Integrated Behavioral Health in Family Medicine Supports Resident Learning by Working to Achieve the Quintuple Aim

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ABSTRACT

Integrated behavioral health (IBH) in primary care settings has been touted as improving access to behavioral health services. In this case report, we describe a representative IBH team nested in a family medicine residency clinic, led by a behavioral health faculty clinician. Using this patient as an example, we identify ways in which the team was able to achieve elements of the quintuple aim (population health, enhanced patient experience, cost reduction, health equity, and provider well-being). We additionally utilize this case report to provide examples of learning opportunities for medical residents.

KEYWORDS: Integrated behavioral health; family medicine behavioral health education; primary care; quintuple aim

INTRODUCTION

Patients navigating the United States (U.S.) healthcare system in pursuit of behavioral health services face significant challenges.[1] Increased medical complexity, psychiatric co-morbidity, acuity, and unmet social and financial needs (i.e., social determinants of health (SDoH)) further impede efforts to engage in necessary care.[2] Patients unable to access specialty mental health care often rely on primary care settings, overwhelming already overburdened providers seeking to manage their multiple conditions.[3] This dynamic exacerbates occupational stress and burnout[4] among medical residents balancing competing patient care and professional development priorities.[5] Integrated Behavioral Health (IBH) teams with behavioral health faculty embedded within medical residency training clinics teach residents aspects of behavioral health collaboration and coordination, brief assessment and treatment, and communication skills which they can take forward into their primary care practices when they graduate. In this way, IBH teams provide a pathway by which to enhance care for patients coping with multiple medical and behavioral health issues and SDoH needs, maximize learning and support for medical residents,[6] and advance primary care clinics towards meeting the quintuple aim[7]: improved population health, patient experience, healthcare provider well-being, health equity, and reduced per capita cost.

The Family Care Center (FCC) is a resident-led primary care clinic and patient-centered medical home for the Brown Family Medicine Residency of the Warren Alpert Medical School of Brown University. It is a safety net clinic characterized by a high proportion of patients utilizing public insurance and high rates of co-morbidity, psychiatric complexity, and challenges related to SDoH. Patient care is predominantly delivered by residents and advanced medical students overseen by faculty preceptors. In addition, the FCC is staffed by an IBH team offering embedded services comprised of multiple IBH clinicians (i.e., clinical psychologists and a licensed social worker), two bachelor's-level IBH community health workers (CHWs), psychology doctoral students, and a double-boarded family medicine/psychiatry physician who consults three half-days per month.

Some IBH team members, including the double-boarded family medicine/psychiatry physician, additionally serve as behavioral health faculty members, and the IBH team leader serves as the Director of Behavioral Health for the residency program. IBH team members are available for warm handoffs from resident primary care physicians (PCPs) during routine primary care visits. In this way, the IBH team provides an interprofessional behavioral health integration learning experience for residents in team-based care. Additional resident learning experiences with the IBH team include observations and co-therapy within the behavioral health faculty members' scheduled clinics, and via co-therapy and/or leading care of patients who present in the weekly walk-in behavioral health open access clinic. The behavioral health open access clinic is an interdisciplinary training clinic comprised of medical residents, medical students, and psychology students, and is supervised by two behavioral health faculty members. The chronic pain group medical visit at the FCC provides another avenue for interdisciplinary collaboration and behavioral health clinical teaching. This monthly medical group visit is led by three medical residents under the supervision of a physician faculty preceptor, and includes the presentation of topics related to coping with chronic pain. Monthly groups typically include resident co-presentations on a behavioral health topic, with a behavioral health faculty member coaching.

CASE REPORT

A 62-year-old male patient dually eligible for Medicaid and Medicare, has been followed for >10 years at the FCC. He has multiple chronic, poorly controlled medical conditions, active behavioral health issues, and SDoH needs impacting his overall well-being and adherence to medical care [**Figure 1**]. His visits have the potential to be overwhelming and unproductive for any primary care provider, but especially a trainee learning how to set agendas and manage several problems simultaneously. The patient was initially referred to an IBH clinician by his resident PCP in 2018 for chronic depression. Initial IBH assessment also identified the patient to be coping with inordinate family-related stress, PTSD, chronic pain and other complex medical conditions, and self-reporting a history of substance use disorder. Given the acuity and expanded understanding of the patient's mental health conditions, the IBH clinician initially recommended that the IBH team assist in guiding the patient to a specialty mental health referral at a community mental health center where he could receive more frequent, sustained therapeutic support. The patient declined outside referral due to his mistrust of new providers; however, he agreed to initiate care at the primary care site, crediting trust established with his primary care team at the FCC, and rapport established with his IBH clinician.

Figure 2 summarizes elements of collaboration between the IBH team and the resident PCP, aligned with quintuple aims and lessons learned. Challenges encountered by the patient included difficulty adhering to recommendations for management of diabetes and sleep apnea, distress due to a difficult interaction with a specialty provider, and escalation of chronic pain symptoms in the context of chronic suicidal ideation. The IBH clinician was able to address those issues in therapy sessions provided within the patient's primary care setting. When SDoH needs presented as a barrier to equitable care, then leading to feelings of hopelessness and immobilization, the IBH team was able to partner with CHWs to facilitate appropriate referrals for community SDoH support, while the IBH clinicians continued to address the psychological impact in their visits. The patient's ongoing engagement with the IBH clinician and the FCC IBH team has provided a pathway to foster trust in the broader healthcare system. Despite the patient's initial decision to decline referral for specialty mental health care, he ultimately requested a referral to a behavioral health clinician with expertise in supporting not only the aforementioned issues, but also LGBTQ-related concerns, a need uncovered via his IBH therapy sessions.

Figure 1. Summary of the patient's medical and mental health issues

Medical diagnoses	Behavioral health issues	Issues related to SDOH
• Chronic pain • Type 2 DM (poorly controlled) • COPD • OSA (poor adherence to CPAP) • Hypertension • Atrial fibrillation • Pancreatitis • Stage 3 Chronic Renal-Insufficiency • Diabetic foot ulcer	• MDD moderate, recurrent -PTSD • Chronic suicidal ideation • Coping with Chronic medical conditions including chronic pain • Distress related to sexual identity exploration • Psychosocial Stressors: family-related, financial, health	• Unable to work (receiving SSDI) • Barriers to healthcare access due to insurance • Limited finances • Housing instability
Involvement of IBH team allowed for better coordination with PCP to optimize treatment for Depression and PTSD, with chronic suicidal ideation; and also improved adherence to treatment for medical conditions, and access to community referral resources for both behavioral health and SDoH needs.		

Figure 2. Impact of IBH in primary care on elements of the Quintuple Aim – examples

Aim	Case Report Example	Learning Points
Population health	Poorly controlled diabetes and sleep apnea due to depression impacting adherence to treatment; IBH team helped patient with adherence	Unmet behavioral health needs can result in poor medical outcomes; Population health is better served when these needs are met
Enhanced patient experience	Patient distress and frustration about mental health referrals resulted in distrust in the system, unwillingness to accept new referrals	IBH clinician is ideal person to address this via support and appropriate referral
Cost reduction	Significant potential cost of missed appointments if pt's mistrust prevented him from going to scheduled referrals	IBH availability can reduce missed appointments due to inappropriate referrals, and can also address issues rapidly in primary care, resulting in fewer ED visits
Health equity	Patient had multiple SDoH barriers to care (losing insurance, financial and transportation barriers) that were able to be comprehensively addressed within primary care	Health equity is achieved when there are fewer barriers to medical care. IBH in primary care can solve these barriers more easily
Provider well-being	Taking care of the patient could have been overwhelming for any provider, especially a medical resident trainee; having the support of the IBH clinician allowed AP (co-author) to focus visits toward pressing medical issues.	IBH can unload the PCP visit by addressing BH concerns separately; supporting providers with complex, challenging patients is important in their wellness

DISCUSSION

Value of IBH in primary care

The case illustrates the challenges faced by primary care teams seeking to support patients with significant behavioral health needs, who may decline specialty mental health services.[8] This case demonstrates a dynamic often seen in primary care, wherein the unique combination of patients' behavioral health diagnoses, psychosocial stressors, and unmet SDoH needs have driven patient experiences of discrimination and suboptimal care in behavioral health clinical settings.[9-11] This in turn results in generalized distrust of systems of behavioral health care. Fortunately, this patient's trust in his primary care clinic and provider provided an avenue to connect with an IBH team, resulting in a sustained trajectory of care through which his PCP and IBH clinician could establish rapport, rebuild trust, and ultimately guide the patient towards specialty care specific to his needs.

Impact of IBH beyond the clinic

The IBH team supports health equity and cost reduction simultaneously by lowering barriers to medical care and preventing inappropriate referrals and emergency department visits. The availability of IBH within the primary care team allows patients to receive behavioral health care more efficiently, at the time of reported need during their PCP visit. Furthermore, timely behavioral health assessment through an IBH clinician supports creating an optimal behavioral health treatment plan and, if necessary, the most fitting referral resources. A positive patient experience with a timely and effective IBH intervention increases the chance that the patient will attend subsequent behavioral health appointments, preventing costly and unnecessary visits to the emergency department.

IBH in learner-focused primary care clinics

Collaboration between this patient's resident-level PCP and IBH clinician highlights pathways by which the IBH team in primary care residency settings brings considerable value to training.

While behavioral health providers can teach residents valuable skills through didactic lecture and workshop experiences, the presence of IBH in the primary care clinic supports robust and comprehensive learning in the context of direct clinical care. Care coordination between PCPs and IBH supports multiple elements of the quintuple aim,[13] and this case provided *in vivo* opportunities for the PCP to observe how IBH team coaching and advocacy smoothed challenges faced by both patient and provider in accessing care. When the patient experienced escalating emotional distress following interactions with medical providers and staff members, the IBH clinician has a unique skill set to counsel patients in these circumstances and assist in providing solutions and strategies.

The Accreditation Council of Graduate Medical Education's (ACGME) program requirements for Family Medicine specify: "there must be faculty members dedicated to the interprofessional integration of behavioral health" into the educational program, and "the curriculum must incorporate behavioral health into all aspects of patient care, including experience in integrated interprofessional behavioral health care in the [primary care practice]".[12] Notably, a qualitative study of FM residency practices found delivery and training experiences in IBH varied widely, despite recognition of the value and benefits to patients and care delivery processes.[13] A survey of FM program directors found only 44% reported fully integrated behavioral health care in their clinics.[14]

Impact of IBH on resident wellness

The presence of behavioral health faculty and the IBH team support resident PCP well-being. In **Figure 2** we highlight that coordination between the IBH clinician and resident PCP helped ensure ample monitoring of behavioral health risks, allowing the PCP to address other complex health conditions. When IBH professionals provide risk assessment, treatment, and safety planning, residents are allowed to focus on patients' complex medical issues, prioritize quality care in the visit, and actively set an agenda. The IBH team also provides additional professional support through facilitating opportunities for residents to reflect on all aspects of the challenging, and ultimately rewarding, journey of caring for patients with complex needs.

Challenges

IBH adoption and sustainment demands significant resources, and faces barriers such as workforce shortages, high rates of occupational burnout, and competing demands on limited resources. IBH faces competition for physical space within primary care clinics, and the ongoing need to demonstrate financial viability via direct reimbursement for behavioral health services. A study comparing residency and non-residency family medicine practices found similar uptake of IBH and similar requirements for interventions and resources to help them overcome challenges associated with dissemination of high levels of BH integration.[15] Despite evidence underscoring the value of IBH, efforts to maintain a robust integration of behavioral health and primary care workflows often include navigating similar roadblocks.[16] Nonetheless, the shifting landscape of healthcare provision and training may yield significant opportunities to advance integration of behavioral health in practice, to the benefit of population health and healthcare spending goals nationwide.[17]

In summary, this case demonstrates key ways in which IBH and resident PCP collaboration advance health services towards the quintuple aims of healthcare improvement, and provides unique and valuable training experiences for our future primary care workforce. ACGME accreditation

requires robust behavioral health training opportunities. This case report illustrates the enhanced value of achieving those requirements via an IBH program.

Challenges include competition for physical space within primary care clinics, and the ongoing need to demonstrate financial viability via direct reimbursement for behavioral health services. Despite evidence underscoring the value of IBH, efforts to maintain a robust integration of behavioral health and primary care workflows often include navigating similar roadblocks.[15] Nonetheless, the shifting landscape of healthcare provision and training may yield significant opportunities to advance integration of behavioral health in practice, to the benefit of populations.

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Disclosures

Acknowledgments: The authors thank IBH CHWs Katherine Delgadillo Soto, BS, and Aldelis Reyes, BA, for their work on the Family Care Center IBH team as they support patients and providers. This work is made possible in part through funding provided by NIDDK (K23DK136978).

Ethical Approval: Our institution does not require ethical approval for reporting individual cases or case series.

Disclaimer: The views expressed herein are those of the authors and do not necessarily reflect the views of the Alpert Medical School of Brown University.

Financial disclosures: The authors report no financial disclosures relevant to this manuscript.

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