The Affordable Care Act and Integration of Primary and Mental Health Care Effects on the Health of Individuals with Comorbid Conditions

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Through the enactment of the Patient Protection and Affordable Care Act (ACA) in 2010, a comprehensive, legal framework to improve several tenets of the healthcare system was established, with eventual cost-containment in mind. The net cost of the ACA is projected to be $1.207 trillion between 2015 – 2025.[1] However, the true cost may be lower because this projection does not include all cost-containment measures.[2] Prior to the passing of the ACA, 15.7% of nonelderly adults, the majority of whom were individuals of lower socioeconomic status and/or racial and ethnic minorities, were uninsured.[3,4] The Urban Institute's 2017 Health Reform Monitoring Survey shows that now only 10.2% of nonelderly adults are uninsured.[3]

The ACA expanded coverage to 17.6 million individuals, now estimated to be more than 20 million, prior to the 2016 open enrollment period.[4,5] The ACA also reformed insurance by setting up marketplaces where consumers could shop for health insurance plans online and preventing insurance companies from excluding preexisting conditions, which extended coverage to 129 million individuals.[6,7] There have been large gains in coverage for low-income individuals and racial and ethnic minorities through provisions like Medicaid expansion, helping to reduce social disparities in healthcare.[8] The ACA also has provisions to improve the health of the population by providing critical preventive services at no cost and requiring health insurance plans to cover 10 essential health benefits, one of which is mental health treatment. This extended coverage to 5.5 million individuals with mental illness (MI). [9,10,11]

An estimated 57.7 million American adults suffer from MI.[12] Over the past several decades, through a focus on deinstitutionalization, establishment of community-situated mental health and rehabilitative services, and development of more effective pharmaceuticals, the mental health outcomes of individuals with MI have improved substantially.[13] However, these improvements have not been reflected in the physical health of individuals with MI. They are twice as likely to develop and three times more likely to die from cardiovascular disease (CVD) than those without MI due to consequences of MI and its treatment and systemic issues in care delivery.[14] A lack of awareness of this increased CVD risk and stigma against MI among primary care providers (PCP), along with the well-documented difficulty for individuals with MI in accessing primary and mental health care results in this population being screened significantly less for CVD risk factors.[15]

As a result, the integration of primary and mental health care has been proposed to improve their cardiovascular health. The ACA has three main provisions to increase integration of care: expanding the existing Substance Abuse and Mental Health Service Administration (SAMHSA) co-location program and allowing the formation of health homes and accountable care organizations.[16,17,18] The present paper discusses these provisions and their effect on the integration of care in the context of the urgency to improve the cardiovascular health of this population.

Problem Statement

As stated earlier, 26.2% of American adults (57.7 million people) have a diagnosable MI, which results in substantial disability and costs.[12] Individuals with MI have more difficulties with both activities and instrumental activities of daily living, higher levels of cognitive impairment, and are unable to work for significantly more days than those without MI.[19] While the mental health care this population receives has improved over the years, their physical health has suffered. Individuals with MI die 15-20 years earlier than those without MI.[20,21,22] Compared to individuals without MI, those with MI are twice as likely to develop CVD, at younger ages, and three times as likely to die from CVD due to the pathology of MI, side effects of medication, and systemic issues surrounding a fragmented system of care delivery.[13]

Cardiovascular health is addressed through the primary care system. However, individuals with MI have difficulty accessing primary care. One reason is that this population was 4.75 times more likely to be uninsured

than those without MI prior to the passing of the ACA.[23,56] Beyond this, the delivery of care poses significant challenges. One of the major physical health care barriers identified by those with MI is difficulty in accessing two separate sources of care: primary and mental health care.[24] Insured individuals with MI were 45% more likely to forego seeking primary care than those without MI.[57] Reported reasons include 'diagnostic overshadowing' wherein PCPs dismissed their physical health complaints by attributing it to their MI, provider stigma against MI, and general disinclination of this population to meet unfamiliar individuals.[24]

There has been ongoing controversy over who is responsible for providing cardiovascular health care to individuals with MI. Mental health care providers (MHCPs) state that PCPs should be responsible because they are trained to provide physical health care.[25] However, PCPs do not feel adequately trained to provide care to individuals with MI.[25] Many PCPs are also unaware that MI is associated with increased CVD risk.[24] Additionally, stigma against MI is also prevalent among PCPs, with 79% of individuals with MI reporting discriminatory experiences with PCPs.[15,36] These factors culminate in individuals with MI receiving significantly poorer quality primary care.[26] Compared to the 71.1% of individuals without MI who are screened for CVD risk factors, as low as 6.0% of those with MI are screened in some areas.[26] Thus, many cases of CVD and associated mortality may have been prevented if they received proper care.

As a result, integration of primary and mental health care has been proposed to improve the cardiovascular health care that individuals with MI receive. The CIHS Standard Framework for Levels of Integrated Health Care, which includes six levels of integration ranging from minimal collaboration (level 1) to full collaboration in a merged integrated practice (level 6), describes degrees of integration (Figure 1).[27] Experimental trials have shown that higher levels of integration (levels 5-6) are the most effective in improving the cardiovascular health of this population.[28]

Preventing CVD and associated mortality does not confer just health benefits to individuals with MI who would have otherwise suffered from CVD. Preventing comorbid CVD and MI offers economic benefits as well. On average, individuals pay around $1,591 a year out of pocket to treat MI.[29] Adding CVD has a multiplicative effect on costs because they would now need care (visits to providers, medications etc.) for both illnesses.[30] Furthermore, reduced income from lost productivity associated with seeking care can place additional stress on individuals with MI.[30]

Comorbid MI and CVD also has large economic consequences that impact the broader U.S. Treatment of comorbid MI and CVD costs 1.5 times as much as treatment of CVD alone.[31] More specifically, the cost to treat comorbid MI and CVD varies from $1457.93 to $2566.95 dollars per comorbid person per month.[32] Absenteeism or taking off of work, due to comorbid MI and CVD, costs the U.S. $43.7 billion over 200 million days lost from work each year.[33] Presenteeism or lost productivity while working, due to comorbid MI and CVD costs the U.S. between $20.8 and $48.3 billion.[34] Therefore, providing proper cardiovascular care to this population according to clinical practice guidelines would result in large-scale economic benefits.

Attempts to solve the inefficient delivery of care to individuals with MI have thus far been unimpressive. While there has been a call to reduce stigma around MI within the primary care system, few concrete steps have been taken directly by primary care facilities to address this issue.[35] Instead, interventions that aim to reduce stigma against individuals with MI among PCPs are underway.[35,36,37] Evidence for the success of these interventions is limited and mixed. Other attempts have focused on solely improving communication, through phone calls or emails, between PCPs and MHCPs.[38] However, communication is only a part of integration and simply increasing it is not enough to improve the care provided to individuals with MI.[38]

Prior plans to integrate mental health and primary care at smaller state and local levels, were met with limited support from key players. For instance, many PCPs and MHCPs argued that their different organizational cultures would impact their ability to collaborate.[32] The resistance of medical providers was also rooted in their

lack of desire to input the additional time and effort that integration necessitates. This reluctance seemed all the more justified due to a lack of specification within these plans on the roles and responsibilities of each player.[32] Additionally, integrated care was generally not funded or incentivized well, making it more difficult to implement.[39] Therefore, previous attempts to integrate care have been largely unsuccessful. As such, successful integration of primary and mental health care remains a necessity.

Policy Description

There are three main ACA provisions that aim to increase integration of care: expanding the existing SAMHSA co-location program, establishing an optional Medicaid State Plan benefit to create Health Homes, and allowing the formation of Accountable Care Organizations. Through the first provision, an additional $50 million in grants was allocated to expand an existing SAMHSA co-location program, the Primary and Behavioral Health Care Integration program (PBHCI).[16] The purpose of the program is to help communities integrate care through the co- location of primary and mental health care services at publicly funded, community-based mental health settings where many individuals with MI already receive care.[16] The settings are primarily accessed by low-income and racial and ethnic minorities with MI, who are unable to afford hospital-based care.[40] This expansion of PBHCI was expected to increase the number of community-based mental health settings with co-location of care and sustain existing co-location settings.[41] Additionally, the expansion was expected to improve the physical health status of individuals with MI who have or are at risk for developing co-occurring chronic diseases, to a greater extent than if these individuals received usual care through separate settings.[16,42]

The ACA also included a provision to provide comprehensive care with an explicit focus on the integration of primary and behavioral health care through the creation of Health Homes (HH).[43] HHs are a Medicaid state plan option wherein states may allow beneficiaries with chronic conditions to designate and receive coordinated care from Health Home service providers.[43] A variety of individuals, such as PCPs, MHCPs, social workers, pharmacists, and community health workers collaborate to form a HH to provide care to patients.[44] Medicaid beneficiaries who have one chronic disease and are at risk for another, have two chronic diseases, or have one serious and persistent MI are eligible for care through HHs.[45] Accordingly, beneficiaries with MI at risk of developing CVD, those who have comorbid MI and CVD, or those with a serious MI alone qualify for HH services.[45] This was expected to improve the physical health care experience received by beneficiaries with chronic conditions such as MI and CVD and subsequently reduce their hospital admissions and emergency room usage.[46] The ACA provision includes 90% federal matching of the payments for HH services provided within the first two years of establishing a HH. This financial incentive was expected to encourage state uptake and implementation of HHs.[46]

Another key provision of the ACA is the Medicare Shared Savings Program (MSSP), which allows health professionals like PCPs and MHCPs to enter into collaborative agreements and form Accountable Care Organizations (ACO) that hold these providers collectively accountable for the quality of care and costs for a group of patients.[18] MSSP allows providers to partner with the CMS to work together and coordinate care for their patients and share in any subsequent savings for the Medicare program.[47] As a follow-up to this provision, CMS introduced the concept of 'Integrated Care Model' in the 2012 State Medicaid Director letter.[48] Along with the provision, this model was expected to increase integration of mental health care services into new and existing ACOs.[48] Consequently, the level of integration of primary and mental health care, as well as the cardiovascular health outcomes of individuals with MI were expected to improve.[49]

These ACA provisions were expected to reduce CVD risk among individuals with MI and lower healthcare costs, primarily through improving the quality of physical health care delivered to individuals with MI.[50] Intrinsic to the improved quality of care is an increase in CVD risk factor screenings among this population, which in turn would highlight the proper secondary and tertiary prevention mechanisms and treatments required

to address screening results.[50]Additionally, through an increase in integration of care and resultant improvements in the quality of care, these provisions aim to improve patient satisfaction and lessen the discomfort of individuals with MI in accessing care, thereby encouraging higher utilization of primary care services.[50] Based on direct and indirect costs associated with comorbid MI and CVD in 2012, an estimated $26.3-$48.3 billion could be saved annually through the integration of primary and mental health care.[32] A significant percentage of these savings ($19.85 billion) is expected to derive from the ability of integrated care to lower the risk of CVD and associated mortality among those with MI.[32] Additionally, their increased risk of CVD and associated mortality is expected to be reduced 1.3-1.5 and 2-fold.[51,52]

The integration of primary and mental health care requires coordination and collaboration among health care professionals and the consolidation of primary and mental health care systems. However, there are unintended consequences to this consolidation and integration of care. Integration between physicians and hospitals strengthens their bargaining position with insurers, particularly for prices of outpatient care.[53] While integration of care is meant to make coordination of care for patients easier among providers, it has been expected to increase the workload of already overworked PCPs and MHCPs because it requires more coordination among providers, including maintaining high levels of communication and keeping more detailed notes and records of patients to facilitate care coordination.[54] Additionally, collaboration of providers with different organizational cultures may lead to strained professional relationships in some cases.[32,55]

Policy Implementation

All three ACA provisions regarding integration of care have gone into effect and have been fully implemented. However, there have been three major challenges in implementation: communication, identifying eligible individuals, and administrative/provider issues. Federal and state legal restrictions on information sharing related to mental health often require practices to obtain additional consent or approval to communicate with one another.[58] Necessary infrastructure for communication also need to be in place to properly coordinate care. Current health information sharing systems like electronic health records (EHR) were not designed for cross-site communication.[58,60] Implementing a new EHR system can also be expensive and many MHCPs are currently ineligible for federal subsidies offered to PCPs for EHR adoption.[59,61]

Another challenge in implementation has been identifying individuals who are eligible to benefit from the ACA provisions. Currently, there is no centralized system for identifying eligible individuals resulting in substantial variation among states.[58] In New York, the state government utilizes a complicated, time-consuming, costly process to identify eligible individuals using the 3 M's Clinical Risk Group software, which then identifies those who generate both the highest costs and have the highest risk of inpatient care admission using an algorithm based on previous claims. A list of these individuals is then sent to Medicaid or Medicare for approval.[62] In Oregon and Rhode Island, providers identify patients who meet eligibility criteria through their interactions with patients and then transfer their names to Medicaid or Medicare for approval.[58,62] However, through this technique, only patients who seek care though the healthcare system are identified.[58,62] Developing a centralized, timely, low-cost process for identifying eligible individuals thus remains a necessity.

Finally, recruiting providers to provide integrated care has been challenging. Providers are hesitant to join integrated care efforts when there is no guarantee that it will lead to sustainable cost savings. Different organizational cultures have also made implementation difficult. For instance, providers had difficulty communicating at SAMSHA co-location facilities because many PCPs reported feeling unwelcomed by MHCPs at these settings.[58] Additionally, integration of care comes with additional costs and workload for providers. The cost of setting up billing processes for care coordination has served as an additional barrier to

provider engagement, especially when extensive documentation is required.[63] For example, in Oregon, providers have to attest to providing services by submitting reports about patients enrolled in HHs every three months.[58]

This also ties into unintended consequences of these provisions. As mentioned earlier, providers consider attesting to providing care to account for per member per month payments and submitting claims as unnecessary administrative burdens.[46] Providers who maintained separate records reported difficulty accessing and sharing patient information.[58] Even providers with stablished EHRs reported difficulty using it to communicate with providers at different facilities.[63,58] Further, as expected, integration of care has strengthened the bargaining power of providers, such that patients of providers who were initially not part of a collaborative system now have to pay more to see these same providers once they have joined integrated care efforts.[53]

Compared to general care, patients with MI receiving care through SAMSHA co-location programs had greater improvements in diastolic blood pressure and total cholesterol levels.[63] However, there were no statistically significant differences in systolic blood pressure, BMI, or triglyceride levels.[63] Thus, although some physical health outcomes improved, overall cardiovascular disease risk among this population did not improve significantly.[64] While there is no specific research on increases in the number of new co-location programs or the maintenance of existing co-location programs, as a result of the ACA provision, there has been a 12% increase in the number of patients with MI accessing primary care through SAMHSA PBHCI programs.[64]

As of 2017, 27 HH State Plan Amendments (SPA) across 19 states have been approved by CMS. One HH SPA has been approved for Maryland. Both MI and CVD are included as eligible conditions in all HH SPAs, except the Missouri Primary Care Practice HH SPA, North Carolina HH SPA, Vermont HH SPA, and Wisconsin HH SPA. Through HHs, there has been a 1.6% reduction in annual hospital admissions for CVD-related outcomes and a 1.02% reduction in emergency department use for CVD-related outcomes among individuals with MI.[46] In Maryland, hospital admissions and emergency department usage among individuals with MI for all causes decreased by roughly 1%.[65] No information about visits related to CVD among this population is available in Maryland. Care coordination, overall quality, patient satisfaction, and utilization of primary care have improved among the few highly integrated (levels 5-6) HHs in both the nation as a whole and in Maryland.[46,66,67] While significant reductions in hypertension were observed in the highly integrated programs, no significant changes were observed in CVD risk factor screenings or in any other cardiovascular health outcomes in Maryland or the U.S. as whole.[67,68]

There are currently 480 MSSP ACOs nationwide and 24 in Maryland.[69] Only 13% of all MSSP ACOs reported significant integration of primary and mental health care.[70] MSSP ACOs reduced spending by $2.8 billion from 2013 to 2015.[71] While ACOs performed better than 90% of all fee-for-service providers on lowering hospital readmissions, only the 3.1% highly integrated (levels 5-6) ACOs provided higher quality cardiovascular health care to individuals with MI, and increased utilization of primary care services among this population.[72] In Maryland, compared to general care, ACOs performed 4.6% and 3.2% better on hypertension and heart failure admissions, respectively, and 2.0% and 6.4% worse on heart failure and CAD prevention, respectively.[73]

In general, across all three provisions, practices with higher levels of integration (levels 5- 6) reported the highest improvements in patient satisfaction, cost containment, increases in the number of individuals with MI accessing physical health care and getting screened for CVD risk factors, and decreases in CVD risk.[75,76,77] Improvements in cardiovascular health outcomes were highest among highly integrated ACOs.[76,77] However, levels of integration for all three programs were generally low (levels 1-3).[78] As a result, overall, these provisions failed to make significant improvements in the cardiovascular health of individuals with MI.[74,78,79]

Conclusion

The enactment of the ACA brought sweeping reforms to health care, most notably, extending coverage to millions of individuals, including millions with MI. Individuals with MI are twice as likely to develop and three times as likely to die from CVD than those without MI, one reason for which involves systemic issues in care delivery. Individuals with MI have reported significant difficulty in accessing two separate sources of care. CVD risk factor screening rates among those who accessed primary care are minimal due to a lack of awareness of their increased CVD risk and stigmatizing attitudes among PCPs. Additionally, treating comorbid MI and CVD costs the U.S. billions annually. Therefore, addressing the lack of integrated care is necessary to improve the cardiovascular health outcomes of individuals with MI and lower healthcare spending.

As such, the ACA included three provisions to improve integration of primary and mental health care: expanding the existing SAMHSA co-location program, and allowing the creation of HHs and MSSP ACOs. These provisions were not policies with little potential to improve the cardiovascular health of individuals with MI to begin with; they were expected to improve several facets of cardiovascular health outcomes by improving the quality of care provided to this population. Prior to implementation, the provisions were therefore appealing and agreeable.

However, mistakes with implementation may have partially accounted for the minimal impact these policies had on improving the cardiovascular health of this population. For example, the lack of capacity of current health information sharing systems for cross-site communication has made integration difficult. Another challenge was having no centralized system in place to identify individuals that were eligible to receive the benefits of these provisions, resulting in states using systems that are either costly and time-consuming or add to provider workload. Additionally, allowing providers to share in savings obtained from improving the quality of care was not enough of an incentive to encourage sufficient rates of uptake of integrated care. Many programs that joined integrated care efforts returned to unintegrated care because profits were insufficient. Therefore, health information sharing systems with a better capacity for cross-site communication, efficient systems to identify eligible individuals, better incentives, and reporting systems that limit provider burden should be put into place to improve uptake and maintenance of integrated care.

Finally, a major weakness is the lack of specificity in these provisions as to what level of integration is required to improve health outcomes. As a result, the levels of integration for the majority of integrated care programs were low (levels 1-3). While integration at these levels have helped lower costs through ACOs, higher levels of integrated care (levels 5 and 6) are required to improve the cardiovascular health outcomes of this population and procure additional savings. In order to encourage integration to the extent required to significantly reduce CVD risk among this population, it is important to recognize that there are two subgroups of individuals with MI: those with serious mental illness (SMI) such as schizophrenia, schizoaffective disorder, severe depression, and bipolar disorder, and those without serious mental illness (NSMI).

Those with NSMI prefer receiving mental health and primary care within the primary care setting, a set-up that has been shown to improve both their mental and physical health.[80] Due to the severity of their MI, those with SMI require more intimate and intensive psychiatric care and thus prefer receiving physical health care in the mental health care setting.[81] This set-up has also been proven to improve the mental and physical health of this subgroup.[81,82]

For both subpopulations, using highly integrated care models would be effective in improving cardiovascular health. Accordingly, primary care facilities should directly employ an MHCP, allowing the PCPs and MHCP to work together within the same setting to provide mental and cardiovascular health care for individuals with NSMI. Similarly, mental health care facilities should directly employ a PCP to work directly with the MHCPs to provide mental and cardiovascular health care to individuals with SMI. Direct employment falls under high

integration (level 5-6), which, based on the findings observed from the implementation of the three ACA provisions, has the highest potential for reducing CVD risk among individuals with MI.[54]

Therefore, the SAMHSA co-location programs and HH provisions, neither of which have significantly improved the cardiovascular health outcomes among this population, should be replaced with a direct employment provision that grants funds and incentives to mental health and primary care facilities that employ PCPs or MHCPs, respectively. Providers would then benefit from this funding, incentives, and savings from improving the health of their patients with MI.

While the majority of MSSP ACOs were unsuccessful in improving the cardiovascular health of individuals with MI, highly integrated (levels 5-6) ACOs successfully improved the quality of care provided to individuals with MI and increased rates of CVD risk factor screenings, improving several cardiovascular health outcomes and reducing costs. Although even highly integrated ACOs did not improve all cardiovascular health outcomes, this may be due to the mistakes in implementation described earlier. Because only Medicare beneficiaries are eligible for MSSP ACOs, the eligible population of individuals with MI, are 65 and older, and are thus likely to also have health problems other than MI and CVD. ACOs would be beneficial to these individuals because ACOs provide an avenue for other health professionals, in addition to PCPs and MHCPs, to coordinate care to improve their overall health. To further focus on improving the cardiovascular health of this population, mental health care facilities that directly employ PCPs and primary care facilities that directly employ MHCPs, could form ACOs with other professionals to improve the cardiovascular health of individuals with SMI and NSMI, respectively.

If the mistakes in implementation were addressed, especially in terms of specifying the level of integration ACOs should utilize, and facilities that directly employed PCPs and MHCPs joined other providers to from ACOs, MSSP ACOs would still have the potential to significantly improve the cardiovascular health outcomes of older individuals with SMI. For individuals with MI ineligible for Medicare, direct employment of PCPs in mental health care settings and MHCPs in primary care settings, as opposed to the SAMSHA colocation programs and HHs, is likely to confer the most benefits to the cardiovascular health of this population.

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Appendix

Figure 1a. CIHS Standard Framework for Levels of Integrated Healthcare: Core Descriptions

COORDINATED KEY ELEMENT: COMMUNICATION		CO LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet non-formal team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Source: SAMHSA-HRSA, Center for Integrated Health Solutions. (2013). CIHS' Standard Framework for Levels of Integrated Healthcare. Washington DC: Heath, B., Romero, P., & Reynold, K.

Figure 1b. CIHS Standard Framework for Levels of Integrated Healthcare: Key Differentiators

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
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	▸▸ All patient health needs are treated for all patients by a team, who function effectively together ▸▸ Patients experience a seamless response to all healthcare needs as they present, in a unified practice

Source: SAMHSA-HRSA, Center for Integrated Health Solutions. (2013). CIHS' Standard Framework for Levels of Integrated Healthcare. Washington DC: Heath, B., Romero, P., & Reynold, K.