A qualitative study of patient experiences of care in integrated behavioral health and primary care settings: more similar than different

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Abstract
Integrated behavioral health and primary care is a patient-centered approach designed to address a person’s physical, emotional, and social healthcare needs. Increasingly, practices are integrating care to help achieve the Quadruple Aim, yet no studies have examined, using qualitative methods, patients’ experiences of care in integrated settings. The purpose of this study was to examine patients’ experiences of care in community-based settings integrating behavioral health and primary care. This is a qualitative study of 24 patients receiving care in five practices participating in Advancing Care Together (ACT). ACT was a 4-year demonstration project (2010–2014) of primary care and community mental health centers (CMHCs) integrating care. We conducted in-depth interviews in 2014 and a multidisciplinary team analyzed data using an inductive qualitative descriptive approach. Nineteen patients described receiving integrated care. Both primary care and CMHC patients felt cared for when the full spectrum of their needs, including physical, emotional, and social circumstances, were addressed. Patients perceived personal, interpersonal, and organizational benefits from integrated care. Interactions with integrated team members helped patients develop and/or improve coping skills; patients shared lessons learned with family and friends. Service proximity, provider continuity and trust, and a number of free initial behavioral health appointments supported patient access to, and engagement with, integrated care. In contrast, patients’ prior experience, provider “mismatch,” clinician turnover, and restrictive insurance coverage presented barriers in accessing and sustaining care. Patients in both primary care and CMHCs perceived similar benefits from integrated care related to personal growth, improved quality, and access to care. Policy makers and practice leadership should attend to proximity, continuity, trust, and cost/coverage as factors that can impede or facilitate engagement with integrated care.

Keywords
Qualitative research, Integrated care, Primary care, Behavioral health, Patient experience

INTRODUCTION
In the USA, an increasing number of local, regional, and national initiatives are aimed at enabling the integration of behavioral health and primary care across diverse settings [1–8]. Integrated care is a patient-centered approach designed to identify and address the majority of a person’s physical and behavioral healthcare needs irrespective of setting [9–11]. Clinicians in integrated settings work together in teams using consultation, coordination, and collaboration [12] to treat patients’ acute and/or chronic physical health conditions as well as a full spectrum of behavioral health needs (e.g., depression and anxiety, substance use conditions, health behavior change, life stressors, stress-related physical symptoms) [11, 13, 14]. Robust evidence from randomized trials and observational studies indicates that integrated care is associated with the achievement of Quadruple Aim objectives [15, 16] through improved quality, better experience of care, controlled costs, and clinician satisfaction [17–33]. This body of quantitative research demonstrates the effectiveness of integrating primary care into community mental health centers (CMHCs) and for integrating behavioral health services into primary care [34–41]. Increased access to needed physical, emotional, and social care may be a primary driver of effectiveness in integrated settings [42–48].

Implications
Practice: Practice leaders are encouraged to build physical and organizational structures that enable engagement of behavioral health providers, primary care clinicians, and practice staff in the same setting in response to a patient’s presenting needs.

Policy: Patients reported benefits from integrated care. Combined with other research that shows integrated care improves patient outcomes, policies are needed that make integrated care financially accessible and support provider continuity.

Research: Research is needed to evaluate the level of services available to patients and the associated improvement in care over time in both healthcare indicators and intermediate process outcomes (e.g., coping skills).
Although qualitative research describes how practices are implementing integrated care [8] and explores provider [19, 42, 46] and administrator [12, 49-55] perspectives, our team found no studies using qualitative methods to explore patients’ experiences receiving care in these settings [56-60]. Quantitative studies demonstrate that patient satisfaction of care significantly increases following integration of care [25, 61]. However, quantitative instruments designed to assess patient perspectives on integrated care for research and quality improvement purposes have been developed using expert opinion rather than patient perspectives [62].

Qualitative research engaging the end users of integrated care (i.e., patients) may provide novel, critical insight into what aspects of integrated care delivery they identify as important. Our overall evaluation of Advancing Care Together (ACT) [14, 63, 64] found both significant and clinically meaningful improvements in clinical outcomes following integration of care across diverse, community-based primary care and behavioral health settings [65]. Importantly, the community-based clinics and CMHCs that participated in ACT were able to make progress toward Quadruple Aim objectives using models of integrated care that were incremental and adapted to the needs and constraints of their local, real-world conditions, not an experimentally controlled context [8, 12, 14, 53-55, 65-69]. Therefore, we conducted this study to understand patients’ perceptions of the care they received in ACT clinics and if these elements differ based on a patient’s specific behavioral or physical health needs and/or the location of care.

MATERIALS AND METHODS

Design and context

We conducted semi-structured interviews to examine patients’ experiences with integrated care. Patients were identified from practices participating in ACT, a 4-year program (2010–2014) funded by The Colorado Health Foundation to test strategies for integrating physical and behavioral health services in real-world primary care practices and CMHCs [14, 64]. ACT practices each designed their approach to integrated care to meet their patients’ needs and to fit the resources in their community. Practices received minimal funding ($50,000 per year) to offset the costs of participating in the mixed methods evaluation [63].

Setting and participants

We purposively selected five ACT practices (two CMHCs, three primary care practices) from which to draw the patient interview sample. These practices had hired staff, were tracking clinical indicators, and were actively delivering integrated care. As summarized in Table 1, practices varied in their ownership, patient panel size, and the activities undertaken to deliver integrated care [8, 14]. Additional information about ACT practices and key aspects of their experience integrating care are detailed in prior publications [12, 14, 53-55, 66-69].

Practices used a tracking sheet to monitor patients who were exposed to the intervention and the level of care received. We reviewed de-identified tracking sheets to identify a maximum variation sample of adult patients seen at each practice in the past 3 months based on age, gender, and the level of integrated care received. To enable comparison, we specifically identified some patients that may not have been exposed to integrated care. We provided a list of approximately 20 patients to the staff champion at each practice with a goal of interviewing five patients per practice. The staff champion contacted patients on this list by telephone to ask if they were interested in participating in an interview about care received. Forty-seven patients agreed to have their contact information shared with the evaluation team. We mailed interested patients a letter explaining the study and a copy of the information sheet, then followed up with a phone call within 1 week to answer questions, obtain informed consent, and schedule an interview time.

Data collection and management

We conducted 25 in-depth interviews; 22 additional patients could not be reached, declined participation, or did not attend their scheduled meeting. All interviews were conducted in 2014, at the end of the 4-year program. The interview guide (see Appendix) was designed to capture the richness and nuances of patient experiences with integrated care. Questions were designed to elicit the full spectrum of patient care received during ACT, including both positive and negative experiences as well as care that was primarily physical, behavioral, or integrated. The guide was refined based on feedback from project consultants and field-testing with community members. Interviews were conducted in person (n = 8) and by phone (n = 17) in the patient’s primary language (i.e., 2 in Spanish, 23 in English). Interviews lasted an average of 25 min (Range: 12-52 min). Participants received a $25 gift card for their time. We collected interviews until saturation was reached, which is the point at which thematic patterns repeat [70, 71]. Interviews were audio-recorded and professionally transcribed. We checked transcripts for accuracy, removed identifiers, and transferred data to Atlas.ti (Version 7.0, Atlas.ti Scientific Software Development GmbH, Berlin, Germany) for data management and analysis. We discarded one interview because of poor audio quality, leaving 24 for analysis. This study was approved by the Oregon Health & Science University Institutional Review Board (#7497).

Analysis

A multidisciplinary team with expertise in psychology, communications, primary care, integrated care, and public health analyzed the data. We analyzed...
Table 1 | Characteristics of the Integrated Practices from Which the Patient Sample Was Drawn (n = 5)

<table>
<thead>
<tr>
<th>Practice code</th>
<th>Characteristics</th>
<th>Patients interviewed, n (%)</th>
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<tbody>
<tr>
<td>A</td>
<td>Private, not-for-profit CMHC located in a rural setting with 7,904 annual visits. As part of ACT, this practice built a new facility that provided both traditional mental health services and primary care; the primary care team also had an embedded BHC. Medical and behavioral health needs were identified through systematic screening or by clinical discretion during patient encounters. Transitions between team members were supported through a warm handoff or by referral. An electronic tool was developed to support information exchange between the separate behavioral health and medical electronic health records at the point of care.</td>
<td>6 (25)</td>
</tr>
<tr>
<td>B</td>
<td>Private, not-for-profit FQHC located in a suburban setting with 4,732 annual patient visits. The CMHC partnered with an FQHC system and a substance abuse treatment center to integrate a primary care team that included a physician's assistant, medical assistant, care coordinator, and substance abuse counselor into an existing CMHC facility. Patients were seen by the primary care team in a separate wing of the main CMHC; patients who lacked a current primary care provider were eligible for treatment at the integrated primary care clinic. Within the primary care clinic, identification of behavioral health challenges (substance use) was done through screening or clinician discretion and transitioned using a warm handoff or warm referral based on staffing coverage.</td>
<td>5 (21)</td>
</tr>
<tr>
<td>C</td>
<td>Clinician-owned primary care clinic located in an urban setting with 47,476 annual patient visits. During ACT, the clinic partnered with the co-located behavioral health agency to embed BHCs directly in primary care. These BHCs remained employees of the behavioral health agency and were contracted to work in primary care. Identification of a behavioral health need was done primarily through clinician discretion, and care was transitioned via warm handoff.</td>
<td>5 (21)</td>
</tr>
<tr>
<td>D</td>
<td>Private, not-for-profit FQHC located in a suburban setting with 14,924 annual patient visits. Prior to ACT, BHCs were co-located on the primary care team; ACT enabled additional BHC coverage and an increased focus on high need populations. Identification of behavioral health needs was primarily accomplished through systematic screening; care transitions were supported by a warm handoff.</td>
<td>2 (8)</td>
</tr>
<tr>
<td>E</td>
<td>Clinician-owned primary care clinic located in a suburban setting with 15,600 annual patient visits. Although a psychologist rented space at the clinic after hours to provide services, ACT enabled the clinic to partner with the local CMHC to hire, train, and supervise a co-located BHC and to expand health coaching services. Identification of behavioral health needs was accomplished through systematic screening and clinician discretion. Care transitions were approached via referral and warm handoff as the practice experimented with staffing, scheduling, and payment structures.</td>
<td>6 (25)</td>
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CMHC = community mental health center; FQHC = federally qualified health center; ACT = advancing care together; BHC = behavioral health consultant.

Interviews using an inductive qualitative descriptive approach to provide a rich, yet straightforward description of the experiences of interest, suggest hypothesis, and inform theory formulation and concept development [72–74]. We chose not to use existing theories or models to guide the process because we wanted to understand patients’ experiences with integrated care in an unmotivated way [75].

We accomplished our analysis in three steps. First, we met weekly to analyze individual patient interviews. This involved reading and reviewing transcripts individually, then discussing as a team the larger patterns within and across patient interviews. Through this process, key findings from the interview were identified and coded (e.g., access to care, integration story). In a second step, we explored how emerging findings manifest across patients paying attention to potential similarities and differences, for example, by setting of care and type of care received. In this step, we noticed that patients reported similar experiences of integrated care regardless if they were seen in what had begun as a primary care setting or a CMHC. Preliminary themes were formulated and discussed by the group with the aim of refining our findings and making connections with the relevant literature. In a third and final step, we comprehensively reviewed each patient’s rich personal story in light of the emergent themes looking for outliers or disconfirming cases. Our use of reflexivity, multiple reviewers, data saturation, and an audit trail are associated with trustworthiness and rigor in qualitative research methods [70, 76–78]. In presenting our results, we use unique codes for each practice (e.g., Practice A) and present generalized case summaries from our data using patient pseudonyms.

RESULTS

We interviewed patients from integrated settings that began as CMHCs (n = 11) and as primary care practices (n = 13). As summarized in Table 2, 67% of the patients we interviewed were female and the average age was 50. Nineteen patients described their experiences receiving integrated care; five male patients reported engaging with the practice for an acute medical condition and did not mention receiving integrated care. Regardless of the initial setting type (i.e., primary care, CMHC), patients described experiences with integrated care that...
were more similar than different. Three main findings are described in detail subsequently.

Patients feel cared for in the context of integration

Patients felt cared for when integrated teams addressed the full spectrum of their presenting needs; they noticed when clinicians spent time with them to understand how life circumstances related to physical or behavioral health symptoms. Life events led patients to seek care across these settings (e.g., job change, medical procedures, interpersonal struggles). As illustrated in Fig. 1, Patient Case 1—which portrays one mother’s experience—patient care stories frequently included descriptions of interacting physical, emotional, and social factors and how practice teams helped patients make treatment decisions and/or manage complicated life circumstances.

Accompanying these stories were details regarding patients’ social histories and the chronic conditions they experienced. A 62-year-old woman described her 5-year history of working with the practice to manage multiple chronic conditions (e.g., thyroid, high blood pressure, stage 3 kidney disease, depression). Her recent experience with integrated care revolved around concerns about her husband’s health and preparing for her fifth hip surgery for osteoarthritis pain:

[t]he surgeries get harder mentally and emotionally. Knowing that your life is going to stop again...It’s hard. [The BHC] has been a life saver for me. … I know now that I need to go in and see her pre-op ...she helps me to slow down and not have as huge an expectation or disappointment in myself. And that is crucial to me for going into surgery in the first place. (Patient 22, Practice E)

Patients viewed inquiries around integrated care as “getting to the bottom of what’s going on” and as an opportunity to connect them to the best setting in which to provide the needed care (Patient 2, Practice A).

Patients reported benefits of integrated care

Patients described personal, interpersonal, and organizational benefits of integration, regardless of

Table 2 | Demographic Characteristics of the Patient Participants (n = 24)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number (%)</th>
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<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>16 (67)</td>
</tr>
<tr>
<td>Male</td>
<td>8 (33)</td>
</tr>
<tr>
<td>Mean age (range)</td>
<td>50 years (20–82 years)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>4 (17)</td>
</tr>
<tr>
<td>Non-Hispanic/Latino</td>
<td>20 (83)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>9 (38)</td>
</tr>
<tr>
<td>Divorced</td>
<td>3 (13)</td>
</tr>
<tr>
<td>Single</td>
<td>7 (29)</td>
</tr>
<tr>
<td>Widowed</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Unknown</td>
<td>4 (17)</td>
</tr>
<tr>
<td>Type of care discussed</td>
<td></td>
</tr>
<tr>
<td>Both physical and behavioral health</td>
<td>19 (79)</td>
</tr>
<tr>
<td>Physical health only</td>
<td>4 (17)</td>
</tr>
<tr>
<td>Behavioral health only</td>
<td>1 (4)</td>
</tr>
</tbody>
</table>

*Of the 20 patients identifying as non-Hispanic/Latino, two preferred not to specify race and one identified as Asian/Pacific Islander. The remaining 17 identified as White.

Figure 1. Patient Case 1 (Patient 2, Practice A)

Alice is a 33-year-old Caucasian woman who “kinda had a nervous breakdown” because of everything that has happened in the past year. Alice has 5 children who range in age from 5-18; four live with her and her current husband. Alice has a number of physical health issues - including COPD and high cholesterol. In the last year she quit smoking, and “totally” had to change her diet and “way of living.” In addition to her physical health challenges, Alice describes a history of trauma as her ex-husband was “very abusive” to her and her children.

Alice and her family were connected with the practice through emergency services after one of her sons violently threatened family members earlier in the year. She reports that the practice “really pulled us through it” and has been a “godsend as far as our family has been concerned.” The entire household, including her husband, now receive medical as well as behavioral health services at the practice and Alice believes “It has really made a difference in our life and our well-being.”

Alice goes to the practice several times a week, and she and her family often have multiple appointments in one day. She feels that the entire staff is “very personable” and appreciates the “comfortable environment” at the practice. Alice notes that the clinical team “really cares” and describes how they “try to get to the bottom of what’s going on.” She also appreciates that providers come to her home when they aren’t able to make it for appointments, stating that staff “really go above and beyond” to make sure her family gets the care it needs.

Fig. 1 | Patient Case 1 (Patient 2, Practice A).
the initial setting type. Patients shared stories of how medical clinicians, BHCs, and ancillary staff helped them work through challenging personal circumstances, including making health behavior changes (e.g., losing weight, stop smoking) and gaining insight into life events (e.g., job transitions, marital tensions). One woman who experienced stress related to a recent hospital admission, difficulty caring for a bipolar son, and grief from her father’s death reflected on her personal growth working with integrated care team members: “They brought me back to life little by little; building me. I have the parts. I just wasn’t using them.” (Patient 10, Practice B)

Interactions with integrated team members helped patients address their healthcare needs as well as to develop and/or improve coping skills (see Patient Case 2, Fig. 2). Patients described working with BHCs to learn how to recognize and accept emotions, set boundaries with others, use breathing-related relaxation techniques, pace activities, positively reframe challenges, and engage in personally rewarding behaviors (e.g., hobbies, socialization). One woman with multiple physical and behavioral health issues noted, “I have started to feel a lot better...[my care] has provided alternative ways of coping with the anger and letting go of baggage.” (Patient 4, Practice A) These interactions helped patients “relax” and recognize when they were “expecting too much of [themselves].” (Patient 22, Practice E)

Operationally, patients noted that integrated care facilitated communication and improved shared knowledge of care plans between clinical team members (see Case 2, Fig. 2). “There seems to be really good communication between the different departments, between the providers...everybody I’ve encountered actually seemed to know what’s going on.” (Patient 4, Practice A) Another patient noted: “People all work together, it’s coordinated. I can count on them to be talking to one another.” (Patient 13, Practice C)

Patients commented that the benefits of integrated care extended beyond themselves, as they encouraged other family members to seek care in these settings and shared lessons learned with others. One patient reflected, “...I took a lot away from my meetings with [the BHC]...I’d go home and I’d call [my friend] and say, ‘This is what she said. I did this and I did that.’ ...My friend...is benefiting from my visits here.” (Patient 15, Practice C)

Factors facilitating patient access to and engagement with integrated care
Service proximity, relationship continuity, trust in practice members, and cost could facilitate or impede how patients experienced integrated care. To patients, access and engagement with services was enhanced by the convenience of having multiple services “under one roof.” One woman with a history of depression, high cholesterol, blood pressure, and diabetes commented:

I went to [practice name] because it has everything. It has your mental health, and it has your doctors and I think that’s very important. ...I don’t like to run back and forth all over the place. I like to have everything just done right there (Patient 5, Practice A)

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Figure 2. Patient Case 2 (Patient 21, Practice E)

Janice is a 56-year-old single white female with a long list of health concerns. She established care at the practice about seven years ago when she moved to the area. She sees her primary care provider for issues related to high cholesterol, asthma, sleep apnea, fibromyalgia, and low blood pressure. She had also seen the nutritionist, who has since departed, to help her manage her weight, and another doctor at the practice for acupuncture and chiropractic needs. She sees several outside specialists, most notably a cardiologist, to help with some of her conditions. Janice has also been seeing the behavioral health consultant [BHC], at the Practice. She is able to see the BHC for free thanks to her insurance coverage and states that she wouldn’t be able get behavioral health care otherwise.

Janice notes that depression runs in her family and that she has a history of taking medication for anxiety and depression. However, a little more than a year ago she decided that she would “do everything all natural” and she stopped taking her depression medications which lead to “a crash.” She was “crying constantly” and her family was worried about her. Janice came in to see her primary care provider for help; the primary care provider put her back on medication and said, “I think you need to go see the [BHC].” Since then, Janice has “seen a lot of progress” thanks to her visits with the BHC, who has helped her make choices to improve work-life balance, self-acceptance, and her ability to communicate with others about what she needs rather than “stuffing stuff down.” Janice notes, “It’s been amazing.” Janice also notes that her primary care provider and BHC discuss her treatment plan, and check in with each other to make sure she is doing well, and keep the cardiologist apprised of her progress.

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Fig. 2 | Patient Case 2 (Patient 21, Practice E).
Having services in the same location enabled patients to engage with medical and BHC team members when a need was identified using a warm handoff as described by the following woman:

I expressed a desire to do something about [my husband]...[the doctor] said wait right here...she brought [the BHC] back into the exam room and introduced me to him and said ‘he’s going to meet with you.’ (Patient 13, Practice C)

However, practices needed to define the roles of practice team members clearly in integrated settings. One patient discontinued integrated services because of perceived redundancy (e.g., medical clinician and BHC were discussing the same things in different encounters).

Patients highlighted the importance of continuity and trust in practice team members. Patients appreciated continuity in both clinical providers and practice staff. They also reported trusting practice team members when they engaged with a new medical doctor or BHC to which they were introduced. Trust was also used to alleviate patient fears around service engagement, particularly for behavioral health care. One patient described how she had “been in therapy years and years ago...and] hesitated about coming back to therapy again [because] I didn’t want to drag up all the old stuff.” (Patient 21, Practice E) Her medical clinician allayed these fears by describing the brief, problem-focused approach their BHC used, and connecting the patient to needed services. Continuity and trust also allowed patients to move in and out of treatment as needed. For example, a male patient commented, I haven’t seen [the BHC] in a while, but nothing’s really come up I need her to help with. When I need help, I know she’ll see me.” (Patient 11, Practice B)

However, patients also described limited access to integrated care team members because clinician turnover disrupted continuity. One patient (#20, Practice E) described how she only received one of the free sessions she was allotted because the BHC went on leave, even though the patient “needed to really go back.” Another patient (#7, Practice B) worked with four different case managers who “kept him stabilized” but the staff were now “all gone.” Additionally, patients described when they discontinued integrated care because of challenges with provider “match” (e.g., BHC had gone to school with patient’s son, primary care clinician would not provide patient with requested pain medications, clinician was brusque/only looked at computer screen).

Cost was also an important factor. Practices provided a number of appointments with the BHC for free and helped patients obtain coverage for primary care services; patients noted they would not have been able to access these services otherwise.

One patient (#21, Practice E) stated, “Initially I came here and I had company paid health insurance...now I pay it myself...I’ve been able to come see [the BHC] without any charge, that’s really been helpful.” Participants reported that practice teams helped connect them with affordable treatment options in the community when integrated services were not covered by insurance or cost too much. Payment/insurance coverage barriers were an issue for patients that needed behavioral health treatment beyond what was offered in the integrated setting as insurance limited the number and type of visits and the provider they could see. A patient (#15, Practice C) commented, “I came to see [the BHC] for the allotted three times [for free]...[insurance] won’t pay after that.” Patients expressed hesitancy to establish care with new BHCs. As illustrated in the following quote, patients did not always follow-up on care when referred out to other services or transferred to another provider in the practice:

We really, really hit it off, but then when my insurance wouldn’t cover it, it really took a toll on me because I like to keep the same counselor. It’s really hard to switch...it’s really, really hard to open up to somebody new. (Patient 5, Practice A)

**DISCUSSION**

Patients sought care for events in their lives and described how clinical teams helped them manage physical, emotional, and social challenges. They described working with practice teams to address their presenting needs as well as learning new coping skills. In addition to these direct benefits, patients encouraged friends and family to seek integrated care and noted that integrated care improved how practice teams communicated and coordinated around their care. Patients also reported that access to and engagement with integrated services was fostered by the physical closeness of services, as well as continuity and trusting relationships with clinical team members. Lack of continuity, patient–clinician mismatch, and cost/coverage barriers made it difficult for patients to engage in and to sustain integrated care. Although we looked for differences in patient experience based on the setting of care (i.e., initially primary care clinic or CMHC), patients reported experiences that were more similar than different across these settings.

To date, various studies have explored provider and administrator perspectives of integrated care [12, 54, 67] and provider satisfaction with integrated care [13, 79]. Our study is one of the first that uses qualitative methods to examine how patients experience integrated care in both community-based primary care and CMHC settings. The study findings add to a growing body of research on patient-centered care and patient experience of team-based care [57, 59] and emphasize how patients appreciate being seen
by medical professionals as people with complex lives, not just health conditions [58, 80, 81]. For example, comprehensive care has been defined by the American Academy of Family Physicians as, “the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events, and environment.” [82] These results affirm the important role of integrated care as a component of the patient-centered medical home [25, 83–85]. Further, our findings highlight the importance of implementing staffing structures in primary care and CMHC settings that enable a more comprehensive approach to providing care that transcends the traditional silos of medical and behavioral healthcare and supports treating the whole person [11, 86–88].

The study findings highlight important dimensions of access to care, which includes finding providers who meet patient needs [89, 90]. While cost of care, particularly for behavioral health, was identified as a factor that limited patient access to integrated services, continuity and trusting relationship with clinicians and staff were also critical [91–94]. Interpersonal rapport enabled patients to come in and out of care as needed and supported the transfer of trust between clinical professionals [95, 96]. One finding that surprised our team was that patients’ stories of care were similar across settings regardless if a setting began as a primary care practice or CMHC. This may be because patients perceive comprehensive care as the norm [82], rather than the fragmented care supported by our current health system. It may also relate to the structure of integrated practices, as we observed that CMHCs embed small integrated primary care practices within their larger structures, which may include BHCs and care coordinators in addition to a medical assistant and primary care clinician. Studies to describe how CMHCs integrate care and the associated impact on patient experiences warrant further exploration. Interestingly, regardless of the level and type of integrated care patients received, none of the participants mentioned feeling stigmatized. This complements the growing body of research that suggests integrating care holds promise for reducing barriers associated with treatment stigma for behavioral health needs [26, 97, 98] and in accessing physical health for patients with serious and persistent mental illness [99].

This study has a few notable limitations. First, patients choose whether or not to participate in this study, and we know little about those that we did not interview. It is possible that patients who agreed to participate were different in some way (e.g., that they had positive experiences with integrated care), and more research is needed to examine if our findings will generalize to the wider population. However, to reduce potential bias in the selection process, we used a rigorous, blinded method to identify our patient sample from five diverse practices. These patients presented with a wide range of physical and behavioral health needs and received various levels of integrated care. Second, we conducted interviews in person as well as over the phone to accommodate patient preferences; while interaction medium may influence patient disclosure, we did not find this to be the case in our sample. Third, while our research approach was to appreciate patient experience from their perspective, while minimizing our own a priori theories and hypotheses, it is impossible to control completely for how our own preconceptions influenced our way of seeing these data. We minimized the influence of bias by having a multidisciplinary team who held each other accountable for their preconceptions during data analysis [100].

This study has implications for policy makers, practice leaders, and for researchers. First, patients perceived benefits from integrated care related to personal and interpersonal growth and improved quality and access to care, regardless of the initial setting type. Patients described how service proximity, continuity, and trust in practice members, and cost could facilitate or impede their experience with integrated care. Combined with other research that shows integrated care improves patient outcomes, policies are needed that make integrated care financially accessible and support provider continuity [12, 15]. Second, practice leaders are encouraged to build physical and organizational structures that enable engagement of behavioral health providers, primary care clinicians, and practice staff in the same setting in response to a patient’s presenting needs [54, 55, 67]. To optimize integrated care delivery, this may include establishing pathways to multiple BHCs to facilitate interpersonal matches (e.g., if gender, age, or prior relationships may be of concern) and advocating for continuity of care in case when patient–provider rapport has been established. Finally, researchers should utilize our findings to conduct longitudinal studies of integrated care that evaluate the influence of multilevel factors on clinical health care indicators (e.g., depression, physical health) and intermediate process outcomes (e.g., coping skills) in relation to the level of integrated care available to patients, their insurance coverage (if any) as well as payment strategies that support and enable sustained implementation of integrated care over time.

Acknowledgements: The authors are thankful to the participating practices and patients. William Miller, MD, and Benjamin Crabtree, PhD provided helpful comments on the interview guide. Erin Thayer, Brianna Muller, and Maribel Cifuentes, RN assisted with interviews. Jennifer Hall, MPH and David Cameron participated in interview coding. This research was supported by a grant from the Colorado Health Foundation (CHF-3848). Dr. M.M. Davis’s time is supported in part by an Agency for Healthcare Research & Quality-funded PCOR K12 award (Award Number 1 K12 HS022981 01).

Compliance with Ethical Standards

Conflict of interest: The authors report no conflicts of interest.

Authors contribution: All authors have contributed sufficiently to this scientific work and share collective responsibility and accountability for the results.
Ethical Approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. The Oregon Health & Science University Institutional Review Board approved the study protocol (IRB #7497). This article does not contain any studies with animals performed by any of the authors.

Informed consent: Informed consent was obtained from all individual participants included in the study. The authors have full control of all primary data and agree to allow the journal to review the data if requested. Findings have not been published elsewhere, nor is the manuscript being simultaneously submitted elsewhere. Preliminary findings were presented at the 43rd Annual North American Primary Care Research Group Meeting in Cancun Mexico (October 2015) and at the Collaborative Family Health Association’s 17th Annual Conference in Portland Oregon (October 2015).

APPENDIX: ACT PATIENT INTERVIEW GUIDE

The questions below are the general topic areas we will explore with interview participants. These questions will be modified in light of what is learned during the interview and to fit the experiences of the interviewee.

Introductory script

We are recording interviews so we can accurately capture patients’ experiences in their own words. This interview will be transcribed and all proper names and places will be coded to protect your identity and privacy. Do I have permission to audiotape our interview?

Thank you for participating in this interview. My name is _______ and I am part of a research team that is studying a program called Advancing Care Together or ACT. ACT is working with 11 clinics in Colorado to discover ways to bring together physical and behavioral health care for patients in one location. Your practice [insert name] is participating in ACT, and I have been working closely with them over the past couple of years to learn how their work is going.

First, I would like to tell you a bit about myself. [hit on probe topics below].

Introduction

1 I would like to get to know you a bit. Please tell me a little about yourself.

(Ask about the following if not volunteered by participant).

Possible probes

i. Education
ii. Age
iii. Occupation
iv. Family (parents, siblings, spouse / significant other, children)
v. Where they live, who they live with
vi. Health history

Grand Tour Questions

We are talking with you today because your clinic is involved in the ACT program, and because you visited [name of clinic] in the last 6 to 12 months. During that time you received help with a health care concern. I’d love to hear more about this.

2 Please tell me the story of the health concern that that brought you into the clinic. Take your time.

Possible probes

i. How did you deal with that?
ii. Who do you talk to when you have that kind of a problem?
iii. How did you address that?

3 I’d like you to walk me through the timeline of this [health issue].

4 What helped you feel better in this situation [tailor to story]? Feel free to think broadly – it could be anything.

Thank you so much for sharing that story. That was really wonderful, and I appreciate it.

Now, we like to talk with you about the things that help you to be healthy and well. We are going to use the word wellbeing.

5 What does wellbeing mean to you?

When we talk about wellbeing, we mean your physical health and wellness – how your body is doing. This includes things like exercise, eating and sleeping, as well as your mental health; how your mind is doing, and how you are feeling – your happiness or sadness, or your state of mind.

6 What helps your overall wellbeing?

Possible Probes

i. What helps you to be physically well?
ii. What influences how you are feeling, your mood or emotions (happy / sad, scared, anxious, angry)?
iii. What help you to stay healthy – eating, exercising, sleeping, drinking, smoking, etc.?
iv. What shapes how well things are going with your friends, family and other social activities?
v. What helps your overall wellbeing?
vi. What hurts your overall wellbeing?

Thanks. Now, I have a few questions about [your clinic].

7 We are talking with you because you’re a patient of [name of clinic]. All I know about you is that you are a patient at this clinic. Please tell me about your experience with this clinic?

Possible probes

i. How long have you been a patient at [clinic]?
ii. What is it like to be a patient at this clinic?
iii. Who do you see when you go to the [clinic name]?

8 Please tell me about your relationship with [insert clinician’s name].
Possible probes

i. What’s it like to have [clinician’s name] as your doctor?
ii. How long have you been seeing Dr.?  
iii. How did [name] become your doctor?
iv. Do other family or friends see [name of doctor].  
Tell me about that?

9. Who else do you see at [name of clinic]?

Possible probes

i. Have you seen [insert name of person]?

10. Could you please tell me about your experience with [insert name]?

i. What led you to see [insert name]?
ii. What did [insert name] do for you?
iii. Can you tell me about this person’s background and training?
iv. Have you ever seen someone like [insert name] before? If so, can you tell me about that?

Before we end the interview, I’d like you ask you one more question.

11. What race and ethnic background do you consider yourself to belong to?

Race:
- Caucasian
- Black/African American
- Asian
- American Indian or Alaskan Native
- Native Hawaiian or Other Pacific Islander

Ethnicity:
- Hispanic or Latino
- Non-Hispanic or Latino

Other demographic characteristics to ask if not yet shared by participant:

Gender:

Age:

Thanks you so much for your time.
I greatly appreciate your willingness to talk with me today.

References


