## Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

<table>
<thead>
<tr>
<th>COORDINATED</th>
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</tr>
</thead>
<tbody>
<tr>
<td>KEY ELEMENT: COMMUNICATION</td>
<td>KEY ELEMENT: PHYSICAL PROXIMITY</td>
<td>KEY ELEMENT: PRACTICE CHANGE</td>
</tr>
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<table>
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<tr>
<th>Behavioral health, primary care and other healthcare providers work:</th>
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<tbody>
<tr>
<td>In separate facilities, where they:</td>
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<tr>
<td>In separate facilities, where they:</td>
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<tr>
<td>In same facility not necessarily same offices, where they:</td>
</tr>
<tr>
<td>In same space within the same facility, where they:</td>
</tr>
<tr>
<td>In same space within the same facility (some shared space), where they:</td>
</tr>
<tr>
<td>In same space within the same facility, sharing all practice space, where they:</td>
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### COORDINATED
- 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

### CO-LOCATED
- 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

### INTEGRATED
- Share some systems, like scheduling or medical records
- Communicate in person as needed
- 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

- 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 face-to-face interactions about some patients
- Have a basic understanding of roles and culture

- Have resolved most or all system issues, functioning as one integrated system
- Communicate consistently at the system, team and individual levels
- Collaborate, driven by shared concept of team care
- Have formal and informal meetings to support integrated model of care
- Have roles and cultures that blur or blend

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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
  - Evidenced-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: CLINICAL DELIVERY**
  - 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

- **COORDINATED**
  - Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place

- **CO-LOCATED**
  - One treatment plan for all patients

- **INTEGRATED**
  - EBPs are team selected, trained and implemented across disciplines as standard practice

### 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

- **KEY DIFFERENTIATOR: PATIENT EXPERIENCE**
  - 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 a team of providers as needed, which feels like a one-stop shop

- **COORDINATED**
  - All patient health needs are treated for all patients by a team, who function effectively together

- **CO-LOCATED**
  - Patients experience a seamless response to all healthcare needs as they present, in a unified practice

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

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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 colocated 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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### Advantages

- Each practice can make timely and autonomous decisions about care
- Readily understood as a practice model by patients and providers
- 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
- 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
- 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 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

- 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
- 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
- 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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