



Delta Center Phase 2 Final Evaluation Report (2021–2024)

November 2024

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Executive Summary

Launched in 2018, the Delta Center for a Thriving Safety Net is an initiative funded by the Robert Wood Johnson Foundation (RWJF) and led by JSI Research & Training Institute, Inc. (JSI). National partners included the National Association of Community Health Centers, National Council for Mental Wellbeing, and Center for Accelerating Care Transformation at Kaiser Permanente Washington Health Research Institute. The ultimate aim of the Delta Center was to cultivate health policy and a care system that are both more equitable and better meet the needs of individuals and families. Recognizing the vital role played by state and national associations in supporting community health centers and community behavioral health organizations, the Delta Center funded state primary care associations (PCAs) and behavioral health state associations (BHSAs) to foster cooperation and collective action among these entities in a State Learning and Action Collaborative. In its second phase (2021–2024), the Delta Center awarded grants to teams of PCAs and BHSAs from seven states: Alaska, Kansas, Louisiana, Mississippi, New Hampshire, Oklahoma, and Pennsylvania.

In this evaluation report, we summarize the progress state associations have made toward advancing policy and practice change during their participation in the Delta Center. The findings are based on qualitative and quantitative data collected through baseline, midpoint, and final surveys and video interviews with 14 associations from the 7 states in Phase 2.

Key Findings

Successful systems change in policy and practice: Top policy priorities for state associations included addressing the workforce crisis, expanding certified community behavioral health clinics (CCBHCs), and building on telehealth policies enacted during the COVID-19 pandemic. Many PCAs and BHSAs achieved policy successes and progress in these areas, often in collaboration with each other. In the area of practice change, grantees also reported increased activity and PCA-BHSA collaboration on provider member training and technical assistance on integrated primary care and behavioral health, as well as equitable service delivery.

Improved collaboration and collective action: PCAs and BHSAs substantially strengthened their partnerships, as demonstrated through increases in the level of mutual trust, greater communication frequency, and joint policy efforts and public presentations. They also increased their collaboration with other key groups, such as state legislators,

state Medicaid agencies, public health departments, and Medicaid managed care plans. PCAs and BHSAs widely regarded the improvements in partnership and collaboration as the most valuable outcome of their participation in the Delta Center. Increased collaboration has provided a strong foundation for future collective action on policy and practice change.

Enhanced engagement and incorporation of consumer voice: Despite challenges, PCAs and BHSAs increased their efforts to engage consumers. They partnered with state-level consumer advocacy groups, sought input from their members' boards, and shared consumer perspectives with their members. At endpoint, 13 of the 14 PCAs and BHSAs reported that consumers informed different aspects of their work, compared to just a few at baseline.

Increased understanding of and efforts to address health equity and racial justice: Associations grew in their understanding and efforts to address health equity and racial justice despite challenges in polarized political environments. More associations engaged in these efforts within their organization, with their membership, and through state policy.

Dedication to continued efforts: At endpoint, 4 of 7 state teams were actively exploring funding opportunities with federal or state agencies and foundations to support their ongoing efforts. Many PCAs and BHSAs were also actively taking steps to operationalize their partnerships through regular communication, shared policy development, and partnership at the board and member level.

Conclusion

PCAs and BHSAs that participated in the second cohort of the Delta Center demonstrated tangible progress on policy and practice improvements through systems change efforts, improved collaboration and collective action, and growth in their approach to both consumer engagement and racial equity. All grantees planned to continue working together in the future, with several actively exploring additional funding opportunities.

To sustain this progress, state associations are encouraged to continue building strategic partnerships, elevate consumer voices, and prioritize equity in both operations and advocacy. For funders, supporting these efforts through flexible, multi-year investments will be essential to strengthening integrated, equitable healthcare systems that can adapt to changing political and social landscapes.

Background

Launched in 2018, the Delta Center for a Thriving Safety Net (Delta Center) aimed to strengthen the ambulatory care safety net as a strategy to advance the Quintuple Aim: better care, better health, lower costs, greater staff well-being, and greater health equity.¹ The Delta Center is supported by the Robert Wood Johnson Foundation and led by JSI Research & Training Institute, Inc (JSI). National partners during the second phase of the initiative, which took place from 2021–2024, included the National Association for Community Health Centers, the National Council for Mental Wellbeing, the Center for Accelerating Care Transformation (ACT Center) at Kaiser Permanente Washington Health Research Institute, and Alternate Frame.

To strengthen the safety net, the Delta Center brought together both national partners alongside state primary care associations (PCAs) and behavioral health state associations (BHSAs) to drive policy and practice changes that foster more equitable care systems and better serve individuals and families. These national and state associations represent community health centers and community behavioral health organizations that collectively provide physical and behavioral healthcare to more than 38 million people nationwide.

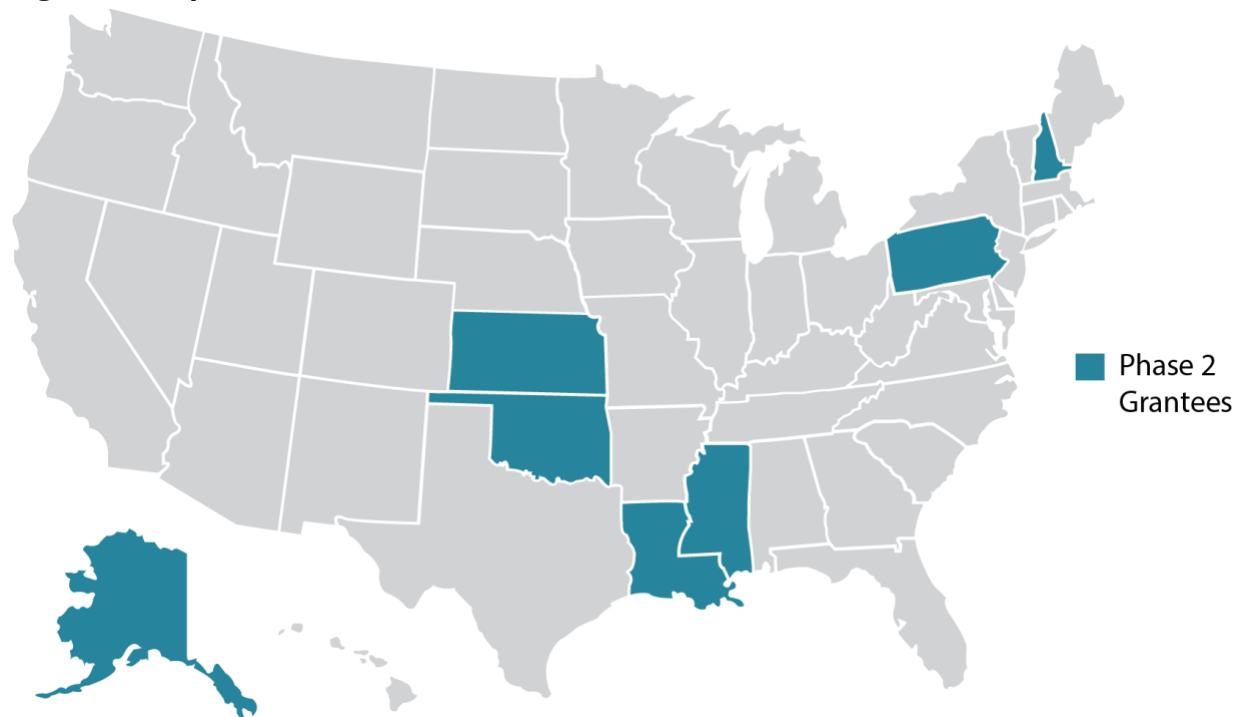
The Delta Center initiative had three goals: 1) foster collaboration and collective action between primary care and behavioral health at the national, state, and local levels; 2) build the knowledge & ability of state associations to ensure that changes in incentives and care systems meet the goals and needs of individuals and families; and 3) elevate insights for the field and for state and national decision makers to influence systems change. Grantees used Delta Center funding to support various policy activities such as research, stakeholder engagement, and building shared policy agendas. While lobbying and legislative advocacy required non-Delta Center funding, this report reflects the important role of Delta Center participation in advancing state associations' progress towards Delta Center goals even when additional funding sources were involved.

Over seven years, the Delta Center provided funding to two cohorts of grantees, a total of 19 state associations. This evaluation focuses on the second cohort (Phase 2), which included teams from seven states: Alaska, Kansas, Louisiana, Mississippi, Oklahoma, New

¹ Nundy S, Cooper LA, Mate KS. The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity. *JAMA*. 2022;327(6):521–522. doi:10.1001/jama.2021.25181

Hampshire, and Pennsylvania (Figure 1). Each state team was composed of both a PCA and a BHSA. In Louisiana, where there is no BHSA, the Louisiana Public Health Institute assumed this role, and the Louisiana team collaborated with the Mississippi team to form a joint “Gulf Coast” team.

Figure 1: Map of Phase 2 Delta Center Grantees



In their initial proposals, state teams outlined collective action projects that would lead to policy and practice changes. Throughout the three-year grant period, the associations participated in a State Learning and Action Collaborative led by the Delta Center program team. The JSI-led program team supported state teams’ learning and relationship development through monthly coaching sessions with a dedicated coach; five virtual and in-person convenings featuring presentations from national experts, opportunities for discussions, and peer sharing; webinars; and access to consultation and technical assistance from Delta Center partners. The program team used co-design activities to tailor content to the associations’ evolving work and needs.

In this evaluation of Phase 2 of the Delta Center, we assessed the state teams’ progress toward Delta Center goals in the areas of collaboration, systems change, consumer engagement, and health equity. We also gathered insights from grantees on the overall impact of the Delta Center on their work. We conclude with recommendations for similar future initiatives.

Methods

JSI and the ACT Center partnered to conduct this mixed methods evaluation. The information collected assessed changes over time, helped tailor technical assistance to PCAs and BHSAs, and compiled lessons to share with the broader field.

Data sources

We assessed Phase 2 through two main information sources: an online survey and video interviews conducted at three time periods (Table 1). A total of 14 state associations participated (7 PCAs and 7 BSAs). Each state association completed an online survey. In addition, the PCA and BHSA from each state participated in a joint video interview together (note: one BHSA was unable to participate in the final joint interview due to a last-minute conflict). Both the surveys and interviews were conducted at three time periods: baseline (July 2021), midpoint (July 2022), and final (July and July 2024). The ACT Center co-conducted the final interviews with JSI.

Table 1. Delta Center Phase 2 Evaluation Data Sources

Data Source	Areas of Inquiry	Timepoints
Online survey	Association-level strategy, state-level policy work, collaboration with counterpart association, member practice change, consumer voice, racial equity, and overall Delta Center reflections	July 2021 July 2022 June 2024
Video interviews	Collaboration with counterpart association, state-level policy work, consumer voice, racial equity, sustainability. Overall impact of the Delta Center*	July 2021 July 2022 July 2024

*July 2024 interviews only

Data analysis

Quantitative data from the baseline, midpoint, and final survey responses were analyzed using SPSS. The evaluation team conducted a comparative analysis of quantitative data between PCAs and BHSAs across the three time points. For qualitative data, notes from each interview were reviewed, with key points summarized and major themes identified.

The evaluation team then further analyzed and synthesized the quantitative and qualitative data to extract themes related to the Delta Center’s objectives, and reviewed Delta Center documents for additional context and clarification.

Further details regarding the evaluation methods can be found in Appendix A.

Results

Successful systems change in policy and practice

The Delta Center grantees made tangible progress on key issues that support a more equitable healthcare system. Top policy priorities for state associations included addressing the workforce crisis, expanding Certified Community Behavioral Health Clinics (CCBHCs), and building on telehealth policies enacted during the COVID-19 pandemic. Many PCAs and BHSAs achieved policy successes and progress in these areas, often in collaboration with each other. In the area of practice change, grantees also reported increased activity and PCA-BHSA collaboration on provider member training and technical assistance on integrated primary care and behavioral health, as well as equitable service delivery.

Achieving success on key policy objectives

Addressing the healthcare workforce crisis was a top priority for all Delta Center grantees. States like New Hampshire and Oklahoma achieved policy successes, including comprehensive workforce laws and loan repayment programs for behavioral health providers. Many states also successfully advocated for regulatory changes, such as Alaska's new Medicaid reimbursement for specific mental health providers within federally qualified health centers (FQHCs) and Kansas's introduction of a "community-based license" for recently graduated mental health workers to practice and bill services for up to two years before passing the standard examination when employed by specific entities like FQHCs. Additionally, states reported that CCBHCs are making significant strides in mitigating workforce challenges in the behavioral health sector. By raising both the scope of services provided and the level of reimbursement for behavioral health services, CCBHCs have been an important model for improving payment for and retention of behavioral healthcare providers. Grantees also reported being actively involved in bolstering the community health worker (CHW) workforce by advocating for Medicaid reimbursement and certification programs.

Expanding CCBHCs was also an important priority for state associations. By the end of the initiative, four associations had successfully advanced or maintained payment model reforms for CCBHCs, up from zero at baseline, with four others working on similar reforms. These reforms varied concerning their implementation, but typically involved either

continuing the success of their involvement in the federal CCBHC demonstration program or securing a Medicaid State Plan Amendment approval by CMS to certify CCBHCs and use their state's Prospective Payment System (PPS) rate methodology for other Medicaid services. There was particularly notable movement on this issue among BHSAs—at the end of the project, all BHSAs were working on CCBHC payment models, and almost half had succeeded.

The stage of CCBHC expansion varied across states. Oklahoma and Pennsylvania, both part of the federal CCBHC demonstration program, focused on increasing the number of CCBHCs in their state, while others pursued planning grants or CCBHC demonstrations. For example, Kansas took independent steps to establish CCBHCs outside of the federal program with bipartisan support at the state level and state funding. Kansas is now leveraging this foundation of state support to become part of the federal demonstration program. Mississippi and New Hampshire are using CCBHC planning grants to apply for the federal demonstration program, with New Hampshire also encouraging community health centers to pursue individual demonstrations through the Substance Abuse and Mental Health Services Administration (SAMHSA). The Delta Center helped PCAs deepen their understanding of CCBHCs and facilitated partnerships between community health centers and CCBHCs, a key requirement of the federal program.

“Anecdotally, I can tell you that I would be dead already if we weren't a CCBHC when it comes to workforce, because we were able to make major advances in improving salary and benefits.”

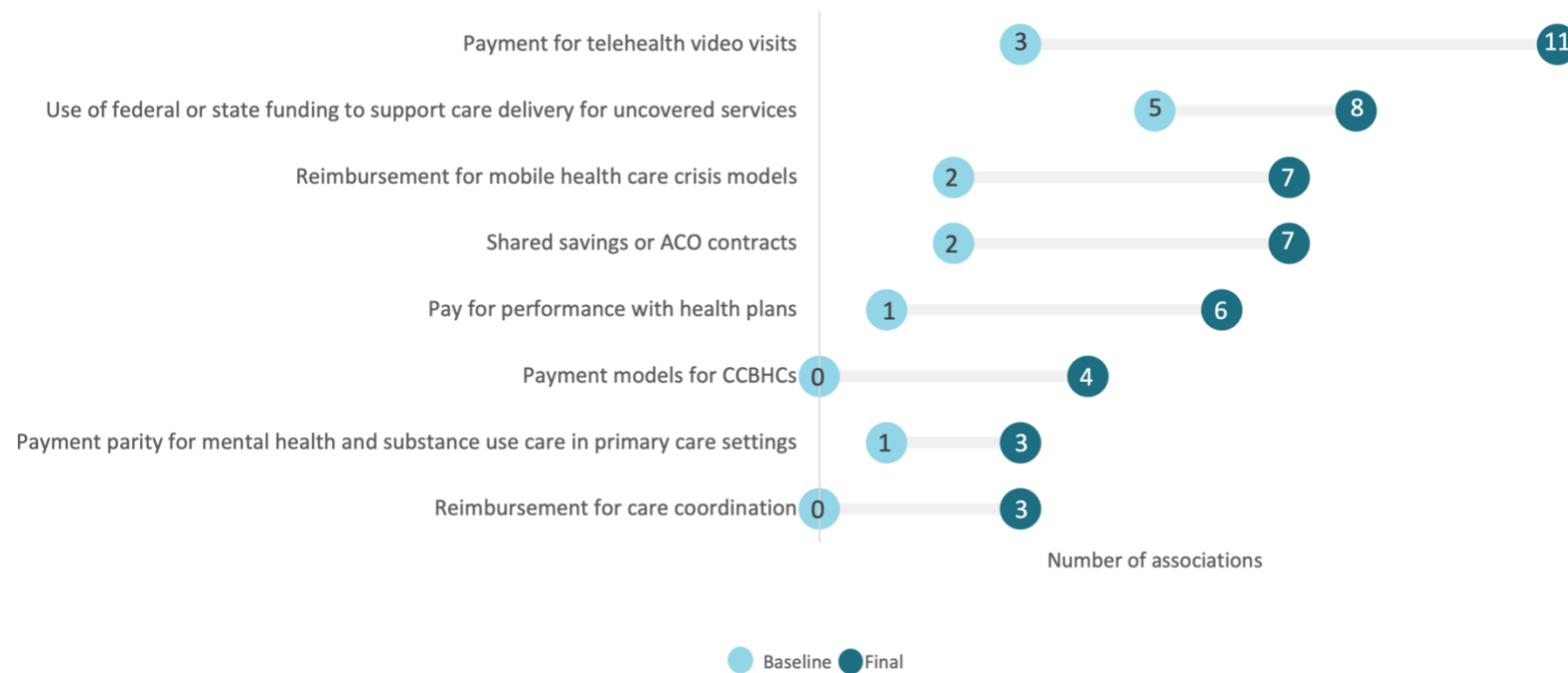
—Behavioral health state association

Telehealth policy was also a key area of policy success for state associations. States reported that the main priority around telehealth legislation was to maintain flexibilities enacted during the COVID-19 pandemic. The number of associations that reported successfully advancing or maintaining telehealth policy with regard to audio-only visit

payment increased from 2 to 10, and from 3 to 11 for telehealth video visit payment. BHSAs have underscored the ongoing value of telehealth in expanding access to behavioral health services, both during and after the pandemic.

Grantees reported that they also made progress across many other issues, such as pay-for-performance for quality with health plans, shared savings or accountable care organization contracts, and support for mental health and substance use care delivery in non-health settings such as schools or shelters (see Figure 2).

Figure 2: State Associations Succeeded in Advancing Key Policy Issues Related to Delta Center Goals
Number of associations successfully advancing or maintaining policy reforms at baseline and final



Beyond the policy successes of individual organizations, PCAs and BHSAs reported increased collaboration with their counterpart associations as a result of relationship-building and discussions of shared policy goals. This collective effort

enhanced the work of both groups. One of the most common areas of policy collaboration was reimbursement for health-related social needs. At baseline, 10 associations were working on this issue and 1 had succeeded, but only 2 were collaborating. By the end of the project, 9 of the associations were working on this issue and 3 had succeeded, and 10 of the 12 reported collaborating.

"We share our talking points back and forth, making sure we're singing from the same song book, and doing our due diligence, then taking those opportunities to touch base with the legislature or...the staffers so that we're delivering the same message."

—Primary care association

The associations' success was not without its challenges. Most PCAs and BHSAs reported navigating difficult political environments during their Delta Center participation, often facing conservative legislative and gubernatorial leadership. Teams emphasized the importance of intentional relationship-building to advance their policy goals, particularly around health equity. They also tailored their language to avoid polarized terms such as "diversity, equity, and inclusion" and instead focused on more politically palatable issues such as rurality or socioeconomic status. Despite their efforts, several state teams were unable to advance high-priority policies such as Medicaid expansion and reimbursement for audio-only telehealth services. Some grantees also spent significant time blocking harmful legislation. Within this challenging landscape, presenting a united front between the PCA and BHSA on key issues was essential.

Even when addressing an issue that seems more like common sense to us—the issue of equity and the importance of equity—how that word can trigger some policymakers... folks have to find a workaround and be creative in the way we address and talk about it in order for us to get to the end goal.”

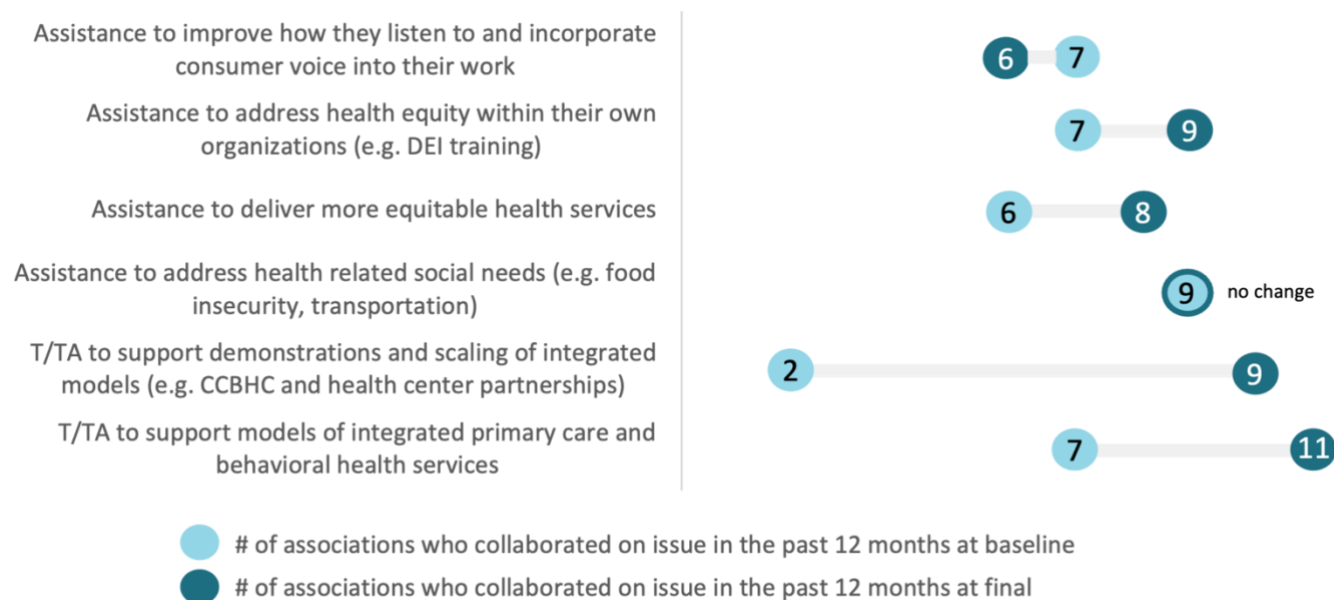
—Behavioral health state association

Supporting member practice change

While policy change was a substantial area of focus for grantees, they also supported member practice change as part of their Delta Center activities to improve primary care and behavioral health integration, health equity, and incorporating consumer voice. The most notable area of growth was training and technical assistance (TTA) to support demonstrations and scaling integrated models, such as partnerships between health centers and CCBHCs. At baseline, only two associations were actively engaged in this work, but by the end of Phase 2, the number had risen to ten (see Figure 4).

Figure 3: State associations increased training and technical assistance related to Delta Center goals.

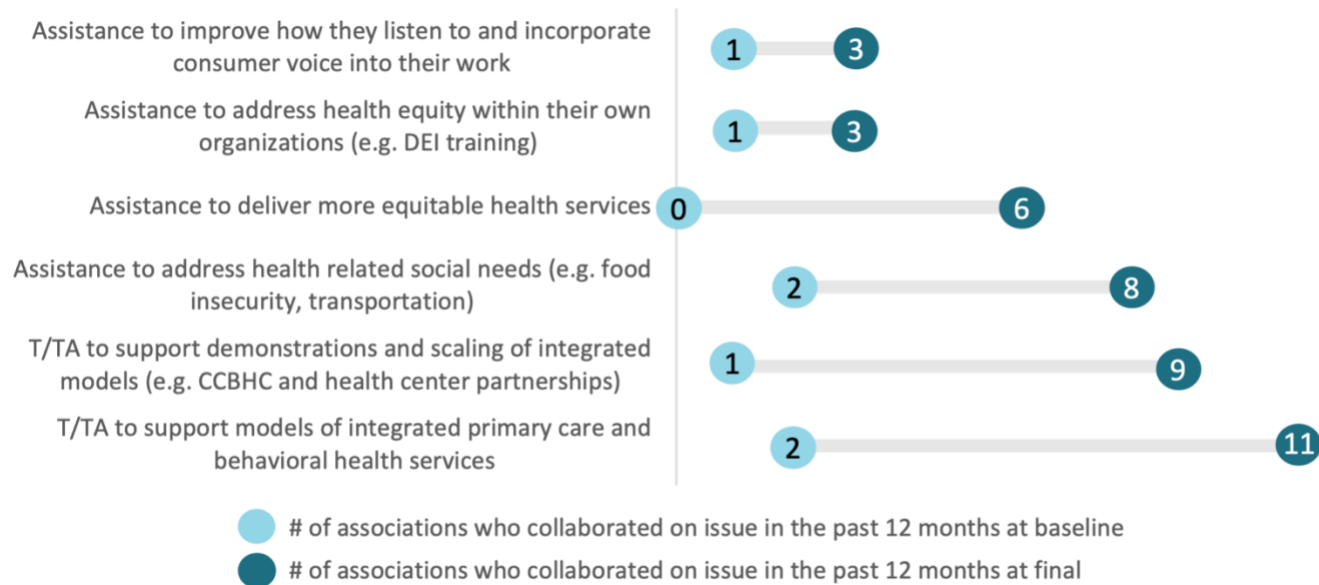
Number of associations providing training and TA to support integration of primary care and behavioral health, health equity, and incorporation of consumer voice at baseline and final



Collaboration between PCAs and BHSAs on these TTA efforts also increased dramatically. For example, the number of associations that reported collaborating with their counterpart on T/TA to support models of integrated primary care and behavioral health services increased from 2 to 11. PCAs and BHSAs also reported increased collaboration in areas such as TTA to deliver more equitable health services (0 at baseline to 6 at the end), assistance to address health-related social needs (2 at baseline to 8 at the end), and other areas (see Figure 4).

Figure 4: State associations worked together to deliver training and TA.

Number of associations collaborating with their counterpart to deliver training and technical assistance to community health centers and community behavioral health organizations



Improved collaboration and collective action

The relationships PCAs and BHSAs fostered throughout their Delta Center participation were an essential foundation to their individual and collective systems change successes. As they worked to better understand one another’s structures and goals, the associations were able to identify opportunities for increased collaboration, especially related to policy and practice change. By working together on shared priorities, they were able to make progress on issues ranging from telehealth legislation to CCBHCs.

While some teams had a history of regular collaboration before participating in the Delta Center, others were less familiar with one another. Despite varying levels of prior partnership, every team cited the Delta Center as the pivotal force in deepening their collaboration and facilitating a valuable exchange of knowledge and diverse perspectives. The enhanced partnership between associations was widely regarded as the most significant outcome of the Delta Center initiative, as it was viewed as a foundation for their collective action on policy and practice change.

Collaborating on policy and practice goals

A primary goal of the Delta Center was to foster collaboration between PCAs and BHSAs in addressing shared policy and practice change priorities. Before their participation, most health centers rarely engaged in joint policy development or public presentations. However, the Delta Center catalyzed increased collaboration, with all PCA-BHSA teams engaging in joint policy formulation and 13 associations delivering joint public presentations by the endpoint. Grantees provided many specific examples of their work in this area. Several associations now conduct joint reviews of policy priorities by both organizations' boards, leading to more focused collaborations and strengthened policy efforts. One state team is integrating each other's work into their Health Resources and Services Administration work plan, which will advance both associations' goals simultaneously. Another team highlighted how their partnership builds on a history of collaboration by establishing common goals and shared learnings, and that will amplify their collective impact. Joint trainings and legislative receptions helped to further solidify these partnerships and signal to other stakeholders, such as Medicaid agencies, that primary care and behavioral health associations are working together to advance changes.

Sharing cross-state experience and knowledge

In addition to building strong partnerships within grantee teams, the Delta Center facilitated relationships between associations across different states. Teams valued connecting with PCAs and BHSAs facing similar challenges in other states, and cross-state sharing of information also led to tangible successes. For example, one PCA reported that they modeled successful CHW legislation after a law that was passed by a state in the first Delta Center cohort, which they learned about at a Delta Center convening. Another PCA successfully passed 340B legislation after borrowing language from another state. Several teams leveraged other states' expertise by inviting individuals from other states to present

at events and conferences. Additionally, a BHSA became a subject matter expert for several states looking to implement CCBHCs.

“Working and learning alongside the other states, seeing similarities, was hugely helpful. You think, how can I do this? And you see others do it.”

—Behavioral health state association

“One of the lasting things coming out of Delta Center isn't just the strengthening relationship within our state, but connections to other state teams. We were invited to another state to join their public health meeting on integrated care. That was really cool.”

—Behavioral health state association

Becoming a stronger force together

As an extension of their improved partnership, PCAs and BHSAs found themselves better equipped to address issues within their respective membership and engage stakeholders from other sectors. They reported new relationships between their respective member organizations that led to improved understanding, co-located services, integrated workflows, more effective operations, and improved ability to identify other opportunities for impact.

There was also a trend toward more collaboration with state entities such as state legislators, state Medicaid offices, Medicaid managed care plans, state offices of rural health, and state public health departments. The number of

associations reporting working with these different entities increased (see Figure 5), and many of them did so together. One state developed a strong relationship with its Medicaid director through its Delta Center project, and as a result, was able to secure care management reimbursement for FQHCs and community mental health centers (CMHCs).

“...there were conversations about how to pull other associations into the work of primary care and behavioral health, especially when it came to common goals. Bringing them into the room, and having these conversations, regardless of where they went, was significant. It created a network and helped with all sorts of projects.”

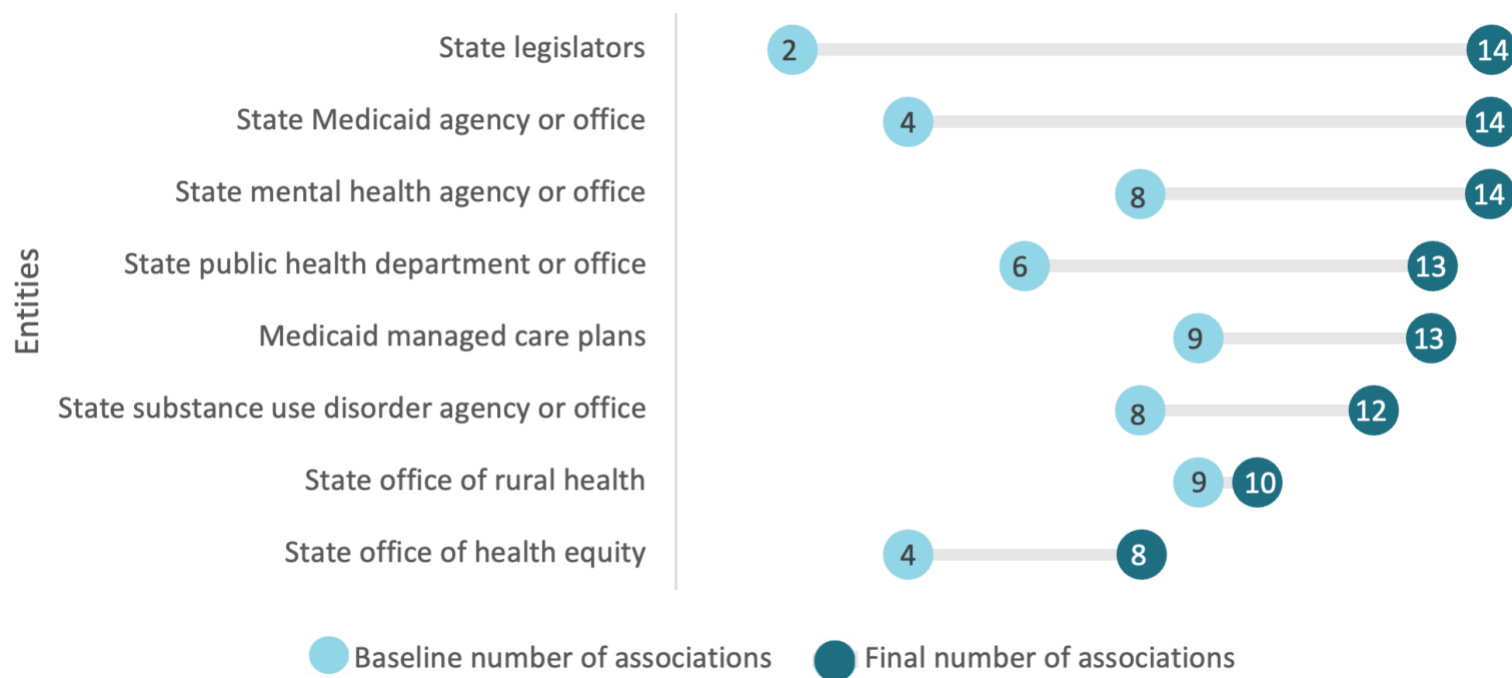
—Behavioral health state association

“The spirit of collaboration pushed us to see what other groups we could work with... It’s pushed us to see what other practices we can share across those different sectors.”

—Primary care association

Figure 5: State associations increased their collaboration with key decisionmakers and partners

Number of associations collaborating with different state entities at baseline and final



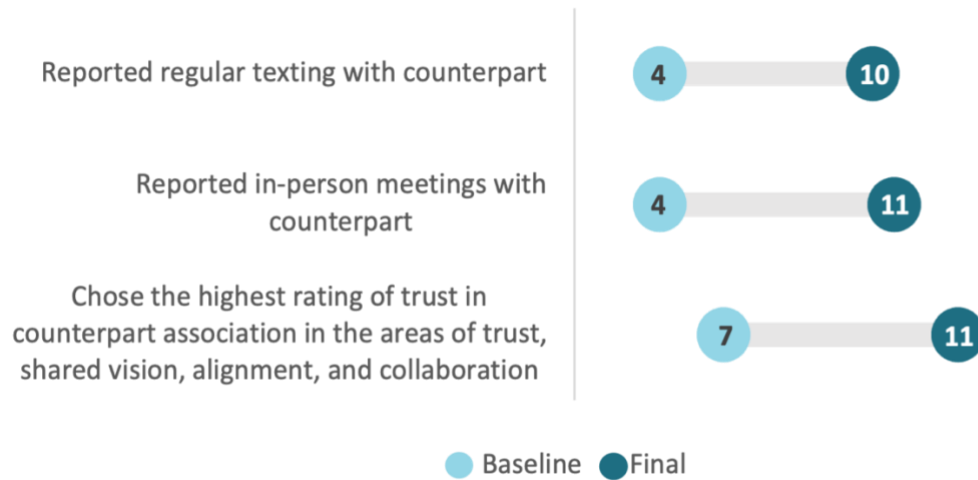
Enhancing communication and understanding

Communication between the PCAs and BHSAs significantly increased, both formally and informally, via emails, video calls, phone calls, texting, and in-person visits. By the grant’s end, the number of grantees reporting regular texting rose from 7 to 10, and in-person visits increased from 4 to 11. In the final survey, 4 associations reported communicating every two to four weeks, and the remaining 10 communicated more frequently. Many PCAs and BHSAs reported that

they now feel confident in calling or texting their partner associations when opportunities or concerns arise—an improvement from their pre-Delta Center relationship.

Figure 6: State associations strengthened their relationship with their counterpart association

Number of associations reporting collaborative practices and trust with their counterpart association at baseline and final.



Most associations rated their relationship with their counterpart association positively in the areas of trust, shared vision, alignment, and collaboration at baseline. They strengthened their partnership in these areas by the endpoint. In the final survey, 11 associations chose the highest rating for trust, compared to 7 at baseline. Associations also gave higher ratings to shared vision and collaboration in the final assessment compared to the baseline.

“Although it might look incremental on paper, I would say the level of collaboration between our two associations is much greater than it ever was before the Delta Center grant.”

—Behavioral health state association

The Delta Center experience has cultivated lasting partnerships among PCA and BHSA state associations, characterized by genuine connections, active communication, and a deepened understanding of one another's strengths and challenges. One team reflected that their two associations “have come to be family, and open to ideas and collaborations.” Further, state associations frequently used terms like “genuine” and “honest” when asked to describe their partnership. As open communication flourished, so did their mutual understanding deepen, laying the groundwork for more substantial conversations. “A lot more conversations happen because of Delta Center,” one association noted. Grantees reported that when they are not in alignment around an issue, the state association teams can talk “because of a deeper mutual understanding of one another.”

Enhanced solicitation and incorporation of consumer voice

Incorporating consumer voice to shape their work was an important component of the Delta Center grantees' efforts. At the outset, PCAs and BHSAs discussed the importance of centering lived experiences and consumer voices. While behavioral health traditionally has had a stronger focus on lived experience, prioritizing consumer engagement and involvement is crucial for progress in primary care and behavioral health alike. Grantees reported that engaging consumers and integrating their input into the association's policy and program development fostered more equitable care systems that better serve individuals and families.

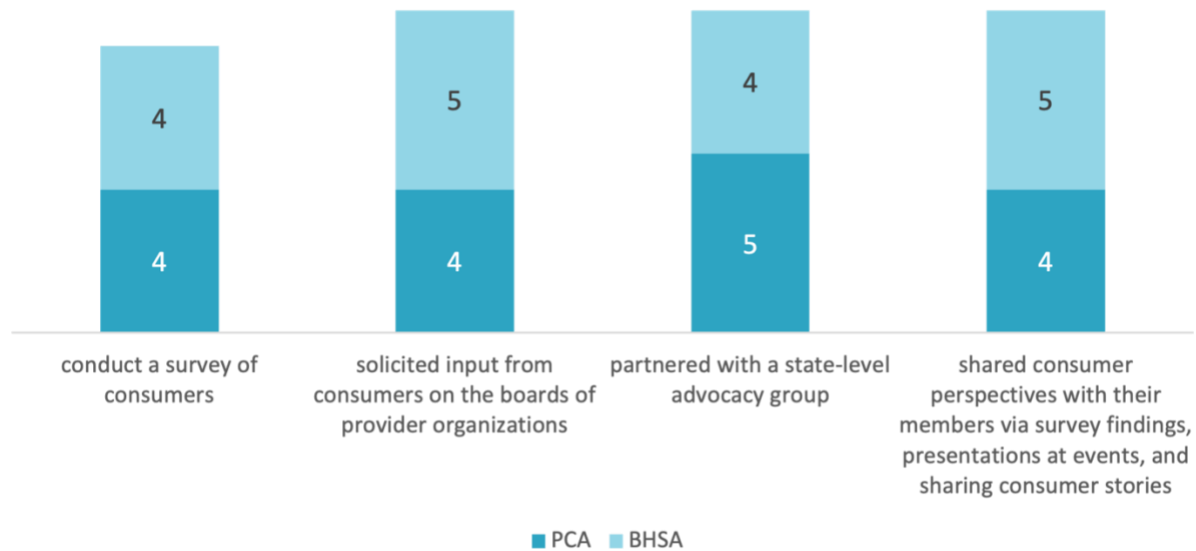
“This notion of lived experience being at the table—not voice of the customer, but really lived experience of the people that are being served, that voice gets more into our day-to-day. I’m really committed to that. I don’t think I’d be there without the Delta Center.”

—Primary care association

At the start of Phase 2, most PCAs and BHSAs reported that consumers did not inform their association’s work in state policy/payment change, practice change among provider members, advancing health equity, or advancing racial equity. By the initiative's end, all BHSAs and nearly all PCAs reported that consumer voice informs their association’s work in specific and/or comprehensive ways. Associations, sometimes as individual associations or together, engaged consumers in a variety of ways, such as conducting a survey and soliciting input from consumers on the boards of provider organizations. The most common practice cited by PCA and BHSA teams for future engagement is partnering with state-level consumer advocacy organizations—a practice currently adopted by 8 PCAs and BHSAs, with 3 more planning to follow suit.

Figure 7: Most PCAs and BHSA's took action to incorporate consumer voice

Number of associations reporting strategies to engage consumers and incorporate consumer voice



"I've appreciated the expectation that we include consumer voice in everything that we do... that has really helped us to hold us accountable and make sure that we're doing that in a meaningful way."

—Behavioral health state association

Notably, most grantees reported difficulty in elevating consumer voices and are still working on best practices for incorporating them into their association-level work. PCA-BHSA teams shared that limited access to consumers was a major obstacle, particularly when it came to capturing diverse new voices and hard-to-reach populations. Some states addressed this issue by utilizing CHWs and targeted engagement strategies. However, data collection and generalizability proved difficult due to the small number of consumers that the associations were able to engage. Other challenges included transportation barriers, maintaining relationships with advocacy groups, and virtual engagement obstacles like Zoom fatigue. Though grantees demonstrated significant growth and learning during their participation in the Delta Center, the sustainability of this dedication to consumer voice may prove challenging due to the lack of grants available for conducting this work.

Increased understanding of and efforts to address health equity and racial justice

The degree and breadth to which PCAs and BHSA's emphasized health equity and racial justice (explicitly or implicitly) in their work varied, largely influenced by their historical programs and political landscapes. Being part of the Delta Center allowed the associations to learn about and focus on racial equity specifically, as well as broader health equity topics, such as rural health and Medicaid access. While participating in the Delta Center, their efforts to advance racial and health equity ranged from internal organizational practices to member-facing initiatives and policy change efforts.

PCAs and BHSA's recognized that looking at their own organizations' practices was an important component of their health equity activities. Progress was evident as the number of associations that made board engagement on addressing racial equity a part of their routine activities increased from 4 to 7 between the baseline and final assessment. One PCA highlighted its commitment to promoting racial equity issues among their board and provider members by working with a consultant who provided tailored training. Additionally, Delta Center trainings significantly

enhanced the understanding of personal biases among individual participants, which fostered a more conscientious approach to their work and their relationships with consumers, families, and communities.

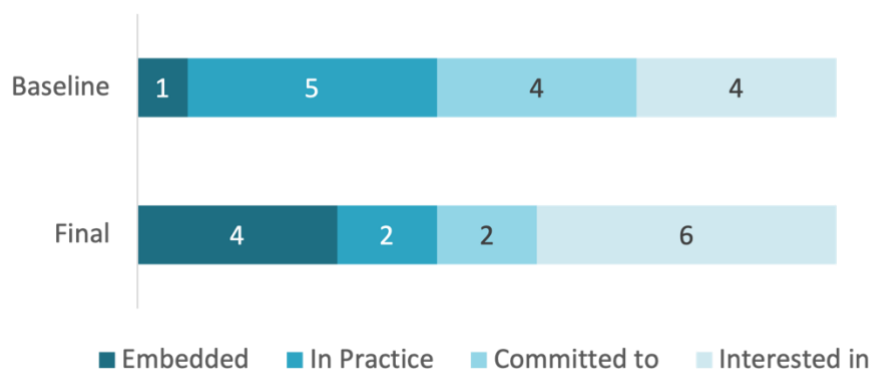
"...[W]e started to realize that if we really wanted to evaluate policies on whether they created equitable[...] access to healthcare, we need to get the voice of the communities that are affected. And we're still trying to figure out a process to do that regularly, and I don't think we're there yet, but we're [...] actually working with [...] some consultants who, I think, can help us develop that process a little better."

—Primary care association

Incorporating racial equity into their provider member trainings at annual meetings and conferences was another important component of state associations' health equity work. By endpoint, 4 associations reported that racial equity-related TTA for their provider members was an embedded practice, compared to 1 at baseline. Grantees noted that listening to the needs of their members (community health centers and CMHCs) and where they were in their openness to learning allowed them to progress at a speed that did not leave members behind.

Figure 8: State associations increasingly adopted racial equity training and TA for their members

Number of associations providing training and technical assistance to support provider members' advancement of racial equity at baseline and final.



“How do you open the door? Enough to where people say, ‘Oh, I didn't know that. That's something I hadn't thought of,’ and begin that conversation versus it's some kind of hammer that someone's doing something wrong.”

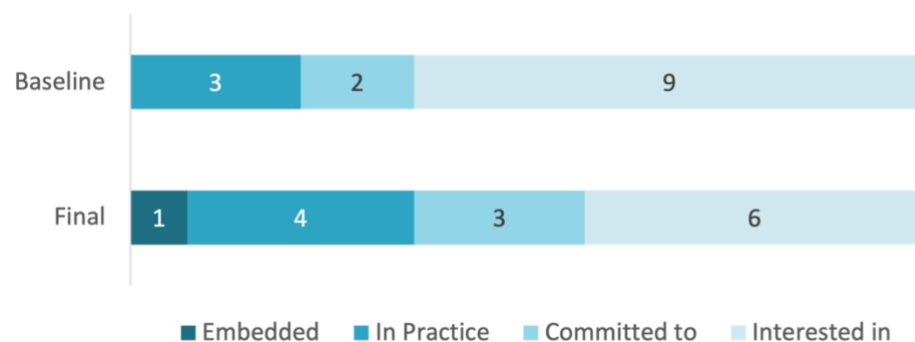
—Primary care association

With regard to state policy work, many associations reported actively working on policies related to health and racial equity. As of the final assessment, 12 associations reported working on or having successfully advanced reimbursement for services related to health-related social needs, and 9 associations reported working with or having successfully advanced policy with their state Medicaid agency to address health disparities in specific racial/ethnic populations.

Overall, there was a slight increase in the number of associations reporting that they were actively pursuing state policies related to racial equity (scored as this work being “in practice” or “embedded”; see the broader shift in Figure 9), from 3 at baseline to 5 at the endpoint. Some associations found it effective to share data with legislators on the diversity of people within the state and the health inequities that exist. Notably, politically conservative environments posed challenges; associations often opted for careful language that framed issues around geography (rural vs. urban), tribal issues, social determinants of health, and access to care as an entry point for more productive discussions with policymakers.

Figure 9: State associations deepened their pursuit of state policies related to racial equity

Number of associations actively pursuing state policies related to racial equity at baseline and final.



PCA-BHSA teams expressed a commitment to continuing to engage in racial equity efforts by educating themselves at the association level, engaging their boards, and offering TTA to their provider members. The majority of associations shared their appreciation for the training Delta Center provided around racial equity and health equity, as it brought these topics to the forefront of their organizations for future planning.

"...those two committees [legislative and policy committee and advocacy committee] have identified social justice and racial equity as policy priorities. And so, it is something that we talk about often. It's something that we're constantly working on trying to embed into our work."

—Behavioral health state association

Dedication to continued efforts

Given the progress and growth PCA-BHSA teams reported experiencing through the Delta Center, they were eager for opportunities to sustain their momentum. Grantees have forged new and stronger relationships that extend beyond the scope of their Delta Center projects. For instance, PCAs and BHSAs are increasingly collaborating with other organizations in coalitions to advance policies related to issues like Medicaid expansion and telehealth. All grantees planned to continue their work together, and many associations were actively taking steps to operationalize their partnerships through regular communication, shared policy development, partnership at the board and provider member level, and more. Importantly, these activities require significant time and resources, which can be challenging for associations that are often understaffed and juggling multiple priorities.

“Our final goal for the grant is to push forward memoranda of understanding of our two associations’ boards and recognize the mutual goal of behavioral health integration access for everyone and that we would affirm our continued mutual partnership and that the associations would protect time in each other’s calendars to discuss in joint discussions. It would be really meaningful. It would be the first time we have MOU with a partner that lays out guidelines with that range of activities.”

—Primary care association

Recognizing the time and resources needed to sustain their work together, at the endpoint, 4 state teams were actively exploring funding opportunities from federal or state agencies or foundations to support their ongoing efforts. Even those not currently seeking funding expressed interest in additional resources if they became available. One grantee noted that there are very few funding opportunities to support association partnerships, so the Delta Center approach was novel and highly valued. They also appreciated the flexibility provided by the Delta Center funding, which allowed them to adapt their work in response to changing state policy and practice environments to ensure they could maximize their impact.

“I think the true impact of the grant may not be determined for quite some time. It was a fairly small grant that I feel changed the trajectory of our organizations...I think a lot might happen as a result of the foundation that was built and the work that was begun that may not have happened otherwise or may have taken much longer to happen. So I don’t think we can truly understand what the impact of this grant is going to have on this state for quite some time, but I’m really quite optimistic that it’s going to be significant.

—Primary care association

Conclusion

PCAs and BHSAs that participated in the second cohort of the Delta Center reported stronger collaboration and collective action, tangible progress on policy and practice systems change efforts, and growth in their approach to consumer engagement and racial equity. All grantees expressed their commitment to continue working together, with four state teams actively exploring new funding opportunities. Others have taken steps to solidify their partnerships through memoranda of understanding, shared policy development, and collaboration at the board and member levels. Most associations plan to continue elevating consumer voice by engaging state-level consumer advocacy organizations. They also reported plans to prioritize racial equity by engaging their boards, providing technical assistance to their members, and pursuing equity-related state policies.

The Delta Center for a Thriving Safety Net is the first-ever major investment in aligning primary care and behavioral health at the national and state association levels. It has succeeded in building and strengthening these foundational relationships, which are essential to driving systemic change in policy and practice. Partnerships at the association level create opportunities to address more than just individual policy issues or practice changes; they foster long-term, sustainable impact. The collaborative efforts of state PCAs and BHSAs have contributed to more responsive and equitable health policies and care systems, impacting thousands of health centers and behavioral health organizations, and the individuals, families, and communities they serve.

As the Delta Center concludes, the following recommendations may help guide other organizations pursuing similar work now or in the future.

Recommendations for other PCAs and BHSAs

1. Prioritize building a strong partnership with your counterpart association.

PCAs and BHSAs emphasized that one of the most valuable aspects of the Delta Center was the opportunity to build or strengthen their relationship with their counterpart association. Even associations that had partnered before found that the initiative deepened their collaboration with one another, which strengthened their joint policy work and provider member trainings. Regular meetings to share priorities and common goals can build trust, shared understanding, and collective

power. Solidifying the partnership through memoranda of understanding (MOUs) or other operational processes can help ensure the relationship endures over time.

- 2. Leverage your relationship to engage other partners.** Throughout the Delta Center, PCAs and BHSAs not only strengthened their relationships with each other, but also expanded collaborations with state legislators, state Medicaid agencies, public health departments, Medicaid managed care plans, and other key stakeholders. Additionally, they reported better relationships between their respective boards and members. Given the capacity and resource constraints faced by many associations and safety net organizations, working together to achieve common goals is essential. Moreover, when multiple organizations come together on a shared issue, they are more likely to capture policymakers' attention.
- 3. Seek opportunities to elevate consumer voice.** PCAs and BHSAs reported significant growth in understanding the importance of incorporating consumer perspectives in their work. Though it can be challenging work, all PCAs and BHSAs can benefit from building their skills to ensure their work is aligned with the needs of, and fosters trust with, the populations that their members serve. Collaborating with a state-level consumer advocacy organization may be a particularly effective strategy that associations should consider.
- 4. Understand your association's role in advancing health equity and racial equity.** PCAs and BHSAs are well-suited to incorporate health equity and racial equity activities into their internal operations, member-facing activities, and policy advocacy efforts, and many are already doing so. The communities served by their members often face a range of disparities related to race, income, rurality, and other factors. This work requires a strategic approach, particularly in more sociopolitically conservative states, but PCAs and BHSAs excel in navigating these dynamics, given their position as trusted sources across the political spectrum. Racial and health equity issues are also areas where collaboration can be powerful. By collaborating with their counterpart association, policymakers, consumers, and other stakeholders, PCAs and BHSAs can build a strong coalition to generate sustained attention and action.

Recommendations for funders

- 1. Invest in collaboration between PCAs and BHSAs.** Grantees in the Delta Center initiative noted the lack of funding mechanisms that are available to support partnership development between PCAs, BHSAs, and similar groups. Both types of associations play critical roles in the healthcare safety net, and the progress they achieved through the Delta Center demonstrates the potential for broader, system-level impact. Additionally, a strong and unified PCA-BHSA team can act as a steadying force within a state's safety-net policy and care system, keeping the focus on the needs of patients and clients even as political leaders and agendas change. Funding partnerships like these represents a valuable investment in creating more integrated, effective, and equitable health systems.
- 2. Allow for flexibility in funding.** PCAs and BHSAs highlighted the value of the Delta Center's flexible grant structure, which allowed them to adapt as political contexts, member needs, and emergent challenges evolved. This approach can be especially helpful if grantees are deepening their focus on certain areas of work, such as consumer engagement and racial equity in the case of the Delta Center. Grantees appreciated having the flexibility to explore how best to focus on these activities in their specific state contexts. A similar approach in future initiatives will empower grantees to be more responsive to changing environments and, and better positioned to maximize their impact.
- 3. Recognize that relationship-building and systems change take time.** Most grantees in the Phase 2 Delta Center cohort had existing relationships, but still found opportunities to address misconceptions, identify shared priorities, and strengthen their communication. These activities take time, but are an essential building block to systems change. Funders should recognize this time requirement by investing in multi-year initiatives that give grantees adequate time to build partnerships. Additionally, changing health policy and care delivery is complex and time-intensive work, especially in conservative state policy environments where change can take years. Funders interested in supporting these efforts should plan for several years of investment before they see significant results.

Appendix A: Evaluation methods

JSI and the ACT Center partnered to conduct this evaluation of the State Learning and Action Collaborative through two main information sources (Table 1). JSI administered online surveys to all 14 state associations (7 BHSAs and 7 PCAs) and co-conducted with the ACT Center 7 video interviews that included 6 BHSAs (one had a last-minute scheduling conflict) and 7 PCAs. The information collected provided a basis to assess changes over time, to help tailor technical assistance to PCAs and BHSAs, and share lessons with the broader field.

Table 1. Delta Center Phase 2 Evaluation Methods

Data Source	Areas of Inquiry	Timepoints
Online survey	Association-level strategy, state-level policy work, collaboration with counterpart association, member practice change, consumer voice, racial equity, and overall Delta Center reflections	July 2021 July 2022 June 2024
Video interviews	Collaboration with counterpart association, state-level policy work, consumer voice, racial equity, sustainability. Overall impact of the Delta Center*	July 2021 July 2022 July 2024

*July 2024 interviews only

Online survey

Grantees were asked to complete an online survey at three timepoints during the initiative: July 2021 (baseline), July 2022 (midpoint), and June 2024 (final). The evaluation team asked that one person from each association serve as the point person for reviewing the survey and working with the most appropriate staff to complete it. The survey was comprised of the following sections:

1. Background
2. Association-level strategy

3. State-level policy work
4. Collaboration with counterpart primary care or behavioral health state association
5. Supporting practice change by working with provider members
6. Consumer voice
7. Advancing racial equity
8. Delta Center reflections (final assessment only)
9. Comments

Video interviews

After the association completed the survey, the evaluation team conducted 60-minute follow-up video interviews with each state team. Interview questions were structured around the following topics:

1. Collaboration with counterpart primary care or behavioral health state association
2. State-level policy work
3. Consumer voice
4. Racial equity
5. Sustainability and overall impact of the Delta Center

Data analysis

Quantitative data from the baseline, midpoint, and final survey responses were analyzed using SPSS. The evaluation team conducted comparative analysis of quantitative data between PCAs and BHSAs and across the three timepoints. For qualitative data, notes from each interview were reviewed, with key points summarized and major themes identified. The evaluation team then further analyzed and synthesized the quantitative and qualitative data to extract themes related to the Delta Center's objectives, and reviewed Delta Center documents for additional context and clarification.