

ORIGINAL RESEARCH

Integrating Behavioral Health and Primary Care: Consulting, Coordinating and Collaborating Among Professionals

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Purpose: This paper sought to describe how clinicians from different backgrounds interact to deliver integrated behavioral and primary health care, and the contextual factors that shape such interactions.

Methods: This was a comparative case study in which a multidisciplinary team used an immersion-crystallization approach to analyze data from observations of practice operations, interviews with practice members, and implementation diaries. The observed practices were drawn from 2 studies: Advancing Care Together, a demonstration project of 11 practices located in Colorado; and the Integration Workforce Study, consisting of 8 practices located across the United States.

Results: Primary care and behavioral health clinicians used 3 interpersonal strategies to work together in integrated settings: consulting, coordinating, and collaborating (3Cs). Consulting occurred when clinicians sought advice, validated care plans, or corroborated perceptions of a patient's needs with another professional. Coordinating involved 2 professionals working in a parallel or in a back-and-forth fashion to achieve a common patient care goal, while delivering care separately. Collaborating involved 2 or more professionals interacting in real time to discuss a patient's presenting symptoms, describe their views on treatment, and jointly develop a care plan. Collaborative behavior emerged when a patient's care or situation was complex or novel. We identified contextual factors shaping use of the 3Cs, including: time to plan patient care, staffing, employing brief therapeutic approaches, proximity of clinical team members, and electronic health record documenting behavior.

Conclusion: Primary care and behavioral health clinicians, through their interactions, consult, coordinate, and collaborate with each other to solve patients' problems. Organizations can create integrated care environments that support these collaborations and health professions training programs should equip clinicians to execute all 3Cs routinely in practice. (J Am Board Fam Med 2015;28:S21–S31.)

Keywords: Behavioral Medicine; Communication; Delivery of Health Care, Integrated; Interdisciplinary Health Team

Compelling research evidence, health care reform initiatives, and clinician and patient needs are driving the integration of primary care and behavioral health services. Emotional, behavioral, and physical comorbidities are common and compound the risk

for undesirable patient health outcomes.^{1–11} Regardless of implementation site, integration requires professionals of different backgrounds interacting to provide care, yet little research has focused on understanding the ways clinicians work

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together on an interpersonal level to deliver integrated care. Given that patients suffer and health care costs increase when professionals are unable to interact to meet patients' physical, emotional, and behavioral health needs, there is an urgency to understand how primary care and behavioral health clinicians work together.^{7,12,13}

We used the Institute of Medicine's definition of primary care, which defines primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."¹⁴ A primary care clinician (PCP) refers to a person who delivers that care. Behavioral health refers to care that addresses emotional, behavioral, and substance use problems. Behavioral health clinicians (BHCs) include psychologists, psychiatrists, licensed clinical social workers, and master's trained therapists.

Research on the phenomenon of interprofessional practice examines barriers and facilitators of how professionals work together.^{15–41} This research has discovered certain critical ingredients that foster successful interprofessional practice such as willingness to communicate with other professionals,^{29–31,34} a willingness to bend traditions to solve problems,^{17,18,24} and shared goals, vision, and philosophy.^{16–18,35–41} Much of the research on interprofessional collaboration relies on conceptual work and self-report data (eg, interviews, surveys). Studying interprofessional interaction "in the wild" provides "higher quality, context-specific guidance to complement theoretical models"⁴⁰ than self-report data. It also conveys a more nuanced understanding of the ways actual professionals interact in

real-world practices, informing efforts to build effective integrated teams, and enhancing education and training.

This research was not tethered to any specific taxonomy or framework, but focused on actual observed interpersonal behaviors of individuals in diverse practices striving to integrate primary care and behavioral health. Our aim was to 1) identify how people work together during routine practice to meet patients' needs, 2) describe these interactions, and 3) determine which contextual factors shape these professional interactions.

Methods

Sample

Nineteen U.S.-based primary care practices and community mental health centers participated in this study. Eleven practices located in Colorado and participating in the Advancing Care Together program and 8 practices located across the United States and participating in the Integration Workforce Study to identify workforce needs for integrated care participated in this study. For more details on the sample for this study see Cohen et al,⁴² in this issue.

Data Collection

Data collection occurred between September 2011 and September 2014, and is described in detail elsewhere.^{43,44} Briefly, we conducted site visits at each practice, where we intensely observed a broad spectrum of clinical operations, both in and out of the examination room, and conducted 1-on-1, semistructured interviews with 2 to 17 practice members at each site. We spent more than 45 days in the field observing 160 patient visits: 98 with PCPs, 45 with BHCs, and 16 with patients who visited with both types of clinicians on the same day of service. We conducted 90 interviews, providing approximately 54 hours of interview data and we prepared more than 1070 pages of field notes to document site-visit observations.

Data Management

We prepared field notes from jottings after each day in the field. Interviews were audio recorded and professionally transcribed, and transcripts were reviewed for accuracy and completeness. All data were deidentified and entered into Atlas.ti (Version 7.0, Atlas.ti Scientific Software Development

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GmbH). The Institutional Review Boards at Oregon Health & Science University and University of Colorado Denver approved this study protocol.

Analysis

We used a grounded theory approach to analyze data, following a 3-stage analysis process informed by the work of Miller and Crabtree⁴⁵ and the immersion-crystallization approach described by Borkan.⁴⁶ Grounded theory is an approach to analysis whereby researchers allow findings to emerge from data analysis rather than impose a priori theories or categories during the data-analysis process. Immersion-crystallization is a process whereby researchers saturate themselves (immersion) in data to identify (crystallize) findings. In the first immersion cycle, our multidisciplinary team read field notes and listened to interviews together to identify and tag segments of text relevant to BHCs and PCPs working together. Once we established a stable method for tagging text, we divided the remaining data meeting regularly to review data and discuss findings. We then engaged in a second immersion-crystallization cycle, analyzing tagged data as a group to identify and empirically define the ways professionals interacted to deliver integrated care. After consulting, coordinating, and collaborating, behaviors were defined and we examined instances when these interpersonal interactions occurred, and where they were absent, comparing these instances to identify contextual factors that shaped these interactions. In our third immersion-crystallization cycle, we reviewed preliminary findings with a larger team of experts to refine findings and make connections with the literature.

Results

The 19 practices varied in practice type, size and ownership, location, years in practice, and years integrating behavioral health and primary care.⁴² All practices had colocated behavioral health and primary care, although referral out for specialty services was common. Six organizations engaged in partnerships with another organization to bring BHCs and PCPs together; others hired the needed professionals. Practices also varied in proximity and shared space of behavioral health and primary care,⁴⁷ and on the strategies used to identify patient need to deliver integrated patient care.⁴²

From this widely varied group of practices, we observed 3 modes of interaction between PCPs and BHCs: consulting, coordinating, and collaborating (3Cs). Below, we provide empirical examples to distinguish between these modes, describe each type of interaction, and identify contextual factors that shape this interaction.

Consulting

Consulting is defined as a care team member with specific professional expertise or experience seeking advice or input from another clinician with different professional expertise or experience in the context of providing patient care. Consulting typically began with 1 person contacting another, either virtually or in person. The advice-seeker offered a brief description of relevant aspects of the patient's case (eg, age, health conditions/illnesses, history of illness, medications) followed by a question. The consulted clinician may seek additional information before answering:

The PCP comes out of a patient room and asks the female obstetrician if there are any antiemetics that this patient can take—she's on a number of psychiatric medications and is having uncontrollable nausea. The obstetrician is not sure; she wonders if the psychiatrist is available for a quick consult. The doctor says she'll try to get the psychiatrist on the phone. The psychiatrist does not answer, so the doctor leaves a message, with a quick summary of the problem—she needs to know about an antiemetic to use in a woman on antipsychotics who cannot keep her medications down because of nausea. The doctor asks for a return call. About 5 minutes after the initial call, the psychiatrist calls back regarding the patient question. They review the medication choices and decide to go with Phenergan (promethazine), because metoclopramide might have a negative interaction with 1 of the antipsychotics (Field Notes, Practice 2).

Coordinating

Coordinating involves 2 or more clinicians working in a parallel in a back-and-forth fashion to care for the same patient, delivering care to the patient in a

manner that has the same goal, yet is accomplished independent of the other clinician. Anyone on the care team could trigger the need for a PCP or BHC, and various strategies were employed (eg, phone, walkie-talkie, pager, walking) to find the needed person. In addition, coordinating primary and behavioral health care during the same day of service required careful management of time and flow of patients and clinicians.⁴⁸ The example below demonstrates how coordinating occurred:

PCP1 comes over to the Medical Assistant (MA) station and asks the BHC to join a patient visit. The BHC agrees. The PCP motions toward the examination room. As they start to walk toward the examination room, PCP2 comes over to speak with the BHC. PCP2 explains to the BHC that she has a patient she saw a long time ago, and now the patient has returned to see her. The patient has a history of depression. PCP2 has tried the patient on multiple medications. The patient is not suicidal. PCP2 says the real issue seems to be anxiety. Could you introduce yourself, give her some information about self-care and relaxation? The BHC agrees. She tells the doctor she will see the patient after this visit (she is going to see a different patient with PCP1). She asks what examination room the patient is in, and PCP2 tells her the patient is in room 14. PCP2 leaves, and the BHC and PCP1 resume walking to the examination room and see the patient together ... Afterward, the BHC finds the other patient she needs to see in examination room 14 (Field Notes, Practice 4).

Several key steps in coordinating primary and behavioral health care for patients were highlighted in this example, including: 1) locating the needed clinician, 2) rapidly briefing the clinician about a patient's needs or by having the coordinating clinician determine the patient need, 3) negotiating a time to meet with the patient, 4) meeting with the patient and identifying a treatment plan (not shown above), and 5) rapidly debriefing after the clinician met with the patient to share what was learned and to discuss the next steps (not mentioned above).

We observed coordinating happening on the same day via a warm handoff between professionals in the same office, as well as through telemedicine exchanges.

Briefing and debriefing, when clinicians inform each other of the steps to be taken to help the patient, were important steps in coordinating, which may happen through any combination of verbal exchange, documentation in medical record notes, or a secure messaging system. In the case above, the PCP briefed the BHC by offering her assessment (ie, depressed patient, not suicidal, not responding to medication because her main problem is anxiety). The PCP also suggested treatments the BHC might offer the patient (ie, educational material, help with relaxation). Debriefing occurred after professionals met with the patient to discuss next steps, and involved BHCs rapidly offering an assessment, reporting information relevant to treatment decisions, and offering a treatment plan. Debriefing informed the next steps, including the actions of others on the care team.

Collaborating

Collaborating involves BHCs and PCPs working to jointly make sense of patients' needs and, together, identifying a treatment plan to best address those needs. Sometimes the PCP and BHC accomplished this by talking together with the patient to discover those needs. Making sense of the case together, what Bloch refers to as the "dual optic,"⁴⁹ distinguishes collaborating from coordinating. We observed clinicians collaborating when caring for patients with complex needs. In the case below, the patient had multiple concerns: trouble sleeping, crying for no reason, and drinking alcohol to sleep. The PCP and patient agreed to bring in the BHC:

The PCP finds the BHC and says she needs help. She describes the patient—trouble sleeping, depression ... but he's also drinking alcohol and has a history of drug use. His main complaint is that the sleep medications are not working. There's also an alcohol smell, and he's crying. The doctor leaves. The BHC reviews the chart notes. We go in the examination room and the BHC greets the patient and says that the doctor asked me to help a bit ... The BHC says that it sounds like he's suffering a lot.

The man starts to cry. The man eventually says that the medications are not working and that he has to drink to knock himself out. He's not getting any sleep and it is horrible. The BHC asks a series of social and diagnostic questions ... **The BHC says that she wants to put her head together with the doctor to see what they can do to help the patient.** 'Do you think you'd be willing to come in and talk with a BHC since it has helped in the past? The patient says, yes, get me back together. The BHC finds the doctor. The BHC points out that much of the patient's motivation is focused on sleeping better. When the patient comes back she might start to work with him on his sobriety. **They talk about medications the patient is on and how there are 2 prescriptions for antidepressants. Together, they identify a plan that includes the doctor prescribing a new sleeping medication that also has mood stabilizing characteristics.** Later, she tells me the patient was positive when she went back in and seemed thankful (Field Notes, Practice 2, **Emphasis added**).

Together, the PCP and BHC made sense of this patient's situation and arrived at a treatment plan to address the patient's problem with sleep and mood. The next example shows that collaboration can also manifest between 2 BHCs:

BHC1 asks how's he doing, referring to a patient BHC2 just saw. BHC2 says he's OK. He does not want to talk much about what is happening. They discuss if having 1 of their physician's assistants leave was a trigger for this patient's relapse—it happened around the same time and the patient's wife thinks it was. BHC1 asks if the patient is interested in day treatment? BHC2 says, yes, I just called. BHC2 asks how long are they in day treatment? BHC1 says 2 to 3 months, and says he'll need something after, too. They discuss how this patient does well in day treatment and then struggles when it ends—not having the

order is hard on him. BHC2 comments that they are going to try to start early in working on that transition so the patient has some structure early and does not decompensate ... and quickly go back to using and it is a quick spiral after that: using, dealing, reckless disregard for life/hopelessness. They look through the patient's note and realize that after his incarceration he was eligible for residential treatment. They wonder if this is still possible. They will run this by the patient as an option (Field Notes, Practice 5).

We most often observed collaboration occurring in situations in which patient care decision making was complex.

Contextual Factors Shaping the 3Cs

Factors affecting clinician-to-clinician interactions (ie, 3Cs) while providing integrated care include availability of structured and unstructured meetings to plan patient care (eg, preclinic huddles, complex care meetings), staffing patterns and employing brief approaches to therapy, location of clinicians in close proximity to each other, and electronic health record (EHR) documenting practices. These contextual factors are described in more detail in Table 1 and below.

Time to Plan Patient Care

Consulting, coordinating, and collaborating happened during structured meetings as well as during the more fluid flow of clinical care. The preclinic huddle, when clinicians and the larger care team gather before the first patient visit to review the schedule and to anticipate and plan for patients' needs, is 1 example of a structured, routinized way to foster the 3Cs. Complex care meetings, formal meetings to identify how best to address the needs of the practice's most complex patients, are another. The example below describes how a patient's care was managed during a planned huddle. The PCP was supporting a nurse practitioner (NP) in the field who was scheduled to see a patient with a wound (and also diagnosed with borderline personality disorder). Before this excerpt, they discussed the wound culture and which antibiotics to prescribe:

Table 1. Contextual Factors that Shape Coordinating, Collaborating and Consulting

Factors	Consulting: Advice Seeking/Giving	Coordinating: Separate, but Aligned Care Delivery	Collaborating: Shared Sense Making, Decision Making
Patient	Problem/situation definable Identified as needing expertise of another provider		Problem/situation is complicated Identified as needing professionals from different backgrounds to make sense of problem/treatment
Clinician	Clinician with expertise to answer patient care question Clinicians from different disciplines work as a team, conduct care team huddles and meet to discuss clinical care, close proximity of team, flexible schedule/ time for warm handoffs.	Clinician with expertise carries out next steps/treatment	Clinicians work together to clarify patients' needs
Practice	Clinicians from different disciplines (often colocated) are rapidly and reliably accessible to answer questions		
System	Support for communication between separate behavioral and medical practices	Support for synchronizing (behavioral and medical) care over time	Support for shared learning about and with the patient.
Problem	Discrete problem Little uncertainty Information, when provided, allows advice seeker to act independently	Definable, discrete problem Moderate uncertainty or routine care need Professional has expertise to address care need Quick discussion positions professionals to act in loosely connected way Engages patient in treatment	Complex, hard-to-define problem that seems intractable to treatment and/or linked to medical or social problem Professionals need longer dialogue to clarify best strategy to deliver and engage patient in treatment

The doctor explains this patient has borderline personality disorder. This means the patient will push people away, saying no you do not like me, and at the same time act like they better like him and take care of him. She says you should start every sentence with: "It must be very hard to . . ." Then she says to the NP: you know what medically needs to be managed, but you need to manage his emotions. It is hard. Borderlines push everyone's buttons. The doctor says the struggle will be getting this patient to the wound center. He just needs to know you still care for him. The pharmacist offers to take a look at the order. She asks the NP to route it to her. She reviews and dis-

cusses it with the NP (Field Notes, Practice 5).

The doctor helped shape how the NP viewed the patient (collaborating), acknowledging her emotional reactions to the patient and offering strategies for working with this patient (consulting). In addition, the pharmacist offered to review the patient's medication order (consulting) to make sure everything was correct.

During active patient care times, the ability to access other clinicians on the care team and having brief unstructured meetings facilitated consulting, coordinating, or collaborating. In the example below, the PCP found the BHC and interrupted her work to engage her help:

The doctor knocks on the BHC's door and says he needs her help. He has a

patient in for acupuncture with bruises on her legs. She says her boyfriend pushed her down. He asked if she feels safe at home and she said no ... The doctor says she's in a room on the third floor and asks if the BHC has time to see her. The BHC is looking at her schedule and says I will put her in at 2:00 PM. The doctor says I do not think she'll come; she says she has a hard time talking about it. The BHC says, I bet. I will come up to see her. The doctor says thank you so much. The BHC says, give me a few minutes. (Field Notes, Practice 1).

Two factors made this coordination possible. First, care team members knew where and how to find each other, as shown in the case above, and had reliable ways to reach a clinician (eg, instant messaging, pager, phone, walkie talkie, physically walking to where she or he is) when they were not in sight. Second, access was enhanced with rules that allow professionals to interrupt each other.

Staffing and Brief-Targeted Therapy

Staffing appropriately to meet patients' needs, flexibility with schedules to accommodate warm hand-offs, having a path for managing patients with longer-term behavioral health needs, and BHCs doing brief, problem-focused therapy (rather than traditional therapy), as well as colocation facilitated 3Cs behaviors. In the example below, the BHC conducted 50-minute counseling sessions and was not located in the clinic where this patient was seen. PCPs gave patients an paper-based referral to see the BHC, and patients scheduled appointments at the front desk. These issues combined to make it difficult for PCPs to engage BHCs in real time, and consulting, coordinating, and collaborating behaviors were limited and only happened when crises arose. For more on staffing and scheduling see Davis et al, this issue.⁴⁸

Patient has anxiety ... highly motivated, engaged, in college, lost funding ... I ask the doctor how the appointment ended and he says he put on the patient's blue sheet that he should make an appointment with a counselor and psychiatric nurse practitioner. He's going to have some blood work done and

then schedule an appointment to see the counselor next week. The patient was very open to talking to a counselor, and unfortunately he left the clinic today without seeing the BHC. (Field Notes Practice 7)

Sharing Information and Space: Creating Closeness

Close physical proximity of clinicians was a factor that fostered consulting, coordinating, and collaborating, just as working at a distance (eg, on separate floors, in distant pods) inhibited these behaviors. Although documentation provided important information about prior patient assessments and treatments, the ability to communicate synchronously was critical to initiating the coordinating process, and this communication was fostered by close proximity of professionals. For more on this, see Gunn et al,⁴⁷ in this issue.

Discussion

This article used direct observations from 19 practices striving for comprehensive primary care to discover how the integration of behavioral health care and primary care can be accomplished in diverse, real-world practices, in ways tailored to patient need and to practice/clinician situations. Our study builds on a continuing scientific effort to illuminate the details of how professionals work together in primary care by conducting basic observational research focused on integrating care.⁵⁰ The observed patterns resolved into 3 distinct types: consulting, coordinating, and collaborating—the 3Cs of working together. These 3 modes do not rank in terms of desirability, appropriateness, or quality—under certain circumstances any 1 of them may be the “best” mode of working together.

The professionals we observed were all working in colocated environments, and interaction among professionals was made possible when partners had established modes of communication with 1 another (eg, mail, pager, email, telephone, video conferencing, or in person).^{51–56} With even the most basic means of communication, certain forms of consultation were possible. Coordination and collaboration emerged when access to one another was expanded to include close physical proximity,⁴⁷ access via compatible schedules and workflows, explicit rules regarding interruptions and timing,⁴⁸

Table 2. Organization and Operating Level Models and Frameworks Addressing Collaboration

Name and Reference	Description
Coordinated, colocated, integrated ^{61–63}	A typology for design of integrated behavioral health in clinics featuring organizational arrangements along with some corresponding descriptions for how clinicians would interact in these arrangements.
Five levels of collaboration ⁶⁴	A typology of escalating levels combining levels of organizational integration with levels of clinical integration and patterns of clinician interaction characterizing each level, or that are hallmarks of those levels (minimal collaboration, basic collaboration at a distance, basic collaboration on site, close collaboration in a partly integrated system, close collaboration in a fully integrated system).
Standard framework for integrated healthcare ⁶⁵	Can be considered an elaboration and extension of the “five levels of collaboration” with more contextual information drawn in that in effect create alternative operating models for behavioral health integration, from less to more integration.
Lexicon for integration of behavioral health and primary Care ⁶⁶	A national consensus functional definition of behavioral health integration: what functions are required, not an operating model or set of levels featuring both “types” and “levels” of practice spatial arrangements and collaborative relationships.
Collaborative care model ^{67,68}	An approach for organizing integrated care that involves an arrangement between a care manager and psychiatrist working in tandem with a primary care team.

and when there were structures supporting communication and information sharing (ie, shared EHR, team huddles, complex case meetings). This finding may help organization leaders design and balance 1) space and infrastructure, 2) workflows and protocols, and 3) the process by which professionals are introduced to each other and trained together in collaborative practice.

Frameworks for clinician interaction with names sounding similar to the 3Cs appear in the literature, such as shown in Table 2. Our work complements these conceptual models or definitions by offering a distillation of observations of real clinicians seeing patients, and by identifying what goes on between people in practice when working on specific clinical cases. Our observations were at the interpersonal level of professionals interacting in real-world practices, along with the features of organizational design that affected those interactions. Similar concepts are highlighted in other models, but with direct practice observations, it may be possible to more effectively understand how and under which circumstances professionals will work together.

Historically problematic, consultation and coordination have been default modes of interaction—the goal of institutional or organizational arrangements—but support only minimal communication between professionals beyond mere referral.^{57,58} Field observations clarify consulting and coordinating behaviors while clearly showing that the closer, more interdependent collaboration behaviors are not merely an incremental augmentation on consultation and coordination (ie, the BHC and PCP

can still work from within their original or “native” perspectives, tools, language, know-how, and culture as they work on a task in front of them). In our observations, collaborating involved establishing a shared understanding regarding illness, health, care, and teamwork across disciplines, rather than separate clinicians doing separate things, even if consultative and coordinated.

Elements of “good clinicianship” are comparable to the elements of “good musicianship” that unite “players” in common sensibilities beyond their “chosen instrument” by their shared appreciation of music and how to harmonize together.⁵⁹ The challenge is to organize a teachable common culture of good clinicianship for PCPs and BHCs working together to deliver comprehensive, whole-person care. This implies good working relationships among clinicians, not just a set of techniques applied without connection to each other. It requires mutual trust and a willingness of PCPs and BHCs to share care, and to share the connection to patients, which is also so important to patients and to the providers who seek and are sustained by these relationships.

Although this observational study provides detailed insight into the ways BHCs and PCPs interact to deliver integrated care, this study is not without limitations. We were able to identify with confidence 3 ways BHCs and PCPs interact; however, we are unable to link these interpersonal behaviors to practice performance, patient experience, or costs. Findings from this study can inform future research to study such associations and outcomes. In addition, evidence suggests that experi-

enced partners improve their clinical skills by learning from each other; not only do they anticipate what their colleague would likely recommend or do, but they sometimes acquire the confidence and skill to do it themselves, or to do it with a less-intensive mode of working together.^{59,60} This suggests that whether partners are consulting, coordinating, or collaborating with each other may have a developmental component. However, additional research is needed to explore this relationship given that it was outside the scope of this study.

Conclusion

PCPs and BHCs consult, coordinate, and collaborate with each other as they work together to deliver integrated care. These 3 modes of working together are not a hierarchy of sophistication or desirability. Each is critically important in particular circumstances. Organizations can create integrated care environments that support the 3Cs, and health professions' training programs should equip clinicians to execute all 3 routinely in practice. Ideally, this would happen in internships and residencies where professionals of different background can be trained together, and then be supported in their subsequent work in practice environments that reinforce working as a health care team.

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References

1. Whooley MA. Depression and cardiovascular disease: Healing the broken-hearted. *JAMA* 2006;295:2874–81.
2. Piette JD, Wagner TH, Potter MB, Schillinger D. Health insurance status, cost-related medication underuse, and outcomes among diabetes patients in three systems of care. *Med Care* 2004;42:102–9.
3. Simon EP, Showers N, Blumenfeld S, Holden G, Wu X. Delivery of home care services after discharge: What really happens. *Health Soc Work* 1995;20:5–14.
4. Katon WJ. Clinical and health services relationships between major depression, depressive symptoms, and general medical illness. *Biol Psychiatry* 2003;54:216–26.
5. Katon WJ. The Institute of Medicine “Chasm” report: Implications for depression collaborative care models. *Gen Hosp Psychiatry* 2003;25:222–9.
6. Katon W, Russo J. Somatic symptoms and depression. *J Fam Pract* 1989;29:65–9.
7. Petterson SM, Phillips RL Jr, Bazemore AW, Dodoo MS, Zhang X, Green LA. Why there must be room for mental health in the medical home. *Am Fam Physician* 2008;77(6):757.
8. Hertz JE, Anschutz CA. Relationships among perceived enactment of autonomy, self-care, and holistic health in community-dwelling older adults. *J Holist Nurs* 2002;20:166–86.
9. Ng TP, Niti M, Tan WC, Cao Z, Ong KC, Eng P. Depressive symptoms and chronic obstructive pulmonary disease: effect on mortality, hospital readmission, symptom burden, functional status, and quality of life. *Arch Intern Med* 2007;167:60–7.
10. Loeppke R, Taitel M, Haufler V, Parry T, Kessler RC, Jinnett K. Health and productivity as a business strategy: a multiemployer study. *J Occup Environ Med* 2009;51:411–28.
11. Lin EH, Heckbert SR, Rutter CM, et al. Depression and increased mortality in diabetes: Unexpected causes of death. *Ann Fam Med* 2009;7:414–21.
12. Melek S, Norris D. Chronic conditions and comorbid psychological disorders. Seattle, WA: Milliman, 2008.
13. Petterson S, Miller BF, Payne-Murphy JC, Phillips RL. Mental health treatment in the primary care setting: Patterns and pathways. *Fam Syst Health* 2014;32:157–66.
14. Institute of Medicine. Part 3: The new definition and an explanation of terms. *Defining primary Care: An interim report*. Washington, DC: The National Academies Press, 1994.
15. Apker J, Propp KM, Zabava Ford WS, Hofmeister N. Collaboration, credibility, compassion, and coordination: professional nurse communication skill sets in health care team interactions. *J Prof Nurs* 2006;22:180–9.
16. Alt-White AC, Charns M, Strayer R. Personal, organizational and managerial factors related to nurse-physician collaboration. *Nurs Adm Q* 1983;8:8–18.
17. Hartgerink JM, Cramm JM, Bakker TJ, van Eijdsden RA, Mackenbach JP, Nieboer AP. The importance of relational coordination for integrated care delivery to older patients in the hospital. *J Nurs Manag* 2014;22:248–56.
18. Hartgerink JM, Cramm JM, Bakker TJ, van Eijdsden AM, Mackenbach JP, Nieboer AP. The importance of multidisciplinary teamwork and team climate for relational coordination among teams delivering care to older patients. *J Adv Nurs* 2014;70:791–9.
19. Pfaff K, Baxter P, Jack S, Ploeg J. An integrative review of the factors influencing new graduate nurse engagement in interprofessional collaboration. *J Adv Nurs* 2014;70:4–20.
20. Pfaff KA, Baxter PE, Ploeg J, Jack SM. A mixed methods exploration of the team and organizational factors that may predict new graduate nurse engage-

- ment in collaborative practice. *J Interprof Care* 2014;28:142–8.
21. Gaboury I, Bujold M, Boon H, Moher D. Interprofessional collaboration within Canadian integrative healthcare clinics: Key components. *Soc Sci Med* 2009;69:707–15.
22. Gaboury I, Lapierre LM, Boon H, Moher D. Interprofessional collaboration within integrative healthcare clinics through the lens of the relationship-centered care model. *J Interprof Care* 2011; 25:124–30.
23. Keshet Y, Popper-Giveon A. Integrative health care in Israel and traditional arab herbal medicine: when health care interfaces with culture and politics. *Med Anthropol Q* 2013;27:368–84.
24. Hollenberg D. Uncharted ground: patterns of professional interaction among complementary/alternative and biomedical practitioners in integrative health care settings. *Soc Sci Med* 2006;62:731–44.
25. Farrell B, Pottie K, Woodend K, et al. Shifts in expectations: evaluating physicians' perceptions as pharmacists become integrated into family practice. *J Interprof Care* 2010;24:80–9.
26. Maxwell L, Odukoya OK, Stone JA, Chui MA. Using a conflict conceptual framework to describe challenges to coordinated patient care from the physicians' and pharmacists' perspective. *Res Social Adm Pharm* 2014;10:824–36.
27. Rubio-Valera M, Jove AM, Hughes CM, Guillen-Sola M, Rovira M, Fernandez A. Factors affecting collaboration between general practitioners and community pharmacists: a qualitative study. *BMC Health Serv Res* 2012;12:188
28. Eve JD. Sustainable practice: how practice development frameworks can influence team work, team culture and philosophy of practice. *J Nurs Manag* 2004;12:124–30.
29. D'Amour D, Goulet L, Labadie JF, Martin-Rodriguez LS, Pineault R. A model and typology of collaboration between professionals in healthcare organizations. *BMC Health Serv Res* 2008;8:188.
30. D'Amour D, Ferrada-Videla M, San Martin Rodriguez L, Beaulieu MD. The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *J Interprof Care* 2005; 19(Suppl 1):116–31.
31. Gask L. Overt and covert barriers to the integration of primary and specialist mental health care. *Soc Sci Med* 2005;61:1785–94.
32. Knowles P. Collaborative communication between psychologists and primary care providers. *J Clin Psychol Med Settings* 2009;16:72–6.
33. Fredheim T, Danbolt LJ, Haavet OR, Kjongsberg K, Lien L. Collaboration between general practitioners and mental health care professionals: a qualitative study. *Int J Ment Health Syst* 2011;5(1):13.
34. San Martín-Rodríguez L, Beaulieu MD, D'Amour D, Ferrada-Videla M. The determinants of successful collaboration: a review of theoretical and empirical studies. *J Interprof Care* 2005;19(Suppl 1): 132–47.
35. Dawson S. Interprofessional working: communication, collaboration. . . perspiration! *Int J Palliat Nurs* 2007;13(10):502–5.
36. Dow AW, DiazGranados D, Mazmanian PE, Retchin SM. Applying organizational science to health care: a framework for collaborative practice. *Acad Med* 2013;88:952–7.
37. Lorenz AD, Mauksch LB, Gawinski BA. Models of collaboration. *Prim Care* 1999;26:401–10.
38. Jones A, Jones D. Improving teamwork, trust and safety: an ethnographic study of an interprofessional initiative. *J Interprof Care* 2011;25:175–81.
39. Reeves S. Ideas for the development of the interprofessional field. *J Interprof Care* 2010;24:217–9.
40. Salas E, Cooke NJ, Rosen MA. On Teams, teamwork, and team performance: discoveries and developments. *Hum Factors* 2008;50:540–7.
41. Casimiro L, Hall P. Barriers and enablers to interprofessional collaboration in health care: Research report. Champlain Region: Academic Health Council, 2011.
42. Cohen DJ, Balasubramanian BA, Davis M, et al. Understanding care integration from the ground up: five organizing constructs that shape integrated practices. *J Am Board Fam Med* 2015;28:S7–S20.
43. Davis M, Balasubramanian BA, Waller E, Miller BF, Green LA, Cohen DJ. Integrating behavioral and physical health care in the real world: early lessons from advancing care together. *J Am Board Fam Med* 2013;26:588–602.
44. Cohen DJ, Davis MM, Hall JD, Gilchrist EC, Miller BF. A guidebook of professional practices for behavioral health and primary care integration: Observations from exemplary sites. Rockville, MD: Agency for Healthcare Research and Quality, 2015.
45. Miller WL, Crabtree BF. The dance of interpretation. In: Crabtree BF, Miller WL, eds. *Doing qualitative research*. 2nd ed. Thousand Oaks, CA: Sage Publications, 1999;127–43.
46. Borkan J. *Immersion/crystallization*, 2nd ed. Thousand Oaks, CA: Sage Publications, 1999.
47. Gunn R, Davis M, Hall J, et al. Designing clinical space for the delivery of integrated behavioral health and primary care. *J Am Board Fam Med* 2015;28: S52–S62.
48. Davis et al. Clinician staffing, scheduling, and engagement strategies among primary care practices delivering integrated care. *J Am Board Fam Med* 2015;28:S32–S40.
49. Bloch DA. The dual optic: Researchers and therapists. *Fam Syst Med* 1989;7:115–9.
50. Stange KC, Zyzanski SJ, Jaén CR, et al. Illuminating the 'black box'. A description of 4454 patient visits to 138 family physicians. *J Fam Pract* 1998;46:377–89.

51. Miller BF, Petterson S, Brown Levey SM, Payne-Murphy JC, Moore M, Bazemore A. Primary care, behavioral health, provider colocation, and rurality. *J Am Board Fam Med* 2014;27:367–74.
52. Miller BF, Petterson S, Burke BT, Phillips RL Jr, Green LA. Proximity of providers: Colocating behavioral health and primary care and the prospects for an integrated workforce. *Am Psychol* 2014;69:443–51.
53. Williams J, Palmes G, Klinepeter K, Pulley A, Foy JM. Referral by pediatricians of children with behavioral health disorders. *Clin Pediatr* 2005;44:343–9.
54. Kolko DJ, Campo J, Kilbourne AM, Hart J, Sakolsky D, Wisniewski S. Collaborative care outcomes for pediatric behavioral health problems: A cluster randomized trial. *Pediatrics* 2014;133(4):e981–92.
55. Blount A, Bayona J. Toward a system of integrated primary care. *Fam Syst Med* 1994;12:171–82.
56. Blount A, DeGirolamo S, Mariani K. Training the collaborative care practitioners of the future. *Fam Syst Health* 2006;24:111–9.
57. Kessler R, Miller BF, Kelly M, et al. Mental health, substance abuse, and health behavior services in patient-centered medical homes. *J Am Board Fam Med* 2014;27:637–44.
58. Massa I, Miller BF, Kessler R. Collaboration between NCQA patient-centered medical homes and specialty behavioral health and medical services. *Transl Behav Med* 2012;1–5.
59. Peek CJ, Heinrich RL. Building a collaborative healthcare organization: From idea to invention to innovation. *Family Syst Med* 1995;13(3–4):327–42.
60. Mitchell P, Matthew W, Golden R, et al. Core principles & values of effective team-based health care. Washington, DC: Institute of Medicine, 2012.
61. Blount A. Integrated primary care: Organizing the evidence. *Fam Syst Health* 2003;21:121–33.
62. Glouberman S, Zimmerman B. Complicated and complex systems: What would successful reform of medicare look like? Vol discussion paper No. 8: Commission on the Future of Health Care in Canada, 2002.
63. Collins C, Hewson DL, Munger R, Wade T. Evolving models of behavioral health integration in primary care. New York, NY: Milbank Memorial Fund, 2010.
64. Doherty WJ, McDaniel SH, Baird MA. Five levels of primary care/behavioral healthcare collaboration. *Behav Healthc Tomorrow* 1996;5:25–7.
65. A standard framework for levels of integrated healthcare. SAMHSA-HRSA Center for Integrated Health Solutions. National Council for Community Behavioral Healthcare, 2013.
66. Peek CJ and the National Integration Academy Council. Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus. In: No.13-IP001-EF AP, ed. Rockville, MD: Agency for Healthcare Research and Quality, 2013.
67. Katon WJ, Lin EH, Von Korff M, et al. Collaborative care for patients with depression and chronic illnesses. *N Engl J Med* 2010;363:2611–20.
68. Unützer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA* 2008;288:2836–45.