A STANDARD FRAMEWORK FOR LEVELS OF INTEGRATED HEALTHCARE

SAMHSA-HRSA
Center for Integrated Health Solutions

ACKNOWLEDGEMENTS

SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

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Jointly funded by the HHS/Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration, and run by the National Council for Community Behavioral Healthcare, CIHS provides training and technical assistance to community behavioral health organizations that received Primary and Behavioral Health Care Integration grants, as well as to community health centers and other primary care and behavioral health organizations.

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ABSTRACT: Integration of healthcare is essential to improve the individual's experience of care, improve the health of the general population, and reduce per capita healthcare costs. The term "integration" is widely and inconsistently used to describe the bringing together of healthcare components. Integration has been used to reference everything from consultation to colocation to a setting of shared health values around treating the whole person, with blurred professional boundaries. There have been no fully updated taxonomies to describe the levels of integration since the 1996 Doherty, McDaniel, and Baird article, which initially proposed five levels of integration. Since this seminal issue brief and preliminary framework, there have been many informal and local adaptations. However without a standard classification of integrated settings, discussions of integration lack clarity and precision, and research cannot confidently examine discrete aspects of integration. This issue brief reviews levels of integrated healthcare and proposes a functional standard framework for classifying sites according to these levels.

KEY WORDS: integration; collaborative care; mental health; behavioral health; collaboration; healthcare

BACKGROUND

Over the last several years, as healthcare reform has taken a prominent national position and mental health and substance abuse treatments have evolved, an increasing number of articles have been written on collaboration and the integration of traditional primary care and behavioral health* practices (Butler, Kane, & McAlpine, 2008; Collins, Hewson, Munger, & Wade, 2010; Funk & Ivbijaro, 2008; Lopez, Coleman-Beattie, & Sanchez, 2008; Mauer, 2006, 2009; Mauer & Jarvis, 2010; Miller, Kessler, & Peek, 2011; Robinson & Reiter, 2007; Russell, 2010). These articles have described a wide variety of collaborative, co-located, and integrated service models.

Developing a standard framework to describe integrated efforts is critical for meaningful dialogue about service design, as well as for research. Until there is a way to reliably categorize integration implementations, meaningful comparisons of implementations or associated health outcomes cannot occur. This point is made throughout the Miller et al. 2011 paper, which calls for a broader "lexicon for the common terms and components for collaborative care so that research questions can be framed in a consistently understood manner" (p. 2). On the clinical side, integrated care developers and implementers will benefit from recognizing the characteristics of practice change that support evolving integration models. Knowing what features of integrated healthcare implementations lead to the most favorable and stable health outcomes will be an important contribution to the health field.

A standard framework also contributes to the orderly evolution of national healthcare reform and aligns with the political and service realities defined by Berwick, Nolan and Whittington (2008). Integration is essential to achieving the triple aim of improved experience of care, improved health of populations, and reduced per capita healthcare cost advocated by Berwick, et al. The lessons learned from a reliable comparison of models and implementations provide the best foundation to inform policy decisions on the structure of more effective healthcare as care integration moves forward.

LEVELS OF INTEGRATION

Doherty, McDaniel, and Baird (1995, 1996) proposed the first classification by level of collaboration and integration. They proposed the five levels of primary care-behavioral healthcare collaboration, recognizing that collaboration and integration of care were evolving and being communicated in wide-ranging ways. Doherty et. al.'s classification involved both the extent of the occurrence of collaboration and the capacity for collaboration in the setting, but they did not focus on specific interactions. An underlying premise of the levels was that as collaboration increased, the adequate handling of complex patients would also increase. The levels recognized by Doherty et al. did not prescribe a particular model as best for all healthcare settings, but rather served as a foundation from which to tease apart the strengths and limitations of a variety of

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This issue brief uses the term behavioral health to describe mental health and substance use.

options. It was proposed that use of the levels would help organizations evaluate their setting in light of their goals for collaboration and to assist in researching outcomes and costs associated with different collaborative models with different patient populations.

In the original framework, Doherty et al. differentiated levels by where they were practiced, the cases adequately handled at each level, and the following descriptions:

▸▸ **LEVEL 1– *Minimal Collaboration:*** Mental health and other healthcare providers work in separate facilities, have separate systems, and rarely communicate about cases.

▸▸ **LEVEL 2 – *Basic Collaboration at a Distance:*** Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. Providers view each other as resources.

▸▸ **LEVEL 3 – *Basic Collaboration Onsite:*** Mental health and other healthcare professionals have separate systems, but share facilities. Proximity supports at least occasional face-to- face meetings and communication improves and is more regular.

▸▸ **LEVEL 4 – *Close Collaboration in a Partly Integrated System:*** Mental health and other healthcare providers share the same sites and have some systems in common such as scheduling or charting. There are regular face-to-face interactions among primary care and behavioral health providers, coordinated treatment plans for difficult patients, and a basic understanding of each other's roles and cultures.

▸▸ **LEVEL 5 – *Close Collaboration in a Fully Integrated System:*** Mental health and other healthcare professionals share the same sites, vision, and systems. All providers are on the same team and have developed an in-depth understanding of each other's roles and areas of expertise.

The following chart summarizes these five levels of collaboration:

MINIMAL COLLABORATION	BASIC COLLABORATION FROM A DISTANCE	BASIC COLLABORATION ONSITE	CLOSE COLLABORATION/ PARTLY INTEGRATED	FULLY INTEGRATED
▸▸ Separate systems ▸▸ Separate facilities ▸▸ Communication is rare ▸▸ Little appreciation of each other's culture	▸▸ Separate systems ▸▸ Separate facilities ▸▸ Periodic focused communication; most written ▸▸ View each other as outside resources ▸▸ Little understand-ing of each other's culture or sharing of influence	▸▸ Separate systems ▸▸ Same facilities ▸▸ Regular communication, occasionally face-to-face ▸▸ Some appreciation of each other's role and general sense of large picture ▸▸ Mental health usually has more influence	▸▸ Some shared systems ▸▸ Same facilities ▸▸ Face-to-Face consultation; coordinated treatment plans ▸▸ Basic appreciation of each other's role and cultures ▸▸ Collaborative routines difficult; time and operation barriers ▸▸ Influence sharing	▸▸ Shared systems and facilities in seamless bio-psychosocial web ▸▸ Consumers and providers have same expectations of system(s) ▸▸ In-depth appreciation of roles and culture ▸▸ Collaborative routines are regular and smooth ▸▸ Conscious influence sharing based on situation and expertise
"Nobody knows my name. Who are you?"	*"I help your consumers."*	*"I am your consultant."*	*"We are a team in the care of consumers"*	*"Together, we teach others how to be a team in care of con-sumers and design a care system."*

These five levels have formed the foundation for most subsequent level adaptations. The idea that integration occurs along a continuum of collaboration and integration is widely supported (Collins, et. al., 2010; Miller, et. al., 2011; Peek, 2007; Reynolds, 2006; Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996; Strohsal, 1998) and adaptations have differed in the number of levels (from three to 10) and the categories used to differentiate or describe levels.

The reason for classification, whether for clinical development or research, has influenced the choice of dimensions used to define each level. For example, Reynolds (2006) used the same five levels, but distinguishes between levels on the basis of functional practice categories, including access, services, funding, governance, evidence-based practice, and data usage. The goal of Reynolds' adaptation is to better capture the patient and staff experience at the different levels; in doing so, it broadens the levels' descriptions and characteristics.

Other papers and reports have classified integrated implementations somewhat differently. MaineHealth (2009) developed a site-specific rating of integration that has four levels along a continuum of integration, with one rating in the first level and three ratings in levels two, three, and four. There are 18 characteristics broadly categorized as integrated services, patient- and family-centeredness, and practice/organization. In the first category, characteristics such as colocation, patient/family involvement, and communication with patients about integrated care are rated. In the second category, characteristics such as organizational leadership for integrated care, providers' engagement, and data systems/patient are rated.

More similar to Doherty et. al., Blount (2003) collapsed the five levels to three: coordinated, co-located, and integrated care. Recent work to develop a lexicon or common conceptual system for collaborative care between behavioral health and primary medical clinicians (Miller et. al., 2011) has also adopted these three levels in describing collaborative care practice.

The Milbank report, Evolving Models of Behavioral Health Integration in Primary Care (Collins et. al., 2010), describes eight models of integration across a variety of settings. This group uses Doherty et. al.'s. five level structure and the terms coordinated, co-located, and integrated to differentiate these models.

STANDARD FRAMEWORK

Doherty et al. established the five levels of integration, recognizing differences in integrated implementations and the various forms collaboration took in each level. Based upon the initial efforts by Doherty et al. and the experience accumulated over the intervening 17 years, the authors of this paper propose a new version of the levels of collaboration/integration. The framework brings together valuable aspects that have evolved since the Doherty et al. paper. The framework also includes several enhancements that enable it to be comprehensive enough to serve as a national standard for future discussion about integrated healthcare, allow organizations implementing integration to gauge their degree of integration against acknowledged benchmarks, and serve as a foundation for comparing healthcare outcomes between integration levels.

Doherty et al. established the concept of levels of implementations that followed a continuum from collaboration to integration. The model in this issue brief retains some of the original categorical descriptions that continue to prove useful today. Blount's use of coordination, colocation, and integration serve as overarching categories. The Milbank report, which brought together Doherty et. al.'s five levels and Blount's broader categories, also informs this conceptual framework.

This new level of integration framework proposes six levels of collaboration/integration. While the overarching framework has three main categories — coordinated, co-located, and integrated care — there are two levels of degree within each category (see Table 1). It is designed to help organizations implementing integration to evaluate their degree of integration across several levels and to determine what next steps they may want to take to enhance their integration initiatives.

Coordinated Care

▶▶ **LEVEL 1 —** *Minimal Collaboration*
Behavioral health and primary care providers work at separate facilities and have separate systems. Providers communicate rarely about cases. When communication occurs, it is usually based on a particular provider's need for specific information about a mutual patient.

▶▶ **LEVEL 2 —** *Basic Collaboration at a Distance*
Behavioral health and primary care providers maintain separate facilities and separate systems. Providers view each other as resources and communicate periodically about shared patients. These communications are typically driven by specific issues. For example, a primary care physician may request copy of a psychiatric evaluation to know if there is a confirmed psychiatric diagnosis. Behavioral health is most often viewed as specialty care.

Co-Located Care

▶▶ **LEVEL 3 —** *Basic Collaboration Onsite*
Behavioral health and primary care providers co-located in the same facility, but may or may not share the same practice space. Providers still use separate systems, but communication becomes more regular due to close proximity, especially by phone or email, with an occasional meeting to discuss shared patients. Movement of patients between practices is most often through a referral process that has a higher likelihood of success because the practices are in the same location. Providers may feel like they are part of a larger team, but the team and how it operates are not clearly defined, leaving most decisions about patient care to be done independently by individual providers.

▶▶ **LEVEL 4 —** *Close Collaboration with Some System Integration*
There is closer collaboration among primary care and behavioral healthcare providers due to colocation in the same practice space, and there is the beginning of integration in care through some shared systems. A typical model may involve a primary care setting embedding a behavioral health provider. In an embedded practice, the primary care front desk schedules all appointments and the behavioral health provider has access and enters notes in the medical record. Often, complex patients with multiple healthcare issues drive the need for consultation, which is done through personal communication. As professionals have more opportunity to share patients, they have a better basic understanding of each other's roles.

Integrated Care

▶▶ **LEVEL 5 —** *Close Collaboration Approaching an Integrated Practice*
There are high levels of collaboration and integration between behavioral and primary care providers. The providers begin to function as a true team, with frequent personal communication. The team actively seeks system solutions as they recognize barriers to care integration for a broader range of patients. However, some issues, like the availability of an integrated medical record, may not be readily resolved. Providers understand the different roles team members need to play and they have started to change their practice and the structure of care to better achieve patient goals.

▶▶ **LEVEL 6 —** *Full Collaboration in a Transformed/Merged Practice*
The highest level of integration involves the greatest amount of practice change. Fuller collaboration between providers has allowed antecedent system cultures (whether from two separate systems or from one evolving system) to blur into a single transformed or merged practice. Providers and patients view the operation as a single health system treating the whole person. The principle of treating the whole person is applied to all patients, not just targeted groups.

Key elements were added to more clearly differentiate between the levels in each overarching category. For coordinated care, the key element is communication. The distinction between Level 1 and Level 2 is frequency and type of communication. With increased communication, providers have stronger relationships and greater understanding of the importance of integrated care and

the skills that different providers possess. This communication increases the coordination of care between separate healthcare entities.

Physical proximity is the key element for the co-located care category. Although colocation does not guarantee greater collaboration or integration, it can be beneficial. Taking advantage of close proximity increases collaboration through face-to-face contact at Level 3. It can also develop the opportunity for trust and relationship building, leading to more sharing of systems — the hallmark of beginning integration at Level 4. However, providers can be co-located and have no integration of their healthcare services. Each provider can still practice independently without communicating with others and with an integrated healthcare plan. Colocation reduces time spent travelling from one practitioner to another, but does not guarantee integration.

At Level 5 and Level 6, practice change is the key element. No site can be fully integrated without changing how both behavioral health and primary care are practiced. The requisite practice change features a blending or blurring of cultures, where no one discipline predominates. Across many integrated implementations at several levels, almost every practitioner wants integrated care, and believes it is the direction for healthcare to move towards, until they realize it requires they change how they practice. It is at that point they often try to change the concepts of their integration efforts to preserve how they currently practice.

A second modification proposed to the original Doherty et al. structure is the use of the terms "collaboration" and "integration." In this framework, collaboration describes how resources — namely, the healthcare professionals — are brought together; integration describes how services are delivered and practices are organized and managed. This idea is similar to Strosahl's (1998) concept that collaborative care involves behavioral health working with primary care, while integration is behavioral health working within and as part of primary care. Recent analysis (Mauer & Jarvis, 2010) indicates that collaboration and integration can effectively originate in either behavioral health or primary care and requires the transformation of both into a single whole. In this standard framework, both collaboration and integration (beginning at Level 3) increase in degree and complexity over the continuum for providers, while similarly decreasing for clients/individuals.

An important enhancement to the levels is also found in a restructuring of the descriptive characteristics defining each level (see Table 1). Each of the six levels begins with a general description followed by key differentiators (see Table 2A and 2B) under the headings clinical delivery, patient experience, practice/organization, and business model. These characteristics help differentiate the levels. They also incorporate some of the functional categories Reynolds (2006) identified in her consumer/staff experiential perspective of the levels of integration, Kodner's (2009) integrated care domains, and MaineHealth's (2009) Site Assessment. Finally, Table 3 describes the strengths and weaknesses of each level so that these can be built upon or addressed.

Although the term behavioral health has been used throughout this framework, integration of substance use treatment and primary care has not been as extensive or prevalent as integration of mental health with primary care. Further work is required to more effectively support substance use integration (Butler, et. al., 2008; Mauer, 2010).

It is worth noting that even if health outcomes improve as levels of integration increase, it is not reasonable to believe that all healthcare settings would be able to easily, or even with difficulty, move to increasing levels of integration. As primary care and behavioral health have evolved in their own professional silos, it has been the authors' experience that the bringing together of these services and service perspectives (usually embodied in separate agencies) into a single, fully integrated healthcare system requires a large amount of administrative, political, and financial investments over a long-term, stepwise, evolutionary process. It is important to aspire to whichever level can be best achieved practically.

At Level 3, colocation may be a necessary and good starting point to build trust between separate, existing systems and to establish a shared history of improved outcomes. This could lead to closer collaboration and integration of vision that moves to Level 4 implementation, possibly leading from there to a Level 5 partnership. Such a partnership may be the highest level attainable or may, in years to come, lead to a joint venture or a merger of the organizations. While this has not been fully researched, merging primary and behavioral health organizations appears necessary at this point for achieving Level 6 integration.

From a data standpoint, this framework also posits that integrated services should be defined by location, not by an algorithm of service code combinations. A single service (e.g., blood pressure check or depression medication check) provided in an integrated site/setting is considered an integrated service because it is provided in the context of that integrated site's whole person care. Conversely, multiple services provided in a single visit are not by definition integrated care; these services could be, and all too often are, provided by separate professionals without meaningful collaboration or integration. By defining the level of integration in terms of setting, the authors of this framework define the context of interventions and the values (e.g., care team, whole health, patient-centered) that form the basis of an integrated site and integrated services. The key performance indicators in an integrated care setting are population-based health status outcomes, not encounter-based process/service data. Individual staff productivity must accompany, and then be replaced by population-based outcomes by site.

Funding structures and accountability must also change. Integrated care is not supported by fee-for-service funding structures that stumble over same day billing restrictions and do not reimburse for consultations between providers, when the patient is not physically present, or electronic contacts or a large volume of care management — all of which are essential for improved health outcomes in an integrated healthcare system. Fee-for-service funding can emphasize the measurement of volume rather than quality. Global or blended funding structures do support integrated healthcare and will be fiscally justified by improved patient outcomes that reduce overall healthcare cost.

CONCLUSION

The level of integration framework is a manageable, practical, and conceptually sound six level framework for integrated healthcare that begins with collaboration (how resources are brought together) and moves through colocation and increasing levels of integration (how services are framed and delivered). This standard framework is needed for clarity and precision of communication, as well as to contribute to research and practice redesign. By implication, the numbering of levels suggests that the higher the level of collaboration/integration, the more potential for positive impact on health outcomes and patient experience. This belief remains a hypothesis and has not been empirically tested. With further research, these benefits of collaboration/integration can be more firmly stated and can identify which aspects of the collaboration, integration, or combination of the two contribute most directly to health outcomes.

Even if health outcomes improve as levels of integration increase, it is not practical to believe that every healthcare setting will be able, at least in the near term, to implement increasing levels of integration. Many integrated implementations will be constrained by community politics, trust between organizational systems, financing, and/or differing service values.

Lastly, this issue brief does not presume to establish a fuller lexicon for integration and healthcare, as much needed as it is. The authors leave that to others better suited to the task and hope that this paper will contribute to such a lexicon. The purpose is to help those delivering services today by presenting a conceptual framework to better understand and differentiate integrated healthcare implementations. The authors believe that this framework will inform discussions about integrated healthcare and that its use will provide opportunity for service redesign that will lead to better conceptual and practical models of care.

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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:
▶ 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	▶ 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	▶ 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 non-formal team	▶ 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	▶ 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	▶ 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	▲ Screening and assessment done according to separate practice models ▲ Separate treatment plans ▲ Evidenced-based practices (EBP) implemented separately	▲ 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	▲ 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	▲ 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	▲ 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	▲ 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	▲ 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	▲ 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	▲ 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	▲ 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	▲ 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	▲ 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					
➤ 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-into collaboration and value placed on having needed information	➤ 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	➤ 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

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	▶ 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 ▶ Referrals may fail due to barriers, leading to patient and provider frustration	▶ 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