



PATHWAYS TO INTEGRATED HEALTH CARE

STRATEGIES for AFRICAN AMERICAN COMMUNITIES and ORGANIZATIONS

Consensus Statements and Recommendations

Prepared by the

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AUTHOR

King Davis, PhD

EDITOR

Beth Bowers, MDiv, MSW

PLANNING COMMITTEE

Tricia B. Bent-Goodley, PhD, MSW
Tracee E. Bryant, MPH
King Davis, PhD

Kimberly Jeffries-Leonard, PhD
Altha Stewart, MD
Levi Thomas, BA Social Work

Michael Torres, MD

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Howard University School of Social Work

- Lucinda A. Acquaye, MSW
- Damien T. Frierson, MA, MSW
- Allessia P. Owens, LMSW

Howard University Department of Psychology

- Victor L. Jones

University of Arkansas for Medical Sciences

- Jennifer R. Ivory, MPH

EXECUTIVE SUMMARY

The Office of Minority Health convened a national dialogue on Effective Holistic Health for African Americans/Blacks. The dialogue was held in Washington DC in August 2010, to address specific and outstanding concerns related to addressing mental health, substance use/abuse, primary care, and the critically needed support services from a holistic health paradigm for Americans of African ancestry in the United States. The black populations in the United States are extremely diverse including those who are descendants of slavery, and the more recent immigrants from African and other parts of the Diaspora.

Recognition and incorporation of findings in this report are critically important to the development and provision of health care services for Americans of African ancestry if the elimination of health disparities and inequities is to occur. To meet the full spectrum of health needs into the coming years will require broad thinking about the diversity of approaches for the achievement of health equity for all.

It is hoped that this report will assist in building systems of prevention by establishing improvements to meaningful access to care for African American individuals and families to holistic and comprehensive behavioral and primary health care through the development of strategies that are culturally designed to meet their needs. This report will additionally make unique contributions to the Department of Health and Human Services by conducting a first ever meeting that focused on complicated issues and prospective solutions that intersect behavioral and primary health care systems of delivery, stigma, cultural competence and proficiency– in a holistic manner.

Forty-five key leaders in health, medicine, mental health, substance use, religion, education, research, advocacy, public policy, and clinical practice developed a set of consensus statements and recommendations for improving the health across the life span of all segments of the diverse American communities of African ancestry across the United States.

Throughout the conference, the participants used a number of terms to refer to the population: African Americans, persons of African Descent, persons of African Ancestry, People of Color, Americans of African Ancestry and black Americans. In this report, these terms were used interchangeably.

The four consensus statements are:

- 1. A long-term response to health disparities in African American communities has been the development of informal or practice based evidence as well as the use of healers. For behavioral health care and related problems, African Americans often seek services from their houses of worship. However, there is a need to assess**

these interventions to determine the effectiveness of their outcomes and how the interventions can become evidence-based practices.

- 2. Reductions in disparities are partially dependent on the quality, quantity, and skills of the health and behavioral health workforce and the type of integrated care applied. There is a need for a more diverse workforce that utilizes culturally and linguistically proficient and competent interventions that are developed within African American communities in addition to those that may also involve adaptations of evidence-based practices from other communities.**
- 3. There is a pressing need to develop and measure a core set of practice standards and criteria that focus on holistic health, wellness, and community based standards.**
- 4. A significant number of the health and behavioral health conditions in African American communities co-morbid with other socio-economic conditions. These co-occurring conditions include substance disorders, severe mental illness, HIV/AIDS, poverty, diabetes, heart disease, low income, unemployment, and homelessness as examples. The presence of multiple conditions increases overall health risks, stigma, costs, and health outcomes.**

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INTRODUCTION

The Department of Health and Human Services, Office of Minority Health, convened a roundtable dialogue on the status of African American health care in August 2010. The intent of the dialogue was to have community leaders, stakeholders, experts, and consumers identify the key health problems in African American populations and propose multiple pathways and strategies for integrating primary care and behavioral health for African American populations. The dialogue was structured around a series of evidenced based research findings that conclude integrated health care is effective in dealing with both primary health and behavioral health problems and may offer advantages over more traditional health care delivery approaches (Unutzer, Schoenbaum, & Druss, 2006).

This brief report is designed to share the range of issues discussed by the participants and their recommended strategies for integrating primary care and behavioral health as equally important elements in an overall holistic health care approach. The rationale for focusing the dialogue specifically on African Americans and integrated health care is found in the long-term disparities experienced by this population from 1900-2000. These disparities are documented in innumerable university, federal and state surveys of overall health status by race and ethnicity (Byrd & Clayton, 2002; Department of Health and Human Services, 2001).

The dialogue involved 45 African Americans from multiple disciplines: psychiatry, primary care, dentistry, nursing, social work, psychology, religion, counseling, and advocacy organizations. An essential question for the participants was whether there are successful integrated health approaches or models currently at work in African American communities. This question is significant in that African American populations have a long history of disparities and delimited access to fragmented primary health and behavioral health care systems (Davis, 2003; Department of Health and Human Services, 2001).

In addition, African Americans have relied on an admixture of the primary care system and

Integrated Health Care is the systematic coordination of physical and behavioral health [mental health & substance abuse]. These problems often occur at the same time and treating both may yield the best results. This is particularly true where there are major disparities in overall health status and barriers to accessing services. Populations of color appear to benefit equally using this approach.

(Alexander, 2008)

their religious organizations for a complex of health and emotional needs to the exclusion of specialty behavioral health care systems (Neighbors, Musick, & Williams, 1998; Snowden, 2000).

The roundtable dialogue focused on several interrelated issues: history and current status of behavioral health, successful models of integrated health care, and issues that determine the success of these models. The participants reached consensus on a series of strategic service, policy, financing, and workforce recommendations for implementing integrated health care.

PROBLEM BACKGROUND

Disparities in behavioral health care for racial and ethnic minority populations are well documented in a number of seminal reports, studies and papers that focus on the scientific, clinical, and policy issues surrounding these disparities.

For example, a key finding, of the Surgeon General’s Report on Mental Health: Culture, Race and Ethnicity (2001), is that living in poverty has the most measurable effects on the rates of mental illness; the National African American Mental Health and Substance Abuse Summit (Davis & Farris, 2003), identified ten areas of importance and recommendations to address behavioral healthcare needs; and the New Freedom Commission identified six goals that need to be achieved in order to affect the complete transformation of the mental

health system including, ‘**disparities in mental health services are eliminated**’.

Disparities should be viewed as a train of events leading to measurable differences in access to, utilization of, or quality of care, health status, or health outcomes.

(Keppel, Peary, & Wagener, 2002)

Yet, little has been done to develop, implement, and disseminate effective strategies that are culturally and linguistically appropriate. Data show that African American populations are over represented in our nation’s most vulnerable populations, such as the poor, the uninsured, the homeless, and the incarcerated, yet have little to poor access to meaningful mental health services. Moreover, for those who do receive mental health interventions, the appropriateness and quality of those treatments remain in question.

Behavioral health consumer responses and interactions with healthcare providers are particularly cogent when a perception of mistreatment, mistrust, disrespect, or general lack of understanding exists. As a result, clinicians can

view symptoms, diagnoses and treatments in ways that diverge from the views of the patients they treat. This has resulted in African Americans being more likely to receive more severe psychotic diagnoses and less likely to receive affective diagnoses when exhibiting the same symptoms as their white counterparts (Whaley, 2004). Primary care settings in African American communities are also the place where the need for supportive services is often identified. And these services are critical for patients to be able to follow the entire plan necessary for recovery, rehabilitation, management of chronic conditions, and maintaining their health and that of their families. Wang (Wang et al., 2006) reported that there has been a significant shift in the locus of mental health care services away from specialty treatment to primary care heightening the need for integrating care across domains.

Developing models of culturally competent and proficient comprehensive healthcare provision bringing together essential elements of primary and behavioral healthcare as well as supportive services will be critically important to a comprehensive elimination of health disparities in the African American communities of this nation.

An important means of conceptualizing the broad health care challenges in African American communities is through identification of the train of events cited by Keppel et al that increase the risk of primary and behavioral health problems in this population. One can hypothesize there is a connection between the extensiveness, pervasiveness, and persistence of this train of events and increased risk of physical and behavioral health problems in this population or any similar population. The train of events listed here is viewed as predictive factors that increase the risk of untreated conditions within vulnerable populations. These events are viewed as not only increasing the risk of illness but also shortening life spans and years of healthy living. In 1900, African American women had an expected life span of 33 years while their male counterparts had a life expectancy of 32.5 years. By 2000, the life expectancy of African American women had reached 70 years while the life expectancy of African American men was 64 years. White females had the longest life expectancy at 77 years and while white males had a life expectancy of 70 years. When severe mental illness is present, life expectancy has been found to decrease by 25 years (Parks, Svendsen, Singer, & Foti, 2006). The premature deaths of persons with severe mental illness are from preventable health causes that tend to go unrecognized and untreated. These findings provide further justification for a more holistic integrated approach to service design and delivery.

Train of Background Events

Unemployment
Poverty
History of Trauma
Crime Victimization
Stigma
Racial Discrimination
Limited Asset Accumulation
Hunger
Disproportionate Arrests
Substandard Housing
Accidents and Physical Injury
Absence of Health Insurance
Low Performing Schools
Involuntary Commitment
Limited Advocacy
Low Political Participation
Absence of Health Literacy
Limited Service Agencies

EPIDEMIOLOGY OF HEALTH DISPARITIES

Throughout the history of race in America, the health status of African Americans has lagged considerably behind those of whites. The disparities are reflected in diagnosis, rates or frequency of disease, types of disorders, years of quality living, and mortality. Most studies of health status include comparative ratings or rankings on 10 causes of mortality in populations. Historically, African Americans have ranked first on 8 of the 10 causes of mortality. In 1990, African Americans ranked first on 8 out of 10 causes of mortality and in 2000 also ranked first on 6 out of the same 10 causes. However, there were major reductions in numbers of deaths from these causes for all populations (Keppel et al., 2002).

Although there are long standing differences in health status or disparities, there are also key differences in help seeking behavior by race. African American populations tend to delay help seeking for primary health and behavioral health problems. Neighbors (Neighbors, 2007) indicates that these delays could extend over several decades. When racial and ethnic groups are compared on 10 leading causes of death, African American populations ranked the highest on the first six of these factors in 1990. Although significant reductions in rates per 100,000 have been made since 1990, there was no change in the rankings by 2010. African Americans ranked second in deaths from diabetes in both 1990 and 2000; third in deaths from accidents; fourth in deaths from liver disease (Keppel et al., 2002).

In 2010, close to 21% of the African American population depended on state and federal Medicaid programs to access health care, (National Center for Health Statistics, 2011). During the same year, close to 25% of the African American population lacked employer based health insurance compared to 16% of the U.S. population as a whole, (National Center for Health Statistics, 2011). Although there have been significant reductions in rates of physical illness within this population, the disparities in health status of African Americans remains a national concern (Davis, 2008).

Leading Causes of Mortality

1. Heart Diseases
2. Malignancies
3. Cerebrovascular Diseases
4. Accidents
5. Diabetes
6. Homicide
7. Liver Disease
8. Chronic Lower Respiratory Diseases
9. HIV/AIDS
10. Septicemia

(Health, United State, 2010 CDC)

HISTORY OF BEHAVIORAL HEALTH DISPARITIES

Mental health care was initiated in the United States in 1765 when the Commonwealth of Virginia opened the first mental institution. However, the prevailing theory of mental illness proposed that Africans [free and enslaved] in North America were immune from mental illness (Davis, 1998; Kramer, Von Korff, & Kessler, 1980). This theory resulted in both an absence of access to services until 1840, but subsequently created an association between race, violence, and mental illness that was carried forward well into the 20th century (Davis et al, 2010).

Virginia opened the first mental hospital in 1765 at Williamsburg. However, the theoretical assumptions that Africans in America were immune from mental disorders denied them access to services. A change in the Virginia statutes took place in 1840 that recognized the presence of severe mental illness in enslaved Africans and allowed segregated care to be provided at the Public Hospital in Williamsburg. However, the rendering of mental health care to enslaved or free Africans in America could not displace care for whites (Dain, 1968; Virginia General Assembly, 1846).

As the Civil War drew to closure, new theories were developed that predicted an exponential increase in the frequency and number of freed slaves who would develop severe mental illness. Part of the support for this revisionist theory was the belief that formerly enslaved individuals would not be able to manage the demands of democracy and freedom, however, another perspective proposed by the Freedman's Bureau concluded that formerly enslaved individuals were in need of back health, mental health, and other services (Denton, 1960). The Freedman's Bureau required that both health and mental health care become available. Virginia responded by developing the first inpatient mental health service for this population. The Central Lunatic Asylum for the Colored Insane was developed in Petersburg, Virginia in 1870. This was the first mental institution of its kind in the world exclusively for African Americans.

Theories of Race & Illness

Throughout the 18-20th centuries, three assumptions were made about race and mental illness. First, Africans were assumed to be immune from the risk of mental illness and other diseases. Second, near the end of slavery, predictions were made that Africans in America would have rates of illness that would greatly exceed that of whites. This second assumption was followed by excessively high rates of admissions and long lengths of stay for African Americans. It was not until the mid 20th century did studies show that a third theory was supported showing there was a limited linkage between race and mental illness.

(Davis, 1998)

EPIDEMIOLOGY OF BEHAVIORAL HEALTH DISPARITIES

Some studies conclude that the rates of mental illnesses show little variation by race (Fischer, 1969; Wang, 2005) over time.

The Epidemiologic Catchment Area studies estimate that close to 25-50% of a population will experience a mental health problem over their lifetime, (Kessler et al., 1994). Based on these generalized estimates, there are close to 14 million African Americans with a diagnosable mental illness in 2011.

Mental health disparities are rarely differences in prevalence and incidence of diseases or disorders by race unlike those found in health disparities. Disparities in mental health more frequently take the form of a service characteristic: access to services, accuracy of diagnoses, type of treatment, comparative effectiveness, location of services, level of cultural competency, proficiency and recovery. The Surgeon General's 2001 report documented the ongoing presence of differences in service quality and access by race and ethnicity, (Department of Health and Human Services, 2001).

The absence of access to competent behavioral health care can result in high levels of untreated illness that exacerbates unemployment, lower productivity, family burden, and homelessness.

A second key element in behavioral health disparities is the difference in help-seeking behavior by race and ethnicity. Although there are minimal differences in the rates of behavioral health disorders, African American help-seeking patterns show wide variation with other populations. Neighbors' studies show that 43% of African Americans seek help exclusively from informal sources, including relatives and friends when there is a behavioral health problem. Only 4% of African Americans seek help exclusively from behavioral health providers with less than half of this group receiving care from a community mental health center. The majority of African Americans who seek formal behavioral health care obtain that care from emergency rooms and physicians. And, 44% seek

Close to 14 million African Americans have some form of behavioral health disorder. These estimates are based on the Epidemiologic Catchment Area Study and its updates and federal data.

16.4% (6.54 million) have anxiety disorders

7.1% (2.84 million) have mood disorders

1.3% (520,000) have schizophrenia

1.2% (482,000) have severe cognitive disorders; and

9.0% (3.6 million) have substance use disorders

(Davis & Johnson, 2002)

help from both formal and informal sources, (National Center for Health Statistics, 2011).

Close to 10% of African Americans who develop behavioral health disorders will access services through churches and ministers (Neighbors et al., 1998). Of particular importance is the finding that if African Americans obtain behavioral health care first from their ministers, the likelihood of their becoming involved in a traditional mental health setting diminishes considerably. Farris (Farris, 2005) noted in her study that African American ministers tend not refer to mental health providers since they attribute causation to spiritual factors that are within their purview of intervention. This finding suggests that there is a marked absence of networking and mutual referral processes between African American ministers and behavioral health providers.

These data also confirm that African Americans significantly underutilize behavioral health care services and may over-rely on more informal approaches to behavioral disorders. Furthermore, help-seeking behavior by African Americans tends to be significantly delayed following the onset of behavioral health symptoms. Neighbors noted that after the onset of depressive symptoms [clinical and bipolar], African Americans may delay obtaining help by up to 30 years resulting in more chronic and disabling conditions, (Neighbors, 2007).

Help-seeking by African Americans with behavioral health problems is also characterized by heavy use of emergency rooms and non-compliance with medication following service use, (Chun-Chung Chow, Jaffee, & Snowden, 2003; Snowden, 2000).

These data suggest that approaches to the design and delivery of integrated or holistic care to African American populations must consider the established paths that are currently used to obtain help. It is also important to recognize the substantial strengths that have characterized these communities for decades and enabled their members to manage adversity. It is because of this history that we must further develop practice-based evidence (PBE). PBE interventions are practices developed in our communities that are successfully

Help seeking behavior involves a number of pro-active steps that take a person, family, or community from the point of recognizing a problem exists to using internal or external resources to solve, lessen, or cure the problem. The help seeking behavior of African Americans is notable by delay and reliance on the Black Church.

African American consumers tend to delay help seeking for some behavioral health problems for many years or even decades. A new approach must be found that integrates established cultural beliefs and patterns into the design and implementation of services.

(Davis, 2010)

providing high quality care even though they have yet to be formally evaluated. Through researching the core practice standards and criteria associated with the high quality care of PBEs, they can be moved on to the lists of evidence-based practices (EBPs).

SUCCESSFUL INTEGRATED CARE MODELS

Wang (2005) notes that there has been a major shift towards the provision of mental health care services within primary care settings. However, primary care physicians are rarely prepared to diagnose, treat, and provide follow-up care to individuals with significant behavioral health care problems. Part of the reason for the absence of preparation is the lack of training in psychiatric diagnosis, medications, and models of care. Although the increase in mental health care episodes occurring in primary care has been evident for a number of years, the models that have been employed have not all been subjected to rigorous study.

To date, only the collaborative care model has been subject to a number of studies that have demonstrated its efficacy with persons with behavioral health disorders. A number of these investigations have included African Americans in the samples, (Sanchez, 2011).

Three examples of holistic integrated care were presented to the dialogue participants. These included the (1) Dimock Center in Roxbury, Massachusetts; (2) Children’s Hospital and Research Center Oakland in Oakland, California; (3) BASIC, in St. Louis, Missouri and New Orleans, Louisiana. Each of these programs reflects varying levels of integration of services in primary and behavioral health while offering a range of other related services.

Models of Integrated Care

Co-location of Service Providers

Collaborative Care

Physician Training in Behavioral Health Care

Screening and Referral

School-based Service

Collaborative care has the most extensive research evidence that demonstrates its effectiveness with persons with mild to moderate behavioral health disorders.

(Alexander, 2008)

THE DIMOCK CENTER

Dimock Center is located in Boston’s inner city and is based on a co-location [integrated or holistic] model of service design and delivery. It includes 3 related components: a) health

and community services, b) child and family development services, and c) behavioral health services in its organizational structure. Dimock is the largest provider of behavioral health care services in the inner city. The 3 components provide acute treatment services, addiction and recovery, outpatient mental health, a broad range of health and dental services for adults, infants, and children. The Center provided services to over 13,000 individual patients in 2010. In its approach to integrated care, the Center provides a Head Start Program, after school services, HIV/AIDS care, shelters, permanent housing for families, and recovery homes. Future plans include broadening the concept of integration to enhance the relationships between primary care and behavioral health.

<http://www.dimockcenter.org>

CHILDREN'S HOSPITAL & RESEARCH CENTER OAKLAND **COMPREHENSIVE SICKLE CELL CENTER**

This program is based on a co-location model that applies integrated health or holistic principles to the care and treatment of individuals with sickle cell disease (SCD) and related problems. SCD is a genetic blood disorder that results in the formation of an altered form of hemoglobin. Hemoglobin is a protein that transports oxygen in the bloodstream. Individuals of all races and ancestries may be carriers of sickle cell traits but those of African, Mediterranean, Middle Eastern, and Caribbean ancestry are most often affected. The disease occurs in 1 out of every 400 Americans of African ancestry while the trait occurs in 1 in 14 Americans of African ancestry. This chronic disease can be characterized by significant pain and potential organ damage across the life span.

Children's Hospital & Research Center Oakland offers the largest program for sickle cell care and research in the Western United States. More than 450 children and 300 adults from Northern California are seen annually. The Comprehensive Sickle Cell Center operates from an integrative health perspective for inpatient and outpatient care. The center endeavors to ensure that all patients with SCD have a medical home and a primary care interface with behavioral health, education, and vocational components.

The center provides additional services funded through the Network of Care grant. Services funded through the Network of Care grant include patient support activities through case management/peer education, increased access to genetic counseling and subspecialty care, patient education/advocacy, and education of health care providers.

<http://www.casicklecell.org>

BASIC INFORMATION CENTER

The BASIC Information Center was developed in 1983 in St. Louis as a pilot program that focused on alcohol dependency and substance abuse. One of the distinguishing features of the Center is its priority on structuring services around the concept of cultural sensitivity. BASIC includes an Alcoholics and Narcotics Anonymous approach with a cultural sensitivity, cultural relevancy overlay.

The rationale for this approach reflects the philosophical view of the founder, Oval Miller. Miller proposes that communities that are marked by alcoholism and substance abuse suffer “cultural survival fatigue”. In part, he views the introduction of substances and their easy access as a deliberative effort to reduce the sense of community closure and social capital within oppressed communities. This orientation then builds in a series of holistic interventions that seek to impact the individual’s use of substances while also positively changing the environment, lifestyle, and distribution of social capital and resources. The overall goal of the BASIC Information Center is to insure that the individual becomes self-sufficient in their recovery. <http://www.basicinc.org>

CONSENSUS STATEMENTS

The participants in the dialogue were assigned to four workgroups and asked to use a basic logic model to reach consensus about the following issues:

1. Identification of the main problem
2. Strategies for approaching the problem
3. Activities or interventions associated with each strategy
4. Outcome measures for each strategy that will provide clear evidence of the level of progress
5. Accountability – identifying what person, group, community, or association is to carry responsibility for actions proposed.

Drafts of the consensus statements were circulated to each of the participants over several weeks. Each participant was asked to rank the statements on the basis of importance. The participants reduced over 150 issues to 7 they considered the most important for using an integrated approach to health care for Americans of African ancestry. The seven issues were combined resulting in the following consensus statements and recommendations.

Data gathered in the early 1900s (.Department of Commerce, 1975) identified a high frequency of social, economic, health, and mental health problems in African American communities. Many of these problems were reflections of the absence of wealth accumulation and the poor living conditions that were evident during slavery, just 35 years earlier. In addition, each of these problems appears to have been related to and exacerbated by the exceptionally high level of poverty within this population. Racial discrimination in employment, education, housing, health care, and justice circumscribed the daily life of African American families resulting in higher than expected frequencies of poor health and mortality. Although rates of socio-economic and health trauma associated with a lower quality of life were reduced significantly between 1900 and 2000, African American populations continued to rank highest in almost all categories (Gamble & Stone, 2006).

Statement of the Problem

Long-standing disparities in access to jobs, income, justice, health, education, and behavioral health care have created an environment in many African American communities that result in increased risk of trauma, disease, lower productivity and quality of life, and excess mortality. Major barriers to accessing service for behavioral health care remain.

FIRST CONSENSUS STATEMENT

A long-term response to health disparities in African American communities has been the development of informal or practice based evidence as well as the use of healers. For behavioral health care and related problems, African Americans often seek services from their houses of worship. However, there is a need to assess these interventions to determine the effectiveness of their outcomes and how the interventions can become evidence based practices.

Rubin defines evidence based practice (EBP) as the use of the “best scientific evidence available in deciding how to intervene” (Rubin & Babbie, 2008). Increasingly, human services interventions are expected to be based on research that demonstrates effective and consistent quality outcomes. Part of the impetus for the emphasis on EBPs is a shift in reimbursement policies of the federal government, state governments, and the private sectors towards research backed methods. Practice based evidence (PBE) is a series of methods that are generated from and supported by practice experience. Few of these PBEs have been subjected to scientific review and thus do not qualify as EBPs. However, many African American practitioners utilize these practice-generated approaches and propose that they obtain excellent results. The consensus of the conference participants is to identify more of these methods and subject them to assessment as a means of understanding their components and moving the approaches into evidence based status.

SECOND CONSENSUS STATEMENT

Reductions in disparities are partially dependent on the quality, quantity, and skills of the health and behavioral health workforce and the type of integrated care applied. There is a need for a more diverse workforce that utilizes culturally and linguistically proficient and competent interventions that are developed within African American communities in addition to those that may also involve adaptations of evidence-based practices from other communities.

The State of New Jersey passed legislation requiring training in cultural competence for licensure and certification (Salas-Lopez, Holmes, Mouson, & Soto-Greene, 2007). The law is based on the assumption that an increased attention to differences in culture will result in an increase in the quality of care provided by physicians and other providers.

The conference participants agreed that this assumption is a reasonable basis for increasing cultural and linguistic competence content in pre-service training as well as in continuing education. New Jersey has inserted a cultural competence requirement into licensure law far exceeding the position of other states and the federal government. Researchers should assess the effect of such a legal requirement on quality of health care outcomes for consumers of color. If there are significant improvements in outcomes expansion of the law as well as clear identification of the important features of cultural competence could be addressed in other states.

THIRD CONSENSUS STATEMENT

There is a pressing need to develop and measure a core set of practice standards and criteria that focus on holistic health, wellness, and community based standards.

In 1998, SAMHSA supported the development of standards of care for populations of color in managed health care (Davis, 1998). A similar set of standards was developed for each of four groups: African Americans, Asian American, Latino Americans, and Native Americans. In addition, a composite set of standards that applied across each of the groups was compiled (Center for Mental Health Health Services, 2000).

FOURTH CONSENSUS STATEMENT

A significant number of the health and behavioral health conditions in African American communities co-morbid with other socio-economic conditions. These co-occurring conditions include substance disorders, severe mental illness, HIV/AIDS, poverty, diabetes, heart disease, low income, unemployment, and homelessness as examples. The presence of multiple conditions increases overall health risks, stigma, costs, and health outcomes.

The Patient Protection and Affordable Care Act of 2010 [PL 111-148] seeks to reduce the multiple barriers to accessing health care by members of the general public. These provisions include restrictions on denial of insurance for pre-existing conditions, parity between health and behavioral health coverage, and elimination of a cost ceiling on health coverage. Included in this new law is an effort to decrease the number of Americans who were uninsured, vulnerable to bankruptcy because of health costs, and adult children who were summarily dropped from their parents' insurance.

RECOMMENDATIONS

“Do something,” was the consistent refrain from the participants. It was clear from the discussions that the group recognized the large number of prior meetings and reports that have had less of an impact than the group deemed valuable. The group discussion also placed a significant value on the recognition of the strengths in African American communities that have contributed to their survival, growth, and contributions – often against overt and structural inequality and racism. There is a clear need to understand the factors that exist within these communities that contribute to their ability to manage in adverse circumstances where such efforts are often viewed as unacceptable by outside groups. The presence of such strengths is important as a basis for building, sustaining, and moving the community towards greater health, wellness, and prevention. Within the existing strengths are key facilitators of or instruments that can be used for further growth and development. Thus doing something includes the recognition there is a foundation within these communities that forms a basis for change. One key foundation is the African American religious tradition where the majority of life issues are brought for resolution.

The group organized their recommendations into three overlapping areas. The first focused on policy.

POLICY RECOMMENDATIONS

- ❖ Build cultural and linguistic proficiency, competence, and awareness into specific requirements for licensure, accreditation, and certification.
- ❖ Increase the recognition in the healthcare workforce of the relationship between behavioral and physical health.
- ❖ Require the use of community based standards to measure quality of service/performance.
- ❖ Enforce existing civil and human rights laws as these apply to discrimination in health care.
- ❖ Improve data collection by demographic characteristics to insure equitable distribution of health care.
- ❖ Support incentives to increase the availability of health providers serving low-income communities
- ❖ Improve reimbursements in Medicaid and Medicare to providers who serve low-income patients.

- ❖ Modify billing in all states to allow same day services in behavioral disorders and physical health.
- ❖ Develop incentives for insuring access to services during weekends and evening hours to decrease use of emergency departments.
- ❖ Increase culturally and linguistically appropriate health information and services.
- ❖ Provide comprehensive health services across the lifespan (including, primary care, reproductive health, mental health/substance use, and dental) to prevent and address health disparities

SEED PROJECT RECOMMENDATIONS

The second set of recommendations addresses Seed Projects needed to improve health and behavioral health care services to African American populations. The discussion of Seed Projects included an emphasis on the process of honoring individuals in the community who are in recovery from addictions and mental illness. Increasingly, community based peer support services have been found to be useful in African American populations. Honoring individuals in recovery and utilizing a range of recovery services is likely to increase resilience and hope. Seed Projects that focus on recovery are of significant value in the approach to integrating care. The recommendations are the following:

- ❖ Increase Health & Wellness Promotion throughout the Lifespan
- ❖ Assess Practice Based Evidence Treatment
- ❖ Identify Key Prototypes of Care Provision
- ❖ Support Care Provision Initiatives that are Integrated
- ❖ Develop Short Training Programs in Integrated Care
- ❖ Promote Prevention Models that address Reproductive Health throughout the Lifespan
- ❖ Develop RFPs to Assess Culturally Oriented and Linguistically Appropriate Curriculum Development and Continuing Education
- ❖ Launch Multiple Health and Behavioral Health Literacy Projects – Develop Literacy Scales to Measure success
- ❖ Establish Demonstration Projects that Seek to Provide Care across the Lifespan
- ❖ Create Training Projects for Providers to Increase Skill in Pain Management
- ❖ Support Patient Navigator Programs with a Focus on Community Empowerment
- ❖ Develop Media Campaigns that Address Consumer Mistrust.

EVALUATION AND RESEARCH RECOMMENDATIONS

The final set of recommendations focuses on needed evaluation and research.

- ❖ Assess the impact of integrated care on African American populations.
- ❖ Develop a research project to study outcomes from health literacy projects to determine best practices.
- ❖ Identify clinics, programs, or services that are successfully integrating behavioral and physical health, and study for replication.
- ❖ Determine the most effective screening tools and practices to improve a patient's ability to participate fully in treatment plans and to follow medication regimen in chronic illness.
- ❖ Study the level of involvement by professional organizations in policy advocacy in physical and behavioral health.
- ❖ Conduct outreach to locate the behavioral health and primary care models of care that are demonstrating promise in the care of African Americans throughout the country.
- ❖ Develop through research of practice based evidence (PBE) programs the core practice standards and criteria associated with high quality care moving them on to the lists of evidence based practices, (EBPs).
- ❖ Conduct a literature review to identify best practices for African American populations.

CONCLUSIONS

Conference participants expressed a degree of frustration throughout their deliberations. The frustration is reflective of numerous efforts over many years to bring about a major change in the level of disparities in their communities and the trauma that result from their continuation. They summarized that frustration in the plea “Do Something”.

What should be done and by whom? This and other short conferences that have been held over several years build on overlapping themes that resonate in the history of African American communities. Those overlapping themes are community involvement, organizational activism, voluntary participation, and mutual support. These activities have been successful in reducing barriers in many social, educational, and economic areas.

Behavioral health care has not been a major priority in African American communities over many decades. These issues have been known throughout the communities but have not garnered the priority given to other social and economic or bread and butter issues such as jobs and housing. African American activism has been directed principally at civil rights issues writ large – desegregation, voting, legal justice, equal pay, jobs, non-discrimination in housing and education, and access to political office. Behavioral health has not garnered this level of priority although its effects are widely known but perhaps not as visible. In addition, African American civil rights organizations have not placed their resources towards barriers and inequities in behavioral health. To date there are few African American voluntary organizations that focus exclusively on advocacy issues related to behavioral health. Furthermore, a limited number of African Americans participate in established behavioral health advocacy organizations at the national or local level. The voices of African Americans are often not heard in these voluntary organizations that seek to influence the quality of treatment, access to services, or changes in public behavioral health policies. This is where “do something” must start.

Change in the 21st century in behavioral health will require a major investment in participation and organization. All African American health disciplines [nursing, psychiatry, psychology, dentistry, and social work] must collaborate to improve care and to develop evidence-based practices that are grounded culturally, linguistically and experientially in African American communities. Parents, caregivers, and consumers must also help to formulate advocacy organizations as well as participate in the existing advocacy efforts at the state, local, and national levels.

There are existing organizations in African American communities that need to unite their efforts and activities in ways that address the continued gaps in service, quality and meaningful access. Religious organizations too must be part of this dialogue at the community level along with the remaining civil rights organizations. In truth, health and

behavioral health are the new civil rights challenges of the 21st century. Limited change will take place without recognition of the need to increase participation, collaboration, evaluation, research, and activism at every level.

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APPENDIX A

**DIALOGUE AND STRATEGIES FOR EFFECTIVE HOLISTIC
HEALTH FOR AFRICAN AMERICANS/BLACKS**

PARTICIPANTS

Lucinda A. Acquaye, MSW
Doctoral Student
Howard University
Washington, DC 20059

Ura Jean Bailey, PhD
Graduate Professor of Human Development
Howard University
Washington, DC 20008

Tricia B. Bent-Goodley, PhD, MSW
Professor
Howard University School of Social Work
Washington, DC 20059

Betty S. Brown, PhD
Clinical Psychologist
Independent Psychologist
New Orleans, LA 70118

Lovetta A. Brown, MD, MPH
Medical Director
Mississippi State Department of Health
Jackson, MS 39215

Tracee E. Bryant, MPH
Executive Director
Black Mental Health Alliance
Baltimore, MD 21211

Nancy Carter
Principal
The Carter Group
Santa Monica, CA 90405

Melissa Clarke, MD
Medical Director
Active Health Management
Silver Spring, MD 20901

Benson George Cooke, EdD
President
The Association of Black Psychologists
Washington, DC 20040

King Davis, PhD
Professor
The University of Texas at Austin
School of Social Work
Austin, TX 78712-0358

Elmer R. Freeman, MSW
Executive Director
Center for Community Health Education Research and Service
Boston, MA 02120

Damien T. Frierson, MA, MSW
Doctoral Student
Howard University
Washington, DC 20059

Millicent Gorham, MBA
Executive Director
National Black Nurses Association
Silver Spring, MD 20910

Napoleon Higgins, MD
Black Psychiatrists of America
Washington, DC 20006

Jennifer R. Ivory, MPH
University of Arkansas for Medical Sciences
Little Rock, AR 72223

Theopia R. Jackson, PhD
Staff Psychologist
Children's Hospital & Research Center Oakland
Department of Psychiatry
Oakland, CA 94506

Kimberly Jeffries-Leonard, PhD
Chief Operating Officer
District of Columbia Department of Health
Washington, DC 20002

Victor L. Jones
Howard University
Washington, DC 20059

Lanetta Jordan, MD, MPH, MSPH
Director, Sickle Cell Services, and
Chief Medical Officer, Sickle Cell Disease Association America
Memorial Healthcare System
Hollywood, FL 33025

Pascale Leone, MPP
Senior Program and Policy Associate
Black Women's Health Imperative
Washington, DC 20036

Rufus Sylvester Lynch, DSW, ACSW
President and Principal Investigator
Institute for the Advancement of Working Families
Philadelphia, PA 19151-2304

Oval L. Miller, BA
CEO/Founder
Black Alcohol/Drug Service Information Center Inc
St. Louis, MO. 63103

Myechia Minter-Jordan, MD, MBA
Chief Medical Officer
Dimock Community Health Center
West Roxbury, MA 02132

Rev. Darlene R. Nipper
Deputy Executive Director
National Gay and Lesbian Task Force
Washington, DC 20005

Allessia P. Owens, LMSW
Doctoral Student
Howard University
Washington, DC 20059

Walter R. Owens, DDS
President
National Dental Association
Washington, DC 20010

Joe D. Powell, LCDC
Board Chairman
National Leadership Council for African American Behavioral Health
Executive Director
Association of Persons Affected by Addiction
Dallas, TX 75219

Annelle B. Primm, MD, MPH
Deputy Medical Director
Director, Minority and National Affairs
American Psychiatric Association
Arlington, VA 22209

Ernest Quimby, PhD
Graduate Associate Professor
Howard University
Department of Sociology & Anthropology DGH
Washington, DC 20059

Alondra Raphael, MSW
Social Gerontologist
AV Adult Day Care
Canyon Country, CA 91387

Deborah Reid, MPS, JD
Senior Attorney
National Health Law Program (NHeLP)
Washington, DC 20005

Bambade Shakoor-Abdullah, PhD
Executive Director
Leadership Development Institute
South Holland, IL 60473

Altha J. Stewart, MD
President
Stewart Behavioral Health Associates
Memphis, TN 38111

Janet Taylor, MD, MPH
Psychiatrist
National Black Women's Health Imperative
Chappaqua, NY 10514

Levi Thomas, BA Social Work
Executive Director
United Family Services, Inc.
Pine Bluff, AR 71611

Michael Torres, MD
President
Center for the Integration of Spirituality and Mental Health Inc.
Baltimore, MD 21230

Leonard Weather, MD
President
National Medical Association
Shreveport, LA 71118

Freddie White-Johnson, M.P.P.A.
President
Fannie Lou Hamer Cancer Foundation
Ruleville, MS 38771
Program Director
Mississippi Network for Cancer Control & Prevention
University of Southern Mississippi
Greenwood, MS 38930

Tony L. Whitehead, PhD, MS.Hyg
Professor of Medical Anthropology
University of Maryland College Park
College Park, MD 20742

FEDERAL REPRESENTATIVES

Beth Bowers, MSW, MDiv
Mental Health Analyst
US DHHS, Office of Minority Health

Teresa Chapa, PhD, MPA
Senior Policy Advisor, Mental Health
US DHHS, Office of Minority Health

Garth Graham, MD, MPH
Deputy Assistant Secretary for Minority Health
US DHHS, Office of Minority Health

Carmen Moten, PhD, MPH
Program Director
National Cancer Institute
National Institutes of Health

Tarsha M. Wilson, Ph.D., MSW, LGSW
Lieutenant Commander, United States Public Health Service
Public Health Analyst
US DHHS, HRSA Office of Women's Health

APPENDIX B

EVENT AGENDA

***Dialogue and Strategies for Effective Holistic Health for
African Americans/Blacks:
Addressing the Integration of Behavioral Health and Primary Care***

August 19 - 20, 2010

Washington, DC

Thursday, August 19th --- Day 1

6:30 AM – 9:00 AM: **Breakfast** In hotel restaurant with ticket

8:00 AM – 9:00 AM: **Registration**

9:00 AM – 9:10 AM: **Welcome & Introductions**

Beth Bowers, M.S.W., M.Div.

Office of Minority Health

United States Department of Health and Human Services

Garth Graham, M.D., M.P.H.

Deputy Assistant Secretary for Minority Health

Office of Minority Health

United States Department of Health and Human Services

9:10 AM – 9:20 AM: **Overview of Meeting Agenda and Goals**

Beth Bowers, M.S.W., M.Div.

9:20 AM – 9:55 AM: **Significance of the Dialogue**

***History of Behavioral Health for African Americans &
Current State of the Need for Holistic/Integrated Care***

King Davis, Ph.D.

School of Social Work

University of Texas, Austin, Texas

9:55 AM - 10:20 AM: **Group Introductions**

- 10:20 AM – 11:40 AM:** **Panel 1 – Successful Integrated Care Models**
Moderator: Tracee Bryant, M.P.H.
Black Mental Health Alliance for Education & Consultation, Baltimore, MD
- Oval Millar, Sr.*
B.A.S.I.C.
St. Louis, Missouri & New Orleans, Louisiana
- Theopia Jackson, Ph.D.*
Oakland Children’s Hospital
Oakland, California
- Myechia Minter-Jordan, M.D., M.B.A.*
The Dimock Center
Roxbury, Massachusetts
- 11:40 AM – 11:55 AM:** **Break**
- 11:55 AM – 1:10 PM:** **Panel 2 – Issues Critical to Successful Integrated/Holistic Care**
Moderator: Tricia Bent-Goodley, Ph.D.
School of Social Work, Howard University, Washington, DC
- Lanetta Jordan, M.D.*
Memorial Hospital
Hollywood, Florida
- Deborah Reid, J.D.*
National Health Law Program
Washington, DC
- Rev. Darlene R. Nipper*
National Gay and Lesbian Task Force
Washington, DC
- 1:10 PM – 2:00 PM:** **Networking Lunch** provided on-site
- 2:00 PM – 2:15 PM:** **Review of Roundtable Assignments and Expected Outcomes**
- Altha Stewart, M.D.*
Memphis, Tennessee

2:30 PM -4:30 PM: Roundtable Break-Outs

- | | |
|------------------|------------------------|
| A) Mental Health | - <i>Olympic Room</i> |
| B) Substance Use | - <i>Bryce Room</i> |
| C) Primary Care | - <i>Yosemite Room</i> |
| D) Training | - <i>Grand Teton</i> |

4:30 PM: Adjourn

Friday, August 20th --- Day 2

6:30 AM – 8:30 AM: Breakfast In hotel restaurant with ticket

8:30 AM – 8:45 AM: Overview of Day One

King Davis, Ph.D.

Review of Roundtable Assignments

Altha Stewart, M.D.

9:00 AM – 10:15 AM: Roundtable/ Break-Out Discussions (continued)

- | | |
|------------------|------------------------|
| A) Mental Health | - <i>Olympic Room</i> |
| B) Substance Use | - <i>Bryce Room</i> |
| C) Primary Care | - <i>Yosemite Room</i> |
| D) Training | - <i>Grand Teton</i> |

10:15 AM – 10:30 AM: Break

10:30 AM – 11:45 AM: Roundtable/ Break-Out Discussions (continued)

- | | |
|------------------|------------------------|
| A) Mental Health | - <i>Olympic Room</i> |
| B) Substance Use | - <i>Bryce Room</i> |
| C) Primary Care | - <i>Yosemite Room</i> |
| D) Training | - <i>Grand Teton</i> |

12:00 PM – 1:30 PM: Working Lunch & Dialogue

12:15 PM – 12:30 PM: Presentation of Individual Roundtable Recommendations

12:30 PM – 1:30 PM: Open Dialogue

1:30 PM – 1:45 PM:	Break
1:45 PM – 3:45 PM:	Consensus Building & Prioritizing
3:45 PM – 4:00 PM:	Overview of Next Steps and Closing Remarks
4:00 PM:	Adjourn