Moving from Competition to Collaboration: Building Strong Partnerships to Make Integration Work

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Deputy Director, Center for Integrated Health Solutions
The National Council for Behavioral Health

- Represents 2,500 community organizations that provide safety-net mental health & substance abuse treatment services to 8M adults, children & families

- Is the national voice for legislation, regulations, and practices that protect & expand access to adequately funded, effective mental health & addictions services
About the Center

In partnership with Health & Human Services (HHS)/Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA). Not right.

Goal: To promote the planning, and development and of integration of primary and behavioral health care for those with serious mental illness and/or substance use disorders and physical health conditions, whether seen in specialty mental health or primary care safety net provider settings across the country.

Purpose: To serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care and related workforce development
What Is Integrated Care?

• Comprehensive screening and assessment
• Identification of a physical and behavioral health “home” that uses opportunities for collaboration and co-location
• Shared development of care plans
• Care coordination to provide support for consumers and providers
• Engagement of consumers in self-management and care planning
What Is Integrated Care? (continued)

• Standardized protocols, e.g., standardized assessment and protocols for CBT and MI that can be tailored to meet individual needs

• Joint, standardized performance measures and feedback mechanisms, e.g., initiation and engagement

• Mechanisms for sharing savings from reductions in high cost use

• Electronic data systems capable of sharing data
Remembering Why We are Working Hard

Loosing My First Client  2009

My Own Family 2013
Client

**Situation**  A client came in with a blood sugar level of 327mg/dl. The client was not enrolled in the integration project and didn’t have a primary care doctor. The client had also just been discharged from a four-year psychiatric hospitalization but was only given a 28-day supply of his somatic medications.

**Obstacles**  Client was running out of meds and his diabetes was out of control. The nurses at the hospital checked his blood sugars 3 times a day but the client had not checked for a week because he didn’t have a blood sugar monitor. He stated that he didn’t have the money to purchase a glucometer and didn’t have a doctor to help him obtain one through his insurance.
Client (continued)

**Actions**  The nurse investigated his insurance and enrolled the client. He was given a primary care physician appointment before his meds ran out. His blood sugar was checked every day by the nurse and he was given a blood sugar monitor the next week and was taught how to use it. The nurse also collaborated with the client’s counselor in order to make sure that the client kept his primary care appointment at the clinic as well as the diabetes nutrition class to which he was referred.

**Results**  The client now checks his blood sugar daily and watches what he eats. He attends the nutrition class and is very eager to lose weight to help control his diabetes. He’s been coming to the walking group at least 2 times a week.
CAN WE LIVE LONGER?
Integrated Healthcare’s Promise

1 month  6 months  3 years  6 years  12 years  18 years  25 years  36 years  45 years  55 years  60 years  70 years  80 years
The PROBLEM

People with mental illness die earlier than the general population and have more co-occurring health conditions.

68% of adults with a mental illness have one or more chronic physical conditions.

More than 1 in 5 adults with mental illness have a co-occurring substance use disorder.
Co-occurrence Between Mental Illness and Other Chronic Health Conditions

- Mental Illness: 21.9% High Blood Pressure
- Mental Illness: 36% Smoking
- Mental Illness: 5.9% Heart Disease
- Mental Illness: 7.9% Diabetes
- Mental Illness: 42% Obesity
- Mental Illness: 15.7% Asthma

No Mental Illness:
- High Blood Pressure: 18.8%
- Smoking: 21%
- Heart Disease: 4.2%
- Diabetes: 6.6%
- Obesity: 35%
- Asthma: 10.6%
The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services. Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.
INTEGRATION WORKS

Community-based addiction treatment can lead to...

- 35% in inpatient costs
- 39% in ER cost
- 26% in total medical cost

Reduce Risk → Reduce Heart Disease
(for people with mental illnesses)

- Maintenance of ideal body weight (BMI = 18.5 – 25)
  - 35%-55% decrease in risk of cardiovascular disease
- Maintenance of active lifestyle (~30 min walk daily)
  - 35%-55% decrease in risk of cardiovascular disease
- Quit Smoking
  - 50% decrease in risk of cardiovascular disease
One integration program* enrolled 170 people with mental illness. After one year in the program, in one month:

- 86 spent fewer nights homeless
- There were 50 fewer hospitalizations for mental health reasons
- 17 fewer nights in detox
- 17 fewer ER visits

This is $213,000 of savings per month.

That's $2,500,000 in savings over the year.

Integration works.
It improves lives.
It saves lives.
And it reduces healthcare costs.
What do we know about the impact of multiple conditions on cost?

Behavioral Integration in Primary Care Setting

- Patient Registry
- Primary Care Provider
- Screening/Monitoring
- Consulting Psychiatrist
- Care Manager
- Relapse Prevention

Stepped Care Approach
Primary Integration in Behavioral Health Setting

Systemic Evaluation and Quality Improvement

- Diabetes Management
- Fitness
- Nutrition
- Stress Management
- Client-led WRAP
- Smoking Cessation
- Yoga

Prevention and Wellness Activities

Community Mental Health Clinic

Federally Qualified Health Center

www.integration.samhsa.gov
Partner Models

- FQHC/CHC bill by encounter rates. Receive the same amount of funding for a 10 minutes visit as they do for a 1 hour visit
- Contracting with FQHC/CHC’s
  - Leasing Options for staff
    - Psychiatrists
      - Consulting Psychiatrist Model (Regional MHC Indiana)
      - LICSW
  - Offset cost for indigent population
    - FQHC/CHC receive federal funds to cover the cost of indigent
  - CMHC can provide Case Management
Barriers to Providing Integrated Care

• Cultural
  ✓ Mental health staff and patients not used to incorporating primary care as part of job
  ✓ Primary Care not used to adults with SMI

• Financial
  ✓ Very rarely funded
  ✓ Billing medical services challenging
  ✓ High no-show rate, take extra time

• Motivation
  ✓ Lack of perceived need for care
Barriers to Providing Integrated Care (continued)

• Organizational
  ✓ Devoting space, time, and money
  ✓ Specialists do not cross boundaries
  ✓ Different languages

• Clinic Location
  ✓ Proximity is crucial; same building is best

• Health Information Technology
  ✓ Challenges sharing patient information
Why Partner?

**Business Strengths:** Each organization can bill for different services: Behavioral Health for case management and Primary Care for health services

**Strengths in Expertise:** Behavioral Health in how people change, motivational interviewing, engagement with clients and Primary Care in continuity of care, standards of care, team-based care and population management
Partnership Options

• With a FQHC
• With hospital systems
• With private for profit health clinics
• With free clinics

• Bi-directionality is key to successful agency partnerships
Two Services in One Day

• **Myth:** The federal government prohibits this or Medicaid won’t pay for this!

• **Reality:** This is a state-by-state Medicaid issue, not a federal rule or regulation

• **Federal Citations:**
  - Medicare will cover a physical health and mental health visit same day/same provider – CFR Title 42 Volume 2, Part 405. Section 405.2463
The Money and the Business Case

Financial models (FFS, case rates, global payments) are critical to selection of business models – how does Medicaid reimburse for care?

In one FFS state, for psychiatric medication service 90862
  • A university medical center clinic is reimbursed $12.50
  • The same visit at a CMHC is reimbursed $39.92
  • At an FQHC, the visit would be reimbursed at $80-88

In a nearby FFS and managed care state, for 90862:
  • A university medical center is reimbursed $19.53 (FFS)
  • The same visit at a CMHC is reimbursed $210.87 (FFS)
  • At an FQHC, the visit would be reimbursed $66.82-155.64 (FFS)
Define “Partner”? 

**partner [pahrt-ner]** _Noun_

- a person who shares or is associated with another in some action or endeavor; sharer; associate
- a collaborator in service provision that works in another domain from the one in which you work
Partnership Challenges: Culture Shock

Primary Care

• Brief, problem-focused communication
• Immediate solution-driven care
• Productivity measured in terms of number of patients seen
• Many evidence-based interventions, disease management as standard part of practice

Behavioral Health

• Process oriented
• Long term planning and coordination
• Productivity measured in units of service
• Individualized approach with evidence based interventions moving into practice--eclectic
Primary and Behavioral Health are Two Different Worlds

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unconditional love</td>
<td>Conditional love</td>
</tr>
<tr>
<td>Continuity is goal</td>
<td>Termination is goal</td>
</tr>
<tr>
<td>No stigma</td>
<td>Stigma common</td>
</tr>
<tr>
<td>No coercion</td>
<td>Coercion possible</td>
</tr>
<tr>
<td>Data shared</td>
<td>Data private</td>
</tr>
<tr>
<td>Large panels</td>
<td>Small panels</td>
</tr>
<tr>
<td>Flexible scheduling</td>
<td>Fixed scheduling</td>
</tr>
<tr>
<td>Fast paced</td>
<td>Slower paced</td>
</tr>
<tr>
<td>Time is independent</td>
<td>Time is dependent—”50 minute hour”</td>
</tr>
<tr>
<td>Flexible boundaries</td>
<td>Firm boundaries</td>
</tr>
<tr>
<td>Treatment external (labs, procedures)</td>
<td>Relationship with provider IS treatment</td>
</tr>
<tr>
<td>Patient not responsible for illness</td>
<td>Patient responsible for participating in treatment</td>
</tr>
</tbody>
</table>
A Few Questions to Consider

• Will your partnership position your organization to be successful in the future?
• How much control are you willing to give up?
• Will your staff adapt to a new model of practice and actually support the integration?
• Are we able to demonstrate that you are accountable for cost, quality and experience outcomes/value?
• How will you ensure that your integration efforts are focused on empowering consumers to lead healthier lives?
• Are we willing to give it the time it takes? Integration is a process, that takes intention and time to make it happen.
Create A Team Across Agencies/Disciplines

“As soon as your dentist gets here, we’ll begin.”
Where Are You Headed?
Integration Continuum

**Collaboration**
We discuss patients, exchange information if needed

**Co-Location**
We are in the same facility, may share some functions/staffing, discuss patients

**Integration**
System-wide transformation, focus on whole health for all patients

--Doherty, 1996, Updated 2013
Co-locating Project Staff ≠ Integration
Starting a Partnership

• Integrated healthcare partnership is similar to a marriage. Put in the time it takes to build a trusting relationship.

• Communication is critical. Use e-mails to document, and phone calls and face-to-face meetings to reduce misunderstandings.

• Regularly scheduled meetings are critical. If necessary, specify time in the agreement.
Integrating Cultures

• Expect/plan for differences in work cultures
• Flexibility is critical—eliminate “That’s the way we do it mentality” and create a new culture of integration
• Take time to help PC and BH learn each other’s roles and ways of operating
• Institute daily huddles and communication flows from the start
Proving Your Value
Lean In and Develop a Referral Relationship

- Provide prevention education on a range of topics (depression screening, SBIRT, sleep hygiene, self care, stress reduction, diabetes, hypertension etc.)
- BH Teach evidence-based skills to consumers and PCPs
- Emphasize home-based self management
- Make recommendations to PCP & PCPs to BH
- BH Provide medication education and support adherence
Meaningful Measurements for all Parties

Must focus on measuring what value you are providing to the patients and to each other!

Establish a set of common measures that reflect patient satisfaction, clinical outcomes, and cost monitoring.
Develop and Periodically Review Your MOU

Create a detailed MOU (we have some samples).
Imagine what you’ll need –

• Monthly meetings with leadership and line staff
• Agreements to enroll with direct messaging
• How will meeting time be paid?
• What data & financial reports do you need?
Partnering Continued

• If the PC partner makes money from seeing your clients what is the agreement about the revenue?
• Will the PC partner lease space in your building?
• What are your agreements about liability and signage?
• Who can see which records?
• Will you have a formal referral process to each other? If yes, be explicit about your expectations about timeliness, uninsured, communication flows
• Will PC and BH jointly interview candidates jointly?
• How will you handle media coverage?
Before You Sign…

• Be very specific about the range of services the health partner will provide. Are services such as nutrition and diabetes counseling included?
• Define how coverage is provided in case of illness or vacation
• Clearly outline the reporting expectations (monthly or quarterly) for billing and revenue generation and patient utilization numbers
Partnering with an FQHC

- Many benefits to partnering with FQHC but since they have to abide by numerous regulations, designing an agreement can be time consuming
- A “Change of Scope” application must be filed in order to provide coverage at a new location – can be a lengthy process
- The “Scope” covers the type of services, location of services, and provider types.
- Important to read the resources available:
FQHC Continued

• If the on-site provider is a P.A. or an APRN, think seriously about requiring some MD time for complex patient cases.

• FQHCs are required to collect a lot of different kinds of data. BH should tap into this expertise and then use it to build the case for additional funding sources.

• An excellent white paper that explains the different collaborations is “Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers” (www.commonwealthfund.org)
Additional Considerations

• Establish a system to communicate promptly if problem exists with client Medicaid/Medicare or private insurance to ensure maximum billing potential

• If primary care partner is responsible for patient billing, make certain that the consumer/client understands he/she may receive a bill/statement from a different entity
Additional Resources

Sample MOUs
http://www.integration.samhas.gov/operations-administration/contracts-mous

Considerations for BH and FQHC partnerships
Things I learned:

Decide how you’ll resolve disagreements

Find your champions in each other’s organizations

Highlight the strengths and successes of your partner

Get back to each other within 24 hours
Partnering means you can expand your services
Screening, Brief Intervention, Referral for Treatment (SBIRT)

- SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders.

  - Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
  - Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
  - Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

A key aspect of SBIRT is the integration and coordination of screening and treatment components into a system of services.
Bi-Directional Referral Processes

Behavioral Health Referrals

Primary Care

Collaborative Care

Behavioral Health

Physical Health Referrals
Many areas of specialty linked by the care coordinator
Sustainability Checklist

• Administrative Sustainability
  • Organizational Infrastructure
  • Human Resources
  • Health Information Technology
• Clinical Sustainability
  • Patients/Consumers
  • Medical Staff
  • Behavioral Health Staff
• Financial Sustainability
  • Billing and Reimbursement
Financial Sustainability

- Do you know what existing billing codes for integrated health are billable in your state and to which third party source?
- Have you walked through your workflow and identified who, can pay for each step of your process - with your clinical and billing staff at the same time?
- Are you advocating for the use of key interim codes in your state if they are currently not available?
- Do you have a business plan for growing your integration business?
- Have you quantified the impact of Medicaid expansion on your business plan in 2014?
How many patients need to be seen?

• Do you know how much money your organization needs to make in order to support your integrated care vision? Key elements - number of consumers seen; how often are they seen per year; payer mix; reimbursement per visit

• Have you identified the baseline caseloads for both primary care and behavioral health clinicians? (i.e., NP = 750, PC = 1500 at 3 visits per patient per year, 15-20 minute visits)

• Are your clinicians seeing enough patients to meet the financial need?
There have been lots of great partners throughout history...
Road Map to Integrating Care

• Identify and engage a partner or hire staff directly
• “Begin with the End in Mind” Creating a joint vision for integrated care using the Framework—how integrated will you be? Organize for Sustainability.
• Developing an MOU that benefits both organizations
• Creating a team, workflows, and a communication plan—make sure all staff become health literate and understand that they each have a specific role in supporting the “whole” health of clients—psychiatrists, therapists and care coordinators/case managers
• Set specific expectations for how often you will meet, how you will address disagreements, how you will showcase and celebrate your work.
• Create exam room space so that it works for the PC providers and staff
• Sustain your efforts by adding integration to your mission statements, policies and procedures, job descriptions and performance evaluations
• Decide to jointly interview all candidates involved in integration prior to hiring
• After hiring-- Explain the lingo, regulations, scheduling and services of BH to PC and PC to BH
Road Map to Integrating Care

• Determine protocols for which health indicators you will collect at what intervals. How are the outcomes shared with all staff that could support the client/patient on his wellness goals?
• Create Individual Client Health Report Cards
• Create an integrated treatment plan
• Determine how you will electronically share patient information—Direct Messaging, CCD, EHR
• Avoid struggles of “who owns the record”.
• Create and use a health registry—to have standards of care, look at changes and address health disparities
• Always line up your workflow—to make every step possible a “billable” event. Use the right credential, at the right time for the right billing code
• Create an onsite lab—better compliance and access for patients
• Create wellness activities or partner with a YMCA—address smoking cessation, weight loss, exercise and nutrition. EBPs are available.
Road Map to Integrating Care

• Primary care providers—invite BH partners or hire BH providers to provide BH assessments and short term solution focused care in your primary care setting—using a “primary care model”

• In behavioral health focus on building sufficient volume to sustain a PC provider: 1200 for MD, 750 for NP

• Develop your enrollment process into integrated care, with as few steps as possible—human “warm handoffs”

• Have clients advise you on the development of integration

• Hire peers into your workforce

• Train staff to be care coordinators and understand health protocols for diabetes, cardiovascular disease, and smoking cessation

• Develop referral systems to each other

• Determine how the team will operate—everyone working at the top of their license, and a quick well managed daily huddle, all trained in Motivational Interviewing and Trauma Informed Care
Road Map to Integrating Care

- Develop protocols for disease management
- Understand and address health disparities
- Using a spreadsheet determine your costs for delivering integrated care and determine all services that are billable both for primary care and behavioral health and which credential can bill for which service.
- Celebrate your own your successes and those of your partner!
Partners: Here’s a Challenge
<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Key Element</th>
<th>Core Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minimal Collaboration</td>
<td>Communication</td>
<td>Have separate systems, communicate about cases only rarely and under compelling circumstances.</td>
</tr>
<tr>
<td>2</td>
<td>Basic Collaboration at a Distance</td>
<td>Communication</td>
<td>Have separate systems, communicate periodically about shared patients.</td>
</tr>
<tr>
<td>3</td>
<td>Basic Collaboration Onsite</td>
<td>Physical Proximity</td>
<td>Have separate systems, communicate regularly about shared patients, by phone or e-mail.</td>
</tr>
<tr>
<td>4</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Physical Proximity</td>
<td>Share some systems, like scheduling or medical records.</td>
</tr>
<tr>
<td>5</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Practice Change</td>
<td>Actively seek system solutions together or develop work-arounds.</td>
</tr>
<tr>
<td>6</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
<td>Practice Change</td>
<td>Have resolved most or all system issues, functioning as one integrated system.</td>
</tr>
</tbody>
</table>

**Table 1. Six Levels of Collaboration/Integration (Core Descriptions)**


www.integration.samhsa.gov
**Table 2A. Six Levels of Collaboration/Integration (Key Differentiators)**

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
</tr>
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<tbody>
<tr>
<td><strong>LEVEL 1</strong></td>
<td><strong>LEVEL 2</strong></td>
<td><strong>LEVEL 3</strong></td>
</tr>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
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</table>

**Key Differentiator: Clinical Delivery**

- Screening and assessment done according to separate practice models
- Separate treatment plans
- Evidenced-based practices (EBP) implemented separately
- Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges
- Separate treatment plans shared based on established relationships between specific providers
- Separate responsibility for care/EBPs
- May agree on a specific screening or other criteria for more effective in-house referral
- Separate service plans with some shared information that informs them
- Some shared knowledge of each other’s EBPs, especially for high utilizers
- Agree on specific screening, based on ability to respond to results
- Collaborative treatment planning for specific patients
- Some EBPs and some training shared, focused on interest or specific population needs
- Consistent set of agreed upon screenings across disciplines, which guide treatment interventions
- Collaborative treatment planning for all shared patients
- EBPs shared across system with some joint monitoring of health conditions for some patients
- Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place
- One treatment plan for all patients
- EBPs are team selected, trained and implemented across disciplines as standard practice

**Key Differentiator: Patient Experience**

- Patient physical and behavioral health needs are treated as separate issues
- Patient must negotiate separate practices and sites on their own with varying degrees of success
- Patient health needs are treated separately, but records are shared, promoting better provider knowledge
- Patients may be referred, but a variety of barriers prevent many patients from accessing care
- Patient health needs are treated separately at the same location
- Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider
- Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers
- Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services
- Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others
- Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop
- Patient needs are treated with for all patients by a team, who function effectively together
- All patient health needs are treated for all patients, inclusive of shared care
- Patients experience a seamless response to all healthcare needs as they present, in a unified practice

# Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

<table>
<thead>
<tr>
<th>Level 1: Minimal Collaboration</th>
<th>Level 2: Basic Collaboration at a Distance</th>
<th>Level 3: Close Collaboration Onsite</th>
<th>Level 4: Close Collaboration Onsite with Some System Integration</th>
<th>Level 5: Close Collaboration Approaching an Integrated Practice</th>
<th>Level 6: Full Collaboration in a Transformed/Merged Integrated Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>No coordination or management of collaborative efforts</td>
<td>Some practice leadership in more systematic information sharing</td>
<td>Organization leaders supportive but often colocation is viewed as a project or program</td>
<td>Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced</td>
<td>Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development</td>
<td>Integrated care and all components embraced by all providers and active involvement in practice change</td>
</tr>
<tr>
<td>Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow</td>
<td>Some provider buy-in to collaboration and value placed on having needed information</td>
<td>Provider buy-in to making referrals work and appreciation of onsite availability</td>
<td>More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components</td>
<td>Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers</td>
<td></td>
</tr>
</tbody>
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**Table Details:**

**Key Differentiator: Practice/Organization**
- No coordination or management of collaborative efforts
- Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow
- Some practice leadership in more systematic information sharing
- Some provider buy-in to collaboration and value placed on having needed information
- Organization leaders supportive but often colocation is viewed as a project or program
- Provider buy-in to making referrals work and appreciation of onsite availability
- Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced
- Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development
- Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers

**Key Differentiator: Business Model**
- Separate funding
- No sharing of resources
- Separate billing practices
- Separate funding
- May share resources for single projects
- Separate billing practices
- Separate funding
- May share facility expenses
- Separate billing practices
- Separate funding, but may share grants
- May share office expenses, staffing costs, or infrastructure
- Separate billing due to system barriers
- Blended funding based on contracts, grants or agreements
- Variety of ways to structure the sharing of all expenses
- Billing function combined or agreed upon process
- Integrated funding, based on multiple sources of revenue
- Resources shared and allocated across whole practice
- Billing maximized for integrated model and single billing structure


[www.integratioon.samhsa.gov](http://www.integratioon.samhsa.gov)
Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

<table>
<thead>
<tr>
<th>LEVEL 1</th>
<th>LEVEL 2</th>
<th>LEVEL 3</th>
<th>LEVEL 4</th>
<th>LEVEL 5</th>
<th>LEVEL 6</th>
</tr>
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<tr>
<td>Minimal Collaboration</td>
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<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
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</tbody>
</table>

### Advantages

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<tr>
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<th>INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each practice can make timely and autonomous decisions about care</td>
<td>Maintains each practice’s basic operating structure, so change is not a disruptive factor</td>
<td>Opportunity to truly treat whole person</td>
</tr>
<tr>
<td>Readily understood as a practice model by patients and providers</td>
<td>Provides some coordination and information-sharing that is helpful to both patients and providers</td>
<td>All or almost all system barriers resolved, allowing providers to practice as high functioning team</td>
</tr>
<tr>
<td></td>
<td>Referrals may fail due to barriers, leading to patient provider frustration</td>
<td>All patient needs addressed as they occur</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue</td>
</tr>
</tbody>
</table>

### Weaknesses

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>Services may overlap, be duplicated or even work against each other</td>
<td>Sharing of information may not be systematic enough to effect overall patient care</td>
<td>Practice changes may create lack of fit for some established providers</td>
</tr>
<tr>
<td>Important aspects of care may not be addressed or take a long time to be diagnosed</td>
<td>No guarantee that information will change plan or strategy of each provider</td>
<td>Sustainability issues may stress the practice</td>
</tr>
<tr>
<td></td>
<td>System issues may limit collaboration</td>
<td>Few models at this level with enough experience to support value</td>
</tr>
<tr>
<td></td>
<td>Proximity may not lead to greater collaboration, limiting value</td>
<td>Outcome expectations not yet established</td>
</tr>
<tr>
<td></td>
<td>Effort is required to develop relationships</td>
<td></td>
</tr>
</tbody>
</table>
Contact

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