An Implementation Blueprint for How to Start Interprofessional Behavioral Health Integration in A Healthcare System: Balancing Patient Needs, Organizational Readiness for Change, Institutional Priorities, and Training Needs.

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Abstract

Background

Poor health behaviors are epidemic and lead to chronic disease. Further, there are already hundreds of behavioral health interventions that have shown efficacy for preventing chronic diseases long term. These services are not yet widely available to patients, especially those at high risk for developing chronic diseases: Health disparities exist by race, ethnicity, income, gender, sexual orientation, mental health status, and area. Additionally, mental health issues are also highly prevalent and largely untreated and can be a barrier to preventative care. In recent years, there has been in a movement towards integrating mental health professionals who do behavioral health medicine into primary care and medical clinics to increase access. While this behavioral health integration has been shown to lead to better patient outcomes and decreased costs, and while this practice is growing in popularity, still very few healthcare systems are utilizing this model. While there are implementation science studies for integrating into a single clinic, no dissemination and implementation study to our knowledge has developed a strategy for integration across a large healthcare system.

Methods

We used four surveys of opinion leaders (N = 12), clinic providers (N = 15), hospital administrators (N = 2), and D&I scientists (N = 27), to asked about barriers and facilitators to integration, as well as: patient need, organizational readiness for change, and student training needs for a sustainable model for integration.

Results

We learned about key barriers and facilitators to integration within this healthcare system. Importantly, we extrapolated or coded numeric values for each clinic for patient need, organizational readiness for change, and student training needs, creating a priority score for each clinic. When we begin integration, we will start with integrating the most-ready clinic with the most in-need patients and the most perceived student-training need, and move down there. With this process, we created a novel implementation science system for identifying and prioritizing clinics for integration, barriers and facilitators in each clinic, and draw from published work and established models in the field (ORIC, Dynamic Sustainability, RE-AIM).

Conclusions

This study provides a blueprint for other healthcare systems to create a plan for sustainable integration of psychological services into medical settings for the benefit of healthcare systems, patients, and public health.

Contributions To The Literature

- Integration of behavioral health into primary care and medical settings has been shown to decrease disparities and increase public health. However, barriers to integration exist and entire healthcare systems are without consistent integration.
- We created a process by which one can engage and survey opinion leaders, clinic providers and staff, and hospital administration, and organize clinic integration balancing patient need, clinic readiness for change, and a sustainable model for integration (e.g., student training needs).
- These findings contribute to recognized gaps in the literature, including how to begin a rollout of behavioral health integration into an entire healthcare system and understanding barriers and facilitators at every level of the system.

Introduction

Chronic diseases are preventable

Maladaptive lifestyle factors such as poor diet, lack of exercise, excessive alcohol intake, cigarette smoking, and sexual risk taking, are among the biggest threats to future health of the US population. Poor health behaviors are epidemic, and can contribute to myriad health issues, including obesity, heart disease, diabetes, and cancer (Enwald & Huotari, 2010; Ginsburg et al., 2012). Over 90% of chronic diseases are preventable through changes in lifestyle factors, also known as behavioral medicine (Bauer et al., 2014; Homer & Hirsch, 2006; CDC, 2018; Schmidt et al., 2018).

Health disparities exist

Further, health disparities exist and persist, such that those in low-income communities and who are part of any minority population are much more likely to die from chronic diseases, as are those who are experiencing mental health issues. For example, those with a diagnosed mental health issue live on average 6–12 years less (Adler & Stewart, 2010; NIMH, 2018). These are largely due to social determinants of health, with recent research differentiating from mid- to down-stream social determinants (e.g. education, risk behaviors, negative neighborhood conditions, access to healthcare) and upstream (e.g. governance, policy) social determinants of health and how they impact health outcomes (Palmer, Ismond, Rodriguez, & Kaufman, 2019). The current COVID-19 pandemic is no exception to these social determinants, with the pandemic imparting its greatest impact on marginalized communities and lower socioeconomic groups (Burström & Tao, 2020). This emerging body of research suggests a radical shift from individualized to systemic policy interventions might be necessary in order to adequately address mental and physical health disparities.

Integration of psychology and behavioral health services can prevent chronic diseases

The integration of behavioral health services by psychologists into medical settings such as primary care and cancer centers can address behavioral health issues (e.g. stress-related physical symptoms, mental health, substance misuse and use disorders, maladaptive health behaviors), increases in health behaviors, decrease health disparities, and prevent chronic diseases (AHRQ, 2018; SAMHSA, 2018; HRSA, 2018). Integrated behavioral health into primary care and medical settings requires that the behavioral health clinician must become a member of the medical team developing relationships with other members of the team, communicating well, and really becoming a part of that team, for care coordination and stabilization, early intervention, and prevention and health promotion (AHRQ, 2018; Holland, Watson, & Dunn, 2011).

Not enough health systems are integrating behavioral health into medical settings

Very few health systems are integrating behavioral health into medical settings (APA, 2018). A recent study showed that 60% of these few settings with integrated services were funded by grants, which is not sustainable nor is it reaching the individuals who need the services most. Many recent studies have identified barriers to integration of behavioral health into medical settings (e.g., Kathol et al., 2010), yet no studies to our knowledge have presented a cohesive framework for identifying clinics for integration and barriers and facilitators within those clinics.

Dissemination and implementation science can address these integration issues

The growing field of dissemination and implementation science provides systematic frameworks and empirical support for dissemination of information and integration of empirically based interventions into medical settings for improving public health (HSRIC, 2018). We can yield the wisdom and research of this field in order to move forward the field of integrated health towards further use towards increasing public health. For example, one study outlined steps for identifying barriers and facilitators to integration of psychological services into a single medical setting (Lewis & Marriott, 2018), though does not detail how to do so for multiple clinics and how to prioritize clinics for integration among multiple available options; it was also a time and resource intensive process. We propose simplifying this model and pull support from the frameworks of Organizational Readiness for Change (ORIC; Weiner, 2009), Dynamic Sustainability Framework (Chambers, 2013), and RE-AIM (Glasgow & Emmons, 2007).

Current project

We will create a novel implementation science system for identifying and prioritizing clinics for integration and barriers and facilitators in each clinic, drawing from published work (Lewis & Marriott, 2018) and established models in the field (PARIHS, ORIC; D&I Models, 2018). We are proposing this project within clinics in the Department of Family Medicine and Cancer Center at Rutgers University, which will have important implications for a diverse, underserved, and in-need population, as well as provide a blueprint for other networks and healthcare systems to begin and move through sustainable

integration of psychological services into medical settings for the benefit of healthcare systems, patients, and public health.

Our research aim is to create a novel system for prioritizing clinics for integration of psychological services in medical settings for increasing mental health and for increasing behavioral health the prevention of chronic diseases. We hope to create sustainable change in the Rutgers healthcare system with the integration of psychological services into medical settings for the sake of a diverse and in-need patient population. We hope to further the fields of behavioral health integration and dissemination and implementation science by yielding and combining wisdom from each for the sake of public health.

Methods

Design

The Behavioral Medicine Lab at Rutgers University utilized this project to identify and survey a number of clinics within the Rutgers University Healthcare System, including clinics within the Rutgers Cancer Institute of New Jersey Department of Family Medicine with the assistance of a behavioral health integration psychologist at the Department of Family Medicine.

The lab first created a comprehensive list of clinics for potential integration through coordination with a mental health integration specialist in the Department of Family Medicine for ten years. Criteria include not currently having mental health services and being medical clinics within the Rutgers-Robert Wood Johnson healthcare system. The lab has already compiled a list of ten cancer clinics in the Rutgers Cancer Institute of New Jersey and three primary care clinics in the Department of Family Medicine. The lab assessed institutional collaboration priorities by surveying integration priorities of Deans and Leaders of Departments with an implementation science survey (Knight, 2008). The lab then sent out surveys of a needs assessment to each clinic. Two leaders for the department, two administrators for the clinic, two medical doctors, two nurses, and two medical doctors completed the surveys to identify barriers and facilitators to integration of psychological services into medical settings, as well as organizational readiness for change. The lab then used the Dynamic Sustainability framework to identify and organize the barriers and facilitators of integration in each clinic.

Based on patient needs (1/3 weighting) organizational readiness for change (1/3 weighting) as well as student training needs (to facilitate sustainable low-cost interventions, 1/3 weighting), we prioritized integration into clinics, and created a blueprint for integration for each clinic. This study was IRB approved and all subjects provided informed consent to participate.

Measures

Assessments were emailed to identified participants through Qualtrics survey software.

Survey 1: Opinion Leaders. We asked opinion leaders to respond to provide identifying information about their title and place of work, and to qualitative open-ended questions to: name clinics in need of

integration, to cite contacts at these clinics, name additional opinion leaders to take the survey, any institutional priorities to influence integration including barriers and facilitators, areas of community need, areas of student training need, and any other factors. We also asked about the importance of integrating psychological and behavioral health services into primary care and medical settings, on a scale from 1 to 10.

Survey 2: Clinic Organizational Readiness for Change. We asked clinic staff (nurses, physicians, administrative staff), to name clinic status of integration of behavioral health, organizational readiness for change for integration of behavioral health, as well as barriers and facilitators to integration. Measures included: Organizational readiness for change survey (Weiner, 2009), Organizational Culture Survey (Glaser 1983; Glaser et al., 1987), Opinion Leader Survey (Valente et al., 2007), and Open ended-questions about barriers and facilitators to integration (Lewis & Marriott, 2018).

Survey 3: Hospital administration. We asked hospital administrators (2 administrators from CINJ, 1 administrator from RWJ) to identify their level of priority regarding integration of behavioral health, as well as barriers and facilitators to integration. Measures included: Integration Priorities Survey (Knight, 2008) and Open ended-questions about barriers and facilitators to integration (Lewis & Marriott, 2018).

Survey 4: D&I scientists. We asked D&I scientists (from the D&I listerv convenience sample) to provide insight about methods for integration of behavioral health into an entire healthcare system. Measures: Integration priorities survey (Knight, 2008) and Open ended-questions about barriers and facilitators to integration (Lewis & Marriott, 2018).

Procedures

The Behavioral Medicine Lab 1. Conducted a needs assessment with surveys, 2. Identified barriers and facilitators to integration (including patient needs, institutional collaboration priorities, organizational readiness for change, and barriers/facilitators identified by the clinics). In addition to aforementioned qualitative coding, we use descriptive statistics and basic bivariate correlations to examine the findings. A STROBE checklist is included to adhere to reporting standards of observation studies.

Results

Survey 1: Opinion leaders

Ten opinion leaders from medical clinics and two from psychological training clinics took the survey (N=12). We used grounded theory to code the open-ended prompts to identify unique barriers and facilitators to integration. We used two coders per entry to reduce bias. Six barriers (i.e., limited office space, limited public transit, limited parking, difficulty obtaining approval from multiple administrative structures including complicated processes and procedures for approval, and possible push back from similar professions), and four facilitators (i.e., comprehensive psychological services was recently pitched by hospital administration, similar professions may welcome the support of psychology, and obvious desire for in house presurgical evaluations) to integration were noted.

Five areas of patient need were elicited, including serving low SES groups [only a few pro bono/low fare clinics], those without cars, health disparities groups in the city, marginal groups at risk of HIV [including undocumented workers]), people living with HIV/AIDS).

Areas of student training needs including integrated health, behavioral health, consultation, interprofessional teams, and team care planning. On a scale of 1-10, importance of integration was 9.8 ($SD = 0.1$).

Survey 2: Clinic ORIC

Clinicians and directors ($N = 15$) completed surveys assessing organizational readiness for implementing change (ORIC), which included questions about knowledge about interdisciplinary teams, the current status of integration in their clinics, their perceived importance, need and desire for integration, and qualitative responses on barriers and facilitators to change in these clinics. Respondents were also asked about burnout. Respondents represented several Rutgers University clinics, including a graduate training clinic in psychology, an affiliate community primary care center, a hospital sleep clinic and pediatric primary care clinic, and a large cancer institute including but not limited to endocrine surgery, surgical oncology, and breast oncology and gynecological oncology. Respondents' roles included clinic director and psychologist, Nurse Navigator, Advanced Practice Nurse, social worker, nurse clinicians, and physicians. The ORIC scale total score ranges from 12 – 60, with higher scores indicating greater organizational readiness for implementing change. Results from the sample demonstrated a wide range of perceived readiness for change across clinics ($M = 26.12$, $SD = 10.49$). There was also a positive correlation between level of satisfaction with being able to help people and degree of integration within the clinic [$r(13) = 0.576$ $p = 0.50$].

Respondents were asked to rank, on a scale of 0 – 100, how important they perceived integration of mental health services into medical settings ($M = 81.2$, $SD = 29.78$). They were also asked to rank their perception of patient need for mental health integration into medical settings ($M = 77.2$, $SD = 27.98$), as well as respondents' personal desire for integration of other disciplines into their clinic ($M = 84.7$, $SD = 28.81$). The range of results are shown in Figures 1-3 (see Figure 1, Figure 2, Figure 3).

Respondents were also asked to share barriers and facilitators to integrating mental health services into their clinics. The most prevalent barrier reported by respondents was financial, with nine of the 15 respondents indicating budget concerns. Additionally, five respondents noted administration and clinicians in positions of power as potential barriers to integration. Few respondents indicated any facilitators to integration, however some listed desire for better patient outcomes, for new clinicians with new ideas, and a demonstrated need for mental health services as facilitators to integration. When asked about whether psychologists-in-training would be appropriate to work in their clinics, 10 of the 15 respondents said that their clinics would be conducive to an integrated training psychologist.

Survey 3: Hospital administration

Two hospital administration leaders (N=2) at CINJ and one at RWJ completed a survey about the desire for integration, barriers and facilitators to integration, and the metrics they would like to see prior to investing in more integration. The desire for further integration of mental health was high, with respondents reporting an average of 8.6 out of 10 desirability for integration. Administrators cited cost, especially in the context of COVID-19 budget crises, as the primary barrier to integration. Desired outcomes demonstrated from preliminary pilot work within their institution was patient quality of life increases, complications decreases, and institutional cost savings.

Survey 4: D&I scientists

Twenty-seven behavioral scientists completed this survey about methods for integration of behavioral health into an entire healthcare system (N=27). A number of theoretical models guiding implementation were noted. Twelve respondents (48%) reported using primary care behavioral health (PCBH) or integrative/collaborative care theoretical models to guide the process of implementation. Other models mentioned include determinant frameworks, AIMS model, biopsychosocial, population-based care, and feminist and multicultural models.

Respondents reported prioritizing integration in primary care/family medicine settings (32%) as well prioritizing clinics with demonstrated interest and readiness (36%) or where patient need was identified (16%). Respondents further highlighted the importance of established relationships (12%) with clinical and administrative leadership and support and buy-in from these professionals (48%) as facilitators to behavioral health integration efforts. Additionally, barriers to successful integration were identified, including billing and reimbursement issues (40%), cost and physical resource concerns (40%), and lack of understanding of behavioral health role and efficacy (44%).

Priority integration list

In order to create a blueprint for where to begin the rollout of behavioral health integration in a healthcare system, these researchers propose a grid measuring patient needs, organizational readiness for change, and student training needs, derived from surveys of clinic providers, stakeholders, opinion leaders and available public health data. Ethically, patient health and wellbeing should be prioritized, followed by clinic organizational readiness for change. As there are inadequate policies for reimbursement for behavioral health integration in the United States, as there is evidence that those who receive training in behavioral health integration tend to practice it more often than those who do not, and as students tend to provide low- or no-cost services, we also incorporated alignment with student training needs. The proposed sustainable intervention includes supervising advanced psychology doctoral students providing services within these clinics. We used self-reported patient needs, as well as public health data about any underserved groups (+10 if mentioned in survey), for the 0-100 patient needs metric. We scaled up ORIC scores to a 0-100 scale to begin integration with the easiest clinics for integration and move on, with lessons learned to the more challenging clinics to integrate, and to conduct additional stakeholder interviews at the bottom 10% ORIC surveys in order to understand the barriers to integration and whether integration is desired or needed. We used psychology stakeholder surveys and interviews to develop a

student training needs 0-100 scale. Total score is the average of these scores by clinic, then clinics were organized by the highest to lowest scores in excel (see Table 2). Two raters double-coded for these values, with an inter-rater reliability of 0.90. Conflicts were resolved via discussion with the study team.

Discussion

Overall, this study aimed develop a blueprint for rollout of behavioral health integration across an entire healthcare system. We surveyed opinion leaders, clinic staff, healthcare system administrators, and D&I scientists. We developed a method for prioritizing rollout of an integration intervention in a healthcare system balancing patient needs, clinic organizational readiness for change, and student training needs (for a more sustainable model of integration in the absence of policy for appropriate reimbursement). We also outlined barriers and facilitators according to the Dynamic Sustainability Framework model that will serve as an implementation blueprint, and that will also serve as targets for implementation science interventions. Finally, we identified administration priorities.

Survey one, the opinion leader survey, identified that the desire for integrated psychologists in the healthcare system is high. Using the Dynamic Sustainability Framework, we can organize barriers and facilitators by individual, family, system, and community levels to address in the integration phase of the project. We use the RE-AIM framework and community based participatory research for future surveys and to prepare for integration.

Survey two, the clinic readiness for change survey, identified that participants overwhelmingly saw the value of integrated behavioral health, the benefit to their patients, and the desire for integration in their clinic, with almost 90% of respondents reporting further integration of behavioral health and other disciplines. In addition, those with degree of job satisfaction, a buffer to burnout, and level of integration in their clinic. Participants overwhelmingly named money as the primary barrier to integration, including administration not investing in integration. Additional barriers were space and time. They did name some facilitators to integration, including desire for better patient outcomes, for new clinicians with new ideas, and a demonstrated need for mental health services.

Survey three, the hospital administrator survey, demonstrated low engagement with this survey among hospital administrators, with only two filling out surveys. Additional engagement is needed in future studies, perhaps in a Community Based Participatory Research framework. These administrators cited cost and time barriers to integration. Desired outcomes demonstrated for preliminary pilot work within their institution in order to invest, which we will include as key outcomes in future research, are: patient quality of life increases, complications decreases, and institutional cost savings.

In survey four, D&I scientists offered areas of consensus as well as divergence when considering the factors involved in the integration of behavioral health. Close to half of respondents noted utilizing the prevailing theoretical models of behavioral health integration, suggesting both the importance of having a framework to inform integration efforts and that a consensus may be emerging around the models to be utilized. In regards to the survey question of what theoretical models of implementation they used, it

appears that some respondents were grouping together models of integration and of treatment in referencing biopsychosocial, cognitive behavioral, and Rogerian models. Survey 4 also helped identify how these D&I scientists decide where to lead integration efforts, or at least where to begin. About a third of respondents suggested that primary care and family medicine clinics were prioritized, but even more respondents highlighted interest and readiness from the clinic as key indicators of where to carry out behavioral health integration. The importance of the clinic being invested in integration was further supported by the finding that around half of respondents identified support and buy-in from clinical and administrative leadership as the greatest facilitator to successful integration. Finally, in addition to concerns over costs, billing, and physical space, respondents noted that a lack of understanding of the role of behavioral health professionals can present a significant barrier to successful integration. Together, these findings should inform future integration efforts to prioritize gaining institutional and professional understanding and buy-in within clinics before rushing ahead with the process.

Using the dynamic sustainability framework, all barriers and facilitators from all surveys are summed in Table 1. We also created a summary of our process for others interested in rollout across a healthcare system or similar research to follow (see Fig. 4).

Limitations

Limitations for this study included a lower number of participants than desired, or for whom we may be able to detect power in even correlational analyses. Limitations also included a lack of participation from hospital leadership; more engagement work is warranted.

Additional takeaways

If you are a scientist entering into a health system, this process is worth doing in order to prioritize integration thoughtfully. It also creates connections- Throughout the last two years, our team has partnered with multiple clinics on integration research projects and clinical work while we think about the larger institution. I now know key players well and have good insights into barriers and facilitators. It is worthwhile to do.

Next steps

We use the RE-AIM framework for next steps for implementation. In addition, using a community based participatory research (CBPR) framework, will build interdisciplinary team of healthcare providers, patients, and administrators to identify convergence of interests around shared goals of integration for key outcomes. Will also include cost and complications data, per this research. Will begin with integration project at top of excel spreadsheet and continue. Will use MOST design for fit of bias interventions. We will apply for funding to follow up with integration into all medical clinics and monitor sustainability long term, utilizing the RE-AIM model as a framework for the implementation science work.

Conclusions

Proposed here is a blueprint for identifying where to begin an integration of behavioral health services rollout within a healthcare system.

Declarations

Ethics approval and consent to participate

This human subject study was approved by Rutgers University IRB and participants provided informed consent.

Consent for publication

Not applicable

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due to the potential ability to identify a research subject with their demographic data and descriptions of barriers and facilitators in their workplace (e.g., the social worker in the cramped gynecology clinic at CINJ [example only; not a real case]) but are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests

Funding

No funding was used for this study.

Authors' contributions

KR created the IRB and lead the study team, involving weekly meetings from conception through completion; each study team member was involved in creation of the project. KR continued to lead including oversight, data analysis, interpretation, coordination, and writing. In addition, SG facilitated revisions to the IRB, assisted with writing, and helped with preliminary data analysis and preliminary writing. JT, MF, MB, and SB each additionally conducted data analysis and results writing for each of the the four surveys, and contributed to writing the discussion.

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Authors' information

KR is a clinical health psychologist who has worked in integrated primary care and cancer settings. She has conducted implementation science project related to primary care integration of behavioral health, smoking cessation into a cancer surgical unit, and now works at a university and healthcare system without significant behavioral health integration. The rest of the authors are advanced graduate students in clinical psychology, each working in integrated, interprofessional settings, with varying degrees of experience with implementation science.

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Tables

Table 1
Barriers and Faciliators; Dynamic Sustainability Framework

Levels of Dynamic Sustainability Framework	Barriers	Facilitators
Individual	Time	Patient need
Provider	Time, professional threat	Patient need, desire better patient outcomes, New clinicians with new ideas
Healthcare system	Cost, office space	Patient need
Broader system/culture	Cost, time	Patient need

Table 2
Blueprint for behavioral health integration

Clinic Name	Patient needs (1-100)	ORIC (1-100)*	Aligns with student training needs (1-100)	Total Score
Family Medicine	70	90	80	80
Chandler Health Center	95	58	80	78
CINJ East Tower	90	55	80	75
Sleep Clinic	70	75	80	75
Otolaryngology	70	72	80	74
UBHC	80	68	70	73
Pain clinic at children's specialized	80	56	80	72
CINJ Primarily Breast and GYN cancers	90	43	80	71
CINJ (Average; specific clinics named)	90	41	80	70
DBT-RU	85	72	50	69
Pediatric Primary Care	80	45	80	68
CINJ Surgical oncology	90	28	80	66
CINJ Unknown	90	23	80	64
Youth anxiety and depression clinic	80	62	50	64
Psychological services center	75	56	60	64
CINJ Endocrine Surgery	90	18	80	63
Department of Nephrology	65	56	60	60
Psychiatry	90	33	30	51
*ORIC not indicated for department of nephrology or children's pain clinic staff, so mean is included for those clinic				

Figures

Figure 1

Survey 2 Clinic Importance of Integration Note. Graph depicts how respondents ranked importance of integrating mental health services into medical settings, on a scale of 0 to 100.

Figure 2

Survey 2 Clinic Perception of Patient Need for Integration Note. Graph depicts how respondents ranked perceived patient need for integrating mental health services into medical settings, on a scale of 0 to 100.

Figure 3

Survey 2 Clinic Desire for Integration Note. Graph depicts how respondents ranked their desire for integrating mental health services into medical settings, on a scale of 0 to 100.

1. Survey local opinion leaders about clinics interested in or that are in need or that would be good for student training needs, as well as barriers and facilitators to integration they've observed. Ask for additional opinion leaders' contact information. Ask for clinic contact information. Hold in person meetings, if possible. Build a stakeholder network via community based participatory research (CBPR) if available.
2. Survey clinics about readiness for change (ORIC), desire for integration, patient need, and openness to trainees or whatever other sustainable model you've created.
3. Engage and survey hospital administrators about barriers and facilitators for integration and desire for metrics outcomes in future studies.
4. Create a spreadsheet of priorities, including patient need, ORIC, and student training match (or other sustainable model match), and rank every clinic on those metrics. Sort by final score highest to lowest, and begin integration at the site with the balance of the most patient needs, highest readiness for change, and where students would be welcome.
5. Sort barriers and facilitators, perhaps by the Dynamic Sustainability Framework Brofenbrenner model.
6. Next steps might include building a participatory action framework and team, assess for type of integration desired at top sites, and follow up to do the integration using the RE-AIM model.

Figure 4

Steps to deciding where to begin a rollout of behavioral health integration in a healthcare system

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [STROBEchecklistcrosssectional.docx](#)