Chapter 2
What Is Integrated Behavioral Health?

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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

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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

Table 2.4 Compatible answers to "what is it" for different audiences and purposes

Person asking	Likely purpose	Sample answer
Physician colleague	Just interested in what you are trying to do	Expanding our clinic team to do better (and feel better) with the behavioral health dimension of our practice…things our patients already bring with them…that we may not always have the time or experience to do as well as we want. "The care you want to provide to your patients."
Clinic nurse or medical assistant	How will this affect my routine and who I work with?	A BH clinician on our clinic team instead of an outside referral… works in clinic space with you and is part of huddles, care planning, and charting…on our team like everyone else…helps patients and helps us.
Operations team	What operational changes to expect?	A BH clinician working on our team from empty exam rooms, offices, or other clinic space…in our huddles, scheduling and EHR systems…coding…picture on the wall with the rest of us…another role on our primary care team.
Clinic manager	What supervision and business model?	Licensed BH provider with own professional supervision but accountable to us (medical director and clinic manager) for teamwork, citizenship, scheduling, care processes…revenue for codes when appropriate, indirect benefit to clinic performance, and [fill in the rest of your business model].

Quality improvement leader	What is the QI opportunity?	Take your pick: Integrated BH processes for 1. Better clinical outcomes for BH conditions 2. Better outcomes for medical or complex conditions where people are depressed, demoralized, anxious, or "stuck" 3. Quicker initial access to BH consultation for patients (and for us) 4. Better connection for any specialty BH referrals 5. Better patient and provider satisfaction 6. Reduced fragmentation and needless cost of care 7. Realistically tailoring medical care to accommodate "social determinants" and "complexity"
Patient	How might this help me?	Your doctor has a partner right in the clinic trained to help our patients with personal, family, stress-related, mental health, or healthy behavior kinds of factors in health and medical care…a stronger medical team when you need it...Right here in the clinic... Where we all know each other.

(continued)

Table 2.4 (continued)

Person asking	Likely purpose	Sample answer
Board member	How might this affect our mission, reputation, and viability?	Our mission is to improve health. BH is also health—Often intertwined with medical conditions and care. We are implicitly "scored" on BH contributors to good primary care via clinical outcomes, patient experience, cost of care, and provider satisfaction. For these reasons, BH integration has broad national uptake. Research and business models are still in development, but BH integration as a normal part of primary care is pretty much settled. The task is how to do it effectively. We know what the functions need to be.
Implementation or process design team	What exactly do we have to build?	Read the AHRQ functional definition (Table 2.3) and go to the published lexicon for other specifics such as the list of elements for shared care plans and elements for follow-up and treatment to target. These are essential functions, but still do not tell us exactly what to do here. So consider how we can tailor these functions to our own practice, at the time we are beginning, at the pace we can move, with our own target starter populations, and with the resources and tolerance for change around us.

the AHRQ definition, but is translated for use by the person and purpose at hand.

These are only examples. You can tailor your own responses that could be given between floor 1 and 2 on an elevator. But they could be followed with "Would you like to know more about that?" This would open the path for another layer of information for anyone interested—such as in Tables 2.1, 2.2, and 2.3 showing the AHRQ definition.

Be Able to Move from General Definitions to Your Own Locally Tailored Implementation

The AHRQ definitions of Tables 2.1, 2.2, and 2.3 or person-specific examples in Table 2.4 do not try to prescribe a specific granular implementation for your practice. There is too much to take into account locally to make any universal detailed prescription realistic. Just as a great definition of "airliner" does not include the mechanical drawings for any specific airplane, the functional definition of integrated behavioral health does not include exactly what to implement in your own clinic. Yet the need remains for a specific implementation that works for your purposes.

Some implementers employ a "model of integration" to help tie general definition to specific implementation. A "model" is simply one of the currently recognized ways to operationalize the functions required in a general definition. Operating models are different means to the same or similar ends, but represent different distinguishable ways to "skin the cat" in different settings. Hence conversations about "what is integrated behavioral health" sometimes include the question, *"What models of integration are out there and should I use one of them?"*

It is worth pausing here to briefly describe common "models" that people may have heard about. Read Table 2.5 as a general guide, knowing that the terminology and specifics within these models are variable, evolving, and entail considerable overlap. For example, the first two models in the table (Primary Care Behavioral Health and Collaborative Care

Table 2.5 Common operating models of behavioral health integration

Common name(s)	Basic approach
1. Primary Care Behavioral Health (PCBH)	Characterized by BH clinicians as on-site members of the primary care team, space and EHR; doing brief interventions using more or less standard algorithms. Degree of standardization, length of intervention, or clinical focus varies [4–7].
2. Collaborative Care Model (CCM)	Defined by a team of primary care provider, care manager, and consulting psychiatrist who reviews registry panels of patients and consults to care manager, PCPs, and other clinical staff of the care team. The psychiatrist is an active consultant, not there to fill a conventional schedule of patients. Often involves considerable standardization and has a long history of research support [8–12].
3. Primary care integrated in mental health settings (bidirectional or "reverse integration")	Primary care clinician expertise brought into mental health settings so that patients who identify mainly with the MH clinic get good primary care right there. This model aims for much of the same functional performance as integration of MH into PC [13, 14].
4. Residency behavioral science education model	Almost universal in family medicine residencies, a behavioral health clinician works as teacher, preceptor, and clinician seeing patients with physicians—already on-site for educational purposes. Pulls in elements from the PCBH model but rhythms, schedules, and scope of activities are different due to being educational programs.
5. Behavioral health integration in specialty medical care	Similar goals and functions as primary care integration but tailored to specialty medical care such as oncology, neurology, endocrinology, occupational health, physical medicine and rehabilitation, developmental pediatrics, or emergency department and hospital. May use a combination of PCBH, CCM, or residency education models.

Table 2.5 (continued)

Common name(s)	Basic approach
6. Family-centered integration or medical family therapy	The family is considered the "client" and recipient of medical care. Family systems are front and center with identified patient embedded in a family system where much of the causality and treatment or self-management opportunities reside. Many principles of PCBH or CCM integration apply, but with the family rather than individual as the "client" [15].
Other variations or hybrids	Specific implementations may combine elements from more than one model above or employ telehealth and other variations on collaboration for rural or other special circumstances.

Model) are sometimes featured independently as anchoring models and sometimes are combined in actual implementations. In academic settings such as family medicine residencies, one or both may be combined with the "residency behavioral science education" model.

Models are a package of design choices. Here are some important things to remember about "models":

1. *Models are shorthand for particular approaches* to accomplishing the same core functions—a pattern of design choices. For example, the Collaborative Care Model archetypically features a primary care physician, care manager, and consulting psychiatrist collaborating using a registry for "treatment to target" for one or more conditions.
2. *Models often emerge from different research or practice cultures*. For example, the Primary Care Behavioral Health model emerges from clinical practice culture, typically aimed at a wide variety of patient conditions and situations ("all comers"). The Collaborative Care Model emerged from a research culture (originally on late-life depression) and has gradually been extended to multiple conditions.
3. *Different models may be chosen based on practicalities*—what or who is available to do the work, and what operational or information systems are available. For example,

the Collaborative Care Model might be difficult to implement in an area with no psychiatrists, or none willing to work as consultants to primary care providers.

4. *All "models" are a means, not an end.* They must accomplish the same basic functions of the AHRQ definition or equivalent general definitions. There is little point in arguing about "which flavor of integrated care" is best [3]. Each model has its own origins and properties, but they tend to mix and converge over time. Keep your eye on the defining functions of integrated behavioral health and "models" as a means to achieving them.

Fidelity to a model or definition also requires realistic local tailoring, whether designing an implementation using a *model* of integration as a pattern, or working directly from the general *definitions*, to work…

…in your own practice,
…with what you can gather around you at the time you begin,
…at the pace you can move,
…with your own target starter populations and purposes, and
…with the resources and tolerance for change around you.

Implementing integrated behavioral health on a meaningful scale requires a definition or model to be scaled up (a pattern to be followed) and local tailoring (making it work well in local reality). There is value in both, and tension between "standardization" and "anything goes" does not go away. These are the characteristics of "polarities" requiring that you strike a balance between them [16–23].

Balance means preserving the *general case* while creating a local *special case*; the *essence* of the definition and what *within it* needs to be locally adapted. And do not leave that balance to the imagination. Actual implementation requires a shared understanding at a practical level of detail on what requires fidelity and what is locally tailored. Let us consider two examples of local tailoring to a specific *model* of integration.

Example 1

The DIAMOND Initiative was a Minnesota statewide initiative for care of depression following the Collaborative Care

Model (CCM), with a care manager and consulting psychiatrist working with primary care providers[1] [12, 17, 22, 24]. Especially because it had to be scaled up to 75 practices statewide, it was essential to be clear what components were essential—the core features—and what aspects of those components the practices had to do or decide for themselves. DIAMOND required fidelity to four components:

1. A stepped care protocol
2. A registry for all DIAMOND patients
3. A care manager working with primary care clinicians, patients, consulting psychiatrist
4. A consulting psychiatrist

These were all required to participate in DIAMOND. Clinic training materials included highly specific definition of those four components plus specifically what the clinics would need to build or adapt to their own situations.[2] Here are a few examples of what every practice did:

- Tracked a certain set of data, but the type of medical record or tracking system was up to the practice.
- Had a dedicated care manager trained by the project, but the discipline was up to the practice, e.g., nurse, social worker, behavioral health clinician, medical assistant.
- Received a care management fee, but each practice negotiated its own rate with payers.

The required functions and what was to be locally decided were made explicit at the outset to minimize confusion across the 75 practices and to prevent both "cookie cutter" prescriptions that would exclude many practices, and so much diffusion of the intervention by "local tailoring" such that "anything goes."

1 The DIAMOND Initiative (Depression Improvement Across Minnesota, Offering a New Direction) was a cooperative effort of 75 practices from small and large provider groups, supported by a financial model from all four major health plans and the Minnesota Dept. of Human Services, and facilitated by the Institute for Clinical Systems Improvement, a regional quality improvement organization.

2 DIAMOND fidelity/local tailoring examples were extracted by the author from training materials supplied to all practices.

Example 2

Local tailoring can be done directly to a functional definition of integrated care without an intervening model. The AHRQ "lexicon" definition of integrated behavioral health does not entail or recommend a "model" such as CCM or PCBH. Table 2.6 shows a worksheet that can be used by your practice to help your implementation team be clear about what your clinic(s) can and must decide or do for yourselves given your local situation. Of course, this worksheet still does not actually tell you what you are going to do. But the "local tailoring" column asks the questions for which you will need answers. You can fill in those specific answers—which would begin to sketch out your own "special case" of integrated behavioral health.

TABLE 2.6 A worksheet for balancing fidelity with local tailoring for integrated behavioral healthcare

Defining functions: what must be in place—fidelity	**Local tailoring: choices you need to make**	**What specifically you will implement**
Clinical "how" functions:		(Write it down here)
1. A practice team of primary care and behavioral health clinicians tailored to the needs of your clinic panel and each patient and situation With shared space, workflows, treatment plans, and practice culture	• The mix of clinical skills and experience needed for your clinic's panel or target sub-population for integrated behavioral health • Your processes for defining the team at the level of each patient, and targeted population • Your particular space and workflows that ensure teamwork in a single, not conflicting practice culture • How you orient and train clinicians for roles	

Table 2.6 (continued)

Defining functions: what must be in place—fidelity	**Local tailoring: choices you need to make**	**What specifically you will implement**
2. With a shared population and mission—a panel of patients in common for total health outcomes Not merely separate responsibility for separately conceived medical and behavioral health	• How you help your clinicians make this cultural shift and get used to thinking of medical and behavioral health both as "health" and "whole person care" • How you make sure interests, incentives, and trust are aligned ("leadership alignment")	
3. Routinely using a systematic clinical approach consisting of shared goals, workflows, and documentation	Your specific processes for: • Identification of those who can benefit • Engaging them in integrated behavioral health • Involving them in decision-making • Making shared care plans in your EHR • Systematic monitoring, follow-up, and treatment adjustment ("treat to target")	

(continued)

Table 2.6 (continued)

Defining functions: what must be in place—fidelity	**Local tailoring: choices you need to make**	**What specifically you will implement**
Organizational "supported by" functions		
4. A community, population, or individuals expecting that behavioral health and primary care will be integrated as a standard of care	How you engage your patients, community groups, provider societies, and local health groups in establishing this as a target standard of care or "north star" in your community	
5. Reliable office practice systems, alignment of leadership and purpose, and sustainable business model Broad-based visible organizational support for what it takes to do integrated behavioral health	• How you reach durable leadership consensus — and align the incentives and reasons • How you will redesign processes to support the functions • The financial workarounds to support the work before standard payment supports it well enough	
6. Continuous quality improvement with routine use of practice and other data to improve effectiveness Track and improve patient outcomes, change and quickly learn from experience. Triple Aim	• How you expand your quality improvement tracking to reflect the integrated behavioral aspects of care, not only medical—a more integrated "scorecard" • How you will report results and use it to improve the integrated system, not only traditional medical outcomes	

Conclusion

This chapter has been a long answer to the question, "What is integrated behavioral health?" All practice leaders and implementers may need to answer this in one or more of the three ways outlined here:

1. What is integrated behavioral health in general (a published, professionally grounded definition—the general case)?
2. What does that mean for me here? (Handy context-specific answers to the "what is it" question for various audiences and occasions)
3. How specifically will we make it work with who we are here? (The locally tailored implementation that you will be creating in your own clinic.)

With these three ways to answer *"what is it,"* your team can retain responsiveness to published literature and definitions while proceeding realistically in your real-world situation with the people in it; preserving the need to remain professionally responsible, *and* be practical about implementing things in the local context, *and* communicating well and briefly to anyone who asks.

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Resources

In addition to providing definitions and frameworks, these two organizations provide a package of resources for integrated behavioral health:

The AHRQ Academy for Integration of Behavioral Health and Primary Care: https://integrationacademy.ahrq.gov

The Substance Abuse and Mental Health Services Administration—Health Resources and Services Administration (SAMHSA-HRSA)'s Center for Integrated Health Solutions: https://www.integration.samhsa.gov