



# Considerations for Behavioral Health Integration Program Implementation in Pediatric Primary Care Settings: A Qualitative Study

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## ABSTRACT

**BACKGROUND:** More than 16% of children in the United States have a behavioral health (BH) disorder, but less than half receive recommended care. Integrated BH programs in primary care settings can address gaps in BH care. This qualitative study sought to understand pediatric primary care clinicians' experiences with the novel multicomponent Behavioral Health Integration Program (BHIP) in a large network of independent pediatric practices and to identify potential barriers and facilitators for implementation of such programs.

**METHODS:** Semistructured interviews were conducted virtually with a purposive sample of clinicians in BHIP practices from November 2021 to April 2022. The Consolidated Framework for Implementation Research was the study's theoretical framework. Interviews were audio-recorded and professionally transcribed. Transcripts were analyzed inductively and deductively using Charmaz's constructivist grounded theory approach.

**RESULTS:** Of the 31 participants, 74% identified as female and 97% as white. Most participants felt that BH care should be

integrated into pediatric primary care and that BHIP helped to do so. Most barriers and facilitators identified centered on inner and outer setting Consolidated Framework for Implementation Research domains, including BH care delivery and finance; practice structures (staffing, training, scope of services, and management); practice culture (leadership, communication, and teamwork); and effects of integration on clinicians.

**CONCLUSIONS:** BHIP provided important support for BH integration across varied settings. Potential considerations for effective implementation in other settings included expanded training for BH clinicians, tailoring integration to organizational and practice-level contexts, and increased advocacy to address the structural factors limiting of BH care delivery.

**KEYWORDS:** behavioral health integration; primary care; implementation

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## WHAT'S NEW

Contextual factors are critical for implementation of pediatric behavioral health (BH) integration programs. Structured support facilitates implementation of BH integration. Community BH linkages are critical for integration programs.

An estimated 16.5% of US children under 18 years old had at least 1 behavioral health (BH) diagnosis in 2016,<sup>1</sup> a percentage that increased during the COVID-19 pandemic.<sup>2,3</sup> Although effective evidence-based treatments exist, more than half of children with BH diagnoses are inadequately treated, resulting in psychosocial impairments,

physical comorbidities, and greater use of health-care services in adulthood.<sup>4</sup> Barriers to diagnosis and treatment of BH disorders include stigma, limited coverage by health insurers, and pervasive shortages of child and adolescent psychiatrists (CAPs) and other BH clinicians (BHCs).<sup>5</sup>

Pediatric primary care clinicians (PCCs) began integrating BH into their practices more than a decade ago, taking advantage of regular visits by the 87% of children who have well-child visits each year.<sup>6–8</sup> BH integration has increased the capacity to identify and treat BH disorders in primary care,<sup>9–11</sup> but implementation challenges persist, including inadequate clinician and staff training, lack of time and space, low reimbursement rates, and lack of community resources.<sup>12–16</sup>

Many pediatric BH integration interventions (summarized in a recent review<sup>17</sup>) have either been research-based clinical trials or quality improvement projects focused on a small number of practices and implemented using standardized policies and procedures.<sup>18–21</sup> Independent health-care networks aiming to integrate BH in their member practices may face more complex implementation and sustainability challenges due to structural and financial differences inherent in independent practices. The Behavioral Health Integration Program (BHIP) supports BH integration in a large, diverse, independent practice association (IPA) affiliated with an academic pediatric medical center in Massachusetts. The IPA comprises approximately 500 PCCs in 80 practices.<sup>22</sup> These practices are financially independent and vary by size, location, payor mix and populations served, but share contracting and a single electronic health record (EHR). BHIP was funded through the affiliated academic medical center and is implemented by the IPA BH team.

BHIP's 4 key elements aim to mitigate known barriers to BH integration. First, practices participate in a 27-hour interdisciplinary learning community (LC) delivered live in an interactive web-based format. The LC focuses on conditions most commonly seen in the primary care setting (anxiety, stress/trauma reactions, depression, suicidality, attention deficit and hyperactivity disorder, behavior disorders, substance abuse) as well as identification and prevention of developmental problems in early childhood. Second, practices are encouraged to enroll in the state-supported child psychiatry access program (MCPAP),<sup>23</sup> whose CAPs provide real-time telephone consultation to PCCs, with follow-up in-person patient evaluation as requested by PCCs. Third, masters' level BHCs are integrated into practices with a 6-month salary guarantee by the IPA. Fourth, clinical, operational, and quality improvement support is provided to practices by IPA integration managers (senior social workers/counselors) and quality improvement specialists. Each practice is asked to designate a BH champion (typically a PCC) to support BHIP implementation. These elements are designed to support the delivery of BH care by the PCC and integrated BHC: the individual practices choose how to deploy these resources based on practice needs, skill, and comfort of PCC and BHCs.

BHIP was launched in 2013 in 13 practices and subsequently expanded to the entire IPA. Prior studies of the first 59 practices participating in BHIP showed that BHIP was feasible and acceptable to practices, increased BH integration, and improved patient access to BH services (screening, BHC and PCC BH visits, prescription of medications for anxiety and depression) without increasing total outpatient BH costs.<sup>24,25</sup> The current qualitative study sought to expand understanding of PCCs experiences with BHIP, to identify potential barriers and facilitators for implementation of BH integration programs in similar settings, and to identify possible considerations for scale-up of such programs in other health-care organizational settings.

## METHODS

We conducted semistructured interviews with pediatric PCCs in practices that had participated in BHIP. The

Consolidated Framework for Implementation Research (CFIR)<sup>26</sup> served as an organizing framework for the study. CFIR consists of a menu of 5 domains with associated constructs that are pertinent to the implementation of complex interventions such as BH integration (Fig. 1). The study was approved by the Boston Children's Hospital Institutional Review Board.

## PARTICIPANTS AND SETTING

We recruited a purposive sample of managing partner clinicians and BH champions from network practices, aiming to achieve variation in practice size, geographical location, estimated percentage of publicly insured patients (MassHealth), and year the practice enrolled in BHIP. Potential participants were sent an invitational e-mail that included a description of the study's objectives and the participant's role. If the clinician declined or did not respond, a second clinician from the practice was invited. If 2 clinicians from the practice declined, a clinician from a comparable practice was invited. Clinicians who expressed interest were contacted to schedule a virtual interview.

## DATA COLLECTION

A semistructured interview guide (Supplementary Appendix) was developed, and pilot tested with 2 clinicians. Interview questions were developed using CFIR domains and existing literature on BH integration.<sup>6,9–13,27–29</sup> An experienced qualitative researcher (SG) and team members trained by SG (BB, ED, MD) conducted interviews via Zoom and a second trained team member took field notes during the interviews. Interviews were audio-recorded, and professionally transcribed verbatim, lasted approximately 45 to 60 minutes and were conducted until data saturation was achieved, defined as no new themes being identified across 3 consecutive interviews after at least 20 interviews.<sup>30</sup>

## ANALYSIS

Charmaz's constructivist approach to grounded theory served as the study's analytic framework.<sup>31</sup> An a priori codebook was developed using the semistructured interview guide and refined after reading the first several transcripts. Analyses were conducted using Dedoose qualitative software (Dedoose Version 9.0.17). The analytic team (BB, ED, MD, SG, SS, KW) coded the first several transcripts to develop coding consistency. Working in pairs, the team then coded each transcript independently and met to resolve discrepancies by consensus; each pair achieved >80% agreement when independently coding. After coding in pairs, the full analytic team met to discuss and resolve residual coding questions, refining the codebook as indicated. Memos were used to identify coding questions and emerging themes; an audit trail of analytic decisions was maintained. Axial coding proceeded as open coding progressed, linking emerging themes to CFIR constructs through discussion and identifying pertinent themes that fell outside of the CFIR framework both deductively and

Consolidated Framework for Implementation Research Constructs		
From: <a href="https://cfirguide.org/">https://cfirguide.org/</a>		
Construct		Short Description
<b>I. INTERVENTION CHARACTERISTICS</b>		
A	Intervention Source	Perception of key stakeholders about whether the intervention is externally or internally developed.
B	Evidence Strength & Quality	Stakeholders' perceptions of the quality and validity of evidence supporting the belief that the intervention will have desired outcomes.
C	Relative Advantage	Stakeholders' perception of the advantage of implementing the intervention versus an alternative solution.
D	Adaptability	The degree to which an intervention can be adapted, tailored, refined, or reinvented to meet local needs.
E	Trialability	The ability to test the intervention on a small scale in the organization, and to be able to reverse course (undo implementation) if warranted.
F	Complexity	Perceived difficulty of implementation, reflected by duration, scope, radicalness, disruptiveness, centrality, and intricacy and number of steps required to implement.
G	Design Quality & Packaging	Perceived excellence in how the intervention is bundled, presented, and assembled.
H	Cost	Costs of the intervention and costs associated with implementing the intervention including investment, supply, and opportunity costs.
<b>II. OUTER SETTING</b>		
A	Patient Needs & Resources	The extent to which patient needs, as well as barriers and facilitators to meet those needs, are accurately known and prioritized by the organization.

**Figure 1.** Domains and constructs of the Consolidated Framework for Implementation Research.

inductively. A summary of themes and subthemes was sent to participants for review and feedback (member checking). Considerations regarding reflexivity included: BB, SG, and LV are pediatric PCCs; HW is a CAP; and JB is a clinical psychologist. HW, JB, and LV developed and lead BHIP, bringing in-depth knowledge and potential related biases to data interpretation; BB is employed by the independent pediatric practice network and both she and SG knew some of the participants professionally.

## RESULTS

We conducted a total of 31 interviews, representing 22 unique practices; 11 participants declined to participate or did not respond. Smaller practices were less likely than larger ones to respond to initial e-mails. A total of 74% of participants identified as female and 97% as white; 55%

of practices have fewer than 5 clinicians. Additional participant and practice characteristics are described in [Table 1](#). Major themes and subthemes represented 2 broad categories: 1) PCCs perspectives on BH Integration and BHIP and 2) considerations for future implementation. Themes and subthemes are shown in [Figure 2](#) and described in detail below with illustrative quotes, followed by study ID, number of clinicians in the practice, and percentage of patients insured by MassHealth, the Medicaid program in Massachusetts; additional quotes are in [Tables 2a and 2b](#).

### PCCs' PERSPECTIVES ON BH INTEGRATION AND BHIP

Subthemes in this section are related to participants' experiences with BHIP and provide a foundation for how

**Table 1.** Characteristics of Participants and Practices

	n (%)
Participants n = 31	
Years in practice	
5 or less	1 (3%)
6–10	1 (3%)
11–20	13 (42%)
More than 20	16 (52%)
Gender	
Female	23 (74%)
Male	8 (26%)
Race	
White	30 (97%)
Other	1 (3%)
Practices n = 22	
Size (#primary care clinicians)	
5 or less	7 (32%)
6–10	6 (27%)
11–20	9 (41%)
Region	
Metro West	9 (41%)
Western	7 (32%)
Southeast	3 (14%)
Northeast	2 (9%)
Central	1 (4%)
Estimated % Medicaid	
0%–25%	10 (45%)
26%–50%	9 (41%)
51%–75%	2 (9%)
75%–100%	1 (5%)

these experiences could potentially inform future BH integration initiatives in similar settings.

**GENERAL PERCEPTIONS OF BH INTEGRATION IN PEDIATRIC PRIMARY CARE**

Nearly all participants felt that some aspects of BH care “belong” in pediatric primary care. They identified various advantages, such as families’ preexisting relationships with

their PCC, billing efficiencies, reduced stigma, and improved access.

*Behavioral and psychiatric health is physical health... this is primary care. This is part of caring for the whole child. This isn't extra. (8–1; 12 clinicians; 47% MassHealth)*

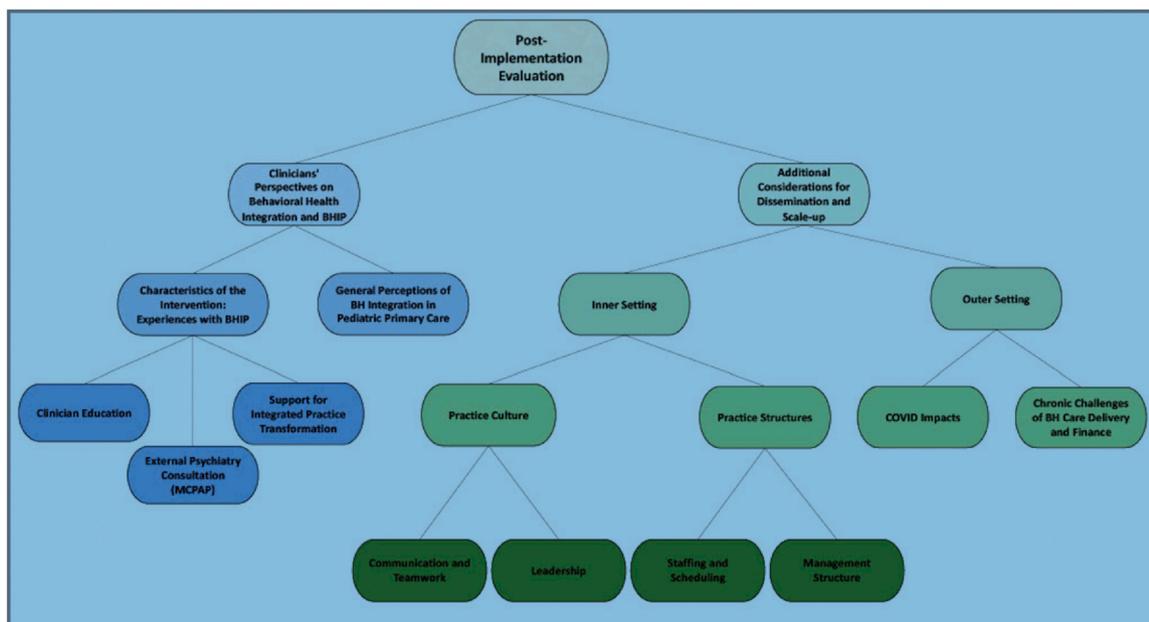
However, some participants also expressed reservations about BH integration, largely related to the appropriate breadth of PCCs’ involvement in BH care and extra burden.

*I'm not sure that it's affected my work-life balance significantly... I mean, it gives me more satisfaction if I can help... that's a plus... It's (also) added stress (9–1; 15 primary care physicians (PCPs); 40% MassHealth)*

**EXPERIENCES WITH BHIP: CHARACTERISTICS OF THE INTERVENTION**

Nearly all participants felt that the 4 elements of BHIP had been useful, and in many cases instrumental, in helping them integrate BH in their practice. Most of the few participants who reported less utility had prior experience with BH integration.

*Clinician education.* Participants who found BHIP’s LC useful felt that they helped to delineate an appropriate scope of BH care, prepared them to assess and treat mild and moderate presentations of common BH disorders, increased comfort in prescribing selective serotonin reuptake inhibitors and using screening tools, and addressed important gaps in pediatric residency training. Many participants preferred an “on-demand” asynchronous format instead of scheduled meetings for convenience. Some participants noted that they would like broader



**Figure 2.** Major themes and associated subthemes. BH indicates behavioral health.

**Table 2a.** Illustrative Quotes—Clinicians Perspectives on Behavioral Health Integration and BHIP

### 1. PCCs' Perspectives on BH Integration and BHIP

#### General Perceptions of BH Integration in Pediatric Primary Care

"We're providing a broader spectrum of care to our patients, which... works for so many reasons. They know us. They're comfortable with us. We're accessible to them. We manage their health insurance billing, and they're not having to pay out of pocket somewhere and then try to get reimbursed... I think there's a whole number of reasons why... (BH) works well in a primary care office." (5-1; 13 PCCs; 9% MassHealth)\*

"When we started... we all realized how much we didn't really know about how helpful... good quality behavioral health care could be.... We were hearing back from people that they all wanted to see our psychologist... There was (patient) buy-in immediately. There was no problem with buy-in from our providers. Now that we've had it, I can't imagine life without it. I can't imagine that somebody's telling me about significant emotional issues in their family that I can't say, Well, I can offer you this." (4-1; 10 PCCs; 23% MassHealth)

"And so, they leave the office with an appointment time, and they leave the office with more than that. They leave the office with hope that, actually, there's going to be some help.... someone cares... I can't tell you how satisfying that's been professionally. For me to know that every time I have an urgent behavioral health problem in my patients or families, I know that we can help them." (2-2; 12 PCCs; 29% MassHealth)

"I'm not sure that it's affected my work-life balance significantly. I mean, it gives me more satisfaction if I can help... that a plus." (9-1; 15 PCCs; 40% MassHealth)

"Every time we've added a behavioral health clinician cost-wise, it's been a moneymaker. And that's not why we took on behavioral health. We felt it was the right thing to do. But lo and behold, it actually contributes money to the bottom line of the practice." (2-2; 12 PCCs; 29% MassHealth)

#### Experiences with BHIP: Characteristics of the Intervention

"We talked about doing this (behavioral health integration) for years before it was available with the (independent pediatric practice network) backing, and we were too nervous to do it... we felt like it would open the floodgates and we wouldn't be able to support it or we wouldn't be able to get reimbursed enough...

But it has proven... to be super helpful. I think it makes all our lives better. It has been moderately successful financially... good enough to know that it's a service that we want to provide, and it's not losing us money." (10-1; 9 PCCs; 61% MassHealth)

"It (initial financial support by BHIP) was very important... I think it made it happen, and I think we would all have been very leery to have brought on the people that we did when we started. But knowing that we had that support, and then finding that..., we could keep this going, and it makes financial sense for us to keep it going, that's great." (21-1; 19 PCCs; 13% MassHealth)

"So, with the mild (behavioral health) issues, we will be able to use our knowledge from the (learning) community education, and with a little bit more complex patients... (they) will be able to use the knowledge of the behavioral health clinician, and with the most complex patient, we have to call the child psych." (20-1; 3 PCCs; 83% MassHealth)

#### Clinician education

"Learning about how to use those (behavioral health) screening forms, I really appreciated that. I do appreciate having the algorithms available to review, just as a reminder how to step up medications, what the exact cut-offs are... It's always great to feel like I have the tools to treat my patients... Just feeling like I have the confidence to do that initial evaluation and start some medications or talk about medications versus no medications..." (11-1; 5 PCPs; 13% MassHealth)

"I think the biggest way that my practice has changed is my comfort level with prescribing SSRIs. I think that really came from the learning community and also the protocols or clinical references that are embedded in Epic have been fantastic." (4-2; 10 PCCs; 23% MassHealth)

"Learning about how to use those (behavioral health) screening forms, I really appreciated that. I do appreciate having the algorithms available to review, just as a reminder how to step up medications, what the exact cut-offs are... It's always great to feel like I have the tools to treat my patients... Just feeling like I have the confidence to do that initial evaluation and start some medications or talk about medications versus no medications..." (11-1; 5 PCCs; 13% MassHealth)

"I think the education of the providers is very important, and... finding ways to keep that up... I guess the big challenge again is moving away from your clinical day. Taking time away from your clinical day to do them (learning communities) is always a challenge. So, on-demand is a great idea for that." (21-1; 19 PCCs; 13% MassHealth)

"I still go back and look at the slides... honestly, before the learning community, I don't think I even knew the names of most of these medicines... I went really from knowing very little and not feeling like it was my responsibility to having really learned a lot." (3-1; 7 PCCs; 22% MassHealth)

"I'm not sure I'm learning anything in particular. It just seems like a review." (15-2; 5 PCCs; 52% MassHealth)

"Yes, (I would like to learn more advanced medication management), I'm also torn because I don't really want to be a psychiatrist." (22-1; 3 PCCs; 17% MassHealth)

**Table 2a.** (Continued)

<i>External psychiatry consultation (MCPAP)</i>	<p>“So, the place where I think it’s failing... is that it can’t get us live psychiatrists for the kids who are really complicated.” (6-1; 6 PCPs; 31% MassHealth)</p> <p>“It’s really nice that virtually always you get a phone call back (from MCPAP) the same day. If there’s a specific medication-related question, I can usually get an answer which is helpful.” (4-1; 10 PCPs; 23% MassHealth)</p> <p>“... If somebody does need a psychiatrist and they agree that that person should be seen, when that works, that’s great.” (4-1; 10 PCCs; 23% MassHealth)</p> <p>I think sometimes it’d be nice to have... the same person (MCPAP clinician) I was going to be talking to. If I have a patient who I’ve called about a month ago, and now I’ve initiated some things and I’m trying to figure out, “Should I be adding something? Should be doing something differently?” I sometimes feel having to re-explain the situation.” (11-1; 5 PCCs; 13% MassHealth)</p> <p>“So, I will call MCPAP for an emergency situation. And they’ll say, ‘Yeah, that sounds terrible’. And maybe that person will get seen 6 weeks later. And maybe at that visit, a recommendation will be made for a different medicine to be tried, but they’re not prescribing that medicine, and they’re referring them back to me and I don’t get a note for a month after that.... And when I need help, I need help. I can’t get it. And it’s frustrating.” (7-1; 8 PCCs; 31% MassHealth)</p> <p>“... their (MCPAP clinician) advice can be helpful but... sometimes I feel like when I’m reaching out to MCPAP, I feel like I’ve done this for a long time and I feel pretty confident and competent... I think when I reach out to them I really, I’m often hoping that they will offer to see that (more complex) patient for me. So maybe my ask is not reasonable.” (3-2; 7 PCCs; 22% MassHealth)</p>
<i>Clinical operation support</i>	<p>“I’m not a behavioral health clinician. I think they (integrated behavioral health clinicians) need people to supervise them and give them feedback. If they have tough cases or things they need to run by people, I think they need that. I think there’s also the logistics of Epic and just how to do things, how to chart, how to bill. I think having people who do their work... (supervise them), I think that’s helpful.” (12-2; 9 PCCs; 57% MassHealth)</p> <p>“I don’t think (internal BH clinician) would have ended up getting hired if we didn’t have the amount of (hiring, contracting, and credentialing) support we have.” (18-1; 2 PCCs; 12% MassHealth)</p> <p>“(Integration Manager) is great. She is always available and is a source of personal as well as professional support with our integrating clinicians... She was immensely involved and essential to our hiring process...” (8-1; 12 PCCs; 47% MassHealth)</p>

BH indicates behavioral health; BHIP, Behavioral Health Integration Program; PCC, primary care clinician; PCP, primary care physician; and SSRI, selective serotonin reuptake inhibitor.

\* Study ID#; # primary care clinicians in practice; % of patients in practice insured by MassHealth.

education about additional disorders and treatments, and which were best suited to the primary care setting. Although some participants would have liked the curriculum to include guidance on providing more advanced BH care, most preferred referring patients with these needs to community-based BH specialists.

*External psychiatry consultation (MCPAP).* Many participants felt that access to psychiatric consultation was an important part of BH integration and that the MCPAP program<sup>22</sup> addressed basic questions about managing common BH disorders well. However, inefficiencies in the referral process, long wait times for in-person evaluations, discontinuity with consultants for follow-up, limitations of the consultation versus direct service model for more severe or complex presentations, and the inability of MCPAP to provide urgent or emergency assessments reduced the utility of MCPAP for some participants. Some PCCs wanted a more continuous relationship with the CAP for their more complicated patients and noted that the model could not replace the need for specialty access.

*Clinical and operational support.* Integration managers were employed by the IPA to provide clinical and operational support for practice BH integration efforts. Familiarity with the integration managers’ role varied across participants. Most participants who were aware of the integration managers’ role found them helpful in tasks such as recruitment and hiring,

clinical support and training of the integrated BHCs, developing billing and clinical workflows, and facilitating partnerships with community-based BHCs. Some participants expressed frustration with the process of credentialing and empanelment of newly hired BHCs and wanted greater flexibility in adapting operational support for individual practice contexts. Interpersonal communication styles influenced satisfaction with operational support for some participants.

*I don’t think (internal BHC) would have ended up getting hired if we didn’t have the amount of (hiring, contracting, and credentialing) support we have.”* (18-1; 2 PCPs; 12% MassHealth)

## CONSIDERATIONS FOR FUTURE IMPLEMENTATION

Subthemes related to future implementation were largely associated with CFIR’s outer and inner setting domains. Characteristics of individuals and process were commented on less frequently and are described within these 2 dominant domains.

### OUTER SETTING (FACTORS EXTERNAL TO THE PRACTICE)

*Chronic challenges of BH care delivery and finance.* Participants universally reported an overwhelming

**Table 2b.** Illustrative Quotes—Considerations for Dissemination and Scale-Up

## 2. Considerations for Future Implementation

### Outer setting

*Chronic challenges of behavioral health care delivery and finance*

“Certainly, it would be nice if we could pay them (community mental health clinicians) better so they can have a job and be there for our patients.” (1-1; PCPs; 24% MassHealth)\*

“I think it’s really just the volume of patients and the lack of community therapists... it’s really about access... it’s the biggest issue.” (5-1; 13 PCPs; 9% MassHealth)

“And you just give people a list of psychiatrists or you’d talk to the therapist... and I feel like what I’m hearing is that you cannot find psychiatric care. Basically, it doesn’t exist.” (17-2; 16 PCPs; 56% MassHealth)

“Part of our model is short-term interventions... and that means that you need to have someone to pass someone off to when they need longer-term interventions.... When there’s not an option or at least there’s a long wait for it; that... (makes it) really hard to maintain your short-term vision... and your ability to then continue to provide care for all your families.” (17-1; 16 PCPs; 56% MassHealth)

“Referring to... a community counselor is kind of a black hole. We don’t necessarily hear anything back... We aren’t getting all that communication that can be so helpful for someone who’s typically doing the medication management.” (18-1; 2 PCPs; 12% MassHealth)

“I think the reimbursement for... community mental health clinicians is pathetic. Certainly, it would be nice if we could pay them better so they can have a job and be there for our patients.” (1-1; PCPs; 24% MassHealth)

“Public versus private health insurance coverage for mental health work is a huge disparity. So, there are times where... our practice is eating a fair amount of the work that we actually do... So I think that on a policy level, I think having insurance companies, both public and private, recognize that mental health care, within the primary care practice, should have parity with payment for physical health.” (8-1; 12 PCPs; 47% MassHealth)

“You don’t always know exactly who gets covered, and you don’t exactly know what the deductible is, you don’t exactly know how much they have to pay before that kicks in. So, you may feel like it’s all ‘covered,’ but you don’t really know. And 1 family has to pony up \$1000, that means a whole lot different than to another family...” (14-2; 22 PCPs; 24% MassHealth)

### COVID impacts

“I think we all feel burnout right now, because of just the volume of patients we’re seeing. That’s not just behavioral health. I think that the level of behavioral health (need) is definitely hard for everybody to manage and then feeling like you can’t (is hard).” (5-1; 13 PCPs; 9% MassHealth)

“So, it’s—it’s really difficult right now, and I think the pandemic has amplified all of these problems. And it has made it much more stressful for providers because we’re seeing so much and we have... even less resources because the... little resources we had (before COVID) are totally booked.” (2-1; 12 PCPs; 29% MassHealth)

### Inner setting

#### Practice structures

*Behavioral health clinician staffing*

“The hiring and paneling is a huge problem. I think it seemed like there were like 20 (IPN) practices that are running ads for behavioral health people right now. Again, there is turnover... It’s very, very hard to replace them.” (4-1; 10 PCPs; 23% MassHealth)

“The hiring and paneling is a huge problem. I think it seemed like there were like 20 (independent pediatric practice network) practices that are running ads for behavioral health people right now. Again, there is turnover... It’s very, very hard to replace them.” (4-1; 10 PCPs; 23% MassHealth)

“One of the biggest challenges and one that we continue to struggle with is the balance between having our clinicians open and available for on-the-fly consults versus having these amazingly talented, exceedingly well-trained humans not being utilized every moment that we can possibly do. So, the on-the-fly work has been a real challenge.” (8-1; 12 PCPs; 47% MassHealth)

“Sometimes it is important to see them on the day when we identify the need, because they may not have time to come back. They may not be willing to come back.” (20-1; 3 PCPs; 83% MassHealth)

### Services offered

“You have to have a (behavioral health) person who is willing to work in the role of an integrated person... people have to have certain willingness to be flexible... if you are a person who needs to focus and stay in a quiet place with beautiful music on while providing services, that’s (primary care pediatric practice) probably not going to be the best place to serve patients. So, an appropriate person... is willing to do quite unpredictable work...” (20-1; 3 PCPs; 83% MassHealth)

“... each of our (behavioral health) clinicians, they may see 300 different people a year... and that’s not what most of them have been trained to do or ever done. And it’s not what all of them feel comfortable doing or satisfied doing. So, that’s actually I think the hardest thing... Most people have never had training in integrated behavioral health.” (9-2; 15 PCPs; 40% MassHealth)

“The outpatient (psychology) model is we’re going to take the first 2 or 3 sessions and get to know each other and do an assessment and build things. And then, we’re going to start to do a care plan.” And we are like, “No they come in, and by the time they walk out the first time, they know how to do some CBT and relaxation skills, right?...” (9-2; 15 PCPs; 40% MassHealth)

Table 2b. (Continued)

Management structures, support staff, and oversight	<p>"I think that our team (behavioral health clinician, medical home care coordinator, practice administrator) is good, and so they get a lot done. And they're not relying necessarily on the (primary care) provider to be involved with a lot of their system processes. They'll share it once they've decided, and I think we're all on board. And... they understand how we operate." (19-1; 5 PCPs; 36% MassHealth)</p> <p>"A lot of this (administrative) work should be done by care coordinators. They could triage. They could talk to the families. They could figure things out. They could help." But that begs the question of, "Yeah, of course, but what about all the other care coordination needs? And where's the priority?" (9-2; 15 PCPs; 40% MassHealth)</p> <p>"Once you get to a certain number of people, having a behavioral health care coordinator makes a big difference... (ours) manages all of that... I think it's harder to give all the nuances to the front desk all the time. "Well, this is an eval, so it needs to be only at this time for this long. These are follow-ups..." (5-1; 13 PCPs; 9% MassHealth)</p> <p>It's felt like the (independent practice network) kept saying, "You... need to do it this way. You need to do a warm handoff." And really, it wasn't what I needed. But I still said, "All right, we'll keep giving it a try..." (15-2; 5 PCPs; 52% MassHealth)</p>
Practice Culture Leadership	<p>"I just think leadership from the top (makes behavioral health integration possible)... they... have seen great value in having a strong behavioral health team... I feel like I've got the dream job some days. I come in, and I have access to all this support. So, I feel very grateful. And I think that comes from initiatives at the top of the practice, where they share the same values... I think that's what brings a strong team to the practice." (14-2; 22 PCPs; 24% MassHealth)</p> <p>"I think a lot of this—this culture, as with everything in a practice, comes from the top down. And I do think (practice owner)... had (a family member affected by a BH disorder)... he wants us to make sure that we're addressing all behavioral health issues as a practice... he's the top of the pyramid here, and if he's telling everybody to do this, everybody's doing it. And so, I think that that's brought a certain level of sensitivity in our practice." (2-1; 12 PCPs; 29% MassHealth)</p>
Communication and teamwork	<p>"I have a way better idea of what's going on (with integrated behavioral health) because I don't get notes from outside clinicians... our note system within EPIC... maintains the... privacy of the therapeutic relationship, but it gives me a goal. Like it gives me a sense of what's going on. I might not have been privy to some information that is integral in making that depression diagnosis." (8-1; 12 PCPs; 47% MassHealth)</p> <p>"Communication with our behavioral health provider... is definitely a big win, I think for the care of the patients, but also just in terms of continuing to... educate ourselves... We've really learned that people... from the behavioral health field have a different way... of setting up boundaries with families, that as pediatricians we don't always do very well... I think we've learned a lot and gained a lot of support from being in this space... integrating it into our medical component of our work as well." (3-2; 7 PCPs; 22% MassHealth)</p> <p>"Before integrating behavioral health into our practice... so much of the burden of having difficult conversations around suicide, substance use, anxiety, depression, PTSD, parenting... was on our shoulders, the onus really was on the primary care provider... so having that behavioral health care specialist there who can take over those conversations... And then just knowing that the care that we're providing together collaboratively is better than the care I could have been able to provide just by myself with my general training." (15-1; 5 PCPs; 52% MassHealth)</p> <p>"And then, if they're (behavioral health clinician) there in floor time, we try and make that be, 'No, we're sitting side by side, and I may be just doing my own regular day of work, but I know you're there and I will pull you in.' So, I think if you talk to them, they would feel they really do have pediatric colleagues. We certainly feel we have behavioral health colleagues. We try not to feel like, 'Well, you're a different department, and so go see the person.' So, it's not cardiology or GI, where they talk, but they're more siloed." (9-2; 15 PCPs; 40% MassHealth)</p> <p>"So, one thing that's unique about our office is that we're physically very small; we only have 4 exam rooms... so... we're communicating constantly... What we have going works for us... I don't think we need... as structured of a (communication) plan because there aren't 10 providers trying to talk to her (behavioral health clinician)..." (18-1; 2 PCPs; 12% MassHealth)</p> <p>"I know and I trust (practice behavioral health clinician)... so I feel like there's less stress on me to be worrying about a kid who I know is being followed by her... I can say, okay I don't have to worry about that kid all night." (18-1; 2 PCPs; 12% MassHealth)</p> <p>"I think making sure that our practice knows that everybody knows that we really couldn't do it without everybody doing their piece. I think culture has been the biggest facilitator for us, and everybody owns a piece of that..." (13-3; 5 PCPs; 19% MassHealth)</p>

BH indicates behavioral health; PCC, primary care clinician; PCP, primary care physician; and PTSD, post traumatic stress disorder.

\* Study ID#; # primary care clinicians in practice; % of patients in practice insured by MassHealth.

demand for BH services and lack of timely access to community-based CAPs and BHCs as longstanding challenges. BH specialist shortages for patients with more complex and severe disorders made it challenging for practices to refer for timely specialty care and many felt compelled to extend treatment to this population. Most participants reported that, even when specialty BH care was available, they were rarely able to communicate with the treating specialist, complicating comanagement.

Many participants felt that low reimbursement rates by insurers for BH services and resultant low pay for BHCs was a major contributor to the shortage of community-based BHCs and services. Variation in what insurance plans covered, subjected to co-pay, and reimbursed were also considered problematic from administrative and patient care perspectives. Advocacy for better reimbursement, particularly for public insurance plans, was felt necessary by some to improve the availability of BH services.

*COVID impacts.* Participants observed that, although pediatric BH care problems predated the COVID-19 pandemic, they had worsened since the pandemic's onset. Many participants felt these twin crises put strain on primary care practice staffing, finances, operational bandwidth, and increased clinician stress and burnout.

#### INNER SETTING (FACTORS INTERNAL TO THE PRACTICE)

##### *Practice structures*

*BHCs staffing.* Many participants experienced difficulties hiring, credentialing, and retaining BHCs with appropriate skills for providing integrated BH services. Scheduling challenges included balancing scheduled individual BH services with the need for urgent access and consultation. Some larger practices with multiple BHCs were able to offer more same-day availability and more choice in clinicians. Financial concerns made offering services that were clinically valued but perceived to have uncertain or inadequate reimbursement (eg, warm hand-offs, prevention) more challenging.

*Services offered.* Although aligned credentialing and contracting through the IPA allowed most patients to see the integrated BHC, insurances differed in which services were covered and how much they were reimbursed. Fiscal sustainability was perceived to be related to insurance mix and choice of service offered; as a result, practices prioritized different BH services and varied in how they delivered them. Some practices focused on delivering therapy for patients with mild to moderate conditions. Others prioritized diagnostic consultations, safety assessments, or group visits for patients with specific disorders (eg, anxiety).

Several participants commented that PCCs do not have a good understanding of what types of BH treatments are most effective for which patients. Some participants felt there was a need to shift BH services from lengthier outpatient therapy models to briefer interventions and to

have same-day access for evaluation and triage of urgent concerns. Some participants felt that most of the integrated BHCs did not bring all the requisite skills to the primary care setting and needed additional training and support. Several practices sought to expand capacity to meet psychiatric needs by hiring advanced-practice psychiatric nurses.

*... each of our (behavioral health) clinicians, they may see 300 different people a year... and that's not what most of them have been trained to do or ever done. And it's not what all of them feel comfortable doing or satisfied doing. (9–2; 15 PCPs; 40% MassHealth)*

*Management structures, support staff, and oversight.* Some participants conceived of the BH “team” as the PCC and BHC only, while others considered all members of the clinical team part of the BH team. Smaller practices tended to have more informal team management, while larger practices often had a core BH team that included a BH champion and representatives from different practice departments who met regularly to address operational issues. Protected time for program development and communication between the PCC and BHC was perceived as a facilitator of BH integration. Practices varied in how they utilized support staff, with some larger programs hiring new staff to optimize efficiency and others utilizing existing, already busy support staff.

Participants discussed the challenges of evaluating and supporting a BHC in the primary care setting. Some felt uncomfortable in this role, feeling that they did not have the necessary skill set. Some noted a higher turnover in practice BHCs compared to PCCs, which they thought might be reflecting a competitive labor market, difficulty finding the right “fit,” and highlighting the need for an effective oversight model. Most participants expressed a belief that BH integration had to be adapted internally to practice contexts.

*If only one way (of integrating BH) is presented, practices will feel they need to do it that way... But I think that different people in different practices need to make it work different ways because different practices are different. (7–1; 8PCPs; 31% MassHealth)*

*Practice culture (underlying set of beliefs, values, and ways of interacting)*

*Leadership.* Formal and informal practice leaders' behaviors were seen by several participants as important to successful BH integration. Examples of facilitative leadership included offering encouragement and demonstrating through personal example that integrating BH care was important and achievable. Making available practice resources such as staffing, space, and time for planning and communication was also perceived as helpful. In some practices, having a PCC with dedicated time to serve as a BH champion was perceived to advance BH program development. Personal experience with pediatric BH conditions was thought to potentially contribute to the prioritization of BH by leaders. A few

participants noted that it was also important to see leaders in the IPA and national leaders prioritize this work.

*Communication and teamwork.* Regular formal and informal communication between PCCs and BHCs and a shared EHR were noted to support team-based BH integration and improve usual care. Communication strategies included messaging through the EHR, regular huddles, and inclusion of BHCs in monthly medical team meetings. Informal communication during the workday was also seen as providing an opportunity for valued interprofessional learning and team development.

## DISCUSSION

This qualitative study is one of the few to describe challenges for BH integration in pediatric primary care, and one of the first to assess integration barriers and facilitators in a large, diverse IPA. Findings include the identification of key factors that may promote or hinder implementation of BH integration programs, including factors that may be unique to large, diverse IPAs.

Several of the current study's findings were consistent with prior studies in smaller settings. Qualitative studies of BH integration in a small number of community health centers serving urban pediatric populations also identified leadership and team organization as facilitators and inadequate staffing, space, provider time, billing, and care coordination challenges as potential barriers.<sup>13,32</sup> Financial challenges and inadequate PCC BH knowledge and skills were identified as barriers and interprofessional communication, collaboration, and leadership as facilitators in a systematic review of pediatric BH integration studies.<sup>10</sup> A recent systematic review assessing the external validity of pediatric BH integration initiatives identified large gaps in the extent to which such initiatives engage all target recipients, identify factors impacting adoption by clinicians, and maintain fidelity to the original conceptualization of the program over time.<sup>33</sup>

Uniquely, the current study highlights the diversity of experiences with BH integration in the context of a multielement initiative intentionally designed to mitigate implementation barriers in a large IPA. Each practice must hire and financially support the BHC, compared to models where a BHC would be an employee of the health system. For smaller practices and practices with a more precarious financial status, the administrative demands and financial risk were more challenging to manage.

Prior studies have suggested that BH integration programs may need to be tailored to patient populations,<sup>34</sup> adding complexity for practices serving diverse patient populations. In this study, wide variation in reimbursements by payor mix made care coordination and financial planning challenging for some practices, with smaller practices potentially having fewer resources to manage these differences. Some practices found BH integration financially advantageous, but it was not clear whether this would be the case without the financial support of the IPA, aligned network contracting, or with different payer mixes. This study also detected differences in the BH

services practices offer, which speaks to potential issues of quality of care identified in other studies.<sup>35</sup> Further research on which integrated BH services are most effective in pediatric primary care settings, how best to prepare both BHCs and PCCs to deliver those services, and the best strategies for implementation of BH integration support programs could increase the delivery of equitable, high-quality BH care. Finally, the strong impact of unmet community BH needs highlights the importance of building strong community linkages and directly addressing how best to address the gap in available BH specialty services.

An estimated 20%–35% of pediatric PCCs experienced burnout prior to the COVID-19.<sup>36</sup> Many participants in the current study felt that BH integration reduced feelings of stress and burnout, consistent with other studies.<sup>13,37</sup> However, a few participants felt that the extension of their scope of practice to BH care increased stress. Future studies should seek to determine the circumstances under which BH integration reduces or increases stress may be warranted so that factors that reduce stress may be incorporated.

This study should be viewed in the context of its strengths and limitations. Other PCCs in the IPA who were not interviewed may have different perspectives than those of the participants. Participants' practices began working with BHIP at different time points and were in different stages of BHIP implementation at the time of the survey, which may have contributed to different perspectives. Participants were practice leaders, whose commitment to BHIP may have differed from other clinicians in their practices and they tended, as is typical for the network, to be female, white, and experienced. This study focused on 1 set of stakeholders; understanding the perspectives of primary care staff, BHCs, insurers, and policymakers will provide an important holistic view of the issue. Practices with different patient populations may also have different perspectives and experiences. Health policies and practices vary across states and additional contextual factors may be identified in different states. This study did not have the capacity to evaluate the cost-benefit of the BHIP program, which would be important to examine to understand the feasibility of future scale-up. The COVID-19 pandemic, with its parallel national BH crisis, generated substantial demands exceeding capacity for both BH and medical services; this context may have increased the magnitude of perceived challenges of integrating BH into pediatric primary care practices.

In conclusion, this study highlighted areas for consideration for the implementation of BH integration programs in large, diverse IPAs. Some inner setting recommendations, including the need to train BHCs in primary care BH services and improve interprofessional collaboration, could likely be implemented and tested more quickly than external setting recommendations relating to structural challenges (eg, capacity, reimbursement, empanelment, credentialing, and enrollment). Consistent with implementation best practices, this

study's findings suggest organizational capacity should be assessed in the target setting prior to implementation of BH integration, including the ability to build a primary care BH workforce, deliver team-based care, create facilitative workflows, and support provider wellness. More broadly, adapting to the state-level contexts of health care finances and delivery will likely be necessary for integrated BH program sustainability. Although programs such as BHIP can make a substantial difference in BH care access for youth, until political action is taken to fully integrate adequately reimbursed BH as part of total health care, BH integration will likely continue to experience substantial challenges in caring for pediatric patients with BH conditions.

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### DECLARATION OF COMPETING INTEREST

None.

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### SUPPLEMENTARY DATA

Supplementary data associated with this article can be found in the online version at [doi:10.1016/j.acap.2023.10.006](https://doi.org/10.1016/j.acap.2023.10.006).

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