Types of Systematic Collaboration/Integration

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Type A – Minimal Collaboration

Description: Behavioral health and other health care professionals work in separate facilities, have separate systems, and communicate about cases only rarely and under compelling circumstances.

Where practiced: Most private practices and agencies.

Advantages: Retains funding and reimbursement strategies for each entity; allows each system to make autonomous and timely decisions about practice using developed expertise; readily understood as a practice model.

Disadvantages: Service may overlap or be duplicated; uncoordinated care often contributes to poor outcomes, important aspects of care may not be addressed.

Type B – Basic Collaboration at a Distance

Description: Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. All communication is driven by specific patient issues. Behavioral health and other health professionals view each other as resources, but they operate in their own worlds, have little sharing of responsibility and little understanding of each other's cultures, and there is little sharing of power and responsibility.

Where practiced: Settings where there are active referral linkages across facilities.

Advantages: Maintains each organizations basic operating structure and cadence of care; provides some level of coordination of care and information sharing that is helpful to both patients and providers.

Disadvantages: No guarantee that shared information will be incorporated into the treatment plan or change the treatment strategy of each provider; does not impact the culture or structure of the separate organizations.

Type C – Basic Collaboration On-Site with Minimal Integration

Description: Behavioral health and other health care professionals have separate systems but share the same facility. They engage in regular communication about shared patients, mostly through phone or letters, but occasionally meet face to face because of their close proximity. They appreciate the importance of each other's roles, may have a sense of being part of a larger, though somewhat ill-defined team, but do not share a common language or an in-depth understanding of each other's worlds. This is the basic co-location model. As in Levels One and Two, medical physicians have considerably more power and influence over case management decisions than the other professionals, who may resent this.

Where practiced: HMO settings and rehabilitation centers where collaboration is facilitated by proximity, but where there is no systemic approach to collaboration and where misunderstandings are common. Also, within some School Based Health Clinics (SBHCs) and within some medical clinics that employ

therapists but engage primarily in referral-oriented co-located services rather than systematic mutual consultation and team building.

Advantages: Increased contact allows for more interaction and communication among professionals that also increases potential for impact on patient care; referrals are more successful due to proximity; systems remain stable and predictable; opportunity for personal relationships between professionals to grow and develop in the best interest of patient care.
Disadvantages: Proximity may not lead to increased levels of collaboration or better understanding of expertise each profession brings to patient care. Does not necessarily lead to the growth of integration – the transformation of both systems into a single healthcare system.

Type D – Close Collaboration On-Site in a Partly Integrated System

Description: Behavioral health and other health care professionals share the same sites and have some systems in common, such as scheduling or charting. There are regular face-to-face interactions about patients, mutual consultation, coordinated treatment plans for difficult cases, and a basic understanding and appreciation for each other's roles and cultures. There is a shared allegiance to a biopsychosocial/systems paradigm. However, the pragmatics are still sometimes difficult, team-building meetings are held only occasionally, and there may be operational discrepancies such as co-pays for behavioral health but not for medical services. There are likely to be unresolved but manageable tensions over medical physicians' greater power and influence on the collaborative team.

Where practiced: Increasingly practiced within Federally Qualified Community Health Centers (FQHC), some Rural Health Clinics (RHC) and especially Provider (hospital operated) RHCs, as well as some group practices and SBHCs committed to collaborative care.

Advantages: Cultural boundaries begin to shift and service planning becomes more mutually shared, which improves responsiveness to patient needs and consequent outcomes. There is a strong opportunity for personal relationships between professionals to grow and develop in the best interest of patient care.

Disadvantages: Potential for tension and conflicting agendas among providers or even triangulation of patients and families may compromise care; system issues may limit collaboration

Type E – Close Collaboration Approaching a Fully Integrated System

Description: Behavioral health and other health care professionals share the same sites, <u>the same vision</u>, and the same systems in a seamless web of biopsychosocial services. Both the providers and the patients have the same expectation of a team offering prevention and treatment. All professionals are committed to a biopsychosocial/systems paradigm and have developed an in-depth understanding of each other's roles and cultures. Regular collaborative team meetings are held to discuss both patient issues and team collaboration issues. There are conscious efforts to balance power and influence among the professionals according to their roles and areas of expertise.

Where practiced: In a small number of well developed FQHC and RHC settings.

Advantages: High level of collaboration contributes to improved patient outcomes; patients experience their care provided by a collaborative care team in one location, which increases likelihood of engagement and adherence to treatment plan; provides better care for patients with chronic , complex illnesses, as well as those needing prevention/early intervention.

Disadvantages: Services may still be delivered in traditional ways for each discipline; separate system silos still operate to limit flexibility of the delivery of care that best meets the needs of the patient as a whole person.

Type F – Full Collaboration in a Transformed Fully Integrated Healthcare System

Description: Providers have overcome barriers and limits imposed by traditional and historic service and funding structures. Antecedent system cultures and allegiances dissolve into a single transformed system. Practice boundaries have also dissolved and care teams use newly evolved methodology to jointly assess, prioritize, and respond to patients' care needs. Providers and patients view the operation as a single health system treating the whole person. One fully integrated record is in use.

Where practiced: In established clinics that have united the resources of primary, behavioral and public health, not just to augment the service array but also as partners in the conceptual leadership of the service structure and design. This is also practiced in a very small number of localized centers of excellence designed and established expressly to achieve a fully integrated service environment.

Advantages: The patient's health and well being becomes the focus of care. Care can occur in brief episodes and be sustained over time.

Disadvantages: There are currently no financial mechanisms to support integrated care that combines health care disciplines. Because this model is new and very limited in its implementation there is even less research currently available to support the value of it.