From Clinics to Communities: Community Health Workers' Perspectives on Taking on the Behavioral Health Care Manager Role for Community-based Geriatric Depression Treatment

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Abstract

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Collaborative care models (CoCM) improve late-life depression outcomes and access, but face implementation barriers into healthcare systems. Task-shifting the behavioral health care manager role (BHCM) of CoCM to community health workers (CHWs) in community-based settings may help expand quality depression care. We conducted a qualitative phenomenological study using semi-structured interviews with 15 certified CHWs from clinical and community-based organizations. Guided by the Theoretical Framework of Acceptability, we explored CHWs' perspectives on strengths, attitudes, perceived self-efficacy, concerns and recommendations for taking on the BHCM role. CHWs reported that their rapport with the community, resource networks, and cultural alignment are strengths. They supported taking on this role to increase mental health access and expressed their prior health promotion and public health background aligns with the BHCM role, though additional training and supervision are needed to deliver psychosocial interventions, monitor symptoms, and infrastructure and role facilitation are needed to build capacity within community organization.

INTRODUCTION

Ample evidence shows that collaborative care models (CoCM)--a team-based intervention that integrates behavioral health care into primary care--improve depression and anxiety outcomes compared to usual care and expands mental health access.[1] Central to CoCM is a task-sharing approach where a behavioral health care manager (BHCM) and psychiatric consultant support primary care physicians (PCPs), with the care manager acting as a link between the patients and the other healthcare providers. CoCM is efficacious for treating geriatric depression and suicidal ideation, but half of these older adults continue to experience significant depressive symptoms.[2,3] This may reflect the limited and variable capacity of primary care clinics to address the complex social, or non-medical, factors that can contribute to late-life depression, known as social determinants of health (SDH).[4,5,6,7] Another challenge to depression care is that the uptake of CoCM into primary care has been limited by reimbursement challenges and BHCM workforce shortages.[8,9,10]

To increase access to quality geriatric depression care, national organizations have recommended expanding the workforce to include trained community-based non-specialist providers to deliver mental health interventions.[11,12] One such workforce are community health workers (CHWs), who are public health workers that are trusted members/have a close understanding of the community and can play an important role in addressing SDH by linking community members to health and social services.[13] Expanding quality depression care to community-based care through CHWs could also address barriers older adults face in seeking health care and the SDH that affect late-life depression.[14]

Prior home/community-based CoCM have used traditional master's-level behavioral health clinicians as care managers,[15] who provide brief psychotherapies, monitor patient

treatment using a population-based approach, and work with the psychiatric consultant to provide treatment recommendations. Studies have shown that lay providers, such as CHWs, can deliver psychosocial interventions and monitor clinical progress with training and supervision.[16–18] In most programs, CHWs were the sole treatment providers, delivering an evidence-based intervention. Multi-component, stepped care models using CHWs as treatment providers have been conducted in low-middle income countries,[19,20] but not in the United States, which is characterized by a more fragmented healthcare system. One case study of a community-based CoCM model trained CHWs in an adapted BHCM role while continuing to address SDH,[21] but has not been replicated beyond one community organization and did not include care coordination with PCPs. Adapting CoCM to community settings with CHWs instead of clinicians as BHCM requires role re-design and infrastructure changes that partnerships between community organizations and healthcare systems. Before formally designing such an intervention, we aim to assess the extent to which this intervention is needed, beneficial and acceptable from the perspective of those who would be delivering the intervention, CHWs.

The aim of this study is to understand CHWs perspectives on expanding their current roles to include aspects of a BHCM and work within an adapted community model of collaborative care. Our specific research questions are:

1. What strengths do CHWs bring into the BHCM role?
2. What are CHWs' attitudes and perceived self-efficacy towards assuming key behavioral health care manager tasks in community settings, and why?
3. What concerns and recommendations do CHWs have about the proposed BHCM role expansion?

METHODS

Study design

We used a qualitative phenomenological approach and interpretivist paradigm to understand the context in which CHWs work, their experiences as public health workers, and their emotional and cognitive responses to the taking on the BHCM role expansion within the proposed community-based CoCM.[22,23] The Institutional Review Board at University of Washington approved this study (STUDY00022055).

Study population

We recruited CHWs who have completed a CHW certification program and were registered as CHWs by their state's Department of Public Health, spoke English, and had at least one year's work experience as a CHW. Recruitment emails that listed the inclusion criteria were sent through state-level CHW organizations, public health networks, and the University of Washington Health Promotion Research Center.

Interested participants contacted the study team via email and were sent an online survey that asked about their employment setting, experience with older adults, and reason for interest. Twenty-nine CHWs responded. From these respondents, we selected 15 participants using purposive sampling.[24] We selected participants who reported working with an older adult population (>50% of the clients) aligning with the focus of the study, and by employment setting: provide services, programs, or resources to community members in non-health care settings, community-based organizations (CBOs). versus clinical organizations, defined as health care settings or public health departments that focus on health needs. Recruiting CHWs from diverse settings would allow us to gather richer contextual and experiential data. Verbal informed consent was obtained from all participants prior to the interview.

Behavioral Health Care Manager components

In addition to the overall adapted model, we asked how CHWs felt about taking on specific BHCM tasks with training and supervision (Suppl. Table 1). Namely, the BHCM tasks were: 1) *administering behavioral health measures*, or validated clinical outcomes measures that assess changes in symptoms over time, to monitor symptoms; 2) *utilizing a registry*, or database that tracks patient information, changes in illness measurements and contacts with health care team members; 3) *working in a healthcare team*, or weekly case review and consultation with a mental health specialist and communicating with a client's primary care provider; and 4) *delivering psychosocial interventions*, or evidence-based depression interventions.

Theoretical Framework of Acceptability

We used the Theoretical Framework of Acceptability (TFA) to guide our interview questions and analyze our data. Acceptability is a key variable in designing or implementing healthcare interventions. TFA was developed to assess the acceptability of healthcare interventions by deliverers or recipients before, during, or after an intervention.[25] This framework was developed from a) systematic review of how acceptability of healthcare interventions had been operationalized and b) defining the limits of the construct and then using qualitative deductive and inductive methods from the systematic review. The framework was compared against other applicable frameworks, including the Theory of Planned Behavior, Theoretical Domains Framework, and Common Sense Framework to come up with the final framework. The final framework proposes that acceptability is a multi-faceted construct consisting of seven emotional and cognitive components: affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs, and self-efficacy. TFA has been commonly used to assess health intervention acceptability among deliverers.[26,27]

Procedures

Prior to the interview, participants were sent and encouraged to review video links and a brief guide explaining the collaborative care model. We used in-depth, one-on-one, semi-structured interviews to understand how CHWs viewed expanding their roles to assume that of a BHCM in community-based CoCM; the infrastructure or support that would be needed; the context of how CHWs currently support health programs.

Guided by the TFA, the interview guide captured affective attitude, burden, self-efficacy, ethicality, in a semi-structured guide with probes (Fig.1). Questions sought to illicit responses regarding perceptions of how CHWs addressed health inequities in their communities and current roles, geriatric mental health concerns and barriers, advantages of a CHW team member, and the perceived self-efficacy, burden, and attitude towards each of the four behavioral health care manager tasks, and the overall acceptability of a community-embedded CHW care manager. The interview guide was iteratively pilot tested and revised by MW with inputs from LC, PR, LS for respective expertise in innovative collaborative care models, lay-delivered psychosocial interviews, health promotion practice for content accuracy and understandability, and pilot tested with a lay person for accessibility. Interviews, which lasted 60-90 minutes, were audio-recorded and transcribed using a professional service. MW, MB, IF listened to the audios and checked the transcripts for accuracy. Participants received a $100 gift card.

Participants were emailed a RedCap[28] survey prior to the interview that collected demographic and employment information. All study data were managed and stored on RedCap.[28]

Analytic Approach

We analyzed demographic data using descriptive statistics in MS Excel. We conducted thematic analysis using Miles and Huberman's approach.[29] Initially, a codebook was developed deductively, informed by the interview guide questions (TFA framework) and then expanded inductively through open coding of the first transcript by the coding team, allowing for the identification of unanticipated concepts and patterns.

To ensure consistency and reliability, the research team coded the initial two transcripts for consensus by engaging in discussions to refine the codebook and resolve discrepancies. This iterative process facilitated the development of a shared understanding of code definitions and applications. Because there were few discrepancies in coding, the remaining transcripts were independently coded by team members using the finalized codebook. The team continued to meet weekly to discuss ambiguities in coding. Codes were then grouped into broader conceptual categories, and a thematic analysis was conducted to identify salient patterns and emergent themes across the dataset as it related to our research questions. We stratified the data based on CHW employment (CBOs or clinic-based) to obtain a more comprehensive understanding of the questions asked. Our analytic process was iterative and reflexive, with regular team meetings to discuss evolving interpretations and ensure analytic rigor. Qualitative analysis was conducted in Dedoose.[30]

RESULTS

Characteristics of CHWs

Demographic information is shown in Table 1. Fifteen certified CHWs participated in the study. Around half were in CBOs (53.3%) or clinics (46.7%), with over half having 1–5 years of experience in the field. Participants were from Arizona (40%), Oregon (33.3%), Texas (13.3%), North Carolina (6.7%), and Washington (6.7%). Most were female (73.3%) and had at least a

college degree (60%). Most participants were of minority status, with only a third of the participants identifying as white. Most were employed full-time (73.3%) and 20% were not born in the United States.

When prompted, CBO-employed CHWs reported helping individuals navigate healthcare and social services and providing evidence-based health education programs—particularly those focused on chronic disease management. They were typically supported through public health grants that aligned with broader organizational missions to address social determinants of health. In contrast, clinic-based CHWs had roles that were more delineated between care coordination and community referrals, or health promotion. Not all clinic-based CHWs delivered evidence-based programs, and their funding was more varied and included grants, healthcare payer support, and emerging insurance reimbursement models.

Main themes

No significant differences were found in themes reported by CBO-based or clinic-based CHWs; therefore, findings are presented collectively, with distinctions noted where relevant. Themes emerged regarding CHWs' strengths, how they felt regarding delivering behavioral health care, and recommendations.

CHW Strengths

Participants reported stigma, ageism, transportation, mobility limitations, inadequate insurance coverage, limited provider availability, and low health literacy as mental health barriers for older adults. They emphasized older adults preferred face-to-face care, which complicates access in an increasingly digital health landscape. Participants also highlighted the potential for CHWs to help address these challenges by leveraging their trusted relationships, knowledge of community resources, and cultural competence. See Table 2 for illustrative quotes.

Trusted intermediaries. CHWs shared that rapport was a strength and allowed clients to share health information with them that they do not bring up to providers. Their trust is built through visible presence and active participation in their communities, their roles in local health and social service events, and word of mouth. This trust enables them to engage clients with healthcare in ways providers often cannot, and to address mental health stigma. Many shared they were an informal ear/confidante for clients outside of more formal support groups or listening sessions.

Leveraging Community Networks and Lived Experience. CHWs shared that their deep knowledge of community resources for health and social needs comes a combination of their training, professional networking, and from their own lived experiences navigating these health and social systems. CHWs emphasized connecting clients to community-based networks that address social needs and facilitate access to healthcare services. They mentioned addressing diverse needs, ranging from from food insecurity to transportation to get to get clinic, to obtaining vaccinations for children or assistance filling out paperwork for insurance or government benefits. Clinic-based CHWs reported feeling that their extensive knowledge of local is not always recognized or leveraged. Some CBO-based CHWs, on the other hand, reported their organizations are implementing electronic systems like UniteUs to track social services referrals because of how fundamental that is to their work.

Health Literacy and Community Mediators. Participants noted that many clients experience low health literacy and struggle to understand health information and feel hesitant to seek clarification due to the perceived authority of healthcare professionals. CHWs emphasized bridging this gap by communicating in ways that resonate with community members—using familiar language, cultural references, and relatable framing. This ability to “speak the language”

of the community not only improves understanding but also helps normalize conversations around mental health, making care more accessible and acceptable.

Attitudes and Perceived Self-Efficacy

Participants reported depression and anxiety as the most prevalent geriatric mental health concerns. Clinic-based CHWs also noted cognitive impairment concerns. Participants supported taking on the BHCM role, citing mental health need, their health promotion background and collaborative nature of the model as reasons why. Illustrative quotes are shown in Table 3.

Mental health needs. CHWs discussed how mental health concerns were often unaddressed because of the existing barriers. They felt that having tools to address mental health would empower them to serve their community and is in line with their values as CHWs to promote health. They expressed that being trained in behavioral health measures to identify and measure symptoms would benefit them in addressing mental health, and that using a registry to track and monitor clients would be a valuable tool. They thought being trained in psychosocial interventions would allow them to better meet community needs, particularly in areas with limited mental health access, and expressed strong interest in being trained. Many reported not having tools to address mental health beyond basic training in Mental Health First Aid.

Analogous work to BHCM. CHWs felt confident that they would be able to learn and apply behavioral health measures, manage the registry, and learn to deliver psychosocial interventions with adequate training, due to past analogous work they had done as CHWs. In terms of behavioral health measures, many CHWs noted prior experience using validated instruments or monitoring health conditions in other programs. Clinic-based CHWs brought up using these tools for early identification measurement-based care, and not for diagnosis.

In terms of the registry, CHWs expressed tracking social service referrals and clients' health outcomes for grant reporting. CBO-CHWs tended to use simpler tools such as excel, while clinic-based CHWs used electronic health systems.

CHWs reported that they felt with adequate training, they could effectively deliver psychosocial interventions, due to prior experience delivering evidence-based health programs for chronic disease self-management. Most of the time, they did not have ongoing supervision in delivering these programs but noted that receiving ongoing supervision would increase their confidence in this role. Notably, two CHWs reported they were already trained and supervised to deliver psychosocial interventions (PEARLS,[31] PMSB[18]). One was a master trainer for an evidence-based program.

Collaborating with mental health specialists would enhance care. CHWs shared that while they often work on teams, they do not usually work closely with healthcare providers—even those employed in clinics. However, they felt that having weekly case reviews with a psychiatric consultant would enhance care quality and increase their confidence as non-clinicians providing care as they can work with an expert. They also expressed that being on a team with a clinician would increase their credibility delivering psychosocial interventions to other healthcare providers, as they felt that the CHW role was still not well understood or legitimized in the health care system. CHWs emphasized that their closer relationships with clients would allow them to contribute relevant information that providers otherwise would not know that would inform clinical assessments and treatment plans.

A community-based model would increase access and insights. In terms of a community-based CoCM (Fig. 2), participants expressed it would reduce barriers to care and allow them to gather richer observational insights—such as environmental and social factors—that are often missed in

clinic-based encounters. Some CBO-based CHWs noted that their organizations are currently exploring models that promote collaboration between CHWs and healthcare providers. Unlike CBO based CHWs, clinic-based CHWs reported that their organizations had more clearly delineated boundaries of social services versus clinical tasks. They worried that CHWs taking on the BHCM role would overlap with existing clinical behavioral health specialists and felt that bringing care into the community for those with access barriers was a strength.

Concerns and Recommendations for Feasibility

Themes emerged regarding types of CHWs to take on this role, concerns, and recommendations for working with PCPs. Illustrative quotes are shown in Table 4.

Ideal candidate. CHWs suggested intentional role selection. The ideal candidate should be passionate about the work, dedicated and culturally or linguistically aligned with the community and their needs. They expressed that the CHWs workforce is diverse and recruiting those with past professional experiences in behavioral health or clinical support roles would be ideal.

A strong training program is essential. CHWs felt they could do this work as long as they were trained. They felt a training program would provide them with competency and mitigate liability risks.

Funding is needed to take on this role. CHWs noted that CHW work is often underfunded due to its limited integration with insurance reimbursement systems and much of their work is grant funded or part of public health initiatives. There would need to be funding to do this work and enough to maintain caseloads that preserve the quality of client relationships—a key strength of their work.

Coaching clients to manage their health would be more feasible if there were not existing partnerships with primary care clinics. CHWs expressed that the developing team should

provide role facilitation for primary care clinics if CHWs had to communicate with PCPs, because most providers do not understand what CHWs do and undervalue them as health workers who know the community. While CHWs are comfortable communicating with PCPs when necessary, they believe it's more practical—given physician time constraints and their mission to empower clients—to coach clients on how to discuss psychiatric recommendations with their PCPs. CHWs saw greater long-term benefit in fostering client self-advocacy.

DISCUSSION

This study contributes to the growing body of literature on task-shifting in behavioral health and mental health interventions using CHWs in the U.S. by examining the acceptability among CHWs to take on the BHCM role in community-based collaborative model. Participants perceived a community-based CoCM using CHWs to be appropriate and advantageous for addressing unmet geriatric mental health needs. Our data suggest that, given adequate training and supervision, integrating CHWs into collaborative care models could increase access to quality mental health services. Our findings also help inform future implementation barriers to community-clinic linkage models of integrated care.

Our results suggest that utilizing CHWs could be one feasible solution to increase CoCM uptake. Several factors related to the BHCM workforce have been identified as key determinants to successful CoCM implementation. High BHCM turnover rates, insufficient full-time equivalent (FTE) staffing, and the difficulty existing health professionals such as nurses face in adopting the care manager role contribute to a reduced BHCM workforce capacity, [32,33,34] which is associated with poor CoCM implementation outcomes. Training CHWs could increase the BHCM workforce. In this study, CHWs expressed confidence and relevance in being able to perform core BHCM tasks--such as administering behavioral health measures, managing

registries, participating in team-based care, and delivering psychosocial interventions—as either they aligned with past analogous work, or they felt that, given their public health background, they could easily learn these tasks with adequate training. Their responses are supported by studies of lay provider-delivered evidence-based mental health interventions.[35–37] The proposed role differed from these prior studies that trained peers or case managers to deliver psychosocial interventions and provide linkage and referrals, because an expanded suite of tasks and working on a team with healthcare providers would be needed. Unlike other models to reduce depressive symptoms or prevent depression,[18] in community-dwelling older adults,[15,38] the intervention would seek to treat higher severity of depression to remission.

Evidence suggests that SDH account for more of the variability in health outcomes than direct medical care,[6,39] and in a case study of CHWs as BCHM while continuing to address SDH, participants achieved depression remission at a higher rate than the expected, which is one third of the time.[21] Our participants discussed being strong resource for clinical and social services referrals. While such resources included SDH needs, CHWs did not emphasize addressing SDH, which could be because this is an assumed part of their jobs and the interview focused on role expansion. Notably, clinic-based CHWs tended to report feeling underutilized in the their knowledge of community resources and linkage, which suggests that addressing SDH are not well-integrated into healthcare systems. Evidence suggests, however, that, addressing SDH as part of a healthcare intervention could reduce morbidity and mortality.[40]

Community-clinic linkages are promising models to address mental health care through SDH, but infrastructure and implementation challenges to forming sustainable partnerships remain.[41] Participants expressed concerns with communicating with PCPs due to time constraints, PCPs not knowing what CHWs are, and being dismissed as healthcare colleagues.

Instead, participants recommended coaching clients to manage their care instead of CHWs communicating with PCPs, as they felt this would be time-consuming. Implementation of a community/home-base CoCM model into community organizations using case managers utilized this coaching approach.[42] A prior observational study of eight partnerships of clinics that had CoCM and a partnering community organization indicated that addressing SDH might offset less effective/fully implemented CoCM in treating depression outcomes,[43] but that forming partnerships between a community organization and a primary clinic is complex and varied.[44] Participants expressed that infrastructure and role clarity must be present for formal partnerships.

This study adds to the limited literature on geriatric mental health care management interventions in community based settings.[17,38,42] To our knowledge, few other studies have explored the acceptability of a healthcare intervention among community health workers using an established framework. A rigorous analytic approach was employed to interpret the data and provide depth through integration of both deductive and inductive strategies.[29] Stratifying CHWs by employment settings (CBO vs clinic) provided richer understanding of CHWS experiences.

This study had several limitations. One limitation was that the study sample size was relatively modest; however, thematic saturation was reached.[45] As an exploratory qualitative study, our sample size is informed by information power, and not by statistical power.[46] Our sample composed of certified CHWs, who may have different characteristics than self-identified non-certified CHWs, but is representative of the CHWs we plan to recruit in our future studies. We acknowledge, however, that certification limits the available CHW workforce to expand mental health access. Although we use purposive sampling to select for employment setting and working with a geriatric population, participants were selected from a pool that responded to email list-serves recruiting for the study. Therefore, the participants here might likely have

greater interest and more self-efficacy in addressing mental health than that of the general CHW population.

This study provides insights into the acceptability and perceived feasibility among CHWs of expanding their roles to include behavioral health care management in a community-based collaborative care model. CHWs expressed confidence in performing core functions of the BHCM and support for this adapted model in expanding mental health care for older adults. They emphasized their unique capacity to address social determinants of health, foster trust, and be a health literacy/community mediator as strengths they would bring to the BHCM role. These findings underscore the potential of partnering with CHWs to expand access to CoCM for older adults, but partnering with primary care systems would be challenging. Future research should expand on this work to explore the perspectives of CoCM clinicians on the acceptability of a CHW care manager, and infrastructure and role re-designs of CHWs to adapt the BHCM to this workforce. These recommendations would be a crucial next step for expanding the BHCM workforce and reach of CoCM to improve late-life depression care.

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Table 1. Demographics and employment characteristics

Characteristic	N (%) or Median (IQR)
Employment setting	
Social service agency	1 (6.7)
Non-profit organization	8 (53.3)
Public Health	1 (6.7)
Healthcare/clinic	7 (46.7)
Years worked as CHW	
1-5 years	8 (53.3)
5-10 years	2 (13.3)
15-20 years	3 (20.0)
More than 20 years	2 (13.3)
State of residence	
Arizona	6 (40.0)
Oregon	5 (33.3)
Texas	2 (13.3)
North Carolina	1 (6.7)
Washington	1 (6.7)
CHW Certification	
Yes	15 (100)
Educational level	
Some college	6 (40.0)
College graduate	6 (40.0)
Master's degree	2 (13.3)
Doctorate	1 (6.7)
Gender	
Female	11 (73.3)
Male	3 (20.0)
Non-binary	1 (6.7)
Age[*] (years)	48.7 ± 9.2
Ethnicity	
White	5 (33.3)
Black or African American	2 (13.3)
Asian or Pacific Islander	1 (6.7)
Native American or Alaska Native	3 (20.0)
Race	
Latino or Hispanic/Spanish	7 (46.7)
Non-Latino or Hispanic/Spanish	8 (53.3)
Employment status	
Full-time	11 (73.3)
Part-time	4 (26.7)
Consultant	4 (26.7)
Born in the United States	
Yes	12 (80.0)
No	4 (20.0)

Table 2. Themes and illustrative quotes of strengths of CHWs for task-shifting BHCM role

Themes	Illustrative Quotes
Trusted intermediaries	"*At work, they call me the miracle worker. I don't know. I get things out of people that other people can't*." *(Participant 15)*."
Leveraging Community Networks and Lived Experience	"*Another I guess plus or positive to the community health worker role is that we do a lot of networking. And I always say, I would not be able to do my job if I didn't have that network or those collaborators. So for example, with Alzheimer's Association, I know the person by the name and phone number where I could just pick up the phone and say, Hey, John* I have this person in my office. Can you help them out? So we'll do the warm handoff, which I think is very, very helpful and successful in getting patients or people to actually go through and follow up on those referrals."(Participant 12)*
Health Literacy and Community Mediators	"*Depression. Okay. Oftentimes, I may not even say in a Black community, for example, they're not going to say the word depression. You don't say that. 'I'm feeling down feeling a little blue today, not the best day.' I know what that means. And so I'll say that to them, 'today's not the best day.... Okay, let's talk about it. Why isn't today the best day?' .... Now we're saying, okay, now we're on the same page. We know you're depressed." (Participant 1)*

*Pseudonym to protect identity

Table 3. Themes and illustrative quotes of CHWs' attitudes and perceived self-efficacy

Themes	Illustrative Quotes
Mental health needs	*"If we had tools for mental health, it would totally be a game changer because for example, at least the population I'm talking to you about, they don't feel like it's that important to make an off-island trip just for talking to someone or to attend a peer-to-peer meeting, things like that. They're not going to do that." (Participant 2)*
Analogous work to BHCM	<u>Behavioral health measures</u> *"You can't imagine how many things we're doing here. That would be something very simple." (Participant 7)* <u>Registry</u> *"Oh, I love that. Heck yeah, they can do that. They can do that" (Participant 1)*
Collaborating with mental health specialists would enhance care	*"I also think that if it's ongoing supervision, that is incredibly helpful because it's different if you just train somebody and say like, okay, go do it. Because you never know what kind of situations might come up." (Participant 14)*
A community-based model would increase access and insights	*"And I think when you do a home visit, you can learn so much more about the person, their environment, how they're living, the safety. There's so many other things that might be unconscious to the person that is ill. But then when you go there, it's like, oh, okay, now I know why they have difficulty breathing, maybe no ventilation, or there's a dirty carpet and patient is asthmatic." (Participant 10)*

Table 4. Themes and illustrative quotes of CHWs' concerns and recommendations for feasibility

Themes	Illustrative Quotes
Ideal candidate	*"I say you could have people that they get up in the morning, this is what they want to do, and they love their job like I do and they work hard. You got to have some people that really want to do this because you got to be built for this kind of work." (Participant 4)*
A strong training program is essential	*"I think there would have to be more extensive training, I think for that to be introduced into the CHW role for sure. You can't play with that kind of thing. These are people's lives and it should be something that's held to a higher caliber, I think, and more extensive training would absolutely be necessary… I think because we're focused on so much of social support versus mental health support. So I think changing or integrating that with social support, that would have to be a program, I guess. I dunno. Although a lot of us have, we've done the mental health first aid training, that's a requirement." (Participant 5)*
Funding is needed to take on this role	*"And the funding, if it costs us money, we need to be able to find a way to recoup that cost kind of thing without charging our clients." (Participant 6)*
Working closely with primary clinics poses difficulties without existing partnerships	*"I mean, the doctor should know why I'm on this team and why I'm calling him. You know what I mean? There should be that transparency. So we don't have to go into that detail all of every time…I don't see it being a barrier with me. I would see it being a challenge for the providers because they're so short on time, and I get it. They're so busy… And then there has to be set a time, like say, when we get a case, we have 48 hours to get back to the client after we receive a new case through Clara, have everything stipulated already beforehand." (Participant 8)* *"I think there would have to be a buy-in from physicians offices. They would have to be invested in this and really believe in it because yeah, my experience has been sometimes they're just like, because I'm a patient advocate in my role as well, so I do call physician's office sometimes, and sometimes they're just like, who are you? What is a community health worker? They're kind of reluctant to deal with me. Thankfully when I do that, when I'm doing home visits. So I'm able to get the client on the phone to grant permission to talk to me about their health, and then I can advocate for them on their behalf. But sometimes they're kind of nonresponsive. It can feel like you're getting the runaround. So I think there does have to be an effort to educate them on this new way of doing healthcare and collaborating with others to provide the support the patient needs." (Participant 3)*

Supplemental Table 1. Description of overall model and its components

Component	Definition
Behavioral health measures	Administering validated clinical outcome measures that assess changes in symptoms over time to monitor symptoms. *Examples:* • Patient Health Questionnaire-9 (PHQ-9) • Generalized Anxiety Disorder-7 (GAD-7)
Online registry	Utilizing a database that tracks patient information, changes in illness measurements, and contacts with health care team members. *Purpose:* • Practice measurement-based care, or using patient reported measures to track outcomes and inform treatment plants • Monitor and prevent attrition • Improve care quality
Healthcare team	Conducing weekly case review and consultation with a mental health specialist on caseload and as needed communication with a client's primary care provider. *Other team members:* • Psychiatric consultant on regular basis • Primary care providers (PCPs) on as needed basis
Psychosocial interventions	Delivering non-medical, evidence-based interventions that improve depressive symptoms. *In this context:* • Behavioral activation intervention to address symptoms of depression and anxiety • Supervised by mental health clinician
Overall model	Partnerships with CHWs in CBOs on community-based CoCM *Specifically:* • CHW care managers within CBOs • Consultant psychiatrist working with CHWs via virtual case review • Mental health clinician supervising CHWs delivering psychosocial interventions • Mental health team contacting PCPs regarding medications, additional workup, recommendations

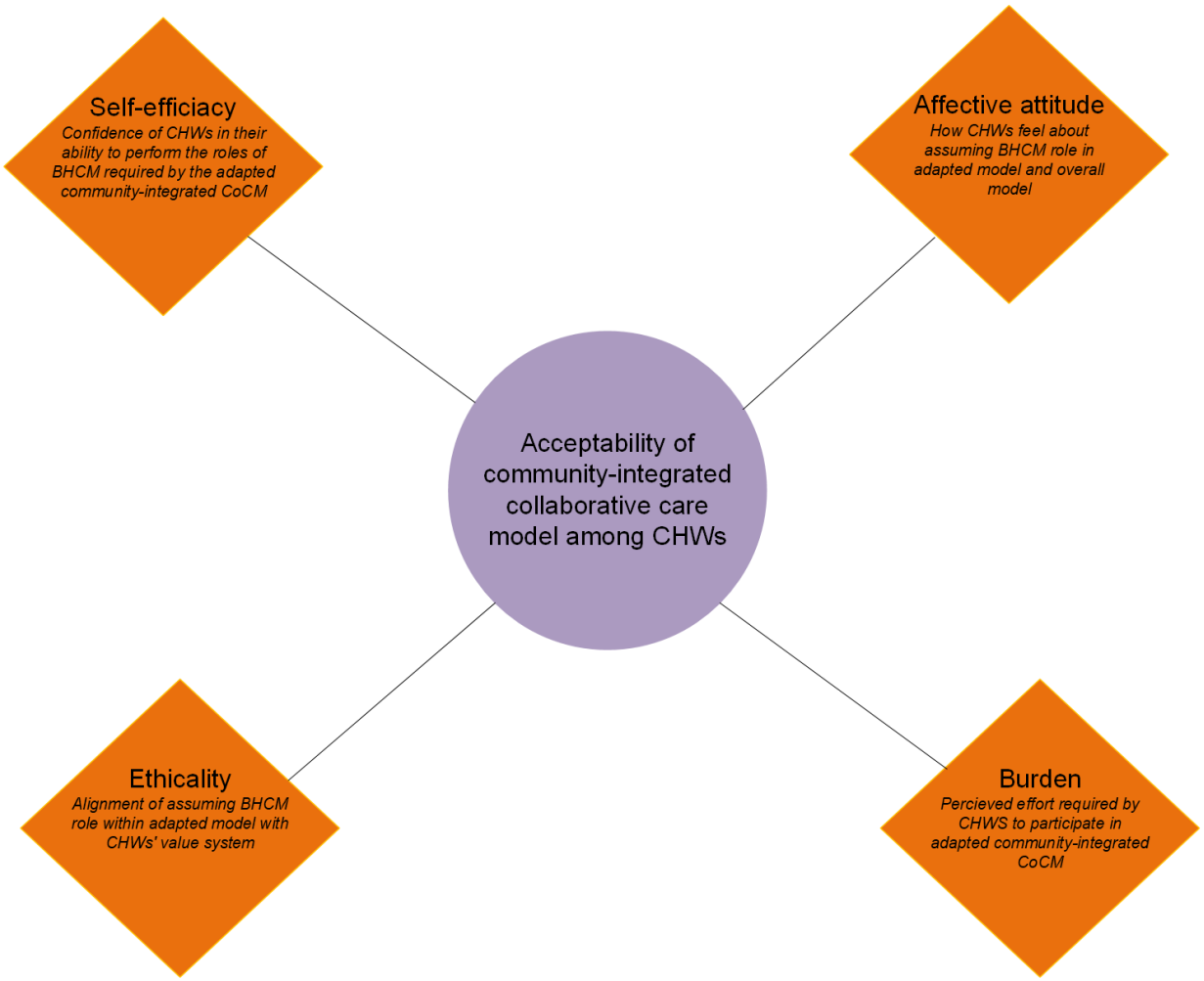

Figure 1. Theoretical framework of acceptability components

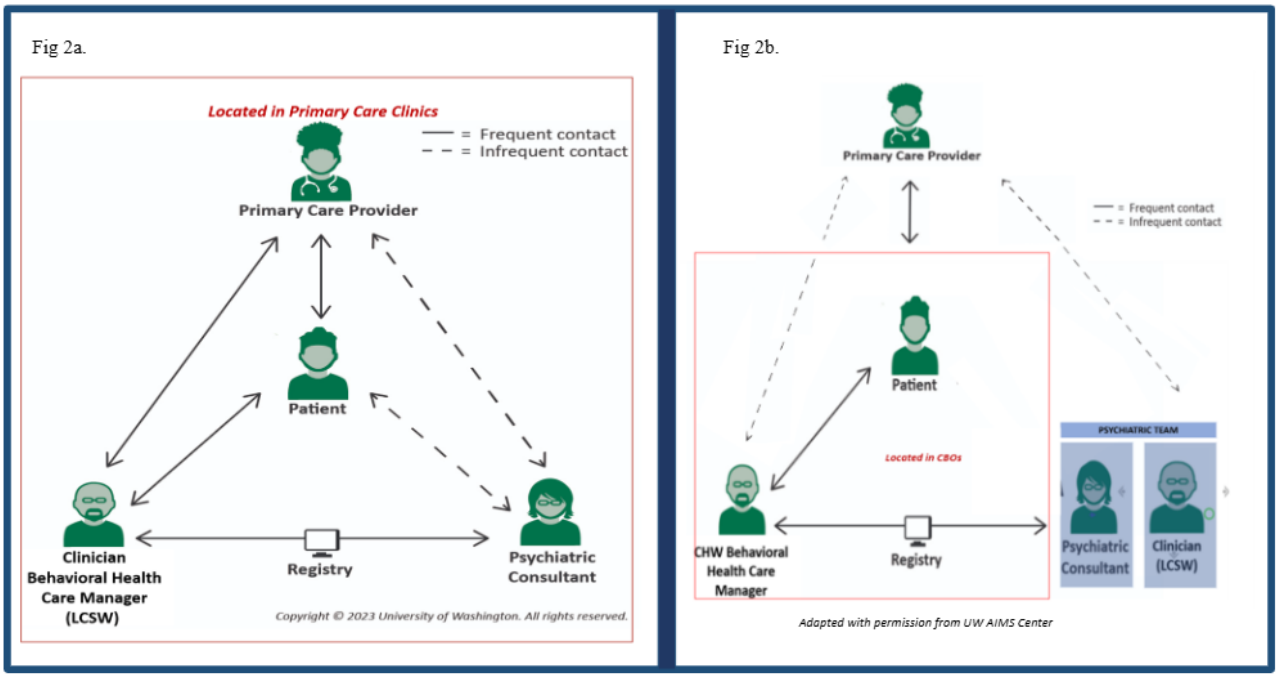

Figure 2. Traditional clinic-based CoCM (Fig. 2a) compared to adapted community-based CoCM (Fig. 2b)