<table>
<thead>
<tr>
<th>COORDINATED KEY ELEMENT: COMMUNICATION</th>
<th>CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY</th>
<th>INTEGRATED KEY ELEMENT: PRACTICE CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LEVEL 1</strong> Minimal Collaboration</td>
<td><strong>LEVEL 3</strong> Close Collaboration Onsite</td>
<td><strong>LEVEL 5</strong> Close Collaboration Onsite</td>
</tr>
<tr>
<td>In separate facilities, where they:</td>
<td>In same facility not necessarily same offices, where they:</td>
<td>In same space within the same facility (some shared space), where they:</td>
</tr>
<tr>
<td>Have separate systems</td>
<td>Have separate systems</td>
<td>Actively seek system solutions together or develop work-a-rounds</td>
</tr>
<tr>
<td>Communicate about cases only rarely and under compelling circumstances</td>
<td>Communicate regularly about shared patients, by phone or e-mail</td>
<td>Communicate in person as needed</td>
</tr>
<tr>
<td>Communicate, driven by specific patient issues</td>
<td>Collaborate, driven by need for each other’s services and more reliable referral</td>
<td>Collaborate, driven by need for consultation and coordinated plans for difficult patients</td>
</tr>
<tr>
<td>May never meet in person</td>
<td>Meet occasionally to discuss cases due to close proximity</td>
<td>Have regular face-to-face interactions about some patients</td>
</tr>
<tr>
<td>Have limited understanding of each other’s roles</td>
<td>Feel part of a larger yet ill-defined team</td>
<td>Have a basic understanding of roles and culture</td>
</tr>
<tr>
<td><strong>LEVEL 2</strong> Basic Collaboration at a Distance</td>
<td><strong>LEVEL 4</strong> Close Collaboration Onsite with Some System Integration</td>
<td><strong>LEVEL 6</strong> Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
<tr>
<td>In separate facilities, where they:</td>
<td>In same space within the same facility, where they:</td>
<td>In same space within the same facility, sharing all practice space, where they:</td>
</tr>
<tr>
<td>Have separate systems</td>
<td>Have separate systems</td>
<td>Have resolved most or all system issues, functioning as one integrated system</td>
</tr>
<tr>
<td>Communicate about cases only rarely and under compelling circumstances</td>
<td>Communicate regularly about shared patients, by phone or e-mail</td>
<td>Communicate consistently at the system, team and individual levels</td>
</tr>
<tr>
<td>Communicate, driven by specific patient issues</td>
<td>Collaborate, driven by need for each other’s services and more reliable referral</td>
<td>Collaborate, driven by shared concept of team care</td>
</tr>
<tr>
<td>May never meet in person</td>
<td>Meet occasionally to discuss cases due to close proximity</td>
<td>Have formal and informal meetings to support integrated model of care</td>
</tr>
<tr>
<td>Have limited understanding of each other’s roles</td>
<td>Feel part of a larger yet ill-defined team</td>
<td>Have roles and cultures that blur or blend</td>
</tr>
</tbody>
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# Table 2A. Six Levels of Collaboration/Integration (Key Differentiators)

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## Key Differentiator: Clinical Delivery

- **COORDINATED**
  - Screening and assessment done according to separate practice models
  - Separate treatment plans
  - Evidence-based practices (EBP) implemented separately

- **CO-LOCATED**
  - 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

- **INTEGRATED**
  - 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

## Key Differentiator: Patient Experience

- **COORDINATED**
  - 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

- **CO-LOCATED**
  - 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

- **INTEGRATED**
  - 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

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**Key Differentiator: Practice/Organization**

- No coordination or management of collaborative efforts
- Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow
- Some practice leadership in more systematic information sharing
- Some provider buy-in to collaboration and value placed on having needed information
- Organization leaders supportive but often colocating is viewed as a project or program
- Provider buy-in to making referrals work and appreciation of onsite availability
- Organization leaders support integration through mutual problem-solving of some system barriers
- More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components
- 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
- Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers
- Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development
- Integrated care and all components embraced by all providers and active involvement in practice change

**Key Differentiator: Business Model**

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

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

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### Advantages

- **COORDINATED**
  - Each practice can make timely and autonomous decisions about care
  - Readily understood as a practice model by patients and providers
- **CO-LOCATED**
  - Maintains each practice’s basic operating structure, so change is not a disruptive factor
  - Provides some coordination and information-sharing that is helpful to both patients and providers
- **INTEGRATED**
  - Removal of some system barriers, like separate records, allows closer collaboration to occur
  - Both behavioral health and medical providers can become more well-informed about what each can provide
  - Patients are viewed as shared which facilitates more complete treatment plans

- High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans
- Provider flexibility increases as system issues and barriers are resolved
- Both provider and patient satisfaction may increase
- Opportunity to truly treat whole person
- All or almost all system barriers resolved, allowing providers to practice as high functioning teams
- All patient needs addressed as they occur
- Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue

### Weaknesses

- **COORDINATED**
  - Services may overlap, be duplicated or even work against each other
  - Important aspects of care may not be addressed or take a long time to be diagnosed
- **CO-LOCATED**
  - Sharing of information may not be systematic enough to effect overall patient care
  - No guarantee that information will change plan or strategy of each provider
  - Referrals may fail due to barriers, leading to patient and provider frustration
- **INTEGRATED**
  - Proximity may not lead to greater collaboration, limiting value
  - Effort is required to develop relationships
  - Limited flexibility, if traditional roles are maintained

- System issues may limit collaboration
- Potential for tension and conflicting agendas among providers as practice boundaries loosen
- Practice changes may create lack of fit for some established providers
- Time is needed to collaborate at this high level and may affect practice productivity or cadence of care
- Sustainability issues may stress the practice
- Few models at this level with enough experience to support value
- Outcome expectations not yet established

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