ORIGINAL RESEARCH

Strategies for Implementing Integrated Behavioral Health into Health Centers

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Background: **Integrated behavioral health (IBH) is a promising approach which embeds behavioral health services into primary care. Yet, IBH has had limited implementation. Our objective was to identify strategies to successfully implement the "Cherokee" IBH model by examining a 2013 to 2019 IBH demonstration project in New Jersey that included Federally Qualified Health Centers (FQHCs) and Community Health Centers (CHCs).**

Methods: **We conducted qualitative semistructured interviews of 18 primary care and behavioral health clinicians from 10 FQHCs/CHCs in 2022. Interview guide questions drew on the Proctor Implementation Outcomes Framework to capture strategies to optimize acceptability, appropriateness, feasibility, fidelity, penetration, and sustainability of IBH implementations. A template approach was used to code data and identify themes.**

Results: **All participating FQHCs/CHCs were still offering IBH services 3 years after the demonstration project, suggesting that strategies were successful in implementing and sustaining IBH. Strategies these FQHCs/CHCs employed included: (1) select champions with experience leading organizational change; (2) provide training that emphasizes how brief behavioral health interventions differ from traditional therapy; (3) develop on-going IBH training procedures for new staff; (4) create physical spaces for behavioral health consultants; (5) establish scheduling systems; and (6) identify local IBH billing codes, policies, and procedures.**

Discussion: **Change management approaches can help in the implementation of IBH; however, additional strategies unique to IBH may be needed to address the attitudinal, organizational, and financial challenges inherent to IBH.**

Conclusion: **Future implementations should apply multi-faceted approaches that address persistent and seemingly intractable barriers that have inhibited IBH integration. (J Am Board Fam Med 2024;37:833–846.)**

Keywords: **Change Management, Community Health Centers, Implementation Science, Integrated Behavioral Health, Integrated Delivery Systems, Mental Health Services, New Jersey, Primary Health Care, Qualitative Research**

Introduction

Integrated behavioral health (IBH) is holistic care delivery which embeds behavioral health and substance use treatment services into primary care.[1] IBH has been shown to reduce health care costs,[2–5] increase patient and provider satisfaction,[3–10] and improve multiple behavioral and physical health outcomes[3–5,7–9,11–15] by facilitating treatment plans that address the interaction between behavioral health and chronic conditions, decreasing mental health stigma, and streamlining access to care. A leading IBH model in the US is the Cherokee Model.[16] Developed by Cherokee Health Systems, the model emphasizes interdisciplinary patient teams, coordinated care through data sharing between primary care

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and behavioral health, and the integration of Behavioral Health Consultants (BHCs) into primary care teams to address mental health concerns as part of the routine visit. BHCs follow the conventional primary care workflow, offering flexible appointment options to see patients independently or concurrently with primary care clinicians. Altogether, the model enables rapid diagnoses, interventions, and follow-up to address potential adherence barriers and motivate patients. An important component of the Model is extensive upfront and on-going training; Cherokee Health Systems offers specialized training to support organizations implementing IBH.[16]

The Cherokee Model was central to an IBH demonstration project in New Jersey. From 2013 to 2019, The Nicholson Foundation funded eleven New Jersey-based Federally Qualified Health Centers (FQHCs) and Community Health Centers (CHCs) to implement IBH using the Cherokee Model. Each site received $225,000 over a 15-month period,[17] designed to support a full-time BHC and additional staff time (eg, physicians, nurse practitioners) to work as an integrated team. Cherokee Health Systems provided training and technical assistance, which included an assessment for specific site needs; advice on necessary implementation components, such as workforce, policies, and procedures; and on-going practical guidance. In addition, sites received access to an IBH billing expert.[18] Three years have passed since the project concluded, providing a unique opportunity for researchers to examine strategies to successfully implement IBH into health centers.

While many studies have reported on the effectiveness of IBH models, few have reported on its implementation into health centers, and none have identified specific strategies needed to effectively implement IBH.[19] IBH implementation in real-world settings is highly variable due to a multitude of organizational, attitudinal, and financial challenges.[20–28] It is vital to identify IBH implementation strategies to mitigate these challenges, as poor or incomplete implementation has been shown to contribute to poor integration of health services, inappropriate variation in clinical care, delayed follow-up, treatment drop-out, and insufficient improvement in symptoms.[20,23,24] The objective of this study was to identify strategies to successfully implement IBH into health centers by examining the IBH demonstration project in New Jersey.

Methods

Design and Study Setting

In this qualitative study, we conducted semistructured, in-depth interviews to identify implementation strategies that were used to successfully implement the IBH model into health centers. Our approach is guided by Proctor's Implementation Outcomes Framework,[29] a seminal framework developed for implementation science research in mental health settings. Proctor et al. define implementation outcomes using 8 domains: acceptability, appropriateness, feasibility, fidelity, penetration, sustainability, cost, and adoption. The cost and adoption domains were not used in our study, as neither varied across sites; cost was covered by the grant and adoption was demonstrated by all having applied for the grant. See Table 1 for domain definitions.

The study setting is a demonstration project in New Jersey funded by The Nicholson Foundation from 2013 to 2019, which provided support to eleven FQHCs and CHCs to implement the Cherokee IBH Model. As part of this demonstration project, licensed clinical social workers (LCSWs) were hired into the BHC role at all participating sites; in New Jersey, LCSWs are eligible to provide and bill for IBH services.[22] Details on the demonstration project are provided elsewhere.[30] Our study was approved by the Rutgers University and Henry J. Austin Health Center Institutional Review Boards.

Sample

To recruit participants, we used critical case sampling to recruit 1 to 2 participants from each clinic.[31] First, we obtained a list of grantees from The Nicholson Foundation, which included a point of contact for the 11 participating FQHCs/CHCs. We emailed each point of contact to request interviews with up to 2 individuals meeting the following criteria: (1) had an active role in the IBH implementation or is very knowledgeable about its implementation; and (2) is either a primary care or behavioral health clinician. Ten clinic contacts responded with names of eligible key informants; 1 was nonresponsive. We ultimately enrolled 18 participants out of the 22 names provided (81.8% participation rate) representing 10 FQHCs/CHCs,

Table 1. Definition of Proctor's Implementation Outcomes Framework Adapted to the Study's Demonstration Project

Domain	Definition
Acceptability	Perception among implementation stakeholders whether the Cherokee Model was agreeable, palatable, or satisfactory.
Adoption	Intention, initial decision, or action to employ the Cherokee Model.
Appropriateness	Perceived fit, relevance, or compatibility of the Cherokee Model for the health center, including the staff and patients.
Cost	Financial impact of an implementation effort.
Feasibility	Extent (e.g., low, medium, high) to which the Cherokee Model can be successfully carried out given resources.
Fidelity	Extent to which the Cherokee Model can be implemented as it was intended by the Model developers.
Penetration	Integration of the Cherokee Model into the health center and its subsystems.
Sustainability	Extent to which the Cherokee Model is maintained or institutionalized within the health center's ongoing, stable operations.

Note: Adoption and Cost domains were not included in the study.

thus comfortably reaching thematic saturation.[32] All participants provided informed consent. No incentives were provided.

Data Collection

Individual, semistructured, in-depth interviews were conducted between June 2022 and September 2022 virtually via Zoom®. Interviews were conducted by 1 to 2 trained interviewers (AMN, RAK), 45 to 60 minutes long, and audio-recorded. Interview guide questions drew on Proctor's Implementation Outcomes Framework.[29] The interview guide (Appendix A) also included questions on participant demographics (gender, ethnicity, race, and years working at current organization).

Data Management

Audio recordings and interview notes were saved in a secure server. Recordings were transcribed using the Zoom® and Temi® professional transcription services. A team member (CV) reviewed transcripts for accuracy, deidentification, and imported them into NVivo Pro® qualitative software[33] for coding and analysis.

Data Analysis

After each interview, the study team met to debrief, adjust interview questions as needed, and assess data saturation. We found no new major themes after the 14th participant, suggesting saturation was reached.[31] We continued interviewing up to 18 to attain participation from all 10 sites that responded. After all interviews were completed, the team met to create the codebook, drawing from Proctor's Implementation Outcomes Framework to inform the initial coding schema.[29]

Using the template approach,[34] 2 study team members, a research analyst (CV) and a public health graduate student (TM) experienced in qualitative data analysis, used NVivo Pro® to code the transcripts using the codebook (deductive approach). To assess inter-rater reliability, the 2 team members coded 3 of the same transcripts separately and discussed discrepancies until consensus was reached. Questions were resolved in weekly team meetings. The team reviewed the resulting themes and revisited transcripts to identify illustrative quotes.

Results

All participating FQHCs/CHCs were still offering IBH services at the time of the interview, suggesting that strategies were successful not only in implementing IBH into primary care but also in enabling the health centers to sustain IBH beyond the demonstration project. Participants shared 6 specific strategies used to increase acceptability, appropriateness, feasibility, fidelity, penetration, and sustainability of the Cherokee IBH model implementation, described below. A table of the strategies with examples in practice is provided in Appendix B. The strategies complemented a deep appreciation for the value of IBH, exemplified by the quote:

> *"When we started screening patients for depression and insomnia, that helped us realize that a lot of patients have these symptoms. It's just that they don't*

bring it up unless specifically asked. [Integrated behavioral health] helps us know how to talk to them and get them the services they need much more efficiently. It helps patients with uncontrolled diabetes or hypertension or other medical problems help us identify barriers to care." (Primary Care Clinician – Internal Medicine, FQHC2)

Characteristics of the 18 participants are shown in Table 2. Participants represented primary care and behavioral health clinicians from 10 FQHCs/CHCs that implemented the Cherokee IBH model. The IBH programs ranged in size, with 1 reporting 1.5 FTE behavioral health clinicians at the time of the interview and another reporting access to 31 FTEs across its affiliated health system.

Acceptability: Select Champions with Experience Leading Organizational Change

IBH implementations benefited from champions who had experience leading organizational change initiatives. Champions can be primary care clinicians, behavioral health providers, or administrators who work closely with leadership to lead the charge on IBH. Participants emphasized that IBH implementation is complex, requiring new staff roles, billing practices, and culture transformation, which meant that champions needed to achieve a mindset shift from every member of the staff, including the nonclinical:

"There was a very steep learning curve that I did not expect. You have to provide face-to-face training with all the physicians, one on one, and also in group settings. . . Patients also see our front desk people, security people, and registration people. All our staff had to be trained." (Behavioral Health Clinician – Social Worker, FQHC1)

Participants reported that champions with prior experience leading organizational change may have established rapport with staff, which can help them promote IBH with those resistant to IBH. The need for IBH buy-in also extended to the patient community; participants noted that some patients have biases toward behavioral health, which a champion could address by ensuring consistent, positive messaging about IBH from all staff that the patient may encounter.

Table 2. Interview Participant Characteristics (n = 18)

Characteristic	n (%)
Participant role	
Primary care clinician (MD, DO)	7 (38.9)
Behavioral health provider (LCSW, DNP, APN, RN)	11 (61.1)
Type of organization	
Federally qualified health center	5 (50.0)
Community health center	5 (50.0)
Gender identity	
Male	5 (27.8)
Female	12 (66.7)
Transgender	1 (5.5)
Ethnicity	
Hispanic/Latino	2 (11.1)
Non-Hispanic/Latino	16 (88.9)
Race	
White	13 (72.2)
Black	1 (5.6)
Asian	1 (5.6)
Other	3 (16.6)
Years at current organization	
1 to 5	6 (33.3)
6 to 10	2 (11.1)
11 to 15	3 (16.7)
16 to 20	4 (22.2)
More than 20	3 (16.7)

Abbreviations: APN, advanced practice nurse; DNP, doctor of nursing practice; DO, doctor of osteopathic medicine; LCSW, licensed clinical social worker; MD, doctor of medicine; RN, registered nurse.

Appropriateness: Provide Training That Emphasizes How Brief Behavioral Health Interventions Differ from Traditional Therapy

IBH implementation requires a clear understanding of how brief interventions delivered in an IBH encounter differs from traditional therapy. The IBH encounter is designed to last 15 to 20 minutes and focus on identifying feasible, behavioral changes to help with patient adherence to a care plan; the IBH encounter is not intended to assess and treat deeply-rooted psychological needs. Participants described that this understanding needed to be clear to all members of the care team, especially the primary care provider and BHC. The primary care provider needs to describe the IBH encounter accurately to a patient during a warm hand-off. Concurrently, the BHC needs to adhere to the brief intervention model to ensure their own availability for other patients; adherence to billing specifications; and ability to meet patients' needs. Participants shared that many social worker training programs emphasize intensive therapy, resulting in some of their BHCs defaulting to the traditional therapy model.

"Some patients are going to require therapy, and it should made be clear that those patients get referred for therapy and that integrated behavioral health is not therapy. It is important to be clear with the social workers about what their role is and what it isn't and being sure not to hire a social worker who can only provide therapy." (Behavioral Health Clinician – Nurse Practitioner, FQHC3)

IBH implementation plans should be mindful about hiring BHCs trained on brief intervention or build in IBH training and role specification.

Feasibility: Create Physical Spaces for Behavioral Health Consultants

Participants emphasized that BHCs needed physical spaces to work near the patient examination rooms so that they are readily available for patient care. The IBH workflow has the BHC come into the examination room immediately following a patient's encounter with a primary care provider. In addition, the BHC needs sufficient space to prepare for new visits, document completed visits, and conduct follow-ups (which are sometimes done via telehealth). For some health centers, identifying this space was the biggest challenge because of physical limitations of the building. Some did not have available offices near the primary care provider offices and patient examination rooms, resulting in delayed or missed IBH encounters. Participants recognized that when BHCs were "out of sight" from the care team, they were underutilized. Health centers with limited space shared workarounds, such as creating workstations in the hallway or having the BHC sit at the front desk during patient visits. Participants noted that space designation for BHCs should be implemented strategically, with the aid of the champion, as space reallocation can have political implications, signaling a shift in care delivery.

"Our absolute number one, way off the charts, so much more important than any other barrier is space. We have struggled from day one to have appropriate space for BHCs to work. And then the second barrier is provider attitudes about who the space belongs to." (Primary Care Clinician – Family Medicine, FQHC4)

Fidelity: Develop on-Going IBH Training Procedures for New Staff

Participants acknowledged that their current IBH training procedures were not as formalized as they desired, citing lack of dedicated resources; however, they shared multiple ways they were able to add IBH conceptual and procedural training into new employee onboarding, ensuring continued fidelity to the Cherokee model. They emphasized that IBH training needed to start during the interview and hiring process, be on-going, and engage multiple practice members (ie, primary care and behavioral health clinicians). The persistent nature of training is reflected in this quote:

"We do pre-employment education to get them to understand what integrated behavioral health is. Then, it's a very long process of orientation. We tell people it's a good year before they're comfortable working here. We do a Monday morning mental health meeting every week. We bring all the therapists and all the psychiatrists. We bring medical people to present to us. We do a lot of meetings like that, where we continue the education both ways – mental health and medical." (Behavioral Health Clinician – Social Worker, CHC1)

Penetration: Establish Scheduling Systems to Connect Behavioral Health Consultants with Patients

A scheduling system and protocol to connect the BHC with the patient are needed to ensure patients who could benefit from IBH are not missed. Processes for scheduling patients for IBH encounters fell into 2 categories: planned and ad-hoc. The planned encounters were often identified during previsit planning (eg, morning huddles), where the primary care providers flagged patients (eg, those with chronic conditions) for the BHC to see later that day.

"Let's say we have a schedule where the providers are going to see 15-20 people that day. In the morning huddle, 2 people the provider might identify and say, '[BHC Name], you definitely have to see Mrs. A and Mrs. B because of X, Y, Z.' They'll say, 'Sure, I'll make room in my schedule for that, and I'll be sure to knock on the door to introduce myself.'" (Primary Care Clinician – Family Medicine, FQHC5)

Ad-hoc encounters were those identified during the primary care visit as benefitting from IBH consultation (eg, patient seemed anxious, had new chronic conditions). Participants shared that providers would either physically bring in the BHC during a visit or use an electronic system, such as *EPIC Secure Chat*, to request the BHC for immediate patient consultation. However, BHCs were not always available for ad-hoc encounters, especially if they were busy seeing other patients or did not

have a desk close to the examination room, which resulted in the need to schedule a separate patient appointment either in-person or via telehealth.

Sustainability: Identify Local IBH Billing Codes, Policies, and Procedures

Successful IBH implementation requires a resource that is knowledgeable on billing codes, policies, and procedures for IBH. The health centers benefitted from The Nicholson Foundation's instrumental work leading up to the demonstration project, which helped expand IBH reimbursement policies across New Jersey. As part of the demonstration project, health centers were connected to a local IBH billing expert, who gave tailored trainings to the centers (ie, type of provider eligible to deliver IBH services, specifications of an IBH encounter in an FQHC/CHC setting, correct billing codes to use). Participants described that the billing expert was a critical resource, who helped make the model financially sustainable.

> *"Nobody knows anything about billing. The rules continue to change. Each insurer has different rules. We had a designated billing expert as part of the grant. It was one of the parts that made the grant not a waste of time. If you couldn't figure out how to bill, it was not sustainable. The help that came in terms of understanding billing in New Jersey and trying to make it economically viable was as important – if not more important – than the support to teach social workers how to provide integrated behavioral health." (Primary Care Clinician – Family Medicine, CHC2)*

Participants warned that incorrect billing could result in patients being charged 2 copays – 1 for a medical visit and 1 for behavioral health – potentially making the patient adverse to future IBH encounters. They remarked that a lot of progress is still needed on IBH reimbursement policies, including increasing reimbursement rates for behavioral health services and expanding the list of eligible providers.

Discussion

The objective of this study was to identify strategies to successfully implement IBH into primary care FQHCs and CHCs by revisiting 10 health centers that participated in an IBH demonstration project between 2013 to 2019. We posited that health centers with sustained IBH programs could share valuable guidance on how they addressed IBH implementation challenges – specifically, strategies to optimize 6 domains of Proctor's Implementation Outcomes Framework: acceptability, appropriateness, feasibility, fidelity, penetration, and sustainability of IBH models.[35–38] Our study revealed 6 key strategies in these domains that helped health centers not only implement IBH but ensure its sustainability beyond the demonstration project. Interestingly, the 6 strategies map to known challenges inherent to IBH implementation – challenges of organization, attitudes, and finances.[20–28]

Organizational challenges encompass insufficient primary care practice infrastructure for IBH workflows[41] and inadequate processes to document IBH encounters in the electronic health record system.[37] Two strategies identified in our study address organizational challenges – identifying the physical space for the BHC and establishing a scheduling system. These strategies help institutionalize the BHC's role in the primary care practice as a core member of the team and workflow. Our findings resonate with a perspective article by Joseph et al. (2017), which opined on the evolving practice of psychiatry in the era of integrated care. The authors suggest parameters that need to be redefined, which include the team structure, communication, treatment planning, and space availability.[42] Our work confirms that these parameters also need to be redefined for the primary care setting to accommodate IBH.

Attitudinal challenges stem from the fragmented US health care system, resulting in IBH being a foreign concept to many medical professionals.[36,43–45] Three implementation strategies addressed attitudinal challenges – identifying a champion with experience leading change, providing training that emphasizes behavioral health interventions, and developing IBH training procedures for new staff. Altogether, these strategies help shift the mindset for all health center staff. Our findings on staff education and training are consistent with Hall et al. (2015), which recommends comprehensive and ongoing IBH training to build an effective IBH care team.[46] Our findings are also consistent with Prom et al. (2021), a qualitative study of 2 IBH clinics, which concluded that IBH implementation needs to be approached using a systems change lens. The authors explicate that buy-in and adoption are essential at multiple levels, from the institution to the individual staff, recommending that IBH implementers use change-management based strategies.[38] Our work extends their findings by providing

implementation components in which change management strategies can be applied.

Finally, financial challenges refer to the insufficient and complicated reimbursement policies for IBH services.[26,47] Some states have made strides in expanding insurance coverage to include IBH services and increasing rates for behavioral health[47]; however, specifications for eligible services and providers remains confusing to many practices.[22,48] Our final identified implementation strategy addresses this challenge – identifying local IBH billing codes, policies, and procedures. Health centers need access to an IBH billing expert or resource that can routinely canvas local IBH billing policies and update IBH centers on how to effectively bill for IBH services. Such an expert/resource is difficult to find, however. Hunter at al. (2018) suggests that practices seek partnerships with academic institutions and related organizations that may have available resources.[49]

Altogether, these strategies signal that IBH is a complex organizational change. Health centers considering IBH may benefit from additionally drawing on organizational change models to guide their implementations – particularly the Practice Change Model,[39,40] which considers primary care practices as complex adaptive systems consisting of a core, adaptive reserve and attentiveness to the local environment. It is hard to discern which of the 6 identified strategies is most important or the most challenging; an assessment of internal and external motivators and capacities for IBH guided by the Practice Change Model is needed to help health centers think through how to tailor these strategies to their specific contexts.

Our study contributes to the limited literature on IBH implementation[38,49] by applying Proctor's Implementation Outcomes Framework[29] to examine IBH implementation in FQHC/CHC settings. It is important to investigate IBH implementation outcomes because the direct clinical effectiveness of IBH is difficult to assess; changes to clinical outcomes (eg, improved mental health and chronic conditions) are not immediate.[49] By examining implementation outcomes, we can assess the extent to which an IBH model is feasible and functional within a primary care setting, which are necessary preconditions for attaining desired changes in clinical or service outcomes.[29] Further, by studying IBH implementation strategies in FQHC/CHC settings, we can better identify strategies that help increase access to IBH services to patient populations that may benefit from it most.

Limitations

The study has limitations. First, by design, the study is focused on 1 state and a specific clinical setting (FQHC/CHC), which may limit transferability. The benefit of focusing on 1 state, however, is the opportunity to minimize the variability of external factors, which allows us to focus on implementation processes. We recognize that FQHCs/CHCs lack many of the financial imperatives of other primary care sites that are organized around different business and clinical models, requiring tailored implementation strategies.[50] As more practices become integrated into health systems, however, there is expected to be more resources for IBH initiatives. Future work is needed to examine IBH implementation in various settings. Second, one of the funded sites did not participate in this study; it is unknown whether their implementation differed. Third, the study reports stakeholders' perceptions only; quantitative data were not available to confirm reported experiences. Note that we explored differences in primary care and behavioral health perceptions and did not find distinguishing themes. Fourth, we did not collect data on number of patients seen by BHCs, due to lack of availability of this data from sites and lack of standardization across sites on how this metric is defined (eg, whether to count unique patients vs total visits). There are on-going efforts in the field to standardize this measure.[51,52]

Conclusion

The success of this IBH demonstration project beyond its funded years bodes promise for future IBH implementations. Our study identified specific strategies used by participating health centers to seek optimal implementation conditions. The strategies employed address critical, known challenges in IBH implementation and have enabled the health centers to sustain IBH. Future implementations of IBH in primary care settings, particularly FQHCs and CHCs, should apply multi-faceted approaches that address persistent and seemingly intractable barriers that have inhibited IBH integration.

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To see this article online, please go to: http://jabfm.org/content/37/5/833.full.

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Appendix A

Interview Guide

Greeting
Hi. My name is…
This is [introduce interviewer 2].
Thank you for agreeing to do this interview.

Study overview / Consent
The purpose of this interview is to gather information about the implementation of a behavioral health integration model known as the Cherokee Model.

In the invitation email, you should have received a consent form that further explains the purpose of this study, your rights and freedoms as a participant, and specific contacts in case you have questions about the interview process. Are there any questions I answer for you?

Permission to record
I am now going to ask you to confirm (yes/no) that we are permitted to record you as described during your participation in this study. Do I have your permission to record this interview, yes or no?

Great. I am going to turn on the recording device and ask you that question again for the record.

[Turn on the recording device.]

Do I have your permission to record this interview, yes or no?

Purpose of the interview
We are speaking with you today because we are interested in learning about the implementation of the behavioral health integration.

You were identified as having either an active role in the implementation of the Cherokee Model at [health center name], which was funded by a grant your health center received from The Nicholson Foundation, or you are very knowledgeable about its implementation.

In this interview, we are interested in hearing about the lessons learned from that implementation, which will help inform future implementations of behavioral health integration in our state.

Introduction of interviewers
We'd like to start by telling you a little bit about ourselves. I am [name]. I work at [name] and I am a [name role and describe what you do].

[Introduce interviewer 2. Interviewer 2 offers a similar introduction. I'll mostly be listening and taking notes during the interview, but I'll chime in along the way or at the end if I have any clarifying questions.]

Question bank

Themes	Questions
Context	1. Tell me about yourself and your role with behavioral health integration.

Implementation Outcomes	2. Is integrated behavioral health currently a part of your center's care delivery? Next, I'm going to ask questions to learn about the facilitators and barriers to implementing integrated behavioral health. 3. If yes to Q2: Tell me about how your health center integrated behavioral health into a routine patient visit. Let's start with what happens pre-visit. *Probe: When is the PHQ-2 or PHQ-9 assessed?* If no to Q2: Tell me about a routine patient visit in your center. Let's start with what happens pre-visit. *Probe: When is the PHQ-2 or PHQ-9 assessed if it is captured?* 4. Tell me about what happens when the patient attends their appointment. We'd like to hear about an in-person visit first, and then we'll ask about a telehealth visit. *Probe: Which members of the care team involved?* 5. Tell me what happens in a telehealth visit. *Probe: Which members of the care team involved?* 6. Tell me what happens post-visit, after the patient leaves the health center. 7. How do you handle billing and reimbursement for integrated behavioral health care? That was very helpful. We'd now like to hear about what has changed about the way your center delivers behavioral health compared to when you first started. 8. What has changed about your health center staff? *Probe: Did the roles of existing staff change? How many new staff were hired? How was the experience recruiting new staff?* 9. How do you educate new staff about integrated behavioral health? 10. How did your organization receive integrated behavioral health? *Probe: How was it received by leadership? Providers? Behavioral health staff? Other staff? Patients?* *Probe: If a champion was mentioned, say, "What makes that person a good champion?"* 11. Overall, what were the top 1-2 facilitators to implementing integrated behavioral health? *Probe: If a champion was mentioned, say, "What makes that person a good champion?"*

	12. Overall, what were the top 1-2 barriers to implementing the integrated behavioral health? Great, let's discuss the future of integrated behavioral health care in your center. 13. How do you foresee the future of integrated behavioral health at your center? 14. What would enable your center to consistently deliver integrated behavioral health? *Probe: Sustainability, financial*
Wrap-Up	That was great. I'd like to now turn to my colleague to see if you she has any clarifying questions or follow-ups for you. [Interviewer 2 asks questions.] 15. Is there anything else that you think is important that you think we should talk about? 16. <u>If we do not have 2 participants identified from this site already</u>: Who else should we talk with to make sure we understand the impact of integrated behavioral health within your health center?
Demographics	I'd like to end with some basic demographic questions to help us describe who we interviewed. You may choose to skip any of these questions. 17. How many years have you worked at this health center? 18. What is your gender identity? 19. Do you identify as Hispanic or Latino? 20. What is your race?

<u>Closure</u>
Thank you for your time. Your participation is extremely helpful to us understanding the implementation facilitators and barriers of integrated behavioral health. If you have any questions or follow-up after this call, please feel free to reach out to me.
[Turn off the recording device.]

Appendix B

Strategies Used in the Cherokee Integrated Health Model Implementation

Implementation Outcome Domain	Implementation Strategy	Concrete Examples from Interviewees
Acceptability	Select champions with experience leading organizational change	• Select a primary care clinician with prior experience leading organizational change. • Select an administrator with prior experience leading organizational change and passion for behavioral health. • Select a behavioral health provider with existing rapport with staff (bottom up approach). • Ensure that the champion has the endorsement of practice leadership (top down approach). • The champion's role is important in ensuring consistent messaging about IBH to staff and patients.
Appropriateness	Provide training that emphasizes how brief behavioral health interventions differ from traditional therapy	• Enroll all members of the care team (or if possible, all members of the practice) in the Cherokee Health Systems training academy for IBH. • Provide training for behavioral health providers on the concept of IBH and why brief interventions are different from traditional therapy. Most behavioral health providers, including social workers, will be more familiar with the traditional therapy. • Provide training to primary care clinicians on the concept of IBH and why brief interventions are different from traditional therapy. This understanding and appreciation are critical to promoting the warm handoff to BHCs. • Provide an overview training of IBH to all staff members to help facilitate the warm handoffs and how IBH information is communicated to patients. • IBH training materials can be found at Cherokee Health Systems, UMass Center for Integrated Care, Rutgers University Behavioral Health Care, University of Michigan, national conferences (such as the Collaborative Family Healthcare Association), and from peer organizations.
Feasibility	Create physical spaces for behavioral health consultants	• Identify an office or desk for the BHC. • If an office is not available, create a workstation in the hallway or have the BHC sit at the front desk during patient visits. • The office/desk should be as close to the primary care clinicians as possible. • Partner with the champion to identify the space, as space reallocation can have political implications. • While not ideal, if the BHC works off-site (i.e., via telehealth), ensure that the primary care clinician explains the role and value of the BHC to the patient and the process for the BHC to follow-up with the patient after the visit.
Fidelity	Develop on-going IBH training procedures for new staff	• For new BHCs, training needs to start during the interview and hiring process; the candidate should be informed upfront about the IBH workflow and culture at the health center. • The BHC job posting should describe the IBH concept and clarify that the BHC's role is different from traditional therapy. • New staff (non-BHCs) should be trained on IBH during the interview and hiring process, as IBH is a part of the health center's services. • Training for new BHCs should be on-going and engage multiple practice members. BHCs should be embedded into care teams comprised of interdisciplinary members, allowing the BHCs to participate in conversations that bridge physical and mental health. • New BHCs would benefit from shadowing current BHCs, allowing for peer and traditional mentorship.
Penetration	Establish scheduling systems to connect behavioral health consultants with patients	• Providers can either physically bring in the BHC during a visit or use an electronic system, such as *EPIC Secure Chat*, to request the BHC for immediate patient consultation. • Use a calendaring system to schedule a BHC visit for during or after the visit (if the patient is not able to stay for a same-day visit with the BHC).
Sustainability	Identify local IBH billing codes, policies, and procedures	• Consult with a local billing expert with expertise in IBH billing codes, policies, and procedures. Have this expert train the health center medical billers and be available for on-going technical support. • Confer with local IBH experts, such as academics, advocacy groups, funding agencies, and other health centers, to trade and learn best practices on IBH billing, policies, and procedures.

Note. Implementation outcome domains are adapted from Proctor et al. (2011). Adoption and Cost domains were not used in this study. BHC = behavioral health consultant; IBH = integrated behavioral health.