

Barbara Cubic  
Ruben Tinajero

Advances in Psychotherapy –  
Evidence-Based Practice

# Integrated Primary Care



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# Integrated Primary Care

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**Barbara Cubic**, PhD, has been recognized as a trailblazer for integrated primary care. She has spent her career advocating for psychologists to work in primary care settings and has trained and mentored hundreds of other professionals to do so. In 2010, she was awarded the PSYCHE prize by the American Psychological Foundation for her work in integrated primary care. She has also been awarded the Outstanding Contributions to Clinical Health Psychology award from the Society of Health Psychology of the American Psychological Association in 2014 and the Ivan Mensch Award for Distinguished Achievement in Teaching by the Association of Psychologist in Academic Health Centers in 2017.

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Advances in Psychotherapy – Evidence-Based Practice, Volume 57

# Integrated Primary Care

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**Library of Congress Cataloging in Publication** information for the print version of this book is available via the Library of Congress Marc Database under the Library of Congress Control Number 2026931560

**Library and Archives Canada Cataloguing in Publication**

Title: Integrated primary care / Barbara Cubic, Ruben Tinajero, Department of Family Medicine, West Virginia University School of Medicine, Morgantown, WV.

Names: Cubic, Barbara, author. | Tinajero, Ruben author.

Series: Advances in psychotherapy--evidence-based practice ; v. 57.

Description: Series statement: Advances in psychotherapy---evidence-based practice ; volume 57 | Includes bibliographical references.

Identifiers: Canadiana (print) 20250311941 | Canadiana (ebook) 20250315890 | ISBN 9780889376106 (softcover) | ISBN 9781616766108 (PDF) | ISBN 9781613346105 (EPUB)

Subjects: LCSH: Clinical health psychology. | LCSH: Mental health services. | LCSH: Integrated delivery of health care. | LCSH: Primary care (Medicine)

Classification: LCC R726.7 .C83 2026 | DDC 616.001/9—dc23

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EUROPE: Hogrefe Publishing GmbH, Merkelstr. 3, 37085 Göttingen, Germany

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EUROPE: Hogrefe Publishing, Merkelstr. 3, 37085 Göttingen, Germany

Phone +49 551 99950 0, Fax +49 551 99950 111; E-mail [publishing@hogrefe.com](mailto:publishing@hogrefe.com)

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SWITZERLAND: Hogrefe Publishing, Länggass-Strasse 76, 3012 Bern

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Format: PDF

ISBN 978-0-88937-610-6 (print) • ISBN 978-1-61676-610-8 (PDF) • ISBN 978-1-61334-610-5 (EPUB)

<https://doi.org/10.1027/00610-000>

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# Acknowledgments

Our experiences in primary care have strengthened us both personally and professionally. We would like to thank our patients, their families, and the many providers we have had the pleasure of working with in primary care. We would also like to thank our many psychology mentors and the psychology trainees who have trusted us to teach them to operate effectively as psychologists in primary care settings.

Barbara would also like to thank her husband, Bill Adams, and her two beautiful daughters, Sarah and Emily, who inspire her daily to be a better person and psychologist. She would like to thank her sister, Susan Supinger, for always being her biggest cheerleader. And, most of all, she would like to thank her father, Ray May, and paternal grandmother, Hancie May, for teaching her the value of education and the importance of being a caring and compassionate person. She also wants to acknowledge the impact her mentors had on her personal and professional life – most notably, Danny Wedding, Don Williamson, and Judy Beck.

Ruben would like to thank his parents, Ruben C. Tinajero and Hilda A. Tinajero, for a lifetime of love and support. He would also like to thank his wonderful wife, Amber, and beautiful daughter, Lila, who have served as sources of motivation for him each day. He wants, as well, to extend his gratitude to his mentors Paula G. Williams, Katherine T. Fortenberry, Timothy W. Smith, and Annette L. Stanton. Lastly, he would like to thank his late aunt, Alma Rosa Arroyo Navarro, who inspired him to achieve his academic dreams.



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# Description

## 1.1 Terminology and Definitions

*Primary care* (PC) is defined as “the provision of *integrated, accessible* health care services by clinicians who are *accountable* for addressing a large majority of personal health care needs, developing a *sustained* partnership with patients, and practicing in the context of *family and community*” (Institute of Medicine, Committee on the Future of Primary Care, 1994). Typically, PC providers are from the disciplines of family medicine, internal medicine, pediatrics, and sometimes obstetrics and gynecology, as these specialties provide care that is preventative, for acute or chronic conditions, across the spectrum of clinical presentations. These specialties also assist patients in the coordination of referrals as needed, often utilize team-based care models, and have continuous relationships with their patients, at times from birth through end of life. PC practices are embedded in communities and integrally connected with community resources. *Primary care providers* (PCPs) provide services in a variety of health care settings including hospitals, outpatient clinics, critical care settings, long-term facilities, and within patients’ homes. In addition to the provision of medical services, PC settings are the most common locations for the provision of behavioral health care. However, PCPs often report being ill-prepared to deal with the behavioral health needs of their patients, and describe this as a point of stress for their practices. In fact, PCPs write prescriptions for psychotropic medications more frequently than any other medical discipline, including psychiatry (Hughes et al., 2024). Because PC is the setting where most patients receive their behavioral health services, it has often been called the de facto mental health system in the United States (Cummings et al., 2001). Patients seen in PC settings for behavioral health needs rarely follow up with specialty mental health providers, despite frequent referrals to do so, which many speculate is due to the stigma associated with obtaining care for mental health needs (Ahad et al., 2023). When surveyed, most patients have reported that they would prefer to receive their behavioral health services in a PC setting because of convenience, lack of stigma, and coordination of care between their PCP and their *behavioral health provider* (BHP; Lang, 2005). The importance of this issue is underscored by the fact that data clearly show that behavioral health issues exacerbate physical health problems and vice versa.

Numerous medical professions are employed within PC settings. In this book, the term “PCP” refers to PC attending physicians, residents, and other

**Primary care is generally the first point of care for most individuals utilizing health care**

**Primary care providers come from a variety of medical specialties**

model for more severe mental illnesses or for those who have not responded to PCBH. PC-MHI integrates best aspects of both models.

## 2.2.1 Primary Care Behavioral Health

In the PCBH model, the BHP does not limit their health care service delivery to only mental health and substance abuse issues; instead, they often treat common health conditions such as pain, obesity, and insomnia. All services provided are evidence-based, and close coordination with the PCP is a necessity. Patients do not begin and end a course of treatment, rather they come in and out of treatment as needed for whatever number of sessions is required. Oftentimes the PCBH provider may only see the patient for one session following a warm handoff. When additional sessions do occur, most often six to eight sessions are considered normative at any given time.

As a result, PCBH attempts to be simultaneously integrated, collaborative, and colocated. Some clinics using a PCBH model are largely integrated, with limited time for colocated therapy sessions, whereas others are largely colocated, with limited time for integrated care. The time allocated to colocation and integration will generally be determined by the number of BHPs within a practice or the needs of a practice. For example, if a PC practice struggles to be able to refer to specialty mental health providers because of a lack of access, the practice may rely more on their BHPs for colocated services than would a practice that has ready access to specialty mental health and, therefore, can utilize their BHPs more for integrated care.

An advantage of the PCBH model is that it can lead to the early identification of factors contributing to chronic diseases and possibly mitigate those factors through interventions such as motivational interviewing and cognitive behavioral techniques (to be discussed in Chapter 4: Treatment). The model has also been shown to improve access to behavioral health services, relationships between providers and their patients, and satisfaction with the health care system, for both patients and their providers (Koehler et al., 2020).

The diversity of the clinical activities that PCBH providers engage in has made it challenging to find empirical evidence for its effectiveness. Therefore, the research behind PCBH that does exist is still advancing, but it is noteworthy that it is already solid. Hunter and colleagues (2018) have provided a qualitative review of published research on PCBH, supporting the utility of the model in terms of increasing patient access to providers, patient satisfaction, provider satisfaction, and positive clinical outcomes.

**PCBH is considered a generalist model that embeds a BHP within a PC practice to provide warm handoffs, assessments, consultations, and brief interventions**

## 2.2.2 Collaborative Care Model (CoCM)

In contrast to the PCBH model, the CoCM is focused primarily on mental health concerns, most notably those that are chronic, such as persistent depression, severe anxiety disorders, bipolar disorder, schizophrenia, and

**The CoCM model focuses on chronic mental health concerns**

and patient identify an agreed-upon point of change. In the *assess* phase, the clinician will utilize motivational interviewing to determine the patient's willingness for change. Goal setting is the primary task for the *assist* phase, and the *arrange* phase is focused on follow-up. Many BHPs are trained to utilize the 5As model to direct their IPC sessions.

### 3.4 Stepped Care

Stepped care is a model for providing care within PC that focuses on the most effective treatments using the fewest resources. If medical situations can be handled at the PC level, then they are. Specialty care is only utilized when PC cannot sufficiently address the needs of the patient. In other words, a hierarchy of care is used that goes from the least to the most intensive care required. For IPC, this would mean that the PCP would address most behavioral health issues, if possible, then a BHP within IPC would be brought in as needed, and then a referral to specialty mental health care would occur only if required.

**Stepped care in primary care delivers effective treatment with minimal resources**

### 3.5 Treat Versus Refer (Serving as a Bridge)

While the diversity of clinical presentations in PC is vast, PC is not the proper place to address all behavioral health issues that patients experience. Conditions that can generally be managed in PC include depressive disorders, anxiety disorders, trauma-related disorders, eating disorders, ADHD, pain, sleep disorders, substance abuse disorders, and somatic disorders, as long as they are mild or moderate in severity. More severe occurrences will be best addressed by specialty mental health services. Psychotic disorders, bipolar disorders, autism, and severe substance abuse disorders, ideally, will not be managed in PC.

Regularly, BHPs in IPC are tasked with making a decision about whether a patient's behavioral health issues can be managed in PC or need to be managed in a specialty mental health setting. However, even though it may be clear that a patient needs more services than can be offered in PC, as many traditional behavioral health settings and providers have long waitlists, and some patients will not agree to seek behavioral health services outside of PC.

Subsequently, IPC BHPs need to create a bridge to more extensive behavioral health care. This bridge may involve more frequent encounters in the IPC setting, longer encounters in the IPC setting, integration of additional resources (e.g., support groups, apps, books), and closer coordination of care with the PCP. For patients reluctant to be seen in specialty mental health settings, the bridge may also include motivational interviewing and psychoeducation to reduce the stigma the patient may fear they will experience if they seek more specific behavioral health treatment.

# 4

## Treatment

### 4.1 Methods of Treatment

A key feature of IPC is the administration of *warm handoffs*. Warm handoffs refer to brief encounters (approximately 10 to 15 minutes) between BHPs and patients that aim to “bridge” the patient into receiving appropriate behavioral health treatment. PCPs identify patients who are appropriate for a warm handoff during clinic encounters. Having BHPs present in nursing and attending physician areas of a clinic can facilitate warm handoffs because they are able to hear discussions amongst providers that can highlight patients that may be appropriate for a warm handoff. Additionally, BHPs that are present in these clinic areas for a designated period of time (e.g., afternoon from 1:00 p.m. to 5:00 p.m.) can spend time reviewing provider’s schedules for appropriate warm handoffs. This process is called scrubbing. Consultation with the referring PCP before a warm handoff gives the BHP a general sense of what concerns may be discussed with a patient and whether the referring provider may want to see the patient again once the warm handoff is completed. It is important for BHPs to be aware of how much time may be used in a clinic room for a warm handoff given the common problem of limited clinic rooms in PC settings. Having a designated room for warm handoffs that require more than 15 minutes (typically the office of a BHP) helps facilitate the workflows of referring providers.

Warm handoffs that are completed by BHPs involve targeted assessments and interventions for a wide range of physical and mental health concerns including depression, anxiety, interpersonal problems (e.g., marital problems), suicide risk, medication adherence, and lifestyle changes such as weight management. Other concerns that may be addressed in a warm handoff include issues related to lack of access to fundamental resources such as housing, air conditioning or heat, winter clothing, or food. Accordingly, BHPs benefit from having knowledge of resources in their clinic and community that can help address these concerns. Furthermore, having clinic policies and procedures for addressing suicidality and homicidal concerns can facilitate warm handoffs in cases in which patients endorse suicidal and/or homicidal ideations, plans, or active intent in the clinic. BHPs are typically involved in numerous activities including individual outpatient care, teaching, or research activities, and thus having a procedure in place to locate BHPs when a warm handoff is deemed appropriate can improve the completion of warm handoffs in a clinic. Patients may also benefit from being referred directly

**BHPs frequently review the schedules of providers for patients who may benefit from a warm handoff**

work have each created curricula that can be utilized by faculty in graduate programs to introduce IPC to trainees and teach them the fundamental principles associated with working in PC settings. Below we discuss an example of one of these curricula.

The American Psychological Association's Society for Health Psychology's Committee on Integrated Primary Care developed a training curriculum (Ward-Zimmerman et al., 2017), which was supported by research on training (Stillman et al., 2018) and can be used by graduate programs to train on IPC. The curriculum titled, *Integrated Primary Care Psychology: An Introductory Curriculum*, was designed primarily to provide trainees with foundational skills for IPC. The comprehensive *plug and play* design of the curriculum was created by nine psychologists with extensive experience and backgrounds in IPC. The curriculum is comprised of four foundational modules (available in a 90-minute or 120-minute version) as well as 18 topic modules (90-minute version). The four foundational modules focus on the basics of understanding the competencies required for working effectively in IPC. These are listed in Table 1. The modules use illustrations, videos, interactive exercises, and the latest empirical support to cover topics including the role of psychology in PC, PC patient needs, common health concerns in a PC setting, and the application of clinical skills in PC. Table 2 lists and describes the 18 specialized topic modules that focus on common mental health issues seen in PC, including depression, anxiety, trauma, substance abuse, and chronic pain.

**Table 1**

Four Foundational Modules From the Integrated Primary Care Psychology: An Introductory Curriculum

Foundational modules		Topics covered
Module 1	Introduction to integrated primary care	Defines the field, identifies key factors leading to integration, and discerns the role of the traditional mental health provider to the role of the psychologist in primary care
Module 2	Across the continuum: Psychology's role in IPC	Discusses the range of patient needs presented in primary care
Module 3	Primary care patients: Who are they and how can psychologists be helpful?	Describes common patient behavioral health concerns in primary care
Module 4	IPC interventions	Identifies the clinical skills associated with providing interventions suited for primary care

Note. IPC = integrated primary care. Adapted from Ward-Zimmerman, et al., 2017.

# 8

## Appendix: Tools and Resources

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Appendix 1: Safety Plan

Appendix 2: Sample of Resources With Worksheets and Handouts  
for Patients

Appendix 3: Sample of App Resources



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To make sure you have permanent direct access to all the materials, we recommend that you download them and save them on your computer.

## Appendix 2: Sample of Resources With Worksheets and Handouts for Patients

This is a **preview** of the content that is available in the downloadable material of this book. Please see p.78 for instructions on how to obtain the full-sized, printable PDF.

### Depression

*Mind over mood: Change how you feel by changing the way you think* (2nd ed.).  
By Dennis Greenberger and Christine A. Padesky.

### Mood Regulation

*DBT skills training: Handouts and worksheets*.  
By Marsha M. Linehan.

### Trauma

*Cognitive processing therapy for PTSD: A comprehensive manual* (1st ed.).  
By Patricia Resick, Candice Monson, and Kathleen Chard.

*Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences, therapist guide* (2nd ed.).  
By Edna Foa, Elizabeth A. Hembree, Barbara Olasov Rothbaum, and Sheila Rauch.

### Anxiety

*Mastery of your anxiety and panic: Workbook for primary care settings*.  
By Michelle G. Craske and David H. Barlow.

### Insomnia

*Cognitive behavioral treatment of insomnia: A session-by-session guide*.  
By Michael L. Perlis, Carla Benson-Jungquist, Michael T. Smith, and Donn A. Posner.  
Sleep diary PDF: <https://www.uclahealth.org/sites/default/files/documents/sleepdiary.pdf>

### Meditation Resources (Websites, Applications)

<https://www.insighttimer.com/>: This website/application offers a large collection of free guided meditations and resources including blogs and videos for common mental health problems. Users of insighttimer have access to meditations that are designed to help with several areas including sleep and stress/anxiety reduction.

YouTube: Jon Kabat-Zinn meditation recordings

Dartmouth Student Wellness Center: Recordings for deep-breathing, meditation, progressive muscle relaxation. <https://students.dartmouth.edu/wellness-center/wellness-mindfulness/mindfulness-meditation/guided-recordings/mindfulness-meditation>

### Assertive Communication

*Your perfect right: Assertiveness and equality in your life and relationships* (10th ed.).  
By Robert Alberti and Michael Emmons.

# Peer Commentaries

*Cubic and Tinajero deliver a pragmatic, experience-rich, and engaging guide to thriving as a behavioral health provider in integrated primary care. With clear “how-to” strategies and compassionate, evidence-based insights, they bring to life the real-world challenges and deep rewards of collaborative healthcare. A must-read for clinicians and graduate students eager to pursue impactful and fulfilling careers in integrated care.*

**Barbara Ward-Zimmerman, PhD**, Past President, Society for Health Psychology (American Psychological Association, Division 38)

*This is a concise and articulate discussion of integrated primary care that links theory with pragmatic application. A must have for psychologists interested in implementing this approach. Also, a marvelous resource for engaging trainees and sparking interest in integrated care models. Ultimate beneficiaries of Drs. Cubic’s and Tinajero’s work will be the myriad of patients and caregivers whose health will be promoted as a result.*

**Daniel Bluestein, MD, MS, CMD-R, AGSF-R**, Professor Emeritus, Department of Family & Community Medicine, Eastern Virginia Medical School, Norfolk, VA

*Thank you to Cubic and Tinajero for providing us with a brief, practical, and accessible description of the richness that is integrated primary care, an approach that increases access for the many patients with biopsychosocial health issues and allows us to provide care we cannot when working in silos. The authors capture the excitement involved in bringing together primary care and behavioral health professionals to team with patients and families in providing whole person, family-oriented care that is sensitive to community and cultural values. While brief, the book is comprehensive and provides a great overview for new students to the field while summarizing it for someone who is deeply embedded in it.*

**Susan McDaniel, PhD, Dr. Laurie Sands Distinguished Professor of Families & Health**, Departments of Psychiatry and Family Medicine, University of Rochester Medical Center, Rochester, NY

*This concise book will help behavioral health professionals understand the context of primary care and develop integrated behavioral health competencies related to evidence-based clinical care, clinical consultation, and practice improvement. The book helps to fill a void in resources to prepare behavioral health professionals for evolving roles in primary care.*

**Nancy Ruddy, PhD**, Affiliate Faculty, Department of Psychology, University of Maine, Orono, ME