




# Improving Integrated Mental Health Care Through an Advanced Practice Registered Nurse–Led Program: Challenges and Successes

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## Abstract

Integrated and collaborative care delivery models have demonstrated efficacy for the management of psychiatric conditions in the primary care environment, yet organizations struggle with implementation of integrated efforts in clinical practice. Delivering care with a population focus versus face-to-face encounters with individual patients requires financial investment and adjustment in care delivery. We discuss the early implementation process of an advanced practice registered nurse (APRN)–led integrated behavioral health care program, including the challenges, barriers, and successes in the first 9 months of the program (January–September 2021), for an academic institution in the Midwest. A total of 161 Patient Health Questionnaire 9 (PHQ-9) and 162 Generalized Anxiety Disorder (GAD-7) rating scales were completed on 86 patients. The mean PHQ-9 score at the initial visit was 11.3 (moderate depression); after 5 visits, it decreased significantly to 8.6 (mild depression) ( $P < .001$ ). The mean GAD-7 score at the initial visit was 10.9 (moderate anxiety); after 5 visits, it decreased significantly to 7.6 (mild anxiety) ( $P < .001$ ). A survey completed by 14 primary care physicians 9 months after program launch revealed improvements in satisfaction with collaboration but, most notably, in perception of access to and overall satisfaction with behavioral health consultation/patient care services. Program challenges included adapting the environment to enhance leadership roles for the program and adjusting to virtual availability of psychiatric support. A case example highlights the value of integrated care along with improved depression and anxiety-related outcomes. Next steps should include efforts that capitalize on nursing leadership strengths while also promoting equity among integrated populations.

## Keywords

mental health and well-being, screening, clinical populations, treatment, quality of care

Integrated and collaborative care delivery models have demonstrated efficacy in the management of psychiatric conditions encountered in the primary care environment.<sup>1,2</sup> Integrated and collaborative models typically provide strategic team-based care to support the psychiatric management of patients in the primary care environment. However, despite the success of these delivery models, organizations struggle with the implementation of integrated efforts into practice. Organizational challenges of initiating integrated and collaborative models can include concerns about financial reimbursement for program start-ups and changing from traditional referral-based treatment for psychiatric services to delivery of services by primary care using structured team approaches.<sup>3,4</sup> Often, because integrated

efforts seek to deliver care using a population approach rather than one focused on face-to-face encounters with individual patients, it is difficult to justify financial reimbursement for

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integrated team members, such as behavioral health providers (BHPs) and psychiatric consultants, at program onset.<sup>5</sup> Furthermore, primary care environments differ in patient needs, scope of practice used for advanced practice providers (APPs), volume of patients, and/or facility accommodations, all of which need to be considered when seeking to initiate a new integrated program to improve access to psychiatric care.

## Purpose

The objective of this case study was to describe the implementation of an advanced practice registered nurse (APRN)-led integrated behavioral health care program, including the challenges, barriers, and successes encountered in the first 9 months. Program development included such factors as health care provider feedback, funding, and the unique primary care environment in which the implementation occurred. Outcome measures include a description of the patient population, progress on patient behavioral health scores, health care provider (ie, primary care physician [PCP] and APP) satisfaction, and access to behavioral health care services. To demonstrate the educational success of the program, we also provide an example of a case patient. To our knowledge, there has only been 1 previous report of a similar Midwest nurse practitioner-led program,<sup>6</sup> which found that integrated implementation efforts, whether nurse-led or not, often require approaches that align with the unique clinical environment. Furthermore, as integrated efforts expand to support access to psychiatric care, we are seeing the need to understand and leverage the expertise of appropriately trained nurse practitioners to serve in the lead roles, as they are well suited to these positions but are often underutilized. Our present work extends the previous literature by creating a nurse-led approach that leverages nurse practitioners in both family practice and psychiatry to serve in the lead roles of an integrated team.

## Methods

Graduate nursing faculty at the University of Nebraska Medical Center (UNMC) put together an APRN-led team in response to a call in a Health Resources & Services Administration (HRSA) training grant for a nurse education, practice, quality, and retention interprofessional collaborative practice program focused on behavioral health integration.<sup>7</sup> A primary focus of the grant is to educate and train current and future nursing workforces to provide interprofessional, evidence-based, integrated behavioral health services. The grant provides funding for up to 3 years (July 2020 through June 2023). The first portion of the 3-year funding was directed to support a full-time BHP; purchase of a registry to track patient progress, including outcome measures and engagement/utilization with the BHP; and integrated role training and tasks for each APRN. The UNMC Institutional Review Board determined the study did not constitute human subjects research and was therefore exempt.

## Study Setting

The urban academic primary care clinic is a patient-centered medical home in the Midwest consisting of 15 PCPs, 2 physician assistants (PAs), and 2 APRNs; the clinic served 7786 patients during July 2019–June 2020. The 2 lead primary care APRNs identified for the grant were trained in family practice, 1 with a master's degree and the other with a doctoral degree. Each APP (PA or APRN) is matched with a group of 3 to 5 physicians and assigned a pod. Although the clinic has 15 PCPs, most do not have a full-time practice at the clinic; rather, they have academic faculty appointments, with their time divided among teaching, service, and practice activities, leaving many patients without access to their full-time provider for medical needs. To address this gap in care, the APRNs and PAs do not maintain a panel of their own patients but instead evaluate and treat patients during visits for acute and chronic conditions, hospital follow-ups, and preoperative examinations for the physicians in their pods. Communication occurs via electronic health records and informal dialogue after patient visits. Physicians are available in person or via telephone/text if immediate patient management questions arise.

Four years before the HRSA grant, the clinic had a part-time licensed mental health care provider serving as the BHP who rotated among several primary care clinics, reducing the opportunity for PCPs to have the BHP meet with the patient using “NOW” visits. A NOW visit is a visit in which the PCP identifies an immediate need for behavioral health services (eg, for anxiety, substance use disorder) during a primary care visit, and the BHP meets with the patient at that time. The PCPs, clinic medical director, organizational behavioral health administrators, and clinic administration were eager to employ a full-time BHP in the clinic. The opportunity to fund a full-time BHP via the HRSA grant incentivized clinic administration to develop an APRN-led integrated program, because the clinic would not be able to support a BHP or a program without external funding. The level of behavioral health integration planned would advance the clinic from a co-located clinic (Level 3)—in which care is provided in the same facility and collaboration is driven by the need for specialty services—to a comprehensive integrated clinic (Level 6)<sup>8</sup>—in which care is provided in a shared practice space and collaboration is driven by team-based care, as a result of the HRSA grant. Clinic integration would occur in a stepwise fashion, including yearly adjustments, with the first few years dedicated to education, training, role development, and adherence to evidence-based practice.

## Collaborative Care Model

The integrated team consists of a BHP (a licensed independent mental health clinician serving as the core of the team receiving PCP referrals), a psychiatric APRN with a doctoral degree and advanced training in integrated care fulfilling the

psychiatric consultant role of providing medication and non-pharmacologic management recommendations, and 2 family practice APRNs charged with facilitating team communication and leading and championing the program. Prior to program implementation, regular meetings were convened for the better part of a year. Training was completed by using online materials from reputable resources on integrated and collaborative care models, including the AIMS Center at the University of Washington and the American Psychiatric Association.<sup>9,10</sup> Clinic-chosen activities from the Step-By-Step Implementation Guide for Collaborative Care were used to guide and inform implementation efforts.<sup>11</sup> Nursing faculty, the integrated team, the clinic medical director, organizational behavioral health administrators, and clinic administration met to determine and complete workflows that would be suitable for the current clinic environment. In addition, prior to patient enrollment, the team discussed and made decisions about integrated training, procedures, processes for communication unique to the pod environment, anticipated barriers, potential challenges, definitions of team member roles, and use of a registry.

### **Access to BHP**

The BHP workflow consisted of 4 scheduled patients per day; PCPs were notified of these visits either by verbal follow-up from the BHP or by communication in the electronic medical record. Previous BHP workflows consisted of 1 patient per hour for the entire clinic day. Clinic administration and PCPs expressed concerns about limiting the number of scheduled visits and the shift from their previous experience. The scheduling was intentional to promote visibility and opportunity for NOW visits. Furthermore, designated time was needed for the BHP to complete registry documentation, attend team meetings, and provide necessary follow-up for enrolled patients, which is congruent with integrated care management.

### **Team Communication**

The integrated team meets virtually on a weekly basis to review registry information and identify any patients who are not improving or could be discharged. Because most PCPs are not available in the clinic on a full-time basis, lead APRNs checked in with PCPs throughout the week to identify any medication or patient-related psychiatric needs that could be addressed through the weekly team meetings. PCPs were reminded of these meetings and encouraged to attend to receive guidance from the psychiatric mental health nurse practitioner consultant in real time, if needed.

### **BHP Visits**

The BHP meets with patients who are referred or scheduled as part of the NOW visit. Referrals are made to the BHP by

physicians and APPs in the clinic for any behavioral health concern. Patients are added to the registry if the team determines the patient is appropriate for retention in the primary care clinic for psychiatric management (ie, patient does not have psychiatric complexity that evidence suggests should be managed by a specialist) and/or likely responsive to time-limited psychotherapy. During the initial meeting, the patient completes baseline assessments of well-being: the 9-item Patient Health Questionnaire (PHQ-9)<sup>12</sup> assesses for depression, and the 7-item Generalized Anxiety Disorder (GAD-7)<sup>13</sup> assesses for anxiety. A PHQ-9 score of 5-9 indicates mild depression, 10-14 moderate depression, 15-19 moderately severe depression, and 20-27 severe depression. A GAD-7 score of 0-4 indicates minimal anxiety symptoms, 5-10 mild anxiety symptoms, 10-14 moderate anxiety symptoms, and 15-21 severe anxiety symptoms. These assessments are also completed at every patient follow-up visit with the BHP for patients with a score >0 for the PHQ-9 and/or GAD-7.

The BHP collaborates with the team to identify patient care successes and barriers by using PHQ-9 and GAD-7 measures, team communication, and patient progress toward goals. The BHP sessions are about 30-45 minutes and use brief psychotherapies. The number of sessions is flexible (ranging from 4 to 8 sessions) if there is no indication that the patient requires long-term therapy; in those instances, the patient is referred to the psychiatry department.

### **BHP Data Collection**

Patient data collected in the registry included psychiatric diagnosis, psychotropic medications being prescribed, age, race, gender, PHQ-9 score, GAD-7 score, number of visits with BHP, type of visit with PCP (NOW or follow-up) when BHP referral was made, communications with patients, and any communication to coordinate care with the integrated team.

### **Provider Satisfaction**

We administered a questionnaire via email to all PCPs to assess their satisfaction with the program at baseline (January 2021) and 9 months later (September 2021) using a 6-point Likert scale (from 1 = strongly disagree to 6 = strongly agree). The 12-item questionnaire assessed 4 areas of PCP satisfaction: collaboration consideration, attitude and perception of BHP services, patient/provider accessibility of BHP services, and overall satisfaction with BHP services. Collaboration consideration was assessed with 3 items related to when PCPs consider referring to BHPs those patients who have psychiatric concerns, who have health behaviors affecting physical or medical conditions, or who present to their provider with psychiatric symptoms that are not the chief concern for the visit. Attitude toward and perception of services were assessed with 3 items inquiring about the BHP serving as a resource, their perception of their

**Table 1.** Types of visits among behavioral health patients (n = 141) in an integrated behavioral health care program led by advanced practice registered nurses at an academic institution in the Midwest, January–September 2021<sup>a</sup>

Variable	January	February	March	April	May	June	July	August	September
Visits attended	0	10	41	43	38	47	42	31	59
No-shows	0	0	11	13	10	11	29	14	14
Cancellations	0	0	19	24	15	34	19	28	25
NOW visit <sup>b</sup>	NA	3	1	7	6	9	8	1	5
Active integrated patients	0	10	32	49	66	89	110	123	141

Abbreviations: BHP, behavioral health provider; NA, not applicable.

<sup>a</sup> All values are numbers. Not all 141 participants provided these data.

<sup>b</sup> A NOW visit refers to an immediate need for behavioral health services (eg, for anxiety, substance use disorder) during a primary care visit, and the BHP meets with the patient at that time.

ability to care for patients with behavioral health issues, and feedback from the BHP. Patient/provider accessibility of services was assessed with 2 items that included the ease of accessing the BHP for patient discussions or as-needed consultations and the availability of the BHP to see the patient shortly after referral. Overall satisfaction with BHP services was assessed with 4 items that asked whether the BHP services were of benefit to patients, the treatment received by patients was effective, the care provided by BHPs was satisfactory, and the BHP consultation/collaboration resource for PCPs to provide care was satisfactory. The grant project director and a staff clinical psychologist developed the questionnaire for the purposes of the grant project.

### Data Analysis

We calculated descriptive statistics on all demographic variables (age, gender, race and ethnicity, diagnoses, and medications), GAD-7 and PHQ-9 scores, and questionnaire responses. We assessed GAD-7 and PHQ-9 scores for normality. We implemented longitudinal hierarchical linear models to assess changes over time in these variables. Hierarchical linear models accommodate the varying number of time points across individuals through the use of restricted maximum likelihood estimation (cases are not deleted listwise). We assessed PCP satisfaction with collaboration consideration, attitude and perception of BHP services, patient/provider accessibility of BHP services, and overall satisfaction with BHP services. We used survey data for quality improvement efforts throughout the program. We used IBM SPSS version 28 (IBM Corp) for all analyses and an  $\alpha$  level of .05 to determine significance.

### Outcomes

During the first 9 months of the program, from January through September 2021, a total of 311 visits were scheduled with the BHP and 141 patients were enrolled in the program registry. An additional 40 NOW visits were conducted by the BHP.

### Demographic Characteristics and Population Description

Of the 107 patients for whom data on demographic and population characteristics were available, the mean (SD) age was 49.4 (17.2) years, 65 (60.7%) identified as female, 40 (37.4%) identified as male, and 2 (1.9%) identified as other gender. Of 103 patients for whom health insurance data were available, 51 (49.5%) had private health insurance, 37 (35.9%) had Medicare, 13 (12.6%) had Medicaid, and 2 (1.9%) had no health insurance. By race and ethnicity, of 106 patients with available data on race and ethnicity, 86 (81.1%) were non-Hispanic White, 9 (8.5%) were non-Hispanic Black or African American, 6 (5.7%) were Hispanic, 1 (0.9%) was American Indian/Alaska Native, and 4 (3.8%) were Other race (ie, not mentioned). Of 107 patients, psychiatric diagnoses included depression or mood-related disorder (n = 62, 57.9%), anxiety including posttraumatic stress disorder (n = 59, 55.1%), attention deficit and disruptive behavior disorders (n = 5, 4.7%), and substance, alcohol, or nicotine use disorders (n = 15, 14.0%). Of 107 patients, antidepressants were prescribed to 54 (50.5%) patients, benzodiazepines with or without an antidepressant were prescribed to 19 (17.8%) patients, and 38 (35.5%) patients were not prescribed any psychotropic medication. Of patients who were prescribed any type of psychotropic medications, 43.5% (30 of 69) were prescribed  $\geq 2$  at a time.

The BHP completed 161 PHQ-9 and 162 GAD-7 ratings on 86 patients. One hundred two patients did not attend follow-up appointments, and 164 follow-up appointments were canceled (Table 1). Of 86 patients who completed PHQ-9 assessments, the mean PHQ-9 score at the initial visit was 11.3 (moderate depression); after 5 visits, the mean score decreased significantly to 8.6 (mild depression) ( $P < .001$ ). Of 86 patients who completed GAD-7 assessments, the mean GAD-7 score at the initial visit was 10.9 (moderate anxiety); after 5 visits, the mean score decreased significantly to 7.6 (mild anxiety) ( $P < .001$ ) (Figure).

Fifteen PCPs in the clinic completed a baseline satisfaction survey in January 2021, and 14 PCPs completed



the follow-up survey in September 2021. After 9 months of delivering integrated behavioral health services, PCPs noted improvement in all areas but most substantially in perception of patient/provider accessibility of BHP services (mean of 4.5 in January to 5.3 in September) and overall satisfaction with behavioral health consultation/patient care services (mean of 5.2 in January to 5.7 in September). The variance of scores decreased substantially from baseline to follow-up (Table 2).

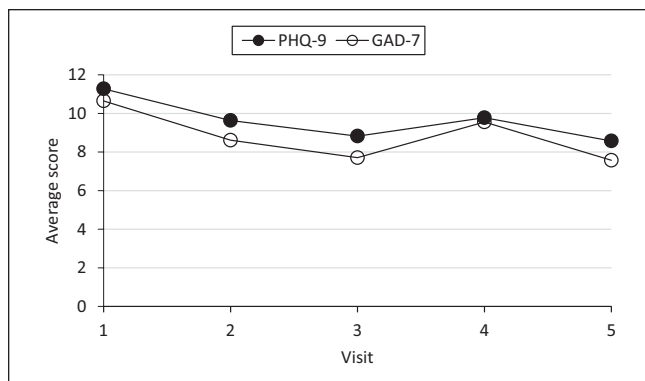
## Lessons Learned

Anticipating how to facilitate communication presented challenges in an environment where the milieu, albeit not intentionally but likely a product of historical functioning, was predominantly driven by physicians. When clinic administration, PCPs, and the clinic medical director were first

approached about APRNs leading the program, they were hesitant about a program that would not be physician led, expressing concerns about how physicians would respond to recommendations from APRNs and/or working in an APRN-led integrated delivery model.

Notably, although APRNs are required to demonstrate leadership competencies in educational training, the operationalization of these developed skills is often limited.<sup>14-16</sup> Viewing APRNs as leaders in an organization is impeded when they are predominantly hired to engage in direct patient care activities.<sup>17</sup> Supporting APRN-led programs capitalizes on their available scope and promotes health care innovation.<sup>16</sup> APRNs in this Midwestern clinic provide episodic care to patients, but ultimate management is determined by the patients' PCPs. The proposed APRN-led program facilitated interdisciplinary collaboration but bucked the traditional top-down processes of nonintegrated primary care operations. Weekly team meetings revealed this shift in dynamics and the importance of building confidence in APRNs to promote successful uptake and effectiveness of the program among physician colleagues, along with navigating the challenges resulting from the historical functioning perceived by PCPs.

The APRN team helped the PCPs to communicate challenges with psychiatric medication management to the lead APRNs; however, the usual in-person psychiatric support provided to PCPs by the psychiatric APRN consultant was hindered because of social distancing measures implemented during the COVID-19 pandemic. The decision was made during program planning to have the psychiatric APRN consultant serve in a supportive role rather than meet with patients directly, with the PCP and BHP directly managing the patient's care. Rationalization for this decision was based on the availability of psychiatric provider time and the importance of shifting to a population focus of treatment versus in-person patient encounters. An important component of integrated care is empowering providers to directly manage patient care with specialist support recommendations and providing education to do so. The integrated team attended monthly "all provider meetings" to review available resources and highlight successes. Yet uptake remained limited despite



**Figure.** Personal Health Questionnaire (PHQ-9) and General Anxiety Disorder (GAD-7) assessments of behavioral health patients ( $n = 86$ ) in an integrated behavioral health care program led by advanced practice registered nurses at an academic institution in the Midwest, January–September 2021. The 9-item PHQ-9<sup>10</sup> assesses depression and the 7-item GAD-7<sup>11</sup> assesses anxiety. A PHQ-9 score of 5-9 indicates mild depression, 10-14 indicates moderate depression, 15-19 indicates moderately severe depression, and 20-27 indicates severe depression. A GAD-7 score of 0-4 indicates minimal anxiety symptoms, 5-10 indicates mild anxiety symptoms, 10-14 indicates moderate anxiety symptoms, and 15-21 indicates severe anxiety symptoms.

**Table 2.** Primary care physician satisfaction with behavioral health provider services in an integrated behavioral health care program led by advanced practice registered nurses at an academic institution in the Midwest, 2021

Factor	Mean (SD) rating <sup>a</sup>	
	January 2021 ( $n = 15$ )	September 2021 ( $n = 14$ )
Collaboration consideration	4.9 (1.3)	5.3 (0.9)
Attitude/perception of services	5.1 (1.3)	5.6 (0.7)
Patient/provider accessibility	4.5 (1.2)	5.3 (0.9)
Overall satisfaction with services	5.2 (1.2)	5.7 (0.6)

<sup>a</sup> Using a 6-point Likert scale, from 1 = strongly disagree to 6 = strongly agree.

continued expressed need from PCPs for psychiatric management. In a mitigation effort, the psychiatric APRN consultant started in-person weekly clinic visits, met with providers, and promoted use of consultation services. In the brief few weeks during which this change was implemented, the number of medication-related consultation questions increased from 1 or 2 per month to 5 per week.

One last notable finding was that the cancellation and no-show rates were not as expected for an integrated program. But, according to available behavioral health clinic data procured by the behavioral health administration, the average no-show rates (25.8%) were similar among BHPs at other clinics affiliated with this organization (email, clinic administration, The Nebraska Medical Center, September 2, 2022). The no-show and cancellation rates were discovered as data were collected and reviewed in team meetings. We speculate that the first-time no-show visit rates among patients who are able to meet with the BHP during their encounter with their PCP at a NOW visit may decrease, but we did not track this information at program onset to verify. Improving these statistics along with other important sustainability factors will be part of quality improvement efforts as the grant continues.

## Successes

To demonstrate the program's success, we provide an example of a case patient. A lead APRN evaluated via telehealth (in adherence to COVID-19 pandemic protocols at the time) a female patient aged <25 years who was experiencing depression and anxiety because of health care issues. The APRN completed PHQ-9 and GAD-7 assessments. The APRN prescribed a selective-serotonin reuptake inhibitor medication (SSRI) and referred the patient for a virtual telehealth appointment with the BHP. The APRN-led team monitored the patient's progress during team meetings. It was revealed in team meetings that common practice in this case and in similar cases was to prescribe an antidepressant and follow up with the patient in 4 to 6 weeks. Yet, based on FDA guidelines,<sup>18</sup> patients aged <25 years should be monitored closely, especially in the first few weeks of treatment, when initiating an SSRI to evaluate response to medication and monitor for safety. The psychiatric APRN consultant provided education and direction based on this awareness, taking into consideration the patient's age, contributing factors, evidence-based practices, and safety monitoring. Specifically, the psychiatric consultant directed the APRN to follow up with the patient more frequently, recommended prompt titration of medication, encouraged behavioral activation, and provided a referral for psychotherapy. The APRN continued to monitor the patient closely and noted symptom improvement. Without integrated psychiatric expertise, this case would have been handled differently, with potential increased safety risks and treatment delays.

After initial challenges in adopting the collaborative model, not only was patient care substantially improved

along standardized metrics of patient outcomes, but physician satisfaction with the collaborative efforts also improved. The perception of patient and PCP access to integrated behavioral health services improved, as did PCPs' orientation toward engaging with collaborative care partners in the shared treatment of patients with psychiatric and/or behavioral health concerns. The grant funding is dispersed across 3 years. The focus of the first year and 9 months of implementation efforts harnessed existing integrated training but also required adaptation to acclimate to the unique clinic environment. Next steps in the grant period are focused on sustainability efforts and solidifying mechanisms to ensure financial viability once funding is discontinued.

## Conclusion

Our preliminary findings of an APRN-led integrated behavioral health program may enable others seeking to implement similar programs and can inform their efforts. Financial constraints, organizational culture, understanding and adoption of a new model, changes in workflow, and instantiation of new organizational leaders can compromise the effectiveness of attempts to implement integrated care. However, eventual progress toward, and ultimate successful transition to, a comprehensive integrated primary care clinic model can not only improve overall staff satisfaction and use of interdisciplinary resources but also lead to better patient outcomes. Furthermore, capitalizing on strengths that are inherent to nursing to promote communication and coordination of services accessible to the clinic is needed, as well as understanding how integrated efforts developed in recent years can be leveraged to promote health equity, quality improvement, and care management with social determinants of health in mind.

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