Ruddy and McDaniel have the collective experience and persuasive examples to convince their readers why integrated care represents the best care available. Context matters. No matter whether joining people to guide their journey toward health or creating change in organizations, we need to understand the perspective of others and the forces that shape their choices. Whether new or experienced to a systems lens, this accessible text will transform your care of patients.

–CATHERINE L. GILLISS, PhD, RN, FAAN; DEAN AND STYLES PROFESSOR OF NURSING, UCSF, SAN FRANCISCO, CA

Complete with theory, policy, and practice evidence to manage the complexities of integrated behavioral health more effectively, Ruddy and McDaniel offer a comprehensive overview of behavioral healthcare integration. Regardless of readers' familiarity with integrated models of care at the clinical-, population-, and system-levels, this book will deepen practice knowledge and understanding.

–LISA DE SAXE ZERDEN, MSW, PhD, UNC CHAPEL HILL SCHOOL OF SOCIAL WORK, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, CHAPEL HILL, NC; & BRIANNA M. LOMBARDI, MSW, PHD, UNC CHAPEL HILL SCHOOL OF MEDICINE, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, CHAPEL HILL, NC

Written by two highly successful forerunners in the field of integrated healthcare, this book describes the challenges implementing integrated models of care and provides a pathway to addressing those barriers. The strong focus on navigating systems effectively makes it a unique resource. The collective wisdom of the authors shines through, making it a must-read for anyone who wants to thrive in integrated primary and specialty care settings.

–BARBARA CUBIC, PhD, PROFESSOR, DIRECTOR OF BEHAVIORAL HEALTH, WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE, DEPARTMENT OF FAMILY MEDICINE, MORGANTOWN, WV

Ruddy and McDaniel offer us a work that is encyclopedic in scope, balanced and authoritative in its content, and, finally ground-breaking for the field of integrated care. It serves as a manual for making integrated behavioral health the standard of care in medical settings, as relevant to clinicians entering the field as to policy makers and organizational leaders on the lead edges of innovation.

–ALEXANDER BLOUNT, EdD, PROFESSOR EMERITUS OF FAMILY MEDICINE AND COMMUNITY HEALTH, UMASS CHAN MEDICAL SCHOOL, WORCESTER, MA; PRESIDENT, INTEGRATED PRIMARY CARE, INC.

For the first time we have a clear and comprehensive account of the field of integrated clinical care—the elements from which it draws, the sociopolitical and economic crucible in which it is forged, the powerful tools that have emerged, and the most promising directions for the future. Drs. Ruddy and McDaniel are two distinguished clinician-scholars who have been there from the beginning, working in and shaping this field, and this volume is a brilliant culmination of decades of work. Well done!

–FRANK DEGRUY, MD, MSFM. PROFESSOR, DEPARTMENT OF FAMILY MEDICINE, UNIVERSITY OF COLORADO, BOULDER, CO

With a focus on systems, this text is a must-read for healthcare professionals who wish to have a sophisticated, yet practical understanding of current health conditions and why integrated care models are our best hope for achieving better health outcomes.

–TERRY STANCIN, PhD, ABPP, PEDIATRIC/CLINICAL CHILD & ADOLESCENT PSYCHOLOGIST, PROFESSOR, CASE WESTERN RESERVE UNIVERSITY, CLEVELAND, OH; FELLOW, AMERICAN PSYCHOLOGICAL ASSOCIATION

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INTRODUCTION

Why a Systemic Lens Is Critical for Integrated Care

We have a neck for a reason. Common sense and decades' worth of data tell us that it is perilous to ignore the connection between our minds and bodies. Yet traditional clinical and training approaches segregate the biomedical and psychosocial aspects of the human experience. The U.S. healthcare system largely bifurcates care for our emotional, physical, and relational wellness. This dualistic, profit-driven structure impedes collaboration that can facilitate coordinated, comprehensive care to the people we serve. The status quo too often stymies service integration efforts aimed at bringing a team approach to necessary services and gathering expertise under one roof.

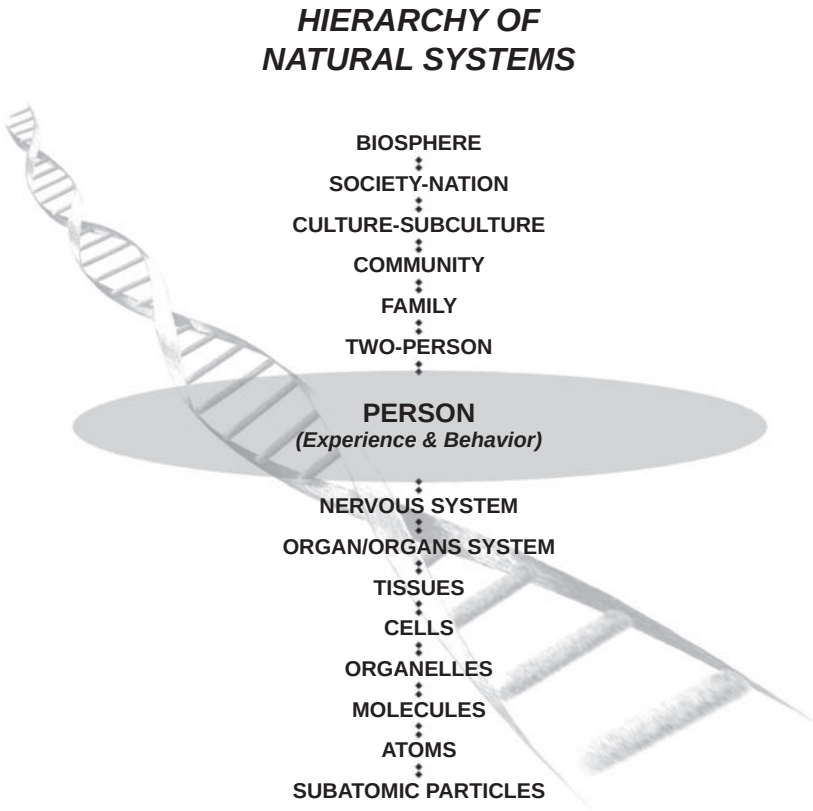
Despite these challenges, the advantages of integration have propelled expansion of interprofessional, team-based care in the latter part of the 20th century (Richman et al., 2020). The movement toward integration of behavioral health into medical care occurred in the context of larger system paradigm shifts over many decades. George Engel's (1977, 1980) description of the biopsychosocial approach in the 1970s spurred evolution in medical training, research, and standards of care. The biopsychosocial approach does

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not focus solely on the interplay of the mind and body. Rather, the approach acknowledges the impact of factors at every level—from the microscopic to the social stratosphere (see Figure 1). This expansion was prescient. In the years since publication of Engel's foundational article, research increasingly shows that social and behavioral factors are some of the most important aspects of health and wellness (Daniel et al., 2018).

Many healthcare professionals recognize and enjoy the benefits of multidisciplinary teams. However, integrated care has yet to become the agreed-upon standard of care. We believe it is critical to replace this parallel play between the medical and behavioral health systems with team-based, collaborative care

FIGURE 1. Hierarchy of Natural Systems



Reprinted from the "The Clinical Application of the Biopsychosocial Model," by G. L. Engel, 1980, *The American Journal of Psychiatry*, *137*(5), p. 537. Copyright 1980 by the American Psychiatric Association. Background illustration printed with permission from Janette Dauenhauer.

that recognizes the patient and family as critical members of the team. We strive to make integrated care normative.

A central tenet of integrated care is to meet people where they are. Integrated care *literally* provides behavioral health services where the public seeks healthcare. Integrated family- and patient-centered care *figuratively* meets people where they are as well. The focus of care reflects the patient's, family's, and community's values and goals, recognizing that patients, families, and communities are more likely to engage when they feel they have a voice and a sense of agency in their own care (Baker, 2020).

Integrated care is part of a movement to care for the whole person. Whole-person healthcare focuses on the meaning of the healthcare experience, with a collaborative stance toward patients and families that emphasizes healing (Hutchinson, 2017). However, whole-person approaches still treat the individual as the unit of care. We advocate a systemic approach that not only recognizes the full spectrum of factors that influence an individual's health but also considers the relationships between these factors. Exploring these interactions enables a deeper reflection on the complexity of the human experience as it relates to our health and wellness.

Along these lines, one of our goals in writing this book is to highlight the importance of a *systemic lens*. A systemic lens recognizes nonlinear or circular/reciprocal causality, focuses on the relationships and patterns, anticipates unintended consequences, and emphasizes the role of the system in creating lasting, intentional change (Stroh, 2015). A systemic lens also enables us to integrate the influence of variables at each level of the system as well as the interplay among them. This interstitial space between our microbiology, organ systems, individual psychology and beliefs, family relationships, community, and culture is critical to improving the health of individuals, families, and communities. Finally, a systemic lens allows us to unravel the complexity of our fragmented healthcare system and revamp it to focus on effective, comprehensive care for patients and families.

This lens is particularly important when one seeks to influence systems in which

- a situation is chronic and defies attempted solutions;
- well-intended stakeholders struggle to align efforts despite shared goals;
- stakeholders tend to focus on optimization of their own part of the system, without consideration of the impact on the whole;
- efforts have, at times, actually undermined the stated goals;
- improvement efforts occur simultaneously with little to no coordination; and
- a focus on specific solutions (e.g., best practices) reduces engagement in continuous learning (Stroh, 2015).

Anyone familiar with our healthcare system will recognize these characteristics. Politicians, patients, and clinicians generally agree that the U.S. healthcare system functions poorly and is not financially sustainable. Ongoing reforms have yet to yield the needed transformative results. Too often, the system is stuck.

This book seeks to chart a path forward. Moving forward requires healthcare professionals to turn the mirror on ourselves and our system. We must create a road map for improving population health via integrating patient- and family-focused behavioral health into our healthcare structure and services. This road map, essentially a treatment plan for our healthcare system, must be evidence-based and cognizant of larger contexts. Therefore, we describe a path forward based on implementation science and clinical assessment, interventions, and outcomes research that recognizes how larger contexts facilitate and complicate efforts to integrate care.

SUCCESSFUL SYSTEMS CHANGE

As any experienced systems thinker appreciates, the foundations, history, systemic barriers and solutions, and clinical applications are intertwined like a bowl of spaghetti. We must be inclusive of the perspectives and expertise of all disciplines and roles because each serves different functions in our healthcare system. Yet each discipline and role ideally understand the larger context in which they function.

Clinicians and direct service staff can best facilitate reform when they understand the essential elements of integration, models of care, their genesis, and the systemic issues that affect care. Frontline clinicians can serve as the canary in the coal mine to inform implementation processes because they experience directly what is and is not working in their system. The more clinicians and staff understand and engage in the implementation process, the more likely the process will be successful. In parallel, administrators and systems architects need to understand and be able to explain exactly how these services look in the real world and how they will improve our healthcare system. They need to be able to highlight how clinicians' roles shift in integrated care while understanding the difficulty of changing clinical patterns. Ideally, their understanding of the end goal and the resources and processes needed to reach this goal can engender true practice transformation. Across the board, everyone needs motivation and a shared mental model of the desired end state, how to get there, why it matters, and how to measure and maintain progress.

Just as the biopsychosocial approach is foundational to integrated care, reflective practice and intentionality are foundational to practice transformation (Horton-Deutsch & Sherwood, 2017). We invite self-reflection regarding your readiness to change from a traditional, siloed approach to integrated, team-based care. Changing one's own behavior is challenging, particularly with regard to professional habits honed over years of training and practice. To successfully evolve toward integrated care, leaders, clinicians, and staff must believe that this shift will help them realize the shared "north star" to serve our communities via exceptional healthcare. To achieve this goal, health professionals must work collectively to alter daily routines and behaviors and adjust their interactions with each other and the patients and families they serve.

As family therapists ourselves, we assist families by helping them identify shared goals, make structural changes, and shift relational dynamics, communication, and behavioral patterns in service of the family's goals. Organizations and practice change efforts must engage in a parallel process to support systemic change toward integration. Successful integration implementation requires shifting healthcare structures, team dynamics, and communication and behavior patterns. As with families, the healthcare system has a strong pull to homeostasis that can derail change efforts (Selladurai et al., 2020). Such change is not simple, and it is not quick. Also as with families, integration implementation is most likely to be successful when stakeholders understand this new model of care and how it addresses some of the root causes of healthcare system pain points.

As change agents, we work with one hand tied behind our backs if we are unfamiliar with systemic concepts. Yet many healthcare professionals have not been trained in these concepts. The next part defines various systemic concepts and outlines how each concept is reflected in our review of systemic integrated care history, implementation, and clinical applications. We hope this helps readers less familiar with systemic thinking understand the meaning and application of these concepts. We encourage the reader to embrace a systemic spirit. As part of your self-reflection, notice any drift into thinking about these systems in a linear, cause-and-effect way and experiment with (or continue) to focus on the relational intertwining of elements and their function in the whole.

As you move forward, consider these wise words from Donella Meadows, an environmental scientist and writer who trained in system dynamics at the Massachusetts Institute of Technology and served as a professor of environmental sciences at Dartmouth. She wrote multiple bestselling books on

systems thinking, as well as *The Global Citizen*, a well-regarded newspaper column that applied a systems perspective to global events.

> I don't think the systems way of seeing is better than the reductionist way of thinking. I think it's complementary and therefore revealing. You can see some things through the lens of the human eye, other things through the lens of the microscope and others through the lens of a telescope and still others through the lens of systems theory. Everything seen through each kind of lens is actually there. Each way of seeing allows our knowledge of the wondrous world in which we live to become a little complete. At a time when the world is more messy, more crowded, more interconnected, more interdependent, and more rapidly changing than ever before, the more ways of seeing, the better. The systems-thinking lens allows us to reclaim our intuition about whole systems and hone our abilities to understand parts, see interconnections, ask "what if" questions about possible future behaviors, and be creative and courageous about system redesign. Then we can use our insights to make a difference in ourselves and our world. (Meadows, 2008, p. 19)

APPLYING AND DEFINING A SYSTEMIC LENS

A systems lens serves as the foundational schema for how we understand integrated care. This lens informed our inclusion of the historical context of integrated care and serves as the underpinning of our approach to integrated care implementation and clinical services.

Part I of the book focuses on the *historical context* of integrated healthcare because the developmental context of any system is critical to understanding a system's current state and future direction. Therefore, we review the emergence and evolution of integrated care as well as the systemic underpinnings of our current healthcare state.

Part II of the book focuses on our belief that a systems lens underlies successful integration *implementation*. A systemic approach to healthcare reform and transformation is based on understanding the structure and regulation processes of the healthcare system. Therefore, in the implementation part of the book we discuss healthcare system structure, organization, subsystems, and interactional patterns.

Part III of the book shifts to address systemically oriented *direct clinical service*. Systemically focused clinical assessment and intervention require a specific mindset and set of competencies that transcend any one discipline. We review key concepts of medical family therapy, its evidence base, and its application in various healthcare settings and populations.

Table 1 describes how these particular concepts are relevant in the three parts of the book: historical context, implementation, and clinical application. These concepts can be difficult to understand based on verbal descriptions; for visual learners we suggest "Habits of a Systems Thinker" from Thinking Tools Studio, available at https://thinkingtoolsstudio.waterscenterst.org/cards. Below are definitions of systems concepts:

- **General systems theory:** A paradigm that recognizes that (a) the whole is greater than the sum of its parts (nonsummativity); (b) systems have hierarchies, executive organization, and subsystems; and (c) systems self-regulate and strive toward self-preservation (Gerhardt, 2019).
- **System:** A coherently organized set of elements interconnected in a pattern or structure that serves a specific purpose or set of purposes (Meadows, 2008).
- **Family system:** The family is an organism in which no one person orchestrates interactional patterns, so no one person can be to blame for issues. In a family systems perspective, all behavior makes sense in context. The patterns of interactions between family members and their context reflect mutually negotiated, often implicit, system rules and norms (Gerhardt, 2019).
- **Complex adaptive system:** A system made up of semiautonomous units that evolve over time, based on schemas or shared mental templates that inform this evolution. Multiple systems and schemas exchange information and/or resources. Understanding a complex adaptive system requires consideration of the way many elements interact with many other elements. This interlocking web of relationships among elements sets the stage for exponential "tipping point" change, depending on levels and natures of interconnection in the system (Dooley, 1997). Complex adaptive systems in healthcare are made up of diverse agents who can learn and adapt or coevolve with their environment, whose relationships are highly interconnected or interdependent, and who self-organize to complete tasks (Noël et al., 2013; Sturmberg, 2018).
- **Systems thinking (or systems lens):** An approach that recognizes nonlinear or circular/reciprocal causality, focuses on the interrelationship and patterns of behavior of system elements, anticipates unintended consequences, and emphasizes the role of the system in creating lasting change (Stroh, 2015).
- **Hierarchy:** An aspect of system structure related to the level of power in different parts of the system, or subsystems (Meadows, 2008).

TABLE 1. How Systems Concepts Can Inform Integrated Care

Concept	Part I: Historical Context	Part II: Implementation	Part III: Clinical Application
General systems theory	Context matters—the healthcare system cannot be well-understood outside of its historical evolution.	Implementation efforts are affected by the interrelation of healthcare system elements and its structure and the system's natural tendency to support the status quo.	The interplay of families, communities, health, and the healthcare system all affect and should be considered in clinical work.
System	A description of how healthcare system elements and their relationships evolved over time	How multiple systems (e.g., education, healthcare, government) can spur and deter implementation of systemic integrated care	How systemic elements in the family affect healthcare management and vice versa
Family systems	Healthcare expanded its purview to include the family system and other social factors in health.	Description of the parallels between family dynamics and healthcare system and clinical team dynamics in healthcare provision	A focus on the assessment and interventions strategies based in family systems theory.
Complex adaptive system	Healthcare increasingly recognizes the complexity inherent in its mission. This recognition has had broad implications for its evolution.	The barriers and facilitators of integrated healthcare are based in and reflect the complexity of our contextual system, practice organizations, and even the interplay of professionals, patients, and families in the provision of clinical care.	A systemic approach to clinical care requires consideration of how multiple systems interact with and around the patient and family.
Systems thinking (or systems lens)	The emergence of systemic thinking, including how this paradigm shift affected healthcare and the evolution of systemic integrated care	A description of how a systemic lens is critical to successful systemic integrated care implementation and practice transformation, including the application of organizational change theory	A description of how health conditions stress family systems, including systemic assessment, intervention strategies, and the interplay of family and clinical team dynamics

Hierarchy	How power hierarchies in the healthcare system have shifted over time	How power differentials across the systems of interest affect implementation and how the various subsystems within the healthcare system relate to one another	How health conditions can affect family structures and hierarchies and the impact of power differentials on team function and care provision
Nonsummativity	How shifting paradigms and mental models of health and healthcare have far-reaching effects on the healthcare system	The import of recognizing nonsummativity in implementation efforts, focusing on potential unanticipated consequences	A means of understanding and addressing challenging patient, family, and care team interconnections and their potential parallel processes
First-order and second-order change	How second-order changes in healthcare contexts related to the evolution of systemic integrated care, and how second-order change in one element (e.g., education system) may facilitate second-order change in other elements	How second-order change, or practice transformation, is the ultimate goal of implementation, requiring development and assessment of system and implementation strategies to foment second-order change	How health conditions can set the stage for second-order changes in families, who often benefit from strategies to manage problematic shifts and seek meaning in the experience by shifting the mental model and interactions in a positive way
Homeostasis	The patterns of recursive change in our healthcare system illustrate the push–pull of change and homeostasis.	Relevant strategies to deal with the inevitable counterweight of homeostasis that must be overcome to achieve practice transformation	How health conditions can disrupt family development and homeostasis and also how some health conditions can actually serve to maintain a homeostasis that is problematic in the long run for the family or clinical team

- **Nonsummativity:** A full understanding of a system requires attention to elements' interrelatedness and organization, particularly in complex adaptive systems. A system's interconnected elements cannot be understood fully in isolation from one another (Goldenberg et al., 2017).
- **First-order and second-order change:** First-order change reflects surface changes that do not fundamentally alter the structure of the system (like rearranging the furniture in a living room). First-order change tends to be transient, as the system self-regulates back to its original state. In contrast, second-order change reflects a shift in the structure and/or rules of the system such that the system itself fundamentally changes (like building a new house with an entirely different living room). Second-order change tends to be more lasting (Gerhardt, 2019).
- **Homeostasis:** The tendency of systems to maintain the status quo and the dynamic process by which a system maintains this equilibrium (Gerhardt, 2019).

ORGANIZATION OF THIS BOOK

Part I of this book focuses on foundational elements of integrated care. In Chapter 1, we outline levels of integration that are common in our healthcare system, ranging from completely separate to fully integrated services. We illustrate each level via a case-based care narrative that contrasts patient encounter experiences to highlight the benefits and challenges of each. We then describe elements that define fully integrated care as well as how these elements are operationalized in different models of integrated care. Additionally, we present a brief, high-level overview of outcomes research on the two established integrated care models. The intent is to ensure that readers recognize key elements of integrated care, the similarities and differences of the models, and their implications for the patient, family, and clinician experience.

In Chapters 2 and 3, we turn to the historical context of systemic integrated behavioral health. We start with historical context to help us chart the path forward, mindful of lessons learned from history. We outline how healthcare is shifting, in parallel with other sciences, from a mechanistic, linear model to a broader, biopsychosocial systemic approach. Our underlying schemas, or mental models, reflect this shift toward contextualization and increased focus on interrelationships and complexity in how we understand and define healthcare. These mental models are foundational, as they reflect "concentrated, personally constructed, internal conceptions of external phenomena (historical, existing or projected), or experience, that affect how a person acts" (Rook, 2013, p. 11).

The shift toward a biopsychosocial systems mental model of healthcare set the stage for the growth of integrated behavioral health. As we embraced this broader, relational approach to healthcare, our standards shifted. The pursuit of these new standards required evolution in care provision, research, and policy reform. Our historical review specifically outlines the emergence of integrated behavioral health. We describe how this new approach required professionals to develop novel concepts and competencies to meet new biopsychosocial relational standards of care. We also describe how these shifts influenced researchers. Researchers began to recognize the need to adjust their mental models and research methodologies to better understand complexity and systems of care. The goal of these evolving research models is to provide more usable guidance to clinicians, policy makers, and healthcare system architects to facilitate evidence-based care and needed process and infrastructure changes. Across the board, our historical review illustrates how healthcare stakeholders slowly realized progress comes only when we recognize the need for a systemic lens and acknowledge the inevitable messy complexity of healthcare.

Part II of the book focuses on the implementation of integrated care. We describe and utilize Lau and colleagues' (2016) conceptual framework regarding elements that influence implementation efforts. They highlight four levels of analysis:

- external contexts, including policy, incentives and funding, dominant paradigm, and infrastructure;
- organizational, including culture, resources, skill mix, and relationships;
- professional, including philosophy of care (which we term *mental model* of care), competencies, professional role, and relationships; and
- intervention, including implementation challenges related to clinical intervention content and modality.

Chapters 4, 5, and 6 parallel the first three levels of analysis: external contexts, the organizational level, and the professional level. (Intervention, the fourth level of analysis in the conceptual model, is the focus of Part III of the book.) Chapter 4 focuses on the interplay of external contexts in healthcare and the movement toward reform and integration. These external contexts include multiple sociocultural systems, such as the health professional education and training system, government healthcare policy, reimbursement systems, and systemic racism and other social issues that affect health. With regard to these sociocultural issues, we argue that change occurs only when we name facilitators and barriers to change, engage in community-based advocacy, and adopt reflective practices to identify opportunities for change. Furthermore, we emphasize the social justice mission inherent in

healthcare reform toward integration. We argue that systemic integrated care can improve inequities, recognizing that the most vulnerable among us often receive subpar care and suffer negative outcomes (Baciu et al., 2017; O'Loughlin et al., 2019).

Chapter 5 shifts to systemic factors at the level of regional and community healthcare organizations and practices. We review how organizational factors such as leadership engagement, culture, and resources affect the implementation process. For example, a practice's culture can influence whether it embraces or rejects change processes. The degree to which the practice has resources to support practice shifts has a significant impact on the implementation process and its outcome (Kyle et al., 2021).

In Chapter 6, we attend to how professionals within the organization approach integration, reflecting both individual and team practice patterns. We review the importance of shared mental models of care, clinician and staff attitudes toward change and collaboration, and professional role definitions. Understanding these elements and associated patterns is crucial to integrated care efforts because a shift toward integration requires clinicians and staff to interact with their community, families, patients, and each other differently than is done in standard care (Blount, 2019a, 2019b).

For each level of analysis, we discuss specific facilitators and barriers to care. Implementation research informs strategies to assess, address, and mitigate or capitalize on these factors. We advocate a measurement-based process in which ongoing assessment informs the need for changes in strategy and approach and provides stakeholders with information regarding their own and their team's performance. In addition, we describe and apply an evidence-based, systemic change management approach that recognizes the need for a strategic process to motivate healthcare organizations and professionals to make necessary changes. We specifically review how leadership and team functioning influence the implementation process. Vignettes illustrate these external large-system, organizational, and professional characteristics as well as the suggested implementation strategies.

Part III of the book illustrates the application of the systemic approach to integrated clinical services, with a specific focus on evidence-based family interventions and the interface of families and health. It is critically important to expand our healthcare purview to engage families, communities, and social structures as allies and partners to achieve optimal care. One of our goals of writing this book is to highlight how clinicians and other healthcare leaders can broaden their lens to include the family and other social systems to improve their effectiveness, even in the fast-paced healthcare environment.

Toward this end, we describe strategies to include family and social issues in clinical care (Chapter 7) and provide a high-level overview of the evidence base for the family's influence on health and the utility of family systems approaches to care (Chapter 8). We apply a relational, systemic lens to adult (Chapter 9), children's (Chapter 10), and women's (Chapter 11) primary care by outlining the application of these concepts to common presentations, illustrating them using clinical descriptions and examples.

HOW TO USE THE BOOK

We examine integrated care from three perspectives: a foundational, historical context; implementation and dissemination; and clinical applications. Parallel to the way a systemic clinician seeks to understand and approach a clinical issue from multiple biopsychosocial perspectives, we seek to explore issues that facilitate and impede the development of integrated care in their contexts.

Just as healthcare is intended to serve the needs of patients, this book is intended to serve the needs of the reader. We hope that reading the book cover to cover builds knowledge from one level of a system to the next. We believe that every chapter in this book instills a deeper understanding of systemic, family-oriented integrated care. At the same time, we recognize that some readers might be primarily interested in specific parts of the book, so we encourage readers to ask themselves, Why did I pick up this book?

Do you have an incomplete understanding of the various levels and approaches of integrated care? Do you need to understand the real-world applications of integrated care models better before you move forward? Chapter 1 describes essential elements of integrated care and clinical models of integration from the patients' and family's experience.

Do you want to understand the historical context of integrated care to inform the process of moving forward from the current state? Chapters 2 and 3 describe the U.S. healthcare system's development with regard to integrated care. We then offer possible pathways to the future.

Do you need to understand the root, systemic issues that complicate and facilitate integration implementation? In Chapter 4, we review external contextual factors that promote or impede integration efforts. We highlight strategies to address these challenges, recognizing that only through individual and collective action will we successfully change the system.

Are you working to begin or enhance integration in a practice or multiple practices in a given healthcare system? In Chapter 5, we offer a review of healthcare organizational barriers and facilitators as well as organizational change

strategies. We draw from numerous existing integrated care implementation guides and offer resources and tips to serve as key elements for successful integrated care implementation. We also outline how to develop a systemic change roadmap based on organizational change principles. The goal is to chart a course forward that aligns with local system values and goals by curating key ingredients and applying them strategically.

Have you struggled to engage various practice members in an integration process? Successful integration requires engagement across functions in the practice team, with ongoing support from key practice team members. In Chapter 6, we review professional practice patterns as they relate to integration efforts as well as strategies to motivate administrators, clinicians, and staff to adopt integrated, team-based care. We also leverage existing training resources and other change-incubation methods as part of an overall, strategic change management process. Our goal is to help the reader motivate and prepare professionals to engage in integrated team-based care.

Are you a clinician working in a healthcare setting, seeking new approaches to meet patients' and family's needs? Perhaps your training did not prepare you for an integrated setting. Perhaps you are finding that siloed, individually oriented assessment and intervention strategies are not optimally effective in a healthcare environment. Part III of the book focuses on direct service, outlining clinical applications of systemic and relational approaches to expand clinical assessment and intervention options. Chapter 7 offers a general overview of medical family therapy, a family-oriented, relational, systemic approach that serves as a helpful mental model to guide clinical practice shifts that support integrated care. Chapter 8 reviews the evidence regarding the interface of health and social connection with a specific focus on family relationships and health. In addition, we review the evidence for family-oriented healthcare assessment and intervention, summarizing large-scale systematic and strategic literature reviews. Chapters 9, 10, and 11 highlight clinical approaches that are useful in adult primary care, pediatrics, and women's health. In each chapter, we outline common presenting concerns, medical family therapy strategies to address these common issues, and collaboration and integrated care strategies that align with the setting's culture and population served. We illustrate these strategies via case vignettes.

In general, each part and chapter of the book can stand alone. We recognize each reader brings contextual knowledge and experience and seeks to apply this information to a specific system in a specific community, time, and place. Because of the dynamic nature of integrated team-based care implementation and provision, the reader may find different parts of the book useful at different times.