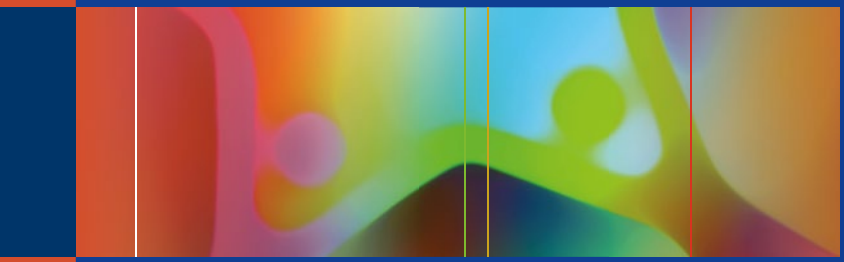
Stephanie B. Gold
Larry A. Green *Editors*



Integrated Behavioral Health in Primary Care

Your Patients Are Waiting

Springer

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Editors
Stephanie B. Gold, MD
Eugene S. Farley, Jr. Health Policy Center
Aurora, CO
USA

Department of Family Medicine
University of Colorado School of Medicine
Aurora, CO
USA

Department of Family Medicine
Denver Health
Denver, CO
USA

Larry A. Green, MD
Eugene S. Farley, Jr. Health Policy Center
Aurora, CO
USA

Department of Family Medicine, University of Colorado School of Medicine,
Aurora, CO
USA

ISBN 978-3-319-98586-2 ISBN 978-3-319-98587-9 (eBook)
https://doi.org/10.1007/978-3-319-98587-9

Library of Congress Control Number: 2018957096

This Springer imprint is published by the registered company Springer Nature Switzerland AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

Acknowledgments

We are indebted to C. J. Peek, who in addition to writing Chap. 2, authored the preambles to each chapter and provided initial thought leadership and guidance on the entire book's development.

We are grateful for the assistance of our independent reviewers for their commentary and suggestions that helped make this a better book: Perry Dickinson, Bob Ferrer, John Flanagan, Bonnie Jortberg, Roger Kathol, Neil Korsen, Samantha Monson, Laura Pickler, and Ali Shmerling, Sarah Hemeida, and Lina Brou at the Eugene S. Farley Jr. Health Policy Center, University of Colorado. Thanks to Emma Gilchrist, also at the Farley Health Policy Center, for her work on Fig. 1.1 in Chap. 1.

We also wish to acknowledge the hardworking practices of the Advancing Care Together project and Integrated Workforce Study whose pioneering efforts in integrated behavioral health and primary care are the foundation of the messages delivered in this book: Axis Health System, Durango, Colorado; Bender Medical Group, Inc., Fort Collins, Colorado; Denver Health and Hospital, Denver, Colorado; Jefferson Center for Mental Health, Wheat Ridge, Colorado; Kaiser Permanente Colorado, Denver, Colorado; Midvalley Family Practice, Basalt, Colorado; Plan de Salud del Valle Inc., Brighton, Colorado; Primary Care Partners, Grand Junction, Colorado; Southeast Mental Health Services, La Junta,

Colorado; University of Colorado Aging Center, Colorado Springs, Colorado; Westminster Medical Clinic, Westminster, Colorado; Cherokee Health Systems, Knoxville, Tennessee; Edward Hines, Jr. VA Hospital – Primary Care Behavioral Health Program, Hines, Illinois; Fairview Clinics – Integrated Primary Care, Fairview Health Services, Minneapolis, Minnesota; Golden Valley Health Centers, Merced, California; Institute for Family Health, New York, New York; Penobscot Community Health Care – Summer Street Health Center, Bangor, Maine; Southcentral Foundation, Anchorage, Alaska; and Swift River Family Medicine, in collaboration with Tri-County Mental Health Services, Rumford, Maine.

Contents

Contributors

Bijal A. Balasubramanian, MBBS, PhD Department of Epidemiology, Human Genetics, and Environmental Sciences, UTHealth School of Public Health in Dallas, Dallas, TX, USA

Caitlin Barba, MPH Westminster Medical Clinic, Westminster, CO, USA

F. Alexander Blount, EdD Department of Clinical Psychology, Antioch University New England, Keene, NH, USA

Department of Family Medicine and Psychiatry, University of Massachusetts Medical School, Amherst, MA, USA

Deborah J. Cohen, PhD Department of Family Medicine, Oregon Health & Science University, Portland, OR, USA

Frank Verloin deGruy III, MD, MSFM Department of Family Medicine, University of Colorado School of Medicine, Aurora, CO, USA

Stephanie B. Gold, MD Eugene S. Farley, Jr. Health Policy Center, Aurora, CO, USA

Department of Family Medicine, University of Colorado School of Medicine, Aurora, CO, USA

Department of Family Medicine, Denver Health, Denver, CO, USA

Larry A. Green, MD Eugene S. Farley, Jr. Health Policy Center, Aurora, CO, USA

Department of Family Medicine, University of Colorado School of Medicine, Aurora, CO, USA

R. Scott Hammond, MD, FAAFP Westminster Medical Clinic, Westminster, CO, USA

Department of Family Medicine, University of Colorado School of Medicine, Aurora, CO, USA

Parinda Khatri, PhD Cherokee Health Systems, Knoxville, TN, USA

Stephanie R. Kirchner, MSPH, RD Eugene S. Farley, Jr. Health Policy Center, Aurora, CO, USA

Department of Family Medicine, University of Colorado School of Medicine, Aurora, CO, USA

Benjamin F. Miller, PsyD Well Being Trust, Oakland, CA, USA

C. J. Peek, PhD Department of Family Medicine and Community Health, University of Minnesota Medical School, Minneapolis, MN, USA

Chapter 1
Why You Should Read this Book

Stephanie B. Gold and Larry A. Green

Behavioral health problems spare no one, and experienced primary care clinicians know this and work with patients with these problems every day. Behavioral health problems constitute major causes of premature mortality and complicate caring for people with acute and chronic diseases of all types [1]. There is widespread agreement that primary care practices have the opportunity to improve millions of lives by improving their care of patients with behavioral health problems.

The case for changing primary care practices to integrate behavioral health and primary care is strong [2–4] (see Fig. 1.1). Not only is there a high prevalence of mental health and substance use disorders, but also low rates of patients with these

S. B. Gold (✉)
Eugene S. Farley, Jr. Health Policy Center, Aurora, CO, USA

Department of Family Medicine, University of Colorado School of Medicine, Aurora, CO, USA

Department of Family Medicine, Denver Health, Denver, CO, USA
e-mail: stephanie.gold@ucdenver.edu

L. A. Green
Eugene S. Farley, Jr. Health Policy Center, Aurora, CO, USA

Department of Family Medicine, University of Colorado School of Medicine, Aurora, CO, USA
e-mail: larry.green@ucdenver.edu

S. B. Gold, L. A. Green (eds.), *Integrated Behavioral Health in Primary Care*, https://doi.org/10.1007/978-3-319-98587-9_1

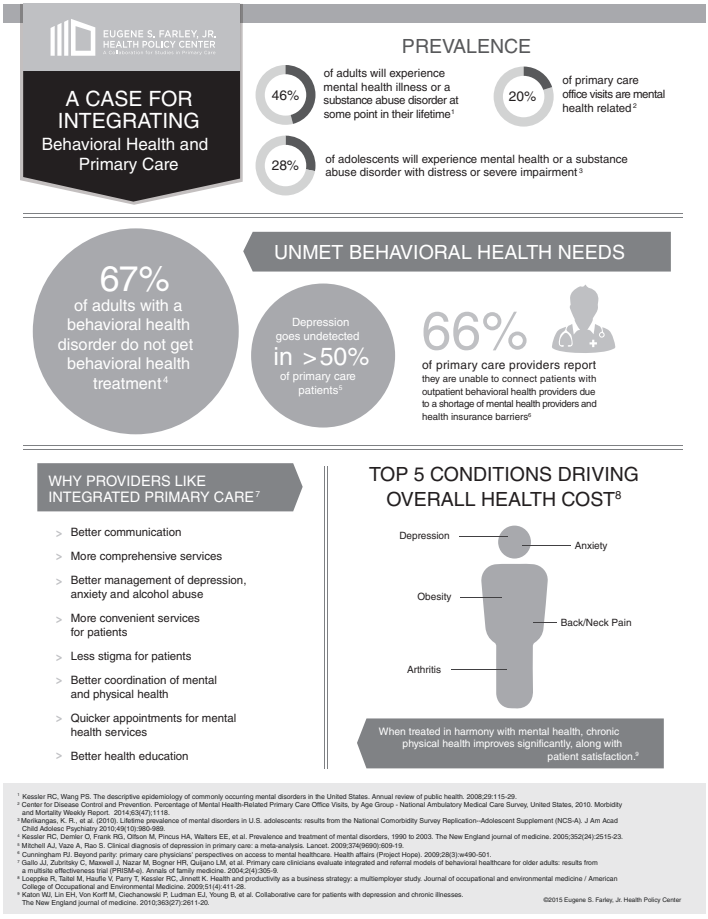

FIGURE 1.1 A case for integrating behavioral health and primary care. (Reproduced with permission from the Eugene S. Farley, Jr. Health Policy Center)

needs receiving treatment. There is a growing body of evidence that integrating behavioral health to meet these needs is feasible, reduces expenditures [5–7], and improves outcomes [8–10]. Here lies the monumental opportunity for primary care clinicians. And this opportunity is the focus of this book.

While many behavioral health problems can be ameliorated or resolved in primary care practices, few frontline primary care practices are fully equipped to address them. There have been a number of books written on behavioral health integration directed toward behavioral health clinicians on what they need to do to change their practice to work in primary care, but there is a paucity of practical guidance for primary care clinicians. This book aims to help fill this gap and provide information specifically for primary care clinicians who recognize that integrating primary care and behavioral health can improve their practices, the lives of their patients, and their own joy of practice.

This book is focused on pragmatic, primary care clinicians who go to work every day aiming to help their patients be healthier. It aspires to be a usable guide for regular practices wanting to take better care of their patients by improving the care of their patients with behavioral health problems. This usability is enhanced by a conversational rather than academic tone, relaying information as would be shared from one clinician to another. This conversational style, however, should not be misinterpreted as indicating a lack of evidence. The chapters purposefully blend published evidence with the real-life experience of practicing primary care clinicians who have integrated behavioral health in their practices. The ideas and principles herein are applicable to diverse patients and any primary care practice, including practices across the globe. Specific examples are used to illustrate concepts, and these particulars are specific to the United States; while the examples may not apply to other countries, the underlying concepts often have parallels in other corners of the world.

This book is also intended for practice change facilitators, practice and system administrators, and other healthcare workers seeking to transform their practices to comprehensively meet the needs of their patients *and avoid a false division of physical and behavioral health problems.* Though it is written for the local primary care team, the language often addresses primary care physicians or primary care clinicians directly—because most books on this subject have been addressed to

behavioral health clinicians or large system administrators. The authors want to be sure to address the local primary care physician in the style and context in which they are familiar. Often a team leader or instigator of change within the practice, the physicians work in close partnership with their clinic manager or administrative partner and their clinical team. So if you are not a physician, please do not take offense or feel excluded when you encounter a sentence addressed straight to a doctor. It is, but it is addressed to you too—all of you who make things happen in a primary care clinic.

This book is not an exhaustive compendium of research and research methods relevant to studying care that integrates primary care and behavioral health. Neither does it delineate the diagnostic and treatment skills necessary to treat behavioral health concerns in a primary care practice. It also does not elaborate all the specific details for all of the models of integration that have been pursued. Instead, this book drills down to essentials primary care clinicians need to know and do to accomplish changes in their practice necessary to integrate behavioral health and primary care in local, real-world environments.

The chapters in this book are grounded in lessons learned and judgments made by early adopters of integrated behavioral health and pioneering change agents, educators, and evaluators. The framework of this book was derived from the insights of a group of early adopters involved in a program called Advancing Care Together (ACT) [11]. The ACT program, sponsored by the Colorado Health Foundation and administered by the Department of Family Medicine at the University of Colorado, brought together 11 primary care practices and community mental health centers in small and large, urban and rural settings across Colorado to integrate behavioral health and primary care as they saw fit. A small amount of funding was provided to support participation in the program's evaluation and learning community. After 3 years of working on integrating care, these innovators came together to share their experiences and insights. Key, hard-won messages emerged that they wanted to pass on as

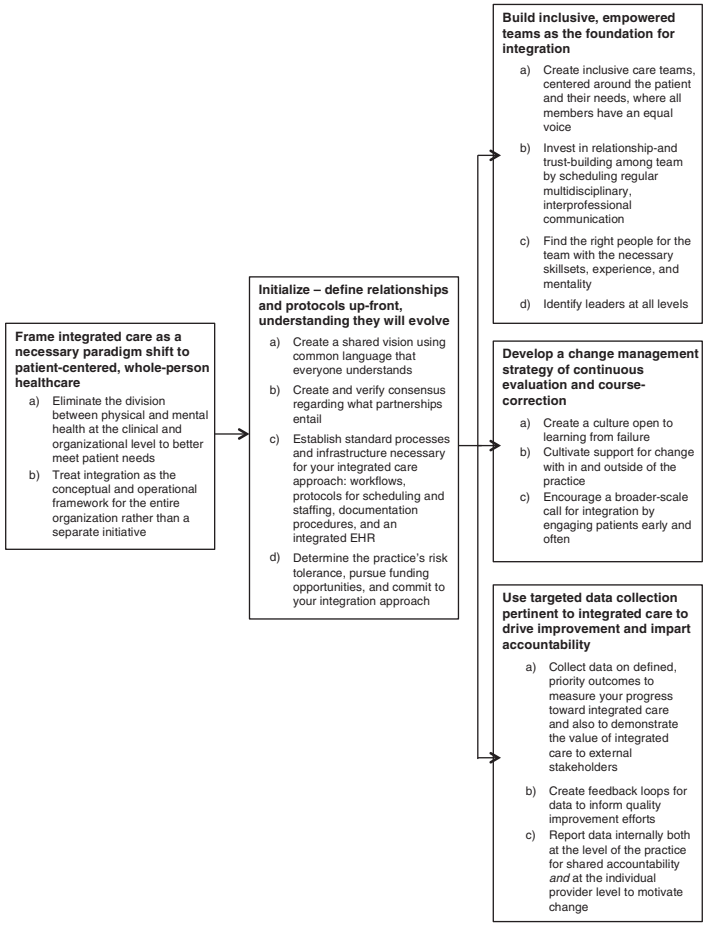

FIGURE 1.2 Lessons learned by early innovators on how to integrate care in your practice: relationships between main themes captured from participants in the Advancing Care Together study at their closing meeting, September 2014. (Reproduced with permission from the American Board of Family Medicine)

colleagues to those willing to follow in their footsteps [12]. These insights were organized and published as shown in Fig. 1.2, and this book expands on their consensus conclusions

and recommendations. It is worth highlighting that these innovators recommended involving your patients early and often as you transform your practice to integrate primary care and behavioral health. After all, patients are experts in themselves.

Additional evaluations of the program from these ACT innovators and others examine the costs of integrating care [13], physical space layouts in an integrated clinic [14], adequate staffing and scheduling [15], the ways in which behavioral health and primary care clinicians interact [16], workforce preparation needs [17], electronic health record challenges and solutions [18], and the extent to which integrated services reached the target population [19]. These publications, like this book, are based in the pragmatism of practicing primary care clinicians and are freely available with many citations to relevant literature not included in this book.

Each of this book's chapter authors has years of experience in integration on the ground; together they combine the perspectives of primary care clinicians, behavioral health clinicians, practice administrators, health system leaders, primary care researchers, and practice transformation experts with concrete steps on how to make integrated behavioral health work. You may notice overlapping areas addressed in multiple chapters through different lenses; the interlocking nature of each chapter is intended to reaffirm and build upon content from other chapters and reflect the value of repetition in adult learning.

In Chap. 2, What Is Integrated Behavioral Health?, you will hear from psychologist CJ Peek about what constitutes integrated behavioral health and words and explanations you can use to make the case for integrating behavioral health to others in your practice and/or larger system. In Chaps. 3 and 4, A Real-Life Story in Getting Started: Designing a Foundation and Building from the Ground Up, family physician Scott Hammond and practice administrator Caitlin Barba tell their story together to help other primary care practices really understand integrated care, what it entails, and what it takes to do it. This story is divided into two parts to cover the can-

did, biographical, 25-year expedition of Westminster Medical Clinic in Colorado. Readers will understand why the following chapters dive deeper into their critical topics.

In Chap. 5, Everyone Leads, family physician Frank deGruy and psychologist and healthcare system clinical officer Parinda Khatri describe the nature and functions of *adaptive* leadership in transforming practice to integrate primary care and behavioral health. It is a function not of one person in a top-down hierarchy but of all team members. In Chap. 6, It Takes a Team, educator and psychologist Alexander ("Sandy") Blount characterizes different models of integration and explores how a team of primary care clinicians, behavioral health clinicians, and other team members can best work together to take care of patients, including strategies for hiring, communication, and developing a team culture. In Chap. 7, Measure What Matters, primary care practice researchers Deborah Cohen and Bijal Balasubramanian provide a practical framework and details about how you can measure your progress to help you make adjustments to your plans and make sure that what you do is leading to the changes you want to see. They affirm that practices do not have to measure everything that can be measured; they should measure what they need to measure so they can see how their practice is changing. In Chap. 8, Where Practice Meets Policy, psychologist and policy expert Ben Miller, practice transformation expert Stephanie Kirchner, and family physician and book co-editor Stephanie Gold characterize the importance of the larger policy environment in which your practice exists. Using current examples from the US, they describe how local policies and situations may lag behind your progress which can constrain or enable your transformation to integrated care. They limit their focus to three areas that are often problematic for primary care practices: financing integrated care, workforce issues, and getting and using the data you need to implement and sustain your approach. They explore workarounds to cope with the status quo until policies can catch up to your advances in practice. Finally, in Chap. 9, we co-editors reprise key messages to send you on your way to integrated care.

If you read this book from start to finish, you will see that the false dichotomy of physical and behavioral health is obsolete and can be replaced with a dramatically improved approach in primary care. You will be able to imagine your course toward robust, integrated primary care for whole people, grounded in evidence but most importantly in the practical realities of everyday clinical practice at the front-lines of healthcare. The whole person care that your patients are waiting for does not happen on its own. It takes commitment, leadership, collaboration, and persistence. But this journey also gives back, fostering joy in practice through working as a part of a team to provide radically improved care for many, if not most, of your patients and seeing the difference it makes in the lives of your patients and their families. Now, let us get clear about what integrated care really is.

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Chapter 2
What Is Integrated Behavioral Health?

C. J. Peek

Preamble

Behavioral health integration can initially mean many things to many people; the concept and its implementation can become a source of confusion for physicians and innovation teams. Clinics can reduce initial ambiguity or confusion with a good enough shared view of what behavioral health integration looks like in action—based on national definitions tailored to the local situation. As a result, clinic leaders and implementers will be much clearer about required functions they need to implement. And their patients will be clearer on what they can expect from integrated behavioral health, once implemented. *CJP*

Introduction

Behavioral health integration can mean many things to many people. This chapter aims to provide physicians (and their teams) with accurate and practical ways to answer a question

C. J. Peek
Department of Family Medicine and Community Health, University of Minnesota Medical School, Minneapolis, MN, USA
e-mail: cjpeek@umn.edu

S. B. Gold, L. A. Green (eds.), *Integrated Behavioral Health in Primary Care*, https://doi.org/10.1007/978-3-319-98587-9_2

they will be asked over and over by different people at different times for different purposes:

"What *is* integrated behavioral health anyway?"

This aim is accomplished by helping a physician champion, other clinicians, and practice team members be comfortable in:

1. Citing and using a published consensus functional definition as a general basis.
2. Using a broad range of handy, concise, and entirely compatible definitions for particular audiences and purposes
3. Being able to move from a general definition to a realistically tailored local implementation

A physician champion or innovation team can retain responsiveness to published literature and definitions while proceeding realistically in his or her own real world and the people in it. While doing this could sound like a recipe for "mush" or "anything goes," this chapter offers systematic thinking on how to tailor your local work to general requirements and focus basic definitions to fit the situation at hand. This is to preserve the clinician's need to remain professionally responsible while being practical "in the moment and on the ground"—communicating well and briefly to anyone who asks.

Think about different compatible definitions for different purposes.

Part of working with definitions and being a systematic good communicator is being comfortable with a wide range of *different,* but compatible and accurate answers to "what is integrated behavioral health," not just one "best" definition. What all these definitions should have in common is being *concise*—which means (1) expressing all the important information and (2) in few words. This implies a balance between "brief" and "detailed enough."

In your communications as a clinician or leader in your clinic, you will constantly be balancing "all the important information" and "in few words." The balance you strike depends on who you are talking to and their purposes—what

aspects they are interested in and how many "pixels" in the picture they need to see right then. A rule of thumb is to create short handy definitions with distillations of key elements from the *full-blown* definitions. In that way, you are not introducing a different "picture," just taking pixels out of the original picture—and you can add them back selectively as needed for different purposes while keeping the essence the same.

As you will see in Sect. 2.1, the published consensus definition (from the United States Agency for Healthcare Research and Quality, AHRQ) contains as much or more information or "pixels" that you could ever want. But it is designed so that it can be progressively streamlined or "compressed"—down to two sentences if needed. As you will see in Sect. 2.2, simply expanding or compressing a general published definition likely does not meet all your needs to answer "what is it" as asked by different people with different purposes. For this purpose, you will need a range of concise answers focused on what that person wants to know.

Use the Published AHRQ Consensus Definition as an Expandable Basis for Conversation

Published agreement exists through AHRQ [1] on what high-level functions are required to count as genuine integrated behavioral health—what it looks like in action. This is an extended consensus definition created by a panel of well-known leaders and implementers in the field. It is an excellent reference, "north star," and professional resource, even though far too detailed for most everyday conversation.

First, the two-sentence "what is it" definition (Table 2.1)*:*

Note the broad scope of what is meant by "behavioral health" in the second sentence, far broader than diagnosable mental illnesses and conditions.

For a little more detail, use the "how" part of the definition. If you use the two-sentence definition but ask, "how do you do it," Table 2.2 shows the required functions of integrated behavioral health. This adds a few more "pixels":

Table 2.1 AHRQ two-sentence "what is it" definition

***What* is integrated behavioral health?**
The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health-care utilization.

Table 2.2 AHRQ two-sentence definition augmented with "how" and "supported by" functions

Clinical how: *What integrated behavioral health needs to look like in action*

1. A practice team of primary care and behavioral health clinicians tailored to the needs of your clinic panel and each patient and situation.
2. With a shared population and mission—a panel of patients in common for total health outcomes.
3. Routinely using a systematic clinical approach consisting of shared goals, workflows, and documentation.

Supported by—organizational functions taking place*:*

4. A community, population, or individuals expecting that behavioral health and primary care will be integrated as a standard of care.
5. Reliable office practice systems, alignment of leadership and purpose, and sustainable business model.
6. Continuous quality improvement with routine use of practice and other data to improve effectiveness.

This definition includes not only a clinical "how," but an organizational "supported by"—because the clinical methods cannot be built or sustained without these organizational supporting functions well enough in place.

This enhancement to the two-sentence definition may be quite enough for most conversations. But at other times, you will hear, "Please be specific about what is involved." Table 2.3 shows the AHRQ definition expanded with many

Table 2.3 AHRQ definition with many of its clarifying sub-points

***What* is integrated behavioral health?**

The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.
This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health-care utilization.

How: *What integrated behavioral health needs to look like in action—defining functions you need to see taking place*

1. *A practice team tailored to the needs of each patient and situation.*
   (The mix suited to serve your target population. For example, different kinds of physicians, behavioral health clinicians, social workers, consulting psychiatrists, care coordinators, clinical pharmacists, or others)
   A. With a suitable range of behavioral health and primary care expertise and role functions available to draw from. So that the team can be defined at the level of each patient and, in general, for targeted populations.
   B. With shared operations, workflows, and practice culture. Shared physical space, workflows that ensure collaboration and shared treatment plans, and unified rather than separate and conflicting medical and behavioral health practice cultures.
   C. Having had formal or on-the-job training. For both medical and behavioral health clinicians—clinical roles and relationships, culture- and team-building.
2. *With a shared population and mission*—a panel of patients in common for total health outcomes
   The patient panel and total health mission is shared by both primary care and behavioral health clinicians—not subdivided into a medical portion and a separate behavioral health portion.

(continued)

Table 2.3 (continued)

3. *Routinely using a systematic clinical approach* to:
   A. Identify those members of the population who need or may benefit
   B. Engage patients and families in identifying their needs for care and clinicians
   C. Involve both patients and clinicians in decision-making
   D. Use an explicit, unified, and shared care plan in a shared electronic medical record
   E. Systematically follow up and adjust treatment plans if patients are not improving as expected ("treat to target") (The presence and routine use of these systematic clinical processes is a defining marker for integrated behavioral health)

***Supported by*—organizational enabling functions taking place**

(The team and clinical functions above are far less likely to take place sustainably without these organizational supports)

4. *A community, population, or individuals expecting behavioral health and primary care to be integrated* as a standard of care (sometimes referred to as "patient demand").
   A general standard of care, not just a localized enhancement or featured program in otherwise separated medical and behavioral health work.

5. *Office systems, alignment of leadership and purpose, and sustainable business model*
   A. Clinic operational systems and office processes consistently support interprofessional communication, shared care plans, tracking care, and other collaborative functions.
   B. Leadership, supervision, and incentives are aligned to support the functions of integrated behavioral health.
   C. The business model sustains integrated behavioral health (or is working toward that end).

6. *And continuous quality improvement and measurement of effectiveness* (to know what is working or not)
   A. Routinely collecting and using practice-based data to track and improve patient outcomes, change what the practice is doing, and quickly learn from experience.
   B. Periodically examining and reporting outcomes—at the clinician and program level—for care, patient experience, and affordability ("Triple Aim") to engage the practice in making changes accordingly.

of its clarifying sub-points. That many "pixels" are likely required for conversations about implementation—"what do I have to build exactly?"

The published AHRQ definition includes much more than you see in Table 2.3, should you need it, e.g., elements of a shared integrated behavioral healthcare plan and elements of systematic follow-up and adjustment of treatment. It has a table of contents with links, with more detail than you probably ever want to know.

The AHRQ definition is not the only useful resource. For example, the SAMHSA-HRSA "Standard Framework for Levels of Integrated Healthcare" has a structure you can adapt in the same way—starting with a one- or two-sentence definition and adding specifics or "pixels" to the picture as needed [2].

But there is more to having a broad repertoire of handy answers to "what is it" than compressing or expanding the AHRQ or other published definitions. You will likely need handy definitions for the needs and concerns of particular audiences and purposes.

Have a Range of Handy Answers to "What Is It" for Particular Audiences and Purposes

A clinician or other practice leader will be asked the "what is integrated behavioral health" question in all kinds of situations by all kinds of people with different purposes and different need for detail. So you will want a range of different, but entirely compatible answers or "definitions" tailored to different people and purposes. Having concise and contextually appropriate answers to "what is integrated behavioral health" can be regarded as a leader function that is open to all—as described in Chap. 5.

Table 2.4 offers examples of equivalent definitions or answers for different persons commonly encountered in the primary care environment. Because these persons have different purposes in asking the question, the answers are different, but equally accurate and almost equivalent. The content within all these sample responses can be found within