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Sustainability in Primary Care and Mental Health Integration Projects in Veterans Health Administration

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Abstract

Objective—To explore staff perceptions about sustainability, commitment to change, participation in change process, and information received about the change project within the Veterans Administration Primary Care and Mental Health Integration (PC-MHI) initiative and to examine differences from the Veterans Health Administration Mental Health Systems Redesign (MHSR) initiative.

Data Sources—Surveys of change team members involved in the Veterans Affairs PC-MHI and MHSR initiatives.

Study Design—One-way analysis of variance examined the relationship between commitment, participation and information, and sustainability. Differences in PC-MHI sustainability were explored by location and job classification. Staff sustainability perceptions were compared with MHSR results.

Principal Findings—Sustainability differed by staff discipline. Difference between MHSR and PC-MHI existed by job function and perceptions about the change benefits. Participation in the change process and information received about the change process were positively correlated with sustainability. Staff commitment to change was positively associated with staff perceptions about the benefits of change and staff attitudes toward change.

Conclusions—Sustainability is an important part of organizational change efforts. Change complexity seems to influence perception about sustainability and impacts staff perceptions about the benefits of change. These perceptions seem to be driven by the information received and opportunities to participate in the change process. Further research is needed to understand how information and participation influence sustainability and affect employee commitment to change.

Keywords

integration; mental health; primary care; sustainability; Veterans Health Administration

Veterans Health Administration (VHA) has made a major effort to meet very high standards in the delivery of health care, in general, and mental health care, in particular. The VHA aspires to a system of care that is population-focused, evidence-based, team-delivered, and veteran-centric. Its goals for excellence in the delivery of mental health care are clearly delineated in the *Uniform Mental Health Services Handbook*.¹ Leaders in VHA recognized early on that merely identifying appropriate practices for the facilities to use would not be sufficient. They would also need to develop the skills and motivation necessary to implement and sustain of these practices. In rolling out goals and practices, one tool available to Veterans Integrated Service Network (VISN) and Mental Health leaders was the Mental Health Systems Redesign (MHSR) project (based on the Institute for Healthcare Improvement model), which was designed to help the VISN and facility mental health leaders learn skills to make the necessary and sustained changes in their systems of care. Staff from all Veterans Affairs (VA) medical centers created a team to select and implement a process improvement project focusing on topics such as managing patient flow, clinical care, and improving access.

Our group previously investigated the characteristics of the change processes in the MHSR project. We explored whether the changes pursued had characteristics of sustainability per the perceptions of the members of the change team.³ The British National Health Service's Sustainability Index (SI) measured staff perceptions. In brief, we found significant heterogeneity in the scores achieved on the SI across VISNs, facilities, and types of staff members replying. Four of the 21 VISNs (19%) with survey responses had scores in the range that would predict lack of sustainability in the British system. Employee perceptions about their involvement, as well as the perceived benefits and credibility of the change differed by job classification, such that administrators rated aspects of change more highly than clinicians. Thus, despite mental health change leaders' involvement in nationwide learning collaborative and coaching efforts at the VISN level, the characteristics thought to be linked to sustainability were rated very differently across projects, VISNs, and types of employees.

The *Uniform Mental Health Services Handbook* mandates the implementation of Primary Care and Mental Health Integration (PC-MHI).⁴⁻⁸ Integration of primary care and mental health services was required in all VA medical centers and large community-based outpatient clinics. Such efforts require a cross-departmental collaboration to design and implement a new system of care to serve all of Veterans' physical and behavioral health needs. Goals of PC-MHI are to (1) promote effective treatment of mental health and substance abuse disorders in primary care settings and (2) increase access to improve the quality of care by addressing unmet treatment needs.^{4,8}

Recently, the VHA Office of Mental Health Operations has promulgated the first report (with many to come) on the progress of VHA facilities and VISNs in implementing these programs and on their effectiveness. Despite the fact that PC-MHI has been rigorously and

repeatedly determined to be effective in decreasing depressive symptoms, improving mortality rates, and decreasing suicidality of depressed veterans and other subjects in primary care clinics,^{9–11} the Office of Mental Health Operations report noted that the implementation of integrated mental health services in primary care (using a blended model of collaborative, colocated care, and disease care management) was lagging behind other implementations of evidence-based practices.¹² The report indicated that there is marked variation in the penetrance rate despite steady growth during the past 3 years. In the fiscal year (FY) 2010, 4.7% of all veterans seen in a primary care setting received integrated treatment, with 5.3% in FY2011, and 5.6% in the first quarter of 2012. The variation across VISNs ranges from 3% to 10% nationally, based on data reported in the VHA PC-MHI Dashboard for the first quarter of 2012, and the variation in penetrance within VISNs is even greater. For example, the rate in an upper Midwestern network composed of 7 medical centers and 30 community outpatient clinics ranged from 3% to 14%.

The PC-MHI intervention differed from the MHSR initiative because of its complexity and mandated top-down changes. Thus, we wondered whether the complexity of the PC-MHI protocols and procedures, and changes driven from the top-down versus participant-developed change projects, would be perceived to be particularly difficult to implement. The context of this study is also important in that we studied PC-MHI versus MHSR implementation in 2 VISNs. The first VISN is an upper Midwestern network composed of 7 medical centers and more than 30 community outpatient clinics. The second VISN is a northeast network composed of 6 medical centers and more than 30 community outpatient clinics. Thus, our study of heterogeneity of implementation and perceived sustainability in these VISNs could inform future efforts to implement other complex changes across the VA.

In addition to British National Health Service's SI measures, we chose to assess affective commitment to the changes specified in the PC-MHI projects, as we hypothesized that the differences we saw in previous studies between clinicians and administrators might reflect a different level of commitment. Employees (including clinicians) play an important role in the implementation and sustainability of quality improvement efforts.¹³ Their role translates into their commitment to the change process. As organizations adapt and transform, it is important that efforts to manage the introduction of new processes or ideas influence employees' affective commitment toward change. Building on organizational commitment research, Herscovitch and Meyer¹⁴ developed a model to assess employee commitment to organizational change. The employee commitment to organizational change model examines employee commitment to a specific change within the organization. It defines commitment as “a force (mind-set) that binds an individual to a course of action deemed necessary for the successful implementation of a change initiative.”^{14(p475)} Recent studies have examined how employee commitment to a change process is shaped by an employee's perceived locus of control and organizational identification^{15,16} and influenced by trust, belief in organizational leadership, and leadership style.^{17–19}

Some of the attributes related to information about the change and participation in the change process that influence employee commitment to change also facilitate or impede change sustainability. For example, a locally generated change idea based on staff needs and supported by an internal champion helps create an intrinsic staff motivation to participate in

the change process. Involvement of staff in quality improvement efforts adapts the change process to the local environment. Parker and colleagues²⁰ classified it as a local participatory approach to quality improvement. Through involvement in the change process, staff attitudes toward change increase the quality and likelihood of sustaining that change.²¹⁻²⁷ Thus, we hypothesized that some deficits inherent in VA-wide mandated changes in terms of affective employee commitment might exist but that these might vary across types of programs and types of employees.

Thus, we surveyed staff involved in PC-MHI implementation efforts from 2 VISNs with ongoing effort to integrate primary care and mental health services. We assessed their responses to the SI and compared them with the responses of participants in other VA mental health implementations, as well as with the standards for these instruments. Because of the complexity of the intervention and that top-down changes were mandated, we hypothesized that PC-MHI perceived sustainability would be lower than for other MH implementations. In other words, staff perceptions of sustainability would differ when they had input in the change process versus having the planned changes being more directive. We also assessed staff perceptions about their commitment to change, participation in and information received about the change process. We predicted that PC-MHI Affective Commitment would be lower than for usual implementations. We predicted that there would be significant differences across classes of employees.

Methods

Study population

We worked with the leadership of the 2 VISNs to get a list of individuals, including physicians, nurses, social workers, and support staff ($n = 106$) involved in PC-MHI initiatives in the 2 VISNs. We sent e-mail invitations asking respondents to voluntarily complete a brief 29-item online survey. Follow-up e-mails were sent as reminders to increase the overall survey response rate. University of Wisconsin Madison researchers functioned as outside evaluators and received and analyzed survey results. Anonymity was promised to all persons completing the survey. No identifiable data or information was shared with any VHA employees or officials. The University of Wisconsin Madison Health Sciences Institutional Review Board approved the research as exempt.

Outcome measures

The online survey assessed staff perceptions related to sustainability, affective commitment to the change, participation in the change process, and information received about the change project.

Sustainability propensity was measured using the British National Health Service's SI.^{22,28} Affective commitment to change assesses the desire of employees to provide support for the change based on a belief in its inherent benefits, not in the correctness of the change.¹⁴ It is measured using the 6-item scale ($\alpha = .92$). Sample items include "This change was a good strategy for this organization" and "This change was not necessary (reverse scored)." In this pilot study, employees were asked to assess their commitment to PC-MHI.

Change Participation is a 4-question scale that was developed to assess an employee's perceived level of participation during an organizational change.²⁹ It was designed to measure employee perceptions regarding their input into the change process. Items focus on employee awareness of opportunities to help introduce the change, ask questions about the change, and participate during the implementation of the change within the organization. For example, "I was able to participate in the implementation of this change." Using employees in the public housing and community development sector, the scale was tested and validated ($\alpha = .72$).

Quality of Change Information is a 4-question scale designed to measure the usefulness and value of the information about the change.³⁰ Sample items include "The information received about this change was useful" and "I was able to ask questions about this change." It was validated in studies ($\alpha = .87$) assessing employee openness to organizational change and acceptance of the organizational change.^{29,30}

In this pilot study, employees responded to each of these scales using a 5-point scale ranging from 1 ("strongly disagree") to 5 ("strongly agree").

Demographic questions included gender, race, ethnicity, and information about job function (eg, administration/management, clinical, clerical/reception); discipline (physician, psychiatrist, nurse, nurse practitioner, licensed practical nurse, psychologist, and other), employment status (full time, part time, contract, and other); and facility and VA tenure.

Analysis

We conducted the analysis in 2 phases. The first part of the analysis explored the survey responses for the PC-MHI initiative in the 2 VISNs. Specifically, we looked at respondent demographics. We employed a 1-way analysis of variance to examine differences in sustainability, employee commitment, and participation and information scores across facilities, by job classification and staff discipline (eg, psychiatrist, social worker). We also explored the correlations between employee commitment, participation and information, and sustainability scores.

The second part of the analysis explored staff perceptions about sustainability when they participated in the identification, selection, and implementation of the change project (MHSR) versus when the project changes were driven using a top-down approach (PC-MHI). In other words, do staff perceptions about sustainability differ on the basis of the complexity of the change and whether the change is driven from the bottom-up as compared with top-down change? We explored differences in respondent demographics and sustainability. The data set for analysis included those staff from 2 VISNs who participated in the PC-MHI ($n = 64$) and included only staff in the 2 VISNs who participated in the MHSR initiative ($n = 50$). The analysis for the overall SI score and the subscales of Process, Staff, and Organization was limited to those respondents who answered all questions within the subscale, Process ($n = 4$), Staff ($n = 4$), or Organization ($n = 2$), or all 10 questions for the overall SI.

Key findings

Participant characteristics—Surveys were sent to 106 VA personnel involved in PC-MHI in the 2 VISNs. A total of 64 (60.4%) responses were received; however, only 51 of the surveys had useable data. Staff demographics are in given in Table 1. Respondent disciplines were nurse, licensed practical nurse, or nurse practitioner ($n = 23$, 35.9%), social workers ($n = 19$, 29.7%), physician or psychiatrist ($n = 11$, 17.2%), or psychologist ($n = 9$, 14.1%). Most respondents were clinicians (79.7%) who worked full time (87.3%) and were females (68.8%). Demographics of this sample differed from those staff from the same 2 VISNs who were surveyed in the MHSR initiative.³ Although the results (Table 1) showed a significant difference in the distribution of respondents by job classification ($\chi^2 = 24.25$, $P = .000$), it is primarily due to how the PC-MHI sample was derived. Differences in tenure also existed between the 2 initiatives. Respondents in the PC-MHI had been employed in the VA on average 5 years less than those persons in the MHSR project (9.1 years vs 13.9 years, $P = .010$) and at their respective facilities, approximately 5.6 years less than the MHSR respondents from the same 2 VISNs.

Table 2 shows the average employee responses for the questions related to sustainability propensity, affective commitment to change, participation in the change process, and information received about the change. The average overall sustainability score across all respondents was 55.50, a score at a level indicating that change may not be sustained within the organization. The average employee response on the other 3 scales was at or below the median scale response. With the exception of the effectiveness question ($P = .048$), the small number of responses did not indicate that significant differences existed across responding facilities. Staff members who identified themselves as physicians, psychiatrists, or psychologists differed in their perceptions about the benefits of the change as compared with social workers ($\mu = 1.86$ vs $\mu = 4.78$, $P = .038$). In other words, the social workers were more likely to perceive that the changes would improve efficiency and make their jobs easier. No differences existed by job classification in the PC-MHI initiative.

Relationship of commitment, participation, and information to sustainability—

We explored the relationship between staff perceptions about sustainability and their affective commitment to the change (ie, Do they believe in the value of the change and actively support it?), their ability to participate in the change process, and their belief that they received adequate information about the change. The results indicate a significant positive correlation between the Participation scale and all parts of the SI (see Table 3). In this pilot study, employee perceptions about the amount of information received about the change process were positively correlated with most parts of the SI except for the questions related to adaptability and senior leadership. Results from the analysis also found significant correlations between an employee's affective commitment to the change and Benefits of the Change and the Affective Commitment to Change Scale ($r = 0.369$, $P = .009$) and staff attitudes toward the change ($r = 0.355$, $P = .012$). A significant positive correlation also exists between the Process subcategory and the Affective Commitment to Change Scale ($r = 0.290$, $P = .045$). To further explore the relationship, we used the median overall sustainability score to create a high-sustain group versus low-sustain group. We compared the difference in the affective commitment to Change, Participation, and Information scale

scores in these 2 groups. Although no difference for affective commitment existed, respondents in the high-sustain group had significantly higher Participation (3.71 vs 2.53, $P = .001$) and Information (4.02 vs 3.06, $P = .001$) scale scores. In other words, staff members who perceived a higher likelihood that the changes would be sustained believed that they had more opportunities to participate in the change process and received more information about the change.

Differences in sustainability perceptions: MHSR versus PC-MHI—We explored how staff perceptions about sustainability differed by comparing how staff members within the 2 VISNs differed in their perceptions about sustainability between the PC-MHI and MHSR initiatives. The analysis focused first on responses to the 10 individual questions in the SI and then explored the differences across the 3 subcategories in the SI: Process, Staff, and Organization. The PC-MHI respondents perceived their processes as significantly less likely to be consistent with sustainability than MHSR respondents. The results found significant differences between staff perceptions of sustainability for 1 question (Table 4). Staff involved in the PC-MHI initiative had a lower perception of the Benefits of the Change (PC-MHI = 3.60 vs MHSR = 5.38, $P = .010$). We looked closer at the response distribution for this question. The Figure shows that more MHSR respondents thought that the change improved efficiencies and made jobs easier whereas respondents in the PC-MHI initiative thought that the change did not improve efficiencies or make jobs easier. The overall difference in the distribution was significant ($\chi^2 = 9.02$, $P = .029$). The results also indicated that staff perceptions about the overall process of sustaining change (eg, the Process subcategory) were also significantly less for staff who participated in the PC-MHI initiative versus the MHSR initiative in the 2 VISNs ($P = .49$).

Although the results indicated no difference within the PC-MHI initiative by job classification, we also explored staff perceptions about sustainability across the 2 initiatives. Because of the small sample of clerical and other support staff ($n = 4$) and clinician administrators ($n = 10$), we excluded these groups from the analysis. The results found that administrators in the PC-MHI initiative have a significantly lower perception of whether the benefits of the change would make jobs easier and improve efficiency ($\mu = 3.92$ vs $\mu = 6.35$, $P = .029$). This same group was also less likely to believe that the process could be adapted to other organizational changes and that a system was in place to support continuous improvement of the PC-MHI efforts ($\mu = 3.91$ vs $\mu = 5.82$, $P = .039$). For the clinician-only group, the results yielded no significant differences between the 2 studies. The P values for each sustainability question were greater than .60 except for staff involvement ($P = .21$). In this case, the PC-MHI clinicians rated their involvement higher (6.53 vs 4.83) than their peers in the MHSR initiative within the 2 VISNs.

Discussion

Efforts to sustain changes associated with PC-MHI are challenging.⁴ As hypothesized, staff members in the PC-MHI initiative did not perceive their projects as having a strong potential for sustainability. They rated all 10 items in the SI as lower than did MHSR respondents. PC-MHI staff ratings of the process factor were significantly lower than those of MHSR staff. Also as hypothesized, staff members differed in their sustainability ratings, with

psychiatrists and psychologists rating the benefits to patients and staff as less credible than social workers. We did find as hypothesized that some deficits existed in terms of affective commitment to change, but there was not a difference across programs and types of employees. Staff perceptions about participation in the change and information received about the change were positively correlated with sustainability and with affective commitment to change.

Prior to this study, we speculated that the reason for reported lags in PC-MHI implementation in the VA was due to the complexity of this change. Changes in scheduling, veteran behavior, primary care provider behavior, and mental health care provider behavior were all required. Complexity of the change process seems to affect staff perceptions regarding the likelihood that the changes will be sustained successfully. Staff members in the PC-MHI initiative were less likely than their colleagues in the MHSR initiative to believe that the changes will improve efficiency and make their jobs easier. The difference may be influenced in how the change projects were selected. Staff members in the MHSR initiative had more input into the selection of the change project and as a result, they, through participation, may have better understood how the change would improve overall efficiency. However, it is not clear how participation in the change process influenced staff perceptions about sustainability. Future research should explore this relationship.

Previous research indicated that staff (clinicians vs managers) had different opinions about whether the benefits of the change were immediately obvious and supported by evidence.³ The small sample size in this pilot study, combined with the fact that the majority of the respondents were clinicians, influenced the results. A comparison across the 2 initiatives within the 2 VISNs was a little more informative despite the small sample size. The results seem to show that intervention complexity and the top-down approach to change influence administrator perceptions about the benefits associated with and the adaptability of the change. From a clinician's perspective, the results may indicate that whether the intervention is complex and top down or simpler and bottom up has limited their belief in the sustainability of a new program or practice. It may also speak to the nature of the change efforts, as clinicians in the PC-MHI believed that they were more actively involved. Future research should explore how the directional implementation and change complexity individually and in conjunction influence staff perceptions of sustainability both within and across job classifications.

The results also indicate that the discipline of the respondent (eg, nurse vs social worker vs physician) may influence their perceptions about sustainability for several questions, including benefits beyond helping patients, effectiveness of the monitoring system, senior leadership support, and the infrastructure to support change. The small sample size limits the generalizability of these results. Future studies should evaluate whether any formative differences across disciplines exist with the VHA.

This is one of the first studies to explore the relationship between sustainability and employee commitment to change. Although limited by the sample size, results seem to imply that staff beliefs about the benefits of the change and their attitudes toward sustaining the change may affect their affective commitment to the change process. The literature on

employee commitment to change indicates that commitment is a target of employee behavior and is influenced by antecedents associated with the change.^{14,31} Similarly, staff perceptions about sustainability could be considered a targeted behavior that an organization might want to influence. Exploratory regression analyses examined predictors of overall sustainability propensity and affective commitment to change. In each case, staff demographic variables (tenure, job, and discipline) as well as perceptions about their ability to participate in the change process and information received about the change process were independent variables. Participation in the change process was the only significant predictor of sustainability propensity ($F = 38.6$, $P = .000$) and affective commitment to change ($F = 6.8$, $P = .012$).

The relationship between higher staff perceptions of sustainability and higher participation and information scores is also important. It provides some evidence supporting the findings that successful efforts to the integration of primary care and mental health services are prevalent in the programs with high-functioning teams, a strong passion for service integration, and a solid primary care physician and behavioral health partnership.⁴ These results also provide evidence of the importance for organizations to adapt strategies to increase staff involvement in the change process and effectively share information about the impact of the change.^{23-27,32-35} However, the applicability of these findings is limited. Questions remain about the role of participation and information within a quality improvement effort. For example, it has been suggested that the source of information is critical and competing demands may influence quality improvement participation.²⁰ Future research needs to explore how information types and sources as well as how levels of participation and competing demands influence commitment to change and employee perceptions of sustainability propensity.

Limitations

The small sample size is a limitation of this study (nonrandom/convenience). The sampling was limited only to staff who participated in the PC-MHI initiative within the 2 VISNs. As a result, the sampling process seems to have only solicited responses from clinicians and not clerical or administrative staff. The absence of these staff in the survey may have limited the discovery of differences in perceptions about sustainability exist across job categories. Since staff from only 2 VISNs were included in the sample, a future study involving a larger sample across multiple VISNs is needed to better generalize the findings within the VHA. The results also reflect staff perceptions of organizational change only within the VHA. Further research is needed to evaluate whether similar results are present in other health care delivery systems.

Conclusion

Sustainability is an important part of organizational change efforts. Results from this study highlight that efforts to sustain more complex changes such as PC-MHI are more challenging than projects targeting systems redesign, which often focus on one specific outcome such as wait times. It also indicates that employees' perception about the change process and their commitment to change are related to staff's perception of sustainability of

organizational change. The role of change in the organization in improving efficiency and making jobs easier is a crucial component associated with staff perceptions of its benefits. These perceptions seem to be driven by the type of information that is received about change and opportunities to participate in the change process. In turn, information and participation may lead to increased employee commitment to change. Despite the promising findings, organizations will still need to explore how they can use information and participation to influence the likelihood that change will be sustained. The SI and employee commitment to change surveys are useful tools for this endeavor.

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Figure.

Staff response distribution for benefits to change question. MSHR indicates Mental Health System Redesign; PC-MHI, Primary Care and Mental Health Integration.

Table 1
Respondent Demographics: PC-MHI Versus MHSR

Employee Demographics	% (n)		χ^2	<i>P</i>
	PC-MHI	MHSR ^a		
Gender			5.63	.060
Male	29.7 (19)	22.5 (9)		
Female	68.8 (44)	65.0 (26)		
Refused/no response	1.6 (1)	12.5 (5)		
Discipline within VA				
Nurse, LPN, or nurse practitioner	35.9 (23)			
Social worker	29.7 (19)			
Physician or psychiatrist	17.2 (11)			
Psychologist	14.1 (9)			
Clerical	1.5 (1)			
No response	1.5 (1)			
Job classification			22.60	.000
Administration/management	14.1 (9)	42 (21)		
Clinician	79.7 (51)	36.0 (18)		
Clinical administrator/management	4.8 (3)	14.0 (7)		
Clerical/reception	1.6 (1)	8.0 (4)		
	Mean (SD)	Mean (SD)	<i>F</i>	
Average tenure, years				
Facility tenure	7.9 (8.2)	13.5 (10.0)	10.42	.001
VA tenure (staff survey)	9.1 (9.3)	14.2 (10.2)	7.57	.006

Abbreviations: LPN, licensed practical nurse; MHSR, Mental Health Systems Redesign; PC-MHI, Primary Care and Mental Health Integration; VA, Veterans Affairs.

^aTen respondents for the 2 VISNs for the MHSR study did not respond to the gender question. Discipline data were not collected as part of the MHSR initiative.

Table 2
PC-MHI Average Respondent Scores

	n	Mean (SD)
Sustainability questions		
Benefits	51	3.60 (3.29)
Credibility	51	4.69 (2.97)
Adaptability	51	4.51 (2.46)
Effectiveness	49	4.15 (2.32)
Staff involvement	48	6.26 (4.02)
Staff attitudes	50	4.49 (4.47)
Senior leadership engagement	50	8.40 (5.09)
Clinical leadership engagement	48	10.59 (5.32)
Organization	49	4.16 (2.64)
Infrastructure	49	4.26 (3.64)
Process subcategory score	49	17.03 (8.83)
Staff subcategory score	46	29.88 (14.89)
Organization subcategory score	49	8.42 (5.64)
Total sustainability score	46	55.50 (27.38)
Affective commitment to change	49	1.83 (0.77)
Participation in the change process	49	2.84 (1.23)
Information about the change process	49	2.44 (1.04)

Abbreviation: PC-MHI, Primary Care and Mental Health Integration.

Table 3
Correlations among Survey Items

	Affective Commitment to Change	Participation in the Change Process	Information About the Change
Affective commitment to change			
Participation in the change process	0.372 ^a		
Information about the change	0.301 ^b	0.733 ^a	
Sustainability: Benefits of the change	0.369 ^a	0.580 ^a	0.521 ^a
Sustainability: Credibility of the benefits	0.096	0.343 ^b	0.352 ^b
Sustainability: Adaptability of the improved process	0.234	0.443 ^a	0.273
Sustainability: Effectiveness of the system to monitor progress	0.203	0.490 ^a	0.297 ^b
Sustainability: Staff involvement	0.015	0.392 ^a	0.370 ^b
Sustainability: Staff attitudes	0.355 ^b	0.605 ^a	0.532 ^a
Sustainability: Senior leadership	0.116	0.473 ^a	0.214
Sustainability: Clinical leadership	0.161	0.531 ^a	0.583 ^a
Sustainability: Fit within the organization	0.163	0.545 ^a	0.351 ^b
Sustainability: Infrastructure	0.223	0.398 ^a	0.366 ^b
Sustainability: Organization category	0.220	0.511 ^a	0.400 ^a
Sustainability: staff category	0.212	0.662 ^a	0.582 ^a
Sustainability: Process category	0.290 ^b	0.588 ^a	0.469 ^a
Total sustainability score	0.254	0.671 ^a	0.560 ^a

^aCorrelation is significant at the .01 level (2-tailed).

^bCorrelation is significant at the .05 level (2-tailed).

Table 4
Staff Sustainability Perceptions: A Comparison of Results from the PC-MHI Versus MHSR Initiatives

SI Category	SI Question	Average Response		Number of Respondents		P
		PC-MHI	MHSRD	PC-MHI	MHSRD	
Process	Benefits ^a	3.60	5.38	51	44	.010
	Credibility ^b	4.69	5.66	51	44	.081
	Adaptability	4.51	5.18	51	44	.174
	Effectiveness	4.15	4.29	49	44	.781
Staff	Staff involvement	6.26	6.58	48	42	.702
	Staff attitudes	4.49	5.53	50	44	.229
	Senior leadership	8.40	9.91	50	44	.180
	Clinical leadership	10.59	10.96	48	44	.735
Organization	Organization	4.16	4.57	49	43	.449
	Infrastructure SI category	4.26	4.90	49	41	.392
	Organization level	8.42	9.53	49	41	.322
	Staff level	29.88	33.00	46	42	.321
	Process level ^a	17.03	20.50	49	44	.049
	Total sustainability	55.50	63.79	46	39	.151

Abbreviations: MSHR, Mental Health System Redesign; PC-MHI, Primary Care and Mental Health Integration; SI, Sustainability Index.

^a Significant at $P > .050$.

^b Significant at $P > .10$.