An Interprofessional Education Workforce Development Program in a Rural State

Tracy Hellem, PhD, RN[1*]

Holly Schleicher, PhD[2]

Jean Carter, MS, PharmD, PhD[3]

Mary-Ann Sontag, PhD[4]

Bryan Cochran, PhD[5]

[1] Associate Professor, Mark & Robyn Jones College of Nursing College, Montana State University, tracy.hellem1@montana.edu

[2] Director of Integrated Behavioral Health, College of Humanities and Sciences, Department of Psychology, University of Montana, holly.schleicher@umontana.edu

[3] Professor Emeritus, Skaggs School of Pharmacy, University of Montana, jean.carter@umontana.edu

[4] Associate Professor, School of Social Work, University of Montana, mary-ann.sontag@umontana.edu

[5] Professor of Psychology & Director of Clinical Training, College of Humanities and Sciences, Department of Psychology, University of Montana, bryan.cochran@umontana.edu

*Correspondence: Tracy Hellem

Abstract

Purpose: There are unique challenges to healthcare delivery in the state of Montana, with most of the population residing in rural areas and a shortage of behavioral health providers. Integrating behavioral health (IBH) providers into primary care settings improves behavioral health outcomes. Workforce development strategies aim to address rural health disparities by training graduate behavioral health students in IBH. The main objective of our program was to expand the behavioral

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health workforce serving rural, vulnerable, and medically underserved populations in Montana through enhanced didactic and experiential training in IBH models.

Method: Graduate students (psychiatric/mental health Doctor of Nursing Practice), Master of Social Work, Master's in counseling education, and PhD clinical psychology) were placed at IBH clinical sites and received didactic and in-clinic interprofessional training. Level of integration and student experiences were assessed.

Findings: Sixty-five students completed the program. On average, sites had close collaboration between behavioral health and primary care providers. A total of 65% of clinical sites were used in all four years of the program. Post-program responses indicate that alumni feel more effective in their current position because of the program; most respondents serve rural residents, and many respondents practice IBH.

Conclusions: A model of training the future workforce using experiential interprofessional learning may improve IBH in rural states.

Keywords: Behavioral health professions**,** integrated behavioral health, interprofessional education, rural health

An Interprofessional Education Workforce Development Program in a Rural State

Healthcare delivery in many areas across the globe faces several challenges, including rurality, financial constraints, healthcare professional shortages, and health inequalities. Interprofessional education and practice can play a critical role in addressing concerns related to access to healthcare delivery. Training the future health profession workforce using interprofessional education and providing them with opportunities to contribute to an interprofessional team allows them to become part of a collaborative, practice-ready workforce. The purpose of the program described in this manuscript was to expand the behavioral health

workforce serving rural, vulnerable, and medically underserved populations in Montana through enhanced didactic and experiential training in integrated behavioral health models and exposure to interprofessional collaborative teamwork for students, as well as the facilitation of higher levels of integrated behavioral health at clinical sites.

Integrated behavioral health (IBH) is a type of interprofessional collaboration where behavioral health providers are integrated into primary care settings, resulting in patients receiving care or treatment from a team of primary care and behavioral health clinicians (Phelan et al., 2023). The ability to provide a spectrum of healthcare needs at a single location may ease some healthcare delivery challenges, as well as address other practice gaps related to managing mental illness and substance use disorders (Isaacs & Mitchell, 2024). Due to its rural nature, Montana is well suited for this healthcare approach. With an estimated 65% of the population residing in rural areas (Service, 2021), defined by the Office of Management and Budget (OMB) as regions outside of metropolitan (at least 50,000 people) and micropolitan (urban area containing 10,000-49,000 people) areas (Childs et al., 2022), and a critical shortage of behavioral health providers (Foundation, 2016), Montana is at an increased risk of poor behavioral health outcomes. Rates of mental illness in youth (Survey, 2019) and substance use disorders among both adults (Centers for Disease Control and Prevention, 2015) and youth (Survey, 2019) in Montana exceed national rates. The suicide rate in Montana has been the highest or near the highest in the United States for nearly 40 years, resulting in suicide as an ongoing public health concern. Research consistently shows a relationship between mental health and suicide, with suicide commonly preceded by a crisis related to a mental health issue, substance abuse, or physical health problem (Jack et al., 2018). The linkages between mental health, substance use concerns, and suicide, paired with rurality and a behavioral health provider shortage faced in Montana, result in a *critical behavioral health need*.

To meet this growing need, a program titled "Behavioral Health Under the Big Sky," as part of the Health Resources and Services Administration (HRSA) Behavioral Health Workforce Education and Training (BHWET) Program, was developed and active from 2017 to 2021. This manuscript describes how this program was implemented and provides perceptions of how it impacted clinical practice beyond graduation.

Method

Model Used for Program Development

When IBH is implemented in professional settings by post-degree professionals whose training did not include IBH specifically or even interprofessional education more broadly, fidelity to the IBH model may be problematic. Graduate education in the United States, however, is typically discipline-specific, with little opportunity to develop and practice needed skills in collaborative care. To promote and optimize IBH in our rural state, "Behavioral Health Under the Big Sky" was based on the team's commitment to two effective and interrelated concepts: IBH and interprofessional education. A logic model was developed to reflect an understanding that teaching about IBH required interprofessional education; the logic model and the concepts it represents were foundational in the development and implementation of the project.

Interprofessional education refers to students from different professionals learning together to enhance collaboration and health outcomes (Martin et al., 2021). Our project utilized interprofessional education to educate students to deliver an effective type of collaborative care: IBH. The logic model identifies activities utilized to achieve desired outcomes, including using an interprofessional faculty team to implement the project and specific training in IBH that was delivered using interprofessional education. Further, the logic model reflects the team's

commitment to improving integration at student training sites, which are components of the care delivery systems across Montana.

Program Development and Implementation

Seven faculty from two universities in Montana plus a director of IBH from one of the universities were assembled from graduate behavioral health education programs (clinical psychology [PhD-level], social work [masters-level], counselor education [masters-level], and psychiatric mental health nursing [Doctor of Nursing Practice]) to implement this program. Drawing on existing academic-clinical relationships at program onset, the program team contacted clinical sites to gauge interest in potential BHWET student placement. Using the Substance Abuse and Mental Health Services Administration (SAMHSA) – HRSA Center for Integrated Health Solutions framework for levels of integrated healthcare (Heath et al., 2013), clinical sites for student placement were at least at level 3 – basic collaboration -- to be considered as a site, defined as basic collaboration, consists of mental health and healthcare professionals from other disciplines using separate systems but share a facility (Heath et al., 2013). Specific criteria for site selection included: 1) capacity to host student interns (including prior experience with student trainees from the two universities involved with this program); 2) willingness to participate in proposed activities; 3) having a licensed on-site supervisor capable of supervising students; and 4) readiness to implement the IBH model.

After site selection, the program team informed all eligible students in their respective education programs about BHWET in the spring semester before their final year. Students applied to BHWET, and the team conducted group interviews with applicants and selected students based on their knowledge of and interest in IBH, interpersonal skills and demeanor, and self-awareness. Students began the program in the subsequent fall semester with an onboarding 2-day event before

the start of the academic year hosted by the program team and attended by both students and clinical site supervisors. IBH training and interprofessional education were provided at the onboarding event, including interprofessional case formulation/consultations, practice communicating across disciplines, and role-playing interactions with other healthcare professionals.

The site and student selection process and onboarding event were repeated each year of the funding period. Annual training was provided by the IBH consultant to sites specific to IBH and interprofessional collaboration. Students completed a three-credit interprofessional education course offered at one of the universities involved in this program or through the Center for Interprofessional Practice, Education, and Research at Creighton University. Another training component was monthly 90-minute meetings where the program team helped to troubleshoot students' difficulties with IBH implementation and other issues that arose at their sites. Finally, the IBH consultant on the project conducted individualized training with sites and site supervisors, as well as shadowing to assess IBH practices. Stipends were provided to students who participated in the program for at least six consecutive months.

Data Collection

Each year demographic data were collected from students. We also collected Levels of Integrated Healthcare using the Integrated Practice Assessment Tool version 2 (IPATv2) (Waxmonsky et al., 2014), a checklist used by the Substance Abuse and Mental Health Services Administration to assess integrated care annually from students Finally, we tracked number and type of placements in rural communities and number of students who graduated during the program.

After program completion, an Internet-based, confidential, 23-item survey was developed using Qualtrics®XM to learn about experiences with the program and current employment status, including practicing in an IBH setting, as well as working with rural, vulnerable, and/or medically underserved populations. Respondents were also asked if they had suggestions for improving the program. The survey was developed in the English language. The survey was distributed by Qualtrics®XM SMS messaging over the course of three weeks (one original invite to complete the survey and two reminder,s) approximately 10-36 months after students completed their BHWET internship.

Analysis

Survey (both demographic and program-completion survey) and IPATv2 data were exported from Qualtrics®XM to IntellectusStatistics™, a web-based analysis program. Descriptive statistics, including measures of central tendency, standard deviations, frequency counts, and percentages were used to describe students accepted into the program, in addition to IPAT v2 data.

Ethical Approval

Considering that the program was related to education as opposed to human subjects research, ethics committee approval was not warranted for implementation of the program. However, for post-program completion data collection, institutional review board approval was provided by one of the universities involved in the program. Respondents to the post-program survey were informed that survey participation was voluntary and that they could choose not to answer any survey items. Respondents consented to take part in the survey by entering the survey. An informed consent statement detailing this consent to participate was posted as an introduction and before entering the survey, with participants accepting the statement to continue.

Findings

Sixty-nine behavioral health graduate students were accepted into the program, 67 of them were placed in rural and/or underserved medical settings, and a total of 65 students completed all requirements related to the program. Two students withdrew from the program prior to site placement, one student withdrew from the program early to pursue a career opportunity, and another student withdrew early for unknown reasons. Of the 65 students who completed the program, 61 graduated during the program period, and four are on track to graduate from their doctoral programs after completing a required internship post-BHWET.

Graduate students were predominantly born between the years of 1980-1989 (n=31, 44.9%), identified as female gender (73.9%, n=51), White (n=58, 84.1%) and not Hispanic or Latino (91.3%, n=63). A little over half of the students (n=37, 53.6%) had previous experience living in a rural area and were not from a disadvantaged background (n=37, 53.6%). See Table 1 for a complete list of student demographics.

Table 1

Student Demographics, N=69

Variable	Frequency (%)
Birth Year	
1960-1969	4 (5.8)
1970-1979	4 (5.8)
1980-1989	31 (44.9)
1990-1999	27 (39.1)
Missing data	3 (4.4)
Gender identification	
Male	16 (23.2)
Female	51 (73.9)
Non-binary	2 (2.9)
Race	
White	58 (84.1)
American Indian or Alaska Native	5 (7.3)
Asian	2 (2.9)
Native Hawaiian or Pacific Islander	1 (1.5)

	More Than One Race	1 (1.5)
	Missing data	2 (2.9)
Ethnicity		
	Not Hispanic or Latino	63 (91.3)
	Missing data	6 (8.7)
Rural Background		
	Yes	37 (53.6)
	No	29 (42.0)
	Missing data	3 (4.4)
Disadvantaged Background		
	Yes	25 (36.2)
	No	37 (53.6)
	Missing data	7 (10.1)
Veteran status		
	Yes	2 (2.9)
	No	64 (92.8)
	Missing data	3 (4.4)
Discipline		
	Clinical psychology (PhD)	16 (23.2)
	Social work (Masters)	18 (26.1)
	Counselor education (Masters)	25 (36.2)
	Psychiatric mental health nursing (DNP)	10 (14.5)
	PhD = Doctor of Philosophy DNP = Doctor of Nursing Practice	

Clinical Sites

Over the four-year program period, a total of 26 clinical sites hosted student trainees. Of the 26 sites, two of them were used as sites for the duration of the four-year program period, six of them were used for three of the years, three of them were used for two of the years, and the remaining 17 were used for one of the four years. The DNP students involved in the program lived across the state of Montana, as the DNP program is a distance program, and thus, some sites were only used once based on the students' geographic location. Furthermore, the COVID-19 pandemic impacted the retention of some sites for BHWET students, given the concern of spreading the virus and limiting contact with clients. Finally, turnover in site supervisors influenced the preservation of some sites, as some new supervisors were unwilling to work with students.

With respect to IPATv2 data relevant to sites, only two years (2020 and 2021) of reliable data were collected. In 2020, the range of IPATv2 levels for clinical sites was 2 to 5 (n=9 sites with missing IPATv2 data for n=2 of them), with a mean integration level of 4.07 (+/- 1.17). In 2021, the range of IPATv2 levels for clinical sites was 2 to 6 (n=14 sites with missing IPATv2 data for n=2 sites), with a mean integration level of 4.25 (+/- 1.34). This means that on average, sites shared some systems, primary care and behavioral health services shared a facility, there were coordinated treatment plans with face-to-face consultation, and there was a fundamental appreciation of primary care and behavioral health roles, as well as challenges with collaboration related to time and operations (Heath et al., 2013).

Table 2

Program Completion Data

N=25	
Variable	*Frequency (%)*
Intern Academic Year	
2017-2018	8 (32.0)
2018-2019	6 (24.0)
2019-2020	4 (16.0)
2020-2021	7 (28.0)
Academic Program	
Clinical psychology (PhD)	6 (24.0)
Social work (Masters)	7 (28.0)
Counselor education (Masters)	8 (32.0)
Psychiatric mental health (DNP)	4 (16.0)
Academic Program Completion	
2018	5 (20.0)
2019	8 (32.0)
2020	4 (16.0)
2021	4 (16.0)
No, currently still enrolled	4 (16.0)
PhD = Doctor of Philosophy DNP = Doctor of Nursing Practice	

Program Completion Survey Findings

Using Qualtrics®[XM] SMS distribution, our program completion survey was distributed to 65 phone numbers. A total of 31 surveys were started and 25 of them were completed, resulting in an 81% completion rate. The majority of respondents, n=8 (32%) were enrolled as program interns in 2017-2018, in the counselor education program (n=8, 32%), and graduated from their academic program in 2019 (n=8; 32%). Refer to Table 2 for a complete outline of program completion data.

Perceptions of the BHWET program and its usefulness post-graduation data are reported in Table 3. Sixty-four percent (n=16) of respondents indicated that they strongly agreed that they learned a great deal about IBH as a program intern and n=17 (68%) strongly agreed that they are more effective in their current job because of their experience in the program**.** Given that graduate students' funding can be difficult to obtain, n=19 (76%) suggested that the stipend provided through the program was useful in funding their education.

Table 3

Perceptions of BHWET Program and Its Utility to Current Practice, N=25

	Level of Agreement				
	Strongly Disagree Frequency (%)	Somewhat Disagree Frequency (%)	Neither Disagree or Agree Frequency (%)	Somewhat Agree Frequency (%)	Strongly Agree Frequency (%)
Survey Questions					
Learned a great deal about IBH in my BHWET position	1 (4.0)	2 (8.0)	0 (0.0)	6 (24.0)	16 (64.0)
BHWET position helped me learn to work as part of a treatment team	2 (8.0)	1 (4.0)	0 (0.0)	8 (32.0)	14 (56.0)
I am more effective in my current job	0 (0.0)	0 (0.0)	3 (12.0)	5 (20.0)	17 (68.0)

because of my BHWET position					
The stipend provided by BHWET was helpful in financing my education	3 (12.0)	0 (0.0)	0 (0.0)	3 (12.0)	19 (76.0)
The monthly student meetings were beneficial	1 (4.0)	3 (3.0)	4 (16.0)	11 (44.0)	5 (20.0)
The onboarding training helped set me up for success during the BHWET program	0 (0.0)	2 (8.0)	3 (12.0)	12 (48.0)	8 (32.0)
BHWET faculty and staff were available to help with difficulties at my BHWET site	1 (4.0)	0 (0.0)	2 (8.0)	9 (36.0)	13 (52.0)
An important aspect of BHWET was learning from the other student interns in the program	0 (0.0)	3 (12.0)	5 (20.0)	3 (12.0)	14 (56.0)
I felt like a valued member of the treatment team at my BHWET site	2 (8.0)	3 (12.0)	4 (16.0)	4 (16.0)	12 (48.0)
I would recommend the BHWET program to other students	0 (0.0)	1 (4.0)	0 (0.0)	4 (16.0)	20 (80.0)
The BHWET program was important part of my education and training	0 (0.0)	0 (0.0)	0 (0.0)	11 (44.0)	14 (56.0)
BHWET = Behavioral Health Workforce Education & Training; IBH = Integrated Behavioral Health					

Data related to clinical setting characteristics after completion of the academic program are outlined in Table 4. Over half (n=14; 56%) of respondents indicated that they are licensed providers, and most of the respondents (64%; n=16) practice in the state of Montana. Further, most respondents (60%; n=15) reported that they currently working with medically, institutionally, or underserved (i.e., low-income and/or institutionally marginalized) populations. Eight (32%) respondents indicated that they work in rural settings, and 28% (n=7) reported that while they do not work in a rural setting, over 25% of the population seeking services at their site travel from a rural area. Finally, n=10 (40%) respondents listed that they currently practice in an IBH setting.

Table 4

Clinical Setting Post-Academic Program Completion

Variable	*Frequency (%)*
Currently Providing Direct Clinical Services	
As a licensed provider	14 (56.0)
Working under another provider's license	7 (28.0)
Not currently providing direct clinical services	4 (16.0)
Working with Medically/ Institutionally/ Underserved Populations	
Yes	15 (60.0)
No	6 (24.0)
Missing	4 (16.0)
Practicing in Montana	
Yes	16 (64.0)
No	4 (16.0)
Missing	5 (20.0)
Practicing in a Rural Setting	
Yes	8 (32.0)
No	6 (24.0)
No, but > 25% of the site's population travels from a rural area to seek services at the site	7 (28.0)
Missing	4 (16.0)
Practicing IBH	
Yes	10 (40.0)

	No	11 (44.0)
	Missing	4 (16.0)
What Elements of IBH are Practiced		
	Co-location with primary care services	10 (40.0)
	Warm handoffs	11 (44.0)
	Inclusive billing	8 (32.0)
	Shared EHR	14 (56.0)
	Team meetings with healthcare professionals from other disciplines	14 (56.0)
	Regular trainings with healthcare professionals from other disciplines	10 (40.0)
	Missing	9 (36.0)
IBH=Integrated Behavioral Health; EHR=Electronic Health Record		

Discussion

The main goal of this program was to expand the behavioral health workforce serving rural, vulnerable, and medically underserved populations in Montana through enhanced didactic and experiential training in IBH models. The program completion survey results suggest that the program was beneficial in preparing recent health behavior student graduates to work collaboratively and effectively in their current positions and consider an IBH model in the practice setting. It is worth noting that while less than half of the BHWET graduates currently practice IBH in the workplace, we view this as an encouraging finding, given that IBH is still a growing field. Although, the finding that less than half of the graduates currently practice IBH may be due to limited clinical agencies using an IBH model in Montana, resulting in a practice gap that warrants further exploration on ways to increase the use of IBH in practice settings.

The results of the program completion survey show that most program alumni serve medically, institutionally, and/or underserved populations, and most of the alumni are involved in serving patients in or from rural areas. Over half of the interns were from a rural area, and some

research shows that students are inclined to return to rural communities that they are from (Wendling et al., 2019). There is limited available evidence on the role of interprofessional education in health behavior programs and the decision to practice in the rural setting. However, there are studies published that suggest that multidisciplinary education programs may spark students' interest in practice among rural and underserved settings, as well as result in an increase in graduates who practice in rural areas (Austin et al., 2019; Pullon et al., 2021).

While each discipline represented in the "Behavioral Health Under the Big Sky Program" serves an important and unique role in behavioral health integration, the discipline of nursing has consistently championed an integrated approach to patient care since the beginning of nursing practices (Soltis-Jarrett, 2020). Early in nursing education, the concept of holistic and patient-centered care, including addressing biological, psychological, social, and spiritual needs of humans, is introduced (Kinchen, 2019). However, the role of advanced practice registered nurses (APRNs), notably psychiatric/mental health APRNs, in IBH models is not yet well defined or it is misrepresented (Soltis-Jarrett, 2020). The exposure that DNP students in the "Behavioral Health Under the Big Sky Program" had to collaborative care in primary and mental health settings enhanced knowledge and skills, including psychiatric/mental health APRN role definition in an IBH model, that will make positive contributions to agencies and clinics that serve citizens of the state of Montana.

Even though this program had promising results, there were lessons learned that may be useful to other programs planning to implement similar projects. A challenge encountered in this project included measuring IBH integration at sites. Students completed the IPATv2 at the onset and completion of their intern year, and the reliability of data collection was jeopardized by student experience with site supervisors, change in leadership, and the COVID pandemic. Seeking IBH

integration input from two sources (sites and students) would have strengthened this data point. Furthermore, an alternative measure for IBH integration to consider for future projects is the Practice Integration Profile (PIP), which offers an opportunity for several stakeholders to validly examine and enhance integrated services on a variety of levels (e.g., practice, policy, and system) (Macchi et al., 2016).

Another challenge faced was staff changes at sites. Site staff turnout impacted relationship building, in addition to affecting the consistency of clinical supervision, along with a mismatch between students and site supervisors. The latter challenge could potentially be avoided with more detailed data collection about sites and students at the beginning of the program year. Moreover, relationship building and satisfaction with relationship data were collected, and future projects may consider employing a validated tool to evaluate relationships between sites and a program. A final challenge consists of the academic year (9-10 months) limiting students' exposure at clinical sites. This project was constrained by the funding agency's limitation of academic year-long internships, which may not be an ideal length for a training period.

There are limitations to this program that should be acknowledged. Students were selected to participate in the program after faculty interviews, and therefore, there may have been selection bias. Alumni survey response rates were low, which may be due to a lack of engagement with the universities up to 36 months post-graduation, and incorrect phone numbers used for survey distribution.

Conclusions

It is well documented that the integration of behavioral health providers in primary care settings has a positive impact on patient outcomes. Using interprofessional education to expose health behavioral students to an IBH model may improve the level of behavioral health integration

in rural states. The findings from the Behavioral Health Under the Big Sky program associated with preparing students to work collaboratively and effectively join the workforce can be used as a lever for advancing interprofessional education and student experiences in behavioral health profession programs. This model of training the future workforce using experiential interprofessional learning can be applied to other educational and work environments.

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Conflicts of Interest

The authors have no conflicts of interest to declare.

References

Austin, C., Berg, E., Heuer, L., Cushman, L., Lindquist, C., & Ripp, J. (2019). Public health and health professional education at a tribal college: A collaborative immersion program in rural North Dakota. *Rural Remote Health*, *19*(3), 5020. https://doi.org/10.22605/rrh5020

Centers for Disease Control and Prevention, Division of Population Health. (2015). *BRFSS Prevalence & Trends Data [online]*. https://www.cdc.gov/brfss/brfssprevalence/

Childs, E. M., Boyas, J. F., & Blackburn, J. R. (2022). Off the beaten path: A scoping review of how 'rural' is defined by the U.S. government for rural health promotion. *Health Promotion Perspectives*, *12*(1), 10-21. https://doi.org/10.34172/hpp.2022.02

Economic Research Service, U.S. Department of Agriculture. (2021). *State fact sheets: Montana*. https://data.ers.usda.gov/reports.aspx?StateFIPS=30&StateName=Montana&ID=17854

Heath, B., Wise Romero, P., & Reynolds, K. A. (2013). *Standard framework for levels of integrated healthcare*. http://medicaldentalintegration.org/wp-content/uploads/2017/10/A_Standard_Framework_for_Levels_.pdf

Isaacs, A. N., & Mitchell, E. K. L. (2024). Mental health integrated care models in primary care and factors that contribute to their effective implementation: A scoping review. *International Journal of Mental Health Systems*, *18*(1), 5. https://doi.org/10.1186/s13033-024-00625-x

Jack, S. P. D., Petrosky, E., Lyons, B. H., Blair, J. M., Ertl, A. M., Sheats, K. J., & Betz, C. J. (2018). Surveillance for Violent Deaths - National Violent Death Reporting System, 27 States, 2015. *MMWR Surveillance Summaries*, *67*(11), 1-32. https://doi.org/10.15585/mmwr.ss6711a1

Kinchen, E. (2019). Holistic nursing values in nurse practitioner education. *International Journal of Nursing Education Scholarship*, *16*(1). https://doi.org/10.1515/ijnes-2018-0082

Macchi, C. R., Kessler, R., Auxier, A., Hitt, J. R., Mullin, D., van Eeghen, C., & Littenberg, B. (2016). The Practice Integration Profile: Rationale, development, method, and research. *Families, Systems, & Health*, *34*(4), 334-341. https://doi.org/10.1037/fsh0000235

Martin, P., Pighills, A., Burge, V., Argus, G., & Sinclair, L. (2021). Promoting interprofessional education and collaborative practice in rural health settings: Learnings from a state-wide multi-methods study. *International Journal of Environmental Research and Public Health*, *18*(10). https://doi.org/10.3390/ijerph18105162

Montana Healthcare Foundation. (2016). *Integrated behavioral health in Montana: A baseline assessment of benefits, challenges and opportunities*. https://mthcf.org/wp-content/uploads/Integrated-Behavioral-Health-Full-Report.pdf

Office of Public Instruction. Youth risk behavior survey. (2019). *Montana 2019 and United States 2019 results*. https://opi.mt.gov/Leadership/Data-Reporting/Youth-Risk-Behavior-Survey

Phelan, S. M., Salinas, M., Pankey, T., Cummings, G., Allen, J. P., Waniger, A., Miller, N. E., Lebow, J., Dovidio, J. F., van Ryn, M., & Doubeni, C. A. (2023). Patient and health care professional perspectives on stigma in integrated behavioral health: Barriers and recommendations. *Annals of Family Medicine*, *21*(Suppl 2), S56-s60. https://doi.org/10.1370/afm.2924

Pullon, S., Garrett, S., Garnett, A., Schwass, E. R., McKinlay, E., Ashworth, N., & Darlow, B. (2021). Five years on: Influences on early career health professionals from a rural interprofessional pre-registration immersion program. *Australian Journal of Rural Health*, *29*(2), 146-157. https://doi.org/10.1111/ajr.12705

Soltis-Jarrett, V. (2020). Integrating behavioral health and substance use models for advanced PMHN practice in primary care: Progress made in the 21st century. *Archives Psychiatric Nursing*, *34*(5), 363-369. https://doi.org/10.1016/j.apnu.2020.07.026

Waxmonsky, J., Auxier, A., Romero, P. W., & Heath, B. (2014). *Integrated Practice Assessment Tool*. https://www.thenationalcouncil.org/resources/integration-practice-assessment-tool-ipat/

Wendling, A. L., Shipman, S. A., Jones, K., Kovar-Gough, I., & Phillips, J. (2019). Defining rural: The predictive value of medical school applicants' rural characteristics on intent to practice in a rural community. *Academic Medicine*, *94*(11S), S14-S20. https://doi.org/10.1097/acm.0000000000002924