Primary Care Providers’ Perceptions of and Experiences With an Integrated Healthcare Model

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Abstract. Objective and Participants: The authors examined the experiences of primary care providers participating in an integrated healthcare service between mental health and primary care in a university health center. In this program, behavioral health providers work collaboratively with primary care providers in the treatment of students. Participants consisted of the 10 primary care providers participating in the program during the summer of 2004.

Methods: The authors evaluated the program using a descriptive survey, analyzed by a combination of measures of central tendency and multidimensional scaling with cluster analysis. Results: They found a 2-dimensional, 3-cluster solution for the last 3 items. Findings indicate that although primary care providers valued behavioral health as a resource, a gap exists between what they believe behavioral health can assist with and their actual referral practice.

Conclusions: These findings indicate a need for further communication about the roles that mental health can play in the collaborative treatment of physical symptoms.

Keywords: behavioral health, collaborative care, college health, health psychology, integrated healthcare, primary care psychology

The American Academy of Family Physicians (AAFP) defines primary care as care received at a patient’s initial point of entry into the healthcare system. The organization suggests that practices are designed to provide health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment of acute and chronic illnesses in a variety of healthcare settings. Primary care physicians are skilled at treating the undifferentiated patient whose symptom origin has not been determined at the time of first encounter. Although approximately 75% of all primary care visits involve some sort of mental health component and many individuals with mental health problems initially seek help from primary care, patients infrequently receive mental health treatment befitting their problem. Psychological interventions have been effective in the treatment of a wide variety of physical ailments. Healthcare providers have begun to shift the paradigm of health service delivery toward a system in which behavioral health and primary care providers collaborate to achieve a common treatment plan that includes medical, behavioral, and social interventions, and patients are encouraged to take a more active role in their own care.

Background

The literature is replete with evidence demonstrating the high prevalence of clinically significant mental health problems that patients present with at primary care. One of the most comprehensive accounts is provided by an international epidemiological study conducted by the World Health Organization in which it investigated the occurrence of psychological disorders in general medicine. Results indicate that 24% of primary care patients met criteria for a mental disorder. The most common International Classification of Diseases, Code 9 (ICD-9) categories of diagnoses were depressive disorders, anxiety disorders, alcohol use disorders, and somatoform disorders.

Undoubtedly, primary care providers are a fundamental part of the US mental health system, treating an estimated 55% of people seeking help for behavioral health disorders, a higher percentage than is served by specialty care providers. In fact, the AAFP cited that 42% of clinical depression diagnoses and 47% of generalized anxiety disorder diagnoses are first identified by primary care physicians—a clinical reality that has led the AAFP to advocate for the formal, systemic recognition of primary care providers’ pivotal role.
in the mental healthcare continuum. Yet detection of behavioral health problems, along with treatment, can be difficult for primary care providers, given time constraints and gaps in training that limit their treatment options. This emphasizes the importance of the collaborative relationship between behavioral health and primary care providers.

Student health is another setting in which the salience of multidisciplinary collaboration is being recognized. Results from the 2004 National College Health Assessment reveal that 7 of the top 10 student-reported health impediments to learning were mental health concerns. In response to these findings, the American College Health Association’s Healthy Campus 2010 initiative includes in its 2005 standards of practice a collaborative approach to health promotion.

**Integrated Health Care**

As a solution, several national leaders have lobbied for the integration of mental health services in primary care. In 1997, the Office of Behavioral and Social Science Research at the National Institutes of Health assembled a workgroup of multidisciplinary health professionals to issue recommendations regarding the integration of behavioral interventions into health care. Similarly, in 2003, the New Freedom Commission on Mental Health called for better coordination between primary care and mental health care, noting that primary care providers may lack the training, time, or resources to appropriately treat mental health patients. Some pragmatic advantages of integrating mental health services into primary care include improved provider education, better and more regular communication between all members of the healthcare team, and more timely feedback for patients. Many clinicians consider integration preferable to referring out for behavioral health services. Peek and Heinrich assert that separated service delivery systems force patients and practitioners to choose between 2 kinds of providers, 2 kinds of care plans, and 2 kinds of practices—when unified comprehensive treatment is desirable.

As the preceding discussion illustrates, the overarching meaning ascribed to integrated health care is that of a unified healthcare delivery system containing components of both primary care and mental health care, preferably with providers at the same location. As Engel proposed in his seminal article outlining the biopsychosocial model of health, integration challenges healthcare providers to embrace a less dualistic, less reductionistic paradigm. Still, integrated health care means more than adopting a biopsychosocial perspective.

**Models of Integration**

Integrated health care takes into account multiple aspects of health. Blount described a continuum of integration between medical and behavioral health providers, categorized as coordinated, co-located, or integrated.

In a coordinated relationship, services are offered across a variety of settings, with information being exchanged on a regular basis. Often, a referral from one provider to another initiates this type of exchange. An example of this model would be a university health center provider who has a relationship with an off-site counselor to whom he or she makes referrals. In this scenario, the 2 providers should communicate their findings to one another, but because of administrative and geographical difficulties, this often presents a challenge.

In a co-located relationship, providers offer distinct services in the same practice setting. Co-located relationships exist on many college campuses, where student health centers and counseling centers share the same physical space but are organizationally distinct. Although many cultural and logistical barriers can exist, clinicians refer patients back and forth, and collaboration is easier because of geographical proximity. The sharing of space and collaboration between different provider groups has been effective at updating primary care providers to the specific services behavioral health providers offer. Simultaneously, the behavioral health provider becomes accustomed to the language and culture of the medical setting.

The third level of integration in Blount’s framework—integrated healthcare—refers to the use of only 1 treatment plan containing elements from both behavioral health and primary care providers. In this modality, behavioral and primary care providers work as teammates, sharing space, file materials, and the duties associated with case conceptualization. In practice, these models may not present themselves as distinctly as they have been described here; Blount did not intend them to be viewed as mutually exclusive. A variety of college health settings are organized to serve their unique populations and administrative structures in the most efficient manner. In fact, the program we examined could be described as a hybrid of Blount’s co-located and integrated modalities.

In many ways, the college campus presents an ideal environment for healthcare integration. Students are a somewhat homogenous population whose activities center on a fixed geographical region. Furthermore, on the university campus, health is conceptualized as part of the developmental process; students who are exposed to and embrace healthy behavior at this point in their lives may carry these practices with them once they leave the campus community. For traditional college students who are also learning the requisite skills of living independently from their parents, integrated health care on the college campus can teach students how to care for their physical and psychological health, as well as the important interplay between the two.

**University of Texas at Austin’s Integrated Healthcare Program**

In 2002, the University of Texas at Austin’s Counseling and Mental Health Center and University Health Services began the implementation of what is now referred to as the Integrated Healthcare Program (IHP). This innovative program partners behavioral health and primary care providers in the medical clinics within University Health Services. The program was intended to increase referral follow-through, improve accessibility, streamline continuity...
of care, advance the quality of patient care, and increase satisfaction of both patient and provider.

The behavioral health providers—currently 2 psychologists and 2 social workers—work alongside their primary care colleagues at the health center. This proximity provides patients with immediate access to IHP services and allows more collegial interaction and consultation among all providers. The behavioral health providers, like the primary care providers, have scheduled clinic appointments but are initially accessible to students only on referral from a primary care provider. They are also available for immediate consultation at the providers’ discretion. As a result of the IHP, participating providers are now part of treatment teams that conceptualize both the mind and the body in student health. They have behavioral health interventions at their disposal to aid in the appropriate treatment of physical symptoms as well as the ability to competently treat mental health issues within the context of primary care.

In evaluating the IHP, we considered the key stakeholders: behavioral health providers, primary care providers, and students. Although we evaluated for all stakeholder groups, this article focuses on primary care providers, as they are the gatekeepers in integrating the systems of care.

We conducted this evaluation to illuminate the behaviors, perceptions, opinions, and experiences of primary care providers during this integration process. We have used the data collected to inform program growth for integrated healthcare services, to foster a more seamless collaboration between provider groups, and to inform other universities that are considering various options for improving collaboration between counseling services and primary care.

**METHODS**

**Participants**

Ten primary care providers who take part in the IHP participated in our evaluation: 6 women and 4 men. The group of providers had an average tenure at University Health Services of 13.1 years that spanned 3 to 25 years, and their ages ranged from 35 to 60 years. Our sample comprised 3 family practitioners, 2 nurse practitioners, 4 internists, and 1 pediatrician—all of the University Health Services providers participating in the IHP at the time (hence, representing the program population well).

**Survey Development**

We designed a survey by modifying previously developed surveys from studies of collaborations among primary care and mental health care. Kainz designed a study to measure primary care providers’ perceptions of their mental health colleagues’ abilities to treat a variety of health issues as well as referral practices for those issues. Gerdes et al. measured primary care providers’ attitudes about their mental health partners, referral practices, and patterns of collaboration among providers ($\alpha = .78$).

By adapting these instruments, we designed Likert-type response items and open-ended questions to address providers’ mental health-related training and ability, their perceptions of patient willingness to accept IHP referrals, and the factors considered prior to making IHP referrals (see Table 1). Three final items contained a list of 29 common primary care complaints, and participants rated each complaint according to their (1) ability to treat the complaint, (2) tendency to refer for the complaint, and (3) perception of the ability of behavioral health providers to assist with the complaint. We computed internal consistency reliability for these 3 items and found Cronbach alphas to be .87, .94, and .86, respectively. The entire survey required approximately 15 minutes to complete, and we pilot-tested it on the medical director prior to data collection.

**Procedure**

The university’s institutional review board approved this project prior to data collection. Over the course of 2 weeks, we scheduled individual 1-hour appointments with all participating primary care providers. During each appointment, we explained the scope of our evaluation effort and the voluntary nature of participation, obtained written informed consent, conducted interviews, and then administered the written surveys. All 10 participants completed the evaluation in full.

**RESULTS**

To analyze the surveys, we calculated item means for each scaled item (see Table 1). In general, the providers

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<th>Question</th>
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<tr>
<td>How active are you in the identification of mental health issues with your patients?</td>
<td>3.50</td>
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<td>During your training, how much experience did you have in diagnosis/treatment of mental health problems?</td>
<td>2.55</td>
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<tr>
<td>How would you rate your ability to treat mental health conditions?</td>
<td>2.85</td>
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<tr>
<td>How willing are your patients to accept mental health diagnoses and treatment?</td>
<td>3.75</td>
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<td>How willing are your patients to accept a referral to a behavioral health counselor?</td>
<td>4.20</td>
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<td>In your practice, when making referral decisions, what priority do you assign the following factors?</td>
<td>3.60</td>
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<tr>
<td>Presenting problem</td>
<td>3.60</td>
</tr>
<tr>
<td>History of problem</td>
<td>5.00</td>
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<tr>
<td>Severity of distress</td>
<td>3.80</td>
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<tr>
<td>Patient’s attitude toward treatment</td>
<td>3.80</td>
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<tr>
<td>Quality of patient’s social support system</td>
<td>3.80</td>
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Westheimer et al. reported having somewhat limited training and ability in the diagnosis and treatment of mental health problems. This suggests a need for additional support in diagnosis, treatment, and availability of alternate treatment options. Providers reported, however, that their patients are generally willing to accept referrals to behavioral health providers, as well as mental health diagnoses and treatment. When considering making an IHP referral, all providers reported placing high priority on the severity of the patient’s distress.

For the 3 items inquiring about primary care providers’ (1) ability to treat the complaint, (2) tendency to refer for the complaint, and (3) perception of the ability of behavioral health providers to assist with the complaint, we used multidimensional scaling (MDS) to examine the dimensionality of the presenting problem responses. We used MDS because it does not require assumptions about the distribution of variables, such that measuring variables on an ordinal scale is sufficient, even with a small sample, such as ours. We then computed cluster analyses for the MDS plots. Fit indexes were favorable for 2-dimensional, 3-cluster solutions for each question. Stress for Figures 1, 2, and 3 was .74, .47, and .98 respectively; $r^2$ for the 3 figures was .98, .99, and .96, respectively. The figures also contain the means of the frequency of endorsement for each symptom.

As depicted in Figure 1, responses seem to indicate a continuum on which providers evaluate their ability to manage presenting problems. Cluster A (Primarily Managed in Traditional Medical Settings) comprises complaints that medical providers can typically diagnose and treat in primary care. Providers gave these complaints the highest ability endorsements. Cluster B (Combination) comprises complaints that are often initially diagnosed in primary care and at times treated solely by medical providers but that might also necessitate some specialty care, depending on the provider’s ability, the patient’s wishes, and the problem’s severity. Providers endorsed these complaints more modestly. Cluster C (Primarily Managed in Traditional Mental Health Settings) includes complaints related to...
mental health concerns. Not surprisingly, these complaints received the lowest endorsements.

Figure 2 depicts provider responses to how often behavioral health providers can assist with the same set of presenting problems. Once more, these complaints appear on a continuum, whereby ratings progressively increased from the lowest in Cluster A (Little Perceived Utility for Mental Health Interventions) to the highest in Cluster C (High Perceived Utility for Mental Health Interventions). As seen in Figure 1, the middle cluster represents a combination of the other 2 symptom types; as such, Cluster B is labeled Moderate Perceived Utility for Mental Health Interventions and received generally moderate ratings. Cluster A is much smaller than the other 2, suggesting that providers recognized the potential for mental health services to augment medical treatment for a wide range of complaints.

However, actual referral practices do not seem to reflect Figure 2 data. Primary care referrals to behavioral health still tend to be for more traditionally psychological problems, although providers endorsed a variety of traditionally medical problems that they believed could be treated by behavioral health.

Figure 3 depicts the frequency with which providers reported making referrals to integrated healthcare colleagues for assistance with the presenting problem. Frequency ratings progressively increased from the lowest in Cluster A to the highest in Cluster C, with a much smaller group in the middle cluster. Cluster A (Traditionally Medical) is large and mostly comprises presenting complaints that are viewed as medical problems, whereas Cluster C (Traditionally Psychological) is also large and mostly comprises presenting complaints that are viewed as solely psychological in nature.

**COMMENT**

The college campus is an ideal environment in which programs of integrative health care can be established. Students, who are learning many independent life skills for the first time, can be exposed to the importance of considering...
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both the mind and the body in health care. The climate of collaboration and inclusion in many student affairs divisions creates an ideal environment for such integration. Also, because of the rapid pace of most college health centers, partnership in the treatment of students with mental health concerns would naturally be welcomed because it could reduce the burden of primary care providers and spread treatment responsibility. In fact, with regard to traditional mental health concerns, providers in this study readily acknowledged their lack of training, saw immense value in the use of integrated health providers, and said they would refer readily for these issues.

In this study, primary care providers with the IHP saw the limits of their ability in treating traditional specialty care patients with mental health concerns, and they recognized the value in collaboration on presenting problems that are traditionally medical but that have some psychological components. When comparing providers’ perceptions of their own abilities and their beliefs about the utility of behavioral health providers to assist in treatment, we found few presenting concerns in which they did not see a role for integrated health providers. Of the presenting concerns that we assessed, respondents rated only 5 below a 3.0 in regard to the frequency that behavioral health providers can be of use in treatment. But despite primary care providers’ perceived limitations in their ability to treat presenting concerns that are not traditionally psychological in nature and their reported knowledge that behavioral health interventions would be helpful in treating these concerns, providers are not as likely to refer for these conditions. In fact, for the 10 presenting problems that were in the middle group of primary care providers’ ratings of their perceptions of the ability of behavioral health to be helpful in treatment, they rated only 1 condition (diabetes) less than 3.0 on average, with a mean for all 10 conditions of 3.41 (SD = 0.94). But when taking these same 10 presenting problems and looking at the frequency of referrals, providers rated themselves only at a 2.33 (SD = 1.04)—a full point lower on a scale of 1 to 5. Providers’ reported behavior with respect to referrals seems to be at odds with their perceptions of behavioral
health providers’ abilities. This is a concern because the IHP exists to provide psychological and behavioral treatments for patients presenting with both mental health and more traditional medical complaints.

One possible reason for this discrepancy is that primary care providers are so inundated with presenting problems that are psychological in nature that they do not want to waste the limited resources of their behavioral health providers on some of the traditionally medical conditions that they believe they are more able to treat (and are accustomed to treating) without behavioral health providers. Also, behavioral health providers are fulfilling their suggested plan for collaboration; they emphasized their capacity for mental health services when they first approached the primary care providers with the idea of integrated care (to ensure buy-in from them). Last, the duality between mind and body is difficult to overcome in traditional Western medicine; changing perceptions is not enough to affect real change in referral practices. In future programming efforts, more emphasis will be placed on continuing to educate and remind primary care providers about the importance of these referrals.

Limitations and Future Directions

The first limitation of this study is the sample size. Although it was sufficient for our analytical techniques and comprised all available primary care providers at the time, generalizability to other settings should be approached with caution. Examining integrated healthcare programs in larger or multiple healthcare settings may allow for a more generalizable sample. Future research should compare behavioral health providers’ perceived abilities and utility, as well as the referral behaviors of primary care providers who are not participating in an integrated healthcare program. Another area of potential concern is our reliance on self-report data and the lack of more objective measures. Also, a pre-post design could have revealed whether provider behaviors and perceptions change with the introduction of the IHP.

Last, we focused exclusively on primary care providers. Although this group is an important stakeholder in this program, measuring student outcomes is important, too. For example, comparing symptom relief data in traditional medicine and integrated healthcare programs in college health would be compelling.

Conclusions

Clearly, patients may come to primary care facilities with complaints that are beyond the scope of typical medical training; the tools available to primary care providers for the treatment of more traditionally physical health problems can be augmented by the skill set of behavioral health providers. The IHP is an example of a program that addresses these 2 limitations in primary care.

Primary care providers have begun to embrace this program because it gives them a sense of support that previously was unavailable. Providers in our sample expressed that prior to the implementation of the program, they felt unable to address the apparent underlying emotional difficulties that troubled their patients. Having more collegial relationships with the behavioral health providers has shifted the manner in which this group of primary care providers serves students’ health needs.

As the providers have admittedly grown as a result of participating in this program, the program, in turn, has been improved because of their willingness to provide feedback and participate in this evaluation. We hope that this program can serve as an example for others in similar settings desiring to integrate their services.

NOTE

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REFERENCES


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