Final Grantee Report

ADVANCING COLORADO'S MENTAL HEALTH CARE

December 2011

CARING FOR COLORADO
FOUNDATION

The Colorado Health Foundation™

THE
COLORADO
TRUST

THE DENVER FOUNDATION

TriWest

Heartland Network
For Social Research

Erin Hall, M.S.
Andrew Keller, Ph.D.

Anita Saranga Coen, M.S.W., L.C.S.W.
Jean Demmler, Ph.D.

Thank you to the staff of each grantee site for their assistance in the evaluation process:

El Paso County Co-occurring Disorders Collaborative
Resource Advocacy Program

Health District of Larimer County
Creating Integrated Services for People
with Co-occurring Disorders

Mesa County Consortium on Health
Expanding the Circle in Mesa County

Summit County Collaborative
Summit Community Care Clinic & Community
Connections Program

Denver Public Schools
Integration of Schools and
Mental Health Systems Project

Prowers County Behavioral Health Integration Project
The Whell Clinic, Larmar High School

Table of Contents

THE MAIN OBJECTIVE
OF THE ACMHC PROJECT
WAS TO IMPROVE
THE INTEGRATION
AND COORDINATION
OF MENTAL HEALTH
SERVICES FOR ADULTS
WITH SERIOUS
MENTAL ILLNESS
AND CHILDREN WITH
SERIOUS EMOTIONAL
DISTURBANCE.

Executive Summary

The 2003 report *The Status of Mental Health Care in Colorado*[1] brought together for the first time information about Colorado's many overlapping and fragmented systems for providing mental health services.

In response to this, four foundations – Caring for Colorado Foundation, The Colorado Health Foundation, The Colorado Trust and The Denver Foundation – created *Advancing Colorado's Mental Health Care (ACMHC)*. ACMHC was a five-year, $4.25 million project providing joint support to community collaboratives to bring together health care providers, human services agencies, and others to integrate mental health care. This project funded six grantees:

1. Two projects integrating mental health and substance use disorder (SUD) services, one in Larimer County (Fort Collins), and one in El Paso County (Colorado Springs);

2. Two projects integrating mental health and primary care services, one in Mesa County (Grand Junction), and one in Summit County; and

3. Two projects integrating mental health services within school settings, one with Denver Public Schools and one in Prowers County.[2]

The main objective of the ACMHC project was to *improve the integration and coordination of mental health services for adults with serious mental illness and children with serious emotional disturbance (SED)*. Each grantee received funding for a year of implementation planning, initial implementation by year two, and achievement of sustainability by year five. TriWest Group served as Project Coordinator, facilitating communication, reporting and accountability; supporting grantees in their development and implementation

---

1   TriWest Group. (2003). The Status of Mental Health Care in Colorado. Mental Health Funders Collaborative: Denver, Colo. See http://www.coloradotrust.org/attachments/0000/2200/MHCCfinalreport.pdf to view the report.

2   Two grantees (Prowers, Summit) also implemented coordination of multi-agency support for children/families.

activities; identifying additional technical assistance (TA) needs and procuring that assistance using funding set aside for this purpose. The Heartland Network for Social Research conducted an independent evaluation to address the question of potential improvement of integration of mental health system components, and to identify barriers and facilitators towards increased integration. Results from that evaluation have been incorporated into this final evaluation report.

ACMHC investment in each community. The project took a strategic approach, establishing multi-year local system change processes with relatively modest sums (approximately $100,000 a year per community, plus an additional $10,000 for TA), to fund a coordinator and related infrastructure to leverage broader system change. In comparison, Colorado was estimated to have spent $1 billion in 2010 on behavioral health care,[3] so the ACMHC investment on an annual basis ($850,000 per year) amounts to less than one-tenth of one percent of annual behavioral health spending in the state.

Implementation of evidence-based practices. Each of the grantees implemented evidence-based practices (EBPs) tailored to the communities served, and all but one were sustained.[4] Across grantees, the estimated value of the sustained, enhanced services on an annual basis is $11.3 million, a single year of value worth between two and three times the overall five-year cost of the grant program.

People served. The ACMHC project is estimated to have improved or expanded services that reached more than 18,000 people over the course of the grant with a per person cost of $181.

Progress on promoting integration. All of the project sites demonstrated more integration at the end of the grant than at its beginning. The independent evaluation by Heartland Network for Social Research[5] focused on the systemic level of services integration. System integration results were rated on five levels from no integration to full integration (Level 5). All grantees achieved at least a basic level of collaboration (Level 2). Two-thirds of grantees achieved some ***services integration*** at the highest level (Level 5). Services integration at Level 5 was achieved in each of the major areas of integration by at least one grantee (mental health/SUD, primary care/mental health, school-based mental health).

Involvement of people receiving services and their families. Grantees involved people receiving a wide range of services. Those with greater involvement tended to experience more breadth and depth of system change. Most grantees observed that employing peers (both individuals served and their families) to deliver services, as well as involving peers more broadly in a variety of roles (advocacy, administration, and evaluation, among others) was underdeveloped, and should be leveraged further in the future.

Barriers encountered, responses and lessons learned. The major barriers encountered related to: (1) separate policy oversight and funding streams for mental health, SUD and primary care, (2) restrictive fee-for-service funding categories that impeded coordination and delivery of needed supports, and (3) differential rules for information sharing. Many of the biggest barriers were related to policy and funding at the state and federal level that were not amenable to change through a local initiative. The following factors helped grantees address these barriers: (1) the collaborative process developed by the participating agencies, (2) flexible TA funding over the entire grant period, (3) targeted TA involving guidance from experts and organizations with past experience regarding such matters, and (4) a project coordinator with both content knowledge in the areas of focus and skills in facilitating cross-agency collaboration. In terms of specific TA, the single most endorsed approach across grantees and integration models was sending representatives to national best practice forums.

---

3   When referencing this report, please use the following citation: TriWest Group. (2011). The Status of Behavioral Health Care in Colorado – 2011 Update. Advancing Colorado's Mental Health Care: Caring for Colorado Foundation, The Colorado Health Foundation, The Colorado Trust, and The Denver Foundation: Denver, CO.

4   El Paso and Larimer implemented integrated mental health/SUD services (Motivational Interviewing in El Paso, and CCISC and IDDT in Larimer); Mesa and Summit implemented integrated mental health/primary care services (Collaborative Care); DPS and Prowers implemented integrated mental health and school services (IDS in Denver and a school-based health clinic in Prowers); and Prowers and Summit implemented integrated coordination of care for multi-agency involved children and families (community resource coordination teams). All but one of those initiatives were sustained (Prowers' community resource coordination team).

5   Demmler, J., and Coen, AS. (June 2011). Advancing Colorado's Mental Health Care Project: Integration of Mental Health Services.

Lessons Learned Across Grantees for Key Stakeholders/Audiences

Lessons for Community Agencies Pursuing Integration

- Integration within large bureaucratic agencies may require program integration as an interim step.

- Proactively anticipating/addressing organizational and cross-agency barriers promotes success.

- Increased integration is most achievable if the effort is focused in a particular area.

- Specific training of staff regarding the concept of integration, its attributes and benefits, is key.

- Explicit cross-training of staff from the services/systems to be integrated promotes integration.

- Positive incentives (such as access to state-of-the-art training) promote participation in integration.

- Stimulants towards integration from more than one service sector or funder promote integration.

Lessons for Funding Agencies

- Integration is possible in all areas attempted: mental health/SUD, mental health/primary care, and school-based mental health care.

- Define the boundaries of integration and included services (system components) beforehand.

- A point person whose primary function is to promote systems change is essential.

- Targeted TA funds can help encourage specific training across agencies and collaboration activities.

- Access to TA is critical from experts in the health areas being integrated, as is commitment to flexible, sustained TA over time and opportunities for cross-grantee learning.

- Until reimbursement for health care better supports integrated care, agencies must seek other funding sources (braided funds, grants, uncompensated care) to pay for some key integrated services.

Lessons for Policy Makers

- Reimbursements for health care must change to better support integrated care.

- Policies for critical human services (e.g., public housing) must change to support integrated care.

- State and federal policies on funding and information sharing must change to support integration.

Lessons for Future Grant Making

- Do it the same way again: a multi-year funding commitment, flexibility to adapt funding and TA over time, and use of a highly competent project coordinator.

- Focus efforts up front by clearly defining the services and using an incremental, stepwise approach.

- Require a full-time project director throughout the entire grant period (or, at least, through year four).

- Continue funder collaboration to "inspire" grantee collaboration and sensitize funders to challenges.

- New initiatives are needed to address state-level funding barriers.

DEVELOP PERSON-CENTERED SYSTEMS OF CARE THAT BUILD ON THE EXISTING STRENGTHS OF EACH PERSON SERVED, AND ACTIVELY INVOLVE EACH INDIVIDUAL AND FAMILY IN MAKING DECISIONS FOR THEIR CARE.

Main Report

INTRODUCTION

Background and Project Design

In 2002, eight Colorado grantmaking foundations[6] formed a collaborative to study mental health needs in the state. The resulting 2003 report – *The Status of Mental Health Care in Colorado*[7] – brought together for the first time information about Colorado's many overlapping and fragmented systems for providing mental health services. In response to the 2003 Status Report, four foundations – Caring for Colorado Foundation, The Colorado Health Foundation, The Colorado Trust and The Denver Foundation (referred to as the Funding Partners) – created Advancing Colorado's Mental Health Care (ACMHC).

ACMHC was a five-year, $4.25 million project providing joint support to community collaboratives to bring together health care providers, human services agencies, and others to address the tremendous needs detailed in the 2003 study. This project funded six grantees:

- Two projects integrating mental health and substance use disorder SUD services, one in Larimer County (Fort Collins), and one in El Paso County (Colorado Springs);

- Two projects integrating mental health and primary care services, one in Mesa County (Grand Junction) and one in Summit County; and

- Two projects integrating mental health services within school settings, one with Denver Public Schools and one in Prowers County.

---

6   Caring for Colorado Foundation, The Colorado Trust, Daniels Fund, The Denver Foundation, First Data Western Union Foundation, The Colorado Health Foundation (known at that time as HealthONE Alliance), Rose Community Foundation, and Rose Women's Organization.

7   TriWest Group. (2003). The Status of Mental Health Care in Colorado. Mental Health Funders Collaborative: Denver, CO. See http://www.coloradotrust.org/attachments/0000/2200/MHCCfinalreport.pdf to view the report.

In addition, two grantees (Prowers and Summit) implemented projects to coordinate multi-agency supports for children and families with high needs.

Purpose and Objectives

The main objective of the ACMHC project was to *improve the integration and coordination of mental health services for adults with SMI and children with SED*.

The focus was on the system level, with an emphasis on initiating a process of ongoing system-change and improvement, to promote integration and coordination of care for people with multiple and severe needs. The two target populations were as follows:

- **Serious Mental Illness (SMI)** – This term refers to adults and older adults whose diagnoses are seen as more severe, such as schizophrenia, severe bipolar disorder, or severe depression. A subgroup of these people is defined as having a Serious and Persistent Mental Illness (SPMI), which seriously impairs their ability to be self-sufficient and has either persisted for more than a year or resulted in psychiatric hospitalization.

- **Serious Emotional Disturbance (SED)** – This term refers to children and youth ages newborn - 17 who have emotional or mental health problems so serious that their ability to function is significantly impaired, or their ability to stay in their natural homes may be in jeopardy.

The project envisioned transformed systems of care where people received an integrated array of mental health services utilizing EBPs. More specifically, project objectives sought to help grantee communities:

- Support the integration of mental health services within communities so that services are provided seamlessly across agencies, regardless of funding sources, organizational structures, or policy and practice differences.

- Utilize EBPs.

- Develop person-centered systems of care that build on the existing strengths of each person served, and actively involve each individual and family in making decisions for their care.

- Build community capacity to sustain integrated services over time.

- Evaluate the outcomes of system integration and share the results with other Colorado communities considering system integration.

- Work with community leaders to make the necessary policy changes to promote system integration and the implementation of EBPs more broadly across the state.

Each grantee was funded under a developmental model that was to focus initially on up to one year of implementation planning (October 2005 to September 2006), move by year two (October 2006 to September 2007) into implementation, and achieve sustainability by year five (October 2009 to September 2010). Applicants were to propose specific target populations and a vision for change, using the planning period to prepare for a successful implementation. Expected phases for each grantee were as follows:

- **Phase 1:** Pre-implementation planning (to last no longer than one year);

- **Phase 2:** Implement new delivery system; transition from previous system (to begin no later than the start of year two);

- **Phase 3:** New delivery system is fully functioning; EBPs are in use (to be achieved no later than year three); and

- **Phase 4:** Integrated model is fully functioning (to be achieved no later than year five).

To support this development, the ACMHC Funding Partners contracted with TriWest Group, LLC, out of Boulder, Colo., to serve as Project Coordinator. In this role, TriWest coordinated communication, reporting and accountability on behalf of the Funding Partners, directly supported grantees in their development and implementation activities, and helped communities identify additional TA needs and procure that TA using annual funding set aside exclusively for this purpose.

To evaluate the main objective of the project, to *improve the integration and coordination of mental health services for adults with SMI and children with SED*, the Funding Partners contracted with Heartland Network for Social Research. This study began during the second year of the project, and addressed the nature and extent of system integration in each site, identifying unique and common barriers and facilitators to the process of integration. Results from that evaluation have been incorporated into this final evaluation report. Evaluation of service effectiveness (i.e., change at the client/service recipient level) was not included in the independent evaluation. Grantees were, however, expected to address these outcomes.

Grantee Communities

The project procurement process defined "community" broadly, and allowed applicants to target a service area, such as a city, county, or region, and/or a population group such as people with disabilities, the homeless, the incarcerated, children and adolescents placed out of their homes, and underserved cultural and racial groups. All six communities defined their populations differently:

- **Denver Public Schools** focused on elementary school age children in Denver with SED. The overall project focus was systemic, but most effort concentrated on the development of an Intensive Day School (IDS) program focused on serving children who would otherwise be at-risk of being placed out-of-district in day treatment or residential programs, because of the severity of their SED-related behavioral needs. Given the size of the city, the project focused primarily on the school district as a community within Denver.

- **El Paso County** focused on adults with co-occurring mental health and SUD needs who did not have insurance - an important subpopulation of the broader county.

- **Larimer County** focused on all adults with co-occurring mental health and SUD needs, with an additional emphasis on those with the highest levels of need.

- **Mesa County** focused on people with mental health needs presenting for care in multiple primary care settings, including the Marillac Clinic's program for people without insurance, a major family medicine residency program, and private practices.

- **Prowers County** focused primarily on high school age youth with mental health needs presenting for care through a school-based clinic. Prowers also had a second emphasis on families with needs who required coordination of services across multiple agencies.

- **Summit County** focused primarily on people with mental health needs presenting for care in primary care settings. Summit also had a second emphasis on families with needs requiring coordination across multiple agencies.

Report Approach

This report addresses the accomplishments of the grantees across the primary objectives of the process defined for the procurement by the Funding Partners. Data sources for the report include the grantee reports over the five-year period, the final evaluation report by the Heartland Network for Social Research (Heartland), and data tracked by TriWest in our role as Project Coordinator. The report is organized as follows:

- Analysis of the overall ACMHC investment in each community;

- A summary of ACMHC accomplishments, including (1) implementation of EBPs, (2) people directly served, and (3) progress on promoting integration;

- Analysis of the process of project implementation, including barriers encountered, the value of training and TA received, involvement of people served and their families, and factors related to sustainability; and

- Analysis of lessons learned and recommendations for future grant makers.

ACMHC INVESTMENT IN EACH COMMUNITY

At its broadest level, the project sought to sow the seeds of change to promote integration across Colorado's broader behavioral health systems. The project took a strategic approach, seeking to establish multi-year local-system change processes using relatively modest sums (approximately $100,000 a year per community, plus an additional $10,000 annually for TA), to fund a coordinator and related infrastructure to leverage broader system change. The actual annual investment per community was relatively similar, as funding a change agent and related infrastructure costs is not readily scalable.

The ACMHC project was a major investment in each community, attempting to leverage change strategically. As a proportion of overall behavioral health care spending the investment was targeted to maximize impact. Colorado was estimated to have spent more than $1 billion in 2010 on behavioral health care, so the $4.25 million investment on an annual basis ($850,000 per year) amounts to less than one-tenth of 1 percent of annual behavioral health spending in the state. Actual average annual expenditures just for grantees (see the table below), total less than two-tenths of 1 percent of the annual behavioral health spending in the six identified counties.

Locally, each of the communities involved in the ACMHC project spends millions of dollars annually on a per capita basis for behavioral health services, ranging from millions in the smaller communities (Prowers, Summit) to tens of millions in the medium sized communities (Larimer, Mesa), to more than $100 million in the large communities (Denver, El Paso County).[8] The table below summarizes the relative annual ACMHC investment in each community's behavioral health system.

ACMHC INVESTMENT BY COMMUNITY – PROPORTION OF LOCAL BEHAVIORAL HEALTH FUNDING					
GRANTEE	2010 POPULATION	PERCENT OF STATE	ESTIMATED BH FUNDING	AVERAGE ANNUAL ACMHC GRANT FUNDING	PROPORTION OF LOCAL BEHAVIORAL HEALTH FUNDING
Denver	600,158	11.9%	$119 million	$126,181	0.11%
El Paso	622,263	12.4%	$124 million	$119,758	0.10%
Larimer	299,630	6.0%	$60 million	$115,007	0.19%
Mesa	146,723	2.9%	$29 million	$131,854	0.45%
Prowers	12,551	0.2%	$2.5 million	$55,124	2.2%
Summit	27,994	0.6%	$5.6 million	$104,380	1.9%
Total	**1,709,319**	**34.0%**	**$340 million**	**$653,304**	**0.19%**

ACMHC ACCOMPLISHMENTS

Implementation of Evidence-Based Practices

Each of the grantees implemented EBPs tailored to the communities served. The two grantees that focused on **integrated mental health and SUD services** (El Paso and Larimer Counties) both implemented two levels of EBPs, one aimed at the broader community level and one focused on people with more intensive needs. The range of interventions implemented by the two communities varied based on the developmental level of the integration efforts: El Paso County initiated its integration efforts through this grant, whereas Larimer County was beginning the implementation stage of a multi-year integration effort that started under a prior planning grant.

- **Broader community level.** El Paso County focused on training clinicians across the county in a single model of care: Motivational Interviewing,[9] one of the most widely implemented approaches nationally for promoting behavioral change in complex disorders. Larimer County took a more intensive change management approach, continuing implementation of the Comprehensive, Continuous, Integrated System of Care (CCISC) model,[10] planning for which was initiated under the prior grant.

---

8   2010 census figures from http://quickfacts.census.gov/qfd/states/08/08077.html were used to allocate the $1 billion 2010 estimate across the six counties on a per capita basis as a rough basis of comparison.

9   See http://www.motivationalinterview.org/Documents/1%20A%20MI%20Definition%20Principles%20&%20Approach%20V4%20012911.pdf for more information.

10   See http://www.ziapartners.com/resources/comprehensive-continuous-integrated-system-of-care-ccisc/ for more information.

- **Intensive intervention for people with high needs** – Each community took a different approach with this, with El Paso County focusing on development of a network of Resource Advocates able to provide peer support (using the Georgia Peer Support model[11] and the Adult Needs and Strengths Assessment or ANSA[12]) and Larimer County developing an intensive team-based model for people with the highest co-occurring needs using Integrated Dual Disorder Treatment (IDDT).[13]

The two grantees (Mesa and Summit Counties) focused on **integrated primary care/mental health services** implemented similar models of integrated care originally developed, beginning in 2000, across multiple prior grants through the Marillac Clinic in Grand Junction, Colo., as an adaptation of the collaborative care model (this model has been used in multiple applications,[14] most notably depression-focused interventions such as IMPACT and DIAMOND[15]). The Mesa County project expanded the Marillac Clinic model to two other settings (a partnership in a family medicine residency program by St. Mary's Family Medicine Center and Colorado West Regional Mental Health and a private practice partnership between Primary Care Partners and Behavioral Health and Wellness), modifying the model in each setting to fit the service delivery approach of each and expanding access to integrated care to an estimated 60 percent of primary care capacity in Mesa County.[16] The Summit County project

implemented a similar program as a collaboration between the Summit Community Clinic and Colorado West Regional Mental Health.

The two grantees that focused on **integrated school-based services** (Denver Public Schools and Prowers County) had different emphases, given the differences in the populations of the two communities. Specifically, Denver County is the second largest county in Colorado (the school system itself serves nearly 80,000 students a year), and in comparison Prowers is one of the state's smallest counties (with a population of just over 12,500 that shrank more than 13 percent from 2000 to 2010[17]). The primary accomplishment of the Prowers grant was the establishment of an integrated mental health component of a school-based health center within the largest high school in Lamar.[18] Denver Public Schools created a new level of integrated care between the district's existing affective and behavioral needs classes (which did not include integrated mental health staff) and external mental health treatment programs that were primarily treatment programs with a minimal education component. This program is called the Intensive Day School (IDS), and incorporates multiple evidence-based components within a model that, in aggregate, may represent a new standard of best practice for Colorado schools.

---

11   See http://www.rand.org/pubs/technical_reports/2008/RAND_TR584.pdf for more information on peer support (the Georgia Model is discussed on pp. 8-9).

12   See http://www.praedfoundation.org/About%20the%20ANSA.html for more information.

13   For more information see http://www.ohiosamiccoe.cwru.edu/library/media/iddtoverview.pdf.

14   Katon, W.J., Roy-Byrne, P., Russo, J. and Cowley, D. (2002). Cost-effectiveness and cost offset of a collaborative care intervention for primary care patients with panic disorder. Archives of General Psychiatry, 59, 1098-1104.

15   See the following studies:

      Katon, W., Von Korff, M., et al. (1999). Stepped collaborative care for primary care patients with persistent symptoms of depression: A randomized trial. Archives of General Psychiatry, 56, 1109-1115.

      Unutzer, J., Katon, W., et al. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. Journal of American Medical Association, 288, 2836-2845.

      Katon, W.J., Schoembaum, M., Fan, M., Callahan, C.M., Williams, J., Hunkeler, E., Harpole, L., Zhou, A.X., Langston, C., & Unützer, J. (2005). Cost-effectiveness of improving primary care treatment of late-life depression. Arch Gen Psychiatry. 2005;62:1313-1320. Downloaded at http://archpsyc.ama-assn.org/cgi/reprint/62/12/1313.pdf.

      Institute for Clinical System Improvement. (2008). The DIAMOND Initiative. Retrieved at: http://www.hogg.utexas.edu/uploads/documents/rls15_resrc_natl1_oftedahl.pdf.

16   Fact sheet developed in 2010 by the Mesa County Integrated Care Council.

17   http://quickfacts.census.gov/qfd/states/08/08099.html

18   For more information on the evidence underlying school-based health centers, see the following summary developed by the Colorado Association for School Based Health Care: http://www.casbhc.org/publications/ToddsTips/Bibliography%20of%20Journal%20Articles%20and%20Other%20Sources%20-%202nd%20edition%202009%20(2).pdf.

Summit County also implemented a child and family-focused intervention for high-risk children served by multiple agencies. The Community Connections program provided integrated and family-focused coordination support based on a Resource Coordination Team model,[19] a promising practice used in many communities in Colorado and nationally (the Boulder County, Colorado IMPACT team is one well-known example). The program was successfully established and sustained. Prowers County also attempted to establish a Community Evaluation and Referral Team to coordinate multi-agency supports for families with high needs, but the program was discontinued prior to the end of the grant period, due to too few referrals. Both programs used the best-practice Child and Adolescent Needs and Strengths (CANS) screening and assessment protocol.[20]

The table that follows summarizes the capacity established and sustained in each community past the five-year grant period. As can be seen, projects focusing on intensive services developed smaller ongoing capacity than projects with a broader emphasis. To put this in context, average annual costs of care per person are provided in the table, and an overall system integration impact is calculated by multiplying the integrated capacity by its annual estimated costs.

Across all six grantees, the estimated value of the sustained, enhanced services on an annual basis is $11.33 million, a single year of value worth between two to three times the overall five-year cost of the grant program. As the table shows, projects that focused on training (such as El Paso County's Motivational Interviewing training program) had a broad system impact across multiple clinicians, providing care to a significant number of people. While the value of that care delivery is very high (nearly $3 million in the case of El Paso County and more than $6 million in Larimer County, conservatively estimated), this value represents a significant, but modest enhancement to services already available. Most programs sustained represented entirely new services, redirected from other ongoing funding. While the ongoing value of those services is less (totaling just over $1.9 million per year total across all sustained programs), these services represent a full redirection of existing resources into the new program.

---

19 For more information, see: TriWest Group. (2003). Colorado in Context: State Detention Systems and Best Practices in Juvenile Detention Alternatives. Boulder, Colo.

20 For more information, see: http://www.praedfoundation.org/About%20the%20CANS.html.

ADVANCING COLORADO'S MENTAL HEALTH CARE

EVIDENCE-BASED PRACTICE (EBP) CAPACITY DEVELOPED BY EACH GRANTEE

GRANTEE	EBP IMPLEMENTED	INITIAL CAPACITY	SUSTAINED 2010 CAPACITY	ANNUAL COST PER SLOT/PERSON/STAFF	SUSTAINED ANNUAL SYSTEM IMPACT
Mental Health/SUD Integration – Broader Community					
El Paso	Motivational Interviewing	3 Clinicians	70 Clinicians; 13 Supervisors	$40,800 per Staff[21]	$2.98 million of Enhanced Services
Larimer	CCISC	Minimal	Over 1,000 Clinicians Trained	$40,800 per Staff	$6.12 million[23] of Enhanced Services
Mental Health/SUD Integration – Intensive					
El Paso	Peer Support	None	13.5 FTE Staff	$57,600 per FTE[24]	$777,600
Larimer	IDDT	None	16 Slots	$12,500 per slot[25]	$200,000
Primary Care/Mental Health Integration					
Mesa	Collaborative Care	4.0 FTE	6.83 FTE	$81,000 per FTE[26]	$229,230 new $553,230 total
Summit	Collaborative Care	None	0.69 FTE	$81,000 per FTE[27]	$55,688
School-Based Mental Health Integration					
Denver	Intensive Day School	None	20 Annual Slots[28]	$25,000 per slot[29]	$500,000
Prowers	School-Based Health Clinic	None	273 Students Per Year	$517 per student[30]	$141,050
Multi-Agency Integration for Children and Families					
Prowers	Community Evaluation and Referral Team	None	None	Not Applicable	Not Applicable
Summit	Community Resource Team	None	25 – 30 Families per Year	$364 Per Family[31]	$10,000[32]
Estimated Sustained Ongoing Annual Impact Across All Grantees – Overall					**$11.3 million**

21 The value of integrated capacity per staff member was calculated by TriWest assuming 10 hours per staff member per week for 48 weeks per year at $85 per hour. This is a conservative estimate assuming that many staff only practice part time and that only a part of their practice would be available to persons with co-occurring disorders. It should be kept in mind that Motivational Interviewing is applicable for a range of needs.

22 This is a duplicated figure across multiple trainings. An unduplicated count of people trained was not feasible.

23 A precise figure was not calculable, given the range of training provided and the diversity of people receiving the training. Nor was it possible to calculate a total number of clinicians trained, since the number of persons trained is duplicated. This estimate was therefore derived by taking a conservative estimate of 150 unduplicated behavioral health clinicians trained, and multiplying it by the same conservative per staff cost figure used for El Paso County.

24 The value of Resource Advocate capacity per staff member FTE was calculated by TriWest assuming 24 hours per full-time staff member per week for 48 weeks per year at $50 per hour. This is a conservative estimate, given that many community mental health centers bill peer support at much higher hourly rates.

25 The Larimer CDDT program calculated Year 1 costs at $13,790 per slot for a 12-person team. Based on this estimate and national data, TriWest estimates an ongoing cost of $12,500 per slot for a 16-person team.

26 Using national figures on integrated care costs (IMPACT, from http://impact-uw.org/files/FinancingIMPACT.pdf), it is estimated that each FTE will serve 180 people per year (3 percent of overall population of 6,000 per FTE) times an estimated cost of $450 per episode, yielding a per FTE value estimate of $81,000. In its final report, Mesa County reported Marillac costs for its program at $365,000 for two counselors, one care manager and a director, who together care for 400 people at any one time. On a per FTE level, this equates to $91,250 per FTE. To account for variation in the non-Marillac clinics, the national figures are used.

27 The national figure of $81,000 per FTE used to estimate Mesa County costs was also used for Summit County. See previous footnote for the methodology.

28 In its final report, DPS estimated the 2010 final capacity at a range of 15 to 24 students at any one time for the entire year; given the range, we used a program capacity estimate of 20 students for this analysis.

29 This estimate was derived by taking the 2010 program costs and dividing them by 20 ongoing slots.

30 The per person cost was computed using 2009 CASBHC program data analyzed in the 2011 TriWest Colorado Status report. That report computed $3.1 million in annual school-based health center behavioral health spending, and 6,000 students served, yielding a per student cost of $516.67.

31 The per family costs were calculated by dividing the annual program costs by the average family capacity (27.5).

32 To calculate overall costs, we reviewed cost reports from the grantee. Just the costs of consumer/family partner stipends and school personnel ranged from a high of $25,600 in year three to a low of $6,850 in year five. These costs also do not factor in the value of in-kind time from community agency personnel participating in the team. An average of the high and low costs is $16,225. The trend was for costs to come down over time, however, so the year five costs are probably the best indicator of ongoing costs of the program. Adding in a conservative estimate of other agency costs yields the figure of $10,000 used in this analysis.

The People Served Through ACMHC

Quantitative analyses. The ACMHC project is estimated to have improved or expanded services that reached more than 18,000 people over the course of the grant. Across all grantee expenditures, the per person cost of the program was $181. Program impact was measured on a per person basis by grantee, as seen in the table that follows. The table presents the total number of people served across the grantees, and total expenditures per grantee to determine spending per person. The total numbers of people served include actual persons served by programs and estimates of the number of people served by the clinicians receiving the evidence-based training described above. It should be noted that grantees implementing training initiatives (El Paso and Larimer) and primary care integration (Mesa and Summit) had the broadest impact and lowest per person costs. Prowers' school-based program also had broad impact for a much smaller investment of funds. While the DPS program cost much more per person, it should be kept in mind that the costs of day treatment or residential care would be many times higher per child.

ACMHC INVESTMENTS PER PERSON SERVED			
GRANTEES	**NUMBER OF PEOPLE SERVED**	**TOTAL ACMHC GRANT FUNDING**	**GRANT FUNDING PER PERSON SERVED**
Overall	18,042	$3,261,521	$181
Mental Health/SUD Integration			
El Paso[33]	3,792	$598,792	$158
Larimer[34]	7,217	$575,036	$80
Primary Care/Mental Health Integration			
Mesa	4,868	$659,270	$135
Summit[35]	1,250	$521,898	$418
School-Based Mental Health Integration			
Denver	76	$630,903	$8,301
Prowers[36]	839	$275,621	$329

---

33 This includes 432 adults receiving peer support from the Resource Advocate program and an estimated 3,360 people served by the 70 clinicians receiving training in Motivational Interviewing (48 each per year, based on the assumption in the cost analysis above that each clinician would provide 10 hours of care per week for 48 weeks per year and that each person served would utilize 10 hours of care).

34 This includes 17 adults receiving IDDT services and an estimated 7,200 people served by the 150 clinicians receiving training in EBPs (48 each per year, based on the assumption in the cost analysis above that each clinician would provide 10 hours of care per week for 48 weeks per year, and that each person served would utilize 10 hours of care).

35 This data and the following demographic tables include some Community Connections cases that received multi-agency coordination supports.

36 These data and the following demographic tables include some Community Evaluation and Referral Team cases that received multi-agency coordination supports.

ADVANCING COLORADO'S MENTAL HEALTH CARE

The following table gives a breakdown of major demographic information among people served. For El Paso and Larimer Counties, these figures apply only to the relatively smaller proportion of people receiving direct services (not the number estimated to receive services from the clinicians participating in the training programs). The number of people receiving direct services by grantee is noted in the table in the gender section. An asterisk by the county name indicates that the program reported there may be duplication in the counts of people served, either across reporting periods, or sites where services were provided.

KEY DEMOGRAPHICS BY GENDER ACROSS PEOPLE SERVED

GENDER	NUMBER SERVED	FEMALE	MALE
Overall	7,482	58.9%	41.1%
Mental Health/SUD Integration			
El Paso	432	29.2%	70.8%
Larimer	17	17.6%	82.4%
Primary Care/Mental Health Integration			
Mesa *	4,868	61.3%	38.7%
Summit	1,250	64.2%	35.8%
School-Based Mental Health Integration			
Denver	76	25.0%	75.0%
Prowers *	839	56.0%	44.0%

KEY DEMOGRAPHICS BY AGE ACROSS PEOPLE SERVED

AGE	0-5	6-12	13-18	19-20	21-59	60+
Overall	1.5%	3.1%	10.0%	2.1%	72.6%	10.7%
Mental Health /SUD Integration						
El Paso	0.0%	0.0%	0.0%	3.5%	87.5%	9.0%
Larimer	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Primary Care/Mental Health Integration						
Mesa *	1.5%	0.9%	2.6%	1.4%	78.5%	15.1%
Summit	2.9%	7.5%	2.8%	2.0%	83.7%	1.1%
School-Based Mental Health Integration						
Denver	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Prowers *	0.7%	2.4%	70.2%	6.0%	19.8%	0.9%

KEY DEMOGRAPHICS BY RACE/ETHNICITY ACROSS PEOPLE SERVED

RACE/ETHNICITY	ASIAN AMERICAN/ PACIFIC ISLANDER	HISPANIC/ LATINO	CAUCASIAN	AFRICAN AMERICAN	AMERICAN INDIAN/ ALASKA NATIVE	OTHER
Overall	0.7%	26.2%	70.0%	1.4%	0.5%	1.3%
Mental Health/SUD Integration						
El Paso	1.9%	14.4%	65.0%	9.5%	0.9%	8.3%
Larimer	0.0%	0.0%	88.2%	0.0%	0.0%	11.8%
Primary Care/Mental Health Integration						
Mesa *	0.7%	19.7%	77.9%	0.5%	0.5%	0.7%
Summit	0.6%	39.2%	57.1%	0.8%	0.3%	2.0%
School-Based Mental Health Integration						
Denver	1.3%	30.3%	28.9%	35.5%	4.0%	0.0%
Prowers *	0.2%	51.0%	48.7%	0.0%	0.0%	0.1%

Case vignettes. Grantees were asked to provide two case vignettes for each EBP implemented. One was to exemplify the best-case scenario of improvement for persons served by the grant. The other was to exemplify typical improvement for persons served by the grant. These vignettes are presented in summary form in Appendix One.

Progress in Promoting Integration

Grantees were asked to provide information about integration in the way services are provided. A distinction was made between implementing a specific service that itself is integrated, and broader organizational collaboration regarding how agencies work together to deliver services in an integrated fashion.

Implementation of integrated services. As described in the section on EBPs, all of the communities implemented integrated services defined as services designed to address multiple needs:

• El Paso and Larimer implemented integrated mental health/SUD services (Motivational Interviewing in El Paso, and CCISC and IDDT in Larimer);

• Mesa and Summit implemented integrated primary care/mental health services (Collaborative Care);

• DPS and Prowers implemented integrated mental health and school services (IDS in Denver and a school-based health clinic in Prowers); and

• Prowers and Summit implemented coordination of care for multi-agency involved children and families (community resource coordination teams).

All but one (Prowers' community resource coordination team) of those initiatives were sustained.

Organizational integration. Regarding how they work together to deliver more integrated services and promote system integration, the grantees tended to focus on the **quality of relationships** within the local partnerships as a major facilitative factor in addressing barriers (see previous section), and furthering integration efforts. Grantees emphasized relational factors: communication, shared understanding, reductions in pre-existing negative attitudes toward specific agencies, widening the range of resource sharing, strengthening ties between individual partners (bilateral relationship and collaboration improvements that added to the effectiveness of the overall collaboration), broadening the range of organizations involved, co-location, formalization of collaboration status (by laws, 501(c) (3) formation), merger, cross-training, and training in clinical skills that cut across fragmented systems (such as Motivational Interviewing, trauma-informed care, and assessment protocols such as the CANS and ANSA).

The independent evaluation by Heartland Network for Social Research[37] focused on this systemic level of integration, measuring the construct of **services integration**, which Demmler and Coen defined as follows:

> "Services integration" includes the concepts of collaboration and coordination of services, but it is a more complex concept. Collaboration and coordination are necessary, but not sufficient elements of integration. Full services integration is more than the sum of the parts of the system – it is a new organization which requires new culture, new rules, new tasks and new language. Services integration is measured on a ranked scale developed by William Doherty and his colleagues and adapted by the Colorado Behavioral Health Council. Levels of collaboration are identified as points on the following 5-point ordinal scale in which there is no services integration in Levels 1 and 2 and subsequently minimal, partly and fully integrated systems in Levels 3, 4 and 5:

- Level 1: Minimum collaboration (professionals work in separate facilities, have separate systems and rarely communicate about cases);

- Level 2: Basic collaboration at a distance;

- Level 3: Basic collaboration on-site with minimal integration;

- Level 4: Close collaboration in a partly integrated system; and

- Level 5: Close collaboration in a fully integrated system (professionals work as team sharing the facility and sharing a biopsychosocial paradigm of care).

Data used to assess integration came from an inter-organizational survey administered to all major partner agencies of each initiative, supplemented by qualitative key-informant interview findings. The survey was administered initially in year two and again in year five. Key trends include:

- All grantees achieved at least a basic level of collaboration (Level 2).

- Two-thirds of grantees (four) achieved services integration at the highest level (Level 5) for at least some component of their local system.

- Services integration at Level 5 was achieved in each of the major areas of integration by at least one grantee (mental health/SUD, primary care/mental health, school-based mental health).

---

37   Demmler, J., and Coen, AS. (June 2011). Advancing Colorado's Mental Health Care Project: Integration of Mental Health Services.

The following table summarizes results from the evaluation by type of integration and grantee:

ACHIEVEMENT OF SYSTEMIC SERVICES INTEGRATION	
TYPE OF INTEGRATION / GRANTEE	**LEVEL OF SERVICES INTEGRATION ACHIEVED**
Mental Health/SUD Integration	
El Paso	**Level 2.5 (between basic collaboration at a distance and close collaboration on-site) — There was very close collaboration** between some agencies, even though the staff were not co-located. There was a strong commitment to cross-training professionals from multiple systems in the same EBPs for the treatment of co-occurring disorders. One health agency integrated staff on site.
Larimer	**Level 5 (close collaboration in a fully integrated system)** — While some challenges remain regarding coordination of funding streams and policy variation, services for co-occurring mental health and SUD were highly integrated. Additionally, Community Dual Disorders Team (CDDT) employing IDDT was fully integrated.
Primary Care/Mental Health Integration	
Mesa Integration was assessed in two primary care settings: (1) St. Mary's Family Medicine Center, and (2) Behavioral Health and Wellness co-located with Primary Care Partners	• St. Mary's Family Medicine Center: **Level 5 (close collaboration in a fully integrated system)** — Co-located services are provided and co-facilitated groups are practiced. Mental health providers work as members of the clinic team to form an integrated care team. • Behavioral Health and Wellness/Primary Care Partners: **Level 4 (close collaboration in a partly integrated system)** — Mental health professionals are co-located with psychiatric consultation.
Summit	**Level 5 (close collaboration in a fully integrated system)** — While some challenges remain regarding coordination of funding streams and roles necessary to perform integrated care, primary care/mental health services were highly integrated at the Summit Community Care Clinic.
School-Based Mental Health Integration	
DPS Integration was assessed at two levels: (1) for the Intensive Day School (IDS) program, and (2) for integration with other DPS and external service providers for IDS students	• IDS: **Level 5 (close collaboration in a fully integrated system)** — School and mental health staff worked as a team to promote both academic achievement and emotional wellness. • System integration: **Level 2 (basic collaboration at a distance where professionals work in separate facilities, but have active referral linkages)** — While other DPS, community health and human services were not integrated with IDS, efforts were made to coordinate these services at the individual student/family level.
Prowers	**Level 3 (basic collaboration on-site)** — Both the primary care provider from High Plains Community Health Center and a mental health provider from Southeast Mental Health Services were co-located in the Lamar High School.
Multi-Agency Integration for Children and Families	
Prowers	Not assessed as program was not sustained.
Summit Integration was assessed at two levels: (1) the Community Connections resource coordination team and (2) school-based primary care and behavioral health services	• Community Connections: **Level 2 (basic collaboration at a distance where professionals work in separate facilities, but have active referral linkages)** — The team enhances the collaboration among services and ensures active referral linkages. • School-based component: **Level 3 (basic collaboration on-site)** — Primary and behavioral care is co-located and provided in schools.

Involvement of People Receiving Services and Their Families

Grantees were asked to look back and describe the involvement and role of people receiving services. Grantees focused on a wide range of ways in which they involved people served, as summarized in the table below.

STRATEGIES TO INVOLVE PEOPLE SERVED AND THEIR FAMILIES

- Treating people receiving services and their families with respect and as partners in the service delivery process.

- Employing peers and family members as service providers.

- Developing peer-run support groups for people served and their families.

- Involving peer/consumer/family advocacy agencies in the collaborative (several grantees had such organizations as leading partners from the start).

- Promoting attendance of people receiving services and their families at steering committee and working committee meetings (one grantee noted this was a struggle with volunteers, even with provision of stipends and transportation reimbursement; however, grantees with more years of experience involving volunteers and those drawing on paid peer staff were more successful in engaging such involvement in an ongoing way).

- Involving peers (both people receiving services and their families) in development and review of grant applications and key project documents.

- Providing training delivered by people receiving services and their families regarding recovery (both training for other people receiving services and their families to support their recovery, as well as training for service delivery agency staff, to more successfully partner with people in their recovery)

- Soliciting the feedback of people receiving services and their families through surveys and direct input.

- Organizing a peer/consumer/youth/family advisory committee to advise the broader collaborative.

- Sharing personal stories of recovery via video and personal testimonials.

Several grantees observed that employing peers (both individuals served and their families) to deliver services and involving people served and their families more broadly was underdeveloped and should be resources leveraged further in the future. Grantees were uniformly positive about this involvement, though there was a range in the breadth of endorsement from those that focused primarily on partnering when delivering services to those that employed nearly all of the involvement strategies noted above. In general, those grantees that described greater involvement were those that experienced broader breadth and depth of systems change overall (El Paso, Larimer, Mesa and Summit).

PROJECT IMPLEMENTATION

Most project resources went to fund coordinator positions that initially focused primarily on community organization and program development. Five of the six communities (all but Denver, which did not invest substantially in community-level planning beyond the IDS program) sustained an ongoing community-level planning process that functioned more independently at the end of the grant period. The Funders supported this model by allowing projects to change spending during the year and annually through updated project budgets. The pool of flexible TA funds also facilitated this process. The overall focus on a dynamic, community-level intervention was critical. All grantees made modifications over the course of the grant period, changing their priorities and/or scope to adjust to barriers encountered and opportunities presented. Those were primarily positive changes that improved the likelihood of project success. A summary of project goals, progress and accomplishments for each grantee are provided in Appendix Two.

Barriers Encountered

A range of policy barriers were described by the grantees, as seen in the list that follows. The major barriers encountered related to: (1) separate policy oversight and funding streams for mental health, SUD and primary care, (2) restrictive fee-for-service funding categories that impeded coordination and delivery of needed supports, and (3) differential rules for information sharing (with mental health and school rules under the Family Educational Rights and Privacy Act/FERPA causing the largest problems).

Many of the biggest barriers were related to policy and funding at the state and federal level that were not amenable to change through a local initiative. In coping with these challenges at the local level and moving integration forward despite them, however, the following common themes across grantees were identified, including: (1) the collaborative process developed by the participating agencies to make the most of limitations, to facilitate integrated service development and provision, (2) flexible TA funding over the entire grant period, and (3) targeted TA (by the project coordinator directly, as well as more broadly through the flexible funds), to inform efforts to sort through the complex issues involved with guidance from experts and organizations with past experience regarding such matters. From our observations, TriWest would identify a fourth factor: the presence of a Project Coordinator with two skills sets: (1) content knowledge in the areas of integration, and (2) skills in facilitating cross-agency collaboration. Other facilitative factors noted included: (1) partner agencies willing and able to collaborate and coordinate resources, (2) local champions for the reforms beyond the program coordinator, and (3) a competent workforce.

MAJOR BARRIERS TO INTEGRATION – POLICY AND FUNDING

Mental Health/SUD Integration

Policy Barriers

- **Conflicting licensing requirements for mental health and SUD professionals.** Licensing requirements for community mental health providers are separate from requirements for community SUD agencies, impeding a range of integration efforts, including requirements for progress notes and treatment plans (often requiring dual medical records), billing rules, and processes for hiring and supervising clinicians.

- **Lower priority on co-occurring disorders by SUD system.** SUD funding in Colorado and nationally is much lower on a per capita basis than mental health funding. As a result, nationally most co-occurring disorder services are funded through mental health systems. SUD systems tend to focus only on SUD treatment. This was a barrier to collaboration with SUD system partners.

Funding Barriers

- **Separate funding streams for mental health and SUD services.** While the state has integrated oversight of mental health and SUD services through the Division of Behavioral Health, funding remains separate (reflecting separate block-grant funding streams at the federal level, and separate allocations at the state level). Rules for accessing these funding streams vary and are often inconsistent.

- **Restrictiveness of fee-for-service categories generally.** For those with the most intensive needs, activities such as transportation, outreach and informal contacts do not always fit billing codes for "case management" or "individual therapy." There is a need to fund these additional activities - to make evidence-based approaches such as IDDT work - and integrated approaches more generally.

- **Barriers to Medicaid eligibility for SUD conditions.** Barriers to Medicaid eligibility for adults without dependent children are one roadblock. Furthermore, a SUD diagnosis alone does not qualify as a disability for Medicaid, further limiting the applicability of this funding stream for people in need.

- **Narrow Medicaid SUD benefit.** Colorado began to fund SUD services for the first time in 2008, midway through the grant period. The Medicaid SUD benefit is much narrower than the mental health benefit, so people with primarily SUD needs are limited in the services they can receive. Eligibility for mental health funding is needed to provide the full range of care. Medicaid SUD services also have restrictions on providers that further limit access to these funds.

- **Differences in pay scales.** Differences between mental health and SUD pay scales necessitated explicit attention to support staff in both settings.

Primary Care/Mental Health Integration

Policy Barriers

- **Non-overlapping education of medical/health/mental health professionals.** The education of most medical and health professionals takes place in silos, with each profession/discipline developing its own language and culture, and little education on how to work together as a team. Integrated care settings generally have to carry out this supplemental cross-education.

- **Workforce limitations.** Rural and small town communities in particular faced challenges in recruiting, hiring, and retaining qualified clinical staff. These human resource issues were particularly acute with respect to psychiatrists and bilingual mental health providers.

Funding Barriers

- **Carved-out mental health funding.** The practice of having firms that administer and manage mental health and SUD care administratively - separate from the rest of health care funding - leads to fragmented care. Regardless of its relative value overall, this system (in both Medicaid and private insurance settings) perpetuates the notion that the mind and body are separate, fragments care delivery, adds additional administrative costs, and makes it more difficult to hold providers accountable. Furthermore, cost savings resulting from effective and integrated behavioral health treatment on medical/surgical costs cannot be readily identified and used to improve and incentivize care outcomes.

- **Restrictiveness of fee-for-service categories generally.** Fee-for-service billing is a serious barrier to integrated care. On the medical side, it rewards physicians for performing procedures and tests, encourages shorter office visits, and promotes the treatment of presenting problems across multiple visits. Time spent collaborating with colleagues is not covered, nor are other services central to integrated care. This is particularly problematic for complex high-need people with mental health and SUD needs.

- **Differences in pay scales** – Differences between medical and mental health pay scales necessitated explicit attention to support staff in both settings.

- **Differences in agency requirements** – Related to the broader issues of disparate funding streams were differential agency policies regarding sliding scales and service eligibility. While state, federal and payer rules drove this, local agency policies also played a role.

School-Based Mental Health Integration

Policy Barriers

- **Referrals for school versus mental health needs** – Schools have an overarching education mandate that requires them to place students to optimize individual and classroom functioning. A mental health program is specialized to help one subset of students in need of alternative placements, but not all children with behavioral conditions that impede participation in a general education setting. Intensive integrated programs need to develop an understanding of their role in this larger system.

- **Adapting to environmental change** – During the five-year grant period, schools coped with multiple challenges, including changing student numbers (more in Denver, less in Prowers). The education system was also pursuing its own reforms related to improving educational opportunities during the grant timeframe. The Denver program had to adapt to a change in the school building in which it was located (change to a dual-language curriculum).

Funding Barriers

- **Limited availability of start-up funding.** Funding for the first year of Prowers' school based health center was not available, so local funds had to be stretched to cover a limited start up. Ongoing funding was available through grants. Expansion of the DPS IDS program was limited by a lack of start-up, despite wide consensus of its value among stakeholders.

Multi-Agency Integration for Children and Families

Policy Barriers

- **Sharing of information across agencies.** As noted above, Colorado's Mental Health Act imposes confidentiality requirements for non-physician mental health professionals that are stricter than the HIPAA requirements governing physicians (including psychiatrists) and health professionals. The Family Educational Rights and Privacy Act (FERPA) adds restrictions for schools. Other agencies have additional rules and processes that complicate the process.

Funding Barriers

- **Separate funding streams across agencies.** The most challenging policy barrier was the need to tie all services to a specific funding stream, and the variations and inconsistencies across agency funding streams for children and families, including mental health, SUD, education, child welfare, juvenile justice, and basic welfare supports. Efforts to pool resources or fund cross-agency coordination efforts were consistently frustrated, and expenditures consistently had to be tied back to a single funding stream and authority, adding administrative burden even when it was feasible.

- **Limited funds to assist basic needs.** Families often required cash to assist them in making progress such as paying for medications, gasoline, or utilities/rent. Requirements for these supports often were time-consuming or impossible to meet, taking away from treatment coordination efforts.

Training and Technical Assistance

Grantees were asked to look back and identify the most useful and the least useful TA they received. One of the most universally endorsed strengths was the process for receiving TA through a flexible set of funds that extended across the entire grant period. Being able to tailor training and assistance over time in response to emerging opportunities and challenges was noted at some level by all grantees as a key to their success. In terms of specific TA, the single most endorsed approach across grantees and integration models was sending collaborative representatives to national forums to learn about best practices regarding integration (both national conferences and site visits to model programs). Given that all six grantees were implementing proven approaches in a new community, the ability to directly learn from others who had already implemented the approach was highly valued. While grantees also endorsed the use of TA to bring specific trainers to their community, they more frequently endorsed the value of sending local change agents to be immersed in the perspectives of multiple experts and similar organizations seeking to implement like practices.

MOST USEFUL TECHNICAL ASSISTANCE

Mental Health/SUD Integration

- Attending national co-occurring treatment conferences (Ohio SAMI Conference, ZiaPartners Unconference, others)
- Visiting model programs in other states (IDDT)
- Training in Motivational Interviewing
- Coaching on program implementation by ACMHC Project Coordinator

Primary Care/Mental Health Integration

- Attending national conferences (Collaborative Family Health Care Association/CFHA)
- Certificate Program in Primary Care Behavioral Health by University of Massachusetts Medical School via videoconference
- Variety of targeted training for local-agency direct service staff
- ACMHC cross-site grantee meetings for mutual support and joint training of grantees

School-Based Mental Health Integration

- Attending national conferences (National Assembly of School Based Health Centers)
- Development of the IDS program design by the ACMHC Project Coordinator
- Training and follow-up coaching in CANS by the ACMHC Project Coordinator
- Support designing the local evaluation by the ACMHC Project Coordinator

Multi-Agency Integration for Children and Families

- Coaching on program implementation by ACMHC Project Coordinator

LEAST USEFUL TECHNICAL ASSISTANCE

Grantees were also asked to describe the least useful TA they encountered. Interestingly, none of the grantees criticized the actual training provided; instead, they focused on the process of receiving the assistance. Examples included:

- Attempts to send staff to training in another Colorado community 90 minutes away rather than bringing the training to their community.

- Consultation by the ACMHC Project Coordinator to develop the local evaluation plan for a grantee with more refined, content specific needs was not specific enough to move them forward and was helpful only in confirming the direction of their efforts.

- Premature efforts to develop a mental health registry before buy-in and planning for shared medical information was established.

- Early efforts to address billing for integrated care facilitated by the ACMHC Project Coordinator did not identify solutions, but did build awareness of the need for broader structural change.

- Two grantees noted that the one-time CANS training by the ACMHC Project Coordinator was not sufficient to support implementation; one nonetheless found the training useful, while the other found the tool "too cumbersome"; neither grantee invested in the follow-up coaching that Summit used and that was related to their positive experience of the same training.

- Attempts to bring in outside facilitators and grant writers were sometimes not seen as helpful given the complexity of the local issues involved that required detailed knowledge of the community.

- General trainings on collaboration were not seen as particularly useful.

Factors Related to Sustainability

The previous section on the EBPs implemented described the range of services sustained following the project (all services other than the Prowers community resource team). Grantees were asked to describe additional processes, structures, and activities that will and will not be sustained after funding from this grant ends. These are summarized below.

ADDITIONAL SYSTEM CHANGES THAT WILL BE SUSTAINED
SYSTEM CHANGES SUSTAINED
Mental Health/SUD Integration
• Community-level collaborative group to guide continued integration. • Continued training in Motivational Interviewing and other co-occurring disorder treatment. • Continued assessment of community needs related to integration. • Fidelity monitoring of EBPs implemented.
Primary Care/Mental Health Integration
• Community-level collaborative group to guide continued integration. • Management position to promote integration. • A website with detailed information regarding local mental health and SUD resources.
School-Based Mental Health Integration
• Increased awareness among school personnel of mental health needs and associated improvements in need identification and referral processes.

IMPORTANT SYSTEM CHANGES THAT WILL NOT BE SUSTAINED AND WHY	
SYSTEM CHANGE NOT SUSTAINED	**CONTRIBUTING FACTORS**
Mental Health/SUD Integration	
Evaluation of project effectiveness	Ongoing evaluation was not seen as feasible given costs
Project manager to promote integration	Functions of that position that continue to be needed were taken over by direct service managers; the development activity will not be sustained
Intensity of training	While training will be sustained, it will not be as frequent or broad-based
Primary Care/Mental Health Integration	
Peer specialist position at Marillac	Lack of funding stream to support position
Primary Care Behavioral Health Certificate Program	Lack of new funding to supplement cost
School-Based Mental Health Integration	
Project manager to oversee program and expand integrated programming	Functions of that position that continue to be needed were taken over by direct service managers; the development activity will not be sustained
Funding of IDS beyond the 2010-11 school year	Given continued and growing funding pressure on Colorado schools, special programs such as IDS will continue to need to justify continued existence and ongoing program integrity

LESSONS LEARNED AND RECOMMENDATIONS FOR GRANT MAKERS

Lessons learned. Heartland's independent evaluation looked more systemically across grantees to identify lessons learned that were applicable for three types of stakeholders/audiences: (1) community agencies that seek to implement strategies to improve service/system integration, (2) funding agencies, and (3) federal and state policy makers. These are summarized in the following table, with additional details for specific grantees added for illustration:

LESSONS LEARNED ACROSS GRANTEES FOR KEY STAKEHOLDERS/AUDIENCES

Lessons for Community Agencies Pursuing Integration

1. **Increased integration within large bureaucratic agencies may require discrete program** integration as an interim step, given the challenges involved, as with the IDS program at DPS.

2. **Anticipating significant organizational and cross-agency barriers, and proactively addressing them during initial envisioning** of the proposed integration promotes success. Grantees with the clearest visions initially (Larimer, Mesa) achieved the most, as did those that were most successful in year one in defining their vision (Summit and DPS for its IDS program).

3. **Increased integration is most achievable if the effort is focused in a particular area.** Grantees with multiple emphases either abandoned additional emphases or achieved a lower level of integration.

4. **Specific training of staff regarding the concept of integration**, its attributes and benefits, is key.

5. **Explicit cross-training of staff** from the services/systems to be integrated promotes integration.

6. **Positive incentives ("carrots") for organizations that comprise the service system** (such as access to state-of-the-art training) promote integration.

7. **Stimulants towards integration from more than one service sector or funder** promote integration.

Lessons for Funding Agencies

1. **Increased integration is possible in all three areas of integration attempted:** mental health/SUD, primary care/mental health, and school-based mental health services.

2. **A scope of integration with defined boundaries and identified services** (system components) promotes likelihood of success. Efforts with the DPS IDS program, and more broadly in Larimer, Mesa and Summit, demonstrated this.

3. **A point person whose primary function is to promote systems change in the form of integrated programs or services is essential.** Grantees that had this from the start (DPS, Larimer, Mesa and Summit) and those with broad buy in across system stakeholders (Larimer, Mesa and Summit, joined in year two by El Paso and year four by Prowers) achieved more.

4. **Additional funds used as "carrots" to encourage specific training across agencies or collaboration activities promotes integration.**

5. **The availability and accessibility of TA is critical** from a group of experts in the health areas being integrated, as is commitment to flexible, sustained funding of assistance over time with explicit opportunities for grantee stakeholders from different sites to learn from each other.

6. **Until reimbursement for health care better supports integrated care, agencies must seek other funding sources to pay for some key integrated services.** ACMHC grantees both braided diverse funding streams to fund components of integrated approaches, and funded discrete components not covered through additional grants or uncompensated efforts.

Lessons for Policy Makers

1. **Reimbursement of health care must change to better support integrated care**, as current funding streams are not adequate for any of the integration efforts attempted under this initiative.

2. **Policies guiding access to critical human services for people with severe needs (e.g., public housing) must change to better support integrated care.** Public housing authorities often refuse to rent housing units to persons who have broken rules related to substances, despite protections under the American with Disabilities Act. Such policies are inconsistent with the long-term, unconditional commitment needed for approaches such as IDDT.

3. **State and federal policies must change to support integration**, particularly those related to separate funding streams (state and federal) and sharing of health information (Colorado Mental Health Act).

RECOMMENDATIONS FOR GRANT MAKERS

Both the independent Heartland evaluation and grantees offered suggestions for foundations funding similar projects in the future. Those that seem most critical from TriWest's perspective as overall project coordinator include:

- **Do it the same way again.** Both Heartland and the grantees emphasized the importance of (1) the multi-year funding commitment, (2) flexibility to adapt funding and TA over time to emerging needs and opportunities, and (3) use of a "highly competent group" with specific content knowledge relevant to the project, to manage the grant and interactions with grantees.

- **Focus integration efforts more.** Integration requires a "well-articulated understanding of the services that will be the effort's focus" and an incremental, stepwise approach across the many areas of change.

- **Require a full-time project director.** Funders may want to require that local project directors in the future be full-time staff throughout the project tenure, given how critical this role is to project success.

- **Continue Funder collaboration.** The model of the Funding Partners collaborating to oversee this project was seen as "inspiring," and important in sensitizing the funders to the challenges faced by the grantees in their efforts to collaborate across organizations with similar values, but distinct missions.

- **New initiatives are needed to address state-level funding barriers.** Heartland and nearly all the grantees emphasized the need for system change and the critical role foundations can play in convening stakeholders, decision-makers, and experts to integrate funding streams, reduce barriers to funding integrated care, and ensure that funding for integrated care and EBPs cover the costs of all critical components.

OTHER SUGGESTIONS MADE BY GRANTEES AND HEARTLAND INCLUDE THE FOLLOWING:

- **Promote training about integrated care** in both professional education and in-service training of medical and behavioral health personnel.

- **Continue funder involvement**, as the high level of involvement – especially site visits - by the funders in the current project was widely endorsed as positive.

- **Increase opportunities for cross-grantee training**, as the all grantee meetings were widely endorsed and some grantees asked for more opportunities to engage in cross-training.

- **Ongoing commitment to system change is critical**, as services for people with complex needs require complicated system changes, and foundations are critical to such change.

- **Be willing to fund smaller organizations**, given that, as one grantee emphasized, small organizations are "nimble and flexible," and able to pursue actual change, whereas larger organizations are often less so.

- **Address policy barriers in public housing** to ensure policy congruence and reduce conflicts between public mental health systems and public housing.

Appendix One: ACMHC Case Vignettes

SUMMARY OF ACMHC CASE VIGNETTES	
BEST CASE	**TYPICAL CASE**
Mental Health/SUD Integration	
El Paso County (Resource Advocates)	
Max is a 47-year-old male who identifies as French and American Indian. He suffers from alcoholism and exhibited delusional and paranoid behavior. Max arrived at the Salvation Army New Hope Homeless Shelter in Colorado Springs, Colo., having been homeless for many years, with no income or benefits. He was referred for substance abuse counseling, but was unwilling to participate after two months. Max met with the Resource Advocate Coordinator, and learned about the Collaborative and its continuum of care. He asked for time to think it over and, after one more meeting, agreed to receive services. With Resource Advocate assistance, Max applied for and received needed benefits, and is now housed in a grant-funded three-person transitional housing unit through New Hope Homeless Shelter. He successfully completed treatment and after care services tailored to co-occurring disorders, reporting that this was the first time (after eight prior attempts) that the services addressed his unique needs. He is now on psychotropic medication, and has been clean and sober for more than three years. He attends self-help meetings (AA and Double Trouble) and a consumer-run drop-in center, where he shoots pool. Max now has a female friend who he sees in town and recently took to a movie. All of the involved agencies are Collaborative partners.	Deb is a 52-year-old Hispanic female who had been homeless for 12 years before showing up at the Resource Advocate Program (RAP) to ask for assistance. She had a history of many psychiatric hospitalizations, and had abandoned her four children (ages 10, 11, 14, and 16). She reported drinking whenever possible, frequently to the point of passing out. She reported being sexually assaulted three times while homeless and physically beaten by her partner to the point where she had been hospitalized with a concussion. Deb was diagnosed with Bipolar Disorder at the age of 28, but received services only off and on, when funding permitted or when hospitalized. Since Deb began working with RAP and the Collaborative, she has accessed work rehabilitation services with Division of Vocational Rehabilitation and is now working part-time less than a mile from the supported housing unit where she lives and receives intensive case management services. Co-occurring treatment services are being provided by Bridge to Awareness. Since beginning treatment, she has re-initiated contact with three of her children, and now spends holidays with them, frequently babysitting her seven year-old grandson, whom she saw for the first time last year. All of the involved agencies are Collaborative partners.
Larimer County (IDDT)	
Jackie is a 47-year-old single Caucasian mother of two. Upon intake, her diagnoses were alcohol abuse and Bipolar II, as well as a number of physical ailments. She had experienced two episodes of inpatient care, and was in legal trouble after a complicated divorce with child custody issues. She had no medical benefits, and was unemployed and homeless. Through the assistance of the Community Dual Disorders Team (CDDT), she was able to obtain a housing voucher through Fort Collins Housing Authority, qualify for Medicaid and food stamps, regain stable visitation with her children, and successfully complete her probation. She has had nearly 18 months of sobriety with only a couple of brief relapses during very stressful times. One of her children recently graduated from high school, and she now cares for her school-aged child through a split-custody arrangement. Jackie eventually got involved in a workforce training program and received support to enroll in Front Range Community College, where she is following a course of study to become a paralegal. With the team's assistance, she applied for and received a permanent Section Eight housing voucher.	Dave is a 24-year-old Caucasian male who had dropped out of high school at an early age, because of social difficulties related to diagnoses of schizoaffective disorder and poly-substance dependence. After much family turmoil, he left home at age 16, and spent his time working odd jobs and living with friends or on the streets. He was arrested for street crimes, leading to jail time and probation. Dave over-utilized other county resources, frequently going to the emergency room, detox, and inpatient psychiatric treatment, most often for drug overdoses and other suicidal behavior. He had attempted other outpatient treatment programs, but had been unsuccessful. When he came into the program, Dave was provided with a housing voucher, and very quickly became a regular participant in treatment. Within a few months (with the help of Job Services), he obtained a part-time job in highway maintenance, but was laid off after a year. Despite attempts to find work, he has been unsuccessful. Through CDDT, he applied for and received benefits. Despite Dave's regular participation in treatment, progress has been slow. Over time, there has been a marked decrease in use of alcohol and "hard" drugs, but he continues to abuse marijuana. He has had fewer visits to the emergency room, detox, and inpatient care, but still uses these at times. Currently, Dave is off probation and enrolled in GED classes.

SUMMARY OF ACMHC CASE VIGNETTES	
BEST CASE	**TYPICAL CASE**
Primary Care/Mental Health Integration	
Mesa County (Collaborative Care through Marillac Clinic)	
Juana is a 44-year old Hispanic female who first came to Marillac Clinic for a urinary tract infection, but manifested a high stress level. Counseling was recommended, but she declined. At her next appointment, she presented with a high level of fear and met with the behaviorist, who assessed risks, developed a safety plan, and scheduled a follow-up appointment. Three days later, she was briefly hospitalized at St. Mary's Hospital. Over the next year, Juana was seen by the behaviorist 17 times, including three joint appointments with her medical provider. Her mental health waxed and waned based on stress levels at home (including domestic violence). She rarely took medications, and was increasingly psychotic, with two additional hospitalizations. Two times she presented with bruises that she said came from her husband, and received additional medical care. Given her history of not taking medication, Marillac coordinated services with Colorado West Regional Mental Health to access their psychiatrist for an injectable antipsychotic. She improved markedly, filed for divorce, re-engaged as a parent, and manifested no psychotic features. Juana now has been employed for a year. Her son, who was at one point involved with the juvenile justice system, has finished school and married, and her daughter is doing well in high school. Neither psychosis nor depression recurred.	Susie is a 40-year-old Caucasian female who moved to Mesa County to live with her parents, unable to take care of herself due to chronic pain. At her first visit to Marillac Clinic, she complained of "all over" pain impairing her daily functioning, and was diagnosed with fibromyalgia and depression. Prior to care at Marillac, Susie was receiving increasing amounts of narcotic pain medication and muscle relaxants to manage various pains, and increasing amounts of benzodiazepine medication to manage mental health issues. Her medical and mental health care were disjointed. Susie was introduced to the behavioral health team by the case manager. The team assessed her needs, and she began mental health counseling, as well as a chronic pain group, and exercise in a warm pool through St. Mary's Life Center. Her medical and mental health providers began to see her in joint appointments. Susie moved to low-income housing designed for individuals with complex needs and involvement with multiple services. This change increased Susie's independence, and gave her more opportunities to socialize. She was also referred to a recovery group facilitated by the Consumer Peer Specialist. She continues to receive comprehensive support through Marillac, including help navigating the disability eligibility process and approximately one clinic interaction a month.
Summit County (Collaborative Care through Summit Community Care Clinic/SCCC and Colorado West Regional Mental Health/ CWRMH)	
Don is a 38-year-old male who presented at SCCC after an emergency room visit. He had a very low clotting level, and had been abusing alcohol daily for many years. He had tried to quit in the past, but consistently ended up having seizures and being hospitalized, experiences that were very traumatic for him. Don, his long-term girlfriend, and the care team came up with the following plan: enter detox with medication to help him with the withdrawal (detox is run by CWRMH and is adjacent to SCCC and CWRMH), notify the emergency room of his status and the fact that he may need admission, and plans for a visitation schedule with his girlfriend to ease his anxiety. Don was admitted to the hospital, where he was treated with respect and dignity. Both SCCC and CWRMH were notified of his discharge, and, per the plan for follow up services, Don met with his physician within a couple days of discharge, received follow-up outreach from detox staff, began treatment in a SUD group, began individual counseling related to his trauma history, and engaged in a peer support group. He is gainfully employed, sober, and in a strong relationship.	Pat is a 49-year-old single Caucasian male with Type II diabetes and Schizoaffective Disorder. He has held a series of food service jobs for varying lengths of time, occasionally having health insurance, but most often not. He has been served by SCCC and CWRMH for many years. In the past year, with the expansion of integrated care services, Pat became much more engaged and active in his treatment. He attends the diabetes support and peer support groups, and often comes to one of the treatment settings when he is struggling with a mental health or medical issue (where both needs are met). In one instance, Pat was changing jobs again and in crisis: very upset and declining in his diabetic self-care. He came to the clinic and received the diabetic supplies he lacked, emergency care within 30 minutes with CWRMH psychiatric staff, connection with a peer support group member, and a clear plan to move forward within hours. His case was reviewed at a joint staff meeting the next week, to review the plan and ensure that the interventions were helpful.

SUMMARY OF ACMHC CASE VIGNETTES

BEST CASE	TYPICAL CASE
School-Based Mental Health Integration	
DPS (DPS provided examples for each of the IDS program's primary evidence-based components)	
Parent Empowerment Program – Abigail is a 55-year-old African American grandmother raising her grandson. In the early stages of treatment, she was uncertain if she was going to be able to keep her grandson in the home, and was considering pursuing an alternative placement for him. Abigail was able to get support through parenting skills, and stabilization of her grandson's school and treatment situation, which allowed him to remain in her home, and her to continue to be able to keep her job (rather than home-school him). Abigail was able to become an advocate for her grandson, and celebrated his discharge from a self-contained placement during his 6th grade school year. Abigail also became a key support for other caregivers.	Parent Empowerment Program – Patricia is a 42-year-old Caucasian female married to Barry, a 40-year-old Caucasian male. Their adopted daughter, Maggie, is a 10-year-old Hispanic girl diagnosed with Reactive Attachment Disorder transitioning from a day treatment facility. The parents were very concerned that Maggie could not return to a public school setting, given her unique needs, social deficits, physical aggression, tantrums, and general belligerence. Behavior at home put that placement at risk. Since attending the Parent Empowerment Program, the family reports that they are more adept at setting appropriate limits and now share insights with other parents in the program. Without IDS, Maggie's ability to live at home would have continued to be at risk, and she may have been referred to residential treatment or a return to day treatment.
Peace for Kids (formerly known as ART) – Charles started IDS in the 4th grade. He is African American and had suffered multiple losses, including his mother. He struggled with impulsivity, emotional control, property destruction, and multiple suspensions for staff assault. By 5th grade in IDS, Charles had a high degree of academic success and involvement, transitioning to a general classroom setting for 6th grade. Without IDS, he likely would have been placed in day treatment or residential care.	Peace for Kids – Monique was 10 when she started with IDS. She is multi-racial (Hispanic and African American). Monique was diagnosed with post-traumatic stress disorder, and experienced extreme emotional reactivity and aggression toward peers. By the end of 6th grade, she had moved back to a mainstream setting. In 7th grade, her new school consulted with IDS to problem-solve new concerns, and she was doing well at last report. Without IDS, she would likely have gone to an Affective Needs class, perhaps for her entire academic career.
Nonviolent Crisis Intervention – April is a nine-year-old Hispanic female with private insurance. Referral behaviors included physical aggression, extreme opposition, refusal to engage in activities, and poor social skills. Upon intake, April displayed incredibly high levels of physical aggression, and would require physical restraints on at least a weekly basis. Staff developed a Behavior Intervention Plan to address crises and identify ways to minimize crisis triggers. This allowed April to stay in and adjust to IDS, building trust and relationships. The frequency of her physical restraints and tantrums decreased significantly. She was recently assessed for gifted and talented programming. Without IDS, it is unlikely April would have been maintained in a public school setting.	Nonviolent Crisis Intervention – Victor is an 11-year-old multi-racial male. Referral concerns included flat affect, lethargy, refusal to come to school, sleeping, suicidal ideation, and refusal to participate in instruction. Psychiatric assessment was inconclusive, and his parent was reluctant to consistently administer prescribed medications. Victor entered the IDS program near the end of 5th grade, and struggled with expectations and rules. Several times, he attempted to leave the school to walk home (from Northwest Denver to the extreme Northeast corner of Denver), and staff would intervene, leading to physical aggression and restraints. Staff began to engage him in multiple behavior contracts, de-escalating the situations when he would leave school, and simply return him to class. Victor progressed at IDS, and was transitioned to an Affective Needs middle school program, where he has demonstrated mixed progress, but no recent instances of physical aggression.

SUMMARY OF ACMHC CASE VIGNETTES

BEST CASE	TYPICAL CASE
Prowers (School-based Health Center – SBHC)	
Lois is a 16-year-old female student in the 10th grade. She came to the SBHC because she was having trouble urinating, and was afraid she may have a sexually transmitted infection (STI), though she had not been sexually active for some time. After completing an assessment, it was discovered that she had a urethral polyp and was going to need minor surgery to have it removed. Staff supported her in sorting through her treatment options, determining with her that she would need to have the procedure done at High Plains Community Health Center, which would involve talking to her mom due to the need to miss school and possibly need pain medications. With support, Lois did so, and was very relieved that she did not have an STI. Her mom was supportive of having the polyp removed. Lois did so, and is now pain free.	Rob is an 18-year-old male student in the 12th grade who was brought to the attention of the school nurse. His friends were concerned about him because he only drank water at lunch and did not "ever eat any food." After talking with Rob, staff discovered that he wanted to be a model (and was already doing some modeling in Denver on weekends), and he believed that he could not eat any food if he was to maintain his thin build. If Rob did consume calories, he would work out for hours and run several miles to burn them off. He was referred to the nutritionist and health coach who did extensive teaching and developed a workout plan for Rob. He began to build muscle tone (which he was happy about), eat more healthily, and feel better overall about himself. His friends noticed a difference in his energy levels and overall appearance. Rob is now enrolled in college classes, and still modeling on weekends.
Multi-Agency Integration for Children and Families	
Prowers (Community Evaluation and Referral Team – CERT)	
Carlos is a 45-year-old Hispanic male referred to CERT by his probation officer, because he was struggling with meeting the demands of working with multiple area agencies. He was involved with Department of Social Services, Vocational Rehabilitation, and a SUD treatment agency in addition to the legal system. Needs included sub-standard housing, lack of a driver's license, unemployment, sobriety, and caring for his two daughters. Carlos met with the CERT, and a plan was developed to address the housing needs, help him keep appointments, and find transportation. The team met six times to review progress and adjust goals, and agencies frequently provided necessary support to meet the requirements of other agencies. Carlos secured adequate housing, continued sobriety, and kept his daughters with him at home. Without CERT, it is likely that he would have had his probation revoked, gone to prison, and left his daughters placed with other family or in foster care.	Linda is a Caucasian middle-aged female referred to CERT, as she and her husband were unable to pay for medications. She was referred to the Patient Navigator at High Plains Community Health Center, her primary care provider, for assistance in paying for the medications. Since most pharmaceutical companies were no longer providing discounts for their products, however, the project coordinator worked with the couple to cut costs in other areas to pay for the prescriptions. Linda was provided information about SHARE, a program offering packages of food at greatly reduced costs. No CERT meeting was held, as she was not involved with any area agencies nor was she eligible for services.

SUMMARY OF ACMHC CASE VIGNETTES

BEST CASE	TYPICAL CASE
Summit (Community Connections using a community resource team)	
Jan is a 24-year-old Caucasian mother and her three children (ages eight, four and 16 months) who were referred through another community agency. Her eight-year-old son was experiencing behavioral problems at school. Recently, the father of the two youngest children was arrested for assault charges against a family friend in their home. The parents separated, and the mother became overwhelmed as a single parent. She was also worried about her eldest son's concerns (physical health complaints, anxiety about his mom's safety, and increased sensitivity and defensiveness at school with his peers and teachers). The family liaison met twice with the family to determine their goals and complete the CANS. When the family's situation was reviewed by the Community Resource Team, multiple services were offered based on Jan's goals, including: mentoring, rent assistance, individual and play therapy, a mother's support group, advocate services, legal aid, and psychiatric services. The mom and son chose to enlist the support of a mentor. The mom enrolled herself in individual counseling, and the eldest and middle son in play therapy through Medicaid funding. In addition, Jan was connected to general assistance for rent/clothing vouchers, and she was coached and directed to legal aid services. The Family Liaison helped connect the mom to these resources. The family remained engaged with the program for 10 months before voluntarily ending involvement. By that time, Jan was gainfully employed, and her eldest son had improved both academically and behaviorally in school, and was still connected to his mentor. This mother is known to various community agencies, and has contacted them in the past prior to her involvement in Community Connections, yet the family had continued with periods of crisis. This time, the integration support and family-focused approach of the family liaison and the Community Resource Team assisted the family in achieving their designated goals.	Anita is a 42-year-old Latino mother with two children (a nine-year-old daughter and six-year-old son), who were referred through a community agency. Anita's daughter was experiencing emotional and behavioral problems at school, and both children struggled in their academics. Although the children were well connected to school support, Anita struggled with her efforts as a single mother, concerned about her children growing up without their fathers in their lives, and the children's difficulty communicating and trusting her about their concerns. The family liaison met twice with the family and individually with the two children, to determine their goals and complete the CANS. When the family's situation was reviewed at the Community Resource Team, multiple services were offered based on Anita's goals, including: mentoring, collaboration with the school, immigration services, individual counseling for the mom, parenting classes, play therapy for her daughter, and funds for counseling. Initially, Anita's interest in services was support from the family liaison in the family's interactions with the school and mentoring. Rapport building was slow, but steady. Eventually, she expressed interest in counseling services for herself and soon began steady therapy with a bilingual therapist. Anita then self-initiated a discussion with her primary care doctor about anti-depressant medication, and obtained this. Anita's increased confidence was apparent at school and in her children's communication and behaviors. Anita was referred to parenting classes in Spanish, and attended all sessions with scholarship assistance. Counseling was initially paid by her health insurance, then by herself, with assistance from an outside agency, due to the counselor not accepting health insurance. The children were connected to outside activities, including a recreation center summer camp program and recreational soccer, all supported by the family liaison. The family has remained involved with the Community Connections program for almost a year, and has recently expressed interest in terminating services based on their progress and gains.

Appendix Two: Goals and Implementation Progress

GOALS AND IMPLEMENTATION PROGRESS BY GRANTEE

GRANTEES AND GOALS	PROGRESS AND ACCOMPLISHMENTS
Denver Public Schools (DPS)	
1. At a system level, develop a comprehensive, systematic approach to improving the mental health status of students. The new system of care will identify mental health problems early and, when needed, provide appropriate evidence-based support/links to effective service. 2. To create a systemic change in how DPS supports students with mental health needs. Systemic change will include: (1) the creation of Resource Coordination Teams in each building, (2) development of a common identification process used in all sites, (3) mapping of building and community resources, (4) training for school staff on issues relating to mental health, (5) continued provision of school-based mental health support services, (6) creation of additional school-based services, (7) referral to community agencies for mental health support, and (8) continuous review of data, to improve the coordinated mental health system and the individual treatment. 3. Managing a systemic change through linkages to qualified community partners, improved professional development, and implementation of evidence-based, culturally competent programs, DPS and its partners will foster a systemic change in the way our community understands and addresses mental health.	• The original intent was to develop a districtwide system to individualize planning regarding mental health needs for students based on Resource Coordination Teams (see goal #2 for details). This was not achieved, and the independent evaluation in retrospect deemed this goal to be overly ambitious. Partnerships with other agencies were also not expanded at the district level. • Per the independent evaluation, however, such a system (consistent with goals #2 and #3) was developed for the small number of students actually served by IDS. • Instead, grant activities shifted to be an impetus to further dialogue in DPS to identify students with mental health concerns. Before the grant, there was no programming for these students. The referral process from elementary schools for alternative placements more explicitly identified mental health and behavioral problems post-implementation, and the criteria for placement into IDS became more responsive, over time, to student emotional needs as opposed to classroom management needs. • IDS input helped catalyze interest in a common emotional needs identification process. A DPS taskforce set criteria for designating a student with Significant Identifiable Emotional Disability and chose the Behavior Assessment System for Children-II (BASC II) as a tool. • The IDS psychologist and social worker are frequently utilized by others in the district as resources for more effective and coordinated mental health care. They have led multiple district trainings and supervise interns. The IDS psychologist is a member of the DPS Crisis Team, Psych/Social Work Leadership Team, and the Significant Identifiable Emotional Disability Assessment Task Force.
El Paso County	
1. Individuals with a co-occurring disorder will have timely access to seamless, culturally competent services that enable them to achieve the outcomes they desire regardless of ability to pay. 2. To create successful, collaborative working relationships between and among mental health and SUD treatment agencies, as well as supportive services across El Paso County. 3. Individual treatment goals developed by the consumer in collaboration with family members, community agency representatives, treatment providers and the Resource Advocate will guide the planning and delivery of services, define the membership of the service team and establish standards against which outcomes are measured.	• A system for uninsured adults was developed, based on the Resource Advocate program and supported by comprehensive community training in Motivational Interviewing, as well as other supplemental training. This included development of 52 permanent housing placements, agency realignment to support integrated mental health/SUD care (co-location at one agency and integrated service offerings at six agencies), and implementation of a best practice needs/strengths assessment scale (ANSA). • Twelve of the 15 agencies originally participating in the project remain as active participants and contributors on the Steering Committee, measures of collaboration increased over time, and the Steering Committee was sustained beyond the grant period with an expanded mission. 100 percent of collaborative member agencies gave matching resources, funds, and/or staff during the grant. • The project developed a comprehensive, multi-agency, person-centered service planning process through the Resource Advocate program. Sixty-three behavioral health professionals were trained in the person-centered treatment process. Use of the ANSA was adopted by eight agencies, with training provided. Consumer and family involvement in the local behavioral health planning grew from two individuals to 12.

GOALS AND IMPLEMENTATION PROGRESS BY GRANTEE

GRANTEES AND GOALS	PROGRESS AND ACCOMPLISHMENTS
Larimer County	
1. Clients will be welcomed at all agencies, and will develop hopeful empathic relationships with agency staff. 2. Clients needing multiple services will experience the system as seamless, and be able to negotiate the system with ease. 3. Clients will have access to a variety of effective opportunities for recovery, including Integrated Dual Disorder Treatment (IDDT).	• More than 1,000 clinicians have received training in co-occurring disorder treatment over the course of the grant. A budget has been established and a plan is in progress to ensure ongoing co-occurring treatment training. • Initial efforts to work with the five partner agencies around co-occurring capability have been expanded to include providers and organizations throughout the community. Regular meetings of established committees have continued. All partner agencies now routinely screen for co-occurring disorders, and the availability of treatment groups for co-occurring disorders has quadrupled. A "guiding principles" document around integrated co-occurring treatment has been developed, and is in the process of being adopted by partner agencies as part of their policies and procedures. • The number of dually credentialed clinicians at primary treatment agencies has increased with the existence of the expectation of dual credentialing and supports implemented to ensure it. • An IDDT program now exists in the community, currently serving 15 individuals (with plans to expand to serve up to 20 additional individuals). External reviews documented very high levels of model fidelity. Participants have remained in the program, and most remain housed. Outcomes show reductions in emergency, inpatient, and criminal-justice service utilization and costs.

GOALS AND IMPLEMENTATION PROGRESS BY GRANTEE

GRANTEES AND GOALS	PROGRESS AND ACCOMPLISHMENTS
Mesa County	
1. Clinical goals: • Grow integrated mental health services in primary care settings, and improve clinical skills of integrated mental health staff in primary care settings. • Increase awareness and utilization of peer support resources among primary care clinic staff and in the community. • Promote a population-based disease management protocol for mental illness (this goal was dropped in year three, but was accomplished). 2. Operational goals: • Administrative and collaborative support of clinical goals. • Ensure that data are collected to document grant activities/outcomes and to support the provision of integrated care. 3. Financial goal: • Develop resources to sustain the integrated care model when the ACMHC grant program ends. • In year five, a single goal superseded the above: Finalize/implement clinical operational, and financial plans to sustain and grow integrated health care services in Mesa County, Colorado, after completion of the ACMHC project. • The project initially had one additional goal that was dropped in year three and no longer pursued: Explore the integration of assertive community treatment (ACT) and early childhood services into primary care in years three-five.	• Clinical progress: 1. Marillac's integrated care model was adapted and expanded to two very different sites: (1) St. Mary's Family Medicine Center (SMFMC) and (2) a private practice setting (co-location of Behavioral Health and Wellness co-located with Primary Care Partners). 2. Marillac Clinic implemented evidenced-based depression care guidelines and added Consumer Peer Specialists to its team. SMFMC implemented a population-based depression model as part of its electronic medical record, using the guidelines established by Health TeamWorks. 3. Efforts to expand to a small-practice site (Marillac's Palisade Clinic) met with mixed results (only supports part-time position, and scheduling is a challenge). 4. Colorado West Regional Mental Health (CWRMH) and Marillac negotiated arrangements to place a medical provider at CWRMH to serve uninsured people with serious and persistent mental illness, beginning in January 2011. 5. Behavioral Health and Wellness and Primary Care Partners began the process of discussing a merger. • Operational progress: 1. SMFMC and their partner (CWRMH) overcame many operational hurdles across two distinct organizations by: sharing data, dedicating staff to collaborative billing functions, and sharing clinical staff supervision. 2. The evaluation was successfully implemented, with tracking of integrated services simplified/improved and consumer/provider satisfaction surveys added. 3. The Council carried out numerous community education and outreach activities to support integrated care. Local leaders also shared their expertise at various local, regional, and national forums. 4. In March 2009, the Council established a more formal organizational structure as the Integrated Care Council of Mesa County, formalizing bylaws, a mission statement, and its role in the community. By the end of the grant, the Integrated Care Council had begun the process of incorporating as a 501(c)(3) nonprofit organization. 5. By year five, all sites either implemented or planned implementation of electronic medical records with the functionality to support integrated services that will facilitate sharing of information between sites. 6. The Community Education and Outreach Committee developed a relationship with the nursing and psychology departments at Mesa State College and arranged student placements at SMFMC. • Financial progress: 1. Initially, financial sustainability planning focused on the existing reimbursement system to fund integrated care. Due to multiple barriers the conversation shifted beyond procedure code billing to the patient-centered medical home (funding salaried positions for care managers and establishing per member, per month care management fees). 2. St. Mary's Hospital agreed to assume the grant-funded portion of the therapist position at SMFMC. It is also anticipated that the .33 FTE therapist position at Western Colorado Pediatrics (involving CWRMH) will likely be renewed, and perhaps expanded.

GOALS AND IMPLEMENTATION PROGRESS BY GRANTEE

GRANTEES AND GOALS	PROGRESS AND ACCOMPLISHMENTS
Prowers County	
The overall goal was to make behavioral health care accessible to all 14,220 residents of Prowers County through collaboration among key stakeholders. This goal was narrowed in year two to the establishment of: 1. A Community Evaluation and Referral Team (CERT), and 2. A school-based health clinic. The project originally proposed an additional jail diversion program and nurse-family partnership expansion. By year two, it became evident that this was too much, and a decision was made to eliminate the jail-diversion program and the nurse-family partnership.	• CERT implementation: 　1. The CERT was implemented by year two. The Project Coordinator handled most activities without the need for a collaborative CERT meeting. 　2. Over time, interest by the partners waned, and the project was discontinued by year five. • School-based health clinic implementation: 　1. A planning grant was secured from the Colorado Department of Public Health and Environment (CDPHE) in year two. Needs assessment and community acceptance building were carried out, and the clinic opened at Lamar High School early in year three. 　2. There was no funding for personnel, operating costs, or other expenses during the initial year. All partners donated staff time, operating costs, and supplies, demonstrating their commitment. Sixty-eight students were served. 　3. Beginning in year four, the project received funding from CDPHE for medical staff, substance abuse counselors, and a mental health therapist, as well as medical supplies, marketing and education, and staff travel. Numbers increased each year to 273 students by year five, and 154 students in the first three months of the following year. 　4. The project extended its oversight and evaluation one additional school year to continue sustainability efforts.

GRANTEES AND GOALS	PROGRESS AND ACCOMPLISHMENTS
Summit County	

1. Develop an effective community-based decision making system to guide the development and implementation of a fully integrated mental health system responsive to the needs of people with severe needs.
 	
2. Develop a comprehensive continuum of evidence-based mental health approaches and practices.
 	
3. Work with all levels of the community to increase awareness of the needs of people with emotional disturbances and mental illness, to change policies that restrict services for this population, and provide trainings for professionals and community members on effective supports.
 	
4. Use results of the local evaluation to improve governance, service delivery for the new integrated mental health system, sustainability, and replication purposes.
	• Community-based decision making:
	  1. The local ACMHC Steering Committee met regularly to oversee the project specific work-group activities and provide oversight on the direction of the initiatives. It developed mission, values and roles, and participated in a yearly process survey to assess the effectiveness of the group's interaction.
	  2. The Steering Committee partnered with: (1) the local Early Childhood Mental Health Advisory Group to work on system building for individuals aged newborn-18; (2) the Summit County Health Assessment 2020 Steering Committee, to champion and create an action plan for a coordinated mental health system; and (3) the local Network of Care (Summitcares.org), to create a comprehensive repository of referral information for mental health and SUD services (private and public therapists, and agencies, as well as qualifications, specialties and explanation of licenses). At the end of the grant, the maintenance and leadership of this function was passed on to CWRMH.
	
	• Establish a continuum of EBPs:
	  1. CWRMH and the Summit Community Care Clinic (SCCC) collaborated to form an integrated care pilot site with a full-time bilingual therapist, part-time psychiatrist, a certified addictions counselor, and peer support specialists. Included evaluation component based on national models. Created a memorandum of understanding in year five for sustainability of the program.
	  2. Implemented a service coordination model (Community Connections) for multi-agency involved families based through a Community Resource Team. Began serving families with children ages six-12 with mental health challenges. Expanded the age range of eligible children to age 14 in year three and through high school in year five.
	  3. Implemented consultation/referral helpline between High Country Health Care (private primary care provider) and CWRMH.
	
	• Community-level activities:
	  1. Multiple public awareness events and training were carried out in collaboration with the Mental Health Association of Colorado's Summit County chapter. Over time, this transitioned to sole leadership by the ACMHC Steering Committee.
	  2. Outreach/collaboration with the local Family and Intercultural Resource Center on Cultural Competency.
	
	• Evaluation related activities:
	  1. Developed evaluation plan for the services implemented, and gathered baseline data. Integrated care efforts were aligned with a broader national project secured after initial implementation.
	  2. Integrated care data was used to create treatment protocols at the clinic.
	  3. Data from the Community Connections evaluation was used to modify family interactions.
	  4. An annual process survey with the ACMHC Steering Committee was to inform protocols and activities.
	  5. Used evaluation data from the Community Connections program in grant writing for sustainability.
	  6. Evaluation activities will be sustained in all areas.

Appendix Three: Executive Summary of Independent Evaluation Findings on Services Integration[38]

Promoting Integrated Services

Advancing Colorado's Mental Health Care (ACMHC) was a $4.25 million five-year mental health care systems change and improvement project implemented in six communities across Colorado from 2005 through 2010. ACMHC was funded jointly by four Colorado-based foundations: Caring for Colorado Foundation, the Colorado Health Foundation, the Colorado Trust, and the Denver Foundation. In addition to funding grantee organizations located in each of six communities, the ACMHC Project contracted with TriWest Group to provide TA to grantees for the development and implementation of community plans intended to achieve these goals and Heartland Network for Social Research to conduct an independent program evaluation.

A primary focus of the ACMHC project was to improve the integration and coordination of mental health services for adults with SMI and children with SED. Mental health services research indicates that increases in services integration result in more person-centered services and positive quality of life outcomes for individuals with co-occurring disorders or problems and their families.

The efforts of the six grantee sites addressed three combinations of service areas for potential integration. The grantee sites are listed under each of the three integration types according to the project focus. It is important to note that the Summit County project, unlike the other five projects, had two integration foci that addressed both adult and children/youth service systems. The Summit County Collaborative is therefore listed twice -- under integration types #1 and #3.

1) Mental health and primary care services for adults with these co-occurring needs --

   Expanding The Circle in Mesa County Project

   The Summit County Collaborative -- adult system of care

2) Mental health and SUD services for adults with these co-occurring disorders -

   El Paso County's Co-occurring Collaborative

   Creating Integrated Services for People with Co-occurring Disorders Project (Larimer County)

3) Mental health services for children and youth (and their families) with complex and individualized needs in health, child protection, social skills, academic achievement, or community and vocational adjustment.

   Denver Public Schools (DPS) Integration of Schools and Mental Health Systems Project

   Prowers County Behavioral Health Integration Project

   The Summit County Collaborative - children, youth and family system of care

Evaluation of Services Integration

The primary evaluation question was: **Are mental health systems in the six communities more <u>integrated and person-centered</u> at the end of the five-year project than at baseline?** To better understand how to build strong systems of care, the corollary evaluative questions were: **What are barriers/challenges and facilitators to integration?**

The units of analysis for the evaluation were the *set of mental health and other service components of the systems targeted for integration by grantees.* Service systems are comprised of many organizations (service system components), and it was typical that a subset of the system components was targeted for system change. The term "services integration" is used throughout the report. This term refers to the set of services (system components) selected from larger systems of services that actively participated in these explicit processes of integration.

---

38 Demmler, J., and Coen, AS. (June 2011). Advancing Colorado's Mental Health Care Project: Integration of Mental Health Services.

"Services integration" includes the concepts of collaboration and coordination of services, but it is a more complex concept. Collaboration and coordination are necessary, but not sufficient elements of integration. Full services integration is more than the sum of the parts of the system - it is a new organization that requires new culture, new rules, new tasks and new language. Services integration is measured on a ranked scale developed by William Doherty and his colleagues, and adapted by the Colorado Behavioral Health Council. Levels of collaboration are identified as points on the following 5-point ordinal scale in which there is no services integration in Levels 1 and 2 and subsequently *minimal*, *partly* and *fully integrated systems* in Levels 3, 4 and 5:

Level 1: *Minimum collaboration (professionals work in separate facilities, have separate systems and rarely communicate about cases)*

Level 2: *Basic collaboration at a distance*

Level 3: *Basic collaboration on-site with minimal integration*

Level 4: *Close collaboration in a partly integrated system*

Level 5: *Close collaboration in a fully integrated system (professionals work as team sharing the facility and sharing a bio-psychosocial paradigm of care)*

Because the scale reflects the dual dimensions of collaboration and integration, reference to these levels are noted as LOC/Services Integration.

Services Integration Data Sources

Given the variation of proposed types of integration and strategies to increase integration among the selected services, the evaluation design is a multi-case study. Both qualitative and quantitative data have informed the answers to the evaluative questions.

Use of a similar measurement of integration across sites was determined to be essential to assist in the comparison of organizational outcomes. In an attempt to meet this challenge, an inter-organizational survey (IOS) was crafted as a quantitative measurement tool. The survey was used to collect "baseline" data in the summer/fall of 2007; a follow-up measurement was conducted after the end of the grant. It is important to note here that this "baseline" timeframe was well into the second year of the ACMHC project. A year of planning had been undertaken, and grantees had begun to implement their plans by the middle of year two.

In addition to the repeated-measures survey data, the evaluators used data provided by the grantees in the form of progress reports, key-informant interviews and observations of collaboration activities. Descriptions of project activities, as well as identified challenges and facilitators, were documented in reports. Follow-up interviews were conducted with project coordinators and other stakeholders who were identified as persons with potential relevant knowledge about the efforts towards integration. In three sites, Denver, Summit, and Larimer counties, the evaluators also conducted case studies of individuals/families who had been clients of new programs. All of these qualitative data sources were used to augment the quantitative survey data to make judgments regarding the potential increase in services integration.

Evaluative Findings

Overall, the ACMHC project intention to increase integration of mental health services in grantee communities was successfully accomplished. In five of the six grantee communities, there was evidence of increased services integration; some sites made far more progress toward full services integration than others. In El Paso, Larimer, Summit and Mesa counties, there have been substantial increases. In Prowers County, there was progress toward integration, but the progress was limited to the establishment of co-located primary care and behavioral health in a local high school health clinic. The sixth site, located In Denver, was unique in its organizational environment and its achievement. Located within the large and complex organization of DPS, the Denver project developed "from scratch" a fully integrated mental health

and academic program for youth with serious mental health problems within DPS. There was little evidence of increased integration of community services with DPS services, but there was evidence of a small increase in integration of services within the very large DPS organization that resulted from the establishment of the DPS integrated program. Additional evaluative findings addressed the level of services integration evident at the end of the grant period for each site. The LOC/Services Integration ranks discussed above were used to identify each project's location along such a continuum. These evaluative judgments for each site are presented below:

- **Denver County.** The Intensive Day School (IDS) program established within DPS provided fully integrated academic, social and mental health services. The program coordinator, teachers, paraprofessionals, social worker and psychologist worked together as a team to value and promote academic achievement and emotional wellness for the enrolled students and their families. LOC/services integration of the IDS with other DPS programs and community health and human services remained at **Level 2: basic collaboration at a distance, where professionals work in separate facilities, but have active referral linkages**.

- **El Paso County.** At the end of the grant, this site achieved a LOC/services integration rank between a Level 2: basic collaboration at a distance, and Level 3: close collaboration on-site. A few core agencies worked closely with each other around specific clients. In this way, there was very close collaboration between some agencies, even though the staff were not co-located. A strong commitment to cross-training professionals from multiple systems in the same EBPs for the treatment of co-occurring disorders suggests a somewhat unique approach to integration. Also, among the service system components, one health agency hired a behavioral health professional to join the agency staff and demonstrated **Level 3: close collaboration on-site.** Co-located behavioral health and physical health professionals share clients, regular communication about these clients, and use of the same organizational system infrastructure.

- **Larimer County.** While there remain challenges with regard to funding for the integrated services and policy variation across the array of services needed for a population that has co-occurring mental health/SUD, this set of services was integrated at the highest level on the continuum - **Level 5: close collaboration in a fully integrated system at the end of the grant.** Additionally, the Larimer project established a fully integrated program, the Community Dual Disorders Team (CDDT) serving this population. CDDT staff are co-located, trained in specific skills to treat persons with dual disorders, employ co-facilitated treatment and work as an integrated care team.

- **Mesa County.** This project increased integration in two primary care settings. 1) The first setting is the St. Mary's Family Medicine Center which has established an adapted model of primary care/mental health care integration that achieved **Level 5: close collaboration in a fully integrated system.** Co-located services are provided and co-facilitated groups are practiced. Mental health providers work as members of the clinic team to form an integrated care team.

  A second setting houses a private mental health practice and primary care/pediatric medical practices. The level of integration achieved is **Level 4: close collaboration in a partly integrated system.** Mental health professionals are co-located in the pediatric office to provide evaluation, therapy and case management services to Medicaid children and their families. In addition, there is psychiatric consultation regarding specific cases that includes a psychiatrist, a mental health therapist and a pediatric medical provider.

- **Prowers County.** At the end of the grant the components of the system of care that involved the school-based clinic achieved **Level 3: basic collaboration on-site.** No such collaboration existed before the ACMHC grant. By the end of the grant both the primary care provider from High Plains Community Health Center and a mental health provider from Southeast Mental Health Services were co-located in the Lamar High School. Because the mechanism proposed to increase services integration among the wider range of agencies that provide services to children, youth and families (the Community Evaluation and Referral Teams) has been discontinued, a LOC/services integration rank is not provided.

- **Summit County: Adult System of Care.** While funding the tasks and roles necessary to perform integrated care continues to be a challenge, the services provided at the Summit Community Care Clinic achieved a **Level 5: close collaboration in a fully integrated system** at the end of the grant. This integrated care includes universal mental health screening for all individuals who seek medical care at the clinic. Behavioral health professionals employed by the clinic work as an integrated care team with both the primary care providers and the patients.

  Summit County: Youth System of Care. Most of the youth system of care at the end of the grant was at **Level 2: basic collaboration at a distance where professionals work in separate facilities, but have active referral linkages.** The Community Connections Program and its Community Resource Team enhance the collaboration among services and ensure active referral linkages. In the latter part of the grant, one segment of this system of care, primary care and behavioral care, increased to Level 3: basic collaboration on-site because this care is co-located in schools.

ACMHC Lessons Learned and Recommendations

What are the lessons learned regarding successful integration and coordination of mental health systems? Largely confirmatory of what is known or assumed by many in the field, these lessons highlight the hard work, challenges and successes of services integration. Lessons are presented that are applicable for three types of stakeholders/audiences, a) community agencies that seek to implement strategies to improve service/system integration, b) funding agencies, and c) federal and state policy makers.

LESSONS LEARNED FOR COMMUNITY STAKEHOLDERS

1. Increased integration of units within large bureaucratic agencies with mental health services presents a unique set of challenges. Program integration within such large organizations may be an important or critical step toward service/system integration.

2. Increased integration is more likely achievable if significant organizational and cross-agency barriers are anticipated and proactively addressed at the initial envisioning of the proposed integrated service or system.

3. Increased integration is most achievable if the effort is focused. Trying to do too much means some proposed grant strategies are abandoned or a strategy does not result in the anticipated increased integration or service coordination.

4. Increased integration requires specific training of staff with regard to the concept of integration, its attributes and benefits.

5. Increased integration is most likely to result when there is explicit cross-training of staff from the services/systems to be integrated.

6. Increased integration is likely to be facilitated by "carrots" for organizations that comprise the service system. Incentives to increase participation in training is an example of such a "carrot."

7. Increased integration is most likely to take place if stimulants towards integration occur from more than one service sector or funder.

LESSONS LEARNED FOR FUNDING AGENCIES

1. Increased integration is possible in all three types of services integration proposed for this broad "system change" project. Increases occurred in: a) primary care/mental health in a primary care setting; b) mental health/SUD treatment for adults; and c) mental health services for students with complex and individualized needs in health, child protection, social skills, academic achievement, or community and vocational adjustment.

2. Increased integration is a more likely outcome if projects have a scope of integration with defined boundaries and identified services (system components).

3. Increased integration is facilitated by a point person whose primary function is to promote systems change in the form of integrated programs or services.

4. Increased integration is facilitated by additional funds that could be used as "carrots" to encourage specific training across agencies or collaboration activities.

5. Given the innovative character of integration in these sites, the availability and accessibility of TA from a group of experts has been an important contribution toward achieving integration. Funding for TA is essential, as is explicit opportunities for stakeholders from different sites to learn from each other.

6. As long as reimbursement policies are not crafted to promote integrated care, agencies must seek other funding sources to pay for direct integrated services. An important lesson from ACMHC is that initial support of these staff positions by the Funding Partners resulted in community agencies picking up selected costs of integrated care.

LESSONS LEARNED FOR POLICY MAKERS

1. Local agency managers and staff who seek to conduct integrated care for persons with co-occurring mental health/SUD continue to be challenged with regards to reimbursement of co-facilitated treatment.

2. Local agency managers and staff seeking to provide integrated care also struggle to be reimbursed for the tasks necessary to delivery specific services. (For example, the professional time needed to ensure continuity of care among professionals, i.e. "warm handoffs" either to medical or mental health staff, and care management are not currently reimbursed.)

3. There is a critical incongruence of public housing policy and policy of some mental health programs targeted to persons with co-occurring mental health/SUD. The public housing authority can refuse to rent its housing units to persons who have broken rules. Treatment approaches such as the Community Dual Disorders Team (CDDT) have a different policy, one that does not "fire the patient." In one case, the client cannot receive a service after a rule is broken and in the other case, the team attempts to keep the client engaged in treatment even if he or she is not always compliant with the treatment plan. These incongruent policies have been a challenge for long-term clients and staff of programs that serve persons who have co-occurring mental health/SUD.

4. The regional and national challenges of separate funding streams and confidentiality of patient information require specific attention, because local ACMHC integration efforts faced challenges and barriers due to current federal and state policies.

RECOMMENDATIONS

1. Begin the process of integration with a well-articulated understanding of the services that will be the effort's focus. Identify the components of a system, and expected attributes of integration. Try not to use the term "integration" as only a broad concept, but define the type of integration that is expected as the organizational outcome.

2. Because integration is an incremental process, recognize that increased integration is both possible and takes time. Focus on one aspect of services integration, and plan steps toward the achievement of integrated services.

3. Establish a state-level review to determine how reimbursement policies for state-funded services and private insurance are obstacles for the development of integrated services, and propose revised policies to facilitate integrated care reimbursement.

4. Within the discussion of health care reform, policy makers should identify specific tasks of integrated primary care, mental health care and SUD treatment that are required for effective care, and recommend the inclusion of these roles or tasks in the cost of providing good care.

5. Promote training about integrated care in both professional education and in-service training of medical and behavioral health personnel.

6. Establish a task force of mental health professionals and housing administrators to review policy congruence and conflicts between public mental health systems and public housing.

Appendix Four: Summaries of Integration Efforts by Grantee From the Independent External Evaluation[39]

Denver Public Schools: Integration of Schools and Mental Health Systems Project

INTEGRATION SUMMARY

Project intent. The ACMHC project intent was to "create a systemic change" in how the Denver Public School District (DPS) supports students with mental health issues by developing a continuum of support and services to reflect the needs of students with a range of mental health problems and needs. This was an ambitious, complex, multi-tiered plan that called for integration in three organizational spheres: 1) within a proposed specialized DPS program, the Intensive Day School (IDS), 2) within DPS, and 3) among Denver's community-based child/family serving agencies that included DPS. The integration process in each sphere would require its own strategies and skills.

Increase in program integration? The IDS developed as an entirely new and unique program during the course of the ACMHC grant. Developed for youth who have SED, there was equal emphasis on academic and social/emotional needs of these youth, as well as support and education for families. At the end of the grant period, **as a program within DPS, the IDS provided fully integrated academic, social and mental health services**. The program coordinator, teachers, paraprofessionals, social worker and psychologist worked together as a team to value and promote academic achievement and emotional wellness for the enrolled students and their families. The IDS continued after grant funding, albeit without the project director position, as a program model of integrated services.

Increase in services integration within DPS? There were a few signs of increased services integration within DPS by the end of the grant. Most prominent was the acknowledgement of staff in the Special Education department regarding important differences in student and service needs between students with primary mental health versus conduct/behavior problems and in DPS' efforts to address these needs. This understanding, more congruent with the views of IDS, enhances collaboration of DPS staff. There were significant organizational barriers, however, to

achieving integration of services for children with mental health problems within DPS. Chief among these were: 1) the dual oversight and administration by DPS. Prevention and Intervention and Special Education departments, and 2) minimal involvement of Special Education in the initial grant writing and lack of Special Education's buy-in for important processes that were planned (for example, the enrollment of non-Special Education students into IDS, or the right of IDS to refuse a recommended placement).

Increase in mental health services/system integration? At the community/system level, there was substantial coordination of services with the Mental Health Center of Denver (MHCD), a primary referral source for IDS. There was limited, but important, collaboration of IDS with other agencies such as the Denver Department of Human Services, and other referring agencies. While important and foundational to broader system integration, this collaboration was chiefly at the client level, rather than the service system level.

Important service system integration efforts were made early in the project and then again at the end of the project, but there were significant barriers to broader system-level integration. These included: 1) the high level (needed) of focus on the development and implementation of IDS program required significant time and effort from the project director, leaving less time for the very different work needed to engage and maintain engagement of community partners beyond client-level collaboration and information exchange; 2) at least in part, the differing skill sets for program development and system integration presented a challenge for the project director; 3) at least one important partner, a parent advocacy group, was lost when it became clear that the IDS would not enroll students who were not designated as Special Education. There is a need in the community for services to other youth who have serious problems and very limited access to services; 4) there did not seem to be a system/community integration agenda – when community partners did meet, the time was usually spent discussing the specifics of the IDS, which, while very important, did not give partners the substance needed to engage (e.g., funding, access), and finally, 5) the broader integration envisioned was most likely beyond

---

what could be accomplished realistically with a small group of individuals within a very large organization within a very large community.

At the end of the grant, the LOC/Services Integration remained at **Level 2: basic collaboration at a distance**. IDS, MHCD and a few other community agency staff were aware they were resources for one another, and communicated about shared clients and families. Future efforts at service system integration will be aided by the foundational work that resulted in what is likely an integrated-model program within the district and the state.

LESSONS LEARNED

1) It is possible to develop and implement an integrated-model program within a complex organizational structure without full services/system integration; however, the program is more vulnerable with regard to sustainability and fidelity.

2) When considering services/system integration, it is critical to consider its community and organizational context. Reviewers and funders of proposals may not always be aware of the complex relationships among and within departments of large organizations and how these may affect the implementation of a project. It was only after the evaluator started documenting and diagramming the organizational structure, roles, and responsibilities of the many players, that some inherent challenges became evident. Requiring the applicant to be more explicit in this regard as well as securing clear buy-in from all components would be helpful in many respects.

3) Assisting grantees to identify realistic goals and objectives early on in the process of services integration would facilitate the very focused effort required to achieve increased services integration.

El Paso County
Co-occurring Disorders Collaborative

INTEGRATION SUMMARY

Project intent. The intent of this project was to create a seamless, culturally competent system of care that enables **uninsured adults with co-occurring SMI and SUD who are residents of El Paso County** to achieve their desired outcomes.

Increase in mental health services/system integration?
Services integration of a wide array of services for persons who have co-occurring mental health/SUD increased over the course of the ACMHC grant. The project director led the El Paso County Co-Occurring Disorders Collaborative (a.k.a. the Collaborative), representing more than a dozen direct and non-direct service agencies. Staff from these agencies met regularly to consider critical system-level issues such as policy, cross-training, reimbursement strategies, advocacy for the target population, as well as the sustainability of funding for collaborative activities. An integrative program, the Resource Advocacy Program – staffed by Resource Coordinators, themselves consumers of mental health and/or SUD services – provided support and a coordinating function for the newer users of the system. The Collaborative worked toward a system where "any door is okay" by providing substantial amounts of cross-training in best practices to providers throughout the system, and the plan to place Resource Coordinators throughout the system.

At the end of the grant, this site achieved a LOC/services integration **between a Level 2: basic collaboration at a distance and Level 3: close collaboration of co-located staff**. The foundation for system integration was set by the Collaborative. Key agencies remained engaged throughout the project. Collaborative members advocated as a new entity, and valued their membership. They demonstrated more than "basic collaboration." A few core agencies worked closely with each other around specific clients. In this way, there was very close collaboration between some agencies, even though the staff were not co-located. Also, among the service system components, one health agency hired a behavioral health professional to join the agency staff and demonstrated **Level 3: close collaboration of co-located staff**. These behavioral care and medical staff shared clients, regular communication about these clients, and use of the same organizational system infrastructure.

1) The importance of leadership cannot be overstated. This site experienced early turnover in key staff, and found a project director with skills in community leadership, group facilitation, training, and program development and implementation. If one person does not have these skills, it is important that the roles be filled by multiple staff members.

2) An important theme throughout this implementation was flexibility. This site was challenged with a difficult political climate, shrinking community funds, and multiple service agencies with different as well as overlapping roles. They did "whatever it took" to keep moving forward, i.e. using flexible dollars to target needed resources, creating incentives for agencies to participate, and figuring out how to work with agencies that may not have been the easiest to work with, rather than writing them off and moving on without them.

LARIMER County – Creating Integrated Services for People with Co-occurring Disorders Project

INTEGRATION SUMMARY

Project intent. The ACMHC Larimer County project intended to "create system changes" to better serve persons who have co-occurring mental illness/SUD. An integrated system would provide better "access to co-occurring services." Treatment and other services for both disorders would be available at one location and "treatment would be more than the sum of combining mental health and substance treatments." To achieve this goal, clinicians would be trained specifically to treat persons with co-occurring disorders.

Increase in mental health services/system integration?
The integration of public mental health services and SUD treatment services increased substantially over the course of the grant. These services are now under the auspices of one organization, and a large number of staff members employed by this organization have been cross-trained as addiction counselors and mental health workers. While there remain challenges with regard to funding for the integrated services and policy variation across the array of services needed for this population, this system achieved a

Level 5: close collaboration in a fully integrated system on the LOC/services integration continuum.

Concurrently, the Larimer project established a fully integrated program serving persons with co-occurring mental health/SUD This program, the Community Dual Disorders Team (CDDT), is an adaptation of the evidence-based Individual Dual Diagnosis Team. CDDT staff members are co-located, trained to treat persons with dual disorders, employ co-facilitated treatment and work as an integrated care team.

LESSONS LEARNED

1) There are incongruent policies of service eligibility across two services in this project that created a major challenge to accessing subsidized housing units for persons with co-occurring mental health/SUD. The public housing authority can refuse to rent its housing units to persons who have broken its rules. The Community Dual Disorders Team (CDDT) has the opposite policy, one that does not "fire the patient" if a client is not compliant with a treatment plan. Rather, CDDT staff attempt to keep the client engaged in treatment and essential to that treatment is a stable residence. Further integration of mental health care and housing services would require a review of policies and development of shared policy for this population.

2) The difficult work of service system integration is likely more successful when it is promoted in multiple ways, and is conducted within a community that has a pre-existing collaborative body focused on this system change. The accomplishment of full integration of public mental health services and SUD treatment was facilitated by the combined efforts of cross-training and program development supported by the ACMHC grant, and other pre-existing and concurrent community efforts to promote integration of these two systems.

Expanding the Circle in MESA County

INTEGRATION SUMMARY

Project intent. The proposed project would expand the "Marillac Model," a model of integrated primary care/mental health care developed at this private, nonprofit medical clinic to other medical and social service settings. Prior to the ACMHC grant, integrated care was established and refined with the assistance of a grant from the Robert Wood Johnson Foundation.

Increase in mental health services/system integration? This project increased integration in two primary care settings.

1) The first setting is the St. Mary's Family Medicine Center, which established an adapted model of primary care developed at the Marillac Clinic. A **Level 5: close collaboration in a fully integrated system** was achieved in which services are co-located and where co-facilitated groups are practiced. Mental health providers work as members of the clinic team to form an integrated care team.

2) A second setting houses both a private mental health practice and primary care/pediatric medical practices. Integration increased such that the mental health professionals are co-located in the pediatric office (not just co-located in the same building) for 9.5 hours each week. Colorado West Regional Mental Health Center contracts with the private mental health practice to provide evaluation, therapy and case management services to Medicaid children and their families. In addition, there is psychiatric consultation regarding specific cases that include a psychiatrist, a mental health therapist and a pediatric medical provider. The LOC/services integration achieved was **Level 4 - close collaboration in a partly integrated system**.

LESSONS LEARNED

1) The full integration of primary care/mental health services was accomplished because there was both a model of integration that could be almost replicated and a setting willing to absorb the additional cost of integrated care needed to implement this model. While the integration at the St. Mary's Family Medicine Center is not precisely the same as that of the Marillac Clinic, many of the important elements of integration were known to the grantee and clinic staff and could be

either replicated or easily adapted to the new setting.

2) The St. Mary's Family Medicine Center gained a well-versed champion of the integration of primary care/mental health care during the course of the grant. Such a champion is an important element of the development of integrated care. The hiring of Dr. Randall Reitz as faculty in the residency program greatly facilitated the increase to full integration in this setting. Dr. Reitz promoted the model of an integrated care team and trained residents in this model.

3) Training of both mental health and primary care staff performed a critical role in the expansion of the integrated care model in this site. The commitment of persons who had interest in learning about the elements of integrated care in the national Certificate Program in Primary Care/Behavioral Health provided both an understanding of the overall concept of integrated care, and concrete and practical lessons about the success of integrated care in primary care settings.

PROWERS County Behavioral Health Integration Project

Integration Summary

Project intent. The Prowers County Behavioral Health Integration Project intended to establish four new components to the mental health system as ways "to integrate and pool the resources of various agencies in the community" (grantee proposal). Once the planning was in progress, the new components selected to be implemented were the community evaluation teams (CERT) and a school-based health clinic that would integrate primary care/mental health care.

Increase in mental health services/system integration? Increased collaboration of mental health care, primary care, and education systems has been established in a school-based health clinic. Located at Lamar High School, a federally qualified health clinic provider is co-located with a public mental health worker. A student advisory group named this clinic WHELL, or We Help Everyone Live Longer. The implementation of this aspect of the ACMHC project was assisted by a complementary planning grant from the Colorado Department of Public Health and Environment (CDPHE) and additional CDPHE grant

funds for clinic staff salaries. At the end of the grant, the components of the system of care for youth involved in the school-based clinic had achieved **Level 3: basic collaboration on-site**, a step prior to services integration.

The second ACMHC implemented strategy toward increased integration, the Community Evaluation and Referral Team (CERT), was implemented to a limited extent, but discontinued at the end of the grant. While the project coordinator performed a role that assisted clients to obtain services, the CERT did not function as proposed. Agency staff did not meet regularly to collaboratively work to facilitate services for families. Project coordinators assumed the role of a case manager who would broker services without multi-agency meetings. Real or perceived limited resources among agencies impacted the potential collaboration.

LESSONS LEARNED

1) Coordinating grant awards to implement the very challenging effort to integrate services proved to be a successful strategy. The sustainable portion of this project to integrate services, the school-based health clinic, was supported not by one grant (ACMHC), but by two simultaneous grant awards. This additional grant award not only made possible the health clinic's sustainability, but also provided additional encouragement to organizational staff to pursue a project that had known challenges to implementation among the residents of Prowers County.

2) Real or perceived limited agency resources resulted in a "non-starter" in the effort to integrate the wide array of community resources. Although there are multiple factors that contributed to the inability to fully implement and sustain the service coordination aspect of the grant, one stated reason by staff was the lack of agency resources to assist basic needs of very low-income residents of the county. Very scarce resources, whether real or perceived, in a rural area in a time of economic recession may be a substantial challenge to increasing services integration.

SUMMIT County Collaborative – Adult System of Care

INTEGRATION SUMMARY

Project intent. The Summit County Collaborative proposed to integrate mental health services into primary care settings. The initial setting would be the Summit Community Care Clinic (SCCC), an independent, nonprofit clinic that serves low and moderate-income residents of Summit County. The model to be implemented would be based on the "Marillac Model," a model developed by the Marillac Clinic, which serves low-income residents in and around Grand Junction, Colo. Additional mental and physical health collaboration efforts would be conducted in a private, for-profit medical practice (High Country Health Care in Frisco) and with a private, nonprofit hospital in Frisco (St. Anthony Summit Medical Center), as a way to "expand integrated care."

Increase in mental health services/system integration? By adapting the integrated care model of the Marillac Clinic, integration of mental health services and primary care provided at the Summit Community Care Clinic increased to a great extent over the course of the ACMHC grant. While there continued to be the challenge of funding the tasks and roles necessary to perform integrated care, the services provided at the Summit Community Care Clinic achieved **Level 5: close collaboration in a fully integrated system** at the end of the grant. This integrated care includes universal mental health screening for all individuals who seek medical care at the clinic. Behavioral health professionals employed by the clinic work as an integrated care team with both the primary care providers and the patients, who indicate mental health needs on the initial mental health screen.

This very substantial integration increase of mental and physical health care was essentially limited to the services of Colorado West Regional Mental Health Center and the Summit Community Care Clinic, because there was minimal expansion of integration of mental health and physical care in the other two proposed settings. A consultation/referral helpline between High Country Health Care and Colorado West Regional Mental Health Care was maintained over the course of the grant period.

LESSONS LEARNED

1) Within five years, full integration of primary care/ mental health can be achieved (using the resources of a nonprofit community mental health center and a primary care clinic) in a setting that is not dependent upon cost reimbursement for provided services.

2) Learning and applying implementation lessons and essential elements of integration from an existing model of integrative care is a useful strategy to achieve full (Level 5) integration.

3) Given the amount of work required to develop integrated care in one setting, additional resources (either in-kind or awarded) allocated to integration efforts would be an important consideration if more than one integration effort is to be undertaken within one grant period.

SUMMIT County Collaborative - Youth System of Care

INTEGRATION SUMMARY

Project intent. Under the auspices of the ACMHC grant in Summit County, there were three discrete efforts to change and improve the system of care for children, youth and families: 1) the Community Connections program, 2) behavioral health care in school-based clinics, and 3) "development of an effective community-based decision-making system to guide the development and implementation of a fully integrated mental health system," as abstracted from the grantee proposal.

Increase in mental health services/system integration?
Through the establishment of the Community Connections Program and its Community Resource Team, the ACMHC grant contributed to increased collaboration of services for youth and their families. A formal Letter of Collaboration describes the expectations among 10 agencies. Under the auspices of the Summit Community Care Clinic and its newly created position of Behavioral Health Director, behavioral health services were added to primary care, immunizations, and oral health care already provided in two Summit County schools. The goal to establish a communitywide oversight body that would make funding decisions for services for both preschool and school-age youth and their families was not fully achieved. A comprehensive directory of mental health

and SUD resources that resulted from this effort is available on the Summit County website, and contributes to increased collaboration and coordination of services within the system of care.

For the most part, the youth system of care at the end of the grant was at **Level 2: Basic collaboration at a distance** on the LOC/services integration continuum. In the latter part of the grant, one segment of this system of care, primary care and behavioral care, increased to **Level 3: basic collaboration on-site**, because this care is co-located in schools.

LESSON LEARNED

Of the three discrete efforts to change/improve the system of care for children/youth and families, the concrete programmatic efforts with more limited target populations were achieved while the effort that addressed the needs of the widest possible population (ages newborn-18 years), and attempted major change in system structure, was not attained through the grant process. The effort to develop an effective community-based decision making system not only targeted a very wide range of agencies, but also sought to include both public and private providers of mental health and human services. A lesson of systems change toward greater integration from this site is that, if there are multiple integrative strategies, effort may gravitate to the more concrete or programmatic (and perhaps less difficult) aspects of service coordination. To achieve improved integration of a wide array of agencies whose targeted populations are varied, a grant effort that solely focuses on this most challenging goal might be required to successfully achieve system change in this very large arena.

Final Grantee Report
ADVANCING COLORADO'S MENTAL HEALTH CARE
DECEMBER 2011

CARING FOR COLORADO
FOUNDATION

The Colorado Health Foundation™

THE COLORADO TRUST

THE DENVER FOUNDATION