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For more than 30 years, my professional mission has been to build integrated behavioral health capacity throughout the healthcare workforce. As a Board-Certified Clinical Health Psychologist, I have pursued that mission through integrated clinical practice, medical education, interprofessional workforce development, scholarship, mentorship, and national leadership. Since joining the Texas College of Osteopathic Medicine at UNT Health Fort Worth in 1993, I have worked to prepare physicians and other healthcare professionals to integrate behavioral health into everyday clinical practice while advancing the Primary Care Behavioral Health (PCBH) model through education, innovation, collaborative care, and systems-level leadership.

My career began in the Department of Psychiatry and Human Behavior, where I primarily practiced neuropsychology and provided psychotherapy, neuropsychological assessment, and consultation-liaison services for patients with diverse medical and mental health conditions. Approximately seven years later, I intentionally joined the Department of Family Medicine because I recognized the opportunity to build integrated behavioral health capacity within primary care and, ultimately, throughout the healthcare workforce.

For more than two decades, I have practiced integrated behavioral healthcare alongside Family Medicine physicians and residents. As the only behavioral health provider collaborating with multiple physicians, I experienced both the opportunities and gaps in integrating behavioral health into primary care. Those experiences shaped my conviction that the long-term success of the PCBH model depends upon preparing every primary care clinician to recognize behavioral health as an integral component of patient care and to confidently address behavioral health and psychosocial concerns collaboratively within primary care. This realization fundamentally shaped the remainder of my career.

For more than twenty years, I directed the longitudinal Clinical Communication Skills curriculum within our Osteopathic Medical Practice course, helping prepare approximately 6,000 future physicians to deliver humanistic, patient-centered, integrated behavioral healthcare. Rather than teaching communication as an isolated skill, I intentionally embedded behavioral health principles throughout students' training, reinforcing their application within every standardized patient encounter. Every patient scenario incorporated meaningful psychosocial complexity, requiring students to routinely assess stressors, emotional responses, illness beliefs, coping strategies, and behavioral influences on health while emphasizing partnership with patients through behavioral health strategies and integrated care.

Drawing upon principles from cognitive psychology, neuroscience, and the science of learning, I intentionally designed educational experiences that moved integrated behavioral health skills beyond knowledge acquisition into routine clinical reasoning. My goal was not simply to teach communication, but to operationalize integrated behavioral healthcare within medical education so that behavioral health assessment, empathic inquiry, collaborative care, and attention to psychosocial factors became expected components of every patient encounter.

I later expanded this curriculum by teaching advanced communication strategies using community volunteers with chronic illness rather than standardized patients. Individuals living with traumatic brain injury, diabetes, myocardial infarction, COPD, chronic pain, gynecologic cancer, and other complex conditions shared their illness journeys alongside the organ systems students were studying. These authentic encounters enabled students to integrate biomedical knowledge with lived patient experience and were consistently identified as among the most meaningful experiences of their preclinical education.

Recognizing that integrated care requires clinicians to synthesize biomedical and behavioral perspectives, I subsequently co-developed an innovative Clinical Integration course. Designed around Miller's Pyramid of Clinical Competence, the course integrated biomedical science, physical examination, clinical reasoning, and behavioral health assessment into authentic patient encounters. Students received joint evaluation and feedback from physician and behavioral health faculty, formulated both biomedical and psychosocial diagnoses, and incorporated behavioral health recommendations into every patient management plan. This interprofessional teaching model reinforced collaborative practice as the expected standard of care while contributing to above-national-average performance on national board examinations in humanism and clinical skills.

My commitment to workforce development has extended across the educational continuum. During my career, I have taught approximately 6,000 medical students, 2,000 physician assistant students, 100 Family Medicine residents**,** graduate biomedical science students, doctoral psychology trainees, postdoctoral fellows, and practicing healthcare professionals through continuing education. Early on, I developed and directed a year-long Clinical Health Psychology/Behavioral Medicine Preceptorship that embedded doctoral psychology students within Family Medicine, Geriatrics, and Osteopathic Manipulative Medicine rotations alongside medical students. During accreditation review, reviewers from the American Psychological Association described this innovative interprofessional model as "the training model of the future."

Beyond direct teaching, I have mentored 35 medical students, 31 doctoral psychology students, 10 Family Medicine residents, graduate students, postdoctoral fellows, and junior faculty in scholarly activity while providing 26 faculty development programs that helped educators integrate behavioral science into medical education.

My scholarly work has focused on translating integrated behavioral health principles into education and clinical practice. I have authored 25 peer-reviewed manuscripts, 46 published abstracts, textbook chapters, and more than 120 national and international presentations, most involving interprofessional collaboration. As Principal Investigator or Co-Investigator, I have secured more than $1.3 million in competitive funding supporting interprofessional initiatives addressing obesity, diabetes, cancer, behavioral medicine, and chronic disease management.

Nationally, I have sought opportunities to advance integrated behavioral healthcare beyond my institution through leadership and collaboration. I have served on committees within the Collaborative Family Healthcare Association, the National Academies of Practice, The Obesity Society, and the Society of Teachers of Family Medicine. Recently, I was selected to co-author the Clinical Communication module for STFM's national Behavioral Health Curriculum, serve as a faculty item writer for the Psychiatry-Neuroscience section of COMLEX-USA Level 2, and participate on the National Board of Osteopathic Medical Examiners' Core Competency Capstone for DOs “CARE” Subcommittee, strengthening national assessment of humanism and clinical competence for osteopathic licensure.

Looking back over my career, I realize my greatest contribution has not been a single curriculum, clinic, publication, or leadership role. Rather, it has been systematically building integrated behavioral health capacity by embedding the principles of the PCBH model into clinical practice, medical education, interprofessional training, scholarship, and national service. My goal has always been to prepare clinicians who possess the knowledge, skills, and clinical judgment to make integrated behavioral healthcare a natural and expected component of patient care. It would be an extraordinary honor to have those efforts recognized through the Outstanding Contributions to the Primary Care Behavioral Health Model Award.