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Medical Family Therapy in Rural Community Health: A Longitudinal "Peek" into Integrated Care Successes

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Abstract

Integrated behavioral health care (IBHC) continues to grow as an evidence-based service delivery model adopted by healthcare systems all over the world to better care for the holistic needs of patients and their families. Medical family therapy (MedFT), as a field, has offered innovation to IBHC models by delivering biopsychosocial-spiritual (BPS-S), relational, and family-oriented care across a variety of healthcare contexts. This article details a longitudinal review of a program, spanning 16 years, that grew from no behavioral health services to one that is highly integrated, and embeds MedFTs in a number of rural community health centers. This model highlights the importance of interdisciplinary teams, including Peek's clinical, operational, financial, and training worlds, as well as decision-making metrics for systems that predominately care for underserved and minoritized populations. The authors illustrate a framework for how the levels of primary care/behavioral healthcare collaboration relate to the work and practice of MedFTs as conceptualized through the MedFT Health Care Continuum and meet the BPS-S needs of diverse populations seeking pediatric, adult, and dental healthcare services. Also described are shifts made in the model over time based on (a) growth in cultural humility, (b) relationally-oriented practice, operations, finance, and training data, and (c) research informed decisions. Recommendations include ways MedFTs can facilitate provider and administrative buy-in, assess model fidelity, and strive for quality outcomes for patients.

Keywords Collaboration · Community health center · Integrated care · Medical family therapy · Underserved populations · Behavioral health · Primary care

Community health centers (CHCs) are Federally Qualified Healthcare Centers that provide affordable, accessible care to patients in urban and rural communities. According to federal guidelines in the United States, CHCs must be located in underserved areas, governed by a community-majority board, provide a core set of primary care services, and offer a sliding scale fee to patients under 200% of the Federal Poverty Level. In 2020, 1400 health centers served 27 million patients and reported over 110 million visits (Health Resources and Services Administration [HRSA], 2020). Of these patients, at least 30% were at 101% (or above) of the Federal Poverty Level and 23% lacked any form of health insurance (HRSA, 2018).

HRSA documented that over 6500 mental health and substance abuse providers are employed within CHCs and offer access to services in the nation's most underserved communities. In fact, CHC patients made 9.9 million visits directly pertaining to mental health and 1.2 million related to alcohol related disorders in 2017; there was an estimated 120% increase in these services in 2020 (HRSA 2018; 2020). Interestingly, only hypertension, overweight and obesity, and diabetes resulted in more visits per patient than depression (HRSA, 2018). These trends highlight that patients are in need of and are accessing mental health and substance use services to address prevalent psychosocial issues. Having these services available within CHCs is particularly meaningful for a patient population facing greater health disparities, significant financial barriers to care, and logistical barriers for treatment, such as difficulty getting time off of work to seek medical and behavioral health services.

CHCs have the potential to use a coordinated (i.e., services exist in different settings, with separate treatment plans, and minimal contact between providers; Blount,

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2003) or integrated (i.e., nearly all patients receive shared medical and behavioral health care, shared treatment plans, with frequent communication between types of providers; Doherty, et al., 1996; Peek & the National Integration Academy Council, 2013) care system while maintaining a whole person orientation (American Academy of Family Physicians, 2007). Since approximately 70% of all primary care visits involve mental health symptoms (National Association of State Mental Health Program Directors, 2012), the movement toward integrated behavioral health care (IBHC) (i.e., extending medical and behavioral health services simultaneously for patients) is needed to ensure that the biopsychosocial-spiritual (BPS-S; Engel, 1977, 1980; Wright et al., 1996) needs of patients and their families are addressed, and that medical and behavioral health services are delivered in a collaborative, family-centered manner.

CHCs are known to effectively use team-based approaches when caring for patients with complex health problems (Hing et al., 2011; Hodgson et al., 2018). These approaches have been extended to uninsured and underserved communities for their primary care, dental services, and behavioral and mental health care. As the number of CHCs has increased, the demand for these comprehensive services has also increased (Rosenblatt et al., 2006). Since the passing of the Patient Protection and Affordable Care Act in 2010 and again with the CARES Act in 2020 (S.3549), there has been more attention and funding directed toward CHCs to integrate primary care and behavioral and mental health services to improve patient experiences, quality of care, and population health (National Institute of Mental Health, 2017).

Thus, the purpose of this article is to: (a) describe the role of medical family therapy (MedFT) in context of a longitudinal IBHC model of care, (b) illustrate, in context of CHCs, the continuum of skills implemented in the model through the MedFT Health Care Continuum (Hodgson et al., 2014), (c) offer a 16-year snapshot description of an IBHC model implemented in rural CHCs and, (d) provide recommendations for MedFTs who aim to develop, implement, and/or expand an IBHC model.

Family Therapists in Health Care

Medical family therapy was first published by name in 1992 by McDaniel, Hepworth, and Doherty, who shared a vision that MedFT was a way of extending systemic care (von Bertalanaffy, 1968) via Engel's biopsychosocial (BPS) model (1977, 1980). Tyndall et al's (2010) Delphi study expanded on the earlier work by garnering a professional consensus (from MedFT clinicians, researchers, and trainers) toward a rigorous definition of MedFT. These experts described MedFT as a field sourced from:

a BPSS [biopsychosocial-spiritual] perspective and marriage and family therapy, but also informed by systems theory. The practice of MedFT spans a variety of clinical settings with a strong focus on the relationships of the patient and the collaboration between and among the healthcare providers, the patient, and the patient's family/support system. MedFTs are endorsers of patient and family agency and facilitators of healthy workplace dynamics (pp. 68–69).

Then in 2018, the American Association for Marriage and Family Therapy adopted the "Competencies for Family Therapists Working in Healthcare Settings" written by a team of clinical, researcher, and policy experts in MedFT (AAMFT, 2018) which expanded beyond the definition and competencies previously published (Tyndall et al., 2010, 2014). These competencies captured ways in which MedFTs are unique from other mental health providers, particularly in healthcare contexts due to their in-depth training in relational health and ability to engage with patients, family members, providers, and community supports to appropriately assess, diagnose, and intervene based on research informed practice standards and current policy, laws, and regulations.

MedFTs who have adopted these competencies are skilled at working simultaneously with patients, their family members, and providers with the added ability to recognize the systemic interface of clinical, operational, financial, and training worlds (i.e., the Four World View; Peek, 2008). Peek's vision was to encourage all levels of a health care system to acknowledge how change in patient care influences each of these four worlds. For example, a healthcare organization can consider the financial mechanisms for paying for IBHC, but if there is not a clear evidence-based clinical model, operational processes (e.g., documentation, workflow), or continuous training of the team to adopt and maintain it, the model will not be successfully launched or sustainable.

In this article, we offer a longitudinal snapshot of a model that the authors created and have implemented over the past 16 years, while the MedFT field continued to evolve. Our model is grounded in a framework that consists of two continuums and the interface between them: the five levels of primary care/behavioral healthcare collaboration (PCBHC; Doherty et al., 1996; see Fig. 1) and the MedFT Health Care Continuum (MedFT-HCC; Hodgson et al., 2014; see Fig. 1). This framework has afforded opportunities for trainees and providers to build IBHC across the four worlds and a continuum of skill sets.

Level 1	Level 2	Level 3	Level 4	Level 5
Rarely… 1) Applies a relational and/or biopsychosocial-spiritual (BPSS) lens in practice, research, and/or policy/advocacy work. 2) Conducts research on healthcare topics including relational and/or BPSS aspects of health, and writes in collaboration with other healthcare researchers. 3) Includes individuals, couples, families, AND healthcare professionals into their work. 4) Advocates and advances clinical models and policies that promote relational or BPSS health and well-being.	*Occasionally …*	*Usually…*	*Consistently…*	*Proficiently…*
			Skills 1-4 apply to levels 1-5	
	.	5) Trained to apply a broad range of family therapy and BPSS interventions and conduct family therapy.	**Skill 5 applies to levels 3-5**	
			6) Experienced in conducting BPSS research across traditional and integrated care practice contexts.	**Skills 6-8 apply to levels 4 & 5**
			7) Integrated in outpatient and/or inpatient healthcare teams, attends to the needs of healthcare team members, is a part of healthcare team meetings, and/or practices conjointly with diverse healthcare professionals. 8) Identified as a MedFT clinician or MedFT researcher and integrates in/with healthcare contexts/ professionals into most of their work.	9) Experienced at administrating, supervising in diverse medical contexts (i.e., primary, secondary, and tertiary care systems) incorporating both traditional and integrated care models. 10) Experienced in training healthcare professionals in family therapy and MedFT practice, research, policy, and/or administration.
Primary Care/Behavioral Healthcare Collaboration (Doherty, McDaniel, and Baird, 1996)				
Level 1 Minimal collaboration with other providers (separate systems, separate facilities, rare communication with HCP)	**Level 2** Basic collaboration from a distance (separate systems, separate facilities, periodic letter and phone contact with HCP)	**Level 3** Basic collaboration on-site (consult model only; regular communication-occasionally face-to-face with HCP)	**Level 4** Close collaboration in a partly IC system (some shared systems; same facilities; face to face consultation with HCP; collaborative routines difficult)	**Level 5** Close collaboration in a fully IC system (shared systems and facilities; all HCPs function face-to-face as a team; regularly collaborate)

Fig. 1 Medical family therapy health care continuum (Hodgson et al., 2014)

Levels of Primary Care/Behavioral Healthcare Collaboration

In 1996, Doherty et al. introduced the levels of primary care/ behavioral healthcare collaboration (PCBHC). It included five levels of behavioral health integration and collaboration ranging from minimal collaboration with other healthcare disciplines to close collaboration in a fully integrated system. According to this continuum, at Level 1 (minimal collaboration), medical and behavioral health providers practice in separate locations in non-integrated systems. Provider collaboration is minimal and is limited to referrals on an as-needed basis. At Level 2 (basic collaboration), providers have separate systems at separate sites and there is basic collaboration between providers on shared patients, perhaps through email or an occasional phone/e-mail conversation. At Level 3 (basic collaboration on site), this basic collaboration has been augmented by co-location with occasional face-to-face meetings and more regular communication between providers about patient care. Systems may still be separate (e.g., separate documentation and scheduling systems) and the adoption of the biopsychosocial framework (Engel, 1977, 1980) is limited to patients with more serious/notable mental health conditions and/or providers who have a specific interest in biopsychosocial care models.[1] Although behavioral health providers may be utilized as consultants at the lower levels of collaboration, at Levels 4 and 5 they become integrated as part of the primary care treatment team. At Level 4 (close collaboration in a partly integrated system), there is ongoing face-to-face provider collaboration, coordinated treatment plans for patients, and some shared systems (e.g., providers document in the same Electronic Health Record and/or scheduling system). Level 5 (close collaboration in a fully integrated system) is characterized by all members of the healthcare team, including mental health professionals, staff, lab techs, billing specialists, etc., sharing the same space, care philosophy, and systems (e.g., shared clinical, operational, billing, and training systems). All providers and staff function as members of the same team, as well as know and understand each other's roles and areas of expertise. In 2013, the Substance Abuse and Mental Health Services Administration added a level to mark the importance of integrated medical records beyond the work conducted via clinical practice (Heath et al., 2013).

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[1] McDaniel et al. (1992) did not acknowledge spirituality as a unique descriptor to the BPS framework.

Medical Family Therapy Health Care Continuum

Developed by MedFT innovators in IBHC, the MedFT-Health Care Continuum (MedFT-HCC; Hodgson et al., 2014) was constructed to illustrate the practice and application of MedFT along a graduated path. Level one begins with the rare application of MedFT concepts and ideas to one whereby the MedFT is consistent and proficient in its application and infused within the roles they are assigned (e.g., as a clinician, administrator, researcher, leader, educator, and/or policy maker). The MedFT-HCC offers a way to characterize the family-centered and relational role of a behavioral health provider and describes how the provider moves through the continuum based on the setting and various responsibilities that MedFTs can have while working in a healthcare context. The continuum is an important contribution to the literature in MedFT, because it recognizes that MedFTs may not function solely as clinicians, but also as researchers, trainers, leaders, supervisors, and/or policy makers; all of which are important to the development of IBHC models.

MedFTs at Level 1 rarely apply relational or BPS-S practices and/or rarely incorporate partners, families, or healthcare systems into their work. This level often includes professionals from many different disciplines who recognize that working from a relational perspective is beneficial, although they might only take a relational or BPS-S perspective in certain settings (e.g., hospice, labor and delivery, pediatric care) or situations (e.g., when needing to make a referral, when one family member is the health care proxy for another family member). At Level 2, the MedFT occasionally implements the applications in Level 1, and by Level 3, the MedFT is usually applying a relational and BPS-S practice, but is specifically trained to apply a broad range of family therapy interventions and conduct family therapy in the healthcare context. MedFTs at this level would be members of any discipline who advocates for and are informed by relational and/or BPS-S care/research when certain situations arise in their context/work (e.g., patient needs to be monitored closely at home). Level 4 represents the MedFT who is consistently applying relational and/or BPS-S knowledge and skills into their practice, research, policy, and/or advocacy work. These MedFTs are experienced in using their knowledge and skills in both traditional mental health (i.e., the typical 50-min couple, family, larger system session) and integrated care contexts (i.e., MedFTs who work in tandem with a variety of medical and spiritual health providers when extending care/research/training). Level 4 MedFTs are recognized as part of the healthcare team, attend conjoint meetings, and are clearly identified as a MedFT in their work context. Finally, Level 5 represents proficiency as

a MedFT in that the MedFT is able to serve as an administrator, supervisor, educator, researcher, and trainer in either a mental health or medical context. In Level 5, the MedFT is proficiently trained and experienced in family therapy and MedFT practice, research, policy, and/or administration, including the interface with diverse healthcare providers and staff, diagnoses, research, complications across BPS-S domains, and ethical standards.

According to the MedFT-Health Care Continuum, a MedFT could function in any of the five levels of PCBHC developed by Doherty et al. (1996), depending on frequency of application, training, and the establishment of MedFT as one's professional identity. The MedFT-HCC model allows MedFTs to determine which level fits best with their respective experience and level of training, offering a more inclusive perspective on how to engage different disciplines in the promotion of relational and systemic IBHC healthcare while also honoring the needs of the specific IBHC healthcare context.

Medical Family Therapy and Integrated Behavioral Health Care

Family therapy was built on a foundation whereby multiple disciplines (e.g., psychiatry, social work, biology, mathematics) contributed to its ideas and theories. Therefore, the authors of this article endorse a way to also be more inclusive in the various ways that MedFTs can recognize their professional diversity within the field, while still maintaining that training and increased skills are needed to fully function at the highest level of PCBHC continuum and the MedFT-HCC, conjointly.

The relationship between the PCBHC and the MedFT-HCC continuums are particularly relevant because the vision of the founders of MedFT (McDaniel et al., 1992) was to provide care through a systemic and relationally based biopsychosocial framework. That philosophy was central to the education of all the MedFTs trained by the originators of the MedFT-HCC (Hodgson et al., 2014). Furthermore, the PCBHC has been used by hundreds if not thousands of MedFTs as a guide to determining the readiness and investment in collaborative and integrated care among providers, administrators, and research teams.

The PCBHC continuum spurred the development of the IBHC model discussed in this article which then influenced the creation the MedFT-HCC. This IBHC model highlights an example of how family therapists in healthcare contexts can progressively increase their knowledge of and involvement in collaboration and expand MedFT beyond clinical practice and into supervisory, administrative, research, educational, and policy making roles. This progression occurs while also strengthening MedFTs personal and professional

cultural humility (i.e., a lifelong process in openness, self-awareness, self-reflection, and critique of self in context of relationships with diverse ethnic, racial, sexual preference, social status, and healthcare provider/patient interactions; Foronda et al., 2016).

Below is a brief snapshot of an IBHC model that was constructed in one CHC across six sites (and growing), united in the basic principles of the MedFT-HCC and PCBHC and grounded in a BPS-S framework (Engel, 1977) of patient and family-centered care. Its developers remain committed to the interconnectedness of physical health, psychological well-being, and social factors, while also embracing the spiritual dimension that can also influence health decisions and outcomes (Wright et al., 1996). This IBHC model illustrates the BPS-S dynamics that influence health and illness, includes the relational systems that drive patient decision making across the four worlds, and allows for the versatility necessary to serve a variety of diverse populations and cultural contexts. While the authors have developed IBHC models in several contexts (e.g., schools, military installations, and numerous healthcare contexts), the example below is of a longitudinal project using both the PCBHC and MedFT-HCC continuum to provide relational evidence-based care to underserved populations served though several rural CHC clinics.

A Snapshot of IBHC in One CHC

The initial conceptualization for the MedFT-HCC model began in 2006 when an opportunity to initiate an IBHC model was funded through a local foundation. The program was a pilot project at one site within a rural CHC system for individuals who were struggling with uncontrolled diabetes. By 2008, the IBHC model had expanded to provide services to patients who had struggled with diabetes and depression, as well as other complex and comorbid diagnoses that seemed especially challenging to the primary care providers.

The increased delivery of services was made possible through the vision and support of a "champion" within the rural CHC system, and a new line of funding devoted to promoting the expansion of the MedFT services. The number of patients has nearly doubled over our time with this collaborative. As of 2021, 37,972 patients receive services annually, but only about one-quarter to one-third are seen in one of the six clinic locations, including a dental clinic and school-based clinic; others are seen through outreach (i.e., agricultural workers who are treated on farm properties). Approximately 89% of the patients are uninsured. Half of the clinic's patients are migrant or seasonal farm workers, and two-thirds speak Spanish as their primary language. Many of these rural patients also have unmet behavioral health needs stemming from economic stressors, historical oppression, lack of geographic proximity to loved ones, substance abuse, family dynamics such as divorce and domestic violence, and other BPS-S challenges.

Initially (in 2006), the IBHC model included one MedFT who worked alongside designated healthcare staff (i.e., only those funded by the grant) to offer BPS-S care to those who were newly diagnosed with diabetes or who had uncontrolled diabetes. At that time, the MedFT worked on the IBHC team alongside one certified diabetes health educator and a dietician who had 25% of her workload committed to this program. Since then, over 150 MedFTs have been trained in IBHC throughout the past 16 years to work in one or more of clinics within this CHC. The delivery of care area includes rural clinics that span a 54-mile radius and serve over 29 counties.

Early in the development of this model, the MedFTs benefitted from providers and staff were committed to the success of the pilot program, including outreach staff that were a type of collaborator for the MedFTs. These staff were called promotoras. Promotoras are trusted members of their community who help patients learn about all of the new services and, oftentimes, transport patients from their home or work to the CHC to receive care. The promotoras were essential team members that assisted in bridging trust between patients, providers, including the MedFTs. In these earlier years, the promotoras would encourage the MedFTs to join them in going to the homes of patients who needed supportive care and mental health services. Serving as interpreters, the promotoras helped ensure that those oftentimes unable to make it into the clinic were getting screened for some of the more common mental health issues (e.g., depression, anxiety, substance use) and provided with brief intervention and/or referrals for specialized services. It was a powerful partnership that transitioned into a different collaborative model of care over the years. Currently, the promotoras refer patients to be seen in the clinics and since the onset of COVID-19, telehealth is provided to extend services remotely.

Over the course of the partnership with this CHC system, MedFTs have grown in their ability to collaborate with front desk staff, lab techs, medical assistants, dieticians, care coordinators, primary care and dental providers, schoolteachers and administrators, the chief of operations, executive officer, and financial officer. The team also grew in the number of bilingual and bicultural MedFTs. The MedFTs have learned to deliver BPS-S treatment to all patients regardless of whether their presenting problem included mental health concerns or not. Most importantly, they have realized that building strong collaborative relationships with all team members is a part of providing quality care. MedFTs work hard to ensure that all members of the team are heard (i.e., agency) and actively involved (i.e., communion).

Patient Identification and Intake

At the outset of the program, the IBHC team worked with the in-house data analyst to learn about the outcome capabilities of the Electronic Health Record (EHR). Based on content in the EHR portal, the team was able to access the name and contact information for all patients (a) seen at the clinic of focus, (b) who had attended at least one medical appointment in the previous 12 months, and (c) who had a Hemoglobin A1c (HbA1c) higher than 7.0 (i.e., typically indicated as uncontrolled diabetes; American Diabetes Association [ADA], 2017). The IBHC team then worked to build a registry of these patients and called each to make them aware of services that may help them in better managing the symptoms associated with their diagnosis. Success hinged on the IBHC team's ability to work together, as well as their ability to co-construct and co-implement assessments and treatments for BPS-S factors that influenced patients with uncontrolled Type 2 diabetes to reduce their HbA1c and symptoms pertaining to depression (Phelps et al., 2009, 2012). Understanding the dynamics and unique needs of the population served through this CHC was essential given that (a) approximately 86% of these patients were Hispanic or African American, (b) nearly 70% of the visits were for patients who had one or more chronic condition, and (c) 89% had no health insurance.

Patients were referred to the IBHC team by the in-house primary care providers (PCPs) and 398 newly diagnosed or uncontrolled diabetics completed at least one visit with a member of the IBHC team or the full IBHC team from January 2007 to March 2009. All appointments were crafted around a patient-centered treatment plan. Patients were encouraged to bring their family members/support persons to each session. Throughout this initial pilot program, there were 292 first visits whereby treatment plans with the MedFT were documented in progress notes, 171 second visits, 103 third visits, 64 fourth visits, and 47 fifth visits.

During each initial visit, patients were provided with information about the services available to them, based on the skill set and training of each IBHC member. The patients provided information pertaining to their diabetes and completed a series of questionnaires. From this first visit, IBHC sessions were then established for those interested in receiving diabetes management services. Once IBHC treatments were established, a BPS-S history was taken (Hodgson et al., 2007), followed by the creation of treatment goals with the patient, family (if present), and the IBHC team.

At follow up visits, each patient's goals were used to determine the primary focus. For instance, a patient might have goals that focus more on nutritional needs than psychosocial needs. If a patient only had limited psychosocial goals, they might spend most of the IBHC visit on issues primarily addressed by the dietician and diabetes educator with

fewer issues addressed with the MedFT. However, treatment still focused on the comprehensive well-being of the patient, given the IBHC philosophy whereby improvements in any domain of health—physical, emotional, social, or spiritual—will promote well-being in all other domains (Aamar et al., 2015). The healthcare environment was kept flexible, so each patient and their family could receive treatment that was tailored to their unique needs. Walking with cultural humility was continuously critical in this effort.

From the years 2007–2009, the program was operating at a Level 3 both on the MedFT-HCC and PCBHC continuums, "usually" applying a relational and BPS-S practice and basic collaboration on site, respectively. However, the remainder of this location (i.e., all treatment for patients that were not diabetic) and all other locations under this CHC system were at a Level 2 of the PCBHC continuum (basic collaboration) and were most likely referring to MedFT-HCC Level 1 or 2 behavioral health providers in the community (i.e., providers who rarely to occasionally applied relational and BPS-S practices into their work). In the early years of the model, behavioral and mental health support were offered to the PCPs by the MedFT within the co-located facility, however care was rarely collaborative between the medical providers and the MedFT.

Workflow Updates for Integrated Behavioral Health Care

In 2007, the program was expanded at the initial implementation site, which is the longest standing IBHC practice in this CHC system. The decision to begin IBHC at this site occurred based on the promising results from the preliminary analysis of the pilot project (Phelps et al., 2009, 2012), which highlighted that patients were in need of and interested in accessing IBHC services. Every attempt was made for the MedFT to be more present and visible while the clinic was open. The MedFT would not sit in an office waiting for patients to arrive, but instead be present in the hallways and gathering spaces where the nurses and providers could see them and access them quickly. Over time, patients grew to understand that family members or support persons were welcome in the exam room, and the MedFT was skilled in including them into the interview when appropriate.

Despite the incorporation of MedFTs into the mainstream center's practice in 2007, the PCPs rarely used the IBHC model. Instead, they expressed their preference for referring patients to the MedFTs for traditional behavioral health sessions (i.e., 50 min in a separate room), because that was what they were familiar with from previous behavioral health providers prior to working at this CHC (e.g., marriage and family therapists, psychologists, social workers), and it was consistent with what they were taught during their medical/nursing school and/or residency. However, once they began to experience the benefits of an integrated model

(i.e., commonly via patients who struggled with anxiety, depression, or treatment plans), their referrals for traditional psychotherapy decreased dramatically and the demand for integrated care services and MedFT intervention noticeably increased.

To help advance the process of engaging in the IBHC model, traditional therapy encounters were limited to no more than 25% of the MedFTs' workload. The remaining 75% of time was dedicated to IBHC, emphasizing on the floor encounters in exam rooms with the healthcare team. MedFTs were encouraged to schedule traditional sessions on site for patients who would benefit from brief short-term therapy (i.e., 4–6 sessions) related to BPS-S concerns.

In the IBHC model, behavioral health services were more commonly delivered at the point of care (prior to, during, or after care provided by the PCP), which was more beneficial for patients and clinic workflow than scheduling traditional follow up appointments with the MedFT only at a future date. Patient encounters increased by 300% after implementing the IBHC model, allowing MedFTs to serve more of the population on-site, and move beyond the co-located model that restricts both the number of patients served in a day via traditional 50-min encounters and face-to-face interactions with healthcare team members. It also permitted the MedFTs to move from a crisis-behavioral health model to a model that also identified patients at-risk for or presenting with complex BPS-S concerns. As one example, the Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001) was implemented as a way to screen for common symptoms of depression and potential suicidal ideation among patients. In 2008, of the 11,891 patients who were seen in a CHC clinic, 87 PHQ-9s were captured in the EHR portal. Implementing the PHQ-9 was a test to the clinical time and collaboration with patients and providers, the operational workflow in the clinic and documentation portal, and the training opportunities with medical and MedFT providers; patients were not billed for receiving the PHQ-9 screener.

### Expanding the Program Throughout the Organization

By late 2008, MedFTs were added to two additional CHC locations and by 2009, IBHC was the model of care at all locations within this CHC system. As the model was more widely adopted by the CHC providers, system-wide, it allowed for MedFTs to expand their services to include behavioral health issues (e.g., nutrition and physical activity, smoking cessation, medication adherence, stress, sleep hygiene, familial strengths and challenges, and coping strategies). This expansion was part of the CHC's strategic plan, so that patients and providers could embrace behavioral health screenings and intervention as routine parts of healthcare visits. In fact, a three-pronged workflow strategy was developed to help train providers and ensure patients

would get the right level of IBHC services (see Fig. 2). For example, if a patient had a depression diagnosis on their problem list, the MedFT would refer to the previous notes written by a member of the IBHC team and PCP to review prior depression and anxiety screening scores. They would reassess to see if the scores changed in severity, collaborate with the PCP to develop a strategy for treatment (if appropriate), and deliver a brief intervention and follow up with the patient and/or family members present. This same workflow protocol is used today.

Since 2008, each location has employed at least one MedFT to assess patients for depression, anxiety, substance use, and a variety of other behavioral health factors that may influence patients' health, serving as a training site for master's and doctoral level MedFTs from a nearby university. Following the system-wide expansion of IBHC, most MedFTs were predominantly practicing at either a Level 4 or 5 on the MedFT-HCC. Only a few providers practiced at Level 3, showing increased competence in and preference for collaboration. As a result of the gradual and deliberate expansion process, each MedFT was integrated into the system with fewer challenges to overcome than their predecessors. Collaboration with providers, integration into the healthcare system, and competence with the model had improved dramatically. Collaboration occurred more fluidly with the patient and their family, billing staff, primary care providers, and health center administrators to ensure that patients and families understood their care plan while promoting positive communication and collaboration among all stakeholders within the CHC. The operational systems (e.g., documentation and scheduling) were also expanded to be more inclusive of MedFT involvement, and the BPS-S lens was gradually adopted by almost all providers.

In 2011, a pediatric practice was added to the CHC system. This practice was receptive to starting at a higher level of integration despite having less experience with IBHC and MedFTs. This was due to the BPS-S philosophy already in place with several of the PCPs and healthcare team members, including the medical assistants, nurses, and health educators. This practice quickly established a PCBHC Level 4 as their service delivery model of choice with an increasing frequency of Level 5 encounters. Interestingly, by the end of 2011, 1896 PHQ-9 screeners had been conducted from the 10,128 patients who had attended at least one medical visit and a protocol was created to add the Generalized Anxiety Disorder-7 (Spitzer et al., 2006) screener to encounters beginning in 2012.

In 2013, health coaches were added to our team to attend to behavioral health concerns related to chronic medical illness, thereby shifting the skill set of the MedFTs to address more complex mental health diagnoses comorbid with chronic health conditions. With the transition toward the DSM-5 (American Psychiatric Association, 2013), the
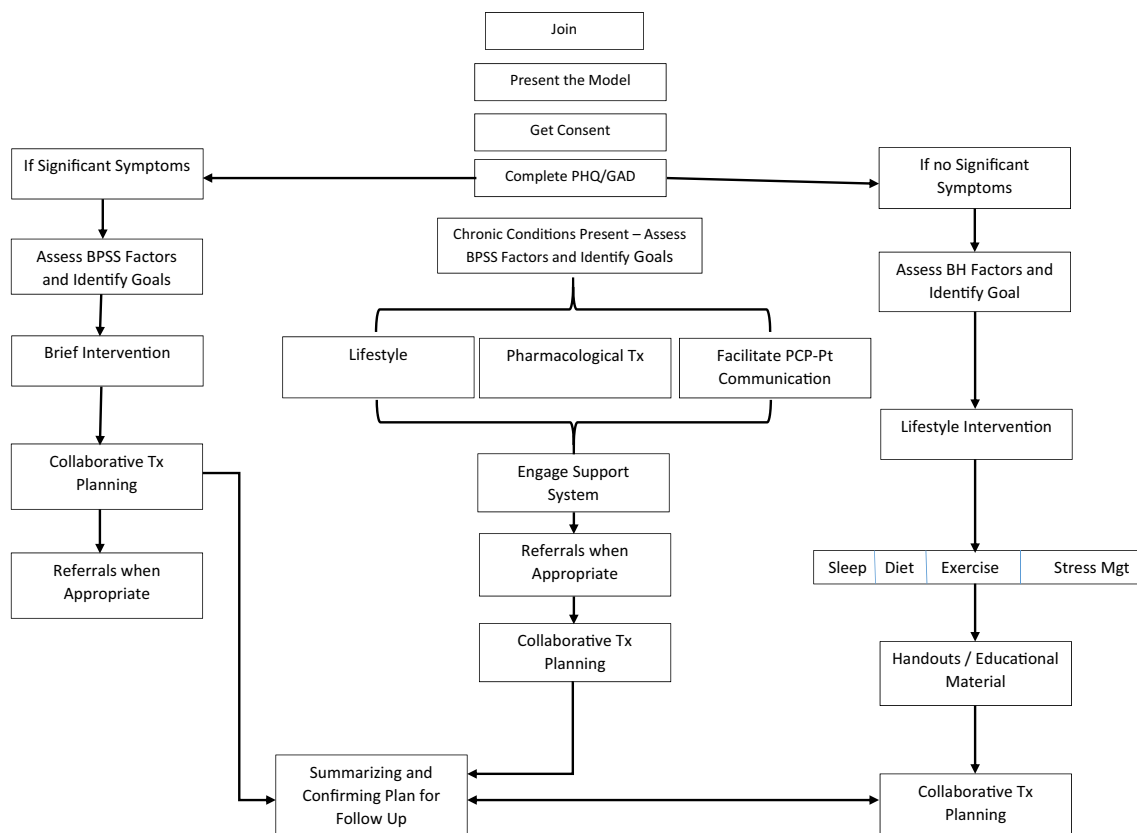
Fig. 2 Integrated behavioral health care flow chart

continuous economic challenges in the state, the implementation of the Patient Protection and Affordable Care Act (2010), and the number of patients who struggled with multiple complex conditions, the use of health coaches was necessary to appropriately attend to the BPS-S needs of the population. As such, master's level marriage and family therapists (MFTs) in their first year of clinical preparation were trained in health coaching and taught how to join with patients, assess and intervene in several critical behavioral health areas: physical activity, family support, nutrition, sleep hygiene, smoking cessation, and stress management. Once assessed, the health coach would intervene by working with the patient to design a patient/family-centered SMART health goal (Doran, 1981). This goal was to be worked on between appointments. If a more significant concern was expressed by the patient (e.g., chronic pain, child maltreatment, suicidal ideation), the health coach collaborated with the appropriate provider to better meet the patient's needs (e.g., medical doctor, nurse, MedFT, or dietician; see Fig. 2). By adding the health coaches into the system, MedFTs were able to maximize their skill set to a Level 5 proficiency by focusing on the mental health symptoms of the patient/patient's family, assisting master's level clinicians and health coaches on questions pertaining to operational workflow,

and participating as IBHC trainers for new providers that were hired into the CHC.

As of 2015, every CHC location has operated at a Level 4 or 5 in terms of the MedFT-HCC continuum and Level 4 or 5 on the PCBHC continuum. However, two significant shifts occurred in 2016: (a) a 100-h IBHC bootcamp was created to ensure that every health coach and MedFT received the same in-depth training on clinical, operational, and billing processes and had the chance to practice through role plays and EHR templates and (b) the MedFT team was given the opportunity to help shape the EHR by including a series of pediatric and adult behavioral health screeners (that had been indicated for the diverse population we serve) to better track patients' health goals and progress.

First, through the IBHC bootcamp, MedFTs were trained on the MEDSTAT acronym (based out of Solution Focused Therapy; Giorlando, & Schilling, 1997) and the health coaches were trained on the OARS DEARS acronym (based out of Motivational Interviewing; Miller & Rollnick, 2002). Both learned about the importance of honoring relational, cultural, and diverse influencers when navigating through their interventions. Each new team member then had to complete a list of IBHC competencies. Furthermore, three sessions with patients, led by the health coach or MedFT,

were reviewed using an IBHC shadowing rubric. Once cleared (i.e., approved by a clinical supervisor to work independently), the health coach or MedFT was allowed to see patients and families. Health coaches and MedFTs continued to be reviewed at least biweekly to ensure fidelity to the model (see Appendix 1).

Continuous feedback from the MedFTs was important to further strengthen the model. For example, new screeners were added to the clinical model and into the EHR template with foci including healthy eating, sleep hygiene, health promotion behaviors, stress levels, suicide risk, and social determinants of health. Based on adjustments to the EHR templates, it was easier to discern that 83% of all behavioral health encounters were conducted through IBHC compared to the 17% conducted through the in-house family therapy referral system (i.e., co-location service model). In addition, we could discern that 95% of the IBHC visits with the MedFT were 30 min or less (which is standard practice for IBHC models; Collins et al., 2010), meaning that more patients could be served than in a traditional 45–50 min therapy encounter.

Shifts in the IBHC model from 2015 to 2017 resulted in a significant increase in patient contact, as evidenced by 4043 completed PHQ-9s and 2309 GAD-7 screeners (of the 11,124 patients seen in clinic). Serving twice the number of patients from an underserved population was deemed a significant resource. One of the most relevant findings from 2017 was that patients with uncontrolled diabetes were more likely to return for a follow up visit when receiving IBHC (70% returned) compared to receiving care from their PCP without IBHC (49%).

In 2018, another innovation for IBHC emerged through the inclusion of a MedFT in one of the CHC's dental clinics. Initially this integration was challenging as the dental clinic had a different EHR system than the medical side of the CHC and there was only one office space that had a door to secure confidentiality needed for mental health screenings and treatment. Furthermore, the MedFT was only on-site for 10 h a week. Given the importance in building a model that would work in the dental clinic, a more consistent model of IBHC was not enacted until 2020. Even though the MedFT was only able to be on site intermittently (face to face) with patients due to the COVID-19 pandemic, and they were only contracted for 10 h a week, 109 patients were screened with the PHQ-9. Just more than 20 patients were treated regularly throughout the year for complex mental health and relational health concerns. Interestingly, many of these patients did not have a primary care provider and most would have never been identified as experiencing mental health concerns had it not been for this MedFTs contribution to the dental clinic.

While it is still too early to discern how the COVID-19 pandemic influenced the patients and providers throughout this CHC, what we do know is that the level of mental health services were substantial with the smallest IBHC team since 2006. Preliminary findings suggest that the team of seven MedFTs who were contracted for 10–15 h a week completed 6495 PHQ-9 and 3019 GAD-7 screeners in English and Spanish with the 13,842 patients who received care in 2020. Furthermore, the MedFTs were actively following 685 patients who had positive PHQ-9 scores, meaning that the patient's score indicated the need for follow up care.

Lessons Learned

Many valuable clinical, operational, financial, and educational lessons have been learned throughout the IBHC implementation process within this rural CHC system. The MedFTs, through in-depth training have contributed relationally-based and cultural humble care into the practice of IBHC, however there has been a continuous need to update the evidence-based protocols as well as operational and billing policies (Muse et al., 2017), particularly through changes in federal billing and telehealth transformation throughout the pandemic.

Clinical World

The implementation of IBHC through this FQHC has made a clear difference in the services provided to patients. One early lesson from the clinical world was the realization that a recruitment pipeline was needed to ensure we were growing enough professionals to fill the IBHC needs of each site. By growing and sustaining IBHC over the past 16 years, thousands of patients have learned that their psychosocial and spiritual health are just as important as their physical health. Based on early clinical successes, the IBHC model pivoted over time to include diverse services such as case management, health coaching, and MedFT. The expansiveness of the services and size of the team has afforded patients a way to receive a variety of mental, behavioral, social, and relational health services in tandem with medical and/or dental health all in one location. Through these additions, the IBHC team has welcomed conversations about social needs such as food insecurity, health behaviors such as tobacco use and stress management, as well as treatment options associated with mental health diagnoses. Furthermore, the IBHC team has constructed a mutually beneficial relationship with each collaborator on site (i.e., other healthcare providers, billing specialists, and administrators), further strengthening the quality of care extended to patients.

A second lesson learned from the clinical world was the realization that accountability measures were needed to ensure that the IBHC model was effective, efficient, safe, equitable, and ethical. The use of regular fidelity checklists and evaluation metrics provided the leadership with

information that resulted in the development of a rigorous training model for the behavioral health team. Through the provision of a 100-h bootcamp, clinicians were able to better join, assess, diagnose, and treat complex psychosocial experiences (e.g., suicidal ideation, child maltreatment, and trauma) that were presented in primary care and dental visits. Availing patient access to well-trained behavioral health providers (across differing roles) as part of their medical visit resulted in the ability to expeditiously attend to numerous psychosocial concerns with immediate treatment options, compared to previous care whereby the patient may have left the visit with undetected or undertreated mental health concerns or referred out for services in the community.

Operational World

A most important lesson learned from the operational world was that for any IBHC model to be successful, there must be champions on site who can encourage practice, procedures, and policies across the disciplines that support the best collaborative care and continuity of care for all patients. These champions should represent various stakeholder groups invested in the care provided by the healthcare system (e.g., patients, front line healthcare providers, on-site specialists, administrators). Most importantly, these champions should represent the voice of the patients who would receive its services or participants who partake in its research. We have encouraged the IBHC team to become more involved in the community so that they can better understand access to care for patients and facilitate opportunities to maximize continuity of care. We require our team to engage in at least one outreach event a month (e.g., conducting screenings at schools, elder centers) to continuously strengthen relationships between IBHC providers and our rural families /communities while also strengthening and challenging our own cultural humility.

A second lesson learned from the operational world was that a decision tree was needed to help maximize efficiency of the IBHC team in context of the overall workflow for each site. Once health concern(s) were identified using patient, provider, and health information resources, a decision tree was constructed that outlined an IBHC workflow based on presenting concern of the patient(s). This decision tree allowed each team member (based on their role) a way to prioritize care based on presenting concern and preferred outcomes. Once the decision tree was constructed, assessments and treatment protocols were created in alignment with each stage of care.

There are many examples for evidence-based IBHC models (e.g., Hodgson et al., 2018; Martin et al., 2014), but the center or clinic will need to determine what best fits their population and available resources. We learned quickly that the team will need to decide the most appropriate

PCBHC level for the patients and context, as well as the level of MedFT-HCC requested or indicated for the site. At times it is helpful to have collaborators from outside the system, such as experts in IBHC or Level 5 trainers from the MedFT-HCC, to assist with the retraining of healthcare teams. Regardless of the training protocol crafted, it should include ongoing didactic training, live observation, and fidelity checks as well as assessment measures so that providers remain true to the model, thereby maximizing efficiency of care (Lamson et al., 2014; Pratt & Lamson, 2012).

A final lesson learned from the operational world was that there was an important distinction to be made between co-locating behavioral health providers (like MedFTs in the physical location) and integrating them as part of the healthcare team. Early on, the developers of this IBHC model realized that if the MedFTs were not visually locatable to the primary care providers when they entered and exited exam rooms, collaboration often ceased to take place. Some sites had a few nursing or medical assistants who would seek out the MedFT's whereabouts in the clinic and subsequently served as the champions for IBHC. However, if the MedFTs were not in clear view, and there was not a champion who sought them out for the patient, the PCPs would revert back to their former workflow patterns. Workflow changes, like adding joint case conferences to provider schedules and positioning MedFT workstations in the main hallways where patient care took place, were critical adjustments.

Financial World

The work described in this manuscript has largely been supported through federal grant funding. However, the Center's leadership witnessed MedFTs added value (e.g., quality care to patients, enhanced the well-being and collaboration with all staff and providers, and improvements in physical and mental health of patients) soon after the first IBHC grant was funded. This resulted in permanent MedFT salaries (i.e., not grant funded). The first full-time behavioral health provider (a bilingual therapist) was hired in 2007. By 2016, the FQHC hired a behavioral health administrator with oversight over numerous behavioral health employees. This hire increased the number of full-time employees on hard funds, rather than soft funds (e.g., grants) exponentially.

Overall, FQHCs are designed to provide comprehensive services that span primary care, dental care, behavioral health, case management, transportation, and translation services (of which are not covered by fee-for-service Medicaid). In place of a fee-for-service reimbursement system, FQHCs receive a single, bundled rate for each qualifying patient visit that covers services and supplies used for each patient care visit. This bipartisan payment methodology, passed by Congress, is referred to as the FQHC Prospective Payment System (PPS). It ensures FQHCs remain financially

viable in partnership with Medicaid and Medicare. Given that the PPS is oftentimes still not sufficient to cover patient care costs, many FQHCs have moved to alternative payment methodologies such as value-based payment arrangements. As the payor mix has changed over the years, resultant to the Affordable Care Act, administration has worked to construct a fiscally responsible plan to ensure all patients have equal access to behavioral health services. The complexities associated with reimbursement and billing are continuous and offer a revolving lesson learned experience.

Educational World

Peeks' fourth world (i.e., training and education) has been necessary at many levels of the creation, implementation, and sustainability of the IBHC model. The Center's leadership team noticed that a segment needed to be added into the orientation for new PCPs and healthcare team members (e.g., nurses, medical techs, case managers) so that they would better understand the IBHC model and the roles of health coaches in contrast to MedFTs. What Peek (2008), as well as our leadership team realized is that there was turnover in the workforce, which meant there needed to be a plan in place for onboarding new team members. Once a provider/team member adopted the IBHC work style, it was very difficult to get that provider to change. Therefore, orientation and model fidelity checklists were crucial to the success of the IBHC model.

Patients, too, needed to be educated about the new IBHC model, so a flag system was developed in the EHR in year one that alerted the MedFT to know whether or not a patient needed to be educated about the IBHC model before introducing themselves as a member of the healthcare team. It was especially important for all PCPs to inform patients about the inclusion of a MedFT as part of the healthcare team because it was another means of ensuring consent for this type of treatment and for the potential of mental health services (Hodgson et al., 2013).

With regard to consent, it was important that providers did not solely rely on the documentation completed when patients established their care, as many patients did not thoroughly read or fully comprehend the written materials. Without the trust and consent of the patient, as well as the confidence of the provider, the MedFT encounters would not be productive or ethical. In our case, each visit began with a dual consent process whereby MedFTs introduced themselves and their role, describing to patients that they see all patients who come to the clinic. Our aim was to minimize stigma often associated with mental health questions or symptoms. After providing a brief description of their role, the MedFT asked for consent to continue with the appointment. A second level of consent was sought after informing the patient that content shared during the appointment would be documented in the same chart as the one used by the primary care provider. Consent through these processes maximized the likelihood for team-based care while also honoring the strengths and challenges voiced by the patient/family. The lesson learned through this two-pronged consent was that providers and patients needed to be aware of the shifts into mental health treatment or treatment plans that were in context of their medical treatment plan.

Finally, and most importantly, the insight gained through this world has been the need for continuous understanding and respect for cultural acceptance, sensitivity, and humility. In addition to in-depth training on diversity, equity, and inclusion in the 100-h bootcamp, most MedFTs quickly learned key phrases and words in Spanish to help communicate with patients. Initially our team included one bilingual provider but has grown to include one-third to one-half of our team. For those who are not bilingual, we have secured a technology system that allows for live, synchronous, and encrypted translation for patient and provider during any visit. In addition, the team is trained to attend to pronouns when shared by patients. Language and linguists are also attended to on all forms and educational handouts to maximize cultural sensitivity and attention to ability, sexual orientation, and gender identities.

All IBHC team members have received training on cultural and global awareness, sensitivity, and cultural humility (McDowell et al., 2017). To be part of our team, MedFTs must continuously work to improve their competency in cultural awareness and sensitivity as part of their requirements for clinical and/or research practices. Weekly supervision sessions include discussions that prompt and assess members' cultural humility. Furthermore, trainings pertaining to diversity are encouraged to strengthen clinical competencies and team members' cultural humility. Trainings range from recognition of racial, ethnic, religious, sexual orientation and gender identities, age, military versus civilian status, and ability through each interaction (re: building rapport/joining, assessing, diagnosing, and intervening).

Cultural awareness and sensitivity for MedFTs also includes an understanding of indicated interventions that are most appropriate for and have relevant outcomes with specific minoritized populations, rather than identifying interventions that have only been successful with majority populations and applying them to all individuals, couples, or families regardless of their social location (Hodgson et al., 2018; Lewis et al., 2014; Shin, et al., 2003). The lessons learned through cultural humility have been countless, through numerous ongoing interactions with patients, MedFT students, MedFT supervisors, the larger IBHC team, and CHC providers and leadership.

Conclusion

This article provided a framework for how the primary care/behavioral healthcare collaboration (PCBHC; Doherty et al., 1996) relates to the work and practice of MedFTs as conceptualized through the MedFT Health Care Continuum (MedFT-HCC; Hodgson et al., 2014). The description of an IBHC model in a rural community health system demonstrated that as MedFTs moved through the MedFT-HCC, the level of integration between medical and behavioral health care also increased. In the presented rural CHC system example, the MedFTs were key in providing BPS-S care to patients. Lessons learned from the process of integrating MedFTs into the community health system included the importance of provider buy-in, and collaboration between healthcare providers, along with incorporating the voice of the patient and the family/support system. It is the authors' hope that this article will demonstrate how MedFTs are valuable assets in efforts to merge medical and psychosocial care in a healthcare system, as well as to help MedFTs navigate their role in IBHC. Federal expectations for CHCs have increased, and behavioral health integration is at the forefront of transforming healthcare across the nation. MedFTs can thereby fulfill a great need in CHCs by providing family-centered behavioral and mental healthcare, while at the same time attend to the larger system and quality improvement efforts.

Appendix 1: Behavioral Health Program Clinical Evaluation Form

Behavioral Health Program Clinical Evaluation Form

Name: _____

Supervisor: _____

Date: _____

Interviewing skills	Not Performed (when this skill was relevant and BHP did not use it)	Attempted did not meet expectation	Met expectation –Skill successfully and consistently performed when relevant	Exceeded Expectation	Connected to Assessment and Goal	N/A
1. Introduces self and the IC model smoothly ( ) conveys the BHP role to all new patients ( ); identifies self as a student ( ); and explains the role of the supervisor in the encounter ( ).						
2. Obtains verbal consent for BH service ( ); for shared documentation ( ); to consent for tx with others present in the room ( )						
3. Confirms Date of Birth (telehealth only)						
4. Effectively joins with patient						
5. Explores BPSS factors impacting the identified problem(s)						
6. Prioritizes patient's needs to be addressed in the encounter						
7. Utilizes MI/SF interventions as suitable for primary care						
a. BH trainee assumes a non-judgmental, empathic, and encouraging stance.						
b. Conversation centered on the patient's desired health goals ( ); empowers patient to set health goals ( ); and include support persons they want involved ( )						
c. Collects all elements for S ☐ M ☐ A ☐ R ☐ T ☐						
d. Collaborates with patient to acknowledge and scale level of ambivalence towards change						
e. Effectively utilizes the four basic skills of MI O ☐ A ☐ R ☐ S ☐						
f. Effectively utilizes MI interventions consistent with stage of change: D ☐ E ☐ A ☐ R ☐ S ☐						
g. Effectively utilizes SF interventions M ☐ E ☐ D ☐ S ☐ T ☐ A ☐ T ☐						
h. Administers PHQ ( ); GAD ( ); and other relevant screening and assessment instruments appropriate to the encounter						
8. Assists PCP in identifying target behaviors.						
9. Demonstrates consistent awareness of the impact of diversity issues including cultural, race, ethnicity, occupation, socioeconomic, religious, ability, gender, and sexual orientation.						
Consultation Skills						
1. Consults with PCP ☐ before ☐ after encounter						
2. Recommendations are tailored to the pace of primary care (brief, functional, practical) / telehealth encounter						
Practice Management						
1. Keeps most visits between 15-20 minutes. Rapidly **identifies problem, establishes assessment, delivers intervention, and develops plan.**						
2. Stays within consultant model while utilizing, as necessary and appropriate, internal resources (PCP, BHC handouts)						
3. Reflects and displays awareness of clinic policies (e.g., need to know), professional ethics (e.g., confidentiality), and state statuses (e.g., mandated report) as relevant to clinical practice. Discusses ethical concerns with supervisor.						

Name: _____

Supervisor: _____

Date: _____

Documentation skills	Did not meet expectation	Meets Expectation Attempted (BHP was aware of relevant skill and attempted to use it)	Exceeded Expectation Skill successfully performed	Connected Assessment and Goal at maximum skill set	Proper use of diagnosis code and billing code
1. Accurately completed EHR documentation					
Chart 1					
Chart 2					
Chart 3					
2. Accurately completed billing documentation					
Chart 1					
Chart 2					
Chart 3					

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