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AN EXPLORATION OF INTEGRATED HEALTHCARE ON UNIVERSITY CAMPUSES

by

Devon Dockstader

B.S., Colorado State University, 2016

A Research Paper

Submitted in Partial Fulfillment of the Requirements for the
Master of Science Degree

School of Psychological and Behavioral Sciences
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AN EXPLORATION OF INTEGRATED HEALTHCARE ON UNIVERSITY CAMPUSES

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Devon Dockstader

A Research Paper Submitted in Partial

Fulfillment of the Requirements

for the Degree of

Master of Science

in the field of Psychology

Approved by:

Kathleen Chwalisz, Ph.D., Chair

Graduate School
Southern Illinois University Carbondale
June 24, 2022

DEDICATION

This paper is dedicated to the women of my lineage who came before me but were denied the opportunity to pursue higher education. And my cat.

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CHAPTER 1

REVIEW OF THE LITERATURE

The integration of behavioral health services into primary care settings has been suggested by scholars as a solution to fractured healthcare systems and associated disparate health outcomes (e.g., Reiger et al., 1993; Blount, 1998; Byrd, et al., 2005; Petterson et al., 2014). Researchers have estimated as many as 50-70% of all patients seeking medical services are experiencing some form of psychological distress (e.g., Gatchel & Oordt, 2003; Belar, 2008). These estimates suggest that primary care is where many behavioral health concerns are initially observed, assessed, and treated, demonstrating the importance of the primary care physician in the management of behavioral health conditions. Furthermore, primary medical settings have been designed to assess for biological origins of symptom presentation, resulting in many medical providers failing to contextualize medical concerns through a biopsychosocial model (Blount, 1998). This dynamic has been further compounded by time constraints of the medical system and medical training which do not account for specialty mental health care or the complexity of comorbidities (Kessler & Stafford, 2008). Beacham et al. (2012) argued that the bidirectional relationship between chronic medical conditions (e.g., chronic pain) and mental health conditions (e.g., anxiety, depression) demonstrates increased need for a multidisciplinary approach to health that integrative health systems can facilitate.

There have been numerous suggested benefits of integrated healthcare including better patient care and outcomes, higher job satisfaction, better communication and reduced economic burdens (Blount, 1998; Blount et al., 2007; Hemmings, 2000). At the same time, there has been a lack of conceptual clarity in the literature about integrated healthcare approaches and how they can be applied and compared (Kodner, 2009). Further, the process of integration has remained

poorly understood outside of the resource rich Veteran Affairs (VA) medical system that is best situated for randomized control trials (e.g., Pomerantz & Sayers, 2010; Vogel et al., 2016).

Moreover, descriptions of the integrative process, implementations of healthcare integration, and evaluations of healthcare integration for similar medical sites (e.g., university health centers) remain poorly understood. Blount (2003) asserted that success or failure of integration outcomes rely heavily on the commitment of providers because of the effort that coordination among providers requires. However, there remains a dearth of empirical investigations of the varying aspects that provide support or barriers to successful integration that meet the purported benefits by scholars and researchers.

Process of Integration

Integrated healthcare has developed into a common term to explain any collaborative healthcare provider partnership in pursuit of improving patient care. Blount (1998) contended that the process of integrating behavioral health services into primary care is complex and requires individual, organizational, and system level shifts in the conceptualization and practice of medical care. Integrated health care has remained ill-defined and unstandardized (Kodner, 2009). This lack of standardization has created difficulty in assessing and implementing specific programs that fit the needs of the patient population that can be applied reliably to other similar sites (Kodner, 2009). Moreover, much of the existing evidence concerning integrated healthcare has primarily focused on condition-specific patient populations (e.g., depression) or manualized treatments regularly employed in the VA medical system (Vogel et al., 2016).

Conceptualizations of integrated healthcare remain inconsistent in the literature. Lack of proper evidence detailing the variables that impact the process of integration from development to implementation may be contributing to the difficulty in properly evaluating the efficacy of

integrated healthcare. This lack of a contextualized understanding of integration has left little evidence established for how different variations of collaborative care can be generalized to real world contexts (Blount, 2003; Kwan & Nease, 2013). Furthermore, the available evidence has not included important information about the impacts of the implementation on any of the purported outcomes of integrated health care such as: improved access to services, clinical outcomes, adherence to treatment, patient satisfaction, and cost offsets (Peek et al., 2014). Limited information regarding how integrated healthcare conceptualizations lead to implementation may leave clinic administrators with no guide to replicate successful frameworks in different settings (Keys, 2012). A more contextualized understanding would include knowledge of variations in frameworks to support integrated healthcare at different levels of care and evidence of applicability to different patient populations.

Health care teams and their relationship to integrated care remain complicated and weakly understood constructs. The proper functioning of healthcare teams has been implicated as the foundation for successful integration implementation and outcomes. Kwan and Nease (2013) have called for more qualitative methods to identify how nuances of attitudes, principles, and beliefs about integrated health care from stakeholders that influence the integration process and resultant team functioning. These theorists have argued that explorations of individual-level variables would assist in describing what supports competent integration of behavioral health into primary care. Scholars have contended knowledge of the structural aspects of integration and the various perspectives of the stakeholders involved is necessary to understand integrated healthcare (Lloyd & Wait, 2005). As Blount (1998) described, integrated healthcare has demonstrated to be most effective when patient populations are precisely identified, services

offered are accurately specified, and expectations between behavioral and medical providers are properly established.

Conceptualizations of Integrated Healthcare

Blount (2003) argued that the evidence for integrated care is scattered, largely due to an inadequate conceptual system by which to evaluate efficacy and standardize definitions. The author described integrated care through categories that support the dimensions of: (a) the relationship of behavioral health and medical providers, (b) relationship of service to populations, (c) specificity of services provided, and (d) reconsidering outcomes. Categories that distinguished the relationships between behavioral health and medical providers included an understanding of the variances in practice settings between services that are coordinated, co-located, or fully integrated. The author asserted these separations are conducive to informing how the hierarchy of integration is present in practice despite the categories not being mutually exclusive (i.e., co-located but not coordinated, integrated but not co-located). Coordinated services included practice settings in different locations. Co-located services included practice in the same setting. Integration was defined by medical providers sharing one treatment plan for each specific patient.

Blount (2003) noted the relationship of services to populations can be organized according to whether they are targeted and non-targeted. Targeted settings were designed for specific populations (e.g., depression) and non-targeted settings were designed to be available to anyone seeking behavioral health services. The author argued that identifying the relationship between populations and services provided better supports the ability to properly evaluate and compare the outcomes of different practice settings. For example, targeted population settings have been better suited for randomized control trials which supports a large body of evidence for

these settings. However, this has left a scarcity of evidence regarding the efficacy of non-targeted settings.

Blount (2003) described the specificity of services provided through the categories of specified or non-specified treatment modalities. Specificity of services refers to the degree that the behavioral treatment was informed by protocol and procedures or an emphasis on clinical judgment. Specified treatment modalities focused on protocols were better suited for randomized control trials, eliciting more research in this setting design. Unspecified treatments were more typically utilized in co-located and coordinated care, making it difficult to evaluate and compare outcomes for these practice settings. Lastly, the author asserted that differentiating between large scale and small-scale integration efforts is necessary for offering potential models that fit the practice setting integration was designed on. This differentiation was necessary for comparison against possible future integration efforts at similar practice settings.

Finally, Blount (2003) offered a challenge in the way researchers conceptualize and evaluate integration outcomes. The scholar argued that much of the research on the process of integration focuses on the impacts that are most likely to be valued by the intended audience (e.g., medication compliance, cost offsets). Instead of investigating such impacts, the author suggested expansion of which outcomes are valued (e.g., patient/provider satisfaction) when evaluating impacts of behavioral health in primary care.

Boon and colleagues (2004) argued that a “one size fits all” approach to healthcare models is limiting. These authors developed a conceptual framework to assist in comparison and evaluation of the different variations of collaborative healthcare practices. These scholars operationalized team-oriented healthcare practices through seven different models along a continuum ranging in complexity from non-integrative (e.g., parallel practice) to integrative

practice with collaborative, consultative, coordinated, multidisciplinary, and interdisciplinary in between. The framework was informed by the overall components of integrative healthcare and how the components changed along the continuum including: philosophy and values, structure, process, and outcomes. These components allowed for focus on trends and patterns in patient care. Furthermore, the authors utilized these components to identify the changes in values and individual autonomy in practice as collaboration becomes more integrated. The continuum structure allowed for more flexible conceptualizations of the utilizations, necessary skills, and challenges present in different models along the continuum of team-oriented care.

Boon et al. (2004) asserted that the philosophy of integrative practice emphasizes the importance of varying perspectives in a holistic approach to patient care and health management. Shifts along the continuum from non-integrative to integrative required a variety of healthcare perspectives and increased knowledge on the diversity in determinants of health. Further, the scholars indicated that reliance on the biomedical scientific model became less useful as more approaches to patient care were incorporated. Shifts toward increasing integration also modified the structure of the practice model by increasing the complexity in response to increased collaboration and focus on broader considerations for determinants of health. Similarly, the traditional hierarchies and reliance on defined roles decreased to prioritize the facilitation of relationships and trust among team members.

The scholars described changes in the process of team-oriented care as one moves along the continuum from non-integrative to integrative particularly as demands for communication and number of people involved increased. As practice models became more integrated, patient participation in medical care increased and consensus-based decision making was prioritized over individual practitioner autonomy. Movement from parallel practice to integrative practice

required changes in how outcomes were valued and evaluated to account for the diversity of perspectives and individual needs. For example, these changes included focusing on well-being as an outcome target as defined by patients and their overall experiences in care rather than just standard physical and mental health outcomes. These outcome measures offer more contextualized evaluations of the efficacy of different practice models for patients and practitioners, echoing similar suggestions made by other scholars (Blount, 2003).

Kodner (2009) defined integration as a nested concept with origins in organizational and managerial sciences, asserting that business practices often contributed to our understanding of integrated care. The author asserted that integrated care is necessary for the evolution and sustainability of healthcare systems. However, integrated care remains an imprecise and complex concept. The author argued that integrated care can be organized through five dimensions: (a) foci of integration, (b) types of integration, (c) levels of integration, (d) breadth of integration, and (e) degree of integration. Foci of integration provided meaningful information about the types of populations integration efforts are serving. The author forwarded the idea that the research literature demonstrates that complex patients with the highest needs benefit the most from integrated care (Leutz, 1999). Therefore, knowledge of populations (e.g., vulnerable subgroups, entire communities) and possible disease focus (e.g., chronic illness) can assist in determining focus areas for integration efforts.

In the second dimension, Kodner (2009) described six different types of integration: (a) functional integration defined by coordination of support services, (b) organizational integration defined by relationships between collaborative healthcare organizations, (c) professional integration defined by relationships between providers, (d) service or clinical integration defined by coordination of services to a single person, discipline, or time, (e) normative integration

defined by shared professional values and goals, and (f) systemic integration defined by congruence of organizational policies and culture. Related to the second dimension, the authors explicated levels of integration by operation: (a) funding, (b) administrative, (c) organizational, (d) service delivery, (e) clinical (Kodner & Spreeuwenberg, 2002). Researchers have demonstrated that when interventions utilized in care incorporate multiple levels and types of integration, patient outcomes and system performance is improved (Kodner & Kyriacou, 2000).

Kodner (2009) illustrated the fourth dimension, breadth of integration, by the range of services the healthcare system offers. The scholar contended that breadth of integration can be measured by: (a) horizontal organization which includes similar integration between two healthcare sites with similar levels (e.g., two hospitals), or (b) vertical integration which includes combining similar sites from different integration levels (e.g., community health center, hospital). In the last dimension, the scholar was informed by the framework of Walter Leutz (1999) who described health care integration through three different designs: (a) linkage, (b) structured coordination, and (c) full integration. Leutz (1999) described linkage as the framework that requires and elicits the least amount of change resulting in providers working together as needed. Structured coordination involved organizational processes to facilitate collaboration. These organizational processes maintained separate service responsibilities, eligibility criteria, and funding. In the final degree of integration, fully integrated, integration required a complete transformation where responsibilities, finances, and resources are shared to deliver a continuous healthcare experience.

Call for Integrated Care in University Health Centers

Counseling services have been demonstrated to assist in retention rates and bolstering overall academic performance (Svanum & Zody, 2001; Megivern et al., 2003; Downs et al.,

2018). Large national samples of college students surveyed through the Healthy Minds Study (2019) and the American College Health Association (2020) indicated that mental health concerns in this population are increasing in complexity, severity, and prevalence with nearly half of students surveyed endorsing moderate to serious psychological distress. Further, the most recent Association for University and College Counseling Center Directors (AUCCCD) survey collected from 477 counseling center directors revealed a significant increase in stress related to the ongoing COVID-19 pandemic (Gorman et al., 2020). Many clinic directors reported a decrease in demand likely due to changes in service delivery.

College-aged populations are particularly important for early detection and prevention of mental health disorders, which often have onsets within or before this age range and can further complicate any underlying medical conditions being treated (Anderson et al., 2010). Moreover, mental health conditions have ranked in the top five diagnostic categories seen in university health centers (Turner and Keller, 2015). However, surveys of college students and clinic directors have suggested that most college students will not seek or receive services at their university health center, with access barriers frequently cited as a reason for delayed treatment (Gorman et al., 2020). Hypothesized to be largely related to decreases in stigma, help-seeking behaviors have increased substantially since 2007 (Lipson et al., 2019). Nevertheless, the average person has often delayed or avoided treatment resulting in a multitude of complications that impact the healthcare system, disability prevalence, and productivity loss (e.g., Kessler et al., 2005; Erksine et al., 2015). Erksine and colleagues (2015) utilized data from the Global Burden of Disease Study 2010 to demonstrate that mental health conditions are the leading cause of disability in children and youth worldwide. Moreover, the researchers argued that further

attention on access and prevention in this demographic would elicit many long-term benefits for society.

Researchers have reported an association between psychopathology and academic performance, however, there continues to be a limited understanding of scope and intervention needs (Eisenberg et al., 2009; Schwitzer et al., 2018; Duffy et al., 2020). Researchers have also argued that prevalence of mental health concerns is increasing in college-aged populations results in lower quality of life, physical health, and general well-being (Eisenberg et al., 2011; Turner & Kelly, 2015). Oswalt and colleagues (2020) examined trends and changes in diagnoses and utilization of mental health services over time using information from the American College Health Assessment (ACHA-NCHA II). A hierarchical binary logistic regression controlling for demographic variables and time revealed significant increases for anxiety, ADHD, depression, insomnia, OCD, and panic attacks between the years of 2009-2015. However, time was not a significant predictor for bulimia, bipolar, and schizophrenia which may suggest these diagnoses evolve later or are incorrectly misdiagnosed.

These findings were consistent with other studies confirming the increasing prevalence of mental health conditions. Particularly, researchers have found that depression and anxiety for this population was associated with lower GPA, suicidal ideation, substance use, and self-injury (Buchanan, 2012; Lipson et al., 2019). Some researchers have criticized how much of mental health diagnoses attributed to college-aged populations matriculated before and were merely exacerbated by the college environment (Oswalt et al., 2020). These researchers argued that the identification of these mental health diagnoses may just be due to increased access to services or increased autonomy to seek services. Moreover, this data may suggest that not only are diagnoses and utilization patterns increasing over time, but there remains a possible

responsibility of universities to provide services that support students' health-seeking behaviors and mitigate the consequences of mental health concerns on academic performance and well-being. In response to this dynamic of inadequate resources, Oswalt and colleagues (2020) identified possible solutions which are often employed in integrated health centers such as pre-screening measures in medical visits, short-term therapy options, increased collaboration, and holistic approaches to meet student needs.

Despite suggestions that university health centers may be good candidates for integration of behavioral services into primary care, a paucity of empirical evidence remains to evaluate decisions for integration, process, and outcomes. This literature review of integrated healthcare in university health centers reveals that the bulk of empirical evidence is concentrated on various influencing variables evaluated post-integration (e.g., perceptions/attitudes, work satisfaction, training backgrounds, referral rates) rather than explications of variables that prompted the process of integration or if desired outcomes were met. There have been articles written on the integrated care model as it relates to provider satisfaction (Funderbunk et al., 2012), provider perceptions of working with mental health concerns in a university setting (Pratt et al., 2012), how to better train providers to work in a collaborative environment (Larkin et al., 2016), and increasing affirmative care access for LGBTQ individuals (Heredia et al., 2021). However, little is known about variables impacting pre-integration decisions and subsequent process or framework of specific clinics.

In one of the first published empirical studies to evaluate the possible benefits of incorporating behavioral health into primary care within a university health center, Alschuler and colleagues (2008) examined how behavioral questionnaires impacted a medical provider's treatment recommendations and referral rates. Two hundred participants were randomly assigned

to either the experimental condition consisting of the Patient Health Questionnaire (PHQ; Spitzer et al., 1999) and the College Health Questionnaire (CHQ) which was designed specifically for this study. The control condition received medical treatment as usual and both conditions completed post visit questionnaires regarding satisfaction with services. The CHQ consisted of 18 questions among dimensions of weight loss, substance use, sexual identity, risky sexual behaviors, and college adjustment concerns. The design of the CHQ was meant to evaluate information not captured on the PHQ that may provide context to possible disruptions experienced due to behavioral health concerns. Moreover, medical providers in this study endorsed modest confidence in their ability to treat mental health conditions based on their prior education and training concerning behavioral health. This endorsement of modest confidence is supported in other areas of the literature together with arguments for expanding behavioral health training for medical providers who routinely focus primarily on biological causes of disease due to their training backgrounds (Blount, 2003).

Results of the study suggested that behavioral questionnaires do facilitate more conversations about behavioral health concerns with medical providers and increase the likelihood of receiving psychotropic medications in a university setting. However, results indicated that referrals for further behavioral health treatment did not increase. Referral rates were higher for participants who met diagnostic criteria on the PHQ, however this was not statistically significant. These results are in alignment with Blount (2003)'s suggestion that co-locating services and increasing referrals is not enough to facilitate the full ideals of integrative health services and team collaboration. Further, increased referrals alone are not a strong indication of a collaborative health team explicated within the integrated care literature. The

results of this study may suggest that moderately integrated clinics (e.g., co-located) and minimized financial barriers may not be enough to facilitate integration.

Alschuler and colleagues (2008) identified that both conditions endorsed high satisfaction with medical visits. However, 62.5% of the participants experimental (i.e., behavioral health screening) condition endorsed that the questionnaires as helpful for facilitating conversations about behavioral health concerns. This suggests that even if behavioral screeners do not result in more counseling referrals, they do assist in deeper conversations about experiences with mental health that can result in treatment that may not have been accessed before (e.g., psychotropic medications, acknowledgement of loss of functionality). Further, behavioral screeners may provide some structure to assist the medical provider in identifying areas of concern for the patient.

In the Alschuler et al. (2008) study, medical providers reported that the questionnaires were helpful for guiding treatment, but they cautioned against the time it added to medical appointments. However, medical providers also endorsed an overall interest in increasing their collaboration with behavioral health and their own comfort with treating behavioral health conditions in the medical clinic. Finally, most providers and patients endorsed a preference for continuing the use of screening questionnaires in the future. Still, within the experimental condition, providers discussed behavioral health with only 70% of patients who met criteria through the PHQ and fewer than 50% of the patients who met criteria even received treatment (e.g., medications, referrals). This illuminates the reality that the most likely treatment for mental health concerns was no treatment. The researchers noted this dynamic was likely informed by system-level (e.g., short medical appointments), individual-level (e.g., provider training and

comfort), and setting-level (e.g., providing care based on traditional medical model) characteristics that ultimately resulted in insufficient care.

In response to this increased demand for mental health services, scholars have contended that alternative models of healthcare, in particular integrated care models, may facilitate better medical and behavioral outcomes while reducing barriers to access for college-aged populations (e.g., Brunner et al., 2014; De Luca et al., 2016). Reducing barriers to access through comprehensive models of healthcare could support the suggestion from scholars that this age group should be assessed from a prevention standpoint with increasingly high needs (Anderson, 2010; Turner & Keller, 2015). However, Brunner and colleagues (2017) proposed that traditional assumptions of integrated care models need to be expanded to demonstrate the establishment of holistic counseling services on college campuses. This may support the need for future investigations of integration among university health centers. Still, there is little known about organizational structures and experiences integrating university health centers or the benefits and challenges encountered. This knowledge could assist in providing frameworks for other universities interested in integrating behavioral health services into primary care.

There have been limited investigations of evolving best practices of integrated health settings on college campuses. For example, Anderson and colleagues (2010) surveyed and interviewed students and clinic directors at various student health centers considered to be integrated. This was achieved in three parts. The first part involved establishing a baseline for what the current structures of student health center services were across the United States. A web-based survey consisting of 111 questions was sent via a listserv eliciting 359 completed surveys across all American College Health Association (ACHA) regional areas. Based on these results, 92 clinics were deemed integrated and completed further survey questions about

structure, services, and fiscal components. The final part consisted of student health center directors selected for case study interviews about the specifics of their clinic functionality, rationale for integration, and outcomes.

Overall, results of the web-based survey indicated that 59% of respondents were from public universities, and 41.5% were from private universities. Moreover, most respondents were from urban areas (79.7%) and had an enrollment lower than 14,999 (73%). However, the demographics of the 92 integrated centers revealed nearly half ($n = 38$) had undergraduate enrollments under 5,000 followed by universities ranging 5,000-9,999 ($n = 16$); and ($n = 26$) from universities with enrollments of 10,000-19,999. Finally, larger schools made up less than 10% of integrated centers ($n = 9$). These demographics suggest that smaller schools were more likely to be integrated and this may be in part due to lower resources and higher unmet needs on smaller campuses (Anderson et al., 2010).

Factors of interest in the results included variables encompassing the impacts of integration on counseling structure and operations. Anderson and colleagues (2010) identified the desire to improve continuity of care (45.7%, $n = 42$) as the most frequently reported contributing factor influencing the decision to integrate. This was followed by philosophy of care (40.2 %, $n = 37$) and an upper administrative decision (32.6%, $n = 30$). Most centers reported that quality, efficiency, utilization of services, and increased ability to meet student needs were distinctly improved or improved following integration of services. This suggests that many of the purported benefits of integrated healthcare may be attainable within a university health center setting. If the university has a smaller student population and reduced access to resources compared to larger, more urban, university settings, then that may include more flexibility and community-based resources than small rural institutions.

As suggested in conceptual aspects of the integrated healthcare literature (Blount 2003, Kwan & Nease, 2013, Dickinson, 2015), shared record-keeping and physical space continue to be factors of concern among stakeholders. Despite such concerns, record-keeping and space remain integral parts of conceptualizing the functionality of different integration models. In Anderson and colleagues (2010) investigation of 92 integrated clinics, the slight majority (56.5%) indicated separated physical spaces with the remaining clinics (43.5%) endorsed shared spaces. Further, the results of this survey revealed that the significant majority (84.8%) kept separate records often resulting in duplications and barriers to collaborative care compounded by lack of shared physical spaces in some clinics. The researchers' results supported some concerns that poorly understood variations in clinic organization structures and lack of detailed information on the integration process reduced the ability to capitalize on the efforts and promises of integrated healthcare.

Scholars have historically provided criticism that lack of shared records and physical spaces may undermine the outcomes asserted by integrated healthcare literature and reduce the ability for replication in other sites (Blount, 1999; Blount, 2003; Cohen, 2015). Similarly, Keys (2012) argued an improper merger of healthcare services could result in profit losses and quality of care without any increase in continuity of care for behavioral health. This author asserted that a poor integration process is more damaging than continuing to navigate a current service structure. Keys (2012) argued that while the integrated care discourse is expanding, much of the content of discussions is redundant and does not provide proper evidence for suggestions to merge healthcare services or combine varying career philosophies into a collaborative service.

Despite this article being published nearly a decade ago, there continues to be a scarcity of evidence to what Keys (2012) would describe as a proper framework for successful mergers.

Vogel et al. (2016) contended the collective understanding of the purpose of the merger and facilitating the integration of career philosophies remains poorly understood within the literature outside of few existing research studies on integrating medical and behavioral health outside of the standardized VA system. The author argued that identifying barriers and increasing communication among the various stakeholders warrants further exploration. Moreover, empirical studies on the process of integration for sites outside the VA system are needed with a demand for variation in understanding how funding sources, structural organization, beliefs about integration, training backgrounds, and size impact the process of integration.

Case Example

Scholars have called for a more contextualized understanding of the process of integration through the examination of various experiences and beliefs of stakeholders about integrated healthcare (Kwan & Nease, 2013). Moreover, little evidence is available describing the process of integration and even less so from a qualitative methods framework that would allow for an in-depth construction of a model for pursuing integration at similar sites. The process of integration has continued to remain unexplored at university health centers which have been suggested as good sites for pursuing the integration of behavioral and physical health (Alschuler et al., 2008). The following study is the most thorough example detailing and understanding the process of integration at a university health center that I was able to find.

Zvonkovic (2019) conducted a qualitative focus-group study at a rural mid-sized Midwest university at the beginning stages of planning for the implementation of integrating physical and behavioral health at the Student Health Center. The researcher utilized grounded theory methodology (Corbin & Strauss, 2015) to examine the complex variables impacting the process of integration at a university health center. This university health center was a facility

that had a variety of co-located services (e.g., primary care, counseling and psychological services, psychiatry, physical therapy, emergency dental). Focus group interviews were conducted with various stakeholder groups within the center as well as support staff. Participants also completed a survey in which they provided demographic and professional information, and they completed the Attitudes Toward Integrated Healthcare Scale (ATIHCS; Zvonkovic, 2015). Data analysis revealed a grounded theory model depicting how staff member's experiences, attitudes, and values interact together to influence the early stages of integration at a university health center.

Zvonkovic (2019)'s model of the integration process included individual-level variables, organization-level variables, and communication variables that reciprocally affect each other, with the resulting shared construct of integration in the center of the model. Establishing a shared construct of integration facilitated the proper delivery of integrated healthcare and is worthwhile to re-evaluate following integration to assess changes in beliefs about integrated healthcare (Wistow et al., 2008). Due to the early stages of integration at the time of this study, the shared construct of integration remained difficult to co-construct (Zvonkovic, 2019).

Individual-Level Variables

Zvonkovic (2019) identified three individual-level variables influencing integration including: (a) attitude toward integration, (b) training or clinical background, and (c) roles and responsibilities. The identified variables could be a facilitator of integration or a barrier to integration depending on their different personal (e.g., attitudes) and professional experiences (e.g., prior knowledge of integrated care, training background) being in alignment with the overall principles of integration (e.g., working collaboratively, synergy of physical and mental health). The researcher described some of the staff as being resistant to the possible changes of

integration and how that may impact their job functioning and duties. Further, not all staff endorsed the belief that integration produces higher quality and continuity of care which likely impacted the overall process, and possibly success, of integration at this site.

Kwan and Nease (2013) argued that the most successful integrations of behavioral health into primary care constitute a staff comprised of shared values around how healthcare is delivered with a desire to contribute to that shared value. Disparate values, beliefs, and prior experience or knowledge of integrated healthcare likely contributed to the incomplete co-construction of integration identified in Zvonkovic (2019)'s model. Moreover, staff members endorsed being less likely to consult with colleagues whose competency was unknown. This is noted in the study as a barrier to the underlying principles of collaboration espoused to be essential for proper functioning and outcomes. Individual variables, specifically attitudes, have been well demonstrated to impact integration outcomes within the literature (Laws et al., 2008; Funderbunk et al., 2012). Medical doctors' attitudes (Leipzig et al., 2002) and training can positively influence attitude changes about collaboration and communication (Park et al., 2014).

Organization-Level Variables

Variables at the organization-level included the influence of top-down decision-making (e.g., administrators) and the overall organizational culture of the Student Health Center (e.g., how integration was presented, interpersonal dynamics among staff). Organizational decision-making became evident regarding how orientation to care was established and how these decisions impacted the daily functioning of the agency. Some of the narratives captured during data collection described feelings of confusion about the reasons for the administration's decision to integrate and this may have influenced the lack of buy-in noted by some of the staff. Moreover, many aspects of the adopted model of integration at this site were in direct contrast to

the rhythms of role duties and expectations that were previously established. Zvonkovic (2019) described structural barriers related to achieving the aims of integration which were compounded by the fast-paced nature of medical appointments that do not leave time for integration efforts (e.g., collaboration, team meetings). Similar conclusions have been reached in other studies detailing how the time constraints of medical appointments make it difficult to prioritize any possible presenting mental health concerns even with the addition of pre-screeners (Alschuler et al., 2008).

Other structural barriers revealed in Zvonkovic (2019)'s study included hierarchies among staff that were supported by an overall distrust of the administration's decision to integrate. The differences in accumulated power and utilization of it without explanations to parts of staff resulted in resistance to certain aspects of integration and acceptance of others. Zvonkovic (2019) noted that department-driven decisions that appeared to reduce gaps in care were more positively received than decisions made at the administrator level. The relational power dynamics coupled with isolated decision-making acted as a barrier to integration at this site. Power differentials resulted in low motivation for integration efforts and creating relationships with colleagues. However, building relationships for collaboration is essential to the functioning of integrated care and trusting the competency of colleagues (Blount, 2003).

Communication

Communication was an influencing variable for all aspects of the integration process, but particularly in staff's ability to make meaningful relationships and thus coordinate patient care (Zvonkovic, 2019). Communication was central to understanding how collaborating patient care evolved at this site and how individual variables impacted this process. At the organization-level, communication was key to understanding how decisions about care were conveyed to staff. This

dynamic demonstrated the importance of communication in relationship to both individual-level variables and organization-level variables and therefore the strength of the shared construct of integration.

Structural facilitators of communication included sharing medical records, embedding a behavioral health staff member in the medical clinic for easy consultations and patient hand-offs, and agency initiatives to increase face to face time between staff from different departments. Barriers that impeded the success of integration included insufficient communication between staff about patient care, disputes over the level of access to behavioral health records, and lack of follow-up after referrals across departments. However, communication has been demonstrated to support collaboration, a core principle of integrated care, and without communication disruptions in continuity of care are more likely. The researcher acknowledged that communication strategies were in their early stages during the process of this study. The process of integration is constantly evolving. Meeting the complex needs of patient care should be approached with consideration to avoid improper mergers of behavioral and medical health, thus reducing the asserted benefits of integration (Keys, 2012).

Conclusion

Scholars have suggested the integration of behavioral health into primary care may result in improved health outcomes, increased cost efficiency, and better continuity of care (Byrd et al., 2005; Petterson et al., 2014). However, in pursuit of these goals, there remains a paucity of empirical research demonstrating the efficacy of these practices at different sites outside of the standardized, and resource rich, Veterans Affairs (VA) system (Vogel et al., 2016). Scholars have demonstrated the importance of approaching the process of integration with specific frameworks in mind based on population served, design of physical spaces, resources, and time

(Blount, 1998; Blount, 2003). These scholars argued without proper conceptualizations of integration, it is difficult to assess the recorded benefits of this healthcare design. Further, a lack of conceptualization of integration may create barriers for other sites considering integration. Establishment of a baseline for what may work integration is necessary. University health centers have been suggested as good sites for integration (Alschuler et al., 2008; Anderson et al., 2010). However, little empirical research is available to substantiate this claim. Zvonkovic (2019) highlighted the critical importance of effective communication and relationships in healthcare integration in a university health center. Continued examination of integration processes is necessary to expand our understanding of how integration works in practice and how to sustain it to meet the desired outcomes.

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