

Patient Views of Behavioral Health Providers in Primary Care: A Qualitative Study of 2 Southeastern Clinics

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Abstract

Background: Limited research is available around patient experience of integrated behavioral health care in primary care settings. **Objective:** We sought to identify the major themes through which patients described their integrated behavioral health care experiences as a means of informing and improving clinic processes of integrated health care delivery. **Methods:** We captured viewpoints from 16 patients who experienced an integrated behavioral health care model from 2 primary care clinics and completed at least 3 visits with a behavioral health provider (BHP). Using grounded theory analyses, we coded and analyzed transcriptions for emergent themes. **Analysis:** The interview process yielded 3 major themes related to the BHP including (a) the BHPs' clinic presence made behavioral health care more convenient and accessible, (b) BHPs worked within time and program limitations, and (c) BHPs helped with coping, wellness, and patient-care team communication. **Conclusion:** The BHPs serving in a large primary care practice and a Federally Qualified Health Center played an important role in connecting patients with behavioral health care and improving care team collaboration, both in terms of communication within the team and between the team and the patient/family.

Keywords

access to care, behavioral health, clinician–patient relationship, patient, feedback, patient satisfaction

Introduction

Integrated behavioral health care within the primary care clinic setting allows patients to access both medical and behavioral health services under the same roof. The integrated care approach is a biopsychosocial care delivery model, wherein medical and behavioral health providers (BHPs) work collaboratively to meet patients' needs (1,2). The use of integrated care models has risen dramatically, and a comprehensive review has addressed the financial and operational features suggesting optimism for sustainability (3).

Patient perspectives of integrated care are “important measures of progress toward integration,” affording program administrators and providers with feedback on model implementation phase and success (4). A qualitative study of patient experience with integrated behavioral health care versus community mental health care found similar experiences and benefits from receiving integrated care services as traditional mental health services (5). Higher levels of

patient satisfaction with behavioral health services appear to be correlated with good continuity of care (6) and older age (7). A recent review of the Primary Care Behavioral Health model research indicated that implementation has had overall success but evaluation of such models is needed (8). Further understanding of patient health outcomes and patient perceptions can inform the process of integrated behavioral health care implementation.

We propose that by understanding patients' experience with a BHP, the process of care delivery in primary care clinics can be improved. We utilized a care delivery model

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Table 1. Interview Questions.

<ol style="list-style-type: none"> 1. Could you tell me a little bit about yourself, such as activities you enjoy doing? 2. Could you tell me about what happened when you were first introduced to the behavioral health provider (BHP)? 3. Could you tell me about how well the BHP helped you with whatever was making you feel worse than your concern? 4. What else do you think we need to know about your experience with the BHP so we can improve patient care?
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that incorporates behavioral health care as part of the primary care visit. When primary care providers (PCPs) identify behavioral health needs, “warm handoffs” (i.e., PCP introduction of BHP to patient during the clinical visit) are used whenever possible (9,10). The primary goal of this qualitative analysis is to examine the experiences of a multi-racial/ethnic sample of patients who have received behavioral health care through their primary care clinic. The scope of analysis includes exploration of patient feedback regarding experiences with BHPs in integrated primary care.

Methods

Patient inclusion criteria consisted of (a) being a primary care patient at a family medicine clinic or an affiliated Federally Qualified Health Center (FQHC) located in the Southeastern United States, and (b) having attended at least 3 visits with a BHP as part of their primary care within the last year. In these clinic visits, BHPs utilized brief strength-based interventions (eg, Motivational Interviewing, Cognitive Behavioral Therapy, and Solution-Focused Brief Therapy) to affect health behavior change and improve physical and emotional/mental wellness.

We contacted 24 eligible patients randomly within pre-sorted pools based on race/ethnicity in order to obtain a representative multiracial/ethnic sample. Trained project team members conducted participant recruitment by phone. All participants completed informed consent. A trained bilingual team member conducted interviews off-site from the clinics in participants’ preferred language (English or Spanish). The interviewer used a semistructured interview guide (Table 1) containing 4 primary questions which were selected and worded with careful attention to minimizing response-bias toward researcher objectives (11). Although the 4 primary questions stayed consistent throughout interviews, the interviewer, using an iterative process, allowed the data gathered to refine their probe and follow-up questions to hone in on emerging themes (11). Participants received a \$50 gift card as an incentive for participation. The institutional review board of Wake Forest School of Medicine approved this study.

The interviews were transcribed and, in the case of the Spanish interviews (n = 5), translated and transcribed using our internal Clinical and Translational Science Institute. Team members checked each resulting transcript against the

Table 2. Emergent Themes (3) and Thematic Clusters (8).

<ol style="list-style-type: none"> 1. BHPs’ clinic presence made behavioral health care more convenient and accessible <ol style="list-style-type: none"> a. Mechanism by which BHPs were introduced to participants varied b. Service minimized logistical barriers to seeking behavioral health care 2. BHPs worked within time and program scope limitations <ol style="list-style-type: none"> a. Participants did not feel rushed in spite of time limitations b. Participants would have liked to have seen BHPs for more/longer sessions c. Participants and BHPs had different expectations of sessions 3. BHPs helped with coping, wellness, and patient-care team communication <ol style="list-style-type: none"> a. BH support and tools were appreciated b. Participants felt connected to and understood by BHPs c. BHPs helped keep care team connected
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audio recording for accuracy. Coding was ongoing throughout the interview process and entailed attaching a “code” or descriptive tag to the transcribed text. Using a grounded theory approach (11), the interviewer coded transcripts line-by-line assigning first codes (initial, open coding) to the transcript. Another team member also read transcripts and reviewed the assigned codes. These 2 team members discussed any points of disagreement in coding until they reached mutual resolution. Next, continuing close review of the transcripts, the interviewer and 2 additional team members developed second codes (selective and focused coding) consisting of first codes grouped together in an increasingly analytical framework. Throughout the process of coding and analysis, team members engaged in a process of memo writing. This took the form of analytical notations on the codes and the relationships between them (i.e., jotted notes that evolved into large spreadsheets used to organize the data and notations) as a means of moving from focused codes to larger, abstract constructs that eventually emerged as themes and subthemes. The team members also explored relationships between themes and participant gender using ATLAS.ti 8.1.3 (12). Analysis identified 8 thematic clusters, or groupings of themes, that we ultimately partitioned into 3 overarching, emergent themes (Table 2).

Findings

We recruited 16 patients representing a multiracial/ethnic sample with the majority of interviews from women (Table 3). Half of the participants had never been married and the majority had at least a high school education. Three themes emerged related to participants’ experience and perceptions of receiving integrated care at their clinic. Emergent themes were (a) BHPs’ clinic presence made behavioral health care more convenient and accessible, (b) BHPs worked within time and program scope limitations, and

Table 3. Patient Characteristics.

Demographics	Mean (Range)
Age	43.5 years (19-62)
	Frequency
Gender	
Men	5
Women	11
Marital status	
Never married	8
Married	6
Living as married	0
Widowed/separated/divorced	2
Level of education	
Less than 12	3
12 years or high school equivalent (GED)	5
Some college or post high school training	3
Bachelor's degree or greater	5
Race	
Non-Hispanic white	5
Black, African American	5
Asian	1
Hispanic	5

(c) BHPs helped with coping, wellness, and patient-care team communication.

Behavioral Health Providers' Clinic Presence Made Behavioral Health Care More Convenient and Accessible

The first emergent theme consisted of 2 thematic clusters: (a) Mechanism by which BHPs were introduced to participants varied, and (b) Service minimized logistical barriers to seeking behavioral health care.

Introduction to BHP. Participants were asked about how they were first introduced to the BHP (see Table 1, question 2). The interviewer asked this question in an open-ended, non-leading way, without terminology such as “warm handoff,” in an effort to gauge participants’ experience of this introduction. In response, about two-thirds of participants described the steps of a warm handoff in their explanation of how they were introduced to the BHP (13,14). This entailed the provider introducing the BHP to the participant in the examination room after addressing the purpose of the visit and establishing need. The remaining third of participants reported different processes, including meeting the BHP in the examination room before the provider arrived, the BHP introducing themselves after the provider but without the provider present, and the participant calling after leaving the clinic to schedule an appointment with the designated BHP. One participant whose response fell into the warm handoff cluster described the experience of meeting the BHP as follows:

[The provider] says, “Well, I’m going to call [the BHP] up to come and introduce herself and see if it’s a good fit, or if you’re interested in the program.” So [the BHP] came up to the room and I feel like [my provider] was in the room, as well. 36-year-old black woman.

Participants’ responses related to how they were introduced to and first met the BHP were clustered under this subtheme. Responses varied from the warm handoff to other alternative methods of introduction and first meeting. Participants’ experience of the BHPs and the BHPs’ services are captured in subsequent themes and thematic clusters.

Barriers to care. Nearly all participants explicitly stated that they would not have obtained needed behavioral health care services had it not been for the presence of BHPs at point of care in the clinic. Participants cited cost of community-based behavioral health services, language differences, high time and energy commitment associated with finding community-based services, and discomfort or skepticism to seeking behavioral health care as barriers to connecting with community-based services.

One participant stated that “I might have [sought out a community BHP] eventually, but it would have been, like, years later, and then, I would have to find somebody around” (40-year-old non-Hispanic white woman). Similarly, another participant noted that, “I’m very skeptical when it comes to therapists and things like that. I don’t think I would have actively sought one out” (26-year-old black woman). Three of the 5 Spanish-speaking participants expressed gratitude that Spanish-speaking BHPs were available.

Several participants highlighted appreciation about BHP’s availability for ongoing, often-as-needed support, as part of their primary care. For example, one participant stated, “If I needed to see her as an emergency, she was available to me” (42-year-old Hispanic woman). In contrast, 2 participants mentioned times where a BHP was hard to contact by phone.

Behavioral Health Providers Worked Within Time and Program Scope Limitations

Three thematic clusters fell under the second emergent theme: (a) participants did not feel rushed in spite of time limitations, (b) participants would have liked to have seen BHPs for more/longer sessions, and (c) participants and BHPs had different expectations of sessions.

Program time limitations. Behavioral health provider visits were typically shorter and less frequent than traditional outpatient sessions by design (approximately 30 minutes every 2-3 weeks vs 50 minutes weekly). Over a third of participants, which included 3 of the 5 men, stated that the time spent per session and between sessions was appropriate. “Sometimes I don’t need to talk for 45 minutes, sometimes, I need to go: ‘Yeah, this really annoyed me this week. I don’t

know how to process it” (31-year-old white man). This participant stated that often a “10 minute” check-in with the BHP at his primary care visit was enough.

More exposure to BHPs. Several participants in the study expressed that they would have liked and/or needed more time and/or sessions with their BHP. One participant shared, “[The BHP] couldn’t see me every week, even though I would want to see her every week, because I felt like that’s what my needs were” (36-year-old black woman). Several participants also stated that they sometimes felt rushed by the length of sessions and that the BHPs behavior in response to shorter sessions (e.g., “clock watching” and “restless[ness]” as explained by a 61-year-old Hispanic woman) further compounded this rushed experience.

Session expectations. A few participants expressed that their expectations for behavioral health sessions differed from their BHPs’. Differing expectations included disagreement over the treatment plan and/or way in which participant was triaged, wanting the BHP to focus more on facilitating referral to and communication with outside behavioral health services, and feeling that the BHP “did not [get] to know [me] that well,” (19-year-old Asian woman). This participant expanded, “The questions that the behavioral health provider would ask me were kind of just temporary fixes and didn’t really get to the grand scheme of what I was trying to communicate to her.”

Behavioral Health Providers Helped With Coping, Wellness, and Patient Care Team Communication

The third emergent theme encapsulated 3 thematic clusters: (a) appreciation of BHP support and tools, (b) participants felt connected to and understood by BHPs, and (c) BHPs helped keep care team connected.

Behavioral health provider support and tools. Participants reported benefit from the support and tools that BHPs provided. Behavioral health support included assisting with perspective shifting (e.g., “[I] leave with a better mindset” [20-year-old white man], increased awareness (e.g., BHP “point[ed] out things that I was ignoring” [31-year-old white man]), and setting time aside for reflection and self-care. Participants also stated BHPs offered helpful advice, reassurance, and homework in the form of brief readings, worksheets, or activities for participants to complete between sessions.

Participants appreciated tools shared by BHPs such as mindfulness phone applications, breathing techniques, and physical activity plans. A participant reported that “I have something in my bedroom closet that I have posted up on the wall that [the BHP] gave me, and it says: ‘What have you done for yourself today?’” (62-year-old black woman). According to this participant, this tool helped her to remember her own needs. Another participant stated that the BHP

“helped me with some exercises that I can do to help myself. That I can walk, breathe, turn this way, she gave me some explanations that have really helped me out, because I still do them now.” (62-year-old Hispanic man).

Connection to BHP. Participants reported they felt emotionally connected to and understood by BHPs. Participants described BHPs as good listeners who were empathic, patient, nonjudgmental, and trustworthy. One participant stated, “she put herself in my shoes” (43-year-old Hispanic woman). The environment of trust and understanding that the BHPs created allowed participants to feel comfortable sharing their experiences and ultimately making changes to improve their lives. A participant struggling with weight stated that the BHP’s support to change “gradually” eventually helped the patient to make lasting change.

If you pressure me, I get depressed and I do the unhealthy behavior more. She did it gradually and that allowed me to adapt to my new life that I was meant to live, or that she showed me. And then I tried. (37-year-old Hispanic man)

On the other hand, 2 participants shared times they felt their BHP did not understand them. Concerns included feeling that BHP support was “pitying” (19-year-old Asian woman) rather than empathic and not liking being touched by BHP:

I got a pat on the back, and I’m like: “Don’t touch me. I’m not like that.” But that being said, I cried for a minute [about issue] and then, I let it go. And, it was good, and after that, we laughed. So, it worked out well. (61-year-old white man)

Both participants who stated times when they did not feel understood also reported that, overall, they were pleased with the service and able to make desired improvement in their lives.

Behavioral health providers helped keep care team connected. Behavioral health providers’ ability to facilitate effective communication and collaboration both within the care team and between the care team, patient, and family was a salient issue for participants. One participant, who identified his wife as a caregiver, stated that sessions with the BHP helped his wife feel more connected to the care team and supported in her role. He reported, “After that [first meeting], [my wife] wanted to go . . . she felt such at ease after that” (61-year-old white man). Participants used phrases like “connected team partnership” (36-year-old black woman) to describe BHP-facilitated collaboration. Participants appreciated that BHPs helped further inform the PCPs’ baseline knowledge of participants’ experience and that patient successes were celebrated by a cohesive team working together toward improvements.

Gender Differences

Exploration of the relationship between themes and participant gender yielded some notable results. A higher proportion of women than men stated that they would have liked more time with the BHP (5 of 11 women vs 1 of 5 men), whereas a higher proportion of men than women stated that the amount of time with the BHP was enough (3 of 5 men vs 3 of 11 women). In terms of BHPs' use of tools (e.g., methods, techniques), more men (4 of 5 men vs 6 of 11 women) stated appreciation for tools suggested.

Discussion

Although providers practicing integrated behavioral health care and working with BHPs strive to provide optimal patient care (9,15), evaluation of delivery and patient perception of care is necessary. The American College of Physicians recommends integration of behavioral health care into primary care along with more research to define effective and efficient approaches to care integration (16). There is limited knowledge about patient perceptions regarding integrated behavioral health care in primary care settings (4). Our analysis of 16 transcripts of interviews with a multiracial/ethnic sample addresses this issue in more depth. According to participants, BHPs embedded in primary care settings played an important role in (a) connecting patients with behavioral health care and (b) improving care team collaboration, both in terms of communication within the team and between the team and the patient/family (17,18). Participants acknowledged that while BHPs' navigation of the primary care setting did affect session length and frequency, this navigation was largely successful; participants' felt BHPs addressed their behavioral health needs.

The importance of BHP availability within primary care regardless of style of introduction has direct clinical and operational implications for integrated health care teams. Warm handoffs are an established way to connect BHPs with patients in need of behavioral health care and can facilitate successful patient engagement (9,10,19). Introducing patients to BHPs at point of primary care is essential; a warm handoff was the preferred approach in this study, although some recent data suggest the warm handoff may not increase rate of behavioral health-care follow-up (20). Researchers have found support for utilization of a warm handoff method (with written documentation in the electronic health record) to promote same-day access to a BHP (13,21).

We found participants, particularly men, valued the tools BHPs shared with them. This may be an important consideration for BHPs working with patients, especially men, in primary care as well as for providers introducing patients to behavioral health services available in the clinic. For example, patients whose PCPs give them tangible examples of tools BHPs utilize may be better oriented to

what behavioral health care in a primary care setting entails. This information may lead to increased consent to engaging in treatment.

Participants indicated overall satisfaction with the care received from embedded BHPs, yet they recognized ways in which behavioral health care in this setting was distinct from behavioral health care received in traditional settings (e.g., shorter and less frequent sessions, higher levels of communication between providers). The somewhat conflicting thematic clusters found in the second emergent theme (BHPs Worked Within Time and Program Scope Limitations) suggests the importance of both communication and flexibility in operationalizing integrated behavioral health care. Specifically, this finding indicates a need for (a) clinic guidelines and procedures to support communication between providers and patients to negotiate integrated behavioral health care service expectations, and (b) flexibility on the part of the clinic and providers to meet patients' varying needs from the patient-BHP relationship (i.e., frequency and duration of appointment, as well as level of access to BHP) and referral protocol when the BHPs and integrated behavioral health care services cannot meet those needs.

Future directions for research include studies on the operationalization of integrated behavioral health care for different presenting problems and populations. In particular, there is a need for studies related to the effectiveness and cost analysis of integrated behavioral health care (22). The field would also benefit from analysis of larger patient samples and/or greater number of primary care clinics.

Strengths and Limits of the Study

A strength point of the present research is that our sample includes patients' views voiced from a large practice and a smaller FQHC. This qualitative study of a multiracial/ethnic sample advances our knowledge about patient perspectives on the integrated behavioral health care experience. Limitations of this study includes a small sample size of patient interviews not generalizable across regions. Therefore, the sample is too small for statistical testing. Since the data are specific to patients who interacted with a BHP on at least 3 occasions, the research findings are also not generalizable to participants at integrated health care practices who saw a BHP fewer times.

Clinical Implications

Primary care providers, staff, and clinic administrators should consider the role of the patient voice in implementing integrated behavioral health care. Feedback from the patient perspective has informed our clinic process to ensure improved delivery of behavioral health care. For example, to better fulfill patient expectations, we have planned teaching sessions for our BHPs to discuss agenda setting and

identifying specific goals for each session. Our overall findings support the importance of BHPs' clinic presence in making behavioral health care more convenient and accessible. To do this, however, BHPs must strive to work within the time and program limitations of an integrated behavioral health model in a primary care setting. Findings also highlight the role of BHPs in orienting patients to the scope of integrated behavioral health care services and helping patients navigate within this model or outside it when another model of care (i.e., traditional mental health care, psychiatric services) may better meet patient needs. Ultimately, the patient viewpoint of integrated behavioral health care implementation and operations is essential for the success and sustainability of this model.

Declaration of Conflicting Interests

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