

Appendix 2 (as supplied by the authors): Interview guide

Challenges in Integrated Mental Health Care Research: Understanding Primary Care Providers' Participation in the PARTNERS Study

In this study we are interested in understanding your experience of the PARTNERS randomized controlled trial of an integrated care model for management of depression, anxiety and alcohol use disorders in primary care settings. We're interested in your perspective on the clinical intervention under study, as well as your perspective on participating in a randomized controlled trial.

General / Early Impressions

How did you first hear about the PARTNERS study? Probes: written or oral material; from study personnel or from someone at your site? How useful was the information you received in deciding whether you wanted to be involved? Is this type of information more persuasive if it comes from a peer?

How did you decide whether to participate in the study? What appealed to you at the outset? What did you hope that you and your patients would get out of participating? Was there anything that didn't appeal to you or that you had reservations about? Did you discuss the study with anyone else (e.g. in your practice setting) and if so how did that influence you?

Have you participated in randomized controlled trials or other clinical research previously? (As an investigator, collaborator, study participant, or referring provider?) How was your experience of PARTNERS similar to or different from other research experiences? Please explain.

Integrated Care Interventions

You may remember the PARTNERS study involved multiple components that are typically bundled and referred to as "integrated care". I'd like to hear your opinions about each component. I'll describe each component and how it was enacted in the PARTNERS study. I'd like to know your perspective on how it was provided in PARTNERS and how it could be provided in future studies.

Patient support for self-management is a key component of integrated care and focuses on coaching and problem-solving approaches that aim to help patients better manage their symptoms and care. In general, what do you think about this type of support for patients? How important is it? Who do you think should provide it and how? In the PARTNERS study patients randomized to the integrated care intervention received 3 months of weekly telephone monitoring followed by 3 months of maintenance monthly telephone monitoring, with no additional monitoring when they had few or no symptoms. The MHT helped them monitor symptoms, adhere to treatment, and provided education and support. What do you think about this way of delivering patient support for self-management?

Providing timely clinical information to patient's health care providers is also a core element of integrated care. This typically involves providing the results of patient report symptom rating scales to their clinical team, and can involve providing individual patient-level data and/or practice-level data. In

PARTNERS, you received information (such as findings and recommendations) from the MHT following the baseline assessment and ongoing on an “as needed” basis.

Was this data useful to you? Please explain. E.g. did it inform the care you provide?

Did you receive you any other information about the study at all during your participation? E.g. newsletter or other correspondence from the study coordinators?

Are there any ways you think the data / reports could be improved? (e.g. frequency, type of information, ability to further communicate)

Expert input was a component that provided guidance to primary care providers. It could be done a number of ways, e.g. providing clinical practice guidelines or care pathways, or providing individual case-based consultation on-site or at a distance, ‘on the fly’ or at a pre-scheduled time. In PARTNERS this was provided by receiving evidence-based treatment recommendations by the MHT and the project psychiatrist, and by receiving treatment updates and progress reports from the MHT, as required. How did you receive the input? What did you do with the information/input you received? Were there things about the input or about your practice or work week that made it easier or harder to implement the recommendations, i.e. that made it more or less likely that you would do so?

Probes: integration into PCP workflow, value of / trust in the suggestions, perception of them being suggestions versus expectations i.e. retaining or relinquishing control, perception of feasibility, comfort level with implementing the recommendations.)

What do you think about the role for expert input and the different ways it could be provided? What are your preferences for how this guidance could/should be provided and by whom?

Interaction with MHT or psychiatrist? Seen as resource?

Probes: preference for expert-generalist (FP) or expert-specialist (psychiatrist), frequency and mode of communication, level of detail, organization of information, etc.

Delivery system redesign refers to redefining roles and responsibilities in care delivery, for example having other clinical providers who aren’t physicians provide self-management support, symptom monitoring, and clinical information management. In PARTNERS this again refers to the Mental Health Technician and the study providing the symptom monitoring and feeding data back to you. What was it like for you to have responsibilities divvied up in this way? Who do you think should provide the different aspects of, say, depression care? Who do you think should provide the different aspects of, say, addictions care? Please explain.

Links to community resources outside the primary care team may be a part of integrated care interventions but were not featured in the PARTNERS study. During our interviews we’ve heard different perspectives on whether identifying community resources is something that should be done by the MHT versus by the local primary care team. In your opinion, how important is this component to achieving good outcomes for your patients? Probe: What types of community resources are relevant / important

to you? (e.g. housing support, employment, exercise groups, peer support) How important would it be for future integrated care initiatives to provide information about community resources? Please explain.

Leadership support and/or staff training to implement integrated care can also be a core component of integrated care. Did you encounter this while participating in the PARTNERS study? What form did it take? How important is leadership support and/or staff training for implementing integrated care initiatives? Please explain. (Probe: If they endorse a role for this, get them to describe specifically what they think is needed. E.g. if leadership, clinical or administrative leadership or both? What leadership activities? If training, what topics, what format, what frequency?)

This next question is not specific to the PARTNERS study. Thinking about all of the components of integrated care that we've been talking about, i.e., support for self-management, clinical information flow, decision support, redistribution of roles, links to community resources, and leadership and staff training, do you have any opinions about the bundling or combination of the different components? Anything that seems particularly important? Complementary? Redundant? Unnecessary? Contradictory? Please explain.

In your opinion, does integrated care make it more likely that patients will recover from their mental health conditions? Please explain.

The endpoints that were measured in the study were rate of remission or recovery for patients with clinical depression, generalized anxiety disorder, panic disorder, and/or alcohol misuse. The study measured a number of outcomes throughout the intervention related to these disorders, in addition to measures for cognition; pain; mental health treatment; patient satisfaction; and, mental, physical, social, and vocational functioning. Are any of these outcomes meaningful from your perspective? Are there other outcomes that matter a great deal to you as a primary care provider for your patients?

Referrals

Tell me about the types of patients you referred to PARTNERS and the reasons why you referred them.

Can you walk me through how you referred someone, e.g. how you explained the study to people (menu that they can choose from, not an "either or")?

Were there other patients with depression, anxiety and alcohol use disorders that you chose not to refer? What influenced you to refer or not to refer? Probes: clinical workflow / time / remembering, likelihood of patient acceptance to participate, likelihood of patient being deemed eligible for the study, perceived need for / utility / relevance of the intervention, anticipated workload

During our interviews we've often heard that remembering/forgetting can be a challenge. What kind of reminders to refer to the study do you think are effective? (or What kind of reminders would you prefer to receive?)

We also heard that sometimes patients were offered the study but declined it. Can you think of any reasons why your patients might have declined a referral to the study?

Thinking of a time when you referred someone to the study, can you walk me through their care? How were you caring for them before the study? At what point did you decide to refer? (Probe for the exact moment when it crossed their mind and/or when they decided, what cued them?) What steps did you need to take to refer them? Was there anything that made it easier to refer them? Was there anything that hindered you or posed a barrier that you needed to overcome in order to refer them?

In this study, patients with depression, anxiety disorders, and/or alcohol use disorders were eligible, and patients with other mental illnesses such as bipolar disorder, PTSD, or substance use disorders were ineligible. Did these criteria influence your perspective on the study? Please explain. What types of patients would you want to see integrated care interventions for in the future? Please explain.

Compared to other primary care providers who participated including providers at your practice, you tended to refer to the PARTNERS study more frequently/less frequently. Does that surprise you or is that what you would have guessed? Why do you think you might have referred more frequently/less frequently compared with other primary care providers?

Compared to other primary care **practices** that participated, your **practice** tended to refer to the PARTNERS study more frequently/less frequently. Were there things about the leadership, communication, workflow, patients, clinical or administrative team, opportunities for training and/or for reflection on practice, culture of the organization, or other factors that may have contributed to the practice's referral patterns?

Randomized controlled trials / intervention studies

As you know, in a RCT patients are randomly allocated – in this case either to receive the integrated care intervention (i.e. connection with a MHT and the other components) or to receive symptom assessments every 4 months with the results of those assessments fed back to you. What was it like for you to refer patients knowing they would be randomized? How did that influence your decision to refer or not to refer, or whom to refer, to the study?

Future Interventions and Studies

Would it have been helpful for the research team to meet with you or to have visited your site at the outset and/or on a regular basis to support implementation? Would it have been helpful for either the study team or someone at your site to proactively help you identify suitable patients? E.g. pre-clinic chart review, query of your EMR, identifying people who are known to your team who are eligible?

How would you feel about the study team inviting your patients once you've agreed to their suitability? How would this work in your setting (Not concerned about mechanics but more your reaction to pre-screening and inviting patients)?

This interview and others like it will shape future integrated care interventions and studies. What, if anything, would you like to tell the researchers about what you'd want to see in future integrated care models? What, if anything should be kept similar to PARTNERS? What would you change? Probe for reasoning: estimated likelihood of benefit to patients? Benefits / convenience to primary care providers? Feasibility of implementation?