

ORIGINAL RESEARCH

Approaches to Behavioral Health Integration at High Performing Primary Care Practices

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Introduction: Behavioral health (BH) integration has been proposed as an important strategy to help primary care practices meet the needs of their patient population, but there is little research on the ways in which practices are integrating BH services. This article describes the goals for BH integration at 30 high-performing primary care practices and strategies to operationalize these goals.

Methods: We conducted a qualitative analysis of BH integration at 30 US primary care practices that had been selected for the Learning from Effective Ambulatory Practices (LEAP) project following an interview-based assessment and rating process. Data collection included formal and informal interviews with practice leaders and staff, as well as observations of clinical encounters. We used a template analysis approach to thematically analyze data.

Results: Most LEAP practices looked to BH integration to help them provide timely BH care for all patients, share the work of providing BH-related care, meet the full spectrum of patient needs, and improve the capacity and functioning of care teams. Practices operationalized these goals in various ways, including universal BH screening and involving BH specialists in chronic illness care. As they worked toward their BH integration goals, LEAP practices faced common challenges related to staffing, health information technology, funding, and community resources.

Discussion: High-performing primary care practices share common goals for BH integration, as well as common challenges operationalizing these goals. As US residents increasingly receive BH services in primary care, it is critical to remove barriers to BH integration and support primary care practices in meeting a full spectrum of patient needs. (J Am Board Fam Med 2018;31:691–701.)

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Nearly 1 in 5 US residents is struggling with behavioral health (BH) issues,¹ including mental health or substance use conditions, and most of these individuals are not receiving treatment in the specialty mental health and substance use treatment systems. An estimated 43% to 60% of individuals

with BH conditions are receiving treatment solely in primary care settings,² and researchers estimate between 30% and 80% of all primary care visits are driven at least in part by BH issues.³

Previous research shows that integrating BH services into primary care can enhance access to treatment for mental health and substance use issues,^{4,5} reduce costs,⁶ improve patient experiences of care,^{5,7} and improve patient outcomes.^{7,8} BH integration may particularly benefit patients with multiple chronic conditions, who often struggle with BH challenges that complicate their ability to manage their health.^{9,10} Through BH integration, primary care practices can identify and address patients' physical health, mental health, health behaviors, substance use, life stressors, and barriers to wellness.^{11,12}

Previous research has demonstrated the effectiveness of various models of BH integra-

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tion.^{5,8,13–15} Key components of evidence-based BH treatment in primary care include care management for patients with BH issues and population-based systematic monitoring of BH indicators.^{13,16–19}

Increasingly, integrated BH is seen as an expectation of primary care.²⁰ Although numerous resources are available to aid primary care practices in integrating BH services into their treatment offerings,²¹ there is little research on the ways in which primary care practices are operationalizing BH integration.²² This article describes common goals related to BH integration at 30 high-performing primary care practices, common and pioneering strategies to operationalize those goals, and challenges related to integrating BH services into primary care.

Methods

In 2012, the Robert Wood Johnson Foundation created a national program called Primary Care Team: Learning from Effective Ambulatory Practices (LEAP). The LEAP project's goals were to select 30 high-performing primary care practices, study the practices, and disseminate the findings in publications and in a web-based Primary Care Team Guide (www.improvingprimarycare.org).²³ A National Advisory Committee of primary care experts played key roles in selecting practices, planning site visits, and developing the Team Guide. Briefly, site selection involved nomination by the National Advisory Committee, 45-minute phone interviews to collect data on practice characteristics and performance, and a review and grading of practice data. Practices were not selected based on BH integration but rather for showing innovation in their use of workforce to provide team-based care. EW and MF codirect the project, which is based at the MacColl Center for Health Care Innovation, Seattle, WA. Further details about the LEAP project's methods and the selection of the LEAP practices are available in earlier publications about the project.^{24,25}

Site Visits

We conducted 3-day site visits to each of the 30 selected practices in 2012 and 2013. All site visit teams included a clinician investigator, a qualitative researcher, and a research assistant. Site visits involved a combination of structured and unstruc-

tured components to allow for systematic data collection as well as unanticipated insights. Activities included a tour, demonstration of the electronic health record (EHR) system, formal semistructured and informal unstructured interviews with practice leaders and staff, shadowing staff and patients, observing team meetings, and collecting practice tools and documents. Staff interviews generally included BH specialists if present on the practice team. Following site visits, project staff convened the LEAP practices in October 2013 for a semistructured in-person meeting to identify and discuss important themes and innovations observed across practices. BH integration was identified as a major area of focus for many LEAP practices. The project team also conducted a brief follow-up web-based survey (SurveyMonkey Inc, San Mateo, CA) in 2016, which asked practices to report the number of various staff positions at their clinic and use free-text fields to describe changes experienced since the 2013 site visits. Because most survey responses were not specific to BH integration, this analysis focuses on the 2013 site visit data and incorporates 2016 data on BH staffing changes.

Data Analysis

We used Atlas.ti to organize and store qualitative data from site visits and learning sessions. Data included interview transcripts, site visitor notes, field notes from shadowing staff and patients, and transcripts from the in-person meeting. To thematically analyze our qualitative data, we used a template analysis approach that drew on both *a priori* and emergent codes.^{26–29} The code list was developed using a multistage, iterative process. In the first phase of analysis, project team members led by the LEAP qualitative leads (CH, DC) coded the data by using broad codes to capture important primary care team member roles and functions. One of the broad codes, “behavioral health integration,” captured “how the practice enables patients to access BH services in primary care, from colocation to full integration, with any type of BH provider.” This code, which covered both mental health and substance use services, yielded 744 pages of data.

In the next phase of analysis, 4 researchers (PB, DC, SM, CH) developed subcodes for the BH integration data based on both emergent themes in the text and prominent issues around BH integration found in peer-reviewed and gray literature.

The researchers then independently subcoded the BH integration data and compared their coding to clarify and revise code definitions based on emergent themes during analysis. After comparing coding reliability for 5 practices, researchers reached a high level of coding agreement and divided the remaining practices for independent subcoding.

Five team members (PB, DC, SM, EW, MF) then reviewed data from each subcode and discussed emergent themes and relationships with other authors. The lead author (PB) identified an organizing construct that matched the coded data and summarized themes with supporting quotes in a coding memo. Through iterative discussions about the coding memo, coauthors further identified connections in the data, interpreted findings, and focused the scope of the article.

Results

The 30 LEAP practices represent a range of organization types, sizes, and settings (Table 1). At the time of our site visits in 2013, 25 LEAP practices (83.3%) had at least one BH specialist available onsite to provide services in the practice. We defined a “BH specialist” as any clinical team member with formal training whose primary role was to provide therapy or medication management for mental health or substance use issues. These individuals included licensed clinical social workers, psychologists, and psychiatric nurse practitioners, among others. LEAP practices had a mean of 1.8 BH specialists available onsite (range, 0 to 9), with larger practices generally having more BH staff. Six practices (20.0%) mentioned providing BH specialists with training specific to working in primary care.

Twenty LEAP practices (66.7%) billed insurers and other payers for BH services, typically by hiring BH specialists with the proper credentials to bill under state policies. Nine practices (30.0%) supplemented these billable services with grant-funded programs and 10 (33.3%) contracted with external organizations to provide BH care.

When leaders and staff at LEAP practices described their philosophy and vision of BH integration, 4 key goals emerged. Specifically, LEAP practices looked to BH integration to help them provide timely BH care for all patients, share the work of providing BH-related care, meet the full spectrum of patient needs, and improve the capac-

ity and functioning of care teams (Table 2). This article will describe common strategies to operationalize each goal and pioneering strategies that might hold promise as a future direction for BH integration. We classified strategies as “common” if they were present in 10 or more practices and as “pioneering” if they were present in fewer than 10 practices and the site visit data suggested they were important for operationalizing the practices’ goals for BH integration.

Providing Timely BH Care for All Patients

LEAP practices looked to BH integration to help them proactively identify and respond to patients’ BH needs. To accomplish this, many practices conducted routine screening for BH issues, provided access to a consulting psychiatrist, offered “stepped care” consisting of short-term counseling in the practice and referrals to external organizations for longer-term, more intensive therapy, and conducted monitoring and follow-up of BH-related issues.

The most common screenings were those for depression (22 practices, 73.3%), and some practices additionally screened for substance use (8 practices, 26.7%) and anxiety (6 practices, 20.0%). Seventeen practices (56.7%) conducted universal screening, meaning that a primary care team member screened all patients or all new patients for BH conditions, usually as part of the intake and rooming process.

If a screening test or team member identified a BH issue, 22 LEAP practices (73.3%) provided “warm handoffs” to BH specialists. These in-person referrals involved a primary care team member introducing a patient to an onsite BH specialist, thus facilitating the patient’s transition to BH services.⁹ Availability for these handoffs varied. Under the most common arrangement (12 practices, 40.0%), BH specialists had a combination of scheduled appointments and open time for warm handoffs. For example, a BH specialist might spend the first 30 minutes of every hour in scheduled appointments and then be available for warm handoffs during the last 30 minutes.

At 4 LEAP practices (13.3%), at least one BH specialist was routinely available for warm handoffs. Practices accomplished this by instituting open-access scheduling or by designating a BH specialist to be “on call” for emergent BH issues each day. As a BH specialist at an urban family medicine residency noted, “We have a rotating

Table 1. Characteristics of Learning from Effective Ambulatory Practices and Behavioral Health Integration, 2013

Characteristic	N = 30*	%
Practice characteristics		
Organization type		
Federally qualified health center	15	50.0
Private practice, multispecialty group	9	30.0
Private practice, primary care only	6	20.0
Number of sites in practice organization		
One	7	23.3
2 to 5	6	20.0
6 to 10	8	26.7
11 to 20	4	13.3
Setting		
Urban	9	30.0
Suburban	8	26.7
Rural	11	36.7
Multiple	2	6.7
BH specialist staffing characteristics		
Any BH specialist present at practice [†]	25	83.3
Masters'-level therapists (such as LCSWs)	21	70.0
BH prescribers (psychiatrists or psychiatric NPs)	16	53.3
Psychologists	8	26.7
Substance abuse counselors	3	10.0
Complementary/alternative BH providers (such as art therapists, dance movement therapists)	3	10.0
Affiliation of BH specialist when present (N = 25) [‡]		
Employed by the practice	14	56.0
Employed by an external organization	8	32.0
Mixed (some BH staff employed by practice, some employed by external organization)	2	8.0
Unknown	1	4.0
BH-related services available		
Any BH-related screening [†]	22	73.3
Depression (PHQ or others)	22	73.3
Substance use	8	26.7
Anxiety	6	20.0
Any BH-related services [†]	27	90.0
Short-term therapeutic approaches	20	66.7
CBT, DBT, and/or ACT	8	26.7
Complementary/alternative BH therapies	5	16.7
Any access to BH prescribers (psychiatrists or psychiatric NPs) [†]	18	60.0
Via in-person appointments and consultations	16	53.3
Via telemedicine or phone	3	10.0
Substance use counseling or programs available in the practice	7	23.3

BH, behavioral health; CBT, cognitive behavioral therapy; DBT, dialectical behavioral therapy; ACT, acceptance and commitment therapy; PCP, primary care provider; PHQ, Patient Health Questionnaire; LCSW, licensed clinical social workers; NP, nurse practitioner.

*Except where otherwise noted.

[†]Multiple options could apply to each site.

[‡]25 of 30 LEAP practices had at least one BH specialist available to provide BH services at the practice.

pager, we have a [BH] faculty person who is on call at all times.”

After identifying patients with BH issues, LEAP practices sought to match patients to the right level

of BH services. Twenty practices (66.7%) followed a “stepped care” approach³⁰ that started with short-term therapy in the practice followed by a referral to mental health specialty care if more intensive

Table 2. Key Goals Related to Behavioral Health Integration and Strategies to Operationalize These Goals as Observed at Learning from Effective Ambulatory Practices, 2013

Key Goals of BH Integration in Primary Care	Description of Goal	Common Strategies* for Operationalizing This Goal	Pioneering Strategies [†] That May Merit Further Exploration
Provide timely BH care for all patients	Team members understand that primary care practices play a key role in proactively identifying BH issues, connecting patients to BH services in a timely manner, and providing immediate assistance to patients in crisis.	Screening all patients or all new patients for BH-related issues (universal screening). Providing short-term therapy in the practice followed by referrals to mental health specialty care for patients needing longer-term, more intensive services (stepped care).	Maximizing BH specialists' availability by instituting open-access scheduling or on-call rotations. Using registries and other health IT tools to systematically track and follow up on patients' BH-related needs.
Share the work of providing BH-related care	The practice recognizes that BH integration can ease the burden on individual clinicians by involving multiple team members in identifying, addressing, and following up on patients' BH needs.	Providing onsite access to BH specialists. Delegating BH-related screening to MAs or RNs. Using care coordinators, community resource specialists, or front desk staff to connect patients to external BH resources.	Colocating BH and primary care working areas to facilitate regular interdisciplinary communication. Delegating BH-related assessments and follow-up to RNs, care coordinators, health coaches, or layperson BH assistants.
Meet the full spectrum of patient needs	Team members understand how physical, mental, behavioral, and social needs can affect a patient's wellness, and they share a philosophy that primary care practices must attend to the full range of factors that influence a patient's health.	Offering a wide array of services in the practice, including BH therapy, psychiatric medication management, and chronic pain management services. Offering BH services to support patients in managing chronic conditions.	Offering in-house substance use counseling or programs. Ensuring each patient has an interdisciplinary care plan tailored to his or her specific needs.
Improve the capacity and functioning of care teams	The practice recognizes that BH integration can improve team functioning and reduce staff burnout by expanding the skills of team members, promoting positive team dynamics, and improving communication.	Training primary care staff on BH-related competencies, such as suicide prevention or working with patients who have substance use issues.	Involving BH specialists in improving teambuilding, problem-solving, and interpersonal relationships. Involving BH specialists in facilitating regular team huddles or meetings

BH, behavioral health; LEAP, Learning from Effective Ambulatory Practices; IT, information technology; MA, medical assistant; RN, registered nurse.

*Strategies were classified as "common" if they were identified in 10 or more LEAP practices.

†Strategies were classified as "pioneering" if (1) they were identified in fewer than 10 LEAP practices and (2) the site visit data suggested they were key for operationalizing the practice's goals for BH integration.

services were needed. The length of short-term services ranged from 3 sessions to 6 months of therapy or more. The short-term therapy generally focused on helping patients cope with everyday life stressors by drawing on personal strengths, bolstering problem-solving skills, and collaborating on action planning.

For patients needing BH-related medication, 16 practices (53.3%) provided onsite access to BH prescribers like psychiatrists or psychiatric nurse practitioners. The onsite availability of these BH prescribers ranged from every day to twice per month, with

the most common availability (7 of 16 practices, 43.8%) being 1 to 3 days per week.

In describing how they monitor and follow-up with patients about BH issues, only 6 LEAP practices (20.0%) cited specific models such as Collaborative Care,⁸ the Nuka Model,³¹ or the Air Force Model.³² However, even without citing a specific model, sites were practicing key components of evidence-based BH integration such as providing care management for patients with BH issues (7 practices, 23.3%), conducting repeated assessments of tools like the Patient Health Question-

naire to monitor patient symptoms over time (6 practices, 20.0%), and using registries or other health information technology (IT) tools to track and follow up on patients' BH-related needs (5 practices, 16.7%).

Sharing the Work of Providing BH-Related Care

Addressing the BH needs of patients involves a substantial amount of work and has the potential to overburden primary care providers and other staff. To ease this burden, LEAP practices looked to BH integration to promote the sharing of BH-related tasks among multiple team members.

At 25 LEAP practices (83.3%), the primary care team included BH specialists who provided therapy or BH medication management. Other team members, including medical assistants, registered nurses, and care coordinators, shared the work of identifying, addressing, and following up on patients' BH needs (Table 3). For example, 18 practices (60.0%) had medical assistants or registered nurses conduct BH screening, and several practices had primary care team members connect patients to external BH resources and follow-up with patients about BH issues.

To support the sharing of BH care among multiple primary care team members, 11 LEAP practices (36.7%) emphasized the importance of an organizational culture of trust, teamwork, and collaboration. As a licensed clinical social worker at a suburban private practice said, "Integration is you are actually a part of the team, you are a peer on the team ... and you have really open communication, and that is what is expected."

Eight practices (26.7%) additionally sought to facilitate teamwork and interdisciplinary communication through the use of their physical space. This included positioning BH therapy rooms in the same area as primary care examination rooms or by providing shared administrative space for BH specialists and primary care providers.

Meeting the Full Spectrum of Patient Needs

LEAP practices understand how physical, mental, behavioral, and social concerns affect a patient's overall wellness, and they see BH integration as a way to help them attend to a wide range of patient needs. As the regional medical director of a rural multispecialty medical group noted, "We have a patient in the middle and we have this team around them ... The challenge is to make the patient part

of the team, and at the same time making sure they have all the support systems around them from a community standpoint and a clinic standpoint."

BH integration not only helped practices meet patients' mental, behavioral, and social needs, it also enhanced other services they offered. For example, 22 LEAP practices (73.3%) used BH services to support their chronic pain management offerings,³³ and 12 practices (40.0%) used BH services to support patients in managing chronic illnesses, such as involving BH specialists in diabetes group visits. Seven practices (23.3%) offered suboxone programs to treat opioid dependency, and 7 practices (23.3%) offered counseling or programs for other types of substance use. Five practices (16.7%) offered complementary or alternative BH services, including mindfulness, art therapy, and dance movement therapy.

Six practices (20.0%) emphasized the importance of coordinating this wide array of services under interdisciplinary care plans tailored to each patient. These interdisciplinary care plans ensure primary care team members, BH specialists, patients, and families are on the same page about the patient's health goals. As a BH specialist at a suburban private practice noted, "Part of integration from the patient perspective really is just having 1 treatment plan for your problem, so it is not [that] the mental health person came up with 1 plan to treat your depression and then the doctor came up with another; it is all 1 plan."

Improving the Capacity and Functioning of Care Teams

LEAP practices frequently drew on the strengths of BH specialists to expand the skills of team members, improve team functioning, and reduce staff burnout. For example, BH specialists at twelve LEAP practices (40.0%) trained primary care staff on BH-related competencies, such as understanding common mental health conditions, talking to patients who are in crisis, preventing suicide, and working with patients who have substance use issues.

BH specialists also used their training to promote positive primary care team dynamics. For example, 7 LEAP practices (23.3%) mentioned using BH specialists to help care team members with teambuilding, problem-solving, and interpersonal relationships, and 6 practices (20.0%) noted that BH specialists promote open communication in

Table 3. Common Behavioral Health Services Performed by Primary Care Team Members at Learning from Effective Ambulatory Practices, 2013†

	Elicit BH Concerns during Interactions with Patients	Conduct BH Screening	Administer BH Assessments	Connect Patients to BH Services Inside or Outside the Clinic	Collaborate with Other Team Members on BH-Related Treatment Planning	Prescribe Psychiatric Medications	Conduct BH-Related Monitoring and Follow-up	Help Run Programs or Group Visits Related to BH or Chronic Pain
PCP	X			X	X	X		X
BH specialist	X		X	X	X	X*	X	X
Layperson BH assistant	X		X	X	X			
RN	X	X		X	X		X	
MA	X	X		X	X			
MA care coordinator				X	X		X	
Front desk staff								
Health coach				X			X	X
OT								X
PT/PT assistant								X
Nutritionist								X

*BH prescribers (e.g., psychiatrists, psychiatric nurse practitioners) prescribed psychiatric medications but other BH specialists (e.g., psychologists, masters-level therapists) did not. BH, behavioral health; PCP, primary care provider; RN, registered nurse; MA, medical assistant; OT, occupational therapist; PT, physical therapist; PCP, primary care provider. †“X” denotes that the identified team members performed the identified services at multiple LEAP practices.

their practice by facilitating regular team meetings. As the BH director at a rural federally qualified health center noted, “Our behavioral health consultants lead our weekly huddles and they also really just facilitate the flow in the clinic.”

Challenges Related to BH integration

As LEAP practices worked to operationalize their goals for BH integration, they encountered challenges related to staffing, IT, funding, and community resources. For example, 10 practices (33.3%) described staffing-related challenges, which included difficulty hiring BH specialists (6 practices, 20.0%), high turnover among BH specialists (2 practices, 6.7%), and difficulty recruiting and retaining BH specialists who were interested in providing short-term interventions in a primary care setting (2 practices, 6.7%). As the BH manager at one urban federally qualified health center noted, “Most of our cohorts in the field prefer to do long-term therapy ... They are used to taking time to engage people in therapy and understanding—but our pace is very fast, and it is quite challenging for social workers in our field to adapt to this setting.”

Thirteen practices (43.3%) mentioned health IT-related challenges. These included difficulties exchanging EHR notes between primary care and BH staff (8 practices, 26.7%) and an inability to obtain the necessary data to monitor and follow-up with patients experiencing depression or chronic pain (6 practices, 20.0%).

Although most practices (20 practices, 66.7%) wanted to expand their BH staff and services, they faced difficulty finding the financial resources to do so. Fifteen practices (50.0%) described a lack of public funding or state regulations that made it difficult to obtain reimbursement for BH services. In addition, 4 practices (13.3%) mentioned an inability to obtain funding for specific BH offerings, such as group visits for patients with depression.

LEAP practices also described a need for more robust local BH resources, noting that patients struggling with severe mental illness, homelessness, or substance use typically need a higher level of BH services than can be provided in primary care. BH specialists at twelve LEAP practices (40.0%) said they could not refer their most severe patients to specialty mental health or substance use treatment

because such services did not exist in their community.

BH Staffing Changes from 2013 to 2016

Between the 2013 site visits and the 2016 follow-up survey, the number of LEAP practices with BH specialists remained stable at 25 practices (83.3%). The number of practices with dedicated substance use counselors among their BH staff increased from 3 practices (10.0%) in 2013 to 7 practices (23.3%) in 2016. No other notable changes in BH staffing or services were mentioned in the 2016 survey.

Discussion

The LEAP project found that high-performing primary care practices share common understandings about the rationale for and role of BH integration in primary care. Specifically, the practices embraced BH integration to provide timely BH care for all patients, share the work of providing BH-related care, meet the full spectrum of patient needs, and improve the capacity and functioning of care teams. Together, these goals form a common vision of BH integration that transcends organization type, practice size, and setting.

LEAP practices operationalized these goals in various ways, such as universal BH screening and involving BH specialists in chronic illness care. Some strategies were less common but may hold promise as a future direction for BH integration. In fact, many of the pioneering strategies we identified in LEAP practices align with the growing literature on real-world implementation of BH integration.^{9,34–37} For example, practices across the United States are experimenting with open-access scheduling and on-call rotations to facilitate warm handoffs,³⁸ using registries and other health IT tools to systematically track and follow up on patients’ BH-related needs,^{11,39} offering in-house counseling or programs for substance use and opioid dependency,^{33,40} developing interdisciplinary care plans,³⁴ and colocating primary care and BH staff to facilitate teamwork and interdisciplinary communication.⁴¹ Other strategies identified in the literature, such as establishing rapid referral pathways for BH services,³⁷ creating custom EHR templates for BH data,³⁹ or developing clinic-specific training manuals about BH integration,⁴² were ei-

ther not present in LEAP practices or not mentioned in our interviews.

Only a few practices mentioned specific evidence-based models of BH integration. However, even without citing a specific model, practices had implemented key components of evidence-based BH integration, such as care management and measurement-based care for patients with BH issues. This suggests that local experimentation and problem solving among primary care practices can lead to a range of innovative BH integration activities, some of which may mirror evidence-based models. Future research could explore whether these examples of local innovation, such as open-access scheduling or having BH specialists lead team huddles, would amplify the effectiveness of existing evidence-based models. Other areas for future research include testing the relative impact of individual strategies, including warm handoffs, colocation, interdisciplinary care plans, and BH registries.

This article has certain limitations. Our findings reflect themes we observed in the 30 LEAP practices, which were selected for having innovative workforce models but not specifically for their models of BH integration. Not all practices had integrated BH services, and we did not systematically collect specific details of each practice's BH integration work, such as the full-time equivalency status of BH specialists. We did not obtain data on BH outcomes, so we are unable to assess the effectiveness of the LEAP practices' BH integration models. In addition, we do not have a comparison group of lower-functioning practices, so we are not able to assess the extent to which BH integration activities at LEAP sites differed from other primary care practices working to integrate BH services. Nevertheless, our findings are relevant and useful to primary care stakeholders, given that LEAP sites were carefully selected for workforce innovations and provided evidence during the selection process suggesting overall high performance.

In fact, the high functioning of the LEAP practices may be related to their BH integration efforts. Nearly all LEAP practices had onsite access to BH specialists, which is notable given that this was uncommon among US primary care practices at the time of our site selection in 2012.⁴³ LEAP practices also involved other non-BH team members in addressing patients' BH needs, demonstrating that BH-related care can be shared among primary care

teams and need not be the sole responsibility of BH specialists.

Like many US primary care practices working to advance their BH integration work, LEAP practices faced common challenges related to staffing,^{38,42} health IT,³⁹ and funding.⁴⁴ This demonstrates the serious difficulties involved in achieving BH integration, even for exemplary innovative practices. Overcoming these challenges will require stakeholders to collaborate on removing barriers to BH integration. Possible approaches could include redesigning health IT systems to better track and communicate about BH treatment, developing new primary care-specific training programs for BH specialists, and advocating for new payment models to better incentivize the delivery of BH services in primary care.

Many efforts are already underway nationally to better support BH integration. For example, new codes created under the 2017 Medicare Physician Fee Schedule allow primary care practices to bill for key BH services, such as care management and consultation with psychiatric providers.⁴⁵ New payment models also are available through the State Innovation Models initiative,⁴⁶ Comprehensive Primary Care Plus,⁴⁷ and Medicaid transformation demonstrations, such as the one in Washington state.⁴⁸ Tools and resources also are available to support practices in integrating BH services, including those from the SAMSHA-HRSA Center for Integrated Health Solutions,⁴⁹ the University of Washington's AIMS Center,⁵⁰ the Safety Net Medical Home Initiative,⁵¹ and tools from the LEAP practices themselves, which are available from the Primary Care Team Guide (<http://improvingprimarycare.org/>).²³

These funding initiatives, tools, and resources have great potential to help primary care practices advance on the path to BH integration. However, more support is needed. Primary care practices are the front lines for identifying and responding to a wide range of patient needs, and BH integration can help practices address patients' behavioral health,⁸ physical health,¹³ chronic pain,⁵² substance use,^{18,19} and opioid dependency.^{18,53,54} As the US health care system works toward providing comprehensive, whole-person care, it will be critical to eliminate barriers to BH integration and support primary care practices in providing the best possible care to meet a wide spectrum of patient needs.

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To see this article online, please go to: <http://jabfm.org/content/31/5/691.full>.

References

1. Center for Behavioral Health Statistics and Quality. Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2016.
2. Kessler R, Stafford D. Primary care is the de facto mental health system. In: Kessler R, Stafford D, eds. Collaborative medicine case studies: evidence in practice. New York, NY: Springer New York; 2008;9–21.
3. Wodarski JS. The integrated behavioral health service delivery system model. *Soc Work Public Health* 2014;29:301–17.
4. Johnson-Lawrence V, Zivin K, Szymanski BR, Pfeiffer PN, McCarthy JF. VA primary care-mental health integration: patient characteristics and receipt of mental health services, 2008–2010. *Psychiatr Serv* 2012;63:1137–41.
5. Unutzer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA* 2002;288:2836–45.
6. Unutzer J, Katon WJ, Fan MY, et al. Long-term cost effects of collaborative care for late-life depression. *Am J Manag Care* 2008;14:95–100.
7. Balasubramanian BA, Cohen DJ, Jetelina KK, et al. Outcomes of integrated behavioral health with primary care. *J Am Board Fam Med* 2017;30:130–9.
8. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev* 2012;10:CD006525.
9. 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 Suppl 1:S7–20.
10. Miller BF, Brown Levey SM, Payne-Murphy JC, Kwan BM. Outlining the scope of behavioral health practice in integrated primary care: dispelling the myth of the one-trick mental health pony. *Fam Syst Health* 2014;32:338–43.
11. Gold SB, Green LA, Peek CJ. From our practices to yours: key messages for the journey to integrated behavioral health. *J Am Board Fam Med* 2017;30:25–34.
12. Peek CJ, National Integration Academy Council. *Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus*. Rockville, MD: Agency for Healthcare Research and Quality; 2013.
13. 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.
14. Collins C, Hewson DL, Munger R, Wade T. *Evolving Models of Behavioral Health Integration in Primary Care*. New York, NY: Milbank Memorial Fund; 2010.
15. Gerrity M. *Evolving Models of Behavioral Health Integration: Evidence Update 2010–2015*. New York, NY: Milbank Memorial Fund; 2016.
16. Roy-Byrne P, Craske MG, Sullivan G, et al. Delivery of evidence-based treatment for multiple anxiety disorders in primary care: a randomized controlled trial. *JAMA* 2010;303:1921–8.
17. Fortney JC, Pyne JM, Kimbrell TA, et al. Telemedicine-based collaborative care for posttraumatic stress disorder: a randomized clinical trial. *JAMA Psychiatry* 2015;72:58–67.
18. Watkins KE, Ober AJ, Lamp K, et al. Collaborative care for opioid and alcohol use disorders in primary care: the SUMMIT randomized clinical trial. *JAMA Intern Med* 2017;177:1480–8.
19. Oslin DW, Lynch KG, Maisto SA, et al. A randomized clinical trial of alcohol care management delivered in Department of Veterans Affairs primary care clinics versus specialty addiction treatment. *J Gen Intern Med* 2014;29:162–8.
20. NCQA. *Introduction to PCMH 2017*. Washington, DC: National Committee for Quality Assurance; 2017.
21. Substance Abuse and Mental Health Services Administration. SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). 2017; Available from: <https://www.samhsa.gov/integrated-health-solutions>. Accessed August 19, 2017.
22. Mauksch LB, Fogarty CT. In search of a perennial philosophy for behavioral health integration in primary care. *Fam Syst Health* 2016;34:79–82.
23. MacColl Center for Health Care Innovation, Robert Wood Johnson Foundation. *Primary Care Team Guide*. 2017. Available from: <http://improvingprimarycare.org/>. Accessed August 19, 2017.
24. Wagner EH, Flinter M, Hsu C, et al. Effective team-based primary care: observations from innovative practices. *BMC Fam Pract* 2017;18:13.
25. Ladden MD, Bodenheimer T, Fishman NW, et al. The emerging primary care workforce: preliminary observations from the primary care team: learning from effective ambulatory practices project. *Acad Med* 2013;88:1830–4.

26. Gibbs G. *Analyzing qualitative data*. London, England: SAGE Publications, Ltd; 2007.
27. King N. *Qualitative organizational research: core methods and current challenges*. London, England: Sage Publications, Inc.; 2012.
28. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
29. Crabtree BF, Miller WL. Using codes and code manuals: a template organizing style of interpretation. In: Miller BF, Crabtree WL eds. *Doing qualitative research*: 2nd ed. Thousand Oaks, CA: Sage Publications; 1999. P. 163–77.
30. AIMS Center (Advancing Integrated Mental Health Solutions). Stepped model of integrated behavioral health care. 2017. Available from: <https://aims.uw.edu/stepped-model-integrated-behavioral-health-care>. Accessed August 19, 2017.
31. Gottlieb K. The Nuka System of Care: improving health through ownership and relationships. *Int J Circumpolar Health* 2013;72.
32. Primary Behavioral Health Care Services, Practice Manual version 2.0. Lackland AFB, Texas: U.S. Air Force Medical Operations Agency; 2011.
33. Parchman ML, Von Korff M, Baldwin LM, et al. Primary care clinic re-design for prescription opioid management. *J Am Board Fam Med* 2017;30:44–51.
34. Cohen DJ, Davis M, Balasubramanian BA, et al. Integrating behavioral health and primary care: consulting, coordinating and collaborating among professionals. *J Am Board Fam Med* 2015;28 Suppl 1:S21–31.
35. Dickinson WP. Strategies to support the integration of behavioral health and primary care: what have we learned thus far? *J Am Board Fam Med* 2015;28 Suppl 1:S102–106.
36. Clark KD, Miller BF, Green LA, de Gruy FV, Davis M, Cohen DJ. Implementation of behavioral health interventions in real world scenarios: managing complex change. *Fam Syst Health* 2017;35:36–45.
37. 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.
38. Davis MM, Balasubramanian BA, Cifuentes M, et al. Clinician staffing, scheduling, and engagement strategies among primary care practices delivering integrated care. *J Am Board Fam Med* 2015;28 Suppl 1:S32–40.
39. Cifuentes M, Davis M, Fernald D, Gunn R, Dickinson P, Cohen DJ. Electronic health record challenges, workarounds, and solutions observed in practices integrating behavioral health and primary care. *J Am Board Fam Med* 2015;28 Suppl 1:S63–72.
40. Gurewicz D, Prottas J, Sirkin JT. Managing care for patients with substance abuse disorders at community health centers. *J Subst Abuse Treat* 2014;46: 227–31.
41. Gunn R, Davis MM, Hall J, et al. Designing clinical space for the delivery of integrated behavioral health and primary care. *J Am Board Fam Med* 2015;28 Suppl 1:S52–62.
42. Hall J, Cohen DJ, Davis M, et al. Preparing the workforce for behavioral health and primary care integration. *J Am Board Fam Med* 2015;28 Suppl 1:S41–51.
43. Peikes DN, Reid RJ, Day TJ, et al. Staffing patterns of primary care practices in the comprehensive primary care initiative. *Ann Fam Med* 2014;12:142–9.
44. Wallace NT, Cohen DJ, Gunn R, et al. Start-up and ongoing practice expenses of behavioral health and primary care integration interventions in the advancing care together (ACT) program. *J Am Board Fam Med* 2015;28 Suppl 1:S86–97.
45. Press MJ, Howe R, Schoenbaum M, et al. Medicare payment for behavioral health integration. *N Engl J Med* 2017;376:405–7.
46. Centers for Medicare & Medicaid Services. *State Innovation Models Initiative: General Information*. 2017. Available from: <https://innovation.cms.gov/initiatives/state-innovations/>. Accessed October 3, 2017.
47. Centers for Medicare & Medicaid Services. *Comprehensive Primary Care Plus*. 2017. Available from: <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/>. Accessed October 3, 2017.
48. Washington State Health Care Authority. *Medicaid transformation*. 2017. Accessed October 3, 2017. Available from: <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation>.
49. Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration. *SAMHSA-HRSA Center for Integrated Health Solutions*. Available from: <https://www.integration.samhsa.gov/>. Accessed October 3, 2017.
50. University of Washington AIMS Center. *Collaborative Care Implementation Guide*. 2017. Available from: <http://aims.uw.edu/collaborative-care/implementation-guide>. Accessed October 3, 2017.
51. Ratzliff A. *Organized, Evidence-Based Care Supplement: Behavioral Health Integration*. Seattle, WA: Qualis Health, MacColl Center for Health Care Innovation, University of Washington's AIMS Center; 2014.
52. Dobscha SK, Corson K, Perrin NA, et al. Collaborative care for chronic pain in primary care: a cluster randomized trial. *JAMA* 2009;301:1242–52.
53. Alford DP, LaBelle CT, Kretsch N, et al. Collaborative care of opioid-addicted patients in primary care using buprenorphine: five-year experience. *Arch Intern Med* 2011;171:425–31.
54. Fiellin DA, Pantalon MV, Chawarski MC, et al. Counseling plus buprenorphine-naloxone maintenance therapy for opioid dependence. *N Engl J Med* 2006;355:365–74.