

**Evaluation of the Closing the Gap
on Access and Integration:
Primary and Behavioral Care Summits
Final Report**

Submitted To:



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EXECUTIVE SUMMARY

Summit Initiative Evaluation

Four “Closing the Gap on Access and Integration: Primary and Behavioral Health Care” Summits were conducted in 2004 by the Health Resources and Services Administration (HRSA) through the National Health Service Corps (NHSC), and in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA). During these facilitated meetings, stakeholders from several states worked to develop State-specific strategic Action Plans. The plans aimed to increase the supply of mental and behavioral health services and providers in underserved communities and to integrate mental health, substance abuse, and primary care services.

REDA International, Inc. (REDA) with the assistance of staff from J & E Associates, Inc. conducted an evaluation of the process and outcomes of the Summits. The primary goal of the evaluation was to answer the following questions:

- ◆ Is the Summit initiative process an effective mechanism for promoting state and community-level change in the provision and integration of primary and behavioral health care?
- ◆ What are the states’ major accomplishments in the evaluation period following the Summits?
- ◆ How do states use HRSA, SAMHSA, and other public and private grants and programs to implement their Action Plans?

The evaluation of the process and outcomes of the Summit initiative was conducted between October 2004 and June 2006. It used a variety of data collection methods selected to answer specific evaluation questions. Compiled data were analyzed using qualitative and quantitative data analysis techniques.

Summit Process Evaluation Highlights

The data for the process evaluation of the Summits were collected on-site, and the analysis was conducted in the months following the Summits. The majority (84%) of Summit participants regarded the Summit meetings as well organized and effective in helping states develop working teams and preliminary Action Plans. The Summits attracted a variety of stakeholders. 311 registered participants included the following:

- ◆ primary care or behavioral health service providers (53%)
- ◆ representatives of non-state primary care or behavioral health organizations (19%)
- ◆ representatives of state organizations (19%)
- ◆ consumers (2%)
- ◆ academicians (7%)

The Summits produced intended and immediate results. All state teams created Action Plans that laid out statewide plans to promote integration of primary care, mental health and substance abuse services in each state. Many state teams developed strong collaborative relationships to carry on the implementation of their Action Plans after the Summits. The three central themes of the Summits and the Action Plans were the following:

- ◆ Building a seamless system of care, defined as a “care system in which a consumer’s physical and mental health and substance abuse treatment needs are quickly identified and treated, regardless of which system of care the consumer enters first.”
- ◆ Workforce training and development, defined as “increasing the number and quality of professionals and para-professionals, in collaboration with primary care, who can screen, assess and treat mental health and substance abuse needs.”
- ◆ Building partnerships and collaborations, defined as “creating new relationships and/or building on existing community leadership teams to form committed partnerships and resource leveraging for providing and integrating mental health, substance abuse and primary care services in underserved areas.”

These three areas were identified as essential building blocks for the integration models. All state Action Plans included activities pertaining to each of the three areas, while building on specific state circumstances and challenges.

While the majority of the Summit participants were satisfied with the way the Summits had been conducted, there was a number of shortcomings that participants pointed out during the Summit evaluation. A set of recommendations was developed to improve the summit model as a vehicle of promoting change, including the following:

- ◆ Recruitment. It is essential to involve state level decision makers in the process.
- ◆ Pre-summit preparation. Invitees should be informed about the planned summit a few months in advance so they could plan to attend; they also must be provided with summit materials well in advance. It is important to ensure that the purpose of the summit is clear to the invitees.
- ◆ The Summit process. Agenda should be flexible to accommodate various needs of participating states. Participants should not feel rushed through the process. More networking events and information on various sources of funding should be included in the agenda.
- ◆ Follow-up support. Follow-up technical and financial assistance with plan implementation would be helpful for the success of the initiative.

Summit Outcomes Evaluation Highlights

The evaluation of the Summits’ outcomes was conducted in two rounds, with 72% participation rate in the first round of evaluation, and 100% participation rate in the second round of evaluation. Multiple data collection methods were used, including state

update forms, telephone interviews, and multi-state teleconferences. The gathered information showed that by the end of the evaluation period in June 2006, the Summit Initiative had produced promising achievements in most of the participating states, including the following:

- ◆ 77% of states¹ have established a permanent team or other entity that is responsible for overseeing and coordinating the implementation of the state's Action Plan. 40% of these states said they have all the key players on their teams;
- ◆ In 67% of states, the Action Plan implementation efforts are led by state bodies or agencies with strong connection to state bodies;
- ◆ 100% of states have had accomplishments in building a seamless system of care; 92% of states have integrated services in some health centers or for certain populations;
- ◆ 83% of states have had accomplishments in workforce training and development;
- ◆ 96% of states have had accomplishments in building partnerships and collaborations;
- ◆ 67% of states have involved consumers in the Action Plan implementation;
- ◆ 59% of states have obtained federal assistance that was fully or in part used for integration-related activities.

Overall, 39% of team leads said their states have made good to excellent progress in integrating health services in their states. Over a quarter (26%) of team leads said they made good to excellent progress in implementing their Action Plans. The majority (61%) of team leads attributed some of their integration-related accomplishments to the Summit Initiative, and an additional 22% said that most or all of their accomplishments are a direct result of the Summits.

The evaluation found that the main impediment to the integration initiative is the lack of targeted funding. Various economic, political and environmental factors, like slow economic growth, the Iraq war, and Hurricanes Katrina and Rita, significantly reduced federal, state, and alternative funders' revenues that could have supported change. At the same time, rising health care and insurance costs increased competition for public health dollars among existing programs, leaving even less money for new initiatives. It is extremely difficult right now to convince State elected officials to appropriate new money or to change the way federal program dollars are spent when their attention is on cutting their State budgets.

In addition to the lack of funding for the initiative, the team leads reported many other problems and challenges. The most significant of them were the following:

- ◆ Reimbursement regulations, including Medicaid/Medicare;
- ◆ Structural and regulatory barriers;
- ◆ Lack of workforce with cross-discipline training
- ◆ Cultural differences among professional groups;

¹ Throughout the Report twenty-two states, the District of Columbia and Puerto Rico make up 100%, unless otherwise specified. Two states (Delaware and New Hampshire) withdrew their participation.

Recommendations to support implementation of the integration initiative were developed, based on assistance requests expressed by evaluation participants. Below are the highlights of the recommendations for the follow-up support.

- ◆ Technical assistance, to provide state teams with information and support in integration-related activities.
- ◆ Workforce development assistance in a form of competitive grants, to assist states in setting up training programs to provide cross-training to providers to prepare them for working in an integrated health care setting.
- ◆ Pilot projects support in a form of competitive grants, to provide evidence on benefits of integration to policy makers, consumers and providers.
- ◆ Publicity campaigns, to raise awareness of the integrated health care among policy makers, state officials, consumer organizations and other stakeholders.

The Summit Initiative appears to have been a well-conceived and worthwhile effort on the part of the Federal government to help states expand and integrate primary and behavioral health services. While the foundation for service integration was established in most of the participating states, the lack of resources prevented them from fully implementing their Action Plans. Implementation of the recommended follow-up assistance described in the last chapter of this Report would support the state teams and ensure that the states continue to progress with the initiative.

INTRODUCTION

Two reports from the U.S. Surgeon General issued in 1999 and 2001 attracted national attention to the problem of “striking disparities” in the availability of mental and behavioral health services in underserved communities. Lack of access is particularly great in rural and inner-city communities among racial and ethnic minority Americans. As a direct response to these problems, the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) joined forces in 2000 to develop and implement the Mental and Behavioral Health Summit Initiative.

The original purpose of the initiative was to help the states and communities develop and execute plans to increase the supply of mental health, behavioral health, and substance abuse services and providers in underserved communities within primary care settings. Over time the purpose of the initiative evolved so that the focus was on promoting the *integration of mental health, substance abuse, and primary care services*, regardless of the care setting.

The first series of four facilitated meetings, called Summits, was conducted between September 2000 and September 2001. Teams of stakeholders from 25 states were invited to participate in these Summits. In addition to these meetings, HRSA and SAMHSA, as part of the Summit Initiative, supported the implementation of the plans through planning/implementation grants and other technical assistance efforts. They also conducted a follow-up meeting with team leaders and consumer representatives from each of the Summit states in January 2002. REDA, under contract to HRSA, conducted an evaluation of these Summits and prepared a report that documented the extent to which State Action Plans had been fully developed and implemented, assessed the Summit Initiative approach as a vehicle for implementing change in states and communities, and presented recommendations for future action.

The second series of four Summits was conducted between June and December 2004. Representatives from the remaining 25 states, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin were invited to participate. The Summits were conducted in following locations:

- ◆ New Orleans, Louisiana, in June;
- ◆ Falls Church, Virginia, in October;
- ◆ Albuquerque, New Mexico, in November;
- ◆ Seattle, Washington, in December.

The Summit meetings included plenary sessions on service integration, workforce training and development, and building partnerships and collaborations. Facilitators conducted breakout sessions on each of these topics in which the state teams were encouraged to create Action Plans for their states. These Action Plans contained

statewide plans to promote integration of healthcare services by implementing activities in three major areas:

- ◆ Building a seamless system of care, defined as a “care system in which a consumer’s physical and mental health and substance abuse treatment needs are quickly identified and treated, regardless of which system of care the consumer enters first.”
- ◆ Workforce training and development, defined as “increasing the number and quality of professionals and para-professionals, in collaboration with primary care, who can screen, assess and treat mental health and substance abuse needs.”
- ◆ Building partnerships and collaborations, defined as “creating new relationships and/or building on existing community leadership teams to form committed partnerships and resource leveraging for providing and integrating mental health, substance abuse and primary care services in underserved areas.”

In order to determine whether the Summits had achieved their intended outcomes, HRSA contracted with REDA to conduct an evaluation. This report, prepared two years after the first Summit meeting, presents the results of the evaluation activities that occurred during this period. Specifically, this report:

- ◆ Assesses the Summit approach as a vehicle for promoting service integration and access in states and communities,
- ◆ Documents the extent to which State plans have been developed and implemented, and
- ◆ Presents recommendations for future action.

The evaluation consisted of two separate parts:

- ◆ Process evaluation of the Summit meetings themselves, and
- ◆ Evaluation of the Action Plan implementation activities carried out by participant states during the evaluation period following the Summits.

The first part of this report presents a comprehensive overview of all four Summits, including Summit organization, participants’ opinions of the Summits, and recommendations for improvement derived from the participant and facilitator evaluations².

The second part presents the results of the follow-up evaluation performed by REDA’s evaluation team between January 2005 and July 2006. The evaluation was designed to document the progress made since the Summits by the participant states in promoting the integration of primary and behavioral health care. To ensure the collection of the most objective and complete information for the evaluation, multiple sources of data were used: questionnaires, interviews, teleconferences, and document reviews.

² REDA International Inc. has submitted the *Summary Report on the Conduct and Evaluation of All Summits* to HRSA in January 2005.

The evaluation reviewed the overall “state of the State” for each participating State to determine if other factors affected the results of its initiative. For instance, at the Summit meeting each State identified its underserved populations and generated a preliminary list of needs, resources, and barriers to improved service. Its Action Plan was developed within the context of these unique State circumstances. During the implementation phase, the team had to work within the political, economic, and organizational constraints of the State environment. Each of these factors could have accelerated or impeded the team’s efforts to integrate primary and behavioral health care.

The report concludes with a set of recommendations for future action on how to support states in their efforts to promote integration of primary and behavioral health care. This section focuses on the recommendations to HRSA that may assist states in developing integrated health care systems.

Finally, the appendices include the summaries of the achievements of the participant states in implementing their Action Plans, information about team leads, and the instruments used to collect the data.

Chapter 1. EVALUATION DESIGN

This chapter presents the evaluation design and consists of the following sections:

- ◆ Summit Initiative Process,
- ◆ State Action Plan Implementation,
- ◆ Evaluation Methodology, and
- ◆ State Participation in the Follow-up Activities.

Summit Initiative Process section presents the overview of the Summit model, including details of the Summit meetings. State Action Plan Implementation sections discusses the necessary components of the in-state implementation of service integration and variables that could affect the implementation. Evaluation Methodology section outlines evaluation questions and data collection methods. The last section presents statistics of state participation in the follow-up activities.

1.1. Summit Initiative Process

The primary purpose of the evaluation was to assess the Summit Initiative process as a vehicle for increasing the provision and integration of primary care, mental health and substance abuse services in states that have participated in the HRSA/SAMHSA Primary and Behavioral Health Care Summit Initiative.

Exhibit 1.1.1 on the following page presents a graphic overview of the intervention process as experienced by an individual State. As shown in the exhibit (dark gray areas), there were two phases in the process:

- 1) *Summit Meeting*. The federally funded Summit meeting brought together a group of officials and stakeholders to:
 - a. Generate State-specific strategies (a state Action Plan) for enhancing systems and infrastructures to support primary and behavioral health care integration in community-based settings; and
 - b. Develop a committed team of leaders to move forward with their State Action Plan after the Summit.
- 2) *Action Plan Implementation*. During this phase, the State team members identified available public and private resources to support the implementation of their State Action Plan, and began implementing the Plan.

Representatives from 29 states and administrative entities (including 25 states, the District of Columbia and three insular areas) were invited to participate in four multi-day Closing the Gap Summits in 2004 (see Table 1.1.1 for a list of states invited to participate in each Summit). Of those, representatives from 26 states and administrative entities

attended the four Summits. Nevada, the Virgin Islands and the Pacific Basin were invited but did not attend the Summits.

During each Summit, teams of participants from four to eleven states developed their State Action Plans. Upon registering, participants received articles on various health, mental health, and substance abuse topics and a compilation of related statistics for their individual states. Participating stakeholders for various states included primary care and mental health and substance abuse service providers, consumers, provider and advocacy organization representatives, academicians, State Medicaid Directors, mental health and substance abuse State authorities, State primary care authorities, representatives from governors' offices, legislators, and other key officials.

Exhibit 1.1.1. Overview of Summit Initiative Process

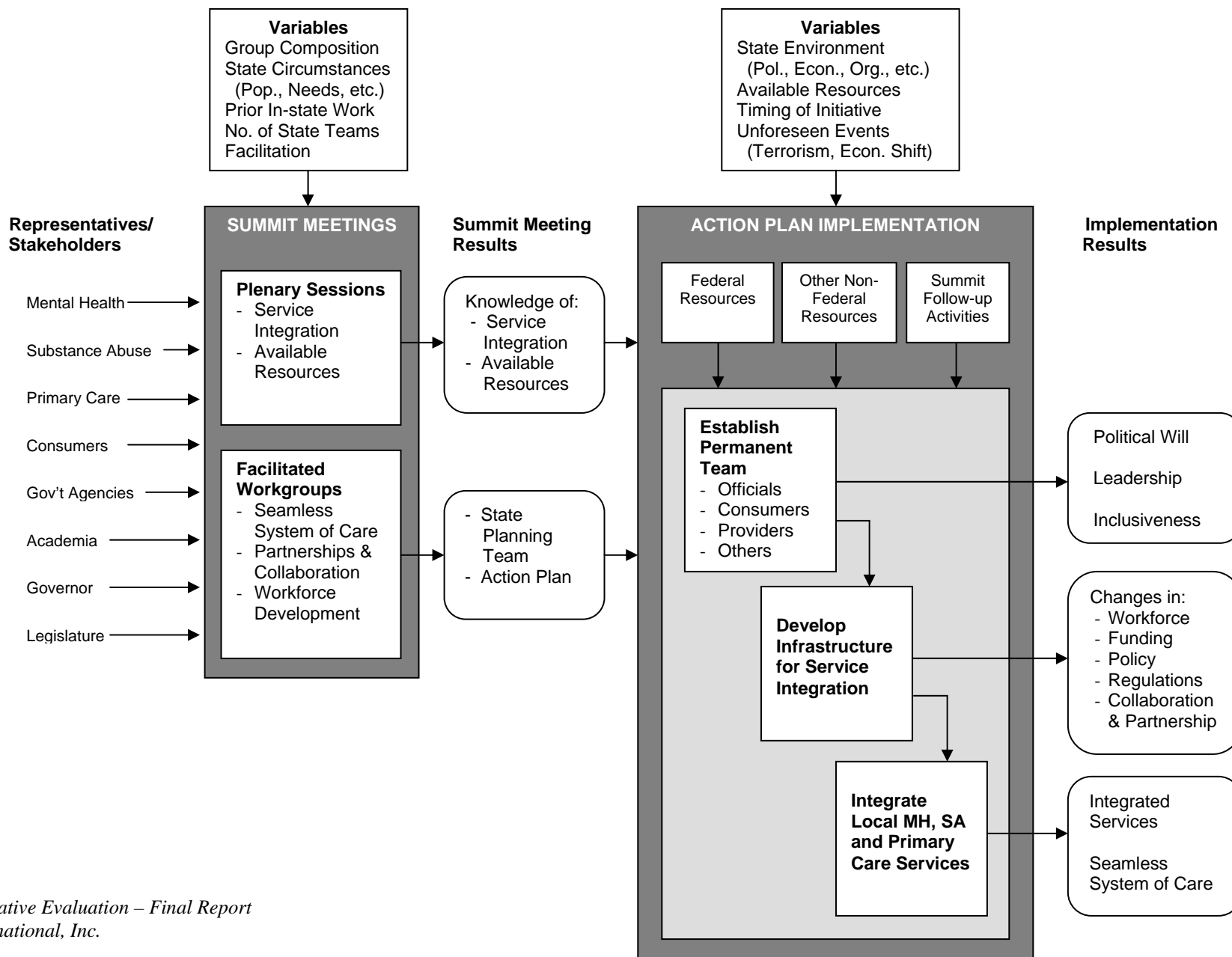


Table 1.1.1. States Invited to Participate in Each Summit

New Orleans, LA June 14-16, 2004	Falls Church, VA October 25-27, 2004	Albuquerque, NM November 8-10, 2004	Seattle, WA December 7-9, 2004
Arkansas Louisiana Oklahoma Texas	Connecticut Delaware Maine Massachusetts New Hampshire New Jersey Puerto Rico Rhode Island Vermont Virgin Islands* Washington, DC	Arizona Colorado New Mexico Utah Wyoming	Alaska California Hawaii Idaho Montana Nevada* Oregon Washington Pacific Basin*

*Did not participate

The Summit meetings included plenary sessions on service integration, team building, and lessons learned from previous efforts to integrate primary and behavioral health care. However, the bulk of the time was spent in facilitated breakout sessions in which the teams created their Action Plans. In developing State-specific plans, participants addressed the following issues:

- 1) Strategies for creating a seamless system of care,
- 2) Developing and training a workforce to provide integrated services, and
- 3) Strategies for developing partnerships and collaborations.

The same lead facilitator (Maggie McGlynn of McGlynn Associates) was used for each of the Summit meetings. She also trained HRSA and SAMHSA personnel and others to serve as facilitators to help the State teams develop their plans.

As a result of attending the plenary sessions and from the resource materials provided, participants at the conclusion of each Summit better understood service integration and the resources available to help implement their Action Plans. In addition, during the facilitated work sessions, participants were given an opportunity to establish working teams with specific assignments and responsibilities for implementing the plans.

1.2. State Action Plan Implementation

As shown in Exhibit 1.1.1 (light gray area), in-state implementation of service integration had three primary components:

- ◆ *Establishment of a permanent team, group, or council to oversee, direct, and facilitate the integration of mental health, substance abuse, and primary care*

services. The group was supposed to be recognized and sanctioned by the appropriate State authorities and its members were to include State and local officials, service providers, consumers, and other stakeholders. By establishing such a group, the State would demonstrate its political will to integrate services and provide leadership for the integration initiative. It would also create a mechanism through which all interested parties could participate in the planning and implementation process.

- ◆ *Development of the infrastructure needed for service integration.* In order to integrate local service delivery systems, states needed to create an “infrastructure” that would support the integration of primary and behavioral health care. This involved various changes, including securing financial resources, training and developing a workforce skilled in providing integrated care, changing policies and regulations to promote service integration, and creating cooperative agreements, collaborations, and partnerships.
- ◆ *Integration of local service delivery systems.* The success of the state initiative would result in the integration of primary and behavioral health care at the local level. Consumers would experience this success as a seamless system of care.

Resources. Summit participants were encouraged to make use of available federal resources to help implement their Action Plans. Such resources include the SAMHSA community expansion grants and the placement of mental health and substance abuse service providers through the National Health Service Corps Scholarship and Loan Repayment Program. In addition, participating states could use State and local funds, foundation grants, and other non-federal resources to support implementation of their integration initiatives.

Variables Affecting Implementation. There are a number of variables that could potentially affect a State’s ability to use the Summit process to create and successfully implement an Action Plan for integrating primary and behavioral health care. Some of these are related to the composition and readiness of the teams that attend the Summits. The evaluation assessed whether each team had the right mix of people at the Summit (consumers, providers, those with authority to make things happen locally, etc.) and, if not, whether these individuals were later involved in the State planning and implementation process.

States also differed in the degree to which they were involved in efforts to integrate primary and behavioral health care prior to the Summit meeting. For some, the Summit was the first opportunity for people concerned with mental health, substance abuse, and primary care services to meet and plan jointly. For others, joint planning had been ongoing, and the Summit and follow-up activities became additional resources they could use to move more quickly to the next stage in the process.

The evaluation reviewed the overall “state of the State” for each participating State to determine if other factors affected the results of its initiative. For instance, at the Summit

meeting each State identified its underserved populations and generated a preliminary list of needs, resources, and barriers to improved service. Its Action Plan was developed within the context of these unique State circumstances. During the implementation phase, the team had to work within the political, economic, and organizational constraints of the State environment. Each of these factors could have accelerated or impeded the team's efforts to integrate primary and behavioral health care.

Finally, the evaluation looked to determine if unforeseen events — such as terrorist attacks, a natural disaster, or a State economic shift — affected the success of State initiatives.

1.3. Evaluation Methodology

The evaluation of the process and outcomes of the Summit initiative was conducted between October 2004 and June 2006. It aimed at measuring changes within the participating states on variables of interest to HRSA, SAMHSA, states, and communities. The evaluation sought to achieve the following:

- ◆ Compare actual accomplishments to those proposed in the State Action Plans in the three areas highlighted during the Summits: seamless system of care, workforce development and collaboration/partnerships.
- ◆ Assess changes in the Summit states regarding the integration of primary care and behavioral health services in areas such as policy, joint planning, funding, and innovative service delivery; as well as in areas such as community development, consumer participation, and innovative use of existing resources.
- ◆ Examine Summit states' use of HRSA, SAMHSA, and other related programs and grants as resources or tools for implementing their Action Plans.
- ◆ Critically examine the Summit process as a method of promoting State- and community-level change in the integration of primary care and behavioral health services.

The evaluation of the Summit process was conducted between October 2004 and December 2004, and the results of this evaluation were summarized in the report *Summary Report on the Conduct and Evaluation of All Summits*³. The evaluation of the state-specific outcomes of the four “Closing the Gap on Access and Integration” Summits was conducted in two rounds. The first round of outcome evaluation activities took place between December 2004 and October 2005. The second round took place between February and June of 2006.

The following sections identify the specific evaluation questions that were addressed and the methods of collecting and analyzing data to answer these questions. The questions

³ The report was submitted to HRSA in January 2005.

were based on the variables that were examined in the study. Most variables were measured by gleaning information from reports generated by the participants (State Action Plans and update reports), teleconferences and existing documents. Evaluation results of the summit process were based on analysis of the data obtained through evaluator observations at Summits, and by analyzing responses to specific questions posed to team leaders, facilitators, and federal officials.

1.3.1. Evaluation Questions

The following evaluation questions, which were specified prior to the beginning of the evaluation process, emerged from the research REDA conducted in evaluating the first round of the Summits in 2000-2001. These questions guided the evaluation design, the choice of data collection methods, and the analysis of the collected data.

1. Is the Summit initiative process an effective mechanism for promoting State- and community-level change in the provision and integration of primary and behavioral health care?

The first question addressed the issues of whether the Summit initiative process was implemented as intended and whether it produced the immediate results in promoting change.

1.1. Did the Summits attract the right mix of stakeholders from states eligible to participate in the initiative?

This is a two-part question. First, how many of the states eligible to participate in one of the Summits took advantage of the opportunity and sent a team of stakeholders? Second, how many stakeholders participated from each State, and was this group composed of the appropriate individuals and representatives needed to develop and implement a workable State Action Plan?

1.2. Did the Summit meetings produce the types of collaborative relationships and Action Plans needed so that State teams could continue to work productively following the meetings?

Part of the evaluation focused on how the Summits were conducted and whether their immediate goals were met: that is, whether each participating State 1) developed an Action Plan while at the meeting and 2) established a core team of leaders that could continue working together to implement the plan after the Summit. The evaluation specifically examined whether information provided at the Summit was sufficient for planning, if facilitation was adequate, and if the overall format of the Summit was conducive to team building and strategy development. Evaluation information collected at each of the Summits was analyzed promptly and delivered to HRSA/SAMHSA so that the quality of the subsequent Summit meetings could be improved.

1.3. Were the Summit follow-up activities useful to participants?

Team leaders and other representatives from the participating states had an opportunity to rate the usefulness of follow-up activities such as periodic teleconferences and the sharing of progress reports.

2. What are the states' major accomplishments in the evaluation period following the Summit?

The evaluation assessed the accomplishments of each state in the period following their participation in a Summit. Two separate assessments were done at six to twelve months following the Summits, and eighteen to twenty-four months following the Summits, to chronicle states' progress. The overall evaluation question about states' accomplishments was divided into four major sub-questions:

2.1. Did each State establish a permanent team or other entity responsible for overseeing and coordinating the implementation of the Action Plan developed at the Summit?

Without an established team to provide leadership and champion the goals of the initiative, implementation can easily falter. The evaluation sought to determine whether such an entity had been established in each State. The review addressed such questions as: Which groups and interests (government agencies, consumers, providers, elected officials, and other stakeholders) were represented on the team? How was it organized? What authority did it have? Was there an official entity that took overall responsibility for the success of the Action Plan implementation?

2.2. What are the actual accomplishments compared to those proposed in the Action Plans?

This question addressed the issue of whether or not teams were able to formulate specific objectives in the Summit meetings and then carry them out according to schedule. During the Summit, each team developed a plan of action that included action steps and intended outcomes they planned to achieve in three areas: building of a seamless system of care, workforce training and development, and creating partnerships and collaborations. The evaluation sought to determine whether states had accomplished their objectives in each area.

2.3. What implementation barriers did states encounter and how were these resolved?

As described above, there are many variables that can impede implementation of the Action Plans. Some of these, such as laws or policies that restrict service integration, may have been anticipated and even addressed in the Action Plans; others, such as terrorist attacks or natural disasters, are less likely to be anticipated. The evaluation documented the implementation barriers that states encountered — both foreseen and

unforeseen — and their success in overcoming these barriers. This report identifies common barriers across states and provides examples of successful resolutions.

2.4. What exemplary changes have occurred in the states regarding the integration of primary and behavioral health care?

It was anticipated that some of the states would initiate particularly successful integration initiatives or develop innovative ways of increasing the provision of mental health and substance abuse services in primary care settings. These changes may be in areas such as policy, joint planning, funding, community development, consumer participation, and innovative use of existing resources. Team leaders were asked to identify any integration initiatives or other innovations in their states that they felt were exemplary or constituted a promising practice. They were also asked to provide a brief description of such initiatives.

3. How do states use HRSA, SAMHSA, and other public and private grants and programs to implement their Action Plans?

As a result of the Summits, states should have had a greater awareness of federal and other public and private resources available to them. The evaluation aimed to determine if states drew down new HRSA and SAMHSA resources following their participation in the Summits and/or if they used these resources in new ways.

Team leaders were asked to report on their use of other federal resources to further the implementation of their Action Plans. They were also asked whether they had been able to secure additional State or local funds, foundation grants, community support, etc. Problems experienced by states in securing needed resources were also documented.

1.3.2. Data Collection Methods

To ensure collection of the most complete and accurate data, a variety of methods were used to collect data for the evaluation of the Summits and post-summit activities. The selection of data collection methods was based on the appropriateness for the research questions, and the feasibility. The methods included the following:

Collection and Review of Existing Documents. REDA collected and reviewed a variety of documents pertaining to the four Summits and post-summit activities. These include:

- ◆ Summit notebooks, including the State Action Plan framework,
- ◆ Summit participant lists,
- ◆ State Action Plans developed at the Summits,
- ◆ Write-ups on exemplary integration initiatives, service innovations, model policies, etc. that states generated as part of their implementation, and
- ◆ Participant lists and materials from follow-up teleconferences.

Summit Evaluation Forms and Observations. Evaluators attended each Summit to observe the sessions. Facilitator debriefing meetings followed each Summit. Evaluation forms were distributed to participants at each Summit so they could rate the quality and usefulness of the following:

- ◆ Summit plenary sessions and speakers,
- ◆ Resource information and handout materials,
- ◆ The facilitated work sessions and the facilitators,
- ◆ The Action Plans they developed at the Summit, and
- ◆ The overall Summit experience and results.

The evaluation form provided participants the opportunity to comment on each of these topics and make suggestions for improving subsequent Summit meetings.

A similar evaluation form was distributed to facilitators following the Summit meeting to obtain their opinions on the same topics. In addition, facilitators had the opportunity to rate the groups they facilitated on factors such as readiness to participate in the summit and commitment to implement the State Action Plan.

State Update Reports. At the Summits, facilitators asked two to three participants from each State to volunteer to serve as points of contact for the evaluation of post-Summit implementation. One of these individuals, the “team leader,” was asked to complete a State Update Report form in the first round of evaluation activities that took place between January and October of 2005. This form also served as a base for the second round of the evaluation activities that took place a few months after the first one. The form (Appendix E) was used to assess and summarize the State’s progress to date in implementing its State Action Plan and promoting service integration.

Using the State Update Report Form, team leaders were asked to provide information on the following topics:

- ◆ Leadership and organization of the State initiative;
- ◆ Participation, coordination, partnerships, and collaboration among agencies, groups, and organizations;
- ◆ Action Plan accomplishments in the areas of workforce training and development and partnerships and collaboration;
- ◆ Other notable accomplishments (e.g., demonstration projects, in-State Summits, etc.);
- ◆ Changes in the Action Plans;
- ◆ Use of federal and other resources to implement the Action Plan;
- ◆ Degree of consumer involvement in plan development and implementation;
- ◆ Barriers encountered and actions taken to overcome barriers; and
- ◆ Impact of unforeseen events (economy, natural disasters, terrorism, etc.) on their planning and implementation.

Following the Summits, evaluation team members contacted the team leaders via e-mail and worked with states to ensure that update information was provided.

Telephone Interviews with Team Leaders. During the second round of the evaluation activities, we conducted a series of telephone interviews with the team leaders from all states that participated in the Summits. In these interviews, we used questions from the same State Update Report Form that had been used in the first round of the evaluation. The interview format of the data collection allowed us to obtain more detailed information on recent accomplishments in the implementation of State Action Plans, as well as to receive participants' assessment of the Summits as a vehicle of promoting the integrated model. The interviews took place between February and May of 2006 and lasted between 30 and 60 minutes. In a number of states, the team leads were unable to provide information about all aspects of integration, and in these cases additional interviews were conducted to fill the data gaps (see Appendix C for the information on the interviews).

Multi-State Teleconferences. At the end of each of the two rounds of evaluation activities following the four Summit meetings, multi-state teleconferences were conducted. The first round of multi-state teleconferences was held between May and October of 2005. The second round took place in May and June of 2006. The evaluation team scheduled the teleconferences in a way that maximized the participation rate. To prompt informed discussions, prior to each teleconference we sent to participants an agenda and a summary of accomplishments of each state participating in the call. The primary purpose of the teleconferences was to gather evaluative information, such as suggested solutions to common implementation barriers. For the Summit participants, teleconferences provided an opportunity to learn about the progress achieved by other states in implementing their plans, seek solutions to common implementation barriers, and share promising practices and lessons learned (see Appendix D for the information on the multi-state teleconferences).

The questions discussed during the multi-state teleconferences focused on issues raised in the update reports. The teleconferences functioned similarly to social science focus groups. Rich qualitative data gained from the group discussions supported the interpretation of quantitative information gathered from the update reports and the analysis of secondary data. Teleconference discussions provided an opportunity to ask probing questions and to find out why something worked or did not work. An evaluation team member skilled in group facilitation guided the teleconferences using questions developed by the team. REDA utilized the Broadwing Teleconferencing service, a conference call service that connects all of the participants via dial-in, and records the conversation for further analysis.

Summary of Data Collection Methods. Table 1.3.1 is a summary table that shows the sources of data for each of the key evaluation questions.

Table 1.3.1. Key Evaluation Questions by Data Source

Evaluation Questions	DATA SOURCES			
	Existing Documents	Summit Evaluation Forms	State Update Reports and Interviews	Multi-State Conferences
1. Summit intervention				
1.1. Appropriate stakeholders involved	X	X	X	X
1.2. Summit meeting goals met	X	X	X	
1.3. Usefulness of follow-up activities			X	X
2. State accomplishments				
2.1. Establishment of in-state team			X	X
2.2. Proposed versus actual accomplishments			X	X
2.3. Barriers and solutions	X		X	X
2.4. Exemplary changes	X		X	X
3. Use of federal and other resources	X		X	X

1.4. State Participation in the Follow-up Activities

Following the Summits, the State Update Report Form (Appendix E) was used during both rounds of the evaluation to collect data on state accomplishments. In the first round of the evaluation, we distributed and collected these forms via email. Out of twenty-five states represented in the four Summits⁴, seventeen (68%) submitted 6-month update reports. Of those, two states (12%) reported making excellent progress in implementing their state Action Plans; six states (35%) said they had made good progress; five states (29%) evaluated their progress as fair; and the remaining four states (24%) said they had made no progress.

During the second round of the evaluation, we again used the State Update Report Form and a list of additional questions to collect data via telephone interviews with state representatives and team leads. We conducted telephone interviews with twenty-seven individuals from twenty-five states, achieving a participation rate of 100% for the second round of evaluation activities. Of the twenty-five states that participated in the second round of evaluation, one state (4%) reported making excellent progress in implementing its Action Plan; four states (16%) reported making good progress; eleven states (44%)

⁴ The original number of participant states was twenty-six, but following the Summits the New Hampshire Department of Health indicated that the state did not want to participate in the Summit initiative or evaluation activities. Consequently, New Hampshire was excluded from the analysis of the Summit outcomes.

reported making fair progress, and eight states (32%) reported making poor progress. One state (4%) did not use its Action Plan.

Having collected information on the progress of State Action Plan implementation, we analyzed this information and compiled the state summaries that were used in drafting teleconference agendas. In the first round of multi-state teleconferences conducted between May and October of 2005, representatives from thirteen states (52% of all Summit states) participated in the teleconferences. The second round of multi-state teleconferences was conducted in May and June of 2006. Eleven states (44% of all Summit states) took part in the second round of teleconferences⁵. The primary purpose of the multi-state teleconferences was to collect additional information on integrated health care in participating states. In addition, these teleconferences gave representatives from the participating states an opportunity to discuss their progress, describe problems that they encountered in implementing their Action Plans, share solutions, and talk about resources needed for their initiatives and other issues of interest.

⁵ Eight states (32% of all states-Summit attendees) participated in both rounds of teleconferences. See Appendix C for the list of participants of the second round of teleconferences.

Chapter 2. THE SUMMIT INITIATIVE PROCESS: ASSESSMENT AND RECOMMENDATIONS

In January 2005, REDA submitted to HRSA the *Summary Report on the Conduct and Evaluation of All Summits*. The report, based on evaluator observations and questionnaires completed by Summit participants, provided qualitative and quantitative information on the effectiveness of the Summit meetings as a model of promoting integrated health care among states. The report chronicled how the Summits were organized and conducted, how participants were recruited, who attended the meetings, their feelings about the Summit process, and the immediate outcomes or results of the Summit meetings. Those surveyed included representatives of twenty-four states⁶, the District of Columbia, and Puerto Rico, as well as summit facilitators.

REDA collected the evaluation data during the Summits, and analyzed the data in the following months. The evaluation of the Summits focused on (1) recruitment and participation, (2) the Summit process, (3) the results of the Summit, and (4) recommendations for Summit improvement. Below is a summary of the evaluation results based on these four areas.

This chapter presents the most important findings of the assessment of the Summit initiative process, and our recommendations for improvement in the event that HRSA uses a Summit-type process in the future. The following evaluation questions are addressed in this chapter:

- ◆ Is the Summit initiative process an effective mechanism for promoting State- and community-level change in the provision and integration of primary and behavioral health care?
- ◆ Did the Summits attract the right mix of stakeholders from states eligible to participate in the initiative?

The first question addressed the issues of whether the Summit initiative process was implemented as intended and whether it produced the immediate results in promoting change. The second question is a two-part question. First, how many of the states eligible to participate in one of the Summits took advantage of the opportunity and sent a team of stakeholders? Second, how many stakeholders participated from each State, and was this group composed of the appropriate individuals and representatives needed to develop and implement a workable State Action Plan?

More detailed information on the evaluation of the Summit process, including cross-Summit comparisons, is available in the *Summary Report on the Conduct and Evaluation of All Summits* report.

⁶ Participation of one state (New Hampshire) was later recalled. While we excluded New Hampshire from the evaluation of the summit outcomes, we did preserve it for the evaluation of the summit process in this section of the report.

2.1. Recruitment and Participation

The teams consisted of 4 to 33 representatives from each state. Although there was a concerted effort to recruit individuals from all eligible states, four states had only one representative: New Hampshire, Puerto Rico, Montana, and Idaho. Individuals from these states were all able to participate in the process and create Action Plans for service integration in their states; however, as one of these individuals noted, “This is a great plan for me, not for [my] state.” Table 2.1.1 shows the participation rates from different states:

Table 2.1.1. Summit Attendance by State

New Orleans, LA		Falls Church, VA		Albuquerque, NM		Seattle, WA	
Arkansas	6	Connecticut	6	Arizona	20	Alaska	10
Louisiana	33	Delaware	5	Colorado	9	California	26
Oklahoma	9	Maine	15	New Mexico	13	Hawaii	10
Texas	31	Massachusetts	18	Utah	5	Idaho	1
		New Hampshire	1	Wyoming	4	Montana	1
		New Jersey	4			Oregon	22
		Puerto Rico	1			Washington	30
		Rhode Island	5				
		Vermont	15				
		Washington D.C.	11				
Subtotal	79		81		51		100
TOTAL							311

A variety of stakeholders, including practitioners, policy makers, and consumers of primary care and behavioral health services, were invited to participate in the Summit meetings. As the Table 2.1.2 shows, over half of all 311 participants were providers, almost evenly split between primary and behavioral health practitioners. Policy-makers composed 19% of the registered participants, and legislators were absent altogether. 19% of participants were non-state organization representatives, including advocacy groups, healthcare foundations and associations. The remaining participants were consumers (2%) and academicians (7%). Summit participants generally committed themselves in their Action Plans to try to engage stakeholders who were absent from the Summits in their post-Summit service integration efforts.

Host state teams had their own unique set of participation challenges. Registration for the host state was usually full prior to the Summit, and waitlists were created to accommodate the additional demand. While the first day of the Summit was well attended by the host state team, a large number of participants either failed to return the next day or sporadically attended Summit meetings. At that point, it was too late to bring waitlist participants into the Summit process. The premature departure by host state team members created problems within these teams resulting in some members stating that they did not feel a team was created that would act upon the Action Plan. To address this issue, host state participants for the final Summit in Seattle were told that their

registration was contingent on their participation in all three days of the Summit. This significantly reduced the host state participation problem.

Table 2.1.2. Registered Summit Participants by Area⁷

Participants by Area	LA Summit	VA Summit	NM Summit	WA Summit	TOTAL No.	TOTAL %
PROVIDERS						
PC providers	22	12	8	27	69	22%
Social Workers	4	4	0	4	12	4%
MH providers	9	9	7	6	31	10%
SA providers	2	3	1	2	8	3%
BH providers	7	9	16	12	44	14%
All BH providers	18	21	24	20	83	27%
Subtotal providers	44	37	32	51	164	53%
STATE OFFICIALS						
PC state officials (PCO, etc)	8	16	3	15	42	14%
MH state officials	0	2	0	2	4	1%
SA state officials	1	1	1	1	4	1%
BH state officials	1	2	1	2	6	2%
All BH officials	3	5	2	5	14	4%
Medicaid/Medicare office	3	0	1	0	4	1%
Legislature	0	0	0	0	0	0%
Subtotal state officials	13	21	6	20	60	19%
NON-STATE ORGANIZATIONS						
PC organizations (PCA, etc)	12	4	3	10	29	9%
MH organizations	1	7	2	7	17	5%
SA organizations	1	0	1	0	2	1%
BH organizations	4	4	1	2	11	4%
All BH organizations	6	11	4	9	30	10%
Subtotal non-state	18	15	7	19	59	19%
OTHER						
Consumers	0	0	1	4	5	2%
Academicians	4	8	5	6	23	7%
TOTAL	79	81	51	100	311	100%

⁷ This table is based on the lists of participants with advanced registration. The actual list of participants varied slightly, since some people dropped out at the last moment, and others, especially from the host states, arrived at the meetings without going through pre-registration process.

2.2. Summit Process

As with any dynamic process, the basic Summit process was modified and improved with each successive Summit. The major changes included:

- ◆ Plenary sessions were distributed over the three days of the Summit, rather than having several of them the first day.
- ◆ Additional opportunities were added for interaction with the plenary speakers (e.g., consultation sessions with individual teams and adding a question and answer forum).
- ◆ The addition of a plenary session on rural mental health.
- ◆ The introduction of the model of integration during the first plenary session.
- ◆ An e-mail message was sent to registrants prior to the Summit suggesting that they familiarize themselves with integration efforts currently underway in their state.
- ◆ Clearer instructions provided to the host state team discussing participation requirements.

Two factors also positively impacted the facilitation process. First, facilitators improved their skills with each successive Summit. Second, in each successive Summit modifications were made to the facilitation documents and tools as recommended by the facilitators.

2.3. Summit Results

The Summit process produced its intended and immediate results. All state teams—regardless of size, even those with just one individual—created Action Plans that addressed the issues of seamless system of care, workforce training and development, and partnership and collaboration.

Team leaders were selected by their groups or self-identified for each state. These leaders agreed to be contacted after the Summits to provide updates on the implementation of their Action Plans and for other evaluation activities.

During the second round of evaluation two years after the New Orleans Summit and over eighteen months after the Falls Church, Albuquerque, and Seattle Summits, team leads were asked to evaluate the usefulness of the Summits they attended. Some participants expressed satisfaction with how meetings were conducted. For example, one team lead said: “The Summit was good. It brought partners together, it enabled us to talk to other states, and it was good to create it as a movement.”

Some other participants were less happy with the way Summits were organized. The composition of the invited teams was the main complaint. For example, the team lead from Colorado said that the meeting he attended was not announced to them “until late in process and, as a result, key players were not there. The state was absent, policy makers

were absent. Those present were interested providers with no access to decision makers and no opportunity to influence their decision-making.”

New Orleans and Albuquerque Summits had particularly low representation of state officials: 16% and 12% respectively. Some state teams that attended Summits had only providers on their teams.

Nonetheless, over a half of the evaluation participants said they thought the Summit meetings were a “good” or an “excellent” way to jumpstart the implementation of the integrated model in their states. Figure 2.3.1 presents the distribution of team leads’ opinions about the effectiveness of the Summits:

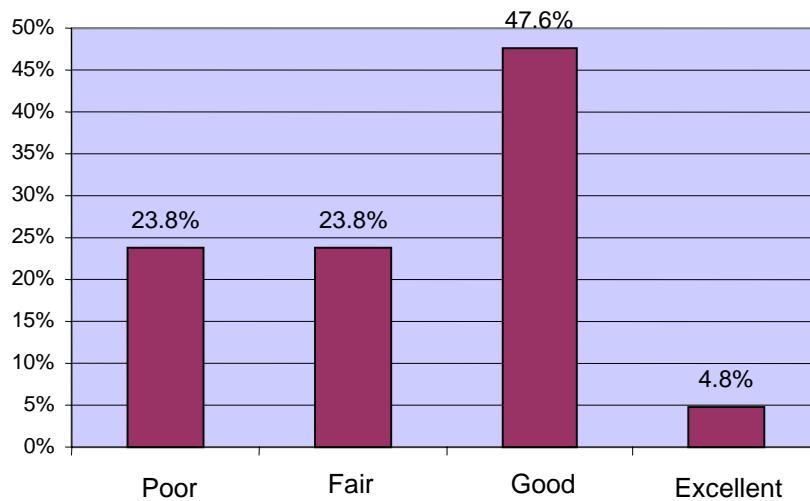


Figure 2.3.1. Evaluation of Summit Effectiveness by Participants (n=21)⁸

Summit participants gave a number of reasons for the “poor” and “fair” evaluations of the Summits. The main themes were the following:

- ◆ Recruitment: absence of the policy makers from the state teams;
- ◆ Preparation: insufficient time to prepare for the meetings;
- ◆ Understanding the Purpose: the purposes of the meetings were not well understood by all invitees prior to the meetings, hence in some cases wrong people attended;
- ◆ Process: agenda imposed on participants whether they wanted to follow it or not;
- ◆ Follow-up: follow-up support with implementation of the Action Plan was needed.

⁸ The percent of Summit participants who rated Summits as good or excellent was significantly higher right after the Summits. In the evaluation forms distributed to the participants at the Summits 84% of all participants said the Summits were either excellent or good. These results were reported in the Summary Report on the Conduct and Evaluation of all Summits.

For many states, Summits helped galvanize their pre-existing effort with regard to the integrated care. For example, the team lead from Oregon said that while he did not find the agenda of the Washington Summit particularly useful, the meeting itself was a turning point in their integration efforts. It helped bring together interested parties and finally establish a dialogue about needs, priorities and strategies.

2.4. Recommendations

In the event that HRSA and/or SAMHSA are interested in using a Summit-type process in the future to promote planning among state or local groups, the following are some recommendations for improvement derived from the participant and facilitator evaluations, organized as pre-Summit preparation recommendations, Summit process recommendations, and post-Summit follow-up recommendations:

Pre-Summit Preparation

- ◆ ***Materials*** – Participants mentioned that they had not had a chance to review the resource materials prior to beginning their state Action Plans. In future summits, the materials should be sent to the participants prior to the actual Summits to increase participant base knowledge and stimulate integration of ideas and conversations within state agencies.
- ◆ ***Participant lists*** – Some participants felt it would have been helpful to know who would attend the Summit from their state so that meetings or communications could take place prior to attending the meeting. Additionally, when state team members are shown the participant lists, they may be able to recruit others in the states that are not registered and who may be more appropriate.
- ◆ ***Summit planning*** – Participants mentioned a dearth of lead-time. This situation may have been created by the additional time it took to recruit participants. For many, travel outside of their state is difficult or impossible within a short timeframe. Further lead-time may also enable state representatives to participate.
- ◆ ***Clarity of purpose*** – State teams that had already been working toward integrating services often came to the Summit with a different set of expectations from those that were just beginning the discussion of integration. Participants from the more advanced states often wanted help with issues that the Summit was not designed to address, such as overcoming state-specific financial or legislative barriers to integration. Promotional materials and draft agendas should be as specific as possible about the content, structure, and expected outcomes of the Summit.

Summit Process

- ◆ **Funding** – Many participants mentioned the need for a discussion on funding, both within and outside of their own state team. Summit participants were interested in understanding federal funding streams and how to successfully tap into them, the future of funding, and where funding might be obtained in the private sector.
- ◆ **Time constraints** – Many participants and facilitators felt rushed through the process. Extending the Summit meeting to include the morning of the first day would help ease the time crunch.
- ◆ **Networking** – Many participants felt that they did not have enough time to network with individuals from states other than their own. To facilitate this networking, future Summits should include a formal networking event.
- ◆ **Cultural sensitivity** – Summit planners should be sensitive to the cultural needs of participants from diverse backgrounds. Diversity should be represented or at least addressed in the plenary panels. For example, a participant from Alaska noted, "Western medicine has not worked for Native people, often makes us sicker. These plans still are overly focused on allopathic medicine and the 'good old white boys system.'" Additionally, all religious holidays should be avoided when scheduling a Summit. For example, Hanukkah began on December 7th and continued for the duration of the Seattle Summit.

Post-Summit Follow-Up

Maintaining contact – Many facilitators recommended maintaining contact with the states to continue to encourage the integration discussion and practice through a pacing event and/or a list serve. The pacing event was mentioned as something that could occur after the conclusion of the evaluation follow-ups. The list serve was discussed in terms of a learning community where best practices, barriers and successful solutions, chances for collaboration, and questions could be shared among states and federal agencies.

Chapter 3. IN-STATE INTEGRATION LEADERSHIP

This chapter focuses on the state accomplishments in establishing in-state leadership to promote the integration of mental health, substance abuse, and primary care services following the 2004 Closing the Gap Summits. The following evaluation question guided data collection and analysis:

- ◆ Did each State establish a permanent team or other entity responsible for overseeing and coordinating the implementation of the Action Plan developed at the Summit?

The following data sources were used to answer this question: state update reports, telephone interviews with team leaders, multi-state teleconferences, and pre-existing documents.

3.1. Coordinating Agency

According to the logic model for the Summit Initiative presented in Exhibit 1.1.1, each of the 26 states that participated in the Summits was to establish a permanent team responsible for overseeing and coordinating the implementation of its Action Plan. The establishment of such teams was one of the initiative's highest priorities. Toward this end, key stakeholders in the areas of mental health, substance abuse, and primary care were invited to participate in the Summit meetings. In most states, there had been little communication or joint work across these disciplines before the Summits. The hope was that Summit participants from each state would constitute the nucleus of an expanded, permanent team to be established in the state following the Summit.

During the two rounds of evaluation activities, we asked team leads and state representatives to describe how integration efforts were being coordinated and if a particular agency, group, or organization had assumed lead responsibility for Action Plan implementation. Officials in two of the states, Delaware and New Hampshire, concluded that the individuals from their states who had participated in the Summit did not have the authority to represent the state and develop an Action Plan on its behalf. Therefore, no permanent teams were established in these two states and no further work was done on implementing the Action Plans. In four other states, work continues on tasks identified in the state Action Plan, but no coordinating body or leadership team has been established. These states are Colorado, Idaho, New Jersey, and Wyoming.

In total, 20 of the 26 states (77%) have established a permanent team or other entity that is responsible for overseeing and coordinating the implementation of the state's Action Plan. Table 3.1.1 provides an overview of how these states have organized themselves to implement their Action Plans.

Table 3.1.1. Coordinating Body to Implement State Action Plan

Coordinating Body	No. of states	Percent* (n=20)
Steering committee	9	45%
Interagency council	3	15%
Directed by a single agency	5	25%
Other	6	30%

* Total is over 100% because multiple responses were possible

In three states integration efforts are coordinated by two entities: by a steering committee and an interagency council in Arizona, and by a steering committee and a single agency in Texas and Vermont. The three states where the efforts are coordinated just by a single agency are the District of Columbia (where the Primary Care Association is leading the efforts), Alaska (by the Department of Health and Social Services) and Puerto Rico (by the Department of Health). Examples of “other” ways of organizing include a planning committee (Arkansas), a healthcare foundation (Maine), an informal group (Connecticut), a Summit group (Massachusetts and California), and an interagency group (Rhode Island).

In the 20 states that have established leadership teams, an average of 7.5 agencies and organizations are represented in each team. The range is from five to sixteen agencies and organizations per team. Table 3.1.2 shows the types of agencies and organizations that are currently members of the leadership teams.

Table 3.1.2. Agencies and Organizations in Leadership Teams

Participating Agencies and Organizations	No. of states	Percent (n=20)
Primary Care Providers	17	85%
Mental Health Department	15	75%
Primary Care Association	14	70%
Substance Abuse Department	14	70%
Mental Health Service Providers	13	65%
Health Department	12	60%
Mental Health Advocacy Organization	11	55%
Primary Care Organization	10	50%
Substance Abuse Service Providers	10	50%
Medicaid Office	9	45%
University or College	8	40%
Consumer Organization	7	35%
Other	6	30%
Substance Abuse Service Advocacy Organization	4	20%
Family Member Organization	4	20%
Governor's Office	4	20%
Legislature	2	10%
Other Elected Officials	1	5%

As evident from Table 3.1.2, the following groups most often participate in the leadership teams:

- ◆ primary care and mental health providers
- ◆ behavioral health departments
- ◆ primary care associations
- ◆ departments of health

Evaluation found that policy makers and consumer/advocacy groups are the least likely to be involved in in-state integration promotion efforts.

The team leads in 8 of the 20 states with leadership teams (40%) said that their teams include all the key players needed to promote service integration. These states are New Mexico, Oklahoma, Oregon, Rhode Island, Texas, Utah, Vermont, and Washington. Four of these eight states (New Mexico, Oklahoma, Texas, and Washington) were awarded a SAMHSA Mental Health Transformation Grant in 2005. This grant further boosted their organizational representation by providing both incentives and resources to build capacity

for this effort. The other four states have had an initiative underway for a significant period of time, and their teams had a chance to involve all the important players.

Most of the leadership teams still do not have all key stakeholders that need to be involved in the initiative. Table 3.1.3 shows which agencies and organizations still need to be involved in the leadership teams, according to the team leads. Policy makers (representatives of the state Legislature and Governor's Office) top the list.

Table 3.1.3. Agencies and Organizations Needed on the Leadership Teams

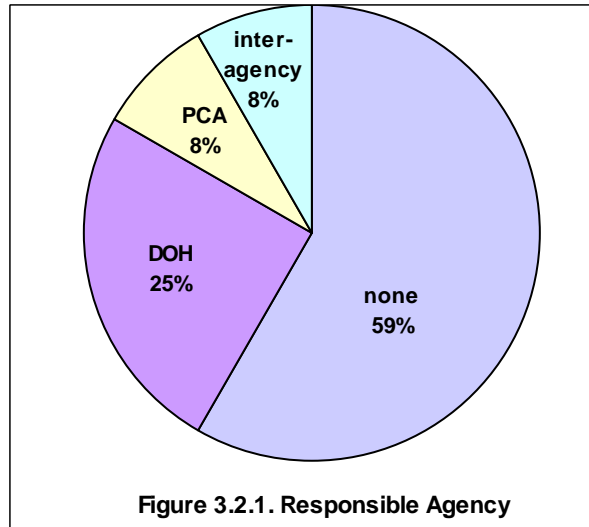
Missing Agencies and Organizations	No. of states (n=18 ⁹)	Percent
Legislature	6	33.3%
Governor's Office	4	22.2%
Primary Care Association	3	16.7%
Mental Health Department	3	16.7%
University or College	3	16.7%
Other Elected Officials	3	16.7%
Health Department	2	11.1%
Substance Abuse Department	2	11.1%
Medicaid Office	2	11.1%
Consumer Organization	2	11.1%
Family Member Organization	2	11.1%
Primary Care Providers	2	11.1%
Other (<i>Please list</i>):	2	11.1%
Primary Care Organization	1	5.6%
Mental Health Service Providers	1	5.6%
Substance Abuse Service Providers	1	5.6%

Summit participants from Colorado, Idaho, New Jersey, and Wyoming were not able to generate statewide support to jump-start the implementation of their state Action Plans. Consequently, there are no interdisciplinary leadership teams in these states. The team leads from these four states reported that their efforts to promote service integration are currently limited to the community health centers where they work. They are hopeful that eventually state officials will take notice of their programs and will use them as examples to promote integration statewide. A detailed description of activities to promote integrated services these states can be found in the Appendix B.

⁹ Of twenty states that have assembled integration leadership teams, two did not indicate their composition.

3.2. Responsible Agency

In addition to assessing how the integration efforts were being coordinated, we asked state team leads if a particular agency, group or organization had taken lead responsibility for implementing the State Action Plan. Figure 3.2.1 shows the distribution of how the efforts are organized. Ten of the twenty-four states that were still implementing their Action Plans (42%) reported having such an entity. In six cases out of ten (60%) the agency that took responsibility was the department of health or human services; in two states (20%) the primary care association took on this responsibility; and in the remaining two states (20%) an interagency team became the responsible entity. All ten agencies that took on responsibility for the integration initiative in their states are state bodies or have strong connections to state bodies.



3.3. State Involvement

Based on the composition of the leadership team and the comments of the state team leads, we assessed the level of state involvement in promoting the integrated health care in the states that participated in the Closing the Gap Summits. Figure 3.3.1 shows the distribution of state involvement. Of the twenty-four states analyzed, seven (29%) reported having no involvement from state agencies or officials in this initiative. In sixteen states (67%) the state government assumed a firm leadership position with regard to implementation of the State Action Plan as well as overall promotion of the integrated model of healthcare. The remaining state had only marginal involvement from state officials on the leadership team.

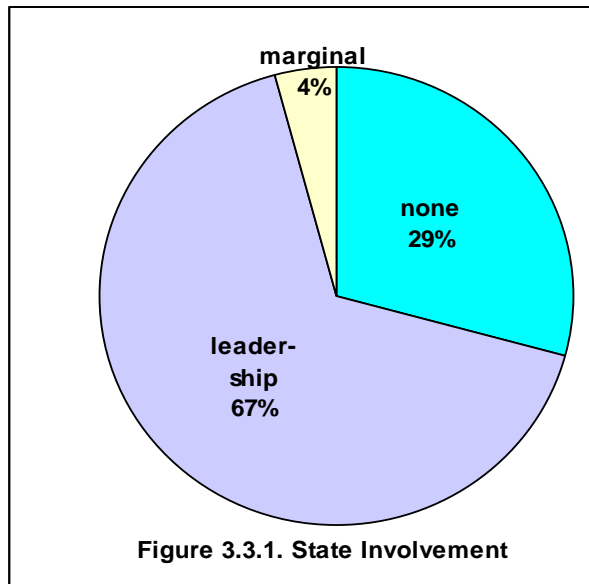


Table 3.3.1 presents an overview of the in-state leadership established to promote integration in twenty-two states, Puerto Rico, and the District of Columbia.

Table 3.3.1. Summary of In-State Leadership to Promote Integration

STATE	Coordinating agency	All key players	Responsible agency	State involvement
New Orleans, LA				
Arkansas (6)*	committee	no	none	yes, marginal
Louisiana (33)	steering committee	no	yes: Integration Team (Dept. of Health and Hospitals)	yes, leadership
Oklahoma (9)	steering committee	yes	none	yes, leadership
Texas (31)	steering committee and single agency	yes	yes: TSHP (Texas Institute of Health)	yes, leadership
Falls Church, VA				
Connecticut (6)	informal group	no	none	none
District of Columbia (15)	single agency	no	yes, Primary Care Association	yes, leadership
Maine (15)	healthcare foundation	no	yes, Primary Care Association	yes, leadership
Massachusetts (18)	summit group	no	none	yes, leadership
New Jersey (4)	none	no	none	none
Puerto Rico (1)	single agency	n/a	yes, Health Dept.	yes
Rhode Island (5)	interagency group	yes	none	yes, leadership
Vermont (15)	steering committee and single agency	yes	yes, Department of Health	yes, leadership
Albuquerque, NM				
Arizona (20)	steering committee; council	no	none	yes, leadership
Colorado (9)	none	no	none	none
New Mexico (13)	working group	yes	none	yes, leadership
Utah (5)	interagency council	yes	yes, UBHN (interagency council)	yes, leadership
Wyoming (4)	none	no	none	none
Seattle, WA				
Alaska (10)	single agency	no	yes, Dept. of Health and Social Services	yes, leadership
California (26)	summit group	no	none	none
Hawaii (10)	steering committee	no	yes, Department of Health	yes, leadership
Idaho (1)	none	no	none	none
Montana (1)	steering committee	no	none	none
Oregon (22)	steering committee	yes	yes, Department of Human Services	yes, leadership
Washington (30)	steering committee	yes	none	yes, leadership

* Number in parentheses is the number of participants from this state at the Summit meeting.

All team leads concurred that state leadership is essential for the development of successful integration initiatives. All the success stories so far come from the states where state government is not simply involved in the efforts to integrate services, but has assumed a firm leadership position both politically and financially. On the other hand, those states that reported “no progress” in implementing their state Action Plans complained of the lack of involvement and interest on the part of their state agencies. In most cases when representatives of state agencies had not participated in the Summit in the first place, little was accomplished after the Summit. In the worst cases, state agencies have made it more difficult for community health centers to integrate services. For example, one participant said:

One barrier that we ran into that had a really chilling effect on integration is that our state Department of Health made a decision that CHCs and FQHCs cannot bill for the second visit on the same day if it is a mental health visit. So it gets to the heart of the integrated model because then we cannot bill for those services. Consequently, the message from the state is “Do not go there.” So some of my colleagues who have embraced the model are now talking about abandoning it because they cannot financially sustain it. There has been a request from the PCA to HRSA and SAMHSA to tell the state that this is illegal, but we received a response that basically they do not want to get involved.

In the states where state agencies were not involved, any progress that was made was achieved at the local level, following a grassroots initiative. Individual community health centers, recognizing the importance of integration for improving services to their communities, have attempted to establish mental health and behavioral health components within their system and some of those attempts have been very successful. In some cases, integration happened because community health centers received less money from the state government and so they had to “cut corners and be creative.”

Chapter 4. ASSESSMENT OF THE SUMMIT INITIATIVE OUTCOMES: ACTION PLAN ACCOMPLISHMENTS

This chapter focuses on the state accomplishments in promoting integrated health care following the Closing the Gap Summits in 2004. The following evaluation questions guided the data collection and analysis:

1. What are the states' major accomplishments in the evaluation period following the Summit?
 - ◆ What are the actual accomplishments compared to those proposed in the Action Plans?
 - ◆ What exemplary changes have occurred in the states regarding the integration of primary and behavioral health care?
2. How do states use HRSA, SAMHSA, and other public and private grants and programs to implement their Action Plans?

In addition to these questions, we collected information on other relevant issues such as consumer participation in promoting the integration of health services. Data sources included: state update reports, telephone interviews with team leaders, multi-state teleconferences, and pre-existing documents.

The data collection and analysis focused on the three areas of importance addressed in the Summits:

- ◆ Building a seamless system of care, defined as a “care system in which a consumer’s physical and mental health and substance abuse treatment needs are quickly identified and treated, regardless of which system of care the consumer enters first.”
- ◆ Workforce training and development, defined as “increasing the number and quality of professionals and para-professionals, in collaboration with primary care, who can screen, assess and treat mental health and substance abuse needs.”
- ◆ Building partnerships and collaborations, defined as “creating new relationships and/or building on existing community leadership teams to form committed partnerships and resource leveraging for providing and integrating mental health, substance abuse and primary care services in underserved areas.”

During the Summits, state teams developed Action Plans that included objectives and action steps in these areas. Much of the focus of the two rounds of evaluation was on gathering information about these specific activities. However, we found that in many states the original Action Plans have evolved since the Summits as the states’ needs became better recognized and political and economic circumstances changed. One and a half to two years after the Summits, the boundaries between Action Plan activities and other integration-related activities in the states often became blurred.

In this report we consider all integration-related activities that were reported to us by the state team leads, even if they were not part of the original Action Plans. Therefore, in addition to examining progress in building seamless systems of care, workforce training and development, and creation of partnerships and collaborations, we also evaluated other achievements (for example, changes in law and policy, demonstration projects, and innovative use of existing resources). The state team leads were also asked to report on the sources of funding used to fuel their initiatives, and whether they used federal funding. The level of consumer participation in the initiative was also considered.

4.1. Seamless System of Care

A seamless system of care was defined for Summit participants as a “care system in which a consumer’s physical and mental health and substance abuse treatment needs are quickly identified and treated, regardless of which system of care the consumer enters first.” An integrated care system can range from one in which all screening and treatment services are provided in a single setting (co-located healthcare setting) to one in which the treatment systems operate separately but have additional mechanisms and procedures in place—such as a common intake form or a case management system—so that consumers receive help in all areas of need.

In both rounds of the evaluation, team leaders were asked what they had accomplished to date in establishing a seamless system of care. Team leaders were given an opportunity to enumerate all accomplished activities, and then asked about specific activities listed in their Action Plans. Table 4.1.1 summarizes the major accomplishments of the twenty-four states that continued to implement their Action Plans following the Summits.¹⁰ The table indicates whether a particular activity is state-supported, locally initiated, or both.

The detailed explanation of the columns can be found after the table.

¹⁰ To compile this table and subsequent tables on workforce development and collaborations we used information from the state update forms and the in-depth telephone interviews conducted with state team leads in the second round of evaluation. This information has not been independently verified for completeness or accuracy. Since for most states only one individual was interviewed, the information presented for a particular state may not completely capture all the ongoing integration efforts in the state.

Table 4.1.1. Accomplishments by States in Developing a Seamless System of Care

ACTIVITIES	STATE SUPPORTED	LOCALLY INITIATED	No. (%) (n=24)
Health services integrated in select health centers (including co-location) or for select populations	AK; AZ; DC; HI; MA; ME; NM; OK; OR; PR; RI, UT; TX; WA	AR; AZ; CO; CT; LA; ME; NM; OK; OR; WA; WY;	19 (79.2%)
Funding for integration initiative sought/obtained from federal, state or local sources	AK; AZ; ME; NM; OK; OR; PR; TX; UT; VT; WA	AK; AZ; CA; CO; ID; MT; NJ; NM; TX; VT; WA	17 (70.8%)
Integration pilot/demonstration projects developed	AZ; DC; LA; MA; ME; NM; OK; OR; TX; VT; WA	AZ; CA; MT; WA	13 (54.2%)
The state implementation plan discussed and updated	AK; AZ; DC; HI; LA; ME; OK; OR; WA	CO; ID; MT; NJ	13 (54.2%)
Data collected on needs, current provision of services, barriers to integration, and other pertinent issues	AK; AZ; DC; HI; MA; OK; OR; RI; UT; WA	ID; NJ; VT	13 (54.2%)
Behavioral health practitioner brought into primary care setting	MA; ME; NM; OR; UT; VT; WA	CO; ID; NJ; OR; WA	10 (41.7%)
Statewide summit or conference on integration conducted/planned	HI; ME; NM; OK; OR; RI; TX; VT; WA	-	9 (37.5%)
Consumers involved/trained in understanding and using the integrated system of care	NM; OK; RI; TX; VT	AZ; CT	7 (29.2%)
Public discussion and education campaign on the integrated health care model initiated/continued	AZ; HI; MA; OR; RI; VT; WA	AZ; WA	7 (29.2%)
Screening tools and common protocols developed	LA; MA; NM; OK; PR; VT	ID; NM	7 (29.2%)
Regional/local leadership established and local plans are developed	AZ; LA	AZ; CA; CO; LA; WA	5 (20.8%)
Legislation that aids integration efforts passed/considered	LA; NM; OR; WA	-	4 (16.7%)
Funding/reimbursement issues addressed by insurance companies and state agencies	HI; NM; OR; RI	-	4 (16.7%)
Financial incentives for CHCs to incorporate behavioral services considered/created	AZ; DC; OR	-	3 (12.5%)
New facilities for integrated care built/planned	AK; DC	-	2 (8.3%)
Other activities	OK; ME; NM	CO; MT	5 (21%)
TOTAL (Unduplicated Counts)	16 states (66.7%)	17 states (70.8%)	24 (100%)

“State Supported” Column

In states that are listed in the “State Supported” column, the specified activities are supported by state institutions, like the Department of Health, or by state-level organizations, such as the Primary Care Association.

For example, in Alaska, the Department of Health and Social Services leads the integration efforts. Under its leadership the state Action Plan is discussed and updated, data collected, and new facilities for integrated care are built. Through their efforts to improve behavioral health services for children, the Department of Health and Social Services has gained the support of the state legislature, providers, and the Denali Commission (a state, federal, and local partnership that has been a major donor of facility improvement funding). The achievements of the states in this column are typically statewide, are more permanent, and have further-reaching effects.

“Locally Initiated” Column

In states that are listed in the “Locally Initiated” column, the described activities are initiated at the local level, by the service providers themselves. These achievements, while significant, are local and limited to a specific location. Most of the activities in the states that are listed in the “Locally Initiated” column are similar to the case of Idaho: they are local, suffer from limited resources (both financial and human), and are more like an organizational experiment rather than an institutionalized practice.

For example, the sole Summit participant from Idaho has been unable to generate support from state officials for this initiative, and all integration activities in Idaho documented in this report have been initiated at a single community health clinic. These activities include placing a mental health professional in a primary care setting, collecting data on the current provision of services and service gaps, searching for funding, and developing common screening protocols.

Duplicated Cases

In a number of cases, an activity can be both initiated at the local level and supported at the state institution level. In these instances the state’s name appears in both columns.

For example, in Oregon some local community health centers are very active in trying to implement an integrated model. There have been a number of projects where one or more behavioral health specialists have been co-located in primary care clinics. In turn, the state agencies are assisting the effort by offering to lower some regulatory barriers and provide technical assistance for some of the centers.

Number of Cases Column

The last column shows the unduplicated total number of states where each activity is taking place, regardless of whether it is state supported or locally initiated. For example, if Arizona appears in both “State Supported” and “Locally Initiated” columns, it will only be counted once for the purpose of the total counts found in the last column.

As is evident from this table, all 24 states have conducted some activities toward building a seamless system of care. Some states, such as Arizona, the District of Columbia, Texas,

and Washington, are undoubtedly more active than others, and they show support for the initiative from both state institutions and at the grassroots level. Typically integration efforts are a lot further along in these states. Other states, like Montana, are in the very beginning of this process.

For the purpose of analysis, the activities from Table 4.1.1 were grouped in six clusters and are described in the following sections. The clusters include:

- ◆ Service integration
- ◆ Integration preparation activities
- ◆ Integration promotion activities
- ◆ Regional leadership
- ◆ Advanced integration activities
- ◆ Other activities

4.1.1. Service Integration

The most common activity among those listed is the actual integration of services in select locations or for select populations. Below is the excerpt from the Table 4.1.1 with these activities:

ACTIVITIES	State Supported	Locally Initiated	No.*
Health services integrated in select health centers (including co-location) or for select populations	AK; AZ; DC; HI; MA; ME; NM; OK; OR; PR; RI; UT; TX; WA	AR; AZ; CO; CT; LA; ME; NM; OK; OR; WA; WY;	19
Behavioral health practitioner brought into primary care setting	MA; ME; NM; OR; VT; UT; WA	CO; ID; NJ; OR; WA	10
TOTAL (Unduplicated Counts)	15	13	22

* The numbers in the last column are unduplicated.

As the table demonstrates, twenty-two of the states have integrated services in some health centers or for certain populations (like children or pregnant women). While this push for integration in a specific location or for specific populations typically comes from health care providers themselves, it is more successful when supported by state agencies or through a federal grant. Without such support, providers can only achieve limited integration within their centers.

For example, a Summit participant from New Jersey runs a community health center where she hired an on-site mental health professional who has been involved in both patient screening and their newly expanded counseling services. Currently, this mental health professional screens each patient for mental health and substance abuse conditions before they are referred to a treating physician. Although New Jersey state officials showed no interest in the integrated model, the Summit participant believes that the integration happening in her health

center will generate positive outcomes and data, and will eventually attract the attention of other providers as well as state officials.

Collaborations between specialty behavioral health service providers and primary care venues have been ongoing in a number of states, and many business agreements have been established in order to promote seamless access to health services.

For example, Mountain Park Health Center (MPHC) in Arizona has been tracking the ingress of primary care patients into specialty behavioral health care. With the assistance of behavioral health consultants, patients referred through Mountain Park Health Center have been attending their initial behavioral health appointments 69% of the time. This rate is substantially higher than the national average of 25% when such referrals are made in non-integrated health systems.

Integration of services for specific populations occurs in a number of states. For example, Vermont has established a psychiatric consulting model for pediatric and family care that is focused on child psychiatry in five practices throughout the state. In Oklahoma, a community health center has partnered with the Veterans Administration in an effort to improve mental health and substance abuse services for veterans. Behavioral health services have become fully available for veterans and have slowly evolved into the predominant service offered by this health center.

A good example of collaboration between local service providers and state officials is an integration project in Maricopa County, Arizona, where Mountain Park Health Center has been able to develop an integrated model with support from two separate HRSA grants, one for planning and one for implementation. MPHC has successfully implemented integration for specific populations, for example, some groups of children, pregnant women and breastfeeding mothers. The initiative for these programs came from the different clinics that are associated with MPHC in Maricopa County, and it was supported by the state in the implementation efforts.

The fact that integrated services are provided, to some extent, in twenty-two of the twenty-four states is indicative of widespread support for this approach at both state and local levels. In addition, primary care centers in a number of these states bring in behavioral health practitioners to serve their patients. Only two state leads, from California and Montana, did not indicate any health service integration or co-location in their states. Teams from these states reported experiencing significant problems in their attempts to involve state officials on their teams and begin implementing their Action Plans. Appendix B provides a detailed description of the situation in these states.

4.1.2. Integration Preparation Activities

Table 4.1.1 also indicates that there is a lot of activity in the areas associated with the initial stages of implementing an integrated model: data collection, development of a statewide implementation plan, and the search for funding are three activities pivotal to the initial stage of the development of a new service delivery system. Implementation of pilot/demonstration projects is also part of the overall data collection process. Their goal

is to show that the proposed model is viable and has significant advantages when compared to the traditional model of service delivery. The excerpt from Table 4.1.1 below shows that there are more states in the column with state-supported activities than with local initiatives:

ACTIVITIES	State Supported	Locally Initiated	No.*
Funding for integration initiative sought/obtained from federal, state or local sources	AK; AZ; ME; MT; NM; OK; OR; PR; TX; UT; VT; WA	AK; AZ; CA; CO; ID; MT; NJ; NM; TX; VT; WA	17
Integration pilot/demonstration projects developed	AZ; DC; LA; ME; MA; MT; NM; OK; OR; TX; VT; WA	AZ; CA; WA	13
The state implementation plan discussed and updated	AK; AZ; DC; HI; LA; ME; OK; OR; WA	CO; ID; MT; NJ	13
Data collected on needs, current provision of services, barriers to integration, and other pertinent issues	AK; AZ; DC; HI; MA; OK; OR; RI; UT; WA	ID; NJ; VT	13
TOTAL (Unduplicated Counts)	16	11	21

* The numbers in the last column are unduplicated.

Given the relative novelty of the integrated health care model, it seems natural that the states need to conduct needs assessments and identify resources before any statewide changes in the health system can be made. Three states that are not listed are Arkansas, Connecticut, and Wyoming. The level of integration-related activities in these three states is very low¹¹. Other twenty-one states are implementing some or all of these “initial stage” activities.

For example, with regard to data collection and planning, much of the resources in the District of Columbia are currently directed toward identifying the problems that exist in the local health care system. They have been looking for the gaps in service provision and discussing how they can logistically integrate primary and behavioral services. Their plan has been to map integration before they move to implement any of their ideas. As the team lead pointed out, “Right now what we’re doing is going over what the issues are and that is taking a lot of time in talking about what are the holes, what are the services, and what’s available. Once you can map the system, which is taking most of the time, we need to figure out how we’re going to attack it and see how we’re going to make sure the primary care system is invested in having the mental health system just as organized as they are in terms of being able to access and pay for the services.”

The search for funding is an essential part of this process and, as can be seen from the Table, most state teams are actively looking for new funding sources. HRSA expansion

¹¹ See detailed descriptions of state activities in Appendix A.

grants were frequently mentioned by the state team leads as very helpful to community health centers in developing integrated services. Five states¹² have received a SAMHSA Mental Health Transformation Grant, although these grants seem to have become connected with the integration initiative only in Texas and Washington. In Washington, according to their team lead, existing integration efforts were subsumed by the activities funded through the Transformation grant. The grant has changed the integration agenda and the schedule for its implementation entirely.

Many state team leads commented on the fact that the search for funding is also instrumental in forging new partnerships and developing ideas into solid plans. While few teams still use the original Action Plan as the main guiding instrument, a majority of states have some type of plan for implementing integrated health services in their states.

4.1.3. *Integration Promotion Activities*

Some activities described by team leads in the interviews are aimed at promoting the integrated system of care to wider groups of stakeholders, including conducting a statewide summit or a conference on integration, involving consumers in the planning process, launching public discussions of the integrated model, as well as the development of actual screening tools and protocols. Fourteen of the twenty-four states are engaged in these types of activities. In some of these states the integration initiative was well under way before the Summit. In Arizona, Massachusetts, Rhode Island, Oklahoma, Oregon, Texas, Vermont and Washington services had been integrated in select sites or for certain populations prior to the Summits. In the remaining states the Summit meetings helped team leaders jumpstart their efforts to build an integrated health care system. Overall, as seen from the excerpt from Table 4.1.1 below, most of the described activities are state-supported.

ACTIVITIES	State Supported	Locally Initiated	No.*
Statewide summit or conference on integration conducted/planned	HI; ME; NM; OK; OR; RI; TX; VT; WA	-	9
Consumers involved/trained in understanding and using the integrated system of care	NM; OK; RI; TX; VT	AZ; CT	7
Public discussion and education campaign on the integrated health care model initiated/continued	AZ; HI; MA; OR; RI; VT; WA	AZ; WA	7
Screening tools and common protocols developed	LA; MA; NM; OK; PR; VT	ID; NM	7
TOTAL (Unduplicated Counts)	13	4	14

* The numbers in the last column are unduplicated.

¹² These states are Connecticut, Oklahoma, New Mexico, Texas and Washington.

Statewide Summits or Conferences

Statewide summits or conferences on integration have a goal of getting stakeholders to discuss different integration models and state-specific challenges and priorities, and promote partnerships and collaborations.

For example, in Hawaii much of the post-summit effort has been concentrated on organizing a statewide summit on integration that will take place in the fall of 2006 and will, according to the team lead, “bring stakeholders together to discuss the importance of integration and to show examples of integration.” The conference will also give policymakers as well as providers an opportunity to “look at integration from a strategic standpoint”.

Consumer Involvement

States that are more advanced in their integration efforts also seem to have greater consumer involvement. In some states the initiative is at times consumer-driven. For example, the team lead from Vermont explains how the integrated services for children in Vermont came about:

Actually, this whole initiative from the children’s mental health perspective was conceived by consumers. I have been meeting with a bunch of families from the Federation of Families for Children’s Mental Health. There were parents of kids that were in there twenties and there were about 50 of them. I was asking them about when they first noticed that something was wrong with their child and they all said within the first year of life. I asked them who they went to see to get some kind of consultation and they said their pediatrician. I also asked them what kind of advice they were given, and they were given advice like, “I know there is something wrong, but I don’t know what to do.” Or, “Maybe the child will grow out of it.” Or, “I am not sure that I see anything.” As a result of that, those families then talked about a long waiting period where they lost jobs because of the child’s inability of staying in childcare or in school or a poor school performance. They were the ones that wrote a document that really emphasized the need for us to support primary care and family in a way of looking at substance abuse, mental health, and primary care as an initiative. That is a long story of the way this initiative really got started in the children’s mental health world. It is also one that shows that families were the ones who were really driving this movement and they continue to be partners at the table and pushing and looking to get this kind of care.

Public Discussions and Education Campaigns

Public discussions and education campaigns on the benefits of integrated health care services have been initiated in a number of states. For example, Massachusetts has initiated an integration publicity campaign for consumers; public service announcements have been run on the radio, television, and in print in Arizona; and an integration conference has been publicized in Hawaii.

For example, the team lead of Rhode Island said that they had published information on some of the strengths of integrated care models. “We have actually pulled in the current Surgeon General and Dr. Satcher, before Dr. Carmona, to do kick-offs to formal publications with press releases in the state on the integrated model of care.” Much of the focus of such public discussions is not

simply to promote the concept of integrated services among providers, but also to give practitioners from various disciplines an opportunity to learn each other’s professional language.

Screening Tools and Protocols

Additionally, at this advanced stage of initiative development there may be concerted efforts by providers to develop common screening tools and protocols. Team leads from seven states indicated that they have developed or were in the process of developing such tools.

4.1.4. Regional Leadership

Five states have established leadership teams in different parts of the state that have developed local service integration plans. The excerpt from Table 4.1.1 below shows that in two of these states, Arizona and Louisiana, the state actively supports these regional leadership teams:

ACTIVITIES	State Supported	Locally Initiated	No.*
Regional/local leadership established and local plans are developed	AZ; LA	AZ; CA; CO; LA; WA	5

* The number in the last column is unduplicated.

Four of the five states (Arizona, California, Colorado and Washington) are geographically vast states with large populations where areas have different needs, priorities, and resources. Local leadership and region-specific planning are essential for the success of the integration initiative in these states.

For example, health practitioners in Northern Colorado have created the North Colorado Health Alliance. Weld County mental health and substance abuse centers, community health centers, hospitals, and residency programs are all involved in this alliance and are working together as they never have done before. The Alliance has recently convened to discuss how integrated care should be implemented throughout their county. A local approach to planning and implementation seems to be both appropriate and effective in states such as Colorado.

In some states, like Arizona, integration efforts were regionalized from the start. A regional steering committee and also a number of subcommittees are formed with the needs of specific patient populations in mind. Local integration pilot projects and other integration-related activities are undertaken with the guidance of local leadership.

Louisiana presents a special case as it saw an upsurge of integration-related activity as it struggled to provide health services in the aftermath of Hurricanes Katrina and Rita. Following the hurricanes, integration of health services seemed to occur naturally as local providers realized that that they needed to deal with both the physical and behavioral health care needs of a traumatized population. Louisiana also had the advantage of

hosting one of the Summits which enabled a large number of people to attend and then bring the Summit’s message back to their communities. At the local level, regional committees had been established and tasked with the responsibility of developing “next steps” specific to their regions. Local community-based organizations had also begun to integrate their services. Louisiana’s integration team had been very inclusive and active prior to the hurricanes.

Since the hurricanes, however, the central leadership has become so consumed with addressing current crises that they are unable to coordinate the implementation of the statewide plan. State officials who led the integration efforts prior to the hurricanes do however send a strong signal of support to local leaders, even when they are not able to offer direct assistance.

4.1.5. Advanced Integration Activities

Finally, the remaining activities listed in Table 4.1.1 are the ones found in the states with a high level of commitment to service integration. As seen from the excerpt from Table 4.1.1 below, only those teams where the initiative is supported by the state have made some progress in these activities:

ACTIVITIES	State Supported	Locally Initiated	No.*
Legislation that aids integration efforts passed/considered	LA; NM; OR; WA	-	4
Funding/reimbursement issues addressed by insurance companies and state agencies	HI; NM; OR; RI	-	4
Financial incentives for CHCs to incorporate behavioral services considered/created	AZ; DC; OR	-	3
New facilities for integrated care built/planned	AK; DC	-	2
TOTAL (Unduplicated Counts)	9	-	9

* The number in the last column is unduplicated.

Legislation

Perhaps the most important activity in this set is “Legislation that aids integration efforts passed/considered.” Four states have introduced or passed such legislation since the Summits took place in 2004. For example, in Louisiana the state legislature is currently looking into a proposal to merge the Office of Addictive Disorders, the Office of Mental Health, and two of the Offices of Behavioral Health Services. Approval of this proposal would be a major step toward service integration. In New Mexico, legislation was passed in 2006 that eased the licensing restrictions on behavioral health providers, thus increasing the pool of behavioral health providers.

Funding and Reimbursement

Understanding that funding and reimbursement problems are the major hurdles on the road to integration of health services, four states have already initiated discussions with insurance companies and state and federal agencies. These efforts originate at the state level in Hawaii, New Mexico, Oregon and Rhode Island.

Financial Incentives

Even more important are the initiatives in Arizona, the District of Columbia, and Oregon to offer financial incentives to community health centers to incorporate behavioral services in their primary care setting.

For example, in Oregon the Department of Human Services has also issued a request for proposals that focuses on bringing local groups together to identify how they want to integrate services. The idea is for these local groups to devise clear plans for integration that would be easily approved by the state. They would then implement their plans as described in the proposal and provide progress data to the state. In return, the state would ease regulatory restrictions that have negatively impacted the efforts to integrate health services.

New Facilities

Finally, Alaska and the District of Columbia are committed to building new facilities for the integrated clinics. In the District of Columbia, the team lead explained, “Basically, what we’re trying to do is to do the bricks and mortar in terms of building community health centers in areas where they are supposed to be and including all services, including dental and mental health within those facilities. ... When we build them, we’re not thinking of square footage just for the pediatricians and the nurse practitioners. We’re thinking about square footage for dentists, we’re thinking about square footage for mental health and how we set that up including sound-proof areas and things like that.” Similar efforts are underway in Alaska, where community clinics are remodeled to include behavioral health rooms and counseling rooms.

4.1.6. “Other” Activities

A number of states conducted a range of other activities related to integration but not included in Table 4.1.1. Oklahoma’s steering committee reported having plans and making steps toward making medical records accessible across areas of health service provision. In Maine, Oklahoma, and New Mexico, telemedicine receives a lot of attention and funding because of its potential to bring both primary and behavioral health care to remote and underserved areas in a less expensive way.

In Colorado, through the Northern Colorado Health Alliance, a Summit participant is leading an effort to extend the services of the integrated service center to serve as a “behavioral health crisis triage center.” Its goal will be to decrease the number of behavioral health patients who are inappropriately admitted to the inpatient psychiatric treatment unit from emergency rooms. The local police will be instructed to use this center for behavioral health emergencies as opposed to the hospital emergency department. In Montana, the steering committee has been developing a “prevention

model” that will “work hand in hand with integrated care” and will be appropriate for the extremely rural areas that are prevalent throughout the state of Montana.

4.2. Workforce Training and Development

Workforce training and development was defined at the Summits as “increasing the number and quality of professionals and para-professionals, in collaboration with primary care, who can screen, assess and treat mental health and substance abuse needs.” In their Action Plans developed at the Summits, State teams established objectives for increasing the numbers of professionals and paraprofessionals – particularly in primary care settings – who can screen, assess and treat mental health and substance abuse problems in underserved populations.

In both rounds of the evaluation, team leaders were asked what has been accomplished since the Summits with regard to workforce training and development. As with the assessment of the seamless system of care, team leaders were given an opportunity to enumerate all accomplished activities, and then asked about specific activities listed in their Action Plans. Table 4.2.1 presents accomplishments of the twenty-four states in workforce training and development. It is organized similarly to Table 4.1.1 that summarized accomplishments in the area of seamless systems of care.

Table 4.2.1. Accomplishments by States in Workforce Training and Development

ACTIVITIES	State Supported	Locally Initiated	No.* (%) n=24
Training programs for development of integrated health care workforce in place/planned	AK; AZ; MA; ME; NM; OR; PR; RI; TX; UT	AZ; CO; ID; MT; NJ; UT	14 (58.3%)
Cross-discipline training promoted/introduced in academic institutions.	AK; AZ; MA; NM; OK; OR; PR; TX; VT	AZ; CA; CO; ID; MT	13 (54.2%)
Workforce development discussed at interagency meetings or at the statewide summit or conference	AZ; DC; NM; OK; OR; PR; TX; VT; WA	-	9 (37.5%)
Funding for workforce training and development sought/obtained	AZ; NM; VT; WA	AZ; CO; MT; NJ	7 (29.2%)
Curricula for integrated care training developed/planned	AK; AZ; OK; TX	AZ; MT	5 (20.8%)
Core competencies developed	MA; OR	CO; VT	4 (16.7%)
Other activities	DC; NM	AZ; ID	4 (16.7%)
TOTAL (Unduplicated Counts)	15 states (62.5%)	8 states (33.3%)	20 (83.3%)

* The number in the last column is unduplicated.

As Table 4.2.1 demonstrates, 83% of the states have made some accomplishments in workforce training and development. This is very significant since integration efforts cannot proceed without trained personnel.

Training Programs

Sixteen of the studied twenty-four states have some kind of training programs for development of integrated health care workforce in place or in planning stages. In some states these programs are well developed.

For example, in Rhode Island a number of cross-discipline training initiatives are underway. Presentations are periodically conducted in Rhode Island emergency departments that discuss assessing the behavioral health of patients. The team lead has worked with the lead social worker from the Rhode Island Hospital to develop a training program for that hospital's workforce. She has also been engaged in annual training efforts with the Academy of Family Practice Physicians. In addition, Rhode Island participates in the annual training program, SEARCH,¹³ which takes practitioners out of their chosen disciplines and transplants them into settings where they are exposed to a new range of health issues, working along with practitioners from different disciplines. The team lead has partnered with universities throughout Rhode Island to promote and implement this program.

Some states, like Maine, have established programs that place students in clinical rotations and expose them to integration efforts taking place in community health centers throughout the state. Such programs are very successful in helping young professionals prepare for work in integrated settings.

For example, in Oregon the steering committee has successfully included the concept of behavioral health and primary care integration as a training issue in several key venues, including a safety network group and a mental health task force that have been directly overseen by the Governor's office or its delegates. They have also distributed key documents (internal and national) to appropriate persons to raise the relevance of workforce development to this initiative. In addition, the Behavioral Health Workforce Initiative has included behavioral health integration with primary care as one of four key areas they focus on.

Cross-Discipline Academic Training

More educational institutions now include integration in their curricula. For example, the University of Alaska has been expanding its doctoral program in social work to incorporate integrated health care into its curriculum. In Vermont, the University of Vermont has collaborated with the Department of Health in the development of new workforce training mechanisms. For the past four years, the university has sponsored regional primary care and mental health conferences where workforce training is a central topic for discussion.

¹³ SEARCH (Student/Resident Experiences around Community Health) is a national program provided by the National Health Service Corps.

At the local level, individual healthcare providers are seeking to partner with educational institutions and residency programs in order to promote cross-discipline training.

For example, in Colorado Springs a grant from a local Colorado foundation is currently funding an internship program that brings fourth-year PhD psychology students into a senior health clinic to offer mental health services. Both graduate student psychology interns and the existing staff are trained in integrated health care. In Montana, American Psychological Association (APA) interns are conducting their internships in rural community health centers.

Curricula and Core Competencies

Five of the thirteen states that promote cross-discipline training in academic institutions also emphasize the development of curricula on integrated care. Five other states' integration steering committees reported on their efforts to develop core competency training. Through establishing core competencies in integrated health care, they are looking to influence the academic community and employment-based training programs, and to include integration training in the core curricula.

Interagency Meetings

In eight states workforce development is on the agenda of interagency meetings, including statewide conferences or summits. In Washington, the Mental Health Transformation Group included workforce development issues on its agenda.

For example, in Oregon, an overall health care workforce institute has been developed. Its organizers held a meeting in August of 2005 during which they looked at four particular functional areas to try to identify the following, according to the Oregon's team lead: "What are the core competencies in those areas? What are the core curricula that need to be developed to promote the creation of those competencies in behavioral health workers of various levels of expertise? Those four areas include the skills and knowledge that a person who was co-located in a primary care setting would need to have. There is that specific content purpose." That initiative has now moved forward and they are in the process of trying to develop a public-private partnership to sustain workforce development in the behavioral health area, some of which has been articulated in position papers and projects that have been done by a group called the Annapolis Coalition at a national level.

Funding

Seven states initiated an active search for funding for workforce development initiatives. Local integration teams in several states are searching for funds to start cross-discipline training programs. In rural Montana members of the integration steering committee have "initiated efforts to secure start-up money and have initiated a community foundation to administer the [integration] training efforts." In Weld County, Colorado, a Summit participant is preparing a grant proposal that he will submit to Health One Alliance. The funds that he hopes to acquire through this grant will be used to create specialized integration training for each discipline that is involved in the integration initiative in his area of the state.

For example, Arizona has been addressing the issue of co-occurring disorders in behavioral health and substance abuse, which requires practitioners to engage in extensive cross-training since 1998. A program has been in place that trains substance abuse and mental health practitioners in generalist health care environments so that they acquire the skills necessary to screen for co-occurring disorders. Arizona has also applied for the Screening Brief Intervention Referral and Treatment Grant (SBIRT). If this grant is awarded, they will look to incorporate integrated care into the medical curricula at Arizona State University and the nursing curricula at Northern Arizona University.

Other Activities

Finally, four states are listed as implementing “other” activities in the area of workforce training and development. These activities include the following:

- ◆ In the District of Columbia a new tuition reimbursement program has been proposed in an effort to attract a higher caliber workforce to the community health profession.
- ◆ In New Mexico, legislation that eases the licensing restrictions for behavioral health professionals was passed in 2006. This legislation will have a positive effect on behavioral workforce development, especially for the underserved populations that are currently suffering from the lack of behavioral health practitioners. The New Mexico integration team is also conducting compensation surveys for health care professionals in preparation for advising legislators and state personnel on compensation issues.
- ◆ In Arizona, efforts to assemble a database on the training and cultural competencies of the workforce are underway. Such a database will facilitate communication among providers.
- ◆ Finally, in Idaho, the Summit participant is currently organizing a Behavioral Health Breakfast that will provide practitioners from different disciplines with an opportunity to interact in an informal setting.

Overall, there is less activity by the states in the area of workforce training and development than in the building of a seamless system of care. Nearly all team leads commented on the great difficulties encountered in trying to introduce some changes in existing workforce-training programs. The main reasons cited for these difficulties are the following:

- ◆ ideological barriers between academic institutions and health care organizations
- ◆ lack of local, state and federal assistance
- ◆ lack of convincing evidence to support these changes.

Very few teams have been able to locate financial resources to support the initiative, and without funding the implementation of workforce training and development sections of State Action Plans proves difficult.

4.3. Partnerships and Collaborations

Building of an integrated health care system is a challenge that involves collaboration of many agencies, groups and organizations. That is why the Summits put a special emphasis on activities that would help state leadership teams foster new partnerships with key players and stakeholders. These activities were defined at the Summits as “creating new relationships and/or building on existing community leadership teams to form committed partnerships and resource leveraging for providing and integrating mental health, substance abuse and primary care services in underserved areas.”

In both rounds of the evaluation, team leaders were asked what has been accomplished since the Summits with regard to building partnerships and collaborations. As with the assessment of the seamless system of care and workforce training and development, team leaders were given an opportunity to enumerate all accomplished activities, and then asked about accomplishments with regard to specific activities listed in their Action Plans. Table 4.3.1 presents the accomplishments of the twenty-four states in building partnerships and collaborations.

Table 4.3.1. Accomplishments by States in Building Partnerships and Collaborations

ACTIVITIES	State Supported	Locally Initiated	No.* (%) n=24
Interagency partnerships and/or collaborations established among organizations to develop the integrated system	AK; AZ; DC; HI; LA; MA; ME; NM; OK; OR; RI; TX; UT; VT; WA;	AR; AZ; CA; CO; MA; MT; OK; OR; PR; UT; WA; WY	21 (87.5%)
Activities implemented to involve consumer organizations in planning and implementation of the integrated model	AK; AZ; ME; OK; OR; PR; VT	AZ; CA; MT; VT; WY	10 (41.7%)
Inter-organizational meetings and other activities conducted to promote the integrated model	PR; UT; VT;	AZ; CA; ID; MT; NJ; PR; UT; WY	9 (37.5%)
Statewide interagency forum, summit or conference on integration conducted/planned	HI; LA; MA; ME; OK; RI; TX; UT	-	8 (33.3%)
Public meetings planned/conducted in communities to engage stakeholders	AZ; HI; LA; VT; WA	PR	5 (20.8%)
Activities to increase coordination between primary and behavioral health providers are implemented	AZ; MA; UT; VT	-	4 (16.7%)

Funding sought/obtained for activities to boost interagency collaboration	ME; TX; VT; WA	-	4 (16.7%)
TOTAL (Unduplicated Counts)	16 states (66.7%)	14 states (58.3%)	23 (95.8%)

* The number in the last column is unduplicated.

All states but one have established interagency partnerships and collaborations, or are engaged in activities with the purpose of creating such partnerships and collaborations. The one team lead who indicated no awareness of any partnerships or collaborations is from Connecticut where the Summit participants proceeded to implement their state Action Plan in their individual community health centers.

Interagency Partnerships

Team leads from twenty-one states indicated that some interagency partnerships and collaborations had been established to advance and promote the integrated model. Some interagency partnerships have been in existence for quite a while.

For example, in Alaska, primary care and behavioral health leaders have come together through the Denali Commission to set guidelines and make decisions with regard to funding appropriations. They have been using information from the communities in which the targeted health centers reside and have actively involved community leaders in this process. They conduct meetings between the division directors of public health, behavioral health, and health care services and deputy commissioners to get buy-in and support specifically for the integrated initiative.

In some states partnerships are formed at the local level. Many of those are formed as working relationships to help address needs of their patients better, and gradually get involved in promoting the integration, too.

For example, in Arkansas where three community health centers have been collaborating for years: White River Rural Health (primary care), Boston Mountain Rural Health Center (primary care), and Health Resources of Arkansas (behavioral health). They are engaged in cooperative efforts, utilizing the same staff, and bringing behavioral health into primary care settings. According to the Arkansas team lead, these community health centers are setting examples and establishing integrated care models that can be shared in the future with others who will seek to establish the integrated service delivery of health care.

Consumer Involvement

Over a third of the states have implemented some activities to involve consumer organizations in planning and implementation of an integrated model of health care. For example, in Maine, using the Maternal and Child Health Services Title V Block Grant, a community health center and its advisory board place consumers with mental health issues either onto their board or on the advisory council of consumers with mental illness or behavioral health dysfunction. In addition, the state integration team works closely with NAMI Maine on consumer advocacy issues. In California, consumers are involved

in all elements of Mental Health Services Act (Proposition 63)¹⁴. Through this Act, consumers are also increasingly drawn into the planning process and as liaisons with primary care.

Inter-Organizational Meetings

Team leads from nine states indicated that inter-organizational meetings and other activities are conducted in their state with the purpose of promoting service integration. Typically, these are activities and meetings that are not conducted routinely and that have a goal of informing stakeholders and other key players about the benefits of integrated health care delivery. In most of the states listed in this category, these meetings are initiated at the local level.

For example, the integration steering committee in Montana has been actively promoting the integrated model for their state. The current members of this committee held meetings and discussions with HRSA, the veterans hospital psychology intern program, a public school district, a region-wide healthcare system, a consumer group, a regional educational group (WICHE), the state educational system, and a variety of other organizations. In addition, they made efforts to form a partnership with the St. Vincent's Health Care System.

Statewide Interagency Conference

In eight states, a statewide interagency forum, summit or conference on integration has been conducted or is currently in the planning stage. The largest conference on integration that is currently planned is organized by the Collaborative Family Healthcare Association, and will take place in Rhode Island in November of 2006. Rhode Island, Maine, and Massachusetts are involved in its organization. Other states held or will soon hold conferences within their own states.

Such conferences are essential for building partnerships and collaborations because they bring together stakeholders from various agencies, facilitate dialogue, and promote communication across disciplines and organizations. In Hawaii, Louisiana, and Maine steering committees and relevant state agencies are in the process of organizing statewide conferences on integration. In Maine they hold annual conferences where integration is included in the agenda. In Texas, a statewide summit has been conducted involving major stakeholders (DOH, MHMR, NHSC, etc.) with a purpose of developing an integrated health care plan.

Public Meetings

In five states, public meetings are conducted in various communities to engage stakeholders. For example, as a part of work on the transformation of mental health in Washington, committee members are holding public meetings to gather ideas and input on critical questions about what currently works in mental health service delivery system,

¹⁴ In November 2004 California voters passed landmark legislation that places a 1 percent tax on the adjusted gross income of Californians earning \$1 million or more and commits these revenues to the support of county-operated mental health services. When Proposition 63 became state law in January 2005, it became known as the Mental Health Services Act (MHSA). Source: <http://www.chcf.org/topics/view.cfm?itemID=110806>, accessed on July 17, 2006.

what does not work, and what types of changes are needed. Similar efforts to involve consumers during the formative phase of integrated service implementation are underway in Arizona, Hawaii, Louisiana, and Vermont.

Activities That Increase Coordination

Team leads in four states reported conducting activities that aim to increase coordination between primary and behavioral health providers. Such activities can range from regular cross-discipline forums to statewide programs to improve communication and understanding among providers.

For example, the Utah Behavioral Health Network implemented a statewide plan to monitor and increase coordination between primary care and behavioral health providers. Since the implementation of this plan, record reviews have been ongoing and community health centers have been increasingly monitored via preferred practice guidelines as defined by the State.

Funding

Finally, steering committees in four states said they are seeking funding specifically for activities that will boost interagency collaborations and building of partnerships. For example, Maine sought a grant from SAMHSA to establish an institute to support the integration of primary care and mental health through information and system change. Many public and private agencies became involved. Although the grant was not awarded, they are planning to apply again.

4.4. Consumer Involvement

Few of the participating states had consumer representatives on their teams. At the Summit meetings, the importance of consumer involvement was emphasized, and many Action Plans developed during the Summits contained activities to involve consumers in the initiative. At the time of the evaluation, sixteen states (67%) reported consumer participation in the initiative in their states. Table 4.4.1 demonstrates the extent of consumer involvement in these states.

Table 4.4.1 Consumer Involvement in the Integration Initiative

STATE	CONSUMER INVOLVEMENT
Alaska	Consumers are involved in the integrated care initiative. The Mental Health Trust has a large consumer input, as well as Mental Health boards. There have also been public hearings for some of the regulations.
Arizona	Consumers are involved in the review and input stages of the integrated care initiative. They also played a significant role in the needs assessment process initiated by the state.
California	At the county level consumers are involved in the planning and review stages

	of the integrated care initiative.
Connecticut	Consumers are being involved by individual health centers that are conscious of their importance in the process of developing a seamless system of care.
District of Columbia	The team lead explained that consumers are currently involved in the planning, review, and input stages of integrated care.
Hawaii	Consumers are involved in the planning, review, and input stages of the integrated care initiative.
Maine	Consumers and consumer organizations are involved in the planning and review stages of the integrated care initiative. They assisted in the implementation of pilot projects throughout the state.
Montana	Consumers are currently actively involved on the levels of planning, review, and input at various points in the process. A consumer group has also been active with the integrated care steering committee.
Oklahoma	Consumers and consumer organizations play an important role in the review and input stages of this initiative's development.
Oregon	Consumers and consumer organizations are involved in the planning stage of the integrated care initiative.
Puerto Rico	Consumers had been involved in this initiative.
Rhode Island	Consumers are actively involved, through the Allied Advocacy Group, in planning and review stages of the promotion of the integrated care initiative.
Texas	Consumers are currently actively involved on the levels of planning, review and input at various points in the process.
Utah	Consumers were involved in the planning stage of the integrated care initiative.
Vermont	Consumers and consumer organizations are active in the planning and review stages of the integrated care initiative. It was consumer input that led to the establishment of the initial pilot integration projects.
Wyoming	NAMI was contacted by the integration steering committee to enlist their support for the integration.

The remaining eight states (Arkansas, Colorado, Idaho, Louisiana, Massachusetts, New Jersey, New Mexico, and Washington) currently do not have consumers involved in their integration efforts. Team leads from Massachusetts and Washington indicated that consumers will likely become involved as the planning process advances.

4.5. Federal Grants

Locating resources needed for implementation of the State Action Plan is one of the major challenges that the integration teams face. During the Summits, the teams were offered information on existing sources of federal funding that can be used for the integration initiative. Many of the team leads indicated that they took advantage of these opportunities.

During the two rounds of the evaluation the team leads were asked if they have received any assistance from HRSA, SAMHSA, or another federal agency in implementing their Action Plans since the Summit. Table 4.5.1 presents an overview of the types of federal funding and the list of states that received this assistance. Only grants that were used for the integration initiative are considered in this table.

Table 4.5.1 Federal Grants Received by Participating States

Type of Assistance	States Receiving This Type of Assistance	No. (%) n=24
SAMHSA grants (SBIRT, etc.)	AZ; NM; UT	3 (12.5%)
SAMHSA Mental Health Transformation State Incentive Grant	CT; NM; OK; TX; WA	5 (20.8%)
HRSA grants (block grants, etc.)	AZ; CO; MA; ME	4 (16.7%)
NHSC Clinicians	AK; HI; MA	3 (12.5%)
Other Federal Assistance	MT	1 (4.2%)
TOTAL (Unduplicated Counts)	13 states	13 (54.2%)

The largest funding is provided by the SAMHSA Mental Health Transformation State Initiative Grants (MHT SIG) that were awarded to five of the studied states, including Connecticut, New Mexico, Oklahoma, Texas and Washington. These grants are listed in Table 4.5.1 under a separate category since their impact on the integration efforts is not equal across the awardees:

- ◆ In both Texas and Washington this grant has already had a positive impact on the integration efforts by the state leadership.
- ◆ In Oklahoma and New Mexico the funding provided through this grant has not yet been utilized for the integration purposes.
- ◆ In Connecticut, the team lead was not associated in any way with the Transformation Working Group assembled as a result of the MHT SIG awarded to Connecticut by SAMHSA.

In total, team leads from twelve states indicated that they used federal grants. Leads from a number of other states said they had applied for a grant and were waiting to hear from a federal agency. The thirteenth state is Montana, which received “other” federal assistance. It included funding provided by the Veterans Hospital at Fort Meade to provide help in program development. All interviewed team leads indicated a need for more federal assistance targeted for the integration initiative.

4.6. Assessment of Progress

In the interviews conducted for the second round of evaluation, team leads were asked to assess the progress that had been made in their states in integrating behavioral and primary care¹⁵. A four-point scale was used ranging from poor to excellent. Twenty-three of the twenty-four team leads provided ratings. Nine states were reported as making good or excellent progress. Less than a quarter of the states had made poor to no progress. Nine team leads evaluated the progress in integrating health services in their states as fair.

In a separate question, team leads were asked to evaluate their progress in implementing the State Action Plans that were developed at the Summits. Seventeen team leads evaluated their progress as either poor or fair, and only two team leads said they had made excellent progress.

Figure 4.6.1 shows the distribution of team leads’ assessment of the overall progress in their states to integrate behavioral and primary health care services as compared to the their assessment of the implementation of their State Action Plans.

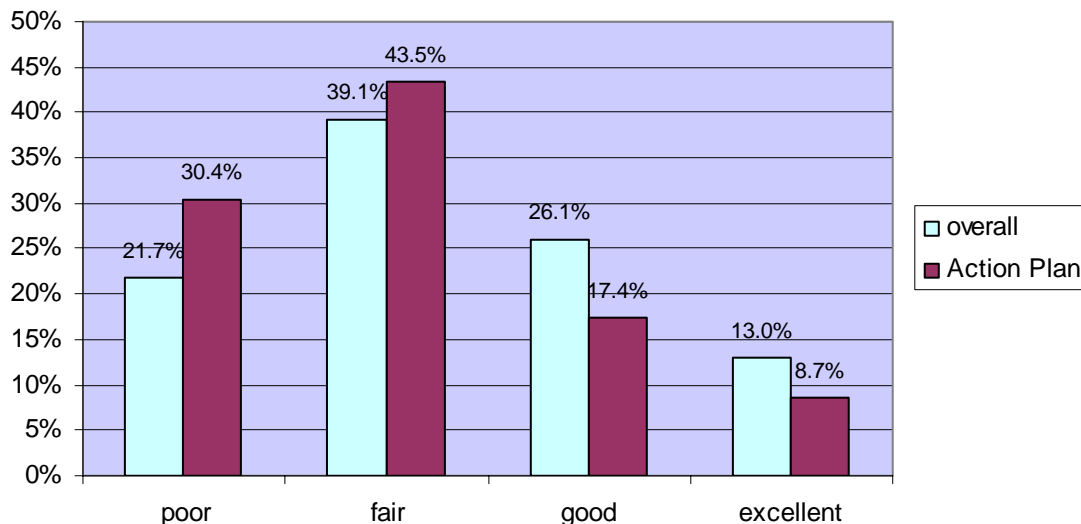


Figure 4.6.1. Comparison of the Evaluation of the Overall Progress and Action Plan Implementation (n=23)

¹⁵ See questionnaires in Appendix D.

There are several reasons why team leads evaluated the overall progress to integrate health services higher than the implementation of the State Action Plans, including the following:

- ◆ Some Action Plans contained unrealistic time frames for the specified activities to be implemented.
- ◆ In other cases, teams had to re-evaluate their priorities following the Summits as new information shed light on both needs and opportunities.
- ◆ Yet in other cases, the Action Plans developed during the Summits stopped playing a guiding role because the state team leadership had changed.

In two states the Action Plan implementation was evaluated as “excellent” because the original plan was modest and only contained activities that team members present at the Summit could accomplish themselves. Obstacles and barriers to Action Plan implementation will be discussed in detail in chapter 5.

Summits’ Contribution to Success

Team leads were also asked to evaluate how much the Summits contributed to their state’s overall accomplishments in integrating health services. The majority of respondents said that “some” of the accomplishments were the direct result of the Summits. Figure 4.6.2 shows the distribution of team leads’ opinions with regard to this question:

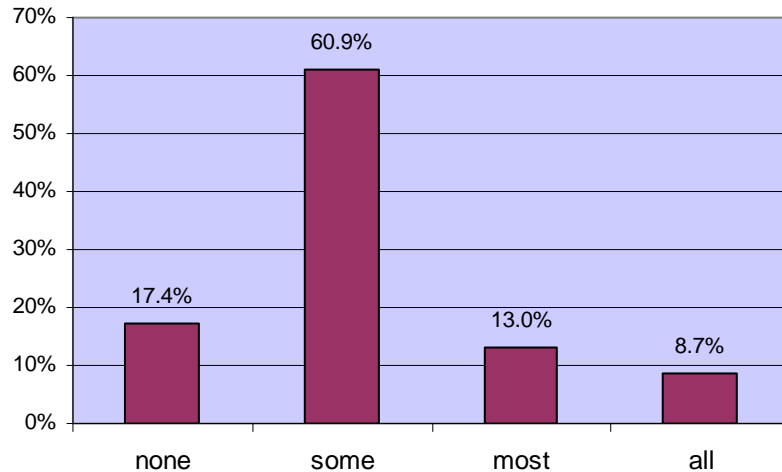


Figure 4.6.2. Summits’ Contribution to Overall Progress

The five team leads who said that “most” or “all” accomplishments are the result of the Summits typically were not engaged in an integration initiative prior to the Summit. For example, the participants from Idaho and Montana were both the sole representatives from their states at the Summit. They said that all integrated-related activities that they have conducted have been the direct result of the Summit that they attended. Team leads from Connecticut, New Jersey, and Hawaii said that “most” of the accomplishments were a result of the Summits they attended. In Connecticut and New Jersey team leads implemented their Action Plans in the community health centers that they run.

Many team leads expressed hope that HRSA would come back to the issue of integrated health care and will provide follow-up assistance or another set of meetings. As Vermont team lead put it, “I think the Closing the Gap Summit would be helpful to have every year and to encourage that the same people attend. You have the same leadership, plus others, and you use that as a work group. It is much more effective to do that at a conference than to do it on a conference call or a progress report.”

Overall the evaluation found substantial achievements in promoting integrated health care services across all twenty-four states. Table 4.6.1 presents an overview of integration accomplishments, consumer involvement, and the use of federal resources that team leads reported during the evaluation.

Table 4.6.1. Overview of Integration Accomplishments and Obstacles

STATE (number of participants)	Integration accomplishments*				Consumer involvement	Federal resources
	Seamless system of care	Workforce training and development	Partnerships and collaborations	Other accomplishments		
New Orleans Summit						
Arkansas (6)	none	-	fair	none	no	no
Louisiana (33)	good	fair	good	good	no	no
Oklahoma (9)	excellent	good	good	good	yes	yes
Texas (31)	good	good	excellent	excellent	yes	yes
Falls Church Summit						
Connecticut (6)	none	none	none	good	yes	no
District of Columbia (15)	fair	good	fair	good	yes	-
Maine (15)	excellent	fair	good	-	yes	yes
Massachusetts (18)	excellent	excellent	excellent	good	no	yes
New Jersey (4)	none	none	none	fair	no	no
Puerto Rico (1)	fair	-	-	-	yes	-
Rhode Island (5)	good	excellent	excellent	fair	yes	no
Vermont (15)	excellent	fair	fair	excellent	yes	no
Albuquerque Summit						
Arizona (20)	excellent	excellent	excellent	excellent	yes	yes
Colorado (9)	fair	poor	good	good	no	yes
New Mexico (13)	good	good	good	fair	no	yes
Utah (5)	good	poor	fair	good	yes	yes
Wyoming (4)	none	none	none	poor	yes	no
Seattle, WA						
Alaska (10)	good	good	good	good	no	yes
California (26)	none	poor	poor	poor	yes	no
Hawaii (10)	fair	none	fair	fair	yes	yes
Idaho (1)	none	none	none	poor	no	no
Montana (1)	good	good	fair	none	yes	yes
Oregon (22)	good	excellent	fair	good	yes	no
Washington (30)	good	good	excellent	good	no	yes

*Accomplishments are measured as Excellent, Good, Fair or Poor; (-) No information is available

Chapter 5. CHALLENGES AND RECOMMENDED ASSISTANCE

This chapter presents an overview of challenges faced by state integration teams, and provides a list of recommendations to federal agencies that seek to assist states in developing the integrated health care system. The evaluation question “What implementation barriers did states encounter and how were they resolved?” is answered in the first section of this chapter.

5.1. Challenges of Promoting Integration

Summit participants reported many problems and challenges in their attempts to promote integrated health care systems in their states. Chief among them are the following:

- ◆ Lack of financial and human resources;
- ◆ Reimbursement regulations, including Medicaid/Medicare;
- ◆ Structural and regulatory barriers;
- ◆ Lack of workforce with cross-discipline training
- ◆ Cultural differences among professional groups;

Lack of Financial And Human Resources

The first and most frequently cited challenge is that of finding resources for the initiative. Very few states have designated funding for new integration-related activities, and typically it comes earmarked for specific projects or programs. Consequently, team leads complain that implementing their Action Plans is almost never a high priority in their states. Additional resources are needed to conduct comprehensive needs assessments, develop state-specific integration plans, publicize the integration model both to providers and policy-makers, and develop screening protocols, among other activities.

Currently, community health centers can obtain resources to, for example, co-locate a behavioral specialist in a primary care setting, but other necessary and related activities, like data collection or strategic planning, are either secondary priorities, or do not happen at all.

For example, as a Colorado team lead, who is the HRSA-funded director of behavioral health services for the community health clinic, observed, “It comes down to sustainability funding. We can’t support ourselves, myself included, with the limited billing that we could do currently with the carve-out system that we are handicapped in using. We can’t support our salaries or the cost of having me here full time at this time with that reimbursement source. If the HRSA grant goes away, I would go away.”

Reimbursement Regulations

The second most frequently cited obstacle to the integration of health services is the uncertainty of reimbursement. Providers are reluctant to commit to the integration initiative insofar as they are not convinced that the payers are supportive. Currently, there is a lot of confusion regarding this issue.

For example, an evaluation participant from Massachusetts noted, “Because most people on the ground are dealing with multiple payers, we tend to end up defaulting to the most restrictive. And so the fact that somebody else has taken steps to make it better or that somebody else is reaching out gets lost. So some payers, for instance, pay for the health and behavior codes, but they often aren’t very clear about it. There is not a master list [of payable codes].” This participant suggested mandating payers to produce a handbook of payable codes for the integrated services.

Another impediment is Medicaid/Medicare reimbursement regulations. Team leads repeatedly mentioned the Medicaid reimbursement regulation that prohibits reimbursement of more than one visit per patient per day. This regulation goes against the very idea of the integration, since it often prevents the conjoint treatment of physical and behavioral problems.

Structural and Regulatory Barriers

Some team leads commented on the dual problems of structural and regulatory barriers. Existing structures of primary and behavioral health care delivery are organized in parallel to one another. Each has an elaborate and expensive infrastructure that is resistant to change. Models of the integrated health care cut across those lines of division and naturally encounter a lot of resistance.

For example, the team lead from Vermont notes that in Vermont “the mental health system, at the state level, has always been based on serving the most severely disabled. As we move into integrated health systems, we need to retool as a mental health division on how to provide preventative care and how to promote healthy development as well, in adults and kids. It is a conceptual twist for the mental health to really participate with primary care, to be able to make that twist towards prevention and promoting healthy development.”

Another example of a structural obstacle is clinical record requirements that are much more stringent and comprehensive in mental health than in primary care services. Which system will be adhered to in an integrated model? A related obstacle is regulatory rules regarding payments for primary care and behavioral care visits. Currently, the two systems of rules are quite different. For the integration efforts to succeed they need to be reconciled. A dialogue involving providers of care and payers is needed to resolve this issue.

Lack of Workforce

The need for a workforce that is capable of working in an integrated setting is demonstrably urgent. Most of the team leads commented about the lack of a qualified cross-trained workforce. Training a new kind of providers that would be able to work in the integrated setting is not simply a matter of funding. Different integration models require a different type of provider training.

For example, an evaluation participant from Oregon explained, “To work as a co-located behavioral health specialist in a primary care setting or to be a primary

care provider who is more fully functional and able to see and work with people with behavioral health problems, there are two different sets of core competencies that those two different [types of providers] need to have. They have not, in my view, been very well developed in training programs around the country and they need to be.” More specific core competencies need to be developed for different integrated clinical models and involved providers. “Or else — adds the Oregon participant —we will have a lot of clinical models set up, but we won’t have the right people to work in them.”

Cultural Differences

Finally, cultural differences among professional groups were mentioned by team leads as a factor impeding integration. Pre-existing biases and resentments are complicating the communication process between providers from different disciplines.

For example, the Colorado team lead observed that for some physicians it is difficult to accept using behavioral health consultants to help provide health care, and vice versa. “There are some physicians that have difficulty with that concept of the bio-psycho-social model of healthcare. Although of course that’s not true for all physicians. I think it goes both ways. There is a paradigm shift for mental health people to successfully practice in the primary care clinic, and that is shifting away from your traditional focus on the patient and 50 minute/hour appointments and 90 minute family therapy appointments, and to work in a briefer, problem focused, consultative model of integration.”

Evaluation participants also mentioned a host of other important issues related to workforce. Some team leads pointed out the importance of cultural competence in the new workforce.

For example, the District of Columbia evaluation participant said: “We have a goulash, I’m sure other cities do as well, in terms of whether [patients are] from the Pacific Rim or whether they are from Central America. We are finding alcoholism, for example, in our Latino community from Central America. This is an issue that we need to deal with but are there enough providers who are culturally competent to be able to provide that care? The answer seems to be ‘no’.”

Other Issues

Other widely recognized problems are associated with the stigma and misconceptions relating to substance abuse and mental health care, particularly in smaller population “frontier” states. All of these barriers will require a lot of work to overcome in order to assure the development and support of integrated systems. Overall, the participants acknowledged that while there are a lot of local efforts that fuel the initiative, lack of awareness of the seriousness of behavioral health problems, and mainly the lack of incentives to consider and implement change impede the integration efforts.

5.2. Requested Federal Assistance

Targeted Funding

Team leads were asked what else federal agencies could do to help advance the integration initiative in their states. The most common request was to provide targeted funding for the integration-related activities, including pilot projects. All interviewed team leads said that designated funding for the initiative would be very helpful.

For example, the team lead from Hawaii said: “We need resources, resources, resources. It does not do any good to say that here is this initiative and you should get everyone around the table if you don’t provide resource to get those people around the table. This is the main thing.”

Both state and federal grants were mentioned as necessary for pushing the initiative forward. Participants of the Falls Church Summit suggested that it would be good to have HRSA/SAMHSA grants to fund state-level planning efforts. They also asked that HRSA and SAMHSA let them know what is available and how it can be accessed, beyond just adding a mental health capability to community health center grants. One suggestion was that perhaps mental health clinic funding should be earmarked for the seriously and persistently mentally ill so that health centers can address the less intense needs for behavioral health care. Some participants complained that the fact that HRSA grants for integration are so small and few in numbers, sends a “wrong message” that this effort is not valued as important at the federal level.

Follow-Up Support

Team leads from six states said that some follow-up technical assistance would be much appreciated. Currently many team leads lack critical information that would help them obtain wider support and new funding streams for the initiative. One team lead pointed out that HRSA and SAMHSA have not shown that the integration model provides fiscal benefit to the states: “From the point of view of funders, have we shown that integration of services makes a difference? Maybe some resources should go to studying the integrated model, and put a price tag on it. Some math has to be done about the net benefit that this model brings to the table. Because until we can prove to funders that there is a fiscal benefit, I am not sure we will get much support.”

Currently many team leads indicated that they feel isolated, unsupported and uninformed in their pursuit of the goal of health care integration. They are particularly in need of information on successful integration projects.

For example, the team lead from Washington suggested a larger federal role in facilitating the flow of information among interested parties: “We need a support group. Many people just do it on the local level, they make integration happen. They create this model, and they have these wonderful success stories. I think it is important to continue this effort of sharing the knowledge. I think that the drivers of this initiative are community health centers. Maybe it is time to have pilot projects at the community health center level, to get started. People need to learn what it means to integrate. Money is helpful, of course, but it is not all.”

Such follow-up support would also signify that federal agencies are fully committed to fulfilling a leadership role for this initiative. A number of team leads expressed an opinion that federal agencies should both provide leadership for the initiative and communicate this commitment to states. As one evaluation participant said:

One of the major barriers in developing an integrated system is the fact that HRSA has not communicated with the existing CHCs that there is indeed a desire for an integrated system on their part. In going around and talking with directors of CHCs I hear that “Yes, it is an interesting idea, but I’ve got enough on my plate now.” There is no pressure on the part of HRSA to get those individuals to even look at it. I feel it is not the kind of support from HRSA or SAMHSA that we were promised during the Summit. We get a pat on the back that we are doing a great job, but we need real help out here if it is something that HRSA and SAMHSA truly believe has to happen.

Medicare/Medicaid Reimbursement

Specifically, this commitment should be seen in addressing one of the most serious impediments to the initiative: Medicaid and Medicare reimbursement rules which currently make it difficult to claim integrated services. This problem is seen by most team leads as a failure on the part of the federal agencies to work together. Many participants agree that political pressure from the federal level on state Medicaid agencies would help a great deal with the reimbursement issues.

For example, an evaluation participant from California noted: “On the Medicaid discounting side—the billing—it has gotten worse: it used to be that visits involving mental health diagnosis were discounted; so now if primary care physicians use mental health diagnosis, these visits also get discounted. Thus the message is out there that mental health services are not valued as highly as primary care services. And this [comes from] the federal level. Thus we have a feeling that the Feds are disingenuous in this whole integration effort.”

Workforce Training and Development Assistance

One of the most important areas of building integrated health care involves workforce training and development. As the previous section of the report shows, very few states have significant achievements in workforce development. Many team leads wished for technical assistance from HRSA and SAMHSA in this area, such as SAMHSA tool kits. Information on core competencies for integrated care would help to shape new curricula. Targeted funding for cross-training would also help jumpstart movement in this area.

State-Specific Summits

Finally, some evaluation participants pointed out that it would be good to have federal funding for state-specific summits where they could get higher-level state officials involved. The need for such a summit is particularly acute in states where a successful integrated model is in place but there are no statewide programs to disseminate and promote the model. Such a summit would be helpful for practitioners from different professional areas to begin a dialogue, for the policy makers to realize the needs, and for all stakeholders to begin forming partnerships.

5.3. The Role of the State in Integration Efforts

While many of the described challenges are quite similar from state to state, one variable appears to make a decisive difference in determining how great the challenges are to those attempting to develop an integrated system of care. This variable is the degree of involvement of state leaders and department heads in the integration initiative. As the data presented in chapters 3 and 4 shows, few integration-related activities have been accomplished in those states that do not have state-level involvement in the initiative.

Typically, certain limited results can be achieved at the local level even without state support. For example, a number of team leads from the states with low levels of state involvement reported the following accomplishments:

- ◆ some success in local service integration (Table 4.1.1),
- ◆ search for funding for integration-related activities (Table 4.1.1),
- ◆ local cross-discipline training programs (Table 4.2.1), and
- ◆ interagency partnerships and collaborations (Table 4.3.1).

However, as table 5.3.1 clearly demonstrates, in the states with low levels of state involvement in the initiative, the success of the State Action Plan implementation – as well as overall progress in integrating primary and behavioral health care – is quite poor. All team leads in the states where the state agencies assumed leadership position evaluated their progress as ranging from “fair” to “excellent.” However, of eight states with minimal state involvement, six evaluated their progress to implement State Action Plan as “poor,” and two evaluated it as “fair.” Seven of those team leads evaluated their overall progress to integrate health services as “poor,” and only one as “fair.”

Table 5.3.1. Overview of Leadership, Resources and Progress

STATE (number of participants)	In-state leadership to promote integration			Use of federal resources	Consumer participation	Assessment of progress to implement State Action Plan*	Assessment of progress to integrate primary and behavioral care*
	Coordinating agency	Responsible agency	Level of state involvement in the effort				
New Orleans, LA							
Arkansas (6)	committee	none	yes, marginal	no	no	poor	poor
Louisiana (33)	steering committee	yes: Integration Team (Department of Health and Hospitals)	yes, leadership	no	no	fair	good
Oklahoma (9)	steering committee	none	yes, leadership	yes	yes	fair	good
Texas (31)	steering committee and single agency	yes: TSHP (Texas Institute of Health)	yes, leadership	yes	yes	good	fair
Falls Church, VA							
Connecticut (6)	interagency council	none	none	no	yes	poor	poor
District of Columbia (15)	single agency	yes, Primary Care Association	yes, leadership	-	yes	poor	fair
Maine (15)	healthcare foundation	yes, Primary Care Association	yes, leadership	yes	yes	good	excellent
Massachusetts (18)	summit group	none	yes, leadership	yes	yes	fair	fair
New Jersey (4)	none	none	none	no	no	poor	poor
Puerto Rico	single agency	yes, Dept. of Health	yes	-	yes	fair	fair
Rhode Island (5)	interagency group	none	yes, leadership	no	yes	good	good
Vermont (15)	steering committee and single agency	yes, Department of Health	yes, leadership	no	yes	fair	good

STATE (number of participants)	In-state leadership to promote integration			Use of federal resources	Consumer participation	Assessment of progress to implement State Action Plan*	Assessment of progress to integrate primary and behavioral care*
	Coordinating agency	Responsible agency	Level of state involvement in the effort				
Albuquerque, NM							
Arizona (20)	steering committee; council	none	yes, leadership	yes	yes	fair	good
Colorado (9)	none	none	none	yes	no	poor	fair
New Mexico (13)	working group	none	yes, leadership	yes	no	fair	fair
Utah (5)	interagency council	yes, UBHN (interagency council)	yes, leadership	yes	yes	good	fair
Wyoming (4)	none	none	none	no	no	poor	poor
Seattle, WA							
Alaska (10)	single agency	yes, Dept. of Health and Social Services	yes, leadership	yes	no	fair	good
California (26)	summit group	none	none	no	no	poor	poor
Hawaii (10)	steering committee	yes, Department of Health	yes, leadership	yes	yes	fair	fair
Idaho (1)	none	none	none	no	no	fair	poor
Montana (1)	steering committee	none	none	yes	yes	fair	poor
Oregon (22)	steering committee	yes, Department of Human Services	yes, leadership	no	yes	excellent	good
Washington (30)	steering committee	none	yes, leadership	yes	no	poor	fair

*Progress is measured as Excellent, Good, Fair or Poor; (-) No information is available

5.4. Recommendations to the Federal Agencies

Based on the information presented in the earlier sections of this chapter, the evaluation team has developed a set of recommendations to the federal agencies that will assist them in devising new strategies to promote the integrated model. These recommendations take into account the evaluation analysis that includes such factors as state involvement in the current integration effort, presence of the strong leadership, identified needs and available resources.

In compiling a list of recommendations, we took into account a substantial difference in needs between groups of states, indicated by team leads in the interviews for the second round of evaluation. Specifically, there is an identifiable difference between challenges and priorities as described by the team leads from the states with high level of state involvement in the integration initiative, and needs specified by the team leads from the states with low level of state involvement. Consequently, the evaluation results indicate that these two groups of states may benefit most from different types of assistance, specifically:

To the states with demonstrated high involvement of state agencies in the initiative:

- ◆ Technical assistance
- ◆ Targeted funding for workforce development
- ◆ Targeted funding for pilot projects

To the states with low involvement of state agencies in the initiative:

- ◆ Outreach to policy makers and state officials in the relevant offices
- ◆ Awareness campaign to providers of health services and other stakeholders
- ◆ Targeted funding for pilot projects

Table 5.4.1 outlines the tasks that should be addressed through each of the four different types of assistance. It also describes the means by which assistance can be delivered, and the expected outcomes.

Technical assistance is potentially a very cost-effective way to help leadership teams advance the integration initiatives in their states, especially when the integrated model is already known among providers and state officials. Many team leads indicated the need for such assistance from federal agencies. Table 5.4.1 outlines specific needs that might be addressed through technical assistance. Many of these tasks can be accomplished with the help of a designated website and a qualified integration consultant.

Workforce development assistance in a form of competitive grants is especially needed in the states where there are ongoing efforts on the ground to set up integrated health care models. Such assistance should take into account the difference in workforce needs under different clinical models of integration. Ideally, such assistance should include a goal of achieving sustainability in provision of workforce training after the end of the grant.

Table 5.4.1. Recommended Areas of Federal Assistance to States and Health Care Providers

	TECHNICAL ASSISTANCE	WORKFORCE DEVELOPMENT	PILOT PROJECTS	AWARENESS CAMPAIGNS
TASKS	<p><u>Provide information on:</u></p> <ul style="list-style-type: none"> ◆ clinical models and how to set them up ◆ available federal and private resources available to community health centers as well as states ◆ successful integration projects ◆ fiscal benefits of the model <p><u>Provide support for:</u></p> <ul style="list-style-type: none"> ◆ workforce development, including core competencies and curricula ◆ setting up integrated services 	<p><u>Train workforce</u> to work in an integrated setting with attention to:</p> <ul style="list-style-type: none"> ◆ Core competencies for integrated service providers ◆ Curricula for cross-discipline training ◆ Cultural competence of service delivery professionals ◆ Consumer involvement in the treatment 	<p><u>Provide data</u> on benefits of integration for policy makers, providers, consumers and other stakeholders on the following issues:</p> <ul style="list-style-type: none"> ◆ Improved services ◆ Fiscal benefits to the healthcare system ◆ Overall benefits to the consumers 	<p><u>Generate awareness</u> of the benefits of the integrated model by:</p> <ul style="list-style-type: none"> ◆ Direct mailing to health care providers, state policy makers and officials, consumer groups, and other stakeholders ◆ Information and publicity generating events, such as: conferences, meetings and media events.
MEANS	<ul style="list-style-type: none"> ◆ Designated website containing pertinent information and interactive support tools ◆ Technical assistance consultant(s) 	Designated funding to providers and states in a form of competitive grants	Designated funding to providers and states in the form of competitive grants	Federally sponsored activities and events
OUTCOMES	<ul style="list-style-type: none"> ◆ Service delivery professionals are provided with customized assistance and support on demand. ◆ State officials and policy makers are informed about existing structural and regulatory barriers. ◆ Information is provided on how integration works in different states; success stories are presented; challenges and accomplishments are discussed. 	<ul style="list-style-type: none"> ◆ New integrated settings have cross-trained workforce. ◆ Cultural differences among professionals groups are ameliorated. 	Data is available to inform policy makers, providers and general public about benefits of the integrated health care as well as existing structural barriers.	Awareness of the benefits of the integrated model is generated among health service providers, policy-makers, and consumers. All stakeholders are better informed.

Pilot projects are very important because they can provide valuable data on the health benefits of integration to consumers and providers, and on the fiscal benefits of the model compared to traditional service delivery. Policy makers, providers, consumers, and other stakeholders will all benefit from the information gained in pilot projects. The information will be useful for making decisions about which models of the integration are most applicable for the needs of targeted populations, for deciding how to improve the regulatory environment, and in promoting the idea of integrated services among the general public, as well as for other purposes.

Awareness campaigns can be seen as an effective way to inform policy makers, state officials, consumer organizations and other stakeholders about the benefits of the integrated health care system. Two such types of assistance are proposed:

- ◆ Direct mailings to the stakeholders, including primary and behavioral health care providers, state officials and policy makers, consumer organizations and advocacy groups, and other interested parties.
- ◆ Publicity events, including statewide conferences on integrations, local meetings and summits, and media events.

The overall goal of such awareness campaigns is to provide stakeholders with the most up-to-date information about benefits of existing integration models, data from pilot projects, and available federal, state, and private support for the integration.

CONCLUSION

The Summit Initiative was an ambitious undertaking conceived and initiated by HRSA and SAMHSA, to leverage major changes in the design and delivery of mental health, substance abuse, and primary care services in 25 states and several US territories. The premise was that the ingredients for change—motivation, human resources, and revenues—were available to states, and that the federally funded Summit Initiative would serve as the catalyst activating these ingredients to promote service expansion and integration on a wide scale.

The design of the initiative was straightforward and economical. The two administrations would jointly host a series of three-day Summit meetings. At these Summits, participants would learn about various integration models and about the public and private resources available to them for expanding mental health and substance abuse treatment services to underserved populations. They would work in State teams, under the direction of trained facilitators, to develop state specific Action Plans for how to access and use these resources. The Summit teams, composed of a cross-section of stakeholders, would become the nucleus of a larger network of interested parties who would promote service integration in their respective states.

The Summit meetings were regarded by most participants as well organized and effective in helping states develop working teams and preliminary Action Plans. However, many participants found that the Summit Initiative 2004 was not very effective in bringing policy makers as well as consumers to the table (see chapter 2). In addition, the financial and technical assistance provided by HRSA and SAMHSA to implement the Action Plans was reported to be insufficient. A set of recommendations was developed by the evaluation team to improve the summit model as a vehicle of promoting change, including the following:

- ◆ Recruitment. It is essential to involve state level decision makers in the process.
- ◆ Pre-summit preparation. Invitees should be informed about the planned summit a few months in advance so they could plan to attend; they also must be provided with summit materials well in advance. It is important to ensure that the purpose of the summit is clear to the invitees.
- ◆ Summit Process. Agenda should be flexible to accommodate various needs of participating states. Participants should not feel rushed through the process. Networking events and information on various sources of funding should be included in the agenda.
- ◆ Follow-up support. Follow-up technical and financial assistance with plan implementation would be helpful for the success of the initiative.

By the end of the evaluation period in June 2006, the Summit Initiative had produced promising achievements in most of the participating states. Two-thirds of participating states continued to implement their Action Plans with active leadership from relevant state agencies. Many had achieved tangible results in the two years since the first Summit meetings, including the following:

- ◆ 77% of states¹⁶ have established a permanent team or other entity that is responsible for overseeing and coordinating the implementation of the state's Action Plan. 40% of these states said they have all the key players on their teams;
- ◆ In 67% of states, the Action Plan implementation efforts are led by state bodies or agencies with strong connection to state bodies;
- ◆ 100% of states have had accomplishments in building a seamless system of care; 92% of states have integrated services in some health centers or for certain populations;
- ◆ 83% of states have had accomplishments in workforce training and development;
- ◆ 96% of states have had accomplishments in building partnerships and collaborations;
- ◆ 67% of states have involved consumers in the Action Plan implementation;
- ◆ 59% of states have obtained federal assistance that was fully or in part used for integration-related activities.

Overall, 39% of team leads said their states have made good to excellent progress in integrating health services in their states. 26% of team leads said they made good to excellent progress in implementing their Action Plans. 61% of team leads attributed some of their integration-related accomplishments to the Summit Initiative, and an additional 22% said that most or all of their accomplishments are a direct result of the Summits.

The evaluation found that the main impediment to the integration initiative is the lack of targeted funding. Various economic, political and environmental factors, like slow economic growth, the Iraq war, and Hurricanes Katrina and Rita, significantly reduced federal, state, and alternative funders' revenues that could have supported change. At the same time, rising health care and insurance costs increased competition for public health dollars among existing programs, leaving even less money for new initiatives. In addition to the lack of funding for the initiative, the team leads reported many other problems and challenges. Chapter 5 described problems and challenges experienced by state teams most frequently. The most significant of them include the following:

- ◆ Lack of funding for the initiative
- ◆ Reimbursement regulations, including Medicaid/Medicare
- ◆ Structural and regulatory barriers
- ◆ Lack of workforce with cross-discipline training
- ◆ Cultural differences among professional groups

Based on assistance requests expressed by evaluation participants, the evaluation team developed recommendations to support implementation of the integration initiative. Below are the highlights of the recommendations for the follow-up support.

¹⁶ Here and throughout the Report twenty-two states, the District of Columbia and Puerto Rico are counted as 100%, unless specified. Two states (Delaware and New Hampshire) withdrew their participation.

- ◆ Technical assistance, to provide state teams with information and support in integration-related activities.
- ◆ Workforce development assistance in a form of competitive grants, to assist states in setting up training programs to provide cross-training to providers to prepare them for working in an integrated health care setting.
- ◆ Pilot projects support in a form of competitive grants, to provide evidence on benefits of integration to policy makers, consumers and providers.
- ◆ Publicity campaigns, to raise awareness of the integrated health care among policy makers, state officials, consumer organizations and other stakeholders.

The Summit Initiative appears to have been a well-conceived and worthwhile effort on the part of the Federal government to help states expand and integrate primary and behavioral health services. While the foundation for service integration was established in most of the participating states, the lack of resources prevented them from fully implementing their Action Plans. Implementation of the recommended follow-up assistance described in the last chapter of this Report would support the state teams and ensure that the states continue to progress with the initiative.

APPENDIX A: At-A-Glance Summaries of State Accomplishments

NEW ORLEANS SUMMIT PARTICIPANTS

Arkansas

Unforeseen events have directly impacted how the Arkansas State Action Plan has been implemented. Specifically, both of the individuals who had assumed lead responsibility for this initiative have passed away. Their passing has impacted the integration efforts in that much of the motivation that had existed in Arkansas following the Summit due to their efforts was lost. Nevertheless, the current team lead from Arkansas explained that a number of community health clinics have taken it upon themselves to integrate their services without leadership or coordination from a central agency. These health centers have been collaborating for years and are engaged in cooperative activities, such as sharing staff, which will allow behavioral health to be brought into primary care settings. The team lead explained that federal funding and state or federal leadership would be needed to move this effort forward. In Arkansas, those involved with integration are starting to question how they can continue to promote integrated services without these key elements. The costs of integration are affecting their delivery of integrated care and may come to outweigh the benefits if a solution is not found.

Louisiana

The Primary Care/Behavioral Healthcare Integration Team has been the acting steering committee and lead organization for the integrated care initiative in Louisiana. They had been meeting monthly until Katrina, and are planning to resume meetings again. In the interim, coordination of integrated care activities has occurred through local planning bodies that have seen participation from many of the New Orleans Summit participants. Integration of services has frequently occurred in local health centers as a response to the crises caused by the hurricanes. Regional committees have been established and tasked with the responsibility of developing “next steps” specific to their regions. Local community based organizations have also begun to integrate their services. The team lead explained that Hurricane Katrina has enabled partnerships to form where they were once impossible. Due to the level of need that currently exists in Louisiana for health services, agencies and organizations have been working together as they never have before to ensure the medical needs of Louisiana residents are met. Unfortunately, the training and development of Louisiana’s workforce has been severely limited by the hurricanes. Former accomplishments have been rendered ineffective, due to facility destruction and workforce flight, and basic residency programs will now need to take place before additional training mechanisms can be introduced. To move this initiative forward, the team lead indicated that funding, planning data, and interest from others would be needed.

Oklahoma

On a project-specific basis, a steering committee meets to discuss the implementation of the integrated care initiative. Oklahoma had been awarded a SAMHSA Mental Health

Transformation grant, and now is in the midst of a highly active period of reformation. Thus, incorporating integrated care into a wide-ranging set of priorities was proving difficult but possible thanks to commitments from primary care representatives and others. Specific accomplishments include the development of a variety of pilot projects, the use of a SAMHSA MHT SIG to develop screening tools for behavioral health settings, and the active involvement of consumers in each stage of the planning process. The team lead reported that they had active consumer participation in the grant application process, in agency recruitment, and in the peer education stage of integrated care development.

Texas

Although Texas does not appear to have directly implemented the Action Plan created during the New Orleans Summit, nor met as a “Summit team,” there is a very active working group, the Texas Strategic Health Partnership (TSHP), which was created as a result of state legislation known as HB 2292. The Department of State Health Services and its Commissioner spearhead current integration efforts. The work of the Mental Health Workgroup, a subgroup of TSHP, will also add to a seamless system of care. According to the state lead, there was a massive integration of care in Texas in response to Hurricanes Katrina and Rita in the fall of 2005. They have been able to provide integrated services in a disaster mode, but haven’t done it in a systemic, organizational way. Workforce training and development activities are in the planning stages. They have been discussed at a statewide summit and The Shared Vision Project of the Texas Institute for Health Policy Research has been formulating plans to address this area of need. Since 2004, Texas also brought the Mental Health Workgroup together, applied for the Mental Health Transformation grant (MHT SIG), and was one of seven states that received it. As a result, Texas now has a Governor-appointed group called TWG (Transformation Work Group) that is an active leadership team. Interest from others, examples of successful integration, and planning data will be needed to move this initiative forward.

FALLS CHURCH SUMMIT PARTICIPANTS

Connecticut

An informal group is currently promoting the integrated health care initiative. According to the team lead, there is no central lead agency. The coordination of this effort has suffered due to a lack of time. Meetings have been difficult to schedule and participation has been difficult to generate. There are a number of independent efforts underway in separate community health centers. Planning data, funding, and interest from others are all needed if Connecticut is going to advance this effort any further.

Delaware

There has been little communication among Summit participants since the Summit, and all efforts to promote the integrated model have been undertaken by non-participants. The Action Plan that had been developed during the Summit was abandoned shortly after the Summit, as it was not deemed appropriate as a statewide plan. Currently, integration of

primary and behavioral health care is on the agenda of interagency public policy discussions. Lack of information on the gaps in service provision prompted agencies to focus on the data collection and analysis that is expected to take another year. The data collection focuses on the number of mental health service providers, their geographic location, and the types of services that they provide. The results will inform future policies with regard to integration. In the past six months, there have also been many discussions about the need to train a new kind of health care services providers, focusing on the connection between the mind and the body. These discussions involved representatives from multiple state agencies and private sector (providers, nursing homes, hospitals).

Maine

The Primary Care Association currently has lead responsibility for the integration initiative in Maine. Through a HRSA maternal care block grant, MeHAF has partnered with the Maine Center for Disease Control (CDC) (formerly the Bureau of Health) to implement a pilot approach to the integration of behavioral health and primary care in community health centers specifically focusing on women of reproductive age. This pilot has been modeled after the Chronic Care Model and the results are being documented. The team lead has addressed the Maine Association of Mental Health Services Conference on the issue of federally qualified and community health centers and their role in the integrated model. The lead organization (MPCA) has also utilized annual state conferences to spread information about integrated care, and also held day-long workshops with state participants on integration efforts and also integration in a managed care environment. Since the Summit, the Primary Care Association has engaged in multiple teleconferences with the Mental Health Association, and the state to address the state action plan that was developed at the Falls Church Summit and to update it accordingly. The statewide effort has been taken up by the largest health foundation in the state of Maine, known as the Maine Health Access Foundation, as one of its top two strategic priorities. Obstacles to the integrated care initiative include Medicaid/Medicare billing requirements and reimbursement uncertainty.

Massachusetts

After the reorganization was completed and the EOHHS Strategic Plan underway, the state agencies developed department-wide strategic plans. Phase I of the Department of Mental Health Plan was developed on April 12, 2005. An overarching goal of the Mental health Plan is to redesign and implement a unified behavioral health system. This includes coordination with other state agencies, a comprehensive quality improvement plan, and the development of a data-driven decision support system. The Department of Public Health's Bureau of Substance Abuse Services has made public their strategic plan in June 2005. In addition, within the Department of Public Health, the Division of Primary Care and Health Access and the Division of Perinatal and Early Childhood Health have implemented a demonstration project to increase provider screening and appropriate follow-up for alcohol and drug use during routine prenatal care through systems development and clinician training and support. The MassHealth Behavioral Health Programs Unit, Department of Mental Health funded a comprehensive evaluation of the Behavioral Health Program for the Primary Care Clinician Plan. This evaluation

provided background information on the integration of mental health, substance abuse, and primary care.

New Jersey

There is no central leadership or coordination in New Jersey for the integrated care initiative. The state has been involved with Federally Qualified Health Centers but their focus has been on the budget and the uncompensated care fund. As a result, all integrated care accomplishments have taken place within AtlantiCare, the medical center in which the team lead is an acting project director. Through her efforts, integration is occurring and an integrated care model is being formed. The team lead hired an on-site mental health professional who has been involved in both patient screening and their newly expanded counseling services. The team lead also teaches at Rutgers University and is on the state licensing board for drug and alcohol counselors. Through these roles she continually promotes integrated care. To move this initiative forward, the team lead will need funding, interest from others, and shared examples of successful integration.

Rhode Island

Rhode Island had been working with the integrated care concept for upwards of seven years prior to the Summit. They had a group of state agencies and providers in place, known as the Allied Advocacy Group (AAG), with whom the summit participants immediately began to work to implement their state action plan. Since the Summit the Governor's office has become active in this longstanding integration movement as has the Office of Health and Human Services. There is a great deal of support for integration in Rhode Island and their accomplishments to date attest to that fact. Integrated care models can be found within family practices, military clinics, and a number of community health centers. Many of these models are providing consistent feedback and data to the AAG. Rhode Island also participates in national cross-discipline placement program SEARCH. Rhode Island will be holding a multi-state conference in November where the team lead hopes they and their national partners will be able to generate interest in the integrated care idea amongst their federal representatives. Obstacles to the initiative have included Medicaid reimbursement issues, cultural differences in their workforce, and the highly confusing allocation of state resources.

Vermont

The Vermont Department of Health (DOH) has been the lead organization for the integrated care initiative. Since the Summit, the team lead has been given full authority to focus the Department of Health on this initiative and expand it. DOH decided that integration would do best if it were built on several activities as opposed to becoming one all encompassing effort. In this way, they could form a number of smaller steering committees that address integration complexities and scheduling issues independently. The integration initiative has been incorporated into the workings of the Blueprint Project, a program through the Vermont Governor's Office and Department of Health that has been addressing the reorganization of the health delivery system around chronic care and chronic illness models. The team lead has been involved in the Medicaid authority's efforts to assemble a statewide care management program for high cost individuals. They have worked closely with Medicaid to ensure that the mentally ill are

included within this care management system. They have also been establishing different sites where mental health workers are co-located in primary care offices. The University of Vermont has been active with the Department of Health in the development of workforce training mechanisms. Through the University of Vermont's V-chip program, they have also continuously gained knowledge with regard to workforce development. To ensure this momentum and support was maintained, the team lead indicated that they would need funding, examples from other states, and more time.

Washington, D.C.

Integrated care in Washington, D.C. is being lead by the D.C. Primary Care Association. Through its health care finance reform committee, key players, including the city ombudsman for long-term care, Mental Health, Medicaid, and various other city officials are collaborating over issues related to Primary Care and Community Health Centers and mapping a more cost-effective health care model. It is health care finance reform that has lead to the integrated care concept receiving attention at this point in its development. Substantial achievements have been made in promoting integrated health care services in DC. For instance, the city is developing a community health worker program to establish connections among community health workers. It has been proposed that a loan repayment program be instituted so as to attract a highly qualified workforce to the community health care arena. Lastly, a program, known as Medical Homes D.C., will provide the funding for the construction of community health facilities that will be able to house multiple disciplines under one roof. Obstacles to integrated care have included a lack of funding and a system that is currently disparate and difficult to reconfigure.

ALBUQUERQUE SUMMIT PARTICIPANTS

Arizona

Summit participants from Arizona, in conjunction with the Mountain Park Health Center and the North County Community Health Center, make up the current steering committee which has assumed lead responsibility for the integrated care initiative. The team lead indicated that if the local models were successful they would use them to pilot further efforts throughout the state. The focus, at this point, is to collect data and develop successful examples of integrated care before they seek a full buy-in from state agencies. Funding has been acquired from HRSA, in the form of two separate grants for the planning and implementation of the Mountain Park and North County models. The team lead hopes Arizona will soon be able to integrate services for co-occurring disorders and incorporate a training element into university curricula throughout the state. Finally, a project is undertaken by several subcommittees to assemble a database, with regard to the training and cultural competency of their workforce, that will facilitate communication delivery amongst the various clinics and providers. Obstacles have been encountered in the form of Medicaid and infrastructure barriers.

Colorado

From county to county, the integration initiative is being implemented without central leadership or state involvement. The team lead reported that since the Summit there has

been little to no communication between the Summit attendees and all accomplishments are the result of local initiatives. For instance, in a local community health center they have hired a bi-lingual, bi-cultural, nurse practitioner and co-located four bi-lingual, bi-cultural mental health professionals. Potential legislation has been introduced that would enable integration at the local drug and alcohol detoxification center where current licensing barriers currently restrict integrated practice. The concept of integrated care had been in place in Colorado prior to the Summits. As a result, local partnerships were in place, namely the Northern Colorado Health Alliance, and now are utilized to implement the state action plan. So too were local initiatives, such as a School based Health Center project, which bring multiple disciplines together in an effort to integrate services within communities. Obstacles to integration in Colorado include a lack of funding, a lack of state involvement and awareness, the difficulty of integrating unrelated disciplines, and legislative barriers.

New Mexico

Through an informal working group, known as the New Mexico Interagency Behavioral Health Collaborative, the integrated health care initiative has been coordinated through regular meetings and discussions. The inclusion of key stakeholders in this Collaborative has been a major accomplishment. So too are the integration projects that have come out of expanding Screening Brief Intervention and Treatment Grant (SBIRT) priorities. Twenty-two sites have been funded by this grant and both integrated screening protocols and the defining of explicit outcomes have been addressed. Ten substance abuse counselors have been designated as “circuit riding” counselors and travel regularly to rural communities to offer behavioral health services. New Mexico has also carved money out of the state budget, unrelated to the SBIRT, to fund demonstration projects that will integrate behavioral health services into primary care settings. To train and develop their workforce, the team lead explained the Behavioral Health Collaborative has been looking to expand the use of SBIRT teleconferences. They have also increased opportunities for behavioral health training for primary care providers in SBIRT sites and have enabled family planning providers to acquire continuing education units on domestic violence and substance abuse. Finally, in 2006, a piece of legislation was passed which eased the licensing restrictions that existed for behavioral health providers. Obstacles to integration have included a lack of funding, insufficient time, and a number of issues that have arisen due to restrictions set by the state health care system.

Utah

The Utah Behavioral Health Network currently has lead responsibility for the integration initiative in the state of Utah. Through UBHN, integration team members are able to coordinate with State Health and Human Services Representatives on plans and updates regarding implementation. A number of Federally Qualified Health Centers are currently sharing staff throughout the state. A statewide plan to track, monitor and increase coordination between physical health and mental health/substance abuse services has successfully implemented. Since then, they have continued this effort by conducting an ongoing “record review” and have been monitoring community health centers via “preferred practice guidelines.” A grant was awarded that has provided funding for a midlevel psychiatric provider to co-locate within a Salt Lake City community health

center. This grant has also allowed the same community health center to partner with the local mental health agency to provide care for the homeless in Salt Lake. They are also working to develop a base-line measurement that they hope to be able to use as they continue to implement the integrated care model. Obstacles to integration revolve primarily around Medicaid/Medicare reimbursement issues.

Wyoming

There is no leadership with regard to the implementation of the State Action Plan. Little progress has been made with the activities that were compiled during the Summit. The interviewed Summit participant explained that the Albuquerque Summit provided him with a better understanding of the benefits of the integrated model and motivated him to influence his health center to begin integrating health services. Since the Summit, this participant has looked to integrate some of the services his behavioral health care clinic offers with those of their counterpart primary care providers. In turn, his clinic has developed better collaborative relationships with some of the primary care physicians that see his clinic's patients. There are a number of major obstacles to the integrated care initiative that are impacting its progress in Wyoming, including the lack of funding and difficulty of integrating services in a geographically large, mountainous, and rural state. Even though "the model is ideal for a frontier environment," the lack of leadership, support, and resources is not allowing this plan to move forward.

SEATTLE SUMMIT PARTICIPANTS

Alaska

The Health Planning, Assistance and Development Department within the Alaskan Department of Health and Social Services have both lead and coordinating responsibility for the integrated care initiative. A wide base of leadership and participation from a number of agencies has allowed for progress to be made in the promotion of integrated care though most of the accomplishments have been unrelated to the Closing the Gap Summit. Mental Health has been a pertinent issue in Alaska and creating a new initiative was unrealistic in light of the number of efforts that were already underway.

Nevertheless, a comprehensive integrated mental health plan was assembled this past year, facility improvements have been planned as a result of the Denali Commission, and local services are expanding as the overall continuum of care for behavioral health is improved. The state university has also been involved with this initiative and has played an important role in the development of a workforce that able to handle the integration of health services. Obstacles to the integrated care initiative have included competing priorities, a lack of time, and a lack of funding. The team lead explained that they would need to refocus their efforts on tangible outcomes in order to increase their level of accomplishment with this initiative.

California

The current effort in California is being driven from the ground-up. The state is not involved in this initiative and, according to the team lead, seems to believe that integration of healthcare would be too costly to implement. There is no central

leadership for this initiative at this time. Nevertheless, from county to county, various individuals who believe in this idea are driving the local integration activity. Medicaid reimbursement is not assured under the current system for services provided through an integrated care system. The team lead indicated that legislation has been introduced at the state level that seeks to change Medicaid billing processes and address general reimbursement issues. It is not clear at this point in time whether this legislation will ease the burden on integrated care providers. Other obstacles to integration in California include the sheer size of the state, the number of vested interests that exist, and the unwillingness of the county-run mental health system to change.

Hawaii

A Steering Committee, composed of the team lead, representatives from the Hawaii Primary Care Association, the Office of Planning and Development, and the Office of Adult Mental Health Services, has been assembled. Getting these various players involved and forming this committee has been a major accomplishment. The Hawaii Department of Health, which has significant internal support for integrated care, currently has lead responsibility for the integrated care initiative. Lack of resources dedicated to the integration initiative has made it difficult to organize and plan. Nevertheless, the steering committee is organizing a conference to discuss integrated care and that will take place in the fall of 2006. At this conference the team lead hopes they will be able to share successful integration models, identify needs within their local communities, and generate interest from key stakeholders who have yet to buy into this initiative.

Idaho

Since the Seattle Summit, the sole Summit participant from Idaho has been unable to generate additional support for the integrated care initiative. As a result, the Summit participant has focused on the implementation of the State Action Plan within his own community health center. The Summit participant worked with the Primary Care Association and with the Idaho Medical Society to raise awareness of the lack of mental health access among target populations. Within his health center, this participant has hired a full time mental health supervisor and is in the process of recruiting a psychiatric medication provider as well. He has also been acquiring planning data for the future training and development of his workforce. The Summit participant explained that efforts to develop partnerships and collaborations had not been successful to date. If this initiative is going to be successful in the future, this participant explained that funding, time, and increased support from key stakeholders would be needed.

Montana

The team lead reported that he worked locally with the Ashland Community Health Center to submit a HRSA grant for the expansion of their Primary Care Unit. They are also seeking to develop a model of fully integrated health care that will be appropriate to serve the rural areas that are prevalent throughout Montana. To accomplish this, the team lead organized a steering committee that is currently in the process of developing a comprehensive prevention model that will work hand-in-hand with the integrated care model, though the planning up to this point has been inconsistent. Through this prevention model, the steering committee plans to address the areas of a seamless system

of care and workforce training and development. Currently, they are in the planning stages as they continue to seek funding for the future implementation of integrated care from both HRSA and the St. Vincent Healthcare System. The team lead identified several obstacles, including lack of state support, funding shortages, and general time restrictions that continue to inhibit their ability to implement the state action plan.

Oregon

Department of Human Services has assumed lead responsibility for promoting integrated care in Oregon, with a core-working group that was established to lead the integration efforts. Major regulatory, administrative, billing and financing barriers to building a seamless system of care have been identified and integration pilot projects are being established. In addition, there are a lot of grassroots efforts spurring the initiative. For example, Clackamas County has merged its health and mental health offices into one administrative body, an effort that was led by two participants of the Summit. Now they are in the process of figuring out how to co-locate or integrate mental health and addiction services more effectively. Consequently, there is an increased demand for a workforce that is co-trained. The concept of integration of behavioral health and primary care as a training issue was successfully included in several key training venues. Overall, there is a broad support for integration across the state both on the state level, and on the community level. Although there are still massive barriers on the road to integration, there are both political will and popular support present to move the initiative along.

Washington

The team lead from Washington explained that a significant amount of activity had taken place with regard to Mental Health due to their receipt of a SAMHSA Mental Health Transformation Grant. This Grant has led to active participation from both public and private entities, a complete reworking of the Mental Health system, and has altered the focus on integrated care which is now viewed less as a strategic initiative under “Closing the Gap” and more as one of the many results that will come out of the MHT SIG. Integration is viewed as a necessary step in health service delivery and efforts are in place to develop and implement an integrated system of care. A piece of legislation, which made funding available to community health centers, has been instrumental in this process. The integration leadership team has also collected data to better understand where there are collaborative arrangements and efforts to integrate primary care and behavioral health which has been instrumental in their ability to influence the allocation of MHT SIG funds and have become source documents for the larger transformation project. Through the transformation grant, a pilot project to address workforce development issues has been created. So too has a “common enrollment” system within community health centers through which information is being collected and reported to state agencies regardless of the services provided. Obstacles to integration have included Medicaid/Medicare reimbursement, a lack of time, and confusion over whether to integrate mental health into primary care or vice versa.

APPENDIX B: In-Depth State Summaries

A variety of methods were used to collect data for the evaluation of post-summit activities. The selection of data collection methods was based on the appropriateness for the research questions, and the feasibility. The methods used to collect information for the state summaries include the following:

State Update Reports. At the Summits, facilitators asked participants from each State to volunteer to serve as points of contact for the evaluation of post-Summit implementation. These individuals, the “team leads,” were asked to complete a State Update Report form (Appendix D) in the first round of evaluation activities that took place between January and October of 2005. This form also served as a base for the second round of the evaluation activities that took place a few months after the first one.

Telephone Interviews with Team Leaders. During the second round of the evaluation, a series of telephone interviews with the team leads or their substitutes were conducted. In these interviews, we used questions from the same State Update Report form that had been used in the first round of the evaluation. The interviews took place between February and May of 2006 and lasted between 30 and 60 minutes. In a number of states, the team leads were unable to provide information about all aspects of integration, and in these cases additional interviews were conducted to fill the data gaps (see Appendix B for the information on the interviews).

Multi-State Teleconferences. At the end of each of the two rounds of evaluation activities following the four Summit meetings, multi-state teleconferences were conducted. The first round of multi-state teleconferences was held between May and October of 2005. The second round took place in May and June of 2006 (see Appendix C for the information on the multi-state teleconferences).

The summaries are organized in the following manner. Each summary starts with the participation at the Summit and background information on the history of the initiative in the state, where applicable. The subsequent sections include summaries of the following:

- ◆ In-state leadership to implement the Action Plan;
- ◆ Action Plan accomplishments;
- ◆ Use of Federal resources;
- ◆ Consumer participation, and
- ◆ Assessment of progress.

Note: Information contained in the summaries has not been independently verified for completeness or accuracy. Since, for most states, only one individual was interviewed, the information presented for a particular state may not completely capture all the ongoing integration efforts in the state.

ALASKA

The ten registered participants from Alaska at the Seattle Summit were emblematic of the wide-ranging participation that existed prior to this meeting. They included state officials, university and consumer representatives, and providers. Because Alaska is densely populated within a small geographic area of the state, the team lead explained that meetings take place often among those who are working on health service integration. Alaska's rural makeup also lends itself to integrated health care. As a result, integration has been an important issue in that it is viewed as a major step towards improving health services for the greater Alaskan population and has been part of the greater movement to improve the Alaskan health system for some time. With this much activity already in place, the Action Plan developed at the Summit was merely added to the existing integration initiative and has since remained a minor feature.

In-State Leadership to Implement the Action Plan

The Health Planning, Assistance and Development Department within the Alaskan Department of Health and Social Services, has both lead and coordinating responsibility for the integrated care initiative. Through their effort to improve behavioral health services for children, the Department of Health and Social Services has gained the support of the state legislature, providers, and the Denali Commission, a state, federal, local partnership that has been a major donor of facility improvement funding. Additional participation has also come from the Primary Care Association, a primary care organization, a mental health advocacy organization, a consumer organization, and the University of Alaska. This increasing base of leadership and participation has allowed significant progress to be made in the promotion of integrated care in Alaska.

While the members of this department meet often to discuss the wide range of issues facing the Alaskan health care system, including integration of services, they have not met regularly to specifically discuss integration as it relates to Closing the Gap. The reason for this is that there has been so much going on with regard to behavioral health, health systems, and integration in the state of Alaska that working with an initiative separate from that which they were already doing would have been unnecessarily challenging and unproductive.

Action Plan Accomplishments

Seamless System of Care

The Denali Commission's involvement in this initiative has led to an increased focus on facilities planning as it relates to the integration of behavioral health into primary care settings. They have secured over \$40 million per year for this process and will soon begin to remodel existing facilities to increase their ability to handle multiple areas of health care. The commission has been using information provided by communities to make funding allocation decisions. The team lead also explained that they had designed behavioral health organizations that would be responsive to a broad base of health services, not only behavioral health care.

Leaders within the Department of Health had also come together to form the “Comprehensive Integrated Mental Health Plan.” This plan was formed around the major issues that exist in behavioral health care. Though this plan was statutorily required of the department, it is a major step toward creating a seamless system of care.

Also, proposed changes to the residential psychiatric treatment units were focusing on the overall continuum of care and seeking to utilize community health centers to the best of their abilities. The purpose was to link various parts of the health system to address care provisions at the local level.

The team lead explained that this area of their Action Plan was continuously evolving and that that in itself was posing a major challenge. The volume of activities in Alaska has been immense and keeping up with the constant change had led to a rapidly changing integration plan. In her opinion, this had been limiting their effectiveness as their focus was in constant flux. In order to move this plan forward, she felt strongly that they needed to reconfirm their initial commitments and rearrange their priorities so as to ensure the greatest needs were being addressed.

Summary of Action Plan accomplishments in seamless system of care

	Action Plan Activity	Status
1	Identify and collect [information] about current efforts underway within the state to integrate behavioral health and primary care services	Accomplished

Workforce Training and Development

Through the Department of Health and Social Services, a Behavioral Health Workforce Development Network has been working on the idea of interdisciplinary training. This network is composed of the Department of Health and Social Services, tribal organizations, universities, and the Alaska Mental Health Trust. According to the team lead, their recommendations were recently included in the “Comprehensive Mental Health Plan.”

The University of Alaska has also been expanding its programs. It now offers a doctoral program in social work that has incorporated integrated health care into its curriculum. The team lead explained that the university’s representation initially lacked the authority it needed to coordinate and implement these changes. Higher-level administrators have since become involved and these issues have been resolved.

Additional obstacles in this area have been a lack of resources, retention issues, and the rural location of many of their health centers. Thus, the team lead explained that they should instead focus their efforts on those needs that could be readily addressed before moving on to more visionary projects.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	To develop an integrated action plan around workforce issues	Accomplished
2	Behavioral Health Integration Workforce Development Network <ul style="list-style-type: none"> • Department of Behavioral Health workgroup will align with the Network around core competencies • Primary Care Association will work with Primary Care Organization to bring primary care into the network. • Invite tribal health corporation to be part of the network. • Coordination/Alignment of all state conferences. 	Accomplished
3	Increase the numbers of master level behavioral health clinicians that also have traditional healing training	Accomplished

Partnerships and Collaborations

Through the Denali Commission, primary care and behavioral health leaders have come together to set guidelines and make decisions with regard to funding appropriations. They have been using information from the communities in which the targeted health centers reside and have actively involved community leaders in this process. Otherwise, partnerships in Alaska were already in place.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Convene meeting between the division directors of public health, behavioral health and health care services and deputy commissioners to get buy-in and support	Accomplished

Other Accomplishments

The team lead discussed changes in regulations, local service integration, and secured grant funding as other accomplishments that had taken place with regard to the integrated care initiative.

Use of Federal Resources

The team lead explained that she has been very involved with HRSA in her efforts to locate funding for health initiatives in Alaska. With regard to the integrated care

initiative, she discussed the increased use of National Health Service Corps clinicians throughout the state and the proposed loan repayment program she had been working with HRSA to create.

Consumer Participation

The team lead explained that consumers were not involved with the integrated care initiative.

Assessment of Progress

The team lead explained that from this point on Alaska would “be as busy with integration as it possibly could be.” There is too great a need in her state for integrated services due to astounding statistics in the areas of alcoholism, suicide, and drug abuse. However, she was not sure that the Closing the Gap idea would still be relevant.

Overall, the team lead evaluated her state’s progress to integrate primary and behavioral care as “good.” She evaluated her state’s progress to implement the State Action Plan as between “good” and “fair” due to the fact that activities had been accomplished but that the Action Plan had not become a key component of the existing integrated care initiative.

The team lead felt the Summit she attended was “poor” and that only some of the accomplishments in her state could be attributed the meeting. In Alaska’s case, she felt that a statewide Summit would have been much more effective as integration was already in place and they were in need of more examples and direct assistance from HRSA and SAMHSA than they ultimately received at the Seattle Summit.

ARIZONA

Arizona's registration list from the Albuquerque Summit included twenty participants from both the public and private sectors. Among these participants were primary care and behavioral health service providers, state officials, university representatives, and managed care providers. Since the Summit, according to the team lead, the integrated care initiative has been intentionally developed in such a way that the bottom level, which includes community health centers and local healthcare agencies, drives the effort while the top level, which includes state level officials and the summit participants, provides assistance and support. Upon their return from the Summit, the participants, along with state officials, devised this implementation method so as to ensure the integrated care initiative was both feasible and worthwhile. If this proves to be the case, they will then look to promote integration to the legislature and governor's office and ultimately seek to effect state policy. Thus far, the participants remain optimistic as a pilot project has been developed and a number of local initiatives have taken shape—all of which are working towards healthcare integration.

In-State Leadership to Implement the Action Plan

The Mountain Park Healthcare Agency has been leading the effort to implement the State Action Plan developed by the Arizona Summit participants. The state participants, who have supported this initiative since the Summit, have maintained regional steering committees and continue to oversee the activities of the integration pilot project for the state. Additional participation has also come from the Arizona Primary Care Association, the Primary Care Organization, the Health, Mental Health, and Substance Abuse Departments, the Medicaid Office, Mental Health Advocacy Organizations, mental health, substance abuse, and primary care service providers, state universities, the Governor's office, Human Service Consulting Agency, and Maricopa County Juvenile Probation Services.

The pilot project has occurred through the Mountain Park Health Center, over which the Mountain Park Healthcare Agency maintains administrative control. Because the HRSA grant that has supported the pilot project required sufficient planning before implementation activities would be funded, this center worked diligently to develop a model for integration but has only just sent in its application for implementation funding.

Nevertheless, a number of other health centers in the Mountain Park Health Agency's network in Maricopa County and in Northern Arizona have continued to work with integration. Their efforts have received guidance from a regional steering committee and also a number of subcommittees that were formed with the needs of specific patient populations in mind.

Action Plan Accomplishments

Seamless System of Care

Collaborations between specialty behavioral health service providers and primary care venues have been ongoing and many business agreements have been established in order to promote seamless access to health services. Mountain Park Health Center has been

tracking the ingress of primary care patients into specialty behavioral health care. With the assistance of behavioral health consultants, patients referred through Mountain Park Health Center have been attending their initial behavioral health appointments 69% of the time. That statistic has continued to compare favorably to the national average of 25% when referrals occur in non-integrated health systems. Mountain Park Health Center has also integrated services for specific populations in Maricopa County and has developed a model for integrated care that it seeks to implement with the assistance of a HRSA grant. In Northern Arizona, a similar endeavor has been organized through the North Country Community Health Center. Northern Arizona stakeholders have continued to consult with Summit members from Maricopa County to ensure their projects maintain parallel goals and are consistent with the goals of the State Plan. In developing these models, community collaborations were utilized as a means of creating a seamless system of care.

According to the team lead, Medicaid reimbursement for behavioral health screening, brief intervention and referral in primary care venues has been highly constrained due to contractual and policy barriers. This has created a major obstacle that the state will need to address if incentives to integrate health care services are going to be established.

Summary of Action Plan accomplishments in seamless system of care

	Action Plan Activity	Status
1	[Conduct] Survey of Arizona Community Behavioral Health Providers and Arizona Community Health Care Association to identify integrated providers	Accomplished
2	<ul style="list-style-type: none"> • Disseminate letter from AHCCCS clarifying directives to Arizona Council of Behavioral Health providers and Arizona Community Health Center Association • Include integrated care in the final report of Governor's group on evidence based practices. • Decide on 3 evidence-based practices that will be commonly used by all behavioral health and primary care in Arizona for one child-adolescent evidence based practice, one suicide prevention evidence based practice, and one substance abuse evidence based practice • Get clear funding and billing instructions from AHCCCS/ADHS-DBHS for implementation of co-located care • Develop one outcome measure for each evidence-based practice that can show implementation effectiveness • Develop technical assistance as needed 	Not accomplished

3	<ul style="list-style-type: none"> • Identify current access to integrated care sites • Develop behavioral health screening tool for community health center staff to utilize 	In progress
4	<ul style="list-style-type: none"> • Expand awareness of Memphis model of Crisis Intervention and Treatment (CIT) with focus on dissemination to schools, parks and recreation; faith based organizations, other community organizations, and businesses • [Make] Public service announcements, radio, television, newspapers, general audience publication 	In progress
6	Develop and integrate a funding model to support integration of care	In progress

Workforce Training and Development

Through the Co-Occurring State Incentive Grant, Arizona has been addressing the issue of co-occurring disorders. The funding provided by this grant has been used to direct a program in behavioral health that requires practitioners to engage in extensive cross training in the co-occurring disorders of substance abuse and mental illness. The purpose of this program has been to ensure that practitioners in the Arizona criminal justice system screen and assess for co-occurring disorders. Arizona has also applied for the Screening, Brief Intervention and Referral Grant. If this grant is awarded, the focus will be to incorporate integrated care into the medical curricula at Arizona State University and the nursing curricula at Northern Arizona, as well as working with the existing Screening and Brief Intervention grant at the University of Arizona.

Mountain Park Health Center Behavioral Health Practitioners are conducting training at Arizona State University (ASU), School of Nursing for future Nurse Practitioners. Also, the ASU Department of Health and Human Services has requested that Mountain Park Health Center supervise interns within their degree program to enhance the working knowledge of human service professionals in the area of integrated care. A Phoenix based sub-committee has been investigating opportunities to house training curricula for behavioral health and primary care providers at Mountain Park Health Center. This planning includes in vivo training environments and didactic instruction in the benefits and efficacy of Integrated Behavioral Health Service Provision and the Evidence Supported Treatments used by both specialty areas.

Several sub-committees have come together in an attempt to plan activities specific to training and increasing the cultural competency of their workforce. They have discussed the creation of a database to facilitate communication delivery among the various clinics and providers. Cross training and venue sharing approaches have also been incorporated into Phoenix and Northern Arizona HRSA-funded community integration forums.

The major obstacle that has impacted this area of the integrated care initiative has been the existing Arizona health care system. The existing infrastructure is not prepared to handle integrated care and, thus, limits the opportunity for effective workforce training and development around integration of health services.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	<ul style="list-style-type: none"> • Collaborate and coordinate with educational institutions for curriculum development for integration • Assess what's already happening within training programs regarding integrated care • Engage an expert to identify successful models nationwide • Develop cross-training and interdisciplinary experiences, and identify practice sites • Develop a workforce projection model that takes into account changing demographics and the value of integrated health care delivery systems 	Accomplished
2	Provide continuing medical education and continuing education on integrated care competencies (ICC) model for existing health care professionals (evidence-based competencies)	In progress
3	Build on existing programs attracting youth to medical health professions by including behavioral health and integrated practices in promotion materials targeting inner city and rural youth, middle school and high school populations	In progress
4	Provide evidence/data showing the benefits of integration and the impact on workforce projections	In progress

Partnerships and Collaborations

The team lead identified that there has been strong representation from community stakeholders in both Northern Arizona and Phoenix. The steering committees and sub-committees that are guiding this effort have been formalized, positively attended, and have witnessed broad representation from key stakeholders. Continued support from the Governor's office, the Arizona Association of Community Health Centers, and St. Luke's

Health Initiative has been instrumental to the success of many of the local integration projects. So too has the Regional Behavioral Health Authority which has provided continued support and technical assistance to local health centers.

The team lead indicated that both funding and examples from others would be needed to move this area of the integrated care initiative forward.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Create an integrated electronic medical data system that includes clinical record for primary health care provider, laboratory, pharmacy, and hospital and integrates data collection for demographics; encounter data, cost data, and billing data	In progress
2	Convene a statewide best practice forum on integrated behavioral and primary health care based on core group present at the Albuquerque Summit	Not accomplished
3	[Create] State-wide leadership task force to include Governors office, ADHS, AHCCCS, local representatives from current successful, experienced based models – defining parameters of success for integration (“Shared Vision”) that related appropriately to rural /frontier areas as well as urban, that includes data collection and methods of evaluation to avoid duplication of services and efforts	Accomplished

Other Accomplishments

The team discussed successful local service integration projects, secured state funding, and an ongoing community development initiative that has been looking to impact the schools around the Mountain Park Health Center.

Use of Federal Resources

The team lead discussed the use of a SAMHSA discretionary grant, technical assistance on planning, and two separate HRSA grants in promoting the integrated care initiative.

Consumer Participation

The team lead explained that consumers had been involved in the review and input stages of the integrated care initiative. They also played a significant role in the needs assessment process as they widely attended focus group meetings and filled out surveys administered by the state.

Assessment of Progress

The team lead explained that there was enough momentum in Arizona to move the

integrated care initiative forward. In five years, he believes integration will continue to occur, out of necessity, in rural communities and that valuable data will be acquired through these efforts. The pilot projects will also continue to develop, become more established, and build technical infrastructures that will lead to a better general understanding of integrated care in practice.

The team lead evaluated the Arizona's progress to integrate behavioral health and primary care as "good." He evaluated Arizona's progress to implement their State Action Plan as "fair."

The team lead felt that the Summit he attended was a "good" way to jumpstart integration activities in Arizona and that some of the accomplishments that had taken place could be directly attributed to the meeting. However, he also explained that in states such as Arizona, where integration has been working, the Federal government needed to be more involved. Partnership requirements needed to be specified in order to make it easier for state agencies to make decisions on coordinating integrated care. He would also like to see SAMHSA make additional investments in this effort in order to "get the ball rolling."

ARKANSAS

Since the Summit, unforeseen events have directly impacted how the Arkansas State Action Plan that was developed by the state participants has been implemented. Specifically, both of the individuals who had assumed lead responsibility for this initiative have passed away. Their passing has been a tremendous blow to integration efforts in that much of the motivation that had existed in Arkansas following the Summit due to their efforts was lost. Nevertheless, integration is happening in Arkansas and the default team lead, who was interviewed for this stage of the evaluation, was able to comment on integrated care accomplishments despite the fact that he was not present at the Summit.

In-State Leadership to Implement the Action Plan

The team lead from Arkansas explained that about two years ago, the state's planning commission formed a committee that was to lead the integration initiative. This committee is composed of members from Health Resources of Arkansas, White River Rural Health, and Boston Mountain Rural Health Center. Since its formation, this committee has rarely met and has shown no productive activity with regard to this effort. As a result, a number of community health clinics have taken it upon themselves to integrate their services without leadership or coordination from a central agency.

The team lead indicated that the primary care and mental health divisions of the Arkansas Department of Health and Human Services would need to be involved to move this effort forward. At this point, however, state buy-in has yet to occur, as this effort seems to be viewed as a costly and complicated initiative that is not worth the time or funding it will take to implement it statewide.

Action Plan Accomplishments

Seamless System of Care

The team lead indicated that White River Rural Health, a primary care organization, and Health Resources of Arkansas, a behavioral health organization, had been sharing staff in an effort to bring behavioral health into a primary care setting. This effort has been very successful and has created a model through which integrated services are now offered to the populations served by these organizations.

Another community health center, Boston Mountain Rural Health Center, has also integrated its services and currently provides “comprehensive primary healthcare services to the entire family. Services include primary medical, dental, mental health and preventive health services.”¹

The team lead explained that while there are concrete examples of seamless systems of care operating throughout Arkansas, federal funding and state or federal leadership are needed to move this effort forward. In Arkansas, those involved with integration are starting to question how they can continue to promote integrated services without these key elements. The costs of integration are affecting their delivery of integrated care and

¹ Source: http://www.chc-ar.org/health_maps_boston.html, accessed June 8, 2006.

may come to outweigh the benefits if a solution is not found. For instance, the uncertainty of Medicaid reimbursement is a huge impediment for community health centers whose budgets are already tight. Without certainty that they will be able to bill for the services that they are providing, these centers may ultimately decide that integration is too much of a financial risk.

Summary of Action Plan accomplishments in seamless system of care

	Action Plan Activity	Status
1	Recruit a broader task force whose members are representative of behavioral health and primary care	In progress: several attempts have been made but little has been accomplished thus far
2	Convene a statewide summit	Not accomplished

Workforce Training and Development

The team lead was not aware of any accomplishments in this area within his community health center and was unable to comment on activities within other community health centers.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Design strategies to attract high school students to careers in community mental health, substance abuse, and primary care	Not accomplished
2	Approach academic institutions regarding concepts of integrated behavioral health and primary care	Not accomplished

Partnerships and Collaborations

The team lead explained that three community health centers, White River Rural Health (primary care), Boston Mountain Rural Health Center (primary care), and Health Resources of Arkansas (behavioral health), have been collaborating for years. They are engaged in cooperative efforts, utilizing the same staff, and bringing behavioral health into primary care settings. According to the team lead, these community health centers are setting examples and establishing integrated care models that can be shared in the future with others who seek to establish the integrated service delivery of health care.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Identify success stories and models	Not accomplished
2	Present success stories at a statewide summit	Not accomplished

Other Accomplishments

The team lead was unaware of any other accomplishments

Use of Federal Resources

The team lead was not aware of the use of Federal resources for promoting integrated health care within the State of Arkansas.

Consumer Participation

The team lead indicated that there was no consumer participation in the integration initiative in the State of Arkansas.

Assessment of Progress

The team lead evaluated Arkansas's overall progress to integrate primary and behavioral care as "poor." He also evaluated the overall progress of Arkansas to implement the Action Plan that was developed at the New Orleans Summit as "poor."

The team lead from Arkansas was unable to evaluate the Summit meeting since he was not one of the participants from Arkansas. Nevertheless, he did feel that some of the accomplishments that had taken place in Arkansas were a direct result of the Summit based upon the enthusiasm for integration of health services that he witnessed between his late colleagues upon their return from New Orleans.

Overall, the team lead does not foresee change in the very near future. A lack of understanding and enthusiasm with regard to the integrated model is still prevalent among state officials. The team lead fears that unless state officials are swayed by the established examples of integration that are present throughout their state, the momentum for this initiative may ultimately subside.

CALIFORNIA

Two Summit participants were interviewed for the second stage of the evaluation. The first was the CEO of a non-profit primary care health center who provided input and background with regard to integrated care developments at the local level. The second was the acting Director of Behavioral Health for Orange County who provided a broader perspective concerning developments at both the county and state levels. Due to the lack of communication between the local and county levels since the Seattle Summit, these two interviews were necessary to provide a more in-depth look at integrated care activities in the state of California than would have been obtained by relying on a single interview.

Integration of health services in California is currently strongly influenced by Proposition 63, a piece of legislation that creates a 1% tax on taxable personal income above \$1 million to fund expanded health services for mentally ill children, adults, and seniors². It was passed a month before the Seattle Summit and has since changed the behavioral health service provision landscape in California. As a result, the Summit participants returned to a flurry of activity and program delays due to the increased drive among behavioral health agencies and providers to prepare plans and acquire a piece of the \$400 million expected from Proposition 63. Thus, integrated care has not progressed much beyond the planning stages and has yet to become a state supported initiative.

In-State Leadership to Implement the Action Plan

The Primary Care Association, Medicaid Office (Cal-Optima), a substance abuse service advocacy organization, substance abuse service providers, and primary care providers are all currently participating in the integrated care initiative. In Orange County, California, central leadership has come from the Health Funders Partnership, a group of county and community providers and agencies, which has a central steering committee and issue-specific committees working with the integrated care initiative. The Health Funders Partnership meets every other month and has discussed issues such as the impact of behavioral health on primary care and the potential that exists in the coordination of these services. However, their involvement and support for this initiative has not yet reached local level providers and the local level provider from Orange County, interviewed for this evaluation, indicated that he had yet to move forward on the integrated care initiative himself.

The state has not been involved in this initiative. According to the county and local level participants interviewed for this stage of the evaluation, the state seemingly believes that the costs of implementing this initiative are too great and has remained uninvolved as a result. This has impacted the integrated care initiative in that the sheer size of California makes program coordination, at the state level, difficult to begin with. Without state leadership, the coordination of this initiative has been nearly impossible and a disjointed effort marked by a lack of collaboration both within, and across, California counties has resulted.

² From <http://www.smartvoter.org/2004/11/02/ca/state/prop/63/> accessed on June 22, 2006

Action Plan Accomplishments

Seamless System of Care

The county level participant explained that, through the Health Funders Partnership, steps were being taken to organize a system in which liaisons provide communication assistance to community health centers in neighboring counties. Behavioral health clinics in Orange County have already incorporated substance abuse services into their mental health clinics and are looking to further coordinate with physical care clinics as well. His behavioral health division has also undertaken a performance improvement project through which they will then contract and work with primary care, regardless of site. Finally, as the medical director, he has been involved in Cal-Optima's quality improvement efforts.

At the local level, according to the CEO of Shasta Community Health Center, the main focus has been on refining the integrated model. From county to county, local level efforts have been highly decentralized and are typically resulting in unsupported experimentation. Thus, local progress with the integrated care initiative has been modest and has yet to show a great deal of promise at this point.

To move this area of the integrated initiative forward, funding, examples from others, and increased interest will be needed at the county level. While at the local level, Medicaid reimbursement issues will need to be resolved and resistance to this initiative, from state and county officials, will need to be tempered before additional accomplishments will be made.

Summary of Action Plan accomplishments in developing a seamless system of care

The California State Action Plan that was developed during the Albuquerque Summit did not contain activities pertaining to the development of a seamless system of care.

Workforce Training and Development

Neither of interviewed participants was aware of accomplishments in this area specifically related to the integrated care initiative. Obstacles that had inhibited workforce training and development included a lack of funding and the widespread need for a highly trained, competent workforce in a state where wages can not keep up with the constantly increasing cost of living.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Contact Office of Statewide Health Planning Division (OSHPD) to compile report of various work force enhancement models and resource lists; Research existing models	Not accomplished
2	Identify educational institutions that would be	Accomplished

	interested in developing certification programs in integrated care in mental health, substance abuse and primary care	
3	Enlist collaboration of area Health education Centers	Not accomplished

Partnerships and Collaborations

At the county level, the major accomplishment was the recent involvement of behavioral health providers in the Health Funders Partnership. Also, the Cal-Optima performance improvement project has created a collaborative opportunity in which primary care, community clinics, and a variety of practitioners have been involved in providing feedback regarding proposed areas of improvement.

The local level participant did not discuss any accomplishments in this area of the integrated care initiative.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	<ul style="list-style-type: none"> • Identify current examples of integration/collaboration encompassing clinical, structural and financial implementations • After best practices are identified, conduct joint meeting between Behavioral Health and Primary Care in each county/region to review and advance promising practices • [Conduct] Statewide summit to further advance California Primary Care Behavioral Integration Initiative 	In progress
2	Convene an interagency planning group to adopt policies which promote structural, clinical, and financial integration of mental health, substance abuse and primary care	Accomplished
3	Work with State Department to advocate legislative action	Not accomplished

Other Accomplishments

The county level participant discussed accomplishments in the areas of local service integration, increased state funding, and an accomplished demonstration project.

Use of Federal Resources

The participants were unaware of the use of Federal Resources to assist in the implementation of their State Action Plan.

Consumer Participation

The county level participant indicated that consumers had been involved in the planning and review stages of the integrated care initiative. At the local level, consumer participation had yet to become a feature of this initiative.

Assessment of Progress

The county level participant was optimistic about the future of integrated care and explained that in five years he anticipated the establishment of a Network of Care program where clinical information will be easily communicated between health centers. He also foresaw the development of an electronic health record for behavioral health clients that would be made available to both mental health and primary care physicians. With regard to current accomplishments, however, he evaluated both California's progress to integrate primary and behavioral care and implement their State Action Plan as "fair."

The local level participant, on the other hand, did not expect much progress to occur at all. In his opinion, the funding shortage that surrounds this initiative is a terminal problem that will not be easily rectified. With this in mind, he evaluated both California's progress to integrate primary and behavioral care and implement their State Action Plan as "poor."

The participants had varying opinions of the Seattle Summit. While the county level participant felt the Summit had been a "fair" way to jumpstart integration in California, the local level participant felt it had been "poor." Also, the county level participant attributed some of the accomplishments to the meeting while the local level participant attributed none. Each participant indicated that a statewide Summit or regional meetings would have been more effective for the state of California. The lack of support from state officials and agencies has been a major problem at this point and both seemed to believe that this was a direct result of the lack of state level participation at the Albuquerque Summit. Finally, the local level participant recommended that HRSA and SAMHSA come together to form a comprehensive integration model that can then be shared with the states.

COLORADO

Since the Summit, there has been little communication among the Albuquerque Summit participants and the enthusiasm that arose during the development of their State Action Plan has been lost. Still, the two Summit participants who were interviewed for the second round of the evaluation indicated that integrated care is occurring in Colorado due to the steps each has taken to implement the State Action Plan within their own agencies. They are aware of similar initiatives underway in other parts of Colorado as well.

In-State Leadership to Implement the Action Plan

Implementation of the Action Plan has occurred on a region-by-region basis and has been driven by individual community health centers and community mental health centers. There is no central leadership and no coordinating body responsible for promoting the integration initiative statewide. While there have been efforts to integrate health services in Colorado since 2003, they are locally driven and are not supported by the state.

Action Plan Accomplishments

Seamless System of Care

The building of a seamless system of care is taking place within a number of locations throughout Colorado as a bottom-up initiative. For instance, in Weld County, one of the Summit participants has worked with his community mental health center and a community health center to develop an integration plan that focuses on workforce development and cultural competencies. Community mental health center staff members are co-located at the Community Health Center office, and as a result of a HRSA grant, a bi-lingual, bi-cultural nurse practitioner and mental health professional is now working in both the mental health center and the community health center.

Within this Summit participant's mental health center, psychiatrists make daily rounds in its acute treatment unit. The plan is to eventually integrate these services with a detoxification unit that the local drug and alcohol treatment provider has established. Also, through the Northern Colorado Health Alliance, this Summit participant is leading an effort to extend the services of the integrated service center to serve as a "behavioral health crisis triage center." Its goal will be to decrease the number of behavioral health patients who are inappropriately admitted to the inpatient psychiatric treatment unit from emergency rooms. The local police will be instructed to use this center for behavioral health emergencies as opposed to the hospital emergency department.

In Colorado Springs, the Peak Vista Community Health Clinic has integrated its services. Through a HRSA grant, awarded in 2003, another Summit participant was brought on as the Director of Behavioral Health. His efforts have resulted in the creation of fully operational mental health clinics within most of Peak Vista's primary care units.

According to these Summit participants, numerous obstacles have impacted the creation of a seamless system of care. With regard to the promotion of the integrated model, the Summit participants have struggled with the business planning process, the staff buy-in, and the compatibility of different health care approaches. Because mental health,

substance abuse, and primary care are separate practices with different cultures and operational requirements, integrating their services is proving to be both difficult and time consuming.

Legislative barriers that restrict the integration of health services have been difficult to overcome as well. However, new legislation has been introduced in the State Senate that should remove some of the barriers.

Finally, Medicaid has been a huge impediment to the creation of a seamless system of care. Reimbursement issues are causing different disciplines to fear one another as CPT codes fail to recognize integrated services in the state of Colorado.

Summary of Action Plan accomplishments in developing a seamless system of care

The Colorado State Action Plan that was developed during the Albuquerque Summit did not contain activities pertaining to the development of a seamless system of care.

Workforce Training and Development

To train and develop a workforce that is able to offer integrated services, the Summit participants have engaged in a variety of activities. In Weld County, the Summit participant is preparing a grant proposal that he will submit to Health One Alliance. The funds that he hopes to acquire through this grant will be used to create specialized integration training for each discipline that is involved in the integration initiative in his area of the state.

In Colorado Springs, a local grant from a local Colorado foundation is currently funding an internship program that brings fourth year Ph.D. psychology students into a senior health clinic to offer mental health services. In the Colorado Springs, both graduate student psychology interns and the existing staff are trained in the integrated health care.

These Summit participants emphasized their belief that workforce training and development poses a tremendous challenge to those who seek to integrate health care services. In addition to the lack of funding that exists to implement workforce training projects, a general misunderstanding pervades the relationships between primary and behavioral health care and makes it difficult to ensure that training meets the goals of the integrated model. Within their clinics, primary care clinicians have shown that they are unsure as to how to use mental health clinicians to provide health care. They do not seem to realize that incorporating behavioral health experts into their range of services will enable them to offer better care for their patients.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Convene providers to share philosophies, mission, and activities pertaining to their discipline; within six months hold four or more regional meetings between mental	Not accomplished

	health, substance abuse, and primary care to begin the discussion; identify what providers need to integrate effectively and identify their motivation; conduct a gap analysis between what is current practice and the goal of integration; provide training in those areas identified in the gap analysis.	
2	Explore programs in other states to increase awareness of what is currently happening in integrated professional education; disseminate information to education programs on core competencies for primary care and behavioral care professional; make connections with professional organizations in regard to core competencies and training opportunities; expand current programs such as the University of Colorado School of Professional Psychology.	Not accomplished

Partnerships and Collaborations

In order to establish partnerships and collaborative opportunities to assist in the integration of care, Weld County health practitioners have created the North Colorado Health Alliance. Weld County mental health and substance abuse centers, community health centers, hospitals, and residency programs are all involved in this alliance and are working together as they never have done before. According to this Summit participant, the Alliance has recently convened to discuss how integrated care should be implemented throughout their county. In addition, a two-year-old school-based health center project has been looking to bring integrated services to Weld County schools. The focus of this project is to provide both primary care and mental health services to students on-site.

The Peak Vista Community Health Center, in Colorado Springs, has a partnership with University of Colorado's satellite psychology program in Colorado Springs. This partnership has bolstered this health center's workforce training and development efforts through an internship program that exposes students to integrated care well before they enter the professional workforce.

Because these programs are funded and administrated separately at the federal and state levels, they end up being delivered separately at the local level. Thus, coordination statewide, awareness across county lines, and cross-county partnerships are non-existent in Colorado at this time.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Convene a Colorado state summit; identify positive financial impact of integration on state resources; identify	Not accomplished

	barriers that negatively affect collaboration; recruit substance abuse representation to team; explore funding sources.	
2	Identify stakeholders (at the local and state levels) in the integration; distribute information about integration (via state summit, training to stakeholder groups); gather state specific and community specific data on co-morbidity; identify what is working that produces better patient outcomes, cost-benefit [analysis].	Not accomplished
3	Identify barriers to integration.	Not accomplished
4	Identify a Champion for integration efforts in Colorado.	Not accomplished

Other Accomplishments

The Summit participants enumerated other accomplishments, including policy and regulation changes, changes in law, community development initiatives, and the innovative use of existing resources.

Use of Federal Resources

Each Summit participant indicated that HRSA grants had been used to integrate services within their health centers. Neither was aware of any other federal resources being used to promote integration in Colorado.

Consumer Participation

Consumers are not involved in the implementation of integrated healthcare in Colorado.

Assessment of Progress

The Summit participants evaluated Colorado's progress toward integration as "poor" and "behind schedule." They also indicated that the state's progress toward implementing their State Action Plan was "poor," though they both emphasized the fact that local integration efforts had been much more successful. With this in mind, the Summit participant from Weld County expressed his optimism about the future of integration in Colorado. He believes that in the next five years mental health and primary care will continue to integrate and that co-location will become prevalent throughout Colorado.

With regard to their assessment of the Albuquerque Summit, these Summit participants both felt that some of the accomplishments could be attributed to the meeting in Albuquerque that they attended. The Summit participant from Colorado Springs expressed his discontent with the absence of state officials, Medicaid representatives, and policy makers from the Summit meeting. He recommended that HRSA do a better job of marketing the Summit earlier in the planning process.

CONNECTICUT

Of the six registered representatives from Connecticut who attended the Falls Church Summit, five were service providers. Since the Summit, they had not developed a coordinated effort to begin implementing the State Action Plan in Connecticut. Instead, the Summit participants focused their efforts on promoting the idea of integration within the health care centers where they work. No state officials have been involved in their efforts. The Summit participants were not involved in the task force established to secure a Mental Health Transformation Grant (MHT SIG) from SAMHSA, which was awarded to Connecticut in September of 2005.

In-State Leadership to Implement the Action Plan

There is no in-state leadership to implement the Action Plan. A number of behavioral and primary care providers implemented various activities to advance the integration initiative in their facilities, but there is no coordinating entity responsible for overseeing these activities. All the information flow and interagency communication is accomplished on an informal basis.

Action Plan Accomplishments

Seamless System of Care

Individual health centers develop their own integration plans and focus on accomplishing them. For example, a FQHC, where the team lead directs Behavioral Health Care, has co-located behavioral and primary health care units. Since the Summit, the team lead worked on increasing the coordination between behavioral and primary care of their patients. Formalized case reviews are now conducted on a monthly basis where shared cases are discussed by primary and behavioral care providers. However, the team lead called their co-located facility a “luxury that many agencies don’t have”. The tool kit for primary care that the team lead brought from the Summit meeting was an important way to open up the dialogue and help develop the existing arrangement.

Billing is the major obstacle in advancing this type of cross-disciplinary coordination. At this point, the case review and coordination is conducted on a consultation basis and is not billable. To further promote integration, this issue must be resolved to allow billing for both primary and behavioral care consultation services.

Summary of Action Plan accomplishments in seamless system of care

	Outcomes	Accomplishments
1	Develop a system of care where all information is accurate and accessible to all health care providers (mental health, primary care, substance abuse, and pharmacists).	In process: some agencies exploring EMR resources for implementation.
2	To implement electronic medical records across	Not accomplished

	the state. Uniform assessment protocols and tools. Free exchange of information.	
3	Educate and support clients to become involved in their treatment planning and execution options. Outcome: 75% of clients participate in the development of their person centered plan that leads to their recovery and addresses all primary care and behavioral health needs	In process: [health care] agencies are doing this independently.
4	Establish funding that supports a seamless system of care	Not accomplished

Workforce Training and Development

No coordinated statewide activities to implement workforce training and development activities specified in the State Action Plan were reported.

Summary of Action Plan accomplishments in workforce training and development

	Outcomes	Accomplishments
1	Provide student training in integrated care facilities with reimbursement, to create formalized training programs	Not accomplished
2	Designate a percentage of state and federal loan repayment programs for clinicians in primary and behavioral health care working in integrated settings.	Not accomplished

Partnerships and Collaborations

The team lead reported that the only activity in building partnerships and collaborations for promoting the integrated model was to involve consumers in planning and implementing the integrated model. Individual health care centers are accomplishing this in their own facilities. No coordinated statewide activities to build partnerships and collaborations were reported.

Summary of Action Plan accomplishments in partnerships and collaborations

	Outcomes	Accomplishments
1	Create a group to serve as a facilitator for a state planning process for integrating primary care and behavioral health care and engage stakeholders, organize and facilitate statewide stakeholder meeting	Not accomplished
2	Pilot a model integrating primary care and behavioral	Not accomplished

	health care	
3	Involve consumers in planning and implementation of the integrated model	In progress: [health care] Agencies are doing this independently.

Other Accomplishments

The team lead reported local service integration, community development initiative, and innovative use of existing resources as “other accomplishments”. These accomplishments are not statewide and are a product of work done by individual health centers that are committed to advancing the integrated model.

Use of Federal Resources

The team lead was unaware of the use of Federal resources for the integrated care initiative.

Consumer Participation

Individual health centers understand the importance of involving consumers in developing a seamless system of care and are including them in that process.

Assessment of Progress

There is a lot of enthusiasm and support for the integrated health care model at the individual health center level, although differences exist among centers. Lack of centralized coordination is negatively impacting the process.

The team lead evaluated both their progress to implement the State Action Plan and to promote integration as “poor”. The absence of state officials at the Summit was cited as the main reason for this. The team lead evaluated the Summit itself as a “good” way to jump-start the building of integrated health care, provided that the right people were in attendance. In the case of her FQHC, all the accomplishments made toward integration were a result of the Summit meeting in Falls Church.

DELAWARE

Five representatives of various public policy institutions from Delaware attended the Falls Church Summit. It was not clearly understood by these participants that the main purpose of the Summit was to help the group develop a statewide action plan for promoting integrated health care in their state. Hence, the document that had been developed during the Summit was abandoned shortly after the Summit. There has been little communication among Summit participants since the Summit, and all efforts to promote the integrated model belonged to other initiatives.

In-State Leadership to Implement the Action Plan

There is no leadership for the implementation of the Action Plan in Delaware.

Action Plan Accomplishments

The Action Plan, as a guiding document, was abandoned since its activities are currently not considered appropriate as a statewide plan. However, there are other integration-related activities happening in Delaware that were described by the state contact. These activities are reported here as pertaining to building a seamless system of care, workforce training and development, and building partnerships and collaborations.

Seamless System of Care

There have been ongoing discussions among various public policy agencies aimed at determining priorities with regard to building a seamless system of care. Current efforts are focused on obtaining accurate data on mental health service provision and gaps. The Delaware Health Care Commission is focused on collecting and analyzing these data before any specific integration building activities can be implemented. To identify gaps in mental health services, focus groups were conducted with providers and consumers. Both geography and the nature of services were considered. The data collection on the number of mental health service providers, their geographic location, and the types of services that they provide is ongoing and is anticipated to take another year. After the data are collected and analyzed, specific plans will be designed to address the gaps in services, as well as integration of primary and behavioral health services.

Workforce Training and Development

In the past six months, there have been many discussions about the need to train a new kind of health care service provider, focusing on the connection between the mind and the body. In the first stage, these discussions involved representatives from multiple state agencies, but later the private sector (providers, nursing homes, hospitals) became involved as well.

Partnerships and Collaborations

Ongoing interagency discussions that involve the private sector will help build partnerships.

Other Accomplishments

There are no other accomplishments.

Use of Federal Resources

There is no information on the use of Federal resources to promote integration in Delaware.

Consumer Participation

Consumers are not involved in the implementation of integrated healthcare in Delaware since the State is currently in its data collection stage. However, consumers have been involved in the current data collection activities aimed at assessing mental service provision gaps in Delaware.

Assessment of Progress

According to the Delaware contact, it was not made clear to the State's Summit participants that the purpose of the Summit was to develop a statewide action plan. Individuals who attended the Summit had neither the expertise nor the authority to develop such a plan. Consequently, the State Action Plan that was developed during the Summit is not currently used as a guiding document.

Integration of primary and behavioral health care is nevertheless on the agenda of interagency public policy discussions. Lack of information on gaps in service provision prompted agencies to focus on the data collection and analysis which is expected to take another year. The results will inform future policies with regard to health service integration.

DISTRICT OF COLUMBIA

With the recent resignation of the head of the Department of Mental Health, the integrated care initiative had been on hold within the Department while they located a replacement. The new head, who was recently brought in, has been made aware of the integration initiative. The team lead, who was interviewed for the second round of the evaluation, believed that this department's involvement will increase and that progress towards integration will be made. The team lead was not one of the fifteen registered participants in attendance at the Falls Church Summit and the integration activities on which he reported were not all related to the Summit meeting. Nevertheless, the integrated health care model has become a common model used by health care providers in the District of Columbia and, as a result, the team lead was optimistic about the future of this initiative.

In-State Leadership to Implement the Action Plan

The D.C. Primary Care Association has been the lead organization for this initiative. Through its Health Financing Reform Committee, discussions have been taking place on how mental health services can be improved. Their focus has been on "right care, at the right place, at the right time." Additional participation has come from the Mental Health Department, Substance Abuse Department, the Medicaid Office, and primary care providers.

The team lead indicated that the formation of the Health Financing Reform Committee has been a major achievement and that its work will positively impact the promotion of integrated care in Washington, D.C. He emphasized, however, that the formation of this committee and its discussions on integrated care did not result from the State Action Plan. Instead this initiative emerged from the city's efforts to reform health care finance and improve health service delivery.

Action Plan Accomplishment

Seamless System of Care

In order to create a seamless system of care, the Health Finance Reform Committee has been fully involved in identifying the problems that exist in the D.C. health care system. They have been looking for gaps and discussing how they can logistically integrate primary and behavioral services. Their plan has been to map integration before they move to implement any of their ideas.

The team lead believed these discussions will continue well into the future and will eventually lead to change. But before a seamless system can be fully implemented, the team lead explained that some major obstacles would need to be resolved. For instance, communication between providers and Medicaid must be improved.

The team lead also explained that the health center locations needed to be re-assessed so as to ensure that they are where the need is greatest. With regard to this obstacle, a major effort has been undertaken known as Medical Homes D.C. Its purpose is to bring health services to District residents by building or reconstructing community health centers so

that they are able to house multiple disciplines in one building. As of spring 2006, nearly \$27 million had been set aside by the city for this program. When Medical Homes achieves its goal, a seamless system should result as mental health and primary care physicians begin working side by side within these community health centers.

Summary of Action Plan accomplishments in developing a seamless system of care

	Action Plan Activity	Status
1	Create financial incentives (reimbursement model, capitated system) to encourage primary care clinics to incorporate mental health and substance abuse services	In progress: has been discussed but still figuring out how to accomplish.
2	Develop a pilot project that ensures eligibility, access and utilization to all who qualify for primary care, mental health, and substance abuse services under an integrated system of care	Accomplished
3	Streamline Department of Mental Health's certification process to become a core agency; simplify the intake process	Not accomplished
4	Create a secure, comprehensive electronic medical records system with eligibility information that ensures quality and coordinated care	Not accomplished
5	Hold two community forums on subject of need for integrated services	Accomplished

Workforce Training and Development

The city has been developing a community health worker program that will hopefully increase communication among providers while also increasing the appeal of the community health profession. Somewhat related to this has been the city's push to create a loan repayment program in the hopes of attracting highly qualified health workers. This should not only benefit the community health system in terms of recruiting and numbers but will also positively impact the level of service being offered.

The team lead felt strongly that publicizing the programs' features and generating interest in these efforts would increase funding for and improve the community health workforce and ultimately benefit integration.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Provide internal and external training opportunities	Not accomplished

	on integrated systems model for everyone from clinic staff to leadership, and include an emphasis on cultural competency training with associated funding incentives	
2	Continue and expand monthly meeting of Department of Mental Health and DC Alliance to discuss integration of mental health and substance abuse services	Not accomplished
3	Conduct an organizational assessment of staff competencies and processes along with a demand analysis of health care needs across the district (public and private) to determine current and future program and workforce needs	Not accomplished

Partnerships and Collaborations

Through the D.C. Primary Care Association’s Finance Reform Committee, the D.C. Department of Mental Health, the D.C. Department of Health, Medicare, the D.C. Public Schools, the ombudsman for longterm care, primary care providers, and Medicaid-managed organizations have been collaborating, since December, on a quarterly basis. Increased discussion among these organizations has been a major accomplishment.

Summary of Action Plan accomplishments in partnerships and collaborations

The Washington, D.C. State Action Plan that was developed during the Falls Church Summit did not contain activities pertaining to the development of partnerships and collaborations.

Other Accomplishments

The team lead did not report any other accomplishments related to the integration initiative.

Use of Federal Resources

The team lead was unable to comment on the use of Federal Resources to aid in the implementation of integrated care.

Consumer Participation

The team lead explained that consumers are currently involved in the planning, review, and input stages of integrated care.

Assessment of Progress

The team lead believed that there was enough momentum in Washington, D.C. to move the integrated care initiative forward. In the next year, he foresaw increasing communication between mental health providers, the Department of Health, and primary care providers with regard to the integration of services. As the Medical Homes program

advances, he was very confident that integrated care would be found throughout D.C. in a wide range of health care settings.

Currently, the team lead evaluated the District's progress to integrate primary and behavioral care as "fair." The team lead evaluated the District's progress to implement their State Action Plan as "poor."

HAWAII

According to the team lead, Chief of the Department of Health, Family Health Services Division, the integrated care initiative has been in the planning stages since the ten registered participants returned from the Seattle Summit. While the Summit saw participation from state and county level officials and service providers, and generated interest in integrated care, an all-consuming state legislative session has since created a situation where many of the key players have been pre-occupied and unable to provide their assistance to this initiative. Yet, while this has delayed their progress, the team lead explained that they had been able to achieve their initial goal of organizing a statewide conference. This conference will assemble key players, from both public and private industry, to discuss health service issues and promote the integrated care initiative.

In-State Leadership to Implement the Action Plan

The Department of Health maintains its role as the lead organization for the integrated care initiative. Under its umbrella fall a number of key departments and associations, such as the Primary Care Association, the Mental Health Department, and the Substance Abuse Department, whose involvement will be imperative to the future success of this initiative. In order to coordinate integrated care activities, a steering committee composed of the team lead, representatives from the Hawaiian Primary Care Association, the Office of Planning and Development, and the Office of Adult Mental Health Services, has been assembled. Additional participation has also come from both primary care and mental health service providers and the Native American Health Care System.

The focus of this steering committee, thus far, has been the organization of a statewide conference. They had been meeting monthly, prior to the state legislative sessions, to plan and will continue to do so after the legislative sessions have ended. In addition to these meetings, this committee has also convened to discuss their needs assessment process.

The team lead indicated that the major obstacle facing leadership at this point has been a significant lack of time to organize and plan. Ensuring key stakeholders' participation has been incredibly difficult due to both planning complexities and the state legislative session. Moreover, the amount of time spent organizing and coordinating the state conference has made it difficult for the integrated care initiative to progress much further.

Action Plan Accomplishments

Seamless System of Care

The major accomplishment in this area has been the increased discussion that has taken place with regard to the planning of the statewide conference. The team lead hopes this conference will spur additional accomplishments in the future.

Nevertheless, the team lead was able to comment on a number of obstacles encountered in their attempts to create a seamless system of care. From the lack of understanding across disciplines, to the lack of resources that exist for such an initiative, a seamless

system of care will continuously prove to be difficult to implement unless additional staff, new legislation, and agreement across disciplines are acquired.

Summary of Action Plan accomplishments in developing a seamless system of care

	Action Plan Activity	Status
1	<ul style="list-style-type: none"> • Submit a state Action Plan • Conduct a survey of services available • Publicize effort and collect information to prepare for a state conference 	In progress
2	<ul style="list-style-type: none"> • Take inventory of providers and currently existing memoranda of understanding • Identify benefits of integration to providers • Develop a marketing strategy 	In progress
3	Research/identify existing “best practices” and adapt information appropriate to the specific areas to achieve parity	In progress
4	Identify core administrative and clinical elements that can be captured at intake and encourage their use in all disciplines	Not accomplished
5	Work with insurance companies and state agencies to address funding and negotiate solutions	In progress

Workforce Training and Development

The major accomplishments in this area also relate to the planning of the statewide conference. The team lead hopes that the issues of workforce training and development will be discussed during this conference, and new plans and activities will emerge from it. To ensure progress is made in this area in the future, the team lead said she would need additional staff who were able to assist in the implementation of training and development activities.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Develop and expand cross-agency training opportunities by: <ul style="list-style-type: none"> • Surveying agencies for interest in participating in internship/practicum/clinical rotation training • Establish brokerage system through memorandums of understanding 	Not accomplished

2	Expand integrated public mental health rotations and fellowships	Not accomplished
3	Through an interdisciplinary committee, develop core competencies and protocols for integrated services for mid-level providers	Not accomplished

Partnerships and Collaborations

In forming the steering committee and organizing the statewide conference, the team lead explained that a great deal had been accomplished in the area of building partnerships and collaborations. Discussions were ongoing and meetings were taking place regularly between those involved in this initiative. Moreover, the statewide conference will provide an opportunity for extensive collaboration among organizations, associations, and providers whose involvement will ensure the continued promotion of the integrated care initiative.

The team lead identified funding and examples from others as areas where she would need additional assistance if accomplishments were to be made with regard to partnerships and collaborations in the future.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	<ul style="list-style-type: none"> • Take inventory of providers and currently existing memoranda of understanding • Identify benefits of integration to providers • Develop a marketing strategy 	Accomplished
2	Educate community on collaboration development models that work by: <ul style="list-style-type: none"> • Including integration education and models in conferences currently being planned • Creating a “steering committee” to work with specific sites • Conducting meetings in local communities to identify needs 	Accomplished
3	Identify stakeholders through survey strategies and by engaging service providers	Accomplished

Other Accomplishments

The team lead stated that state funds had been secured to assist in the implementation of the integrated care initiative.

Use of Federal Resources

The team lead was aware of the use of National Health Service Corps Clinicians but did not know specifics as to how they were being utilized.

Consumer Participation

The team lead indicated that consumers had been involved in the planning, review, and input stages of the integrated care initiative.

Assessment of Progress

While little has happened in Hawaii by way of tangible accomplishments, aside from the planning of the statewide conference, the team lead believed there was still plenty of momentum to keep this initiative moving forward. In the next five years, she anticipated having key players at the table discussing the importance of integrating mental health services with community health centers. She also felt confident that they will have identified best practices and put some standards of policies and procedures in place to guide the implementation of integrated care activities.

Overall, the team lead evaluated the progress of Hawaii to integrate primary and behavioral care and to implement the State Action Plan as “fair.” She evaluated the Summit she attended as a “good” way to jump-start the implementation of integrated services in her state and explained that most of the accomplishments that had taken place thus far were a direct result of the meeting. However, she explained that her state was in need of examples of successful integration from other states as they were difficult to come by due to both their isolated geography and lack of resources.

IDAHO

The Idaho summit participant was the only attendee from that state at the Seattle Summit. As a result, all activities that have taken place in Idaho with regard to integrated care can be directly attributed to his actions within his community health center. According to this participant, the Seattle Summit became the primary impetus for the introduction of the integrated health care model in Idaho. All resulting activities in promoting integrated care occurred following the implementation of the State Action Plan that was developed during the Summit.

In-State Leadership to Implement the Action Plan

Since the Seattle Summit, the sole participant from Idaho has been unable to generate additional support for this initiative. As a result, he has approached the implementation of the State Action Plan from the perspective of his community health center. The Summit participant worked with the Primary Care Association and with the Idaho Medical Society to raise awareness of the lack of mental health access among target populations. According to the Summit participant, there is general interest throughout the State of Idaho in the idea of integrated health care.

Action Plan Accomplishments

Seamless System of Care

Building of the seamless system of care in Idaho is currently limited to the community health center run by the Summit participant. One of the important achievements in this area was hiring a full time mental health supervisor at his community health center. In addition, the Summit participant is currently in the process of interviewing a psychiatric medication provider as well. The new hires should allow for increased delivery of mental health services within his community health center. The Summit participant has also applied for a grant to fund the development of behavioral health screening tools for primary care settings.

While he has made strides towards integration, he explained that his efforts within his community health center had been “floundering.” It has been very difficult to provide integrated services as funding, support, and leadership from state or federal agencies are absent. Nevertheless, if this model works within his community health center, the Summit participant plans to expand his focus and promote the integrated health care model to other community health centers throughout the state of Idaho.

Summary of Action Plan accomplishments in seamless system of care

	Action Plan Activity	Status
1	Collaborate with public health and community health centers to evaluate service delivery.	In progress: the Summit participant has talked to the Public Health Department about integrating their services within his community health center. They have

		collaborated on some levels but a great deal more needs to be accomplished.
2	Provide screening tools to community health centers for primary care, for substance abuse, and depression.	In progress: the Summit participant's community health center is currently applying for a grant that will fund the development of screening tools. He also met with his Primary Care Association to discuss creating a statewide collaborative effort to incorporate substance abuse screening tools into community health centers.
3	Target funding for integrated health care services.	In progress: the summit participant has been reallocating resources within his community health center to support an integrated care model.
4	"Get specific" regarding vision of how services are provided (diagnosis, counseling, referral).	Not accomplished
5	Apply for Mental Health Expansion Grant for community health center.	Accomplished, but turned down

Workforce Training and Development

The Summit participant indicated that little progress has been made in the area of workforce training and development. While the Summit participant has been able to acquire planning data for the future implementation of this area of his Action Plan, it is clear that a lack of time, funding, and support have inhibited his ability to accomplish more.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Involve primary care clinicians in Depression Collaborative at CHC. Survey clinicians regarding attitudes towards depression screening and treatment; specify screening evaluation and treatment protocols.	Accomplished
2	Work with residency programs regarding collaborative model and depression; identify who is	Accomplished

	training psychology and social work students at the graduate level.	
3	Identify barriers to increasing the number of midlevel providers (billing, production, independence).	Not accomplished
4	Train Clinicians to screen for substance abuse and mental health after (a) Referral systems are developed (b) Clinicians' "buy-in" is obtained	In progress: the need for a referral system has been identified.
5	Organize a Behavioral Health breakfast – for communication and educational training.	In progress

Partnerships and Collaboration

The Summit participant explained that the effort to develop partnerships and collaborations had not been successful to date. He has struggled to generate awareness of the integrated model among key stakeholders.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Identify the parties that are working on mental health issues on the state level; include Public Health, community health centers, IPCA, IMA, and Mental Health Association.	Not accomplished
2	Help legislature and hospitals realize how community health centers can help patients.	In progress: the Summit participant has met with Legislature to talk about mental health funding.
3	Meet with Idaho Mental Health Association to discuss integration.	Not accomplished

Other Accomplishments

The Summit participant did not discuss any other accomplishments in the state of Idaho.

Use of Federal Resources

The Summit participant was unaware of the use of Federal resources in the state of Idaho.

Consumer Participation

The Summit participant did not discuss consumer participation in the state of Idaho.

Assessment of Progress

The Summit participant evaluated Idaho's overall progress to integrate primary and behavioral care as "poor." He evaluated the overall progress of Idaho to implement the Action Plan that he developed at the Seattle Summit as "fair." This rating was based on his accomplishments within his own community health center.

The Summit participant from Idaho evaluated the Summit meeting he attended as a "fair" way to jump-start the implementation of integrated services in his state. In his opinion, examples of successful integration in other states would have been helpful. So, too, would have been the mandatory attendance of state officials. The Summit participant advised that in states such as Idaho, HRSA considers holding state conferences so as to ensure the idea of integrated care is not lost at the state level.

LOUISIANA

Louisiana had thirty-three registered participants from State agencies, local health clinics, and private health organizations at the New Orleans Summit. This wide-ranging participation translated into a number of accomplishments in Louisiana with regard to integration despite some unforeseen setbacks caused by Hurricanes Katrina and Rita.

Of these setbacks, Hurricane Katrina has clearly been the most difficult to overcome. Nevertheless, the team lead was very optimistic about integrated health care and felt that the hurricanes had provided Louisiana with an opportunity to rethink how their system was organized and prioritize service integration in every element of their recovery.

In-State Leadership to Implement the Action Plan

The Primary Care/Behavioral Healthcare Integration Team³ has been the acting steering committee and lead organization for the integrated care initiative in Louisiana. They had been meeting monthly until Katrina, which has delayed their activity for the past six months. The team lead is confident they will reconvene in the future and fill the leadership void that is currently impacting the integrated care initiative in Louisiana. Until this happens, coordination of integrated care activities will occur through local planning bodies. Many of the Summit participants are involved with these bodies and their input will be instrumental, as service integration becomes a key feature of health service reconstruction post Katrina.

Action Plan Accomplishments

Seamless System of Care

In their pre-Katrina meetings, the Primary Care/Behavioral Health Integration Team had been focusing on the development of a feasible State Action Plan that would be specific to Louisiana. They brought in a renowned management consultant from the National Council of Community Behavioral Healthcare, to facilitate their meetings, and were making progress towards establishing a seamless model using best practices. Since Katrina, most of the resources have been directed toward coping with the crisis, and the integration of services frequently occurs in local health centers in response to the crises caused by the hurricanes. Currently, the state legislature is considering a proposal to merge the Office of Addictive Disorders, the Office of Mental Health, and two of the Offices of Behavioral Health Services. Approval of this proposal would be a major step toward service integration.

At the local level, regional committees have been established and tasked with the responsibility of developing “next steps” specific to their regions. Local community-based organizations have also begun to integrate their services.

³ This leadership team is composed of the DHH, the Governor’s Office, regional health care districts, FQHC’s, the Louisiana Primary Care Association, and local grassroots organizations.

While much has been accomplished in this area, the team lead indicated that planning data, funding, examples, and interest from others would be needed if integration were to succeed.

Summary of Action Plan accomplishments in seamless system of care

	Action Plan Activity	Status
1	Convene a leadership team to develop a comprehensive briefing document that combines the summit plan and other existing information.	Accomplished
2	Identify three to five priority areas for regional discussion and conduct a social marketing campaign to explain why local service agencies should implement the integration model based upon these areas.	In progress: they have identified priority areas but have not conducted a social marketing campaign.
3	Initiate grant requests.	Not accomplished
4	Create a single point of entry and access.	In progress: the elements are in place and implementation should follow.
5	Develop and begin implementing local plans (as they are tied to Governor's Health Care Reform Plan).	In progress
6	Look to establish common screening tools; establish the process by which people share information, make referrals, and follow up; establish a tool for prevention and intervention specific to each discipline; publish this information on a website for easy access.	In progress
7	Lead an education campaign across various sections of the health care population; patients, policy makers, providers, etc.	Not accomplished
8	Provide reimbursement to mid-level mental health practitioners to increase available services.	Not accomplished

Workforce Training and Development

Hurricane Katrina had its most destabilizing impact upon the development of an integrated care initiative. Medical Schools throughout Louisiana were heavily affected by the storm and many were rendered inoperable due to structural damages. Thus, internship programs started by the Office of Mental Health, that sought to bridge the working relationships between the Office of Mental Health and the Office of Addictive Disorders, have been put on hold. Moreover, there was a mass exodus of the existing workforce following the storm. This has rendered former accomplishments ineffective. Basic residency programs will need to take place to train a new workforce before further training mechanisms can be introduced.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Follow through on state plan to create cross-training opportunities across disciplines.	Not accomplished

Partnerships and Collaborations

The team lead explained that Hurricane Katrina has enabled partnerships to form where they were once impossible. Due to the level of need that currently exists in Louisiana for health services, agencies and organizations have been working together as never before to ensure the medical needs of Louisiana residents are met. The Governor's Reform Panel was established to govern the processing of the Initiative. The Commission on Mental Health has included the state plan for service integration into their planning documents and has shown a general acceptance of the integration idea. A Consensus Conference has been planned to discuss the utilization of screening and assessment tools for patients with co-occurring symptomatic behaviors. Regional teams have been developed to coordinate local integration efforts that are being lead by local planning authorities. Finally, in New Orleans, the local planning authority has worked with the affected parishes to develop service integration plans that can be implemented through the general recovery plan.

To continue this progress, the team lead explained that planning data, examples, and interest from others would be needed.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Hold local and rural meetings.	Accomplished
2	Develop an integration task force that includes representation from multiple sectors (i.e. private health care physicians, consumers, others).	Accomplished

Other Accomplishments

The team lead discussed a number of other accomplishments that had occurred with regard to the implementation of the integrated care initiative. She indicated that changes in policy were underway, local service integration was occurring, and grant funding had been secured for reconstruction that would then be used for service integration. She also explained that community development initiatives were in progress, existing resources were being used in innovative ways to aid integration measures, and demonstration projects were being developed throughout the state.

Use of Federal Resources

The team lead was unaware of the use of Federal resources for the implementation of the integrated care initiative.

Consumer Participation

The team lead indicated that consumers were not involved in the implementation of the integrated care initiative.

Assessment of Progress

The team lead evaluated Louisiana's progress toward integration as "behind schedule" due to both Hurricane Katrina and state budget problems. Yet, she remained optimistic that integration would exist throughout Louisiana in future years as models are currently being established to provide the necessary foundation for the future success of integration.

The team lead evaluated her state's progress to integrate primary and behavioral care as "good" and felt they had made "fair" progress towards implementing their State Action Plan.

With regard to the New Orleans Summit, the team lead felt that the meeting was a "fair" way to jumpstart integration within Louisiana and that some of the accomplishments she had discussed could be attributed to it. However, she strongly believed that, beyond the Summit, the Federal government needed to do more if service integration was going to be successful. Specifically, she asked that Federal policies, regulations, and financial mechanisms be tied to integration so as to ensure progress beyond the local integration phase and attract greater interest statewide.

MAINE

Summit participants from Maine included state officials, health center directors, health care providers, and the Primary Care Association. Since the Falls Church Summit, much has happened in the state of Maine with regard to integrated care. However, due to the complex nature of this initiative, and the variety of issues that have arisen as they have worked to create an integrated care model, the State Action Plan, developed by the fifteen registered Summit participants, has yet to fully align with the accomplishments that have taken place throughout the state.

In-State Leadership to Implement the Action Plan

The integrated care initiative has witnessed a great deal of support from state agencies, private providers, and consumer organizations. The Primary Care Association currently has lead responsibility for the implementation of this initiative while the largest healthcare foundation in the state, known as the Maine Health Access Foundation, has been coordinating the effort. Also providing key support for this initiative are the Maine Department of Mental Health, mental health service providers, primary care service providers, and the Governor's office.

There has been a general belief in the state of Maine that the integrated care model presents a wide range of possibilities for the patients it will ultimately benefit. This belief has sustained the integrated care initiative, despite the setbacks this initiative has encountered, and has generated the amount of leadership and support that has been in place since the Summit.

Action Plan Accomplishments

Seamless System of Care

Numerous conference calls and meetings have taken place among the Primary Care Association, Maine Association of Mental Health Services, and various state agencies to address the Action Plan, as it currently exists, and to update it accordingly. Their main topic of conversation has been the integration of health care into the realm of behavioral health managed care. They are also looking to model a seamless system of care.

The team lead discussed the many projects that are underway that seek to improve the quality of care in the primary care setting. The focus has been on creating a "care model." The Primary Care Association has partnered with the Maine Center of Disease Control (CDC) to implement a pilot approach to the integration of behavioral health and primary care in community health centers for women of reproductive age and to model it after the Chronic Care Model. This effort has been supported by a HRSA Maternal Care block grant and has provided the opportunity to document key measures and utilize screening methods.

The Primary Care Association has also been actively engaged with the community health centers in Aroostook County. These centers have added behavioral health physicians to their primary care teams. Recently, they have increased their behavioral health staff and

have been forging ahead with their efforts despite the impediments caused by Medicaid reimbursement problems.

It is these reimbursement issues that have posed the biggest problem for those in Maine who support this initiative. The Primary Care Association has gone to Blue Cross and Blue Shield to promote integration recognition for Medicare/Medicaid coding. Yet, resistance to integration continues, as Blue Cross and Blue Shield has refused to adopt these codes. As a result, health centers that are piloting the integration effort have been doing so at their own risk.

Summary of Action Plan accomplishments in developing a seamless system of care

	Action Plan Activity	Status
1	Address regulatory barriers to seamless system of care	Not accomplished: insurance carriers have been unwilling to recognize Medicaid codes related to integrated services.
2	Establish baseline outcomes by which they can measure progress	In progress

Workforce Training and Development

The team lead discussed a very successful research program that places students in clinical rotations and exposes them to integration efforts that are taking place in community health centers statewide. There has also been an ongoing movement in Maine toward the use of telemedicine. With regard to integration, telemedicine would bring behavioral health services to the hinterlands of the state and cut much of the cost associated with providing such services in an integrated care setting. The Maine Access Foundation has been working with the office of Maine Care Services to look at the delivery of care through telemedicine and to make it reimbursable.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Develop a strategy to educate primary care providers on diagnosing/treating substance abuse, mental health, and co-occurring disorders. Start training behavioral health providers on primary care issues on providing proper referrals. Promote collaboration/integrated care teaching	In progress
2	Use SEARCH training program to encourage medical students to have community mental health experience	Not accomplished

Partnerships and Collaborations

The Primary Care Association has a strong partnership with the Department of Health that has generated numerous opportunities for collaboration across disciplines. They have been working together, consistently, to address issues related to both mental health and substance abuse. Through this partnership, additional parties have been brought in, such as the Governor's office and providers, whose input and support are imperative to the continued success of the integrated care initiative in the state of Maine.

Nevertheless, to sustain these partnerships and form new collaborative opportunities, funding will be needed. The team lead fears that this effort will no longer be sustainable should funding become unavailable to those who have committed themselves to the successful promotion of integrated care.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	<p>Establish institute of integration comprised of MPCA, MAMHS, NAMI, MASAP, MPA, MHA, DHHS, BDS, OSA, Governor's Office, and the Muskie School of Public Service</p> <ul style="list-style-type: none"> • Develop Mission Statement • Seek planning grant to assist in this progress • Share information in all forms across disciplines 	In progress: seeking funding to establish these partnerships.

Other Accomplishments

The team lead did not discuss any other accomplishments with regard to the integrated care initiative.

Use of Federal Resources

Aside from the Maternal Health block grant that was being used to fund the implementation of a pilot approach to the integration of behavioral health and primary care in community health centers for women of reproductive age, the team lead was unaware of the use of any additional federal resources to aid in the implementation of the Action Plan.

Consumer Participation

The team lead indicated that consumers were involved in the planning and review stages of the integrated care initiative and that they had assisted in the implementation of pilot projects throughout the state.

Assessment of Progress

At their current rate of progress, and without increased funding or a solution to the reimbursement issues, the team lead felt that, in the next five years, little in the way of momentous changes would take place in Maine. However, he insisted that there was enough momentum, for the time being, to keep things going. He foresaw continuous opportunities to educate the community about integrated care. Data will continue to be harvested from the pilot projects that are already underway, and incremental improvements will likely be made.

The team lead evaluated his state's overall progress to integrate primary and behavioral care as "excellent." He evaluated his state's progress to implement the State Action Plan as "good."

He evaluated the Summit he attended as a "good" way to jump start integration in his state and explained that some of the accomplishments that had taken place could be attributed to the Summit.

The team lead felt very strongly that HRSA needed to make this initiative a priority and provide a "vehicle to make progress possible." He hoped that HRSA would become more involved, be it through providing technical assistance, funding, or a mechanism through which information could be shared. Those in Maine who have been working with this initiative have been "doing so on a shoestring" and if changes are not made, the sustainability of this initiative will be lost.

MASSACHUSETTS

It is important to provide a context for what is happening in the Commonwealth of Massachusetts. The Executive Office of Health and Human Services was reorganized during the first six months for the Romney administration (July 2003). The intent was to build a new organizational approach to more effectively and cost-efficiently provide services and programs and facilitate interagency collaboration. For the first time in its thirty-year history, the Secretary's Office and the EOHHS Agency Leadership sat down at the same table and together made difficult budget cut recommendations and began a joint planning process. The overall challenge was to implement the reorganization and develop the fiscal year 2004 Budget in the midst of continued economic challenges. This began a strategic planning process that culminated in the development of "Forging the Future: the EOHHS 2005-2006 Strategic Plan on October 4, 2004. Mental health and substance abuse had emerged as critical lynchpin services that cut across all the offices in a fundamental way. Operating principles were established and a roadmap of priorities and strategies was developed. The EOHHS Strategic Plan reflects many of the key goals as outlined at the HRSA/SAMHSA Closing the Gap Summit.

In-State Leadership and Action Plan Accomplishments

After the reorganization was completed and the EOHHS Strategic Plan underway, the state agencies developed department-wide strategic plans. Phase I of the Department of Mental Health Plan was developed on April 12, 2005. An overarching goal of the Mental health Plan is to redesign and implement a unified behavioral health system. This includes coordination with other state agencies, a comprehensive quality improvement plan, and the development of a data-driven decision support system. The Department of Public Health's Bureau of Substance Abuse Services has made public their strategic plan in June 2005. In addition, within the Department of Public Health, the Division of Primary Care and Health Access and the Division of Perinatal and Early Childhood Health have implemented a demonstration project to increase provider screening and appropriate follow-up for alcohol and drug use during routine prenatal care through systems development and clinician training and support. The MassHealth Behavioral Health Programs Unit, Department of Mental Health funded a comprehensive evaluation of the Behavioral Health Program for the Primary Care Clinician Plan. This evaluation provided background information on the integration of mental health, substance abuse, and primary care.

Action Plan Accomplishments

Seamless System of Care

Pilot Demonstration Sites. A proposal has been written for the Department of Mental Health by the Mental Health and Substance Abuse Corporations of Massachusetts, the Massachusetts League of Community Health Centers, and the University of Massachusetts Center for Health Policy and Research to establish demonstration projects to improve coordination of behavioral and primary care services and these demonstration sites are underway.

Interagency Collaboration. Various interagency collaborative efforts between the Departments of Mental Health, Public Health, Social Services, Youth Services, and the Massachusetts Behavioral Health Partnership have taken place around coordinating service systems for children and adolescents. This has included cross-agency training and deployment of uniform screening and assessment tools as well as training on evidence-based services for adolescents.

Summary of Action Plan accomplishments in seamless system of care

	Action Plan Activity	Status
1	Reach agreement on definition of integration and on outcomes for measurement	In progress
2	Develop an inventory of functioning integration programs	In progress
3	Develop unified marketing strategies across primary care, mental health, and substance abuse; Generate a publicity campaign in print	Not accomplished
4	Identify barriers to integration, including regulatory	Accomplished

Workforce Training and Development

The Child Psychiatry Access Project has expanded the ability of child psychiatrists to provide consultative services (including but not limited to psychopharmacological services) to the pediatric community and to receive adequate reimbursement for these expanded services. The model that was developed ensures that consultative psychiatric services are integrated with local service systems and includes active involvement with local pediatric primary care providers.

In the spring of 2005, providers were trained on substance abuse and behavioral health screening and assessment. A collaborative forum, organized by the Bureau of Substance Abuse Services and Boston Medical Center, targeted physicians for the expansion of Buprenorphine treatment for opioid dependent persons. This included technical assistance, an overview of the treatment model and best practices and other training.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Core competencies are identified and promoted	In progress
2	Funding is identified for education and training	Not accomplished
3	Mental health and substance abuse trainees are placed in primary care settings	In progress

4	Loan repayment/scholarship opportunities for professionals working in integrated sites	Accomplished
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Partnerships and Collaborations

As mentioned earlier, a proposal has been written for the Department of Mental Health (DMH) to establish demonstration projects to improve coordination of behavioral and primary care services. Various interagency collaborative efforts between state agencies have taken place around coordinating service systems for children and adolescents. The community health center and community mental health center demonstration site implementation is underway.

The Massachusetts Consortium on Depression in Primary Care (MCDPC) is a collaboration of the Commonwealth of Massachusetts' Division of Medical Assistance (DMA) and the Department of Family Medicine and Community Health at the University of Massachusetts Medical School/UMass Memorial Health Care (UMMS/UMMHC-DFM). The MCDPC consists of the DMA and its contracted health plans. MCDPC was formed to meet the challenge of improving depression identification, and treatment for MassHealth (e.g., Medicaid) insured adults in Massachusetts.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Identify and convene stakeholders to support the integrated model	Not accomplished
2	Marketing to policy makers and legislators to promote change	Not accomplished
3	Convene a forum representing primary care, mental health, and substance abuse providers	Not accomplished

Use of Federal Resources

The Massachusetts Primary Care Office has prioritized its efforts to increase Mental Health Professional Shortage Designations in order to increase the possible placement of National Health Service Corps and other loan repayors within behavioral health settings.

Assessment of Progress

Background information on the integration of mental health, substance abuse, and primary care has been collected and this will serve as the foundation for next steps. The team from Massachusetts evaluated overall progress and the implementation of the plan developed at the Closing the Gap Conference to integrate primary and behavioral care as "fair."

MONTANA

Montana had a single representative in attendance at the Seattle, Washington “Closing the Gap on Access and Integration” Summit. This representative developed a State Action Plan based upon his personal ability to accomplish the designated activities. Consequently, the State Action Plan was generally focused on this representative’s Community Health Center, not statewide integration, and has resulted in local accomplishments and a lack of statewide support. Nevertheless, the Summit was responsible for the local integration activities that have taken place in Montana as no work had been done previous to this representative’s attendance.

In-State Leadership to Implement the Action Plan

The Montana team lead reported that the majority of activities taking place in the state following the Summit had occurred at the local level. State level officials have yet to buy into this initiative and their non-involvement has directly impacted how the Action Plan has been implemented. Nevertheless, steps have been taken at the grassroots level and implementation of the integrated model has been achieved, to a moderate degree, locally.

A steering committee has been organized which includes representatives of various agencies⁴. This committee has developed a comprehensive rural health care prevention model that will work “hand in hand” with integrated care. While this committee has acted as the Steering Committee for the integration effort, it has not taken lead responsibility. The involvement of key officials and stakeholders is necessary to assure successful implementation of the Action Plan. State level organizations and officials such as the Primary Care Association, Primary Care Organization, Health Department, Mental Health Department, Substance Abuse Department, the Governor’s office, and the State Legislature should participate

Finally, Montana has encountered several problems in either organizing or gaining the cooperation of the individuals or groups who are needed to implement the Action Plan. The first is the status of their team lead as a part time employee of the Ashland Community Health Center. In this capacity, he has neither the time nor the funds, and is unable to travel as necessary to implement the plan. Montana is also inhibited by the lack of funding that exists statewide for this initiative.

Action Plan Accomplishments

Seamless System of Care

Montana has a number of accomplishments in developing a seamless system of care. In March of 2005, the lead person attended a Regional Conference in Mesa, Arizona, sponsored by WICHE, where he participated in presentations on Rural Workforce Training in Mental Health. He also attended a workshop in Coeur d’Alene on developing

⁴ These agencies and organizations include the Mental Health Advocacy Organization, a Consumer Organization, Mental Health Service Providers, Substance Abuse Service Providers, a Community Health Center, the Mental Health Component of WICHE, the American Psychological Association, the Veterans Hospital at Fort Meade (MD), and Youth Care.

an integrated health service delivery system. The lead person also met with Senators Max Baucus and Conrad Burns “to discuss funding for Montana Integrated Care delivery” and with “numerous offices in HRSA to discuss the proposed prevention model.”

Since these meetings, the steering committee has further developed this prevention model so that it will “work hand in hand with integrated care” and will be appropriate for the extremely rural areas that are prevalent throughout Montana. Montana has also worked with the Ashland Community Health Center to write a proposal to HRSA with regard to the expansion grant so that they can begin to “do integrated health.” Lastly, Montana has been in discussions with the St. Vincent’s Healthcare System to see if they would provide startup funding for this initiative.

Montana’s Action Plan has not changed in respect to developing a Seamless System of Care. However, in order to move this plan ahead, Montana will need planning data, funding, and interest from others.

Summary of Action Plan accomplishments in developing a seamless system of care

	Action Plan Activity	Status
1	Develop and fund pilots that are community based	In progress

Workforce Training and Development

With respect to workforce training and development, significant progress has been made at the local level. The first accomplishment was the incorporation of a “comprehensive delivery model” into the “prevention model” that has been developed by the steering committee. Moreover, this committee has developed a curriculum “that will focus on two tracks: first, the training of existing health care programs and, second, the teaching of a new breed of healthcare professionals for the provision of health care.”

Several members of this committee have also “initiated efforts to secure start-up money and have initiated a community foundation to administer the training efforts.” To secure funding and support for the development of their workforce, “a Community Health Center that provides a organized body through which they are able to apply for grants and implement integration” has been formed. Finally, American Psychological Association interns are conducting their internships in rural Community Health Centers in Montana and South Dakota.

Montana’s Action Plan has not changed in respect to workforce training and development. However, in order to move this plan ahead, Montana would need funding and interest from others. Until these key elements are acquired, Montana’s efforts in this area will continue flounder. Lack of funding and inadequate staffing has negatively impacted the implementation of the Action Plan.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Develop a training program for existing practitioners in integrative issues by: Meet with primary care providers; contact community health centers if interested in training; adapt curriculum from Florida	In progress
2	Develop proposals for curriculum development; explore training sites and existing centers; identify teachers, mentors, and elders	In progress
3	Discuss having advantages for interns, etc. with community health center's, Indian Health Services, and Veteran's Administration	In progress
4	Meet with (appropriate) academic officials w/in University Departments of Nursing/Psychology/Psychiatry	Accomplished
5	Get Universities involved in integration training	Not accomplished

Partnerships and Collaboration

Establishing a steering committee has been the major accomplishment in Montana with regard to the development of necessary partnerships and collaborations. The current members of this committee held meetings and discussions with HRSA, the Veterans Hospital Psychology Intern program, a public school district, a region wide healthcare system, a consumer group, a regional educational group (WICHE), the state educational system, a local community college, the Indian Health Service, a substance abuse organization, a private provider, a staff member of Senator Burns' office, and a Coal Development corporate member. In addition, efforts are being made to form an additional partnership with the St. Vincent's Health Care System. (double check actual organization names for capitalization)

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Meet with Health and Human Service Department leaders dealing with SSA to determine state interest in integrated services and propose desired efforts of integration	Not accomplished
2	Meet with Saint Vincent Foundation Board of	In progress

	Directors	
3	Meet with Indian Health Services, from Ft. Meade area office, Veteran’s Administration, HRSA, SAMSHA and CSAT/CSAP	Accomplished

Other Accomplishments

The team lead did not discuss any other accomplishments with regard to the integrated care initiative.

Use of Federal Resources

Some program development assistance came from the Veterans hospital at Fort Meade.

Consumer Participation

Consumers are currently actively involved in planning, reviewing, and providing feedback during various stages of the integration process.

Assessment of Progress

At the local level, as a result of a successful grassroots effort to integrate primary and behavioral care, Montana has rated its overall progress as “excellent.” Moreover, Montana has rated its ability to implement the Action Plan as “excellent.” This rating is a direct result of the fact that the state lead was the only participant from his state at the Summit and, thus, developed an Action Plan geared towards his anticipated personal level of accomplishment.

At the state level, however, due to the non-involvement of state officials in this initiative, Montana has rated its progress as “poor.” If this “poor” progress continues, the state lead indicated that, in a year to five years, Montana will most likely continue to achieve at the local level only.

According to the team lead, all of the local level accomplishments that have taken place with regard to integrated care can be attributed to the Closing the Gap on Access and Integration Summit. The team lead acknowledged, however, that, in the case of Montana, the Summit was not the preferred method, as state involvement was not mandatory and, consequently, Montana has struggled to obtain top-level support for this initiative.

NEW JERSEY

Of the four registered participants from New Jersey at the Falls Church Summit, three had initially committed to working together. Due to unforeseen circumstances, only the team lead remained active as of the second round evaluation interview. Nevertheless, working within her own health center, the team lead continues to promote the integrated care idea and has successfully implemented various activities from the State Action Plan that she and her fellow participants developed during the Summit.

In-State Leadership to Implement the Action Plan

There is no central leadership or coordination in New Jersey for the integrated care initiative. The state has been involved with Federally Qualified Health Centers but their focus has been on the budget and the uncompensated care fund. Thus, focusing their attention on an additional initiative has proven to be unrealistic at this time.

As a result, all activities that have taken place have occurred within AtlantiCare, the medical center in which the team lead is an acting project director. Through her efforts, integration is occurring and an integrated care model is being formed.

Action Plan Accomplishments

Seamless System of Care

Within AtlantiCare, the team lead hired an on-site mental health professional who has been involved in both patient screening and newly expanded counseling services. Currently, this mental health professional screens each patient for mental health and substance abuse conditions before referring them to a treating physician.

Though integration in the team lead's health center is a permanent practice, she explained that a great deal more was needed if this initiative was going to catch on statewide. Specifically, she identified funding and examples and interest from others as desperately needed for the successful promotion of this initiative.

Summary of Action Plan accomplishments in developing a seamless system of care

	Action Plan Activity	Status
1	Survey Primary Care Association members (21).	Accomplished
2	Seek funding under HRSA expansion grants.	Accomplished: no funding was awarded
3	Increase the number of community health centers that are expanding behavioral health services.	Not accomplished

Workforce Training and Development

The team lead teaches at Rutgers University and is on the state licensing board for drug and alcohol counselors. Through these roles she continually promotes integrated care among students and practicing counselors while at the same time marketing the behavioral health profession. She has also utilized pharmaceutical company training grants to provide training opportunities for her health center's staff on integration.

In order to accomplish more in this area, the team lead felt very strongly that examples of successful workforce training and development activities were needed. She would also benefit from increased interest from others.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Conduct, through the Primary Care Association, web-based cross-discipline training "Grand Rounds."	Not accomplished
2	State office of minority health administers and analyzes data obtained through their dissemination and collection of a cultural & linguistic competency tool.	Not accomplished
3	Encourage and support primary care staff to go to training in behavioral health.	Not accomplished
4	In order to encourage more presentations, utilize pharmaceutical companies for training purposes. <ul style="list-style-type: none"> • Programs on integrated behavioral/primary care to be funded through training grants provided by them. • They provide speakers and disseminate informational materials. 	Accomplished within her health center, not statewide
5	Develop a marketing strategy with respect to increasing the number of health care professionals with interest and expertise in behavioral health care. Add health care professionals with interest and expertise in behavioral health to existing NJPCA-CHC marketing campaign.	Accomplished within her health center, not statewide.
6	Conduct a County or Statewide meeting focusing on mentorships with provider associations.	Not accomplished

Partnerships and Collaborations

The team lead has been in contact with the Primary Care Association. Through these discussions, the team lead has learned that the Association does not view integration as an important initiative at this time. According to the team lead, the senior PCA leadership does not fully understand how integration works and does not see a need to replace their existing service model with, what they consider to be, a non-viable, unproven initiative.

If partnerships and collaborations are going to be attained, the team lead will need not only funding and interest from others, but examples of successful integration projects that she can use to support her claims of the viability of this initiative.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Conduct county or statewide meeting on evidence based practice to increase collaborative co-locations of primary and behavioral care.	Not accomplished
2	Partner with academia through internships and preceptorships with students.	Not accomplished
3	Conduct a meeting with PCA to communicate why integration is important.	Not accomplished

Other Accomplishments

The team lead did not report any other accomplishments.

Use of Federal Resources

The team lead was unaware of the use of federal resources for promoting the integrated care initiative.

Consumer Participation

The team lead indicated that consumers were not involved in the promotion of the integrated care initiative.

Assessment of Progress

The team lead evaluated her state's progress to integrate primary and behavioral care as "poor." She evaluated her state's progress to implement their State Action Plan as "poor" as well.

Nevertheless, she explained that the Falls Church Summit had influenced her greatly and that most of the accomplishments that had taken place in her health center were a result

of her attendance. However, due to the lack of state representation at the Summit, she explained that the Summit had been a “poor” way to jump-start integration statewide in New Jersey.

The team lead asked that HRSA arrange collaboration for the sharing of integrated care ideas. She needs examples of positive integration outcomes to pass on to both health centers and key officials. These would help her promote the integrated care initiative and enable her to increase awareness and participation statewide.

NEW MEXICO

New Mexico received a SAMHSA Mental Health Transformation Grant in 2005. So far, none of the funding received from this grant was allocated to the promotion of integrated care. Thus, efforts initiated by a number of the thirteen registered Summit participants (including state officials, service providers, and university representatives) to promote integration have predominately focused on acquiring the interest of the major funding recipients. They hope to influence the inclusion of integration in the transformation projects that these funding recipients have undertaken. Otherwise, due to the activities of an informal working group, the integrated care initiative has achieved some success at both the state and local level.

In-State Leadership to Implement the Action Plan

Through an informal working group, known as the New Mexico Interagency Behavioral Health Collaborative⁵, the integrated health care initiative has been coordinated through regular meetings and discussions on the integration of behavioral health into primary care. As far as the team lead was concerned, this Collaborative has all the key stakeholders on board. Moreover, he explained that the Collaborative had gained the support of Value Options, the behavioral health managed care organization that, as of 2005, has overall responsibility for the reimbursement of New Mexico's mental health and substance abuse providers for pre-approved services and treatments.

Action Plan Accomplishments

Seamless System of Care

The team lead, who is the acting Office Director of the New Mexico Office of Primary Care/Rural Health, explained that several projects have come out of expanding Screening Brief Intervention and Treatment Grant (SBIRT) priorities. Thanks to the clear commitment of the key partners to shared objectives, a continued focus has been on broadening the ongoing behavioral health activities underway since this grant was first awarded in 2003. Twenty-two sites have been funded by this grant and both integrated screening protocols and the defining of explicit outcomes have been addressed.

In addition to these SBIRT activities, the team lead discussed the addition of ten substance abuse counselors who have been designated as "circuit riding" counselors and travel regularly to rural communities to offer behavioral health services. New Mexico has also carved money out of the state budget, unrelated to the SBIRT, to fund demonstration projects that will integrate behavioral health services into primary care settings. To accomplish this, the state has developed a request for proposal (RFP) for

⁵ Key members of the New Mexico Interagency Behavioral Health Purchasing Collaborative include the Aging and Long-term Services Department, the Administrative Office of the Courts, the Children Youth and Families Department, the New Mexico Corrections Department, the Department of Finance and Administration, the Department of Health, the Department of Labor, the Department of Transportation, the Developmental Disabilities Planning Council, the Division of Vocational Rehabilitation, the Governor's Commission on Disability, the Governor's Health Policy Advisor, the Health Policy Commission, the Human Services Department, the Indian Affairs Department, the Mortgage Finance Authority, and the Public Education Department (Source: www.state.nm.us/hsd/bhdwg/, accessed on July 5, 2006).

local integration projects. Ultimately, this RFP would fund between four and six pilot integration sites and would allow for training and follow up at an additional six to ten sites.

In developing a seamless system of care, the team lead explained that a variety of issues had arisen. For example, the Behavioral Health Collaborative and Value Options had been wrestling with the issue of who was responsible for reimbursement when a patient was treated for both health and behavioral health in a primary care setting. In March of 2006, this issue was resolved when it was agreed that visits to health centers would be paid for with medical dollars that had been allocated for primary care services. Another issue has been the fact that Value Options had proposed the creation of its own medical screening and care protocols. The concern, according to the team lead, has been that this would lead to separate silos of care and that the ability to integrate would be lost. Hopefully, Value Options' involvement with the Behavioral Health Collaborative will alter their thinking about how such an issue should be dealt with.

As for obstacles, the team lead explained that the existing focus of the behavioral health system on high risk and severely mentally ill patients was creating a funding problem that would ultimately impact their ability to integrate. Most of the dollars allocated for mental health services have been earmarked for the treatment of high-risk subsets of the patient population. This has left insufficient funding for the preventive services that will ultimately be the majority of the services offered through the integrated model. This model needs to be altered if a seamless system were to be successfully developed.

Summary of Action Plan accomplishments in seamless system of care

	Action Plan Activity	Status
1	<p>Bring interested stakeholders together (including consumers) to develop a position paper and identify funding options</p> <ul style="list-style-type: none"> • Identify organization, current providers of mental health policy makers and funders • Assemble a core group to develop paper and begin developing integration plan • Lobby State legislators to solicit funding: Primary Care Associations, Sangre de Cristo, HMOs 	In progress
2	Identify and support the use of population-appropriate integrated screening protocols. The health care providers adopt a shared set of principles and protocols that increase the chances that clients get appropriately matched at the right level of care	Accomplished
3	Define explicit outcomes and accountability for all consumers regardless of location. Minimize disparities between urban and rural setting by availability and acceptability	Accomplished

Workforce Training and Development

The team lead explained that his division has been conducting annual compensation surveys of health care professionals. He also indicated that the Behavioral Health Collaborative has been looking to expand the use of SBIRT teleconferences, which had been used to successfully aid scattered primary care clinics in their treatment of health disorders, to deal with behavioral health and substance abuse issues as well. Through the SBIRT, primary care providers have witnessed increased opportunities for behavioral health training. Family planning providers have also acquired the ability to get continuing education units on domestic violence and substance abuse. Finally, in 2006, a piece of legislation was passed which eased the licensing restrictions that existed for behavioral health providers.

Obstacles in this area included a lack of funding, time, and insufficient authority to require behavioral health training in primary care settings. In addition, over 50% of health consumers in New Mexico are underinsured or uninsured and unable to pay for services. As a result, training continues to be inadequately funded and support for this initiative is dwindling.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	[Conduct] compensation survey for health care professionals in preparation for advising legislature and state personnel providers of compensation increase recommendations. Increase compensation for mental health providers to draw more people into the profession	Accomplished
2	Integrated Care conference where awards are given (funded from Department of Health) and motivational keynotes are made. Develop champions at all levels to promote a trans-disciplinary approach to care	Not accomplished
3	Increase practice training site for integrated sites: <ul style="list-style-type: none"> • Use City of Albuquerque multi service center training site • Identify practitioners and clinics that are open to integrated care • Lobby State and Federal legislatures to put more money in this area 	Accomplished
4	Develop common vocabulary that is shared among primary care, mental health and substance abuse providers: <ul style="list-style-type: none"> • Secure funding for integrated care conference (funded 	In progress

	by Dept. of Health) <ul style="list-style-type: none"> Develop integrated care vocabulary primer to be distributed at conferences 	
5	Increase multi-culturally competent and multilingual providers	Accomplished

Partnerships and Collaborations

The team lead stated that the inclusion of key players in the Behavioral Health Collaborative had been a major accomplishment. He also explained that program leaders have committed themselves to the integration pilots that would be developed through the RFP. In order to proceed, funding will be needed.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	[Create] shared evidence based assessment intervention and treatment. Adopt existing tools through a sub-committee of clinicians that represent all members of integrated behavioral health/primary health providers (convene a subcommittee; gather tools to review; make a decision on which tool to use; field test the tool)	In progress
2	Adopt or adapt existing bi-directional forms and process. Common, bi-directional referrals and care coordination (the referral out brings information back)	In progress
3	Develop peer support network and plans as preventative measure for enacting them if the clients' condition worsens: <ul style="list-style-type: none"> Adopt or adapt "WRAP" (Wellness, Recovery Action Plans) program for physical health conditions Involve peers with chronic condition in development of "Integrated Programs" Provide group units for common behavioral and medical conditions 	In progress
4	Streamline funding so that payer sources will cover comprehensive services (purchasing collaborative) i.e. physical health and behavioral health. Require the behavioral health purchasing collaborative to partner with primary care providers	In progress

5	Identify regions and appropriate entities to conduct assessment utilizing existing data. [Conduct] statewide assessment to determine gaps between primary care and behavioral health by region	Not accomplished
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Other Accomplishments

The other accomplishment discussed by the team lead was the SBIRT statewide demonstration project.

Use of Federal Resources

The team lead was unaware of the use of Federal Resources in promoting the integrated care initiative.

Consumer Participation

The team lead explained that consumers were not involved in this initiative.

Assessment of Progress

The team lead indicated that there was enough momentum in the state of New Mexico to maintain their current rate of progress. Within five years, he expects the integration demonstration projects to be firmly in place and anticipates an increase in the number of advocates promoting integrated care as these sites begin to generate meaningful results.

The team lead evaluated both New Mexico's overall progress to integrate primary care and to implement their State Action Plan's behavioral care as "fair."

With regard to the Albuquerque Summit, the team lead felt that the meeting was a "fair" way to jump-start the implementation of integrated services in New Mexico and that some of the accomplishments that had taken place could be attributed to it.

Finally, the team lead felt that HRSA needed to assist more in the development of training efforts. He proposed on-line and on-site trainings, such as the WICHE grand rounds, and asked that additional conferences be scheduled with regard to integrated care.

OKLAHOMA

Oklahoma had nine registered participants at the New Orleans Summit including state officials, service providers, primary care association representatives, and state university representatives. While a SAMHSA Mental Health Transformation State Incentive Grant was awarded to Oklahoma in 2005, money has yet to be allocated directly to the integrated care initiative. Nevertheless, integration has continued to be a key focus of those involved with mental health care in Oklahoma. Those who were present at the Summit have maintained contact and have worked, at times, directly on integration-related issues. However, competing priorities and a lack of time have impacted the progress of this initiative at this point in its development.

In-State Leadership to Implement the Action Plan

Participation in the integrated care initiative has come from the Health, Mental Health, and Substance Abuse Departments, the Primary Care Association, the Medicaid Office, a mental health advocacy organization, a consumer organization, a family member organization, mental health and substance abuse service providers, and the state university. According to the team lead, an informal network, which includes representatives from state departments, the Primary Care Association, and other Summit participants, has acted as the steering committee for this initiative but has yet to assume responsibility for the implementation of the State Action Plan. This network met several times in the first year following the New Orleans Summit to discuss integrated health care and develop a state specific model.

However, the team lead explained that due to the extensive number of mental health priorities that currently exist in Oklahoma, as a result of the Mental Health Transformation Grant, cooperation and participation in this initiative has suffered. Steering committee meetings have tapered off and communication between local and state participants has decreased. Nevertheless, local level initiatives have been developed within individual health centers that view integrated health care as a necessary step in the improvement of their health services. State level officials, including the Commissioner of the Department of Mental Health and Substance Abuse Services and Oklahoma's Secretary of Health, have also displayed unwavering dedication to this initiative. All in all, the future of integration in Oklahoma appears to hold a great deal of promise.

Action Plan Accomplishments

Seamless System of Care

The team lead explained that a number of community health centers were practicing integrated health care. Through a partnership with a community mental health center, a local community health center has been offering mental health services to its patients. The health center director initiated this partnership as he realized the benefit of integrating health services for the population served by his health center. Another community health center has partnered with the Veterans Association in an effort to improve health services for veterans. At this point, behavioral health services have become fully available for veterans and have slowly evolved into the predominant service

offered by this health center. Other health centers have also been practicing integrated care through their use of screening tools, by increasing the behavioral health training opportunities for their staff and consumer bases, and in their development of population-specific pilot efforts.

Rural health centers have been utilizing telemedicine to access services they are unable to provide to their patients onsite. According to the team lead, three counties have been involved in the development of this service. Also, by July 1, 2008, comprehensive electronic records should become available to all community health centers in the state of Oklahoma.

Finally, Oklahoma will be using the SAMHSA Mental Health Transformation Grant to develop screening tools for behavioral health settings. Specifically, he explained that screening questions would be used to identify mental illness or substance abuse. This tool will be tested for all environments and primary care will be included in its development, though a formalized agreement has yet to be established.

The team lead explained that the major obstacle had been a lack of time due to competing priorities and the number of other initiatives that exist in the state of Oklahoma. In addition, it had proven difficult to get different professional cultures to work together. Nevertheless, progress has been made, commitments have been reached with both mental health and primary care, and the team lead was optimistic that further accomplishments would follow.

Summary of Action Plan accomplishments in seamless system of care

	Action Plan Activity	Status
1	Develop and disseminate uniform screening tools for behavioral health and primary care providers to use in identifying needs of clients.	In progress
2	Form a subgroup to promote cross-utilization and acceptance of consent forms in order to overcome confidentiality barriers and allow client data sharing.	Not accomplished
3	[Increase] Number of providers in rural and underserved areas utilizing information technology	Not accomplished

Workforce Training and Development

The team lead explained that a workforce development taskforce had been formed as a working arm of Oklahoma's Children's Behavioral Health Partnership. The taskforce has also identified a communication network with AHE (University Based Rural Health).

Obstacles to this area of the integration initiative have arisen out of the inherent difficulty that exists in trying to impact an academic curriculum. However, the team lead explained

that impacting the curriculum would be a major priority of the Mental Health Transformation Grant.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Meeting with DMHSAS and AHEC directors to discuss ways to increase opportunities in rural and underserved areas.	In progress
2	Convene meeting with higher education officials and workgroup representatives to discuss credentialing issues and the development of integrated curriculum models.	Not accomplished

Partnerships and Collaborations

A statewide Summit was held on March 8, 2006. Led by the Primary Care Association, with the assistance of the Department of Mental Health and Substance Abuse Services, this Summit featured two integration related speakers. The first was the director of the Michigan Primary Care Association. She discussed an integration model that had been operating successfully in Michigan for years through a partnership between a community health center and a community mental health center. The second speaker focused on the opportunities for behavioral health that existed as a result of the Mental Health Transformation Grant.

Collaborations have also been occurring among consumers who have been working with the agencies and formed their own consumer group. In addition, they have been involved with the Grant advisory board and have become active with issues such as children's health, known as the kids' initiative.

A partnership between a community health center and the Veterans Association has made behavioral health services more accessible to the served veterans. Prior to the formation of this partnership, veterans were required to travel long distances to obtain behavioral health services. Seeing the problem this created, the director of this community health center sought assistance from the Veterans Associations and ultimately received their support in increasing this center's ability to offer such services.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Identify and solicit commitments from additional collaborators; produce a list of additionally culturally competent and diverse collaborators.	Not accomplished

Other Accomplishments

The team lead discussed local service integration projects, an increase in state funding, the innovative use of existing resources, and a demonstration project as other accomplishments that had taken place with regard to the integrated care initiative.

Use of Federal Resources

The team lead discussed Oklahoma's intent to utilize SAMHSA Mental Health Transformation Grant and how integration would play a major role in these efforts.

Consumer Participation

The team lead was happy with the current involvement of consumers in this initiative though he would like to see their presence at policy meetings increase. At this point, he explained that consumers played an important role in the review and input stages of this initiative's development.

Assessment of Progress

The team lead evaluated Oklahoma's overall progress to integrate primary and behavioral care as "good" and felt that they had made "fair" progress with the implementation of their State Action Plan.

The team lead evaluated the Summit as a "good" way to jump-start integration activities in Oklahoma and explained that some of the accomplishments that had taken place could be directly attributed to it.

The team lead asked that Federal agencies do more to identify best practices and experts in the area of integrated health care. This knowledge has been lacking and the team lead would like HRSA to disseminate this type of information to those involved in this initiative.

OREGON

The integrated care initiative in Oregon grew out of a mental health crisis. The legislature had cut mental health funding and, as a result, a large population was destined to lose access to mental health services. Recognizing the significant negative impact this cut in funding would have, the Mental Health Division called on those within its network who had access to community health providers and asked that they respond to this impending crisis. In developing their response, it became clear that there was a need for more linking and integration among community health centers as well as healthcare plans for Medicaid, mental health organizations, and others.

The integrated care initiative was a natural next step that found a wealth of support at both the state and local levels during the months preceding the Seattle Summit. Thus, the Seattle Summit provided an opportunity for the twenty-two registered participants, including state and county officials, service providers, and consumer representatives, to clarify their vision, add new elements to their integration plan, and consolidate their efforts. Since the Summit, state leadership has acknowledged the need to address this issue and has linked activities at the top levels of the state's Department of Human Services. Oregon has also seen several key reports emerge from an exhaustive legislative session that acknowledged the critical nature of the mental health crisis and recommended that resources be focused on addressing it.

In-State Leadership to Implement the Action Plan

The Department of Human Services has maintained lead responsibility for this initiative and has been directly responsible for the implementation of the State Action Plan. Under its guidance, a two level steering committee coordinates activities related to integrated care. Level one of this steering committee involves participation from key officials from state agencies⁶. Level two involves participation from a less formal stakeholder group composed of the Primary Care Association, consumer organizations, providers, universities, and various other interested parties⁷. The primary steering committee has been meeting on a regular basis to address organizational, coordination, and regulatory issues that were raised at the Summit and in subsequent meetings with the broader stakeholder group. Many of the organizations involved in the stakeholder group were present at the Seattle Summit while those that were not joined quickly thereafter.

Unfortunately, according to the team lead, there has been a lack of funding in the Department of Human Services, as a result of a major budget deficit, and resources have been unavailable to fund an initiative of this scale. In addition, the dependence of this initiative on a number of state agencies has made meeting coordination and planning very difficult. Nevertheless, leadership has moved forward with this idea, as they believe this initiative presents a tangible solution to a major crisis in health service availability.

⁶Agency and state level participation includes the Health Department, Mental Health Department, Substance Abuse Department, Medicaid Office, Governor's Office, and the state Legislature

⁷Stakeholder group participation includes a mental health advocacy organization, a consumer organization, a family member organization, mental health service providers, substance abuse service providers, primary care providers, and state universities

Action Plan Accomplishments

Seamless System of Care

Oregon has implemented several promising initiatives that should aid in the creation of a seamless health system. As required by the Centers for Medicare and Medicaid Services, the Medicaid Performance Initiative conducts bi-annual evaluations of Medicaid/Medicare service performance and seeks out areas for improvement. The Department of Human Services has decided that, in fiscal year 2007, one of the performance improvement projects will focus on the integration of behavioral health and primary care. The central steering committee has taken the lead on this project and hopes that it will provide the leverage needed to ensure that Medicaid focuses on the recognition of services provided through integrated care providers.

The Department of Human Services has also issued a request for proposal that focuses on bringing local groups together to identify how integration should be implemented. The idea has been for these local groups to devise clear plans for integration that would be easily approved by the state. They would then implement their plans, as described in the proposal, and provide progress data to the state. In return, the state would ease regulatory restrictions that had negatively impacted the efforts to integrate health services.

The steering committee has successfully identified the specific barriers associated with the creation of a seamless system of care. They felt this would be necessary if they were going to provide guidance in the areas of billing, finance, and clinical records. They have now moved on to addressing these barriers within the state bureaucracy and at the local partnership level.

At the grassroots level, communication lines have been opened between primary care and the behavioral health specialty organizations. A number of behavioral health specialists have been co-located in primary care clinics throughout the state. In Clackamas and Multnomah Counties, community health clinics have been working to figure out how they go about co-locating services and integrating mental health and substance abuse services more effectively. While Multnomah County's progress has been stalled due to an election cycle, Clackamas County community health centers have gone so far as to integrate their behavioral health, public health, and primary care services. They have also decided that they will only hire behavioral health clinicians who have been co-trained in both mental health and substance abuse services.

According to the team lead, obstacles have arisen due to Federal Medicare/Medicaid regulations. Integration efforts have encountered constant interference due to inflexible billing codes that do not accommodate integrated services. In addition, the team lead explained that planning data and funding would be needed to move the integrated care initiative forward in this area.

Summary of Action Plan accomplishments in seamless system of care

	Action Plan Activity	Status
1	Develop, in conjunction with Federal officials and “existing blended service clinicians,” statewide policies that provide guidance and framework that support flexible integration models.	Not accomplished
2	Define and implement administrative rules that reduce paperwork and other administrative structures that create barriers to integration.	Not accomplished
3	Develop a framework for full and partial integration pilots “for the safety net system of healthcare” while working on “setting policy that goes beyond the safety net.”	In progress

Workforce Training and Development

The team lead explained that the steering committee had successfully included the concept of behavioral health and primary care integration as a training issue in several key venues, including a safety network group and a mental health task force directly overseen by the Governor’s office or its delegates. They had also distributed key documents (internal and national) to appropriate persons to raise the relevance of workforce development to this initiative.

The steering committee has also begun a “Behavioral Health Workforce Initiative” that was kicked-off during a forum in late August of 2005. The purpose of this initiative has been to address core competencies and core curricula in four key areas, including behavioral health integration into primary care. Through smaller workgroups, these workforce areas have been measured, a significant number of responses have been tabulated, and core competencies have been established. A main focus of this initiative has been to influence graduate schools, community colleges, and employment-based training programs, which deal with behavioral health instruction, to include integration training in their core curricula. The team lead explained that this initiative was currently in the process of being subsumed under the Oregon Healthcare Workforce Institute; a training mechanism developed by organizations such as Kaiser Permanente.

Finally, a number of the larger provider organizations in Oregon have developed training programs that will cover some of the bigger agencies. In Clackmas County, for instance, these training programs have provided the means through which health service employees receive integrated service training. Also, in Portland, the largest agency in the metropolitan area has formed its own training organization and one of the largest addiction service organizations has developed its own training group.

The team lead explained that this area of the Action Plan had been incredibly difficult to implement. He cited ideological barriers between academic institutions and health care organizations, the lack of Federal government assistance, and the lack of convincing evidence to support these changes as the current obstacles facing workforce training and development activities in Oregon. In his opinion, funding and an increase in interest from others will be needed if more is to be accomplished in this area of the Action Plan.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Use a state conference to: <ul style="list-style-type: none"> • Develop core curricula and core competencies. • Create a process for training program buy-in for primary care and behavioral health, employer input and buy-in, establish task force to accomplish these tasks. • Investigate areas such as loan repayment, scholarships, and association leadership. 	Accomplished
2	Develop a career path in mental health careers that incorporate integration with primary care and create roles that are not bound by a degree.	Not accomplished
3	Develop strategies to analyze the characteristics of and positive aspects of mental health careers and increase awareness of these careers amongst high school graduates.	In progress

Partnerships and Collaborations

Due to widespread interest in integrated health care, partnerships and collaborations have occurred across all levels of government and among health providers in all disciplines. For instance, the core working group and sub steering committees involve participation from Department of Health Services, the Medicaid office, the Office of Mental Health and Addiction Services, public and private health providers, and a key person from the public health office who is involved in the activities and operations of health clinics throughout the state. In developing a number of workforce training initiatives, state agencies, providers, and the Governor's Office have worked together to incorporate their ideas into a unified workforce-training institute, known as the Oregon Health Care Workforce Institute.

The team lead explained that the lack of funding had been the biggest issue Oregon had encountered in this area of the Action Plan. Without additional funding, he feared that successful partnerships would soon begin to falter and eventually fail, creating a disjointed, uncoordinated, integration effort.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Establish a cooperative partnership with representation from mental health, substance abuse, primary care, and consumers.	In progress

Other Accomplishments

The team lead discussed proposed legislative changes and a demonstration project as other accomplishments that had taken place with regard to the integrated care initiative.

Use of Federal Resources

The team lead explained that federal resources had not been utilized to implement their integrated care Action Plan.

Consumer Participation

According to the team lead, consumers were involved in the planning stage of the integrated care initiative.

Assessment of Progress

The team lead explained that, in his opinion, it is unclear at this point where the integrated care initiative is headed in Oregon. The team lead evaluated Oregon's progress to integrate primary and behavioral care as "good." He evaluated the overall progress of Oregon to implement their State Action Plan as "excellent."

The team lead explained that the Summit meeting he attended was a "good" way to jump-start the implementation of integrated services in Oregon and that some of the accomplishments were a direct result of the meeting. However, he indicated that the collaborative effect of the Summit was the only worthwhile aspect of the meeting.

Finally, the team lead was emphatic about the need to change the current state of affairs surrounding integrated care at the Federal level. He felt very strongly that HRSA and SAMHSA needed to work more closely together on this issue. He cited the frustration shown by HRSA over the lack of funding that exists to reform mental health as a clear example of the inadequate collaboration that has been occurring at the Federal level. In conclusion, the team lead recommended that HRSA and SAMHSA align their efforts to effectively model integration and "promote the notion that integration and linking care is extremely important and needs to be promoted."

PUERTO RICO

Puerto Rico's sole representative at the Falls Church Summit was the executive director of a community health center. Since the Summit, she has reached out to the health community in an effort to garner support for the integrated care initiative and has achieved reasonable success. The State Action Plan has been utilized and continues to be implemented.

In-State Leadership to Implement the Action Plan

The team lead and the Department of Health maintain responsibility for the implementation of the State Action Plan. Upon her return from the Summit, the team lead solicited the support of the Department of Health whose Health Reform committee assumed responsibility for the promotion of this initiative.

Action Plan Accomplishments

Seamless System of Care

The team lead explained that the major accomplishments in this area had been acquiring the support of the state government, overcoming cultural barriers between providers, and improving provider and consumer literacy. Obstacles to the development of a seamless system of care have included political shifting, a lack of understanding with regard to integrated health care, and a lack of clarity when it comes to initiative objectives. To move this initiative forward, the team lead explained that she would need increased interest from state officials.

Summary of Action Plan accomplishments in seamless system of care

	Action Plan Activity	Status
1	Recruit stakeholders, from the PH, PC, MF, & SA providers and policy makers.	In progress
2	Hold meetings and workshops with political members who will help support our goals.	In progress
3	Develop/initiate a training strategy through education, conferences, & meetings.	In progress
4	Recruit stakeholders, from the PH, PC, MF, & SA providers and policy makers.	In progress
5	Develop a common language & a common understanding of roles/responsibilities and protocol between systems.	In progress

Workforce Training and Development

The team lead identified an increase in cross-training opportunities, the development of continuing education programs, and the creation of in-service training for providers as the major accomplishments in workforce training and development. She explained that political changes and a lack of compromise on behalf of the community at large had been significant obstacles that they have yet to overcome. To increase their success in this area, the team lead indicated that the community would need to be educated about the benefits of integration.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Initiate an in-service training program.	In progress
2	Begin dialogue with profession of educational and guild organizations regarding training and continuing education requirements.	In progress
3	Create cross-training opportunities.	Accomplished

Partnerships and Collaborations

The team lead discussed the sharing of experiences as a major accomplishment in this area of the integrated care initiative. However, a lack of time and interest had presented obstacles that they have been unable to overcome. To move this area of the integrated care initiative forward, the team lead explained that increased interest from state officials and an increase in funding would be needed.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Contact other health centers to share information regarding collaborative integrated care models.	Accomplished
2	Host a forum meeting for primary care and mental health stakeholders.	In progress
3	Begin a dialogue with local schools of psychiatry to address “fulfilling our goals.”	In progress
4	Conduct meetings with the intention of forming partnerships with schools of health.	In progress
5	Hold meetings with policy makers.	In progress

Other Accomplishments

The team lead discussed local service integration, increased Federal and local funding, a community development initiative, and the innovative use of existing resources as other accomplishments that had taken place with regard to the integrated care initiative.

Use of Federal Resources

The team lead was unaware of the use of Federal Resources to aid in the implementation of their State Action Plan.

Consumer Participation

The team lead explained that consumers had been involved in this initiative through their congress.

Assessment of Progress

The team lead evaluated her state's progress to integrate primary and behavioral care and to implement their State Action Plan as "fair."

She felt that the Summit meeting that she had attended was a "good" way to jump-start the implementation of integrated services in her state. However, she then went on to explain that none of the accomplishments that had taken place could be attributed to the meeting.

The team lead recommended that HRSA arrange additional meetings with politicians and increase communication among professionals in order to aid in the promotion of integrated health care.

RHODE ISLAND

Each of the five registered Falls Church Summit participants has remained involved in the integrated care initiative. These participants included state officials, service providers, and a consumer organization representative. Through the central leadership group, they have overseen both the promotion of integration and the coordination of the State Action Plan that they developed at the Summit. Efforts to promote integration have been in place in Rhode Island for about seven years. Thus, the Summit served as an opportunity for these participants to collaborate and formulate a plan for implementation.

In-State Leadership to Implement the Action Plan

The longstanding leadership group for the integrated care initiative has been the Allied Advocacy Group (AAG). The Allied Advocacy Group “consists of approximately thirty or forty organizations and individuals that meet quarterly to discuss initiatives and efforts that are going on in the field of either behavioral healthcare or primary care that are examples and models for linkages between those two systems.”⁸ A key advisory committee, known as the Primary Care Physicians Advisory Committee, which has had the support of the lead psychiatrist for the State of Rhode Island for the past eight years, has also been continuously involved with the AAG.

The AAG has two publications through which it promotes integrated care. It has also brought in two surgeon generals in recent years to present their recommendations to the state on the integration of primary and behavioral care. In the past year, the Governor’s office has become actively involved in this initiative as well. An individual from that office has been working with the team lead, and ultimately with the AAG, and has provided a key area of support for this initiative that was lacking prior to his involvement.

The Department of Health has a new director with whom the team lead and the AAG have had multiple discussions. Through these discussions, they hope to make him aware of the integrated care initiative and the tremendous grassroots support that exists for integration.

Upon her return from the Falls Church Summit, the team lead formally presented the State Action Plan to the AAG. This Plan was adopted and has since played a valuable role in their promotion of integrated care.

Action Plan Accomplishments

Seamless System of Care

Throughout Rhode Island, seamless systems of care are already in place. A number of family practice doctors and community health centers, all over the state, are actively involved in the co-location of behavioral health services in primary care settings.

The team lead also identified a number of obstacles that they had encountered. Cultural differences between professional groups have made co-locating services difficult because

⁸ Source: <http://www.mhrh.state.ri.us/MINUTES%207-12-05.htm> accessed on June 13, 2006.

backgrounds and training needs are different from one discipline to the next. This poses a problem in that co-locating behavioral health in a primary care setting, for instance, may create a situation that is unfavorable with regard to the professional needs or expectations of those behavioral health practitioners. Also, resources within behavioral health, primary care, and substance abuse come from different sources and are difficult to combine. Finally, the reimbursement issues and the problems with CPT codes that arise when services are integrated are a constant source of confusion for those who are practicing or promoting integrated care.

Summary of Action Plan accomplishments in developing a seamless system of care

The Rhode Island State Action Plan that was developed during Falls Church Summit did not contain activities pertaining to the development of a seamless system of care.

Workforce Training and Development

Through SEARCH (Student/Resident Experiences Around Community Health), the team lead, who is the acting Chief of Primary Care at the Rhode Island Department of Health, has ongoing interdisciplinary training programs that include both primary and behavioral health care. SEARCH takes practitioners out of their disciplines and transplants them into settings where they are exposed to a different range of health issues. The team lead has partnered with universities throughout Rhode Island to promote and implement this program.

The team lead also identified numerous other training efforts that are either in place or being planned. For instance, presentations were conducted in the Rhode Island Emergency Departments that discussed accessing the behavioral healthcare system. The team lead has worked with the lead social worker from the Rhode Island Hospital to develop a training program for that hospital's workforce. Also, the team lead has been engaged in annual training efforts with the Academy of Family Practice Physicians.

Training efforts with regard to the integration initiative are occurring throughout Rhode Island. However, the team lead indicated that funding, time, and persistent dedication would be needed to ensure this progress is maintained.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Restart state behavioral health/emergency service/ED training to reduce stigma against mentally ill and substance abuse disorders	Accomplished
2	Train prison staff on work with mentally ill	Accomplished
3	Develop new strategies in addressing nursing shortages in behavioral health	In progress: this has proven very difficult due to issues such as licensure and workforce un-

	preparedness.
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Partnerships and Collaborations

A conference on overcoming substance abuse, mental illness, and physical illness has been planned, with the Allied Advocacy Group's support, and will be taking place in Newport, Rhode Island, this November. This has been a major accomplishment and will provide an invaluable collaborative opportunity for those involved in the integration initiative, both in Rhode Island and nationwide. Participants will include health care professionals, politicians, and a wide range of other stakeholders.

The team lead is constantly involved in discussions with the Office of Minority Health, NAMI, and OASIS over access to healthcare. Through the AAG, state agencies, private providers and consumers collaborate on a quarterly basis and continually discuss how they can improve health services for the residents of Rhode Island. The Rhode Island secretariat has also attended AAG planning meetings and has been engaged on the issue of increasing health care access for the uninsured.

Due to the statewide interest in integrated care, partnerships and collaborative opportunities have formed without extensive promotion efforts. Yet, to ensure they continue into the future, the team lead discussed the fact that funding would be needed.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Build partnerships with the Office of Minority Health, NAMI, OASIS to increase access to care.	Accomplished
2	Meet with secretariat to explore opportunities to enhance integration and access for primary and behavioral health for the uninsured.	Accomplished
3	Conduct assessment of existing integrated services and share models with medical directors of CHCs and CMHCs	Accomplished
4	Enhance school-based clinics through partnerships with Rhode Island Health Association and community health centers and identify best practices.	Accomplished though funding cutbacks will impact their ability to continue with this effort in the future.

Other Accomplishments

The team lead discussed accomplishments in the area of local service integration. Throughout the state of Rhode Island, a number of community health centers had been successful at integrating mental health with primary care or vice versa.

Use of Federal Resources

The team lead was unaware of the use of Federal Resources for the promotion of the integrated care initiative.

Consumer Participation

The team lead indicated that consumers were actively involved, through the AAG, in the planning and review stages of the promotion of the integrated care initiative.

Assessment of Progress

The team lead has been very optimistic about the future of the integrated care initiative in Rhode Island. In the next five years, she expected to see continuing expansion of co-located sites, a better understanding of CPT coding, and increased access to care as the number of insured patients increases. The team lead also hopes to have more providers who are double board certified, in psychology and medicine, and able to think “a lot broader.”

The team lead evaluated her state’s progress as both “good” and “on schedule.” She also evaluated her state’s progress to implement the State Action Plan as “good.”

With regard to the Summit that she and her colleagues attended, she felt it had been a “good” way to jump-start integration activities in Rhode Island and that some of her State’s accomplishments were a direct result of the meeting.

Other than Summits, the team lead indicated that the National Governor’s Association, the National Conference of State Legislatures, the National Association of Community Health Centers, and the National Association of Community Mental Health Centers should become more involved in the integrated care initiative. They should be used to promote this idea further and should host events to discuss this initiative.

TEXAS

Texas had a delegation of thirty-one people attending the Summit in New Orleans, including service providers, state officials, Medicare and Medicaid representatives, and educational institutions. The integrated model had been quite well known in Texas before the Summit, and efforts were underway to align the system of service delivery with the integrated model. Texas had formed the Texas Strategic Health Partnership Mental Health Workgroup that was unrelated to the group that attended the Summit but that has done much of the same kind of work. Thus, all current advancements of the initiative are not a direct result of the Summit, but are in conjunction with it.

In-State Leadership to Implement the Action Plan

The Texas team lead reported that a number of initiatives were started in Texas prior to the Summit in New Orleans, and these initiatives have affected how the Action Plan is implemented. The first was the passage of legislation HB 2292 in the 2003 that resulted in the reorganization of health and human services in Texas including mental health, substance abuse, mental retardation, public health, and other related services. Planning for the reorganization under this bill continued in 2003-2004. The year 2004 was one of major reshuffling, when mental health, substance abuse, and public health were brought under one umbrella. The organizational chart has undergone many revisions, and it is still not settled.

Although Texas does not appear to have directly implemented the Action Plan created during the New Orleans Summit, nor met as a “Summit team,” there is a very active working group, the Texas Strategic Health Partnership (TSHP), which was created as a result of state legislation. Responses to the update report were based on the actions and work done in the TSHP. Representatives of the following agencies, groups, and organizations are involved in the existing integration effort: a Primary Care Association, the Department of Health, the Mental Health and Substance Abuse Departments, a mental health advocacy organization, a consumer organization, a family member organization, mental health, substance abuse and primary care providers, an academic institution, and other member of the TSHP.

According to the state lead, there was a massive integration of care in Texas in response to Hurricanes Katrina and Rita in the fall of 2005. They have been able to provide integrated services in a disaster mode, but haven’t done it in a systemic, organizational way. The Department of State Health Services and its Commissioner spearhead all the current integration efforts.

Action Plan Accomplishments

Seamless System of Care

According to team lead, “The reorganization of State government in Texas, as called for by HB 2292, has occurred and at least an identifiable organizational structure is now in place at the state level.” Additionally, “some mental health benefits have been reinstated in the CHIP benefit package in Texas.” The work of the Mental Health Workgroup, a subgroup of TSHP, will also add to a seamless system of care.

The good response to both hurricanes, in terms of provision of health care, was an important outcome: “have we not had at least a conceptual framework of a seamless system of care it would have been much harder to handle the crisis.” To move ahead with the seamless system of care, planning data, funding, examples of consultation from others, and interest by others are needed.

Summary of Action Plan accomplishments in developing a seamless system of care

	Activity	Status
1	Identify the number of integrated clinics needed. Develop integrated clinics while reducing the number of CMHC/CHCs. Percent of integrated clinics: year 1: 30%; year 2: 50%	In progress: since 2004, integrated FQHCs increase about 20%
2	Involve business community for collaboration. Identify two or more business organizations with multiple locations. Develop an integrated model for implementation in a business site (for example, Wal-Mart)	In progress: there have been some discussions with Wal-Mart.
3	Develop a pilot project	Accomplished: it was an answer to the crises
4	Convene a statewide summit involving major stakeholders (DOH, MHMR, NHSC, etc) with a purpose of development of an integrated health care plan	Accomplished.
5	Consumer training in understanding and using the integrated system of care. Core group train in 20 communities in 12 months.	Accomplished by the Texas consumer group

Workforce Training and Development

As the lead person reported, little progress in the area of workforce training and development can be made until the State has completed its reorganization, and the role and function of the Behavioral Health Service System is restructured. The Shared Vision Project⁹ is created by the Texas Institute for Health Policy Research, of which the Mental Health Workgroup is a part. The Institute and the Workgroup are aware of these issues and are formulating plans that will include the need for workforce development related to behavioral health services.

⁹ The purpose of the Shared Vision project is to weigh the diverse interests of health care stakeholders - including consumers - and provide a Shared Vision for the effective and efficient delivery of health care and ultimately to improve the health of people living in Texas. Source: <http://www.texasforums.org/content/view/13/49/>, accessed on June 5, 2006.

In February 2006, the Hogg Foundation held a summit to discuss the next steps Texas should take. National speakers were brought in. The foundation is looking at how to create incentives for broader training. Colleges and universities are looking at workforce demands in light of increasing behavioral health demands. This is being done by the Higher Education Coordinating Board that is the prevailing agency.

Planning data, funding, examples or consultations from others, and interest by others are necessary to move ahead. The formation of the Mental Health Workgroup as part of the TSHP is the key organizational structure for partnerships and collaborations.

Summary of Action Plan accomplishments in workforce training and development

	Activity	Status
1	CME requirement in integrated care for all primary care physicians. Integrated CME units to offer 10 times a year, at diverse locations. 30% of primary care physicians are trained in substance abuse and mental health	Accomplished
2	Providers training: 50% of staff in community mental health centers, substance abuse treatment centers and primary care clinics trained at end of 24 months	In progress
3	Community college para-professional training program; curriculum development; educators buy-in; funding; 80% of community college graduates know about integrated system	In progress

Partnerships and Collaboration

The formation and work of the Mental Health Workgroup of the Texas Strategic Health Partnership that consists of representatives of various agencies and organizations is an important achievement. Since 2004, Texas assembled this diverse group, applied for the Mental Health Transformation grant (MHT SIG), and was one of seven states that received it. Under MHT SIG, the Governor appointed cabinet-level persons from fifteen different agencies to discuss improvements to the system. As a result, Texas now has a Governor-appointed group called the Transformation Work Group (TWG) that is an active leadership team.

Summary of Action Plan accomplishments in workforce training and development

	Activity	Status
1	Form integrated health association including stakeholders, by January 2005, one single	In progress: the turf issue has not yet been settled to produce a single

	voice for Texas on integrated health care	voice, but working toward it.
2	Establish joint purchasing alliance by 2006	Accomplished
3	Develop partnerships with business community	In progress

Other Accomplishments

Other accomplishments in Texas include obtaining local funding for promoting integrated care, securing foundation funding (through the Hogg Foundation), innovative use of existing resources, and demonstration projects.

Use of Federal Resources

The Mental Health Transformation Grant from SAMHSA that was awarded to Texas in September 2005 will have a big impact on the development of integrated care.

Consumer Participation

Consumers are currently actively involved in the planning, review and input stages of the process.

Assessment of Progress

The lead person evaluated the state's efforts to implement the State Action Plan as "good" although "behind schedule." There is a strong momentum to integrate health services that was born out of both the work of the TSHP Group and the response to the hurricane crises. The Mental Health Transformation Grant will aid in defining priorities for promoting the integrated model. For future development, interest in increasing the number of integrated clinics in Texas is high. Future activities will involve listening to the business community as a payer; changing benefit packages; promoting new promising initiatives, like telemedicine; and investing in training.

Despite significant achievements, the lead person evaluated the overall integration of primary and behavioral care on the state level as fair. Much of the accomplishments were in response to crises. Substantial systemic changes are needed to make the integrated model work on an everyday basis. According to the lead person, only some of the accomplishments in promoting the integrated model can be attributed to the Closing the Gap Summit, since the TSHP Group commenced its activity prior to the Summit and many of the active members of the Group did not attend the Summit.

UTAH

Of the five registered participants at the Albuquerque Summit, four have continued to coordinate their initiative efforts with those of the central leadership body. The fifth recently stepped down and was replaced by the current team lead who was interviewed for the second round of the evaluation. According to the team lead, the Summit was very effective as a means of promoting integrated care in the state of Utah and has led to many integrated care accomplishments. Moreover, the State Action Plan developed at the Summit has been a useful tool in both the promotion and implementation of integrated care activities.

In-State Leadership to Implement the Action Plan

The Utah Behavioral Health Network (UBHN) has assumed both leadership and coordination responsibilities for the integrated care initiative. Its members include public mental health and substance abuse providers, local authorities and the State Division of Substance Abuse and Mental Health. Through UBHN, members are working to coordinate with Federally Qualified Health Centers, private health providers, and health plans from across the state. UBHN has also enabled the creation of a central forum that coordinates activities and continuously receives updates with regard to the implementation of integrated care activities.

According to the team lead, if the integrated care initiative were going to progress, it would be imperative that state policy makers become more involved. The team lead explained that their support was needed when it came to the allocation of funding for this initiative.

Action Plan Accomplishments

Seamless System of Care

The team lead discussed a number of behavioral health centers in Utah that have formalized contracts with Federally Qualified Health Centers, as well as community mental health centers that are attempting to co-locate their services within primary care units. For instance, as a result of a SAMHSA grant, a midlevel psychiatric provider has been co-located within a Salt Lake City community health center. In addition, this same community health center has partnered with the local mental health agency as a means of providing more thorough care to the homeless population.

To ensure progress within such health centers was being tracked, the Division of Substance Abuse and Mental Health implemented a statewide plan to monitor and increase coordination between primary care and behavioral health providers. Since the implementation of this plan, record reviews have been ongoing and community mental health centers have been increasingly monitored via preferred practice guidelines as defined by the State.

Summary of Action Plan accomplishments in developing a seamless system of care

	Action Plan Activity	Status
1	Salt Lake County to pilot Recovery Support Network for substance abuse, mental health, and primary care providers	In progress

Workforce Training and Development

The team lead through his division, Adult Programs, has been providing technical assistance on-site to community health centers through which he has introduced the integrated model. Individual centers have also implemented training efforts in this area. Nevertheless, the team lead recognized the need for more standardized methods.

To answer this need, the team lead discussed UBHN's ongoing effort to develop baseline methods for use in implementing integrated care activities in the future. A key feature of these methods will be workforce training and development where the planning data that are eventually acquired will be instrumental in the creation of future programs to address this need.

To ensure success in this area, the team lead indicated that examples of successful training and development efforts elsewhere were needed. So, too, is interest from others. The accomplishments thus far within individual health centers have been isolated and have yet to generate widespread interest.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Develop core competency training for graduate level clinicians by impacting curriculums at University of Utah & BYU & encouraging these schools to adopt a curriculum incorporating "integration"	Not accomplished
2	Provide training for staff who are currently participating in integration activities or who are interested in developing integration activities. For instance, primary care presence at substance abuse/mental health state conferences and vice-versa	In progress

Partnerships and Collaborations

In applying for a SAMHSA grant that ultimately funded their co-location and coordination efforts, a community health center in Salt Lake City initiated collaborative interactions among itself, a community homeless shelter, Volunteers of America, Valley Mental Health, Utah Hospital Association, and a variety of other public and private providers.

In addition, through the co-located services offered by Federally Qualified Health Centers across the state, mental health and primary care providers have been working together to implement integrated health care models.

In light of these successes, the team lead indicated that planning data, funding, and interest from others were needed to ensure that additional parties could be brought on board and that partnerships could be formed with key players from both state and federal offices.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Convene meetings and bring Utah Association of Counties together to provide opportunities for stakeholders to collaborate, discuss, and learn about each other's roles	Accomplished
2	Engage PC providers (such as Utah Behavioral Health Network, Intermountain Health Care Comm. Partnership Division, and FQHCs) about possible integration of behavioral health and primary care	In progress
3	Identify key champions & stakeholders at the State level (Health Department, Health and Human Services, Medicaid, etc.)	Accomplished

Other Accomplishments

The team lead explained that local service integration, secured government funding, and the innovative use of existing resources had also been accomplished with regard to the integrated care initiative.

Use of Federal Resources

The team lead discussed the use of a SAMHSA grant to implement the co-location of a psychiatric service provider in a Salt Lake City community health center.

Consumer Participation

The team lead indicated that consumers were involved in the planning stage of the integrated care initiative.

Assessment of Progress

The team lead felt confident that in the next five years much progress would be made with regard to the integrated care initiative. Through UBHN, a baseline should be established through which integration plans and methods will be developed. These plans

will be provided to community health centers throughout the state and will assist in successful implementation of the integrated care model.

Overall, the team lead evaluated Utah's progress to integrate primary and behavioral care as "fair." He evaluated Utah's progress to implement the State Action Plan as "good."

With regard to the Summit, he felt that the meeting itself was an "excellent" way to jump-start the implementation of integrated services in Utah and attributed most of the state's accomplishments to that meeting.

VERMONT

The fifteen participants from Vermont attended the Falls Church Summit and included state and county level officials and service providers. Integration had been in place in Vermont prior to the Falls Church Summit due to a consumer driven effort to increase access to behavioral health within children's pediatric clinics. Thus, the Summit served as a means through which these participants could collaborate, devise a plan for implementation, and expand the state's integration focus.

In-State Leadership to Implement the Action Plan

The Vermont Department of Health (DOH) has been the lead organization for the integrated care initiative. Since the Summit, the team lead, the acting Director of the Child, Adolescent, and Family Unit of the Vermont State Department of Developmental and Mental Health Services, Division of Mental Health, has been given full authority to focus the Department of Health on this initiative and expand it. Under the direction of the DOH, a longstanding steering committee has coordinated all integration activities. This committee has been expanding its focus to include adult health in addition to child health, its original area of focus.

Since the beginning of Vermont's movement toward integrated care, there has been a tremendous amount of support from state agencies, private providers, and consumer organizations. Due to this ever-expanding participation, the DOH decided that integration would succeed if it were built on several activities instead of becoming one all-encompassing effort. In this way, they could utilize the wide participation to form a number of smaller steering committees that address integration complexities and scheduling issues independently¹⁰.

Action Plan Accomplishments

Seamless System of Care

The integration initiative has been incorporated into the workings of the Blueprint Project, a program through the Vermont Governor's Office and Department of Health that has been addressing the reorganization of the health delivery system around chronic care and chronic illness models. As a result, mental health has become a feature within the coordination of chronic care conditions.

The team lead has been involved in the Medicaid authority's efforts to assemble a statewide care management program for high cost individuals. They have worked closely with Medicaid to ensure that the mentally ill are included within this care management system. The system itself will bring a nurse and a social worker into district offices around the state. Their purpose will be to assist in teaching high risk patients, most of

¹⁰This ever expanding participation now includes the Primary Care Association, Primary Care Organization, Health Department, Mental Health Department, Substance Abuse Department, Medicaid Office, Mental Health Advocacy Organization, Substance Abuse Service Advocacy Organization, Consumer Organization, Family Member Organization, Mental Health Service Providers, Substance Abuse Service Providers, Primary Care Providers, University, Governor's Office, and the state Legislature.

whom have severe mental disorders, self-management skills and to coordinate care within the surrounding community. They have also been establishing different sites where mental health workers are co-located in primary care offices. To date, they have successfully established a psychiatric consultation model for pediatric and family care in five practices throughout the state.

The team lead explained that if they were going to successfully expand their efforts, several obstacles must be resolved. For instance, the financing system must address the fact that Medicaid reimbursement has been unavailable for co-located services and consultations. Also, Vermont's mental health system is structurally separate from primary care, and it has remained unclear how to integrate services without remodeling this system or altering the existing infrastructure.

Summary of Action Plan accomplishments in developing a seamless system of care

	Action Plan Activity	Status
1.	Convene key stakeholders meeting in the state	In progress
2.	Create common protocols between primary care, mental health, and substance abuse	In progress
3.	Develop a sustainable integrated system of care	In progress: they are seeking funding that will allow them to continue this program
4.	Identify reimbursable codes for mental health, substance abuse, and primary care that are accepted by payers. Identify services that are not currently reimbursed	In progress
5.	Create "Medical Home" concept and package it in a marketable way	In progress

Workforce Training and Development

The University of Vermont has been active with the Department of Health in the development of workforce training mechanisms. For the past four years, the university has sponsored a regional primary care/mental health conference where workforce training is a central topic for discussion. They have also continuously gained knowledge with regard to workforce development through the University of Vermont's V-chip program, a population-based child and adolescent health services research and quality improvement program¹¹, and through pilot projects that have been established across the state.

¹¹ Source: <http://www.med.uvm.edu/vchip/TB8+BL.asp?SiteAreaID=514>, accessed June 30, 2006.

The team lead indicated that obstacles encountered in this area of the integrated care initiative mirrored those encountered in establishing a seamless system of care.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Create leadership team including people from primary care, mental health, and substance abuse	Not accomplished
2	Develop a set of core competencies for primary care/substance abuse/mental health that support an integrated care system	In progress
3	Increase primary care providers' knowledge of mental health, substance abuse, and vise-versa	In progress

Partnerships and Collaborations

In coordinating the primary care, substance abuse, and mental health stakeholders' application for a SAMHSA's Mental Health Transformation Grant, the team lead and the Department of Health generated a tremendous amount of momentum for the integrated care initiative. Though they were unsuccessful in obtaining the grant, the department heads, the health commissioner, and other key players were present at these grant meetings and formed relationships that will carry this initiative in the future.

To maintain this momentum and support, the team lead indicated that they would need funding, examples from other states, and more time to shape these partnerships.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Create a total of twenty-four collaborative between primary care, mental health and substance abuse: twelve adults, twelve youth. Hold community meetings of stakeholders	In progress

Other Accomplishments

In addition to local integration efforts and funding opportunities, the team lead stated that a person from the Department of Health has been involved in the community development efforts that were affiliated with the integrated care projects.

Use of Federal Resources

The team lead was unaware of the use of Federal Resources for the integrated care initiative. However, he would like to be immediately notified if any funding opportunities become available for this initiative.

Consumer Participation

The team lead indicated that consumers were active in the planning and review stages of the integrated care initiative. Consumer input resulted in the establishment of the initial pilot integration projects.

Assessment of Progress

Due to the overwhelming support for the integration initiative that the State of Vermont has witnessed in recent years, the team lead was optimistic about the future of integrated care. In the next five years, the team lead was confident that a steering committee would be formed that will focus on integration as a key feature of the major initiatives that are currently underway. Of these major initiatives, the Blueprint Project will continue to provide valuable information on the effectiveness of integrated care in a primary care setting. So, too, will the Medicaid restructuring project. Its evolving leadership will be focusing its efforts on integrated care.

The team lead evaluated the overall progress of his state to integrate primary and behavioral care as “good.” He evaluated the progress of his state to implement the State Action Plan as “fair” but attributed this rating strictly to his state’s failure to acquire a Mental Health Transformation Grant.

Lack of funding has been the key issue for the state of Vermont. The team lead indicated that the potential for creative thinking on behalf of consumers, local leaders, and state officials exists and could sustain this initiative for the time being. However, the current fervor for this initiative is likely to dwindle and the initiative will cease to progress.

Finally, the team lead evaluated the Summit he attended as a “good” way to jump-start integration in Vermont by providing a vehicle for collaboration. He indicated that some of the accomplishments were a direct result of the Summit.

WASHINGTON

Washington had thirty registered participants at the Seattle Summit including state officials, service providers, and representatives of primary care associations. Since the Summit, Washington has experienced immense change with regard to its mental health services. This has come as a result of SAMHSA's Mental Health Transformation Grant (MHT SIG) awarded to Washington in 2005. Efforts to reform mental health services have been drastically altered and the focus has shifted in such a way that any and all planning activities that have taken place in past year have been strictly related to projects resulting from this grant. Thus, the integrated care initiative is no longer an independent initiative, as it has instead become an integral feature of the planning activities surrounding the Mental Health Transformation Grant.

In-State Leadership to Implement the Action Plan

The Summit participants had initially formed a steering committee that met twice monthly to organize a statewide summit. This committee had been taking small steps with regard to integrated care because funding and participation concerns were prevalent at each meeting. Since the Mental Health Transformation Grant was awarded, however, these meetings are held less frequently because the members of the steering committee have joined in the mental health transformation planning efforts. These efforts have encountered a tremendous drive, wide-ranging interest, and active participation¹². For instance, the lead group, the Joint Mental Health Task Force, has witnessed an unprecedented increase in interest and participation in both mental health transformation and integrated health care¹³. As a result of this grant, the Joint Mental Health Task Force now recognizes the benefit of integrating services as a means of reforming the mental health system.

Local level leadership has come from individual community health centers. To overcome Medicaid reimbursement restrictions, new legislation has been passed which provides mental health funding to community health centers that establish contracts with behavioral health subcontractors. This funding had originally been available only to behavioral health subcontractors who sought to treat the severely mentally ill. This access to funding has increased the incentive to integrate and decreased the apprehensiveness that often follows service integration. Thus, while state level leadership and support will lead to fundamental changes in mental health services, these funded local level efforts will provide the information needed to formulate models for future health service integration.

¹² The Primary Care Association, a primary care organization, the Mental Health and Substance Abuse Departments, the Medicaid Office, mental health advocacy organizations, mental health service providers, and community health centers are all currently participating in this initiative.

¹³ This task force consists of twenty-three public and private members.

Action Plan Accomplishments

Seamless System of Care

Prior to the Mental Health Transformation Grant, the Department of Health had issued three surveys (Community Mental Health Integration with Community Health, Community Mental Health Providers who coordinate and provide chemical dependency services, and for Chemical dependency providers who coordinate substance abuse) with the intention of acquiring a better understanding of both where and how services were being integrated throughout the state. The results of these surveys illustrated a surprising level of cooperation among mental health centers and community health centers, identified the need for mental health transformation, and led to state level recognition of the importance of integrating substance abuse services. With this survey data, the Department of Health acquired a common data set on which measure progress. This data has also given mental health advocates a significant voice in the Mental Health Transformation Grant planning activities.

An omnibus bill has provided the opportunity for local commissioners to issue a sales tax. The funds raised by this tax will be used to develop health service models that provide integrated substance abuse and mental health services. The Department of Health has assumed responsibility for guiding the implementation of this bill. So far, four out of twenty nine counties have passed this self-tax.

Through a small tribal grant, which is awarded by the Office of Community and Rural Health, a tribal clinic has been acting as a model for the integration of behavioral health and primary care. The Office of Community and Rural Health has supported this effort by locating funding and securing National Health Service Corps social workers. The results of this pilot will be used to assist the greater integration effort. Also, within community health centers, common enrollment has become a standard practice. Resident nurses compile data about registered patients and submit this data to the state regardless of the type of service that is eventually received.

The team lead indicated that accomplishing more in this area had been very difficult. The Mental Health Transformation Grant has created an atmosphere of constant change. Therefore, many state agencies and organizations have simply been too busy to adopt the integrated care initiative in addition to their current projects. Also, the idea that a publicly funded mental health system services the general populace pervades the health community and has made it difficult to prove that change is necessary. Nevertheless, the survey data and a recent increase in the participation of both the Primary Care Association and the Community Mental Health Association should lead to future accomplishments.

Summary of Action Plan accomplishments in seamless system of care

	Action Plan Activity	Status
1	<ul style="list-style-type: none"> Identify 3 committed participants from mental health, 	Accomplished but

	<p>primary care, and substance abuse to participate on Integration Planning Group</p> <ul style="list-style-type: none"> • Make educational presentations at 6 conferences. • Develop a 10-point integration plan. 	has subsided since the Mental Health Transformation Grant was awarded.
2	Use government contracting agencies to evaluate and revise existing integration codes and to then disseminate the information	Not accomplished
3	Get industry players involved	Not accomplished
4	Identify successful integration models and, through them, identify criteria and characteristics of an integrated system (i.e. universal patient info, universal access to info, etc.)	Accomplished
5	<p>Develop integration practices for screening, referral, assessment and treatment with “feedback loops” by:</p> <ul style="list-style-type: none"> • Developing comprehensive screening questions and eligibility criteria to address full spectrum of clinical care needs • Encourage co-location for providers 	Accomplished

Workforce Training and Development

Prior to the Mental Health Transformation Grant, it had been agreed upon by the steering committee members that this aspect of the Action Plan held a high level of significance. As planning has taken place around this grant, at least one pilot project was in the mental health community. Information from this assessment has been constantly fed into the larger transformation process to ensure that an understanding develops regarding gaps that exist in the local health care system.

If this area of the integration initiative is progress, funding will need to be acquired, Medicaid reimbursement problems will need to be resolved, and credentialing and licensing restrictions will need to be alleviated.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	<p>Develop a catalogue of resources and train providers, using cross-training methods, through:</p> <ul style="list-style-type: none"> • The Integration Task Force’s appointed “Integration of Training Sub-Committee” 	Not accomplished

	<ul style="list-style-type: none"> Jointly selected, or developed, outcome based, cross-training, curricular outlines with Continuing Educational Units Identified, existing, technical assistance and other curricular resources 	
2	Develop a common core curriculum for entry level that crosses all disciplines and make sure there is an integrated component across all disciplines, especially in regards to working with the underserved	Not accomplished
3	Develop an educational curriculum that builds on skills of natural helper, case manager, etc, at the community college level	Not accomplished
4	Educate “panel” members on needs of integrated mental health, substance abuse, and chemical dependency	Not accomplished
5	Develop action plans to address curriculum development training programs	Not accomplished

Partnerships and Collaborations

Prior to the Mental Health Transformation Grant, partnerships had been formed as a result of interest generated at the Seattle Summit. However, limited resources existed because programs and policies were mandated by legislation to implement changes prior to planning for integration. (please check if meaning has been altered) Nevertheless, partners worked together to survey providers in order to develop a better understanding of existing integrated health services. The Summit participants also submitted an abstract on primary care integration into behavioral health for a presentation at an upcoming Joint Public Health Conference.

Since the Mental Health Transformation Grant, the Summit participants have held multiple “close-out” meetings with mental health and substance abuse agencies to transition the work that had started immediately following the Summits to more effective avenues. They have broadened their dialogue to include issues such as health services to veterans and the homeless in rural areas (check meaning here). They are also trying to influence policy by providing input, highlighting public mental health issues, and influencing the planning activities that are taking place around the Mental Health Transformation Grant. In addition, they have worked to help their state partners better understand community health centers, their role, and the collaborative efforts that exist among them.

Finally, the Office of Community and Rural Health helped fund a community health center and community mental health center presentation at a joint public health

conference in October of 2005. The topic of the presentation was the integration of children’s psychiatric services into a local health clinic to increase children’s access to behavioral health services. The county in which this had taken place had consistently failed to meet the mental health needs of its youth and, thus, integration had been utilized to counter this deficiency.

In order to move partnerships and collaborations forward, the team explained that funding and examples from others would be needed.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Hold Integration Summit	Not accomplished
2	Create an educational and advocacy network across the state and across the disciplines	Not accomplished
3	Create action plans at each level of integration- local, regional, state, and federal	Not accomplished

Other Accomplishments

The team lead indicated that progress had been made with regard to changes in policy and law, local service integration, and increases in state and federal government funding. She also discussed accomplishments with a community development initiative, the innovative use of existing resources, and a demonstration project.

Use of Federal Resources

The Mental Health Transformation Grant has provided substantial funding for mental health programs that will most likely utilize the integrated model as they continue to change the mental health system. Prior to this grant, the team lead explained that they had been planning on applying for both HRSA and SAMSHA grants but that they encountered problems in locating the information they needed to do so.

Consumer Participation

Consumers have not been involved in the integrated care initiative. However, they have been involved in the Mental Health Transformation Grant planning and may ultimately play a role in service integration.

Assessment of Progress

The team lead evaluated Washington’s progress to integrate primary and behavioral care as “fair.” She evaluated Washington’s overall progress to implement their State Action Plan as “poor” and, due to the Mental Health Transformation Grant, felt that it had essentially become an irrelevant plan at this point. In five years, the team lead anticipated

that the role of mental health and the promotion of integrated care would continue to increase as the Mental Health Transformation Grant plan is implemented.

The team lead evaluated the Summit she had attended as a “fair” way to jump-start the implementation of integrated services in her state and explained that some of the accomplishments that had taken place could be attributed to the meeting. Nevertheless, she wished HRSA/SAMHSA would increase opportunities for community health centers to apply for grant funding and provide assistance with regard to the implementation of integration plans.

WYOMING

Since the Albuquerque Summit, the four registered Wyoming Summit participants, who included local service providers and a consumer organization representative, have not communicated and leadership for this initiative has yet to emerge. Thus, integration efforts in Wyoming have occurred due to a grassroots initiative on the part of individual providers, such as the Summit participant who was interviewed for the second round of the evaluation.

In-State Leadership to Implement the Action Plan

There is no leadership to speak of with regard to the implementation of the State Action Plan. Little progress has been made with the activities that were compiled during the Summit. The Summit participant explained that the Albuquerque Summit provided the Wyoming participants with a better understanding of the benefits of the integrated model and motivated to begin integrating health services within his health center.

The State of Wyoming has not been involved in this initiative. This Summit participant indicated that he had contacted several state officials but had yet to receive any responses.

Action Plan Accomplishments

Seamless System of Care

The Summit participant has looked to integrate some of the services his behavioral health care clinic offers with those of their counterpart primary care providers. In turn, his clinic has developed better collaborative relationships with some of the primary care physicians that treat his patients. This accomplishment is a result of his own efforts upon learning about the benefits of the integrated model during the Summit. Another community health center in Cheyenne, Wyoming, has a collaborative relationship with the local health center. The Summit participant was unable to elaborate on how integration being implemented among those service providers.

Summary of Action Plan accomplishments in developing a seamless system of care

	Action Plan Activity	Status
1	Promote understanding of integrated care; identify the state officials and others who have an impact on integrated care; form Healthcare Integration Committee	Not Accomplished

Workforce Training and Development

The Summit participant was unaware of any accomplishments with regard to workforce training and development.

Summary of Action Plan accomplishments in workforce training and development

	Action Plan Activity	Status
1	Recruit additional mental health and substance abuse practitioners to the state	Not Accomplished
2	Contact Wyoming Primary Care Office for assistance	Accomplished
3	Convene groups of academicians and clinicians to develop an educational plan around integration including best practices, use of technology in training, use of grants and other resources; develop an educational plan; create educational subcommittee of Healthcare Integration Committee	Not Accomplished

Partnerships and Collaborations

Through the efforts of the Summit participant, collaboration is occurring among practitioners within his health center and primary care providers who serve the same patients.

Summary of Action Plan accomplishments in partnerships and collaborations

	Action Plan Activity	Status
1	Enlist NAMI to provide physical health providers with information about NAMI services.	Accomplished
2	Include integration as a topic in state conference on consumer leadership.	Not Accomplished
3	Contact Wyoming Department of Health, Medical Association, University of Wyoming, and the Department of Family Services to identify initiatives underway that provide opportunities for collaboration.	Not Accomplished

Other Accomplishments

The team lead did not discuss any other accomplishments with regard to the integrated care initiative.

Use of Federal Resources

The Summit participant was unaware of the use of Federal Resources for this effort.

Consumer Participation

The Summit participant indicated that consumers were not involved in this effort.

Assessment of Progress

The Summit participant explained that the initiative is not progressing at this point. Any momentum as a result of the Summit was lost when the participants returned to Wyoming and realized the complexity of implementing this initiative. Thus, the Summit participant evaluated both the State's progress to integrate its services and the State's progress toward the implementation of the State Action Plan as "poor."

The integrated care initiative is experiencing major obstacles that are impeding its progress. Among these are the lack of funding and difficulty of integrating services in a geographically large, mountainous, and rural state such as Wyoming. Even though "the model is ideal for a frontier environment," the lack of leadership, support, and resources is not allowing this plan to move forward.

The Summit participant acknowledged that the Summit meeting was very informative. However, because state officials, primary care providers, and other key players from Wyoming were not in attendance, the Summit did little to influence statewide integration.

APPENDIX C: Interview and Participant Information

STATE	Interview Date	Interviewee's Name	Interviewee's Position	Contact Information
Alaska	5/12/06	Pat Carr*	Director, State Office of Mental Health	(907) 465-8618 pat_carr@health.state.ak.us
Arizona	5/11/06	Robert Evans*	Director, Division for Substance Abuse Policy, Arizona Governor's Office	(602) 542-3456; (602) 364-2232 revans@az.gov
Arkansas	4/13/06	David Coleman	Chief Operating Officer, Health Resources of Arkansas	(870) 973-8900*4*2 dcoleman@hra-health.org
California	3/24/06	Dean Germano	Chief Executive Officer, Shasta Community Health Center	(530) 246-5704 dgermano@shastahealth.org
	5/18/06	Alan Edwards	Medical Director, Orange County Behavioral Health Services	(714) 568-5756 aedwards@ochca.com
Colorado	3/6/06	Wayne Maxwell	Executive Director, North Range Behavioral Health	(970) 347-2120 wayne.maxwell@northrange.org
	5/9/06	Brian DeSantis	Director of Behavioral Health, Peak Vista Community Health Clinics	(719) 632-5700 bdesantis@peakvista.org
Connecticut	6/09/06	Meghan O'Hanlon	Director of Behavioral Health, Community Health Services	(860) 808-8798 mhall04548@yahoo.com
Delaware	6/12/06	Paula Roy*	Executive Director, Delaware Health Care Commission	(302) 672-5187 Paula.Roy@state.de.us
Washington, D	4/24/06	David Rose	Chief, Bureau of Primary Health Care, District of Columbia Department of Health	(202) 442-8984 david.rose@dc.gov
Hawaii	4/10/06	Loretta Fuddy*	Chief, Hawaii Department of Health, Family Health Division	(808) 586-4121(2) loretta.fuddy@fhds.health.state.hi.us
Idaho	4/6/06	Jonathan Bowman*	Medical Director, Terry Reilly Health Services	(208) 467-4431 jbowman@trhs.org

APPENDIX C: Interview Participants

STATE	Interview Date	Interviewee's Name	Interviewee's Position	Contact Information
Louisiana	4/11/06	Kristie Nichols*	Director, Louisiana Department of Health and Hospitals, Bureau of Primary Care and Rural Health	(225) 342-3814 knichols@dhh.la.gov
Maine	3/20/06	Kevin Lewis*	Executive Director, Maine Primary Care Association	(207) 621-0677 kalewis@mepca.org
Massachusetts	3/30/06	Sabine Hedberg	Project Director, UMass Medical School Center for Health Policy and Research	(508) 856-8421 Sabine.Hedberg@umassmed.edu
Montana	3/27/06	Arthur McDonald*	Director, Ashland Community Health Center	(406) 784-2346 ritamcd@rangeweb.net
New Jersey	3/20/06	Sandy Festa*	Project Director, AtlantiCare Health Services	(609) 344-5714 Sandy.Festa@atlanticare.org
New Mexico	3/9/06	Harvey Licht*	Office Director, Office of Primary Care/Rural Health	(505) 841-5869 harvey.licht@state.nm.us
Oklahoma	2/23/06	Rand Baker*	Deputy Commissioner, Oklahoma Department of Mental Health and Substance Abuse Services	(405) 522-3877 rbaker@odmhsas.org
	7/7/06	Judy Grant	Director of Community Development, Oklahoma Primary Care Association	(405) 424-2282 ext 104 jgrant@okpca.org
Oregon	3/31/06	David Pollack	Professor of Psychiatry, Oregon Health Sciences University	(503) 945-7816 david.pollack@state.or.us
Puerto Rico	written report, 7/7/06	Louisa Rivera	Executive Director, Gurabo Community Health Center	(787) 737-4866 gurabochcincorp@aol.com
Rhode Island	2/28/06	Mary Anne Miller*	Chief, Rhode Island Department of Health	(401) 222-7625 maryanne.miller@health.ri.gov
Texas	3/30/06	Nancy Speck*	Telehealth Regional Consultant and Coordinator, University of Texas Medical Branch at Galveston	(936) 554-0562 (cell) nspeck@earthlink.net; nspeck@cox-internet.com

APPENDIX C: Interview Participants

STATE	Interview Date	Interviewee's Name	Interviewee's Position	Contact Information
Utah	4/6/06	Robert Snarr	State Adult Programs Manager, Utah Department of Human Services	(801) 538-4080 rsnarr@utah.gov
Vermont	2/24/06	Charlie Biss*	Director, Children's Mental Health, Vermont Department of Health, Division of Mental Health	(802) 652-2009 cbiss@vdh.state.vt.us
Washington	4/4/06	Mary Looker*	Director, Washington Department of Health, Office of Community & Rural Health	(360) 236-2808 mary.looker@doh.wa.gov
Wyoming	5/19/06	Steven Newman*	Director of Psychology, Mountain Regional Services	(307) 638-9515 newman@mrsi.org

* Interviewees in a leadership position in state integration teams.

APPENDIX D: Multi-State Teleconferences Information

The evaluation team conducted four multi-state teleconferences in the first round of the evaluation, and three multi-state teleconferences in the second round of the evaluation. Below is the information on the participants of the second round of teleconferences.

The first multi-state teleconference was conducted on May 25, 2006, and involved the following participants:

- 1) **Arizona:** Rob Evans, Director of the Division of Substance Abuse Policy, AZ Governor's Office
- 2) **Hawaii:** Loretta Fuddy, HI Department of Health
- 3) **Montana:** Arthur McDonald, Director of Ashland Community Health Center
- 4) **Oklahoma:** Rand Baker, Deputy Commissioner, OK Dept. of Mental Health and Substance Abuse Services
- 5) **Oregon:** Joel Young, Health Systems planning Division of the OR Dept. of Human Services
- 6) **Rhode Island:** Mary Anne Miller, Chief of Primary Care, RI Institute of Primary Health

The second multi-state teleconference was conducted on May 31, 2006, and involved the following participants:

- 1) **California:** Doreen Bradshaw, Executive Director of Shasta Consortium of Community Health Centers
- 2) **Colorado:** Brian DeSantis, Head of Behavioral Health for Peak Vista Community Health Centers
- 3) **DC:** David Rose, Chief of Bureau of Primary Health Care, DC Department of Health
- 4) **Oregon:** David Pollack, Professor of Psychiatry, Oregon Health & Science University

The third multi-state teleconference was conducted on June 7, 2006, and involved the following participants:

- 1) **Colorado:** Wayne Maxwell, Executive Director of North Range Behavioral Health
- 2) **Maine:** Kevin Lewis, Executive Director of Maine Primary Care Association
- 3) **Washington:** Mary Looker, Program Manager of Primary Care Office

For all three teleconferences REDA utilized the Broadwing Teleconferencing service, a conference call service that connects all of the participants via dial-in, and records the conversation for further analysis.

APPENDIX E: Instruments Used in the Evaluation

At the Summits, facilitators asked two to three participants from each participating state to volunteer to serve as points of contact for the evaluation of post-Summit implementation. One of these individuals, the “team leader,” was asked to complete a State Update Report form in the first round of evaluation activities that took place between January and October of 2005. This form also served as a base for the second round of the evaluation activities that took place a few months after the first one. The form was used to assess and summarize the State’s progress to date in implementing its State Action Plan and promoting service integration.

Using the State Update Report Form, team leaders were asked to provide information on the following topics:

- ◆ Leadership and organization of the State initiative;
- ◆ Participation, coordination, partnerships, and collaboration among agencies, groups, and organizations;
- ◆ Action plan accomplishments in the areas of workforce training and development and partnerships and collaboration;
- ◆ Other notable accomplishments (e.g., demonstration projects, in-State Summits, etc.);
- ◆ Changes in the action plan;
- ◆ Use of Federal and other resources to implement the action plan;
- ◆ Degree of consumer involvement in plan development and implementation;
- ◆ Barriers encountered and actions taken to overcome barriers; and
- ◆ Impact of unforeseen events (economy, natural disasters, terrorism, etc.) on their planning and implementation.

In the second round of the evaluation one more form was used in addition to the State Update Report form, called “Additional Question”. The purpose of that form was to collection information on the status of implementation of state action plan activities, as well as gather opinions on the usefulness of the Summits, recommended federal assistance, and other issues. This form was used in telephone interviews with team leaders and other evaluation participants. Both forms are found in this appendix.

STATE ACTION PLAN UPDATE

State Contact Information

State	
Name of Interviewee	
Title	
Organization	
Street Address 1	
Street Address 2	
City/State/Zip	
Phone	
Fax	
E-mail	

Organizing to Implement the Action Plan

1. By answering the following questions, please describe how your State has organized itself to implement the action plan that was developed at the Summit.

a. What agencies, groups, or organizations are participating in this effort? (*Mark an "X" in front of all that apply*)

- | | |
|---|--|
| <input type="checkbox"/> Primary Care Association | <input type="checkbox"/> Family Member Organization |
| <input type="checkbox"/> Primary Care Organization | <input type="checkbox"/> Mental Health Service Providers |
| <input type="checkbox"/> Health Department | <input type="checkbox"/> Substance Abuse Service |
| <input type="checkbox"/> Mental Health Department | <input type="checkbox"/> Providers |
| <input type="checkbox"/> Substance Abuse Department | <input type="checkbox"/> Primary Care Providers |
| <input type="checkbox"/> Medicaid Office | <input type="checkbox"/> University or College |
| <input type="checkbox"/> Mental Health Advocacy | <input type="checkbox"/> Governor's Office |
| <input type="checkbox"/> Organization | <input type="checkbox"/> Legislature |
| <input type="checkbox"/> Substance Abuse Service | <input type="checkbox"/> Other Elected Officials |
| <input type="checkbox"/> Advocacy Organization | <input type="checkbox"/> Other (<i>Please list</i>): |
| <input type="checkbox"/> Consumer Organization | |

b. How is this effort coordinated?

- Steering Committee
- Interagency Council
- Directed by a Single Agency
- Other (*Please specify*):

- c. Does a particular agency, group, or organization have lead responsibility for implementing the State action plan?

No Yes (*Please specify*):

- d. Please briefly describe how members of your Summit team have continued to work toward implementing your action plan. (For instance, do you meet regularly, have you established committees and/or subcommittees, developed a list serve, etc.?)

2. Do you currently have all of the key officials and stakeholders involved who are needed to successfully implement the action plan?

Yes No

If not, who else needs to be involved? (*Mark an "X" in front of all that apply*)

- | | |
|--|--|
| <input type="checkbox"/> Primary Care Association | <input type="checkbox"/> Family Member Organization |
| <input type="checkbox"/> Primary Care Organization | <input type="checkbox"/> Mental Health Service Providers |
| <input type="checkbox"/> Health Department | <input type="checkbox"/> Substance Abuse Service Providers |
| <input type="checkbox"/> Mental Health Department | <input type="checkbox"/> Primary Care Providers |
| <input type="checkbox"/> Substance Abuse Department | <input type="checkbox"/> University or College |
| <input type="checkbox"/> Medicaid Office | <input type="checkbox"/> Governor's Office |
| <input type="checkbox"/> Mental Health Advocacy Organization | <input type="checkbox"/> Legislature |
| <input type="checkbox"/> Substance Abuse Service Advocacy Organization | <input type="checkbox"/> Other Elected Officials |
| <input type="checkbox"/> Consumer Organization | <input type="checkbox"/> Other (<i>Please list</i>): |

3. Have you encountered problems in either organizing or gaining the cooperation of individuals or groups who are needed to implement the action plan?

Yes No

If yes, what were these problems and how have you addressed them?

Action Plan Accomplishments

In the Summit meetings, States developed action plans that addressed three major areas: seamless system of care, workforce training and development, and partnerships/collaboration. Please review your State's action plan and then discuss your State's accomplishments in each of these areas by answering the following questions:

Seamless System of Care

4. Since the Summit, what have been your three main accomplishments in developing a **seamless system of care**?

a.

b.

c.

Other:

5. Has your action plan changed in this area?

No

Yes (*Please specify*):

6. What is needed to move your plan ahead in this area?

Planning Data

Funding

Examples or Consultation from Others

Interest by Others

Other (*Please specify*):

6a. What are the main obstacles that you have encountered in your attempts to develop a seamless system of care (*please list*)?

Workforce Training and Development

7. Since the Summit, what have been your three main accomplishments in the area of **workforce training and development**?

a.

b.

c.

Other:

8. Has your action plan changed in this area?

No Yes (*Please specify*):

9. What is needed to move your plan ahead in this area?

- Planning Data
- Funding
- Examples or Consultation from Others
- Interest by Others
- Other (*Please specify*):

9a. What are the main obstacles that you have encountered in workforce training and development?

Partnerships and Collaboration

10. Since the Summit, what have been your three main accomplishments in developing necessary **partnerships and collaborations**?

a.

b.

c.

Other:

11. Has your action plan changed in this area?

No Yes (*Please specify*):

12. What is needed to move your plan ahead in this area?

- Planning Data
- Funding
- Examples or Consultation from Others
- Interest by Others
- Other (*Please specify*):

12a. What are the main obstacles that you have encountered in developing partnerships and collaborations?

Other Accomplishments

13. What other accomplishments or progress has your State/Region made in integrating mental health, substance abuse, and primary care services? *(Mark an "X" in front of all that apply)*

- Changes in Policy or Regulations
- Changes in Law
- Local Service Integration
- Increased or Secured Government Funding:
 - Federal
 - State
 - Local
- Secured Foundation Grant/Private Funding
- Community Development Initiative
- Innovative Use of Existing Resources
- Demonstration project
- Other *(Please specify):*

Use of Federal Resources

14. Since the Summit have you received any assistance from HRSA, SAMHSA, or another federal agency in implementing your action plan? *(Mark an "X" in front of all that apply)*

- NHSC Clinicians
- SAMHSA Discretionary/Competitive Grants
- Mental Health and/or Substance Abuse Block Grant
- Technical Assistance on Planning
- Technical Assistance on Service Integration
- Other Federal Assistance *(Please specify):*

Consumer Participation

15. How have consumers been involved in the implementation of the State action plan? *(Mark an "X" in front of all that apply)*

- Planning
- Review and input at various points in the process
- Not Involved
- Other *(Please specify):*

Unforeseen Events Affecting Your Plan

16. Since the Summit have any unforeseen events had a significant impact on your State's ability to implement the action plan developed at the Summit? (e.g., a natural disaster/emergency, state budget problems, law or policy changes, etc.)

No Yes (*Please specify*):

Assessment of Progress

17. Would you say that your State is on schedule for achieving the majority of the outcomes or benchmarks listed in your action plan?

On Schedule Behind Schedule Ahead of Schedule

18. Overall, how would you rate the progress that your State has made since the Summit?

Excellent Good Fair Poor

Why?

THANK YOU FOR YOUR PARTICIPATION!

ADDITIONAL QUESTIONS FORM

Telephone interview with

Additions to the State Action Plan Update form:

To Question 4

Your State Action Plan indicated the following activities and benchmarks in the area of development of a seamless system of care. Please tell us how far you have progressed in achieving these results.

	Action Plan Activity	Status
1		
2		
3		

To Question 7

Your State Action Plan indicated the following activities and benchmarks in the area of workforce training and development. Please tell us how far you have progressed in achieving these results.

	Action Plan Activity	Status
1		
2		
3		

To Question 10

Your State Action Plan indicated the following activities and benchmarks in the area of development of partnerships and collaborations. Please tell us how far you have progressed in achieving these results.

	Action Plan Activity	Status
1		
2		
3		

To Question 14

What can Federal agencies do to help advance the integration initiative in your state? Are there other ways Federal agencies can assist in promoting integration?

ADDITIONAL QUESTIONS

1. Is there enough momentum in your state to keep the initiative going? With the existing momentum, where do you see the initiative:

- a. In a year
- b. In five years

2. On a 4-point scale, where 1 is Poor and 4 is Excellent, how would you rate the overall progress of your state to integrate primary and behavioral care?

4 = Excellent 3 = Good 2 = Fair 1 = Poor

3. On a 4-point scale, where 1 is Poor and 4 is Excellent, how would you rate the overall progress of your state to implement the Action Plan that your group developed at the Summit?

4 = Excellent 3 = Good 2 = Fair 1 = Poor

4. In your opinion, how much did the Summit contribute to your state’s accomplishments in integrating primary and behavioral care?

- 4 = all the accomplishments are a result of the Summit
- 3 = most of the accomplishments are a result of the Summit
- 2 = some of the accomplishments are a result of the Summit
- 1 = none of the accomplishments are a result of the Summit
- 0 = there are no accomplishments to speak of

5. In your opinion, was the Summit meeting you attended an effective way to jump-start the implementation of integrated services in your state? Please rate on a 4-point scale, where 1 is Poor and 4 is Excellent.

4 = Excellent 3 = Good 2 = Fair 1 = Poor

6. Besides Summits, are there other ways you would recommend for promoting service integration at the state and local levels?
7. We are planning to conduct a teleconference with team leaders from other states. Are you interested in participating? What would you like to discuss?