The Colorado Health Foundation™

REPORT

The Colorado Blueprint for Promoting Integrated Care Sustainability

March 2012

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Introductory Letter

Despite its potential for improving health outcomes and reducing costs, integrated care faces many challenges that could hamper its sustainability in the long term. Fortunately, the work outlined in this report provides a "blueprint" for helping the model fulfill its promise in Colorado and elsewhere.

For those not acquainted with the term, integrated care is a model of health care delivery that engages individuals and their caregivers in the full range of physical, psychological, social, preventive and therapeutic factors necessary for a healthy life. Practitioners of integrated primary care combine medical and behavioral services to address the whole person — not just one aspect of his or her condition.

The Colorado Health Foundation supports integrated care as a component to its "funding strategy" for improving health care delivery in Colorado — one of seven strategies laddering up to the Foundation's vision of making Colorado the healthiest state in the nation. Frequently, we hear stories from grantees about the positive impact integrated care services have on patient health and provider morale. Unfortunately, we also hear grantees share their struggles of maintaining these services due to reimbursement constraints and the complex nature of billing health plans.

To address some of these concerns, the Foundation and the Collaborative Family Healthcare Association partnered in spring 2011 to launch Promoting Integrated Care Sustainability. PICS is a statewide effort that aims to identify the financial barriers to integrating primary care and behavioral health care services and to propose Colorado-specific solutions that will promote sustainability of this model for the long term.

Throughout 2011, PICS convened an advisory board of integrated care stakeholders (including primary care and behavioral health care providers, health plans, state agencies, elected officials and policy experts) to review an analysis of the financial barriers experienced by integrated care providers in the state.

This report outlines PICS specific policy recommendations for moving Colorado toward financial sustainability of integrated care services. It also includes the findings from the analysis. Additionally, the report profiles policies and practices in other states to move integrated care services toward financial sustainability.

Thanks to the hard work of the PICS project team and advisory board, along with those who took part in interviews and surveys, Colorado has a clearer vision of how it can overcome the hurdles blocking this promising health care model.

It is our hope that the recommendations and information highlighted here will provide a catalyst for building upon the many collaborative and innovative efforts in Colorado and across the country. Together with policymakers and other stakeholders, Colorado can move integrated care to its rightful place in the health care mainstream.

Anne Warhover

Anne Warhover
President and CEO
The Colorado Health Foundation

Overview: Challenges and Opportunities

Research shows that integrated care is a highly effective clinical model for comprehensive health care.[1] Yet, despite proven benefits, health professionals in Colorado and nationwide have encountered difficulties fiscally sustaining the integrated care model due to reimbursement constraints combined with the complex nature of billing health plans.

This report outlines specific recommendations to move Colorado toward financial sustainability of integrated care services, providing an overview of the challenges and opportunities ahead.

What is Integrated Care?

In short, integrated care is a model of health care delivery that engages people in the full range of physical, behavioral, preventive and therapeutic services to support a healthy life. In an integrated care setting, behavioral health and medical providers work together to coordinate treatment and follow-up of a person's health care.

Treating the Mind-Body Connection

Why is integrated care necessary? Statistical evidence supports the need for integrated care. Findings from a recent report demonstrate that more than 68 percent of adults with behavioral health disorders have at least one physical health condition.[2] These individuals have a greater need for coordinated, integrated care because certain behavioral disorders carry higher incidences of obesity, diabetes, asthma, migraines, heart disease and cancers.[3] In addition, 29 percent of adults with a physical health condition also deal with behavioral health disorders.[2] Certain physical health conditions make an individual more likely to develop emotional disorders. For instance, roughly one in five people who suffer from heart attacks become severely depressed.[2] For those who experience both physical and behavioral health disorders, integrated care can offer better access to needed treatment and improved health outcomes.[4]

Financial Issues Impose Barriers

Increasingly, integrated care is gaining recognition as a highly effective clinical model for comprehensive health care.[1, 5] Still, financial sustainability appears to be a substantial barrier for primary care and behavioral health care providers to implementing integrated care.[2, 6] These barriers typically come down to reimbursement issues for behavioral health providers in a primary care setting. The same can be said for primary care providers in behavioral health settings. In fact, many integrated care services simply aren't easily "reimbursable" in the current financing structure.

Integrated Care in Colorado

Currently, there are numerous efforts to integrate physical health and behavioral health services throughout Colorado. Integrated care is especially prominent among Colorado's safety net providers which serve a large number of people who are uninsured or enrolled in public insurance programs such as Medicaid. While providers regularly share stories about the positive impact integrated care services have on patient health and provider morale, they consistently report current payment structures do not adequately cover the costs of providing integrated care services.

Through the 2011 passage of House Bill 1242, Colorado's General Assembly acknowledged that current policies present barriers to integrating care. An attempt to rectify the situation, the law directed the Colorado Department of Health Care Policy and Financing (HCPF, the state's Medicaid agency) to review these issues and propose solutions to promote integrated care.

Also in 2011, the Colorado Health Foundation and the Collaborative Family Healthcare Association launched Promoting Integrated Care Sustainability (PICS). A statewide project, PICS aimed to identify the financial barriers to implementing integrated care and propose Colorado-specific solutions to help move the model into mainstream health care. Throughout 2011, PICS convened an advisory board of stakeholders (including primary care and behavioral health care providers, health plans, state agencies, elected officials and policy experts) to identify and analyze financial barriers to delivering integrated care services in Colorado, and provide recommendations for removing those barriers.

About this Report

This report is intended to help policymakers and others understand the difficulties in achieving financial sustainability in integrated care in Colorado by highlighting specific policy-related solutions for sustaining the model's long-term future.

Findings from the PICS analysis informed this report, which was compiled by PICS's project team. For a complete list of project team members and members of PICS's advisory board, see Page 33. PICS's recommendations are intended to inform and to provide a blueprint for Colorado policymakers, health plans, providers and advocates on changes needed to financially support integrated care — including restructuring the current financing system as a whole.

Over the next several pages, this report will outline PICS's recommendations along with detailed analysis of the barriers and a look at how other states are responding to the challenges and opportunities presented by this promising model of primary health care delivery. HCPF plans to incorporate PICS's findings and recommendations into the HB 11-1242 report to Legislators in spring of 2012.

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1. Butler M, Kane RL, McAlpine D, Kathol, RG, Fu SS, Hagedorn H, Wilt TJ. Integration of Mental Health/Substance Abuse and Primary Care No. 173. AHRQ Publication No. 09-E003. Rockville, MD. Agency for Healthcare Research and Quality. October 2008.
2. Goddell S, Druss B, Reisinger Walker E, Mental Disorders and Medical Comorbidity, Robert Wood Johnson Foundation, Policy Brief, 2011.
3. 1990-1992. National Comorbidity Survey.
4. Kathol RG, Butler M, McAlpine D, Kane RL, Barriers to Physical and Mental Condition Integrated Service Delivery Psychosomatic Medicine. July/August 2010 72:511-518.
5. Collins C, Hewson DL, Munger R, Wade T. "Evolving Models of Behavioral Health Integration in Primary Care 2010," Milbank Memorial Fund, 2010.
6. Mauch D, Kautz C, Smith SA. "Reimbursement of mental health services in primary care settings." Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2008. HHS Pub. No. SMA-08-4324.

Recommendations for Promoting Sustainability

In the spring of 2011, the Colorado Health Foundation and the Collaborative Family Healthcare Association launched Promoting Integrated Care Sustainability (PICS) to identify financial impediments for moving integrated care into to the mainstream of Colorado's health care system.

To assist with the project, PICS convened an advisory board to identify and analyze financial barriers to delivering integrated care services in Colorado. PICS's project team conducted an analysis which included an online survey of 56 integrated care organizations in Colorado (see Appendix A), 29 in-depth interviews of key staff at integrated care sites in Colorado (see Appendix B), and discussions with stakeholders in four other states (California, Maine, Tennessee and Texas) that have advanced integrated care policies and practices (see Appendix C).

This summary outlines specific recommendations for Colorado policymakers, health plans, providers and advocates on steps needed to financially support integrated care.

Moving Forward

Based on its findings and analysis, PICS recommends the following steps be taken in 2012 to move Colorado towards financial sustainability of integrated care:

- Recommendation 1: *Clarify the current billing regulations and train staff in integrated care sites to optimize existing revenue sources to provide cost-efficient, medically necessary care.*
- Recommendation 2: *Resolve confusion about same-day billing restrictions and pursue efforts to reduce administrative barriers.*
- Recommendation 3: *Examine the viability of paying for Health and Behavior Assessment codes under insurance plans.*
- Recommendation 4: *Test and analyze the viability of global funding strategies to financially sustain integrated care services.*
- Recommendation 5: *Plan and implement a standardized statewide data-collection system to document financial, operational and clinical outcomes, and costs of integrated care services.*

PICS Recommendations

This section identifies PICS's five **recommendations** for promoting integrated care sustainability in Colorado; the **barriers** that necessitate the recommendations; the **key findings** that quantify the barriers; and specific **policy actions** for achieving the recommendations.

Recommendation 1:

Clarify the current billing regulations and train staff in integrated care sites to optimize existing revenue sources to provide cost-efficient, medically necessary care.

Barrier: Integrated care services are primarily grant funded and are not moving towards financial sustainability by generating revenue. Integrated care sites report fee-for-service billing is costly and cumbersome.

Key Findings:

- Among the integrated care sites that completed the PICS survey, 78 percent reported covering integrated care costs with grant funding. Revenue generation — including insurance billing and patient fees — only covered 21 percent of the costs associated with providing integrated care.
- Surveyed integrated care sites reported approximately one-third of integrated care costs are written off due to lack of any available revenue stream.
- Both the survey and interviews revealed significant variation in billing for integrated care services. Many integrated care sites reported not billing for behavioral health services due to high administrative costs and lack of knowledge on billing for such services. Providers also had concerns regarding regulatory, coding and auditing practices for specific services.
- Other states have developed state-specific insurance coding sheets to assist integrated care sites in billing for services and have reported success in helping providers recover some of the costs of integrated care services.

Policy action: A Colorado-specific insurance coding sheet for integrated care services would clarify current billing regulations and help integrated care sites optimize the use of existing revenue sources to provide cost-efficient, medically necessary care. Additionally, technical assistance is needed to help administrators effectively use the coding sheet for billing purposes. Health plan and provider involvement in the implementation of this recommendation is essential to ensure accurate information is appropriately disseminated and used.

Recommendation 2:

Resolve confusion about same-day billing restrictions and pursue efforts to reduce administrative barriers.

Barriers: Integrated care sites that participated in the PICS survey indicated that they believed same-day billing for physical health and behavioral health services is not permitted. Additionally, there is confusion and uncertainty regarding what services can be billed on the same day by different providers who work in the same site. Providers reported submitting separate bills for physical health and behavioral health services increases administrative time and costs.

Key Findings:

- Nearly 70 percent of integrated care sites that completed the PICS survey reported that allowing for same-day insurance billing for physical health and behavioral health services would benefit their financial sustainability. This was the most frequently cited solution. In-depth interviews strongly supported the survey findings, with an added concern: individuals who receive integrated care services should not be held responsible for making two co-payments for such services. This could result in an "access-to-care barrier" as an unintended consequence.
- Other states where Medicaid or other health plans allow same-day billing indicated it helps in providing additional revenue, but is seen as a partial solution to the problem. Paying for services on a fee-for-service basis (payment based on volume of services provided) is seen as a "transitional step" in supporting integrated care services.
- If same-day billing is allowed and reimbursed by Colorado Medicaid, reductions in cost in other services would be required to offset the cost of the newly allowed services and achieve break-even budget neutrality. For example, every 1,000 integrated care visits would be equivalent in cost to six inpatient hospital admissions or 128 emergency room visits.[7]
- "Current reimbursement policies for providers providing physical and behavioral health care services on the same day are complicated and the policies create a barrier to the seamless integration of these services for the well-being of the patient," according to a definition in House Bill 1242. Passed by Colorado's General Assembly in 2011, HB 1242 requires the Colorado Department of Health Care Policy and Financing (HCPF, the state's Medicaid agency) to review these issues and propose solutions to promote integrated care.

Policy actions: Same-day billing clarification should be a part of the state-specific coding sheet to be developed under Recommendation One. Health plans and providers should clearly outline the administrative steps required (and clarify the time involved) to submit separate bills for physical health and behavioral health services. They also should work together to reduce or eliminate administrative barriers.

7. Milliman Analysis of Medicaid Cost Equivalents, Stephen P. Melek, October 2011.

Recommendation 3:

Examine the viability of paying for Health and Behavior Assessment codes under insurance plans.

Barriers: Health and Behavior Assessment codes are used to bill for services to help patients adjust to chronic illness and set self-management goals. The focus of services does not relate to a specific mental health diagnosis, but provides assessment and treatment of biopsychosocial factors that may impact a person's ability to manage their health. Health and Behavior Assessment billing codes are not currently reimbursed by Colorado Medicaid or most other insurers in Colorado.

Key Findings:

- PICS interviews demonstrated strong support for reimbursement of Health and Behavior Assessment codes in Colorado. Several providers interviewed expressed support for the use of these codes and described their work as "focused on helping to support the individual and their family/support system in achieving and maintaining a healthy lifestyle."
- Only 19 percent of integrated care sites that completed the PICS survey described success in billing Health and Behavior Assessment codes. Sixty-nine percent of the surveyed sites indicated being able to bill Health and Behavior Assessment codes was a key solution.
- If Health and Behavior Assessment codes were reimbursed by Colorado Medicaid, reductions in cost in other services would be required to offset the cost of the newly allowed services and achieve break-even budget neutrality. For example, every 1,000 integrated care visits would be equivalent in cost to two inpatient hospital admissions or 44 emergency-room visits.[7]
- Other states where Health and Behavior Assessment codes are reimbursed indicated the use of the codes can provide additional revenue and allow for more appropriate coding of integrated care services. Using these codes is best seen as part of a transitional payment strategy and not the solution to the long-term financial sustainability of integrated care services.

Policy actions: Colorado specific health care data is needed to conduct actuarial and economic analyses to substantiate health plan payment for Health and Behavior Assessment codes. Integrated care providers must be active participants in any data collection or analyses.

Recommendation 4:

Test and analyze the viability of global funding strategies to financially sustain integrated care services.

Barriers: Colorado's current health care financing structure does not adequately support the delivery of integrated care services. Integrated behavioral health care interventions differ from traditional behavioral health services in service delivery and time spent. Care is often brief in nature and delivered in high volume, with emphasis on a team-based approach. Codes that accurately reflect the service are often not covered or are poorly compensated. It is well-established both locally and nationally that there is no one "right way" to financially support integration, and that there is no current funding approach that, by itself, will sustain integrated care services. Global payment strategies, defined by a single payment or an enhanced payment for all care received within a fully integrated delivery system, is a recognized model to move integrated care towards long-term financial sustainability.

Key Findings:

- The majority of providers interviewed in PICS's analyses expressed interest in learning more about global funding, how these funding methodologies work and what outcomes would be incentivized. Providers were asked about three reimbursement methodologies: capitation, case rates and pay for performance.
- HB 11-1242 specifically mentions "accountable care organizations" and "medical homes" as health care innovations that promote integration. These models are based on global funding strategies that remove the focus from billing for individual services and instead reimburse services based on coordination of care and outcomes, incentivizing overall patient/population wellness. The federal Affordable Care Act presents states with opportunities to test new global funding strategies via the Center for Medicare and Medicaid Innovation.

Policy actions: Integrated care providers and other stakeholders in Colorado are encouraged to take advantage of local and federal funding opportunities to test and analyze the viability of global funding strategies to financially sustain integrated care services. By thoroughly studying different payment models, examining the costs associated with integration and clearly demonstrating how integrated care can save money, a much stronger policy recommendation can be made to the state. Colorado organizations such as the Center for Improving Value in Health Care (CIVHC), private and public health plans and provider associations are important partners in the development and implementation of global funding strategies.

Recommendation 5:

Plan and implement a standardized statewide data collection system to document financial, operational and clinical outcomes and costs of integrated care services.

Barriers: There is no standardized data collection system to effectively evaluate and manage outcomes, costs and quality of integrated care services provided in Colorado. Sites reported not having the resources (e.g., time, staff, competency and funding) to produce their own standardized data analyses without significant technical assistance.

Key Findings:

- The majority of PICS interview participants indicated a need for robust data collection and analysis to substantiate the costs of integrated care to health plans, funders and senior management. The cost of keeping a data repository internal to each organization is too expensive to set up and maintain. A significant number of interviewees expressed interest in providing information to a statewide data warehouse where they could run data analysis reports focusing on their specific line of business. It is preferable that such data collection be as well integrated into current clinical and practice workflow as possible, re-purposing data elements, collection, and sharing that is already used for purposes of treatment, payment and other health care operations.
- A case for a systematic approach to collect and aggregate integrated care data can be made at both the statewide and clinic-specific levels. Such a statewide system would enable the Colorado Department of Health Care Policy and Financing (HCPF, the state's Medicaid agency) the Department of Human Services and other Colorado health plans to analyze data and develop more flexible payment and programmatic strategies and models. To the extent possible, these efforts should follow national standards for documentation of services, outcomes, payments and other transactions to leverage investments in existing systems and to reduce redundancy and re-work in the data collection process.

Policy actions: Colorado organizations such as the Colorado Regional Health Information Organization, Quality Health Network, Center for Improving Value in Health Care (CIVHC), the Department of Human Services, the Department of Public Health and Environment and HCPF should partner with integrated care service providers to ensure systems being developed to collect, analyze and use health data include common health care service data elements to measure cost, outcomes and quality.

Conclusion

Despite more than 25 years of research demonstrating the inseparability of behavioral health and physical health, current policies continue to perpetuate a fragmented and inefficient health care system that compensates behavioral health and physical health separately. To address these barriers, policies need to emerge that support adequate payment for integrated care.

Appendix A: PICS Survey Results

This appendix details the findings of an online survey sent to approximately 110 integrated care sites in Colorado to identify barriers and challenges in implementing integrated care. Fifty-six integrated care sites responded to the survey.

Survey Limitations

Caution must be exercised when reviewing the data. The data are descriptive and should not be taken as inferential. There are several limitations to the survey that need to be taken into account:

- The survey allowed respondents to provide numerical estimates.
- The project team received duplicate surveys from three clinical sites. Data from the most complete survey was included in the final data analysis.
- The project team surveyed multi-site systems where the central office completed the survey for the entire system and a local clinic also completed the survey for the services provided in their building. The team chose to include both surveys in these instances.
- Respondents were allowed to leave some questions unanswered and it is not clear if the incomplete data were in response to a lack of knowledge about their own practice, a misunderstanding of the question or a simple refusal to answer the question.
- A number of respondents did not complete the entire survey.
- Many survey items directed the respondents to "check all that apply." These types of questions can result in a floor/ceiling effect (e.g., little differentiation between participants or items within a question).

Interpreting the Data

The results of this survey serve to confirm many of the initial perceptions regarding integrated care in Colorado:

- Integrated care services are well-established in primary care medical settings. Integration of primary care into behavioral health settings is also growing and becoming more diverse.
- The types of integrated care services provided in these settings and disease-specific interventions are also increasing and differentiating.
- Under the current funding structure, integrated care services are not self-sustaining. Most financial support for integrated care services comes from grants (78 percent) with only 21 percent of the costs being covered by collecting revenue from providing the services.

The survey also verifies there are many obstacles to sustaining integrated care in Colorado — the most common being service providers are not easily able to bill for the integrated case services they deliver. Key billing obstacles include:

- Confusion about same-day billing for medical and behavioral health services
- Lack of access to Health and Behavior Assessment codes
- Heavy administrative burden for billing physical health and behavioral health services separately
- Poor fit between integrated care services and traditional fee-for-service billing
- Lack of infrastructure for billing for behavioral health services among medical clinics.

A number of potential solutions were highlighted, most of which mirror the obstacles. These include:

- Allowing access to same-day billing of medical and behavioral health services
- Reimbursement for Health and Behavior Assessment codes
- Moving away from fee-for-service models and toward global funding strategies such as the use of capitation rates, case rates and pay-for-performance
- Providing technical assistance to clinic staff regarding what is permitted in the current billing system to maximize billing and collections.

Description of Integrated Care Sites

Survey respondents reflect the full spectrum of integrated care in Colorado. The majority (87 percent) described settings where behavioral health services were integrated into primary care medical settings, with the remaining 13 percent reporting on a setting where primary care medical services were integrated into behavioral health settings.

Figure 1 shows the type of integrated care setting among the 56 integrated care sites.

Figure 1: Type of Integrated Care Setting

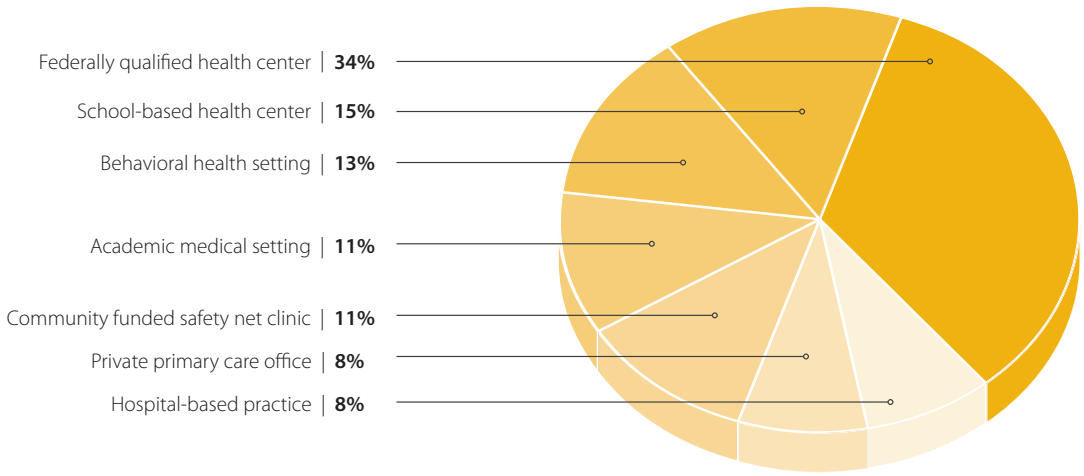
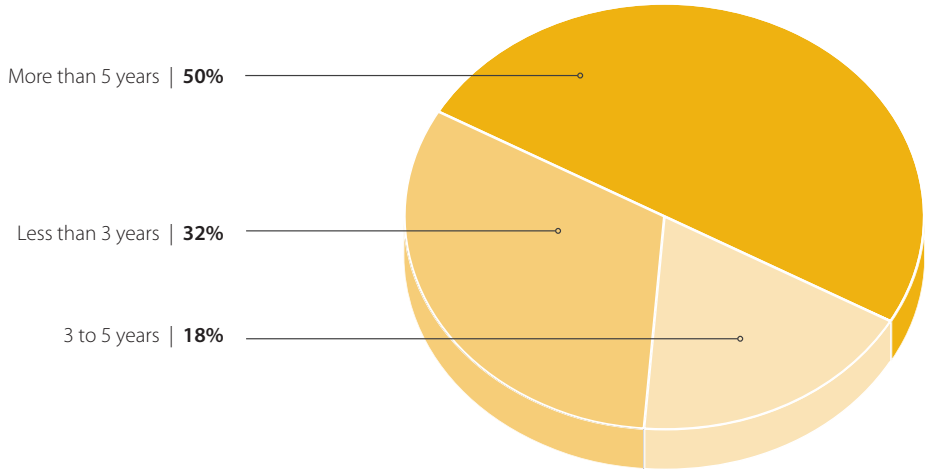


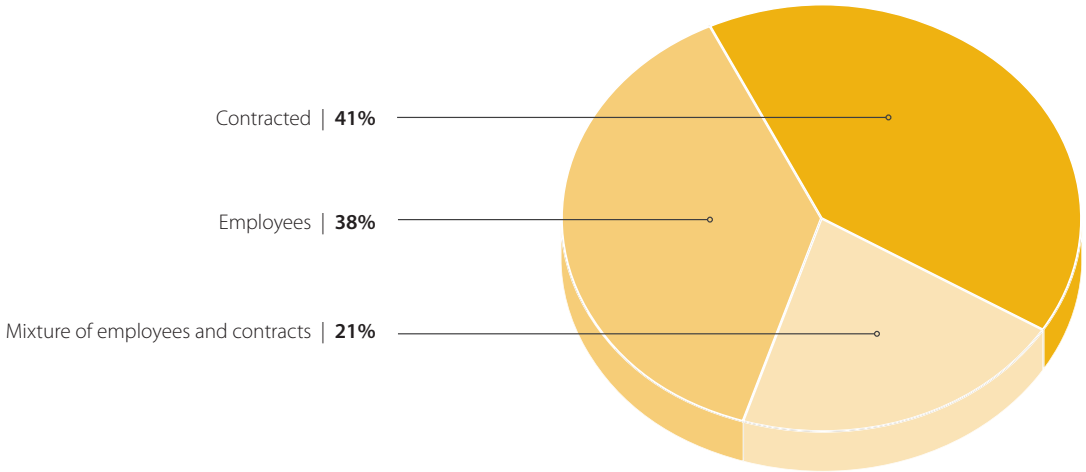
Figure 2 shows the number of years of experience providing integrated care services among the 56 integrated care sites responding to the survey. Half of the sites reported providing integrated care services for five years or longer.

Figure 2: Years Providing Integrated Care Services



Staffing arrangements for the integrated clinicians (behavioral health care providers integrated into primary care settings or primary care providers integrated into behavioral health care settings) were almost evenly split between hiring staff and contracting for services. A smaller percentage of sites used both approaches, as shown in Figure 3.

Figure 3: Staffing Arrangements for Integrated Clinicians



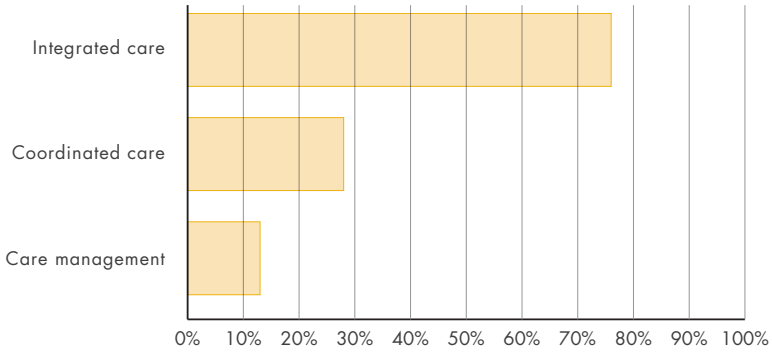
Because there are many different models for integrating medical and behavioral health services, respondents were asked to choose one or more descriptor(s) that best fits the model(s) of integration practiced at their sites.

The Options Provided:

- **Integrated care model** — A loosely integrated, on-site primary care and behavioral health team, providing services using a unified care plan. This model often involves organizational integration, sometimes including social and other services. A shared electronic health record is most often present.
- **Coordinated care model** — Behavioral health and primary care providers practice separately within their respective systems. Information regarding mutual patients may be exchanged as needed with appropriate releases signed. Collaboration can be limited outside of the initial referral. It is sometimes described as a "bidirectional referral and communication model."
- **Care management model** — A specific type of service providing assessment, intervention, care coordination and follow up, which is often disease-specific.

Most respondents (76 percent) selected "integrated care" as the model best describing the care provided at their site. See Figure 4.

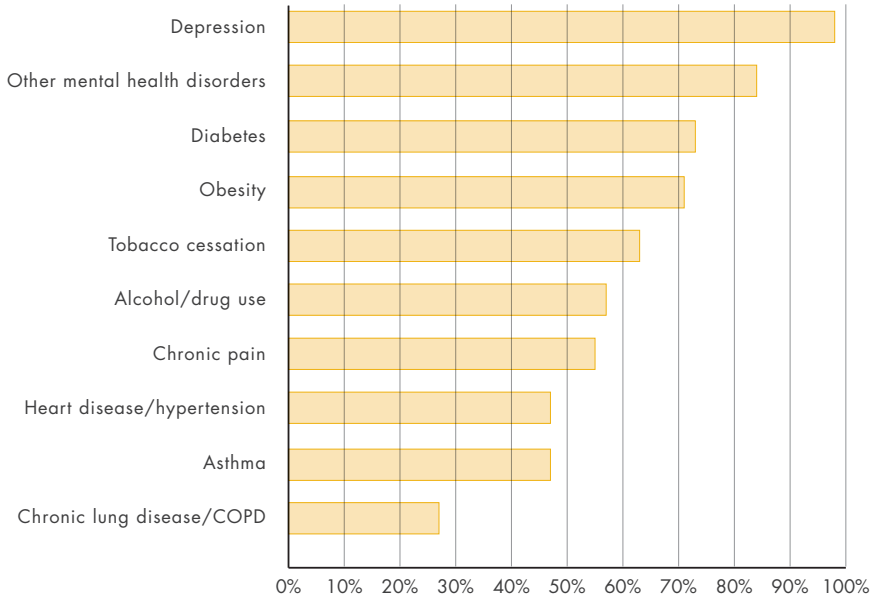
Figure 4: Model of Integration



Note: Survey respondents could select multiple options.

Nearly all sites surveyed offer integrated care programs that target specific illnesses, with 98 percent targeting depression among other easily identified illnesses. Figure 5 shows the distribution of targeted chronic conditions for integrated care programs among the sites surveyed.

Figure 5: Chronic Conditions Targeted at Integrated Care Sites



Note: Survey respondents could select multiple options.

While the majority of respondents described offering condition-specific integrated care programs, 70 percent of survey respondents stated that they had no revenue source to cover the costs of the aforementioned targeted services. Of the 30 percent who did receive targeted funds, 64 percent received fee-for-service funds, 21 percent received a care management fee and 14 percent used a fee-per-patient system.

Service Counts and Demographics

The size of integrated care sites and number of services varied widely between survey respondents. For example, the average number of services offered site-wide varied from 100 per month to almost 31,000 per month (together, the sites averaged 3,738 per month). More specific to integrated care, the average number of behavioral health services offered per month varied from 15 to 3,000 (together, the sites averaged 337 behavioral health visits per month). There was a similarly wide variability in the number of joint appointments in which both a medical and behavioral care provider saw the same patient during at least part of the same appointment — with monthly averages varying from 0 to 1,000 (the collective average was 85). Calculated differently, these data indicate that nine percent of patient visits were provided by a behavioral health professional and two percent of patient visits were scheduled as joint appointments — appointments with both a primary care and behavioral health provider.

Average demographic characteristics of surveyed sites include:

Figure 6: **Gender:**

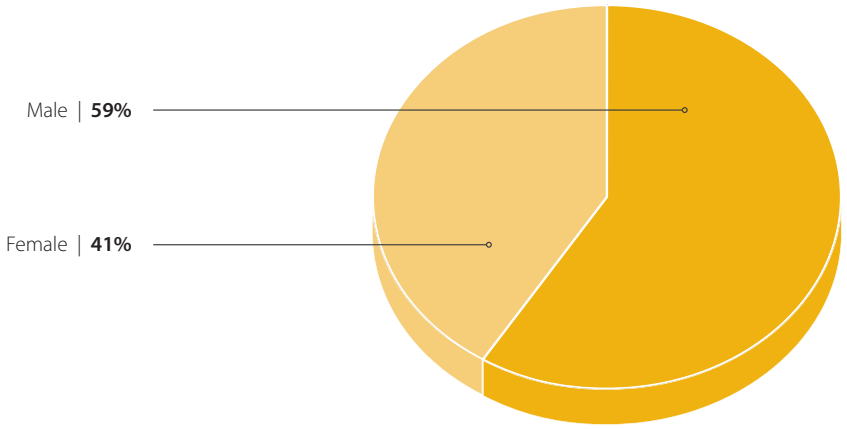


Figure 7: **Age:**

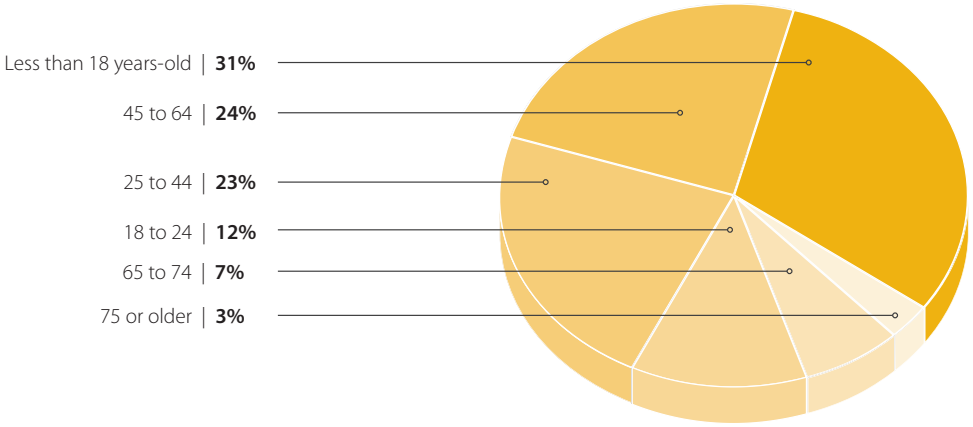


Figure 8: Payer distribution:

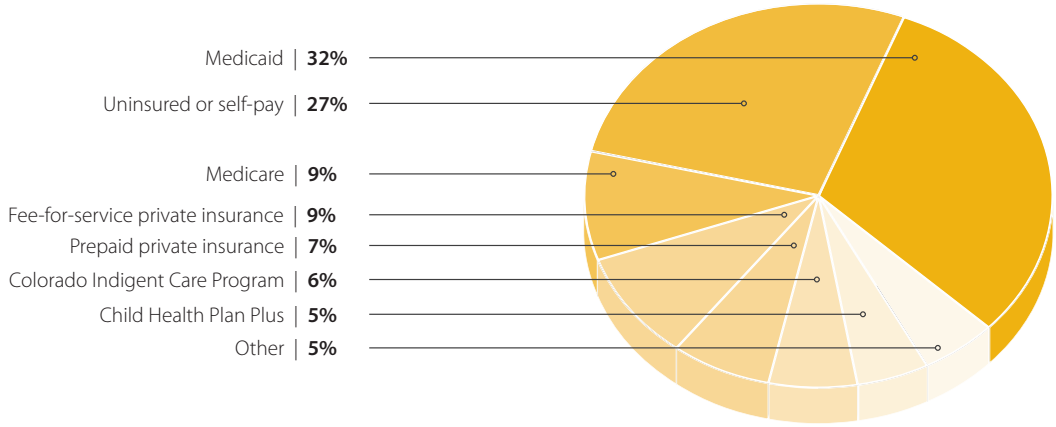
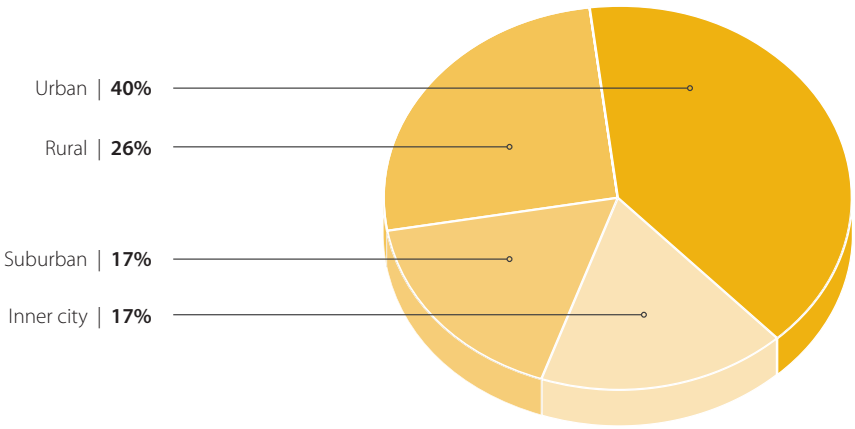


Figure 9: Geographic distribution of sites:

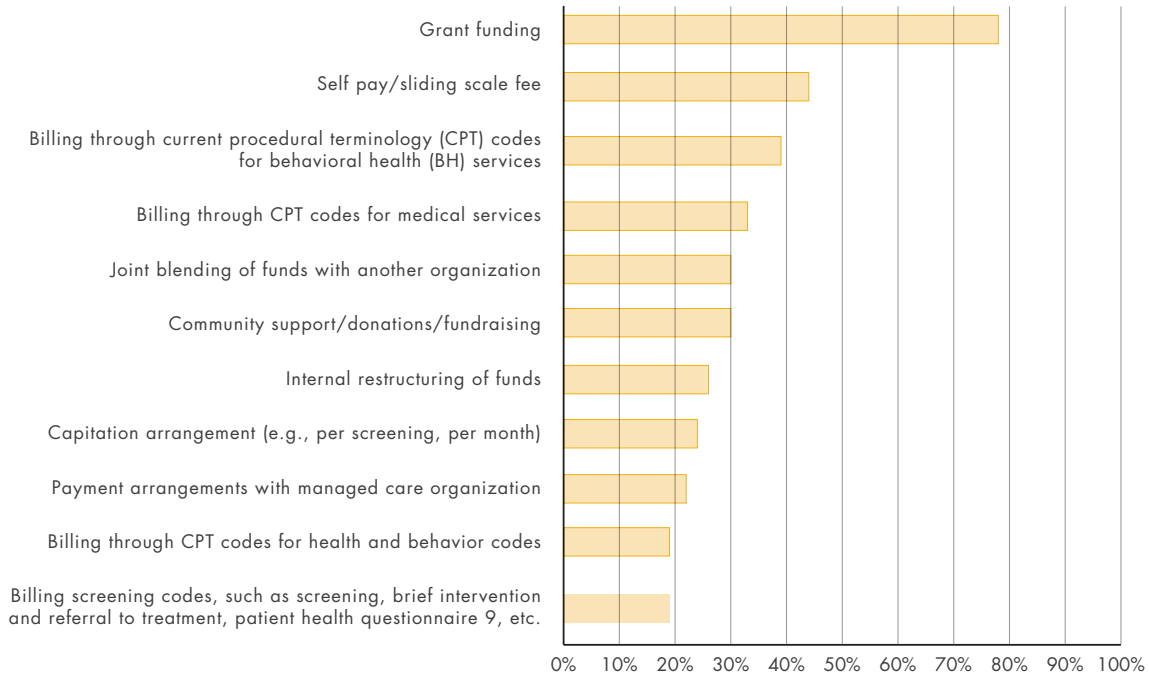


Funding Integrated Care

There was a wide disparity in the sources of funds for financing integrated care services. Respondents were given a list of different sources of funds. Grants were clearly the most common source of revenues with 78 percent of the sites receiving grant funds to support their integrated services. The next most frequent funding source was patient self pay or sliding scale fee at 44 percent.

Figure 10 shows the percentages of the all sources of funds that were cited by 5 percent or more of the sites.

Figure 10: Sources of Funds for Integrated Care Services

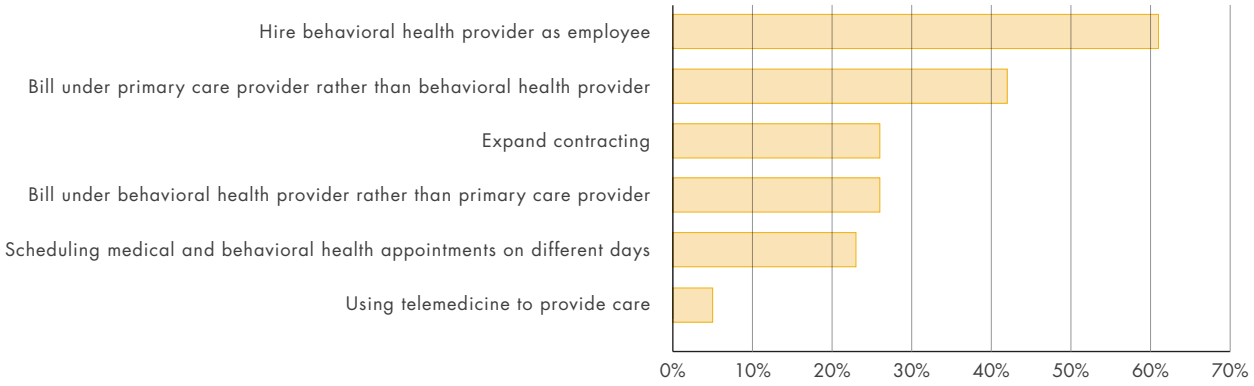


Note: Survey respondents could select multiple options.

The funding sources described in Figure 10 were simplified into three categories (clinic revenues, grant funds and absorbing the costs without revenue). On average, the respondents indicated that 47 percent of the costs are covered through grant funds, 32 percent are covered by writing off the costs entirely. Only 21 percent of the participants reported the costs associated with integrated care are covered by actual revenue generated by the services themselves.

Responding sites implemented a number of "work-arounds" to develop additional support for integrated care services, as shown in Figure 11. These "work-arounds" are not sources of revenue, but rather operational and financial practices that support the delivery of integrated care services.

Figure 11: "Work-arounds" that Make Integrated Care More Financially Viable



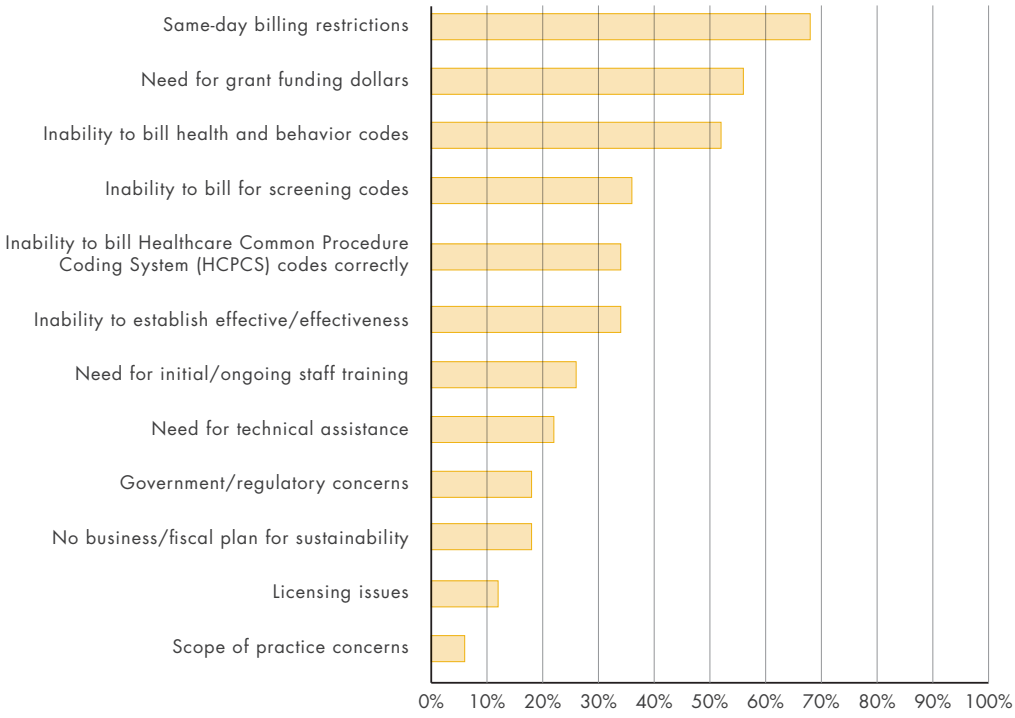
Note: Survey respondents could select multiple options.

Clinics listed other types of "work-arounds," such as writing off all expenses in the belief that the services will reduce cost in other areas; writing off expenses as a training cost; soliciting community donations and participating in shared billing arrangements between medical and behavioral health providers.

Funding Obstacles and Solutions

Respondents were asked to identify which funding obstacles impacted their site. Three obstacles were listed by more than 50 percent of the respondents: same-day billing restrictions (68 percent); the need for grant funding dollars (56 percent); and the inability to bill health and behavior codes (52 percent). Figure 12 shows the distribution of these responses among the respondents.

Figure 12: Funding Obstacles

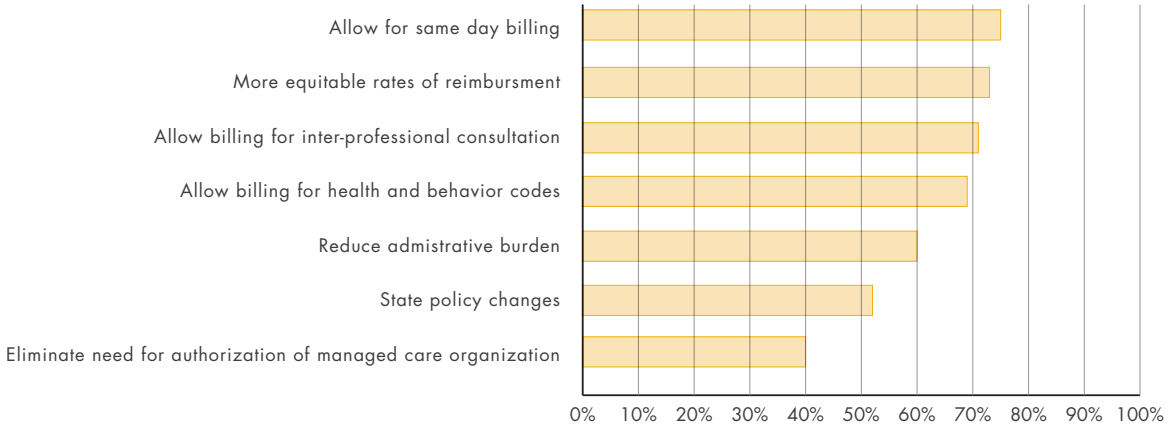


Note: Survey respondents could select multiple options.

A number of funding obstacles were related to billing. Survey respondents reported that submitting separate bills for medical and behavioral services increases administrative time and costs. Additionally, there is confusion and uncertainty regarding what services can be billed on the same day by different providers (primary care and behavioral health) who work with the same patients in the same site.

Similar results were found when participants made recommendations to solving the obstacles to financially sustaining integrated services, as shown in Figure 13:

Figure 13: Funding Solutions



Note: Survey respondents could select multiple options.

Other proposed solutions included eliminating the Medicaid carve-out for behavioral health services (Behavioral health services, in both Medicaid and most commercial plans, are separate or "carved-out" from physical health and paid under a different arrangement), creating integrated care-specific billing codes, using pay-for-performance incentives and allowing billing for clinicians-in-training.

Appendix B: PICS Interview Results

This appendix focuses on interviews of primary care and behavioral health providers and administrative staff at integrated care sites in Colorado regarding the challenges they face implementing the integrated care model. Participants who took part in the interviews also completed an online survey.

In total, 44 participants who work in a variety of integrated care settings were interviewed. The participants represented 29 of the 56 integrated care sites from the initial online survey. Sites volunteered for participation in the in-depth interviews.

Sites interviewed included: school-based health centers; pediatric clinics; hospital-based family residency programs; several metro and rural safety net clinics for the uninsured and underinsured; Federally Qualified Health Centers (FQHCs); community mental health centers (CMHCs); a university-based substance abuse treatment organization; a low-income geropsychology clinic; a large managed care provider and a university-based family practice clinic.

The diversity of sites accounted for substantial differences in the way integrated care services are organized, delivered and financed. Participants shared a strong depth of experience — more than 90 percent of those interviewed had more than three years in integrated care practice. The majority of those in primary care sites spoke of the inclusion of behavioral health care services now "being a necessity" for delivery of effective care services and that integrated care services "were the only way we will deliver care in the future." A few organizations defined primary care, behavioral health and oral health as the "essential components of the three-legged stool" that needed to be in place to deliver effective integrated care services — especially for populations served by safety net providers.

These interviews provided a wealth of knowledge that is difficult to obtain in other ways, though it should be noted that this analysis is qualitative in nature and subject to knowledge of and information shared by site interviewees.

Defining Integrated Care Services

Interviewees generally concurred on the basic definition of "integrated care services." This definition, provided by one of the participants, captures the essence of how most participants defined integrated care: "primary care and behavioral health care delivered to one individual or family in a team-based setting with open collaboration and appropriate sharing of information to achieve a coordinated, outcome-focused plan of care." Health self-management goals, set in partnership with the person/family being served, were also considered a key part of that shared definition. This type of care delivery was often considered the organizational mission for most of the interviewees, with acknowledgment that there are many challenges to achieving this goal.

Shared Challenges

Shared challenges identified by participants included:

- **Fostering a transformation/culture change within organizations** — To bring primary care and behavioral health providers together to form a care team, understanding what each team member does and how that can contribute to an effective patient outcome.
- **Developing a shared electronic health record** — Where primary care and behavioral health information could be stored and easily accessed.
- **Maintaining a clear delineation** — Of how integrated care services are organized, supervised and accounted for clinically, operationally and financially.
- **Building strong leadership** — Among the clinical, operational and financial staff from the care delivery level to the senior management team.
- **Delivering integrated care services in a patient-centered way** — Emphasis is on delivering integrated care services in a location most conducive for the individual/family receiving services, while eliminating barriers for access to care, such as transportation, child care, cost, etc.
- **Adjusting to the unique physical setting of different sites (whether primary care or behavioral health)** — Exam rooms can present unique challenges for utilization of space for behavioral health professionals. Behavioral therapy rooms are not equipped with sinks and exam tables which primary care providers need to do their job and to be in compliance with regulatory standards.

Expenditures and Costs

Expenses related to the implementation of integrated care services were relatively consistent across most organizations. Costs were defined as: salary and benefits; initial and ongoing training; electronic health record/electronic medical record expense (including customization of information technology and training); physical site modification expenses; billing expenses; office space/supplies and clinical supervision.

There were no significant differences noted among fixed, variable and ongoing costs. Startup costs focused mostly on salary and benefits, training and physical site modifications (if undertaken at time of implementation). Startup costs were often covered by grant funding from private foundations, community assistance, federal expansion grants, etc.

As primary care providers begin to locate in behavioral health sites, there are additional costs for ensuring that the worksite can accommodate physical health care (e.g., lab equipment onsite, tile floors and surfaces that can be easily sanitized and cleaned, sinks in room, etc.).

Workforce and Service Delivery

Most primary care and behavioral health professionals working in integrated care settings are direct-hire employees (either to the primary care site, the behavioral health site or a combination of both). Most organizations contracted for psychiatric services on an hourly basis because psychiatrist time is expensive and difficult to access in many areas.

A number of integrated care service partnerships host a behavioral health provider from a community mental health center (CMHC) within the primary care site. Benefits noted in such partnerships include access to onsite behavioral health services with licensed mental health professionals and easier referral to services at the CMHC site. Some concerns expressed by the primary care sites related to the supervision of the behavioral health professional on site, with primary care practices wanting greater ability to direct how the behavioral health professionals used their time. There also were challenges with duplicate documentation in primary care and CMHC charts.

Wide variances were noted in how these partnerships were organized and funded — ranging from close working partnerships in which funds were intermingled and shared to a co-located model with limited interface. Notably, in kind donations of space and resources were more common than not across both primary care and behavioral health sites.

A large number of programs used a wide variety of training programs to provide services and deliver care. The most common program offered family residency training, post-doctoral psychology placements and master's level internships in social work and counseling. Several sites suggested that it would benefit the financial sustainability of their organizations if they could bill for student services provided at a lower rate.

Lastly, some primary care organizations hire their own behavioral health employees to deliver integrated care services. Most positions are full time with flexible work schedules. All levels of mental health licensure were found at these organizations. It was noted by several respondents that the specific professional discipline was not nearly as important as the person's ability to be flexible and to embrace and consistently practice the principles of integrated care. Interviewees spoke of the need to develop a clinically sound workforce and the ability to deliver care in a time-efficient, fiscally sound and quality-driven manner.

Current Funding of Integrated Care Services

New revenues for the delivery of integrated care services were rare and did not adequately cover the costs of services. Most of those interviewed spoke of the enhanced quality of care and collaborative team outcomes for the patient and their family as the first level results. Many were hopeful that this improved care experience might result in fiscal savings by providing cost offset with more expensive levels of care and greater patient engagement into their treatment experience.

Billing and Coding

The review of Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and use of other codes for billing produced some unanticipated results. Primary care evaluation and management (E & M) codes were commonly used by medical providers eligible to bill for them.

Codes 99201 – 99205 (new patient, any age) and 99211 – 99215 (established patient, any age) were used for general office visits when the patient had a presenting issue/problem. Codes 99381 – 99387 (new patient) and 99391 – 99397 (established patient) were used for preventive medicine visits. Most primary care organizations prefer billing under the E & M umbrella — because of higher rates of reimbursement and fewer challenges in getting paid. For the behavioral health organizations trying to bill physical health services, the challenge was great, as there was little understanding of and familiarity with the codes that needed to be billed.

Behavioral health services were billed by behavioral health professionals under the standard psychotherapy codes. The most common ones used were 90801(assessment), 90804 (individual psychotherapy), 90806 (individual psychotherapy), 90847 (family therapy) and 90853 (group therapy), with 90862 for medication management by a psychiatrist, clinical nurse specialist or physician's assistant. The majority of organizations interviewed were not billing under the standard psychotherapy codes for services in primary care sites. The reasons listed include:

- **Billing for behavioral health services is labor-intensive with low reimbursement rates received** — One organization found that after the cost of labor and time was factored in, the average reimbursement was approximately $11 per service on average. To defray these costs, the organization charged their patients a flat rate fee of $10 for services up to a half hour and $20 for services up to one hour. A representative for the organization stated the fee improved access to care and removed barriers for patients. However, the flat fee still came nowhere near covering the actual cost of the care delivered.
- **Billing for "carved-out" behavioral health services is challenging** — Behavioral health services, in both Medicaid and commercial services, are separate or "carved out" from physical health and paid under a different arrangement. Becoming a provider in various behavioral health networks is often challenging, along with inconsistent billing practices between different organizations.
- **Retrofitting billing systems for new disciplines within organizations/agencies were costly** — Some organizations which dedicated a great deal of resources to the process were billing in a relatively seamless manner. However, representatives for these organizations maintained that it took much perseverance, time and money to get to that point.
- **Organizations with Community Mental Health Center employees onsite, in combination with their own internal behavioral health employees, expressed concerns about the complexity of managing these employees** — Primary care sites that bill Medicaid for behavioral health services need to maintain behavioral health staff as separate, credentialed providers under the behavioral health organization (BHO). As delineated earlier, this was not always feasible for a variety of reasons. Such arrangements are challenging to oversee and negotiate in the day-to-day delivery of services.
- **Medicare billing only allows reimbursement for behavioral health services by licensed psychologists and social workers (and not for licensed marriage and family therapists, licensed professional counselors, or any clinician without a license)** — In short, Medicare has a complex and restrictive billing system for behavioral health services.
- **Copayments for behavioral health services are not on parity with physical health care** — Behavioral health copayments are often higher than copayments for primary physical health care. In some cases (such as shortened sessions), the copayments cost more than the actual session reimbursement itself.

Health and Behavior Assessment Codes (96150-96155) are generally not being paid by insurance plans. Colorado Medicaid currently does not pay for these codes. Commercial plans rarely cover these codes (when they do, it's usually when a licensed psychologist renders the services). Several interviewees indicated they felt the use of these codes was often more appropriate in integrated care practice, rather than a psychiatric diagnosis code. Health and Behavior Assessment codes represent services that can be offered to patients with established illnesses or symptoms or who are not diagnosed with a mental illness and may benefit from evaluations and treatments focused on biopsychosocial factors related to their physical health status. Services typically offered focus on patient adherence to medical treatment, symptom management, health-promoting behaviors, health-related risk-taking behaviors and overall adjustment to illness. Sites indicated that these codes more realistically describe their interventions and the purpose of their integrated care services.

Screening, Brief Intervention and Referral to Treatment (SBIRT) screening and billing for substance abuse was inconsistently done across the interview sites. A large number of representatives for these sites described lack of substance-abuse oriented skill sets and competencies in their integrated care team as being one of their substantial deficits. Pain management, drug seeking patients, benzodiazepine use and dependency and alcohol use and dependence also were among the challenges cited. Many practices described solid practitioner competency in mental health, but not in substance abuse. SBIRT billing and reimbursement was not clearly understood by most organizations.

Joint Funding of Integrated Care Services

Funding of integration services through funds being blended with another organization, capitation (set amount per health plan member), case rates, episode of care payments, shared risk arrangements or pay for performance were almost nonexistent. The only capitation contracts noted were the CMHCs, who are capitated to provide services by the Behavioral Health Organizations under the current Medicaid behavioral health contract. As mentioned before, a few highly evolved integrated care sites shared funds for services, but those arrangements were not the norm.

Grant Funding Provides Short-term Fix

Interim solutions for funding integrated care included tapping into an organization's reserve funds with hopes of offsetting costs with other operational expenditures. Other interviewees suggested seeking grant opportunities from non-traditional sources, such as advocacy organizations, membership organizations, etc. Grant funding was a large part of the dollars needed to develop, implement and sustain integrated care services. Many expressed concerns that integrated care is built and sustained on grant dollars, creating a "house of cards" for integrated care funding that could easily tumble down. For the most part, interview participants concurred that integrated care services are financially unsustainable in the current environment.

The Benefits of Integrated Care

Despite financial and organizational challenges, many interviewees maintain that integrated care remains "the best way to deliver care services." Combining behavioral health and primary care services was almost universally hailed by participants as "the right thing to do" and an effective approach for delivering care services.

Benefits realized through integrated care programs were almost all anecdotal in nature — especially in regards to offsetting costs. A majority of those interviewed felt there was some cost offset realized in areas that couldn't be

substantiated or defined. Interviewees expressed a strong interest in measuring the cost offset and demonstrating financial value in their integrated care work.

Provider and patient satisfaction in integrated care settings was represented as anecdotal. Primary care and behavioral health providers were described as "much happier" working in integrated care settings and felt supported in the work they did with patients. A representative for one organization described a tough financial time, where layoffs were being considered. Several of the primary care staff came forward, offering to be laid off, so that the organization could retain their behavioral health professionals. The majority of interviewees indicated that providers would not return to working in a non-integrated care setting. Patient satisfaction was often described through glowing comments on patient satisfaction surveys. Patients liked "getting care in one place" and often indicated a preference for care in their designated primary care site. Interviewees also noted that patients avoid the "stigma" of seeking behavioral health services in an integrated care setting.

Participants also said integrated care fostered improved adherence to care plans and increased stability of patient health. Interviewees indicated their patients were "getting better" under the integrated care model with "less stress on providers" and "more common engagement in care planning."

Assistance and Training Needs

Many of the interviewees expressed their organizations could benefit from more technical assistance to effectively implement integrated care services. Suggestions included:

- Data warehousing, including data analytics and reporting
- Cost offset modeling
- Fiscal reimbursement, including billing, coding and setting up effective, efficient billing systems
- Best practices in integrated care
- Setting up a practice/clinic to deliver an efficient integrated care system
- Funding models, with risks/benefits explained

Interviewees were interested in additional training in the clinical, operational and financial aspects of integrated care. The ongoing challenge of workforce development and staff turnover also was identified as a concern, with the cost and financial sustainability of providing training as the primary concern. Some interviewees reported they were comfortable with their integrated care programs and operational systems and did not need additional technical assistance or training.

Governmental and Regulatory Concerns

Interviewees expressed concerns about a number of governmental and regulatory issues pertaining to integrated care, including:

- Sharing clinical information between primary care and behavioral health, especially in an electronic health record (EHR)
- The legality of billing for a physical health and behavioral health visit on the same day, with questions regarding "unintended consequences" of billing for two visits in one day, such as double copayments, etc.
- Licensing issues for sites; such as need for dual licensure (mental health, substance abuse, etc.)
- Efficient documentation for integrated care services, such as elimination of the Colorado Client Assessment Record (CCAR)

Exploring Different Funding Models

Nearly all interviewees were open to different funding strategies, including pay-for-performance, capitation and case rate models — or, at least in learning more about them. However, some participants noted that pay-for-performance indicators need to be aligned with actual, achievable practices and accompanied by real-time data availability and analysis.

Appendix C: Integrated Care in Other States

In exploring how to make integrated care financially sustainable in Colorado, Promoting Integrated Care Sustainability analyzed how other states are responding to the challenges and opportunities presented by this promising model of primary health care delivery. The analysis included interviews with stakeholders in California, Maine, Tennessee and Texas, which have advanced integrated care policies and practices.

The PICS project team developed a standard set of questions for each state, but quickly learned it was difficult for those interviewed to directly respond to a pre-determined format because of the variation in state health care systems and models for implementing integrated care.

Findings from this analysis informed specific recommendations to move Colorado toward financial sustainability of integrated care services.

In conducting the interviews, the project team met with the following integrated care stakeholders:

- State health agency representatives (Texas and Maine)
- Foundations (Texas and Maine)
- Physical and behavioral health providers (Maine and Tennessee)
- Quality assurance/advocacy organizations (California and Maine)
- Integrated health care delivery networks (Maine)

Common Themes

Despite vast geographic and cultural differences, universal themes were common to each of the states regarding integrated care:

- State dollars are dwindling for delivery of health care services combined with pressure to provide services more efficiently and effectively.
- Integrated care services are increasingly recognized as the preferred infrastructure for the care delivery system, especially with the evolution of the Patient Centered Medical Home and the Accountable Care Organization.
- State agencies for mental health, substance use and physical health are more often separate, with strong initiatives underway to integrate and build collaboration. In some states, the agencies remain separate, but are under a single state authority for specific functions, such as Medicaid.
- Different types of provider organizations (e.g., Federally Qualified Health Centers and community mental health centers) are working more closely together for greater infrastructure and administrative efficiencies.

- Carve-outs, meaning separate delivery and payment systems for physical health and behavioral health, are often seen as a challenge to the financing of fully integrated, person-centered care.
- Technical assistance in building the infrastructure for integrated care, along with a need for integrated care workforce development, were identified as substantial concerns in building an effective system of care.

Key Lessons

The following lessons emerged from discussions and site visits with other states:

- **Fee-for-service models have inherent infrastructure problems in effectively delivering integrated care services** — The focus on paying for volume of services, rather than on the value of the services, does not support aligned financial and quality outcome incentives across physical and behavioral health systems. Several states are using fee for service coding, specifically for Health and Behavior Assessment Codes and for same day billing, as a transitional strategy to move to global funding payment mechanisms.
- **Incentives must be aligned to ensure collaboration, while assessing and rewarding high quality care** — Infrastructure service delivery redesign needs to engage providers in collaborative payment reform strategies, with primary care and behavioral health as equal partners in solving challenges such as health information technology, data standards and communication.
- **Statewide data networks to collect and report on all aspects of integrated care are needed** — This involves the need for consistent definitions and data use elements to be set for electronic health records, fiscal reporting and quality indicators. Data is needed on all levels to make solid, informed decisions, ranging from provider to policy to payer.
- **Policy issues related to integrated care need strong leadership and focus at the state level** — Legislative and policy initiatives in integrated care encompass a wide variation (e.g., medical home standards to opiate prescribing/oversight to workforce development) and need dedicated oversight to ensure a clear focus and direction.
- **Aligning forces for quality improvement in health care across employers, government and not for profit entities with a focus on universal measurement for integration, performance, utilization and quality is desired** — Using specific standards as core expectations, such as Patient Centered Medical Home elements, can assist in that process.
- **Technical assistance and training is needed for providers, along with the development of learning communities, to share best practices in fiscal sustainability and infrastructure development.**

State Highlights

The Colorado PICS project team reached out to integrated care leaders in four states to learn about efforts to integrate primary physical health care and behavioral health care services. These discussions revealed other states are experiencing similar challenges as Colorado and are working to implement a variety of policies and practices to move toward financial sustainability of integrated care services.

California

Integrated care initiatives discussed: Integrated Behavioral Health project; Community Clinics Initiative
Policies and practices highlighted:

- Proposition 63 (1 percent tax on millionaires) passed in 2004. Created a state funding source for training and technical assistance for primary care and behavioral health integration to occur. Degree to which it is occurring is highly variable and dependent on county leadership.
- California Institute for Mental Health developed series of billing training sessions to assist integrated care sites.
- Community Clinics Initiative will fund up to seven integrated care partnerships that will also explore development of alternative payment strategies and reforms that will incentivize the implementation and sustainability of integrated health care.
- Recent renewal of Center for Medicare and Medicaid Services 1115 waiver has enabled counties to finance integrated care services at the local level, subject to local county discretion.
- Medicaid opened Health and Behavior Assessment codes to allow behavioral health providers to bill for non-psychiatric diagnoses.

Resources:
Proposition 63-Mental Health Services Act – www.dmh.ca.gov
California Institute for Mental Health – www.cimh.org
Community Clinics Initiative – www.communityclinics.org
Integrated Behavioral Health Project – www.ibhp.org

Maine

Integrated care initiatives discussed: Maine Health Access Foundation; Maine Department of Health and Human Services
Policies and practices highlighted:

- MaineHealth developed a billing and payment guide for integrated care practices. Maine Health Access Foundation (MeHAF), through a contract with MaineHealth, provides training sessions and on-site technical assistance related to reimbursement and licensure issues for practices interested in integrating behavioral health and primary care.
- Primary care providers are testing different ways to contract with behavioral health clinicians to ensure the right level of expertise and service.
- More than 100 sites in Maine now integrate care, including specialty care.
- Through MeHAF support, integrated care is a core element of the patient-centered medical home pilot. It is also being incorporated into developing Accountable Care Organizations and other payment reform initiatives.

- MeHAF and the Maine Primary Care Association are working with the Health Research and Services Administration to fully implement integrated care into all federally qualified health centers in the state.
- Same-day billing under Medicaid for medical and behavioral health services provided during a single appointment is allowed.
- Medicaid opened Health and Behavior Assessment codes to allow behavioral health providers to bill for non-psychiatric diagnoses.

Resources:
MaineHealth Mental Health Integration – www.mainehealth.org
Maine Integrated Health Initiative – www.mehaf.org

Tennessee

Integrated care initiatives discussed: Cherokee Health Systems
Policies and practices highlighted:

- Cherokee Health Systems provides care and services in 18 counties. Cherokee began as a community mental health center (CMHC), started providing primary care as part of the care model in 1984 and subsequently became an federally qualified health center (FQHC) while remaining a CMHC as well. Other CMHCs have moved to the model of building primary care and obtaining FQHC status.
- Same-day billing under Medicaid for medical and behavioral health services provided during a single appointment is allowed
- Medicaid opened Health and Behavioral Assessment codes to allow behavioral health providers to bill for non-psychiatric diagnoses.

Resources:
Cherokee Health Systems – www.cherokeehealth.com

Texas

Integrated care initiatives discussed: Texas Department of Health and Human Services; Hogg Foundation for Mental Health
Policies and practices highlighted:

- In 2009, the state legislature passed House Bill 2196 to form a work group to recommend best practices in policy, training and service delivery to promote the integration of health and behavioral health services in Texas. The work group submitted a report in the state legislature in 2011 which includes a summary of financial barriers to integrated care.
- The Hogg Foundation funded an integrated care financing worksheet and hosted a webinar to launch the dissemination of the worksheet.
- Same-day billing under Medicaid is allowed, but is not allowed in the federally qualified health centers.
- Medicaid opened Health and Behavioral Assessment codes to allow behavioral health providers to bill for primary care diagnoses.

Resources:
Integration of Health and Behavioral Health Workgroup Report – www.hhsc.state.tx.us
Integrated Health Financing Worksheet – www.hogg.utexas.edu

About Promoting Integrated Care Sustainability

In the spring of 2011, the Colorado Health Foundation and the Collaborative Family Healthcare Association launched Promoting Integrated Care Sustainability (or PICS); an effort to identify financial impediments to move integrated care to the mainstream of Colorado's health care system.

For more information about PICS, contact the project team at COPICS@ColoradoHealth.org

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About the Colorado Health Foundation

The Colorado Health Foundation works to make Colorado the healthiest state in the nation by increasing the number of Coloradans with health insurance; ensuring they have access to quality, coordinated care; and encouraging healthy living. The Foundation invests in the community through grants and initiatives to health-related nonprofits that focus on these goals, as well as operating medical education programs to increase the health care workforce. For more information, please visit www.ColoradoHealth.org.

About the Collaborative Family Healthcare Association

The Collaborative Family Healthcare Association (CFHA) promotes a comprehensive and cost-effective model of health care delivery that integrates mind and body, individual and family, patients, providers and communities. CFHA achieves this mission through education, training, partnering, consultation, research and advocacy. For more information, please visit www.CFHA.net

Acknowledgements

The Collaborative Family Healthcare Association and the Colorado Health Foundation would like to thank the members of the Promoting Integrated Care Sustainability project team and advisory board for their assistance and guidance on this project.

We also would like to thank individuals and organizations in the states of California, Maine, Tennessee and Texas who assisted us, including Mary Rainwater, Becky Boober, Dennis Freeman, Lynda Foster, Katherine Sanchez and Rick Ybarra.

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