Assessing cross-sector stakeholder readiness to advance and sustain statewide behavioral integration beyond a State Innovation Model (SIM) initiative

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Abstract

Integrated care is recognized as a promising approach to comprehensive health care and reductions in health care costs. However, the integration of behavioral health and primary care is complex and often difficult to implement. Successful and sustainable integration efforts require coordination and alignment both within health care organizations and across multiple sectors. Furthermore, implementation progress and outcomes are shaped by the readiness of stakeholders to work together toward integrated care. In the context of a Colorado State Innovation Model (SIM) effort, we examined stakeholder readiness to advance and sustain partnerships for behavioral health integration beyond the period of grant funding. Partnership readiness was assessed using the *Readiness for Cross-sector Partnerships Questionnaire* (RCP) in spring 2019. Participants from 67 organizations represented seven sectors: government, health care, academic, practice transformation, advocacy, payer, and other. RCP analyses indicated a moderate level of readiness among Colorado stakeholders for partnering to continue the work of behavioral health integration initiated by SIM. Stakeholders indicated their highest readiness levels for *general capacity* and lowest for *innovation-specific capacity*. Five thematic categories emerged from the open-ended questions pertaining to partnership experiences: (a) collaboration and relationships, (b) capacity and leadership, (c) measurement and outcomes, (d) financing integrated care, and (e) sustainability of the cross-sector partnership. Partnering across sectors to advance integrated behavioral health and create more equitable access to services is inherently complex and nonlinear in nature. The RCP usefully identifies opportunities to strengthen the sustainability of integrated care efforts.

Keywords

Mental health is a major public health priority in the USA [1]. Each year, approximately 20% of Americans experience mental illness [2]. Nearly 50% of Americans will be diagnosed with a mental illness at some point in their lifetime [3]. Only 41% of individuals with serious mental illness receive treatment annually [4]. Fragmented care is among the largest barriers to mental health care in the

Implications

Practice: Practitioners participating in cross-sector partnerships to advance behavioral health integration should understand the motivation and capacities of partnering organizations, both of which fluctuate overtime.

Policy: Policymakers seeking to scale systemic efforts of behavioral health integration should ensure sustainable funding of a designated central convening body.

Research: Future research can apply this novel readiness tool when evaluating the readiness of cross-sector partners to advance and sustain behavioral health integration.

USA, particularly among minority racial and ethnic populations [5]. The historic separation of care for mental and physical health conditions disregards natural interdependency of mind-body experiences that define health and well-being, resulting in sub-optimal health outcomes and high national health care costs [6].

Integrated care is a systematic and cost-effective team-based approach to patient-centered care that involves a collaboration among primary care and behavioral health clinicians and patients and families to provide comprehensive health care [7]. This approach to care targets a range of psycho-social issues, including substance use, health behaviors, life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization [7]. Integrated care is associated with improved mental health outcomes and patient health care experiences and decreased health care costs [8–13].

While recognized as a promising approach to comprehensive health care, integrated care is highly complex and difficult to implement. Successful and sustainable integration efforts require coordination and alignment both within the

health care sector and across multiple sectors [14]. For example, collaboration among the payer, government, and health care sectors is important to create alternative payment models that adequately encompass both mental and physical health care costs and incentivize integration. Implementation progress and outcomes are shaped by the readiness of stakeholders to work together [15].

Readiness refers to the extent to which an organization is willing and able to engage in an innovation (e.g., a program, practice, or policy) [16–18]. Scaccia et al. developed a readiness framework comprised of three components: motivation, innovation-specific capacity, and general capacity or $R = MC^2$ (*Readiness = Motivation × Innovation-Specific Capacity × General Capacity*) [19]. *Motivation* refers to the perceived incentives and disincentives of putting an innovation into practice. *Innovation-specific capacity* captures the knowledge, skills, and conditions needed for a particular innovation. *General capacity* refers to the structural, operational, and cultural aspects of an organization that impact its capabilities. Each $R = MC^2$ component is associated with a series of measurable subcomponents (e.g., relative advantage, priority, leadership, and culture).

The $R = MC^2$ framework rests on three premises [20]: (a) Readiness is dynamic and fluctuates over time as setting characteristics (e.g., staff capacity and availability of resources) evolve. (b) Readiness is a continuous rather than dichotomous construct. Organizations vary in degree of readiness for engaging with an innovation. (c) Readiness for an innovation can be advanced through active supports (e.g., training, technical assistance, and quality monitoring) provided to the organization. Since inception, the $R = MC^2$ framework has been widely adapted for use across various local, state, and national community health initiatives, including for coalition building [19], behavioral health integration [15], medication optimization services [21], and tobacco prevention [20]. In this article, we describe an assessment of stakeholder readiness to advance and sustain partnerships for statewide behavioral health integration, which draws on $R = MC^2$.

THE CONTEXT

Between February 2015 and January 2019, Colorado was awarded $62.9 million by the Centers for Medicare and Medicaid Services for its State Innovation Model (SIM) to transform the health care system by integrating behavioral and physical health care and supporting providers to gain the skills needed to succeed with alternative payment models. The focus on increasing access to integrated services built on years of work across the state, including the Promoting Integrated Care Sustainability Project [22], Advancing Care Together initiative [23], and Sustaining Healthcare Access Integrated Primary Care Efforts, an alternative payment model demonstration [12]. Led by the Colorado Governor's Office, SIM worked with 328 of the state's primary care practice sites and four community mental health centers. Cross-sector stakeholder engagement was a key strategy in SIM. In June 2105, workgroups were established representing key pillars of SIM (payment reform, population health, practice transformation, and health information technology) and critical areas of strategic focus (workforce, evaluation, and consumer engagement). The workgroups were designed to include a wide variety of stakeholder expertise and to provide insight and guidance across the SIM initiative. Additionally, multistakeholder symposiums were hosted to promote active cross-sector engagement between payers and primary care practices. As SIM funding drew to an end in 2019, emphasis was placed on maintaining stakeholder momentum to build on successes achieved in integrated behavioral and physical health care through this initiative. This article reports learnings from our state-level partnership readiness assessment to inform a broader systems approach to integrated care.

METHOD

Participants

As SIM concluded in Colorado, a total of 266 stakeholders from 125 organizations were identified by the Farley Health Policy Center-Carolina Team and invited to participate in a survey assessing organizational readiness to continue partnering across sectors to advance and sustain behavioral health integration. Respondents were selected based on involvement in cross-sector partnerships in SIM. A minimum of three respondents per organization was requested in the assessment. Initial contacts were invited to share the assessment with other appropriate potential respondents. FHPC-Carolina Team worked with a primary organizational liaison to identify appropriate respondents when initial contacts were not available.

Procedure

The readiness assessment used a cross-sectional, mixed-methods design, involving quantitative and qualitative data collected through an online survey. Two weeks prior to survey administration, we provided a 1 hr webinar to inform stakeholders about the purpose of the survey, to discuss how the data would be synthesized and shared with stakeholders, and to answer questions. The webinar served to encourage stakeholders to complete the survey and to provide candid responses. We indicated that all data would be deidentified and aggregated in a final assessment report. A link to the webinar recording was included with the live survey for stakeholders who missed the scheduled session.

Stakeholders completed the survey in Qualtrics between March 12 and April 10, 2019. Four group

email reminders were sent in addition to individual outreach to encourage survey responses. This assessment was conducted to inform quality improvement efforts and thus, exempt from institutional review board review.

Measures

The *Readiness for Cross-sector Partnerships Questionnaire (RCP)* assesses the willingness and ability of organizations to partner cross-sectorally. Specifically, this questionnaire was designed to assess the readiness of stakeholders to work together to advance and sustain integrated behavioral health care. The instrument is completed by organizational staff representing different roles (e.g., executive leadership, middle management, and operational staff) within each organization involved in a shared cross-sector partnership. The RCP captures key components and subcomponents of readiness through 61 quantitative items (Fig. 1). Response choices utilize a seven-point Likert scale (1—Strongly Disagree; 7—Strongly Agree); for example: "There is a high level of support for cross-sector partnerships among members of our organization." Cronbach alpha values for the RCP subcomponents ranged from 0.70 to 0.95. In this analysis, we omitted four subcomponents with suboptimal reliability statistics (i.e., Complexity; Innovation-Specific Knowledge, Skills, and Supports; Resource Utilization; and Staff Capacity). The questionnaire requires approximately 15 min to complete.

Questionnaire development

The RCP was adapted from the Readiness Diagnostic Scale, an evidence-based instrument originally developed for a community coalition-building initiative [24]. We used a systematic and iterative process for customizing the tool to the context of partnerships through tool development methods outlined by Devellis [25]. The first stage involved an in-depth review of peer-reviewed literature and tools pertaining to assessing cross-sector partnerships. Relevant assessment items were compiled into a data set and coded into thematic content areas by three research team members. We then used a team-based approach to independently rank and jointly identify the final set of partnership-specific items. Where appropriate, the language of existing items was modified to increase clarity. The full RCP was subsequently shared with Colorado stakeholders and subject matter experts for two rounds of feedback and revision.

Organizational and respondent characteristics, and partnering experiences

In addition to the RCP, the online survey included questions pertaining to organizational characteristics (name, zip code, type of organization based on mission, and sector) and respondent characteristics (e.g., professional role and involvement in SIM). We also assessed respondent experiences with partnering to advance statewide behavioral health integration. Specifically, we measured partnership satisfaction and perceived progress using five items on a seven-point Likert scale (1—Strongly Disagree; 7—Strongly Agree); and we assessed general partnership experiences through four open-ended questions pertaining to: (a) facilitators and barriers to partnership effectiveness, or lack thereof; (b) most meaningful aspects of partnering; (c) concerns about partnering across sectors; and (d) helpful resources and supports.

Data analysis

We used basic descriptive statistics to analyze sample characteristics and items pertaining to partnership
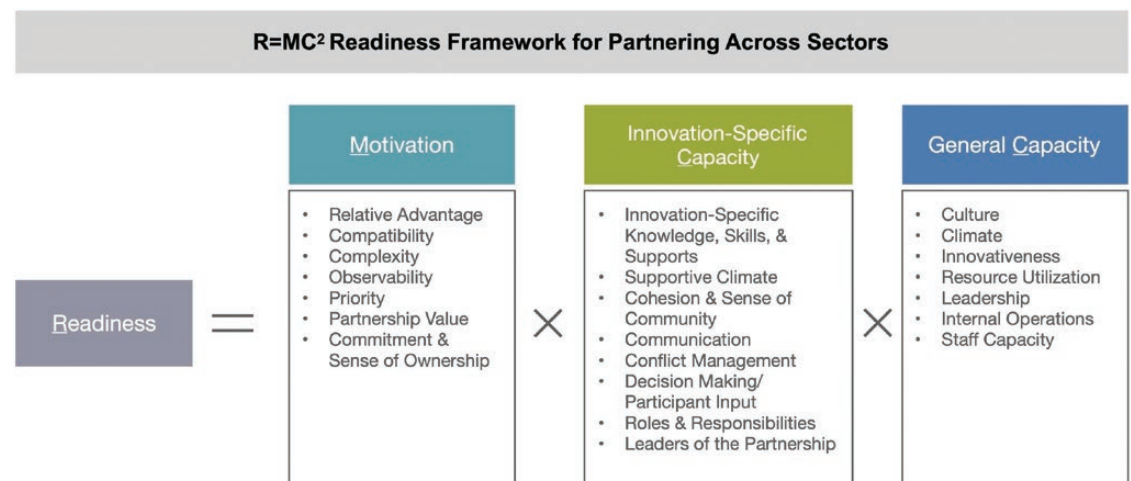

Fig 1 | R = MC^2 readiness framework for cross-sector partnerships. This figure depicts the components and subcomponents that influence readiness for cross-sector partnerships. The components of R = MC^2 are motivation, innovation-specific capacity, and general capacity. Each component is composed of a set of subcomponents. R = MC^2 refers to Readiness = Motivation × Innovation-Specific Capacity × General Capacity.

experiences. Aggregate readiness scores were calculated using mean scores at three RCP scale levels: item, subcomponent, and component level. Readiness data were also organized and analyzed by sector through mean scores.

Three researchers (E.C.G., S.B.G., and S.K.) coded the data from the four open-ended questions using qualitative content analysis [26]. We used ATLAS.ti for coding and data management. The first third of the data were coded in iterative cycles, with three researchers coding the same defined sections of text and then meeting to review new codes to improve intercoder agreement. Once the code list reached saturation, the remainder of the data was coded independently. The coders continued to meet regularly to refine the code list. Code co-occurrence tables in ATLAS.ti were used to compare findings across sectors and organizations.

RESULTS

Sample characteristics
Analyses included a total of 75 participants from 67 organizations and seven sectors (54% response rate). The largest proportion of respondents were from the government and health care sectors (24% of all respondents, n = 18 each). Individuals in leadership or supervisory positions were nearly two-thirds of the sample. Approximately three-quarters of the respondents were members of an SIM workgroup or advisory group. The majority of the respondents in the SIM workgroup represented the practice transformation or health technology workgroups (17.2%, n = 11 for each), followed by the steering committee (14.1%, n = 9) and population health (12.5%, n = 8) workgroups. See Table 1 for a summary of sample characteristics.

Readiness for cross-sector partnerships
RCP analyses indicated a moderate level of readiness among Coloradan stakeholders for partnering to continue the work of behavioral health integration initiated by SIM. Stakeholders indicated the highest readiness levels for *general capacity* (M = 5.83; standard deviation [SD] = 0.87), and lowest for *innovation-specific capacity* (M = 5.23; SD = 0.97), although variability across readiness component scores were modest. Table 2 depicts average readiness subcomponent scores across respondents. The highest subcomponent score was observed for *compatibility (M = 6.20, SD = 0.79)*, indicating that stakeholders

Table 1 | Respondent characteristics

Characteristic		% (*n*)
Sector	Government	24.0% (18)
	Health care	24.0% (18)
	Practice transformation	18.7% (14)
	Academic	12.0% (9)
	Advocacy	8.0% (6)
	Other	8.0% (6)
	Payer	5.3% (4)
Professional role	Director (operations, clinical, etc)	32.0% (24)
	Other	26.7% (20)
	Manager	21.3% (16)
	Executive director or CEO	14.6% (11)
	Administrator	4.0% (3)
	Coordinator	1.3% (1)
SIM workgroup participants	Yes	70.7% (53)
	No	29.3% (22)
SIM workgroup	Health information technology workgroup	17.2% (11)
	Practice transformation workgroup	17.2% (11)
	SIM steering committee	14.1% (9)
	Population health workgroup	12.5% (8)
	Workforce workgroup	10.9% (7)
	Evaluation workgroup	9.4% (6)
	SIM advisory board	6.3% (4)
	Consumer engagement workgroup	6.3% (4)
	SIM quality assurance committee	3.1% (2)
	Payment reform workgroup	1.6% (1)
	Policy workgroup	1.6% (1)

SIM State Innovation Model.

Table 2 | Subcomponent scores across respondents (*N* = 75)

Subcomponent	Definition	M (*SD*)
Compatibility	This innovation fits with how things are done here.	6.20 (0.79)
Culture	Norms and values of how we do things in my organization.	6.14 (0.97)
Relative advantage	This innovation seems better than what is currently being done.	6.13 (0.89)
Partnership value	This innovation brings value to our organization.	5.94 (0.95)
Leadership	Effectiveness of our leaders.	5.94 (1.13)
Innovativeness	Openness to change in general.	5.87 (1.01)
Commitment/ownership	Our organization cares about this innovation.	5.74 (1.26)
Cohesion/sense of community	Feeling of connection between stakeholders in the innovation.	5.64 (1.07)
Internal operations	Effectiveness at communication and teamwork.	5.59 (0.97)
Climate	The feeling of being part of this organization.	5.59 (0.98)
Observability	Ability to see that this innovation is leading to outcomes.	5.57 (1.25)
Decision-making/participant input	Ease, interest, and involvement in decision-making for the innovation.	5.48 (1.04)
Leaders of the partnership	Leadership supports the innovation and is engaged with the effort.	5.43 (1.07)
Priority	Importance of this innovation compared to other things our organization does.	5.27 (1.39)
Communication	Sufficient information sharing to do this innovation.	5.17 (1.20)
Roles and responsibilities	Clear understanding of organizational roles for supporting the innovation.	5.09 (1.23)
Supportive climate	Necessary supports, processes, and resources to enable this innovation.	4.94 (1.25)
Conflict management	Beliefs that conflicts surrounding the innovation will be addressed appropriately.	4.85 (1.15)

Readiness subcomponent scores are on a gray-scale. Higher scores are represented by lighter gray; lower scores are represented by a darker gray.

believe involvement in the cross-sector partnerships fits well with the goals and context of their organization. *Conflict management (M = 4.85, SD = 1.15)* was rated lowest, highlighting an opportunity to develop more effective processes for addressing conflicts and sensitive issues among partnering stakeholders.

Readiness by sector

Table 3 displays readiness component and subcomponent scores across the seven sectors. At the component level, readiness scores were highest for the "other" sector (*M* = 5.99–6.88) and lowest in the payer sector (*M* = 4.68–5.86). Comparing the three readiness components, all sectors scored lowest in innovation-specific capacity. This indicates that, regardless of sector, organizations most need additional support (e.g., workforce development/training/education, technical assistance, and resources) around partnership maintenance. At the subcomponent level, readiness scores varied across sectors with no sector consistently scoring lowest or highest on any subcomponent. The payer sector had the lowest subcomponent score (supportive climate: *M* = 3.94; *SD* = 0.80). The "other" sector had the highest subcomponent scores (culture and leadership: *M* = 7.00; *SD* = 0.00).

Readiness in the health care and government sectors

Subsector-level analyses of the readiness data revealed variability among the organizational types comprising the health care and government sectors. The health care sector reflected three types of

organizations: primary care practices, behavioral health organizations, and health systems. Motivation and innovation-specific capacity were higher for primary care and behavioral care practices than health systems, whereas general capacity was higher for health systems compared to primary care and behavioral health (see Table 4). The government sector included two types of organizations: local public health departments and state agencies. We found higher readiness levels in all three components in local public health departments (range: 5.78–6.50) compared to state agencies (range: 4.91–5.44). Both local public health departments and state agencies had lower readiness scores in innovation-specific capacity than general capacity or motivation (see Table 4).

Partnership experiences

Overall, respondents were moderately satisfied with their cross-sector partnerships for advancing and sustaining integrated care (*M* = 4.89; *SD* = 0.97). Respondents mostly agreed that their organization's motivation and capacity for holding conversations with cross-sector partners were improved through the SIM initiative (*M* = 5.37, *SD* = 1.10). Five thematic categories emerged from the open-ended questions assessing partnership experiences: collaboration and relationships, capacity and leadership, measurement and outcomes, financing integrated care, and sustainability of the cross-sector partnership. We provide an outline of the themes and supporting quotes in Table 5.

Table 3 | Mean readiness components and subcomponents scores across sectors

Component	Advocacy (N=6)	Education (N=9)	Government (N=18)	Health Care (N=18)	Other (N=6)	Payer (N=4)	Practice Transformation (N=14)
Motivation	5.50	5.88	6.05	5.50	6.05	4.98	6.12
Innovation-Specific Capacity	4.57	5.36	5.44	4.95	5.99	4.68	5.34
General Capacity	5.96	5.63	5.67	5.70	6.88	5.86	5.80
Subcomponent							
Relative Advantage	6.08	6.11	6.39	6.03	6.00	5.63	6.18
Partnership Value	5.94	6.04	6.13	5.72	6.06	5.08	6.12
Compatibility	6.13	6.22	6.33	5.97	6.42	5.56	6.43
Observability	4.75	5.72	5.89	5.14	5.83	4.88	6.04
Priority	4.75	5.17	5.50	4.89	5.83	4.13	5.86
Commitment/ Ownership	5.33	6.04	6.07	5.24	6.17	4.58	6.07
Communication	4.08	5.39	5.42	4.86	6.00	4.25	5.50
Conflict Management	4.22	4.67	5.17	4.72	5.39	4.25	4.93
Decision Making/ Participant Input	4.83	5.62	5.73	5.34	6.27	4.85	5.36
Roles and Responsibilities	4.61	4.93	5.35	4.80	5.67	4.50	5.36
Supportive Climate	4.21	5.14	4.99	4.78	5.92	3.94	5.14
Leaders of the Partnership	4.78	5.85	5.37	5.06	6.39	5.83	5.48
Cohesion/ Sense of Community	5.22	5.93	6.06	5.11	6.28	5.17	5.64
Culture	6.56	6.07	6.13	6.07	7.00	6.08	5.76
Climate	5.89	5.48	5.50	5.13	6.78	5.58	5.71
Internal Operations	5.78	5.19	5.56	5.33	6.72	5.83	5.60
Innovativeness	5.42	5.72	5.47	6.19	6.92	5.88	5.82
Leadership	6.17	5.67	5.70	5.76	7.00	5.92	6.12

The "Other" sector represents responses from sectors working on health and health care issues that only had one or two respondents, including a philanthropic organization, a nonprofit research institute, a consulting firm, and health information technology organizations. Readiness subcomponent scores are on a gray-scale. Higher scores are represented by lighter gray; lower scores are represented by a darker gray.

Collaboration and relationships

Sectors identified cross-sector partnerships as meaningful for advancing and sustaining integrated care in Colorado. Many sectors reported that the overarching goals and strategy of SIM contributed to success and that alignment is critical to sustainability. However, the lack of a unified vision for behavioral health in the state was also frequently noted. New and strengthened relationships were cited as a key contributing factor to improved partnerships. Communications and the infrastructure SIM provided for facilitated dialogue were cited as supports for successful partnerships by all sectors except for payers. The majority of sectors highlighted the valuable contribution of shared learning and resources. All sectors also recognized broad representation across stakeholder entities brought expertise from a variety of perspectives, diversity in representation, opportunities to bring visibility to the work, and contributions outside of traditional health care.

While improved relationships and trust were reported across sectors, government, behavioral health organizations, practice transformation organizations, and "other" identified mistrust and the territorial nature of organizations as a concern. Behavioral health organizations noted that shifting partners' needs limited the success of cross-sector partnerships. Behavioral health organizations also specifically identified the importance of including the integration of primary care services into behavioral health settings as well as behavioral health into primary care. At the same time, a local public health agency reported that cross-sector partnerships facilitated a slow breakdown of "historical mistrust," allowing agencies that have competed in the past to learn how to work together.

Capacity and leadership

The dedicated funds and time from SIM improved the capacity of cross-sector partners to collaborate. However, stakeholders across all sectors noted concerns about insufficient capacity for new work and participation in the cross-sector partnership, specifically referencing lack of time, resources, and staffing. Stakeholders from the advocacy sector,

Table 4 | Mean readiness scores across subsectors of health care and government

Component	Health Care Primary Care (N=3)	Health Care Behavioral Health (N=9)	Health Care Health System (N=6)	Government: Local Public Heath (N=11)	Government: State Agency (N=7)
Motivation	5.79	5.80	4.91	6.50	5.34
Innovation-Specific Capacity	5.38	5.10	4.53	5.78	4.91
General Capacity	5.46	5.61	5.96	5.82	5.44
Subcomponent					
Relative Advantage	6.17	6.33	5.50	6.73	5.86
Partnership Value	6.11	6.15	4.89	6.61	5.38
Compatibility	6.33	6.08	5.63	6.70	5.75
Observability	5.50	5.28	4.75	6.36	5.14
Priority	5.17	5.50	3.83	5.95	4.79
Commitment/Ownership	5.44	5.44	4.83	6.67	5.14
Communication	5.33	5.06	4.33	5.68	5.00
Conflict Management	5.11	4.89	4.28	5.52	4.62
Decision Making/ Participant Input	5.93	5.29	5.13	6.11	5.14
Roles and Responsibilities	4.78	5.11	4.33	5.88	4.52
Supportive Climate	5.25	4.78	4.54	5.43	4.29
Leaders of the Partnership	5.44	5.33	4.44	5.55	5.10
Cohesion/ Sense of Community	5.78	5.22	4.61	6.27	5.71
Culture	5.56	5.93	6.56	6.18	6.05
Climate	4.56	5.00	5.61	5.70	5.19
Internal Operations	5.33	5.22	5.50	5.64	5.43
Innovativeness	6.17	6.22	6.17	5.64	5.21
Leadership	5.67	5.67	5.94	5.94	5.33

Readiness subcomponent scores are on a gray-scale. Higher scores are represented by lighter gray; lower scores are represented by a darker gray.

payer sector, state agencies, and primary care stated their time to participate was limited by competing priorities. The availability of staff dedicated to the work of the cross-sector partnership contributed to integrated care efforts.

Central leadership to convene and coordinate cross-sector partnerships was noted as a key contributor to progress, though some concerns were brought forward from the payer and health care sectors that the leadership needs to provide more clarity. Stakeholders reported that the participation of their individual organization in cross-sector partnerships is dependent on their own leadership's decisions and motivation related to integrated care.

Measurement and outcomes
All sectors except for the payer sector reported that the opportunity to improve patient outcomes was a

meaningful aspect of their participation in the cross-sector partnership. In the health care and government sectors, stakeholders identified that there is inadequate infrastructure to capture or share data. Capturing data within a sector is complicated by the fact that the work of integration in one sector may lead to benefits in a different sector. The ability to observe and measure outcomes across sectors needs development. Moreover, significant time may be required before some longer-term benefits are achieved.

Financing integrated care
While behavioral health organizations and local public health agencies noted that increased available funding as a result of the cross-sector partnerships contributed to progress, all sectors described a need for further collaborative work on payment reform aligned across all payers. Stakeholders in multiple

Table 5 | Qualitative themes and representative quotations from the Colorado State Innovation Model (SIM) stakeholder readiness assessment

Theme	Quote
Collaboration and relationships: Cross-sector partnerships are meaningful for advancing integrated behavioral health; SIM provided an opportunity to test integrated care models and facilitated meaningful dialogue	"The facilitation of an active dialogue across multiple stakeholders regarding both operational and financial aspects of integration have contributed the most to improvement." *[Academic]*
Need relationships and trust for meaningful partnerships; mistrust and desire to "protect one's turf" are concerns of some sectors	"Relationships are the key contributor to improvements in partnerships." *[Government—Local Public Health Agency]* "The territorial nature of the system is a challenge to true integration." *[Other—Health Information Exchange]*
Alignment of goals and strategy across sectors is critical	"Health care is complex and needs to be coordinated across many organizations. Developing strong collaborations among organizations that aligned clinically and financially are key for sustainability." *[Health care—Behavioral Health Organization]*
Need for inclusive representation of stakeholders across sectors	"Complex issues need multiple skills, experiences, backgrounds and perspectives to address." *[Academic]*
Shared learning and resources contribute to successful partnerships	"Relying on the expertise of various partners means that none of us has to 'recreate the wheel'." [Health care—*Behavioral Health care Organization*]
Capacity and leadership: Philanthropy Buy-in of leadership within organization is key	"Increased awareness of the benefits of behavioral health among health system leadership has helped." *[Healthcare- Primary Care]*
Importance of central leadership to set a clear direction of the cross-sector partnership	"Ongoing leadership in the state and a place to continue to gather to discuss our ongoing work." *[Other - Philanthropy]*
Participation limited by time, resources, staffing, and competing priorities; dedicated resources from SIM helped alleviate this	"Limitations on this improvement are result of our funding and other priorities within our organization's mission and vision, as well as staff capacity to learn about and engage with behavioral health innovation." *[Advocacy]* "The targeted focus of this initiative has helped improve this due to the dedicated time, efforts, and funds to support attention to the conversation." *[Academic]*
Measurement and outcomes: Impact on outcomes is a meaningful aspect of participation in the cross-sector partnership	"Cross-sector partnerships improve our ability to address all the things that keep people healthy both in and outside of the clinic." *[Practice Transformation]*
Limited ability to share and capture data within and across sectors	"...improved outcomes are often seen across systems and in ways that can be difficult to capture, especially with cost savings..." [Health care—Behavioral *health*]
Financing integrated care: Need for continued cross-sector partnerships to develop alternative payment models supporting integration	"Meaningful, all-payer payment reforms must support these efforts." *[Advocacy]*
Need for better information on financing integration	"... better understanding of the benefits and costs of integration from multiple perspectives." *[Academic]*
Sustainability of the cross-sector partnerships: Call for continuation of the cross-sector partnerships with a defined sustainability plan	"Having a well-thought out strategy or road map with input from key players that uses time efficiently and is successful; yes... a big ask..." *[Healthcare—Health system]*
Need for funding to continue the cross-sector partnership (both for the role of the convener and for participating organizations)	"Funding and/or dedicated staff to those efforts in a longer term capacity as part of an organization's foundation. Perhaps legislative policy funds, small amounts which could be carved out to support FTE dedicated to these very targeted efforts." *[Academic]*

sectors highlighted the need for better payer engagement in the cross-sector partnership to achieve this. A payer and a respondent from the education sector called for better information on the costs and benefits of integration to support payment reform efforts.

Sustainability of the cross-sector partnership
All sectors recognized the value of continuing the statewide cross-sector partnership and noted the need for a sustainability plan with identified leadership, clearly articulated goals, and funding

mechanisms beyond short-term pilots or grant funding. They expressed concerns that, in the absence of a dedicated central convener, there is not sufficient time, attention, or capacity for collaborative work. In addition to funding for a central convener, stakeholders from the payer, academic, government, and "other" sectors called for funding to support staff time within participating organizations. Other recommendations regarding sustained cross-sector partnership work included legislative change and continuation of workgroups and practice transformation support.

DISCUSSION

Overall, there was recognition across sectors that cross-sector partnerships serve a key role in advancing behavioral health integration at a state level, and there were moderate-to-high levels of readiness among stakeholders to continue the work of SIM. These findings bear important implications for future efforts to develop and sustain cross-sector partnerships to integrate behavioral health.

First, a central coordinating body supports statewide scaling. SIM provided infrastructure, communications, and dedicated time to facilitate dialogues that advanced the cross-sector partnerships. There is a need for sustainability planning to ensure this central leadership long term without solely relying on temporary grant funding [27]. Second, organizational leadership buy-in is critical. The convener should foster a common understanding among members regarding the importance of behavioral health integration, providing evidence of benefits applicable to each sector. Third, it is important for the central coordinating body to monitor partnership effectiveness, as attributes of the partnership fluctuate over time. A set of guiding principles and continuous feedback loops can support a successful partnership from the start. Across the sectors, the lowest readiness scores were observed in innovation-specific capacity, suggesting a need for tailored guidance on partnership operations, particularly around conflict management. Conflict is common in cross-sector partnerships and may be exacerbated by real or perceived power differentials between organizations [28]. In addition to developing strategies early on for how conflict will be managed, inclusive representation and continuous trust building may help prevent conflicts [28]. This may be particularly applicable to the health care sector, where the historic separation of behavioral health and primary care [29] has created mistrust and feeling the need to "protect one's turf," which may impede collaborative efforts.

Comparing sectors and subsectors, the lowest levels of innovation-specific capacity were observed in advocacy organizations, payers, and health systems. This may reflect that these organizations were the most removed from the on-the-ground work of integration compared to primary care practices, practice transformation organizations, and local public

health agencies. Advocacy groups and payers also noted that competing priorities affected their participation. Given these findings, extra efforts to support the engagement of these sectors may be particularly critical. Some respondents specifically called out the need for more engagement of payers, noting a continued need to work collaboratively to further payment reform as a desired outcome of the cross-sector partnership. Aligning behavioral health and physical health payment models will contribute to more efficient and cost-effective care [14]. Demonstrating return on investment may be an important mechanism to support buy-in from this sector.

Lastly, the ability to share data and capture outcomes within and across sectors remains a barrier to cross-sector partnerships and is an important area of future work. This need has also been identified previously [30]. Behavioral health integration thought leaders recommend the following: (a) establish a public set of health indicators for well-being/behavioral health focused on wellness (rather than illness), including measures of social connectedness and self-efficacy; (b) link existing real-time data between health systems and other health and human service programs; and (c) improve accessibility and presentation of community-level data [14].

Limitations

Several sampling and analytic limitations are important to note along with data insights. First, while the response rate was over 50% (67 of 125 organizations), some variability within sectors may not be captured due to the smaller sample size of select organizational types (e.g., payers). Participants included in this assessment were selected based on involvement with the SIM initiative, which may introduce selection bias. Participation was voluntary, rendering the possible influence of volunteer bias. Additionally, the findings reflected in this article draw on the experiences of Colorado and may not generalize to other states in the USA. Many stakeholders in Colorado have significant experience with behavioral health integration; as such, issues related to partnering raised by these stakeholders may differ from those in another state at a less mature stage of behavioral health integration. We used descriptive statistics in this manuscript to understand trends in stakeholder readiness. This analytic approach was appropriate for the manuscript aim but precludes inferences about similar cross-sector partnerships at large. Future administrations of the RCP can advance this work by examining associations between partnership readiness and partnership outcomes (e.g., *Which RCP readiness subcomponents are most critical to partnership outcomes?*), including variables that mediate or moderate the relationship between readiness and outcomes, such as length of cross-sector partnership experience. Finally, the qualitative data summarized in this manuscript reflect open-ended questions that were supplemental to the readiness scale.

A more targeted inquiry on the themes identified in this assessment, along with the readiness trends, would be valuable for understanding the characteristics and interplay of issues identified.

CONCLUSION

Partnering across sectors to advance integrated behavioral health and create more equitable access to services is inherently complex and nonlinear in nature. Readiness to partner for the long term is critical to the success of statewide efforts. The *Readiness for Cross-Sector Partnerships* assessment helps to identify opportunities to strengthen the sustainability of this work. In future projects, this tool could be used at the outset to plan for sustainable partnerships from the beginning.

Compliance with Ethical Standards

Conflicts of Interest: The authors of this manuscript declare that they have no conflicts of interest.

Author Contributions: ECG, SK, SLW, VS contributed to the concept and design of the study; VS, TK, LS led the development and analysis of the readiness questionnaire; SBG, ECG, SK analyzed and interpreted qualitative data; all authors contributed to the drafting, review, and approval of the manuscript.

Ethical Approval: This initiative was for quality improvement purposes and exempt from institutional review board review. This article does not contain any studies with animals performed by any of the authors.

Informed Consent: The content of the assessment described in this study focuses on the topic of partnerships. Informed consent was not required.

Transparency Statement: The survey instrument used in this manuscript may be available by emailing the corresponding author.

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