On the Frontier: Exploring Rural Psychologist Practice in Integrated Behavioral Health Care

A Dissertation
SUBMITTED TO THE FACULTY OF THE
UNIVERISITY OF MINNESOTA
BY

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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

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August 2018

Acknowledgements

This study was made possible by the generosity of many. Thank you to the study participants for giving time, expertise, and sharing lived experiences.

To my advisor, Tabitha Grier-Reed: thank you for facilitating my passion and energy while teaching me how to become a researcher. Throughout this journey you've given me many gifts that I will continue to use in my career.

To my advisor, Tom Skovholt: thank you for helping me navigate this boat and providing encouragement and guidance with each row. I am forever grateful for your patience, persistence, and challenge to grow as a practitioner.

To Carrie Burke: you have demonstrated the strength of being rooted and in doing so, you have helped me grow – thank you.

To those at the University of Maine Counseling Center: thank you for a truly remarkable rural training year and for an ever-present care along with the gift of feedback.

Sincere thanks to Yue Lyu, Hannah Boldt, Christopher Stolp-Smith, and Mary Clare Lindsey for assisting me with the data analysis.

To my parents, John and Julie: thank you for instilling in me a value for education. I have been so fortunate to learn from you both. Thank you for your support, encouragement, and love along the way.

To Bree, thank you for your selfless love.

Finally, to Dawson, for unlocking a joy so deep in the midst of this journey.

Dedication

"The profession of psychology demands a tolerance for ambiguity. Things are never finished. At one end of the spectrum is Pollyanna and at the other end is cynicism."

-Anonymous study participant

This dissertation is dedicated to those nameless helpers who work and live on the frontier.

Abstract

Research on psychologists in integrated behavioral health care (IBHC) remains sparse (McDaniel et al., 2014) and appears non-existent for rurally located psychologists. A study of doctoral-level licensed psychologists practicing in rurally located IBHC settings was conducted. The study had three main objectives: to understand the nature of the work of rural psychologists in IBHC, to explore what impacts the rural and IBHC setting have on psychologists, and to identify the characteristics that psychologists perceive as important for working effectively in rurally located IBHC settings. Eight participants completed in-person semi-structured interviews. A qualitative methodological approach using Consensual Qualitative Research (CQR) (Hill et al., 2005) focused on accumulating information-rich data that may be relevant (Packer, 2010) to the practice of rurally located IBHC psychologists. The examination resulted in seven domains, including nine general categories, 14 typical categories, and six variant categories.

Major findings correspond with established descriptions of integrated care (McDaniel et al., 2014; American Psychological Association [APA], 2008) and include collaboration as integral and close physical proximity to other medical team members as important. Related to the rural setting, results provide a point of integration for understanding the experiences of being both rurally located and an IBHC psychologist. Findings correspond with the experiences of rural psychologists reported in the literature (Cordes, 1989; Hogan, 2003; DeLoen, 1989). Finally, results provide a point of illumination for better understanding characteristics seen as important to working effectively in rurally located IBHC.

Providing an intimate portrait of rural IBHC practice, findings combine notions of rural practice and integrated health care, while extending views on rurally located IBHC practice. The results hold practical implications for psychologists in rurally located IBHC settings. Of particular interest are the unique roles a psychologist has in these settings, the ethical issues that emerge within integrated care, and the characteristics deemed important for being successful in these settings. Limitations and future considerations are discussed.

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Chapter 1: Introduction

Rural communities across the United States face the serious challenge of having limited access to few behavioral health care providers. In 2015, 34.5 percent of U.S counties had no licensed psychologist and 66.4 percent of counties had no more than five psychologists (Lin, Stamm, & Christidis, 2016). The most recent US Census report finds that 19.3 percent of the US population is rurally located across 97.3 percent of the land (Ratcliffe, Burd, Holder, & Fields, 2016; Harowski, Turner, & LeVine, 2006). This is a significant public health concern; many people do not have access to behavioral health care.

Immense geographic isolation is a tangible marker for the barriers to behavioral health care. Intangible markers for rural populations include lack of adequate access to psychiatric services and social welfare support, cultural values that impact utilization of behavioral health services due to stigmatization, confidentiality concerns within small communities, and issues related to socioeconomic status and access to health insurance (Harowski et al., 2006; Mackie, 2015; Wagenfeld, 1997; Schank et al., 2010; Helbok, Haldeman, & Gallardo, 2010).

Recently, primary care clinics have been referred to as the de facto behavioral health care system (Ray-Sannerud et al., 2012). People living in rural areas seeking behavioral health care are more likely to visit a primary care physician than a mental health specialist (Gale & Lambert, 2006). These care settings typically do not have the capacity to adequately meet patients' behavioral health needs. As Donaldson et al. (1996) found, rural populations are more likely to present mental health issues somatically. This may explain why approximately 70 to 85 percent of primary care visits are attributable to

bio-psycho-social and behavioral causes (Engle, 1980). Yet, behavioral health problems often go undiagnosed and untreated by physicians when psychologists are not integrated (Bray & Rogers, 1995; Coyne, Schwenk, & Fechner-Bates, 1995).

Lately, such contextual factors have led the American Psychological Association (APA) to state the importance of partnering with medical care providers to "expand psychology's role in advancing health" (Riding-Malon & Werth, 2014; Breckler, 2010). Recommendations from McDaniel et al. (2014) and Breckler (2010) call for psychologists to transition into primary care settings. Psychologists, especially those who are rurally located, have an opportunity to meet patients where they are–in the primary care setting.

Significance of the study. In recent years, budding professional interest for psychologists to practice in integrated behavioral health care (IBHC) has resulted in establishing the APA Integrated Health Care Alliance, a February 2016 feature in the Monitor on Psychology on integrated care, and the creation of an APA Primary Care Training Task Force. Yet, literature on IBHC for psychologists remains sparse (McDaniel et al., 2014) and appears non-existent for rurally located IBHC practice.

I reviewed policy implications and examined literature related to the impact of having a psychologist practice on a rurally located integrated care team. While no studies examined rural psychologists specifically, research suggests that when behavioral health care is delivered in collaboration with primary health care, patient outcomes and interprofessional consultation related to behavioral health improve (Hedrick et al., 2003; McDaniel et al., 2014; Ray-Sannerud et al., 2012; Butler et al., 2008). Despite these promising outcomes, little is known about the professional implications on rurally located

IBHC psychologists and, in particular, how psychologists can be effective contributing members in integrated care settings.

Aims of the study. I designed this study to provide clarity on the relationship between rural practice and IBHC. By exploring this linkage, I intend to deliver an in-depth understanding of the professional roles and tasks for integrated care psychologists. Clearly articulating the relationship between rural practice issues and integrated care settings should increase the effectiveness of treatment considerations for patients as well as recognize potential professional issues related to ethics, rural settings, and psychologist characteristics that have received little attention in the past. This exploration may enhance patient care for rural populations, further delineate the crude map rural psychologists rely on to navigate integrated care settings, and possibly point to new directions for study. I designed my research questions and data analysis to investigate the nuanced interactions of being rurally located and working as an IBHC psychologist. I employed a qualitative methodological approach and used CQR (Consensual Qualitative Research) (Hill et al., 2005) to focus on accumulating information-rich data that may be relevant (Packer, 2010) to the practice as a rurally located IBHC psychologist.

Purpose of study. This study explores the linkage between rural and IBHC psychologists and develops an understanding of their professional roles and tasks. The study is also designed to examine how rural settings may inform the work of integrated care psychologists. Finally, the study design sought to understand the characteristics that may be important for psychologists as they practice in this setting.

I developed three research questions to focus this qualitative inquiry into rurally located IBHC psychologists: (1) What is the nature of the work of rural psychologists in

IBHC?, (2) What impact does the rural and IBHC setting have on professional practice?, and (3) What characteristics do psychologists see as important for working effectively in rurally located IBHC settings? Analysis of participant responses to these questions is intended to illuminate an in-depth understanding of the professional role of a rurally located IBHC psychologist.

Chapter 2: Literature Review

The purpose of this review is to examine the state of research on rurally located psychologists practicing in IBHC. I begin with a review of policies that shape rural practice and have led to the establishment of integrated models of care. I then review literature assessing IBHC outcomes, the impact such models of care have on patients, and competencies suggested for psychologist who practice in primary care as well as rural and small community settings.

Policy Review

A history of federal policies has molded the delivery of behavioral health care in rural communities. The most recent example came from the sweeping legislation in the Patient Protection and Affordable Care Act (ACA). I offer a brief review of substantive policies to understand the current challenges and opportunities for addressing the behavioral health needs of rural populations. This review begins with the de-institutionalization movement of the 1960s and ends with the ACA of 2010. Federal policies are explored with particular attention to their impact on rural populations and IBHC.

De-Institutionalization. In 1963 Congress passed the Community Mental Health Centers Act (CMHC) (P.L. 88-164, Title II). The CMHC Act led to the creation of CMHCs throughout rural US. This drastically altered the mental hospital system, which housed nearly half a million patients in 1955 compared to some 40,000 in 2014 (Mechanic, 2014). Frank, Koyanagi, and McGuire (1997) state that during this transition from government-run institutions to privatized care there was very little incentive for private insurers to begin covering services that had been paid for by the public sector, resulting in a huge chasm in care. Treatment for behavioral health care was not covered

by insurance providers or was covered at a higher payment rate than physical medical care. The increased financial barrier to behavioral health services persisted for decades, with many suffering people unable to afford care.

Medicare and Medicaid. The passage of Medicare and Medicaid in 1965 resulted in a decrease in the percentage of people in mental hospitals by 65 percent from 1965 to 1985 (Mechanic, 2014). Medicaid became the single largest payer of mental health services in the US (retrieved from https://www.medicaid.gov/medicaid/benefits/bhs/index.html). Four years after the passage of Medicare and Medicaid, in 1969, the National Institute of Mental Health (NIMH) began collecting rural demographic and sociocultural data to better identify rural health needs.

Federal Office of Rural Health Policy. The Federal Office of Rural Health Policy (FORHP) was established in 1987 through the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203). DeLeon et al. (1989) wrote, "In essence, the Office of Rural Health Policy… was given the responsibility of ensuring that the federal government adopts an integrated and coordinated approach to meeting the unique health care needs of rural America (p. 1300)." In 1987, the FORHP required that services provided by clinical psychologists within certified rural health clinics be reimbursable under Medicare and Medicaid. Furthermore, in 1989, reimbursable services provided by psychologists were expanded from rural health clinics to community mental health services and then to all rural settings. These changes recognized the critical contributions of psychologists to underserved rural populations' behavioral health needs.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAE) of 2008. Prior to the passage of the MHPAE, insurance coverage for "behavioral health care often required a higher level of cost sharing (e.g., coinsurance of 50 percent compared with 20 percent for outpatient medical services)" (Barry, Huskamp, & Goldman, 2010). This legislation eliminated the differences in insurance coverage between behavioral and physical health care, creating equal benefits for deductibles, copayments, and coinsurance. The emphasis of physical and behavioral medical care from the passage of MHPAE provides great opportunity for rural psychologists to address behavioral health needs.

The Patient Protection and Affordable Care Act. The goal of the ACA is to ensure that all Americans have access to high-quality, affordable, and comprehensive health insurance plans (Mechanic & Olfson, 2016). In conjunction with MHPAE, the ACA "provides the largest potential yet to expand access to behavioral health and substance abuse services and to forge greater integration between behavioral and medical services" (Mechanic & Olfson, 2016, p. 516). This potential for expansion requires rural psychologists to find their place within the new structures of care. Former APA President, Patrick DeLeon, wrote that the ACA legislation will have an "extraordinarily positive impact upon rural America" (Ali et al., 2016, p. 18). Initial findings suggest an improvement in access, affordability, and quality of care (Uberoi, Finegold, & Gee, 2016). Three important facets of the ACA impact rural psychologists, including: essential benefits, Accountable Care Organizations (ACO), and depression and substance abuse screenings.

Essential Benefits. All health plans under the ACA must provide coverage of 10 essential benefit categories. Access to care for mental health and substance abuse disorders are classified as one of these 10 essential health benefits, which may be of particular interest to rural psychologists. Due to this essential benefit an estimated 62 million Americans can now seek affordable mental health treatment (Beronio et al., 2013). Garfield et al. (2011) estimates that when the ACA is fully implemented in 2019, 3.7 million individuals with severe mental disorders will have gained coverage under the ACA.

Accountable Care Organization. A program that is driven by incentives to organize care on the foundation of primary care is called an Accountable Care Organization (ACO). An ACO seeks to improve quality of care while reducing unnecessary costs. Therefore, primary medical care is one of the most essential structures to implement the ACA (Beronio et al., 2013). Mandated prevention services without cost sharing include depression screening, alcohol abuse screening, and behavioral counseling (Beronio et al., 2013). Rural psychologists are well positioned to deliver such screenings as well as provide counseling within this mandate in primary care settings.

Depression and Substance Abuse Screenings. ACOs are evaluated on numerous performance benchmarks, one being depression screenings. Lewis et al. (2014) found that ACOs are motivated to incorporate depression screenings and track such screenings within their electronic health records. Yet, Lewis et al. (2014) found that most ACOs had done very little to integrate behavioral health care into their primary care settings. This could be a great opportunity for rural psychologists to fill an essential and unmet need in primary care settings.

Policy Implications. By understanding the policies that have led to IBHC, psychologists are able to advocate for improving access to mental health care among the rural population as well as be involved in redesigning healthcare delivery and regulations (Clay, 2011). Having reviewed the policies that shaped rural practice and led to the establishment of integrated models of care, I will now focus on the evolution of treatments and psychologists' trainings for rural integrated behavioral health care.

Integrated Behavioral Health Care Review

Recent literature on IBHC has focused on important issues such as detection of behavioral health issues by integrated care teams versus physicians (Coyne et al., 1995; Hedrick et al., 2003) as well as assessing different models of integrated care (Ray-Sannerud et al., 2012; Butler et al., 2008). Yet, there remains a lack of research literature examining the function of psychologists on rurally located IBHC teams. The following review synthesizes recent findings, offers suggestions for future research, and bridges the gap between integrated behavioral health care and rural practice in order to focus on rurally located IBHC psychologists.

Using Google Scholar and PsycINFO I conducted a review of substantive literature by using search terms: "Rural," "Integrated Primary Care," "Psychologist," and "Mental health." No empirical research articles were located that specifically discuss the outcomes of having psychologists practice as part of a rural integrated primary care team. The review is organized to understand physician limitations in detecting behavioral health needs, assessing IBHC models, and competencies for primary care and rural psychologists.

Detection of Depression by Primary Care Physicians. Coyne et al. (1995) examined the detection of major depression of 1,580 family practice patients in both rural and suburban communities. The study used the Center for Epidemiologic Studies Depression Scale (CES-D) and a Structured Clinical Interview form DSM-III (SCID). Mental health professionals documented the severity of the diagnoses of depression from 'mild' to 'severe'. Interrater reliability was 97% for symptom level and 93% for diagnostic decision. Physicians completed a rating scale for all patients that included a direct question about whether the patient was depressed (Coyne et al., 1995).

The major findings indicated the rate of detection of depression by physicians was poor. The physicians detected only 27.9% of patients with a depressive disorder. These findings from Coyne et al. (1995) speak to the need for psychologists to be present within a primary care setting as many primary care providers are unprepared to accurately diagnose and subsequently treat mental health diagnoses like depression.

Integrated Behavioral Health Outcomes. Ray-Sannerud et al. (2012) conducted a longitudinal study of 664 primary care patients who received care from BHCs (Behavioral Health Care Consultants) within a family medicine clinic. They had patients complete the Behavioral Health Measure (BHM) (Kopta & Lowry, 2002) at check-in at each primary mental health care appointment. The treatments primarily consisted of cognitive behavioral therapy as well as providing psycheducational information about self-care strategies related to sleep hygiene, exercise, progressive muscle relation, and mindfulness training. Using mixed effects modeling they found that patients improved from their first to last BHC appointment with gains maintained on an average of two years after intervention. The authors claim that based on their findings, having a

behavioral health care member as a referral option on a care team in primary care "supports patient symptom reduction and functional improvement across the course of integrated primary care treatment in general" (Ray-Sannerud et al., 2012, p. 66).

Effectiveness of Integrated Behavioral Health Care. Hedrick et al.'s (2003) study objectives were to compare the effects of the two models of care on treatment for depression. With two consult-liaison care clinics, which were considered the traditional model, the primary care provider maintained responsibility for treatment of depressive symptoms and consulted with or referred to a specialist as needed. The other two clinics utilized collaborative care in which the clinical psychologist, a psychiatrist, social workers, and a psychology technician team met weekly to develop treatment plans for each patient. Hedrick et al.'s (2003) major finding was that through collaborative care, patients decreased their depressive symptomatology quicker than with just a consultant-liaison model.

Butler et al. (2008) conducted a meta-analysis assessing the effectiveness of integration of mental health care into primary care. These authors found that most studies of behavioral health care integration tended to focus on treating depression in primary care settings while a few studies focused on anxiety (Butler et al., 2008). Moreover, financial barriers remained the major impediment to integrated care due to the typical fee-for-service reimbursement policy (Butler et al., 2008). Furthermore, they found organizational barriers included a resistance to change and concerns related to translating integrated program models into real-world clinical settings (Butler et al., 2008). The review applied quantitative and qualitative analyses to assess randomized controlled trials and high quality quasi-experimental studies that had been conducted in

the US from 1950 to 2007 (Butler et al., 2008). Their analysis found that overall integrated care achieved positive outcomes (Butler et al., 2008). However, due to the un-uniformed implementation of integrated care, they found it was not possible to distinguish specific effects for the treatment of mental health problems (Butler et al., 2008). Similar to Hedrick et al. (2003), Butler et al. (2008) found that when comparing integration with traditional primary care, there were no clear differences in outcomes. Overall, the work of Butler et al. (2008) synthesizes much of the literature over the past 50 years incorporating primary and behavioral health care.

Integrated Behavioral Health Care Psychologist Competencies. McDaniel et al. (2014), described competencies for psychology practice in primary care among six broad domains, where an interorganizational workgroup of 16 group members reviewed existing literature on psychology competencies and primary care practice and then assigned these to one or more of the six competency clusters. The clusters included science, systems, professionalism, relationships, application, and education.

In the cluster of science, the authors state that primary care psychologists need to 'stretch' their knowledge and be exposed to scientific foundations to include knowledge in areas of "human physiology, clinical pathology, basic pharmacology and psychopharmacology, epidemiology, and public health policy" (McDaniel et al., 2014, p. 414). Primary care psychologists must also have competencies to function on interdisciplinary research projects, evaluate clinical programs, and develop practice standards (McDaniel et al., 2014). In the cluster of systems, primary care psychologists must understand interdisciplinary systems, leadership and administration, and advocacy. This included understanding how health care policy affects the practice of psychologists

within the system. In the cluster of professionalism, competencies included a focus on ethics within primary care settings. In the cluster of relationships there was an emphasis on competencies related to interprofessionalism, and not only building, but also sustaining relationships among primary care providers. This was connected to the ability to achieve higher quality of care as well as cost-effective health care. In the cluster of application there was an emphasis on evidence-based interventions. The authors discussed the need for psychologists to adopt a "public health psychologist" hat in addition to their traditional roles (McDaniel et al., 2014, p. 425). Lastly, within the cluster of education, teaching and supervision were critical. The authors believe primary care psychologists serve as educators to health care providers and therefore need to be able to provide feedback to their integrated care team. This report provides a comprehensive starting point for psychologists in order to thrive within a rural primary care setting.

Rurally Located Psychologists. Related to the competency of ethics, Schank (1998), conducted a foundational qualitative research study with 16 rural and small-community psychologists as they described boundary dilemmas faced in daily practice. Her findings included eight themes: (a) the reality of overlapping social relationships; (b) the reality of overlapping business or professional relationships; (c) the effects of overlapping relationships on members of the psychologist's own family; (d) seeing more than one family member, or seeing people who have friendships with each other as individual clients; (e) getting unsolicited out-of-therapy information about clients; (f) high visibility and lack of privacy; (g) collecting unpaid bills from clients; and (h) bartering. Schank's (1998) findings have impacted the professional understanding of

rural and small community ethics. For my purpose, her study and results provide a foundation for conducting a qualitative analysis with rural psychologists.

Discussion of Literature. Federal policies will continue to shape how practice is delivered, and psychologists are well positioned to advance behavioral health care in rural communities. Based on the review of policy and literature related to rurally located IBHC, there is building evidence for improved patient care outcomes from having a psychologist on an IBHC team. The research reviewed here substantiates the benefits of behavioral health care, from having a psychologist in the primary care setting to meeting rural patients where they are seeking care, however, little, if any research attention has focused on the role of the psychologist in rurally located IBHC (Coyne et al., 1995; Ray-Sannerud et al., 2012; Butler et al., 2008).

If the primary care setting continues to be the most visited setting for rural residents seeking help (Mechanic & Olfson, 2016), and IBHC has been found to decrease patient symptomatology (Butler et al., 2008; Ray-Sannerud et al., 2012), then it could be advantageous to have psychologists practice among rurally located integrated primary care teams. In fact, several of the polices reviewed discussed the need for psychologists to practice in rural integrated primary care settings (McDaniel et al., 2014; Mechanic & Olfson, 2016; Lewis et al., 2014); however, no articles have discussed professional implications for working in rurally located IBHC. This gap in the literature provides an opening for examining the role of psychologists in rurally located IBHC settings.

Chapter 3: Methodology

The purpose of this study was to understand the work of rural psychologists in integrated behavioral health care settings (IBHC). I sought to understand the unique implications for psychologists practicing in a rural setting as well as within an integrated model of behavioral health care. Specifically, I focused on identifying what characteristics psychologists see as important for working effectively in these settings. I selected a qualitative approach for the purpose of understanding the unique implications for each psychologist. As Patton (2005) stated, "qualitative methods permit inquiry into selected issues in great depth with careful attention to detail, context, and nuance (p. 227)." The methods employed in this study permitted me to pay particular attention to the detail, context, and nuance described by each participant. This chapter provides an overview of participants, settings, procedures, and analysis including a detailed description of the Consensual Qualitative Research (CQR; Hill et al., 2005; Hill, Thompson, & Williams, 1997) process employed.

Participants

Eight, Ph.D. Licensed Psychologists, self-identifying as working in integrated behavioral health care (IBHC), participated in the study. All participants were employed as health psychologists at one of six health care settings rurally located in the state of Minnesota. The demographic makeup included four female participants (50%) and four male participants (50%). Ranging in age from their thirties to their sixties: two participants were between 30-39 years of age, four participants were between 40-55 years of age, and two participants were between 56-65 years of age. All eight participants identified a White. Two participants disclosed that their theoretical orientation was

“pragmatism”. The remaining six participants did not disclose their theoretical orientation.

Settings

Rurally Located. Rural was operationalized using established criteria from the rural-urban continuum codes developed by Packer (2010). Research conducted by Morrill, Cromartie, and Hart (1999) found that a census-tract approach to defining the construct of rural helps to improve the accuracy of the definition. The rural-urban continuum codes were developed from Morrill et al.'s (2016) research parsing out metropolitan counties by the population size of their metro area, and nonmetropolitan counties by the degree of urbanization and adjacency to a metro area. Morrill et al. (2016) developed a code system of 10 codes from 1 - metro areas including a population of more than 1 million to 10 - rural area fewer than 2,500 people. I decided to operationalize the term rurally located if the psychologist resided in a rural urban continuum code of 6-10. These codes represented the distance from a metropolitan or urban area with: 6 being a micropolitan area defined as at least 10,000 but less than 50,000 people with low commuting; 7 being a small town defined as 2,500-9,999 people; 8 being a small town with high commuting; 9 being a small town with low commuting; and, 10 being rural—fewer than 2,500 people.

Integrated Behavioral Health Care (IBHC). I also relied on a previously established definition of IBHC developed by the American Psychological Association’s taskforce on Integrated Behavioral Health Care (McDaniel et al., 2014; APA, 2008). The adopted definition describes: “an approach characterized by a high degree of collaboration and communication among health professionals" (McDaniel et al.,

2014). All eight participants in this study met inclusion criteria of working within both rurally located and IBHC settings.

Procedures

Recruitment and Selection. This study was conducted with the approval of the Institutional Review Board at the University of Minnesota. To recruit participants, I submitted a Mailing List Request Form to the Minnesota Board of Psychology. The request was approved, and I received a mailing list of 4,308 licensed practitioners. I followed LeCompte's (1984) recommendation to establish criterion-based sampling. Participant inclusion criteria included four qualitative variables: (1) completion of Ph.D. degree (2) registered Licensed Psychologist in the state of Minnesota, (3) rurally located as categorized from 6-10 on the rural-urban continuum code, and (4) self-identified as an IBHC psychologist. A total of 71 psychologists seemed to meet the first three inclusion criteria for this study. The final criteria required that potential participants self-identify at the time of participant recruitment.

My first point of contact with potential participants was by mailing 71 research packets. Each mailing included a study invitation describing the purpose of the study, a study inclusion questionnaire, and a self-addressed return envelope (See Appendix A). I asked three questions on the study inclusion questionnaire: (1) their location of practice by zip code, (2) if they identify as practicing within an IBHC setting, and (3) if they would be willing to be interviewed in-person in their own rural office location, by the researcher.

Of the 71 mailings, all with self-addressed return postage, only 13 were returned over the course of four weeks. Five potential participants marked "no" to describing their

work as meeting the definition for IBHC described in the previous section. After the initial mailing, there were eight study participants who defined their work as within an IBHC setting and who consented to being interviewed.

A second attempt was made to recruit more participants based on literature recommending 8-15 participants (see Hill et al., 2005; 1997; Levitt et al., 2018; Patton, 2005). Utilizing the email address from the mailing list for those who had not responded to the initial mailing, I sent individual emails with attachments of the study invitation and a request to respond via email. Four potential participants replied to the email. Each identified as meeting the inclusion criteria and consented to being interviewed.

With each of the 12 potential participants, I attempted to schedule a 50 minute in-person individual interview (See Appendix B for an example). Throughout the scheduling process, three potential participants did not respond to finalize an interview time and date. An additional participant was excluded due to a differing interpretation of IBHC psychologist. In that particular case, the participant had considered community integration instead of specific integration within a health care setting. After much effort, the final number of participants included eight people – five from the first wave of respondents and three from the second.

Interviews. I developed open-ended interview questions from a review of existing literature, consultation with co-advisors, and competency recommendations from the American Psychological Association (McDaniel et al., 2014). Following Patton's (2005) guidelines for developing a matrix to solicit several types of responses, interview questions focused on four areas: (1) describing the unique work for psychologists in an IBHC setting, (2) discussing interactions with other health professionals, (3) exploring

how the rural setting informs work and ethics, and (4) identifying characteristics important to being effective in the setting. (See Appendix C for the interview protocol).

One week prior to each scheduled interview, I sent the interview questions and informed consent form to participants (see Appendix D for the informed consent). On the day of the interview in their rural office setting, prior to recording, I reviewed the informed consent document, answered any questions about participation, and documented consent. At the end of each interview, I wrote notes about observable features of the space in which the interview was conducted as well as the rapport built with the participant. Given the great travel distance required to conduct interviews in rural locations and the full schedules of the participants, the entire month of June 2017 was taken for data collection. The least travel distance from the University of Minnesota to a participant's office was 133 miles, while the most was 306 miles. The total distance traveled was over 1,400 miles to collect the data during the in-person interviews.

Transcription. I transcribed all interviews verbatim using qualitative research software. All information was de-identified and grammatical errors were corrected. Each transcript was assigned a code number to maintain confidentiality, and then I sent two transcripts to each research team member.

Research Team

Demographics. As Denzin and Lincoln (1998) wrote, "research is an interactive process shaped by . . . personal history, biography, gender, social class, race and ethnicity. . ." (p. 4). The research team in this study included Yue Lyu, Hannah Boldt, Christopher Stolp-Smith, Mary Clare Lindsey, and me as the principal investigator. There were four White and one Asian identified research team members. Three were female,

and two were male; ages ranged from 23-34. Three of the five team members were M.A students from the Counseling and Student Personnel Psychology program at the University of Minnesota and two were doctoral candidates in counseling psychology — one from the University of St. Thomas and one from the University of Minnesota.

Bias. Bias reflection is defined as discussing and reflecting on "personal issues that make it difficult for researchers to respond objectively to the data" (Hill et al., 1997, p. 539). Bias reflection took place prior to data analysis. The research team examined our expectations by responding in writing to a bias statement prompt as recommended by Hill et al. (2005), and then we discussed our biases during in-person meetings. During this process we examined our expectations for the study as well as our biases regarding rural practice and integrated behavioral health care. Three team members shared their experience growing up in a rural community and the perceived stigma at the time associated with seeking mental health care. Another team member shared their specific bias of rural populations potentially holding homophobic values and wondering if rural practitioners may reflect that generalization. Lastly, a team member discussed their bias about low-paying jobs in rural areas and their assumption that well- trained psychologists would likely seek employment in urban areas for financial reasons.

Training. All team members were provided background readings on the research topic. In order to find a common language for discussing rural integrated care an article from Peterson, Turgesen, Fisk, and McCarthy (2017) titled *Integrated Care in Rural Health: Seeking Sustainability* was shared. Selected readings from Hill et al. (2005) on domains, coding, and cross-analysis were shared to deepen the team's understanding of the consensual process. Finally, a draft of my thesis proposal was provided for a review

of relevant literature. Weekly emails were sent back and forth to members of the research team throughout the months of June and July 2017 discussing tasks and providing context. A feminist qualitative paradigm proposed by Hill et al. (1997) that "relies on mutual respect, equal involvement, and shared power" (p. 523) was adapted to facilitate the consensual process. This perspective was addressed during in-person meetings by acknowledging potential power dynamics between the primary researcher and the other four research team members, focusing on team cohesiveness, and encouraging the exploration of discomfort present in arguing throughout the consensual process. I held individual face-to-face meetings with each team member to review their assignments. The total number of training hours ranged between 5-10 hours for each team member.

Data Analysis

We analyzed the data using Consensual Qualitative Research (CQR; Hill et al., 2005; 1997) methods. Hill et al. (2005) describe the philosophical foundations of CQR as "predominantly constructivist, with some post-positivist elements" (p. 197). CQR relies on naturalistic, interactive, qualitative methods. Meaning in this study emerged from the words spoken by participants as well as from their individual context. The key aspects of CQR include: interviews, domains, core ideas, and cross-analysis. Our consensual process included individual, paired, and group consensual analysis. Each team member spent 15-20 hours engaged in data analysis. I participated in each aspect of the analysis for all cases which totaled 84 hours.

Domains. I began the analysis by creating a start list (Hill et al., 2005; Miles Huberman, & Saldaña, 1994) of six domains based on my review of the literature, interview questions, and sense of the data. I then provided the domain list to the other

four research team members. Team members individually reviewed the raw data from their two assigned transcripts and engaged in a cross-analysis of the initial domain list. As a result of the cross-analysis the research team consensually determined to alter the start list to include seven domains.

Core Ideas. Following the development of the domains, I read each transcript individually to develop core ideas from the raw data. In a parallel process each team member worked individually to develop core ideas from the two transcripts assigned to them. I then met face-to-face for paired consensual analysis with each team member to finalize core ideas for each transcript. In a few transcripts, core ideas could be included in two or more domains. Following Hill et al.'s (2005) recommendations, the research team processed double coded core ideas as a group and whenever possible, paired the doubled coded core ideas with the most predominate domain.

Final Categories. To create the final categories four of the five research team members met together to discuss clusters of core ideas that fit into each domain. The other member could not meet because of their work and travel schedule. To prepare for the group meetings, each team member worked with their two assigned transcripts to review all of the core ideas within a single domain and clustered similar core ideas by identifying common elements. (I engaged in this process to fill in for the fifth team member.) Team members were instructed to create a category structure that captured most if not all of the core ideas within each domain. Category titles were derived from the data rather than from preconceived notions. The research team met for a total of five hours (spanning two group meetings) to consensually identify categories across all transcripts. I assigned each category a label to demonstrate representativeness of the data:

general (7-8 cases), typical (4-6 cases), variant (2-3 cases), and rare (l case) (Hill et al., 2005; 1997).

Chapter 4: Results

This study addressed three major research questions:

1) What is the nature of the work of rural psychologists in integrated behavioral health care (IBHC)?
    a. How do psychologists describe their professional roles?
    b. What tasks do psychologists perform in IBHC settings?
    c. How do psychologists communicate on integrated care teams?
2) What impact does the rural and IBHC setting have on professional practice?
    a. How does being rurally located inform practice?
    b. How does IBHC facilitate or impede patient care?
    c. What ethical issues arise from rurally located IBHC?
3) What characteristics do psychologists see as important for working effectively in rurally located IBHC settings?

The CQR process employed resulted in the identification of 31 categories across seven domains. (See Table 1 for an overview of all results.) In this chapter I provide a detailed a description of the general and typical categories as they are considered to have practical implications related to my central research questions (Ponterotto, 2005). I have listed core ideas associated with the variant categories in the corresponding appendices for each domain. There were no rare categories identified in this study.

Table 1. *Domains and General, Typical, and Variant Categories for Rural Integrated Behavioral Health Care Psychologists*

Domain	General (7-8 cases)	Typical (4-6 cases)	Variant (2-3 cases)
1. Definition of Rurally located *IBHC		- Physical Proximity Facilitates Collaboration - IBHC Depends on Context of Setting	- The Practice of Psychology with Medical Cultural Influences
2. Psychologist Professional Roles in Rurally located IBHC	- Psychologist as Consultative Educator - Psychologist as Flexible Generalist - Psychologist as a Medical Team Member		- Psychologist Reception of Warm Handoff - Psychologist as Community Member
3. Communication in Rurally Located IBHC	- Communication Enhances Patient Care - Communication Broadens Relationships - Communication Mediated by Electronic Health Records		
4. Rural Matters		- Vast *Catchment and Void of Resources - Rural Settings are Distinct - Broad Practice Scope - Stigma on the Decline	- Lack of Transportation - Professional Isolation - Lack of Anonymity
5. Rural Ethical Issues in IBHC	- Continual Boundary Maintenance	- Confidentiality - Stretching of Competence	
6. IBHC Setting Impact on Patient		- Decreased Stigma - Increased Efficiency - Constraints of Resources Impacts Patient Care	
7. Effective Characteristics of Psychologists in IBHC	- Valuing Flexibility - Valuing Responsibility	- Valuing Team Relationships - Valuing Self-care - Valuing Advocacy	- Interest in Medical Culture - Valuing Humility

*IBHC is abbreviated for Integrated Behavioral Health Care
*Catchment is defined as the area from which an institution attracts a population that uses its services

Domain 1 Definition of Rurally Located IBHC

The first domain, Definition of Rurally Located IBHC, includes two typical categories that described the rurally located IBHC psychologists. The first category, Physical Proximity Facilitates Collaboration, was evident across five cases. The second category, Integrated Care Depends on Context of Setting, was evident across four cases. The variant category—The Practice of Psychology with Medical Cultural Influences—can be found in Appendix E.

Physical Proximity Facilitates Collaboration. The first category, Physical Proximity Facilitates Collaboration, was the most common description for how participants described their work. This included formal and informal collaboration. As participants discussed their role as a psychologist in an IBHC setting, they spoke about how collaboration happens. For example, one participant described the practice of psychology as being the same as traditional psychotherapy, but having a greater focus on collaboration, stating that "The main difference is the attention paid to what other providers are doing for a client (Case 6)." Another participant noted that psychologists conduct diagnosis, provide education, consultation, and psychotherapy and do this in both formal and informal ways with patients and as a team member. Participants' understandings of collaboration were described in both personal and professional experiences. For example, below is an excerpt from one interview.

> We do it all the time, in fact you know where I just came from? The hospital, I was doing a consult, this would have been somebody who is on a 72-hour hold. She has been a longer-term methamphetamine addict, and also has a history of depression, so we just wanted to consult in terms of we are going to discharge her today, so what would you recommend? (Case 4).

Most participants spoke about how psychologists in IBHC rely on close physical proximity to other health professionals and services. Participants were acutely aware of their physical proximity to a primary care doctor. Examples included being within walking distance to the emergency room, initial examination room, inpatient psychiatric unit, children's residential treatment facility, and a nurse station.

IBHC Depends on Context of Setting. The second category, IBHC Depends on Context of Setting, encompassed a focus on context and the challenge of defining integrated care. One participant encapsulated the challenge as follows:

> I don't know if there is a specific job description that is going to apply to every psychologist in every integrated care setting because I think it depends on the clinic and depends on the pairs [of medical providers] that I think [influence] the kind of work a psychologist could do (Case 3).

Most participants identified the health care setting and medical culture as having a direct impact on the practice of psychology. See below for examples.

> The work of integrated care psychologists is similar to psychologists elsewhere, except more attention is paid to the context of the setting. You pay attention to what other providers are doing (Case 6).

> The whole idea of team is a really popular concept now….rather than a psychologist having their own panel of patients, this initiative is really saying that the team will have a panel of patients so these 500 patients belong to the team. It is not like Dr. J has her own practice and Dr. P has his own practice, but that we as a team share a panel of patients and that we will huddle every morning and discuss who on our team is coming in for an appointment today. We may say these 30 patients are coming in and I may say this one and this one and this one are patients that I need to see (Case 3).

As participants discussed the importance of context they each spoke to their own individual setting. Some participants worked in the same hallway as primary care doctors, surgeons, and nurses; others were located a floor or two away from primary care doctors,

while still others were located in stand-alone buildings, separated from the physical health care locations. Most participants referenced how physical proximity either advances or hinders collaboration with other health professionals.

Domain 2 Psychologist Professional Roles in Rurally Located IBHC

The second domain, Psychologist Professional Roles in Rurally located IBHC, includes three general categories. Psychologist as Consultative Educator, Psychologist as Generalists, and Psychologist as Medical Team Member. All three of these categories were evident across seven of the eight cases. The two variant categories—Psychologist Reception of Warm Handoff and Psychologist as Community Member—can be found in Appendix E.

Psychologists as Consultative Educator. Psychologist as Consultative Educator emphasized the collaborative and didactic roles that present in the setting. Most participants noted that they do not operate within a vacuum in an integrated care setting, but rather engage with patients, medical staff, and the community to provide consultation, psycho-education, and support. See below for excerpts from two interviews.

> The role of psychologists in a rural setting is to collaborate with other people from patients' network of providers, such as the medical provider, the social worker or community support worker (Case 2).

> An integrated care psychologist, roles include psychoeducation, with both patients and medical staff, and informal and formal consultation with patients and medical staff (Case 3).

This role also seemed to challenge some traditional schemas of the profession as described below:

> Psychologists are trained to be individualistic, but integrated care calls for collaboration and communication about patients…Integrated care psychologists balance between traditional care and a consultative model of

> care that is team based. Because we are physically located next door a lot more consultation takes place. It is collaborative… There is a lot of caution, dialogue, reflection, and self-challenging about core professional schemas (Case 5).

Yet, participants placed a high value on collaboration, as one participant said: "It would be challenging to practice without a care team as it would feel like practicing on an island" (Case 5).

The focus on collaboration seemed to introduce a new level of integration among health professionals as stated by another participant: "The professional implications for rural psychologists in an integrated care setting is to have the awareness that mental health is connected with physical health. Psychologists should promote the body and mind as a whole" (Case 8).

Psychologist as Flexible Generalists. Most participants used the word flexible to define their role as a generalist in a rurally located IBHC setting. The IBHC and rural settings both seemed to drive the need for flexible generalists as one participant put it, "Integrated care psychologists have to deal with every kind of disorder and condition" (Case 6). Further acknowledging the need for flexibility another participant noted that: "The type of services being provided and needs of individual clients dictate the time spent with a client. Psychologists need to be flexible to ensure needs are met" (Case 1). Finally, a participant shared that with "being the only person in the clinic trained in primary care behavioral health, much learning happens on the fly for my colleagues" (Case 5).

The second and more prevalent aspect among participants was the impact of being rurally located on the role of flexible generalists. Several participants connected being rurally located to an almost forced flexibility. One participant noted, "Rural psychologists

are required to be generalists. You can have specialty training but need to be willing to expand your training" (Case 7). Another participant noted that she had worked in both rural and urban locations, and she compared the two by stating, "In urban areas, therapists have specialty areas that they hone…. but rural psychologists are required to be generalists. You can have specialty training but need to be willing to expand your training" (Case 6). Finally, a participant discussed the hazard of not practicing as a flexible generalist emphasizing that, "Rural psychologists cannot be too rigid in the presenting issues or populations that they work with, because it would require turning many people away for services. There is not an easy referral option in most rural settings" (Case 8).

Psychologist as a Medical Team Member. The third category, Psychologist as a Medical Team Member, included implications for practicing as a psychologist in a medical setting including, limited time, intra-professional relationships, and traditional care vs. integrated care. With respect to time, one participant described the practice as "more short-term and brief" (Case 5) while another addressed the caseloads: "The amount of paperwork [is] daunting…I maintain a caseload of 45-60 patients each week" (Case 4). Moreover, there was a need to adapt to develop intra-professional relationships within the medical setting. A participant shared the following:

> Psychologists need to adapt to medical culture in rural settings to fully engage in integrative care in order for there to be team unity and mutual understanding of each person's individual role, and in particular the life of a physician in the clinic (Case 3).

One participant described challenges related to historical competition among professions: "Historically tense relationships are a result of competition between psychologists and psychiatrists" (Case 6). Other participants spoke directly to tension

between traditional care and integrated behavioral health care, including the challenge of "practicing traditional psychotherapy while balancing same day, urgent crisis, and hospital consults" (Case 5). Also included in the tension were shorter amounts of time spent with patients. One participant shared her struggle: "I struggle with the contemporary view of seeing many patients in a short amount of time and believe that the underlying concerns often go unaddressed" (Case 3). However, this seemed to be the direction of integrated care settings as described by another participant: "We [the medical clinic] are on the path toward true integrated care, however in the future we would like to see both 50-minute appointments as well as brief 15 minute visits" (Case 8).

Domain 3 Communication for Psychologists in IBHC

The third domain, Communication for Psychologists in IBHC, includes three general categories. The first category, Communication Enhances Patient Care, was found in all eight cases. The second and third categories, Communication Broadens Relationships and Communication Mediated by Electronic Health Records, were identified in seven cases.

Communication Enhances Patient Care. Data from all eight cases were included in this category as participants reflected on their relationships with fellow health professionals in IBHC settings. Participants seemed to support expanding communication among team members and discussed the positive impact it has on patient care. For example, one participant said that "working with different health professionals helps to broaden perspectives" and that "a collaborative approach helps form a well-rounded and accurate picture of a client" (Case 1).

Participants discussed broadening perspectives to better conceptualize physical and mental health. Another participant expanded by saying, "It's collaborative and you're paying attention to what other health professionals are noting about that patient" (Case 6). The focus of psychologists is not only on the patient, but also on the team of health professionals. Several participants mentioned team meetings where such conversations took place. One noted that: "The whole point of the daily meetings is to gather and combine all the information and collaborate together…everyone involved can both listen and contribute" (Case 6).

Still, there was tension for psychologists on an integrated health team. One participant summarized the tension as follows: "Psychologists are generally trained for private, one-on-one practice but in this setting, you have to be team-based and willing to discuss" (Case 5). Another participant noted that, "work as a psychologist in an integrated setting is similar but requires more relationships and communication" (Case 7).

Communication Broadens Relationships. This category also included data from seven cases. Communication was described across a variety of formal and informal means such as face-to-face communication, brief hallway chats, getting lunch, and online communication. See below for an example of formal communication:

> Well-functioning teams huddle in the morning together and raise issues about specific patients that are coming in for an appointment that day. This is a chance for the psychologist to communicate to a physician and vice-versa, i.e., medical consult, suicidal ideation, etc. (Case 3).

Informal consultations tended to take place "in the hallway", "over lunch or whenever people are available" (Case 4). Trust is important for broadening relationships. A participant noted that, "Teamwork is the ability to work together with trust and optimal communication" (Case 3), and communication was intimately linked with collaboration

and gaining a holistic view of patients. One participant described the importance of the communication process as follows:

> The collaboration between the team relied on a lot of consultations, such as dropping in [the] office to communicate, communicating through electronic medical records, from which viewing the patients as a whole is very important (Case 8).

Communication Mediated by Electronic Health Records. Communication Mediated by Electronic Health Records (EHR) included data from most participants as they spoke at length on the topic of EHRs. Most core ideas connected to topics of ethics and the utility of EHR mediated communication to promote and facilitate communication on behalf of the patient. For example, one participant asserted that: "Being on the same electronic health record allows easy communication with care providers" (Case 2). Another said, "Patient communication is facilitated by the chart on the electronic health record" (Case 6). In addition, one research participant shared that: "The electronic health records enhance communication across providers [because] you are able to share notes with other care providers" (Case 7). Highlighting the importance of communication while working in a large health system a participant shared the following:

> Precise and efficient communication is a necessary tool in integrative care settings and can be done in person or online via electronic health records. Brief communication can give relevant information to the person meeting with a patient and can even save time for both staff and patients (Case 3).

Participants also discussed the ethical issues that arise when mental health notes are reported in the EHR. These included issues related to EHR access such as having heath care practitioners from various fields (i.e., dental assistant) in the entire health care system able to view mental health records.

> Some are uncomfortable with patient access to mental health records… but record transparency is beneficial…. electronic health records have created potential ethical issues, but not sharing mental health notes with other health professions, I feel is not integrated care, because integrated care is about team based care... (Case 5).

Overall, the complex issue of patient privacy seemed to be heightened by being both rurally located and using EHRs.

Domain 4 Rural Matters

The fourth domain, Rural Matters, includes four typical categories. The first category, Vast Catchment and Void of Resources was evident across six of eight cases. Next, Distinctiveness of Rural Settings and Broad Practice Scope were evident across five cases and Stigma on the Decline was evident across four cases. The three variant cases - Lack of Transportation, Lack of Anonymity, and Professional Isolation – are found in Appendix E.

Vast Catchment and Void of Resources. Vast Catchment and Void of Resources represents a myriad of rural issues associated with providing health services to geographically vast areas and having a lack of referral resources nearby. Participants were keenly aware of the vast distances their patients travel for appointments. One participant said, "This clinic ends up providing services for a lot of surrounding cities and towns because it is rural and there are fewer options…. The nearest counseling centers are 90, 44, and 50 miles away" (Case 6). Furthermore, the vast distance between towns was a barrier for referral to other providers as another participant said, "The number of referrals speaks to a need in rural America" (Case 5). This need is exemplified below:

> We have a significantly large geographical catchment area, but a relatively small population, which makes referrals difficult because we are located in a rural community (Case 4).

> Due to our large catchment area of seeing patients 30-50 miles away, you get patients from rural towns that travel long distances to meet with you, so schedules are very booked and clinics are overloaded. It is not easy to refer when there are no nearby referral sources (Case 8).
>
> There is not an applied behavior analyst within 200 miles of me, so you do the best you can. Which means there is more and more demand for consultation and education (Case 1).

Distinctiveness of Rural Settings. Distinctiveness of Rural Settings accentuated the variety present in rurally located IBHC settings. Participants spoke to unique issues that they connected to their particular setting including: chemical dependency, harsh weather conditions, and unique cultural aspects, one participant summarized rural distinctiveness by stating, "Each rural setting has its own flavor and norms" (Case 7). Another participant stated "[There are] unexpected aspects of working in rural settings and an underestimating of the uniqueness of each rural culture" (Case 7). An example of the distinctiveness included how a location may cater to a specific cultural or ethnic group. For example, a participant stated, "We serve several nearby Native American populations and see chemical dependency as a persistent issue. Currently six of ten inpatients I see have active chemical dependency" (Case 6).

Broad Practice Scope. While a few participants noted that they hold specializations, participants foremost identified strongly as generalists and connected that identity to being rurally located. One participant reviewed their case list for the day and said, "Over a typical day I will see ages 12-66 of different presenting concerns, conduct therapy and assessment" (Case 4). Another participant noted, "In a rural setting there are limited resources separated by vast distance. That means we see any mental health

disorder" (Case 6). Finally, a participant expressed their enjoyment in practicing within a rural setting when they said:

> Being rurally located with a large catchment area forces me to practice as a generalist. Having a specialty practice would be very challenging [because there are not enough patients for a narrow specialty]. Being a generalist practicing across the life span and across presenting concerns is fun (Case 8).

This sentiment was shared by another participant stating, "I enjoy the scope, newness, and unpredictability of the work" (Case 7).

Stigma on the Decline. Stigma on the Decline was evident in four cases. This category captured the potential for decreased stigma in small towns along with changing attitudes. See below:

> There is more mental health stigma in a small town, but it has gotten better recently. I believe that offering behavioral health care in a clinic setting makes it easier for patients to overcome some stigma issues (Case 3).

> Mental health stigma has deceased in this community. We have received a positive response to talks about mental health in particular in the wake of several recent suicides (Case 1).

> Mental health care has been around for 25-30 years, so there is less stigma. We all work hard to make it not a big deal. We are very integrated (Case 7).

Domain 5 Rural Ethical Issues in IBHC

The fifth domain, Rural Ethical Issues in IBHC, included issues of boundaries, confidentiality, and competency. The general category, Continual Boundary Maintenance, was evident across seven of the eight cases. The two typical categories, Confidentiality and Stretching of Competence, were evident across six of the eight cases.

Continual Boundary Maintenance. The first category, Continual Boundary Maintenance, included boundary issues emblematic to rural practice and issues specific to

the IBHC setting. Participants spoke to the thoughtfulness required to maintain boundaries, roles, and dual relationships with patients and even healthcare colleagues. On the one hand, dual relationships seemed inevitable.

> There is too much overlap and if you were to practice from the standpoint of having no overlap in relationships, there would be no one that could be your patient in a rural setting. So, maintaining standards of confidentiality and talking with patients about it is something you need to do often (Case 4).

> I have not had a patient that I have not held a multiple role with. I'm colleagues with their physician, and in a community of 3,000 and 900 employees at the health clinic, everybody knows everybody (Case 5).

On the other hand, some dual relationships seemed untenable.

> It is common for medical doctors to treat other medical doctors, as in the AMA ethics code it is written as a privilege. However, for psychologists to co-workers, it becomes different due to infringement of objectivity and it being again APA and MN Board of Ethics…Dual relationships in the integrated care rural setting are always straining the boundaries of what is acceptable. So, consultation is relied on to navigate…In this setting we have treated co-workers, physicians, a nurse. We have also denied care to some that are too close relationships (Case 3).

Beyond highlighting the attentiveness required, participants also discussed the challenge of navigating boundary issues. Below are excerpts from three interviews.

> Mental health practitioners can perpetuate the stigma by being uncomfortable with it themselves, I am not going to bring up therapy issues in non-therapy spaces just like OBGYNs are not going to bring up gynecological issues in public (Case 5).

> It is a more challenging practice because you are never outside of your role as psychologist. Former patients will approach you while at the store and you will need to tell them, this is not the place to discuss this (Case 4).

> Due to multiple relationships in the rural setting, psychologists need to be aware of their boundaries by remembering which hat they are wearing as well as be willing to maintain boundaries with patients who may blur boundaries (Case 6).

Confidentiality. The second category, Confidentiality, described issues of confidentiality as they relate to being rurally located, working on an IBHC team, and using EHR. The difficulty was encapsulated by one participant who said that, "It is nearly impossible to maintain real confidentiality in rural areas" (Case 6). Anonymity was difficult if not impossible.

> Therapists have to walk a fine line of being specific but not too specific. If I am too specific with advice giving to a priest, it will signal that I know who the client is. The very smallest piece of information can identify someone in a small town (Case 6).

Furthermore, most participants discussed tension between maintaining EHRs (Electronic Health Records) for patients and participating on integrated health teams. A participant shared the following:

> The EHR has created ethical issues relating to what level of providers within the hospital system can have access to the mental health notes of a patient. In this system, we have just transitioned to all medical providers having access to a patient's mental health notes. That has created implications in our informed consent process with patients, where we inform patients that all medical staff will have access to their records (Case 8).

Another participant noted how they have remedied keeping information confidential while also being transparent within the EHR for the patient when they said, "information that is not relevant to health history tends to live outside of the note in the psychologist's head, but information that is relevant for a physician tends to be included in the note" (Case 3).

Stretching of Competence. The final category, Stretching of Competence, included issues present in the context of IBHC rurally located settings, namely a tension to respond to the needs of patients and the IBHC setting. One participant described the tension of responding to patient needs while assessing professional competence in the

following dilemma, “It is an ethical dilemma when faced with a specialized disorder (ex: trichotillomania) where you can either refer knowing it's unaffordable or try to treat them” (Case 3). Another participant described the tension of responding to the IBHC setting when they said, “Psychologists can feel pressured to practice outside of their competence in an IBHC. Self-monitoring happens regularly around the issues of competence” (Case 3). For example, as one participant shared: “Physicians see psychologists as experts in mental health and will approach to consult over medication recommendations” (Case 3). Several participants noted that they need to explain to the physicians that they are unable to provide such recommendations because it is outside of their competence.

Domain 6 IBHC Setting Impact on Patient

The sixth domain, IBHC Impact on Patient, includes three typical categories: Decreased Stigma, Increased Efficiency, and Constraints of Resources Impacts Patient Care. The first two categories were evident across six cases and the third category was evident across four cases.

Decreased Stigma. Decreased Stigma, emphasized participants’ perceptions for how practicing in an IBHC setting facilitates access for patients and de-stigmatizes mental health care. For example, a participant said:

> Working in an integrated health care setting facilitates my work with patients because it reduces the stigma. A patient might feel like ‘there is something wrong with me’ if they need to go to a special place only for that. However, here everyone goes to the clinic, so it is destigmatizing because it’s a place everyone comes to (Case 8).

Furthermore, participants spoke to the influence they have on the medical health team. A participant said, “Physicians tend to be more aware of bio-psycho-social nature

nowadays, in conjunction with writing a medication prescription they will also refer the client to meet with a psychologist" (Case 3).

Increased Efficiency. The second category, Increased Efficiency, related to the idea of how patients receive, follow-up, and schedule care. A participant said, "You have increased (un-limited) access in an integrative setting" (Case 5). Another participant said, "Patients can get very frustrated when the system is not working. So, having an integrated care therapist might minimize that" (Case 5). A participant praised efficiency for improving access and follow-up appointments, discussing a decreased no-show rate for mental health care due to integration:

> Only 1 in 4 follow through with an out-of-building referral, 75-80% of referrals follow through on appointments when in-house and, the integrative setting facilitates low no-show rates (nationally: 25-40%, integrative care 11-14%, this practice 4-7%) (Case 5).

Finally, a participant discussed having the support of administrative assistants maintaining scheduling. The participant said that when a cancelation arises on his schedule it is typically filled with another patient, thanks to the administrative assistant staff. Another participant noted that for many years she had always taken care of scheduling herself, but recently with a transition to an IBHC model she is able to focus more on patient care than spending time scheduling clients.

Constraints of Resources Impacts Patient Care. The third category, Constraints of Resources Impacts Patient Care, focused on how the setting influences care for patients. A participant noted limited crisis support and the use of the Emergency Room as a means to address suicidal patients. She said, "because of limited resources, I've had to admit suicidal patients to the E.R. I once had a patient who literally sat in the E.R for eight hours waiting for transport to an inpatient unit" (Case 8). Another patient said, "A

lack of providers creates access issues for clients to get the supports they need. Attempting to even make a referral, results in lost time that could be used providing psychology services" (Case 1).

Domain 7 Effective Characteristics of Psychologists in IBHC

The seventh domain, Effective Characteristics of Psychologist in IBHC, includes seven categories. The general categories of Valuing Flexibility and Valuing Responsibility were evident across seven cases. The typical categories of Valuing Relationships, Valuing Self-care, and Valuing Advocacy were evident across five. The variant categories—Interest in Medical Culture and Valuing Humility—can be found in Appendix E.

Valuing Flexibility. The first category, Valuing Flexibility, accentuated the characteristic of flexibility as a value for the role of psychologist in rurally located IBHC. As one participant stated: "Flexibility is key, honoring the fact that patients sometimes go through great distances and effort just to make it to the hospital" (Case 6). The need to self-reflect and make adjustments is illustrated below:

> Constant self-awareness and self-reflection is important, but especially in a rural setting and in integrated care where it demands reflection of core professional schemas and being willing to modify as necessary (Case 5).

A third participant summed it up this way: "The profession of psychology demands a tolerance for ambiguity. Things are never finished. At one end of the spectrum is Pollyanna and at the other end is cynicism" (Case 4).

Valuing Responsibility. The second category, Valuing Responsibility, emphasized going the extra mile by taking responsibility for being a psychologist among a team of providers. There was a need, among the research participants, to represent the

profession of psychologists with integrity in the medical setting as well as within the rural community. One participant stated that: "Sometimes it makes sense to do some extra things to make sure the care stays consistent for a patient. I will communicate with other providers in order to make sure my patients' needs are getting met" (Case 2). Another participant stated that, "Accessibility goes outside of the 8-5 hours….the quickest way to develop a strong relationship with a physician is to show-up in the emergency room when asked, and to be in the trenches with them" (Case 3).

Valuing Team Relationships. The third category, Valuing Team Relationships, focused on teamwork and success. Participants suggested that working collaboratively on a team benefits everyone involved. One participant connected this characteristic as being the difference between success and failure, "if you're not part of the [broader rural] community, you will not be successful" (Case 5). Another participant shared the following:

> I feel that in working with a team of other professionals it is important to be effective in integrated care. Gaining experience working as part of a team and learning to respect all of the parts of the puzzle. Lastly, I always need to be aware that there are many 'masters' to please including the patient, organization, ethics board, state board, and APA (Case 8).

Valuing Self-Care. Valuing Self-Care focused on how to care for oneself and have a support network. This ranged from noting what type of patients a psychologist will and will not work with within the limits of not having many other practitioners for referral to discussing the importance of finding both professional and personal support. One participant advised, "To avoid burnout find a small group of people who will not demand that you stay in character" (Case 6). Another participant discussed the importance of feeling comfortable in a small community: "An effective psychologist

needs to find out if they are comfortable with being in the public, if not they may experience burnout because of the exhaustion of needing to self-monitor" (Case 8). Lastly, one participant described a balanced life stating that: "I have a good marriage, lots of hobbies, a strong faith, children and grandchildren, and run every day and find that this all helps in not experiencing burnout" (Case 4).

Valuing Advocacy. The final category, Valuing Advocacy, emphasized the importance of being a consistent advocate for patients and recognizing barriers to treatment. For example, one participant said, "The effective characteristic for rural psychologists is to recognize the barriers of treating the patients, such as poverty" (Case 2). Another participant stated, "The effective characteristic for rural psychologists are to follow up on appointments, which is beneficial to make clients feel the treatment is consistent…acting like…an advocate" (Case 6).

Chapter 5: Discussion

My examination of rurally located IBHC psychologists resulted in seven domains, including nine general categories, 14 typical categories, and six variant categories. Providing an intimate portrait, my findings combine notions of rural practice and integrated healthcare, while extending views on rurally located IBHC practice. In this chapter, I discuss these findings in the context of my primary research questions focused on the nature of the work for rurally located IBHC psychologists, issues specific to the rural context, and characteristics important for effectiveness in these settings.

Nature of the Work for Rurally Located IBHC Psychologists. Corresponding with established descriptions of integrated care (McDaniel et al., 2014; APA, 2008), collaboration was integral to the work of rurally located IBHC psychologists in ways that diverged from traditional care. These findings were consistent with Gunn et al. (2015) who found that for rural IBHC psychologists, close physical proximity to other medical team members was crucial as it allowed for formal and informal collaboration.

Similar to Sobel's (1984) description of a rural psychologist as highly consultative, Psychologist as Consultative Educator was a primary role illuminated across interviews. Yet in the IBHC settings, this role could challenge traditional schemas of the profession, as one participant said, "Psychologists are trained to be individualistic, but integrated care calls for collaboration and communication about patients…" (Case 5). As Riding-Malon and Werth (2014) assert, rural therapists benefit when they creatively collaborate with other health care professionals in rural communities.

The role of flexible generalist identified across interviews also aligned with existing literature (Heyman & VandenBos, 1989; Sobel, 1984). Schank and Skovholt

(2006) state that in rural areas the "need to be a generalist requires the ability to work with diverse problems and cope with a relative lack of other resources in the community" (p. 6). As it applies to IBHC settings, participants spoke of pressure from other health professionals to be flexible as well as the issue of having a lack of referral sources nearby, similar to scholarship published by Hogan (2003).

Extending previous research, my findings underscored the role of psychologists as medical team members. This required adapting to issues related to intra-professional relationships and balancing traditional care vs. integrated care. Discussing the cultural shift one participant said that, "psychologists need to adapt to medical culture…for there to be team unity and mutual understanding of each person's individual role" (Case 3). Higher caseloads and limited time with patients accompanied this role.

As discussed in the literature, communication was essential to the functioning of psychologists on integrated care teams (Hedrick et al., 2003). Communication was imperative to patient care as one participant said, "working with different health professionals helps to broaden perspectives…[and] helps form a well-rounded and accurate picture of a client" (Case 1). Broadening relationships seemed to happen by participating in team huddles, brief face-to-face communication, getting lunch, and online communication such as using EHRs. Most participants discussed at length the importance of using EHRs for facilitating communication.

Finally, similar to findings by Butler et al. (2008) noting that each setting has its own integrated care model, I found that each of the settings seemed unique. It was difficult for research participants in my study to clearly define the work of rural psychologists across IBHC settings. Instead, participants stressed that each context is

made up of its own team of health providers and therefore "every integrated care setting …depends on the clinic and depends on the pairs [of medical providers] that [influence] the kind of work a psychologist could do" (Case 3).

Impact of Rurally Located IBCH on Professional Practice. Related to the rural setting, my results provide a point of integration for understanding the experiences of rurally located IBHC psychologists. Several categories correspond with the experiences of rural psychologists reported in the literature (Cordes, 1989; DeLoen, 1989; Hogan, 2003). This included challenges with providing services to a geographically vast area and having few referral resources (Admundson, 2001; Lin et al., 2016). For example, my category Vast Catchment and Void of Resources illuminated well-documented challenges (Harowski et al., 2006; Mackie, 2015; Wagenfeld, 1997). As one participant said, "we have a significantly large geographical catchment area, but a relatively small population, which makes referrals difficult because we are located in a rural community" (Case 4). This also included having a broad scope of practice. Rural psychologists operated as flexible generalists in order to balance the potential harm of referring a patient to another provider who may be many miles away. For instance, for one participant, the nearest counseling centers were 90, 44, and 50 miles away.

Expanding traditional notions of rural ethics (Schank & Skovholt, 2006), my findings included categories related to boundaries, confidentiality, and the stretching of competence in rurally located IBHC. All of the above themes connected to established literature, but some of my findings on rurally located IBHC psychologists connected to emerging literature on providing care to fellow colleagues and the use of EHRs to communicate with intra-disciplinary teams. For example, my findings indicated that

psychologists can be tasked with providing care to their medical colleagues. As a participant stated:

> It is common for medical doctors to treat other medical doctors, as in the AMA ethics code it is written as a privilege. However, for psychologists to co-workers, it becomes different due to infringement of objectivity and it being again APA and MN Board of Ethics…Dual relationships in the integrated care rural setting are always straining the boundaries of what is acceptable. So, consultation is relied on to navigate…In this setting we have treated co-workers, physicians, and nurses. While we have also denied care to some that are too close of relationships (Case 3).

In addition, I found that EHRs complicated issues of confidentiality. These included issues related to EHR access for health care practitioners from various fields in the entire health care system (i.e., dental assistant) being able to view mental health records. This required updates to informed consent and psychologists' considerations for what is included in notes.

These findings aligned with ethical issues for rural psychologists identified in the literature (Schank et al., 2010; Schank & Skovholt, 1997; Schank & Skovholt, 2006) and extended applications to IBHC settings. For example, Schank and Skovholt (2006) noted, "small community psychologists are likely to have out of session contact with clients" (p. 56). This was true in my study as psychologists discussed dual relationships and maintaining boundaries with people who are patients when outside of the clinic setting. Yet, in the case of integrated care, this also extended to potentially working side by side as colleagues to people who were also patients of psychologists.

A significant departure from previous research, my findings suggest decreasing stigma for mental health in the rural setting in large part due to IBHC. Participants emphasized that perceptions of stigma for seeking mental health care had decreased and

this was attributed to integrated care. For example, a participant said, "working in an integrated health care setting …reduces stigma…here, everyone goes to the clinic, so it is destigmatizing because it's a place everyone comes to" (Case 8). Relatedly the IBHC setting seemed to increase access and efficiency of care as suggested by Peterson et al. (2017).

Characteristics for Working Effectively in Rurally Located IBHC. This study provides a point of illumination for better understanding characteristics seen as important to working effectively in rurally located IBHC. Characteristics identified by participants correspond to integrated care competency recommendations identified by McDaniel et al. (2014). For example, intersecting with the idea of flexible generalist, one participant said, "flexibility is key" (Case 6). Echoing McDaniel et al.'s (2014) recommendation that psychologists "stretch" their knowledge, a participant discussed, "constant self-awareness and self-reflection" in modifying professional schemas regarding the work of psychologists. Furthermore, discussions of a broad scope of practice and the stretching of competence were typical across interviews (see Table 1). This connects with Riding-Malon and Werth's (2014) charge for rural psychologists to "expand psychology's role in advancing health" (p. 89).

Valuing self-care took on additional significance as it connected to feeling like one is under a microscope in a small community. This connected to prior findings by Skovholt and Trotter-Mathison (2016). One participant described the importance of feeling "comfortable with being in the public, if not [you] may experience burnout because of the exhaustion of needing to self-monitor" (Case 8).

Characteristics of effective psychologists extended to valuing responsibility which seemed distinctive in IBHC. Participants emphasized going the extra mile and representing the profession of psychologists with integrity in the medical setting as well as within the rural community. One participant stated that: "Accessibility goes outside of the 8-5 hours…. the quickest way to develop a strong relationship with a physician is to show-up in the emergency room when asked and to be in the trenches with them" (Case 3). This echoed McDaniel's (2014) recommendation related to the importance of interprofessionalism that focuses on building and also sustaining relationships with other providers. Interestingly, an emphasis on accessibility can be at odds with self-care.

Implications for Practice

These results hold practical implications for psychologists in a rural integrated care setting. Of particular interest are (a) collaboration verse loss of autonomy (b) the unique roles a psychologist has in these settings, (c) the ethical issues that have emerged within integrated care, and (d) the characteristics deemed important for being successful in this setting. Each of these areas is discussed below.

Autonomy. Health policy implications have encouraged the development of integrated behavioral health care (Beronio et al., 2013; Lewis et al., 2014; Mechanic & Olfson, 2016). Private independent practice psychologists may fear a loss of professional autonomy, status, or power in transitioning to IBHC settings. Yet, my results did not identify a fear related to loss of autonomy or power. Several participants from my study reported being treated as equals to physicians from being referred to by the professional title of "Doctor" by patients and staff to having parking privileges in the parking lot. Working in an IBHC setting may bolster the reputation and status of psychologists to

be on par with that of physicians. Along with destigmatizing mental health, IBHC settings may advance the status and role of psychologists in the minds of patients and other health providers. As Rozensky and Janicke (2011) reported, "psychologists must be proud to call themselves psychologists [in integrated care settings]" (p. 365).

Roles. Echoing the roles for rural psychologists found in Schank and Skovholt (2006), the roles of a rural integrated care psychologist are vast and varied. In this study primary roles included being a consultative, flexible generalist and medical team member. In practice, developing and maintaining a wide scope of practice may be useful for a flexible generalist within an integrated care setting as psychologists seem to be called on to approach a variety of presenting concerns. Communication and collaboration skills also appear necessary for team-based care. Finally, ethical dilemmas related to maintaining boundaries of competence may be exacerbated in these settings.

Ethics. Electronic Health Records dominate the flow of communication within an integrated care setting and create new ethical challenges. For psychologists to fully integrate and not just be co-located in a clinic setting, they need to be prepared to be involved in conversations around patient confidentiality, health record access, and informed consent. There is an ethical obligation to patients to discuss the limits of confidentiality and this will continue to need careful attention by integrated care psychologists and the broader profession.

Characteristics. For longevity and effectiveness in rural IBHC, psychologists may find it useful to consider characteristics of flexibility, integrity, team relationships, self-care, and advocacy. These emerged from participant data as characteristics important to professional success within a rurally located IBHC setting. While some themes such as

self-care and professional and patient advocacy are approached in academic training programs, others such as integrity, team relationships, and learning to be flexible are not emphasized. The aspect of holding a characteristic of integrity seemed to be important as psychologists may be the only representative of their profession on a team, and these interprofessional relationships create unique challenges with implications for balancing flexibility while remaining grounded in the principles of professional practice.

Limitations

These results should be interpreted in light of limitations. One major limitation is that I did not include an auditor in this study. As Hill et al. (2005) state, "in the life of consensual qualitative research projects, auditors play an important role in determining the quality and eventual completion of the research" (p. 135). Although I operated from a feminist orientation to encourage multiple perspectives, and I included multiple levels of cross-analysis (at the pairwise and groupwise level), including an auditor would have provided an additional check with respect to the potential for groupthink as well as strengthening the internal validity or trustworthiness of these findings. Along those lines, not all of my research team members were able to participate in the group analysis to determine categories; only four of the five members participated. Again, having an additional voice and perspective could have strengthened the results.

In this study, those included as rurally located IBHC psychologists were a narrowly defined group, excluding psychologists without a Ph.D. Furthermore, although I invited the entire population of rurally located, Ph.D., psychologists in Minnesota who met the inclusion criteria to participate in this study (N=71), only eight (approximately 11%) identified as IBHC psychologists and consented to participation. It is possible that

those who agreed to participate in this study may have differed in significant ways from those who did not agree to participate. As a result, the perspectives and experiences included herein may not necessarily reflect the perspectives of all rurally located IBHC psychologists in Minnesota.

Considering the national dynamics within the changing landscape of the rural U.S., little to no attention was given to how changing demographics may be impacting the practice of psychology in this study. Colby and Ortman (2017) project that the non-Hispanic White majority would reach its peak in 2024 at just under 200 million people and would then decrease by 20 million people by 2060. This projection suggests that in the very near future, the historically present majority will be fading until it, too, becomes a minority. Meanwhile, the same projections show that Hispanic, Black, and Asian populations are slated to increase, and in some cases double, by 2060 (Colby & Ortman, 2017). This impact will not be limited to urban areas, but will be, and already has been, the reality of rural communities across the nation. Often this change can be even more visible within a rural community. Due to the small population density, slight variations in demographics can result in noticeable demographic shifts. Thus, a final limitation of this study is the inattention given to important factors of race, ethnicity, social class, and other important identity variables. For example, there is a growing Hispanic population throughout the rural Midwest and no Hispanic identified psychologists were represented in this study. This represents an area for future research.

Conclusion

Results of this study provide an understanding of the work of rural psychologists in integrated behavioral health care settings. The findings about rural psychology in

IBHC lend empirical support to changes in traditional conceptions of psychology that may advance access for mental health care. The nature of the work in some settings has changed in the 21st century to become more integrated—conceptualized around health, not just mental health. The approach is interdisciplinary, exploring mind-body connections and engaging patients more holistically. Engaging in the complex work of navigating ethical boundaries and the emerging use of electronic health records in integrated behavioral healthcare settings, it is evident that despite a lack of resources rural psychologists continue to be on the frontier of the profession.

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http://dx.doi.org/10.1037/10489-002

Appendix A: Mailing

University of Minnesota

Twin Cities Campus	***Counseling and Student Personnel Psychology Program***	*250 Education Sciences Building* *56 East River Road |Minneapolis, MN 55455*
	Department of Educational Psychology *College of Education and Human Development*	*Office: 612-624-6827| Fax: 612-624-8241* *http://www.cehd.umn.edu/edpsych/cspp* *Email: cspp@umn.edu*

Good Morning,

My name is Tom Allen and I am a doctoral candidate in an APA-approved Counseling and Student Personnel Psychology program at the University of Minnesota under the supervision of Thomas M. Skovholt, PhD, LP. I obtained your email and mailing address from the Minnesota Board of Psychology and am contacting you based on your listing as a PhD licensed psychologist presumably practicing in a rural county in Minnesota.

I am conducting a study to identify the characteristics of effective integrated care psychologists practicing in rural communities. I would like to invite you to consider becoming a participant in the study. I personally come from a rural background and have focused my doctoral research on rural practice as I work toward becoming a practitioner. I'll be traveling around the state of Minnesota interviewing rural psychologists from June to July. I hope that if you identify as a rural integrated care psychologist, you will consider meeting with me to discuss your views for effective integrated care practice.

Background Information

Despite the importance of rural psychologists, little research has been conducted to identify the unique characteristics of rural practice, especially for those in integrated care. This study seeks to investigate what skills, awareness, and knowledge are needed to be considered an effective rural psychologist in an integrated care setting. For the purpose of this study, integrated care is defined as "an approach characterized by a high degree of collaboration and communication among health professionals." This definition does not limit to psychologists practicing in a primary care setting. For example, an integrated rural psychologist might be practicing independently, but working closely with a local provider to coordinate care.

Next Steps

If you are interested in becoming a participant, please respond to this email by addressing the following questions. I will then contact you to set up a face-to-face interview lasting 50 minutes.

1. Preferred Contact Information

2. What is the location (s) of your practice by zip code?

3. Do you identify as practicing within an integrated care setting?

For the purpose of this study integrated care is defined as "an approach characterized by a high degree of collaboration and communication among health professionals."

Yes or No

4. Are you willing to be interviewed about your view of integrated practice?

Specifically, the interview will cover what skills, awareness, and knowledge are needed to be considered an effective rural psychologist in an integrated care setting.

Yes or No

If you have any questions or concerns about this study, contact me at allen441@umn.edu or 612-581-4523. You may also contact my faculty advisor, Thomas M. Skovholt, PhD, LP at skovh001@umn.edu or 612-625-3573. Thank you for your consideration in becoming a study participant.

I greatly appreciate your time and consideration,

Tom Allen

Appendix B. Scheduling Email

Dear Dr. Name,

I was so grateful to have received your return letter indicating that you are open to becoming a participant in the study on effective integrated care psychologists practicing in rural communities. As a study participant I'm asking that you complete a semi-structured interview with me in person. I will be traveling to meet with you in person whenever it best fits your schedule.

Next Steps

- Scheduling: What would be the best way to get on your schedule? I'm able to visit you whenever it is most convenient for you.
- Ideally, our interview would take place at your place of practice on a weekday between: May 28th-June 30th
- Length of Interview: The interview is designed to take 50-60 minutes.
- Informed Consent: I've attached a copy of the informed consent document that I will review prior to beginning our interview. If you have any questions or concerns about participating in this study you are welcome to contact myself or my advisor, Thomas Skovholt, PhD., L.P. email/phone.

I look forward to our time together!

Thank you,

Tom Allen

Appendix C: Interview Protocol

Protocol Title: Effective Rural Psychologists

Version Date: 04/02/2017

Semi-structured interview questions

You will have 50 min to respond to the following questions

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1. What is the work of psychologists in an integrated care setting?
    a. How would you describe your work?
2. How do you work with other health professionals in your setting?
    a. Describe teamwork
    b. Describe communication
    c. Describe collaboration
3. How does your rural setting impact your work?
4. How does the way in which your setting is structured facilitate or impede your work with patients/clients?
   -Consider mental health stigma, access issues, ect.
5. What ethical issues arise in your work?
   –Eg. Channels of communication, data sharing, Electronic Health Records
6. This last questions is aimed at how psychologists can be better at working in integrated care in rural settings. From your lived experience what does it take for psychologists to be effective in integrated care in a rural setting?
7. Is there anything else you would like to add?

Appendix D: Consent Form

CONSENT FORM

Effective Rural Psychologists in Integrated Care Settings

You are invited to be in a research study of effective rural psychologists in integrated care settings. You were selected as a possible participant because of your profession as a psychologist and work setting in integrated care. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Thomas Skovholt, Ph.D. L.P., and Tom Allen Ph.D. Candidate in Educational Psychology at the University of Minnesota.

Background Information

The purpose of this study is to identify what skills, awareness, and knowledge rural psychologists find as being effective for counseling in an integrated care setting. Despite the importance of rural psychologists, little research has been conducted on identifying the unique characteristics of rural practice. Since rural populations are more likely to visit a primary care setting, this study seeks to investigate what skills, awareness, and knowledge are needed to be considered an effective rural psychologist in an integrated care setting.

For this study, integrated care is defined as "approach characterized by a high degree of collaboration and communication among health professionals."

Procedures:

If you agree to participate in this study, you will be invited to schedule a face-to-face interview at your office the interview will take approximately an hour. The interview will be audio recorded.

Risks and Benefits of Being in the Study

The risks associated with participation are expected to be minimal. Your responses will be deidentified and aggregated. There may be no direct benefit to you as a participant; however, the information provided in the interviews is expected to benefit the understanding of integrated behavioral health practice in rural settings. The potential benefit of the participant will be to reflect on effective integration within rural settings. As health psychologist are being encouraged to engage in integrated care from the American Psychological Association, spending an hour discussing what is going well may foster an increase in professional self-efficacy.

Compensation:

There is no compensation for participation in this study.

Confidentiality:

The records of this study will be kept private. No information will be included that would make it possible for a subject to be identified. In the case that aspects of this study might

be published, no information about your participating will be made public. Research records will be kept in a locked file in a locked room; only the researchers will have access to the records. Audio recordings and transcripts will be stored in an encrypted file and will be deleted after the dissertation is completed.

Voluntary Nature of the Study:
Your decision on whether to participate in this study will not in any way affect your relationship with the University of Minnesota, or the investigator.

Contacts and Questions:
If you have questions about research appointments, the study, research results, or other concerns contact the researchers. You may ask any questions you have now, or if you have questions later, you are encouraged to contact them:

Thomas Skovholt Ph.D. L.P.

Thomas Allen Ph.D. Candidate

To share feedback **privately** about your research experience, including any concerns about the study, call the Research Participants Advocate Line: 612-625-1650 or give feedback online at www.irb.umn.edu/report.html. You may also contact the Human Research Protection Program in writing at D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455.

You will be given a copy of this form to keep for your records.

Statement of Consent:
I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature: _____ _ Date: _____
Signature of Investigator: _____ Date:_____

Appendix E: Table 2: Variant Categories for Rural Integrated Behavioral Health Care Psychologists

Table 2. *Variant Categories for Rural Integrated Behavioral Health Care Psychologists*

Domain		Category		Number of Cases	Description
1	Definition of Rurally located IBHC	-	The Practice of Psychology with Medical Cultural Influences	Three (4,5,6)	- The practice is faster pace, collaborative, and team based. This includes shorter visits, higher patient volume, and more consultation.
2	Psychologist Professional Roles in Rurally located IBHC	-	Psychologist Reception of Warm Handoff	Three (2, 3, 6) Three (2, 5, 6)	- Psychologists receive referrals in real time from physicians.
		-	Psychologist as Community Member		- Psychologists are embedded in the community.
4	Rural Matters	-	Lack of Transportation	Three (3, 6, 7) Two (1, 6)	- Lack of public transportation for patients, limits referral options.
		-	Professional Isolation	Two (4, 5)	- Isolation can be draining for psychologists
		-	Lack of Anonymity		- Rural psychologists have little anonymity
7	Effective Characteristics of Psychologists in IBHC	-	Interest in Medical Culture	Three (1, 3, 7) Two (3, 6)	- Psychologists need to be interested in the culture of medicine in order to understand how to function within it.
		-	Valuing Humility		- Psychologists need to be humble and foster mutual respect among teams.
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