

ORIGINAL RESEARCH

Behavioral Health in Independently Owned Family Medicine Practices

Brooke Ike, MPH¹, Brennan Keiser, MSW¹, Ajla Pleho, MPH¹, Kris Pui Kwan Ma, PhD¹, Annie Koempel, PhD, RD², Madeline Byrd, MEd², Andrew Bazemore, MD, MPH², Sebastian Tong, MD, MPH¹

¹ Department of Family Medicine, University of Washington, ² American Board of Family Medicine

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Introduction: Mental health and substance use diagnoses are increasing, and many patients cannot access behavioral health (BH) care. One-third of family physicians work in independently owned practices, but only a minority work collaboratively with BH clinicians. Our study sought to describe barriers to implementing integrated BH in independently owned family medicine practices and the alternate approaches family physicians are using to offer BH care services to their patients.

Methods: We recruited eligible family physicians who completed the American Board of Family Medicine 2021-2022 Continuous Certification questionnaire. We interviewed 16 family physicians working in independently owned family medicine practices. Interviews were analyzed using a qualitative exploratory design guided by the Framework Method.

Results: Participants identified cost, staffing, and space as principal barriers to implementing and sustaining integrated BH at independent practices. In the absence of integrated BH, participants reported that they provide BH support to their patients in the form of assessment and diagnosis, basic medication management, coaching on BH skills, and referring to outside resources.

Conclusions: This study highlights that barriers to integrating BH at independent family medicine practices align with those at larger health systems, but that the nuances of those barriers differ based on the smaller practice context. Family physicians at independent practices are filling in BH services gaps to the best of their abilities but are constrained by training and resource limitations. Targeted strategies, particularly addressing cost, staffing, and clinical space limitations, are needed to support independent family physicians in achieving sustainable access to integrated BH care.

Keywords: Access to Care, Doctor Patient Relations, Health Disparities, Health Services, Primary Care Physicians, Primary Health Care, Quality of Care, Emergency Room Visits, Workforce, Behavioral Health

Introduction

Rising mental health and substance use rates in America exceed the behavioral health (BH) workforce capacity.¹ The National Academies of Sciences, Engineering, and Medicine called for greater BH services integration into primary care to improve mental health and overall health outcomes, reduce healthcare utilization and cost, and increase patient and physician satisfaction.²⁻⁴ Previous work reported that 38.8% of family physicians worked with BH clinicians in their primary site of practice, but only 12.3% for those in independently-owned practices.⁵

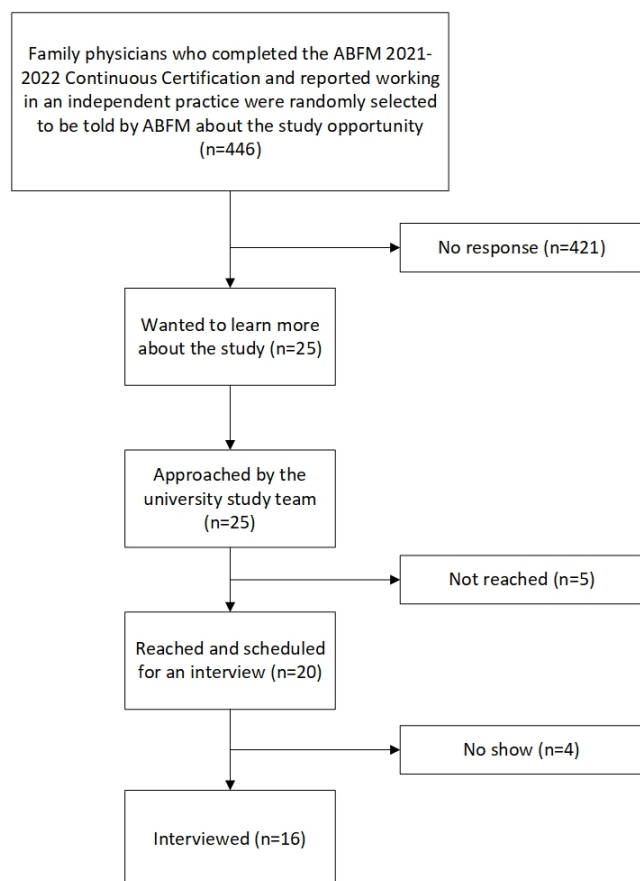
While research has examined barriers to implementing integrated behavioral health (IBH), this work has focused on large health system and federally-funded healthcare settings.⁶⁻⁸ However, one-third of family physicians work in independently-owned practices.⁹ These practices face substantial financial stressors and more frequently serve so-

cially vulnerable patients compared to non-independent practices; as such, these practices may need more support in meeting patient needs.¹⁰ Understanding the barriers to IBH in independently-owned practices would inform targeted approaches to increase BH access for patients and reduce the burden of family physicians to provide behavioral healthcare. Our study examines barriers to IBH in independently-owned family medicine practices and alternate approaches family physicians are using to offer BH services.

Methods

Study Design

We used a qualitative descriptive approach¹¹ to explore and describe family physicians' perspectives on barriers to IBH and alternate methods they use to address patients' BH needs. This study followed the Consolidated Criteria

Figure 1. Family Physician Recruitment.

Abbreviation: ABFM, American Board of Family Medicine.

for Reporting Qualitative Research checklist. The University of Washington Institutional Review Board deemed the study exempt (category 2) as disclosure of participant responses would not reasonably place the subjects at risk (#00017886).

Sample and Setting

We conducted this study in partnership with the American Board of Family Medicine (ABFM), a not-for-profit organization whose mission is to safeguard the public through rigorous standards for education, board certification, support for improvement, and research. We used random purposeful sampling^{12,13} to recruit family physicians who work in independently-owned practices both with and without IBH using their responses from the ABFM 2021-2022 Continuous Certification examination questionnaire¹⁴ (see [Figure 1](#)). Random purposeful sampling was chosen to minimize any potential outreach bias and expand our sample's variability.¹⁵ ABFM staff emailed physicians meeting the sampling criteria to share the research aims and ask if they were interested to learn more from the university study team. The university team emailed the 25 interested physicians to invite them to participate in the interview. Sixteen physicians participated in interviews between July 24, 2023 and June 24, 2024.

Data Collection

We used semi-structured interviews to gather comparable data while giving participants the freedom to provide perspectives on their own terms.¹⁶ Interview questions covered current BH approaches and barriers to IBH (see supplemental materials). University staff with no prior relationship with participants conducted interviews: a family physician (ST), a primary care psychologist (KM), and a research coordinator (AP). The interviews lasted 45–60-minutes, took place via video call, and were audio-recorded and transcribed. After the interview, participants completed a survey on their characteristics using REDCap (Research Electronic Data Capture), a secure, web-based software platform. Participants received a \$200 gift card.

Analysis

The seven stages of the Framework Method¹⁷ guided analysis. The coding team (ST, KM, AP) familiarized themselves with the data by conducting interviews and reading two transcripts before evenly dividing transcripts for coding. The codebook started with broad category codes developed deductively based on research questions (e.g., barriers to setting up IBH), and expanded inductively through open coding and consensus-building discussions between the analyst team (BI, ST, KM, AP) until no new codes arose. We used inductive coding to elicit barriers and approaches that were unique to the independent practice setting. The coded data were charted into two framework matrices (one for barriers to IBH and one for alternative approaches to IBH) by a qualitative research scientist (BI), who carefully reduced data while retaining the original meaning. Prior to charting, BI read all transcripts to familiarize with source data. The matrices enabled the analyst team to visualize the data as a whole and by IBH status. Interpretation involved memoing impressions, clustering, and factoring themes.¹⁸ We used Dedoose for data management.¹⁸

Lincoln and Guba's¹⁹ criteria were used for data trustworthiness. For credibility that findings reflected participants' perspectives, we triangulated findings across multiple analysts and conducted peer debriefing. To facilitate understanding of our results' transferability, we provided descriptions of participants and their perspectives. For dependability and confirmability, we maintained audit trails through codebooks, Case Analysis Forms,¹³ and analysis matrices.¹⁷ We used researcher reflexive memoing and analyst discussions to examine any hidden assumptions or biases.¹³

We conducted descriptive analyses of survey data to describe participant characteristics. To categorize participant's practice type, two analysts (BI, ST) applied categories outlined by the American College of Physicians²⁰ (group, solo, direct primary care and contractor) to participant's descriptions of their practice with 100% agreement.

Table 1. Family Physician Interview Sample.

	Interviews (n=16)*
Years since completed residency	23 (+/-15)
Clinical hours per week	33 (+/-14)
At a practice with Integrated Behavioral Health	
Yes	6 (37.5%)
No	10 (62.5%)
Type of practice	
Group practice	7 (43.8%)
Solo practice	5 (31.3%)
Direct primary care	3 (18.8%)
Contractor	1 (6.3%)
Gender	
Female	8 (50.0%)
Male	7 (43.8%)
Prefer not to answer	1 (6.3%)
Ethnicity	
Hispanic	3 (18.8%)
Not Hispanic	13 (81.3%)
Race	
White	9 (56.3%)
Asian or Asian American	3 (18.8%)
Black or African American	1 (6.3%)
American Indian or Alaskan Native	0 (0.0%)
Middle Eastern and/or North African descent	0 (0.0%)
Native Hawaiian or Other Pacific Islander	0 (0.0%)
Other	2 (12.5%)†
Prefer not to answer	1 (6.3%)
State	
California	3 (18.8%)
District of Columbia	1 (6.3%)
Illinois	1 (6.3%)
Massachusetts	1 (6.3%)
Maryland	1 (6.3%)
New Jersey	1 (6.3%)
New York	3 (18.8%)
Tennessee	1 (6.3%)
Texas	2 (12.5%)
Washington	2 (12.5%)

Notes: *Data are M (\pm SD) or n (%); †Hispanic (n=1), Cuban (n=1)

Results

A diverse sample of family physicians participated in the study (see [Table 1](#)). Approximately 63% did not have IBH at their practice. Physicians came from varied independent practice types (43% group practice, 31% solo practice, 19% direct primary care practice, 6% contractor), and were located across 9 states and the District of Columbia.

Barriers to Implementing and Sustaining IBH

Participants reported three barriers to implementing and sustaining IBH: cost, staffing, and space.

Cost

Most physicians reported concern about finances related to IBH. Physicians expressed uncertainty about how IBH reim-

bursement works and whether it makes financial sense, particularly with recent Medicare reimbursement reductions. “I have no clue about how reimbursement is, if it’s worth it or not” (P1). There were also concerns that IBH was incongruent with fee-for-service.

“I don’t get a capitation to take care of the patient. If that was the case, then yes, you’d want to bring mental health in house to decrease utilization elsewhere, but our system isn’t structured that way” (P25).

Physicians reported reservations about overhead costs. Some practices were minimally staffed and physicians thought IBH would require bringing on additional staff, such as billing personnel, which would be cost prohibitive. A physician from a solo practice related that their profit margins are small (about 2%), leaving no room for financial missteps and no financial surplus to cover new salaries. This physician worried it might take “3 years for [a BH clinician] to finally pay for themselves” (P21). There were concerns that higher operational expenses could increase patients’ out-of-pocket costs. Additionally, a physician at a practice with IBH reported patients could not take advantage of the IBH clinicians because, “they’re cash pay only; there’s an obstruction there for people who can’t afford it” (P27).

Physicians stated that data from a cost-benefit analysis could help overcome financial concerns. Data on IBH effectiveness could help motivate adoption and maintenance of an IBH program, including data about services uptake, care quality, hospitalization risk, substance use disorder rates, overdose rates, and fiscal impact. “I think that’s the kind of data that somebody in my position would probably really listen to if they’re trying to make the decision whether to do this” (P20). Because practices vary significantly in their structure, financial circumstances, staffing, and patient panel, one physician emphasized that practices would need different solutions that are specific to their “micro culture” (P2).

Staffing

Participants shared that hiring appropriate BH clinicians is a barrier. Most participants reported a BH clinician shortage in their area. Additionally, participants stressed the need to consider if the services offered by the BH clinicians would be affordable for their patients (e.g., sliding scale options) and congruent to their patients’ language and culture made hiring even more challenging.

Physicians reported different BH needs, which factored into IBH staffing considerations. Several physicians expressed that they thought they might have too many patients with BH needs to be able to handle in-house without overworking a BH clinician or needing to still externally refer patients. Others voiced concerns they did not have enough patients with BH needs to justify bringing in a BH clinician. “Certainly, we want to make sure we have enough cases and have business for them, as opposed to, you know, wasting their time” (P11). Additionally, it was mentioned that hiring IBH staff would require new training and potential EHR challenges to facilitate optimal care coordination.

As with cost, physicians noted that modeling anticipated BH demand and optimal staff configurations could help overcome staffing concerns. Further, one physician with IBH experience highlighted that training on how to collaborate with BH clinicians, delineating clear roles for family physicians and BH clinicians, and implementing EHR referral systems would ease BH staff integration into independent practices.

Space

Participants often described their independent practice as physically small, which was seen as a potential barrier to bringing BH clinicians in-house.

“My exam room and my office are combined into one space... If I had somebody come, where would I put them? And where would they do the sessions with the patients? ...The logistics of just the physical space would be a barrier” (P10).

Although space was mentioned as a barrier, most physicians did not see it as insurmountable and shared potential solutions, such as relocation, telehealth BH, scheduling BH clinicians when there were fewer physicians practicing, or decorating exam rooms to make them more therapy friendly.

What Independent Practices Are Doing Instead of IBH

The 10 participants from practices without IBH reported providing BH support to their patients through assessment, diagnosis, referrals to outside resources, medication management, and coaching.

Assessment and Diagnosis

Physicians reported that they assess BH and diagnose at annual check-ups or if a patient presents with a specific concern. Most physicians used standard screeners (e.g., PHQ-9), history assessment, and checking for underlying conditions, such as sleep issues. However, four physicians preferred not to use screeners. These physicians relayed that they knew their patients well, allowing for assessment and diagnosis of behavioral health conditions through conversation. Additionally, they reported that their patients either had a strong dislike of screeners or did not have the health literacy to complete the screeners.

“I know that there are a lot of validated tools for BH assessments.... for our patient demographic, that might not be the best idea anyway because I think that there’ll be some pushback. Not necessarily because they thought it was a bad thing, but that might reveal literacy deficits... one of the things we do to really gain trust is just talk and act in a very familiar way. ‘Hey, what’s going on?’ ...Then you can still assess people really quickly” (P23).

Physicians were comfortable diagnosing anxiety, depression, and sleep issues, but had mixed comfort levels assessing attention deficit disorder, schizophrenia, and bipolar disorder.

Referrals to External BH Clinicians

Nearly every physician said there were long waitlists in their area for BH clinicians and that clinicians did not always take their patients' insurance. Despite the lack of BH clinicians, physicians reported connecting patients to these resources using varied approaches. Sometimes physicians recommended their patients call their Employee Assistance Program or insurance and see who is on their plan, but many physicians reported trying their "best to recommend people" (P2) through random internet searches, cold calling, or asking family, friends, or other patients for BH clinician recommendations. Only a few physicians had trusting, collaborative relationships with BH providers.

Some physicians reported referring to virtual BH programs. Such referrals could be made from within the EHRs, insurance coverage was good, there were not long wait times, and their patients seemed satisfied with the care. "[The virtual program is] pretty expedient about following up with the patient, where the patient doesn't have to make a phone call and be put on hold and wait for an appointment" (P21).

Physicians expressed frustration with inconsistent, difficult, or non-existent communication with external BH clinicians. This was reported to be a problem when the physician did not have a relationship with the clinician, or the clinician was from a virtual platform where privacy rules made it challenging to get information about BH care.

Medication management

Participants conveyed that they regularly prescribed for BH conditions, either because they were comfortable doing it, or their patients needed treatment while attempting to find a BH clinician. Similar to assessment and diagnosis, physicians reported feeling comfortable prescribing for anxiety and depression, but had mixed comfort levels prescribing for attention deficit disorder, schizophrenia, and bipolar disorder. Most physicians expressed discomfort continuing to prescribe medications after attempting multiple medications without success. Some physicians, despite their own discomfort, felt it was still important to prescribe something for patients with attention deficit disorder, schizophrenia, and bipolar disorder while the patient waited to see a BH clinician.

"I've had to become comfortable with how to use those medications, but then, you know, that's not necessarily the most elegant solution just because that's not all I do. Somebody who's scaled two or three or four SSRIs or Wellbutrin who I'm looking at putting on, you know, Vraylar or Rexulti or something like that... those patients tend to require a little closer monitoring initially, and we can do that. We have same-day appointments on our end. We try to make up for the... inadequacies in the system... But we can only do so much in a day just like everybody else" (P20).

Direct Behavioral Health Coaching

Some physicians reported that they did basic counseling or coaching when a patient preferred it or there was a lack

of BH clinicians in their community. Physicians provided psychoeducation, cognitive behavioral therapy (CBT), coping skills training, and wellness coaching. Some physicians utilized longer appointments (e.g., through concierge care) and others fit direct coaching into the standard 15-minute appointment with more frequent follow-up visits. Physicians discussed not having the necessary training (e.g., for complex conditions like schizophrenia or treatment-resistant depression), systemic support (e.g., electronic health record pop-ups), or time (e.g., 15-minute appointments) to address complex BH concerns.

Discussion

This study highlights the contextual variability across independent family medicine practices in terms of barriers to IBH as well as alternative BH approaches. In support of previous research that also identified systemic barriers of cost and workforce shortages,²¹ our findings imply that independent practices will require tailored strategies to support IBH depending on contextual determinants,²² such as existing approaches to BH, practice size, reimbursement structure, and physician preferences.

Unsurprisingly, financing is at the forefront of independent family physicians' minds. Our findings show that existing reimbursement models may be particularly challenging for independent practices, given smaller patient panels, fewer staff, and tight profit margins that may not cover IBH start-up expenses. Grants are often necessary to cover IBH start-up costs²³ while sustainment could be aided by enhancing billing code application to maximize revenue in a fee-for-service model.²⁴ Independent practices might benefit from different strategies to effectively finance IBH: grant identification and application consultation, toolkits on billing best practices, including newer codes for collaborative care coordination,²⁵ or IBH resource and personnel sharing across practices to create economies of scale.

Challenges related to staffing, both in terms of providing BH services and back-end administration, could be addressed in varied ways. Increased use of telehealth BH consultations could expand access to areas with worker shortages or practices without space to collocate BH clinicians. Additionally, growing numbers of state-run Medicaid programs allow shifting some BH tasks to community health workers (CHWs),²⁶ who are more cost-effective to hire and retain. Finally, additional documentation required for IBH programs can be streamlined through standardized processes, optimizing electronic health records, and leveraging AI for routine tasks.^{27,28}

This study revealed that independent family physicians conduct a range of BH services, from assessment to treatment. The findings that physicians sometimes depart from evidence-based screening tools, offer direct behavioral coaching, and can feel uncomfortable providing indicated BH services to patients that are unable or unwilling to go elsewhere underscore the need for supports to increase the quality of first-line BH care provided by independent family physicians. Education on the value and use of BH screeners,²⁹ clearer protocols for assessment and treatment, com-

prehensive training on brief interventions such as CBT,³⁰ well-defined roles for family physicians, and improved BH referral network infrastructure would help physicians make decisions about assessment, diagnosis, treatment plans, and the circumstances that require referral to specialized services. This could help ensure that the BH services provided are the right fit for each patient and improve care quality.

While it is important to support family physicians in improving the quality of the BH care they are already providing, evidence on the effectiveness of IBH to potentially decrease BH disparities,^{31,32} improve access to BH care,^{33,34} and reduce utilization of other healthcare cost drivers,³⁵ such as emergency department visits, associated with severe BH conditions³⁶ suggests we should explore ways to support independent practices in implementing IBH. As IBH is a complex set of practices and exists on a spectrum that can be supported through multiple care models,^{24,37} a logical next step is to elicit more information on the preferences these independent practices have regarding IBH outcomes and feasible implementation strategies to achieve them. Given that most of the previous work in IBH has occurred in larger health systems, future studies employing methods to specify implementation strategies²² for independent practices could provide invaluable information about how to help move the needle in these practices.

This study is limited in its reliance on the perspectives of family physicians who self-selected to participate. While our sample included physicians from diverse independent practice types and locales, we did not intentionally sample participants from specific types of independent practices, states, or patient population served. Finally, we did not include administrators or patients in our study, and future research should explore their perspectives, improvement opportunities, and the decisions required for successful implementation in independent practices.

Conclusions

Barriers to integrating BH at independent family medicine practices align with those at larger health systems, but the

nuances of those barriers differ based on the smaller practice context. Family physicians at independent practices are filling in BH service gaps for their patients to the best of their abilities but are constrained by training and resource limitations. Strategies are needed to support independent family physicians in improving BH care.

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Conflict of interest

Annie Koempel, Madeline Byrd, and Andrew Bazemore are employees of the American Board of Family Medicine. The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Corresponding author:

Brooke Ike, MPH, University of Washington, Department of Family Medicine
bike2@uw.edu

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Appendix

Interview Questions

For clinicians currently working in an integrated setting

Tell me about your practice.

- How long have you been in practice?
- Size/location? Population served?
- Ownership and organization structures?

Questions about current model of integration

- How did your integrated behavioral health program start?
 - Who championed this?
 - Was it a family physician?
 - What was the impetus?
- What type of behavioral health professional do you work with?
- Can you walk me through the process of getting a patient referred to and working with a behavioral health professional?
 - Probe for these if necessary: process, warm hand-offs, communication [verbal, written/EHR], collaboration)
- What are your thoughts about the current model you are working in?
 - What infrastructure and resources did your practice have to build and maintain IBH services? Where did they obtain them?
 - What were some successes you had with IBH services?

- Probe about success in terms of their own benchmarks - if they collect any data on patients, or maybe in terms of team functioning

- What challenges do you have with using this IBH model?
- What do you understand about the effects/benefits of IBH?
 - Probes: on patient outcomes, clinic workflow, clinician well-being/satisfaction, etc?
- Have there been any negative effects from IBH in your practice?
 - Probes: on patient outcomes, clinic workflow, clinician well-being/satisfaction, etc?

What barriers did you face in implementing and maintaining IBH?

- Potential probes include: Perceived need, Stigma, Policies (local, state, federal, other), Staffing, Reimbursement/financial concerns, Telehealth

What supported the implementation and maintenance of IBH at your practice?

What would you do differently if your practice were to start again? What would you want to change now?

Is there anything else you'd like to add about anything we talked about?