doi: 10.4087/FOUNDATIONREVIEW-D-12-00024.1

Moving From Partnership to Collective Accountability and Sustainable Change: Applying a Systems-Change Model to Foundations' Evolving Roles

Karen W. Linkins, Ph.D., Desert Vista Consulting; Lynda E. Frost, J.D., Ph.D., Hogg Foundation for Mental Health; Becky Hayes Boober, Ph.D., Maine Health Access Foundation; and Jennifer J. Brya, M.A., M.P.P., Desert Vista Consulting

Keywords: Sustainability, systems Change, collective accountability, integrated care

Key Points

- In a time of scarce resources and significant needs, funders may seek to maximize the impact of their grantmaking through collaboration. While many foundations move well from identifying a problem to building broader awareness and forging key partnerships, they typically flounder in trying to move beyond collaboration to a sense of mutual responsibility or collective accountability for the greater good, which is a precondition for sustainable systems change.
- This article discusses three complex initiatives that made sustainable changes in integrated behavioral health and primary care. Using a conceptual framework based on the Building Blocks of Systems Change model, this article focuses on achieving collective accountability and sustainable systems change, highlights common challenges, and presents guidelines for funders.
- While the article details how various policy approaches and tools drove cultural transformation in these three funding regions, the conceptual framework and lessons learned apply to a broad range of environments and intended outcomes. These lessons can be used to move initiatives to collective accountability and systems change, so that the change becomes the new "normal," independent of external funding or expectations.

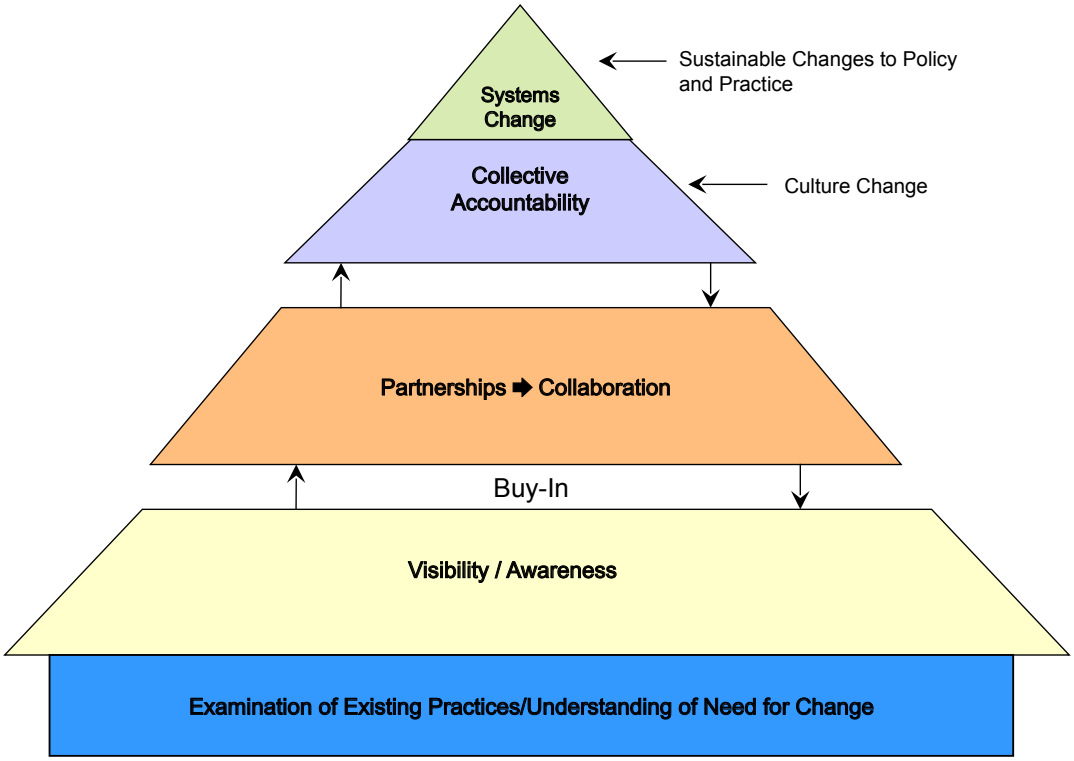
Introduction

In a time of scarce resources and significant needs, funders may seek to maximize the impact of their grantmaking through collaboration. Foundations partner with other foundations to co-fund initiatives, or they partner with advocacy and trade associations to improve the policy environment. Many foundations move well from identifying a problem and needed changes to building broader awareness and forging key partnerships. Typically, though, they flounder in trying to move beyond partnership and collaboration to a sense of mutual responsibility or collective accountability for the greater good, which is a pre-condition for sustainable systems change.

The systems-change[1] process is complex and dynamic, and involves multiple interrelated players, strategies, and programs. Increasingly funders frame their work as focused on systems change, but too often their initiatives fail to reach their goals (Foster-Fishman & Behrens, 2007). Typically, demonstrations and interventions are implemented to address a problem, yet the

[1] There is a vast literature on systems theory and what constitutes a system. In general, systems are a collection of interacting, interdependent parts that function as a whole and include subsystems, networks, and overlapping or nested components (Ackoff & Rovin, 2003; Foster-Fishman & Behrens, 2007). In this article, we use "systems change" to refer to "an intentional process designed to alter the status quo by shifting and realigning the form and function of a targeted system" (Foster-Fishman, Nowell, & Yang, p. 197, 2007).

FIGURE 1 Building Blocks of Systems Change



result is rarely sufficient to cause a sustainable and permanent change. Institutionalizing and spreading a new approach requires changes in organizational cultures and behaviors, as well as policies, practices, and procedures within and across organizations. For systems-change investments to succeed, it is essential that programs move beyond the immediate goals of a specific intervention and transform into changes that are sustainable beyond the investment of grant funds and the funded initiative.

This article provides examples of three complex initiatives that made sustainable changes in integrated behavioral health and primary care. Using a conceptual framework based on the Building Blocks of Systems Change model (Linkins, Brya, & Chandler, 2008), this article focuses on achieving collective accountability and sustainable systems change, highlights common challenges, and presents guidelines for funders. It details how various policy approaches and tools drove cultural transformation in the different funding regions. While the examples are health-related initiatives in Texas, California, and Maine, the conceptual framework and lessons learned apply to a broad range of environments and intended outcomes. These lessons can be used to move initiatives to collective accountability and systems change, so that the change becomes the new "normal," independent of external funding or expectations.

Building Blocks of Systems Change

The Building Blocks of Systems Change model (Linkins et al., 2008) was developed as a practical conceptual tool (see Figure 1) to help align the activities and expectations of funders and grantees in designing and building strategies to achieve lasting systems and policy change. The model

TABLE 1 Key Questions to Address at Each Systems-Change Level

Domain 1: Identifying and Examining the Problem	
• What system(s) do you want to change? • Who has the authority to make those changes? • What are the key relationships and system interactions? Do they support or get in the way of your goal? • What are the power dynamics within the community? • What data are available to show the status and issues that need to change?	• Is there identified leadership (within or outside of the system) with a vision for how to change the system? Does that leader have the ability, willingness, and influence to achieve the change? • Who needs to be educated to create buy-in for change?
Domain 2: Raising Visibility and Awareness	
• What information, presentations, publications, and trainings have been developed and disseminated? To whom? • What evidence of potential or actual program impact has been generated and how has it been disseminated?	• What reinforcement trainings have been necessary to maintain or generate buy-in or public will? • Have key stakeholders been invited to participate in a collaborative?
Domain 3: Developing Partnerships and Collaborations	
• How have partnerships and collaborations across systems changed referrals, service delivery, and transition planning? How have these changes been formalized (e.g., MOUs)? • What new protocols have been developed due to greater collaboration? • What new partnerships have resulted from implementing the program or initiative?	• How are partners sharing or leveraging resources/staff across systems to improve efficiency? • How does collaboration improve communication and data sharing? • How is the partner organization reducing fragmentation?
Domain 4: Achieving a Sense of Collective Accountability	
• Does the partnership/collaboration extend beyond the original target population or issue addressed by the funded initiative? • Are data being shared consistently across systems to better understand and address the needs of the population and the impact of programs/services? • Is collaboration part of the "culture" and way of doing business across systems involved in the grant-funded program?	• Does cross-system collaboration lead to new joint funding opportunities? • Are funding streams pooled or blended across systems to better serve a shared population or address a shared concern? • Do collaborative partners share a vision for policy and advocacy activities?
Domain 5: Sustaining Changes to Policies and Practices	

understands that the progression toward systems change is dynamic and ever evolving within programs and among the various participating stakeholders and systems. By design, it offers an accessible way to approach systems change by highlighting the key domains of implementation activities that occur during this complex process. Maintaining broad classifications enables the range of stakeholders (e.g., funders, grantees, other partners) participating in systems-change initiatives to identify or categorize where the majority of effort and resources are going and to make adjustments as necessary. There are several key questions associated with each domain of the Building Blocks of Systems Change model that facilitate the development of indicators to assess progress toward systems change within and across organizations and communities. (See Table 1.) These key questions help funders and grantees analyze their work and ground the array of implementation activities within the five domains related to systems change.

While systems change is not a linear process, the Building Blocks framework positions the first three domains (understanding the problem, visibility and awareness, partnership and collaboration) of the progression as foundational. Interestingly, these three domains are where many systems-change-oriented initiatives concentrate activities and allocate the majority of their resources. During these stages of systems-change "growth," there are continuous feedback loops that facilitate the progression by generating buy-in across partners or providing data or evidence to build and support greater awareness of the issues being addressed. As organizations gain greater visibility about a given problem or population, they acquire more partners and often deepen their collaborations; this, in turn, brings about a deeper understanding of the problem and reinforces the recognition that change is needed. In addition, feedback can strengthen and improve implementation and enhance cross-system learning. The collaborations built are experienced as "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve a common goal" (Mattessich, Murray-Close, & Monsey, p. 39, 2001).

Complex systems-change initiatives commonly involve activities and interventions at both the practice and broader policy levels. Depending on their design, activities at both levels can fall within any of the domains. Additionally, a dynamic interaction occurs across the two levels, wherein activities at the practice level generate the evidence, momentum, and public will to foster engagement at the policy level and vice versa.

Long-term systems change occurs primarily within the final two domains (collective accountability and sustainable change), which are the most difficult to achieve and to sustain. Collective accountability assumes a much deeper commitment to the change process within and across organizations, and between the practice and policy levels, building on previously established buy-in and a comprehensive understanding of the problem. Collective accountability occurs when organizations develop the capacity to balance internal interests with interests across other organizations and systems to support a common goal or address a shared community need. By definition, a systems change is fully sustainable and is not connected to grant funds or external expectations, but rather an organizational or cross-system priority relating to new policies, culture, communication, or practices.

Designing and Implementing a Systems- and Policy-Change Initiative: Integrated Health Care

Integrated health care is a fitting exemplar for the systems-change progression. It requires the systematic coordination of behavioral and physical health services and a redesign of current delivery systems (Collins, Hewson, Munger, & Wade, 2010). As is typical of foundation-led systems-change initiatives, transforming the health care system to provide truly integrated health care requires culture and practice changes at the macro policy level as well as at the provider-practice level, and requires multiple, coordinated strategies to address the myriad challenges involved. The goal of integrated health care is to increase access to quality, patient-centered care and capitalizes on the fact that a majority of patients initially seek behavioral-health treatment in a primary care set-

ting, with as many as 70 percent of visits having a psychosocial cause (Wang et al., 2006; Robinson & Reiter, 2007). Recent research documenting 25-year early mortality for individuals treated for behavioral-health conditions in publicly-funded specialty settings (Parks, Svendsen, Singer, & Forti, 2006) highlights the importance of improving access to physical health services in these settings. With roughly half of the population experiencing a behavioral-health condition over the course of its lifetime and a high frequency of co-occurring disorders (Kessler et al., 2005), it makes sense to better coordinate care in a range of settings. In fact, a wealth of studies show improved outcomes through integrated care (Hogg Foundation for Mental Health, 2008). Key elements of integrated systems include a capacity for screening, patient education/self-management, medication, psychotherapy, coordinated care, clinical monitoring, medication consultation, standardized follow-up, formal stepped care, and supervision (Butler et al., 2008).

Foundations' efforts to build a broad, cross-system sense of collective responsibility and accountability can be frustrated by the fragmentation and lack of coordination across organizations and systems. Health care and behavioral health, like other established systems, have structures and cultures that define policies, procedures, operational practices, and reimbursement and performance incentives. These structures and cultures develop siloed approaches to professional training and discipline-specific normed practices, reimbursement systems (which are seldom cross-disciplinary), and licensing and other field-specific regulations. Programs are established separately from one another and develop distinct organizational cultures and expectations. For example, primary care practices are pressured to see as many patients as possible daily to remain fiscally viable. Therefore, appointments with patients typically last seven to 12 minutes and are very focused. Screening tools include medical tests and short questionnaires. Conversely, behavioral-health specialists are governed by separate agencies that emphasize longer sessions with patients (usually 45 to 50 minutes), extensive documentation, lengthy psychosocial assessments, and strict confidentiality laws designed to protect patients from stigma and abuses that were systemic historically. This creates a very different practice culture that is reinforced by the reimbursement practices of public and private payers.

Recent health-system reforms and integrated-care initiatives require dramatic changes in both primary care and behavioral-health fields, as well as changes at four levels: patient care, practice, organizational, and systemic (including regulatory, financial, and other policy). Simultaneous, multilevel change is necessary for almost any complex system-redesign initiative, regardless of the field.

Three integrated care initiatives – sponsored by the Hogg Foundation for Mental Health, The California Endowment, and the Maine Health Access Foundation – provide rich examples of the range of activities, strategies, and resources necessary for systemic change and to overcome the challenges in complex systems like health and behavioral health. The three foundations launched initiatives nearly concurrently in 2005 and 2006 and made significant, multiyear investments in transforming and advancing the field of integrated care in their respective states and nationally through improved service access, reduced stigma, and improved treatment outcomes for underserved populations.

Building a Base for Systems Change at the Practice and Policy Levels

To build a core base for advancing integrated care and achieving systems change, the foundations invested significantly in key activities designed to understand the problem (Domain 1), build visibility and awareness (Domain 2), and expand partnerships and collaborations (Domain 3). After investing in environmental scans and literature reviews to define the issues and understand the problem, all three initiated at least one major grantmaking program at the practice level, funding organizations to change service mechanisms to integrate behavioral and primary health care, along with rigorous evaluations to establish further evidence to advance integrated policies and practices in their respective states. Process evalu-

ations helped grantees enhance their work and outcome evaluations provided policy-relevant data on improvements in access to quality care. The three grantmakers also created learning communities to enhance buy-in, provide better access to relevant research findings, share experiences and ideas in shifting organizational culture to an integrated practice, and develop "champions" for integration.

A critical investment across all three initiatives was to engage in policy work to educate key stakeholders and promote improved policy support for integrated health care. Each foundation devised and supported policy-focused strategies on parallel but related tracks, while the practice-level grantmaking aimed to build visibility and awareness and to create partnerships across and beyond the health and behavioral-health communities. These partnerships and collaboratives were essential to advance the field of integrated care, but likely would have been slow to develop without the opportunities generated and facilitated by the foundations. This policy work and cross-stakeholder relationship building benefited significantly from the interplay between real-time learnings from the practice-level grants, which identified key challenges and opportunities requiring attention, and intervention at the policy level.

Texas Integrated Health Care Initiative

The Hogg Foundation began its work at Domain 1, surveying the landscape in Texas and identifying opportunities for improvement (Hogg Foundation, 2008). It quickly moved to Domain 2 (visibility and awareness) and initiated a $2.6 million, three-year funding initiative in 2006, funding providers across the state to implement the collaborative care model of integration, which at that point had the most solid research support of all models. Other Domain 2 activities included a statewide conference for hundreds of people in 2008 and a multiyear learning community begun in 2009. These activities also created momentum to address issues in Domain 3 (partnership and collaboration).

This policy work and cross-stakeholder relationship building benefited significantly from the interplay between real-time learnings from the practice-level grants, which identified key challenges and opportunities requiring attention, and intervention at the policy level.

The foundation worked formally and informally to improve partnerships around integrated care. It reached out to foundations across the nation already advancing interests around integrated care, including the Maine Health Access Foundation and The California Endowment. It created a small group of key stakeholders that met to communicate about activities and identify common interests. The growth in Texas activity and interest around integration led the Collaborative Family Healthcare Association to ask Hogg to co-host its 2012 national conference in Texas and to coordinate a Texas policy summit focused on integration. The foundation also launched a new round of multiyear integration planning and implementation grants in 2012.

In some ways, the success of the foundation's work at the level of Domain 3 highlighted the difficulty in shifting efforts to Domains 4 and 5, at which enduring systems change would happen. The work at Domain 3 frequently focused on organizational culture change at the provider level and worked to address policy barriers at that level. But over time, it became clear to foundation staff that to create lasting change, efforts needed to focus on statewide systems and policy change to address challenges like structural racism, enduring stigma, and established power imbalances (Kubisch, Auspos, Brown, Buck, & Dewar, 2011).

The primary goal of creating strong partnerships and collaborations was to create a policy environment to encourage the implementation and spread of model practices in community health centers throughout the state. Working in partnership rather than in isolation was a critical ingredient for advancing the agenda of integrated care in California and resulted in joint participation in strategic policy initiatives, training and technical assistance efforts, conference planning, and developing presentations for state and national audiences

California Integrated Behavioral Health Project

The California Integrated Behavioral Health Project's (IBHP) initial work at Domain 1 involved a targeted literature review and interviews with national experts to identify unmet needs and best practices in advancing integrated care, California stakeholder interviews to identify policy barriers that affect access to integrated care, and site visits across the state to identify vanguard clinics implementing integration programs. Based on this initial work, IBHP implemented several core strategies in Domains 2 and 3 from 2007-2011:

1. three phases of grantmaking to identify, enhance, and improve promising clinic practices;

2. building and supporting (through training and technical assistance) a learning community of providers and stakeholders in the fields of primary care and behavioral health; and

3. advancing a policy and advocacy agenda to affect systems changes "in the trenches" and at the state level, including establishing and strengthening strategic partnerships among providers and provider associations.

To promote visibility and awareness, IBHP created a website, which functioned as a clearinghouse for resources, materials, and research related to integrated behavioral health; collaborated with state primary care and mental health associations to sponsor training for administrators and clinicians; and developed a toolkit to support collaborations between primary care and county mental health providers.

As visibility and awareness grew, IBHP worked to develop and strengthen partnerships and collaborations (Domain 3) with local, state, and national stakeholders in an effort to develop and advance policy and advocacy goals. The primary goal of creating strong partnerships and collaborations was to create a policy environment to encourage the implementation and spread of model practices in community health centers throughout the state. Working in partnership rather than in isolation was a critical ingredient for advancing the agenda of integrated care in California and resulted in joint participation in strategic policy initiatives, training and technical assistance efforts, conference planning, and developing presentations for state and national audiences (Brya & Linkins, 2010).

Maine's Integrated Care Initiative

Maine's Integrated Care Initiative Domain 1 and 2 activities paralleled the Texas and California experiences. When the Maine Health Access Foundation (MeHAF) launched its $10 million investment in integrating behavioral health and primary care in 2005, it was committed to a deep partnership and sustained engagement with grantee organizations and state agencies to use the initiative to transform the health care system into a more patient-centered model of care. Rather than designing the initiative inter-

nally, MeHAF convened thought leaders from stakeholder groups to create a shared vision of integrated care.

This input and the voices Mainers documented, through 160 focus groups around the state, shaped the integrated care implementation framework and a logic model. One-year planning grants and three rounds of three-year implementation grants were awarded beginning in 2007 and spanning six years. Both direct client services and activities that change the systems of care were supported through 42 grant projects in more than 100 sites involving more than 150 partners across the state. Many of the projects not only continued in the post-grant years, but also expanded integrated care to new practice sites. As of 2012, 25 percent of primary care practices in Maine provided integrated behavioral health and primary care as well as some specialty care such as dental services as a result of this foundation initiative.

To support activities in Domain 3 (partnership and collaboration), a policy committee was established and worked to generate state-level policy changes and to expand collective commitment and accountability. Many state officials and legislators joined providers, employers, payers, and other key stakeholders to create changes. Policymakers endorsed integrated care and included it in budgets, health care laws, and new health-reform programs. This created an infrastructure for sustaining the work for the long term.

Moving Beyond Partnerships to Achieve Collective Accountability and Sustainable Change

Developing a sense of collective accountability across partnerships is an important, yet difficult, stage for many organizations and communities to achieve. The vision, commitment, and buy-in that are critical ingredients of functioning collaborations are not enough to achieve collective accountability. That requires organizations to focus more on the community than on their own organizational interests and to overcome issues related to competition for funding, organizational culture, and the tendency to work in silos. In this stage, collaboration across systems advances beyond the funded initiative, and partners expand their focus to address policy issues or problems that can be improved through a collaborative process in the community.

Across the three states, several common challenges threatened the progression to collective accountability. These included

- competition across providers and systems, and lack of accountability for outcomes;
- lack of clear "champions" to own and move the agenda;
- categorical funding and cost controls; and
- professional training focused on specialization, not on collaborative work.

Yet foundations in all three states were well positioned to help identify specific barriers and coordinate efforts to overcome them in order to realize collective accountability and sustainable systems change. The role of the foundations was in the change process rather than supporting the interests of any given system.

Kania and Kramer's concept of collective impact provides some guidance for foundations seeking to overcome barriers and shift their work to Domains 4 and 5: They distinguish collective-impact initiatives from simple collaboration by their "centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants" (2011, p. 38). They compare technical problems, which easily can be addressed by a single foundation with one intervention, with more complex adaptive problems in which the solution is not clear. Behavioral-health challenges tend to present adaptive problems (Frost, 2011) needing work at Domains 4 and 5. Kania and Kramer note that for these problems, foundations cannot impose solutions. They should instead follow Kramer's "four practices of catalytic philanthropy": "1. Take Responsibility for Achieving Results. … 2. Mobilize a Campaign for Change. … 3. Use All Available Tools. … 4. Create Actionable Knowledge" (2009, p. 32-35).

The foundations did not assume responsibility for results in isolation of other stakeholders. Instead, they recognized the lack of a clear and needed champion for integrated care across the sectors of stakeholders and facilitated collective action, harnessing the interests of diverse organizations to focus on systemic change to improve care access and treatment outcomes.

Strategies to overcome barriers to collective accountability varied by state, reflecting to a certain extent structural and cultural differences in the states, but they generally fell within Kramer's four practices.

1. Take Responsibility for Achieving Results'

All three foundations assumed an activist and facilitative role in their approach to promoting integrated health care. While grantmaking constituted an important activity for each foundation, it was far from the only role. The foundations articulated a vision for integrated care across the safety net that catalyzed a more intentional commitment to promoting integrated care at the policy and practice levels. They guided a process that expanded coordination among stakeholders and identified common concerns and goals. Learning communities and grant funding for collaborative efforts supported cooperation rather than competition among providers. While these foundation strategies did not eliminate competition, they incentivized collaboration around common goals.

Additionally, the foundations participated in and often prompted processes to develop local (Stone, Frost, Van Norman, & Casey, 2010), state, and federal processes of collective accountability for common goals. Identifying community- or population-based outcome measures focused energy on collaborative accomplishments rather than program-specific outputs. Recent changes in federal health policy amplified this attention to collective outcomes.

'2. Mobilize a Campaign for Change'

The shifting national health-policy landscape (e.g., national health reform and requirements for improved clinical and quality outcomes) became strong leverage points for deeper collaborative efforts in each of the three states. The foundations did not assume responsibility for results in isolation of other stakeholders. Instead, they recognized the lack of a clear and needed champion for integrated care across the sectors of stakeholders and facilitated collective action, harnessing the interests of diverse organizations to focus on systemic change to improve care access and treatment outcomes. Using focus groups, stakeholder meetings, state and national conferences, and learning communities, the foundations generated a shared vision and enthusiasm for working toward its realization. Sponsoring these processes created the space, a forum, and resources for primary care, mental health, and substance-use service stakeholders to partner and work outside their own organizations and, when needed, to overcome the challenge of not having a clear champion to drive the transformation.

For example, in California, IBHP served as a nimble advocate for integration because of its independence from the priorities and agendas of stakeholder organizations affiliated with specific delivery systems. This independence allowed IBHP to elevate to a unique position of thought leadership to support cross-sector coalition building by establishing an integrated policy steering committee comprised of leaders in health and behavioral health at the state and local levels, professional associations, consumers, and other key stakeholders. This committee enabled stakeholders to work beyond

their organizational purview to identify and prioritize the policy agenda for integrated care in California.

The Maine Health Access Foundation convened an integrated-care policy committee charged with creating a supportive environment to expand and sustain integrated care across a variety of settings. Because of Maine's strong tradition of collaborative efforts, the foundation was able to galvanize partnership efforts to engage in Domain 4 and 5 activities. Working in a small state, many of the key stakeholders in Maine already had histories of cooperating on major initiatives. The stakeholders prioritized the policy issues affecting integrated care and developed a work plan with specific action steps and objectives to effect policy change. Convening a group of policymakers to develop strategies for supporting integrated care could easily be a Domain 3 activity, especially if the responsibility of implementing a work plan fell on the staff of just one or two organizations. What transcended Maine's work into Domain 4 level was the extent to which each of the partnering organizations assumed active roles in the work plan's execution. All members educated new state officials on key issues, resulting in strong policy support for integrated care that continued into a new administration despite a change in political party. Cross-system stakeholders worked collaboratively to use outcome data to build a business case for integrated care, prompt changes in reimbursement and credentialing policies, and develop integrated-care workforce development activities. By achieving a sense of collective accountability, stakeholders created major policy shifts that facilitated the sustainability of integrated care by embedding it as a required component of many state-level initiatives.

A similar small group convened by the Hogg Foundation initiated a process that led to the passage of Texas House Bill 2196 in 2009, creating the Integration of Health and Behavioral Health Services Workgroup. The bill named key workgroup members and identified Hogg as a participant and a provider of administrative support. The workgroup had a mandate "to recommend best practices in policy, training, and service delivery for the promotion of healthcare integration" and issued a report to the Legislature in 2010 (Texas Health and Human Services Commission, 2010). Many of the workgroup members and other stakeholders continued to meet years afterward to continue coordinating efforts to implement integrated care in a variety of settings across the state.

'3. Use All Available Tools'

The foundations clearly moved beyond a traditional focus on nonprofits as their exclusive partners by working with state and local agencies, professional associations, consumer groups, universities, and advocacy organizations. For example, the spread of integrated care in California, seeded by the investment of IBHP, evolved into sustained interest and commitment through various funding streams and activities across the public and private sectors. State policies, programs, and pilot demonstrations were developed that focused on increasing access to services and improving health outcomes for individuals with complex conditions through coordinated and managed care. In addition, IBHP served as a catalyst for various sectors of the health care system (e.g., primary care, mental health, substance use, health plans) to work together differently by focusing on the needs of shared populations, creating a vision for the safety net-system of care, conceptualizing "health homes" to include behavioral health, and participating in learning collaboratives aimed to transform the delivery system and share lessons learned throughout the state. IBHP also engaged in multiple information dissemination, legislator education, and policy briefing activities to ensure that integrated care was a core component of California's Medicaid waiver to expand low-income health coverage and shift fee-for-service populations into managed care.

In Maine, MeHAF identified federal agencies as overlooked partners at the national, state, and local levels. It hosted regional and national

The changing policy context involving national and state health reform set in motion changes in the provider community and health plans that facilitated a more collective approach across the fields of health and behavioral health.

representatives of federal agencies on site visits of grantees deeply engaged in providing integrated care. MeHAF and other foundations also worked with Grantmakers in Health to bring together federal agencies and foundations that support integrated care to explore ways to closely partner to help sustain integrated care. The national agencies/foundations partnership has met several times and developed a joint and coordinated plan of priorities and activities.

The Hogg Foundation recognized the structural power imbalances in many integrated settings, which followed a traditional medical model that put patients in a passive role. Hogg convened stakeholders to identify remedies. It collaborated with the state health agency to develop a program to train and certify peer support specialists with a holistic approach to health. It coordinated with the Collaborative Family Healthcare Association to co-host the 2012 national conference and include scholarships for consumers and e-patients to ensure substantial participation, as well as a new Award of Distinction for a Consumer, Patient, or Family Advocate to recognize the key role of consumers in integrated health care. Addressing structural issues like weak patient engagement requires sustained collaborative work at Domains 4 and 5.

Local, state, and federal policy work was a key focus of activities coordinated by the foundations. The changing policy context involving national and state health reform set in motion changes in the provider community and health plans that facilitated a more collective approach across the fields of health and behavioral health. Collaborative policy work naturally engaged partners in adopting strategies for sustainable changes to policies and barriers, moving the work into Domain 5. For example, one national payer elected to reduce categorical funding by piloting new reimbursement options in Maine, opening health and behavior codes for primary care practices to receive payment for behavioral-health assessment and services. The Maine pilot cut costs and improved patient health outcomes, so the payer has spread this option to 14 other states. Also, integrated care was included in the state budget and in major payment and health care reform initiatives. Sufficient staffing is key to effective policy work. The Hogg Foundation collaborated with another foundation and the Collaborative Family Healthcare Association to dedicate a policy fellow to improve the policy environment for integrated care.

Perhaps one of the most critical tools is the quality of the relationships built through the collaborative efforts. By carefully building trust among the partners, the collaboration creates opportunities to bond as a cohesive group. This, in turn, moves members beyond turf issues and competing missions to a collective commitment to champion the initiative. It also builds opportunities to create a policy environment that sustains the work. For example, if issues between two organizations arise, members of the group who have learned to trust one another are more willing to immediately reach out and resolve the problem rather than having it create problems. If one member organization identifies resources or other opportunities suited for another collaborative member, it might reach out to the partner to share the information. In the long run, this generates more resources for the entire group.

Using all available tools is especially essential when complications arise. For example, when cost-cutting language adopted in the Maine state budget inadvertently eliminated most

reimbursements for integrated care in hospital-affiliated primary care practices, members of the MeHAF policy committee responded collectively. They worked closely with Department of Health and Human Services leadership to determine best strategies to rectify the problem, capitalizing on strengths each member organization brought to the table. The language in the budget was revoked, primarily because of broad-based support for the changes rather than advocacy only by organizations with vested interests. Complex challenges often require multiple strategies to overcome.

'4. Create Actionable Knowledge'

Actionable knowledge transforms data collected and reported into compelling information that can motivate action. Consistent with the first building block (understanding the problem), background research and data collection are an important first step in the systems-change process. Focus groups, surveys, literature reviews, and conferences all constituted means to gather information about integration.

However, Domains 4 and 5 require a more sophisticated use of information to motivate stakeholders to improve practice and drive sustainable change. All three foundations used process evaluations to guide activities and make adjustments to maximize impact. Summative evaluations added to the knowledge base for achieving good outcomes in integrated programs. The foundations also created clearinghouses and resource guides to share relevant information (Hogg Foundation, 2008; Integrated Behavioral Health Program, 2009). The Hogg Foundation funded a data registry as part of a collaborative care project and continued to fund the registry after the end of the grant program in order to facilitate the collection of data relevant to health outcomes and program effectiveness. IBHP established and maintained a comprehensive clearinghouse-style website, cataloging seminal information and data to build the case for and expand the implementation of integrated care.

Knowledge transfer in the form of training new workforce participants can shape systems for decades to come. A key barrier to integrated care is professional training that occurs in silos and focuses on specialization, not collaboration. Curricular change typically is slow and incremental in higher education, with institutional and individual incentives to maintain the status quo. Under a three-year federal grant for interprofessional training, several Hogg Foundation staff partnered with tenured faculty members to develop a health care curriculum focused on providing integrated and culturally competent care to underserved populations. The curriculum was delivered in a seminar format to psychology predoctoral students and interns along with psychiatry residents and fellows.

The Hogg Foundation also synthesized knowledge to more directly address a structural barrier to integrated health care: institutional racism leading to a lack of culturally competent services in many settings. Hogg collaborated with the federal Department of Health and Human Services Office of Minority Health to convene a group of academics, practitioners, and consumers with expertise in health care disparities and integrated health care. The resulting consensus report identified strategies and approaches to foster culturally appropriate care in integrated settings (Sanchez, Chapa, Ybarra, & Martinez, 2012). Hogg hosted a conference for stakeholders across Texas to discuss the implementation of these strategies in their home settings. It also gathered foundations across the country with an interest in funding integrated health care to identify funding strategies designed to reduce health disparities and promote integrated health care.

Another example of actionable knowledge resulted when the three foundations started pooling and leveraging the emerging insights from their respective initiatives to encourage Grantmakers in Health to establish an integrated care affinity group for grantmakers active with behavioral health. Through webinars, national conference sessions, tools created jointly, and

Another example of actionable knowledge resulted when the three foundations started pooling and leveraging the emerging insights from their respective initiatives to encourage Grantmakers in Health to establish an integrated care affinity group for grantmakers active with behavioral health.

other strategies, the participating foundations have been able to share findings and to identify key elements that help sustain the efforts.

Lessons Learned and Conclusion

Many integrated-care initiatives focus on supporting activities that address the first three domains of the Building Blocks of Systems Change model, with a strong emphasis on the third domain of partnership and collaboration. This is not surprising, given that the ability to reach Domains 4 and 5 is predicated on the quality and successful work in the first three domains. The three initiatives examined in this article were framed with a goal of systems change. Yet all three initially focused substantial activities in Domains 1-3 that eventually allowed an effective progression to Domains 4 and 5. Having a clear goal of achieving systems change at the outset may have increased their likelihood of success (Behrens & Foster-Fishman, 2007).

There are a number of lessons the three foundations learned as initiative activities transformed into collective accountability and systems change (Domains 4 and 5). First, it is essential to remember the perspectives of the "end user" (patients or consumers in the case of integrated care), engage them in the design and implementation work throughout the process, and keep them at the center of implementation and policy decisions. Including service recipients as board members, staff, and consultants as well as beneficiaries improves the quality of programs by grounding them in the needs of the recipients, who also become some of the most active and vocal champions for the initiative.

Second, collective accountability can be enhanced by shifting the focus from the interests of individual organizations to the needs of a shared population, community, or going concern. This moves the discussion beyond turf issues and what is convenient for organizations or providers. It also tends to equalize the power dynamics within the group. A high-quality needs assessment or environmental scan provides an objective means to reconcile competitive interests and identify common ground.

Another strategy for developing collective accountability is to transcend participating organizations' individual interests by collectively maximizing all the resources, including innovative ideas, represented around the table. Of course recipients can be better served if organizations let go of turf and latch onto getting results. But that broader focus can be hard to achieve without a respected, neutral facilitator. In the end, the foundations found that through persistent effort, organizations could shift their focus to common goals and desired outcomes. Those collaborative efforts then led to a net gain on the resources originally invested in the form of new private and federal dollars in support of the common goals.

A key lesson was learning to facilitate groups in a manner designed to move a collaborative partnership into a higher level of collective accountability. This requires a more nuanced approach than the usual convening that foundations undertake. Having the right people at the table is not enough. It is essential to foster a dialogue that connects the perspectives and experiences of consumers, frontline practitioners, administrators, evaluators, and policymakers to make needed changes to sustain successful programs. Foundations are well positioned to create a neutral environment for expressing ideas, exploring strategic solutions, testing, and

sharing success and failures as equal learning opportunities. Members of the group need to know from the start that the foundation is committed to the group and to its work over the long haul. This highlights the foundation's value of the work, creates the expectation that it is worth the time and effort of members to develop the necessary long-term relationships, and assures members that they can take appropriate risks for innovation without losing foundational support.

Many of the challenges the foundations faced were rooted in the external environment and structures with vested interests in maintaining the status quo. But internal challenges were not insignificant and also had to be addressed to move toward systems change. Foundations that want to ensure lasting changes through collective accountability need to increase the tolerance for risk taking among their board and their staff. This includes the risk of funding innovative projects that might not succeed but would generate lessons through the failure. It entails making multiyear commitments that provide organizations with the stability and focus to pursue fundamental change. It involves the risk of putting diverse stakeholders together to create policy when they have histories of contentious relationships. Finally, it means exploring strategies that are too innovative to be evidence-based – yet. It requires foundations to move beyond comfort zones and into a more activist role. However, without taking these risks, foundations will continue to stagnate in Domains 1-3 and not capitalize on the opportunities for meaningful systemic changes.

The key strategy and essential sustaining characteristic of systems-change initiatives is relationship building for sustained change and progress toward shared goals. Solid relationships are necessary to overcome competition for financing, differences in organizational culture and professional training, and histories of disconnection or even antagonism. Strong collaboration can shift the focus from organizational interests to the needs and interests of the beneficiaries. This change in focus often highlights unanticipated populations, social issues, or public policies that can be improved through collaborative action. For foundations to promote systems change of this magnitude requires a long time horizon and an orientation to collective accomplishments, not specific results that can easily be linked back to foundation dollars. This challenge is not insignificant, but the potential benefit to society is worth the effort to shift funding initiatives from simple partnership to collective accountability and sustainable change.

References

Ackoff, R. L., & Rovin, S. (2003). *Redesigning society.* Stanford, CA: Stanford Business Books.

Behrens, T. R., & Foster-Fishman, P. G. (2007). Developing operating principles for systems change. *American Journal of Community Psychology, 39,* 411-414.

Brya, J. J., & Linkins, K. W. (2010). *Integrated Behavioral Health Project evaluation: An assessment of the field and IBHP's contributions.* San Francisco: Tides Foundation.

Butler, M., Kane, R. L., McAlpine, D., Kathol, R. G., Fu, S. S., Hagedorn, H., & Wilt, T. J. (2008). *Integration of mental health/substance abuse and primary care No. 173* (Prepared by the Minnesota Evidence-Based Practice Center under Contract No. 290-02-0009). AHRQ Publication No. 09-E003. Rockville, MD: Agency for Healthcare Research and Quality.

Collins, C., Hewson, D. L., Munger, R., & and Wade, T. (2010). *Evolving models of behavioral health integration in primary care.* New York: Milbank Memorial Fund. Available online at http://www.milbank.org/reports/10430EvolvingCare/10430EvolvingCare.html

Foster-Fishman, P. G., & Behrens, T. R. (2007). Systems change reborn: Rethinking our theories, methods, and efforts in human services reform and community-based change. *American Journal of Community Psychology, 39,* 191-196.

Foster-Fishman, P. G., Nowell, B., & Yang, H. (2007). Putting the system back into systems change: A framework for understanding and changing organizational and community systems. *American Journal of Community Psychology, 39,* 197-215.

Frost, L. E. (2011). *Effective behavioral health funding in an era of health care reform: Views from the field.* Washington, DC: Grantmakers in Health. Available online at http://www.gih.org/files/usrdoc/Effective_Behavioral_Health_Funding_Hogg_July_2011.pdf

Integrated Behavioral Health Program. (2009). *Partners in health: Primary care and county mental health toolkit.* Available online at www.ibhp.org.

Hogg Foundation for Mental Health. (2008). *Connecting body and mind: A resource guide to integrated health care in Texas and the United States.* Austin, TX: Author.

Kania, J. & Kramer, M. (2011). Collective impact. *Stanford Social Innovation Review, 9*(1), 36-41.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication, *Archives of General Psychiatry, 62,* 593-602.

Kramer, M. (2009). Catalytic philanthropy. *Stanford Social Innovation Review, 7*(4), 30-35.

Kubisch, A., Auspos, P., Brown, P., Buck, E., & Dewar, T. (2011). Voices from the field III: Lessons and challenges for foundations based on two decades of community-change efforts. *Foundation Review, 3*(1-2), 138-149.

Linkins, K. W., Brya, J. J., & Chandler, D. (2008). *The frequent users of health services initiative: Final report.* Oakland, CA: California Healthcare Foundation. Available online at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/F/PDF%20FUHSIEvaluationReport.pdf

Mattessich, P. W., Murray-Close, M., & Monsey, B. R. (2001). *Collaboration: What makes it work* (2nd Ed.). St. Paul, MN: Amherst H. Wilder Foundation.

Parks, J., Svendsen, D., Singer, P., & Forti, M. E. (2006). *Morbidity and mortality in people with serious mental illness.* Alexandria, VA: National Association of State Mental Health Program Directors.

Robinson, P., & Reiter, J. (2007). *Behavioral consultation and primary care: A guide to integrating services.* New York: Springer.

Sanchez, K., Chapa, T., Ybarra, R. & Martinez, O. N. (2012). *Enhancing the delivery of health care: Eliminating health disparities through a culturally and linguistically centered integrated health care approach: Consensus statements and recommendations.* Austin, TX: Hogg Foundation for Mental Health. Available online at http://www.hogg.utexas.edu/uploads/documents/FinalReport%20-ConsensusStatementsRecommendations.pdf

Stone, S., Frost, L., Van Norman, J. R. & Casey, K. (2010). *Creating a mentally healthy community through the use of behavioral health indicators. Applied Research in Quality of Life, 5*(4), 273-285.

Texas Health and Human Services Commission. (2010). *Integration of Health and Behavioral Health Services Workgroup: Report to the 81st Legislature.* Austin, TX: Author. Available online at http://www.hhsc.state.tx.us/reports/2010/IntegrationReport_73010.pdf

Wang, P., Demler, O., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R.C. (2006). Changing profiles of services sectors used for mental health care in the United States. *American Journal of Psychiatry, 163,* 1187-1198.

Lynda E. Frost, J.D., Ph.D., is director of planning and programs at the Hogg Foundation for Mental Health and a clinical associate professor of educational policy and planning at the University of Texas at Austin. Correspondence concerning this article should be addressed to Lynda E. Frost, University of Texas, Hogg Foundation for Mental Health, 3001 Lake Austin Boulevard, Fourth Floor, Austin, TX 78703 (email: lynda.frost@austin.utexas.edu).

Karen W. Linkins, Ph.D., is a principal at Desert Vista Consulting and is directing the California Mental Health Services Act Integrated Care Initiative on behalf of the Tides Center.

Becky Hayes Boober, Ph.D., is a senior program officer at the Maine Health Access Foundation.

Jennifer J. Brya, M.A., M.P.P., is a principal at Desert Vista Consulting.