

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

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"> ▶▶ Screening and assessment done according to separate practice models ▶▶ Separate treatment plans ▶▶ Evidenced-based practices (EBP) implemented separately 	<ul style="list-style-type: none"> ▶▶ 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 	<ul style="list-style-type: none"> ▶▶ 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 	<ul style="list-style-type: none"> ▶▶ Agree on specific screening, based on ability to respond to results ▶▶ Collaborative treatment planning for specific patients ▶▶ Some EBPs and some training shared, focused on interest or specific population needs 	<ul style="list-style-type: none"> ▶▶ Consistent set of agreed upon screenings across disciplines, which guide treatment interventions ▶▶ Collaborative treatment planning for all shared patients ▶▶ EBPs shared across system with some joint monitoring of health conditions for some patients 	<ul style="list-style-type: none"> ▶▶ Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place ▶▶ One treatment plan for all patients ▶▶ EBPs are team selected, trained and implemented across disciplines as standard practice
Key Differentiator: Patient Experience					
<ul style="list-style-type: none"> ▶▶ 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 	<ul style="list-style-type: none"> ▶▶ 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 	<ul style="list-style-type: none"> ▶▶ 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 	<ul style="list-style-type: none"> ▶▶ Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers ▶▶ Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services 	<ul style="list-style-type: none"> ▶▶ Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others ▶▶ Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop 	<ul style="list-style-type: none"> ▶▶ All patient health needs are treated for all patients by a team, who function effectively together ▶▶ Patients experience a seamless response to all healthcare needs as they present, in a unified practice

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"> » 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 	<ul style="list-style-type: none"> » Some practice leadership in more systematic information sharing » Some provider buy-into collaboration and value placed on having needed information 	<ul style="list-style-type: none"> » Organization leaders supportive but often colocation is viewed as a project or program » Provider buy-in to making referrals work and appreciation of onsite availability 	<ul style="list-style-type: none"> » 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 	<ul style="list-style-type: none"> » 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 	<ul style="list-style-type: none"> » 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					
<ul style="list-style-type: none"> » Separate funding » No sharing of resources » Separate billing practices 	<ul style="list-style-type: none"> » Separate funding » May share resources for single projects » Separate billing practices 	<ul style="list-style-type: none"> » Separate funding » May share facility expenses » Separate billing practices 	<ul style="list-style-type: none"> » Separate funding, but may share grants » May share office expenses, staffing costs, or infrastructure » Separate billing due to system barriers 	<ul style="list-style-type: none"> » 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 	<ul style="list-style-type: none"> » Integrated funding, based on multiple sources of revenue » Resources shared and allocated across whole practice » Billing maximized for integrated model and single billing structure

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
Advantages					
<ul style="list-style-type: none"> ▶▶ Each practice can make timely and autonomous decisions about care ▶▶ Readily understood as a practice model by patients and providers 	<ul style="list-style-type: none"> ▶▶ 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 	<ul style="list-style-type: none"> ▶▶ Colocation allows for more direct interaction and communication among professionals to impact patient care ▶▶ Referrals more successful due to proximity ▶▶ Opportunity to develop closer professional relationships 	<ul style="list-style-type: none"> ▶▶ 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 	<ul style="list-style-type: none"> ▶▶ 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 	<ul style="list-style-type: none"> ▶▶ Opportunity to truly treat whole person ▶▶ All or almost all system barriers resolved, allowing providers to practice as high functioning team ▶▶ 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					
<ul style="list-style-type: none"> ▶▶ 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 	<ul style="list-style-type: none"> ▶▶ 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 	<ul style="list-style-type: none"> ▶▶ Proximity may not lead to greater collaboration, limiting value ▶▶ Effort is required to develop relationships ▶▶ Limited flexibility, if traditional roles are maintained 	<ul style="list-style-type: none"> ▶▶ System issues may limit collaboration ▶▶ Potential for tension and conflicting agendas among providers as practice boundaries loosen 	<ul style="list-style-type: none"> ▶▶ 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 	<ul style="list-style-type: none"> ▶▶ Sustainability issues may stress the practice ▶▶ Few models at this level with enough experience to support value ▶▶ Outcome expectations not yet established