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Leadership Strategies for Navigating the Integration of Physical and Behavioral Healthcare

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This is to certify that the doctoral study by

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and that any and all revisions required by
the review committee have been made.

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Walden University
2025

Abstract

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Doctoral Study Submitted in Partial Fulfillment

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Abstract

The separation of physical and behavioral healthcare and a dominant medical model have left a void in practice and research, especially pertaining to the leadership strategies necessary to integrate the two forms of care in college campus healthcare clinics. This is especially important given the rise of mental health concerns on and off college campuses. Without integration, there are missed opportunities for care delivery, in general, and a missed opportunity for the provision of care to individuals who historically have not accessed physical and behavioral healthcare at equivalent rates as other populations. The subject of care integration is addressed in this qualitative study by reviewing the leadership strategies that may hinder integration, examining organizational barriers to integration, and exploring practices of integration found in the literature. The Baldrige Excellence Framework was used to evaluate the organizational efforts toward and the barriers to the integration of physical and behavioral healthcare in a midsized university health and wellness clinic in the southeastern United States. Data were collected from a semi-structured interview with a leader of the organization, the university website, organizational consultation reports, peer reviewed literature articles, and proprietary organizational materials. This process resulted in 10 recommendations designed to improve integrative care by addressing barriers that are common in the literature. By increasing integration, social change can be realized by creating access to care for students who previously have not been exposed to or sought out behavioral healthcare. This is especially true for those populations that have traditionally been underserved and are historically less likely to seek out behavioral healthcare.

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Section 1a: The Behavioral Health Organization

Introduction

The organization that is the object of this research problem is the health and wellness center of a medium-sized, private university with around 11,000 students in the southeastern United States. The physical health and behavioral health departments are two of three departments within the health and wellness building. Each provides services to full-time undergraduate students and to those graduate students who have elected the student insurance coverage or who are willing to pay out of pocket for services. The assistant vice president of wellness, the behavioral health leader in this case study, oversees both departments. However, each of these departments has its own personnel structure with slight variations appropriate to the profession, and each department has a director who is a medical doctor with numerous staffing levels under their supervision.

The physical health department provides a full range of services including women's health, preventative and episodic care, emergency contraception, various physical health screening services, immunizations, and more. The behavioral health department provides individual, group, and crisis counseling along with case management, psychiatric medication services, and substance use prevention and treatment services. As the university continues to increase its enrollment, the demand for services grows in accordance. Over the past 3 years, each department has added several providers and will continue to do so to meet the needs of the students. Each department's growth has led to an increased need for physical space; this has resulted in the moving of a third department out of the building so that the behavioral and physical health

departments can house the appropriate number of providers needed to meet the needs of the students. These departments have separate but similar missions, visions, and goals that seek to enhance the overall wellness of the university community by providing high-quality care, protecting each student's privacy, and being the student's first choice for behavioral and physical healthcare.

Practice Problem

There is commonly known to be a strong distinction between behavioral and physical healthcare in practice, qualifications, and locale, but integration has been moderate in pace and inconsistent in process. Currently, there is a lack of published research regarding effective integration processes, and there is no existing, unified model of how behavioral and physical health care should integrate (Adler et al., 2023; Staab et al., 2022). This lack of integration can be the cause of missed opportunities at providing comprehensive care by not identifying critical behavioral and physical health issues.

The initial interview with the behavioral health leader detailed how this organization has made attempts at integration that were primarily focused on personnel and not care delivery processes. The lack of integration prompted the leader to hire an external organizational consultant for guidance regarding departmental integration. The results led to separate staffing and leadership structures and a shareable electronic health record system. Since then, there have been no efforts at formalizing the integration of behavioral and physical healthcare.

This doctoral study seeks to answer a variety of questions related to the integration of behavioral and physical healthcare by addressing leadership strategies that

facilitate integration, examining organizational barriers to integration, and exploring practices of integration found in literature. Specifically, this study has attempted to find answers to questions such as:

- What leadership behaviors have contributed to or hindered the integration of the physical health and behavioral health departments?
- What leadership strategies can be used to navigate barriers and promote departmental integration?
- How do personnel and staffing issues hinder or facilitate department integration?
- How do financial issues influence or restrict integration of the behavioral and physical health departments?
- What existing models of behavioral health and physical health integration exist in research literature?
- What additional leadership strategies can be implemented to navigate barriers to integration?

Purpose

To address the practice problem of integrating behavioral and physical healthcare, much information was required given the complexity of each department, the organizational and departmental structures, and the human elements involved. These range from the leadership structure and governance and throughout all other personnel, all of whom play a part in departmental integration. Understanding this, the focus was placed on several key categories found within the Baldridge Excellence Framework:

leadership, strategy, customers, measurement analysis, knowledge management, workforce, and operations. Information was gleaned from the exploration of the core values and concepts such as the organization's visionary leadership, its systems perspective, agility and resilience, organizational learning, its focus on success and innovation, management by fact, societal contributions, ethics and transparency, and, especially, patient focused excellence (Baldridge Excellence Framework, 2021). Each of these categories, values, and concepts holds valuable information that can produce actionable insight into the development of leadership strategies that will help this organization achieve its goal of behavioral and physical healthcare integration. The research questions were addressed through a review of relevant literature, formal and informal information gathering from leadership, a review of policies and procedures, and a review of other pertinent internal data. This information has been synthesized so that actionable steps toward the integration of behavioral and physical healthcare services can be presented to the behavioral health organization.

Significance

This organization has faced issues with integration; therefore, this case study provides further leadership strategies for integrating the behavioral and physical health departments and the care they provide. Previous attempts at integration, even with external consultative support, have resulted in limited departmental and care integration. Continued integration has been voiced as a desire directly by the behavioral health leader. Much benefit can be had by deviating from the common practice of delegation over integration; students will no longer be passed between departments, they will have

informed expectations, and they will reduce the number of events wherein existing conditions are overlooked (Adler et al., 2023). The status quo of the predominating medical model can also be addressed through the process of integration, creating space and processes for behavioral health issues to be appropriately identified and addressed (Chatwiriyaphong et al., 2023). By addressing the issues of delegation and moving beyond the solidarity of the predominant medical model, social change may be affected. While some patients may seek treatment for physical ailments, they may not feel comfortable pursuing behavioral health treatment and the same concerns apply conversely. By integrating these departments, the health and wellness clinic stands to improve the overall level of care provided, and for conditions that may not have previously been acknowledged or addressed.

Summary

This organization has shown efforts at integrating its departments and care; presently, the leader of this organization has directly expressed a desire for improved integration. The organization already has accomplished two steps toward integration that many organizations have yet to realize: collocation and a shared electronic health record. What is lacking has been determined through this process and addressing these areas will improve service provision, increasing the patients' quality of care.

In determining the strategies needed to facilitate integration, one must understand more of this organization. The staffing structures, services provided, regulatory bodies, departmental systems and more must be scrupulously investigated. The achievement of

such provided invaluable steps in the production of actionable strategies toward integration.

Section 1b: Organizational Profile

Introduction

In the U.S. healthcare system, behavioral and physical healthcare are distinctively different in treatment and screening methods and often occupy different physical locations of treatment centers. As healthcare continues to trend toward a holistic approach, the integration of behavioral and physical healthcare becomes prioritized where possible. This is the case for the health and wellness center in question, which is a medium-sized, private university in the southeastern United States. The physical and behavioral health center provides services to all full-time undergraduate students and to those graduate students who have elected the student insurance or who are willing to pay out of pocket. This organization has faced issues with integrating care and despite having made some effort at removing barriers to integration, it has not been successful at enhanced integration. This study was enacted as a result of a qualitative, semi-structured interview with the behavioral health leader who oversees the behavioral and physical healthcare clinic at a midsized private university in the southeastern United States. In combination with the interview, the organization's policies were thoroughly reviewed, and the directors of the behavioral and physical healthcare clinics were informally interviewed as well. Through the processes described, this study answered the research questions.

Organizational Profile and Key Factors

Governance Structure and Relationship to Parent Organization

At the university in question, the office of the president has 10 senior leaders under direct report. Relevant to this research problem is the vice president for student affairs and strategic initiatives. This is the position under which falls the office of assistant vice president of wellness, the behavioral health leader of focus who oversees the medical and behavioral health department, the wellness department, and the fitness and recreation department.

The medical departmental structure contains a medical doctor as the medical director, a doctor of nursing as the director of medical services, nurse practitioners and physician assistants, registered nurses, licensed practical nurses, and medical assistants. The behavioral health department has a medical doctor/psychiatrist as the medical director, a doctor of nursing/psychiatric nurse practitioner, a licensed mental health counselor as the director of counseling, licensed professional counselors with education in mental health counseling and social work, a registered mental health counseling intern, and graduate-level counseling interns.

The university contracts with a local hospital system, which provides behavioral and physical healthcare staff. The parent hospital organization is not involved in the daily operations of the facility and only maintains administrative aspects such as payroll, benefits, and training. The behavioral health and medical departments share an electronic health record system. This is a positive finding as the lack of a common record system has been noted as a barrier to departmental treatment integration (Weston et al., 2023).

While the records are shared, there is only one behavioral health screening tool used within this organization's physical healthcare department, the Patient Health Questionnaire-2, while the behavioral healthcare department uses both the Patient Health Questionnaire-4 and the Patient Health Questionnaire-9. These are brief assessments of mood, anxiety, depression, and suicidality; the numerical denotation represents the number of questions in the screening tool.

Service Offerings

The health and wellness center is committed to actions that benefit the community as well as engaging in activities that better others. The medical clinic provides a full range of services including preventative care and episodic health care to all currently enrolled students and offers wellness services and health information for preventing illness and maintaining an energetic life.

Mission, Vision, and Values

The vision is that student medical services will be the student's first choice for accessible, quality healthcare, education and safety delivered by competent and compassionate professionals. Their mission is to provide students with high-quality evidence-based medical care, behavioral health care, and health education to support collegiate success and sustained wellness. Their values include embracing patient-centered care that is innovative and respectful to the individual patient.

Core Competencies

The medical services department provides multiple services for full-time students including sexual and reproductive health, pharmacy, women's health, rapid laboratory

testing, and episodic care. Counseling services assists students in dealing with the challenges that college life brings. This is a confidential place where students can come to discuss a variety of issues impacting their functioning to ensure academic success.

Part of the focus of this practice problem was to identify a cohesive vision, mission, and values for the behavioral health department. While there is currently no central location for this information for either department, the behavioral health department has multiple, incomplete versions in circulation. This may contribute to the existing barriers to integration of care.

Organizational Background and Context

This organization is a medium-sized, private university with around 11,000 students in the southeastern United States. The physical and behavioral health center provides care services to all full-time undergraduate students and graduate students who have elected the student insurance plan or are willing to pay a fee for service. Exact demographics are not made available through the university website and were only available through third party, online sources and therefore cannot be verified at this time. However, this may be a supplemental recommendation during this analysis. To begin to understand how integration impacts social change and what impacts it has on the student body in general, accurate demographics must be obtained.

In 2013, the organization hired an external organizational consulting firm to examine issues related to the integration of these two departments. While this action produced positive results, it also somewhat reinforced a lack of integration. This process clearly defined separate physical and behavioral health leadership structures and

departmental guidelines, but these actions made it possible for the behavioral health department to operate outside of the predominant medical model. Since that time, each department has run more efficiently but in a nonintegral manner. The physical health clinic provides care to far more students than does the behavioral health. Similarly, the behavioral health clinic provides services to many students who do not use the physical healthcare services. It is only through the shared electronic health record that medical professionals have a glimpse, if completed accurately by the patient, into what mental health concerns the patient may or may not have. This is only effective if the providers check the scores routinely and communicate the results among each other and interdepartmentally. All other information must be gleaned from the provider's interactions with the patient. Additionally, there is no formalized policy for how any behavioral health concerns are relayed to the mental health practitioners nor is there a formalized referral process to the behavioral health department; the same is true pertaining to a process that would screen and refer from the behavioral health department to the medical department.

There is currently no regulatory body, neither from the university nor from the parent hospital organization; this will change as the organization pursues accreditation. However, a lack of accreditation or recent accreditation must be noted in this case study. Further, all revenue is generated through direct insurance billing, with the exception of the rare self-pay student, through the student insurance program, United Healthcare Student Resources. Each full-time student pays for this policy through the payment of their tuition. Therefore, between the university, the hospital, and a third party insurer,

there is no regulatory process for the behavioral health department and limited regulatory measures for the medical department. Of course, each provider has regulatory requirements attached to their licenses and the governmental regulation attached to medical clinics in general, which are monitored by the parent hospital organization. Currently, the physical health department is seeking accreditation and will then be subject to more regulation. The behavioral health department may soon seek accreditation as well, which would lend more regulatory oversight to the accrediting body.

Regarding fiscal resource planning, each department has its own budget that is financed directly through the reimbursement of billable services. Personnel positions are budgeted for in the same manner, but the medical department has a larger and more itemized budget because of the necessary medical supplies and the number and type of staff. The behavioral health department has a limited office supplies budget in addition to salaries; the remainder of the budget is allotted for training, staff development, and annual increases in pay. Any needs arising outside of the budget cycle or those not included in the existing budget must go through a major needs request process explaining the need and requesting additional funds.

Summary

Like most physical and behavioral healthcare organizations, true integration is a new frontier, and the process will pose some challenges. The separation of care present in this and so many other clinics presents missed opportunities for identifying conditions of the body and mind that would not otherwise be addressed. This gap of care may also inhibit underserved populations who are less likely to seek medical and mental healthcare

services. Therefore, this organization's participation and willingness in this case study has offered an opportunity to provide clear leadership strategies for integrating physical and behavioral healthcare. The initial interview with the organizational leader legitimized this practice problem and revealed previous efforts at staffing changes, the creation of a shared records system, and informal communications as the basis for future and present integration.

Section 2: Background and Approach—Leadership Strategy and Assessment

Introduction

Historically, these departments were managed as one unit, from a medical model perspective and by a medical practitioner; this presents a concern (Chatwiriyaphong et al., 2023). The recommendations made by an organizational consultant initially seem counterintuitive. It was determined that the departments needed to be divided and managed by professionals from the respective fields. This division allowed for departmental uniquity, better working relationships, and more collaboration, which somewhat benefited care integration. However, the benefits of this action were limited, and the departments continued to lack true integration of behavioral and physical healthcare services. As discussed, true integration of care has not been achieved within this organization but is still a desired outcome of the behavioral health leader.

Despite major departmental shifts that were brought about by the recommendations of the external organizational consultant and increased collaboration, no formalized service integration plan exists. As a result, there are potentially missed opportunities for early diagnosis of physical and behavioral health needs and certain underserved consumers may also miss opportunities to receive services that they would not normally have available to them or that they would not normally seek. Therefore, the practice problem was addressed by utilizing the Baldridge Excellence Framework (2021) in conjunction with a rigorous literature review which has produced an actionable plan for integrating behavioral and physical healthcare services within this organization. A review of the existing literature dedicated to the integration of behavioral and physical

healthcare services, although sparse, supports the need for a formalized integration approach. The literature, in combination with the results of the Baldridge Excellence Framework (2021), have provided useful steps and strategies for the facilitation of integration. However, these must fit within the leadership structure that is currently in place and must be done in a manner that also fits with the current methods of service delivery and consumer relations.

Supporting Literature

In recent peer-reviewed literature, scholars have noted the lack of research on behavioral and physical healthcare services integration (Adler et al., 2023; Notice et al., 2022). In addition to there being a lack of relevant and current research available, the literature has demonstrated several difficulties and barriers facing the integration of these services. Barriers include the lack of a formalized approach to integration, insufficient training, inadequate or nonexistent screening systems, insufficient funding, separate electronic health records, separate treatment locations, and a preponderance of the existent medical treatment model (Adeniran et al., 2023; Adler et al., 2023; Chatwiriyaphong et al., 2023; Dawson et al., 2023; Lombardi et al., 2023; Menear et al., 2023).

The exploration of literature for this practice problem was completed by searching scholarly databases. Using the Walden University online library, these sources were located within the following databases: American Psychological Association PsychInfo, Psychology, Health and Medicine, EBSCOhost, and Sage Journals. American Psychological Association (APA) PsychInfo is an abstracting and indexing database with

over 5 million documents covering the social and behavioral sciences. Psychology, Health and Medicine is a multidisciplinary journal based in the United Kingdom and facilitates a peer-reviewed forum where practice issues related to medicine and psychological health can be addressed (Scimago Journal and Country Rank, 2024). EBSCOhost is an online research database and platform that is used by institutions of higher learning worldwide. Sage Journals is a publisher of journals, books, and other library resources globally. Search terms for this practice problem included *integration*, *coordination*, *behavioral health*, *mental health*, *physical health*, *medical*, *challenges*, *barriers*, and *difficulties*.

Each article selected has been peer-reviewed and was published within the last 3 years. As stated, the literature has explored several themes related to the integration of these healthcare services. First, several of the authors noted how there was not a large body of applicable literature on this topic. Second, there are no apparent, commonly accepted models of integration available in the literature. This was gleaned from the absence of any mention of such, the few approaches discussed within the literature, the proposition of some new models of integration, and the discussion of numerous treatment settings lacking integration (Adeniran et al., 2023; Adler et al., 2023; Chatwiriyaphong et al., 2023; Lombardi et al., 2023). Third, there are numerous, common barriers to integration such as location, record keeping, funding, staffing issues, existence of dominant treatment models, screening issues, and a lack of sufficient relative training among providers (Dawson et al., 2023; Lombardi et al., 2023; Menear et al., 2023). Fourth, barriers to integration exist across multiple treatment settings. Fifth and equally

notable, none of the initial searches produced any data regarding the integration of university physical and behavioral healthcare services. Additional searches completed later in the study produced one article focused on university clinics such as this, but it sought only to determine and classify the integration status of universities that responded to the surveys and did not speak to integration barriers or methods (Readdean et al., 2021).

The determination from this literature review is that the practice problem, as it relates to this organization, is applicable and that there is a realistic opportunity and need for the strategic planning of integrative services. This requires codified policies and procedures that outline how to screen and refer for behavioral and physical health conditions as well as the process for communication between departments. Additionally, these policies and procedures should prescribe appropriate training requirements for the implementation of screening and referral methods and for the use of a shared electronic health record.

The variety of discussions on integrative services found within the literature articles support the practice problem for this organization, especially as it relates to the vision of the assistant vice president of wellness that was pursued previously but was never seen through to full fruition. The goal of integrated physical and behavioral healthcare services on this university campus houses a large number of prospective benefits for the student population. This will not only serve as a checks and balances system for potential issues that may not have otherwise been noticed but also an access

point for populations that have a history of not utilizing or having access to physical or behavioral healthcare services.

Barriers to the integration of behavioral and physical healthcare services are being addressed in literature but in an inconsistent manner and as a result, no consistent models or methodologies for increasing integration currently exist. This is despite the Substance Abuse and Mental Health Services Administration's development of the Center of Excellence for Integrated Health Solutions, a resource hub providing tools and support for the integration of physical and behavioral healthcare (National Council for Mental Wellbeing, 2024). Furthermore, the process of increasing integration appears in the literature to be in the beginning stages where some researchers are experimenting with nurse practitioner-led clinics, substance use treatment programs, inpatient care facilities, and primary care facilities. Also of importance, none of the research found thus far addresses the topic of integration originating from the behavioral healthcare services side (Dawson et al., 2023; Lombardi et al., 2023; Menear et al., 2023).

Further, the barriers to integration are multifaceted. Adeniran et al. (2023) addressed the perspective of patient and provider barriers such as sociodemographics, legal implications, confidentiality concerns, financial implications, and disinterest. Meanwhile, Adler et al. (2023) focused on a broad perspective barrier, integrating within existing models. The literature continues to support the problem by focusing on integration of behavioral and physical healthcare services in settings such as inpatient medical facilities, pediatric care, federally qualified health centers, substance abuse treatment, primary care, occupational health, mental health inpatient units, and among

rural populations (Adeniran et al., 2023; Dawson et al., 2023; Lombardi et al., 2023; Menear et al., 2023; Nicolotti, 2022; Notice et al., 2022; Utter et al., 2023; Weston et al., 2023). Of special note, it has been shown that in some instances, certain minority populations such as Black and Hispanic individuals are likely to benefit from integrated behavioral and physical healthcare through behavioral health screening and engagement efforts that occur during their physical healthcare visits (Woodward et al., 2024). Therefore, the existing literature has provided data and has highlighted a lack of data pertaining to this practice problem. This was done by exploring various aspects to integration, detailed barriers to integration, and most importantly, by underscoring the absence of literature addressing the problem of integration. The absence of a common approach to integration and the identified need for the integration of physical and behavioral healthcare services across a wide array of treatment settings, further underscores the pertinence of this practice problem.

Sources of Evidence

The production of an actionable plan for the integration of behavioral and physical healthcare services will require multiple approaches of information gathering, research data consultation, and solution generation. The Baldridge Excellence Framework (2021), data gained from the interview of the organizational leader, and an in-depth synthetization of the available literature led to a plan for integration for this organization.

Interviews conducted with the behavioral health leader were completed using a semi-structured approach that allowed for much open dialogue. The questions were

designed to gain an understanding of what is and has been the biggest concern facing this organization in recent history, what has been done to remedy these issues thus far, and what the assistant vice president of wellness envisions for addressing these issues long term. The results of the interview provided a greater understanding and clearer perspective on the practice problem. The data collected from the interview and the literature were processed as part of the Baldridge Excellence Framework (2021) and then used to create a plan of action that will promote facilitative processes and remove barriers to the integration of behavioral and physical healthcare. Previous organizational consultation data were provided in tandem with the interview; this consultation addressed broader barriers to integration but did not provide a method for ongoing improvements for the integrative process. A review of the data gained from the interview in conjunction with the information in the organizational consultation provided insight into the practice problem and was used to build current recommendations that address strategic planning for the integration of behavioral and physical healthcare services at this organization.

Leadership Strategy and Assessment

Each department has well-structured and clearly defined roles and expectations for service delivery that have been determined by the university and enacted by the hospital personnel. Additionally, both departments are working toward accreditation with a recognized collegiate behavioral and physical healthcare accrediting body. As a result, there have been few personnel management issues, but when they arise, the leader expects to be informed but allows the department heads to manage them.

At a minimum, the organization leader meets with the departmental heads once a week and stays in additional contact as needed. Quarterly, the parent hospital organization meets with the organization leader and the department heads to discuss contract agreements and expectations. The organizational leader takes a somewhat laissez-faire approach to the management of the behavioral and physical health departments; this is in part due to her leadership style and in part due to her ability to trust her departmental leaders who are seasoned professionals within their fields. She has also worked with one of the department heads for over 10 years and this is a contributing factor supporting lower amounts of oversight.

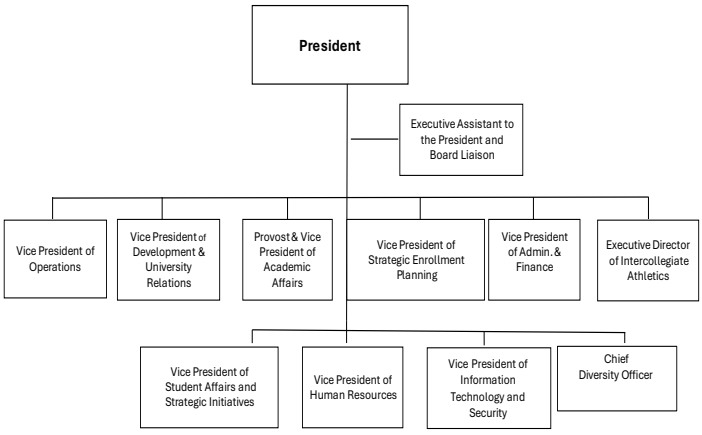
There are limited formalized methods for developing strategy within this organization; this will serve as a nonessential recommendation at the close of this practice problem. What may be considered strategy planning is the annual reporting process during which the department heads are required to produce short-term and long-term goals, learning objectives, and departmental outcomes. Although these may not directly impact the strategic processes of the larger organization, the organization uses the departmental annual review process to identify potential strategic changes, goals, and/or outcomes. If actionable changes are identified, policy changes can be implemented through the chains of command described below.

The office of the president of the university has the following 10 senior leaders under direct report: vice president of student affairs and strategic initiatives, vice president of strategic enrollment planning, vice president of administration and finance, vice president of information technology and security, executive director of

intercollegiate athletics, vice president of human resources, provost and vice president of academic affairs, vice president of development and university relations, vice president of operations, and chief diversity officer. Under the vice president of student affairs and strategic initiatives falls the office of assistant vice president of wellness; this person, my organizational behavioral health leader, oversees the Medical and Behavioral Health Department, the Wellness Department, and the Fitness and Recreation Department. The assistant vice president has the authority to implement most strategic steps on her own authority with exception of items that exceed the budget, impact the physical space on campus, or directly impact the larger university community and/or the president. These items require more than just the relational, laissez-faire, and mutual understanding approaches from which much of the university operates. However, these processes are not codified outside of the structure described above and displayed in Figure 1.

Figure 1

University Senior Staff Organizational Chart



Regarding the departments whose responsibility falls under the assistant vice president, as is the case with senior staff decision-making processes, there are also formalized organizational structures that lack codified strategic planning and implementation processes. As was previously noted, the medical director is a licensed physician under whose purview the other providers practice. Daily operations, strategic initiatives, and planning are conducted by the director of medical services. As is the case with the physical health department, the medical director for the behavioral health department is a licensed physician who is a psychiatrist, under whose purview the other providers practice. The director of counseling services conducts daily operations, strategic initiatives, and planning for the behavioral health department.

Figure 2

Physical Healthcare Department Organization Chart

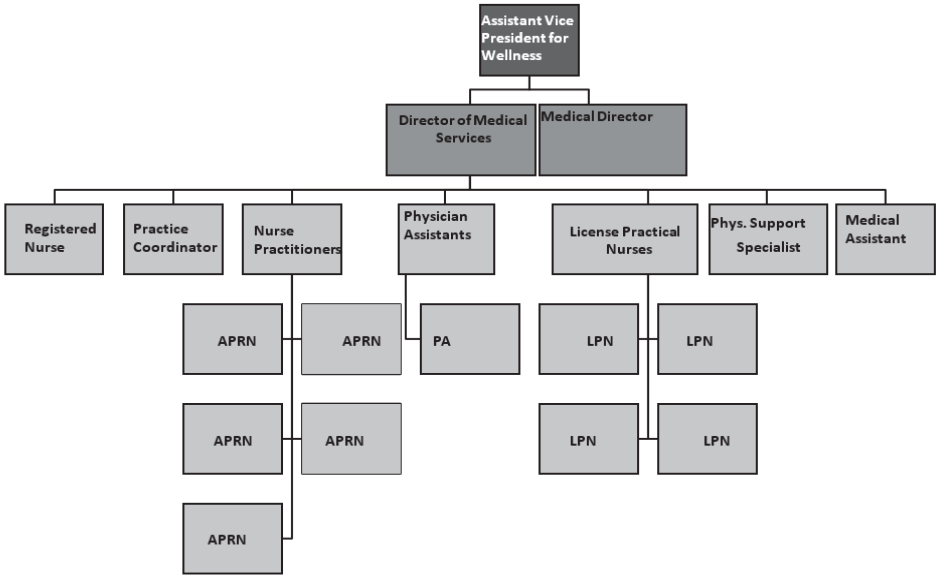
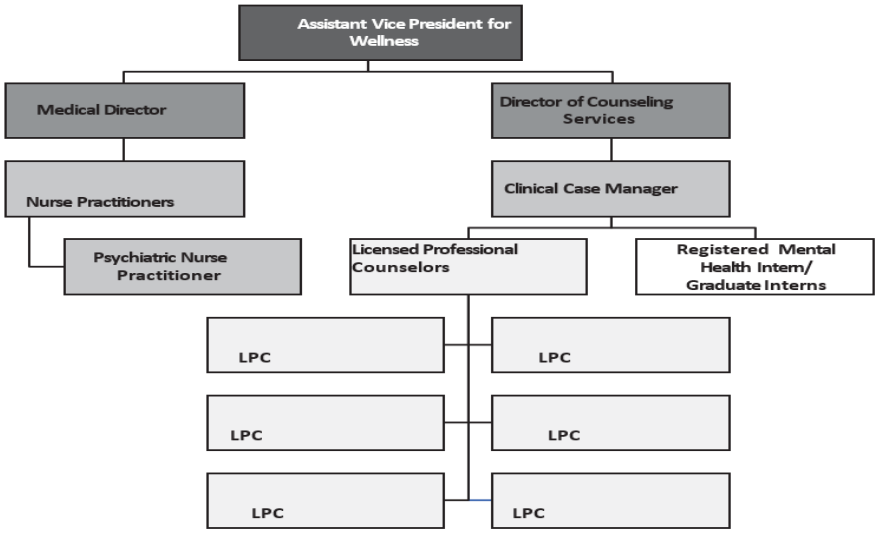


Figure 3

Behavioral Healthcare Staff Organization Chart



Given the depth of these departments and the number of personnel involved in strategic planning, the need for formalized interdepartmental strategic planning and development becomes ever more apparent. Without these processes in place, the organization risks missing opportunities to best serve its students by not having a consistent method of evaluating services provided nor a forum to generate and initiate new concepts. This, along with a host of other issues that may come from inconsistent review and growth processes, could be remedied in an integration based strategic planning and implementation process in addition to the organization's policies and procedures.

Clients/Population Served

There are currently 11,047 students enrolled at this university, all of which are eligible for behavioral and physical healthcare services at the on-campus health and wellness center. Full-time undergraduate students receive free care on campus through their student health insurance; this is also true for all full-time international students. Part-time undergraduate and domestic graduate students have the ability to opt into and purchase student health insurance or to pay a fee for service. Exact data for these respective categories is not readily available on the university website nor third-party demographic reporting sites. According to one unnamed reporting site, 87% of the student population consists of individuals under the age of 24, indicating a majority of students are undergraduates and, therefore, eligible for free services at the campus health and wellness center.

The physical healthcare department acts as a primary care provider for students while they are away from home; students can receive services such as vaccinations, women's healthcare, complete blood panels, sexually transmitted infections testing, viral testing, and referrals for imaging and other specialized services. Although students can initially be seen for urgent care concerns, they will be referred off campus for treatment; the physical healthcare department is bypassed in the event of emergencies.

The behavioral healthcare department treats all manners of psychiatric disorders, according to severity levels. However, predominantly, the most common presenting issues are anxiety, depression, adjustment issues, and disordered eating issues. If a student's treatment needs are deemed to be beyond the scope of the behavioral healthcare

department, they are referred off campus and, if needed, family involvement is encouraged. In severe situations, students can be involuntarily hospitalized for immediate higher level behavioral healthcare treatment.

Basic information on students is obtained through a data syncing process that enters their enrollment information into the electronic health record using Workday, a workforce/data management program. This includes basic demographic data such as sex/gender, race/ethnicity, international status, first generation student status, physical address, contact information, and emergency contact information among other data.

The physical healthcare department sends students an at home medical history form that they must complete prior to being seen in the office. The behavioral healthcare department first has a triage call with students to learn about their needs and presenting issues. They then meet with a counselor, in person, and complete a comprehensive biopsychosocial wherein much pertinent data is obtained about their lives and presenting issues and concerns. Additionally, each behavioral healthcare appointment is prefaced by two screening forms, the Patient Healthcare Questionnaire-4 and the Patient Healthcare Questionnaire-9; these are used as screening tools for anxiety, depression, and basic neuropsychological dysfunction. The physical healthcare department uses one behavioral health screening tool, the Patient Healthcare Questionnaire-2; the number of questions asked of the student corresponds with the name of each of the screening tools. According to the interview with the behavioral health leader of this organization, there are no current formalized processes to determine and track the precise number of behavioral health diagnoses and the same is true for physical health conditions. Although there is not a

consistent need for this information, it will benefit the health and wellness department by better informing practice provisions and available services.

Students are engaged via on campus tabling events wherein physical and behavioral healthcare staff host information tables in common, high traffic areas on campus. These moments provide information through direct conversation, handouts, flyers, and business cards. Students are sometimes engaged in the classrooms during their mandatory, introductory new student courses wherein they learn about many of the services the university has to offer. Some student workers are also engaged during mass resident advisor training; information is then disseminated from the resident advisors to the residents on their floors. There are additional informative videos about the services provided by both departments on the university website. As this university is primarily a destination university, the orientation process is conducted solely online and is mandatory for all incoming students; during this process they will also be furnished information about on campus services.

Currently, the university behavioral and physical healthcare departments are not meeting the outreach requirements set forth by accrediting body of which formal accreditation is pending. There are also no formalized policies or procedures indicating a need or requirement for outreach to the students. The behavioral health leader has expressed a strong desire to formalize these and increase the campus outreach processes as she recognizes the lost potential caused by the barriers to integration of care provided in this center.

Analytical Strategy

The nature of this project was that of a qualitative case study on a behavioral health organization, a college health and wellness center, and its ability to integrate care with the physical healthcare department within the same center. The role of the researcher took that of a scholarly approach to organizational consultation specifically as it relates to the concept of integration of behavioral and physical healthcare. With the number of U.S. college students facing increased mental health issues, approximately 50 percent with 83 percent experiencing a negative impact on their academic performance, the benefits of integrating these forms of care are supported and evident (Ulupinar, & Zalaquett, 2022).

Information was gathered through a semi-structured interview with the leader of the organization, the assistant vice president of wellness. This information illuminated a longstanding area of concern for the wellness center in that full integration of services has not been achieved despite years long efforts, collocation, and a shared electronic health record system. Insights collected during the interview were examined in conjunction with data from a previous external organizational consultation, a review of all departmental policy and procedures, and an in-depth review of organizational systems and structures through which gaps and barriers to integration surfaced. The aforementioned data, processed using the Baldridge Excellence Framework, has provided a pathway to bridging gaps and eliminating barriers to integration of behavioral and physical healthcare within this organization (Baldridge Excellence Framework, 2021).

Summary

The practice problem being addressed in this case study is one of limited integration of behavioral and physical healthcare within a university health and wellness center. The cause of which relates to previous progress made toward integration with little to no follow up action supporting continued steps toward integration. The literature supports that these limitations of integration may adversely impact college students and more so for some minority students (Ulupinar, & Zalaquett, 2022). Historically, this organization has done well at integrating organizationally but not in practice. College health centers are trending toward organizational integration wherein the behavioral and physical healthcare departments are working under similar or related organizational structures but without any policies that call for the integrative practice of care (Readdean et al., 2021). The information gathered from interviews, departmental review, applicable literature, and previous organizational consultant recommendations has been synthesized using the Baldridge Excellence Framework. Recommendations have been developed regarding policy planning, screening, training, and more.

Thus far, preliminary suppositions indicate that the success of this organization is in part the cause of the non-addressal of the existing barriers to integration. This organization has positive working relationships between departments that promote informal integrative processes that have worked without any major missteps. However, this is cause for concern as there are gaps in integrative care resultant to a lack of policy on activities that promote integration, some of which may not ever be recognized due to the lack of formalized integration policies and procedures. This has gone overlooked due

to the success of the organization; however, it is difficult if not impossible to ascertain what opportunities for integrative care have been missed. Furthermore, what help has not been provided to the student population through these missed opportunities? Without addressing these concerns, the university could continue successful operation but would run the risk of not providing the best care possible to its students. The development of a strategic plan addressing these gaps and barriers to integration would address the longstanding concerns of the behavioral health leader and best serve the student population, including the traditionally underserved, who are historically less likely to engage in behavioral health services. If the university is to house a truly integrated physical and behavioral healthcare clinic, remaining in situ is not feasible.

Section 3: Measurement, Analysis, and Knowledge Management Components of the Organization

Introduction

The Baldrige Excellence Framework was used to complete an internal evaluation of organizational integration among behavioral and physical healthcare departments at a health and wellness clinic at a moderate sized university in the southeastern United States. This was the result of an informal, semi-structured interview with the organizational leader. From this interview, the practice problem related to barriers to care integration was determined to be important to the leader for the functioning of the clinic and the students it serves. Based on the Baldrige Excellence Framework, an organizational profile was developed and the organization as a whole was then analyzed according to 17 additional health care criteria items. This information was synthesized in tandem with information gathered from the interview and subsequent interactions with leadership and recent literature on the subject. Additionally, information was obtained from internal organizational documents. The current state of operations where the center is overseen by a university administrator and the assistant vice president of wellness and operated contractually through outsourced physical and behavioral health services has been in effect since 2016. This categorizes the clinic as organizationally integrated, despite there still being many barriers to care integration (Readdean et al., 2021).

While there are informal practices supporting warm handoffs, referrals, and a shared electronic health record, there is a lack of formal policies pertaining to the training of personnel on integrative practices and a lack of procedures for effective sharing of the

electronic health record, screening, referral, and care coordination. Given the volume of services provided in this clinic and the number of personnel involved in service delivery, there is a high probability of missed care delivery opportunities, primarily unaddressed behavioral health concerns that could be identified and addressed during physical health interventions. The positive functioning and working relationships between the two departments are suspected to be some of the main proponents of continued barriers to the true integration of services. While the informal processes reflect positively on care provided, it is difficult, if not impossible, to determine the number of missed opportunities for integrated service delivery. While the assistant vice president of wellness is pleased with the operation of the clinic, she understands the opportunities at stake. Providing the most comprehensive care to the university students prompted inquiry into current practices related to the integration of care. The implementation of the Baldridge Excellence Framework has illuminated gaps in formal policies and procedures that would institute integrative practices, directly addressing the practice problem in question (Baldridge Excellence Framework, 2021).

Analysis of the Organization

Workforce, Operations, and Development

The clinic provides over 10,000 combined physical and behavioral health services annually with the majority of these taking place during the fall and spring semesters as this university is a destination school with low summertime enrollment. Services are provided by approximately 20 to 25 personnel equally divided between the two departments.

The capability and capacity of the organization's personnel is first determined through the standards set forth in the job requirements description and those are then evaluated during multiple interview processes. The parent organization, a local hospital system, is responsible for degree and license verification in addition to background screening. All human resources responsibilities are managed by the hospital, and job postings are included in this process. While there are many benefits of the outsourcing model used in this clinic, some issues arise related to recruitment and hiring of behavioral health staff through the hospital, and there has been mention of using a third-party organization that deals specifically with the recruitment of college behavioral health staff as it is not intuitive to apply for a college behavioral health position on a hospital website. Furthermore, there have been historical issues with the job postings when managed by the hospital human resources system.

The parent hospital organization's control and maintenance of all activities pertaining to human resources dictates that it oversees nearly all aspects of workforce management, retention, and development. This is achieved through various offerings such as an annual professional development reimbursement with an annual maximum amount of $3750 at the time of this writing, tuition reimbursement offerings with an annual maximum amount of $5400, a dedicated institution for team member growth and development where employees can choose from a variety of training areas that meet their personal and/or professional interests, up to 3 paid professional development days annually, and annual reviews and compensation increases. Retention is encouraged through this benefits package, training stipends, tuition reimbursement, and a hefty,

accrued time off policy. Additionally, the hospital conducts annual Press Ganey surveys where team members are provided a space to evaluate their supervisor, team, company, and personal satisfaction in their role. However, this is all a product of the parent hospital. The university has a higher turnover rate than that of the wellness center, so these concepts must be looked at independently of the university human resources processes while maintaining focus on the university as the primary behavioral and physical health organization. The university may be able to gain a better understanding of what it takes to reduce turnover and increase retention by examining the hiring and retention practices of the hospital with a long-term goal of mirroring some of the policies. However, there are clear benefits of having these specialty services outsourced as many colleges do, such as competitive salary offerings, assignment of liability, and the team member benefits (Readden et al., 2021). This is information that can be clarified through ongoing discussions and nonessential adjunct recommendations furnished to the assistant vice president of wellness.

As there is some existing collaboration among these departments, there are more opportunities for improvements in workforce engagement, which will provide pathways to providing the best treatment to the students as well as the development of a more unified working relationship between departments. As was alluded to, the biggest issues related to a lack of collaboration are unseen until a bigger issue arises. As has been the case for most of medical history, collaboration between physical and behavioral healthcare has been mostly non-existent and seemingly inconsequential. However, as knowledge about the connections between physical and behavioral health issues has

grown, the missed opportunities for treatment have been realized. Therefore, it is the desire of the organizational leader to close the gaps and remove the barriers to integration so that this center can provide a higher standard of care.

Service Design and Management

The university's behavioral and physical healthcare departments offer services that are common to industry standards; however, specialty care can be added to the delivery service options based on need. This may be a separate area needing to be addressed if this organization is going to move away from a reactionary service design and management model. The university must learn to navigate the balance of moving away from a reactionary model and the dangers of overcompensation in service delivery options. Currently, there are considerations for adding service delivery questions to the customer satisfaction surveys being disseminated. This will allow a more informed decision-making process surrounding the existing service design which can directly impact integration efforts.

Organizational Operations Management

This is yet another area that is managed via mostly informal processes in both departments, with the exception of higher levels of management. The sole formalized process ensuring effective operations management is the weekly staff meetings. All other operations management processes are informal and occur through daily staff interactions that reinforce existing policy. The pending accreditation process will be addressing this issue through the installation of required formal peer review processes, more detailed and documented management meetings, and policies supporting such.

In reference to upper management, formalized processes include weekly, monthly, quarterly, and annual meetings with directors, hospital department managers, and university officials. These occur outside the scope of the accreditation process and should be reviewed and addressed as part of the recommendations proffered. Minimally, recommendations could be made for formalized interagency policies ensuring such meetings take place. Lastly, the results of the Press Ganey annual surveys are reviewed with each department and improvement goals are mandated. This serves as an internal source of recommendations originating from staff rather than consumers.

Knowledge Management

Organizational Measurement and Improvement

Presently, there are no systems in place regarding the measurement and analysis of performance improvement and outcomes. A new customer satisfaction survey is currently being implemented. Recently, adjustments were made to it to include the addition of a service integration question. The results of this survey will be reviewed during periodic peer reviews and annual expectations and outcomes meetings. The customer satisfaction survey will be emailed to each student automatically through the electronic health record system; this will occur at the time the clinician finalizes the visit note. Survey question topics include provider competency perception, attentiveness, helpfulness, and knowledge. An integration question was added and inquires if the physical healthcare provider addressed the student's mental health at any point during their health visit. This will better inform the level of integration or barriers should the university implement the recommendations from this study. Although, it is likely that this

part of the survey will undergo continued improvement and revision. The original survey which was replaced by the most current version mostly addressed issues such as wait time issues and preference of telehealth. The ending of COVID-19 conditions and the addition of several team members and interns have rendered this survey obsolete, creating the need for an updated survey. This survey was also operated through a free online survey tool company; the new survey utilizes a survey program provided by the university ostensibly keeping the information more proprietary. Given the newness of the customer satisfaction survey, use of the data will be limited to the individual departments with the exception of being shared at some university level meetings. Among providers, the results will be reviewed, and adjustments and improvements will be made accordingly. Regarding this health and wellness center, there is no organizational measurement system in place at the parent hospital organization level.

Organizational Proprietary Assets Management

All computer hardware and software are owned or licensed for use by the university and then provided to the clinics for use. The university also contracts with an electronic health record platform called Medicat; this contract is set to expire in the summer of 2025, and a new web-based, single sign on platform called Pyramed will be put in place. There are no hard copies of patient records, and the system automatically purges records from the primary system once students have been inactive for 7 years. The parent organization does not involve itself with any of these details but is responsible for office supplies, ergonomic equipment requests, and miscellaneous breakroom items. The university information and technology department maintains data security related

operations and training. Both the behavioral and the physical healthcare departments store primary information that is relevant to operations, staffing, and procedures in a cloud storage system, specifically OneDrive/SharePoint, which is managed by the parent hospital organization. The university has similar information, in different formats, stored in another cloud storage system, DropBox/SharePoint. The OneDrive/SharePoint can be accessed through each employee's parent hospital email; the DropBox/SharePoint can be accessed through the university email system. However, specific permissions are required to access certain documents. All information within the cloud storage system has a hard copy that is kept on site in multiples.

Regarding knowledge assets, the behavioral healthcare department has an informal policy on sharing knowledge, skills, and abilities that are gained during staff training and skill building. As discussed, all staff are encouraged to utilize the skill development budget by attending certifications and workshops. This information and any relevant materials are offered to the other team members.

Summary

The health and wellness clinic at this university has faced challenges to being fully integrated since its inception over 20 years ago. In the last 10 years, strides have been made regarding the integration process, but there are still barriers to the full integration of the physical health and behavioral health department. Overcoming these barriers to integration are the object of focus for this practice problem. Without formalized systems addressing measurement, analysis, and organizational performance, it has been difficult to determine any deficits in the current integration model. However,

this case study has shown that the lack of deficits has contributed to the perception of a lack of necessity for further steps toward integration. Therefore, the measurement of treatment outcomes and integrative efforts should be used to better inform current and future integration efforts.

Section 4: Results—Analysis, Implications, and Preparation of Findings

This study was enacted after a qualitative, semi-structured interview with a behavioral health leader who oversees the behavioral and physical healthcare clinic at a midsized private university in the southeastern United States. In combination with the interview, the organization's policies were thoroughly reviewed, and the directors of the behavioral and physical healthcare clinics were informally interviewed as well. The evidence obtained corresponds with the literature in that this organization has many of the same barriers to integration as well as facilitating factors as do other facilities discussed in the literature. The issues in this organization align with those in the articles, specifically related to the appropriate use of the electronic health record, adequate training, and formalized referral processes among other things.

The information gathered was synthesized along with data from recent literature on the integration of medical and behavioral health services across a variety of settings. The interview revealed a multi-year effort at integrating services within this clinic, which produced some organizational changes that have served to somewhat reduce barriers to integration. However, after some progression toward integration by utilizing organizational restructuring where each department was given its own leadership structure, as opposed to one medical model driven structure, and the addition of a shared electronic health record, there has been no more movement on the remaining barriers to integration. The success of the clinic contributes to this lack of progression toward integration. There is much informal communication between the personnel in each department that has produced positive results for those students who utilize both services.

For instance, informal discussions with department heads and personal knowledge revealed that it is not uncommon for a medical provider to call a behavioral health provider when concerns for the student arise during a physical healthcare appointment. Additionally, some physical healthcare student patients have been informally "sent" down to the behavioral healthcare department with an email or phone call being the closest representation of an official referral. These kinds of collaboration resulting from a shared electronic health record and collocation have been beneficial for the student and act as a testament to the potential for enhanced integration of physical and behavioral healthcare services. But the positives that have come from these successes have diffused the perceived need for formalized processes that will ensure increased integration. Policies on certain processes will ensure all staff from both departments will be trained in certain screening tools, how to communicate needs between departments, and how to refer students between departments, among other things. This will mostly require new policies and additional training. Eventually, systems will need to be in place to track and monitor students who receive integrated care so that the benefits of integration can be better understood.

Information that was synthesized from the literature review was compared with interview results and organizational policies and procedures. This process illuminated barriers to the integration of behavioral and physical healthcare. These barriers were discussed with the director of the behavioral and physical healthcare departments, neither of whom are the original organizational interviewee, to generate concepts for the removal of previously mentioned barriers and to increase integration.

Throughout the progression of this study, the organization began pursuing an accreditation primarily for the medical clinic. However, this accreditation has a strong behavioral health component specific to clinics that are collocated on college campuses. This has contributed momentum to this practice problem and aligned with the timeframes for recommendation and implementation as well.

Analysis, Results, and Implications

Organizational measurement and improvement actions have been implemented in the form of a customer satisfaction survey. Statistical analysis has been completed regarding student usage of services and customer satisfaction; however, this has not been completed since the revamping of the satisfaction survey discussed previously. This is a recently updated process that will entail regular review of received feedback, likely occurring at the close of each semester. The results are discussed in a peer review fashion using a triadic structure and are also relayed to the director of each clinic. The results are also shared with the university's office of professional development.

The only key finding currently available is that the clinics have never attempted to measure or officially understand, in any fashion, the barriers to integration nor the level of integration. Since the time the departments were given separate organizational and leadership structures, it has been assumed that integration was being achieved because of collocation, shared electronic health record, and informal communication between departments. Based on the information gathered for this study, steps can be taken to better understand the level of integration presently being attained and how this can be improved upon. Formal recommendations discuss the need for evaluative methods that

will closely look at how the providers are trained, how students are screened, and if appropriate action is being taken to ensure students are being correctly referred to the requisite services.

Client Services and Proposed Initiatives

Through document review, a semi-structured interview, informal conversations, and personal observation, it has been determined that the university physical health department provides a full range of services including women's health, preventative and episodic care, emergency contraception, viral and contagion care, various physical health screening services, and immunizations. What cannot be provided within the clinic is referred out to more specialized community care. The behavioral health department provides individual, group, and crisis counseling along with case management, psychiatric medication services, and substance use prevention and treatment services. A range of focus areas are treated within the behavioral health department to include grief, anxiety, depression, adjustment issues, and traumatic experiences such as sexual violence, all forms of abuse, addiction issues, disordered eating, and psychiatric medication management. Additionally, there are varying levels of case management that can involve the student's family, faculty, or social systems. The severity of these issues and the level of care is determined on a case-by-case basis, and if the client's treatment needs exceed those of the capabilities of the behavioral health clinic, off campus referrals are made for higher levels of care.

Client Focused Results

How the data obtained from the satisfaction surveys will be used has yet to be determined, and a review of the policies and procedures determined that there are no processes in place for how this data will be used. Clinic usage data is primarily used for reporting and budgeting purposes but was recently used to determine whether there was a need for increased office space and an increase in service providers. However, this was an ad hoc process but provided some insight into how client-based data can be regularly used and in a predetermined manner. Much of the response to community needs is reactionary rather than preparatory at least in part to the lack of formal processes aimed at better understanding the needs of clients and implementing initiatives to address them.

Workforce Focused Results

The university encouraged staff development by offering a robust annual professional development package with reimbursement up to $3,750, tuition reimbursement up to $5,400, a dedicated institution for team member growth and development where employees can choose from a variety of training areas that meet their personal and/or professional interests, up to 3 professional development days annually, and annual market reviews and adjustments as well as annual reviews and compensation increases. Retention is encouraged through this benefits package, training stipends, tuition reimbursement, and a competitive accrued time off policy.

Despite the staff development and retention programs, it is unclear how the feedback received from clients will be used to improve the organizational workforce results; the same is true for how this information will be used to improve the

organizational client-focused results. Perhaps the service providers, when using staff development funds, can be mandated to include physical and behavioral health integration related training programs. What is more likely is that the organization will welcome mandatory training on screening and integrative procedures as part of the annual or semiannual training programs, aside from the professional development benefits. This indicates that more needs to be accomplished by codifying a process that will effectively utilize the workforce development and client-focused data to improve the integration of services and service delivery in general.

Lastly, an additional factor was introduced to this practice problem not through literature, the interview, nor the Baldrige Excellence Framework. The university has begun pursuing accreditation of this clinic and one requirement of this is some level of integration of physical and behavioral healthcare. This has supported the convergence that was already occurring and reinforced the legitimacy of the practice problem.

Leadership and Governance Results

Review of the organizational structure documents revealed detailed information about the hierarchy within the university and the individual clinics; the organizational structure of the parent hospital organization was not examined as its structure is not pertinent to the practice problem. Additionally, personnel evaluation tools and processes were examined and revealed a system that does not use regular evaluation methods and relies solely on annual evaluations. Training protocols were reviewed, but not in depth, and it was determined that there is no organizational training specific to the integration of behavioral and physical healthcare. Lastly, review of the organizational policies and

procedures revealed an absence of formalized policies related to integration. This appears to be a result of the organizational leader and these departments having achieved some progress in the area of integration. The behavioral health leader recounted a history of such disarray amongst these departments that she felt it necessary to hire an external organizational consultant to address those issues. This process resulted in the organization's current status of partial integration. This partial integration is resultant to the separation of departmental leadership, a removal of the medical model within the behavioral healthcare department, and the addition of a shared electronic health record. Since then, the organization has not made any more effort toward integration and has not implemented any processes that would determine the effectiveness of the informal processes that are currently considered integrative.

With exception to the hierarchy and the organizational structure, all other aspects aligned with the barriers noted in the literature. None of the reviewed existing literature, thus far, directly addresses leadership in relation to the integration of behavioral and physical healthcare. From this information, the gaps in training and policy are discussed in relation to organizational leadership. Organizational leadership and its impact on policies and procedures will be the avenue by which many of the recommendations should be implemented, recommendations that will directly address barriers to integration.

Financial and Marketplace Performance Results

This organization is in a unique position which has been briefly touched upon in this proposal. The university does not have the same financial and market experience as

other organizations because of its' arrangement with United Healthcare Student Resources (UHCSR) and due to the expectation of service provision for students regardless of traditional revenue concerns. However, there is still the issue of financing the organization's budget which occurs through the reimbursement of services by UHCSR.

The university's arrangement with UHCSR is such that each full-time student pays $800 a year for their student insurance policy. With roughly 10,000 full-time students, the insurer is receiving $8,000,000 per year. In 2023, the health and wellness center billed approximately $3,000,000 in services which covers the salaries for all staff in the center and provides for a surplus in the budget. This creates a system wherein there is a push for service delivery because that is what the university wants for the students, but also a push to cover the cost of personnel. It is worth noting the contribution this arrangement makes to the cost sharing program used by major health insurance organizations with a surplus of $5,000,000 going back to UHCSR. Ideally this would not solely contribute to UHCSR profits and would help to provide higher-value care to other insured individuals through cost sharing programs (Baicker & Levy, 2015).

At this time, it is unclear how this is relevant to integrated services with the exception to there being a shared budget. However, it is understood that the physical healthcare department has a larger budget due to the number of personnel employed, the higher salary of some of the advanced practitioners, and the higher amount billed for medical services.

Impacts of Findings

An initial review of the external organizational consultation provided by the behavioral health leader allowed for an in depth look at the productivity and underpinnings of the university health and wellness clinic. At the time of that consultation, 2013, the clinic was much farther from integration than it is today. Notably, the current lack of literature and consensus on integration indicates that this was also the case in 2013, indicating less information was available then. It is likely that this played a part in the minimal recommendations made for the health and wellness clinic that addressed integration in more depth.

The external report focused heavily on the health insurance piece and only somewhat on integrative factors as this clinic was somewhat ahead of most other university clinics by way of collocation. As such, the recommendations included the usage of a singular electronic health record for both departments and some organizational changes. Interestingly, the formal recommendations section does not discuss changes in organizational structuring but in the report, there was a current structure chart and a proposed structure chart. The proposed chart did away with a medical professional as the director of both clinics and established independent department directors credentialed in their respective fields. Therefore, collocation in conjunction with the implementation of these proposed changes contributed to a more complete presentation of integration. Significantly, collocation, a shared electronic health record, and field specific leadership no longer meet the criteria for integrated services and would more appropriately fall in the category of collaborative care or collocation treatment models (Utter et al., 2023).

The successes of the collocation treatment model, with some aspects of integration, have led to the perception that this university health and wellness clinic practices integrative care. The reality is that there are no formalized processes currently in place or in use that proactively address integrative service needs. This understanding has produced the most significant findings, that the successes of the collocation model have masked the need for further removal of barriers to integrative treatment and therefore action has not been taken to create and implement formalized policies and procedures specific to integrative procedures. The creation of such processes will give insight into previously missed opportunities for integrative services, ensure the best effort is being made to provide the needed services to students, and provide an additional pathway to behavioral health treatment. This will have an impact on the students care directly but will also empower service providers by ensuring they have a means to best care for the needs of their students.

Positive Social Change Implications

The implementation of policies and procedures designed to identify and address health related issues that are supplemental to the student's primary concerns will provide a pathway to treatment that did not previously exist. By providing this additional pathway, there is potential to help students with issues that they may not have previously been willing to address, were unaware of, or lacked information on the best treatment steps for what they are dealing with. Additionally, despite the population of this university's lack of homogeneity with the general population of the United States, there is still the potential of opening doors for those students who have traditionally been

underserved or have historically allowed mistrust of the healthcare system to prevent or avert them from seeking services. While mistrust of the healthcare system may not be specific to certain fields, there is some research on same-day access to mental health providers following a primary care visit and how this increases the likelihood of completed follow-up services, observed across all racial and ethnic groups (Woodward et al., 2024).

Strengths and Limitations of the Study

Strengths

The most notable strength of this study is the unimpeded access to the detailed workings of the university health and wellness clinic that was perpetually granted to the researcher during this process. This included access to organizational consultation reports dating back around 10 years ago, unfettered access to organizational policies and procedures, freedom to peruse organizational structure charts, and open access to the behavioral health leader and the department supervisors throughout this process. Furthermore, the leadership team has been pursuing an accreditation that has integrative requirements, and this researcher has been given the privilege of being at the forefront of this process. Another aspect of this study might be correctly categorized as a strength and a limitation. Nearly every piece of literature reviewed for this research problem indicated that there is little information available on this topic, that there needs to be additional studies done, and that there is no consensus or commonly accepted model for integration of behavioral and physical healthcare. This paucity of current, applicable research supports the legitimacy of this research problem and emphasizes the importance of the

behavioral health leader's desire for a truly integrated clinic. Additionally, this study provides a new layer to the complexity surrounding integration in that it examines how the successes of a clinic can contribute to its barriers to integration. Lastly, a major strength of this study is how it draws connections between the literature, the gaps in research, and how this university health and wellness clinic has operated for years which allows for a clear path forward toward the removal of barriers to integration and therefore, the operation of a truly integrated clinic.

Limitations

This study was conducted at a private, mid-sized university health and wellness clinic. These details limit the generalizability of the results to non-university clinics. This is true because the location on a college campus automatically guarantees some level of proximity whereas many physical healthcare clinics that are not part of a university do not have this luxury in relation to referable behavioral healthcare clinics. Additionally, many aspects of the demographics may serve as limitations. For instance, the average age range and the racial makeup of the student population do not reflect the general population. The cost of tuition at this university likely also impacts the socioeconomic demographics of the student population in ways that also do not match the general population.

Another potential limitation is that of bias and conflict of interest as the researcher is also an employee and is personally known to all leadership figures discussed throughout this project. However, the nature of the development of this practice problem was one of spontaneity that emerged through a semi-structured interview that began with

general conversation with the assistant vice president of wellness about the history and development of the clinics. The researcher examined potential conflicts that could arise from the researcher's professional relationship and never sought out additional communications regarding the practice problem thereby creating a protective factor wherein there has been no discussion about the workings of this research project with the behavioral health leader, while there has been some spontaneous communication with the behavioral and physical healthcare department directors resultant to normal roles and responsibilities. Often, in observational, qualitative studies, there can be found biases that can over or underestimate the impacts or effects within the study and therefore it is imperative to address potential researcher bias. This can be done by implementing the triangulation method using multiple approaches. In this study, a literature review was conducted at the start and throughout the project and information from this was synthesized and analyzed along with observational data collected within the organization and the interview data (Hammerton & Munafò, 2021).

There are several barriers to integration at this clinic, however, the lack of a formalized screening and referral process has created an information void. There is no way to track what might have been or to determine which students needed integrative services or not. Therefore, by only being able to recommend reductions to future barriers, there is no way to indicate the necessity of integrative services through the completion of this project. This dictates the need for follow-up studies to support the process of integration.

Briefly discussed in the strengths section is the issue of current, relative research. The limiting portion of this is the lack of supporting literature, despite how consistent the lack of research is noted throughout the articles used, this still stands as a limitation and exasperates the need for continued studies such as this.

Summary

The following information is presented to specifically address the research questions proposed at the onset of this study. At the inception of the behavioral health leader's efforts to integrate these clinics there were issues within the leadership structure. At the time, there was one person, a medical professional, who oversaw both clinics and did so from a medical model approach. Correction of this was recommended by the formal organizational consultants and acted upon by the behavioral health leader and the leadership structure was split. This allowed for each department to be managed by leaders from their respective fields. The organizational consultants also recommended for these clinics to adopt a shared electronic health record as this was not in place at the time. This too was considered and enacted upon by the behavioral health leader. Personal communication with the behavioral healthcare department leader indicated that she supported these changes prior to the formal evaluation completion. This concludes the leadership efforts made toward integrating these clinics beyond collocation. With the exception of the former manager who led solely from a medical model, this study found no leadership behaviors that hindered integration. Since the aforementioned changes were implemented, there has been no movement toward further integration. For the purposes of

answering the research questions of this study, this inaction will be considered action hindering the continued integration of these clinics.

Moving forward, it is crucial for leaders within this clinic and university to commit to taking action on the formal recommendations set forth is this study. Primarily by codifying policies and procedures directed at integration. However, merely creating policies will not be sufficient. There needs to be a commitment to maintaining communication between departments and the continual monitoring of adherence to said policies and procedures and the evaluation of how integration can be improved.

Currently, the staffing structure at this clinic provides opportunities for hindering or facilitating integration. The providers, guided by new policies and procedures, must complete integrative treatment behaviors with a level of professionalism that is in line with the standards of their profession and organization. Not every opportunity for integrative practices can be reviewed through auditing procedures and therefore it is the responsibility of the providers to do what is best for the students without the guarantee of persistent oversight. If the providers perform contrarily, there will be missed opportunities for integrative practices, which has unknown consequences. While personnel appear to be the lynchpin for integrating services, it has been determined that there are no financial barriers to integration within this clinic. In fact, the opposite is the case, when budgetary processes are followed, there are sufficient funds for continued efforts at integration. As previously discussed, the current literature does not provide any insight into a commonly accepted approach to the integration of behavioral and physical healthcare. Rather, the studies examined during the literature review discuss similar steps

and concepts in an inconsistent manner and make no attempt to determine a common model of integration. (Adeniran et al., 2023; Adler et al., 2023; Chatwiriyaphong et al., 2023; & Lombardi et al., 2023).

The preceding information on this organization, the literature, the results of the research questions, and the desire of the behavioral leader all warrant continued efforts toward integration within this clinic. These formalized efforts can be achieved through the implementation of structured processes that are detailed in the close of this study in the form of categorical recommendations, steps to achieve recommendations, and a table of proposed timeframes for the enactment of recommendations.

Section 5: Recommendations and Conclusions

During the application of the Baldridge Excellence Framework, it was determined that this organization does not have any policies or procedures in place to address barriers to the integration of behavioral and physical healthcare. The literature review also did not include insight into what role policies and procedures have in addressing barriers to integration aside from the recommendation that familiarity and effectiveness of integrated treatment, competency training, and interdisciplinary treatment meetings can be addressed or prescribed through the implementation of specific policies and procedures (Notice et al., 2022). The first set of recommendations to this organization encompass several policy additions related to the integration of behavioral and physical healthcare. As such, it has been determined that this organization, despite having several precursors to integration, is not operating as a fully integrated clinic as evidenced by the absence of clear systems and protocols addressing the barriers to and screening for potential integrative treatment opportunities. Addressing these concerns from a system wide approach and implementing changes should be accompanied by appropriate notification and training.

When this organization was evaluated by an external consultation firm in 2013, it was determined to be integrated despite the medical model leadership, the lack of a unified electronic health record, and absent formalized integrative processes. This is likely due to the novelty of having collocated facilities at the time. When applied to more modern research articles, it becomes apparent that collocation and the occasional warm handoff do not equate to integration. Moreover, this organization is in need of an internal

information gathering process that is specific to those students who received behavioral healthcare as a result of integration.

In response to the findings of the evaluation, analysis, and synthesis of evidence, this university health and wellness clinic has been provided with the following recommendations to be enacted by the primary behavioral health leader or a designee of their choosing:

1. Commit to a strategic planning process that is dedicated to integration.
2. Consider replacing the Patient Health Questionnaire-2 with a more thorough behavioral health assessment tool.
3. Develop a policy dedicated to the pursuit of integrative behavioral and physical healthcare.
4. Develop operating procedures for the consistent administering of Patient Health Questionnaire-2 (or related assessment) for all students accessing physical healthcare.
5. Provide additional/updated training to medical staff for the recognition of behavioral health needs during the review of students' medical history forms. Consider mandating integrative training through staff development benefits.
6. Develop a level of care rating scale to address the integrative needs of students. For example, emergent, immediate, same day, delayed, or no need for referral.
7. Develop operating procedures for referring students whose scores on the Patient Health Questionnaire-2 (or related assessment) warrant behavioral health

intervention. These procedures should coincide with the rating scale developed in Recommendation 5.

8. Update policy addressing staff meetings and consultations to include periodic integrated staff meetings.

9. Develop a tracking method for students who are referred through integrative services.

10. Update training policy to reflect frequency/consistency of training related to any changes made as a result of these recommendations.

There are currently processes in place that can be utilized or retrofitted to accommodate these recommended changes in procedures. Training in screening, referral, and response procedures will not be difficult to include in the ongoing training that is completed annually. Additionally, as part of the accreditation process, chart reviews are now mandatory and can include a segment on integration barriers. This accreditation process already entails several policy creations and updates, and given the proposed completion of the accreditation process, these recommendations could be implemented during the initial first year evaluation period. Regarding assessment, students already have several screening forms, one of which is a mental health tool, that they use in addition to clinical contact. Using this form or switching it for something more in depth could be easily achieved and would require little to no additional burden on the students or staff. These recommendations have led to the following recommended phases of implementation (see Table 1).

Table 1

Strategy Implementation Process for University Clinic

	Task	Timeline
Phase 1	Identify Integration Committee Members	Week 1
Phase 2	Choose Appropriate Behavioral Health Screening Tool	Month 1
Phase 3	Create Integrative Care Expectations	Months 1-2
Phase 4	Develop Integrative Care Policies and Procedures	Months 1-3
Phase 5	Implement Pilot Period	Months 3-6
Phase 6	Evaluate Implementation of Policies and Procedures	Month 6
Phase 7	Update Policies and Procedures as Needed	Months 6-7
Phase 8	Track and Monitor Integrative Practices	Annually

Phase 1 of the implementation process should not be complicated. The committee should consist of the departmental leaders, the organizational behavioral health leader, and a representative from the behavioral and physical health clinics. The representatives from the clinics should respect and understand the values of those attempting to implement changes in the organization as well as the dynamics and innerworkings of the organization and its personnel by which the changes will be enacted (Melin & Nordqvist, 2008). An understanding of the innerworkings should include a higher level of familiarity with the electronic health record and a sufficient amount of experience within the clinic. Phase 2 should involve all members of the committee when making suggestions and completing research on an integrative screening tool. Ideally, the opinions of each member of the committee will be considered, but the decision-making powers ultimately belong to the behavioral health leader.

Phases 3 and 4 can be completed during the same timeframe and will have some overlap. These phases should include the input of all committee members and follow the basic guidelines for integration previously outlined and with a primary focus on provider

training (Lloyd-Hazlett et al., 2020; Notice et al., 2022). Phase 5 is the implementation period where the committee members, primarily the department leaders, would disseminate the necessary information to the operational staff. Once the personnel have been properly briefed and integrative procedures operationalized, the pilot period can begin. At the close of the pilot period, approximate to the 6-month mark, the committee can assess the outcomes of the pilot and determine what changes are needed during Phase 7. The committee should move through this process with intentionality and should use the entire month to evaluate its findings and make any necessary adjustments to the policy and procedures. Phase 8 will take place during prescribed organizational annual reviews and during the newly implemented accreditation review processes.

Recommendations for Future Studies

From this study it has become evident that any future research on the topic of physical and behavioral healthcare integration should assume there is no consensus as to how integration should occur. Furthermore, future studies should use the Center of Excellence for Integrated Health Solutions, which was developed by the Substance Abuse and Mental Health Services Administration to develop novel approaches to integration and choose from the proposed methods for integration; this could be a singular approach or a combination of approaches. This would allow future researchers to choose evidence backed options that could be further supported by other studies or to create a combination of options of their choosing that could constitute their own model (Staab, 2022).

Choosing baseline criteria to measure the level of integration of services will provide a guided process wherein levels of integration can be determined and assigned.

While the implementation of integration of behavioral and physical healthcare will not be the same for every clinic, there are some core concepts that are crucial to the success of integration. For instance, any clinic attempting integration should have a behavioral health screening tool that is administered to all patients and a training system for said screening should exist. According to the results, the process for referral needs to be clear, regardless of collocation or offsite provider referral; this will entail the most variations between clinics. In the case of collocation, when attainable without heavy burden to the clinics, there should be a shared electronic health record. With enough research and consistency of indicators of integration, a consensus can be made and commonly accepted models of integration can be implemented at clinics across the country and around the world.

Plan for Dissemination

These findings have been presented to the behavioral health leader accompanied by an executive summary of the project. This presentation expounded on the results of the study and was supported by pertinent literature in conjunction with organizational details. The behavioral health leader was offered intervening moments for clarification or commentary. The conclusion of the presentation included a formal review of the proposed recommendations which were discussed in as much detail as desired by the behavioral health leader. Upon conclusion of the presentation, dissemination of this information to the department heads was discussed as an option with the organization leader.

Summary

It has long been the desire of the behavioral health leader of this organization to achieve a fully integrated physical and behavioral healthcare clinic. The purpose of the qualitative case study was to first determine the level of integration of this organization, second to determine the barriers to integration, and third to develop and recommend steps to remove said barriers and thereby enhance the level of integration. Modern healthcare continues toward holistic approaches; therefore, this pursuit is justified in its attempts to integrate the service of these independent departments. Ideally, this study will assist in the development of a unified consensus on the defining factors of integrative care in future studies as the literature review thus far has indicated that none exists at the time of completion of this study.

A thorough review of this organization's operations, personnel structure, and historical attempts at integration has provided a map for how to best meet the currently accepted version of integrated care. By creating new policies and adjusting existent ones, this organization will start the process toward integration. These policies will be followed through the development and implementation of thorough operating procedures that guide clinicians through the integration screening and referral process. Regular training, departmentally integrated treatment meetings, and a systematic approach for tracking students impacted by the integration of services will provide a means for continued implementation and enhanced chances for successful integration of physical and behavioral healthcare. This can all be achieved and consistently implemented within a 1 year timeframe, which is an unofficial, allowable period for major adjustments made

related to the accreditation process. This time frame also does not pose an undue burden on the department heads as they will have significant time to implement some or all of the proposed recommendations, should they be accepted. This course of action will move the university toward truly integrating its physical and behavioral healthcare clinics.

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