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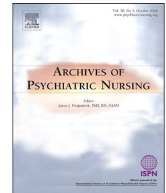

# The TANDEM3-PC: The Foundation for an Innovative, Integrated Behavioral Health NP-led Model of Practice in Rural Primary Care☆

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*Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.*

(Margaret Meade)

## Introduction

The TANDEM3-PC (Together All Nurses Deliver Extraordinary Methods, Meaning and Measures in Primary Care) is an evolving model of Nurse Practitioner (NP)-driven, team-based whole health care in a rural primary care setting. Through a funded, academic-practice partnership (Health Resources & Services Administration-Nurse Education, Practice, Quality and Retention: HRSA-NEPQR), a team of committed interprofessional health care providers, agency staff and a healthcare economist, set out to improve access to integrated, safe, efficient and quality whole health care for underserved, vulnerable populations in rural North Carolina. The purpose of this article is to introduce the TANDEM3-PC model for implementing whole health care practice as well as briefly present the background, philosophical foundation and subsequent articulation for this NP-led model that is being implemented in rural North Carolina (NC). It is important to disseminate this innovative model, its foundation and implementation for other health care providers to consider as they develop strategies for whole health in their own rural primary care practice settings.

## Significance

Approximately ninety-one million adults in the United States live in mental health professional shortage areas, where access to assessment and treatment of psychiatric problems and substance use disorders is inadequate (HRSA, 2016; SAMHSA, 2013). Recent studies have provided additional evidence that there is an ongoing, significant service gap for individuals and families to access mental health care services especially in rural areas across the US (Jones, 2017). This is indeed the case for those who live in North Carolina (NC). Specialty mental health providers (i.e. Psychiatrists, Psychiatric Nurse Practitioners) are in demand and there continues to be severe shortages for accessing psychiatric specialty care services, often including long waiting times between referral and treatment. In 2016, there were 103 HPSA designations for mental health in NC, impacting 1.5 million people and barely 38% of the need was actually met. According to the Health Resources and Services Administration (HRSA), NC would need an additional 45 Psychiatrists (and/or PMH-NPs) to remove the HPSA designation (HRSA, 2016). Although Psychiatric-Mental Health Nurse Practitioners (PMH-NP) have been increasing in the workforce over the past two decades, there is still room for growth.

The impact from the severe shortages in the psychiatric workforce nationally and in NC specifically, has been reported as daunting by the Centers for Disease Control and Prevention (CDC). Of the eight million ambulatory care visits for depression each year, more than half were to a primary care provider (Marcus & Olfson, 2010; Reeves et al., 2011). Additional reports have shown that 70% of individuals and families who present to primary care (and to emergency departments), have a diagnosable psychiatric and/or substance use disorder, yet do not receive sufficient assessment or treatment (Collins, Hewson, Munger, & Wade, 2010). There are several reasons for this disparity in accessible mental health care and one in particular is related to the lack of education and training, for undergraduate and graduate students in the health care professions and also in the healthcare workforce. As academic settings grapple with enhancing their curricula and strive to advance clinical training to address these critical needs, the Opioid Crisis has 'slammed' into health care delivery systems in epidemic proportions in the US. Although there have been multiple models integrating behavioral health into primary care settings over the past decade, not all can be implemented due to staffing, lack of behavioral health specialists and the need to provide sustainability (Gerrity, 2016; Williams Jr et al., 2007). Therefore, this article articulates an example of developing a model at the grass roots, with the focus on the role of Nurse Practitioners in a primary care setting in a rural county in NC.

Nurse Practitioners have been and continue to be, the future of

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health care and in many cases, fill the gaps where there are healthcare access shortages. The quintessential report, *The Future of Nursing: Leading Change, Advancing Health, Transforming Practice* (Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, 2011) made the following key recommendations which provided additional justification for developing this NP-Led model called TANDEM3-PC. There were four key messages which focused on the critical intersection between the health care needs of individuals and families across the lifespan and the actions of the nursing workforce:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States.
- Effective workforce planning and policy making require better data collection and an improved information infrastructure. (Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, 2011, page 1)

To this end, the TANDEM3-PC model builds upon these key messages and recommendations to provide a potential solution: to educate and train all nurses and NPs to integrate behavioral health into community health centers and implement whole health care in NC and beyond. The TANDEM3-PC model is particularly important for the delivery of health care in regions of the United States where there are severe shortages of health care providers as well as providers who can *prescribe and manage psychiatric problems and substance use disorders in primary care settings*. While TANDEM3-PC is team-based, it is an example of a complimentary and/or stand-alone model for healthcare agencies who may not have immediate access to behavioral health consultants and/or psychiatrists.

## Background and philosophical approach to the TANDEM3-PC model

> *Nursing praxis is a* "*thoughtful reflection and action that occur in synchrony, in the direction of transforming the world*".
>
> (Chinn, 1999, p. 2)

The role of an advanced practice registered nurse (APRN) has evolved over the past 60 years as the discipline of nursing has developed its own knowledge, practice, education and research. Not unlike other disciplines, nursing knowledge was initially beholden to the scientific method and subsequently, the medical model, placing the nurse (and his/her knowledge) as an assistant or 'handmaiden' to the physician. Even today, the term 'midlevel' provider or 'physician extender' portends the notion that a Nurse Practitioner (NP) is not a leader, but rather a follower, doing what physicians do. However, over the past several decades, nursing knowledge has moved beyond 'explaining and predicting', to other methods of inquiry that parallel the work that nurses 'do' as they are doing it and to engage with those with whom they care for as part of that process (Soltis-Jarrett, 1997, 2003, 2004). The concept of *nursing praxis* best describes this shift in the second half of the 20th century, whereby nurses began to consider and observe their work, reflect upon their relationship with each other and those with whom they provided nursing care (Thorne, 1996). These nursing care 'actions', innovative and with thoughtful purpose, defined, validated and/or sought to change and/or co-create nursing practice for the good of all. Indeed, there are nurses who continue to develop the notion of praxis nationally and internationally (Blanchet Garneau, Browne, & Varcoe, 2018; Kagan, 2010; Walter, 2017). The process of *praxis* is a dynamic cycle of observation, reflection and action, not unlike quality improvement and the notion of planning, doing, studying and action (PDSA) to improve the work of a group of individuals in a healthcare team or system (IOM, 2011). Praxis may have influenced the quality improvement (QI) methods used by many today although most would not have made this connection without understanding the origins of praxis and the work of Freire (1970).

Paulo Freire (1970), working with underserved, disenfranchised groups of individuals in South America, posited that 'true' and meaningful knowledge emerges only through 'restless impatience' that needs to be harnessed, observed and considered. Freire's notion of praxis is tied to the frustrations that individuals experience when they recognize that what they are doing is not effective or constructive (or meaningful) in their lives yet, they do not understand why it is that way. These frustrations form and grow with a restlessness that can only be relieved by internalizing or externalizing the irritations and the subsequent 'sufferings'. This can be best understood in the social and political movements over the past 100 years and most recently in the "Me too" and "Never again" movements in the USA whereby social groups respectively expressed their internalized frustrations in a public way to illuminate their 'sufferings' and refrain from being 'silenced' by a dominant or established 'voice' that previously held precedence.

The spirit of Freire's work to engage individuals and thus, to also alleviate the oppression and suffering, is best known as *conscientizacao*, a loosely translated word from the Portuguese meaning consciousness raising or awareness from the naïve to the critical social consciousness/realization (Freire, 1970). In short, Freire (1970) promoted the methodology of *conscientizacao* as a means of helping others to learn to (a) become aware of the social, political and economic contradictions which may also oppress, marginalize and/or silence individuals, groups and communities and (b) promote the possibility of taking individual 'action' against (and thus, make changes to) those elements in their lives that may have caused oppression and/or silence. Freire (1970) suggested that individuals, guided by a facilitator, could be encouraged to develop praxis as an inventive and interactive way of life. And through the process of praxis and *conscientizacao*, individuals (and a facilitator) together can proactively encourage creative reflection and thoughtful action to change the world, even as they (the group members) are transformed in the process. Rather than to tell people 'what to do' or how to do it, Freire's notion of praxis is to include people in that process by asking and engaging them to share their ideas and thoughts, their sufferings and their beliefs about how to create a different 'world'. This article also draws on some of the similarities between the concept of 'praxis' and the notion of patient and/or community engagement, which is more familiar to those in community health care settings.

This notion of provider/patient/community engagement and praxis was critically examined at the end of the 20th century as part of a doctoral dissertation (Soltis-Jarrett, 1997, 2004). A methodology emerged through praxis and was coined 'Interactionality' by its facilitator and participants. At that time, Interactionality focused on uncovering the sufferings of individuals diagnosed with *somatization* (*also known as somatoform disorders*) and to empower the individuals to create a more thoughtful plan of action to promote and construct change in their own lives as well as 'to echo' those actions with those who were interacting with and caring for them (health care providers). Somatization is a concept that has historical roots embedded in bias, judgment and prejudice, in many cases because of a lack of understanding of the individual suffering from the chronic somatic symptoms. Somatization is defined as an individual who presents to a health care provider with physical/medical complaints/problems that are medically unfounded. In other words, the individual that is labeled as "somatic" is one who is '*imagining*' their symptoms, illness, distress or disorder (Soltis-Jarrett, 2003, 2011) and frequently labeled as having an illness that is 'all in their head'. In this previous doctoral study, participants who were diagnosed/labeled with somatic-type illnesses and the health care providers who cared for them, met with a facilitator to actively observe, reflect and learn from each other about their health and well-being. Both groups of individuals (patients and health care

providers) were encouraged, through the use of praxis and hence, Interactionality, to be active participants in their own understanding of the diagnoses ascribed (to or by them), and then to determine the future of their health care and the relationships with health care providers. This type of engagement was empowering to both the individuals diagnosed with somatization as well as those providers who cared for them in health care settings. The previous study's outcomes brought about a *conscientizacao* or awareness that forever changed the interactions that each had with the other as they co-created different relationships (a different world/approach) based on a greater understanding and appreciation for the lived experiences of those who suffered from somatization.

More than twenty years later, the tenets, assumptions and methodological techniques developed then, were adapted and used in this new millennium, to guide the enhancement of this unique NP-led model of practice called TANDEM3-PC. The fundamental assumption at the start of this new project was that "*nursing praxis promotes the notion that all action has meaning and that nursing actions can also reflect the values intrinsic to the physical, emotional and social health care needs of a given community. As nurses practice, they are also developing knowledge and identifying questions and areas of concern, being guided by the plurality of their ways of knowing. One of the most fundamental areas of nursing practice begins with our relationships with those whom we* '*nurse*'*, teach, consult with and develop knowledge*" (Soltis-Jarrett, 2003, page 124). And it is within the scope of these relationships that Interactionality promoted the development of this practice-based model and knowledge in nursing.

The ethos of Interactionality continues to evolve and develop through the everyday practice, interactions and engagement that the TANDEM3-PC healthcare team has with each other; their patients and the community. Each day, the members of the team are transforming whole health care in a rural community health center. From the ground up, the TANDEM3-PC model of practice assists the Nurse Practitioners (NP) and their team members to care for individuals, families and communities oppressed by societal constraints (i.e. poverty, unemployment; stigma of behavioral health and substance use problems); and who also suffer from multiple medical and psychiatric comorbidities. The overarching theme is for both the individuals/families and healthcare teams to overcome the barriers of isolation, coordination and integration of whole healthcare. The notion of having co-facilitators (or team members interacting with the patients/families) narrowed the distance between who is the facilitator of their care and who is the learner of their experiences. The TANDEM3-PC model, like Interactionality, can be used "in a group of two or more, employing the distinct features that are inherent in the relationships that nurses have with individuals, in a dialogic, interactive process of emancipatory theory building" (Soltis-Jarrett, 2003, page 124).

The practical underpinnings and seedling model for TANDEM3-PC was ultimately conceptualized and implemented in the mid-1990s for rural aged care assessment teams (ACAT) in South Australia (Soltis-Jarrett, 1995), then, shortly thereafter, was methodologically expanded by doctoral research, (Soltis-Jarrett, 1997, 2003) and now, has been adapted, re-conceptualized and implemented in a large Federally Qualified Health Center (FQHC) in rural North Carolina. By building upon and also adapting the concepts of a Person-Centered Medical Home (SAMHSA-HRSA Center for Integrated Health Solutions, 2014), the healthcare teams implementing this model are actively: (a) demonstrating how NP-led primary care (PC) teams can sustainably implement interprofessional practice that incorporates a Psychiatric-Mental Health Nurse Practitioner (PMH-NP), thereby improving access to integrated, coordinated care for medically underserved and high-risk groups in rural North Carolina; (b) providing interprofessional training that supports integration of culturally sensitive, evidence-based screening, early intervention and treatment models that help meet individual and population health needs, including training health care delivery providers, staff and other health professional students in training; and (c) demonstrating patient and project outcomes related to access, quality, and cost with the assistance of an intraoperative health IT system that incorporates primary care and behavioral health data and enables data-driven rapid cycle performance improvement (Holder & Soltis-Jarrett, 2016).

The TANDEM3-PC model is unique as it brings together a team of healthcare professionals and an organization committed to the care of rural, underserved individuals and families oppressed by unemployment; varying levels of poverty; chronic, comorbid illnesses and limited access to health care services. Although the model follows a structure for gathering data for continuous improvement in the delivery of care, the TANDEM3-PC model has evolved through the use of curiosity and thoughtful intention, grounded in the critical social theories, and subsequently, intertwining an emancipatory pedagogy, practice and learning for the entire healthcare/project team and graduate NP students assigned to learn at the agency and clinical sites.

The TANDEM3-PC team is designed to include two Advanced Practice Registered Nurses (Family NP and Psychiatric-Mental Health NP), a Registered Nurse/Care Coordinator, Medical Assistants and the larger support staff, to demonstrate whole health care 'in TANDEM', in rural NC, where the shortage of primary care and mental health professionals is the greatest. Whole health is defined as the care that results when primary care and behavioral health clinicians work together with individuals and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

## Laying the foundation for implementation: the role of the 'facilitator' in team building

As previously described, this evolving NP-Led model of practice focused initially on two groups of individuals: those individuals *who access and seek care* (the patients) at the rural clinic and the NPs, the nurses and/or health care team members who assess the needs of the individual and *provide the care*. With a facilitator (in this case, the Project Director/Nurse Practitioner), the health care team continues to be encouraged to work together to observe, reflect and create change that is meaningful and empowering, so that the team members could then extend that same process to the individuals and families that are in their service at the clinical setting. In other words, the common 'rules' of engagement or decorum were very important when initiating the process of team building and rapport; including ensuring that the process of co-creating a NP-led model was culturally sensitive and respectful. Getting to know each team member as an individual person as well as understanding the parameters or scope of their work role was (and continues to be), essential for the facilitator to hold and preserve much like one does for patient-centered care. Setting aside time for team meetings, one-on-one interactions and even the gathering of information from written 'field notes' that capture the observations and reflections from the team members, promotes the richness of the team's reflections-in-action (or praxis) over time. Being available to the clinic's NPs and team members at their own pace is another important trend for the facilitator to try to maintain. It is also essential to intertwine the rules of engagement with the Quadruple Aim: "improving the individual experience of care; improving the health of populations; reducing the per capita costs of care for populations" (Berwick, Nolan, & Whittington, 2008, page 759), while also improving satisfaction for the healthcare team members who care for the patients.

Therefore, when creating the framework for this NP-led model, the facilitator (NP/Project Director) and the participants (Team Members and Patients/Families) continue to reflect upon, observe and understand the barriers that are placed inadvertently or without *conscientizacao* within a health care system and subsequently trickled down to how NPs, nurses and team members practice, learn and gather data for knowledge development. The common phrase "we have always done it this way" can also be historically embedded in bias, judgment and prejudices. Starting from where each individual team member and

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each patient 'is at' (or positioned) and honoring their history, their beliefs and cultural background was and continues to be, essential to the development of and the ongoing quality improvement, in the framework for this model (Soltis-Jarrett, 1997).

The next section will briefly describe the work flow and implementation of the TANDEM3-PC model developed for the community health center sites to initiate, promote and develop in rural North Carolina. The quintessential questions for observation and reflection were: How can NPs, as part of an interprofessional health care team, take action and foster change with the community? Can individuals and families participate in the process of this model's development? Is it important for NPs to take the lead or share the process? Was a PMH-NP cost effective when other team members were less expensive? How was the role of a PMH-NP unique to this model? There were strengths and limitations that were uncovered and documented in field notes and in conversations (i.e. team meetings, focus group) with members of the healthcare team over time and provided the structure for change and the ongoing quality improvement that endorsed the TANDEM3-PC model to thrive and thus, promote health and well-being and illness care to the rural population at hand. The steps to co-creating this TANDEM3-PC model will be presented and briefly described next as a means to illuminate the actions/solutions that grew from the limitations/barriers that were unique to this CHC as praxis guided its development.

## Implementing the TANDEM3-PC model: reflection in 'action'

In the early stages of development, four primary themes were identified and addressed as part of the process for examining 'the way things are/were' and whether these 'things' were working for the community health center (CHC) and specifically the healthcare team. This parallels the notion of Freire's praxis: the identification of an individual or group's 'felt sufferings' and frustrations that become illuminated through reflection, observation, discussion and critical discourse. It is through this dialogic and reflective process, that 'true' and meaningful knowledge can emerge and be harnessed, observed and considered for potential change and empowerment (Freire, 1970).

Each of the primary themes will be described in this section as exemplars for the changes and/or 'actions' that assisted the advancement of the TANDEM3-PC model and subsequently created change for the good of all. The themes presented and discussed are: (a.) identifying the work flow as well as the 'felt sufferings' of the team and the people for whom they served; (b.) reflecting on the role of a PMH-NP and its comportment in a CHC; (c.) observation and consideration of the multiple models of current community health care; and (d.) identifying the roles of the team and promoting *emancipatory learning*. A fifth theme, community and patient engagement and outcomes will be addressed in a separate paper as the data becomes more fully analyzed and interpreted.

### *Theme #1: observing, reflecting upon and identifying the work flow and felt sufferings of the team and the people who they served*

> *The term "workflow" refers to the actual manner and sequence in which work is carried out, as opposed to how work is supposed to or believed to be carried out.*
>
> (Holman et al., 2016, p. 29)

"*It was essential to observe, reflect and initially follow the work flow set forth by the community health center overall and at the rural setting before making any recommendations, suggestions and/or changes*" (PI Field note excerpt). "*It was also essential* (*today*) *that I* (*the facilitator/Project Director*) *listened to and validated the frustrations of the team and in particular, the Lead NP Provider at the rural site*" (PI Field note excerpt). "*One cannot observe the workflow without listening to, reflecting upon and understanding the* (*felt*) *sufferings of the workers*" (PI Field note excerpt). The PI posed the following questions: What is the work flow? Who does what task and why? What works and does not work? What do you (NP) need to do to meet the needs for the people that you serve? What is frustrating for you as the Lead Provider (NP)? What do you see as the solution to the inequities and injustice in health care?

Without specifically using the word 'suffering', the facilitator 'joined' (established a professional interpersonal relationship) with the NP Lead Provider and explored situations and stories of individual patients, families and the health and well-being of the community that the team served in the rural clinic. This exploration continues and now includes other members of the healthcare team (new NP Lead Provider; Medical Assistants, RNs), as well as the NP students who observe the TANDEM3-PC model and work with the community of individuals and families served at the rural health clinic. It was through these dialogic conversations, confidential communications and field notes; that the members of the health care team and graduate students assigned to the clinical site, shared updates, stories and narratives of the observations which have occurred and are identified in this manuscript. Even the occasional obituary was shared to remember those who died despite all that the team could do to support their health and well-being. Debriefing frequently occurred to understand more fully the patient/family interactions, the extreme poverty and food deprivation experienced by some of the children and families as well as the injustice and inequity of individuals who did not have access to health care for decades, leading to their multiple comorbidities and for some, mortality.

The outcomes from this reflective process identified that there was a preset flow of tasks that the healthcare team followed. While there are advantages and disadvantages to a 'preset' movement of tasks in any healthcare setting, co-creating a flexible workflow which enhances the strengths of the setting as well as meets the needs of the unique population is not only useful, but transforming for those who create the change, especially if it is not working. The (IOM, 2015; Rowland, 2014) recommends that team-based healthcare is efficient, cost effective and includes every member of the team working to the highest level of their scope of practice. Co-creating a flexible team workflow is both a strategy and a technique that can preserve the advantages of the previous workflow yet can draw on the strengths of the team members and seek to improve its disadvantages that may burden one or more members of the team. Examples of this were most notable when it was observed (and reflected upon in field notes) that the NPs were choosing to do all of the tasks of follow up, phones calls and referrals, in addition to the physical exam, treatment planning and documentation. Adding a component of behavioral health integration to the list of 'tasks' proved to be complicated as it was only adding more work to the 'flow'. This was identified as a major barrier across the larger agency and was consistent with most rural primary care settings in general. Having to manage the whole person in a short amount of (service) time was daunting, especially with the rural population presenting to this clinic with complex, comorbid illnesses including hypertension, diabetes, cancer, pulmonary and cardiac disease often burdened by poverty, unemployment and lack of nutritious food sources. Early data gathered in this project identified that more than 75% of individuals who presented to the CHC also reported symptoms of a psychiatric illness, diagnosis and/or substance use disorder complicating and adding to the high acuity of the population served. This high level of acuity, combined with the 'felt sufferings' of the health care team created the potential for a perfect storm: the burnout of the workers and the potential for inefficiency of the work flow. Therefore, it was essential to consider the work flow and the stream of 'felt suffering' that channeled through the small double wide rural clinic and empower the team to explore the potential for change.

### *Discussion of Theme #1*

The clinic's preset workflow initially illuminated that patients were

greeted by the Receptionist/Medical Assistant (MA) while patient information and demographics were gathered and verified. The MA then triaged the patient, including vital signs, height/weight and reason for visit in an examination room. Screening tools were already being implemented for depression including two questions for substance use as behavioral health integration was previously rolled out across the larger organization. However, it appeared that there were inconsistencies in the work flow when a positive behavioral health screen was identified. As with many primary care settings, lack of knowledge about the assessment and management of depression, anxiety and substance use disorders is pervasive (Abed and Nahid, 2010) and many primary care clinicians have also reported that they are also not comfortable prescribing psychiatric medications (Funk, 2008). In this CHC setting, positive screens were already being identified by the NP upon entering the examination rooms from the paper screening tools. While this was a reasonable work flow, it often did not prepare the NP for knowing how to further assess and manage the 'positive' screens. This also did not prepare the NP for the potential behavioral health problems and/or substance use issues that could unfold after the screening tools were completed and patients had reported their symptoms.

Fortunately, the Lead NP Provider at this clinic was already a champion of the idea of behavioral health integration as she recognized early on in her practice that patients and families sought her out to provide whole health care rather than to be referred out for mental health problems, psychiatric diagnoses and/or substance abuse disorders. The Lead NP provider shared that patients were less likely to follow up on their referrals to specialty psychiatric care, that patients often 'felt stigmatized' by the community and that families also had reported negative experiences (i.e. long waits for appointments, 15-minute medication evaluations and appointments) in the state mental health delivery system. As well, patients and families verbalized that they did not feel that they had an opportunity to share the issues that were troubling them and/or were at the core of their suffering in the community mental health settings. In many instances, patients related that they did not 'trust' the mental health providers in the state agencies, did not feel 'cared for' because of the 'rush' to be seen and then 'handed' or ordered a prescription medication without an opportunity to ask questions or talk about their issues. Mental health counseling was often limited in the number of sessions and also required being assigned to someone that the patient needed to establish trust with in order to 'bare' their soul. Patients at this rural clinic related that their desire to be heard or more importantly listened to, was a common theme that was not being addressed in the mental health system. Therefore, they wanted to be able to talk with the NPs about their 'whole health', because they had a relationship with them, and had established trust over time. Entire families and neighborhoods were presenting to this rural clinic by word of mouth and had established trust and rapport with the NPs. The addition of a Psychiatric-Mental Health Nurse Practitioner (PMH-NP) to the team proved to be an effective and natural addition whereby the NPs would introduce the PMH-NP as another member of their team: a colleague who could help problem solve to promote a better quality of life and the prospect of managing their behavioral health and substance use issues.

It was *painfully* obvious to the healthcare team (in conversations with their patients), that the individuals and families served were also at times, unaware of the social and political inequities and barriers that oppressed their health care needs and management of their illnesses. The potential for treatment (or change) was often verbalized in the notion 'that someone else would be able to fix their situation (politically)' and/or the lack of health care assistance 'was the blame of why they could not be employed'. In order to promote patient engagement, conversations about the promotion of self-awareness, self-care and action took place as part of the treatment planning between the FNP, the PMH-NP and the patients and their families. The aim was to promote patient engagement and active participation in their own health status. It therefore, became even more important to consider how to manage time in the new work flow in order to implement whole health care. The ongoing reflective and dialogic process created more questions to consider.

> *Could the PMH-NP embedded in this setting provide 20–30-minute assessments? Could the patients be seen at the same time by both NPs (PMH-NP and FNP)? Was there an efficient and cost-effective way to manage this possibility? Was the role of a PMH-NP viable for this model? Or was it merely redundant with the BHC role? And what do we do (the team) with the observations of suffering in the patients and families?*
>
> (PI Field notes)

### *Theme #2: reflecting on the role of a PMH-NP and its comportment in a CHC*

Upon reflection, there were two seminal events that lead the way for nurses to be leaders in community mental health in the United States and hence, practice in non-traditional, non-hospital settings: (a.) The National Mental Health Act of 1946 and (b.) The Community Mental Health Act of 1963 (US Congress, 1963). The 1946 Act was a post-war (War of 1939–1945) initiative to address the needs of the returning war veterans and their families, with the notion of providing prevention of psychiatric illnesses and the overall promotion of good health. Funds from this Act provided what is now known as the National Institute of Mental Health (NIMH) and laid the ground work for the Community Mental Health Act of 1963, which was the last legislation that President John F. Kennedy signed into law on October 31, 1963 (United States Congress, 1963). This legislation focused on building not-for-profit mental health centers accessible to <u>all</u> Americans so that those who were suffering from mental health problems and psychiatric illnesses could be assessed and treated while working and living at home, rather than to be institutionalized in hospitals or asylums, which they were frequently called at that time. As part of the Act of 1963, positions were created for nurses to care for individuals and their families in the community, often without specific direction. It was not until Hildegarde Peplau, a pioneer in nursing, worked to further develop the role of an advanced practice psychiatric-mental health nurse with the American Nurses Association (Haber, 2000); and more importantly, to align the role with that of physicians. Some have documented that Peplau's primary and most challenging goal, however, was to create and utilize the role of the advanced practice psychiatric nurse in *non-traditional settings*, (i.e. in homes and non-hospital settings), which was supported by Peplau's clinical work with families and family systems (Barker, 1993, 1995, 1998). The role of a Clinical Nurse Specialist in Psychiatric-Mental Health (PMH-CNS) was duly created in the 1950s, which then transformed into the PMH-NP role at the turn of the millennium (2000). All of this history provides evidence that the role of a community mental health nurse was, and always has been, slated for non-traditional settings and one that was well-positioned to return to work as a member of the interprofessional teams of the 21st century as a PMH-NP. Pulling the thread through the decades provided justification that this was not a new role for the PMH-NP, but one that had been lost along the way due to the challenges in economic funding, changes in the roles of nurses and generations of nurses moving through time who developed theories, knowledge and scholarship, always placing the patient at the center of their care (Soltis-Jarrett, 2016).

### *Discussion of Theme #2*

Is the role of the PMH-NP viable and sustainable in a primary care setting? History has provided evidence that the PMH-NP is an important and necessary member of the community health team and is poised to work in tandem with other health providers and/or act as a liaison to specialty care in the community, in specialty inpatient hospitals and long-term care facilities. History has also illuminated that changes in funding and support for education and training of a

clinically competent workforce (e.g. PMH-NP) has waxed and waned over the past fifty-five years since the inception of the CMH Act of 1963 (Bird, Dempsey, & Hartley, 2002) thus creating an ongoing shortage of psychiatric-mental health providers, especially in rural regions of the US.

The TANDEM3-PC model was created as a potential solution for the lack of access to Whole Health care (more specifically, behavioral health integration) combined with the notion of promoting primary health care professionals (e.g. Family NP) to work to the highest level of their scope of practice. With NPs filling many of the gaps in the Health Shortage Professional Areas (HPSA), could these NPs be educated and trained to screen, assess and manage common behavioral health and substance use problems? "*The camaraderie and willingness to work together was intoxicating and validating…I look forward to working with the team every time*" (PI Field Note). "*There is such comfort experienced when two of us can support one another with these complex individuals*" (PI Field Note).

*Theme #3: reflection-in-action: creating and operationalizing the TANDEM3-PC model*

The third theme was one of action. Once the work flow and roles were conceptualized and understood, it was important to consider models of care that are useful in community health care settings endeavoring to provide behavioral health integration. Multiple models of integration were discussed among the team including the Primary Care Behavioral Health (PCBH) model (Hunter, Goodie, Oordt, & Dobmeyer, 2017; Reiter, Dobmeyer, & Hunter, 2018; Robinson & Reiter, 2016); the IMPACT/AIMS model (Unützer, Katon, Callahan, et al., 2002) and Screen, Brief Intervention, Refer to Treatment (SBIRT) model. There were pros and cons of each approach, notwithstanding the difficulties with having to train staff and strive for rigor, consistency and standardized outcomes. As well, the PCBH model (Reiter et al., 2018) was defined and designed for behavioral health consultants (BHC), an individual with a masters or doctoral behavioral health degree (e.g. Social Work, Psychologist, Licensed Marriage and Family Therapist). The BHC is defined sometimes as a behavioral health clinician who "extends and supports the primary care provider (PCP) and team with brief interventions such as smoking cessation, parenting skills and/or diabetes management" (Reiter et al., 2018, page 112). However, this approach, while extremely useful and effective in some primary care practices, had its own limitations in rural health care. What happened when there was not a BHC? What happens when the patient with complex problems does not respond to the typical approach to treatment of their depression and anxiety? Those using the PCBH model often report that this is when they refer to specialty psychiatric care and either use a consultant or refer for outside treatment (Reiter et al., 2018).

In NC, there are multiple community health care agencies that have successfully embedded BHCs into their primary care settings but have also struggled with their own unique barriers: (a.) lack of training and education for BHC workforce (education) for complex, comorbid medical, behavioral health and substance use problems; (b.) difficulty in recruitment of skilled BHC to work in rural areas (accessibility); and (c.) inability to provide a high patient volume (for sustainability) in order to be able to pay for BHC salaries. These barriers were voiced during statewide meetings linking agencies to one another for collaboration and sharing of ideas over the past five years. The TANDEM3-PC model considered these barriers and also was able to clarify how it was distinctly different from the typical models being used across the state of NC.

As stated in Theme #2, registered nurses and in particular Nurse Practitioners (NP) were a 'thread' that was getting lost in behavioral health integration models. As the PCP workforce transitioned to fill the gaps with non-physicians, the role of a NP became a natural solution to developing another model of care. Although NPs are classified as PCPs, what about the NPs that were committed to working to the highest level of their scope of practice in rural, underserved regions, increasing their education and training to be able to screen, assess, treat and manage individuals and families with complex, comorbid health conditions? What happened when the complex patient needed specialty care but there were no services available for weeks or months? Was there a way to mitigate the referrals to specialty psychiatric care by educating and training the non-PMH-NPs (those with PMH-NP certification) to practice to the highest level without breaching their scope of practice? Without changing the workflow, and without trying to provide BHCs when there were a limited number or limited clinical space, the answers to these questions and cause for reflection were quite simple: to retrace the roots of advanced nursing practice and their roles in community and mental health. Recreating the community health center as it was once meant to be: whole healthcare using mental health consultation, education and practice.

Gerald Caplan's Theory and Practice of Mental Health Consultation (1970) provided the seeds/foundation for addressing these questions and the process for nurturing the seeds of the barriers/problems to be grown into solutions. Caplan (1970) defined consultation as "a process of interaction between two professional persons, the consultant, who is a specialist, and the consultee, who invokes the consultant's help with regard to a current work problem with which he is having some difficulty and which he has decided is within the other's area of specialized expertise. The work problem involves the management or treatment of one or more "clients of the consultee, or the planning or implementation of a program to cater to such clients"" (Caplan, 1970, page 19). As described earlier, previous iterations of this NP-Led model used Caplan's Theory and Practice to guide the clinical process and promote the acquisition of skills with another rural healthcare team (Soltis-Jarrett, 1995). Was it possible to once again apply these tenets of Caplan's theory and practice in this setting? How could the work flow be maintained without compromising the number of patients seen and need to keep moving to see a very full schedule of individuals from cradle to late life? This is where the notion of working "in tandem" unfolded and an evidenced based practice could be used and adapted to promote quality of care, maintain the efficiency of the schedule of patients, while being cost effective. Could a consultation model, originally developed for a community health setting be revitalized? Hence the creation and notion of a tandem bicycle. Metaphorically, two providers 'riding into the exam room', one in the front and one behind. By utilizing the notion of a consultant and consultee model of practice, the PMH-NP and FNP would determine who would 'lead' and who would 'follow' in the assessment of a positive behavioral health screen (e.g. that they were depressed, anxious and/or suffering from a substance use disorder).

Initially patients were cautious about having a PMH-NP as part of their care, in part, due to their previous poor experiences and the stigma associated with psychiatric providers in the rural community. However, once the role of a PMH-NP was introduced in a positive way (i.e. that the FNP entered the room with the PMH-NP and introduced her as 'a co-colleague, a partner in their care'), patients accepted that there were two providers (and thus a team of caring individuals) who were going to help them with their suffering and both happened to be nurses. Less focus was placed on the notion of "psychiatry or psychiatric" and replaced with whole health care and reminding the patients and their families that 'the head is attached to the body'. The notion of a 'tandem bicycle' was coined and used to identify the process by which both NPs could provide the whole healthcare team with the patient/family with the goal of patient-centered health and well-being.

As the TANDEM3-PC model evolved, the PMH-NP may sit in the front seat, 'drive the tandem bicycle' and lead the assessment and management and/or the FNP would sit in the front seat of the bike and lead focusing on a specific complaint. The essential feature was that the patients with complex, comorbid chronic diseases had the benefit of two expert NPs in a rural area of NC if needed. One or the other could leave the examination room to move onto the next patient as the

overlapping of whole health care evolved. This process encouraged efficiency and movement in the work flow as well as the notion that the patient had a team of providers. Both the FNP and PMH-NP could then balance the individual's unique complexities of care, provide whole health interventions and also balance the stress of caring for individuals and families that were in great need of time and understanding as they transverse the possibilities of regaining/retaining their health and well-being, complicated by complex, multi-dimensional physical, behavioral, social and economic inequities. The Quadruple Aim was in process as there was a higher level of satisfaction reported by the providers because they both could balance the high acuity and complexities that were being addressed in this rural community health center.

The PMH-NP in the TANDEM3-PC model has recently transformed even further to provide a form of '*stepped care*', meaning that the patient/family required more definitive and specialized services (even in the short term) in order to be stabilized after being evaluated by the FNP and/or a BHC. This notion of stepped care was learned and utilized in previous models of care (Soltis-Jarrett, 1995). Stepped care has been recently defined as an evidence-based, staged process which includes a hierarchy of interventions, from low to the most intensive and specifically focused on the patient-centered needs. While there are multiple levels within a stepped care approach, they do not operate independently or as one directional steps, but rather offer a range of service option or interventions.

This process also effectively promoted the notion of emancipatory learning across the interprofessional team. For example, the FNP was able to observe the PMH-NP asking assessment questions, engaging patients toward a relationship of trust and rapport so that they could repeat that process when the PMH-NP was not onsite or not in the room. Allowing the FNPs or other team members to observe interviewing skills, a therapeutic interaction and/or the setting of boundaries for difficult patients, was a form of adult learning that was often debriefed and/or discussed later as part of the team meetings. In turn, the PMH-NP was able to provide the added time needed if a patient required additional brief therapeutic interventions. Using several defined evidenced based brief interventions was efficient and promoted successful outcomes.

This notion of the 'tandem bicycle' was also carried forth as part of the 'curbside consultations' whereby the FNPs were able to reach out to the PMH-NP via phone, confidential text and/or the electronic medical record (EMR) to obtain assistance when the PMH-NP was not on site. Throughout this 'curbside' process and onsite tandem work flow, the goal was to embed the PMH-NP (specialized behavioral health services and medication management) as well as also to promote knowledge and skills for the FNP to become more confident assessing and managing integrated behavioral (whole) healthcare. At all times, the FNPs worked within their scope of practice and became more confident in their own practice. They also became more proficient at learning when to refer to the PMH-NP and/or to outside specialty psychiatric care.

### *Discussion of Theme #3*

The notion of emancipatory learning was a natural process that emulated from this flexible work flow. A field note written by the facilitator reflected the kindness, care and concern that was shown by team members to a homeless patient whose body odor permeated the small double wide trailer that housed the clinic. As well, patients (both young and older) frequently presented with blackened or no teeth, soiled and/or ill-fitted clothing. Many times, children presented asking for a snack because they were hungry, (the food stamps and food had run out at their homes). The clinic was quietly offering healthy snacks (fruit, granola bars) and linked individuals to social services to obtain needed food and clothing that fit. The overall role of the collective health care team was observed to be one of empathy, compassion and caring in this rural primary care setting.

Emancipatory learning parallels the ideas of Freire (1970) and focuses on how knowledge and learning can be observed and critically reflected upon to assist not only the patients who can access and receive healthcare; but also, for those who don't have access until something critical or life-threatening occurs. It is important to observe and reflect on how we, as health care providers, assess and manage the healthcare of those with whom we serve. Knowledge (and in particular, nursing and medical knowledge) is inherently entrenched in value-laden beliefs, cultural bias and often leads to unintentional social injustice and inequities. Challenging one's own beliefs, values and bias as part of critical reflection, promotes the possibility for change in ourselves as well as those around us. Emancipatory learning needs to be formed in solidarity with the interests of the least powerful in society, our patients who live in poverty, suffer from oppression and prejudice. Our 'reason for being' a socially conscious health care provider is to not only engage in patient centered care, or collaborate in health care treatment planning, but to listen and to try to understand the patient's sufferings, isolation and marginalization because of their life circumstances. It is essential that if we work with the least powerful, we also strive to help them gain more autonomy and independence, promote them to obtain more control over their health and well-being, and essentially to help them bring about change in their lives for the good of all. Sometimes, just caring and listening is a remarkable agent for change.

Exhibit 1 highlights the flexible flow of the work/tasks in a basic format to illustrate the practical processes inherent in this model.

Observation and reflection was, and continues to be, an important strategy for the Facilitator/NP/PI and team members to initiate and use over time, in order to ensure that the quality of the care is maintained, especially if practice and/or work flow is altered and/or changed. Whether a TANDEM3-PC approach is used or another, team members agreed that it is important to learn to work together with the patient and/or family at the center of their whole health care. While the work flow is strengthened, the team also consolidates their understanding each other's role and how rural healthcare, like its 'patients', are more than just the sum of all its parts. The rural health care team becomes a whole health team, working in unison like the human body.

### *Theme #4: sustainability: roles, teamwork, scope of practice and emancipatory learning*

> *It is important that all members of the health care team learn each other's roles, scope of practice and how to work on a team, while uncovering their own bias, assumptions and beliefs about diseases, illnesses and behaviors, but can this model be sustained?*
>
> (PI Field note excerpt)

Although this may seem to be a 'known/learned skill', many health care professionals in the current workforce have not been *taught* or *coached* on how to work together (Supper et al., 2014). This is gradually being addressed in professional health care programs as part of the IOM initiative called Interprofessional Education (IPE) (IOM, 2015) and it was also an important process for the TANDEM3-PC model. In this particular rural community health center, understanding who was on the 'team' and how it operated was also important to guiding and framing the *whole health* initiative. While the physical/medical needs of patients were being expertly managed by two FNPs and two Medical Assistants (MA), it was acknowledged that there was a growing need for assistance to assess and manage the high acuity of patients being seen for behavioral health and substance use problems co-morbid with their medical/physical problems. Acuity is defined in this model as the measurement of the intensity of care required for a patient that is accomplished by the healthcare provider. In this model, the *intensity of care* assigned (i.e. acuity) to each patient was extended to the entire team utilizing the highest level of their scope of practice, yet, knowing when to refer and/or ask questions. This promoted the healthcare team to expand their knowledge, learning and capacity to be a fully

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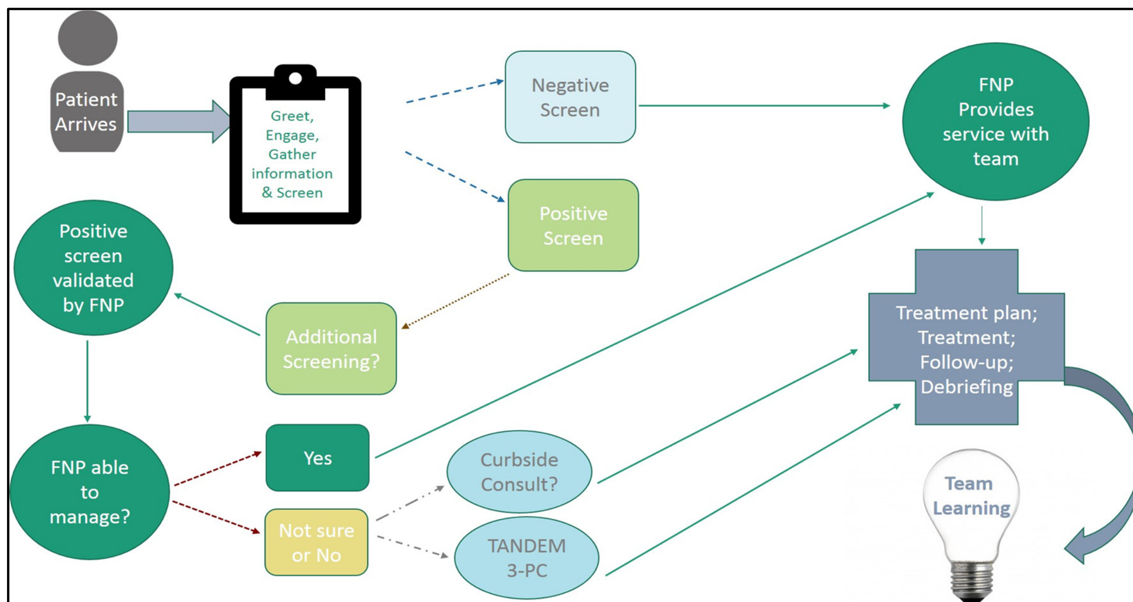


**Exhibit 1.** Flow of tasks for TANDEM3-PC.

functioning member who could approach the potential for learning with curiosity and thoughtful intention. No questions were considered 'unimportant' or 'trite', rather, team members were encouraged to even deconstruct their own beliefs, bias and/or assumptions about diseases, illnesses and/or behaviors different from their own. There were times when questions and thoughts were verbalized and awareness about a personal or cultural belief or bias surfaced within the team. This was what many call a 'teachable moment' and indeed was useful for all members of the team to learn more about an individual, and/or their disease process rather than to accept the bias or belief that may prevent or limit whole health care. When confronted by an 'unknown', whether it is a physical symptom, or a behavioral sign, fear and uncertainty often prevail. As the team evolves over time, it is essential to provide the time and space to explore these 'unknowns' before they grow into monstrous fears and doubts that can distance the relationships between the health care team and their patients/families, as well as the health care team members themselves.

*Discussion of Theme #4*

Consideration of the Triple Aim became more important to the TANDEM3-PC model. Pragmatic questions considered were related to 'who could be the best team member to complete this task'? At what time would that team member be needed? Could a MA or Case Manager complete the task? Does a new role need to be developed or new tasks assigned to promote efficiency and excellence in practice? Where do BHCs fit into this model? These questions were being challenged early on in this project as there were already BHCs embedded in several clinics within this large FQHC and they were deemed to be less expensive and highly effective. Time was needed for observation and reflection on the part of the project team and NP/PI facilitator of the TANDEM3-PC model. Reflection, curiosity and thoughtful intention was required to determine if there was an overlapping of the two roles and whether the role of a PMH-NP would be sustainable over time. More questions and subsequently possibilities for solutions grew from those reflective field notes that began to highlight that there was a role for the PMH-NP that would complement the role of a BHC. It was always there but not necessarily understood in primary care and it was also lost in the translation of the filling the gaps in mental health services not only in NC but nationally and globally: the PMH-NP was the role that filled the gaps of increasing mental health care access and treatment that was created with the decline of psychiatry and psychiatrists. The PMH-NP provided another layer of assessment and care that was ideally suited for community health care and had been there all along. The role of a PMH-NP evolved over nearly sixty years (from the role of a community mental health nurse) when the first community health centers were created and implemented. Pulling up the 'roots' of that role and replanting it in 'here and now' was not only possible, it was even better than before because of the role's evolution over time which fully supported whole health care implementation and the role of a community mental health nurse. It was critical to be able to justify the need for the PMH-NP in this setting, moving forward into the future. This stage, in essence, was a learning curve for the PMH-NP/facilitator/Project Director as she had to cycle through another reflection-in-action phase to promote quality improvement and the future of the model. More importantly, the next cycle needed to demonstrate sustainability and the Quadruple Aim as healthcare moved toward a new model of bundled payments.

**Summary**

The TANDEM3-PC Model was co-created to be a process that promoted a patient-centered, team-based model of whole health care, while addressing the ongoing barriers of assessment and management of individuals and their families who suffer from psychiatric and substance abuse disorders as well as disability that marginalizes individuals from obtaining gainful employment, self-satisfaction and a higher quality of life in rural NC. Like observation, reflection and action, the TANDEM3-PC model ebbs and flows with each patient's needs, the community's challenges, the changing members of the healthcare team and sadly, the financial chaos in a society that, at times, overwhelms us all. However, observing the chaos, reflecting upon it with curiosity and thoughtful intention will allow healthcare providers to perhaps embrace the chaos and give birth to an idea, a project or model that will forever change each person's experience of their world.

Health care in 2018 is, at times, in chaos—impossible to predict or control, however, the TANDEM3PC Model is one example of how a small community of committed individuals can navigate the chaos that is present and abiding in rural health care today. It also provides a framework and model of behavioral health integration that offers the notion of NP-Led teams and increasing access for whole health care by ongoing education, training and learning. Indeed, never doubt that a

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small group of thoughtful, committed citizens can change the world…it is the only thing that ever has….

## References


Abed, F., & Nahid, M. (2010). Understanding the expanding role of primary care physicians (PCPs) to primary psychiatric care physicians (PPCPs): Enhancing the assessment and treatment of psychiatric conditions. *Mental Health in Family Medicine, 7*(1), 17–25.

Barker, P. (1993). The Peplau legacy. *Nursing Times, 89*, 89–91.

Barker, P. (1995). Promoting growth through community mental health nursing. *Mental Health Nursing, 15*, 12–15.

Barker, P. (1998). The future of the Theory of Interpersonal Relations? A personal reflection on Peplau's legac. *Journal of Psychiatric and Mental Health Nursing, 5*, 173–180.

Berwick, D., Nolan, T., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs,* 759–769.

Bird, D., Dempsey, P., & Hartley, D. (2002). *Addressing mental health workforce needs in underserved rural areas: Accomplishments and challenges.* Edmund S. Muskie School of Public Service, Maine Rural Health Research Centerhttp://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.551.6793&rep=rep1&type=pdf, Accessed date: 15 March 2018.

Blanchet Garneau, A., Browne, A. J., & Varcoe, C. (2018). Drawing on antiracist approaches toward a critical anti-discriminatory pedagogy for nursing. *Nursing Inquiry, 25*(1), https://doi.org/10.1111/nin.12211 Jan. (Epub 2017 Jul 7).

Caplan, G. (1970). *Theory and practice of mental health consultation.* New York: Basic Books.

Chinn, P. (1999). *Theory and nursing. Integrated knowledge development.* St Louis: Mosby-Year Book, Inc.

Collins, C., Hewson, D. L., Munger, R., & Wade, T. (2010). *Evolving models of behavioral health integration in primary care.* Milbank Memorial Fund: New York, NY. http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf, Accessed date: 2 March 2018.

Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing (2011). The future of nursing: Leading change. *Advancing health transforming practice*. National Academies Press.

Freire, P. (1970). *Pedagogy of the oppressed.* London: Bloomsbury Academic.

Funk, M. (2008). Integrating mental health into primary healthcare. *Mental Health in Family Medicine, 5*(1), 5–8.

Gerrity, P. (2016). And to think that it happened on 11th street: A nursing approach to community-based holistic care and health care reform. *Alternative Therapies in Health and Medicine, 16*(5), 62–67.

Haber, J. (2000). Hildegard E. Peplau: The psychiatric nursing legacy of a legend. *Journal of the American Psychiatric Nurses Association,* 1078-39036(2), 56–62. https://doi.org/10.1067/mpn.2000.104556.

Holder, M., & Soltis-Jarrett, V. (2016). *Nurse practitioners taking the lead in North Carolina: Interprofessional practice, education, and integration of care (NP lead-NC: IPEIC).* Washington DC: Health Resources and Services Administration, Nurse Education, Practice, Quality and Retention (NEPQR) Grant Submission.

Holman, G. T., Beasley, J. W., Karsh, B. T., Stone, J. A., Smith, P. D., & Wetterneck, T. B. (2016). The myth of standardized workflow in primary care. *Journal of the American Medical Informatics Association,* 29–37.

HRSA Data Warehouse (2016). Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations. as of April 15, 2018 https://datawarehouse.hrsa.gov/topics/shortageareas.aspx.

Hunter, C. L., Goodie, J. L., Oordt, M. S., & Dobmeyer, A. C. (2017). *Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention* (2nd ed.). Washington, DC, US: American Psychological Associationhttps://doi.org/10.1037/0000017-000.

Institute of Medicine (2011). *The future of nursing: Leading change, advancing health.* Washington, DC: The National Academies Press.

Institute of Medicine (2015). *Measuring the impact of Interprofessional education on collaborative practice and patient outcomes.* Washington, DC: National Academies Press.

Jones, J. M. (2017). Factors that affect choice of mental health provider and receipt of outpatient mental health treatment. *The Journal of Behavioral Health Services & Research,* 1–13.

Kagan, P. N. (2010). A nursing manifesto: An emancipatory call for knowledge development, conscience, and praxis. *Nursing Philosophy,* 67–84.

Marcus, S. C., & Olfson, M. (2010). National trends in the treatment for depression from 1998 to 2007. *Archives of General Psychiatry, 67*(12), 1265–1273.

Reeves, W. C., Strine, T. W., Pratt, L. A., Thompson, W., Ahluwalia, I., Dhingra, S. S., … Safran, M. A. (2011). Centers for disease control and prevention (CDC). *MMWR, 60*(3), 1–29.

Reiter, J. T., Dobmeyer, A. C., & Hunter, C. L. (2018). The primary care behavioral health (PCBH) model: An overview and operational definition. *Journal of Clinical Psychology in Medical Settings, 25*, 109–126. https://doi.org/10.1007/s10880-017-9531-x.

Robinson, P. J., & Reiter, J. T. (2016). *Behavioral consultation and primary care: A guide to integrating services* (2nd ed.). Geneva: Springer.

Rowland, P. (2014). Core principles and values of effective team-based health care. *Journal of Interprofessional Care,* 79–80.

SAMHSA (2013). *Nation's substance abuse and mental health workforce issues.* Rockville, MD: SAMHSA. https://www.samhsa.gov/workforce, Accessed date: 2 March 2018.

SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) (2014). Advancing Behavioral Health Integration Within NCQH Recognized Patient-Centered Medical Homes. https://www.integration.samhsa.gov/integrated-care-models/Behavioral_Health_Integration_and_the_Patient_Centered_Medical_Home_FINAL.pdf, Accessed date: 18 March 2018.

Soltis-Jarrett, V. (1995). A psychiatric-mental health clinical specialist in rural South Australia: A consultant to the aged care assessment team. *Holistic Nursing Practice, 9*(5), 30–36.

Soltis-Jarrett, V. (1997). The facilitator in participatory action research: Les raisons d' etre. *Advances in Nursing Science, 20*(2), 45–54.

Soltis-Jarrett, V. (2003). *Finding the health in illness: Challenging the concept of somatization in women. PhD, Flinders University, School of Nursing and Midwifery, xi, 350 leaves.* AUSTRALIA: Flinders University of South Australia.

Soltis-Jarrett, V. (2004). Interactionality: Willfully extending the boundaries of participatory research in psychiatric-mental health nursing. *Advances in Nursing Science, 27*(4), 316–329.

Soltis-Jarrett, V. (2011). His-story or her-story: Deconstruction of the concepts of somatization towards a new approach in advanced nursing practice care. *Perspectives in Psychiatric Care, 47*(4), 183–193.

Soltis-Jarrett, V. (2016). Patient-centered homes and integrated behavioral health care: Re-claiming the role of 'consultant' for psychiatric-mental health nurse practitioner. *Issues in Mental Health Nursing, 37*(6), 387–391.

Supper, I., Catala, O., Lustman, M., Chemla, C., Bourgueil, Y., & Letrilliart, L. (2014). Interprofessional collaboration in primary health care: a review of facilitators and barriers perceived by involved actors. *Journal of Public Health,* 716–727.

Thorne, S. (1996). *Nursing praxis: Knowledge and action.* Thousand Oaks, California: SAGE Publications, Inc.

United States Congress (1963). Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. https://www.gpo.gov/fdsys/pkg/STATUTE-77/pdf/STATUTE-77-Pg282.pdf, Accessed date: 10 May 2018.

Unützer, J., Katon, W., Callahan, C. M., et al. (2002). Collaborative care management of late-life depression in the primary care setting a randomized controlled trial. *JAMA, 288*(22), 2836–2845.

Walter, R. (2017). Emancipatory nursing praxis: A theory of social justice in nursing. *Advances in Nursing Science,* 223–241.

Williams, J. W., Jr., Gerrity, M., Holsinger, T., Dobscha, S., Gaynes, B., & Dietrich, A. (2007). Systematic review of multifaceted interventions to improve depression care. *General Hospital Psychiatry, 29*(2), 91–116.