Peregrine HEALTH

PEREGRINE INTELLIGENCE

Integrating Behavioral Health and Primary Care for FQHCs

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Introduction: Behavioral Health Gaps in FQHCs

Federally Qualified Health Centers are vital to the health safety net, serving largely low-income, Medicaid-covered, uninsured, and minority patients. Many of these patients face complex psychosocial stressors, poverty, trauma, and homelessness, which drive behavioral health needs. Yet we are in a behavioral health crisis: a growing prevalence of anxiety, depression, and substance use disorders, coupled with severe provider shortages. More than 70% of people with these conditions go untreated, and delays in care can stretch across years.[5]

This crisis plays out in primary care. An FQHC's primary care provider often ends up as the first and sometimes only touchpoint for patients' mental health issues. Traditional primary care visits (often only 15–20 minutes) leave little room for complex psychosocial discussions. Moreover, many FQHCs have at most one psychiatrist on staff, if any. Consequently, PCPs without behavioral health

specialists must manage psychiatric medications and counseling with limited time and training. This dynamic overburdens providers and risks fragmented care (through referrals to outside providers) that patients may never complete.

Integrated care offers a solution: treating behavioral health as a fundamental part of primary care. Instead of isolated referrals, patients receive coordinated services, often on the same day and under one roof, through team-based models. In short, behavioral health is no longer "a primary care problem" but a shared care opportunity. Integrating behavioral health with primary care is one way to address the behavioral health crisis, expanding access and bringing care to patients where they already are.

Benefits of Integrating Care: Outcomes and Access

A strong consensus emerges from research: integrated behavioral health improves outcomes across the board. Studies consistently find that patients treated in integrated settings have better clinical outcomes for depression, anxiety, bipolar disorder, PTSD, and substance use disorders compared to usual care. For example, one analysis of 1,000 underserved patients (bipolar and PTSD) in a telehealth-integrated model found substantial improvements in access to care, symptom reduction, and quality of life.[4] Another review noted that integrated care increases patient and provider satisfaction while avoiding expensive interventions such as emergency visits and hospital stays.[2]

Integrated care also directly addresses health equity. FQHC populations include many patients of color and those in rural areas, groups that often face stigma, transportation hurdles, and provider shortages in accessing specialty mental health. By offering behavioral health services in trusted primary care offices, integrated models reduce these barriers. Rural FQHCs using telepsychiatry as part of a broader integrated program have dramatically expanded specialist access. For example, adding a bilingual telepsychiatrist enables consistent mental health care for Latinx patients who previously mistrusted short-term providers.

Importantly, integration transforms care from reactive to preventive. By screening all patients for depression, anxiety, and substance use, clinics catch issues early. A warm-handoff model, where a patient sees a mental health clinician immediately after the PCP visit, can identify needs on the spot. In one example, FQHCs implementing this model reported reducing barriers leading to improved engagement.[2] When patients have to return another day, with another copay, they may never come back. Integrated teams help keep care continuous, extending the reach of primary care to cover both body and mind.

What Successful Integration Looks Like

Successful FQHC programs share several characteristics:

Team-Based Care Models

The most rigorously supported model is the Collaborative Care Model (CoCM), which embeds a behavioral health care manager and psychiatric consultant into the PCP office. The care team regularly reviews patient panels, adjusting treatment collaboratively. In practice, the care manager delivers brief therapy or coaching, the psychiatrist reviews complex cases, and the PCP oversees comprehensive care. One study found that over 90% of primary care providers in CoCM programs agreed it helped treat depression, and 82% reported overall better patient outcomes.[6]

While CoCM is highly structured, other team-based models like Behavioral Health Integration (BHI) offer greater flexibility while still embracing core principles of integrated care. BHI models may not require regular panel reviews or psychiatric consultation for every patient, but still embed behavioral health providers within the primary care team, promote warm handoffs, and support shared care planning. This makes BHI a practical and scalable option for clinics that may lack the resources to fully implement CoCM. By prioritizing collaboration and co-location, BHI helps expand access, improve continuity, and tailor care to local capacity.

Warm Handoffs and Co-Location

Many FQHCs begin by co-locating behavioral health providers within the primary care clinic. In the Cherokee Model, PCPs introduce patients to a behavioral health clinician during the same visit.[2] This reduces drop-off by engaging patients when they are already present for care. Clinics report nearly universal follow-through for same-day warm handoffs, whereas off-site referrals often go unfilled. Full integration happens when teams share treatment plans, progress notes, and population tracking.

Shared Care Plans and Data Systems

Integrated teams need infrastructure to function. Effective FQHCs maintain shared EHRs and registries to track depression scores (like PHQ-9) and medical comorbidities. Care managers monitor patient panels and flag missed appointments. By regularly measuring outcomes teams make data-driven adjustments.

Focus on High-Need Conditions

Most FQHCs begin integration by targeting conditions with high prevalence and proven models: depression, anxiety, and substance use disorders. CoCM and BHI are well-validated for these. Still, integrated principles also apply to other conditions, like PTSD or early-phase psychosis, especially when PCPs can access backup via telehealth. The goal is not to replace psychiatric specialists, but to extend their reach where they are most needed.

In summary, successful integration in an FQHC includes embedded behavioral health clinicians, coordinated same-day workflows, shared electronic systems, and regular case reviews. It is not a plug-in service, but a transformation in how primary care is delivered.

Implementation Strategies and Solutions

Leadership and Change Management

Integration efforts thrive when clinical and executive leadership actively support them. Champions within the organization help navigate change management, train staff, and ensure alignment of operations. Commitment from the top (e.g. reflected in budget, training time, and staffing) demonstrates that behavioral health is a core part of whole-person care.

Staff Training and Roles

Primary care staff need support to confidently take on behavioral health responsibilities. Successful clinics provide targeted training in brief behavioral interventions (such as motivational interviewing or behavioral activation) and integrated workflows. Many use case consultations with off-site specialists so PCPs can manage more complex cases with confidence. Training must be continuous as teams expand.

Workflow Design

Effective integration depends on thoughtful design. Clinics must reserve time for warm handoffs and structure their schedules so that behavioral health clinicians are available when needed. Space constraints may require some creativity. For example, rotating BH consults into exam rooms or shared areas. The aim is to ensure the patient's journey is seamless from PCP to behavioral health provider.

Use of Telehealth and Technology

Telehealth expands access in areas with few behavioral health specialists. FQHCs across the country have used telepsychiatry to serve rural and underserved patients through partnerships. These collaborations maintain quality while reducing wait times. In addition to telehealth, EHR tools prompt screening, auto-refer patients, and help track progress.

Financing and Billing

Billing models must support sustainability. Since 2017, Medicare and some Medicaid plans have allowed FQHCs to bill for the Collaborative Care Model. These codes support care management and psychiatric consultation, providing a revenue stream for integration. Clinics need to understand documentation and coding to fully utilize these opportunities. In addition, HRSA and other grants can provide startup funding for infrastructure and training.

Systemic Impact

The benefits of integration go beyond individual encounters. By treating depression and anxiety alongside diabetes, hypertension, or asthma, clinics see improvements in overall health. Integrated behavioral health promotes adherence, reduces complications, and improves self-management. Financially, this reduces costly events like hospitalizations or ER visits.

Integrated programs also prepare clinics for value-based care. As more payers hold providers accountable for total cost and outcomes, FQHCs with integrated teams are better positioned to succeed. They meet key quality metrics, lower utilization, and provide comprehensive care that resonates with both patients and policymakers.

Finally, integrated care models maximize limited psychiatric resources. Rather than one psychiatrist seeing 20 patients a day, a team-based model allows one psychiatrist to consult dozens of patients through care managers. This multiplier effect is especially important in areas with workforce shortages.

Conclusion

FQHCs are already shouldering much of the behavioral health crisis. Integrated care offers a roadmap for relief and improvement. The evidence is clear: well-implemented models enhance care quality, access, and satisfaction. Integration requires vision, teamwork, data systems, and financing,

but the result is stronger, more efficient, and more compassionate care. For leaders committed to community well-being, this is not just a program, it is a path toward transformation.

Why This Matters to Peregrine

At Peregrine, our mission is to empower community health centers in delivering high-quality care to underserved populations. Understanding and sharing best practices in integrated care is fundamental to that mission. This research highlights the strategies that allow FQHCs to care holistically for patients' physical and behavioral needs. In supporting integrated models, Peregrine reinforces its commitment to evidence-based solutions and whole-patient care. By helping FQHCs bridge the gap between mental and physical health, we contribute to stronger health centers and healthier communities.

Discover more actionable insights for FQHC leaders at
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