

**Behavioral Health/Primary Care Integration Options\* -- Operational Examples**

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration Partly Integrated	Fully Integrated Merged
<b>Access</b>	Two front doors; consumers go to separate sites and organizations for service	Two front doors; cross-system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
<b>Services</b>	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for patient/consumers with high physical and behavioral health needs	Two providers working in consultation; two routine sharing on individual plans, probably serve patients/consumers with all levels of physical and behavioral health needs	Individuals with low behavioral health needs will have all needs met by single provider; those with high behavioral health needs will interact with two providers who work from a single treatment plan in some cases, but not consistently with all consumers	One treatment plan with all patients/consumers, one site for all services, one physician prescribing for all patients/consumers except for some with high physical and behavioral health needs, one set of lab work
<b>Funding</b>	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding with resources shared across organizational needs, maximization of billing and support staff, potential new resources and staffing flexibility
<b>governance</b>	Separate systems with little or no collaboration; patient/consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for specific groups of patients/consumers	Two governing boards that meet together periodically to discuss mutual issues	One governing Board with equal representation from each partner
<b>EBP</b>	Individual Evidence-Based Practices (EBPs) implemented in each system	Two providers, some sharing of information but responsibility for care located in one clinic or the other	Some sharing of EBP's around patients/consumers with high physical and behavioral health needs; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for patients with all levels of behavioral physical health needs	EBP's like PHQ-9, chronic disease self-management across all patients/consumers
<b>Data</b>	Separate systems, often paper-based, little if any sharing of data	Separate data sets, some discussion with each other of what data are shared	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; data sharing on population groups	Fully integrated (electronic) health record with information available to all practitioners on need to know basis, data collection from one source

\*Adapted from MH/Primary Care Integration Options, developed by Kathleen Reynolds, Director, Washtenaw Community Health Organization, Washtenaw County, MI; Based on Doherty, McDaniel and Baird, 1996.