ORIGINAL RESEARCH

Integrated Behavioral Health Implementation and Training in Primary Care: A Practice-Based Research Network Study

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Introduction: **Integrating behavioral health services into primary care has a strong evidence base, but how primary care training programs incorporate integrated behavioral health (IBH) into care delivery and training has not been well described. The goal of this study was to evaluate factors related to successful IBH implementation in family medicine (FM) residency programs and assess perspectives and attitudes on IBH among program leaders.**

Methods: **FM residency programs, all which are required to provide IBH training, were recruited from the American Academy of Family Physicians National Research Network. After completing eligibility screening that included the Integrated Practice Assessment Tool (IPAT) questionnaire, 14 training programs were included. Selected practices identified 3 staff in key roles to be interviewed: medical director or similar, behavioral health professional (BHP), and chief medical officer or similar.**

Results: **Forty-one individuals from 14 FM training programs were interviewed. IPAT scores ranged from 4 (Close Collaboration Onsite) to 6 (Full Collaboration). Screening, outcome tracking, and treatment differed among and within practices. Use of curricula and trainee experience also varied with little standardization. Most participants described similar approaches to communication and collaboration between primary care clinicians and BHPs and believed that IBH should be standard practice. Participants reported space, staff, and billing support as critical for sustainability.**

Conclusions: **Delivery and training experiences in IBH varied widely despite recognition of the value and benefits to patients and care delivery processes. Standardizing resources and training and simplifying and assuring reimbursement for services may promote sustainable and high quality IBH implementation. (J Am Board Fam Med 2023;36:1008–1019.)**

Keywords: **Family Medicine, Integrated Behavioral Health, Integrated Delivery Systems, Patient Care Team, Residency, Practice-Based Research, Primary Health Care, Qualitative Research**

Introduction

Nearly 70% of primary care visits involve discussion or treatment of at least 1 behavioral health concern,[1,2] but there are difficulties in connecting patients to behavioral health services in a timely manner.[3] Logistic and insurance coverage

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challenges[4,5] as well as stigma and unfamiliarity limit access to behavioral health services.[6] These barriers can be reduced through evidence-based integrated behavioral health (IBH) in primary care, in which medical and behavioral health care are delivered in a single setting.[7] IBH increases access to evidence-based care and improves patient outcomes,[8] yielding benefits to patients and practices alike.[9,10]

IBH implementation requires specific skills and specialized training for medical and behavioral health clinicians.[11–13] Family medicine residency training programs are required to have behavioral health faculty and provide training in IBH[14] and typically serve learners from a variety of professional programs (medical, social work, nursing, psychology, etc.). For trainees in family medicine residencies to effectively meet the demand of addressing patient behavioral health needs, training programs must have a curriculum that includes effective models of IBH delivery.[15,16] Apprenticeship is an important element of IBH training, and the formal and informal experience of IBH in family medicine training programs influences and informs future practice of trainees from those programs. However, approaches to IBH delivery and skill development may vary across training programs and have not been well-studied.[17] Thus, we examined delivery of IBH and perspectives about facilitators for and challenges to IBH implementation and training in family medicine residency programs.

Methods

Design and Setting

We conducted a qualitative study with in-depth semistructured interviews of clinicians and administrators in family medicine training programs. The American Academy of Family Physicians (AAFP) Institutional Review Board approved this study, and we followed the Consolidated Criteria for Reporting Qualitative Research (COREQ).[18]

Participant Recruitment

We used purposive sampling to identify family medicine training programs from the Northeast, Midwest, and Pacific Northwest of the US from 2 sources: AAFP National Research Network member practices that were known to have interest in behavioral health studies and practices known to have IBH based on the knowledge of the study team. Designated contacts at the selected practices were sent a survey via Qualtrics (Provo, Utah) to assess for type of IBH training and collect information on the number and types of trainees and behavioral health professionals [BHPs: psychotherapists (psychologists, licensed clinical social workers) and prescribers (psychiatrists, nurse practitioners)]. Of the 20 practices that indicated interest, 6 were determined to be ineligible because they did not have a family medicine residency program.

Data Collection

Designated contacts at each practice were invited to participate and asked to provide the following information about their practice: the IBH model used, for example, Primary Care Behavioral Health Model (PCBH),[19] colocated,[20,21] blended, and Collaborative Care Model (CoCM)[22,23] and the level of behavioral health integration assessed using the Integrated Practice Assessment Tool (IPAT).[24] The IPAT is a brief assessment tool based on a decision tree model designed to place practices on the level of collaboration/integration defined by A Standard Framework for Levels of Integrated Health care.[25] Eligible practices identified 3 people to participate in interviews: the medical director (or similar role), a BHP (who was part of the residency training faculty), and the chief medical officer or other leader. Each practice that completed the research survey and interviews received a $500 stipend.

The research team, comprised of a psychologist, a psychiatrist, a family physician, and advanced degree primary care researchers, developed the interview guide. Two team members (JW and MF) conducted the interviews virtually in English between March 24, 2021, and July 13, 2021. Interviews were audio-recorded and transcribed verbatim and averaged 50 minutes in length. In addition to the practice stipend, each interviewee received $150 for their time.

Data Analysis

An inductive analytic approach was used to analyze the qualitative text.[26,27] The codebook was developed iteratively, and 2 team members (JW and MF) made an initial list of codes. A revised codebook was adopted after 2 iterations based on feedback from MW, CH, and CD. MF and ER coded individual transcripts using Atlas.ti.9. We used ongoing quality assurance where coding was monitored to ensure

coders coded similarly. We pilot tested 1, compared results, and discussed discrepancies. Next, we tested 2 more, compared results, then continued coding manuscripts. Then we went back and recoded the original ones we piloted. Thus, we performed calibration exercises to show coders interpreted text in a similar fashion. Once completed, the 2 coders then assessed 25% of manuscripts to ensure that codes and their definitions were applied accurately; discrepancies were resolved by consensus. Four team members (MF, JW, ER, AN) discussed categories. Development of themes surfaced through multiple readings of the data and comparison across transcripts was undertaken to ensure applicability and inclusiveness. This content was finalized by consensus.

Results

We engaged 14 practices and interviewed 41 participants (Table 1). All practices trained resident physicians; 12 had trainees other than residents (ie, medical students and pharmacy students); and 12 had 15 or more primary care physicians (PCPs) and advanced practice medical providers combined. Across the practices, there were 1 to 9 BHPs (mean = 3.50) and 0 to 34 accessible psychiatric prescribers (mean = 13.5). Respondents identified their IBH model as PCBH, colocated, blended, CoCM, multiple models, or none. We found that respondents may have used different classifications for BHPs (ie, including psychiatrists) and/or may have counted clinicians (psychiatrists and others) who were in their network but outside their practice, while others only counted those practicing onsite. In addition, some respondents may have included residents in clinician counts where others did not. IPAT scores ranged from 4 (Close Collaboration Onsite) to 6 (Full Collaboration) (Table 1).

This report focuses on 5 emergent themes arising from the interviews: IBH delivery, benefits and essential elements, training and learner integration, and structural and policy barriers. For exemplary quotes, refer to Table 2.

Delivery of IBH

Screening

Participants reported screening for depression and/or anxiety at annual wellness visits, behavioral health visits, new patient visits, or other visits based on recent or historic diagnoses or stressors. Other conditions were screened for at some practices including intimate partner violence, alcohol and substance use disorders, and concerns specific to pediatric patients. Positive screens (such as reported psychological distress) triggered a conversation with or referral to a BHP or care manager.

Tracking of Individual and Population Metrics

Participants reported individual-level tracking, population-level tracking, or both. Most participants reported that they tracked quality metrics or screening completion for individual patients, but multiple challenges hampered tracking from being routine, practice-wide, or at the population level: manual entry of data from outside the EHR was time-consuming; inability to search data not captured in the EHR; referrals were not automatic if depression score worsened; and lack of dedicated staff to review the data. A few participants mentioned using registries (eg, for depression or opioid use) to document and track behavioral and mental health services and indicated that this type of monitoring focused on population-level management rather than the individual-level.

Treatment Decision-Making Algorithms

The majority of participants stated either that their practice did not use treatment decision making algorithms to guide behavioral health treatment (9 practices) or that they were not aware of algorithms (2 practices), despite indicating interest in their use. Practices had protocols or EHR recommendations based on screening results, but these were applied with clinician discretion. Algorithms were not used due to both clinical and patient related factors. Clinicians cited perceived disruption to workflow, prior training that emphasized decisions based on clinical interviews, and professional discretion as reasons for not using algorithms. Algorithms were seen as rigid, not allowing for patient buy-in, and/or not recognizing lack of access to suggested treatment.

Communication and Information Sharing

Most stated that BHPs were available to aid in diagnosis, triage, and therapies for specific concerns (eg, eating, developmental disorders). Teams communicated through the EHR, designated internal digital communication platforms, and curbside consults. PCPs had access to social services support via

Table 1. Practice Characteristics

Practice #	IPAT score	IBH Models					Clinicians[2]			Medical Trainees		Allied Health Students				Mental & Behavioral Health		Screeners in EHR					Interviewee Roles		
		PCBH	CoCM	Co-Loc	Blend[1]	Unspecified	Physicians	BHPs	Psychiatric Prescribers	Residents	Medical Students	Pharmacy	PA/NP	MA/CMA	Nursing & Exercise	Psychology Fellows/ Interns	Behavioral Health	Depression	Anxiety	SUD	IPV	MDQ	Residency Faculty	Behavioral Health	Practice Leadership
1	5	✓					<5	1	0	✓	✓	✓					✓	✓					2	1	0
2	4			✓			≥15	2	21	✓	✓		✓					✓					1	1	1
3	5				✓		≥15	6	25	✓	✓		✓					✓					2	1	0
4	4	✓					≥15	2	5	✓	✓	✓					✓	✓	✓				0	2	0
5	5				✓		≥15	3	12	✓	✓			✓			✓	✓					1	1	1
6	4		✓				≥15	2	25	✓	✓			✓	✓			✓	✓	✓	✓		1	1	1
7	6		✓				≥15	2	10	✓								✓					1	1	1
8	5	✓					≥15	2	0	✓	✓					✓		✓	✓	✓			2	1	0
9	4		✓				≥15	4	1	✓	✓		✓										0	2	1
10	5				✓		5-9	1	20	✓	✓	✓			✓			✓	✓	✓	✓	✓	1	1	1
11	5	✓					≥15	9	32	✓	✓	✓				✓		✓					0	1	2
12	4					✓	≥15	5	34	✓	✓					✓		✓		✓			1	2	0
13	5				✓		≥15	5	3	✓	✓				✓		✓	✓	✓				1	1	1
14	5		✓				≥15	5	1	✓													1	1	1

Notes: Check marks denote the presence of the respective category item in the practice where numbers were unknown/unapplicable.
Abbreviations: PCBH, Primary Care Behavioral Health; CoCM, Collaborative Care Model; Co-Loc, Co-Located; SUD, Substance Use Disorder; IPV, Intimate Partner Violence; MDQ, Mood Disorder Questionnaire.
[1]These practices reported using more than one IBH model. Practice 3 reported having a "blended" IBH model, without specification about which models were included. Practice 5 reported both PCBH and Co-Location. Practice 10 reported PCBH and Collaborative Care. Practice 13 reported PCBH, Collaborative Care, and Medical Family Therapy.
[2]Responses were based on participant perception, and numerical estimates may be inflated by inclusion of those outside the practice who are part of the larger health system.

other members of the behavioral health team, such as social workers or care coordinators, either onsite or via telehealth. PCPs also received indirect support from BHPs through informal consults, huddles, case reviews, or warm handoffs.

Providing Therapy in Clinic

All practices provided short-term therapy emphasizing behavior change, self-management, and skill development. Practices often did not have capacity for longer term psychotherapy but occasionally provided it due to lack of referral options.

Perspectives on IBH Benefits and Essential Elements for Successful Delivery

Participants shared that IBH should be standard practice in primary care and that BHP presence is indispensable. They reported that collaboration with members of the behavioral health team made PCPs' roles easier and improved patient outcomes, and that onsite behavioral health services were convenient for patients and improved follow-up. Participants indicated ideal IBH implementation required adequate BHP staffing, protected time for screening and warm handoffs, and onsite psychiatry services. Dedicated space where team members could gather for warm handoffs or conduct therapy or support groups was also recommended. Support with screening, tracking, and billing was reported as necessary to ensure compensation and improve population health. Participants highlighted the need to offer long-term behavioral health services or better connection to external BHPs and psychiatrists to better meet patients' needs, as IBH is most appropriate for finite, short-term treatment. Lastly, some participants stressed the importance of better practice-wide education about IBH workflows to clarify roles and service availability to encourage use.

Table 2. Exemplary Quotations

Category	Exemplary Quotations
Delivery of IBH	
Screening	"Each patient who comes in for a visit gets a PHQ-2. If they screen positive on the PHQ-2, they get the PHQ-9 and the GAD-7. The medical assistants also [ask] questions of safety . . . Those are the baseline screeners that everybody who walks in the door gets."
Tracking	"As far as ACEs [Adverse Childhood Experiences] and depression, there's the ability to look at depression screening over time. [It] is to the individual patient, not something that's population-based at this time."
Treatment Decision-Making Algorithms	"No. It's very provider dependent. We work at a residency practice, so I try to talk about the STAR*D trial [a National Institute of Mental Health funded study on depression treatment], but we have nine full faculty here, so our residents may get a different take on how to augment treatment."
Communication and Information Sharing	"I'm now program director for our residency. Half of my clinical time is spent precepting residents. So when I precept residents, . . . I'm there with our board-certified psychologist precepting, and whether she's in and out seeing her own panel patients, or she's there dedicated to the precepting for the residents, she's right there . . . [She] really participates in the conversation and the precepting for the care of all the resident patients for that session, and if there's direct behavioral health needs, she will take it away and handle the precepting. And if there are other medical needs, she'll still participate. [She'll] give her feedback about other areas that the resident and the attending may not have considered. It's a great resource to have, and [she] also stays consistently engaged and involved. For the majority of patients, there's something that she can help with."
Providing Therapy in Clinic	"I would like to see. . . options for patients to have the short-term intervention provider, as well as more of a specialty long-term option here. I think we lose a lot of people when we try to transition to community providers . . . "
Perspectives on IBH Benefits and Essential Elements for Successful Delivery	"Definitely having a provider for the warm handoffs while we're in clinic, but also having capacity or capability for the individual or group therapy sessions would be I think ideal. Also, having . . . an advanced care provider under a psychiatrist or a psychiatrist assist more with complicated medication management. A tough one for us. . . is to have easy and regular access to a psychiatrist for assistance with prescriptions."
	"I mean, obviously, staffing would be remarkably helpful. What I would add is the billing support and that process. I would add the tracking piece through the EHR, which would be much less difficult to find. It'd be much more user friendly. Probably a new EHR completely would be needed to facilitate [efficient IBH delivery]."
Destigmatizing Behavioral Health and Providing Holistic Care	"Oh, man. After doing this job, I can't imagine doing it any other way. I feel like for the patients, having access to mental health services where they see their provider, I think, takes away a lot of barriers to them actually following through [in getting care and treatment]. There's just a level of comfort with coming to the doctor. It's socially appropriate and acceptable to go to your doctor's office. [Others] don't need to know you're coming to see your therapist versus the doctor or the dietician or whoever you're coming to see. I think there's just this natural level of acceptance to go and get your mental healthcare. Then being part of a multidisciplinary team, I feel like, [it] allows us to really make sure that our patients are being well cared for with all of their needs."
Benefits of Behavioral Health Services in Clinic	
Keeps Behavioral Health Services in Clinic	" . . . our patients have a lot of trauma and a lot of psychiatric needs. There's extremely poor access for psychiatric prescribing and also for mental health therapy services where we practice. It's really hard to get patients into an outside therapy or prescribing situation, unless they have the financial means. Where I practice, it's really diverse. We have a spectrum of socioeconomic diversity, but we really care for patients who are very underserved. [There's] a lot of spillover from federally qualified health centers for people who don't have $150 to spend on a private therapy session. For a lot of our patients, given their comorbid addiction or trauma and mental health issues, having someone onsite who can do interventions and do some brief therapy and counseling and even prescribing is really crucial to them."
Managing Serious Mental Illness and Crisis	"If they're seeing a patient who has active suicidal ideation. . . or severe mental illness, let's say, either in the clinic or on a telemedicine visit, we have an on-call warm handoff schedule. The provider can go and contact [the BHP], whether in clinic or via remote means, and then, after a brief consultation, can connect [the BHP] with the patient who can then take over while the provider continues their clinic day. And then, [the provider and BHP] connect again afterwards . . .[to] plan for further management."
	"On the rare occasion that we have somebody who maybe is presenting with a . . . new onset severe mental illness or an acute flair up that needs a psychiatrist to help weigh in, often we can handle that within our clinic. We have a psychiatrist who oversees residents who are there once a month, and they assess the patient. They don't actually prescribe to the patient. They tell the PCP what to do and work collaboratively with the PCP."

Continued

Table 2. Continued

Category	Exemplary Quotations
Potential Cost Reduction	"If you're thinking about cost savings, we know that having integrated care or having a psychologist, social worker, or somebody who's actually doing therapeutic modalities is going to help reduce the burden on your primary care providers. It's going to save the system some costs in reducing visits to the emergency room. If you can coach somebody on how to manage their panic attacks, then they're probably going to visit the ED less, which saves the whole system money."
Learning to Collaborate and Instilling an IBH Culture	". . . it's a great benefit for the community for one thing, but because our [psychiatry] resources are fairly limited in our area . . . trying to get a patient into a psychiatrist, even trying to get psychiatry in the hospital, is difficult. Having [psychiatry services] available for the community is huge. We have a lot of mental health issues in our area, but it's also great for learners. . . Our behavioral med fellows do their own therapy sessions, and our residents actually rotate with them to see what they do, what they're talking about, what they're discussing, what they're counseling [patients] on . . . [Residents] do a lot of behavioral med didactics, readings, and discussions [with them]. And then, having the extra [behavioral health practice opportunities] like the lifestyle clinic and the ADHD clinic for kids, also provides a whole other learning perspective for the resident that they're not going to get elsewhere. When they're an attending, if they're in an office [without BHP access], at least they have had the education, and they have the base to move on with."
Structural and Policy Barriers to Successful Delivery	"For us, it would probably be more like insurance coverage, co-pays. So if a lot of people don't want top pay co-pays, they feel like they're paying for their medical visit. Why would they have to pay for their mental health visit? That's also a little bit of a sticking point with having them at your office. They feel like, well, if I'm here at the office, why am I paying twice? Even though it's two different people seeing them for two different reasons and two very different visits, patients don't always understand why they would be paying for different services in the same building."
	"Space as well. I really required at least a private office to be able to meet with people. I do meet in exam rooms too, but even that can sometimes be difficult because the medical providers need that space often. I do some groups, and so sometimes in order to do groups, I need some larger . . . meeting spaces. So that's definitely been something to balance and juggle."
	"I am fortunate enough to be employed by an institution. So for me, the financial cost is rolled into my budget and not so much my own cost. I was in private practice before I went into academics. In private practice, I don't think there would be any way I could have afforded to be able to have a behavioral medicine side . . .It does cost money [laughter]."

Abbreviations: IBH, integrated behavioral health; PHQ-2, patient health questionnaire-2; EHR, electronic health record; BHP, behavioral health professional; ED, emergency department; ADHD, attention-deficit/hyperactivity disorder.

Destigmatizing Behavioral Health and Providing Holistic Care

Participants reported that stigma associated with receiving behavioral health care was decreased by the opportunity to receive care within their practice. Patients were more likely to seek and receive IBH services in the primary care practice because of established rapport with staff and comfort with the environment and processes. Participants noted that patients were more likely to follow through with a BHP or care manager if a warm handoff was facilitated by the trusted PCP.

Participants also reported that integration normalized behavioral health as part of health care, enabling a holistic approach. Interdisciplinary teams identified and treated issues early before they became more serious. In addition, BHPs could assist with a breadth of care needs, including depression, anxiety, and chronic diseases. IBH facilitated care coordination with specialists (psychiatrist, dietician, etc.) and ensured that patients' needs were met, addressing whole person care through a team approach.

Benefits of Behavioral Health Services to the Practice

Keeps Behavioral Health Services in Clinic

Participants reported that providing behavioral health services in primary care settings improved behavioral health access and outcomes because of better coordination and retention in care. While some BHPs did not have access to psychiatric prescribers or psychiatrists, BHPs specifically were viewed as an added benefit to patient care, contributing to a more holistic and effective approach to care by multidisciplinary teams.

Managing Serious Mental Illness and Crisis

Participants stressed that having a psychiatrist or other psychiatric provider on staff expanded practice capacity for treatment of more complex mental health diagnoses and appreciated even limited psychiatric contributions: performing chart reviews,

offering treatment guidance, and in some cases, providing feedback to learners' case presentations, conducting didactic sessions, or precepting.

Potential Cost Reduction

Some asserted that integration decreased costs of health care due to decreases in emergency department visits and specialty psychiatric care, as well as alleviating time and access barriers. In some cases, psychiatrists were housed in a Department of Psychiatry, so they were available for referrals and not truly integrated, reinforcing fragmentation of behavioral health care. Participants reported that physical and organizational barriers to connecting with psychiatric providers made it difficult to both access and integrate services into practices, likely increasing cost for both patients and the health care system.

Learning to Collaborate and Instilling an IBH Culture

The engagement of learners in IBH occurred in a variety of forms in these residency programs (Table 3). In most models, all learners shadowed behavioral health team members and gained experience working within an IBH model. Hands-on training for residents and other learners occurred in the form of apprenticeship (learning by doing while immersed in an IBH setting). Participants also described didactic IBH curricula but

Table 3. Training Different Learner Types Together

Learner Type	Role and Collaboration Description
Residents	• Involved care team/BHP in behavioral health change interventions (e.g., smoking cessation, weight loss management, etc.). • Used counseling techniques, listening skills, and motivational interviewing (MI); and observed cognitive behavioral therapy (CBT) in patient care. • Learned when and how to incorporate care team/BHP in providing care. • Received targeted training for integration of BHPs and identification of processes (who needs help, how to reach out for assistance, and understand patient treatment needs). • Exposed to other experiences beyond traditional primary care clinic, e.g., addiction treatment centers, lifestyle clinics (i.e., chronic disease management), ADHD clinics, and resident-run clinics (i.e., non-emergency and preventative care).
Psychology Fellows	• Conducted own therapy sessions. • Participated in huddles, warm handoffs, curbside consults, etc. • Saw both resident and non-resident patients, communicated via a HIPAA compliant app or EHR, and made recommendations. • Participated in warm handoffs and consults.
Psychology/Counseling Interns	• Provided observation and direct care services under BHP supervision. • Performed individual or group counseling. • Supported case management. • Helped with referral process for more complex care for patients. • Followed up with patients by calling and touching base with them. • Helped with care coordination. • Participated in warm handoffs and brief consults.
Medical Students	• Observed in clinic. • Shadowed licensed professionals. • Conducted patient interviews. • Worked with residents in clinics. • Performed workup/intake. • Participated in group sessions (e.g., pregnant women and medication-assisted treatment). • Dedicated time with behavioral health and psychiatry team (if applicable) during rotations. • Exposed to caring for patients on a panel within a multidisciplinary team approach.
Pharmacy Students	• Helped with psychopharmacological questions. • Located in precepting room where they overheard behavioral health input.

Abbreviations: BHP, behavioral health professional; ADHD, attention-deficit/hyperactivity disorder; EHR, electronic health record; HIPAA, health insurance portability and accountability act of 1996.

did not provide details. The approach to didactics appeared to vary across programs and was based on clinical context and IBH model.

Participants reported that learners practice IBH from the beginning of their respective training programs by being immersed in all aspects of patient care, including behavioral health. Residents have their own patient panels under attending physician supervision. Participants described different ways that residents interact with other team members, such as initiating warm handoffs, counseling patients, prescribing medication for less complex cases, referring to BHPs for short-term therapy or other resources for long-term therapy or psychiatrists for those requiring complex medication management.

Structural and Policy Barriers to Successful Delivery

According to participants, structural and policy barriers hindered true behavioral health integration in their residency programs (Figure 1). Barriers included lack of organizational buy-in, inadequate funding, heavy workload, limited space, challenges related to copays, and inadequate reimbursement. Participants described having to justify hiring needed staff and often being supported by grants or other programs rather than through reimbursement or organizational core support. They also reported not having adequate space to conduct patient visits or consult with team members. Participants were able to describe workarounds to most of these structural and policy constraints, except for challenges related to patient insurance coverage and cost. On the patient access side of barriers, participants thought insurers should be required to reimburse behavioral and mental health services similarly to preventive health services, as inadequate coverage often leaves gaps in access to behavioral and mental health services for those who need it most.

Discussion

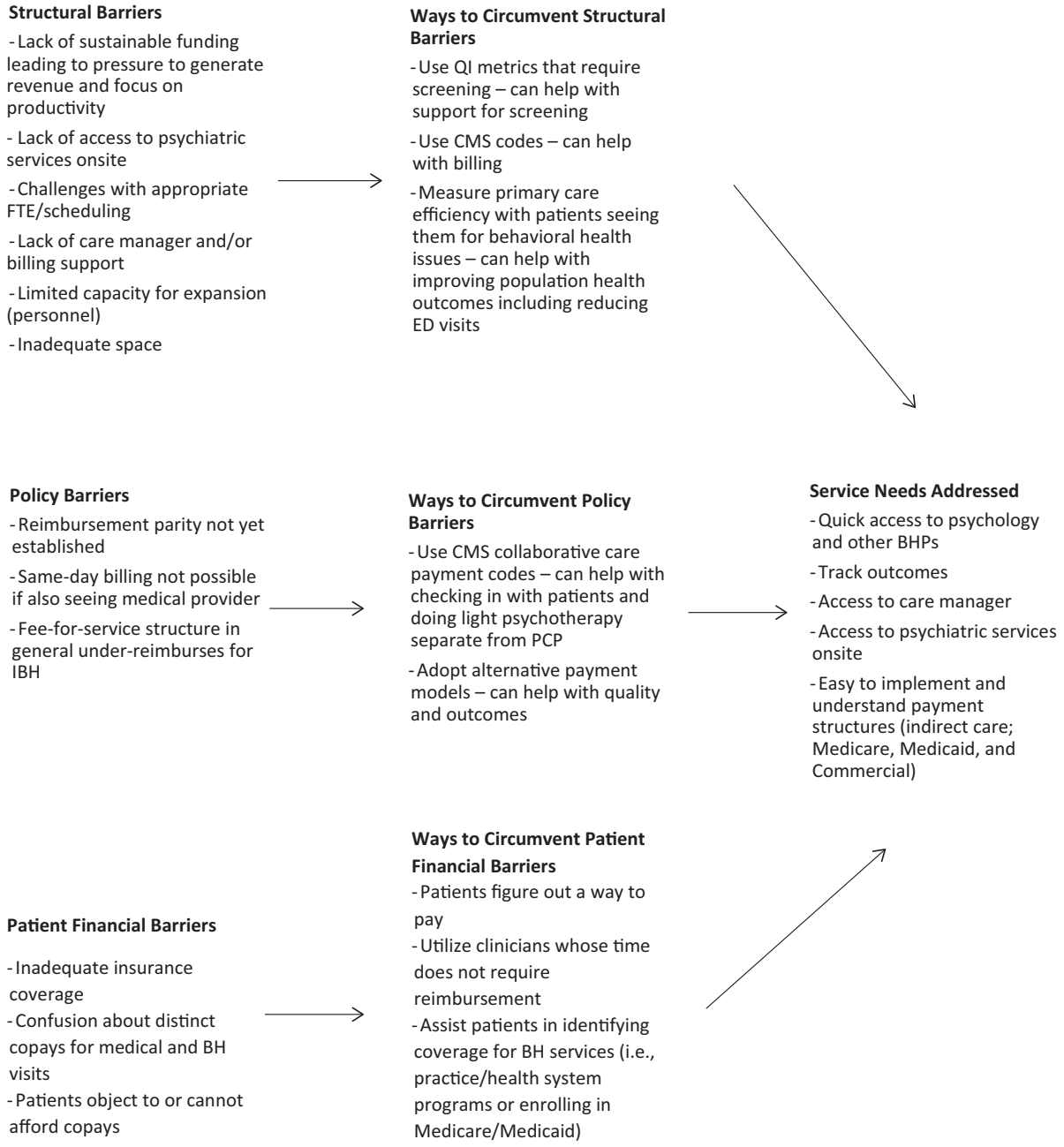
This study describes factors reported as important for successful delivery of IBH in family medicine training programs as well as perspectives regarding IBH training. Though these results are based on our sample of family medicine residency training programs, they are not necessarily unique to training programs. Participants reported the value in IBH models as applied and described strategies they used in care delivery and training. Trainees from multiple disciplines learned from the collaborative processes used to coordinate behavioral health within primary care and their experiences of practicing IBH will influence and inform their future practice. Adequate and appropriate clinic space,[28–30] personnel,[29,31–33] and referral services (eg, seamless access to psychiatry and long-term psychotherapy) were highlighted as key factors for optimizing IBH. For patients, participants highlighted the benefit of IBH to counter the negative effects of stigma of receiving behavioral health services and to increase access to holistic care. Even though participants discussed structural and policy barriers to behavioral health integration, some stated that certain challenges could be addressed within their organization. The exception was insurance coverage which limited patient access and constrained care teams.

Trainees who are exposed to IBH in residency are likely to be well equipped and prepared to address behavioral health concerns, manage complex care scenarios, and navigate care coordination efforts when entering practice after completing training.[34] Furthermore, while some similarities existed among residency programs, there are currently no standardized approaches for teaching IBH, and core competencies that ensure learners have the needed tools to deliver care within IBH practices were not discernible.[35,36] Research is needed to identify best practices and inform approaches to standardize IBH training.

Our study provides important insights about IBH implementation and training in family medicine residency programs for the next generation of primary care clinicians. Our findings support prior reports that IBH may improve patient and clinician satisfaction, outcomes, access, and timely treatment for behavioral health concerns.[22,37–43] Likewise, the results reinforce documentation of barriers found in prior studies such as inadequate staffing (BHPs and care managers), limited access to psychiatric consultation, organizational and financial barriers, patient insurance challenges, and stigma.[30,44–48]

Our findings have important implications for gaining organizational buy-in and support, which may require increased preparedness with data to justify upfront expenses (like office space or salary) when seeking to hire a BHP or invest in a psychiatrist. Our findings suggest that showing better

Figure 1. Structural and policy barriers to IBH in residency programs and potential ways to serve needs.
Abbreviations: **IBH, integrated behavioral health; FTE, full-time equivalent; QI, quality Improvement; CMS, centers for medicare & medicaid services; ED, emergency department; PCP, primary care physicians.**



patient outcomes[37,49] and cost savings[50–52] may influence decisions favorably. Increased communication around IBH models may also build or enrich relationships across teams.[53] In addition, having an IBH structure is a start, but programs need to infuse an IBH working culture through connections and communications that are truly interdisciplinary.[28,54] Clinicians, administrators, and staff may know the intent of IBH, but greater learning and support across organizations may be necessary to accomplish goals.[35] Developing protocols and structures that allow organic interactions between team members is an approach that may improve the implementation of IBH.

There are some limitations to our study. This qualitative study with a small sample size within

select geographical areas has limits regarding the generalizability of the results. In addition, purposeful sampling is prone to selection bias due to investigator judgment. Challenges of newly established programs may be different from challenges reported here. Next, our findings are based on participants' perceptions. We did not provide standardized definitions for participants to minimize information bias, which may have skewed survey responses. In addition, key elements for robust IBH implementation depend on the model deployed. In some cases, onsite access to a behavioral health resource, tracking of outcomes, and addressing financial barriers may be important, while in other contexts adapting to differing needs of patients, embedded psychiatric prescribers, and diversification of the behavioral health team (ie, social workers, psychologists, and care managers) may be more important. We did not collect information from learners, which may have enhanced our findings.[17] Therefore, future studies incorporating learners' perspectives on team-based, interdisciplinary training in IBH is important to inform IBH implementation.[17,55–57] However, the detailed information gained here from clinical teams on the frontline of care can inform the development of IBH playbooks and curricula to support the design and implementation of effective IBH in clinical practice and training environments.

This study examined perspectives on the implementation of IBH in family medicine training environments with implications for developing, maintaining, standardizing, and strengthening IBH programs. As the need for behavioral and mental health services increases, multipronged approaches and policy changes are needed to support cost-effective implementation and impactful IBH training in primary care. Including behavioral and mental health as part of comprehensive care could increase access for patients and improve insurance coverage and payment. In turn, advocacy efforts could emphasize that high levels of integration drive improved population health, patient experience, clinician well-being, and reduced costs.

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