tulip Street,"). NOTE: A survey should be completed for each site at the organization participating in the general health integration project.

Site Name

Address

City/Town

ZIP

* 3. Integration Lead: Identify person responsible for submitting this survey and collaborating with the team at your site convened to provide input in the completion of the General Health Integration Assessment Survey:

First Name

Last Name

Discipline (e.g. MD, RN, etc.)

Position Title

Email Address

Phone Number

4. Integration Team Members

Full Name, Title and Organization (if different from lead organization)

Full Name, Title and Organization (if different from lead organization)

Full Name, Title and Organization (if different from lead organization)

Full Name, Title and Organization (if different from lead organization)

Full Name, Title and Organization (if different from lead organization)

Section 1: Baseline Questions

* 5. Practice description of services and programs (check all that apply)

- [ ] Behavioral health license
- [ ] Medical care license
- [ ] Dual license (medical and behavioral)
- [ ] Personalized Recovery Oriented Services (PROS)
- [ ] Assertive Community Treatment (ACT)
- [ ] Intensive Outpatient Treatment (IOT)

Other (please specify)

* 6. Number of Staff and full-time equivalents (FTEs).
[INDICATE NUMBER OF EACH TYPE OF STAFF IN THIS PRACTICE AND FTE IN A WEEK FOR EACH TYPE]
Please note: FTE is equal to the ratio of the total number of paid hours during a week (part time, full time, contracted) by the number of working hours in an average workweek (typically 40 hours). 1.0 FTE is equivalent to one employee working full-time.

	Number of Staff	FTE in a Week
Psychiatrist		
Psychologist		
Social Worker		
Care Manager		
Primary Care Physician		
Nurse Practitioner		
Registered Nurse		
Physician Assistant		
Medical Assistant		
Credentialed Alcoholism and Substance Abuse Counselor (CASAC)		
Certified Peer Counselors		
Reception and Administrative		
Other		

Other (please specify the type, number of staff, and FTE in a week per other category included)

* 7. Does your practice utilize an electronic health record (EHR)? If yes, please provide the name of the EHR vendor and date of initial use.

If applicable, please provide name of EHR Vendor and date of initial use

* 8. Use and capacity of EHR system: [Choose All that Apply]

- [ ] No EHR system established
- [ ] EHR system currently captures and extracts behavioral health clinical data linked to dates of assessment
- [ ] EHR system currently captures and extracts physical health quantitative data such as blood pressure readings and immunization history
- [ ] EHR system has capability to analyze data across all providers in the practice (e.g., 75% of patients received a flu shot in 2018 for one provider and 25% of patients received flu shot from provider 2)
- [ ] EHR system has capability to analyze practice and patient care outcomes (e.g., number of patients with diabetes whose HbA1C declined to less than 8)
- [ ] EHR system has functionality to track metrics on groups of patients with the same diagnosis (e.g. schizophrenia, diabetes)
- [ ] EHR system has the functionality to create and track referrals to PCPs and specialists

Other (please specify)

* 9. How many individual patients are served by this practice annually (not total visits)?

* 10. What percentage of patients are:

	Percentage (%)
White	
Black or African-American	
Native American or American Indian	
Asian/Pacific Islander	

Other (please specify ethnicity and its associated percentage)

* 11. What percentage of patients are:

	Percentage (%)
Hispanic/Latinx	

Other (please specify ethnicity and its associated percentage)

* 12. What percentage of patients are:

	Percentage (%)
Male	
Female	
Transgender	

Other (please specify ethnicity and its associated percentage)

* 13. What percentage of patients are:

	Percentage (%)
Less than age 18	
Age 18-24	
Age 25-44	
Age 45-64	
Age 65+	

* 14. Please indicate the approximate percentage of patients that that comes from each of the primary payers.

	Percentage (%)
Medicare fee-for-service (FFS)	
Medicare Advantage	
Medicaid FFS	
Medicaid managed care	
Commercial health insurance	
Other government programs [e.g., Veterans, Tricare]	
Self-paying or uninsured	

Other (please specify other streams of revenue and associated percentage)

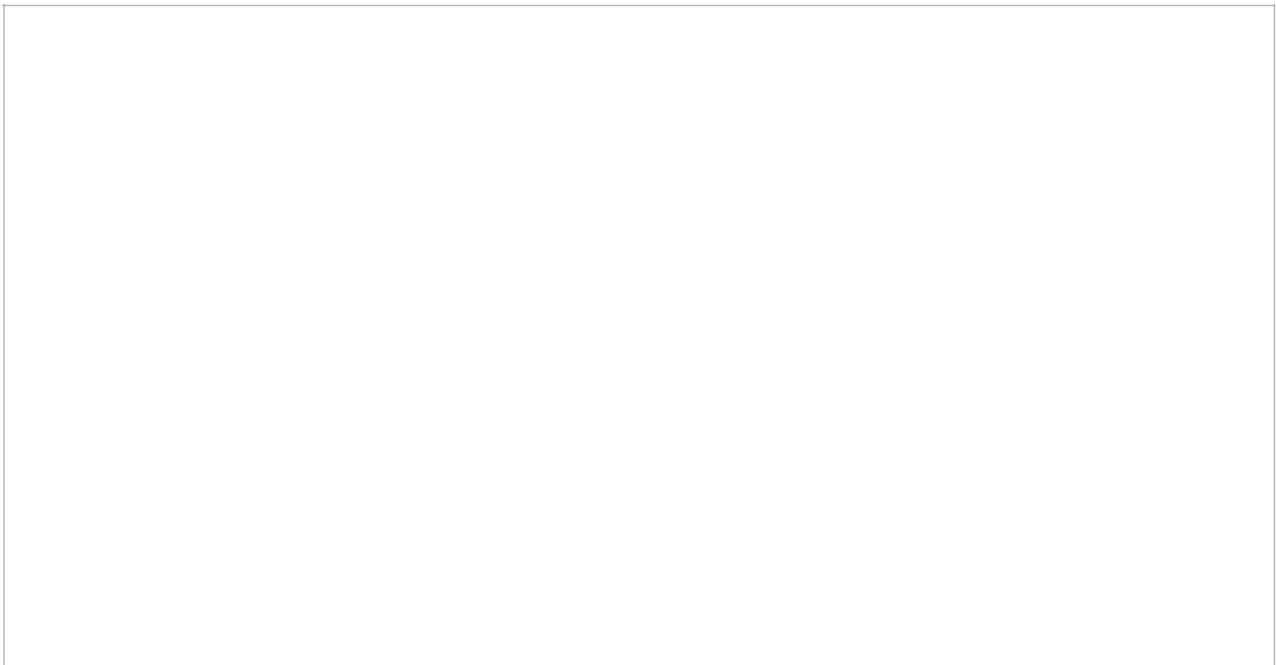
* 15. What kinds of additional designations does your organization have if any? Select all that apply.

- [ ] No Additional Designation
- [ ] Federally Qualified Health Centers (FQHCs)
- [ ] Certified Community Behavioral Health Clinics (CCBHCs)
- [ ] Membership in Behavioral health Independent Physician Associations (IPAs)
- [ ] Membership in a Behavioral Health Care Collaborative (BHCC)
- [ ] Membership in an Accountable Care Organization (ACO)
- [ ] Other (please specify)

16. If your organization is participating in a grant or state program supporting GHI efforts, please specify the name of the program or organization from which you receive support and/or help in general health integration.

17. What type of support for general health integration do you currently receive (e.g., financial, technical assistance, etc.), if any?

18. If your practice has added staff to facilitate general health integration, please specify type, discipline and number of staff:



19. If your practice receives payments for quality measures (behavioral or general health), please specify measures:

20. Has this practice undergone any recent or new quality improvement projects related to general health integration? Please list relevant projects within past 5 years.

21. What are some barriers that you have experienced regarding successful integration of general health care into your practice?

General Health Integration Status Survey - Learning Collaborative Project

General Health Integration Readiness

This section requires the completion of a self-assessment survey on the key integration components present or already underway. These questions mirror the continuum domains and elements found in the General Health Integration Framework. Please answer for each domain and its corresponding element(s) to indicate your level of integration.

Please note, below is a list of key definitions and explanations to clarify the survey (also found in the legend of the Framework):

- **Individuals screening positive must receive follow up by a trained BH provider or PCP (external or co-located). For the purpose of the framework, primary care provider includes M.D., D.O., PA and NP.**
- **Universal health risk factor screenings include overweight/obesity, tobacco use, alcohol and substance use (including opioid use)**
- **Targeted general health risk screenings include above and HbA1c, blood pressure, cholesterol, HIV, hepatitis, colonoscopy, mammogram, pap smear, immunizations, flu shots, annual physical assessment**

- **Common general medical conditions include diabetes, hypertension, hyperlipidemia, coronary artery disease, asthma, arthritis, gastrointestinal disease, tooth and gum disease**
- **Embedded and co-located arrangements include PCPs available through telehealth services**
- **Family caregivers are part of team if appropriate to patient care**

General Health Integration Status Survey - Learning Collaborative Project

Domain #1: Screening, Referral to Care and Follow-Up

* 22. Please select the statement that best describes your site's screening and follow-up for preventive and general medical conditions at least 70% of the time:

- ☐ Response to patient self-report of general health complaints and/or chronic illness with follow-up only when prompted.
- ☐ Systematic screening for universal general health risk factors and proactive health education to support motivation to address risk factors.
- ☐ Systematic, screening and tracking of universal and relevant targeted general health risk factors as well as routine follow-up for general medical conditions with the availability of in-person or telehealth primary care.
- ☐ Analysis of patient population to stratify by severity of medical complexity and/or high cost utilization for proactive assessment tracking within-person or telehealth primary care.

* 23. Please select the statement that best describes the system your site utilizes for primary care referrals and follow-up at least 70% of the time:

- ☐ Referral to external primary care clinician(s) and no/limited follow-up.
- ☐ Formal collaborative agreement with external primary care practice to facilitate referral that includes engagement and communication expectations between behavioral health and PCP.
- ☐ Referral to onsite, co-located PCP or availability of primary care telehealth appointments with assurance of "warm handoffs" when needed.
- ☐ Enhanced referral facilitation to onsite or closely integrated offsite PCPs, with automated data sharing and accountability for engagement.

Domain #2: Evidence-based care for preventive interventions and common general medical conditions

* 24. Please select the statement that best describes how evidence-based guidelines or treatment protocols for preventative interventions are used in your practice at least 70% of the time?

- ☐ Not used or minimal guidelines or protocols used for universal general health risk factor screenings care. No/minimal training for BH providers on preventive screening frequency and results.
- ☐ Routine use of evidence-based guidelines to engage patients on universal general health risk factor screenings with limited training for BH providers on screening frequency and result interpretation.
- ☐ Routine use of evidence-based guidelines for universal and targeted preventive screenings with use of standard workflows for follow-up on positive results. BH staff routinely trained on screening frequency and result interpretation.
- ☐ Systematic tracking and reminder system (embedded in EHR) used to assess need for preventive screenings, workflows for follow-up availability of evidence-based and outcomes driven programs to reduce or mitigate general health risk factors (smoking, alcohol, over weight, etc.).

* 25. Please select the statement that best describes how evidence-based guidelines or treatment protocols for general medical conditions are used in your practice at least 70% of the time?

- ☐ Not used or with minimal guidelines or evidence-based workflows for improving access to care for general medical conditions.
- ☐ Intermittent use of guidelines and/or evidence-based workflows of general medical conditions with limited monitoring activities. BH staff and providers receive limited training on general medical conditions.
- ☐ BH providers and/or embedded PCP routine use of evidence-based guidelines or workflows for patients with general medical conditions, including monitoring treatment measures and linkage/navigation to medical services when appropriate. BH staff receives routine training in basics of common general medical conditions.
- ☐ Use clinical decision-support tools (embedded in EHR) with point of service guidance on active clinical management for BH providers and/or embedded PCPs for patients with general medical conditions.

* 26. Please select the statement that best describes the use of targeted medications by behavioral health prescribers for preventive and general medical conditions at your site at least 70% of the time?

- ☐ None or very limited use of non-psychiatric medications by BH prescribers. Non-psychiatric medication concerns are primarily referred to PCP(s) to manage.
- ☐ Behavioral health prescriber routinely prescribes nicotine replacement therapy (NRT) or other psychiatric medications for smoking reduction.
- ☐ Behavioral health prescriber routinely prescribes smoking cessation as above. May occasionally make minor adjustments to medications for general medical conditions when indicated, keeping PCP informed when doing so.
- ☐ Behavioral health prescriber can prescribe NRT as well as prescribe general medical medications with assistance and consultation of PCP.

* 27. Please select the statement that best describes how you support trauma-informed care at your site at least 70% of the time?

- Behavioral health staff have no or minimal awareness of effects of trauma on integrated health care.
- Limited staff education on trauma and impact on behavioral health and general health care.
- Routine staff education on trauma-informed care model including strategies for managing risk of re-traumatizing. Limited use of validated screening measures for trauma when indicated.
- Adoption of trauma-informed care strategies and trauma informed treatment and protocols by BH clinic for staff at all levels to promote resilience and address re-traumatizing and de-escalation procedures. Routine use of validated trauma assessment tools such as ACES and PCL-C when indicated.

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Domain #3: Ongoing Care Management

* 28. Please select the statement that best describes how patients are monitored and engaged for preventive health and/or general medical conditions by your practice at least 70% of the time:

- None or minimal follow-up of patients referred to primary and medical specialty care.
- Some ability to perform follow-up of general health appointments, encourage medication adherence, and navigation to appointments.
- Routine proactive follow-up and tracking of patient medical outcomes and availability of coaching (in person or using technology application) to ensure engagement and early response.
- Use of tracking tool (i.e. excel tracker or disease registry software) to monitor treatment response and outcomes over time at individual and group level, coaching and proactive follow-up with appointment reminders.

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Domain #4: Self-Management Support that is Culturally Adapted

* 29. Please select the statement that best describes the tools used to promote patient activation and recovery with adaptations for literacy, economic status, language, and cultural norms at least 70% of the time?

- None or minimal patient education on basic general medical conditions and universal general health risk factor screening recommendations.
- Some availability of patient education on basic general health risk factor screening recommendations, including materials/handouts/web-based resources, with limited focus on self-management goal-setting.
- Routine brief patient education delivered in person or technology application, on universal and targeted preventive screening recommendations and general medical conditions. Treatment plans include diet and exercise, with routine use of self-management goal-setting.
- Routine patient education with practical strategies for patient activation and healthy lifestyle habits (exercise and healthy eating) delivered using group education, peer support and/or onsite or community-based exercise programs. Self-management goals outlined in treatment plans. Advance Directives discussed and documented when appropriate.

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Domain #5: Multi-Disciplinary Team (Including Patients) with Dedicated Time to Provide General Care

* 30. Please select the description of a “care team” that best aligns with your practice at least 70% of the time:

- Behavioral health provider(s), patient, family caregiver (if appropriate).
- Behavioral health provider(s), patient, nurse, family caregiver (if appropriate).
- Behavioral health provider(s), patient, nurse, peer, co-located primary care clinician(s) (M.D., D.O., PA, NP), family caregiver (if appropriate).
- Behavioral health provider(s), patient, nurse, peer, primary care clinician(s), care manager focused on general health integration, family caregiver (if appropriate).

* 31. Please select the statement that best describes how the team shares treatment information, case reviews, care plans and feedback at least 70% of the time?

- No or minimal sharing of treatment information and feedback between behavioral health and external PCP.
- Exchange of information (phone, fax) and routine consult retrieval from external PCP on changes of general health status, without regular chart documentation.
- Discussion of assessment and treatment plans in-person, virtual platform or by telephone when necessary, and routine medical and behavioral health notes visible for routine reviews.
- 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 channels.

* 32. Please select the statement that best describes how integrated care training is provided to the team?

- None or minimal training of all staff levels on integrated care approach and incorporation of whole health concepts.
- Some training of all staff levels on integrated care approach and incorporation of whole health concepts.
- Routine training of all staff levels on integrated care approach and incorporation of whole health concepts with role accountabilities defined.
- Systematic annual training for all staff levels with learning materials that targets areas for improvement within the integrated clinic. Job descriptions that include defined responsibilities for integrated behavioral health and physical health care.

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Domain #6: Systemic Quality Improvement

* 33. Please select the statement that best describes the use of quality metrics for physical health program improvement and/or external reporting:

- None or minimal use of general health quality metrics (limited use of data, anecdotes, case series).
- Limited tracking of state or health plan quality metrics, and some ability to track and report group level preventive care screening rates such as smoking, SUD, obesity or HIV screening, etc.
- Periodic monitoring of identified outcome and quality general health integration metrics (e.g., BMI, smoking status, alcohol status, access to annual physical exams, medications, and common chronic disease metrics, primary care indicators) and ability to regularly review performance against benchmarks.
- Ongoing systematic monitoring of population-level performance metrics (balanced mix of PC and behavioral health indicators), ability to respond to findings using formal improvement strategies, and implementation of improvement projects by quality improvement team/champion.

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Domain #7: Linkages with Community and Social Services that Improve General Health

* 34. Please select the statement that best describes your referrals to housing, entitlement, and other social support services made at least 70% of the time?

- No or limited/informal social determinants of health (SDOH) screening and linkages to social service agencies, no formal arrangements.
- Routine screening of SDOH and referrals made to social service agencies, but no formal arrangements established.
- Routine screening of SDOH, with formal arrangements made to social service agencies, with limited capacity for follow-up.
- Detailed psychosocial assessment incorporating broad range of SDOH needs, patients linked to social service organizations/resources to help improve appointment adherence (e.g. transportation tokens, childcare), healthy food sources (e.g. food pantry), with follow-up to close the loop.

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Domain #8: Sustainability

* 35. Please select the statement that best describes your process for billing and outcome reporting to support sustainability of integration efforts at least 70% of the time?

- No or minimal attempts to bill for immunizations, screening and treatment. Services supported primarily by grants or other non-reimbursable sources.
- Billing for screening and treatment services (e.g., preventative care, HBA1c, blood pressure monitoring) under fee-for-services, with process in place for tracking reimbursements for general health care services.
- Fee-for-service billing as well as revenue from quality incentives related to GHI (e.g. diabetes and CV monitoring, tobacco screening, etc.). Able to bill for both primary care services and behavioral health services.
- Receipt of value-based payments (shared savings) that reference achievement of behavioral health and general health outcomes; revenue helps support general health integration services and workforce.

* 36. Please select the statement that best describes your process expanding regulatory and/or licensure opportunities for physical health integration?

- No primary care arrangements that offer physical health services through linkage or partnership.
- Informal primary care arrangements that incorporate the basic array (appointment availability, feedback on engagement, report on required blood work) of desired general health integration services.
- Formalized primary care arrangements, internal or external, with telehealth if appropriate that incorporate patient centered home services.
- Maintain a dual license (primary care/behavioral health) for GHI in a shared services setting and regularly assess the need for administrative or clinical updates as licensure requirements evolve.

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Section 3: Framework Experience

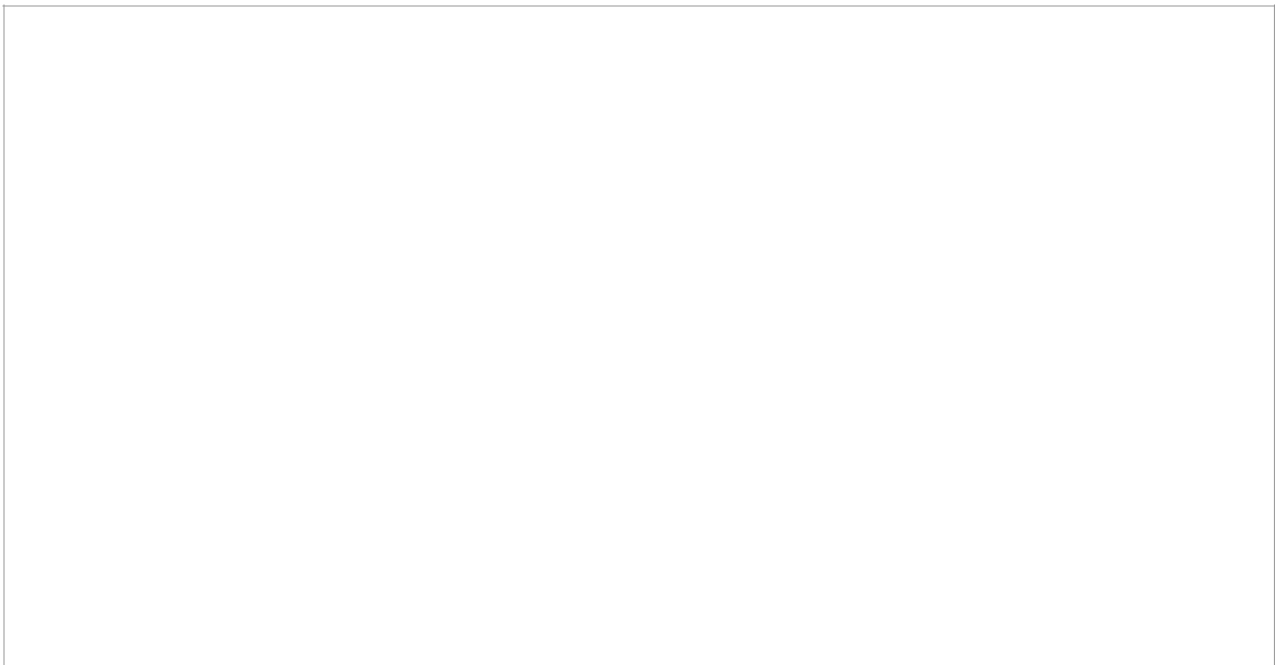
Please provide feedback on your integration team's experience using the framework during the course of completing the survey. We will use your feedback to further improve on its clarity and ease of use for behavioral health clinics advancing physical health care.

* 37. Please describe your experience using the Framework from 1 (least favorable) to 5 (most favorable) on the following dimensions.

	Unfavorable	Somewhat Unfavorable	Indifferent	Somewhat Favorable	Most Favorable
Ease of use of the Framework to describe your current general health integration state	○	○	○	○	○
Ease of understanding the elements of the Framework within a continuum structure	○	○	○	○	○
Ease of using the framework for planning to advance your general health integration	○	○	○	○	○

38. What changes or additions would you like to see to improve the clarity or utility of the Framework?

39. What supports would you need to be able to adopt the Framework in your organization? Please explain.



S5: Variation in the state of GHI among participating clinics

SUBDOMAINS WITH THE MAJORITY OF RESPONSES (>50%) IN THE PRELIMINARY OR INTERMEDIATE I PHASE OF INTEGRATION	SUBDOMAINS WITH THE MAJORITY OF RESPONSES (>50%) IN THE INTERMEDIATE II OR ADVANCED PHASE OF INTEGRATION
Screening, referral to care and follow-ups	Trauma-informed care
Evidence-based care for preventive interventions and common general medical conditions	Self-management supports
Medication management	Quality improvement
Ongoing care management	Social service linkages
Multidisciplinary care team	
Infromation sharing	
Integrated care training	
Sustainability (billing and regulatory)	