Integrated primary care behavioural health in a regional network of FQHC agencies during COVID-19

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ABSTRACT

Objectives (1) Examine the ability to sustain integrated primary care behavioural health (eg, colocation, communication and coordination) in 40 community health centres, during the COVID-19 pandemic and (2) review adaptations and challenges to provide integrated behavioural health via telehealth.

Methods and analysis This qualitative investigation assessed 55 behavioural health consultants (BHCs), via semistructured interviews, spanning 40 practice sites and 10 organisations, on their adjustment to telehealth delivery, modified practice workflows and challenges of maintaining integration while displaced by the pandemic. Assessment of the level of integrated care was also conducted with available semistructured tools.

Results The results highlight rapid service adjustment, positive patient and provider satisfaction, increased but lowered ratings of remote BHC integration and collaboration with the primary care teams and reduced behavioural health screening, compared with prepandemic levels. This investigation also highlights the co-occurring importance of racial disparities and injustice in patient care. In several settings, BHCs had a significant support role for staff self-care.

Conclusion The COVID-19 pandemic, and its subsequent shelter-in-place mandates and telehealth care provision, has altered standard integrated behavioural health practice, yet harnessed the accessible, generalist and team-based spirit to meet the increasing behavioural health needs in this community.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Integrating behavioural health into primary care is effective to increase ease of mental health access, reducing stigma and yielding effective outcomes.
⇒ The COVID-19 pandemic and social isolation have yielded increased psychosocial stressors and contributed to additional psychological distress.
⇒ Telehealth is an effective way to provide behavioural health services yet adapting the Primary Care Behavioral Health model for providing immediate access for patients presents challenges during the remote work of the COVID-19 pandemic.

WHAT THIS STUDY ADDS

⇒ Qualitative interviews were conducted with 55 behavioural health consultants (BHCs) across 40 health centres. BHCs evolved unique site-specific adaptations to provide daily clinical and support services to staff, via telehealth and videoconferencing. Increased referrals for anxiety, depression and race-related stress were observed.
⇒ Standard features of integrated primary care were negatively impacted during the pandemic including routine behavioural health screening, clinic staff huddles and interdisciplinary team meetings. The level of integration scores was lower than prepandemic assessments.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ The COVID-19 pandemic and related stressors will likely contribute to elevated rates of behavioural health and chronic health conditions for years.
⇒ Telehealth will likely have a significant ongoing role in care, even postpandemic; determining how to maintain the essential ingredients of integrated behavioural health with telehealth will require innovation. Likewise, BHCs will need to develop effective strategies to ameliorate race-based stress and prevent primary care team burnout.

INTRODUCTION

The COVID-19 pandemic has impacted every person, industry and aspect of life and has had substantial negative health, economic and well-being consequences. Integrating behavioural health into primary care is an established practice that seeks to increase access and allow earlier detection and response to health concerns while lowering the stigma for mental health, substance use and health behaviour interventions. A detailed explanation of the role of the integrated primary behavioural health provider is available in the extant literature. Integrated primary care behavioural health (PCBH) clinicians have been an essential backstop to help address large gaps in community behavioural health and serve an important triage and intervention role. Integrated behavioural health consultants bolster the
capacity of primary care teams to provide better care for the biopsychosocial needs of the population they serve’ (Kaznler & Ogbeide, 2020, p. S177). Research has demonstrated that COVID-19 infection has direct deleterious effects on increasing and/or initiating symptoms of behavioural health conditions and indirectly contributes to psychological distress through personal loss, catastrophic economic implications and the challenges of social isolation and loneliness.6 7 Integrated behavioural health has been instrumental in other infectious disease outbreaks (eg, HIV/AIDS), helping support patients experiencing psychological distress, the challenges of new care regimens, and health behavioural prevention and intervention.8 9

Primary care will continue to play a frontline role in addressing the pandemic’s sequelae, as well as other preventive, acute and chronic health needs, and integrated behavioural health will continue to have an essential role in this response effort, now and onward. Integrated behavioural health can assist with educating the panel on preventive behaviours to reduce the risk of infection and spread, expand intervention efforts to help patients cope with the biopsychosocial impacts of the COVID-19 pandemic, address vaccine and mask-wearing hesitancy, as well as with the indirect effects on the economy, familial role and loss.9 Likewise, skills in preventive science and education can be deployed to help inform, support and aid staff members in effective coping with COVID-19 stress, pandemic-related precautions and workflows and assist with preventive approaches to moral injury that can arise secondary to the demands of the pandemic.9 Pandemics yield increased psychological distress requiring a greater deployment of behavioural health screening, stress management and coping support, interventions to help with exacerbation of existing psychological conditions, the emergence of new symptoms of distress, and grief and loss support.9 The clinical skills of integrated behavioural health can be readily applied to address surging rates of intimate partner violence, suicidality, community violence and the psychological impact of the economic crisis associated with COVID-19.10

The pandemic has translated into a large-scale, rapid shift into telehealth provision of integrated care. Research has shown that telehealth is as effective as in-person interventions across a broad range of conditions.11 12 For integrated PCBH, some challenges of telehealth in response to the pandemic have already been documented, including: (1) loss of ease of scheduling back-to-back visits with the primary care visit; (2) patients not always being available at the time of visit; (3) distraction of the patient who may be engaging in multiple activities at once during the behavioural health consultation; (4) a drop-off in warm handoffs from care team members; (5) unique challenges to providing family and paediatric telehealth services; and (6) interpretation for individuals whose primary language does not match the clinician.11 Additionally, Perrin11 and colleagues note that many patients may be concerned about video telehealth but may be very open to telephonic visits. Patient availability to participate in telehealth may be affected by lack of reliable WiFi, internet or phone coverage, loss of privacy due to sheltering-in-place with others and discomfort with lack of face-to-face communication.11

The purpose of this investigation was to explore the impact of COVID-19 on a regional network of Federally Qualified Health Centers (FQHCs) using the PCBH model of integration. A series of semistructured interviews were conducted with agency behavioural health consultants (BHCs) to explore how their communication, collaboration and integration with their healthcare teams have been affected and what has changed in their day-to-day practice related to providing telehealth and supporting individuals who are disproportionately affected by the health, loss and economic impact of COVID-19.14

MATERIALS AND METHODS
Qualitative interviewing was conducted by the Health Federation of Philadelphia with 10 independent FQHC partnering agencies to assess organisational responses to COVID-19 and their maintenance of integrated PCBH. The context for this activity is rooted in a 15-year history of training, technical assistance and advocacy to advance integrated primary care in Southeastern Pennsylvania, USA. This work represents an important part of the Health Federation’s overall mission to increase access to high-quality health and human services, especially for vulnerable and under-resourced populations, through a variety of capacity-building efforts.

Semistructured interviews were conducted with each agency independently for approximately 30–45 min to learn more about how health centres were adapting to COVID-19, explore perspectives of telehealth and examine how the fundamentals of integration were being maintained. The semistructured interview questions can be found in box 1 and were developed to explore tenets of integrated care and how the agencies were responding to COVID-19. Interviews were conducted between 18 June 2020 and 28 August 2020. During this time period, Philadelphia, Pennsylvania, remained in a governor-decree state of emergency, secondary to COVID-19, and social distancing and reduced in-person capacity limits remained in effect.

Interviews were conducted with the agency’s BHCs who were available on the day of the interview. The meetings were conducted via video teleconference, and detailed notes were taken during the interviews, summarising the responses of the agency’s BHCs in each meeting. The results being reported are from the live notes summarising the semistructured interviews and subsequent discussions.

All of the agencies’ sites had recently received an integrated practice assessment in 2019 by this facilitator, a yearly initiative conducted to support integrated PCBH by the insurance payer.15 Prior to the pandemic, the U.S. Substance Abuse Mental Health Services Administration
Box 1  Semistructured interview with site behavioural health consultants

Questions
1. How much of your work is via telehealth versus face to face?
2. How are patients referred to you? How are your patients scheduled?
3. How is the communication loop closed with the provider/referrer (postvisit communication)?
4. Is depression, substance use or other screening occurring? How is that done in the patient workflow?
5a. How do care team members huddle about patients?
5b. How do care team members get together and meet?
6. In what ways are MAs/clerical staff helping behavioural health?
7. Any special types of referrals or changes on referrals/visits you are getting in response to current care limitations and COVID-19?
8. Overall impressions on how integration is going compared with pre-COVID-19
Optional #1: any special notes about staff self-care?
Optional #2: any special notes about behavioural health consultant role change?
Optional #3: remarks about telehealth?

- Health Resources Service Administration (SAMHSA-HRSA) integration scale average site score was 5.02 out of 6 (n=31, SD=0.38), using the Integrated Practice Assessment Tool (IPAT), a semistructured clinical interview to help assess overall level of integration of behavioural health and primary care. This score is suggestive of level 5 – close collaboration approaching an integrated practice on ‘SAMHSA-HRSA’s Center for Integrated Care, Six Levels of Collaboration,’ 17 17

For the purposes of this inquiry, the semistructured interview was used for qualitative data (box 1), the IPAT for the overall level of integration and The Integration Self-Assessment Checklist for Integrating Behavioral Health and Ambulatory Care, a semistructured interview, for assessing different aspects of integrated care. 18

These interview questionnaires were administered individually to each agency’s BHCs and respective supervisor, by the primary author, a white male psychologist with a decade of experience in integrated care, during the video-conference call, which generally lasted 45–65 min. Content analysis was used to derive themes from the available data post hoc; consistency was maintained between data provided and findings shared.

Patient and public statement
For the development of this qualitative evaluation, patient or public involvement was not sought, as staff perceptions of workflow and experience were the primary focus.

Funding statement
This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors. Financial support for this project was a part of an ongoing contract with Community Behavioral Health (CBH), a division of the Philadelphia Department of Behavioral Health and Intellectual disAbility Services, that provides managed care behavioral health and substance use services for Medicaid recipients, to the Health Federation to formally support integrated primary care in the region, via training, consultation and annual level of integration assessment.

Competing interests statement
The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Ethics statement
The following data are derived from a programme quality review and does not meet the formal definitions of research. Care has been taken to protect the anonymity and privacy of the individual respondents and agencies that participated in this programmatic review, and is in accordance with the Declaration of Helsinki.

RESULTS
Ten separate semistructured interviews were conducted, one interview with each agency that manages at least one Philadelphia-based Federally Qualified Health Center (FQHC) being supported by the Health Federation of Philadelphia for training and technical assistance. In total, 40 unique FQHC sites and 55 integrated behavioural health consultants participated in the interview.

TELEHEALTH AND BHC LOCATION
Interviewed between June and August 2020, the sites reported that BHCs were providing behavioural health consultation primarily by telehealth. Among the 10 participating agencies, telehealth visits, as a percentage of BHCs visits, ranged from 100% for five agencies, 90%–95% for two agencies, 75%–80% for two agencies and one agency said it ranged from 50% to 100% across their FQHC sites, varying by the clinician. Overwhelmingly, telehealth was provided telephonically; however, video was offered by two-thirds of sites. Patient preference, followed by limited patient access to streaming video, were the primary reasons cited for telephonic services. Sites varied greatly whether the BHC was exclusively located in the office (20%), split time between on-site and remote (30%), or was remotely based (50%). There did not seem to be an immediate relationship between where the BHC was working (eg, remote or onsite) and when the interview was conducted, but work setting determination was more related to the organisation’s social distancing policies since May 2020. It is important to note most sites returned to BHC on-site in September 2020, after the interviews were conducted.

Referrals and communication between BHC and team
Referrals from primary care providers and staff members were mostly via electronic health record (EHR) messages and/or ‘tasking’. BHCs reported that providers would use telephonic outreach (ie, call/text) or specific, non-EHR,
office-preferred, chat programme applications when providers wanted to provide more details or the BHC wanted to clarify the reason for referral. When both the BHC and primary care providers were on-site, in-person handoffs would be periodically used, but EHR messaging remained the predominant way of making referrals. BHCs ‘closed the loop’ after visiting with a referred patient by providing communication to the provider with an EHR message or using the agency’s instant messaging or chat applications.

Some sites decided to allow their BHCs to cover multiple FQHC sites within their agency and used a ‘proxy box’ in the EHR, where referrals would be submitted electronically and the next available BHC would take the next referred individual, regardless of ‘home’ FQHC site. Four sites used the proxy box, and three continued to use this approach throughout the pandemic. Most BHCs noted they managed and conducted their own scheduling, but four agencies noted that providers also could add patients to the BHC schedule directly. ‘Cold’ call visits, or direct outreach to patients, pre-pandemic, in the exam room or waiting room, were reported to be logistically harder to manage, because it was not simply accessing the patients coming into the health centre that day but rather involved outreaching to the entire FQHC panel. In response, BHCs reported enacting one of the following strategies: stopping doing cold calls; BHCs relied on population health applications to ‘hotspot’ patients who could most benefit from BHC outreach calls based on defined parameters (eg, elevated depression screener but had not seen BHC), or BHCs would use the daily provider EHR schedules as guides to whom they could outreach.

**BHC productivity and penetration**

BHCs noted that their overall productivity and number of visits significantly increased during the pandemic. Of the agencies interviewed, eight agencies reported objective increases in the number of completed visits with patients relative to historical averages, and two agencies reported mixed results with great variance between sites and/or BHCs. A general trend was reported of increased penetration by BHCs into the patient panel: anecdotal reports by individual clinicians noted a number of patients who previously had declined, or no-showed for, a BHC visit subsequently completed a telephonic meeting with the BHC and cited the phone instead of in-person as a major reason why they completed the visit. No-shows on scheduled visits were largely reported to be reduced across the agencies.

**Changes in patterns of referral to BHC due to COVID-19 and televised experiences of racial injustice**

All 55 BHCs anecdotally reported increased levels of anxiety and stress among the patients they were referred. There was also a report of increased BHC referrals for anxiety, depression, grief and loss, trauma, somatic complaints and suicidal ideation. Anxiety and stress referrals had been elevated throughout the entirety of the pandemic; however, BHCs reported a more recent trend towards an increase in referrals for depression, suicidal ideation, substance misuse and various adverse events (eg, grief, loss of job, increased community violence, becoming sick with COVID-19, loss of routine, etc). A growing referral reason has been parental worries about supporting children with remote schooling and social isolation. BHCs noted it has been harder to connect patients to outpatient behavioural health and experienced disruptions in care for those connected to outpatient treatment, leading to more collaboration and creative problem solving between the BHCs and their primary care providers to meet patient needs. Chronic health referrals were reported to be reduced compared with baseline.

BHCs also reported an increased desire among patients to engage in discussions of race, prejudice, discrimination and racial injustice in policing. Additionally, during the community activism around the police-related murders of Breonna Taylor and George Floyd in the USA, many patients experienced considerable hardship filling medications at local pharmacies for up to 2 weeks, due to business closures and property destruction: BHCs had a valuable role supporting patients and their clinical teams, networking with colleagues to find local pharmacies providing emergency prescriptions and/or deliveries. One FQHC was damaged by a riot-related fire at a neighbouring business and had to shut down all on-site activities for several months.

**Hallmarks of integrated PCBH: screening, care planning and interdisciplinary meetings**

Prior to COVID-19, all 10 agencies reported universal depression screening, with each patient being screened at least annually. Four agencies reported screening remaining intact with only minor disruption, three agencies reported a significant reduction in screening, particularly for medical telehealth visits, and three agencies have stopped universal screening during the pandemic. An agency’s ability to maintain universal screenings was positively correlated with the continued utilisation of medical assistants and clerical staff throughout the pandemic to support both telehealth and in-person visits: three agencies maintained these staff members’ involvement in both live and remote medical visits, and seven agencies did not use support staff for telemedicine visits.

‘Huddling’ or formally scheduled care planning meetings between BHCs and primary care providers were not universal prior to COVID-19, with 50% of agencies have had previously consistent formal huddles. However, during COVID-19 administrative huddles supplanted most patient care huddles focusing on policy, workflows, which employees were situated remotely and on-site, and agency updates. Only two agencies reported maintaining routinely scheduled clinical huddles, and for one of those agencies, the huddle was not accessible to that day’s remote staff. Therefore, most BHCs had to rely on provider referrals in the EHR, generate visits via cold call
protocols or initiate informal huddling, seeking opportunities to communicate with providers about potential prospective referrals for the day.

Interdisciplinary team meetings, such as complex case discussions, were increasingly becoming common across the 10 agencies prior to COVID-19, with some sites initiating such meetings in late 2019 or early 2020. As a result of COVID-19, interdisciplinary care meetings were largely put on hold, with a few site exceptions. BHCs did report that sites were trying to restore huddles and interdisciplinary meetings in August and September 2020. All 10 agencies reported that sites did maintain their usual supervisory and BHC department meetings.

Overall BHC impressions of maintenance of integrated care and shared care team approach

BHCs felt that all things considered, the core aspects of integration were being well maintained and PCBH integration remained strong, as highlighted by: increased referrals by primary care providers; improved BHC penetration rates into the FQHC panels; back-and-forth communication (eg, ‘closing the loop’) about the BHC visit between the primary care provider and BHC; and increased utilisation of chat applications to enhance collaboration and informal communication. BHCs were quick to acknowledge leadership at varying levels for their advocacy in supporting and maintaining integration.

However, many BHCs felt the remote work decreased their sense of community with their care teams, created a feeling of loss ‘not seeing each other’ and not being able to have workplace traditions, such as lunch together, potlucks, birthday celebrations and providing mutual support around topics like work, child-rearing, pop culture and difficult encounters. BHCs also noted the loss of huddles and opportunities to collaborate with the care team in meetings and informal curbsides as another feeling of loss. At one agency where BHCs had remained on site, the BHCs reported increased comradery with their healthcare team, noting the shared experience working together through COVID-19 had brought them closer together. Another site, where the BHCs worked remotely, noticed that the on-site staff had likewise seemed to grow closer together, and the remote staff would have to work to ‘re-establish rapport’ and closeness when they return.

At two agencies, BHCs noted their roles felt like they had substantially changed, while eight agencies felt that their role remained largely the same. One agency’s BHCs noted an increased demand to assist with social service needs and referrals focused on racial injustice, secondary to the pandemic and community challenges. Another agency was heavily involved in community COVID-19 testing, and this workflow changed the BHCs’ responsibilities and focus substantially. However, both agencies’ staff still noted they felt integrated with their care team and that they maintained the spirit of their BHC roles.

Self-care was a topic that frequently arose during these semistructured interviews. BHCs reported increased demands of higher productivity, higher patient acuity and the societal impacts of COVID-19 closures and remote work and often felt more stressed and more limited in enacting their usual coping repertoire. With increased stress and reduced separation between work and home life during social isolation, BHCs reported the need to actively focus on addressing their own stress management and setting realistic boundaries with work demands. BHCs at three agencies noted they had taken on significant additional roles and initiatives in addressing their team’s self-care. This ranged from healthcare staff often seeking out the BHC to ventilate stress and obtain behavioural health referrals for themselves, to BHCs conducting mindfulness activities before team-wide meetings, to another agency providing a daily BHC-led support group for staff that served as a forum for training on coping skills, providing education and resources and evoking laughter.

BHC impressions of telehealth

BHCs universally held a highly favourable opinion of telehealth and saw an important augmenting role in its continuation postpandemic. BHCs appreciated the ability to reach a wider range of individuals and that it was highly favourable to patients. Patients appreciated the convenience, how it reduced care barriers (eg, time to travel to the FQHC, car fare/cost of mass transit, wait times in the clinic and needing to take time away from responsibilities) and that some patients felt seeing their medical provider and BHC in the same day on-site was overwhelming. BHCs reported reduced no-shows for telehealth visits, noted that a significant number of patients seemed better prepared for visits and were more comfortable than in the office and that establishing rapport was easier than expected. This echoes the emerging PCBH COVID-19 research on reduced no-shows to visit: a trend in a decreased rate of behavioural health screening was not yet seen in the emerging research.19

BHCs reported some frustrating aspects of telehealth, including: patients often endorsed forgetting about the BHC appointment when called but would still be happy to have the support at the moment and go on with the visit; some BHCs reported a high number of calls to reach some participants; some individuals did not have phone access and/or privacy at their residence to discuss personal topics; some patients were multitasking during their sessions, which necessitated assertive confrontations by the BHC; and it could be difficult to do telephonic visits with young children and families. BHCs also reported learning more about patients and their context through the telehealth modality, noted they could conduct high-quality behavioural health interventions over the phone or video and were able to brainstorm strategies to help patients access handouts and resources that would normally be provided by hand in the office.

Facilitator rating of integrated care

The participating FQHCs receive an annual integration assessment in which representatives of different disciplines (eg, medical/nursing, BHC, operations, medical
This retrospective review of 10 primary care agencies, with 40 FQHC sites, and 55 BHCs demonstrated a robust response to COVID-19. There was a collective rapid response to transition care to remote telehealth as soon as the statewide social distancing order was enacted. Feedback from interviews with the 10 agencies’ BHCs demonstrated that the teams rapidly adapted to the remote work, and they felt generally well positioned to provide quality care to their FQHC patients remotely, mostly via telephone. The BHCs noted they were able to meet the increased care acuity and heightened referrals by leveraging clinical resilience, programmatic adaptation and procedural innovation, continuing to offer rather seamless and readily accessible behavioural health support.

Telehealth was perceived by this audience of BHCs as highly favourable. While there was an adjustment period to offering remote services, the telephone was found to be mutually beneficial by patients, primary care providers and BHCs. Interviewees indicated telehealth maintained a strong level of integrated behavioural healthcare for the FQHCs during the pandemic and subsequent social distancing. Telephonic encounters were the major modality of remote care, and this was primarily due to patient access barriers to video telehealth, patient preference or lack of organisational resources to stand-up video telehealth. BHCs were highly in favour of having a continuing augmenting role for telebehavioural health postpandemic to assist patients with challenges accessing the clinic, accommodate those who prefer the remote modality of care and/or for interoffice check-ins.

However, telehealth was not without limitations, notably difficulty using telephonic encounters with children and family-oriented care, privacy and access concerns for procedural innovation, continuing to offer rather seamlessness and readily accessible behavioural health support.

This integration assessment has occurred three times to date at each site, and it is an opportunity to review how integrated care is supporting patient care, health providers and agency goals. Additionally, this annual meeting assesses the level of behavioural health integration on several domains, identifies site needs related to integrated care and collaboratively provides possible action steps for process improvement. Table 1 demonstrates the average integration scores of 31 local FQHC sites as determined in the 2019 interdisciplinary meetings. Additionally, estimated aggregate FQHCs’ integration scores are provided for the sites as of June–August 2020, based on the site BHC interviews. It is important to note these scores are not based on interdisciplinary team visits and may not fully reflect site levels of integration: the 2020 FQHC integration assessments were just beginning in Summer 2020 and will continue through the end of the year, via videoconferencing, as opposed to the typical in-person meetings. The scores in table 1 demonstrate a notable decrease (>0.5) in colocolation, clinical delivery and an overall score, largely based on BHCs being mostly off-site, the lack of integrated care planning meetings and interruptions in clinic behavioural health screening. However, due to considerable agency-led site planning for pandemic operations and implementation of remote BHC telehealth, as well as frequent referral-specific BHC primary care provider communication, FQHCs demonstrated heightened features of integrated practice organisation.

**Table 1** Comparison of level of integration between 2019 and 2020 (during COVID-19 pandemic) in Philadelphia FQHCS

| Level of integration | 2019 Philadelphia FQHC average scores (baseline) | 2020 estimated aggregate site scores (during the pandemic) |
|----------------------|-----------------------------------------------|----------------------------------------------------------|
| Location*            | 5.44                                          | 4                                                        |
| Clinical delivery*   | 4.74                                          | 4                                                        |
| Patient experience*  | 5.39                                          | 5                                                        |
| Practice organisation*| 5.06                                          | 5                                                        |
| Business model*      | 5.19                                          | 5                                                        |
| Overall level of integration† | 5.02 | 4.5 |

*The Integration Self-Assessment Checklist for Integrating Behavioral Health and Ambulatory Care.† The Integrated Practice Assessment Tool (IPAT). FQHCs, Federally Qualified Health Centers.
Another buffering factor for these FQHCs is the ongoing training and technical assistance provided by the Health Federation of Philadelphia. Clinicians and agencies were well versed and well trained in the PCBH model via initial onboarding technical assistance and ongoing training and individual/team consultations, such as monthly BHC continuing education seminars and annual integrated interdisciplinary practice assessments. This provided a good foundation in integrated care for all parties and helped reduce practice drift. Likewise, the Health Federation of Philadelphia was quickly able to respond to the pandemic by shifting in-person training to virtual and provided immediate offerings on telehealth practice, addressing burgeoning racial injustice considerations and assisting behavioural health leadership on the new policy and workflow development. It was mutually fortuitous for the BHCs and the Health Federation of Philadelphia to conduct these reflective meetings with the 10 agencies and their BHCs. The Health Federation of Philadelphia was able to reflect on the training and support needs and prepare for interdisciplinary conversations with the FQHC teams during the annual integration meetings to help support and enhance integrated care during the pandemic. Meanwhile, BHCs found these semistructured interviews to be supportive and to validate the strong integrated care work they were doing, the strain of recent work and the feelings of loss of community and to remind BHCs and their site leadership of the core tenets of integrated care (eg, huddling, interdisciplinary meetings and universal screening). BHCs were also able to express acceptance that high care demands, less than optimal communication and uncertainty about care in the immediate future may have an ongoing impact on the short-term structure and nature of integrated care. These findings highlight that a good bedrock of training, institutional trust and adaptive organisational support helps maintain integrated care, even during times of rapid change and uncertainty. On the horizon, local BHCs are grappling with experiences that suggest reduced patient access to outpatient behavioural health in the community and ever-evolving situational demands. This can lead to practice drift from the PCBH Model without mindful attention to the processes of the model.

The semistructured qualitative interviews highlight that Philadelphia’s FQHCs are reflecting many of the same experiences in PCBH practice that the emerging COVID-19 literature suggests. These interviews validate the rapidly increasing behavioural health need described in COVID-19 related publications.9 10 Likewise, it highlights the ability of integrated behavioural health to meet the rising distress-oriented needs and gaps in the outpatient behavioural health system through telehealth care delivery.11 12 The care delivery challenges experienced in providing telehealth by these 55 BHCs also closely approximate the findings of the emerging literature on COVID-19 and telehealth: patient telehealth access barriers, patient distraction, challenges providing telebehavioural health for paediatric and family care and loss of seamlessness of referrals from healthcare provider to BHC, requiring more outreach effort and time by the BHC to connect to patients.4 11 13 Reduced PCBH interdisciplinary huddling and behavioural health screening has also been reported elsewhere COVID-19 related literature.19

Prevention and health educating roles of integrated behavioural health providers can also be harnessed during an infectious disease pandemic. Behavioural health providers can educate primary care patients on how the infection spreads and provide preventive education (eg, mask-wearing, social distance recommendations). These clinicians can also use motivational interviewing to assist individuals who are engaging in high-risk behaviours that increase their risk of contagion and pandemic spread, as well as pandemic caution fatigue, which is the reduced adherence to pandemic preventive measures over time.20 Culturally appropriate behavioural strategies can be used to address vaccine fears and increase immunisation uptake.21 Likewise, expected elevated increases in the prevalence of obsessive-compulsive disorder and substance use disorders will need BHC screening, education, treatment and/or specialty care referral.22 23

The subsequent exacerbation and attention of racial injustice in policing co-occurred with the COVID-19 pandemic. Integrated behavioural health also provided a critical resource to support those experiencing the effects of this dual pandemic. Knowledge of critical race theory, intersectionality and social determinants of health among PCBH professionals can help with patient care, education and systemic interventions. Consideration should be taken by BHCs on how to do targeted outreach given persons of colour have been disproportionately impacted by the COVID-19 virus and its subsequent economic and familial loss impacts.14 These patients may also have prolonged suffering related to the COVID-19 fallout, due to the intersection of multiple social determinants of health and under-resourcing of employment opportunities, support services and healthcare, especially specialty care providers, in the neighbourhoods the FQHCs serve.24 25

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REFERENCES
1 Cohen DJ, Davis M, Balalasubramanian BA, et al. Integrating behavioral health and primary care: consulting, coordinating and collaborating among professionals. J Am Board Fam Med 2015;28 Suppl (1):S21–31.
2 Peek CJ. Lexicon for behavioral health and primary care integration: concepts and definitions developed by expert consensus. Rockville, MD: Agency for Healthcare Research and Quality, 2013: 1–57.
3 Reiter JT, Dobmeyer AC, Hunter CL. The primary care behavioral health (PCBH) model: an overview and operational definition. J Clin Psychol Med Settings 2018;25:109–26.
4 Kanzler KE, Ogbeide S. Addressing trauma and stress in the COVID-19 pandemic: challenges and the promise of integrated primary care. Psychol Trauma 2020;12:5177–9.
5 Kazdin AE. Innovations in psychosocial interventions and their delivery: Leveraging cutting-edge science to improve the world’s mental health. Oxford University Press, 2018.
6 Adhanom Ghebreyesus T. Addressing mental health needs: an integral part of COVID-19 response. World Psychiatry 2020;19:129–30.
7 Gruber J, Prinstein MJ, Clark LA, et al. Mental health and clinical psychological science in the time of COVID-19: challenges, opportunities, and a call to action. Am Psychol 2021;76:409–26 https://doi.org/10.1037/amp0000159.
8 Eaton LA, Kalichman SC. Social and behavioral health responses to COVID-19: lessons learned from four decades of an HIV pandemic. J Behav Med 2020;43:341–5.
9 Kaslow NJ, Fris-Healy EA, Cattie JE, et al. Flattening the emotional distress curve: a behavioral health pandemic response strategy for COVID-19. Am Psychol 2020;75:875–86.
10 Fisher EB, Miller SM, Evans M, et al. COVID-19, stress, trauma, and peer support-observations from the field. Transl Behav Med 2020;10:503–5.
11 Perrin PB, Rybarczyk BD, Pierce BS, et al. Rapid telepsychology deployment during the COVID-19 pandemic: a special issue commentary and lessons from primary care psychology training. J Clin Psychol 2020;76:1173–85.
12 Varker T, Brand RM, Ward J, et al. Efficacy of synchronous telepsychology interventions for people with anxiety, depression, posttraumatic stress disorder, and adjustment disorder: a rapid evidence assessment. Psychol Serv 2019;16:621–35.
13 Zhou X, Snoswell CL, Harding LE, et al. The role of telehealth in reducing the mental health burden from COVID-19. Telemed J E Health 2020;26:377–9.
14 Novacek DM, Hampton-Anderson JN, Ebor MT, et al. Mental health ramifications of the COVID-19 pandemic for black Americans: clinical and research recommendations. Psychol Trauma 2020;12:449–51.
15 Cos TA, Levkovich N. Can primary care practices develop better behavioral health integration via interdisciplinary assessment and discussion? A 28-site outcome study. Paper presented Collaborative Family Healthcare Association Conference, 2019.
16 Waxmonsky J, Auxier RW, Pratt, et al. Integrated practice assessment tool. Washington, DC: SAMHSA-HRSA center for integrated health solutions, 2014, http://www.integration.samhsa.gov/operations/administration/IPAT_v2_0_FINAL.pdf on July 17, 2016.
17 Heath B, Wise Romero P, Reynolds K. A review and proposed standard framework for levels of integrated healthcare. Washington, D.C. SAMHSA-HRSA center for integrated health solutions, 2013. Available: https://www.pcpcc.org/sites/default/files/2019-07-SAMHSAHRSA%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf.
18 Academy AI. Self-Assessment checklist for integrating behavioral health and ambulatory care, 2013. Available: https://integrationacademy.ahrq.gov/playbook/integrating-behavioral-health-and-ambulatory-care-self-assessment-checklist [Accessed 16 October 2020].
19 Cooper Z, Zerden LDS. How COVID-19 has impacted integrated care practice: lessons from the frontlines. Soc Work Health Care 2021;60:146–56.
20 Ducharme J. Are you experiencing COVID-19 ‘caution fatigue’? Here’s what it is, and how to fight it. TIME. 2020 Apr 30. Available: https://time.com/5829312/covid-19-caution-fatigue/ [Accessed 22 Nov 2020].
21 Thomson A, Vallée-Tourangeau G, Suggs LS. Strategies to increase vaccine acceptance and uptake: from behavioral insights to context-specific, culturally-appropriate, evidence-based communications and interventions. Vaccine 2018;36:6457–8.
22 Banerjee DD. The other side of COVID-19: impact on obsessive compulsive disorder (OCD) and hoarding. Psychiatry Res 2020;288:112966.
23 Rogers AH, Shepherd JM, Carey L, et al. Psychological factors associated with substance use initiation during the COVID-19 pandemic. Psychiatry Res 2020;293:113407.
24 Cummings JR, Allen L, Clennon J, et al. Geographic access to specialty mental health care across high- and low-income us communities. JAMA Psychiatry 2017;74:476–84.
25 Nguyen CA, Chernew ME, Ostrer I. Comparison of healthcare delivery systems in low- and high-income communities. The American Journal of Accountable Care 2019;7:1–18 https://www.ajcnc.com/view/comparison-of-healthcare-delivery-systems-in-low- and-high-income-communities