

Table 1. Six Levels of Collaboration/Integration (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:
<ul style="list-style-type: none"> <li>▶▶ Have separate systems</li> <li>▶▶ Communicate about cases only rarely and under compelling circumstances</li> <li>▶▶ Communicate, driven by provider need</li> <li>▶▶ May never meet in person</li> <li>▶▶ Have limited understanding of each other's roles</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Have separate systems</li> <li>▶▶ Communicate periodically about shared patients</li> <li>▶▶ Communicate, driven by specific patient issues</li> <li>▶▶ May meet as part of larger community</li> <li>▶▶ Appreciate each other's roles as resources</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Have separate systems</li> <li>▶▶ Communicate regularly about shared patients, by phone or e-mail</li> <li>▶▶ Collaborate, driven by need for each other's services and more reliable referral</li> <li>▶▶ Meet occasionally to discuss cases due to close proximity</li> <li>▶▶ Feel part of a larger yet non-formal team</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Share some systems, like scheduling or medical records</li> <li>▶▶ Communicate in person as needed</li> <li>▶▶ Collaborate, driven by need for consultation and coordinated plans for difficult patients</li> <li>▶▶ Have regular face-to-face interactions about some patients</li> <li>▶▶ Have a basic understanding of roles and culture</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Actively seek system solutions together or develop work-a-rounds</li> <li>▶▶ Communicate frequently in person</li> <li>▶▶ Collaborate, driven by desire to be a member of the care team</li> <li>▶▶ Have regular team meetings to discuss overall patient care and specific patient issues</li> <li>▶▶ Have an in-depth understanding of roles and culture</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Have resolved most or all system issues, functioning as one integrated system</li> <li>▶▶ Communicate consistently at the system, team and individual levels</li> <li>▶▶ Collaborate, driven by shared concept of team care</li> <li>▶▶ Have formal and informal meetings to support integrated model of care</li> <li>▶▶ Have roles and cultures that blur or blend</li> </ul>

Table 2A. Six Levels of Collaboration/Integration (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					
<ul style="list-style-type: none"> <li>▶▶ Screening and assessment done according to separate practice models</li> <li>▶▶ Separate treatment plans</li> <li>▶▶ Evidenced-based practices (EBP) implemented separately</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges</li> <li>▶▶ Separate treatment plans shared based on established relationships between specific providers</li> <li>▶▶ Separate responsibility for care/EBPs</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ May agree on a specific screening or other criteria for more effective in-house referral</li> <li>▶▶ Separate service plans with some shared information that informs them</li> <li>▶▶ Some shared knowledge of each other's EBPs, especially for high utilizers</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Agree on specific screening, based on ability to respond to results</li> <li>▶▶ Collaborative treatment planning for specific patients</li> <li>▶▶ Some EBPs and some training shared, focused on interest or specific population needs</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Consistent set of agreed upon screenings across disciplines, which guide treatment interventions</li> <li>▶▶ Collaborative treatment planning for all shared patients</li> <li>▶▶ EBPs shared across system with some joint monitoring of health conditions for some patients</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place</li> <li>▶▶ One treatment plan for all patients</li> <li>▶▶ EBPs are team selected, trained and implemented across disciplines as standard practice</li> </ul>
Key Differentiator: Patient Experience					
<ul style="list-style-type: none"> <li>▶▶ Patient physical and behavioral health needs are treated as separate issues</li> <li>▶▶ Patient must negotiate separate practices and sites on their own with varying degrees of success</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Patient health needs are treated separately, but records are shared, promoting better provider knowledge</li> <li>▶▶ Patients may be referred, but a variety of barriers prevent many patients from accessing care</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Patient health needs are treated separately at the same location</li> <li>▶▶ Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers</li> <li>▶▶ Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others</li> <li>▶▶ Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ All patient health needs are treated for all patients by a team, who function effectively together</li> <li>▶▶ Patients experience a seamless response to all healthcare needs as they present, in a unified practice</li> </ul>

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

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: Practice/Organization					
<ul style="list-style-type: none"> <li>▶▶ No coordination or management of collaborative efforts</li> <li>▶▶ Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Some practice leadership in more systematic information sharing</li> <li>▶▶ Some provider buy-into collaboration and value placed on having needed information</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Organization leaders supportive but often colocation is viewed as a project or program</li> <li>▶▶ Provider buy-in to making referrals work and appreciation of onsite availability</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Organization leaders support integration through mutual problem-solving of some system barriers</li> <li>▶▶ More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced</li> <li>▶▶ Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development</li> <li>▶▶ Integrated care and all components embraced by all providers and active involvement in practice change</li> </ul>
Key Differentiator: Business Model					
<ul style="list-style-type: none"> <li>▶▶ Separate funding</li> <li>▶▶ No sharing of resources</li> <li>▶▶ Separate billing practices</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Separate funding</li> <li>▶▶ May share resources for single projects</li> <li>▶▶ Separate billing practices</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Separate funding</li> <li>▶▶ May share facility expenses</li> <li>▶▶ Separate billing practices</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Separate funding, but may share grants</li> <li>▶▶ May share office expenses, staffing costs, or infrastructure</li> <li>▶▶ Separate billing due to system barriers</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Blended funding based on contracts, grants or agreements</li> <li>▶▶ Variety of ways to structure the sharing of all expenses</li> <li>▶▶ Billing function combined or agreed upon process</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Integrated funding, based on multiple sources of revenue</li> <li>▶▶ Resources shared and allocated across whole practice</li> <li>▶▶ Billing maximized for integrated model and single billing structure</li> </ul>

Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

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
<b>Advantages</b>					
<ul style="list-style-type: none"> <li>▶▶ Each practice can make timely and autonomous decisions about care</li> <li>▶▶ Readily understood as a practice model by patients and providers</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Maintains each practice's basic operating structure, so change is not a disruptive factor</li> <li>▶▶ Provides some coordination and information-sharing that is helpful to both patients and providers</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Colocation allows for more direct interaction and communication among professionals to impact patient care</li> <li>▶▶ Referrals more successful due to proximity</li> <li>▶▶ Opportunity to develop closer professional relationships</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Removal of some system barriers, like separate records, allows closer collaboration to occur</li> <li>▶▶ Both behavioral health and medical providers can become more well-informed about what each can provide</li> <li>▶▶ Patients are viewed as shared which facilitates more complete treatment plans</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans</li> <li>▶▶ Provider flexibility increases as system issues and barriers are resolved</li> <li>▶▶ Both provider and patient satisfaction may increase</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Opportunity to truly treat whole person</li> <li>▶▶ All or almost all system barriers resolved, allowing providers to practice as high functioning team</li> <li>▶▶ All patient needs addressed as they occur</li> <li>▶▶ Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue</li> </ul>
<b>Weaknesses</b>					
<ul style="list-style-type: none"> <li>▶▶ Services may overlap, be duplicated or even work against each other</li> <li>▶▶ Important aspects of care may not be addressed or take a long time to be diagnosed</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Sharing of information may not be systematic enough to effect overall patient care</li> <li>▶▶ No guarantee that information will change plan or strategy of each provider</li> <li>▶▶ Referrals may fail due to barriers, leading to patient and provider frustration</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Proximity may not lead to greater collaboration, limiting value</li> <li>▶▶ Effort is required to develop relationships</li> <li>▶▶ Limited flexibility, if traditional roles are maintained</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ System issues may limit collaboration</li> <li>▶▶ Potential for tension and conflicting agendas among providers as practice boundaries loosen</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Practice changes may create lack of fit for some established providers</li> <li>▶▶ Time is needed to collaborate at this high level and may affect practice productivity or cadence of care</li> </ul>	<ul style="list-style-type: none"> <li>▶▶ Sustainability issues may stress the practice</li> <li>▶▶ Few models at this level with enough experience to support value</li> <li>▶▶ Outcome expectations not yet established</li> </ul>