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

Participant Feedback Report

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November 3, 2006

PARTICIPANT FEEDBACK REPORT

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 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 was analyzed using qualitative and quantitative data analysis techniques.

Summit Process Evaluation Highlights

The data for the evaluation of the Summits was collected on-site, and the analysis was conducted in the months following the Summits. 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 with implementation of their Action Plans after the Summits. The three central themes of the Summits and the Action Plans included 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 information on specific state circumstances and challenges.

While 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 must 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.
- 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.

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 obtained

information showed that by the end of the evaluation period in May 2006, the Summit Initiative had produced promising achievements in most of the participating states, including the following:

- 77% of states[1] 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 the 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 additional 22% said that most or all of their accomplishments are a direct result of the Summits.

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, 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 include the following:

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

[1] 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.

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.

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.