

# Integrated Behavioral Health Project Evaluation: An Assessment of the Field and IBHP's Contributions

February 2010

**Desert Vista Consulting**

Jennifer J. Brya, MA, MPP

Karen W. Linkins, Ph.D.

## I. Introduction

The California Endowment funded the Integrated Behavioral Health Project (IBHP), a four-year program implemented in 2006, to advance the field of integrated behavioral health,<sup>1</sup> improve access to behavioral health services, reduce stigma, and improve treatment outcomes for underserved populations. To advance the field, IBHP implemented several core strategies: 1) grant making to identify, enhance, and improve promising clinic practices; 2) building and supporting (through training and technical assistance) a Learning Community of providers and stakeholders in the fields of primary care and behavioral health; and 3) advancing a policy and advocacy agenda to affect systems changes “in the trenches” and at the state level, including establishing and strengthening strategic partnerships.

The goal of this report is to show how the IBHP has and continues to cultivate the field of integrated behavioral health through their work as “nimble advocates” in California and nationally. We use The James Irvine Foundation’s “Strong Field Framework”<sup>2</sup> to examine the current state of the integrated behavioral health field, and assess how the various strategies implemented under IBHP contributed to the field building effort. The final section of the report provides a summary assessment of the state of the field and IBHPs contribution. Because the IBHP is currently implementing Phase III of their grantmaking and policy and advocacy work, the analysis of their contribution to the field will be updated as the work progresses.

## II. Assessing the Status of the Integrated Behavioral Health Field and the Contributions of IBHP

A core assumption regarding the value of “field building” is that it is a critical part of systems change. According to The James Irvine Foundation, “field” is defined as a community of individuals and organizations coalescing around a common goal (i.e., systems change) and using similar approaches to achieving this change. The Strong Field Framework identifies **five key components** for assessing the strengths and weaknesses of any given field:

- Shared identity,
- Standards of practice,
- Knowledge base,
- Leadership and grassroots support, and
- Funding and supporting data.

We use this framework to assess the current state of the field of integration and the contributions of IBHP using several data sources: targeted literature and website reviews, the team’s monthly policy

---

<sup>1</sup> For the purposes of this document, “integrated behavioral health” is used to represent the concept of integrating behavioral health (mental health, substance use, and behavioral/psychosocial interventions) and primary care.

<sup>2</sup> The James Irvine Foundation, (2009) *“The Strong Field Framework: A Guide and Toolkit for Funders and Nonprofits Committed to Large-Scale impact.”*

tracking logs, and targeted key informant interviews with grantees and integrated behavioral health stakeholders.

**Defining the Integrated Behavioral Health Field:** For the purposes of this assessment, we use the following definition of the field of integrated behavioral health developed by the IBHP team: *individuals and organizations with a shared philosophy of improving the access and quality of care for safety net populations through integrated primary care and behavioral health services.* While the scope of stakeholders included in this definition is broad, it represents the array of community health clinics, associations, government agencies, policymakers and state/national stakeholders the IBHP team currently collaborates with to advance the field through policy and systems change efforts.

### III. Current Status of the Integrated Behavioral Health Field

The following section assesses the state of the field of integration according to the five components of The Strong Field Framework.

#### A. Shared Identity

Shared identity assumes that stakeholders share a common purpose or set of core values. Key questions to assess progress toward shared identity include: do individuals/organizations identify as field members? Are stakeholders in agreement about what the field is trying to accomplish? and Are there common approaches to achieving the overall goal?

*Many individuals and organizations do not consider “integrated behavioral health” as their primary identity or purpose.* A challenge to shared identity in the integrated behavioral health field is that the majority of interested stakeholders primarily identify as working in either the primary care, mental health or addictions treatment fields. The unifying commitment to integration represents a secondary commitment to improving health and behavioral health access and outcomes. Therefore, while there appears to be a growing critical mass of stakeholders advocating for, researching, and implementing integrated behavioral health, there are competing identities and integrated behavioral health is often not the primary focus of the stakeholders involved.

*There is not a “shared vocabulary” for the concept, process, and practice of integrating health and behavioral health care.* Field member identity is also affected by inconsistencies in terminology related to the concept of “integration” and the variation in terminology within and across stakeholder groups. Terms like “integrated care,” “integrated primary care,” “coordinated care,” “primary care behavioral health,” and “co-located care” are some examples used by researchers and practitioners to describe the clinical and service delivery models or systems. However, these terms are not broadly used in communicating with lay audiences (e.g., patients, consumers, and family members) or in the health policy arena. Concepts and terms like “collaborative care,” “health care for the whole person,” “mind-body health,” “holistic health,” “wellness,” and “team approach” to providing quality health care are efforts to provide more meaningful labels to communicate the concept of integrated care to the lay public. The term “behavioral health” also has different connotations depending on the audience. For individuals in the mental health field, “behavioral health” is used to depict mental health and substance

use services. In many primary care settings with “behavioral health” programs, services focus on behavioral interventions to improve physical health conditions and substance abuse treatment is often not included or available. Lastly, for policy makers, in many ways, the terms used appear less significant than the issues related to clinical outcomes, cost effectiveness, and financing integrated services.

***Stakeholders are in alignment regarding the goals of integrated care.*** At the core, there is a commitment to approaching the health and well-being of individuals holistically by treating both the mind and body. Stakeholders recognize the difficulty of practicing effective primary care without consideration for the range of social and psychological issues affecting people. There is also recognition that current organizational and financing strategies and policies actually create fragmented and uncoordinated systems of care.

***Stakeholders do not agree on the best approaches or strategies for achieving goals.*** Although there is alignment about the goals of integrated behavioral health, there is much less agreement among stakeholders regarding strategies to achieve the goals or the actions that need to be taken to address the organizational and barriers that lead to fragmented and siloed service delivery systems. Integration approaches vary widely from “closed system” models (e.g., the Kaiser Permanente model, the pilot being tested by the California County Medical Services Program (CMSP), Washtinaw Community Health Organization in Michigan, and Inter-Mountain Healthcare in Utah) to statewide strategies (e.g., managed care case rate for providing integrated services through the DIAMOND model in Minnesota and the Community Care of North Carolina program to provide case management) to clinics and clinic systems implementing the IMPACT model through research collaboratives. In addition, there are countless examples nationally of integration initiatives sponsored by foundations, federal initiatives, as well as independent clinics and clinic systems implementing a broad variety of integration models. In addition to not agreeing on clinical and administrative strategies, there is no universal vision for the best strategy for financing integrated care.

## **B. Standards of Practice**

A strong and developed field should have codified standards of practice, including effective models of care, resources to support implementation and replication, and professional development curricula and credentialing. Key questions to stage a field’s progress toward developing standards of practice include: Are there codified practices? Are there demonstrated models that are recognized by stakeholders? and Are there training and professional development opportunities for practitioners?

***Codified standards of practice exist, but are not widely adopted.*** Currently, several national organizations, such as the Agency for Healthcare Research and Quality<sup>3</sup> and the National Council for Quality Assurance are involved in efforts to review and develop standards of practice for integrated behavioral health and related practices. Moreover, in 2007, by request from “the field” (e.g., federally qualified health centers, Veterans Health Administration, and national associations like the National Council for Community Behavioral Health), the Commission on Accreditation of Rehabilitation Facilities

---

<sup>3</sup> In 2008, the Agency for Healthcare Research and Quality published a report on the evidence base for the integration of mental health/substance abuse and primary care.

(CARF) released accreditation standards to guide the integration of primary care and behavioral health services. These standards, now part of the CARF Business Practice and General Behavioral Health program standards, address such requirements as: co-location, staffing, education on wellness and recovery, consent procedures, written procedures for communication and collaboration, and performance measurement indicators that include both medical and behavioral health care. Although these standards now exist, they are not yet widely adopted.

***There are many effective models and core practices for integrated care that are recognized by stakeholders.*** Over the past two decades, numerous practice and clinical models for integrated care have demonstrated effectiveness and been replicated in diverse clinical settings. Examples of widely recognized and cited models include: Strosahl’s Integrated Primary Care model (implemented in various systems and settings, including Kaiser Permanente, US Air Force, and FQHCs); the IMPACT model; Washtenaw Community Health Organization; Intermountain Healthcare; the DIAMOND project (“Depression Improvement Across Minnesota, Offering a New Direction,” a new model for treating depression in primary care under managed care); and the Cherokee model (offered through the Cherokee Health Systems through an organization that provides primary care and mental health services). Core practices frequently cited by field experts include: co-located teams, shared population and mission/scope, clinical system and administrative support (e.g., screening, unified care plans, defined team roles, shared records), organizational and financial system infrastructure, and continuous quality improvement and effectiveness measurement.

***Nationally a variety of education, training, and technical assistance resources are increasingly available, but penetration and adoption of these resources within the primary care and behavioral health workforce is low.*** Over the past decade, as the evidence supporting integrated behavioral health and the networks of organizations implementing models grows, the number of networks and “communities” sharing information through reports, websites, conferences, and trainings has gained momentum. Government agencies like the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration have developed technical assistance materials to aid in the implementation of integrated care. The National Council of Community Behavioral Health is operating a technical assistance center and the National Association of State Mental Health Program Directors<sup>4</sup> developed a technical assistance manual for state mental health authorities. Additionally, the Veterans Administration and two branches of the US Military (Navy and Air Force) have developed practice manuals for behavioral health in primary care. These educational and technical assistance resources and training efforts tend to address more of the program/model design and implementation issues, as well as clinical treatment models and techniques (e.g., motivational interviewing, brief therapy). However, these resources do not address a key challenge to the spread of integrated care – namely the lack of trained medical and behavioral health professionals ready to work in integrated settings.

---

<sup>4</sup> Integrating Behavioral Health into Primary Care Services: Opportunities and Challenges for State Mental Health Authorities.

***The majority of academic training programs for medical and behavioral health professionals do not adequately prepare graduates to work in integrated care settings.*** The educational curricula for medical and behavioral health providers are not in alignment with the needs of integrated behavioral health. Nationally, the majority of academic training programs for medical providers, mental health professionals, and social workers typically do not include specific education and training related to integrating primary care and behavioral health services, or how to work in integrated settings. While there are some academic training programs (e.g., Arizona State University, Loma Linda University) emerging, and professional associations (e.g., the American Psychological Association and the National Association of Social Workers) are advocating for training, sufficient training of the workforce is recognized by the field as a significant challenge in implementing integrated behavioral health programs.

### **C. Knowledge Base**

According to the Strong Field Framework, the strength of a field correlates to the credibility of the research and evidence supporting its goals and activities. Key questions to determine the strength and efficacy of the knowledge base include: How developed is the knowledge base? Are there experts who research the field? How engaged are experts and practitioners in on-going improvements? And How well is knowledge documented and disseminated?

***A strong knowledge base for integrated behavioral health treatment models exists for specific mental health conditions, but there is a knowledge gap for how best to address the diagnostic mix typical in most practice settings.*** The knowledge base for integrated behavioral health is well developed in terms of models and programs that demonstrate clinical effectiveness for specific behavioral health conditions, such as depression, anxiety, at-risk alcohol, and ADHD. However, in the “real world,” there are at least two challenges to implementing these condition-specific models: 1) the diagnostic mix presenting in most clinical settings (i.e., clients served in mental health or primary care settings present with various behavioral health problems, not just depression or alcohol, etc.); and 2) a lack of fidelity implementing the models tested and documented through research due to the need to make adaptations to work in a specific clinic setting.

***Variation in defining priority outcomes of integrated behavioral health affects documentation and dissemination of knowledge.*** There are several outcomes related to integration, including improved access, increased patient satisfaction, improved providers satisfaction, improved patient adherence/compliance with treatment regimens, improved clinical outcomes for patients, cost effectiveness, and offset of medical costs from the addition of behavioral health services. However, these outcomes are not reported consistently in the research literature and stakeholders vary regarding the types of outcomes that are considered important (e.g., advocates for equity in health care might be interested in improved access and patient satisfaction, while administrators might care about improvements in provider productivity, retention, and satisfaction). The literature tends to report primarily clinical outcomes and, to a lesser extent, cost-effectiveness findings. To make the case and advance the field of integration, a broader array of outcomes need to be reported and disseminated.

***A cross-disciplinary network of researchers and practitioners conduct research and continue to be engaged in advancing the evidence-base for integrated behavioral health care.*** The field of integrated behavioral health has and continues to evolve from a growing body of research, much of which is grounded in Wagner’s Chronic Care Model. This research has been supported over the years by public funders (e.g., NIH, NIMH, the Veterans Administration), foundations (e.g., the Robert Wood Johnson Foundation and the MacArthur Foundation), and health systems (e.g., Kaiser Permanente).

***Researchers and other stakeholders are producing high volumes of information on integrated behavioral health, yet it is unclear the extent to which this information is reaching primary care and behavioral health settings and practitioners.*** Increasingly, a number of peer reviewed journals are devoting space to disseminating integrated behavioral health research, including: Families, Systems and Health: The Journal of Collaborative Family Healthcare, The International Journal of Integrated Care, and The Journal of Clinical Psychology in Medical Settings. Additionally, professional associations and organizations like the National Council for Community Behavioral Health and Collaborative Family Healthcare Association disseminate information on integrated behavioral health through conferences, webinars, websites, newsletters, learning communities, and various means. For the broader field, there is little coordination across the range of dissemination points to convey a central message regarding the knowledge base of integrated behavioral health. Therefore, it is difficult to determine the extent to which the knowledge base is accessible to stakeholders in the broader health care field.

#### **D. Leadership & Grassroots Support**

Leadership and support from key constituencies are critical to building and sustaining a field. Key questions to gauge support of leaders and stakeholders include: Are there influential leaders and organizations working to advance the field? and Is there a broad base of support from key constituencies?

***The field of integrated behavioral health is advancing through the efforts of researchers, practitioners, professional associations, health plans, and government agencies. However, support from policymakers lags, especially related to advances in financing.***

The President’s New Freedom Commission on Mental Health in 2003 identified the need for better coordination between primary care and mental health care, and improved dissemination of evidence-based models to enhance the quality of care that occurs at the interface of general medicine and mental health. At the national level, prior to and in response to this report, several national associations, advocacy organizations (e.g., the National Council for Community Behavioral Health and the Carter Center), and government agencies (e.g., the Veterans Administration, the Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, Indian Health Services, and the US Department of Health and Human Services Assistant Secretary for Planning and Evaluation) are providing leadership and actively working to build and sustain the field of integrated behavioral health. In California, statewide entities like the California Institute for Mental Health, the California Primary Care Association, CalMEND, the Integrated Behavioral Health Project, and Kaiser Permanente are providing important leadership to advance integration in California. In addition, there are leaders in integration at the regional and county levels in California, including the Council of Community Clinics in

San Diego, Lake County Tribal Health Consortium, Indian Health in San Bernadino and Sonoma Counties, as well as counties like Alameda, San Mateo, and Shasta. Leadership at the national, state, and local levels continues to evolve.

The majority of the collaborative energy in the field focuses on policy and advocacy efforts to eliminate barriers (e.g., financing, workforce, delivery system design, data sharing, and information technology) that affect integrated behavioral health. However, legislative leadership is lacking to respond sufficiently to advance the field.

***A broad base of constituencies supports integrated behavioral health; however, integrated behavioral health is not always the primary concern of these leaders and organizations and therefore is not always the most pressing legislative issue.***

Competing identities and priorities of leaders and organizations affects the ability of the integrated behavioral health field to maintain a consistently committed broad base of support. It is difficult to maintain the momentum built around collaborative issues when multiple stakeholders are involved. Due to the cross-disciplinary interests supporting integrated behavioral health, it is unclear “who owns” the issue or “where the issue lives.” Advocacy for integrated behavioral health in the political arena is vulnerable to the special interests of each stakeholder organization that may have other priorities based on their membership/constituencies. There is no organization or individual that has taken long-term responsibility for exclusively advancing the field the integrated behavioral health.

## **E. Funding and Supporting Policy**

Funding and supporting policy are important ingredients for advancing a field. Key questions to assess the financing and policy environment include: Are funding streams sufficient and organized to support the field’s goal achievements? Is the policy environment supportive? and Is the field actively involved in helping to develop the policy environment?

***There are currently insufficient funding streams to support the advancement of the field of integrated behavioral health.*** Over the years, grant and special program funding from government agencies and foundations have supported research and pilot programs to develop and build the evidence base and critical mass of stakeholders in the field. However, reimbursement policy is currently not sufficient to support the advancement of the field. While short-term grant opportunities continue to exist, long term sustainable funding for integrated care will require more substantive blending and braiding of funding across the health and behavioral health care systems at the national, state, and local levels.

***Although national and state health care reform efforts are underway, integrated behavioral health is not a top priority on the health policy agenda.*** In California, an example of this lack of legislative support concerns the issue of same day billing that is raised in every forum where barriers to integrated care are discussed. CPCA and other stakeholders include this issue on their legislative agendas annually. However, to date, the California legislature fails to support it. National health reform efforts focus on increasing access to affordable health care coverage for the un- and under-insured, reforming health insurance policies and practices, and reducing health care costs. Integrated behavioral health, while consistent with these goals, is not identified as a specific strategy.

## F. Summary Assessment of the Status of the Integrated Behavioral Health Field

The following table summarizes our assessment of the field of integrated behavioral health, highlighting strengths and weaknesses, using the five components of the Strong Field Framework:

**Table 1: Current Status of the Integrated Behavioral Health Field**

	<b>Strengths</b>	<b>Weaknesses</b>
<b>Shared Identity</b>	<ul style="list-style-type: none"> <li>Field members are aligned regarding the goals of integrated care: to improve access to and quality of care, to treat individuals holistically, and to improve communication and coordination across service systems</li> </ul>	<ul style="list-style-type: none"> <li>Many individuals and organizations do not consider “integrated behavioral health” as their primary identity or purpose</li> <li>No shared vocabulary for the concept, process, or practice of integrating health and behavioral health care</li> <li>Field members do not agree on strategies for achieving integrated behavioral health goals; there is considerable variation in the clinical and financing strategies of integrated behavioral health</li> </ul>
<b>Standards of Practice</b>	<ul style="list-style-type: none"> <li>There are several evidence-based and promising practices in the field</li> <li>Codified standards of practice exist and are growing</li> <li>Practice and clinical models for integrated care have demonstrated effectiveness and are replicated in diverse clinical settings</li> <li>Education, training, and technical assistance resources are increasingly available to field members</li> </ul>	<ul style="list-style-type: none"> <li>Existing practice standards are not widely adopted</li> <li>Penetration of education, training, and technical assistance resources within the primary care and behavioral health workforce is low</li> <li>Academic training programs for medical and behavioral health professionals do not adequately prepare graduates to work in integrated care settings</li> </ul>
<b>Knowledge Base</b>	<ul style="list-style-type: none"> <li>A strong knowledge base for integrated behavioral health treatment models exists for specific mental health conditions</li> <li>A cross-disciplinary network of researchers and practitioners conduct research and continue to be engaged in advancing the evidence-base for integrated behavioral health care</li> <li>Researchers and other stakeholders are producing high volumes of information on integrated behavioral health</li> </ul>	<ul style="list-style-type: none"> <li>There is a knowledge gap for how best to address the diagnostic mix typical in most practice settings</li> <li>Variation in defining priority outcomes of integrated behavioral health affects documentation and dissemination of knowledge</li> <li>It is unclear the extent to which research and information on integration is reaching primary care and behavioral health settings and practitioners</li> </ul>
<b>Leadership and Grassroots Support</b>	<ul style="list-style-type: none"> <li>There are influential leaders in key segments of the field, e.g., researchers, practitioners, professional associations, health plans, and government agencies</li> <li>A broad base of constituencies supports integrated behavioral health</li> </ul>	<ul style="list-style-type: none"> <li>Support from policymakers lags, especially related to advances in financing</li> <li>Integrated behavioral health is not always a primary concern or pressing legislative issue for advocacy organizations</li> </ul>
<b>Funding and Supporting Policy</b>	<ul style="list-style-type: none"> <li>There are collaborative policy efforts underway in California to advance integrated behavioral health through the 1115 Waiver renewal</li> </ul>	<ul style="list-style-type: none"> <li>There are currently insufficient funding streams to support the advancement of the field of integrated behavioral health</li> <li>Integrated behavioral health is not a top priority on the health care agenda at the national level</li> </ul>

## IV. IBHP's Approach and Contribution to Building the Field of Integrated Behavioral Health

Over the course of the project, the Integrated Behavioral Health team implemented several strategies: 1) **grant making**; 2) building and supporting a **Learning Community**; and 3) **policy** and advocacy work. To build capacity to support the information and training needs of the Learning Community, IBHP also invested in **training and technical assistance**. In addition, the team invested time in cultivating and strengthening **partnerships and collaborations** to develop and advance the IBHP policy agenda.

In our analysis, the Strong Field Framework component of Shared Identity is considered an overarching and necessary condition for building a field. Without a shared identity, “individuals and organizations with similar motivations and goals may end up working in isolation or at cross-purposes.” (p. 4 Strong Field Framework) All of the IBHP strategies and activities aimed to build cohesion and promote the core value of enhancing access to care and improving outcomes for the safety net population.

The following section assesses how the core IBHP strategies and activities contributed to building and advancing the field of integrated behavioral health using the core components of the strong field framework.

### A. Grantmaking

The IBHP implemented grant-making in two phases. Phase 1 focused on funding clinics around California that already had developed and implemented integrated behavioral health services. Phase 2 expanded the pool of grantees to include clinics with a range of experience in integrated behavioral health.

**Phase I: The Vanguard.** Grantees funded during Phase I (14 month grants from March 2007 – May 2008) were invited to apply for participation in the IBHP. To identify the Phase 1 grantees, the IBHP team conducted site visits to FQHCs and community clinics around California that had a reputation for innovation in the area of integrated behavioral health. The goal was to identify and fund a core set of clinics and clinic consortia that represented “the state of the art” in integrated behavioral health in California to learn about effective models and practices that could be spread to other clinics in California. Grantees included small and large clinic systems and consortia, located in different geographic areas (Northern to Southern, urban and rural) and serving diverse populations. By design, the seven clinics and two consortia that received funding varied in terms of their integration strategies, clinical modalities and services, and composition of behavioral health staff (e.g., some sites have psychiatrists on site, while others do not).

**Phase II: Competitive Grants Representing the Continuum of Integration.** The Phase II grant-making strategy was competitive and yielded nearly 60 applicants, including clinics and consortia funded during Phase I. The goal of Phase II was to strategically fund special projects “to support and strengthen behavioral health integration efforts underway at clinics and consortia,” with the goal of identifying, elevating, and accelerating promising practices in integrated behavioral health throughout California.

Three types of grants were made in Phase II: 1) Mentor Grants; 2) Learning Grants; and 3) Innovative Project Grants. Six of the grantees funded during Phase I received Mentor Grants to support their roles as leaders within the Learning Community and consultants to the “Learner Clinics.” Clinics receiving Learning Grants were just starting efforts to integrate behavioral health into primary care and had limited experience and infrastructure in place to support (or sustain) a behavioral health program. The goal of offering Learning Grants was to impact the field by increasing the opportunity to spread the knowledge necessary to implement an IBH model to interested clinics with limited capacity.

Innovative Project Grants were awarded to 16 clinics and consortia (including the 6 Mentor grantees) to fund the implementation of special projects, including: 1) expanding intra-clinic collaboration between primary care and behavioral service providers; 2) Enhancing substance abuse treatment within the primary care setting; and 3) advancing the behavioral health data capacity in their clinics using i2i Tracks (integrated electronic health records).

### ***Contributions to the Field through IBHP Grantmaking***

Below we briefly highlight how IBHP’s grantmaking efforts contribute to building the field of integrated behavioral health:

#### ***Standards of Practice***

- Grantees funded under IBHP developed training modules and manuals to support the implementation of integrated behavioral health best practices in other clinic settings. Examples include pain management program curricula, an integrated behavioral health training module for general practice physicians, and a DVD/YouTube training video on the “warm hand off.”

#### ***Knowledge Base***

- In addition to grantmaking, IBHP funded an outcome data collection and analysis effort during Phase I. Grantees were required to collect data using the DUKE and the PHQ-9 to track clinical outcomes of patients receiving behavioral health services at the clinics. To support the grantees in collecting uniform data in Phase I, Gary Bess and Associates (GBA) provided technical assistance to each site. GBA analyzed and compiled baseline data in the aggregate and for each site to assess whether IBH patients improved relative to depression and anxiety, chronic disease and engagement. The intent of the site specific data collection and reports was to provide information and evidence to enable the clinics to track and improve their performance on key behavioral health outcome measures. In addition to patient-level data analysis, GBA developed summary reports of clinics’ overall level of integration and organizational cultural competence. Data results were also disseminated at several national conferences.

#### ***Leadership and Grassroots Support***

- IBHP made strategic grantmaking investments in community clinics seen as “vanguards” in the field of IBH to foster leadership opportunities for exemplary administrators and practitioners in

CA. IBHP provided vanguard sites with additional funding to serve as mentors to less experienced clinic and further expand their roles as leaders in the integration field.

### ***Funding and Supporting Policy***

- IBHP grantmaking efforts provide an organized funding stream to targeted community health clinics to accelerate and enhance integrated behavioral health care services for the safety net population.
- While the IBHP grant funding is not intended for use as “start-up” funds, the financial support did encourage experienced clinics to deepen their integration efforts and document model practices.

### **B. Learning Community**

IBHP is using various strategies to build and support the learning community, including: 1) development of a website ([www.ibhp.org](http://www.ibhp.org)); 2) monthly webcasts in collaboration with CPCA and CIMH; 3) learning community conference calls; and 4) in-person grantee convenings. The IBHP Phase 2 RFP introduced formal mentoring as a new strategy to build and support the learning community. The goals of the mentoring component are to build networks and relationships between providers, coordinate and support on-going communication, and share strategies to improve the quality of integrated programs.

#### ***Contributions to the Field through IBHP’s Development of a Learning Community***

Below we briefly highlight how IBHP’s activities associated with the Learning Community (website, conference calls, convenings and formal mentoring) contribute to building the field of integrated behavioral health.

#### ***Knowledge Base***

- The IBHP website adds significantly to the knowledge base of integrated behavioral health as it serves as a dissemination portal for implementation resources, training materials and conference updates, IBH manuals developed by vanguard clinics, and research findings that provide evidence of the impact and effectiveness of integrated behavioral health.
- Formalizing the concept of a Learning Community and compensating both mentor and learner clinics for their participation demonstrate IBHP’s commitment to knowledge transfer and maximizing learning opportunities.
- In-person conferences and monthly webinars provided grantees opportunities to share knowledge, receive technical assistance and resources from other state/national experts in the field, and discuss best practice strategies (e.g., improving client engagement/reducing no-show rates, improving medical provider buy-in, enhancing communication and collaboration, financing IBH, and funding case management).

### ***Leadership and Grassroots Support***

- The Learning Community provided mentor clinics with a forum to showcase knowledge and expertise and leaders in the field of integrated behavioral health. Mentor sites developed presentations for conference convenings and monthly webinars based on their implementation accomplishments and lessons learned. Many IBHP grantee clinics have developed specific expertise (integrating substance abuse treatment into primary care, implementing pain management groups/protocols, addressing metabolic syndrome, etc.) that their leadership and technical assistance has extended well beyond the IBHP grantee community to community clinics across California.

### **C. Training and Technical Assistance**

IBHP team representatives participate on several committees, present at state and national conferences and, as field experts on integrated care, respond to technical assistance inquiries from providers and administrators across the primary care and mental health fields.

***IBHP Website.*** IBHP developed a website ([www.ibhp.org](http://www.ibhp.org)) to serve as a comprehensive resource and knowledge dissemination tool for the field. The website serves as a virtual library for members of “the field” operating treatment programs that integrate behavioral and medical services.

***Primary Care and County Mental Health Collaboration Tool-Kit.*** IBHP recently released "Partners in Health: Primary Care / County Mental Health Tool Kit" designed to help primary care clinics and government mental health agencies develop collaborative relationships that foster greater service integration for safety net populations. The Tool Kit provides practical, operational advice, forms, strategies and prototypes for integrating mental and physical services. Though the focus is on California counties, much of the Tool Kit information can be generalized to other locales. Included are sample formal agreements and contracts reached between primary care agencies and county mental health agencies; advice from those who have established these working relationships; checklists for MOU and contract content; issues to consider when brokering agreements; and mutual role descriptions.

***Webcasts and Training Activities.*** In 2008, IBHP partnered with CPCA to sponsor a series of webcast seminars focusing on various aspects of integrated care and featuring Kirk Strosahl, Jurgen Unutzer and several other prominent local and national authorities. IBHP was largely responsible for developing the content and securing the expert speakers for the monthly webcasts and marketing this resource to the IBHP grantees. In 2009, IBHP agreed to share the full webcast training series with CIMH to be disseminated to their members on a monthly basis.

In addition, IBHP, in conjunction with CIMH and the California Mental Health Directors Association (CMHDA) sponsored a series of three webcasts to highlight three county examples of collaboration between County DMH and primary care clinics. The three counties whose integration models were featured included: Shasta, San Diego and San Mateo. IBHP moderated all three webcast seminars.

***Responsive TA to state/national constituencies:*** IBHP continues to provide information and responses to inquiries from organizations across the country that have heard of the Initiative and want more information. These organizations include a number of foundations (e.g., Virginia Health Care Foundation; Flinn Foundation of Michigan; Illinois Children’s Foundation; Atlanta Health Foundation, MaineHealth Foundation), clinic administrators and practitioners, government agencies and advocacy organizations. IBHP participates in a national Integrated Behavioral Health Care listserv and often responds to TA question related to reimbursement for IBH, cost-effectiveness data, confidentiality and clinical interventions. In addition, IBHP has responded to inquiries from the Diabetes Prevention Project regarding collaboration on software technology to help patients in primary care clinics self-manage their diabetes; the US Department of Defense TA related to IBH staffing ratios; and Community Health Partnership wanting resources and TA to implement the IMPACT model.

***Clinic specific data analysis and technical assistance.*** During Phase I, the Gary Bess and Associates (GBA) team developed and assisted sites in the collection and analysis of uniform data on patient level outcomes to assess whether IBH patients improved relative to depression and anxiety, chronic disease and engagement. These site specific data collection and reports provided information and evidence to enable the clinics to track and improve their performance on key behavioral health outcome measures. GBA also offered TA and data analysis support to grantees’ Phase II Innovative projects. GBA analyzed a range of grantee-specific data, including: provider/patient satisfaction, no-show rates, provider attitudes on addiction disorder and knowledge of effective addiction treatment interventions.

### ***Contributions to the Field through IBHP’s Training and Technical Assistance***

Below we briefly highlight how IBHP’s training and technical assistance activities and achievements contribute to field building:

#### ***Standards of Practice***

- IBHP contributes to “Standards of Practice” through ongoing documentation of demonstration models of integrated behavioral health. IBHP also provides training and professional development opportunities to build and support the field of practitioners engaged in IBH. Through development of the Primary Care/County Mental Health Collaboration Tool Kit, and other IBH implementation manuals developed by IBHP grantees, IBHP is contributing to the formalization of IBH clinical practices and partnership development.
- IBHP has played a critical role in the development and provision of ongoing training (and cross-training) for primary care and mental health providers involved in integration. IBHP developed a 12 module webcast training series that was originally disseminated to CPCA clinic members. This webcast curriculum has been shared with CIMH in its entirety so that the mental health clinic membership can access the same training content as their primary care counterparts. Working with the same training content promotes consistency in approach and understanding of key IBH concepts.

## **Knowledge Base**

- The website, launched in 2008, has become a primary resource for the field of integrated behavioral health, with links to the IBHP website featured on the NCCBH website and Kirk Strosahl's website under "resources."
- IBHP as a team, has served as a dissemination tool through their ongoing TA to state and national inquiries on strategies for successful implementation of IBH.
- TA related to data collection, outcome measurement and application of data analysis helps strengthen the field by providing evidence of effective interventions and clinical/organizational practices. Documentation of successful clinic practices/models adds to the knowledge base of field-generated evidence supporting integration.

## **D. Partnership and Collaboration**

The IBHP team developed and strengthened their partnerships and collaborations with several local, state and national stakeholder organizations in an effort to develop and facilitate their policy and advocacy goals. This strategy of working with and through partners, rather than trying to advance an agenda in isolation, is a critical ingredient in the success and achievements of the team and their work. The IBHP team leveraged successful partnerships at the local, state and national levels to achieve their goals in advancing the field. Outcomes of these collaborations include joint participation in strategic policy initiatives, training and technical assistance efforts, conference planning and developing presentations for state and national audiences. Key organizational partners at the local, state, and national levels established by the IBHP team included:

### **Local IBHP Partners**

**Community Clinic Association of Los Angeles County (CCALAC)** serves and represents the interests of its free and community clinic Members. The 42 Members operate over 120 sites in L.A. County and they provide quality primary care (including medical, dental and mental health services) for the uninsured and medically underserved populations. IBHP team members have been working with CCALAC to explore opportunities for expanding behavioral health integration.

**Los Angeles Health Action (LAHA):** LA Health Action's overarching goal is to improve the health of low-income Los Angeles County communities through policy advocacy and strategic alliances. In response to LAHA's interests in developing an LA County approach for advancing integrated behavioral health care, the IBHP team conducted site visits at three clinics in South Central LA to assess readiness integration activities and provided feedback in a report to LAHA and TCE LA Regional Office. This resulted in the LA office providing three Community First grants to South LA clinics that are also IBHP grantees. IBHP also collaborated with LAHA on a year-long effort to integrate mental health services in school based health centers in Los Angeles County.

**Los Angeles Unified School District (LAUSD):** IBHP works with the Office of School Based Health to advance integration of mental health services into local school based health centers across all five districts in the county.

**Alameda County Health and Behavioral Health Department.** IBHP works closely with Alameda County Health officials to bring expertise and guidance to LAHA, LAUSD, and CCALAC for implementation of the School-Based Health Centers (SBHCs). Through their relationship with Alameda County, IBHP was able to facilitate a site visit to Alameda County's SBHCs for LAC CEO

**Los Angeles County Department of Mental Health.** IBHP works collaboratively on a routine basis to provide technical assistance and guidance on MHSa funded activities related to Prevention and Early Intervention (PEI) and Innovations grant proposals for LA County. IBHP also advises LA DMH on integrating primary care services into community mental health sites.

### **State IBHP Partners**

**California Primary Care Association (CPCA)** is the primary care association representing more than 600 not-for-profit community clinics and health centers (CCHCs) throughout the State. Licensed by the State, these centers serve California's most medically underserved communities to provide access to health, mental health, dental, prevention and social support services. Encouraged by the Bureau of Primary Health Care to add and integrate mental health and substance abuse services, many have dedicated resources to implement an integrated model

IBHP continues to work very closely with CPCA to assist in their efforts to address the training, financing and policy priorities associated with advancing the integrated care agenda. IBHP and CPCA hold monthly calls to maintain ongoing communication about policy priorities put forward by their membership, including: 1) the issue of "same day visit" reimbursement and new strategies for approaching this issue, given the recent failure to pass this legislation; 2) the issue of marriage and family therapists not being able to bill in primary care settings; and 3) the issue of restricting the number of mental health visits eligible for reimbursement in FQHCs. They also engage in ongoing discussions regarding the content of webinar trainings offered to CPCA member clinics and IBHP grantees. In addition, IBHP participates on CPCA's Standardized Measurement Group to develop a common set of health/behavioral health outcomes for primary care clinics to collect and track.

**California Institute for Mental Health (CIMH)** was founded by the California Mental Health Directors Association as its policy and program development arm. Its mission is to "promote excellence in mental health services through training, technical assistance, research and policy development." CIMH and IBHP have co-sponsored informational webcasts about integrated behavioral care and also partnered to host a seminar familiarizing primary care clinics with mental health concepts and operations. IBHP also worked with CIMH in 2008 to plan a conference about integrated care, attended by both primary care and mental health professionals. Strong partnership between CIMH and IBHP led to the development of the Integration Policy Initiative and opportunities for collaboration around the 1115 Waiver, discussed in the following section under policy efforts.

**County Medical Services Program (CMSP).** CMSP provides health coverage for low-income, indigent adults in thirty-four, primarily rural California counties. In 2007, the CMSP launched a three year pilot program to test the effectiveness of primary care-driven, enhanced mental health and substance abuse treatment services for indigent adults. Several California primary care clinics have received grants as a

part of this pilot in 14 counties, including several IBHP Phase II grantees. IBHP and CMSP have instituted regular check-in calls on the implementation of their behavioral health pilot, and will be sharing results/outcomes as the CMSP pilot and IBHP Phase II projects progress. Leadership from the CMSP project participated in the IBHP grantee convening in May 2008 and there was a joint learning convening for CMSP/IBHP grantees in Summer of 2009. CMSP grantees are now included in the roster of recipients to receive notices for all the CPCA webcasts.

***Social Justice Advisory Committee (CMHDA).*** The Social Justice Advisory Committee acts at the request and direction of the Governing Board of the California Mental Health Director's Association, and advises the Governing Board regarding social justice, mental health policy and advocacy issues related to strategies for preserving funding for vulnerable populations. This committee is the newest established as a permanent advisory committee by the CMHDA, and IBHP participates on this committee to represent the policy issues faced by a growing number of community clinics that provide mental health services.

***State Department of Mental Health.*** IBHP participates on the Stigma and Discrimination Reduction Advisory Committee to share information about how IBH services in primary care increase access to mental health services for those who would not ordinarily seek services in traditional mental health settings due to stigma.

***CalMEND.*** IBHP participates on a Planning Group of the CalMEND Pilot-Collaborative to Integrate Primary Care and Mental Health Services (CPCI). The goal of the advisory group is to develop a knowledge base and a common understanding of two things: the state of the art in integrated service delivery for adults with SMI and co-occurring chronic medical disorders and the recommended approach to assist partnering primary care and mental health organizations achieve improved service delivery. The general commitment of a Planning Group member include planning for the pilot-collaborative, participating in Learning Sessions and the sharing of information using listserv or web-based tools.

***Tides Foundation –Community Clinics Initiative.*** IBHP continues to strengthen and formalize their partnership with the Tides Foundation and CCI to create a strategic plan for advancing the work of IBHP after the project sunsets. CCI is interested in applying lessons learned through IBHP implementation to their own initiatives aimed at expanding the capacity of community health centers.

***The California Endowment:*** TCE is an ongoing partner of IBHP and continues to support their project goals and leverage learnings from IBHP for other TCE funded initiatives. IBHP is developing an IBH library of resources for a new TCE website currently under development.

## **National IBHP Partners**

***National Council for Community Behavioral Health (NCCBH),*** represents 1,300 organizations providing treatment and rehabilitation services to people with mental illness and addiction disorders. A leader in the integration movement, it has been collaborating with other national organizations to champion legislation that would advance care integration.

**Collaborative Family Healthcare Association (CFHA)** is a nonprofit membership organization devoted to integrating health and mental health services. It seeks to strengthen this approach by creating a knowledge base of collaborative family healthcare, by advocating for it locally and nationally, and by developing partnerships linking education, research and service delivery in this area. Its national annual conferences provide training tracks covering the latest progress of federal, state and local efforts to establish successfully integrated programs and overcome policy and financing issues. The IBHP team members have developed a relationship with CFHA through participation at annual conferences, bringing the work of the IBHP to a broader stage. Throughout 2009, the IBHP participated in the CFHA Conference Planning Committee to identify plenary speakers, develop content and presentation tracks for the November 2009 CFHA conference held in San Diego, CA. Select IBPH grantees (CCC of San Diego, Family Health Care Centers of San Diego) will have an opportunity to showcase the strengths of their programs and present integration best practices. The IBHP team is assisting with some of the conference planning activities.

**Hogg Foundation:** IBHP maintains regular dialogue with the Hogg Foundation because of a shared vision for advancing integrated behavioral health in community clinics. The Hogg Foundation currently funds a IBH pilot program initiative in Texas and has used IBHP as a resource specifically around development of a Learning Community. IBHP, Hogg Foundation, Maine Health and Foundation for a Health Kentucky participated in a joint-panel presentation at the national CFHA Conference highlighting the experiences of implementing large scale, statewide integration efforts.

### ***Contributions to the Field through IBHP's Partnerships and Collaborations***

Below we briefly highlight how IBHP's numerous organizational partnerships contribute to building the field of integrated behavioral health.

#### ***Leadership and Grassroots Support***

- To build momentum and support for advancing integrated behavioral health advocacy and policy, IBHP identified exemplary organizations at the local, state and national level with which to collaborate. IBHP has proactively sought strategic partnerships with stakeholder groups that share a similar vision for IBH (CPCA, CIMH, CMSP, CFHA, NCCBH, and Hogg Foundation).
- Because of their neutral voice and expertise in the field, IBHP is often sought out by other organizations for their leadership and success in networking and advancing policy and systems change initiatives (LAC DMH, LAHA, CCALAC, LACUSD, CalMEND, state DMH, and CMHDA's Social Justice Advisory Committee).

#### ***Funding and Supporting Policy***

- The primary goal of creating strong partnerships and collaborations is to create a policy environment that supports and encourages model practices. IBHP is clear that advancing the field of integration, and achieving policy and systems change, is not possible without strong collaborations across the primary care, mental health, and substance use fields. The field of integration is comprised of these other primary fields, making collaboration a requisite for developing a policy agenda.

- Through their partnership with The Tides Foundation, IBHP has successfully leveraged funding for policy development activities, training development and dissemination, conference planning and continued grantmaking.

## **E. Policy Activities**

The IBHP team engages in a variety of policy and systems change activities at the national, state and local levels to promote and advance behavioral health service integration into primary care settings. The following section documents key areas of IBHP's policy work. Because IBHP serves as a resource to the field and does not endorse any single integration model of care, they have maintained neutral ground and attracted a broad array of stakeholder groups in their effort to change policy and transform systems of care. IBHP's policy and advocacy efforts activities include the following:

***Integrated Behavioral Health in LA County School-Based Health Centers:*** Through partnership and collaboration with LAHA, LAUSD, CCALAC and the LAC Board of Supervisors, IBHP drafted a vision for SBHC Wellness Centers that integrate behavioral health services. IBHP team and LAC partners developed a motion to establish IBH in school based clinics in each of the five Districts in the County. IBHP testified at Board hearings, and ultimately the Board voted in favor 5-0. IBHP is tasked with providing technical assistance to the County in developing the SBHC model and drafting standards and guidance for implementation. IBHP continues to work closely with LAHA, LAUSD and CCALAC on next steps for implementation.

***1115 Waiver Renewal:*** IBHP currently participates on a Behavioral Health Technical Workgroup for the 1115 Waiver Renewal process for the Department of Health Care Services (DHCS). IBHP has engaged in multiple information dissemination, legislator education and policy briefing activities in association with the IPI Project, 1115 Waiver opportunities and the promotion of primary care and behavioral health integration. In an effort to move IBH to the policy agenda, the IBHP team has consulted with the Center for Health Care Strategies, the CA Association of Public Hospitals, CA Public Hospital Safety Net Institute, Kaiser Permanente, County Alcohol and Drug Program Administrators Association of CA (CADPAAC), the Insure the Uninsured Project (ITUP), David Maxwell-Jolly at DHCS, and Steve Mayberg at the state Department of Mental Health, in addition to ongoing collaboration with CIMH and CPCA.

***Primary Care, Mental Health and Substance Use Integration Policy Initiative (IPI):*** IBHP has strong collaborative partnerships with both the CA Primary Care Association (CPCA) and the CA Institute of Mental Health (CIMH), and these relationships have been formalized through collaborative work on other project initiatives aimed at moving integrated care forward on California's health care agenda. As a follow-up to the February 2008 CIMH policy conference, IBHP began working with CIMH as a funding partner and as members of the Steering Committee to plan the California Primary Care, Mental Health, and Substance Use Integration Policy Initiative (IPI). IPI is a collaborative project, facilitated by Barbara Mauer and lead by the California Institute of Mental Health (CIMH), the California Primary Care Association (CPCA), and the Integrated Behavioral Health Project (IBHP). IPI is funded by The California Endowment with additional funding provided by IBHP. Central to this Initiative is the convening of an Advisory Group composed of leaders in behavioral health and primary care at the state and local levels,

professional associations, consumers, and others with knowledge that can help prioritize a policy agenda for integrated behavioral health in California.

The Integration Policy Initiative's (IPI) recently published report, California Primary Care, Mental Health and Substance Abuse Initiative, explores models of integrated care throughout the State and makes recommendations for service delivery, financing, policy and regulations and outcome measurement. It also provides a suggested continuum for the health, mental health and substance use care of the safety net mental health population and develops solutions to address specific barriers that could affect the advancement of integrated behavioral health policy.

***Mental Health Services Act (MHSA)***, also known as Proposition 63, was passed in November 2004 by California voters. MHSA is a statewide initiative taxing the state's highest income earners to exclusively fund specified mental health services. The significant funding stream it created along with its emphasis on new approaches has encouraged the transformation of mental health services in California and has fueled the integration of health and behavioral care in the state. County mental health departments are funding and forging partnerships with community agencies, including primary care clinics, to enhance behavioral care services.

The IBHP team has been engaging throughout the state in discussions with clinics and mental health departments on the implementation of MHSA. The IBHP Project Director participates in the local LAC/DMH planning by serving as a delegate on the PE&I Work Group. More recently, IBHP has provided technical assistance and guidance to LAC/DMH on planning around the Innovations component of MHSA. In general, the IBHP continues to work on how the MHSA implementation affects the IBHP integration policy agenda.

***Los Angeles County Department of Mental Health:*** IBHP provides assistance to DMH in developing integrated behavioral health models within community mental health sites. IBHP has assisted in drafting a motion for the Board of Supervisors and developing the IBH model guidelines for the RFP being issued by DMH. IBHP was instrumental in drafting the template for the RFP and will also participate in the analysis of future grant proposals.

### ***Contributions to the Field of IBHP's Policy Activities***

Below we briefly highlight how IBHP's policy and advocacy activities contribute to building the field of integrated behavioral health.

#### ***Leadership and Grassroots Support***

- By definition, the collaborative policy and advocacy activities of IBHP are building grassroots support for change. The vision statement of the Integration Policy Initiative is "Overall health and wellness is embraced as a shared community responsibility." This vision grew out of recognition that service silos and fragmentation do not lead to improved access to care or positive health outcomes. Systems and policy change goals of IBHP have harnessed grass roots support and leadership of multiple organizations with a shared commitment and investment in sustainable change.

- IBHP has occupied a key leadership role in LA County to accelerate the integration of primary care and behavioral health services – in a variety of settings, including school-based health centers, health clinics in South LA, and within mental health centers. Their leadership and expertise has facilitated program and policy change supported by the LAC Board of Supervisors, DMH, LAUSD, and CCLAC.

***Funding and Supporting Policy***

- One of IBHP’s core strategies includes advancing a policy and advocacy agenda to affect systems changes “in the trenches” and at the state level. Therefore, the work of IBHP is actively involved in developing the policy environment in a manner that supports and encourages expansion of integrated behavioral health by eliminating financing , workforce and IT barriers and promoting a change strategy focused on enhanced access, reducing stigma and improving client outcomes.
- IBHP continues to elevate the implementation experiences (successes and challenges)of community health centers for philanthropic audiences to promote additional funding of model programs that serve as learning laboratories at the local level for the broader field of integrated behavioral health.

**F. Summary of Field Contributions**

The following table (Table 2) summarizes how the IBHP activities contribute to building the field of integrated behavioral health based on the Strong Field Framework components. Overall, IBHP’s activities targeted all the core components associated with field building. The greatest level of activity and contribution occurred in the area of “Leadership and Grassroots Support.” This is consistent with and a necessary condition for IBHP’s goal to build capacity for community health clinics to provide integrated behavioral health services and to elevate integration on the policy agenda in California. The area with the least amount of activity by the IBHP team was “Standards of Practice.” This is not surprising since IBHP intentionally did not endorse any specific model of care, recognizing that the local context and capacity of the health care delivery system will influence the relative effectiveness of any given model.

**Table 2: Summary of IBHP Contributions to the Integrated Behavioral Health Field**

IBHP Activity	Strong Field Components Shared Identity			
	Standards of Practice	Knowledge Base	Leadership and Grassroots Support	Funding and Supporting Policy
Grantmaking	X	X	X	X
Learning Community		X	X	
Training & Technical Assistance	X	X		
Partnership & Collaboration			X	X
Policy & Advocacy			X	X

## V. Summary and Conclusion

The analysis presented in this report indicates that there is a field of integrated behavioral health. Stakeholders in the field share common goals to: improve access to and quality of care, treat individuals holistically, and improve communication and coordination across the medical and behavioral health service systems. There is a growing body of evidence supporting the field of integrated behavioral health, including evidence-based clinical interventions, codified practice standards, and resources and training materials to support implementation. The field has a broad base of support and a growing number of leaders from advocacy organizations, professional and trade associations, medical and behavioral health professions, and the research community dedicated to advancing the field of integrated care.

However, there are several weaknesses that need to be addressed for the field of integrated behavioral health to reach full-scale implementation and effectiveness. Cohesiveness of the field is affected by the sheer number of stakeholders involved, most of whom do not see integrated behavioral health care as their primary identity or purpose. This varying level of commitment and engagement can lead to inertia at times, especially when the agenda for change lacks clarity and consensus across all stakeholders. In addition, although the field is increasingly rich with research evidence and training resources, effective dissemination and adoption across medicine and behavioral health systems and providers is extremely variable, leading to inconsistencies in implementation. Further challenges to building the field include an ill-prepared workforce, limited support at the policy level, and insufficient funding streams to support long term integration efforts.

By focusing resources to enhance the capacity of community clinics serving the safety net population, IBHP has contributed to building the field of integrated behavioral health in a more targeted arena. Their contributions to the field include:

- 1) Investing in vanguard clinics to promote their leadership and demonstrate their role as a vital health and behavioral health service provider in communities;
- 2) Establishing a learning community committed to knowledge transfer and dissemination through in-person conferences, monthly trainings, technical assistance from state and national experts;
- 3) Serving as a dissemination portal for implementation resources, training materials, and research findings that provide evidence of the impact and effectiveness of integrated behavioral health; and
- 4) Developing strong partnerships and collaborations to create a policy environment that supports and encourages expansion of integrated behavioral health by eliminating financing, IT, and workforce barriers, and promoting a change strategy focused on enhanced access, stigma reduction, and improved client outcomes.

A major factor leading to IBHP's success in advocating for the advancement of integrated behavioral health is that this was their core mission and primary identity. As such, the team served as "nimble advocates" because of their independence from the priorities and agendas of stakeholder organizations affiliated with specific delivery systems. Coupled with their considerable vision, expertise, and commitment to integrated behavioral health, this independence allowed the team to elevate to a unique position of thought leadership to define and promote the field.