2024, Volume 56, Issue X, 1-7, e-ISSN 1938-3800

Family Medicine

ORIGINAL ARTICLE

When Interruption Becomes Innovation: How Integrated Behavioral Health in Primary Care Adapted During COVID-19

Brianna M. Lombardi, PhD, MSW[a,b,c]; Lisa de Saxe Zerden, PhD, MSW[b,c]; Danya K. Krueger, MSW, MBA[b]; Sundania J.W. Wonnum, PhD, BCD, LCSW[d]; Erica L. Richman, PhD, MSW[c]

AUTHOR AFFILIATIONS:

[a] Department of Family Medicine, School of Medicine, University of North Carolina at Chapel Hill

[b] School of Social Work, University of North Carolina at Chapel Hill

[c] Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill

[d] Division of Clinical and Health Services Research, National Institute of Minority Health and Health Disparities, National Institutes of Health, Bethesda, MD

CORRESPONDING AUTHOR:

Brianna M. Lombardi, Department of Family Medicine, School of Medicine, University of North Carolina at Chapel Hill, brianna_lombardi@med.unc.edu

HOW TO CITE: Lombardi BM, de Saxe Zerden L, Krueger DK, Wonnum SJW, Richman EL. When Interruption Becomes Innovation: How Integrated Behavioral Health in Primary Care Adapted During COVID-19. *Fam Med.* 2024;56(X):1-7. doi: 10.22454/FamMed.2024.168465

PUBLISHED: 15 July 2024

KEYWORDS: COVID19, integrated behavioral health, mental health, primary care, telehealth

ABSTRACT

Background and Objectives: Integrated behavioral health (IBH) delivered in primary care is critical to addressing the growing behavioral health crisis in the United States. COVID-19 prompted changes to the core components of IBH, causing the model to shift. The specifics of how IBH teams adapted and what these adaptations mean for the future of IBH teams in primary care are uncertain.

Methods: We conducted individual interviews with IBH team members using a semistructured interview guide. A purposive convenience sample consisted of primary care clinicians (N=20) from nine states. We used qualitative thematic analysis to code and generate themes.

Results: Four themes emerged: (a) permanent changes to the physical structure of the team; (b) increased reliance on technology for team communication; (c) shift in team collaboration, often occurring asynchronously; and (d) telehealth embraced for IBH.

Conclusions: COVID-19 interrupted the originally designed IBH model of team-based care. Changes to the physical proximity of team members disrupted all other components of IBH, requiring adapted workflows, communication via digital channels, virtual team building, asynchronous care coordination, and remote service delivery. Long-term evaluation of these innovations is needed to examine whether shifts in core components impact model efficacy. Training family medicine, primary care, and behavioral health clinicians for these adapted models of IBH will be needed.

BACKGROUND

Expansion of integrated behavioral health (IBH) delivered in primary care is critical to addressing the growing behavioral health crisis in the United States. Evidence that patients are more likely to receive a behavioral health diagnosis and treatment in primary care compared to specialty mental health settings has been documented.[1,2] COVID-19 disrupted primary care delivery in many ways, requiring modifications to IBH. Social distancing protocols and stay-at-home orders significantly altered operations of primary care, and telehealth services rapidly expanded.[3] Behavioral health clinicians (BHCs) and IBH teams increased the proportion of care delivered via telehealth, which is now supported by regulation and reimbursement parity. Consequently, core components of IBH shifted to allow for this hybrid team arrangement.[3–6] However, how IBH teams adapted to these changes and what these adaptations mean for the future of IBH teams in primary care and for the IBH model long-term are uncertain.[7]

Core Components of IBH

IBH is an evidence-based approach that concurrently addresses patients' behavioral health and physical health needs.[1,8] IBH is an important mechanism for increasing access to behavioral health care, particularly in rural and underserved areas.[8] Nearly a quarter of all family medicine physicians report working collaboratively with a BHC.[9] Although the implementation of IBH varies, some core components are understood as essential to the model's delivery.[1,4,8] One component is shared physical workspace (ie, colocation), which can increase the likelihood of collaboration, ease workflows, support same-day BHC service availability, and facilitate in-person referrals. A second core component of IBH is frequent bidirectional information exchanged between team members. One type of exchange, a curbside consult, occurs when a physician

receives informal clinical feedback. An in-person referral from the provider to the BHC, known as a warm handoff, is also employed to help increase patient treatment engagement. Other core components include a shared treatment plan, shared electronic health records (EHR), huddles that may occur daily or biweekly, and other communication mechanisms to create feedback loops between the physician, BHC, and patient.[4,8]

IBH Adaptations During COVID-19

While virtual teams existed prior to the pandemic,[10] the alacrity in which this transformation occurred required new adaptations to individual primary care practices, among teams, and within broader health systems.[7] Specifically, the Mayo Clinic Division of IBH rapidly deployed adaptations, with concerted virtual meeting times in clinicians' schedules to allow for dedicated communication and collaboration between physicians and BHCs.[11] The swift transition to virtual environments also was reported among clinicians associated with family medicine residency programs, which provided consultations and warm handoffs virtually and synchronously.[12] Similar adaptations have been described in federally qualified health centers,[13] acute outpatient clinics,[14] and Veterans Affairs settings.[15]

Because primary care settings worked to meet the increased need for behavioral health services during COVID-19[11,12,16] by accelerating hybrid working arrangements,[7,12] the impact on teams and IBH care delivery models warrants further exploration. What changes occurred and how those changes impacted training, teaching, delivery, and efficacy of IBH models remain unknown. Accordingly, this qualitative study adopted a constructivist approach to feature IBH team members' perspectives, examine how the pandemic impacted communication, collaboration, and coordination of care, and determine what factors could be leveraged to advance IBH in the future.

METHODS

Study Design and Data Collection

In the spring of 2022, we conducted individual interviews with IBH team members to assess how COVID-19 and telehealth impacted IBH teams and care delivery. The interviews were conducted over Zoom (Zoom Video Communications) and lasted 35 minutes. We developed a semistructured interview guide (Appendix A) with open-ended questions across four topics: (a) description of IBH model before and during the pandemic, including COVID-19-related transitions; (b) components of IBH that were adapted (ie, team location, communication); (c) clinicians' perspectives on long-term use of telehealth for IBH; and (d) lessons learned during COVID-19. The study was deemed exempt by the investigators' university institutional review board. All participants gave their informed consent before beginning the interview.

Study Sample and Recruitment

We used a purposive convenience sample with a snowball sampling strategy to recruit 20 clinicians working in primary care settings (eg, academic, independent, community health) in nine states (Table 1). Recruitment strategies included (a) contacting IBH clinicians familiar with the study team, (b) utilizing a listserv from a national IBH organization, and (c) asking participants to forward the recruitment email. To ensure data saturation, recruitment continued while concurrently reviewing interview data; during the course of the interviews, we recognized when themes remained stagnant and/or consistently presented.[17] Participants each were compensated $50.

Analysis

We used thematic analysis with a constructivist approach and included six interactive phases of analysis.[18] Phase 1 included data familiarization, which involved transcribing audio recordings and thoroughly reading transcriptions. Transcription was conducted in two stages. First, Zoom autogenerated transcripts for each interview. Second, a graduate assistant downloaded and reviewed the transcripts in full, correcting for errors. Two researchers then moved to Phase 2, where they independently generated initial codes (eg, multiple digital platforms for team communication). Codes were added to a shared codebook (Phase 3), and three researchers reviewed the codebook and transcripts to code for themes. Phase 4 involved further review and refinement as researchers moved from multiple individual codes (eg, collaborating with a new provider who they had not met in person) into higher-order themes (eg, team collaboration). Themes were solidified in Phase 5, when the team named and defined them (eg, increased reliance on technology for team communication). Thematic analysis in Phase 6 involved presenting and disseminating results.[18]

RESULTS

Participant Description

We interviewed 20 providers who worked in primary care settings. Study participants included BHCs (n=15) and medical clinicians (eg, family medicine physicians and nurse practitioners (n=5). Table 1 details participants' educational background, regional location, and type of settings represented.

Interview Findings

Table 2 summarizes the findings from the qualitative interviews. Four themes on how IBH practice adapted emerged from the analysis:(a) permanent changes to the physical structure of the team; (b) increased reliance on technology for team communication; (c) shift in team collaboration, often occurring asynchronously; and (d) telehealth embraced for IBH.

Changes in the Physical Structure of the Team

All respondents indicated that the pandemic caused structural changes to IBH delivery, primarily because the team no longer physically shared space. Many BHCs reported either moving to a hybrid or entirely remote environment. One stated,

> When the pandemic happened . . . psych was moved to telehealth, and the clinic kept psych on telehealth going forward because of the space issues. Essentially, they can fit more primary care providers in the physical space

TABLE 1. Participant Educational Background and Work Settings

Characteristics	Participants (N=20) n (%)
Region of the United States	
Northeast	2 (10)
South	7 (35)
Midwest	4 (20)
West	7 (35)
Type of primary care clinic	
Veterans Affairs medical center	1 (5)
Independent primary care clinic	4 (20)
Academic primary care clinic	7 (35)
Primary care clinic for special populations	3 (15)
Community health centers or federally qualified health center	5 (25)
Degree	
MD/DO	3 (15)
PhD	2 (10)
PsyD	4 (20)
MSN	2 (10)
MSW	8 (40)
MFT	1 (5)

TABLE 2. Primary Themes and Illustrative Quotes

Primary themes	Illustrative quotes
Change in the physical structure of the team	"[T]he clinics went to a skeletal team. . . . Initially, [behavioral health clinicians] were remote, with the exception of one. We kept one BHC as the clinic support person live and then everyone else was virtual." "When the pandemic happened . . . psych was moved to telehealth and . . . the clinic has made the decision to keep psych on telehealth going forward because of the space issues. Essentially, they can fit more primary care providers in the physical space if we are virtual." "I've been 2 days on, 3 days off. There have been times where we've thought about shifting to more days on-site. But then, there's been upticks in COVID and then we just don't have the space; our team has grown so much, I think, over the pandemic, from what I've understood, that we just don't have the space for all of us."
Increased reliance on technology for team communication	"What I like to do is, I have my list in Epic of my chronic care patients, and when I'm on-site I see who's coming in to see their provider. I'll message the provider that morning, and be like, Hey, I see [name] is coming in today, let me know if I need to come talk with him about anything, or we'll mini-huddle about that patient. . . . And I'll do that even if I'm not on-site, just in case there's anything that comes up." "It's [telemedicine] just made things more accessible, honestly; patients are able to reach us a little easier because we're at home most of the week and we're right by our phones all day. It's easier for us to get in touch with providers. For urgent, it's more normalized now for us to send a quick text or Epic chat to [a] provider for a question versus before."
Asynchronous team collaboration	"We were off-site for a couple of months, and when we got permission to come back in the office, we still stayed virtual. But we worked in an office for a while and that felt weird. . . . For the first, I don't know how many months, we still—all our meetings were separate. . . . We're still having lunch in our cars because our dining room, it's huge, but everyone can't be in the dining room at the same time; so preferably, it was asked that everyone has lunch in their cars. Our meetings, yeah, they have been virtual since the pandemic, I think, yeah, and they're still virtual, our weekly meetings." "Everything felt more siloed, but it wasn't even just clinical work. It was everything. We didn't have in-person staff meetings, and everything felt very disconnected. I will say I did not feel any more disconnected to my medical providers, as I did everything else, and to my own team, too, because you're not having that bump-ability, you're not having any of that."
Telehealth as the new normal	"It's [telehealth] great and I don't think it's going anywhere; I hope it doesn't because it's another tool for us to connect with our patients. . . . We'll have patients that say, 'hey I prefer to jump on a video visit with you because I don't have childcare or I live an hour away so let's do a virtual today, maybe we'll do it in person next time'; so it's a nice tool to pivot with access to care." "[F]or me it was less of a scramble because I don't need to put a stethoscope on someone. I can have a conversation with them and do a pretty darn good assessment and get them treated without actually seeing them in person." "It's nice to have the flexibility to work from home. . . and we have figured out how to do it, . . . I mean confidentiality, and HIPAA laws, and all that type of stuff. Before COVID, the patient either had to wait or we sent them to the ED if it was an emergency or if we had any thoughts of this patient might hurt themselves. Before COVID, you either had to get them in the clinic, do an assessment, do a treatment plan, and all of that stuff over the phone or get them into the clinic the same day or send them to the ED."

if we are virtual.

This change in physical proximity of team members disrupted all other components of IBH and required adapted workflows that relied less on in-person team and patient interactions. Another shared, "We were all home all the time. . . . We started doing a rotating schedule where we only had two social workers on-site at a given time [for] social distancing." At times, even when team members were in the same physical setting, they did not meet in person.

> We kept completely separate, went to our office even though we were in the same building. . . . Some people had to go in their car for meetings; we had lunch in our cars. We're still having lunch in our cars because everyone can't be in the dining room at the same time. . . . Our meetings have been virtual since the pandemic.

Even after the immediacy of COVID-19 adaptations, hybrid and remote working situations continued. One participant shared, "[I]t's great. . . . Typically on our team it's 2 days on-site 3 days at home." Another BHC offered,

> The primary care providers have returned but not full time. Most of them are doing maybe 1 or 2 days a week in clinic . . . same with the social work staff. . . . It's much more a hybrid model now.

Increased Reliance on Technology for Team Communication

As the physical location of IBH team members shifted, communication increasingly relied on technology. Technology became essential to conduct virtual huddles, do synchronous and asynchronous warm handoffs, and onboard new employees. Participant described a combination of virtual team meetings (ie, Microsoft Teams), in-person discussions to "identify patient issues," or "phone calls with a specific question." Many portrayed these communication changes as largely successful and as an expansion of efforts prior to the pandemic. Yet, others indicated communication challenges because of numerous technologies and waiting involved.

> First you go through [EHR] staff message. . . . You give it a day, then you escalate it to secure chat that usually pings on their phone. If that doesn't work, that's when I'm like, Okay, can I text this person? Most of the time I do, or if it's really urgent, I'll check the schedule and see if they're in clinic . . . and decide if I need to text them or just reach out to another provider for help. It's always a bit of a waiting game, which is hard.

Asynchronous Team Collaboration

The changes in physical colocation and communication patterns also significantly impacted team collaboration. Some described feeling more disconnected: "Everything felt more siloed, but it wasn't even just clinical work. We didn't have in-person staff meetings, and everything felt very disconnected . . . because you're not having that bump-ability." Others described collaborating with clinicians with whom they had never met in person, and they did not always know how to rely on the other's expertise. For example, "A lot of the providers that I work with, they knew my name, but they didn't know the face." This provider discussed updating their profile picture in the EHR to increase recognizability among team members. In some instances, because of existing strong relationships, team members transitioned to remote collaboration more easily. One clinician shared, "Because our program had been well-established before the pandemic hit . . . we were even in kind of tighter communication. We did a really good job of staying in contact."

Warm handoffs were the most significantly changed component of team collaboration, with the least resolution. Since the beginning of the pandemic, most reported that the team did asynchronous or no warm handoffs at all. Specifically, "We don't do warm handoffs as much now. I wish we did. That's just kind of one thing we didn't really anticipate." Respondents described how warm handoffs required more steps and were now coordinated virtually. Several participants explained how their team tried to build cohesion:

> It's super helpful that we huddle every morning. At one point, I was like, Oh, darn, a meeting every single morning; is that overkill? But that's really been key in helping us stay connected. I haven't felt very alone or separated from the team during the pandemic.

Telehealth as the New Normal

Most respondents related that telecommunication was a useful tool for the delivery of IBH for patients. Clinicians described how telehealth increased accessibility of IBH services—most notably due to the patient no longer having to travel to the clinic. One participant shared,

> It's great and I don't think it's going anywhere. It's another tool for us to connect with our patients. . . .We'll have patients that say, "hey I prefer to jump on a video visit with you because I don't have childcare or I live an hour away.". . . It's a nice tool to pivot with access to care.

Despite recognition that telehealth had benefits, drawbacks existed. For example,

> [W]hen folks are struggling with depression, it is important to do those things to get yourself out of the house, but on the other hand, my no-show rates are way down, people can just Zoom me from bed and say I feel really crappy today.

Telecommunication also was described as a challenge for some patient populations. A participant stated, "The majority of that population—our older adults—prefer to talk on the phone. Also, there's a large population of patients with low access to the Internet, to a smartphone, financial insecurity, things like that."

Even with challenges of telecommunication for some populations, all clinicians indicated that they see it as a needed tool that they intend to continue utilizing, at least in part: "I'm hoping it sticks around. . . . The public and the providers find the value of it, and they're going to demand that access moving forward." Another clinician noted, "We have about 20% to 30% of our schedule still virtual." One BHC shared that if two behavioral health crises were occurring, telehealth allowed them to contact another site's BHC to provide care.

> I might be able to reach out, Hey, are you busy? I have two suicidal patients. Can you see this patient? . . . COVID has given us that permission, that this is safe, and we have figured out how to do it [with] confidentiality and HIPAA laws, and all that type of stuff. Before COVID, you either had to get them in the clinic, do an assessment, do a treatment plan, and all of that stuff over the phone or get them into the clinic the same day or send them to the ED.

DISCUSSION

The pandemic changed how IBH is delivered in primary care clinics. As other studies have noted,[7,12,13,16] adaptations made immediately to address the pandemic have largely remained in many clinics across the United States. IBH processes were interrupted and adapted, including (a) a decentralization of the IBH team, (b) asynchronous team communication via technology, (c) new efforts to build team collaboration and cohesion, and (d) increased use of telecommunication to deliver behavioral health care to patients. Clinicians interviewed in this study reported how some adaptations to IBH benefited the patients (eg, decreased transportation burdens) while some benefited the workforce (eg, hybrid schedules). These changes transformed previously understood core elements of IBH. The innovations that were introduced may also benefit patients, the workforce, and the practice.

Health systems have worked to increase IBH buy-in and to design clinical workflows for more than 20 years.[4,5,19,20] Prior to the pandemic, the trend was to adapt clinic settings to include interprofessional members, specifically design workspaces, adopt EHR technologies and workflows to support screening for behavioral health needs, and employ methods for clinicians to provide warm handoffs to optimize coordination of care. Although significant evidence supports the IBH model in primary care,[5,8,20] limited evidence exists about the individual IBH components that are integral to the model's efficacy. Consequently, how the adaptations to core processes of IBH since the pandemic impact the efficacy of the model remains unknown, and more work is needed to discern the impact of adaptations and innovations to IBH.

Future studies could assess whether a virtual warm handoff is as effective as in-person interactions. Do patients feel more satisfied or have increased continuity of care with in-person versus telehealth visits? How are medical students, residents, and other learners trained to work in IBH models given the postpandemic realities? Answers to these questions may help educational institutions and health systems improve the way IBH is delivered to maximize patient care, population health, and provider satisfaction[20]—factors that are especially important given the alarming rates of burnout within primary care since COVID-19's onset.[21]

One of the shifts in IBH impacted how teams communicate and relied more on asynchronous messaging than in-person communication. However, how these changes impacted the quality of team communication is unclear. In one study across 40 health centers, changes to integrated clinics resulted in "less than optimal communication" and decreased communication exchanges.[22] Yet, some literature has documented how asynchronous communication fostered flexible workflows.[13,23] For example, an integrated team from an academic hospital noted how electronic messaging allowed for "more flexible and extended coverage hours" compared to a previously used pager system.[23] Thus, understanding the benefits and risks of changing team communication strategies is needed.

Although the frequency of telehealth has been reduced since the peak of the pandemic, high rates of tele-mental health delivery, along with positive patient perspectives, suggests that delivering IBH via telecommunication will be sustained in the future. Continued research is needed to understand how telehealth supports access to behavioral health services and possibly improves continuity of care. Conversely, education for professionals in the IBH workforce remains elusive. Although tele-psychiatry competencies for graduate medical education have been suggested, much of the literature on the topic predates the pandemic.[24–27] Increased efforts to update interprofessional trainings to support best practices around remote communication and tele-behavioral health will be needed for IBH delivered in primary care.

LIMITATIONS

Findings warrant consideration of study limitations. The recruitment strategy and convenience sample introduced sampling bias in several ways, because IBH clinicians already familiar with the study team and those associated with an IBH serving organization's listserv could skew the sample toward more active IBH. Further, half of the respondents worked within academic primary care settings, which may potentially overlook the experiences and perspectives of providers in nonacademic environments. Data primarily represented BHCs' perspective as compared to physicians or advanced practice providers, limiting a broader understanding of how changes in response to COVID-19 impacted other members of the team. Although requesting clinicians' valuable time is challenging,

longer and more in-depth interviews may offer richer content for thematic analysis. Moreover, geographic variability in how COVID-19 impacted areas within the United States was not considered, and clinical environments described may have varied based on differing COVID-19-related policies. Sample and method generalizability of this study to other settings and populations is limited.

CONCLUSIONS

After years of moving toward colocated and integrated workflows, COVID-19 adaptations changed IBH delivery. Given that IBH is a mechanism to increase access to behavioral health care, assessing the effectiveness of these newer model iterations becomes critically important to training future clinicians, building robust IBH teams, and advancing IBH innovation. Updating existing definitions of IBH models based on new practice realities that include asynchronous and virtual team communication and collaboration will be needed. Furthermore, health settings need to recognize the unique needs of virtual and asynchronous IBH teams and identify how to support and sustain the delivery of the model.

FUNDING DISCLOSURE

This project is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of an award totaling $525,465, with no financing from nongovernmental sources. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the US Government.

REFERENCES

1. Kroenke K, Unutzer J. Closing the false divide: sustainable approaches to integrating mental health services into primary care. *J Gen Intern Med.* 2017;32(4):404-410.
2. Jetty A, Petterson S, Westfall JM, Jabbarpour Y. Assessing primary care contributions to behavioral health: A cross-sectional study using Medical Expenditure Panel Survey. *J Prim Care Community Health.* 2021;12:21501327211023871.
3. Knierim K, Palmer C, Kramer ES. Lessons learned during COVID-19 that can move telehealth in primary care forward. *J Am Board Fam Med.* 2021;34:196-202.
4. Heath B, Romero PW, and KR. A Standard Framework for Levels of Integrated Healthcare. *SAMHSA-HRSA Center for Integrated Health Solutions.* 2013. https://www.pcpcc.org/sites/default/files/resources/SAMHSA-HRSA%202013%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf.
5. Blount A. Integrated primary care: organizing the evidence. *Fam Syst Health.* 2003;21(2):121-133.
6. Bonciani M, Schäfer W, Barsanti S, Heinemann S, Groenewegen PP. The benefits of co-location in primary care practices: the perspectives of general practitioners and patients in 34 countries. *BMC Health Serv Res.* 2018;18(1):132-132.
7. Mitzel LD, Funderburk JS, Buckheit KA, Gass JC, Shepardson RL, Edelman D. Virtual integrated primary care teams: recommendations for team-based care. *Fam Syst Health.* 2021;39(4):638-643.
8. Kwan BM, De N. *The state of the evidence for integrated behavioral health in primary care*. Springer; 2013. .
9. Jabbarpour Y, Jetty A, Dai M, Magill M, Bazemore A. The evolving family medicine team. *J Am Board Fam Med.* 2020;33(4):499-501.
10. Bogucki OE, Mattson AB, Leasure WB, Berg SL, Mulholland HL, Sawchuk CN. Adaptations of an integrated behavioral health program during COVID-19. *Cogn Behav Pract.* 2021;28(4):481-491.
11. Filippi MK, Waxmonsky JA, Williams MD. Integrated behavioral health implementation and training in primary care: a practice-based research network study. *J Am Board Fam Med.* 2024;36(6):19.
12. Cooper Z, Zerden LDS. How COVID-19 has impacted integrated care practice: lessons from the frontlines. *Soc Work Health Care.* 2021;60(2):146-156.
13. Donnelly C, Ashcroft R, Bobbette N. Interprofessional primary care during COVID-19: a survey of the provider perspective. *BMC Fam Pract.* 2021;22(1):31.
14. Lombardi BM, Zerden LDS, Prentice A, Downs SG. Social workers roles in achieving health quality metrics in primary care: a quality improvement case study. *Soc Work Health Care.* 2024;63(2):102-116.
15. Rose L, Tran LD, Asch SM, Vashi A. Assessment of changes in US veterans health administration care delivery methods during the COVID-19 pandemic. *JAMA Netw Open.* 2021;4(10):2129139.
16. Gunn R, Davis MM, Hall J. Designing clinical space for the delivery of integrated behavioral health and primary care. *J Am Board Fam Med.* 2015;28(1):52-62.
17. Guest G, Namey E, Chen M. A simple method to assess and report thematic saturation in qualitative research. *PLoS One.* 2020;15(5):232076.
18. Labra O, Castro C, Wright R, Chamblas I. *Global Social Work: Cutting Edge Issues and Critical Reflections*. IntechOpen; 2020. .
19. Peek CJ. Integrated behavioral health and primary care: a common language, In: M T, A BV, eds. Integrated behavioral health and primary care. Springer; 2013:9-31.
20. Nundy S, Cooper LA, Mate KS. The quintuple aim for health care improvement: a new imperative to advance health equity. *JAMA.* 2022;327(6):521-522.
21. Cunningham AT, Felter J, Smith KR. Burnout and commitment after 18 months of the COVID-19 pandemic: a follow-up qualitative study with primary care teams. *J Am Board Fam Med.* 2023;36(1):105-117.
22. Cos TA, Levkovich N, Tjoa CW, Williams SK, Larach CS. Integrated primary care behavioural health in a regional network of FQHC agencies during COVID-19. *Integr Healthc J.* 2022;4(1):125.
23. Benedetto E, Holmes M, Greig A. Responding to COVID-19 through an integrated primary care/behavioral health program. *Fam Syst Health.* 2021;39(4):644-649.
24. Ghosh A, Verma M, Lal S. A review of models and efficacy of telepsychiatry for inpatient service delivery: proposing a model for Indian settings. *Indian J Psychol Med.* 2020;42(5).
25. Kriechman A, Bonham C. Telemental health in primary care. *Telemental Health*;2013:155-170.

26. Saeed SA, Johnson TL, Bagga M, Glass O. Training residents in the use of telepsychiatry: review of the literature and a proposed elective. *Psychiatr Q.* 2017;88(2):271-283.

27. Sunderji N, Crawford A, Jovanovic M. Telepsychiatry in graduate medical education: a narrative review. *Acad Psychiatry.* 2015;39(1):55-62.